

Gender Transition for Children: Cautionary Tales

by Ann Schneible

As the U.S. battles an unprecedented shortage in infant formula, Daisy Strongin — newly married and expecting her first child — knows that she will never be able to breastfeed her new baby, due to the double mastectomy she had once believed would help align her body with her masculine identity. “The top surgery is hard for me because I can’t breastfeed,” said Strongin, who began identifying as transgender while in high school. “Also, there’s a formula shortage, so that even more makes me wish that I hadn’t cut my breasts off.”

Despite her voice having been permanently deepened by nearly four years on testosterone — “That has been easier for me to accept as a lifelong thing,” Strongin said — she considers herself lucky. She hasn’t lost her fertility or suffered any other physiological consequences, other than having to occasionally shave her face.

Strongin joins a rapidly growing community of “detransitioners” — people who formerly identified as transgender — who experience regret after having taken steps to transition into the opposite sex. This community consists largely of young people, predominantly girls, many of whom had started self-identifying as transgender well before the age of 18.

This demographic is reflective of a 2018 report out of the U.K. that shows a 4,400% increase over the past 10 years in the number of adolescent girls seeking “gender-reassignment” interventions. In the decades leading up to this new phenomenon, the overwhelming majority of people who sought such treatment were adult men. “I think it really has to do with teenage girls,” Strongin said, “coming together and forming communities where they sort of share their own pain, but often — unintentionally — [they] wound each other in the process.”

Meanwhile, the medical community is “exploiting” these girls, she said: “Making money off of them and just kind of reinforcing this false narrative that gender identity is something that is innate and unchangeable.” In fact, the push to provide hormonal and surgical treatments to minors is intensifying. On June 19, The Associated Press reported that the World Professional Association for Transgender Health is lowering the recommended minimum age for beginning hormonal treatments by two years, from 16 to 14, and for some surgeries by a year, to the ages of 15 and 17, depending on the type of surgery.

‘Experimentation on Minors’

For some within this community of detransitioners, their transition had been merely a social one — clothing choices and hair styles that represent their gender identity, a new set of pronouns, a new name, etc. — and was relatively easy to reverse. Many others, however, endure irreversible effects from “gender-affirming” medical interventions, ranging from changes to secondary sex characteristics to fertility struggles and sterilization, as well as an increased risk of long-term health problems.

“This is experimentation on minors,” said Dr. Andre Van Mol, a board-certified family physician based in Redding, California, who serves as co-chair of the American College of Pediatrician’s Committee on Adolescent Sexuality. “It has not proven effective. It’s not proven safe. It’s being driven by sales pitches and ideology,” he told the Register in a phone interview.

While it is true that so-called puberty blockers have been used to treat conditions such as precocious puberty and certain cancers for decades, it doesn’t follow that this treatment is safe for children who experience gender dysphoria. “You can’t apply what is known about one disease to another disease”

when it comes to the outcomes, warns Dr. Paul Hruz, a pediatric endocrinologist and physician-scientist based in St. Louis.

Included among the known risks are diabetes, obesity, heart disease, stroke in natal males who are given estrogen, and weakened bone density leading to osteoporosis later in life, Hruz explained. The use of puberty blockers and cross-sex hormones is “not a benign process,” Hruz told the Register in an interview over Zoom. “We don’t really have any long-term data in children as this proceeds along.”

Despite this, scientists, health professionals, detransitioners and even some adults who self-identify as transgender cannot express concerns over gender transitioning for children without being accused of inciting violence. “In this area, you cannot have a sober discussion about the facts,” said Marcus Evans, a psychoanalyst who had worked 40 years in the U.K.’s National Health Service and had served on the board of the Tavistock Trust, a component of the NHS that operates a gender-identity clinic.

The Tavistock clinic was involved in the *Bell v. Tavistock* case of the Court of Appeals of England and Wales. The court ruled it unlikely that a child under 16 years of age could consent to the use of puberty blockers to treat gender dysphoria, stating: “There is no age-appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years.”

Evans, who outlines his experience with Tavistock in an article for Quillette, first became involved with Tavistock through his wife, psychotherapist Susan Evans, who worked in the gender-identity clinic and became “alarmed” by what she was witnessing. “She felt that people were very quickly moved on to hormone blockers or cross-sex hormones,” but her concerns were shut down, Evans said.

Evans would eventually resign his position with Tavistock, after witnessing firsthand the dismissal of ethical concerns by other clinicians, culminating in a report by David Bell, a senior consultant at the Tavistock Trust, who faced backlash for highlighting these concerns. “There’s violence being done to these kids and their bodies,” Evans told the Register in a Zoom interview. He gave the example of one of his patients who had been put on a waiting list for a double mastectomy after only one consultation with a clinician. “Why isn’t that violence?” he said, describing the removal of “the perfectly normal breast tissue of a girl” as “a surgical attack.”

Questionable Statistics

The incitement of violence is a key point in the narrative of “LGBT” activists, with 2021 being cited as the deadliest year worldwide for people who identify as transgender, although this statistic coincides with a global increase in homicides from the previous year. Moreover, of the 375 transgender-identifying people murdered during the year, 70% of these deaths occurred in South America, at least 58% percent of the victims were sex workers, and nearly all were men who self-identified as trans women.

The percentage of homicides confirmed to be motivated by “transphobia” is also not specified by the report, which was compiled by the activist group Transrespect Versus Transphobia. Another dominant claim by activists is that “trans-identifying” children who are not allowed to socially and medically transition are at a much greater risk of suicide. Variations of the phrase “I would rather have a living son than a dead daughter” have become a mantra for parents who are led by professionals to fear for the life of their child.

However, there is growing evidence that claims of heightened suicidal ideations among trans-identifying children are not adequately substantiated by the science. A 2011 cohort study out of Sweden, for instance, observed that people who had undergone so-called gender-reassignment surgery had a higher mortality risk, especially from suicide, than the general population. And additional studies which allege a link between puberty blockers and lowered suicidality fail to take into account concurrent psychological problems, noted Oxford sociology professor Michael Biggs in a letter to the editor of an academic journal.

In a separate letter, Biggs acknowledged some studies which indicate a higher rate of suicide among youths who identified as transgender, but observes that these numbers have not been adjusted “for accompanying psychological conditions such as autism.” Biggs warned against exaggerating “the prevalence of suicide,” as doing so “might exacerbate the vulnerability of transgender adolescents.”

For her part, Strongin stressed how “wildly irresponsible” it is to tell kids that they will commit suicide if they don’t transition, “especially if they’re at a very mentally vulnerable place. In my case, I was suicidal” prior to taking hormones, “so if you’re telling kids that they will commit suicide if they don’t transition — and that can mean medically or socially — it’s setting them up for that.”

“The idea that I would kill myself if I didn’t socially transition was very plausible for me. It was easy for me to believe,” she said. In addition, Strongin decried the suicidality narrative as putting parents in a “horrible position” and an “impossible situation. A lot of parents who put their kids on puberty blockers think they’re doing the right thing, which is hard to believe, because you don’t [approach] any other physical-dysmorphic disorder [in this way],” she said. “You don’t change the body. It’s about accepting the body.”

These concerns are echoed by the Heritage Foundation’s June 13, 2022, study, which observed a correlation between U.S. states that permit access to puberty blockers and cross-sex hormones to minors without parental consent and a rise in suicidal ideation of children and young adults. Additionally, a 2016 report in *The New Atlantis* noted that “sex-reassigned” individuals were found to be “about 19 times more likely to die by suicide” than other control subjects in the study.

At War with Her Body

As a child, long before she had ever heard the word “transgender,” Strongin expressed interest in being a boy. A self-described “late bloomer” in middle school who preferred to wear boys’ clothes, she first encountered terms like “gender queer” and “gender fluid” as a high-school freshman and eventually found people online with whom she connected. “There are these online communities of people who have weird feelings about their gender, and that was really exciting to me,” she said. “Especially being a 14-year-old girl in high school going through this social transition, just from being a child to becoming a young adult, you really crave to be understood.”

It was around this time that she began identifying as something other than female. A couple of years later, she started to contemplate a trans identity. And at 17, she was going by the name “Ollie.” “I still didn’t feel at home in my body at all,” Strongin said. “I still felt like there was something very much missing, and that really heavily had to do with my gender and my desire to be portrayed as a boy.”

Strongin felt a sense of urgency to move forward with her transition, since she had already “missed out on an entire boyhood.” She said: “I fully believed in this narrative that I had been born in the wrong body” and felt the need to “go on testosterone and medically transition as soon as possible.”

Not long after graduating high school, Strongin was hospitalized for nearly a week after becoming suicidal. Two months later, at 18, while “still very mentally unwell,” she had an appointment to receive testosterone. “There was no deep psychological work that went into the prescription,” she said. “They just gave it to me. I looked the part. I told them I had gender dysphoria. That was enough.”

Although she celebrated her “milestones” — her deepening voice, her mastectomy — she had “a very negative view” of her body, which she really didn’t have before. “It really made me hate my body. I didn’t hate my body before, until I started medically transitioning,” she said. “Slowly I realized that that’s not supposed to happen. That’s not what I was told was going to happen.”

From a clinical perspective, Evans has observed that “there is a lot of self-hatred” in young people who experience gender dysphoria. “They’ve had some sort of psychological collapse,” he said. “They’re quite psychologically fragile. They hate aspects of themselves. And they believe that the ... medical treatment

of their natal sex will bring them in line between how they are and how they see themselves, and that will reduce their self-hatred.”

Broad-Based Objections

The Catholic Church, whose anthropology is irreconcilably in conflict with social and medical attempts to alter one’s natal gender, has become particularly concerned in recent years about the influence that so-called gender ideology can have on children. A 2019 document published by the Congregation for Catholic Education addressed the question of gender theory in the context of education. And a few years prior to this, in the 2016 post-synodal apostolic exhortation *Amoris Laetitia*, Pope Francis writes: “The young need to be helped to accept their own body as it was created, for thinking that we enjoy absolute power over our own bodies turns, often subtly, into thinking that we enjoy absolute power over creation.”

Concerns over the push to allow minors to medically transition, however, are not exclusive to Catholicism, people of faith or even conservative activists. Evans, for instance, supports and even counsels transgender-identifying adults who choose to undergo medical interventions. There are social-media influencers who self-identify as transgender speaking out against children transitioning. And even prominent secular media outlets like the *Los Angeles Times* and *The Washington Post* have published articles recently expressing the views of adults who have undergone gender transitions themselves who question the intensive lobbying in support of gender transitioning by young people.

Strongin, who has expressed being interested in Christianity, holds no religious affiliation and even supports transitioning for adults — although she’s opposed to so-called “bottom surgery,” meaning procedures to cosmetically alter the genitals that often involve sterilization. “The movement against gender-affirming therapy is a hands-across-the-aisle phenomenon,” said Van Mol, a Pentecostal Protestant. “It’s conservative [and] liberal; it’s people of faith and people of no faith. It’s sexual minorities and non-sexual minorities.”

When it comes to this question, Hruz, who is Catholic, said faith and reason are “complementary to each other” and “speak to who we are as human beings. Everyone is seeking that human fulfillment, and I think that there’s much that can be offered to help people [who] struggle with these difficulties,” he said.

A Happy Ending

It wasn’t until Strongin had finished transitioning — after years on testosterone, a mastectomy and a legally changed name — that she started to feel regret, worrying that she may not be able to have children if she continued on this path. “It took a couple years, probably, to actually accept that I knew what I needed to do and stop taking testosterone,” she said. “Go back to being Daisy, and go back to using she/her pronouns. And stop having this war on your body.”

She was already dating her now-husband when she had decided to detransition. Shortly after their marriage, she found out she was expecting their first child and is due later this year. “Now, I’ve been detransitioned for two years — haven’t looked back at all, and I never will.”

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