

# ATTACHMENT D

**THE SCIENCE OF GENDER DYSPHORIA  
AND TRANSSEXUALISM**

**REPORT SUBMITTED TO THE  
FLORIDA AGENCY FOR HEALTHCARE ADMINISTRATION**

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## I. Background & Credentials

1. I am a research scientist and clinical psychologist and am currently the Director of the Toronto Sexuality Centre in Canada. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

2. Over my academic career, my posts have included Senior Scientist and Psychologist at the Centre for Addiction and Mental Health (CAMH), Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3. My scientific expertise spans the biological and non-biological development

of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment and treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. Although I was a member of the hospital's adult forensic program, I remained in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple research projects.

## **II. Summary of Conclusions**

- The scientific research consistently demonstrates that there is more than one distinct phenomenon that can lead to gender dysphoria. These types are distinguished by differing epidemiological and demographic patterns, unique psychological and behavioral profiles, and differing responses to the treatment options.
- Studies show that otherwise mentally healthy adults—undergoing thorough assessment (1–2 year Real Life Experience) and supervised by clinics engaged in gate-keeping roles—adjust well to life as the opposite sex.
- Regarding pre-pubescent children with gender dysphoria, there have been 11 outcomes studies. All 11 reported the majority of children to cease to feel dysphoric by puberty. They typically report being gay or lesbian instead.
- Regarding pubescent and adolescent age minors, there have been (also) 11 follow-up studies of puberty blockers and cross-sex hormones. In four, mental health failed to improve at all. In five, mental health improved, but because psychotherapy and medical interventions were both provided, which one caused the improvement could not be identified. The two remaining studies employed methods that did permit psychotherapy effects to be distinguished from medical effects, and neither found medical intervention to be superior to psychotherapy-only.
- The research importantly distinguishes completed suicides—which occur primarily in biological males and involve the intent to die—from suicidal ideation, gestures, and attempts—which occur primarily in biological females and represent psychological distress and cries for help. The evidence is minimally consistent with transphobia being the predominant cause of suicidality. The evidence is very strongly consistent with the hypothesis that other mental health issues, such as Borderline Personality Disorder (BPD), cause suicidality and unstable identities, including gender identity confusion.
- The international consensus of public health care services is that there remains no evidence to support medicalized transition for youth. The responses in the U.S. stand in stark contrast with Sweden, Finland, France, and the United Kingdom, which are issuing increasingly restrictive statements and policies, including bans on all medical transition of minors.

### **III. Science of Gender Dysphoria and Transsexualism**

6. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria

(cases of *late-onset* gender dysphoria),<sup>1</sup> merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or “rapid-onset” gender dysphoria (ROGD). Very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to another.

### **A. Adult-Onset Gender Dysphoria**

7. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively biological males.<sup>2</sup> They typically report being sexually attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.<sup>3</sup> Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.<sup>4</sup>

#### **1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria**

8. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,<sup>5</sup> Sweden,<sup>6</sup> and the Netherlands.<sup>7</sup>

9. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults

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<sup>1</sup> Blanchard, 1985.

<sup>2</sup> Blanchard, 1990, 1991.

<sup>3</sup> Blanchard, 1988.

<sup>4</sup> Blanchard 1989a, 1989b, 1991.

<sup>5</sup> Blanchard, *et al.*, 1989.

<sup>6</sup> Dhejneberg, *et al.*, 2014.

<sup>7</sup> Wiepjes, *et al.*, 2018.

with gender dysphoria all performed “gate-keeping” procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

10. An important caution applies to interpreting these results: The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

## **2. Mental Health Issues in Adult-Onset Gender Dysphoria**

11. The research evidence on mental health issues in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.<sup>8</sup> A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.<sup>9</sup> There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless demonstrated (1) that rates of mental health issues among people are highly elevated both before *and after* transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients to become “lost to follow-up.” With attrition rates that high, it is unclear to what

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<sup>8</sup> See, e.g., Hepp, *et al.*, 2005.

<sup>9</sup> Dhejne, *et al.*, 2016.

extent the information from the remaining participants would accurately reflect the whole population. The very high rate of “lost to follow-up” leaves open the possibility of considerably more negative results overall.

12. The long-standing and consistent finding that gender dysphoric adults continue to show high rates of mental health issues after transition indicates a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition—that is, transition does not appear to be what causes mental health improvement. Rather, mental health issues should be resolved before any transition, as has been noted in multiple standards of care documents, as detailed in their own section of this report.

## **B. Childhood Onset (Pre-Puberty) Gender Dysphoria**

### **1. Follow-up Studies Show Most Children Desist by Puberty**

13. Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.<sup>10</sup>

14. In total, there have been 11 outcomes studies of these children, listed in Appendix 1. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as “desisters,” whereas children who continue to feel gender dysphoric are often called “persisters.”

15. Notably, in most cases, these children were receiving professional

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<sup>10</sup> Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.*, 2018; Wood, *et al.*, 2013.

psychosocial support across the study period aimed, not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: It is not possible to know to what extent the outcomes were influenced by the psychosocial support or would have emerged regardless. In science, this is referred to as a confound.

16. While the absolute number of those who present as prepubescent children with gender dysphoria and “persist” through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, a clinician cannot take either outcome for granted.

17. It is because of this long-established and unanimous research finding of desistance being probable but not inevitable, that the “watchful waiting” method became the standard approach for assisting gender dysphoric children. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

18. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. That is, gender identity is not the same as sexual orientation, and it cannot be assumed that gender identity is as unchangeable as is sexual orientation. Such is an empirical question, and there has not yet been any such study.

19. It is also important to note that research has not yet identified any reliable

procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and “affirmation.” Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can be weighted. Such “risk prediction” and “test construction” are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.<sup>11</sup>

20. In contrast, one research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children’s “peer preference, toy preference, clothing preference, gender similarity, and gender identity.”<sup>12</sup> They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, “Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability.”<sup>13</sup> Although the Olson team declared that “social transitions may be predictable from gender identification and preferences,”<sup>14</sup> their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.<sup>15</sup> Both of those are lower than the value of .75, so both of those would be more likely than not

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<sup>11</sup> Singh, *et al.* (2021); Steensma *et al.*, 2013.

<sup>12</sup> Rae, *et al.*, 2019, at 671.

<sup>13</sup> Rae, *et al.*, 2019, at 673.

<sup>14</sup> Rae, *et al.*, 2019, at 669.

<sup>15</sup> Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

to desist, rather than to proceed to transition. That is, Olson’s model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

21. Although it remains possible for some future discovery to yield a method to identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *detransition*. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, “transition-on-demand” increases the probability of unnecessary transition and unnecessary medical risks.

## **2. “Watchful Waiting” and “The Dutch Protocol”**

22. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, The Dutch Protocol,<sup>16</sup> including its “Watchful Waiting” period. Internationally, the Dutch Protocol remains the most empirically supported protocol for the treatment of children with gender dysphoria.

23. The purpose of the protocol was to compromise the conflicting needs among: clients’ initial wishes upon assessment, the long-established and repeated observation that those wishes will change in the majority of (but not in all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

24. The Dutch Protocol was developed over many years by the Netherlands’ child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric

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<sup>16</sup> Delemarre-van de Waal & Cohen-Kettenis (2006).

children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach*.<sup>17</sup> The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting period),
- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

25. For youth under age 12, “the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty.”<sup>18</sup>

26. The age cut-offs of the Dutch Approach were not based on any research demonstrating their superiority over other potential age cut-off’s. Rather, they were chosen to correspond to the ages of consent to medical procedures under Dutch law. Nevertheless, whatever the original rationale, the data from this clinic simply contain no information about the safety or efficacy of employing these measures at younger ages.

27. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child’s parents.

28. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. “Watchful Waiting” refers to a child’s developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Rather, such children and families typically present with substantial distress involving both gender and non-gender issues, and it is during the watchful waiting period that a child (and other family members as appropriate) would

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<sup>17</sup> de Vries & Cohen-Kettenis, 2012

<sup>18</sup> de Vries & Cohen-Kettenis, 2012, at 301.

undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, “[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic’s psychologists or psychiatrists.”<sup>19</sup> One is actively treating the person, while carefully “watching” the dysphoria.

### **3. Follow-Up Studies of Puberty Blockers and Cross-Sex Hormones**

29. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many outlets have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. In total, there have been 11 prospective outcomes studies following up gender dysphoric children undergoing medically induced suppression of puberty or cross-sex hormone treatment. Four studies failed to find evidence of improvement in mental health functioning at all, and some groups deteriorated on some variables.<sup>20</sup> Five studies successfully identified evidence of improvement, but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.<sup>21</sup> In the remaining two studies, both psychotherapy and medical interventions were provided, but the studies were designed in such a way as to allow the effects of psychotherapy to be separated from the effects of the puberty-blocking medications.<sup>22</sup> As detailed in the following, neither identified benefits of medication over psychotherapy alone.

#### **a. Four studies found no mental health improvement**

30. Carmichael, *et al.* (2021) recently released its findings from the Tavistock

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<sup>19</sup> de Vries, *et al.*, 2011, at 2280-2281.

<sup>20</sup> Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020; Kuper, *et al.*, 2020.

<sup>21</sup> de Vries, *et al.*, 2011; Tordoff, *et al.*, 2022; van der Miesen, *et al.*, 2020.

<sup>22</sup> Achille, *et al.*, 2020; Costa, *et al.*, 2015.

and Portman clinic in the U.K.<sup>23</sup> Study participants were ages 12–15 (Tanner stage 3 for natal males, Tanner stage 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients’ or their parents’ perspective.

31. In Kuper, *et al.* (2020), a multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.<sup>24</sup> (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to practice guidelines from the Endocrine Society.<sup>25</sup> Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.<sup>26</sup> Notably, whereas the Dutch Protocol includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).<sup>27</sup>

32. Hisle-Gorman, *et al.* (2021) analyzed military families’ healthcare data to compare 963 transgender and gender-diverse youth before versus after hormonal treatment, with their non-gender dysphoric siblings as controls. The study participants included youth undergoing puberty-blocking as well as those undergoing cross-sex hormone treatment, but these subgroups did not differ from each other. Study participants had a mean age of 18 years when beginning the study, but their

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<sup>23</sup> Carmichael, *et al.*, 2021.

<sup>24</sup> Kuper, *et al.*, 2020, at 5.

<sup>25</sup> Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.

<sup>26</sup> Kuper, *et al.*, 2020, at Table 2.

<sup>27</sup> Kuper, *et al.*, 2020, at 4.

initial clinical contacts and diagnoses occurred at a mean age of 10 years. According to the study, “mental health care visits overall did not significantly change following gender-affirming pharmaceutical care,”<sup>28</sup> yet, “psychotropic medication use *increased*,”<sup>29</sup> indicating *deteriorating* mental health.

33. Kaltiala et al. (2020) similarly reported that after cross-sex hormone treatment, “Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems during real-life.”<sup>30</sup> They concluded, “Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development.”<sup>31</sup>

**b. Five studies confounded psychotherapy and medical treatment**

34. The initial enthusiasm for medical blocking of puberty followed largely from early reports from the Dutch clinical research team suggesting at least some mental health improvement.<sup>32</sup> It was when subsequent research studies failed to replicate those successes that it became apparent that the successes were due, not to the medical interventions, but to the psychotherapy that accompanied such interventions in most clinics, including the Dutch clinic.

35. The Dutch clinical research team followed up a cohort of youth at their clinic undergoing puberty suppression<sup>33</sup> and later cross-hormone treatment and surgical sex reassignment.<sup>34</sup> The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and

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<sup>28</sup> Hisle-Gorman, et al., 2021, at 1448.

<sup>29</sup> Hisle-Gorman, et al., 2021, at 1448, emphasis added.

<sup>30</sup> Kaltiala et al., 2020, at 213.

<sup>31</sup> Kaltiala et al., 2020, at 213.

<sup>32</sup> de Vries, *et al.*, 2011; de Vries, *et al.*, 2014

<sup>33</sup> de Vries, *et al.*, 2011.

<sup>34</sup> de Vries, *et al.*, 2014.

general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.<sup>35</sup>

36. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other. The authors of the study were explicit in noting this themselves: “All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents.”<sup>36</sup>

37. In a 2020 update, the Dutch clinic reported continuing to find improvement in transgender adolescents’ psychological functioning, reaching age-typical levels, “after the start of specialized transgender care involving puberty suppression.”<sup>37</sup> Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it again cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors noted again, “The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-

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<sup>35</sup> Biggs, 2020.

<sup>36</sup> de Vries, *et al.* 2011, at 2281.

<sup>37</sup> van der Miesen, *et al.*, 2020, at 699.

term mental health outcomes.”<sup>38</sup>

38. Allen, *et al.* (2019) reported on a sample of 47 youth, ages 13–20, undergoing cross-sex hormone treatment. They reported observing increases in measures of well-being and decreases in measures of suicidality; however, as the authors also noted, “whether a patient is actively receiving psychotherapy” may have been a confounding variable.<sup>39</sup>

39. Tordoff, *et al.* (2022) reported on a sample of youth, ages 13–20 years, treated with either puberty blockers or cross-sex hormones. There were improvements in mental health functioning; however, 62.5% of the sample was again receiving mental health therapy.<sup>40</sup>

**c. Two studies showed no superiority of medical intervention above psychotherapy**

40. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.<sup>41</sup> As those authors concluded, “Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence.”<sup>42</sup> Because psychological support does not pose the physical health risks that hormonal interventions or surgery does (such as loss of reproductive function) however, one

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<sup>38</sup> van der Miesen, *et al.*, 2020, at 703.

<sup>39</sup> Allen, *et al.*, 2019.

<sup>40</sup> Tordoff, *et al.*, 2022, Table 1.

<sup>41</sup> Costa, *et al.*, at 2212 Table 2.

<sup>42</sup> Costa, *et al.*, at 2206.

cannot justify taking on the greater risks of social transition, puberty blockers or surgery without evidence of such treatment producing superior results. Such evidence does not exist. Moreover, this clinical team subsequently released the final version of this preliminary report, finding that neither group actually experienced significant improvement,<sup>43</sup> making moot any discussion of the source any improvement.

41. Achille, *et al.* (2020) at Stony Brook Children’s Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50 of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, “Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional.”<sup>44</sup> The puberty blockers themselves “were introduced in accordance with the Endocrine Society and the WPATH guidelines.”<sup>45</sup> Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, “*most predictors did not reach statistical significance.*”<sup>46</sup> That is, puberty blockers did not improve mental health any more than did mental health care on its own.

#### **d. Conclusions**

42. The authors of the original Dutch studies were careful not to overstate the implications of their results, “We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria.”<sup>47</sup> Nonetheless, many other clinics and clinicians intrepidly proceeded on the basis of only the perceived positives, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that

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<sup>43</sup> Carmichael, *et al.*, 2021.

<sup>44</sup> Achille, *et al.*, 2020, at 2.

<sup>45</sup> Achille, *et al.*, 2020, at 2.

<sup>46</sup> Achille, *et al.*, 2020, at 3 (italics added).

<sup>47</sup> de Vries, *et al.* 2011, at 2282, italics added.

led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, 1 to 2 years<sup>48</sup>) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

43. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for “blindly adopting our research” despite the indications that those results may not actually apply: “We don’t know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type.”<sup>49</sup> Steensma opined that “every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test.” But few if any are doing so.

#### **4. Mental Health Issues in Childhood-Onset Gender Dysphoria**

44. As shown by the outcomes studies, there is little evidence that transition improves the mental well-being of children. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child

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<sup>48</sup> de Vries, *et al.*, 2011.

<sup>49</sup> Tetelepta, 2021.

experiencing depression from social isolation might develop the hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

45. If a child undergoes transition, discovering only then that their mental health or social situations will not in fact change, the medical risks and side-effects (such as sterilization) will have been borne for no reason. If, however, a child resolves the mental health issues first, with the gender dysphoria resolving with it (which the research literature shows to be the case in the large majority), then the child need not undergo transition at all, but retains the opportunity to do so later.

46. Elevated rates of multiple mental health issues among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.<sup>50</sup> A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.<sup>51</sup> When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

47. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD in youth with gender dysphoria. Studies reviewing medical records of children and adolescents

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<sup>50</sup> Wallien, *et al.*, 2007.

<sup>51</sup> Cohen-Kettenis, *et al.*, 2003, at 46.

referred to gender clinics showed 5–26% to have been diagnosed with ASD.<sup>52</sup> Moreover, those authors gave specific caution on the “considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results.”<sup>53</sup> As noted elsewhere herein, when two or more issues are present at the same time, researchers cannot distinguish when a result is associated with or caused by the issue of interest or one of the side issues.<sup>54</sup> The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported “gender variance.”<sup>55</sup>

### **C. Adolescent-Onset Gender Dysphoria**

#### **1. Features of Adolescent-Onset Gender Dysphoria**

48. In the social media age, a third profile has recently begun to present clinically or socially, characteristically distinct from the two previously identified profiles.<sup>56</sup> Unlike adult-onset or childhood-onset gender dysphoria, this group is predominately biologically female. This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD).<sup>57</sup> The majority of cases appear to occur within clusters of peers and in association with increased social media use<sup>58</sup> and especially among people with autism or other neurodevelopmental or mental health issues.<sup>59</sup>

49. It cannot be easily determined whether the self-reported gender dysphoria

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<sup>52</sup> Thrower, *et al.*, 2020.

<sup>53</sup> Thrower, *et al.*, 2020, at 703.

<sup>54</sup> Cohen-Kettenis *et al.*, 2003, at 51; Skelly *et al.*, 2012.

<sup>55</sup> Janssen, *et al.*, 2016.

<sup>56</sup> Kaltiala-Heino, *et al.*, 2015; Littman, 2018.

<sup>57</sup> Littman, 2018.

<sup>58</sup> Littman, 2018.

<sup>59</sup> Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.

is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.<sup>60</sup> (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.<sup>61</sup> Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to adolescent-onset gender dysphoria. The multiple differences already observed between these groups argue against predicting that features present in one type would generalize to be present in all types of gender dysphoria.

## **2. Social Transition and Puberty Blockers with Adolescent Onset**

50. There do not yet exist prospective outcomes studies either for social transition or for medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective*. It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence versus people

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<sup>60</sup> Boivin, *et al.*, 2020.

<sup>61</sup> Biggs, 2020; Littman, 2018.

whose onset was not until adolescence. (Analogously, there are reports failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria.) Studies selecting groups according to their current age instead of their ages of onset produces confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

### 3. Mental Illness in Adolescent-Onset Gender Dysphoria

51. In 2019, a Special Section appeared in the *Archives of Sexual Behavior* titled, “Clinical Approaches to Adolescents with Gender Dysphoria.” It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria, by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University.<sup>62</sup> The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,<sup>63</sup> with suicide attempts ranging 10 to 45%.<sup>64</sup> Self-injurious thoughts and behaviors range 14–39%.<sup>65</sup> Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.<sup>66</sup> Gender dysphoria also overlaps with Autism Spectrum Disorder.<sup>67</sup>

52. Of particular concern in the context of adolescent onset gender dysphoria is Borderline Personality Disorder (BPD; diagnostic criteria to follow). It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD.<sup>68</sup> That is, some people may be misinterpreting their experiencing of the broader “identity disturbance” of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset

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<sup>62</sup> Janssen, *et al.*, 2019.

<sup>63</sup> Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.

<sup>64</sup> Reisner, *et al.*, 2015.

<sup>65</sup> Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.

<sup>66</sup> de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.

<sup>67</sup> de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.

<sup>68</sup> *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

gender dysphoria, BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

53. DSM-5-TR Diagnostic Criteria for Borderline Personality Disorder:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

54. Mistaking cases of BPD for cases of Gender Dysphoria may prevent such youth from receiving the correct mental health services for their condition, and a primary cause for concern is symptom Criterion 5: Recurrent suicidality. (The research on suicide and suicidality are detailed in their own section herein.)

Regarding the provision of mental health care, the distinction between these conditions is crucial: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality.

55. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. The scientific concern presented by BPD is that it poses a potential confound: Samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

#### **IV. Other Scientific Claims Assessed**

##### **A. Suicide and Suicidality**

56. Social media increasingly circulate demands for transition accompanied by hyperbolic warnings of suicide should there be delay or obstacle. Claims accompany admissions that “I’d rather have a trans daughter than a dead son,” and such threats are treated as the justification for referring to affirming gender transitions as ‘life-saving’ or ‘medically necessary’. Such claims convey only grossly misleading misrepresentations of the research literature, however, deploying terms for their shock value rather than accuracy, and exploiting common public misperceptions about suicide. Indeed, suicide prevention research and public health campaigns repeatedly warn against circulating such exaggerations, due to the risk of copy-cat

behavior they encourage.<sup>69</sup>

57. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with different clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.<sup>70</sup> *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified by “If you leave me, I will kill myself.” Professing suicidality is also used for attention-seeking or for the support or sympathy it evokes from others, denoting distress much more frequently than an intent to die.

58. Notwithstanding public misconceptions about the frequency of suicide and related behaviors, the highest rates of suicide are among middle-aged and elderly men in high income countries.<sup>71</sup> Biological males are at three times greater risk of death by suicide than are biological females, whereas suicidal ideation, plans, and attempts are three times more common among biological females.<sup>72</sup> In contrast with completed suicides, the frequency of suicidal ideation, plans, and attempts is highest during adolescence and young adulthood, with reported ideation rates spanning 12.1–33%.<sup>73</sup> Relative to other countries, Americans report elevated rates of each of suicidal ideation (15.6%), plans (5.4%), and attempts (5.0%).<sup>74</sup> Suicide attempts occur up to 30

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<sup>69</sup> Gould & Lake, 2013.

<sup>70</sup> Freeman, *et al.*, 2017.

<sup>71</sup> Turecki & Brent, 2016

<sup>72</sup> Klonsky et al., 2016; Turecki & Brent, 2016

<sup>73</sup> Borges et a., 2010; Nock et al., 2008

<sup>74</sup> Klonsky, et al., 2016.

times more frequently than completed suicides.<sup>75</sup> The rate of completed suicides in the U.S. population is 14.5 per 100,000 people.<sup>76</sup> The widely discrepant numbers representing completed suicides versus transient suicidal ideation has left those statistics open to substantial abuse in the media and social media. Despite public media guidelines urging “Avoid dramatic headlines and strong terms such as ‘suicide epidemic’,”<sup>77</sup> that is exactly what mainstream outlets have done.<sup>78</sup>

59. There is substantial research associating sexual orientation with suicidality, but much less so with completed suicide.<sup>79</sup> More specifically, there is some evidence suggesting gay adult men are more likely to die by suicide than are heterosexual men, but there is less evidence of an analogous pattern among lesbian women. Regarding suicidality, surveys of self-identified LGB Americans repeatedly report rates of suicidal ideation and suicide attempts 2–7 times higher than their heterosexual counterparts. Because of this association of suicidality with sexual orientation, one must apply caution in interpreting findings allegedly about gender identity: Because of the overlap between people who self-identify as non-heterosexual and as non-cis-gendered, correlations detected between suicidality and gender dysphoria may instead reflect (be confounded by) homosexuality. Indeed, other authors have made explicit their surprise that so many studies, purportedly of gender identity, entirely omitted measurement or consideration of sexual orientation, creating the situation where features that seem to be associated with gender identity instead reflect the sexual orientation of the members of the sample.<sup>80</sup>

60. Among post-transition transsexuals, completed suicide rates are elevated,

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<sup>75</sup> Bachman, 2018.

<sup>76</sup> World Health Organization, 2022.

<sup>77</sup> Samaritans, 2020.

<sup>78</sup> E.g., MSNBC, 2015, *Trans youth and suicide: An epidemic*.

<sup>79</sup> Haas, *et al.*, 2011.

<sup>80</sup> McNeil, *et al.* (2017)

but are nonetheless rare.<sup>81</sup> Regarding suicidality, there have been three recent, systematic reviews of the research literature.<sup>82</sup> All three included specific methods to minimize any potential effects of cherry-picking findings from within the research literature. Compiling the results of 108 articles reported from 64 research projects, Adams and Vincent (2019) found an overall average rate of 46.55% for suicidal ideation (ranging 18.18%–95.5%) and an overall average rate of 27.19% for suicidal attempts (ranging 8.57%–52.4%). These findings confirmed those reported by McNeil, *et al.* (2017), whose review of 30 articles revealed a range of 37%–83% for suicidal ideation and 9.8%–43% for suicidal attempts. Thus, on the one hand, these ranges are greater than those reported for the mainstream population—They instead approximate the rates reported among sexual orientation minorities. On the other hand, with measures so lacking in reliability that they produce every result from ‘rare’ to ‘almost everyone’, it is unclear which, if any of them, represents a valid conclusion.

61. McNeil *et al.* (2017) observed also the research to reveal rates of suicidal ideation and suicidal attempts to be related—not to transition status—but to the social support received: The studies reviewed showed support to decrease suicidality, but transition not to. Indeed, in some situations, social support was associated with *increased* suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.<sup>83</sup>

62. Marshall *et al.* (2016) identified and examined 31 studies, again finding rates of suicidal ideation and suicide attempts to be elevated, particularly among biological females, indicating that suicidality patterns correspond to biological sex rather than self-identified gender.<sup>84</sup>

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<sup>81</sup> Wiepjes, *et al.*, 2020.

<sup>82</sup> Adams & Vincent, 2019; Marshall, *et al.*, 2016; McNeil, *et al.* (2017).

<sup>83</sup> Bauer, *et al.*, 2015; Canetto, *et al.*, 2021.

<sup>84</sup> Marshall, *et al.*, 2016.

63. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a ‘medical necessity’. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.<sup>85</sup>

64. The scientific study of suicide is inextricably linked to that of mental illness, and Borderline Personality Disorder is repeatedly documented to be greatly elevated among sexual minorities<sup>86</sup>.

### **B. Conversion Therapy**

65. Activists and social media increasingly, but erroneously, apply the term “conversion therapy” moving farther and farther from what the research has reported. “Conversion therapy” (or “reparative therapy” and other names) was the attempt to change a person’s sexual orientation; however, with the public more frequently accustomed to “LGB” being expanded to “LGBTQ+”, the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, this is only very rarely are mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as already shown unanimously by all follow-up studies. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled “conversion therapy.”<sup>87</sup> Indeed, even actions of non-therapists, unrelated

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<sup>85</sup> McNeil, *et al.*, 2017.

<sup>86</sup> Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.

<sup>87</sup> D’Angelo, *et al.*, 2021.

to any therapy, have been labelled conversion therapy, including the prohibition of biological males competing on female teams.<sup>88</sup>

### **C. Assessing Demands for Social Transition and Affirmation-Only or Affirmation-on-Demand Treatment in Pre-Pubertal Children.**

66. Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with the other parent.

67. Referring to “affirmation” as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word “affirmation” refers to entirely different actions.

68. It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social transition (and puberty blocking) may not begin until age 12 and cross-sex hormonal and other medical interventions, later.

69. Formal clinical approaches to helping children expressing gender dysphoria

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<sup>88</sup> Turban, 2021, March 16.

employ a gate-keeper model, with decision trees to help clinicians decide when and if the potential benefits of affirmation of the new gender would outweigh the potential risks of doing so. Because the gate-keepers and decision-trees generally include the possibility of affirmation in at least some cases, it is misleading to refer to any one approach as “the affirmation approach.” The most extreme decision-tree would be accurately called *affirmation-on-demand*, involving little or no opportunity for children to explore at all whether the distress they feel is due to some other, less obvious, factor, whereas more moderate gate-keeping would endorse transition only in select situations, when the likelihood of regretting transition is minimized.

70. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of “retrospective” rather than “prospective” studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

#### **D. Assessing the “Minority Stress Hypothesis”**

71. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.<sup>89</sup> The association is not entirely straight-forward, however. For example,

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<sup>89</sup> Meyer, 2003.

although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

72. Minority stress is associated, in large part, with being a visible minority. There is little evidence that transgender populations show the patterns suggested by the hypothesis. For example, the minority stress hypothesis would predict differences according to how visibly a person is discernable as a member of the minority, which often changes greatly upon transition. Biological males who are very effeminate stand out throughout childhood, but in some cases can successfully blend in as adult females; whereas the adult-onset transitioners blend in very much as heterosexual cis-gendered males during their youth and begin visibly to stand out in adulthood, only for the first time.

73. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.<sup>90</sup> The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

74. A primary criterion for readiness for transition used by the clinics demonstrating successful transition is the absence or resolution of other mental health concerns, such as suicidality. In the popular media, however, indications of mental health concerns are instead often dismissed as an expectable result caused by Sexual Minority Stress (SMS). It is generally implied that such symptoms will resolve

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<sup>90</sup> Meyer, 2003.

upon transition and integration into an affirming environment.

## **V. Assessing Statements from Professional Associations**

### **A. Understanding the Value of Statements from Professional Associations**

75. The value of position statements from professional associations should be neither over- nor under-estimated. In the ideal, an organization of licensed health care professionals would convene a panel of experts who would systematically collect all the available evidence about an issue, synthesizing it into recommendations or enforceable standards for clinical care, according to the quality of the evidence for each alternative. For politically neutral issues, with relevant expertise contained among association members, this ideal can be readily achievable. For controversial issues with no clear consensus, the optimal statement would summarize each perspective and explicate the strengths and weaknesses of each, providing relatively reserved recommendations and suggestions for future research that might resolve the continuing questions. Several obstacles can hinder that goal, however. Committees within professional organizations are typically volunteer activities, subject to the same internal politics of all human social structures. That is, committee members are not necessarily committees of experts on a topic—they are often committees of generalists handling a wide variety of issues or members of an interest group who feel strongly about political implications of an issue, instead of scientists engaged in the objective study of the topic.

76. Thus, documents from professional associations may represent required standards, the violation of which may merit sanctions, or may represent only recommendations or guidelines. A document may represent the views of an association's full membership or only of the committee's members (or majorities thereof). Documents may be based on systematic, comprehensive reviews of the available research or selected portions of the research. In sum, the weight best placed

on any association's statement is the amount by which that association employed evidence versus other considerations in its process.

**B. Misrepresentations of statements of professional associations.**

77. In the presently highly politicized context, official statements of professional associations have been widely misrepresented. In preparing the present report, I searched the professional research literature for documentation of statements from these bodies and from my own files, for which I have been collecting such information for many years. I was able to identify statements from six such organizations. Although not strictly a medical association, the World Professional Association for Transgender Health (WPATH) also distributed a set of guidelines in wide use and on which other organizations' guidelines are based.

78. Notably, despite that all these medical associations reiterate the need for mental health issues to be resolved before engaging in medical transition, only the AACAP members have medical training in mental health. The other medical specialties include clinical participation with this population, but their assistance in transition generally assumes the mental health aspects have already been assessed and treated beforehand.

79. With the broad exception of the AAP, their statements repeatedly noted instead that:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.
- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.
- Social transition is not generally recommended until after puberty.

Although some other associations have published broad statements of moral support for sexual minorities and against discrimination, they did not include any specific standards or guidelines regarding medical- or transition-related care.

## 1. World Professional Association for Transgender Health (WPATH)

80. The WPATH standards as they relate to prepubescent children begin with the acknowledgement of the known rates of desistance among gender dysphoric children:

[I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).<sup>91</sup>

81. That is, “In most children, gender dysphoria will disappear before, or early in, puberty.”<sup>92</sup>

82. Although WPATH does not refer to puberty blocking medications as “experimental,” the document indicates the non-routine, or at least inconsistent availability of the treatment:

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).<sup>93</sup>

83. WPATH neither endorses nor proscribes social transitions before puberty, instead recognizing the diversity among families’ decisions:

Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.<sup>94</sup>

84. It does caution, however, “Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria.”<sup>95</sup>

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<sup>91</sup> Coleman, *et al.*, 2012, at 172.

<sup>92</sup> Coleman, *et al.*, 2012, at 173.

<sup>93</sup> Coleman, *et al.*, 2012, at 173.

<sup>94</sup> Coleman, *et al.*, 2012, at 176.

<sup>95</sup> Coleman, *et al.*, 2012, at 176 (quoting Drummond, *et al.*, 2008; Wallien & Cohen-Kettenis, 2008).

85. The WPATH standards have been subjected to standardized evaluation, the Appraisal of Guidelines for Research and Evaluation (“AGREE II”) method, as part of an appraisal of all published Clinical Practice Guidelines (CPGs) regarding sex and gender minority healthcare.<sup>96</sup> Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that “[t]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research.”<sup>97</sup> The WPATH guidelines were recommended for use. Indeed, the WPATH guidelines received unanimous ratings of “Do not recommend.”<sup>98</sup>

86. Finally, it should be noted that WPATH is in stark opposition to international standards: Public healthcare systems throughout the world have instead been ending the practice of medical transition of minors, responding to the increasingly recognized risks associated with hormonal interventions and the now clear lack of evidence that medical transition was benefitting most children, as opposed to the mental health counseling accompanying transition.

## **2. Endocrine Society (ES)**

87. The 150,000-member Endocrine Society appointed a nine-member task force, plus a methodologist and a medical writer, who commissioned two systematic reviews of the research literature and, in 2017, published an update of their 2009 recommendations, based on the best available evidence identified. The guideline was co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society (PES), and the World Professional Association for Transgender Health (WPATH).

88. The document acknowledged the frequency of desistance among gender

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<sup>96</sup> Dahlen, *et al.*, 2021.

<sup>97</sup> Dahlen, *et al.*, 2021, at 6.

<sup>98</sup> Dahlen, *et al.*, 2021, at 7.

dysphoric children:

Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called “desisters”). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.<sup>99</sup>

89. The statement similarly acknowledges inability to predict desistance or persistence, “With current knowledge, we cannot predict the psychosexual outcome for any specific child.”<sup>100</sup>

90. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, “In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues.”<sup>101</sup> This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

91. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: “We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional.”<sup>102</sup>

92. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician “provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable

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<sup>99</sup> Hembree, *et al.*, 2017, at 3876.

<sup>100</sup> Hembree, *et al.*, 2017, at 3876.

<sup>101</sup> Hembree, *et al.*, 2017, at 3877.

<sup>102</sup> Hembree, *et al.*, 2017, at 3872.

psychological and social outcomes.”<sup>103</sup>

### **3. Pediatric Endocrine Society and Endocrine Society (ES/PES)**

93. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.<sup>104</sup> Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.<sup>105</sup>

94. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society “recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance.”<sup>106</sup> However, the Endocrine Society makes neither statement. Although the two-page PES document mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: “If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action.”<sup>107</sup> Despite the PES asserting it as “medically necessary,” the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: “We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient’s overall health and/or well-being.”<sup>108</sup>

### **4. American Academy of Child & Adolescent Psychiatry (AACAP)**

95. The 2012 statement of the American Academy of Child & Adolescent Psychiatry (AACAP) is not an affirmation-only policy. It notes:

Just as family rejection is associated with problems such as depression,

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<sup>103</sup> Hembree, *et al.*, 2017, at 3877.

<sup>104</sup> PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.

<sup>105</sup> Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al.*, 2017.

<sup>106</sup> Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

<sup>107</sup> Hembree, *et al.* 2017, at 3883.

<sup>108</sup> Hembree, *et al.*, 2017 at 3872, 3894.

suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.<sup>109</sup>

96. The AACAP’s language repeats the description of the use of puberty blockers only as an exception: “For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues.”<sup>110</sup>

97. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: “In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,”<sup>111</sup> adding that “[c]linicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.”<sup>112</sup>

98. The policy similarly includes a provision for resolving mental health issues: “Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*.”<sup>113</sup> The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).<sup>114</sup>

99. Rather than endorse social transition for prepubertal children, the AACAP

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<sup>109</sup> Adelson & AACAP, 2012, at 969.

<sup>110</sup> Adelson & AACAP, 2012, at 969 (*italics added*).

<sup>111</sup> Adelson & AACAP, 2012, at 963.

<sup>112</sup> Adelson & AACAP, 2012, at 968.

<sup>113</sup> Adelson & AACAP, 2012, at 970 (*italics added*).

<sup>114</sup> Adelson & AACAP, 2012, at 969.

indicates: “There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so.”<sup>115</sup>

### **5. American College of Obstetricians & Gynecologists (ACOG)**

100. The American College of Obstetricians & Gynecologists (ACOG) published a “Committee Opinion” expressing recommendations in 2017. The statement indicates it was developed by the ACOG’s Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: “This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.”<sup>116</sup>

101. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally have a primary health care provider.<sup>117</sup>

102. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE), PES, and the Endocrine Society—and by WPATH.<sup>118</sup> It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: “*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental

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<sup>115</sup> Adelson & AACAP, 2012, at 969.

<sup>116</sup> ACOG, 2017, at 1.

<sup>117</sup> ACOG, 2017, at 1.

<sup>118</sup> ACOG, 2017, at 1, 3.

health professional, has no contraindications to therapy, and displays an understanding of the risks involved.”<sup>119</sup>

103. The “Eligibility and Readiness Criteria” also include, “Diagnosis established for gender dysphoria, transgender, transsexualism.”<sup>120</sup> This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for DSM diagnosis.

104. ACOG’s remaining recommendations pertain only to post-transition, medically oriented concerns. Pre-pubertal social transition is not mentioned in the document, and the outcomes studies of gender dysphoric (prepubescent) children are not cited.

## **6. American College of Physicians (ACP)**

105. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining “family” by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender health care services in public and private health benefit plans.<sup>121</sup>

106. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting “reparative therapy;” however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that “[s]exual orientation and gender identity are inherently different.”<sup>122</sup> It based this statement on the fact that “the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*.”<sup>123</sup> The APA’s document, entitled “Report of the American Psychological Task Force on appropriate therapeutic responses to

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<sup>119</sup> ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (italics added).

<sup>120</sup> ACOG, 2017, at 3 Table 1.

<sup>121</sup> Daniel & Butkus, 2015a, 2015b.

<sup>122</sup> Daniel & Butkus, 2015b, at 2.

<sup>123</sup> Daniel & Butkus, 2015b, at 8 (italics added).

*sexual orientation*” does not include or reference research on gender identity.<sup>124</sup> Despite citing no research about transgenderism, the ACP nonetheless included in its statement: “Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons.”<sup>125</sup> That is, the inclusion of “T” with “LGB” is based on something other than the existing evidence.

107. There is another statement,<sup>126</sup> which was funded by ACP and published in the *Annals of Internal Medicine* under its “*In the Clinic*” feature, noting that “‘In the Clinic’ does not necessarily represent official ACP clinical policy.”<sup>127</sup> The document discusses medical transition procedures for adults rather than for children, except to note that “[n]o medical intervention is indicated for prepubescent youth,”<sup>128</sup> that a “mental health provider can assist the child and family with identifying an appropriate time for a social transition,”<sup>129</sup> and that the “child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is higher than in their cisgender peers.”<sup>130</sup>

## **7. American Academy of Pediatrics (AAP)**

108. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.<sup>131</sup> Moreover, of all

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<sup>124</sup> APA, 2009 (italics added).

<sup>125</sup> Daniel & Butkus, 2015b, at 8 (italics added).

<sup>126</sup> Safer & Tangpricha, 2019.

<sup>127</sup> Safer & Tangpricha, 2019, at ITC1.

<sup>128</sup> Safer & Tangpricha, 2019, at ITC9.

<sup>129</sup> Safer & Tangpricha, 2019, at ITC9.

<sup>130</sup> Safer & Tangpricha, 2019, at ITC9.

<sup>131</sup> Cantor, 2020.

the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.<sup>132</sup>

109. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. See Appendix 2. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, “Has the AAP responded to Dr Cantor? If not, have you any response now?” The AAP Media Relations Manager, Lisa Black, responded: “We do not have anyone available for comment.”

#### **8. The ESPE-LWPES GnRH Analogs Consensus Conference Group**

110. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).<sup>133</sup> Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

111. The effort concluded that “[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely.”<sup>134</sup> However, gender dysphoria was not explicitly mentioned as one of those other conditions.

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<sup>132</sup> Cantor, 2020, at 1.

<sup>133</sup> Carel et al., 2009.

<sup>134</sup> Carel et al. 2009, at 752.

## VI. International Health Care Consensus

### 1. United Kingdom

112. The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes<sup>135</sup>. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019<sup>136</sup>.

113. The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review<sup>137</sup>. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the “cherry-picking” or selective citation favouring or down-playing any one conclusion<sup>138</sup>. The review’s results were unambiguous: “The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low”<sup>139</sup>, again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as “very low” the quality of evidence regarding “body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment”<sup>140</sup>. The report concluded that of the existing research, “The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding....They suggest little change with GnRH analogues [puberty

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<sup>135</sup> Marsh, 2020; Rayner, 2018.

<sup>136</sup> BBC, 2021; Donnelly, 2019.

<sup>137</sup> National Health Service, 2020, Sept. 22.

<sup>138</sup> National Institute for Health and Care Excellence, 2020.

<sup>139</sup> National Institute for Health and Care Excellence, 2020, p. 4.

<sup>140</sup> National Institute for Health and Care Excellence, 2020, p. 5.

blockers] from baseline to follow-up”<sup>141</sup>.

## 2. Finland

114. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment<sup>142</sup>. That study showed that despite the purpose of medical transition to improve mental health: “Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development”<sup>143</sup>. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

115. Consistent with the evidence, Finland’s health care service (Council for Choices in Health Care in Finland—COHERE) thus ended the surgical transition of minors, ruling in 2020 that “Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors” (COHERE, 2020). The review of the research concluded that “[N]o conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development.” COHERE also greatly restricted access to puberty-blocking and other hormonal treatments, indicating they “may be considered if the need for it continues *after* the other psychiatric symptoms have

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<sup>141</sup> National Institute for Health and Care Excellence, 2020, p. 13.

<sup>142</sup> Kaltiala et al., 2020.

<sup>143</sup> Kaltiala et al., 2020, p. 213.

ceased and adolescent development is progressing normally”<sup>144</sup>. The council was explicit in noting the lack of research needed for decision-making, “There is also a need for more information on the *disadvantages* of procedures and on people who regret them”<sup>145</sup>.

### 3. Sweden

116. Sweden’s national health care policy regarding trans issues has developed quite similarly to that of the UK. (Already in place 20 years ago, Swedish health care policy permitted otherwise eligible minors to receive puberty-blockers beginning at age 14 and cross-sex hormones at age 16.) At that time, only small numbers of minors sought medical transition services. An explosion of referrals ensued in 2013–2014. Sweden’s Board of Health and Welfare reported that, in 2018, the number of diagnoses of gender dysphoria was 15 times higher than 2008 among girls ages 13–17.

117. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research<sup>146</sup>. Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence<sup>147</sup>.

118. The SBU report came to the same conclusions as the UK commission. From 2022 forward, the Swedish National Board or Health and Welfare therefore

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<sup>144</sup> Council for Choices in Health Care in Finland, 2020; italics added.

<sup>145</sup> Council for Choices in Health Care in Finland, 2020; italics added.

<sup>146</sup> Orange, 2020, Feb 22.

<sup>147</sup> Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

“recommends restraint when it comes to hormone treatment...Based on the results that have emerged, the National Board of Health and Welfare’s overall conclusion is that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole”<sup>148</sup>. Neither puberty blockers nor cross-sex hormones would be provided under age 16, and patients ages 16–18 would receive such treatments only within research settings (clinical trials monitored by the appropriate Swedish research ethics board).

#### **4. France**

119. In 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments. “[A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause...such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause”<sup>149</sup>. For hormones, the Académie concluded “the greatest reserve is required in their use,” and for surgical treatments, “[T]heir irreversible nature must be emphasized.” The Académie did not outright ban medical interventions, but warned “the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to “detransition”. Rather than medical interventions, it advised health care providers “to extend as much as possible the psychological support phase.” The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, “underlining the addictive character of excessive consultation of social networks which is both

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<sup>148</sup> Swedish National Board of Health and Welfare, 2022.

<sup>149</sup> Académie Nationale de Médecine, 2022, Feb. 25.

harmful to the psychological development of young people and responsible, for a very important part, of the growing sense of gender incongruence.”

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- Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*, 90–97.

## APPENDICES

### Appendix 1

The Outcomes Studies of Childhood-Onset Gender Dysphoria

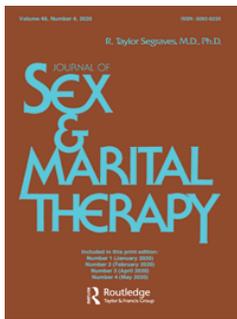
### Appendix 2

Peer-reviewed article:

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46*, 307–313. doi: 10.1080/0092623X.2019.1698481

## Prospective Outcomes Studies of Gender Dysphoric Children

2/16	gay	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. <i>American Journal of Psychiatry</i> , 128, 1283–1289.
4/16	trans-/crossdress	
10/16	straight/uncertain	
2/16	trans-	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. <i>Comprehensive Psychiatry</i> , 19, 363–369.
2/16	uncertain	
12/16	gay	
0/9	trans-	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. <i>Journal of Pediatric Psychology</i> , 4, 29–41.
9/9	gay	
2/45	trans-/crossdress	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. <i>Journal of Nervous and Mental Disease</i> , 172, 90–97.
10/45	uncertain	
33/45	gay	
1/10	trans-	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. <i>Archives of Sexual Behavior</i> , 15, 511–517.
2/10	gay	
3/10	uncertain	
4/10	straight	
1/44	trans-	Green, R. (1987). <i>The "sissy boy syndrome" and the development of homosexuality</i> . New Haven, CT: Yale University Press.
43/44	cis-	
0/8	trans-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? <i>Medical Journal of Australia</i> , 146, 565–569.
8/8	cis-	
21/54	trans-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 47, 1413–1423.
33/54	cis-	
3/25	trans-	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. <i>Developmental Psychology</i> , 44, 34–45.
6/25	lesbian/bi-	
16/25	straight	
47/127	trans-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 52, 582–590.
80/127	cis-	
17/139	trans-	Singh, D., Bradley, S. J., and Zucker, K. J. (2021) A follow-up study of boys with gender identity disorder. <i>Frontiers in Psychiatry</i> , 12, 632784. doi: 10.3389/fpsy.2021.632784
122/139	cis-	



## Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

James M. Cantor

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## Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

James M. Cantor

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### ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation*. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

“[C]onversion” or “reparative” treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. . . . Reparative approaches have been proven to be not only unsuccessful<sup>38</sup> but also deleterious and are considered outside the mainstream of traditional medical practice.<sup>29,39–42</sup>

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol*. 1994;62(2):221–227.
29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry*. 2012;51(9):957–974.
39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health*. 2016;3(2):97–99.
40. Cohen-Kettenis PT, Delemarre van de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med*. 2008;5(8):1892–1897.
41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy*. 2006;3(3):23–39.
42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement*. Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP’s claims struck me as odd because *there are no studies of conversion therapy for gender identity*. Studies of conversion therapy have been limited to *sexual orientation*, and, moreover, to the sexual orientation of *adults*, not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only*. Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: “The practice and ethics of *sexual orientation* conversion therapy” [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP’s citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP’s sources *did* repeatedly emphasize was that:

- A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
- B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
- C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced “conversion”: The majority of children “convert” to cisgender or “desist” from transgender

regardless of any attempt to change them. “Conversion” only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that “gender identity is not synonymous with ‘sexual orientation’” (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP’s fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity*, AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation: “Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through ‘reparative therapy’ *in adults* have found little or no change in *sexual orientation*, while causing significant risk of harm to self-esteem” (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP’s actual view was decidedly neutral, noting the lack of evidence: “Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed” (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: “In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood” (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP’s actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: “Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*” (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic’s lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the “mainstream of traditional medical practice” consists of (the logic being that conversion therapy falls outside what an ‘ideal’ clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: “[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved” (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: “An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the *DSM* and not unique to GIDC)” (Bryant, 2006, p. 35). How this article supports AAP’s claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association’s (APA’s) update of the *DSM*, the statement asserted simply that “The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide.” Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the *DSM* as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the *DSM* revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH’s urging. This makes AAP’s logic entirely backwards: That WPATH’s request to depathologize gender dysphoria was *rejected* suggests that it is WPATH’s view—and therefore the AAP policy—which fall “outside the mainstream of traditional medical practice.” (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used “to prevent children and adolescents from identifying as transgender” (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP’s sources is “delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity” in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP’s stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it “outdated.” The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

[G]ender affirmation is in contrast to the outdated approach in which a child’s gender-diverse assertions are held as “possibly true” until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed “watchful waiting.” This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment (“desisters”).<sup>45,47</sup>

The citations from AAP’s reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268
47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence*, this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of “persistence-after-interruption.” Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistance instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is “outdated” either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: “Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favoured by the standards*, we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5” (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: “When a child’s gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child” (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summarizes the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, “This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population”; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, “Current available research and expert opinion from clinical and research leaders ... will serve as the basis for recommendations” (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP’s statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP’s recommendations are *despite* the existing evidence.

## Disclosure statement

No potential conflict of interest was reported by the author.

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- Rafferty, J., AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, 142(4), e20182162 doi:10.1542/peds.2018-2162
- Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 147–148. doi:10.1016/j.jaac.2014.10.016
- Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 1413–1423. doi:10.1097/CHI.0b013e31818956b9

## Appendix

Count	Group	Study
2/16	gay*	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. <i>American Journal of Psychiatry</i> , 128, 1283–1289.
4/16	trans-/crossdress	
10/16	straight*/uncertain	
2/16	trans-	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. <i>Comprehensive Psychiatry</i> , 19, 363–369.
2/16	uncertain	
12/16	gay	
0/9	trans-	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. <i>Journal of Pediatric Psychology</i> , 4, 29–41.
9/9	gay	
2/45	trans-/crossdress	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. <i>Journal of Nervous and Mental Disease</i> , 172, 90–97.
10/45	uncertain	
33/45	gay	
1/10	trans-	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. <i>Archives of Sexual Behavior</i> , 15, 511–517.
2/10	gay	
3/10	uncertain	
4/10	straight	
1/44	trans-	Green, R. (1987). <i>The "sissy boy syndrome" and the development of homosexuality</i> . New Haven, CT: Yale University Press.
43/44	cis-	
0/8	trans-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? <i>Medical Journal of Australia</i> , 146, 565–569.
8/8	cis-	
21/54	trans-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 47, 1413–1423.
33/54	cis-	
3/25	trans-	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. <i>Developmental Psychology</i> , 44, 34–45.
6/25	lesbian/bi-	
16/25	straight	
17/139	trans-	Singh, D. (2012). <i>A follow-up study of boys with gender identity disorder</i> . Unpublished doctoral dissertation, University of Toronto.
122/139	cis-	
47/127	trans-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 52, 582–590.
80/127	cis-	

\*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.