Understanding Autogynephilic Gender Dysphoria

A psychoeducational resource for parents of adolescent birth-assigned male youth seeking a feminine or female transition

Purpose of document:

This resource is not a generic transgender handout. It is written for situations in which the working clinical formulation is autogynephilic gender dysphoria in a birth-assigned male adolescent. It does not use autogynephilia to invalidate a young person, to shame sexuality, or to imply that transition is never appropriate. It aims to help parents understand the pattern accurately and compassionately, show that they can understand their young person, and undertake informed decision-making about gender-related interventions.

Summary for parents/caregivers

- Autogynephilia (AGP) can be understood as an enduring sexual orientation: a propensity for a birth-assigned male person to experience sexual, romantic, euphoric, or emotionally rewarding feelings in response to imagining himself as female, feminine, or treated as a woman.

- AGP is not merely a fetish in the ordinary pejorative sense (i.e., an acquired interest in non-human objects such as certain garments or fabrics). It appears to be innate and early arising (published literature identifies expressions in early childhood in some individuals) and involves a partial or total inversion of gynephilia (the default male sexual orientation). Intrusive/unwanted and frequent sexual thoughts of being a woman/having a female body typically emerge at or around puberty with androgenic puberty. Historically the most common expression of these feelings has been private dressing in women's clothing (ranging from an isolated item, such as underwear, through to a full cross-dressing experience involving an outfit, cosmetics, a wig, and body prosthetics). These days young people may also express these feelings via online avatars and identities, such as playing as a female character in computer games or having a female/feminine identity on Discord or social media. At other times, the feminine self can be explored via pornography or merely via daydreaming and imagining life as a woman. Over time it can become tied to identity, belonging, comfort, and dysphoria.

- Feminine identities and gender dysphoria rarely emerge immediately with the onset or intensification of AGP feelings in adolescence. Often it takes years (sometimes a decade or more) before the emerging feminine self-concept and related gender dysphoria develop.

- For the adolescent presentation addressed in this resource, AGP is treated as a necessary but not sufficient condition for the development of a feminine self-concept, gender dysphoria, and transition desire. Many AGP natal males live as men; others become non-binary, transfeminine, or transgender women. Exactly why AGP progresses in some males but not others is still not fully understood.

- Parents might initially hope that if the young person understands AGP, the wish to transition will disappear. Our experience is that this is usually false hope. Accurate psychoeducation may reduce shame and increase informed consent, but it often does not make an ego-syntonic trans or feminine identity go away. However, for parents attempting to understand a male adolescent with an inexplicable,

recently emerging feminine identity and transition desire, understanding the role of autogynephilia is critical to being capable of giving informed consent.

- Parents can best support their adolescent by seeking to keep the relationship intact, reduce shame, support careful assessment, make sure medical decisions are informed, and help the adolescent consider realistic options and trade-offs. Some parents come to consider that puberty suppression and/or oestrogen treatment before the age of 18 is in the young person's best interest. Others may decide that the young person should commence medical interventions when they are a legal adult and able to make and pursue decisions about medical transition independently. At King Street Psychology, we rarely write hormone recommendation letters for clients under 18. Rather, if a minor (16 or older) wishes to pursue medical transition and parents support this decision King Street Psychology would provide psychoeducation and family therapy and referral options to public gender clinics who would provide specialist assessment and management of gender-affirming hormone therapy. We would support the client and family by sharing our clinical assessment report and a handover report with the public gender clinic, ensuring assessing clinicians are aware of the client's pathway to gender dysphoria and evidence/rationale for and against paediatric transition for AGP minors.

1. Understanding adolescent emerging gender dysphoria in natal males

Parents can feel frightened, confused, or misled when an adolescent birth-assigned male child announces a wish to transition to a feminine or female role, especially when the history is adolescent-onset, not strongly feminine in early childhood. This can be even more so when an adolescent has a diagnosis of Autism Spectrum Disorder or ADD (Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder) and related mental health and general life challenges are present. Many parents are then exposed to two unhelpful extremes: either AGP is dismissed as "debunked" or anti-transgender (by some advocates and commentators), or on the other hand, AGP is weaponised by some critics of gender transition as a mere fetish or disqualifying sexual interest that is not a valid reason to transition gender socially or medically.

This resource takes a different position, which is in line with the clinical formulation used here: autogynephilia exists, it can be clinically important in adolescent-onset non-androphilic birth-assigned male presentations, and autogynephilia (and transgender identities and gender dysphoria that emerge out of it) can be valid reasons to transition when dysphoria is chronic and unremitting. That being said, given the relative absence of positive representations of autogynephilic lives that do not involve medical transition, and widespread disinformation about the nature and existence of autogynephilia, we want to ensure that decisions being made about transition (by parents and young people) are being done with some basic knowledge of AGP and the diversity of ways of expressing it.

Clinical stance

A clear AGP formulation and a respectful gender-affirming stance are not mutually exclusive. Parents can say: "We believe these feelings are real. We do not think they make you bad or fake. We also want decisions about transition to be informed, paced, and realistic."

2. What autogynephilia is

Autogynephilia literally means "love of oneself as a woman" and was introduced in sexological research to describe a natal male's propensity to be sexually aroused by the thought or image of oneself as female. In clinical work, it is usually more useful to speak of AGP as broader than genital arousal alone. It may include sexual arousal, but also more subtle emotion states including euphoria, longing, attachment, warmth, romance, and relief. After having hidden these feelings for a long time, expressing them via cross-dressing or gender transition can feel like expressing one's authentic self.

Before social or medical transition, the sexual component is usually subjectively apparent to adolescent males i.e., cross-dressing, fantasy, pornography, masturbation, or erections linked to imagining oneself as female or feminine. Very few parents are aware that these feelings are present in their teens. Very occasionally, parents may have found evidence that their teen has been cross-dressing in private (e.g., parcels ordered online or a stash of clothes) or may see evidence of accessing autogynephilia-themed pornography in their search history (e.g., sissy erotica or transgender erotica). This can be confusing to parents. It is also often shameful for the young person. Few adolescent males, even with less stigmatised sexualities (e.g., gay orientations), disclose their sexual interests and behaviours to their parents or clinicians. The same is true for autogynephilic teens, who typically avoid talking about their sexuality, or might speak vaguely about being bisexual, pansexual, or asexual (common labels used by autogynephilic males). Given how stigmatised autogynephilia can be in some communities, and given teens may fear that acknowledging autogynephilia will lead them to be seen as not valid candidates for gender transition, most will not outwardly acknowledge the experience. After social transition or oestrogen/testosterone suppression, the sexual charge commonly becomes less prominent; day-to-day dressing and living as feminine is not continuously arousing. For many, the sexual component becomes unwanted or ego-dystonic, while the gender identity and dysphoria remain ego-syntonic and the main driver of transition.

AGP component	What it can look like	Parent interpretation
Erotic/sexual	Arousal to wearing feminine clothing, imagining breasts or a female body, being treated as a woman, or being sexually desired in a feminine role.	This is clinically relevant information. AGP appears to be a reasonably common and relatively stable sexual-orientation-like pattern. Published estimates suggest that up to approximately 3% of males report some degree of this erotic interest.
Romantic/euphoric	Warmth, excitement, longing, tenderness, or attachment to the imagined feminine self.	These feelings often matter more than arousal in the development of identity.
Identity-forming	Increasing preference to be seen, named, dressed, or socially understood as feminine or female.	The identity is emergent rather than present from early childhood, but it can still become psychologically real and important in adolescence.
Dysphoric	Distress about the male body, male social role, voice, hair, musculature, genitals, or being associated with men.	Dysphoria may develop after repeated contrast between the desired feminine self and the actual male body/role.

3. What AGP is not

Misconception	More accurate clinical message
"It is just a fetish."	The ordinary word "fetish" is usually used to dismiss or humiliate. AGP can involve sexual arousal, but it can also involve romantic attachment, longing, identity, dysphoria, and a wish for a livable social role.
"If it is sexual, it cannot be a real identity."	Sexual orientation is one pathway through which human identity develops. In AGP-related dysphoria, sexual and romantic feelings can scaffold a later feminine identity. That identity can become broader than the original erotic trigger. Think of how a gay identity becomes a core part of the self for a gay individual. Although arousal to the same sex is a necessary component, a gay identity (personal and social identity) is a broader set of feelings, beliefs, attitudes, affiliations, and ways of relating to others that develop in response to, but are not reducible to, one's sexual arousal pattern.
"If we explain AGP, the transition desire will vanish."	Usually not. Once the young person wants to be transgender, non-binary, or feminine, the desire is often ego-syntonic (how the person sees themselves). Psychoeducation may reduce shame and improve decision-making; it should not be presented as a cure.
"AGP people are typical heterosexual males pretending to be women."	Many AGP individuals have never felt like typical heterosexual males. They may be neurodiverse, socially alienated from male norms, unusually inwardly focused on femininity, or emotionally attached to a feminine self. AGP males (by virtue of their AGP) have never been typical heterosexual males or typical males.
"AGP proves medical transition is inappropriate."	No. It changes the formulation and the informed-consent conversation. It does not, by itself, settle whether social or medical transition will be beneficial for a particular person. Most data on the benefits of hormonal and surgical transition in trans women are on samples who are likely predominantly autogynephilic.

4. How AGP can become gender dysphoria

A useful way to think about AGP-related gender dysphoria is this: a sexual-orientation-like pattern gives repeated positive reinforcement to imagining oneself as feminine or female. Over months or years, the imagined feminine self becomes elaborated. The young person may internalise feminine norms, mannerisms, speech patterns, aesthetics, social scripts, and ideals. They may increasingly feel alienated from masculinity and from the category "man". The identity is therefore not simply lying on top of AGP; it is a rich psychological structure that can grow from AGP.

This matters because parents sometimes hear "AGP" and conclude: "So there is no real gender identity." That is too simple. In this model, the feminine identity is emergent rather than innate in the same way as early childhood sex-atypical identity. But emergent does not mean fake. A person can build a psychologically real identity around attachment, sexuality, culture, body image, social feedback, and repeated self-imagination.

A concise formulation

For the adolescent described by this resource: AGP is treated as necessary but not sufficient for AGP-related gender dysphoria. AGP creates the motivational and emotional pathway; identity, dysphoria, personality, social environment, online communities, mental health, family responses, and bodily masculinisation shape whether the person remains male-identified, becomes non-binary, or pursues a transfeminine/woman identity.

5. Distinguishing AGP-related dysphoria from other transfeminine pathways

There is more than one pathway into transfeminine identity. This resource focuses on AGP-related dysphoria, but parents often find it helpful to understand what it is being contrasted with.

Feature	Early extreme femininity / androphilic pathway	AGP-related pathway
Typical early history	Marked feminine interests, play, mannerisms, and identification may be evident from early childhood or emerge in the context of feminine gay male development.	Less obvious or absent childhood femininity. Stronger cross-gender desire may emerge around puberty, adolescence, or early adulthood.
Sexual orientation pattern	Involves exclusive attraction to male bodies/men. Identity questions may involve "feminine gay male" versus "trans woman".	To be autogynephilic, one must be gynephilic (female-attracted). This often includes attraction to female or feminine bodies (“gynephilia”), pseudobisexuality mediated by imagining oneself as female or feminine in relation to a male (“bisexual”), or limited attraction to real people (analloerotic patterns, “asexual”).
Role of arousal/euphoria	No arousal to imagining oneself as female (or male).	Arousal, euphoria, or romantic attachment to the imagined feminine self is central, especially before transition.
Common parent confusion	Parents may say: "We always knew he was feminine and more like a girl. We didn’t know if he would grow out of the girl phase and just be a feminine gay"	Parents may say: "This appeared suddenly out of nowhere at adolescence" "He was not that feminine / or not feminine at all as a child"
Clinical implication	Assess gender dysphoria, sexuality, family support, and co-occurring mental health in the usual way.	Assess the AGP pattern directly and respectfully, because it is central to understanding identity development, dysphoria, and realistic options.

For adolescent-onset AMAB presentations with little history of extreme childhood femininity and a history of arousal, euphoria, or romantic longing to be feminine, AGP should not be treated as a remote or offensive possibility. It should be treated as a central clinical hypothesis to assess directly, given that AGP is almost always present in non-androphilic transfeminine presentations.

6. AGP exists on a continuum

AGP is not all-or-nothing. Some natal males have occasional cross-dressing arousal and little dysphoria. Others experience intense anatomic yearning for breasts, a female body, or a feminine body that retains some male anatomy. Some are strongly attracted to women in the ordinary outward-directed way; for them, relationships with women may temporarily reduce the dominance of AGP. Others are more analloerotic, meaning their erotic and romantic life is largely organised around the self-as-feminine fantasy rather than other people.

This variability helps explain why some AGP individuals remain men, while others find the male role intolerable and pursue medical transition. Anatomic AGP—intense arousal, euphoria, or longing for female or feminine bodily anatomy—appears especially relevant to the wish for medical transition. But there is no simple formula. The clinical question is not merely “Is AGP present?” but “How intense, central, dysphoria-producing, identity-forming, and body-focused is it?” The question is also whether other independent factors are currently leading the young person to lean into their AGP feelings in a way that might not feel as appealing in the future. This might include shame about AGP feelings, lack of positive representation of AGP people who are not transgender, peer factors, or distress and social difficulties linked to neurodivergence and other mental health issues that are being misinterpreted as purely related to gender dysphoria. Although the aforementioned factors can seem intuitively appealing to parents and clinicians, it is important not to overinvest in the idea that changes in these factors (or insight into these factors) will lead to dissolution of the transgender identity or desire to transition over time.

7. Viable life pathways for AGP natal males

A core informed-consent task is to make sure the young person and parents understand that AGP can be lived in more than one way. Discussing alternatives is not conversion therapy (no one approach is framed as superior or desired) and not a disguised attempt to deny transition. It is part of mature decision-making. At the same time, parents should be warned against false hope: in our experience presenting alternatives rarely makes an adolescent who strongly wants transition abandon that goal.

Pathway	Description	Potential advantages	Potential limitations
Male identity with private or selective feminine expression	The person continues living publicly as male and cross-dresses, role-plays, or expresses femininity privately or in selected contexts.	Avoids medical risk and public transition; can work when dysphoria is low and shame is reduced.	Can become restrictive, shame-based, or associated with binge-purge cycles if the person is trying to repress rather than integrate AGP.

Pathway	Description	Potential advantages	Potential limitations
Gender-nonconforming male or androgynous presentation	The person remains male-identified but integrates feminine clothing, aesthetics, mannerisms, or social roles into public life.	Allows integration without claiming womanhood or taking hormones; may reduce shame and compartmentalisation.	May not satisfy body-focused dysphoria or desire to escape the male category.
Non-binary or genderfluid identity without hormones	The person exits a strictly male identity and uses a more flexible gender category, sometimes with social changes only.	Can reduce distress around maleness while preserving medical options for later.	May feel incomplete if the person longs for bodily feminisation.
Non-binary/ transfeminine identity with feminising hormones	The person uses oestrogen and/or androgen suppression to feminise body and reduce libido/erections, while perhaps not claiming womanhood.	Can address body dysphoria and reduce unwanted sexual arousal while maintaining flexible identity language.	Breast growth and fertility effects can be long-lasting; social ambiguity can be stressful.
Trans woman/feminine transition with hormones, no genital surgery	The person socially transitions toward being read and treated as female/feminine, uses hormones, and retains penis/testes.	Matches common AGP transfeminine goals when genital dysphoria is mild or absent.	Passing concerns, stigma, dating/sexual complications, fertility, and ongoing genital incongruence may remain.
Trans woman/feminine transition with genital surgery	The person pursues hormones and later vaginoplasty/labiaplasty or related surgeries.	May relieve severe genital/anatomic dysphoria.	Major surgery with cost, pain, irreversible changes, sexual-function implications, and need for careful adult-level consent.

8. Repression, integration, and shame cycles

A common AGP pattern is a binge-purge cycle: the person feels ashamed, tries to stop cross-dressing or feminine fantasy completely, discards clothing or sexual materials, then experiences mounting tension and eventually returns to the behaviour with more shame. This cycle can train secrecy and self-disgust. It can also make parents overestimate how "compulsive" or "addictive" the identity is, because they mainly see crisis points.

Integration means finding an honest and non-shaming place for AGP in the person's life. Integration may or may not include transition. It could mean private expression, a gender-nonconforming male presentation, non-binary identity, or transfeminine transition. The key is that the young person is not trying to destroy or deny a durable part of themselves through shame and fear.

Parent boundary

Parents do not need to endorse every behaviour or every medical request immediately. But they should avoid disgust, ridicule, surveillance, or sexual interrogation. Sexual details are best explored with a clinician in an age-appropriate, confidential setting.

9. Thinking carefully about medical transition

Medical transition decisions should be neither rushed nor indefinitely obstructed. The task is to ask: What problem is the intervention meant to solve? How likely is it to solve that problem? What are the costs of doing it now, doing it later, or not doing it? What does the adolescent understand about reversibility, fertility, sexuality, physical change, social consequences, and uncertainty?

For AGP-related dysphoria, feminising hormones may be desired for several reasons: breast development, softer skin, less muscle mass, reduced erections and libido, emotional relief from testosterone-driven arousal, and a body that feels closer to the imagined feminine self. These can be real benefits. They also come with trade-offs that must be understood.

Effect of feminising hormone therapy	Typical timeframe / reversibility message
Decreased libido and spontaneous erections	Often begins within 1-3 months and may reduce unwanted arousal. Usually at least partly reversible after stopping, but individual outcomes vary.
Breast growth	Often begins within 3-6 months and develops over 2-3 years. Once developed, breast tissue is not expected to fully reverse.
Fat redistribution, softer skin, reduced muscle mass/strength	Usually gradual and variable. Some changes reverse partially after stopping; degree depends on duration, age, genetics, and activity.
Reduced testicular volume and sperm production	Can occur with oestrogen/androgen suppression. Fertility impact may persist, and fertility preservation should be discussed before treatment.
Facial/body hair and scalp hair	Facial hair usually requires laser/electrolysis for substantial change. Scalp hair effects are variable.
Voice	Oestrogen does not feminise a voice that has deepened through male puberty. Voice therapy may help; surgery is a separate consideration.
Bone health and puberty suppression	When puberty blockers are used, bone density monitoring, calcium/vitamin D, exercise, and specialist oversight matter. Long-term effects require careful follow-up.

Compared with testosterone in trans males

Feminising hormones generally produce fewer irreversible changes than masculinising testosterone, but they are not consequence-free. Breast growth and fertility effects are the major permanent or potentially long-lasting issues to highlight early.

10. Evidence base: what is known and what is not

The evidence base is uneven. Adult studies of transfeminine medical transition often show high satisfaction and improvements in dysphoria or wellbeing, and historically many adult trans women in those samples were likely non-androphilic/AGP even when AGP was not measured. However, the data are not as precise as clinicians or parents would like: many studies are observational, have short follow-up, do not stratify by AGP status, and were conducted in eras when access barriers meant that only more persistent or severely dysphoric people reached hormones or surgery.

For adolescents, the evidence is even less direct. There are no high-quality AGP-specific studies that tell us exactly which AGP adolescents should start blockers or oestrogen at which age. This does not mean "do nothing". It means assessment and consent should be honest about uncertainty, developmental maturity, family support, mental health, dysphoria severity, fertility, and the costs of delay.

Evidence-informed point	Practical implication for parents
AGP is real and clinically important in many birth-assigned male gender-dysphoric presentations.	Do not treat it as an insult, conspiracy, or disqualifying fact. Discuss it accurately.
AGP-specific adolescent outcome data are limited.	Avoid both certainty that transition will solve everything and certainty that it is a mistake.
Adult transition satisfaction and regret data are generally reassuring but imperfect.	Use them as part of consent, not as a guarantee for a particular adolescent.
Adolescents differ in maturity, mental health, neurodevelopment, family support, and dysphoria severity.	Good care is individualised. A generic, one-size-fits-all clinical script is not enough.
Delay has costs as well as benefits.	Waiting can permit maturation and sexual/relationship experience, but may allow further masculinisation, deepen dysphoria, increase distress, and cause relational conflict.

11. Access pathways and assessment

In Australia, adult care may occur through an informed-consent GP pathway at age 18 or after, while a WPATH-style mental health assessment letter may be useful or required for some clinicians and many surgical interventions. For minors, additional legal, developmental, family, paediatric, and capacity safeguards often apply.

A good assessment does not merely ask whether the young person can recite the effects of oestrogen. It explores the history and meaning of dysphoria, the AGP pattern, mental health, neurodevelopment, family dynamics, fertility, alternatives to medical intervention, social transition plans, realistic expectations, and what support will continue after any medical step.

Assessment domain	Questions to clarify
Gender history	When did feminine yearning, dysphoria, or identity begin? Was there childhood extreme femininity or mostly adolescent-onset AGP-linked development?
AGP pattern	What forms are present: transvestic, anatomic, interpersonal, behavioural, physiological, partial/futanari/autogynandromorphophilic? How ego-syntonic or ego-dystonic is each?
Body dysphoria	Which male features are intolerable? Which feminising changes are most desired? What changes are expected from hormones versus surgery, hair removal, or voice work?
Sexuality and relationships	Attraction to women, men, feminine males, trans women, or no one? How much is attraction outward-directed versus mediated by imagining self as feminine?
Mental health and neurodevelopment	Anxiety, depression, autism/ADHD traits, social isolation, trauma, compulsive sexual behaviour, shame, suicidality, eating/body image concerns.
Capacity and consent	Can the adolescent understand benefits, risks, alternatives, unknowns, reversibility, fertility, and the consequences of delaying or proceeding?
Family and social context	Can parents support without controlling? Is school safe? Are online communities helping, pressuring, or escalating dysphoria?
Alternatives and timing	Which non-medical or lower-intensity options have been considered seriously? What would be gained or lost by waiting 3, 6, or 12 months?

12. What parents can do

- Keep the relationship safe.
  - Use the young person's chosen name and pronouns where possible or negotiate respectful interim language if this is genuinely difficult (e.g., using gender-neutral language).
- Avoid sexual shame.
  - Do not use words like dirty, perverted, porn-addicted, fake, or disgusting. Avoid demanding explicit details. Let clinicians handle sexual history with dignity and appropriate confidentiality.
- Ask reality-testing questions kindly.
  - What do you hope hormones will change? What will they not change? What would make transition a success? What would make you regret it? What supports will you need?
- Support broad functioning.

- Depression, anxiety, school avoidance, loneliness, autism/ADHD, sleep, exercise, friendships, and assertiveness still matter. Transition is not a complete mental health plan.

- Hold uncertainty without panic.
  - Parents can be concerned without becoming adversarial. Adolescents often need both autonomy and adults who calmly think several years ahead.

The goal of talking about AGP

The goal is not to catch the adolescent out. The goal is to reduce shame, improve self-knowledge, and make sure any pathway - male integration, non-binary identity, social transition, hormones, or later surgery - is chosen with realistic expectations.

13. What tends to backfire

Parent response	Why it backfires	Better alternative
"This is just a fetish or a sexual interest."	Humiliates the young person and makes honest discussion impossible.	"We understand that these feelings can involve sexuality and identity. We want to understand it without shaming you."
Interrogating masturbation, pornography, or fantasies.	Violates privacy and encourages secrecy or defensive denial.	Ask the clinician to explore sexual history appropriately. Parents can focus on safety, shame, and decision-making.
Pretending AGP is irrelevant because it is controversial.	Leaves parents confused and the adolescent without an accurate explanation of their own pattern.	Use clear, non-pejorative language: AGP exists and can shape identity. If the word “autogynephilia” is too pathologising or carries too much baggage, other terms suggested for the same experience are “autoheterosexual” or “feminine embodiment fantasies.”
Using AGP as a veto against all transition.	Turns psychoeducation into a weapon and may increase polarisation.	Discuss AGP as part of informed consent, alongside dysphoria severity, maturity, fertility, and alternatives.
Rushing to hormones to reduce family conflict.	Medical treatment should not be used mainly to end arguments or anxiety.	Create a paced plan with assessment, medical information, mental health support, and review points.
Blocking indefinitely without a plan.	Can intensify dysphoria, secrecy, online dependence, and distrust.	Name what information, maturity, supports, or milestones would make next steps reasonable.

14. Sample parent script

This script should be adapted to the family. It is intentionally warm, direct, and non-shaming. **Note: It is strongly recommended to discuss with me how it would be most appropriate to have this conversation with your child and tailoring the conversation to them specifically given the sensitivity of this topic and likelihood of being misunderstood and damaging rapport.**

> *"We want you to know that we love you and we believe your distress and your wish to live more femininely are real. We are not going to use one theory or one word to mock you or tell you that you are fake."*
>
> *"At the same time, because we are your parents, we need to understand what is happening and help you make informed decisions. We understand there is a sexual-orientation-like pattern in which some birth-assigned males experience arousal, euphoria, romantic feelings, or strong longing in response to imagining themselves as female or feminine. This type of disposition appears to be something people are born with, and many transgender women who pursue medical transition have these feelings."*
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> *"We also understand that this does not mean you are just pretending or that it is only sexual. For some people, these feelings can develop into a feminine or female identity and gender dysphoria, and transition may feel necessary. For other people, these feelings might not become so strong that they wish to transition, or transition might not feel like the best option in the longer term. We want to be able to talk about that honestly without shame."*
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> *"We are not raising this because we expect it to make you stop wanting transition. We are raising it because if medical transition is the path you choose, we want you to understand your own pathway, what hormones can and cannot do, what effects may be permanent, what alternatives exist, and what supports you will need."*
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> *"We would like us to work with a clinician who can discuss these feelings directly and respectfully, not deny them and not use them against you. We want the conversation to include hormones, fertility, sexuality, dysphoria, mental health, timing, and different possible ways to live with these feelings, including the spectrum from social transition or occasional feminine presentation through to full medical transition."*

15. Questions parents can bring to a clinician

- Do you see this presentation as AGP-related gender dysphoria? If so, how does that change assessment and informed consent?
- How stable and persistent is the adolescent's dysphoria and feminine identity? What would count as evidence of change or instability?
- Which requested interventions address which specific sources of distress?
- What are the likely benefits, limits, and risks of oestrogen, anti-androgens, or puberty blockers in this case?
- What fertility preservation options should be discussed before hormones?
- What non-medical pathways have been discussed without shaming or coercion?
- How are anxiety, depression, autism/ADHD, social functioning, school stress, shame, and compulsive sexual behaviour being assessed and treated?
- What review points will be used if the young person socially transitions or begins hormones?
- How can parents support the adolescent while still participating responsibly in decision-making?

16. When to seek urgent or additional help

- Suicidal thoughts, self-harm, severe depression, panic, psychosis, or rapid functional decline.
- Using unprescribed hormones or anti-androgens, buying medication online, or refusing medical monitoring.
- Severe family conflict, threats, coercion, violence, or homelessness risk.
- Compulsive pornography/fantasy cycles causing major distress or impairment.
- Extreme social isolation, school refusal, eating/body-image crises, or inability to discuss risks and alternatives.
- A parent or adolescent feeling unable to have any conversation without escalation.

17. Glossary

Term	Meaning in this resource
AGP / autogynephilia	A birth-assigned male pattern of sexual, romantic, euphoric, or identity-reinforcing response to imagining oneself as female/feminine or being treated that way.
AMAB / birth-assigned male / natal male	A person whose sex was classified male at birth. This resource uses the terms descriptively, not as an insult.
Ego-syntonic	Experienced as fitting with the self: "This is who I am" or "This is what I want."
Ego-dystonic	Experienced as unwanted, shameful, intrusive, or inconsistent with the self.
Anatomic AGP	AGP focused on having a female or feminine body or body parts.
Transvestic AGP	AGP focused on wearing feminine clothing.
Interpersonal AGP	AGP focused on being seen, desired, or treated by others as female/feminine.
Autogynandromorphophilia	A related pattern involving attraction to imagining oneself as having a mixed feminine-and-male body, for example feminine appearance with a penis.
Pseudobisexuality	Male-directed or receptive sexual fantasy that is mediated by imagining oneself in a feminine/female role, rather than ordinary attraction to male bodies.
Analloerotic	Having little or no outward-directed attraction to real people; erotic life may be mainly self-directed or fantasy-based.
Informed consent	A model in which a person starts treatment after understanding benefits, risks, alternatives, and uncertainties. For minors, capacity and legal/guardian requirements vary.

Term	Meaning in this resource
WPATH	World Professional Association for Transgender Health, publisher of the Standards of Care used internationally.

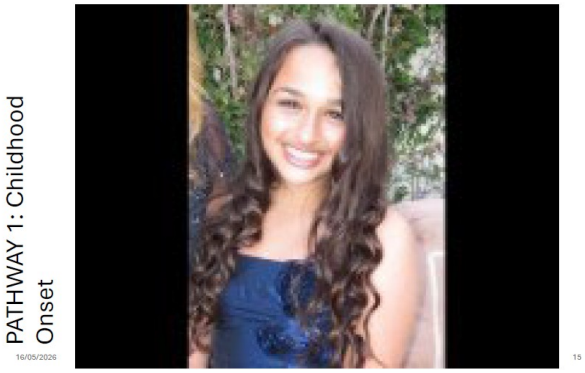
18. Appendix: Developmental pathway figures

The "diversity" of gender diversity

- **Magnus Hirschfeld** (1910): "*The urge to wear clothes of the opposite sex is not a single phenomenon; it arises from a multitude of emotional, psychological, and, sometimes, somatic causes, indicating a diverse group rather than a single, unified condition.*"
- **Harry Benjamin** (1966): "*No single cause explains the urge to change sex; the condition could stem from many paths, biological, psychological, or sociological*," with *"distinct pathways manifesting in varying degrees of cross-gender identification.*"
- **Ray Blanchard** (2005): "*Gender dysphoria is not a single syndrome; rather, it includes distinct subtypes that differ in developmental pathways, motivations, and psychological traits.*"
- **Anne Lawrence** (2008): "*gender dysphoria may arise from a variety of developmental and psychological trajectories, challenging the view of it as a single syndrome. Instead, we see complex presentations that align with unique histories, desires, and personality structures.*"
- **Kenneth Zucker** (2019): "*The experiences of gender dysphoric individuals are heterogeneous, influenced by an interplay of biological, cognitive, and sociocultural factors that do not easily converge into a single explanatory model… suggesting gender dysphoria as a collection of syndromes rather than a uniform condition.*"

	Childhood Onset AMAB & AFAB	Adolescent & Adult Onset AMAB	Adolescent & Adult Onset AFAB
Etiology	Atypical Brain Sex Differentiation Pervasive Gender Nonconformity	Autoheterosexuality	Heterogeneous Atypical Brain Sex Differentiation Autism Spectrum Disorder
Sexuality	Same-sex attracted	Autoheterosexual	Mixed
Course	Historically, most desist by puberty	Progressive (can be intermittent or desist in some cases)	Unknown
Historical Presence	More frequent pediatric clients pre-1970 to ~2000	Most frequent adolescent and adult trans women/non-binary femmes	Most frequent pediatric clients post 2010+

Pathway 1:



See video here of an example of a childhood onset (hypomasculinised androphilic natal male transitioner)

Figure 1. Developmental pathway associated with early extreme femininity/androphilia

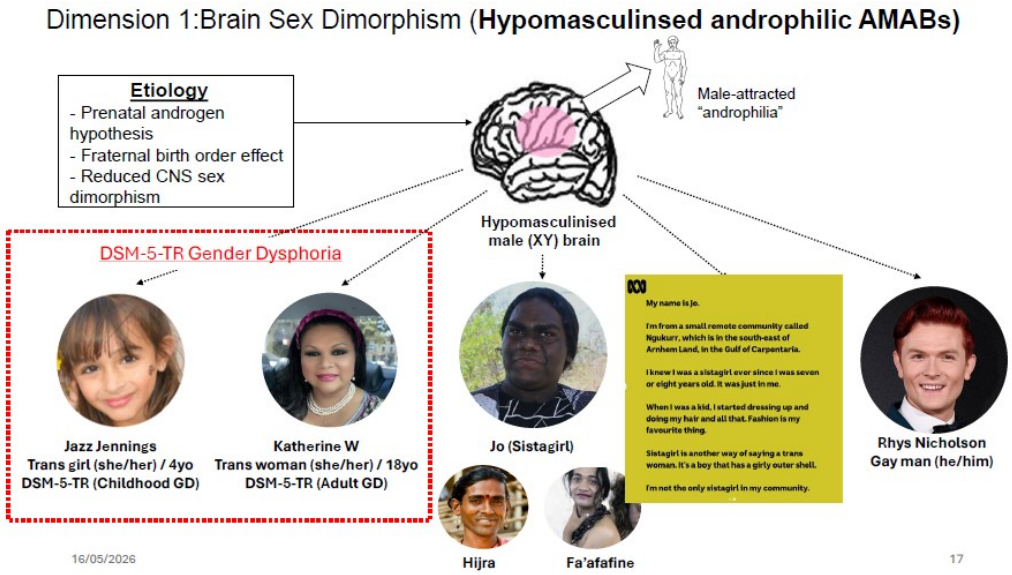
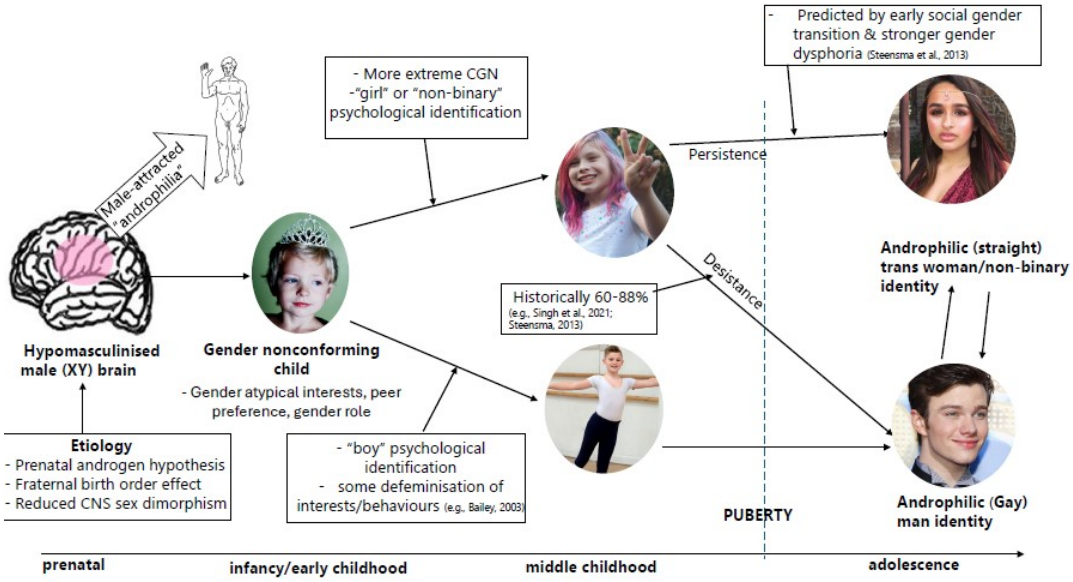


Figure 1 illustrates different ways that hypomasculinised androphilic natal males exist across time and culture (in the West as gay men or male-attracted trans women or non-binary femmes and in traditional cultures as “third-gender” groups like Fa’afafine in Samoa and Hijra of India). Gender non-conformity is present throughout development and evident in behaviour/preferences from infancy onward. Owing to their extreme femininity a subset of these natal males develop the conviction that they are girls (not boys) in early childhood, and while historically most of these young boys have desisted by puberty and grown up to be feminine gay men, a minority persist in their desire to be girls. This is the group that have historically been the majority of child referrals to gender services and those that the Dutch Protocol (puberty suppression at 12 and oestrogen treatment at age 16) was developed to treat. Interestingly however, Pathway 2 (AGP) now predominates in paediatric gender services and is probably more developmentally stable (although more data are needed).



Pathway 2:

See video here of an example of an autogynephilic adolescent natal male transitioner

Figure 2. Autogynephilic/autoheterosexual developmental pathway

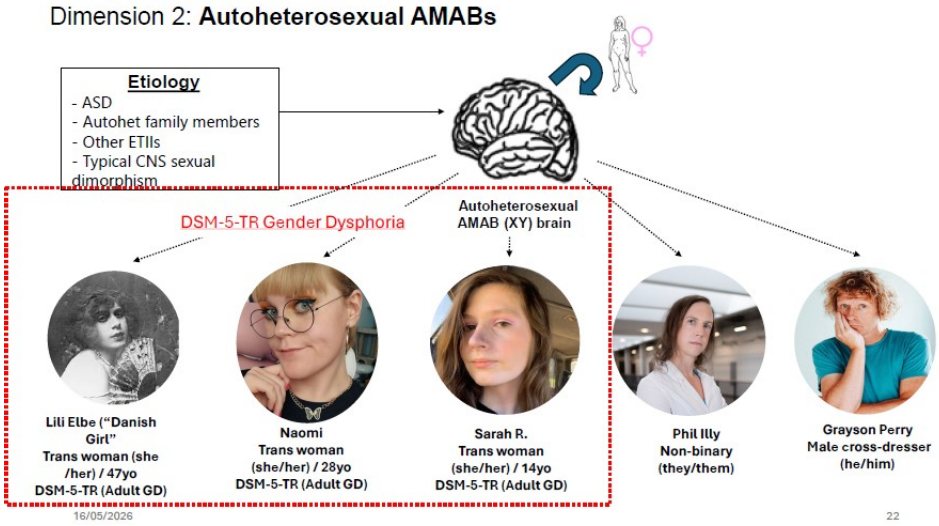
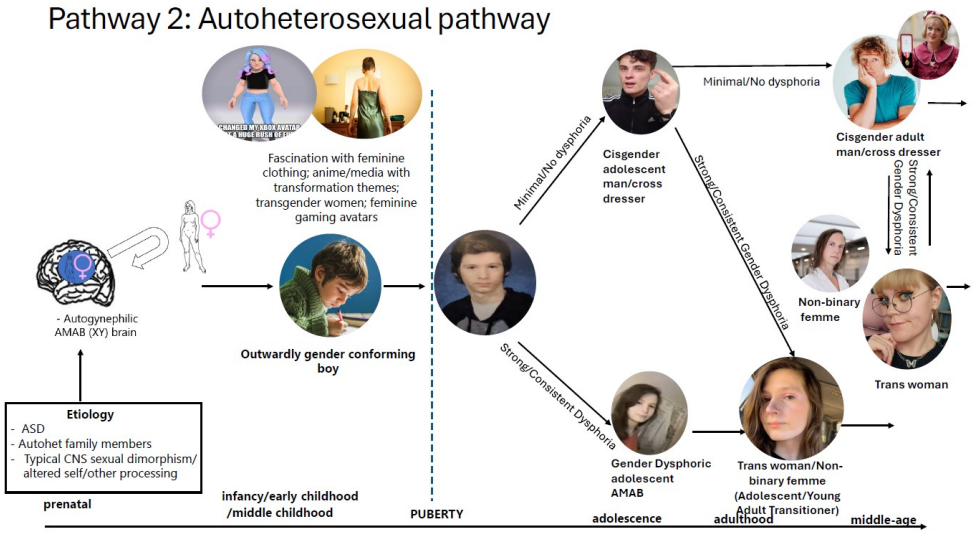
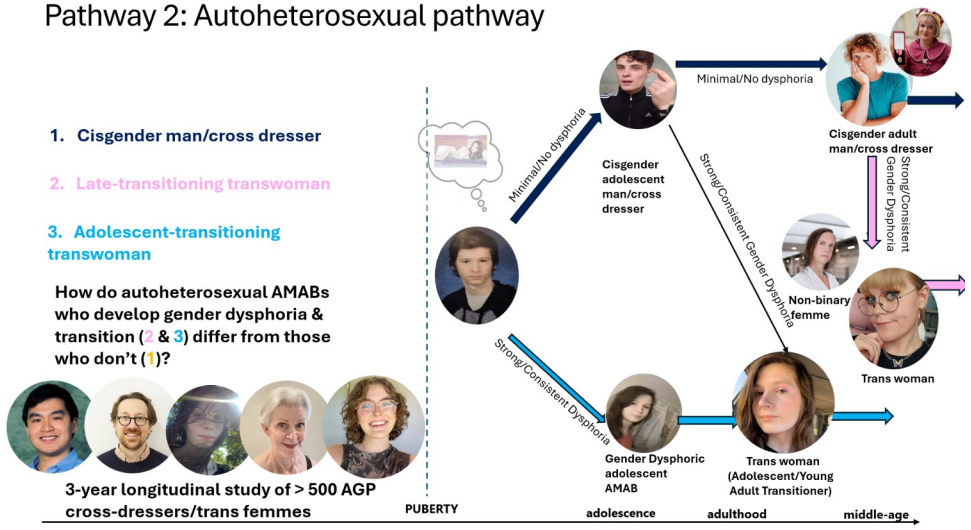


Figure 2 illustrates the diverse ways that the same underlying neurological phenomenon (autogynephilia) can be expressed in distinct ways depending on strength of AGP and other unknown factors (i.e., in some it can lead to clinically significant gender dysphoria and desire to medically transition, see Lili Elbe, Naomi, Scarlet; in others it may lead to milder or absent gender dysphoria, like in non-binary AGP Phil Illy (feminine hair and clothing but without medical transition) and cross-dresser and famous artist, Grayson Perry (who cross-dresses intermittently).





These figures show the developmental trajectory of autogynephilia. Unlike the hypomasculinised androphilic pathway, this group is not made up of effeminate children with pervasive feminine interests, mannerisms, and disposition. There may be mild intermittent emotional experiences of euphoria, fascination with the idea of wearing female clothing, adopting female social role, or having a female body before puberty but this is rarely acted upon and usually not observed by parents. At adolescence AGP feelings become much stronger. Historically, most AGP natal males would conceal this interest, attempt to live as an outwardly typical heterosexual or bisexual male. Some would identify as “cross-dressers” and socialize with other cross-dressers in organisations such as the Sea Horse Society (Sydney). Most would cross-dress in secret. Some of these individuals would pursue transition later in life (often in 30s or 40s) if gender dysphoria and cross-gender identification intensified. In the past couple of decades, with greater acceptance of trans people, some autogynephilic natal males are socially and medically transitioning soon after the onset of AGP feelings in adolescence (such as Scarlet in the video above). In fact, at King Street Psychology we have had some 12-year-old AGP clients, whose parents have referred to assessment and counselling within months of the young person experiencing the onset of feelings and wishing to dress as a girl. The vast majority of natal male referrals to King Street Psychology Clinic (and public gender clinic) are now autogynephilic. Most persist in their desire to pursue hormonal transition including pursuing hormone treatment independently once they are 18 years of age and do not require parent consent or a letter of recommendation from us.

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