TRANSADVOCATE

Singal’s Florida: You’re very wrong about trans kids

By Cristan Williams

Published February 25, 2018 | Updated July 27, 2026
https://www.transadvocate.com/youre-very-wrong-about-trans-kids_n_21938.htm

Abstract

UPDATE: This article was updated to respond to spurious recommendations from the Florida Department of Health, which assert the same debunked claims this article fact-checks. Having learned that the mainstream publication The Atlantic has paid professional anti-trans concern troll Jesse Singal to write about trans issues, I want to address his well-worn arguments before he [...]

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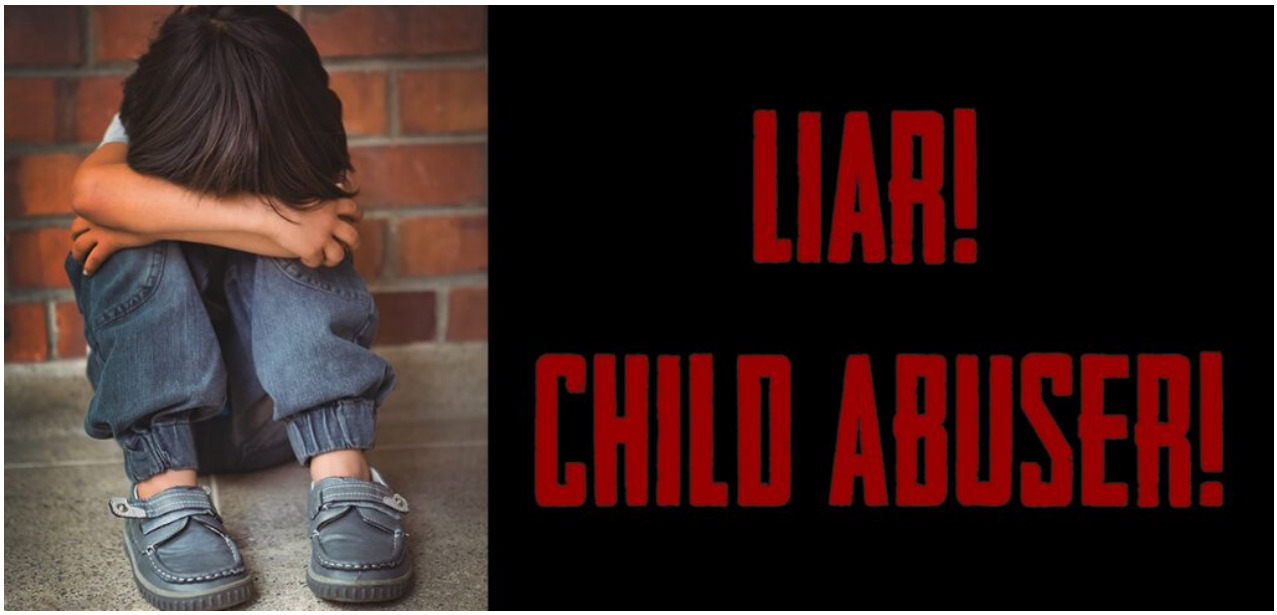

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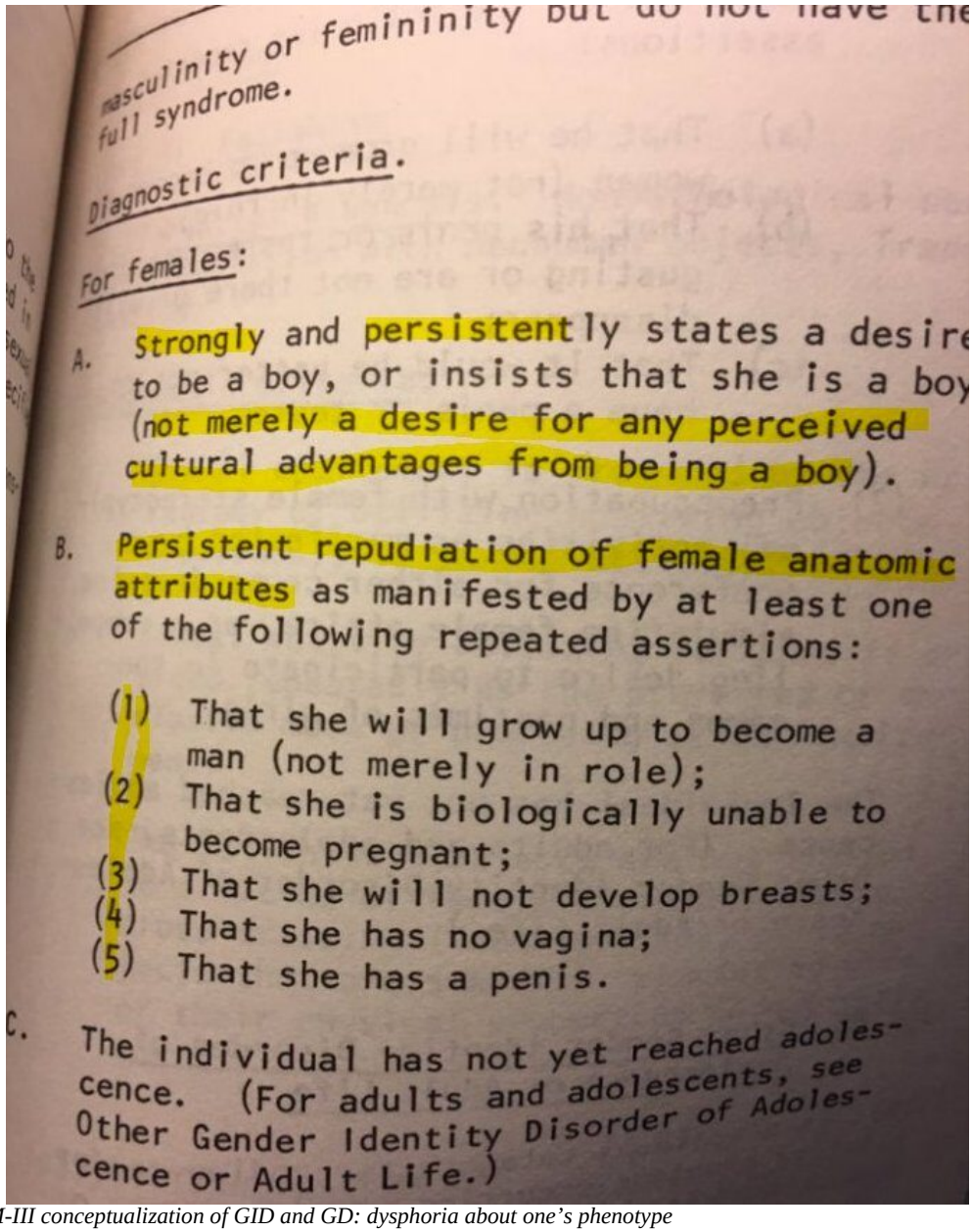
Having learned that the mainstream publication The Atlantic has paid professional anti-trans concern troll Jesse Singal to write about trans issues, I want to address his well-worn arguments before he can make them. To do so, I will assert and then substantiate a few things:

1. The Diagnostic and Statistical Manual of Mental Disorders (DSM) IV Gender Identity Disorder (GID) diagnosis is critically flawed and has harmed people.
2. A DSM-5 Gender Dysphoria (GD) diagnosis is very different from the DSM-IV concept of GID.

3. Pretending that DSM-IV GID research directly applies to those with a DSM-5 GD diagnosis is irrational and harmful.

Jesse Singal has enjoyed a great deal of support from anti-trans groups including those of the political right, the alt-right, and a small fraction of anti-trans self-identified feminists. Singal's anti-trans articles all conflict with at least one of the above three facts. These anti-trans movements, who collectively refer to themselves as "gender critical," exist to obscure the above three facts in pursuit of reducing the number of trans people that exist today.

To understand the problems with the DSM-IV GID, and perhaps better understand why the trans community has fought against it so hard for so long, we need to begin with the DSM-III's conceptualization of GID:



masculinity or femininity but do not have the full syndrome.

Diagnostic criteria.

For females:

A. Strongly and persistently states a desire to be a boy, or insists that she is a boy (not merely a desire for any perceived cultural advantages from being a boy).

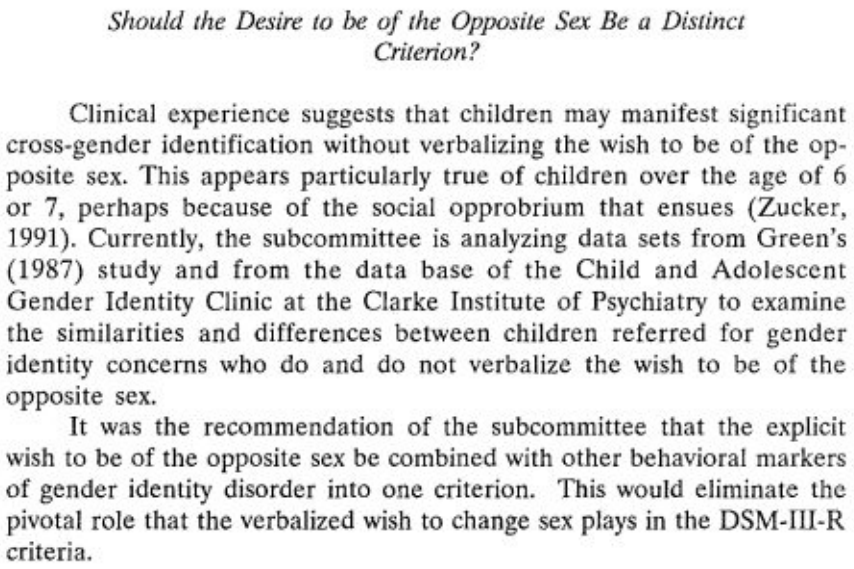
B. Persistent repudiation of female anatomic attributes as manifested by at least one of the following repeated assertions:

(1) That she will grow up to become a man (not merely in role);
(2) That she is biologically unable to become pregnant;
(3) That she will not develop breasts;
(4) That she has no vagina;
(5) That she has a penis.

C. The individual has not yet reached adolescence. (For adults and adolescents, see Other Gender Identity Disorder of Adolescence or Adult Life.)

Figure 1. DSM-III conceptualization of GID and GD: dysphoria about one's phenotype

The DSM-III's understanding of GID meant that one had to express dysphoria regarding their phenotype. Merely being gender nonconforming (GNC) alone was not enough to diagnose a kid with GID. Some sexologists were frustrated with this situation as they wanted a way to put GNC kids into "treatments" designed to make them behave more stereotypically in their gender expression.



Should the Desire to be of the Opposite Sex Be a Distinct Criterion?

Clinical experience suggests that children may manifest significant cross-gender identification without verbalizing the wish to be of the opposite sex. This appears particularly true of children over the age of 6 or 7, perhaps because of the social opprobrium that ensues (Zucker, 1991). Currently, the subcommittee is analyzing data sets from Green's (1987) study and from the data base of the Child and Adolescent Gender Identity Clinic at the Clarke Institute of Psychiatry to examine the similarities and differences between children referred for gender identity concerns who do and do not verbalize the wish to be of the opposite sex.

It was the recommendation of the subcommittee that the explicit wish to be of the opposite sex be combined with other behavioral markers of gender identity disorder into one criterion. This would eliminate the pivotal role that the verbalized wish to change sex plays in the DSM-III-R criteria.

Figure 2. Citing Green & Zucker to target non-transsexual GNC people for a GID diagnosis

Anti-LGBT activist George "Rent Boy" Rekers 1, who was caught by the NY Times after having spent two weeks with a male sex worker from RentBoy.com, teamed up with Dr. Green to produce a study titled, Behavioral Treatment of Deviant Sex-Role Behaviors in a Male Child. In fact, Green facilitated this study by sending "deviant" gender expressing kids to Rekers for him to study. This "research" was the foundation for Green and Rekers' Sissy Boy Syndrome, a "study" that found that putting a group of mostly non-GD GNC kids (with a few GD kids mixed in) through "treatments" designed to make them act more stereotypically male produced a group with a few GD kids mixed in. Yes, you read that correctly. A group made up of mostly non-GD kids produced a group of mostly non-GD kids. Specifically, it found that around 80% of the study participants did not have GD after their "treatments." Remember this 80% number because it shows up over and over again in anti-trans literature.

Worse, this "study" was later implicated in the death of one of its subjects.

Nonetheless, Green's friend, Dr. Zucker, and Zucker's colleagues at the government-run CAMH gender clinic populated the DSM-IV Workgroup and set to work turning the Sissy Boy Syndrome framework into a diagnostic category: the DSM-IV GID. This wasn't a secret. Those involved with the Workgroup published papers and periodic updates explaining their goals:

Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*

SUSAN J. BRADLEY, M.D.[1] AND KENNETH J. ZUCKER, Ph.D.[2]

This article provides a selected overview of the literature on gender identity disorder and psychosexual problems in children and adolescents, with a focus on diagnosis, clinical course, etiology, and treatment.

This article will provide an overview of the broad range of gender identity disorders and psychosexual problems of childhood and adolescence. During childhood, the DSM-III-R (1) diagnosis of gender identity disorder of childhood (GIDC), or its subclinical variants, constitutes the major psychosexual disorder that the child psychiatrist will confront. During adolescence, however, gender identity disorders and psychosexual concerns appear much more similar to their adult counterparts and thus will be discussed in sections on transsexualism, transvestic fetishism, and homosexuality.

Both retrospective and prospective studies have now established that GIDC, or its subclinical variants, are strong precursors to the emergence of transsexualism (homosexual subtype, see Blanchard et al (2)) or a homosexual erotic orientation (3) in adolescence or adulthood. Many adult individuals experiencing severe gender dysphoria or homosexual concerns, however, will not have been seen clinically during childhood nor will they all have bona fide histories of GIDC, particularly transsexuals whose sexual orientation is nonhomosexual (2) and homosexual men and women, many of whom have childhood cross-gender histories that would not meet the complete DSM-III-R criteria for GIDC (4). Moreover, the majority of children who have been followed prospectively do not display post-pubertal gender dysphoria and a minority appear to develop a heterosexual erotic orientation (3). Accordingly, the presenting concerns will be dealt with as though they were distinct entities although the connections among these disorders will be discussed more fully later in this article.

Gender Identity Disorder of Childhood

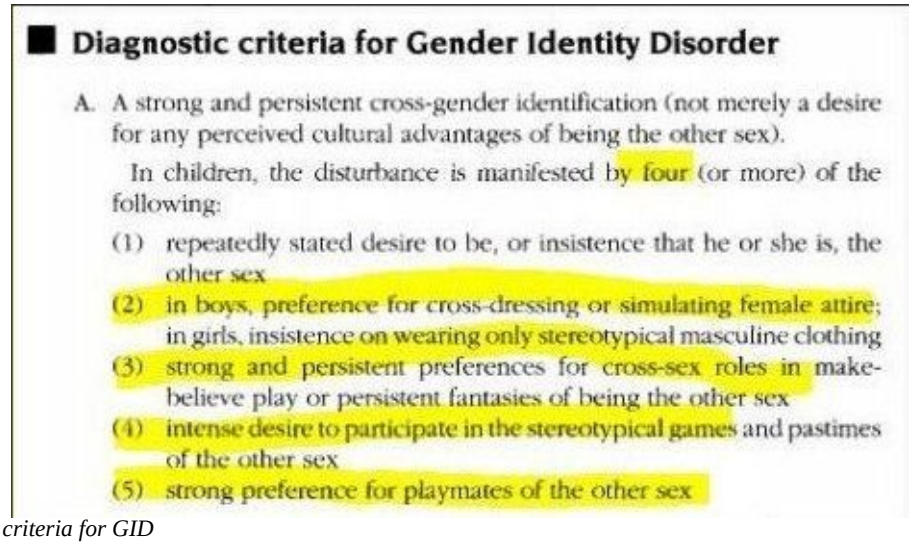
In the DSM-III-R (1), it is stated that:

The essential features of this disorder are persistent and intense distress in a child about his or her assigned sex and the desire to be, or insistence that he or she is, of the other sex. (This disorder is not merely a child's nonconformity to stereotypic sex-role behavior as, for example, in 'tomboyishness' in girls or 'sissyish' behavior in boys, but rather a profound disturbance of the normal sense of maleness or femaleness.) In addition, in a girl there is either persistent marked aversion to normative feminine clothing and insistence on wearing stereotypic masculine clothing, or persistent repudiation of her female anatomic characteristics. In a boy, there is either preoccupation with female stereotypic activities, or persistent repudiation of his male anatomic characteristics. This diagnosis is not given after the onset of puberty.

Revisions of the DSM-III-R criteria for GIDC are currently being considered by the DSM-IV Subcommittee on Gender Identity Disorder of Childhood and Transsexualism, under the auspices of the working group on child and adolescent psychiatric disorders (5). The changes, if accepted, will include 1. identical criteria for boys and girls; 2. elimination of the stated desire to be of the other sex as a distinct criterion; and 3. more specific behavioural criteria that characterize both the cross-gender identification and the discomfort and distress regarding one's assigned sex. A more

Figure 3. Change 2: "Elimination of the stated desire to be of the other sex as a distinct criterion."

These sexologists made it clear that they supported a diagnostic framework that minimized phenotype dysphoria and instead centered itself on nonconforming gender behavior. In fact, this was accomplished in the DSM IV:



Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

(1) repeatedly stated desire to be, or insistence that he or she is, the other sex
(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pastimes of the other sex
(5) strong preference for playmates of the other sex

Figure 4. DSM-IV criteria for GID

Under the DSM-IV, one needs only be GNC to receive a GID diagnosis. This resulted in numerous "transgender" studies using the above Sissy Boy Syndrome-derived metric.

When the American Psychiatric Association issued the DSM-5, the DSM-IV category GID was removed. Many media outlets wrongly reported that GID was being renamed GD, leading many laypeople to believe that GID was basically the same thing as GD. This is a mistaken belief; GID and GD represent two different groups:

GID group: mostly comprised of those who experience anxiety because they are, in some way, gender non-conforming, as well as a relative few who are debilitated by a mismatch between their gender orientation2 and their phenotype.

GD group: comprised of those who are debilitated by a mismatch between their gender orientation and their phenotype.

Unscrupulous writers like Singal proclaim that around 80% of GD kids will stop having GD based on old GID studies that found that most kids with GID do not wind up having GD. Never mind that most GID kids didn't have GD in the first place. To drive the point home regarding the difference between GID within a DSM-IV context and GD within a DSM-5 context, here are both categories:

Gender Dysphoria

Diagnostic Criteria

Gender Dysphoria in Children 302.6 (F64.2)

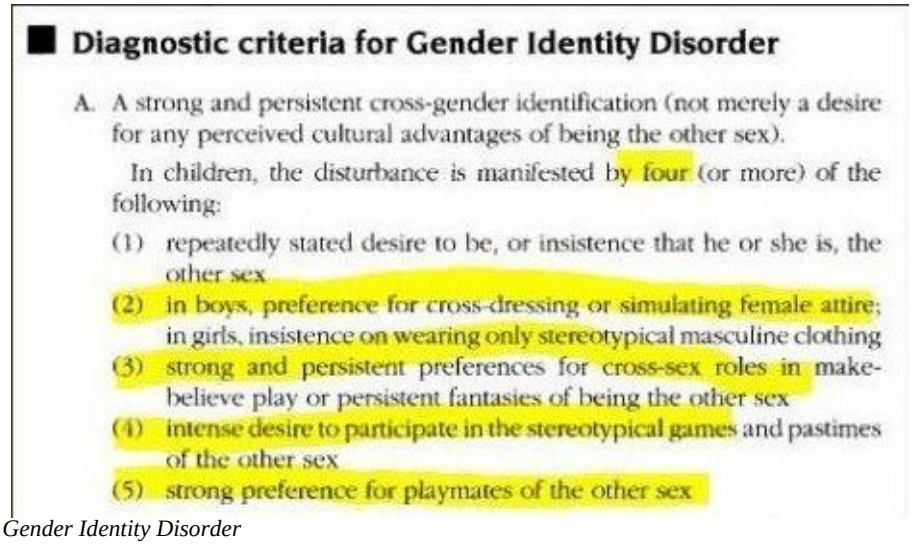
A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

Figure 5. DSM-5 Gender Dysphoria



Diagnostic criteria for Gender Identity Disorder

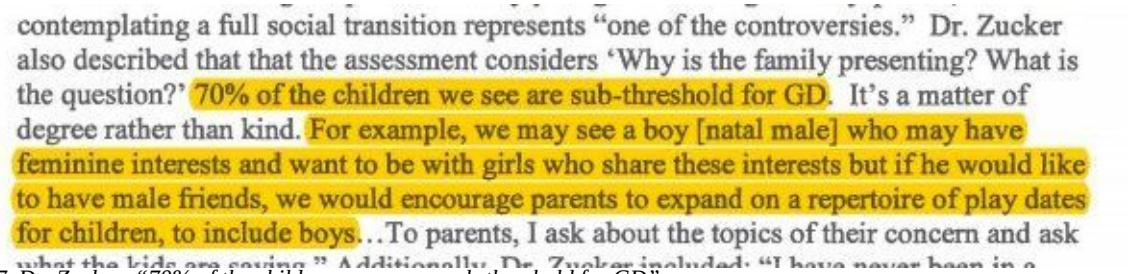
A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

(1) repeatedly stated desire to be, or insistence that he or she is, the other sex
(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pastimes of the other sex
(5) strong preference for playmates of the other sex

Figure 6. DSM-IV Gender Identity Disorder

The point is that many who had a DSM-IV GID diagnosis will not qualify for a DSM-5 GD diagnosis because being gender-nonconforming alone is not enough to get a DSM-5 GD diagnosis. Let's consider just how many kids this difference affects. When asked how many kids Dr. Zucker "treated" at his gender identity clinic for GD, he said that a full 70% of them did not have gender dysphoria in the first place. In fact, these children came into his care merely because they were GNC:



contemplating a full social transition represents "one of the controversies." Dr. Zucker also described that that the assessment considers 'Why is the family presenting? What is the question?' 70% of the children we see are sub-threshold for GD. It's a matter of degree rather than kind. For example, we may see a boy [natal male] who may have feminine interests and want to be with girls who share these interests but if he would like to have male friends, we would encourage parents to expand on a repertoire of play dates for children, to include boys…To parents, I ask about the topics of their concern and ask

Figure 7. Dr. Zucker: "70% of the children we see are sub-threshold for GD"

In its heyday, Zucker's GID clinic was one of the busiest and most prominent clinics of its type in the world, and the vast majority of kids Zucker's clinic "treated" didn't have GD in the first place. Nonetheless, GID kids were treated for GID with behavioral therapies designed to make these kids behave in more stereotypical ways. Under the DSM-5, the only kids Zucker would be able to treat would be the 30% that did, in fact, have GD.

Shortly after the DSM-5 was published, Dr. Zucker's boss was blindsided by a reporter asking him if Zucker's clinic would continue its DSM-IV-centered "treatment" of kids. When Zucker's boss said no, the reporter cited a statement by Zucker claiming that he intended to continue his DSM-IV era "treatments." Shortly thereafter, Zucker was fired, and anti-trans movements across the globe repeated the lie that a cabal of powerful trans activists somehow/someway forced Zucker out and that children would be the worse for it.

An anti-trans site called Transgender Trend recently published a slick booklet targeting schools. The propaganda this booklet spreads is rooted in the notion that a DSM-IV GID diagnosis is exactly the

same thing as a DSM-5 GD diagnosis. Consider the following fact claim in terms of what you now know about the differences between a DSM-IV GID and the DSM-5 GD, particularly where the 80% desistance rate originates from:

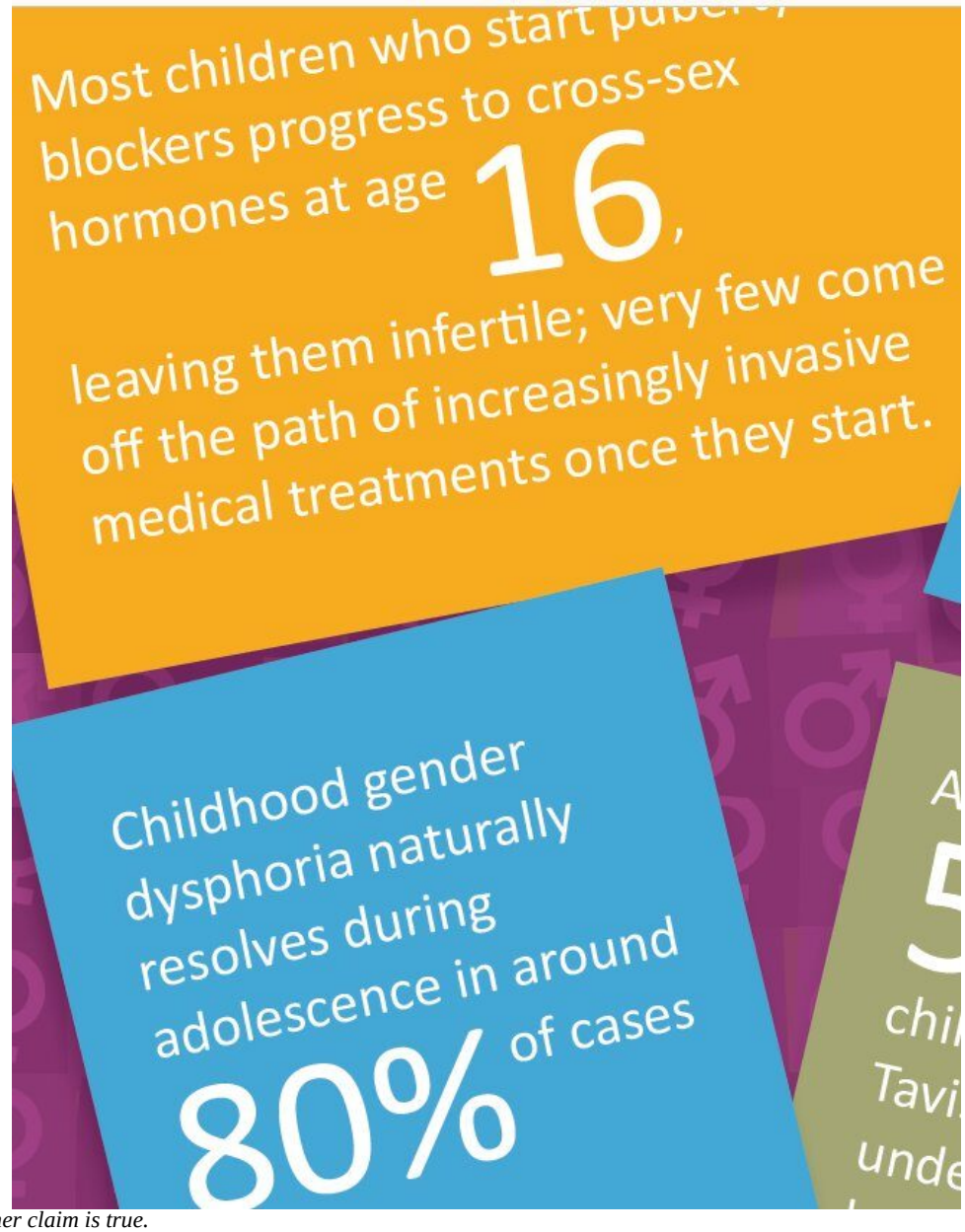
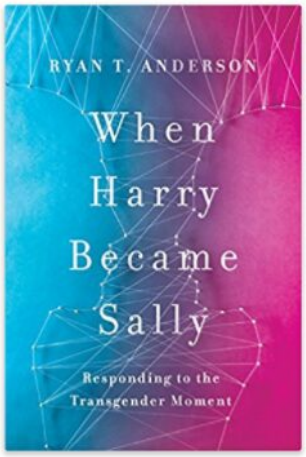


Figure 8. Neither claim is true.

And yet, this claim is even found in the #1 bestseller in Gay & Lesbian Philosophy on Amazon, When Harry Became Sally: Responding to the Transgender Moment by Ryan T. Anderson:



See this image

When Harry Became Sally: Responding to the Transgender Moment

by Ryan T. Anderson (Author)

39 customer reviews

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The transgender movement has hit breakneck speed. In the space of a year, it's gone from something that most Americans had never heard of to a cause claiming the mantle of civil rights.

But can a boy truly be "trapped" in a girl's body? Can modern medicine really "reassign" sex? Is sex something "assigned" in the first place? What's the loving response to a friend or child experiencing a gender-identity conflict? What should our law say on these issues?

Read more

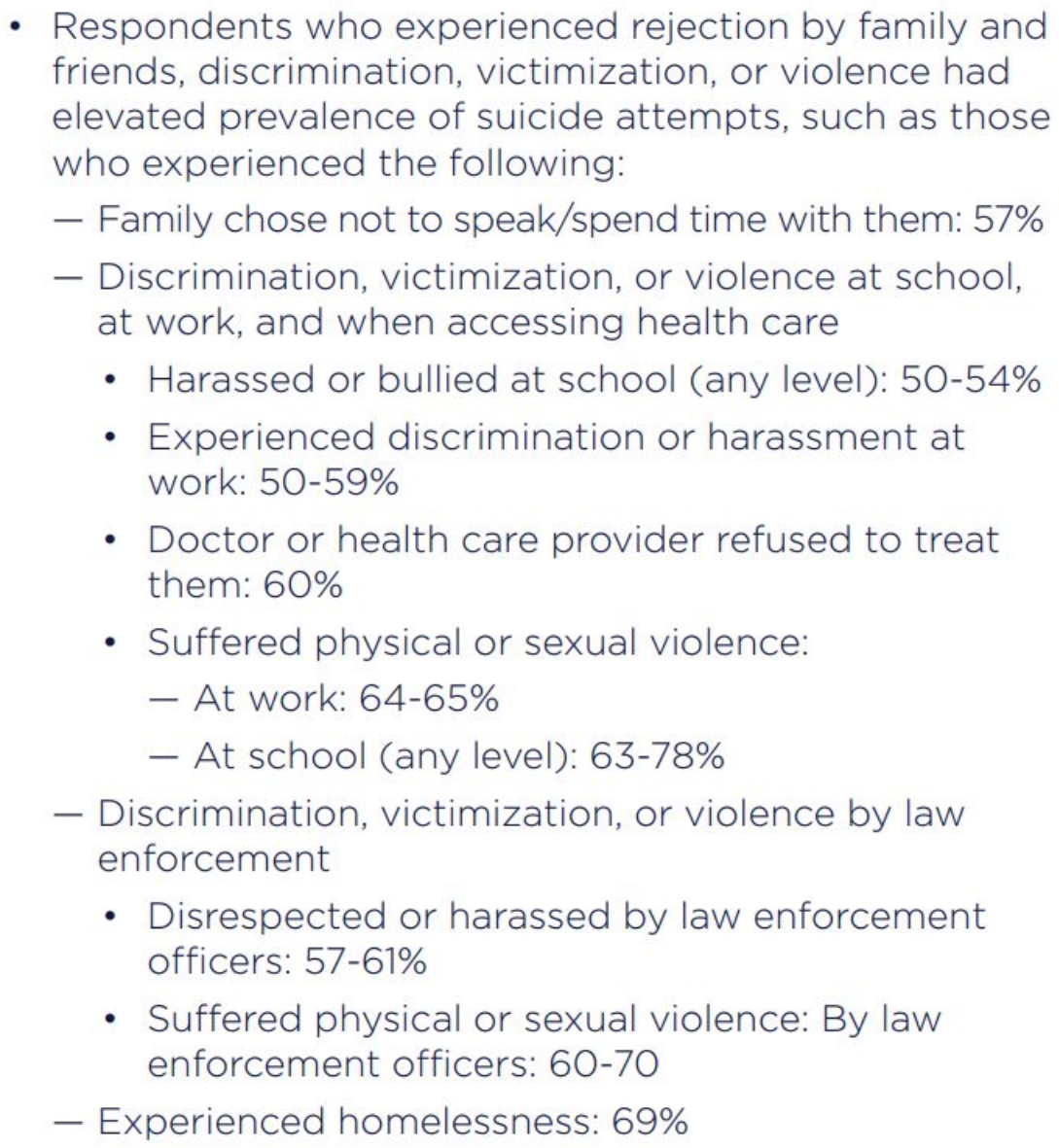
The book claims:

> *In the past 10 years, dozens of pediatric gender clinics have sprung up throughout the United States. In 2007, Boston Children's Hospital "became the first major program in the United States to focus on transgender children and adolescents," as their own website brags.*
> *A decade later, over 45 gender clinics had opened their doors to our nation's children--telling parents that puberty blockers and cross-sex hormones may be the only way to prevent teen suicides. Never mind that according to the best studies--the ones that even transgender activists themselves cite--80 to 95 percent of children with gender dysphoria will come to identify with and embrace their bodily sex.*
> *Never mind that 41 percent of people who identify as transgender will attempt suicide at some point in their lives, compared to 4.6 percent of the general population. Never mind that people who have had transition surgery are nineteen times more likely than average to die by suicide.*
> *These statistics should stop us in our tracks. Clearly, we must work to find ways to effectively prevent these suicides and address the underlying causes. We certainly shouldn't be encouraging children to "transition."*

Anderson both claims and insinuates that in 2017, most kids with GD will stop having GD, that transition itself leads to suicidal feelings, and that because of these things, good people should try to prevent kids from being trans. These are lies. What's more, they're dangerous lies that the author was made aware of.

Certain ideological circles like to perpetuate the long-debunked lie that transition makes people suicidal. The 41% suicidal ideation rate referred to in the above book section seems to be referring to a study that found that trans people who were not supported attempted suicide at a rate of 41%. The study Anderson cites notes: "Based on prior research and the findings of this report, we find that mental health factors and experiences of harassment, discrimination, violence, and rejection may interact to produce a marked vulnerability to suicidal behavior in transgender and gender non-conforming individuals." Backing up this claim are statistics finding a greater burden of suicidal

ideation among those who face specific types of discrimination:



Why would Anderson -an author clearly aware of this study- hide this context in his admonition that "[w]e certainly shouldn't be encouraging children to 'transition.'"? Embedded in Anderson's malevolent -and there is no other word for his disregard of life- is the claim that in 2017, "80 to 95 percent of children with gender dysphoria will come to identify with and embrace their bodily sex." The only research asserting something like this is research on groups of DSM-IV GID kids, specifically the disco-era Sissy Boy Syndrome.

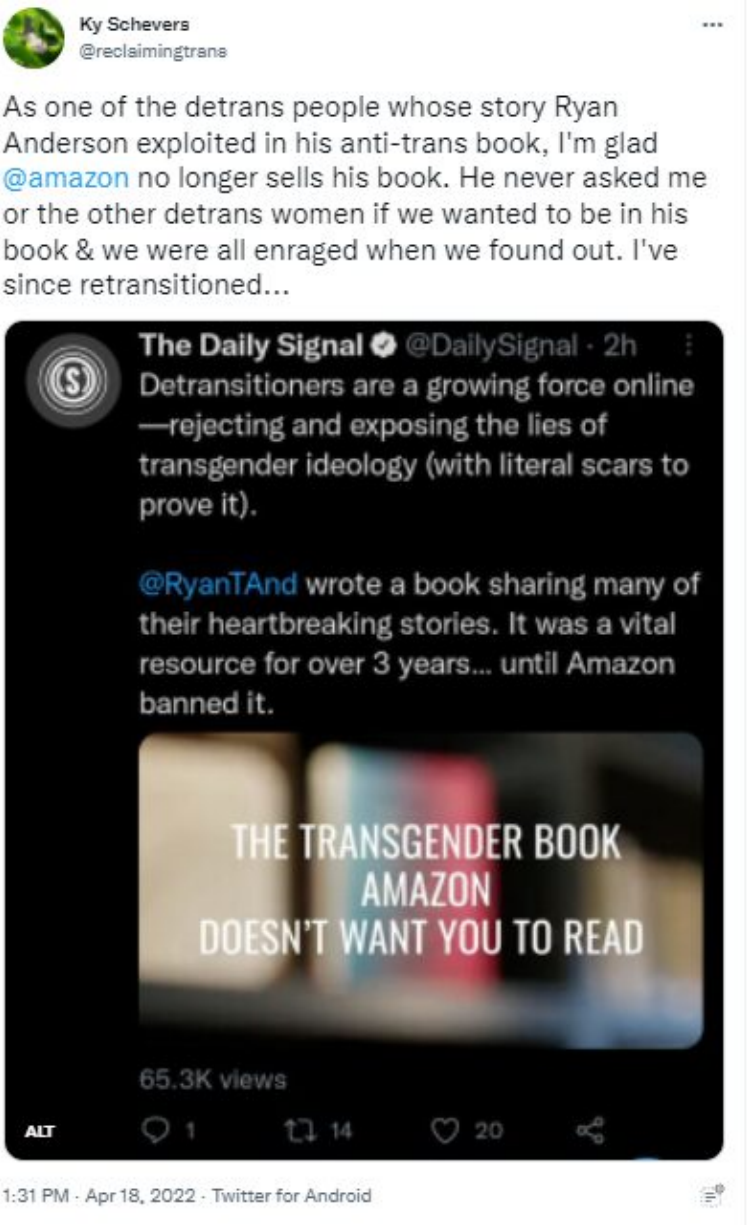


Figure 9. Statement by one of those Anderson exploited.

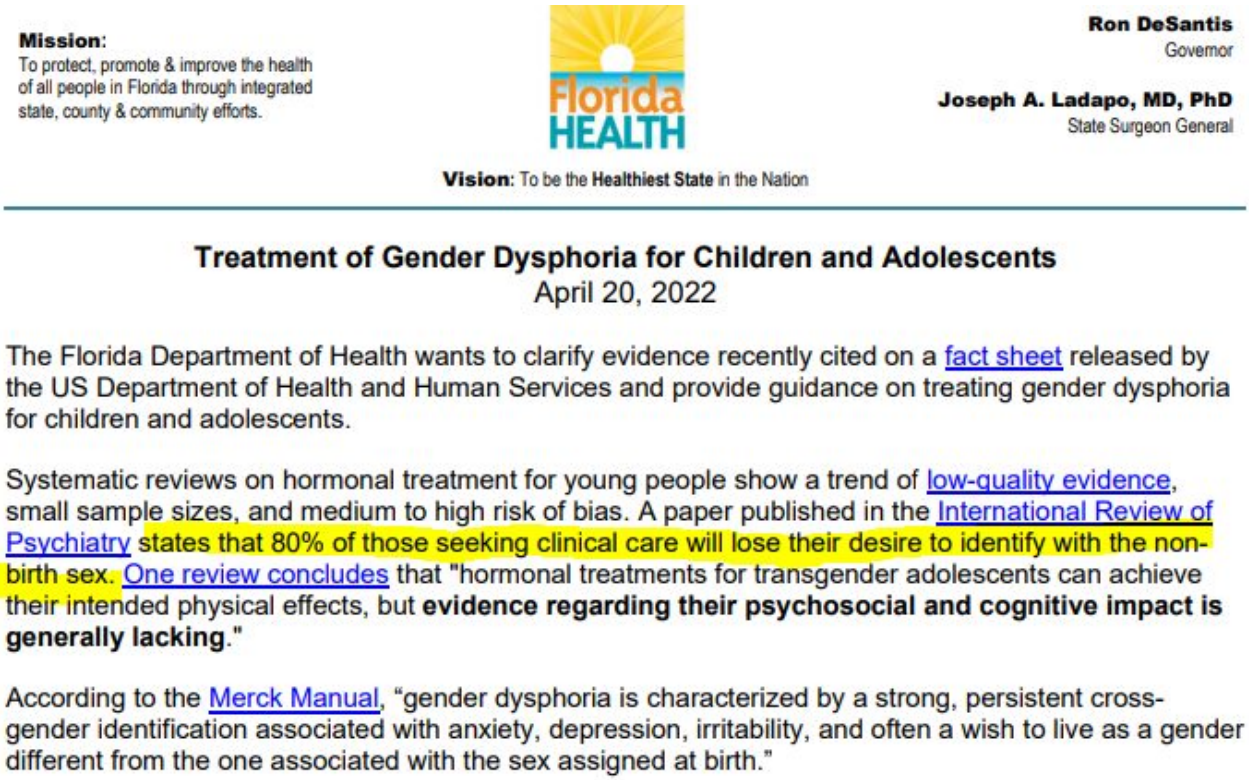
Pretending that DSM-IV GID research applies to a DSM-5 GD diagnosis is more than irresponsible; it's possibly deadly. We're no longer talking about a mixed group of non-GD GNC kids with a relatively few GD kids mixed in; we're talking about a group comprised of 100% GD kids. People like Anderson and groups like Transgender Trend are actively preying on vulnerable parents, who are oftentimes both worried and confused. They lie, telling them that DSM-IV GID research proves that around 80% of DSM-5 GD kids will stop being transgender, facilitating the placement of these kids directly into the at-risk pool.

We may never know the suffering these ideological hucksters cause as they target vulnerable children and families. Remember the Sissy Boy Syndrome kid that killed himself after receiving GID-IV style "treatment"? The kid's name was Kirk Murphy, and, according to Murphy's doctor, was "an

exceptionally effeminate child who played exclusively in a feminine role; who exhibited overwhelmingly feminine gestures, vocal inflections and gait; and who desperately wanted to be a girl."

Promoting DSM-IV GID data as if it were DSM-5 GD data isn't only irrational; it's dangerous. We are no longer talking about a mixed DSM-IV GID group comprised of 70% non-GD GNC kids and 30% GD kids; we're talking about a DSM-5 GD group comprised of GD kids. Lying about this fact will result in needless and avoidable trauma and possibly death.

The Florida State Department of Health issued a "statement" it claimed to be "guidance" to parents and providers urging them to withhold care, based on the exact claims this article debunks.



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Florida HEALTH

Vision: To be the **Healthiest State** in the Nation

Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Treatment of Gender Dysphoria for Children and Adolescents
April 20, 2022

The Florida Department of Health wants to clarify evidence recently cited on a fact sheet released by the US Department of Health and Human Services and provide guidance on treating gender dysphoria for children and adolescents.

Systematic reviews on hormonal treatment for young people show a trend of low-quality evidence, small sample sizes, and medium to high risk of bias. A paper published in the International Review of Psychiatry states that 80% of those seeking clinical care will lose their desire to identify with the non-birth sex. One review concludes that "hormonal treatments for transgender adolescents can achieve their intended physical effects, but **evidence regarding their psychosocial and cognitive impact is generally lacking**."

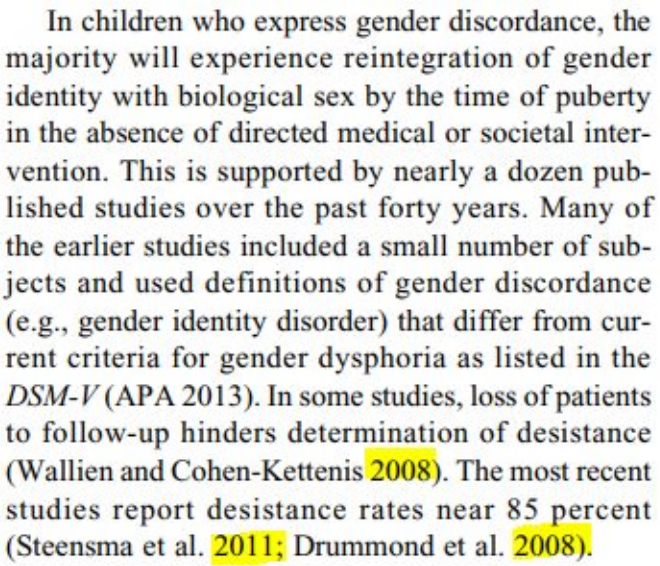
According to the Merck Manual, "gender dysphoria is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the sex assigned at birth."

Every claim asserted by the Florida State Health Dept., with the exception of its initial link to the US Dept. of Health and Human Services, is spurious. Below is a review of the cited references Florida used to rationalize their claims:

Low-Quality Evidence: This is a paper published in a religious journal by a Washington University "researcher." His name is Paul W. Hruz, and he made headlines for "blurring the lines between religious freedom and medicine" when it comes to trans care. Washington University issued the following statement about Hruz's bad-faith "medical" activism:

> *Dr. Hruz is NOT a member of our DSD team, NOR is he an expert in transgender health as he has never taken care of a transgender person. Dr. Hruz admits that he has not treated any transgender patients, patients with gender dysphoria, conducted peer-reviewed research about gender identity, transgender people, or gender dysphoria; and is not a psychiatrist, a psychologist, nor mental health care provider of any kind, who could speak knowledgeably of transgender health."*

The following is a paragraph from the Hruz paper cited by Florida:

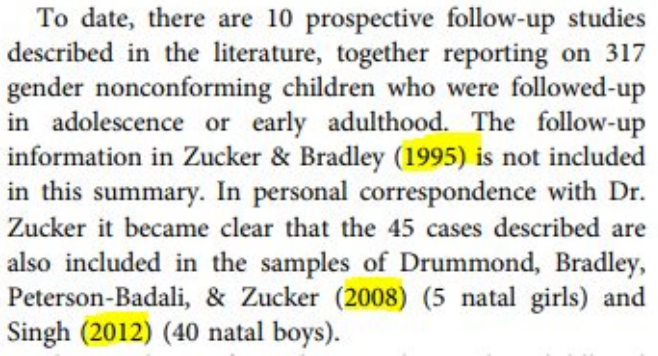


In children who express gender discordance, the majority will experience reintegration of gender identity with biological sex by the time of puberty in the absence of directed medical or societal intervention. This is supported by nearly a dozen published studies over the past forty years. Many of the earlier studies included a small number of subjects and used definitions of gender discordance (e.g., gender identity disorder) that differ from current criteria for gender dysphoria as listed in the *DSM-V* (APA 2013). In some studies, loss of patients to follow-up hinders determination of desistance (Wallien and Cohen-Kettenis 2008). The most recent studies report desistance rates near 85 percent (Steensma et al. 2011; Drummond et al. 2008).

Figure 10. "Low-Quality Evidence"

Clearly, Hruz understands the difference between DSM-IV and DSM 5 cohorts, and yet, Hruz's 2019 "study" cites old DSM-IV data to make claims about post-2019 DSM 5 trans kids. What Hruz is doing is called lying. Moreover, Hruz's "study" cites his own qualitative estimates of the value of trans research using the "Grading of Recommendations, Assessment, Development and Evaluations" system, which was recently shown to produce highly biased findings.

The International Review of Psychiatry: This is particularly disingenuous, as the cited study is about the ways DSM-IV GID and DSM 5 GD are different, and it was within that context that the study remarked on the fact that old DSM-IV GID data showed that many GID kids would stop having GID. At no point does this study claim "that 80% of those seeking clinical care will lose their desire to identify with the nonbirth sex." This is another lie.



To date, there are 10 prospective follow-up studies described in the literature, together reporting on 317 gender nonconforming children who were followed-up in adolescence or early adulthood. The follow-up information in Zucker & Bradley (1995) is not included in this summary. In personal correspondence with Dr. Zucker it became clear that the 45 cases described are also included in the samples of Drummond, Bradley, Peterson-Badali, & Zucker (2008) (5 natal girls) and Singh (2012) (40 natal boys).

Figure 11. "International Review of Psychiatry"

One review concludes: this is a 2018 study on DSM 5 trans kids. As this study was published only 5 years after the clinical formation of the cohort (remember, the DSM 5 was published in 2013), at that time it was correct to note that "hormonal treatments for transgender adolescents can achieve their

intended physical effects, but evidence regarding their psychosocial and cognitive impact is generally lacking."

Merck Manual: citing this Manual is interesting because it both directly undercuts the conclusions the Florida Health Dept. draws and uses long-outdated language and DSM IV data to make claims about DSM 5 cohorts. The definition of gender dysphoria the Merck Manual uses comes from the DSM IV and focuses on gender role dysphoria rather than phenotype dysphoria, which is the essential symptom around which the symptomatology of the DSM 5 cohort is organized. Nevertheless, the Merck Manual uses the DSM 5 standards for diagnosing gender dysphoria in children and states that after the onset of puberty:

> *[I]t is recognized that attempts to force the child to accept the birth-assigned gender role is usually traumatic and unsuccessful. Therefore, the predominant treatment modality is psychologic support and psychoeducation for children and their parents, using a gender-affirmative model as opposed to a gender-pathologizing model. This affirmative approach supports the child in the gender expressed, sometimes including social transition prior to puberty.*

For post-puberty kids with DSM 5 gender dysphoria, the Merck Manual goes on to note:

> *In early adolescents, puberty-blocking agents are more commonly used today. Agents such as leuprolide (gonadotropin releasing hormone agonists) prevent the production of testosterone and estrogen, thereby "blocking" the progression of puberty. These agents may be employed at Tanner Stage II of development, enabling additional time for evaluation of the gender dysphoric youth (see Endocrine Society Guidelines, 2017). If the gender-dysphoric youth wishes to continue with full transition, puberty-blocking agents are discontinued and gender-affirming hormones (previously known as cross-sex hormones) are employed, enabling the onset of puberty in the experienced gender.*

Citing the source of the above medical recommendations -the Merck Manual-- the Florida Health Dept. instructs parents and providers to do the exact opposite for post-pubertal kids:

The Florida Dept. of Health then concern trolls about how the Dept. is terribly concerned about trans surgeries on children, which is something that was never ethical to do in the first place, even as right-wing propagandists continue to claim otherwise. Citing guidelines from the federal Centers for Medicare and Medicaid Services, Sweden, Finland, the United Kingdom, and France, the Florida Dept. of Health correctly notes that nobody believes it to be ethical to perform trans surgeries on children. Again, performing trans surgeries on children was never ethical in the first place. Essentially, this bit of concern trolling is asserting that Florida is taking a brave stand against a practice that doesn't exist in the ethical world of trans care the US Dept. of Health and Human Services outlined.Finally, the Florida Dept. of Health ends its recommendations on a point that we agree with and endorse: "children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider."

Here, I think it is important to note that the AMA recently commented about the dangers of playing politics with the lives of trans kids:

NOTE:

I thought about adding to the above list something about a fake syndrome this anti-trans movement has created and attempted to legitimate, but a good debunking of this fake syndrome called “Rapid Onset Gender Dysphoria” was already done over on the Advocate. I encourage you to take a look.

1. Dr. Rekers was a founding member of the Family Research Council and served on the board of the National Association for Research and Therapy of Homosexuality (NARTH).

2. Within transgender discourse, one’s “gender orientation” references an individual’s subjective and primary experience phenotype. Likewise, Judith Butler contextualized this experience as being one’s “primary experience of the body”.

Suggested citation

Cristan Williams. "Singal’s Florida: You’re very wrong about trans kids." TransAdvocate, February 25, 2018. https://www.transadvocate.com/youre-very-wrong-about-trans-kids_n_21938.htm