CAUSE NO. D-1-GN-23-003616

LAZARO LOE, *et al.*,	§	**IN THE DISTRICT COURT OF**
	§	
***Plaintiffs*,**	§	
v.	§	**TRAVIS COUNTY, TEXAS**
	§	
THE STATE OF TEXAS, *et al.*,	§	
	§	**201st JUDICIAL DISTRICT**
***Defendants*.**	§	

I. CREDENTIALS & SUMMARY OF OPINIONS

1. I am Professor of Sociology at the University of Texas at Austin. I received my Ph.D. from the University of North Carolina at Chapel Hill in 2000. I became an Assistant Professor of Sociology at UT-Austin in 2002, an Associate Professor in 2007, and a full Professor in 2018.

2. I have published numerous articles and four books on sexual relationship behavior and decision-making since 2003.[1] The books, peer-reviewed journal articles, and essays I have written include material on sexual orientation and, more recently, perspectives on transgender medicine. I am an experienced peer reviewer, having reviewed dozens of manuscripts in the past decade on these and related topics—including for top journals in both sociology and sex/sexuality studies (e.g., *Archives of Sexual Behavior*, *Journal of Homosexuality*, etc.). I have extensive survey administration experience as well, having fielded three nationally-representative surveys since 2011, and consulted on survey construction for several others, including the National Study of Family Growth and the National Longitudinal Study of Adolescent to Adult Health (or Add

[1] Regnerus, M. D. (2007). *Forbidden fruit: Sex & religion in the lives of American teenagers*. Oxford University Press.; Regnerus, M. & Uecker, J. (2011). *Premarital sex in America: How young Americans meet, mate, and think about marrying*. Oxford University Press.; Regnerus, M. (2017). *Cheap sex: The transformation of men, marriage, and monogamy* Oxford University Press.; Regnerus, M. (2020). *The future of Christian marriage*. Oxford University Press.

Health). A more complete review of my professional experience, publications, and research is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

3. My experience in the area of transgender research primarily concerns basic methodological matters, involving design, measurement, statistical inference, interpretation of data, and reflections on the research and publication norms that have developed in this new domain in conjunction with media interest and professional and organizational pressures. This leans not only on my knowledge of the research in this domain, but also on the details of quantitative and qualitative research, subjects I have taught to sociology majors at least 20 times since my appointment on the faculty at the University of Texas at Austin. I am not, however, a physician, and I have no experience with the direct treatment of patients.

4. I have been retained as an expert witness by the State of Texas in connection with this litigation. I have actual knowledge of the matters stated in this report. I base the following opinions on my own knowledge, research, experience, and publications, and the work of other academics and writers. The materials I have used to research and write this report are the standard sources used by other experts in my field. I am receiving $250 per hour for my time spent preparing this report. My compensation is not dependent upon the outcome of this litigation or the substance of my opinions.

5. The focus of this report is on science: scientific evidence, researcher conduct, the culture of scientific organizations, the role of values in scientific inquiry, and brief remarks about the declarations submitted by plaintiffs' witnesses Aron Janssen, Johanna Olson-Kennedy, and Daniel Shumer during the preliminary-injunction stage of this litigation.

6. In particular, I focus on the unscientific process by which "affirmative" treatment of transgender-identifying adolescents has come to be the default position advocated by various

professionals and organizations. This is what the sociology of science concerns—an evaluation of how science operates. In this case, I probe how the nascent field of transgender research has, in the United States, come to make premature claims about "standards of care" and profess a level of "consensus" about affirmative care that is not only uncharacteristically rapid for such a new scientific subfield—especially one employing radical procedures on minors—it's also inaccurate. There is no genuine consensus in the West on these matters, save for a segment of American medicine captured (ideologically) by a group of activists. Moreover, there is a pronounced gap between the actual practice of many gender clinicians (and surgeons, etc.), which continues to shift toward earlier and more invasive treatments, and that of the "standards of care," which should signal an urgent need for caution. Something is amiss.

7. A summary of the key points I discuss in this statement includes:

   a. The science of the origins and course of gender identity remain in flux.

   b. The demographics of transgender-identifying adolescents is shifting in ways that are not yet understood.

   c. Adolescent gender transition treatments are not supported by randomized clinical trials—an absence that is difficult to account for.

   d. There is a great deal of evidence that discussion of gender dysphoria and its treatment has been captured by the assumptions of activists.

   e. The evidence for suicide risk among gender dysphoric minors is ambiguous, and the evidence for claims that treatments for adolescent gender transition contribute to sustained, long-term improvement in mental health is weak.

f. The practice of "affirmative" treatment for young people with gender dysphoria is characterized by dubious assumptions and questionable value judgments that increasingly result in a consumer-driven medical culture. There is no neutral standpoint from which to evaluate all this. Activists comprise both the physicians treating the patients and the researchers studying them.

8. My intention is not to offer a comprehensive literature review of the entire field of research in transgender science—or even that which is focused on minors. That is a task unsuited to this document. Rather, one of the central purposes of my report is to describe how and why any supposition that there is a legitimate scientific consensus about treatment for adolescents is unmerited. The research I cite and discuss is compelling evidence favoring a proper interpretation of this field as "in development" rather than as "settled science."

9. I make no claims about the most prudent course of treatment for a particular patient, and I have no desire to stoke identity politics or foster moral panic. Instead, as a sociologist, my claims highlight the unscientific processes by which "gender affirming" treatments have come to appear not simply as the preferred approach but increasingly the only endorsed approach. And among its proponents there is growing pressure to skip the psychological evaluations and move to offer treatments to minors at younger and younger ages, regardless of recommendations. All of this has happened amid a surge in cases of gender dysphoria and transgender identity that emerged suddenly, was unanticipated, and remains demonstrably undertheorized.[2]

[2] Bernadette Wren, who was a senior clinician at the UK Tavistock gender clinic until her retirement, described the situation this way: "There are morally complex, there are clinically complex, there are politically complex issues that we are grappling with and there aren't any easy answers. One of the things about the gender field is you can't plausibly develop a foundational theory of gender identity in which to ground the work." See Gossling, G. (2020). Bernadette Wren: On change. *In mind*. https://100years.tavistockandportman.nhs.uk/bernadette-wren-on-change

In other words, most scholars have been insufficiently curious about these recent developments and appear instead to be more interested in connecting research strategies and conclusions to fit affirmative care prescriptions. This is the "elephant in the room" that ought to give pause to practitioners and their professional societies. But, instead, many have pressed ahead without sufficient interest in understanding why the current realities have come to be. This is not how medical science works in nearly every other branch. Indeed, medical science is often accused of being too slow, cautious, and conservative, preferring—as it typically does—wide and consistent confirmation of stably discernible patient benefits that outweigh the risks involved. That we are talking about minors and matters of informed consent for consequential, life-altering decisions means particular caution ought to be observed—but is not.

10. Lurking in the background are other inexplicable patterns besides a rapid surge in gender dysphoria. Twenty years ago, far more natal males than females exhibited gender dysphoria. Ten years ago, comparable numbers of natal males and females sought help for it. Today, the sex ratio has reversed: for every one natal male seeking help, approximately three natal females do. Why? And why aren't certain researchers more interested in understanding this than in shuttling patients (regardless of their natal sex) toward "affirmative" care?

11. The plaintiffs' witnesses repeatedly reference current treatment regimens, "consensus," "standards of care," etc. But at a basic level, the question is whether any putative consensus has been formed without undue pressure. The evidence suggests that it has not.

12. The plaintiffs' experts repeatedly invoke the "evidence-based guidelines" and "best practices" of U.S. medical associations such as the American Academy of Pediatrics and the Endocrine Society, as well as the World Professional Association for Transgender Health (WPATH) "standards of care." While they emphasize that the "affirmative care" model is based

on graded evidence,[3] they fail to mention that the evidence was actually graded "low" to "very low" quality.[4] They also ignore the starkly contrasting scientific consensus emerging outside American medical professional associations, resulting from comprehensive and systematic evidence reviews.

13. The results of these reviews from the UK, Sweden, Finland, and the state of Florida, have contributed to a growing international consensus emphasizing gender-affirming medicine as experimental and the evidence base weak to non-existent for use in children and young people. Consider that in February 2022, Sweden's National Board of Health and Welfare concluded that currently, for adolescents, "the risks of puberty blockers and gender-affirming treatments are likely to outweigh the expected benefits," and thus the treatments should be offered only in "exceptional" cases.[5] In June of 2023, England's National Health Service officially restricted puberty blockers and hormone interventions to clinical trials, having concluded that "there is not enough evidence to support their safety or clinical effectiveness as a routinely available treatment."[6] Thus both Dr. Janssen's and Dr. Shumer's nearly identical characterizations of these recent changes in Europe are misrepresentations at best. [7]

[3] Expert Affidavit of Daniel Shumer, #52, p. 12.
[4] Dahlen, S., Connolly, D., Arif, I., Junejo, M. H., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: Systematic review and quality assessment. *BMJ open*, *11*(4), e048943; Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *The journal of clinical endocrinology and metabolism*, *102*(11), 3869–3903, https://doi.org/10.1210/jc.2017-01658.
[5] Swedish National Board of Health and Welfare (2022). Care of children and adolescents with gender dysphoria: Summary of National Guidelines-December 2022, p. 3, https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf. The quote is from p. 3.
[6] NHS England (2023) Consultation report for the interim service specification for specialist gender incongruence services for children and young people, *NHS England*, June 9, https://www.england.nhs.uk/wp-content/uploads/2023/06/Consultation-report-on-interim-service-specification-for-Specialist-Gender-Incongruence-Services-for-Children-.pdf. The quote is from p.13.
[7] Expert Affidavit of Aron Janssen, #84, p. 20; Shumer, #89 p. 25.

14. In reality—that is, when you include numerous pediatricians, psychotherapists, some researchers and endocrinologists, together with national health care systems in several European countries—there remains no wide, shared consensus about the prudence and intelligence of giving puberty blockers and cross-sex hormones to adolescents. Only professional organizations whose assertions are partial to transgender activists would suggest there is a consensus. Indeed, how could a scholarly consensus emerge so quickly in a domain that is experiencing a new surge in cases, where research barely existed two decades ago, and where much of what has been written is less than 7 years old? Even some of the most well-known pioneering researchers in the field acknowledge this: "…in actual practice, no consensus exists whether to use these early medical interventions."[8]

15. Clinicians remain divided over age standards and whether putting patients in the driver's seat of their own care is a good idea.[9] Although supporters of "affirmative" treatment approaches tend to formally endorse the experimental "Dutch protocol," the contemporary practice of American gender clinics is not consistent even with that approach. In the Dutch protocol, baseline health and high functioning are required for adolescent patients to proceed through treatment. Psychiatric co-morbidities and the absence of childhood gender dysphoria (i.e., adolescent-onset only) are grounds for exclusion from subsequent treatment.[10] In a clever move, many clinicians are endorsing "affirmative" gender treatment based on research conclusions from a literature whose criteria for patient inclusion had long been notably more selective and

[8] Vrouenraets, L. J., Fredriks, A. M., Hannema, S. E., Cohen-Kettenis, P. T., & de Vries, M. C. (2015). Early medical treatment of children and adolescents with gender dysphoria: An empirical ethical study. *The journal of adolescent health: Official publication of the society for adolescent medicine*, *57*(4), 367–373, https://doi.org/10.1016/j.jadohealth.2015.04.004. The quote is from p. 367.

[9] Edwards-Leeper, L., & Anderson, E. (2021). The mental health establishment is failing trans kids. *Washington Post*, November 24, https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist.

[10] For a description of the protocol, see: Delemarre-van de Waal, H. A., Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European journal of endocrinology*, *155*(suppl 1):S131–S137.

rigorous than it is today. The Dutch protocol is more rigorous and exclusive than the majority of patients who make up published American transgender research samples—in other words, most of the American patients would not qualify for the (experimental) procedures even under the Dutch protocol.

16. While the Dutch clinic is often cited as the best evidence and that upon which American gender clinics are modeled, such as in Dr. Janssen's oral testimony before Florida,[11] it is clear from the plaintiff's three expert reports that they are following an "informed consent" model rather than one focused on mental health assessments and/or a lack of psychiatric co-morbidities. Dr. Janssen argues in his report that the presence of co-morbidities should not preclude access to affirming care; "[r]ather, such conditions should not impair the ability of the patient to make an informed decision or interfere with the accuracy of the diagnosis of Gender Dysphoria."[12] Additionally, a 2022 Reuters investigation amply demonstrated that assessments such as the Dutch model required are not being carried out, with many clinicians willing to dispense medications on a first visit.[13]

17. Hence, treatments of adolescent gender dysphoria are being endorsed based on conclusions from studies whose sample inclusion criteria were far stricter than is commonly the case in practice today. This is a bait-and-switch tactic, in service to a politicized movement to make available transgender medical treatments to adolescent patients who previously would not have been eligible for them.

[11] Sapir, L. (2022). Reason and compassion on gender medicine, *City Journal*, Nov. 4, https://www.city-journal.org/article/reason-and-compassion-on-gender-medicine.
[12] Janssen #69, p. 16.
[13] Terhune, C., Respaut, R., & Conlin, M. (2022). As more transgender children seek medical care, families confront many unknowns, *Reuters,* Oct. 6, https://www.reuters.com/investigates/special-report/usa-transyouth-care/.

18. Dr. Shumer makes the claim that "the use of GnRHa and hormones in adolescents for the treatment of gender dysphoria is the current standard of care and certainly not experimental. This is due to robust evidence of safety and efficacy."[14] This directly contradicts the thorough Swedish review that concluded evidence of both safety and efficacy to be so lacking that "hormone treatment in children with gender dysphoria should be considered experimental treatment."[15]

19. Thomas Steensma of the Dutch Center of Expertise on Gender Dysphoria identifies the experimental nature of it all: "Little research has been done so far on treatment with puberty blockers and hormones in young people. That is why it is also seen as experimental."[16] The nature of the research, given it is "still being evaluated for efficacy, safety, and acceptability," qualifies it as experimental under the American Psychological Association's definition of experimental treatment."[17]

20. Dr. Olson-Kennedy claims in her report that "[t]here are no evidence-based interventions, other than gender-affirming medical care, to treat gender dysphoria for those who need it" and that "[u]nder SB 14, medical providers would be left with no evidence-based treatment approaches to support their adolescent patients with gender dysphoria."[18] Once again, this is in stark contrast to the conclusions of numerous reviews and countries changing course. Due to the lack of substantive evidence for mental health benefits from medical interventions, coupled with

[14] Shumer, #90, p. 23.
[15] Ludvigsson, J. F., Adolfsson, J., Höistad, M., Rydelius, P-A., Kriström, B., Landén, M. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica*, 00, 1–14, https://doi.org/10.1111/apa.16791.
[16] Tetelepta, B. (2021). More research is urgently needed into transgender care for young people. Where does the large increase of children come from? *Voorzij*, February 27, https://www.voorzij.nl/more-research-is-urgently-needed-into-transgender-care-for-young-people-where-does-the-large-increase-of-children-come-from/.
[17] APA, *Dictionary of Psychology*, https://dictionary.apa.org/experimental-treatment. Retrieved: Aug. 13, 2023.
[18] Expert Declaration of Johanna Olson-Kennedy, #69 and #71, p.19

the risk or regret and known harms, "more and more European countries and international professional organizations now recommend psychotherapy rather than hormones and surgeries as the first line of treatment for gender-dysphoric youth."[19] This is not to leave them without care. From the initial Dutch study on, no study has ever conclusively, consistently demonstrated that medical interventions are superior to psychotherapy alone.[20]

II. EXPLAINING THE RECENT SURGE IN GENDER DYSPHORIA AND TRANSGENDER-IDENTIFYING ADOLESCENTS

21. Transgender self-identifications have surged in the United States, and throughout much of the West, in the past 10 years. What had once comprised around 0.3 percent of the total population as recently as 2011 doubled to 0.6 percent by 2016 (with adolescent transgender self-identification comprising 0.7 percent). Since then, the pace of increase has accelerated further, especially among youth. Population-based survey data from 10 states and nine urban school districts found that an average of 1.8 percent of high school students currently identify as transgender.[21] A study in *Pediatrics*, leaning on a 2016 statewide survey in Minnesota, revealed a figure of 2.7 percent.[22] A 2018 application of the CDC's Youth Risk Behavior Survey to just

[19] Kaltiala, R., et al. (2023). Youth gender transition is pushed without evidence, *Wall street journal*, July 13, https://www.wsj.com/articles/trans-gender-affirming-care-transition-hormone-surgery-evidence-c1961e27.
[20] Cantor, J. (2022) The science of gender dysphoria and transsexualism. Report submitted to the Florida Agency for Healthcare Administration, #29, p. 11, https://ahca.myflorida.com/content/download/4865/file/AHCA_GAPMS_June_2022_Attachment_D.pdf.
[21] The states are as follows: Colorado, Delaware, Hawaii, Maine, Maryland, Massachusetts, Michigan, Rhode Island, Vermont, and Wisconsin; the nine large urban school districts are: Boston, Broward County, Cleveland, Detroit, District of Columbia, Los Angeles, New York City, San Diego, and San Francisco; see: Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students-19 states and large urban school districts, 2017. *MMWR morbidity and mortality weekly report*, *68*(3), 67–71, https://doi.org/10.15585/mmwr.mm6803a3.
[22] Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., & Eisenberg, M. E. (2018). Health and care utilization of transgender and gender nonconforming youth: A population-based study. *Pediatrics*, *141*(3): e20171683, https://doi.org/10.1542/peds.2017-1683.

under 5,000 high schoolers in a Northeastern city school district yielded 9.2 percent who reported "incongruence between gender identity and sex assigned at birth."[23] This is no uptick; this is an unexplained explosion that demands attention.

22. Countries like the UK—with a national health system—are better poised to keep centralized statistics about adolescent gender clinic patients. In 2009-10, a total of 32 natal females and 40 natal males were referred to the country's Gender Identity Development Service (or GIDS).[24] A mere five years later, those figures rose to 399 natal females and 250 natal males. By 2018-19, the numbers had climbed to 1,740 natal females and 624 natal males. Beginning in 2011-12, the share of natal females outnumbered those of natal males, but by 2018-19, the sex ratio of referrals had leaped to 2.8 females for every male. This includes 171 children under age 10, 52 of whom are ages 3-6. A similar sex ratio is reported in North American gender clinics.[25] In Spain, referrals for adolescent gender dysphoria grew tenfold between 2012 and 2021 and demonstrated a sex ratio gap of 2.4 natal females for every natal male.[26]

23. Between 2015 and 2019, there was also a 27% increase among American high school boys in the share that identified as nonheterosexuals (from 4.5 to 5.7 percent). The same estimate among girls was even larger: a 46% increase (from 12.2 to 17.8 percent).[27] But the pace

[23] Kidd, K. M., Sequeira, G. M., Douglas, C., Paglisotti, T., Inwards-Breland, D. J., Miller, E., & Coulter, R. W. S. (2021). Prevalence of gender-diverse youth in an urban school district. *Pediatrics*, *147*(6): e2020049823.
[24] Tavistock & Portman NHS Foundation Trust. (2019). Referrals to the gender identity development service (GIDS) level-off in 2018-19, June 28, https://tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/.
[25] Sorbara, J. C., Chiniara, L. N., Thompson, S., & Palmert, M. R. (2020). Mental health and timing of gender-affirming care. *Pediatrics*, *146*(4): e20193600, https://doi.org/10.1542/peds.2019-3600.
[26] Expósito-Campos, P., et al. (2023). Evolution and trends in referrals to a specialist gender identity unit in Spain over 10 years (2012-2021), *The journal of sexual medicine*, *20*(3), 377-387, https://doi.org/10.1093/jsxmed/qdac034.
[27] Rapoport, E., Athanasian, C. E., & Adesman, A. (2021). Prevalence of nonheterosexual identity and same-sex sexual contact among high school students in the US From 2015 to 2019. *JAMA pediatrics*, doi:10.1001/jamapediatrics.2021.1109.

of growth in adolescent transgender self-identifications far eclipses the climb in rates of nonheterosexual orientations. It strains the imagination to suggest there is nothing "social" going on here, especially since we are talking about something that once affected less than 1 in 10,000 children, according to DSM-5 prevalence rates.[28] While affirmative-care proponents seem reticent to acknowledge it, elsewhere researchers assume the social contagion aspect of the surge, connecting it "to the use of digital social networks."[29]

24. Intersex cases, often used to call attention to transgender cases, are distinctive and occur in roughly one in every 5,000 births, an estimate consonant across three continents.[30] They are considered a type of disorder of sex development (DSD), and are not, as has sometimes been suggested, evidence of a "spectrum" of biological sex.

25. Everyone can perceive the surge. Maddeningly, it remains unexplained, as one 2022 study admitted: "At present, it is unclear what accounts for the surge in adolescent referrals to gender identity services, and why adolescent referrals are now predominately birth-assigned females."[31] The explanation that the surge is simply a function of increasing social acceptance does not account in the least for the increasingly disproportionate number of natal females seeking assistance for gender dysphoria, and presenting with "more total problems" than natal males.

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[28] Tavistock & Portman NHS Foundation Trust (2021). Reply to freedom of information request for Charing Cross and GIC waiting and intake figures made by Harry Burns, June 3, https://www.whatdotheyknow.com/request/request_for_charing_cross_gic_wa?nocache=incoming-1805111#incoming-1805111.

[29] Masson, C., Ledrait, A., Cognet, A., & Athéa, N. (2023). From transidentity to transidentification quick triggering of gender dysphoria in adolescents confronting the malaise of puberty. *L'Évolution Psychiatrique*, https://doi.org/10.1016/j.evopsy.2023.03.002.

[30] Kim, K. S., & Kim, J. (2012). Disorders of sex development. *Korean journal of urology*, *53*(1), 1-8. doi: 10.4111/kju.2012.53.1.1; Thyen, U., Lanz, K., Holterhus, P. M., & Hiort, O. (2006). Epidemiology and initial management of ambiguous genitalia at birth in Germany. *Hormone research in paediatrics*, *66*(4), 195-203, https://doi.org/10.1159/000094782; Sax, L. (2002). How common is intersex? A response to Anne Fausto-Sterling. *Journal of sex research*, *39*(3), 174-178, https://doi.org/10.1080/00224490209552139.

[31] Morandini, J.S., Kelly, A., de Graaf, N.M., Carmichael, P., & Dar-Nimrod, I. (2022). Shifts in demographics and mental health co-morbidities among gender dysphoric youth referred to a specialist gender dysphoria service. *Clinical child psychology and psychiatry*, 27(2), 480-491, doi: 10.1177/13591045211046813. The quote is from pages 481-482.

26. Accounting for the surge in adolescent transgender cases has been very challenging for two reasons. First, it was an unexpected development. Ten years ago, there was little clinical literature on females ages 11 to 21 suffering from gender dysphoria.[32] Second, early onset gender dysphoria has been documented for years, but primarily in natal boys—and those typically lacking in extensive comorbidity (that is, co-occurring psychological problems such as anxiety or depression).

27. The new surge in adolescent transgender cases is difficult to simplistically attribute to "pent-up demand"—that is, by suggesting that gender dysphoria and transgender self-identification exhibited longstanding manifestations that simply went undiagnosed or were entirely stigmatized. If that were true, we should be witnessing a parallel and documentable rise in gender dysphoria among, say, middle-aged adults. But no such rise has been observed. As recently as 2020, a Pew research study noted that only 0.2 percent of Gen X respondents (i.e., 40-55-year-olds) identify as transgender.[33]

28. In an attempt to understand the surge, Brown University public health scientist Lisa Littman explored possible "cluster outbreaks" of what she identified as "rapid onset gender dysphoria" (ROGD) among adolescents, meaning that the dysphoria happens suddenly either during or after puberty among teenagers who displayed no indications of such tendency in their childhood.[34] (Others identify this as "adolescent-onset" gender dysphoria.[35]) The study, which inquired of parents of teens, noted that ROGD tended to occur within groups of friends: more

[32] Shrier, A. (2020). *Irreversible damage: The transgender craze seducing our daughters*. Regnery Publishing.
[33] Jones, J. M. (2021). LGBT identification rises to 5.6% in latest U.S. estimate. *Gallup*, February 24, https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx.
[34] Littman, L. (2018). Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. *Plos one*, *13*(8), e0202330, https://doi.org/10.1371/journal.pone.0202330.
[35] de Vries, A. L. (2020). Challenges in timing puberty suppression for gender-nonconforming adolescents. *Pediatrics*, *146*(4), https://doi.org/10.1542/peds.2020-010611; Sevlever, M., & Meyer-Bahlburg, H. F. (2019). Late-onset transgender identity development of adolescents in psychotherapy for mood and anxiety problems: Approach to assessment and treatment. *Archives of sexual behavior*, *48*(7), 1993-2001, https://doi.org/10.1007/s10508-018-1362-9.

than one-third of the friendship groups in the study witnessed half or more of the group identifying as transgender in a similar time frame. This, Littman noted, is about 70 times higher than the expected (0.7%) prevalence rate. Only 13 percent of parents noted no evidence at all of a "social influence."

29. Parents of the adolescents in the study tended to describe "a process of immersion in social media, such as 'binge-watching' YouTube transition videos and excessive use of Tumblr, immediately preceding their child becoming gender dysphoric."[36] Littman also observed that 22 percent of adolescents in her study "had been exposed to online advice about what to say to doctors to get hormones." Moreover, "the vast majority of parents were reasonably sure or positive that their child misrepresented their history to their doctor or therapist."[37] A recent study about the surge in adolescent demand for gender dysphoria treatment in the UK and four Nordic countries similarly noted a potential role of social and media influences.[38]

30. Studies like Littman's are exploratory, however, and not designed to discern causation. Professor Littman did not draw hard conclusions from her survey, which was nonrepresentative and relied on an opt-in sampling strategy that is very common in the study of transgender patients. Rather, she documented the associations between what she describes as the phenomenon of ROGD and certain social and psychiatric conditions.

31. An outcry on social media emerged after the Littman study was published. The journal's editors pledged to "seek further expert assessment on the study's methodology and analyses." That is, they re-reviewed the study, a very unusual move in the sciences. This post-

[36] Littman (2018), p. 3.
[37] *Id*, p. 36.
[38] Kaltiala, R., Bergman, H., Carmichael, P., de Graaf, N. M., Egebjerg Rischel, K., Frisén, L., Schorkopf, M., Suomalainen, L. & Waehre, A. (2020). Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK. *Nordic journal of psychiatry*, *74*(1), 40-44, doi: 10.1080/08039488.2019.1667429.

publication review resulted in no substantive changes to the study's results, suggesting the motivation was rooted in political rather than scientific concerns. This example highlights the challenging atmosphere for documenting, understanding, and attempting to explain what is going on.

32. WPATH mildly criticizes Littman's study in version 8 of their Standards of Care—which became available for preview and comment in December 2021 after 10 years of Version 7. While WPATH claimed Littman's study "contained significant methodological challenges which must be considered as context for the findings," it nevertheless admits much of what Littman revealed, noting that "social influence on gender is salient" and that "by clinical observation an increasing number of youth are coming to self-identify as gender diverse in later adolescence."[39]

33. Professor Littman's exploratory research was lambasted because it introduced the possibility that transgender identity is—at an unknown rate—not innate but developmentally responsive to social cues for an unknown but significant number of cases. If Littman is right, it means greater attention to the diverse origins of gender dysphoria is in order, with likely ramifications for treatment options. But her research is disparaged because this is not in accord with claims of those advocating for aggressively "affirmative" treatment. This isn't how science is supposed to work.

34. The activist attacks on research did not stop with Lisa Littman. A recent study[40] co-authored by well-known sex researcher J. Michael Bailey was immediately decried by activists in an open letter because it provided further corroboration of Littman's description of "rapid

[39] Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L., Deutsch, M. B., ... & Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International journal of transgender health*, *23*(sup1), S1-S259.

[40] Diaz, S., & Bailey, J. M. (2023). Rapid onset gender dysphoria: Parent reports on 1655 possible cases. *Archives of sexual behavior*, *52*(3), 1031-1043, https://link.springer.com/article/10.1007/s10508-023-02576-9.

onset" gender dysphoria, indicating that there was a possible social contagion at work among some trans-identifying teens. After pressure and various tactics, the study was fairly quickly retracted on a manufactured technicality.[41] "Ideological capture," described at length later in the report, clearly extends to scientific journals. That is, evidence and varying perspectives are not to be debated in the scientific record; rather, undesired perspectives are suppressed and prevented from appearing in print. In most other domains of medicine, there is a rush to understand new developments.

35. The surge has ramifications for understanding the very stability of gender identity. Dr. Janssen claims that the "evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender people, further underscores the innate nature and immutable [sic] of gender identity," [42] an assertion which seems out of step with the American Academy of Pediatrics policy statement on the care and support for transgender and gender diverse children and adolescents. The AAP holds that the self-recognition of gender identity "develops over time" and yet "[f]or some people, gender identity can be fluid, shifting in different contexts."[43] Which is it—fluid or fixed?

36. Plaintiffs' expert witness Johanna Olson-Kennedy adds that gender identity, having been coined in 1964, was determined by 1966—fully 57 years ago and before systematic research was conducted—to be impervious to change. Given the existence of "detransitioners," whose accounts are often suppressed, it is difficult to assess gender identity as being immutable. Add in the purported reality of lots of different kinds of gender identities—rather than just male

[41] Bailey, J. M. (2023) Letter of appeal to springer nature, May 25, https://segm.org/sites/default/files/2023-06/Springer%20Nature%20Appeal_25%20May_MJB.pdf; Wright, C. (2023) Anatomy of a scientific scandal, *City Journal,* June 12, https://www.city-journal.org/article/anatomy-of-a-scientific-scandal.
[42] Janssen, #35, p. 7.
[43] Rafferty, J. & Committee on Psychosocial Aspects of Child and Family Health. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*, Pediatrics, 142*(4): e20182162, https://doi.org/10.1542/peds.2018-2162.

and female—and the notion of immutability beggars belief. The rise in nonbinary self-identity undermines the notion of an immutable or durable gender identity. Instead, it suggests fluidity. Columbia University sociologist Tey Meadow reports in her article on the production of legal gender classifications: "Many courts look to medical definitions of sex…. yet there is no consensus about when gender change actually happens."[44]

37. Categorical claims about the immutability of sexual orientation have certainly fared well in legal decisions, as University of Utah psychology professor Lisa Diamond observed.[45] To invoke "immutability" in the absence of a genuine consensus on the etiology of gender dysphoria—especially amid the sudden surge in cases and its sex ratio disparity reversal—suggests political calculation is at work.

III. STUDY CONCLUSIONS OF TRANSGENDER TREATMENT EFFECTS ARE DEMONSTRABLY INADEQUATE.

38. Despite ample scientific resources—adequate funding, the interest of professional organizations, and competent researchers—the science of gender identity (and transgender outcomes) is characterized by modest evidence followed by overreaching conclusions. Any talk of "consensus" or of enduring "standards" are baseless assertions.

39. It remains the fact that little is understood about the long-term physical effects of puberty blockers and cross-sex hormones, especially when they are administered during those years that are critical for biological and brain development.[46] This is in part a function of (1)

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[44] Meadow, T. (2010). "A rose is a rose": On producing legal gender classifications, *Gender & society 24*(6), 814–837, https://doi.org/10.1177/0891243210385918. The quote is from p. 824.

[45] Diamond, L. M. & Rosky, C. J. (2016). Scrutinizing "immutability": Research on sexual orientation and its role in legal advocacy for the rights of sexual minorities rights, *Journal of sex research, 53*(4-5)*,* 363-391, doi: 10.1080/00224499.2016.1139665.

[46] Wren, B. (2014). Thinking postmodern and practising in the enlightenment: Managing uncertainty in the treatment of children and adolescents. *Feminism & psychology, 24*(2), 271–291, https://doi.org/10.1177/0959353514526223. The quote is from p. 287; Heneghan, C., & Jefferson, T. (2019). Gender-affirming hormone in children and adolescents, *BMJ EBM spotlight*, February 25, https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

how few minors experienced these treatments in the past—a small pool to study, and (2) the fact that the surge in such treatments remains less than a decade old, with insufficient opportunity for documenting long-term outcomes. In other words, too few and too new.

40. Adolescence is also a crucial period of social development. Artificially holding a child in a pre-pubescent state for several years while his or her peers navigate the social milestones and minefields of adolescence is likely to have at least some "subtle negative psychosocial and self-confidence effects."[47] Indeed, the American Academy of Pediatrics recognizes that "[d]elaying puberty beyond one's peers can also be stressful and can lead to lower self-esteem and increased risk taking."[48] And the Endocrine Society's guidelines recognize "the sense of social isolation from having the timing of puberty be so out of sync with peers."[49]

41. But what the research does not tell us is the isolated effect of puberty blockers (and similarly, of subsequent cross-sex hormones), since today gender dysphoria infrequently appears apart from other (possibly confounding) psychiatric conditions and the experience of traumas.[50]

42. For example, seven endocrinologists and psychologists recently discussed the clinical characteristics of 79 children presenting to a new gender clinic in Australia, noting a high number of conflicted family situations and documented trauma.[51] Only five percent of their sample was believed to exhibit "healthy" levels of functioning. Despite this, many of the new

[47] Levine, S. (2020) Declaration, U.S. Circuit Court, Dane County, Wisconsin, Case No.: 20-CV- 454. The quote if from p.41.
[48] Rafferty, J. & Committee on Psychosocial Aspects of Child and Family Health (2018). The quote is from p. 5.
[49] Hembree et al. (2017). The quote is from p. 3885.
[50] E.g. In Littman (2018), 62 percent of parents reported their child had been previously diagnosed with a psychiatric disorder, while 48 percent reported a traumatic or stressful event occurring prior to the onset of their child's gender dysphoria. See p. 13.
[51] Kozlowska, K., McClure, G., Chudleigh, C., Maguire, A. M., Gessler, D., Scher, S., & Ambler, G. R. (2021). Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems*, *1*(1), 70-95, https://doi.org/10.1177/26344041211010777.

clinic's patients and their families openly pressed the clinicians to begin medical (hormonal, etc.) treatments, believing that method was the only solution and "that their distress would be completely alleviated if they pursued the pathway of medical treatment." This frustrated the seven scholar-clinicians: "Lost were our efforts to highlight the many different pathways in which gender variation could be expressed, to explain potential adverse effects of medical treatment, to explore issues pertaining to future fertility and child rearing, and to highlight the importance of ongoing psychotherapy." The authors attributed this now-predictable pattern to information that patients received from (1) their peers, (2) previously encountered health workers, and (3) the internet. Many children, they noted, arrived with "strongly entrenched beliefs and with no interest in further exploring their medical, psychological, social, or familial situation." The study's authors also asserted that many of the patients "did not have the cognitive, psychological, or emotional capacity to understand the decisions they were making."[52]

43. Voluntary uptake of fertility preservation efforts by transgender adolescents is low, under five percent, despite majority self-reported claims of interest in "desire for children."[53] A study of pre-treatment fertility counseling among transgender adolescents between 2012 and 2017 revealed documentation of fertility impact of gender-affirming therapy in only 55

[52] *Id.* The quotes are from p. 15.

[53] Chen, D., Simons, L., Johnson, E.K., Lockart, B.A., & Finlayson, C. (2017). Fertility preservation for transgender adolescents. *Journal of adolescent health*, *61*(1), 120-123, https://doi.org/10.1016/j.jadohealth.2017.01.022; Bartholomaeus, C., & Riggs, D.W. (2020). Transgender and non-binary Australians' experiences with healthcare professionals in relation to fertility preservation. *Culture, health & sexuality*, *22*(2), 129-145, DOI: 10.1080/13691058.2019.1580388; Stolk, T.H.R., Asseler, J.D., et al. (2023). Desire for children and fertility preservation in transgender and gender-diverse people: A systematic review. *Best practice & research clinical obstetrics & gynaecology*, *87*, 102312. https://doi.org/10.1016/j.bpobgyn.2023.102312.

percent of records.[54] As affirmative care becomes more aggressive at younger ages, it is unreasonable to presume that fertility counseling will yield much interest. Moreover, earlier preservation efforts mean more years of expensive storage.

44. All these interests and concerns complicate treatment of gender dysphoria. A market increasingly characterized by patient demand for puberty blockers and cross-sex hormones does not make for an atmosphere conducive to addressing pertinent co-occurring diagnoses. But this is exactly what is now developing in the "affirmative care" approach. As psychotherapist Robert Withers observes, "failure to address relevant psychological issues can result in trans people making unnecessary, permanent changes to their bodies, without adequate scientific justification for doing so."[55] Withers additionally notes that "[m]any of today's young people have also made 'gender affirming' medical treatment their goal."[56]

45. Large, longitudinal data collection efforts on the psychological health effects of transgender medicine remain rare but do exist. The Swedish Total Population Register, a massive longitudinal survey effort that collected information from over 9.7 million Swedes, is an example. A study based on this data appeared in 2020 in the *American Journal of Psychiatry*, and purported to constitute high-quality evidence in favor of medical transition for gender dysphoric patients.[57] Its authors tracked dysphoric respondents over time and assessed their subsequent use of mental health treatment (for a mood or anxiety disorder), as well as other related measures (such as hospitalization after a suicide attempt). There was no evidence that initiating hormone

[54] Komorowski, A.S., Fisher, A.R., Jungheim, E.S., Lewis, C.S., & Omurtag, K.R. (2021). Fertility preservation discussions, referral and follow-up in male-to-female and female-to-male adolescent transgender patients. *Human Fertility*, DOI: 10.1080/14647273.2021.2015804.
[55] Withers, R. (2020) Transgender medicalization and the attempt to evade psychological distress. *Journal of analytical psychology*, *65*, 865– 889, https://doi.org/10.1111/1468-5922.12641. The quote is from p. 865.
[56] *Id,* p. 869.
[57] Bränström, R., & Pachankis, J. E. (2020). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: A total population study. *American journal of psychiatry*, *177*(8), 727-734, https://doi.org/10.1176/appi.ajp.2019.19010080.

treatment paid benefits in reduced subsequent use of mental health treatment, but the authors concluded that "gender-affirming" surgery is associated with reduced demand for subsequent mental health treatment in a sample of persons diagnosed with "gender incongruence."

46. However, a cursory reading of the study itself tells a far less optimistic story than the authors' own confident interpretations of the post-surgical data. From the available published data, I was able to calculate the "Number Needed to Treat," or NNT, which is a measure of clinical impact. It helps relate the actual size of the effect of the treatment back to the realities of clinical practice to aid physicians in decisions about whether a particular treatment is "worth it."[58] A high NNT accompanied by significant risk (in the treatment) is considered high-risk, low payoff. On the other hand, a high NNT accompanied by modest risk (such as prescribing a daily statin pill to reduce risk of a subsequent heart attack) is considered low risk, low payoff. In this study, the NNT appears to be a staggering 49, meaning the beneficial effect of transgender surgery (or more commonly, a series of surgeries) is so small that a clinic may have to perform 49 gender-affirming surgeries before they could expect to witness one additional post-surgical patient's reduction in subsequent mental health assistance. If no other treatment was available, or if the treatment was non-invasive and the hazards were insignificant, clinics might consider surgery a low-risk but low-payoff approach. But even the most common surgeries here (e.g., bilateral mastectomy) are considered major surgeries—and particular ones are exceptionally challenging, with elevated likelihood of suffering a complication.[59] Conducting surgery on 49 pa-

[58] Citrome, L. (2014). Quantifying clinical relevance. *Innovations in clinical neuroscience*, *11*(5-6), 26–30.
[59] A recent study revealed that while just over 10 percent of a group of 1,212 adult "transmasculine" patients elected to undergo genital reconstruction surgery, those 129 patients reported 281 complications—more than two per patient, on average—requiring 142 "revisions." The three most common complications: Urethral fistulas or strictures, and worsened mental health. The only documentable benefit? A surge in their "genital self-image." See Robinson,

tients in order to secure one patient who modestly benefits in slightly less psychological services? It ought to give physicians considerable pause, but in an industry increasing characterized by demand-driven care of patients, it does not.

47. The journal received numerous letters pointing out that the study's analysis was flawed and its conclusions unsupported by the data. Almost one year later, the *American Journal of Psychiatry* published seven letters of critique, an editorial note on the subsequent statistical review those critiques prompted, and the resulting correction that nullified the study's claim of a post-surgical mental health benefit. The correction curbed what conclusions the authors had originally made—that "this study provides timely support for policies that ensure coverage of gender-affirming treatments."[60] This example is indicative of a wider trend of "looking" for statistical significance, however weak, to support claims that are consonant with the wishes of transgender medical practitioners.

48. While the Bränström and Pachankis study concerns adults rather than minors, my discussion of it is intended to highlight the unsettledness of the science here, and to suggest that the line between activists and academics is a rather thin one, provoking contests over the meaning of a study's results. Given it is arguably the largest longitudinal dataset capable of tracking the long-term effects of hormones and surgery, its lack of notable findings (following the editor's requested correction) has ramifications for the treatment of adult and adolescent patients alike.

49. There are some cracks forming in the coerced consensus about aggressively treating youthful gender dysphoria. In the past three years, three countries' national gender medicine

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I. S., Blasdel, G., Cohen, O., Zhao, L. C., & Bluebond-Langner, R. (2021). Surgical outcomes following gender affirming penile reconstruction: Patient-reported outcomes from a multi-center, international survey of 129 transmasculine patients. *The journal of sexual medicine*, *18*(4), 800-811, https://doi.org/10.1016/j.jsxm.2021.01.183.

[60] Bränström, R. & Pachankis, J. E. (2020) Correction to Bränström and Pachankis. *American journal of psychiatry* 177(8): 734, https://doi.org/10.1176/appi.ajp.2020.1778correction.

councils have commissioned focused studies on the efficacy of the "affirmative" approach to treating minors. These in-depth reviews by Finland, Sweden, and the UK's National Institute for Health and Care Excellence (NICE) in Britain have all concluded that claims of benefit for medical gender interventions in children are based on "low quality evidence."[61]

50. Sweden's review of the evidence base and ethics considerations found "knowledge gaps and uncertain knowledge" to be a "central theme."[62] A summary of their review of the literature reported the following: "No studies explaining the increase of children and adolescents seeking [treatment] for gender dysphoria were identified. The literature on management and long-term effects in children and adolescents is sparse, particularly regarding gender affirming surgery. All identified studies are observational, and few are controlled or followed-up over time."[63] They conclude by observing that "scientific activity in the field seems high," meaning extensive, but that a "large part of the literature that was considered relevant" was only published after 2017.

51. Denmark is another country that, upon examining the evidence, recently announced restrictions to protect vulnerable minors from medicalized gender change.[64] In contrast to the gender-affirmative approach in the U.S., which can support double mastectomies for 13-

[61] Society for Evidence Based Gender Medicine. (2021). Sweden's Karolinska ends all use of puberty blockers and cross-sex hormones for minors outside of clinical studies, May 5, https://segm.org/Sweden_ends_use_of_Dutch_protocol.

[62] Swedish National Council on Medical Ethics. (2019). Letter to the ministry of health and social affairs re: treatment of gender dysphoria among children and adolescents (unofficial translation), April 26, https://smer.se/wp-content/uploads/2019/04/Skrivelse-konsdysfori-eng-%C3%B6vers%C3%A4ttning.pdf. The quotes are from p. 2.

[63] Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU). (2019). Gender dysphoria in children and adolescents: An overview of the literature. *SBU,* Report No. 307: SBU, 2019/427, https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/report 307.

[64] Lane, B. (2023). Doubt in Denmark: Another progressive country is having doubts about paediatric gender transition, *Gender Clinic News*, August 1, https://www.genderclinicnews.com/p/doubt-in-denmark?r=130uly&utm_campaign=post&utm_medium=web; Rasmussen, J. (2023). B62 was not passed-but the minister of health announced on Tuesday a reduction of children's gender ranging in Dk by 80 and surgical gender ranging for Danish children is now completely prohibited, *Danish Rainbow Council*, June 2, https://www.danskregnbueraad.dk/?offset=1685961081429.

year-olds, [65] no such surgeries will be permitted for any minor under 18 in Denmark. Roughly 80% of minors transitioning from 2015-2022 demonstrated "rapid onset" at puberty. Now, similar to the original Dutch model, childhood-onset gender dysphoria will be required to be considered for a medicalized pathway.[66]

52. The UK's Royal College of General Practitioners issued a report in mid-2019 asserting that "[t]he significant lack of evidence for treatments and interventions which may be offered to people with dysphoria is a major issue facing this area of healthcare."[67] After the report highlights characteristics of the "affirmative" approach, it notes "a significant lack of robust, comprehensive evidence around the outcomes, side effects and unintended consequences of such treatments for people with gender dysphoria, particularly children and young people, which prevents (general practitioners) from helping patients and their families in making an informed decision."

53. The UK NICE pair of reports each concluded that invasive treatment of youth doesn't result in a confident determination of demonstrable success. Those studies, one report notes, "that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confound-

[65] Olson-Kennedy, J., Warus, J., Okonta, V., Belzer, M., & Clark, L. F. (2018). Chest reconstruction and chest dysphoria in transmasculine minors and young adults: comparisons of nonsurgical and postsurgical cohorts. *JAMA pediatrics*, *172*(5), 431-436.

[66] Lane, B. (2023). Doubt in Denmark: Another progressive country is having doubts about paediatric gender transition, *Gender Clinic News*, August 13, https://www.genderclinicnews.com/p/doubt-in-denmark?r=130uly&utm_campaign=post&utm_medium=web; Rasmussen, J. (2023). English translation: B62 was not passed-but the minister of health announced on Tuesday a reduction of children's gender ranging in Dk by 80% & surgical gender ranging for Danish children is now completely prohibited, *Danish Rainbow Council*, June 2, Rainbow https://www.danskregnbueraad.dk/?offset=1685961081429.

[67] Royal College of General Practitioners. (2019). The role of the GP in caring for gender-questioning and transgender patients, *RCGP position statement,* https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2019/RCGP-position-statement-providing-care-for-gender-transgender-patients-june-2019.ashx?la=en.

ing, bias, or chance." The studies "all lack appropriate controls." Moreover, the claims of "clinical effectiveness, safety, and cost-effectiveness" of such treatments clearly are not substantiated.[68] Hence, claims of benefit for medical gender interventions in children are based, the reports observe, on "low quality evidence."[69] These assessments offer reasons to be far more cautious about treating underage persons in such a way that permanently alters bodies as a response to problems of the mind.

54. One conclusion is increasingly obvious in this dispute. We have rapidly reached a stage in the study of transgender medicine where the phrase "peer review" no longer guarantees quality analyses, apt measures, appropriate samples, thoughtful interpretations, and measured conclusions.

55. In sum, the science of transgender medicine—including but not limited to adolescents—does not speak with a univocal voice about the long-term psychological and physical benefits of hormonal and surgical treatment of dysphoria. Much published research in this domain is very recent, relies on nonrepresentative, opt-in samples, "loaded" survey questions, and/or exhibits overreaching conclusions. To suggest the existence of any obvious "consensus" or "standards" from existing research would make little scientific sense.

IV. THE ABSENCE OF RANDOMIZED CLINICAL TRIALS RESEARCH

56. It is undeniable that the protocol of treatments for transgender-identifying youth, including its hormonal regimens, remains at least technically experimental by definition. It's not

[68] National Institute for Health and Care Excellence (NICE). (2021). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria, https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3fq%3dtransgender%26s%3dDate. The quote is from p. 13; National Institute for Health and Care Excellence (NICE). (2021). Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria. https://www.evidence.nhs.uk/document?id=2334889&returnUrl=search%3Fq%3Dgender%2Bdysphoria.
[69] Society for Evidence Based Gender Medicine, *op. cit.*

as if hormonal treatments have never been put to a clinical trial. The hormones estradiol and testosterone certainly have. The same is true of GnRH agonists (i.e., puberty blockers), which have been evaluated for adult infertility, prostate cancer, ovarian protection during chemotherapy, and even for tests of male contraceptives.[70] But these drugs have not been tested in randomized clinical trials as treatments for adolescent gender transition procedures. Puberty blockers have been approved only for treatment of precocious puberty.

57. Randomized trials generally provide high-quality evidence when compared with observational studies. The entire gender medicine industry merits criticism for complicity in failing to conduct such a rigorous clinical trial. Invasive, and even life-threatening, clinical trials are regularly conducted in the quest for lifesaving treatments among children with serious diseases or conditions.

58. It is true that to propose and carry out a randomized placebo-controlled trial in the study of the treatment of gender dysphoria today is not feasible. Some opponents of such a trial appeal to the principle of clinical "equipoise,"[71] namely, the assumption (underlying the ethics of randomized control groups) that there is no clear "better" intervention present. That is, they maintain that there is no clinical equipoise in the case of treating gender dysphoria; a control group in such a randomized trial would, they believe, receive an inferior, less-effective treatment as compared with the "affirmative" approach.

59. But this claim is in no small part a function of the putative "consensus" mentioned above and discussed more fully below. That is, since "affirmative" treatments now seem the

[70] Garner, C. (1994). Uses of GnRH agonists. *Journal of obstetric, gynecologic, & neonatal nursing*, *23*(7), 563-570, https://doi.org/10.1111/j.1552-6909.1994.tb01922.x.
[71] Cook, C., & Sheets, C. (2011). Clinical equipoise and personal equipoise: Two necessary ingredients for reducing bias in manual therapy trials. *Journal of manual & manipulative therapy*, *19*(1), 55-57, doi: 10.1179/106698111X12899036752014.

subject of patient demand and are endorsed by certain American professional organizations, there is indeed an assumption that clinical equipoise is not present. But that is a situation based not on longitudinal medical and social science research but on media-fostered patient demand and premature professional organizational claims and pressure. In other words, any lack of equipoise is more a psychological or cultural than a scientific development.

60. Further, even if equipoise were lacking for randomized *placebo-controlled* trials (i.e., trials that compared groups that did and did not receive hormones), that would be no obstacle to randomized trials *without* placebo groups to "compare different types, dosages and methods of administration of active treatments."[72] But few if any such trials have been conducted. The lack of even dosage studies with control groups highlights how this field of medicine seems to operate with impunity. It highlights the "ideological capture" of the field.

V. THE IDEOLOGICAL CAPTURE OF GENDER DYSPHORIA

61. The plaintiffs' experts wish to present the treatment of gender dysphoria with a medicalized pathway as "settled science," as if there is no debate or disagreement.[73] But a functioning and healthy scientific process allows debate, questions, and new research, especially on novel or controversial questions. However, there is much evidence that such is not how the U.S. medical organizations are currently functioning on transgender issues, but rather have been "ideologically captured."

62. Ideological capture operates not unlike "regulatory capture," a more familiar phrase. The end is the same—the corruption of authority by the successful co-opting of political

[72]Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane database of systematic reviews,* https://doi.org/10.1002/14651858.CD013138.pub2. The quote is from p. 10.
[73] Block, J. (2023). Gender dysphoria in young people is rising—and so is professional disagreement. *BMJ*, *380*, https://www.bmj.com/content/380/bmj.p382.

or professional organizations to serve the aims of a narrow interest group. Ideological capture is characterized by incorrigible commitments to certain conclusions regardless of the data and can lead whole organizations to disregard outcomes that are not consistent with the ideologically-motivated sense of rightness.[74] Ideological capture is inimical to the dissent and open debate that is critical to healthy medical and social science.

63. The ideological capture of gender dysphoria is not mere "conspiracy theory," but is quite real and a documented phenomenon. As I explain below, the ideological capture of gender dysphoria is evidenced by efforts to re-educate people in the use of identity language, by the entrepreneurial explosion of gender clinics across the nation, by pressure-based suppression of open debate (including among most affirmative clinicians and scholars), by inconsistent claims concerning adolescents' ability to give informed consent, and by the tacit endorsement of social media "peer education" about transgender life. It has contributed to suppressing any sense of the wisdom of "watchful waiting," a once-standard harm-reduction move that is now accused of fostering suicidality and has tagged psychological counseling as bordering on "reparative therapy." It fosters the belief that invasive medical—that is, hormonal and surgical—treatments should be performed at earlier ages, as WPATH's 8th edition of their Standards of Care reveals.

64. For instance, plaintiffs' expert witness Dr. Janssen is the co-chair of the Gender Identity Committee of the American Academy of Child and Adolescent Psychiatry (AACAP). In the last two years, his committee has vetoed three different panels, each of which would have included international experts such as Finland's premier gender clinician Riittakerttu Kaltiala,

[74] Chuang, J. A. (2010). Rescuing trafficking from ideological capture: Prostitution reform and anti-trafficking law and policy. *University of Pennsylvania law review*, *158*(6), 1655–1728.

whose work[75] he cites in his report, preventing them from presenting at the AACAP's annual conference.[76] Suppressing voices is not how medical science ought to proceed.

65. Similarly, member-physicians say the American Academy of Pediatrics of has suppressed debate, from refusing to allow informational booths to labeling requests for evidence reviews "transphobic" in the AAP newsletter.[77] Recently, the AAP has announced[78] that it will conduct an evidence review in order to update its 2108 policy statement. However, in official statements, the AAP reaffirmed its current policy and acknowledged that authorizing the review is in part both a standard five-year review as well as motivated by concerns about legislation such as this court is currently considering. While we can hope the scientific process will be open and unbiased, the pre-emptive statements of confidence that their policy is already in the "best interest of children"[79] give reason to at least question whether or not unbiased consideration of the evidence will be the case. The Endocrine Society has demonstrated similar ideological capture in refusing to consider perspectives and evidence counter to its current affirmative position.[80]

[75] Kaltiala, R., Heino, E., Työläjärvi, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*, 74, 213–219.
[76] Sibarium, A. (2023) They support sex changes for children, with safeguards. A top child psychiatry group won't let them speak at its annual conference. *The Washington free beacon,* August 11, https://freebeacon.com/campus/they-support-sex-changes-for-children-with-safeguards-a-top-child-psychiatry-group-wont-let-them-speak-at-its-annual-conference/.
[77] Mason, J. and Sapir, L. (2022) "The American Academy of Pediatrics' dubious transgender science," *Wall Street Journal*, August 18, https://www.wsj.com/articles/the-american-academy-of-pediatrics-dubious-transgender-science-jack-turban-research-social-contagion-gender-dysphoria-puberty-blockers-uk-11660732791.
[78] Wyckoff, A. S. (2023) "AAP re-affirms gender-affirming care policy, authorizes systematic review of evidence to guide update," *AAP News*, August 4, https://publications.aap.org/aapnews/news/25340/AAP-reaffirms-gender-affirming-care-policy.
[79] Ibid.
[80] Eappen, R. and Kingsbury, I. (2023). The Endocrine Society's dangerous transgender politicization, *Wall street journal*, June 29, https://www.wsj.com/articles/the-endocrine-societys-dangerous-politicization-endocrinologists-gender-affirming-care-arkansas-dac768bd?mod=article_inline.

A. Re-education in the Parlance of Gender Ideology

66. To classify something in the social world is to penetrate the imagination, to alter public frameworks of knowledge and discussion, and to shift the perception of everyday life. It is why French sociologist Pierre Bourdieu understood this elite-driven effort as the power of "legitimate naming."[81] In the domains of gender and sexuality—fraught as they are with great moral valence—there is poignant and bitter struggle over words and terms, and the politics of using them or avoiding them. This suggests we are not witnessing a simple quest for better understanding of an emergent population. Rather, social and cultural change are being fostered through scholarship wed to political activism.

67. The complaint and reports submitted by the plaintiffs in the preliminary-injunction stage of this case reflect this ideological effort. For example, Olson-Kennedy's claim that "[e]very person has a gender identity"[82] is freighted with ideological assumptions, as the following considerations show. The Endocrine Society guidelines describe "[e]xamples of conditions with similar features" to gender dysphoria, including "body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate)."[83] Dr. Anne Lawrence, who identifies as transgender, has also noted the parallels between gender dysphoria and body integrity identity disorder (BIID).[84] A person with BIID is able-bodied but identifies as an amputee and reports feeling trapped in a fully functional body. Such persons "often assert [that] their motives for wanting to change their bodies reflect issues of identity."[85]

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[81] Bourdieu, P. (1985). The social space and the genesis of groups. *Theory and society, 14*(6), 723-744.
[82] Olson-Kennedy, #24, p. 5.
[83] Hembree et al., *op. cit.*, p. 3878.
[84] Lawrence, A. A. (2006). Clinical and theoretical parallels between desire for limb amputation and gender identity disorder. *Archives of sexual behavior, 35*, 263-78.
[85] *Ibid*. The quote is from p. 263.

68. Now, it is one thing to recognize that some people with BIID make such identity claims. But it is something else altogether to say that because some people with BIID make that claim, therefore *everyone* has to be defined in terms of whether they identify as able-bodied, as an amputee, or as something in between. To make this further claim is to advocate a highly disputable ideology that says an able-bodied person's identifying as an amputee is not a disorder at all, but simply one of multiple "functional identities" that an able-bodied person may happen to have. But it is another thing (and altogether inappropriate) to use the terms in which persons experiencing mental distress or a pathology understand themselves as the new prism through which all persons must be defined. Claiming that "everyone has a gender identity" is an effort to precisely do that: to define everyone who does *not* suffer gender incongruence in terms of the self-experience of those who do.

69. One of the reasons why advocates include (in their articles, briefs, reports, etc.) sections defining terms is because new words are a source of social change itself. They are not simply illuminating but indoctrinating. Certainly, the challenges of measurement and data collection can benefit from clarification of terms. But they can become vehicles of cultural change themselves by endorsing particular ways of speaking about matters of gender identity that are highly contested. Even official surveys, the root source of so much social science raw data, are not only not exempt from politicization and the fostering of "legitimate naming," but are now a medium of the same.[86]

70. I concur with psychiatrist Dr. Stephen Levine, who has explained that "clinical work in the gender identity arena, which used to be based on symptoms and social, vocational,

[86] For a prime example, see: The GenIUSS Group. (2014). Best practices for asking questions to identify transgender and other gender minority respondents on population-based surveys. J.L. Herman (Ed.), The Williams Institute, https://williamsinstitute.law.ucla.edu/publications/geniuss-trans-pop-based-survey/.

and educational dysfunction, is now based on sociopolitical concepts. Cultural forces have provided a new narrative about the vital importance of having strict consonance between one's sexed body and gender identity."[87] This new narrative is not grounded in evidence-based science but in political activism. Long gone is the era, indeed, the entirety of social history, wherein human communities tolerated diversity in how boys and girls—and men and women—looked, felt, expressed themselves, and acted as sexed creatures. Sadly, in the name of "diversity" standard, predictable differences between persons are being suppressed in pursuit of an "ideal type" of male or female body that hews more closely to what we imagine they ought to be. This is the construction of a mythic uniform manhood and womanhood, rather than the toleration of variance in the same that long marked our common history.

B. The Rapidly Evolving "Consensus"

71. Despite the fact that American professional associations have endorsed the (general) "affirmative" approach to treating dysphoric adolescents, there is no wide, international consensus about its superiority. Nor is there evidence that the consensus is stable;[88] rather, there is an uneven evolution among advocates toward affirming treatments "on demand," with decreasing regard for the Dutch protocol's commitment to (1) a slower pace, with more listening and observation, and (2) the refusal to pursue medical treatments in the absence of childhood gender dysphoria and in the presence of psychiatric co-morbidities. That any purported "consensus" on hormonal and surgical interventions at earlier ages should have developed so rapidly among American professional associations—and with so much projected confidence—in the absence of obvious, consistent indicators of treatment efficacy, and amid a surge in cases of gender

[87] Levine, S. B. (2019). Informed consent for transgendered patients. *Journal of sex & marital therapy, 45*(3), 218-229. The quote is from p. 219.
[88] Vrouenraets et al., *op. cit.*

dysphoria, is suspicious. It suggests, instead, a concerted effort to suppress alternative (or even decade-old) treatment approaches in favor of a demand-driven endorsement of hormonal and surgical treatments.

72. Closely connected to the idea of ideological capture is that of a "Castro consensus," wherein a consensus "is viewed as a proxy for truth."[89] Certainly, "when a consensus is fashioned via the independent and free deliberations of many, it is a strong indicator of truth." But "not all consensuses are independent and freely formed." Some are pieced together by "external pressure," while "dependence among individuals can force consensus around an issue, regardless of the underlying truth of the affirmed position." Indeed, simple bias can lead to a purported (and premature) consensus, given that decision-makers (and researchers) "are both human and political."[90] This is an accurate description of what has occurred in the domain of medicine concerned with the treatment of gender dysphoria.

73. For instance, WPATH, formed in 1979, has evolved from its beginnings as a group of professionals seeking to understand and assist those with gender dysphoria to acting as a professional association that purports to offer "consensus" clinical guidelines while simultaneously acknowledging that "WPATH is committed to advocacy for . . . changes in public policies and legal reforms."[91] WPATH's treatment recommendations shape the recommendations of

[89] Allen, J., Lay, C., & Montanez, G. (2020) A Castro consensus: Understanding the role of dependence in consensus formation, 1-9, https://www.researchgate.net/publication/344703449_A_Castro_Consensus_Understanding_the_Role_of_Dependence_in_Consensus_Formation. The quote is from p. 1.
[90] Socol, Y., Shaki, Y. Y., & Yanovskiy, M. (2019). Interest, bias, and consensus in science and regulation, *Dose-response, 17*, 1-5. https://doi.org/10.1177/1559325819853669.
[91] Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International journal of transgenderism*, *13*(4), 165-232. The quote is from p. 2; Levine, S. B. (2018). Ethical concerns about emerging treatment paradigms for gender dysphoria. *Journal of sex & marital therapy, 44*(1), 29-44; Vrouenraets et al., *op. cit.*

other professional organizations; the APA's guidelines, for example, follow WPATH's recommendations and label any approach other than "affirming" to gender dysphoric youth as "unethical."[92]

74. Despite WPATH's purported "consensus" building, the organization continues to struggle with both the research and clinical communities, as well as their own penchant for establishing—not just recognizing—new ground to cover. Such appears to be the case in their updated Standards of Care version 8, where they devote an entire chapter to "eunuch-identified people," most often natal males who exhibit a "strong urge to live without testicles."[93] If a 17-year-old male presents as "eunuch-identified," this is a valid transgender identity under WPATH guidance, and he should be eligible for "affirming" orchiectomy or more for castration to align his body with his mind. In a 2007 study of this unusual community, researchers noted that the typical time from development of interest to actual castration—physically or chemically—was 18 years.[94] The researchers identified four factors at work in the minds of such persons: sustained abuse during childhood, homosexuality, exposure to animal castration during youth, and religious condemnation of sexuality. The authors noted both BIID and GID among self-identified eunuchs.

[92] American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American psychologist, 70*(9), 832-864.
[93] Hermann, M., & Thorstenson, A. (2015). A rare case of male-to-eunuch gender dysphoria. *Sexual medicine*, *3*(4), 331–333. https://doi.org/10.1002/sm2.81.
[94] Johnson, T. W., Brett, M. A., Roberts, L. F., & Wassersug, R. J. (2007). Eunuchs in contemporary society: Characterizing men who are voluntarily castrated (Part I). *The journal of sexual medicine*, *4*(4), 930-945, https://doi.org/10.1111/j.1743-6109.2007.00521.x.

75. My point about this group is only this. It is beyond ironic that Professor Littman is professionally scourged for observing an exploding number of post-pubertal adolescent dysphoria cases, while WPATH devotes more attention to eunuchs, who as recently as 2015 were considered to be so uncommon as to merit single-case discussion in professional journals.[95]

76. The WPATH "consensus" is not stable. It is clearly evolving in the direction of aggressive affirmation. In the draft preview of Standards of Care version 8, WPATH lowered some of the recommended ages for treatment. No one can suggest anymore that surgery is not being authorized for minors, since WPATH commends age 15 (and above) as appropriate for "chest masculinization" treatment, age 16 for breast augmentation and facial surgeries (e.g., rhinoplasty, tracheal shave, and genioplasty), age 17 for hysterectomy, vaginoplasty, metoidioplasty (or bottom surgery for female-to-male patients), and orchidectomy (the removal of testicles), and 18—the end of status as a minor—for phalloplasty or the construction of a penis in female-to-male transgender patients. The final version removed minimum age limits altogether; WPATH's website explains that after reviewing comments "it was determined that the specific ages would be removed to ensure greater access to care for more people."[96]

77. While claims that genital surgeries for transgender patients are not offered before adulthood remain common, such remarks remain inaccurate. Plaintiffs' expert witness Olson-Kennedy remarks that "it is extraordinarily rare that a minor would undergo genital surgery," yet a 2017 interview-based study of 20 surgeons revealed that vaginoplasties were already being performed years ago on minors by surgeons in the United States.[97] Full gender-affirming surgery in

[95] Hermann & Thorstenson, *op. cit.*
[96] World Professional Association for Transgender Health. (2022). WPATH soc 8: Frequently asked questions, https://www.wpath.org/media/cms/Documents/SOC%20v8/SOC-8%20FAQs%20-%20WEBSITE2.pdf. The quote is from p. 4.
[97] Olson-Kennedy, #63, p. 17; Milrod, C., & Karasic, D. H. (2017). Age is just a number: WPATH-affiliated surgeons' experiences and attitudes toward vaginoplasty in transgender females under 18 years of age in the United States. *The journal of sexual medicine*, *14*(4), 624-634. The Komodo insurance analysis conducted for the Reuters

minors constitutes irreversible surgical sterilization, as even the most ambitious of affirmative clinicians admit.[98]

78. In the short span of a decade, psychiatrists, psychologists, pediatricians, and their patients have been pressed both to think about and to treat child and adolescent dysphoria in one "correct" manner—via the aggressively affirmative approach. Even some early advocates for the Dutch protocol are now concerned about the on-demand, skip-the-counseling version that is emerging.[99] Psychotherapy has now become more difficult to come by, even disparaged as "conversion" therapies, as discussed below.[100]

C. The Entrepreneurial Explosion of Gender Clinics

79. When the contrived consensus about appropriate treatment of gender dysphoria meets a free-market health care delivery system, it is no surprise that the result is an explosion in gender clinics. Less than 15 years ago, the United States featured a solitary pediatric gender clinic (Boston Children's Hospital's Gender Management Service, founded in 2007). But today there are over 300 clinics that provide some form of "gender affirmative" care to minors, ranging from full-service operations (i.e., hormone and surgical services) to private practice doctors that will perform surgeries on minors.

80. Planned Parenthood clinics have similarly (and quickly) added gender medicine delivery to their services. As noted in the organization's recent annual report, they are now "the

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investigation found 56 genital surgeries covered for 13-17 year olds with a gender dysphoria diagnosis for the years 2019-2021. See: Terhune et al., *op. cit.*

[98] Olson-Kennedy, J. (2015). *The future of trans care in the new millennium*. Gender Infinity Annual Conference. https://youtu.be/pO8v--tztSg. What is critical here about the pairing of puberty blockers then cross-sex hormones is that if patients commence puberty blockers early enough, they will not go through puberty (of their natal sex); hence, their gametes do not have enough time to mature (for the purpose of being subsequently harvested for possible future artificial reproduction). See Hudson, J., Nahata, L., Dietz, E., & Quinn, G. P. (2018). Fertility counseling for transgender AYAs. *Clinical practice in pediatric psychology*, *6*(1), 84-92, doi: 10.1037/cpp0000180.

[99] Edwards-Leeper, L., & Anderson, E., *op. cit.*

[100] For example, see Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA psychiatry, 77*(1), 68–76. doi:10.1001/jamapsychiatry.2019.2285.

second largest provider of hormone therapy to those who identify as transgender/have gender dysphoria."[101] Mara Keisling, executive director of the National Center for Transgender Equality, remarked (over five years ago) about Planned Parenthood that "It's possible they're the largest provider of trans health in the country."[102] Formally, the organization now notes that some facilities serve 16- and 17-year-olds with "parental consent."[103] More natal females than males seek out Planned Parenthood's gender services, which can serve as a more stable source of income than abortions. One anonymous employee described them as "cash cows…kept on the hook for the foreseeable future."[104]

81. Nationwide, it is clear that clinics have tended to make their own decisions about treatment, often proving even more aggressive than professional organizations' own recommendations. For example, New York's Mount Sinai Center for Transgender Medicine and Surgery (CTMS) operates with a "patient-centered model," and reported that 45 percent of 139 patients seeking vaginoplasty were deemed ready for surgery, well above the 15 percent who met WPATH's criteria for surgery eligibility.[105] If patients seeking surgical treatments are apt to see their odds of getting it tripled, it is only reasonable to believe that providers with fewer restrictions will thrive.

[101] Planned Parenthood Federation of America. (2021). 2019-2020 annual report, p. 11. https://www.plannedparenthood.org/uploads/filer_public/67/30/67305ea1-8da2-4cee-9191-19228c1d6f70/210219-annual-report-2019-2020-web-final.pdf
[102] Allen, S. (2017, January 10). The attack on Planned Parenthood hurts transgender people, too. *Daily beast*. https://www.thedailybeast.com/the-attack-on-planned-parenthood-hurts-transgender-people-too
[103] https://www.plannedparenthood.org/blog/i-want-to-transition-how-old-do-you-have-to-be-to-get-hrt
[104] Shrier, A. (2021, February 8). Inside Planned Parenthood's gender factory: An ex-reproductive health assistant speaks out. Substack: Abigail Shrier, https://abigailshrier.substack.com/p/inside-planned-parenthoods-gender
[105] Lichtenstein, M., Stein, L., Connolly, E., Goldstein, Z. G., Martinson, T., Tiersten, L., Shin, S. J., Pang, J. H., & Safer, J. D. (2020). The Mount Sinai patient-centered preoperative criteria meant to optimize outcomes are less of a barrier to care than WPATH SOC 7 criteria before transgender-specific surgery. *Transgender Health, 5*(3), 166-172.

82. In a mid-2020 contribution to the *Journal of Medical Ethics*, an Australian attorney and six co-authors make the ethical case for supporting the practice of "ongoing puberty suppression," that is, to "permanently prevent the development of secondary sex characteristics, as a way of affirming (one's) gender identity."[106] There is reason to question the clinical stability of an (affirmative) approach that is so rapidly giving young people suffering from significant psychiatric distress the agency to accept experimental medical interventions with irreversible effects, especially in an ideologically-charged atmosphere where medical professionals hold out the treatments to be the child's only hope of leading a peaceful, happy life. If choice is paramount, there will indeed be a market for long-term maintenance of prepubertal status.

83. In a study published in the *Archives of Sexual Behavior*, a co-author and I observed in a survey of over 5,000 adults that the central framework through which Americans (as well as supplier organizations like Planned Parenthood) perceive the treatment of adolescent transgender patients is that of bodily autonomy and choice. That is, American adults' attitudes about abortion are the strongest predictor of what they think about "affirmative" treatment for minors, even after controlling for religion, political affiliation, voting behavior, and a variety of other factors.[107] This makes sense. And we are not the first to note it. Years ago journalists observed that the same principles at work in understanding abortion attitudes—about access to and

[106] Notini, L., Earp, B. D., Gillam, L., McDougall, R. J., Savulescu, J., Telfer, M., & Pang, K. C. (2020). Forever young? The ethics of ongoing puberty suppression for non-binary adults. *Journal of medical ethics*, *46*(11), 743-752, https://jme.bmj.com/content/46/11/743.abstract.

[107] Regnerus, M. & Vermurlen, B. (2022.) Attitudes toward hormonal and/or surgical interventions for adolescents experiencing gender dysphoria." *Archives of Sexual Behavior*, *51*, 1891-1902. DOI: https://doi.org/10.1007/s10508-021-02214-2.

control over one's body—are applied to decision-making about transgender treatments, even invasive ones. By extension, then, it is unsurprising to see how the authority over treatment decisions, including among minors, appear to have shifted from physician to patient.[108]

D. Pressure-based Suppression of Open Debate

84. Physicians and researchers have been sanctioned for questioning "affirmative" gender treatment. Some have resigned, some have been demoted, and others fired. (Many have endured social media barrages.) A few examples may prove illuminating. Allan Josephson, chief of the University of Louisville's Division of Child and Adolescent Psychiatry and Psychology for nearly 15 years, was demoted after public remarks he offered criticized aspects of affirmative treatment, saying the "notion that gender identity should trump chromosomes, hormones, internal reproductive organs, external genitalia, and secondary sex characteristics when classifying individuals is counter to medical science."[109]

85. The *Archives of Sexual Behavior*'s editor Kenneth Zucker likewise endured professional and personal scrutiny for his work on the transgender experience. Zucker was head of a Toronto addiction and mental health clinic's "Gender Identity Service" until he was fired in 2015 after an external review by two adolescent psychiatrists found his method insufficiently "affirmative" for transgender-identifying youth. His crime? Too much caution, patience in treatment, and displaying concern for parents and family dynamics. (Zucker won a legal settlement and an apology,[110] and he remains the editor-in-chief of *Archives*, the top sexology journal

[108] Urquhart, E. (2016, March 11). Gatekeepers vs. informed consent: Who decides when a trans person can medically transition? *Slate*. https://slate.com/human-interest/2016/03/transgender-patients-and-informed-consent-who-decides-when-transition-treatment-is-appropriate.html

[109] Watkins, M. (2019, March 29). Professor sues U of L, claims he was demoted over comments seen as anti-LGBTQ. *Courier journal*. https://www.courier-journal.com/story/news/2019/03/29/anti-lgbt-comments-university-of-louisville-professor-sues-over-demotion/3300002002/

[110] Rizza, A. (2018, October 7). CAMH to pay more than half a million settlement to head of gender identity clinic after releasing fallacious report. *National post.* https://nationalpost.com/news/camh-reaches-settlement-with-former-head-of-gender-identity-clinic

in the field.) Intimidation of this nature discourages wider interest in this field, narrowing the pool of researchers to those who don't rock the boat or question the purported consensus. This is not how a healthy field of science works.

86. Angela Sämfjord, a child and adolescent psychiatrist at Sahlgrenska University Hospital in Gothenburg, Sweden, launched the Lundstrom Gender Clinic in 2016. Two years later, she resigned because of her own fears about the lack of evidence for hormonal and surgical treatments. Her decision-making process reveals what others have also noted: "There's a lot of tension between some approaches of gender clinics and the trans community. Patients found it hard to accept that they needed to undergo a full mental health assessment before being referred for medical treatment. Parents would say that nobody ever discussed that other issues…might be implicated in the child's dysphoria."[111] Her patients displayed "many psychiatric symptoms," she notes. Gender dysphoria was just "one part of a complex problem." "Concentrating only on the gender dysphoria meant we might miss other things," she held. "When I realized the complexity [of these cases]…and that health care professionals are still expected to okay gender-affirming treatment despite the lack of evidence that we currently have, it preyed on my conscience." Sämfjord's story contributed to Sweden's recent decision to curb hormonal treatments for adolescents.

87. The controversy over a CBS *60 Minutes* segment about detransitioners, which aired on May 23, 2021, provides another sobering illustration of the ideological capture of much of this field of treatment. The popular news program sensed it would be illuminating to have a

[111] McCall, B. & Nainggolan, L. (2021, April 23). Transition therapy for transgender teens drives divide. *WebMD.* https://www.webmd.com/children/news/20210427/transition-therapy-for-transgender-teens-drives-divide

public discussion about patients who have undergone a gender transition but who wish to detransition back to their natal sex. Yet not only did activists seek to alter the *60 Minutes* episode (or prevent it from airing altogether), clinicians did too, including plaintiffs' expert Olson-Kennedy, who posted on social media that "so many of us worked hard to dissuade them from doing this segment." Lesley Stahl, the segment's correspondent and lead interviewer, reported that she could not remember another story "where comments and criticisms began surfacing from advocates before the piece aired."[112] Other major media outlets are feeling comparable pressure to vet transgender news stories prior to release.[113]

88. It is telling that Dr. Olson-Kennedy publicly admitted trying to prevent the stories of detransitioners from airing in the *60 Minutes* segment. In all three expert witness statements for the plaintiffs, no mention of detransition is made. Nowhere does the word appear in Dr. Shumer's report, and it appears only twice in the references of both Dr. Janssen's and Dr. Olson-Kennedy's reports.

89. Similarly, the word "regret" does not appear in Dr. Janssen's report. Yet he must know of this possibility—in Oct. 2021, he gave a panel presentation entitled, "Gender "Detransition" with and without regret," to the American Academy of Child and Adolescent Psychiatry annual conference.[114] Dr. Olson-Kennedy mentions regret once to cite an "extremely low" regret rate for double mastectomy[115] and Dr. Shumer mentions regret once, also to claim that it is

[112] Zubrow, K. (2021, May 23). Inside the 60 Minutes report on transgender healthcare issues. *CBS News*. https://www.cbsnews.com/news/60-minutes-transgender-health-care-issues-2021-05-23/
[113] Manning, S. (2021, June 26). BBC Pride activists demand right to vet transgender news stories on Radio 4's Today programme after host Justin Webb clashed with Pink News CEO over Stonewall's stance on single-sex spaces. *Daily Mail*. https://www.dailymail.co.uk/news/article-9728735/BBC-Pride-activists-demand-right-vet-transgender-news-stories-Radio-4s-Today-programme.html
[114] Janssen, A. (2021). 2.3 Understanding gender "detransition" with and without regret. *Journal of the American Academy of Child & Adolescent Psychiatry*, *60*(10), S4, https://www.jaacap.org/article/S0890-8567(21)00496-2/fulltext.
[115] Olson-Kennedy, #65, p. 18.

low.[116] These cited low rates of regret are challenged by the increasing numbers of young detransitioners, which is perhaps why their voices are being silenced. As more data becomes available, current estimates of the detransition rate ranges to as much as 30%, with initial research showing that a "high proportion initially transitioned before the age of 25."[117] In other words, evidence is mounting that it's the young who are most likely to detransition and experience harm.

90. The *60 Minutes* controversy also sheds light on the new fissure between "conventional" affirmative care and the even more aggressive form of patient-driven care that "affirms without question," a position staked out by Olson-Kennedy, who perceives little advantage to conducting pre-treatment mental health evaluations, and is known to offer cross-sex hormones to patients as young as 12 years old—a position that puts her at odds even with WPATH's aggressive new Standards of Care.[118] The only thing "settled" about transgender medical science is the advocates' frequent use of the term. In reality, the field is perpetually unsettled, and is now shifting toward putting the patient in the driver's seat of their own treatment decisions.

91. A pair of "affirming" clinical psychologists who work with gender dysphoric adolescents, called the *60 Minutes* backlash "unconscionable" and "harmful to detransitioned young people" who are being "made to feel as if their lived experiences are not valid." Moreover, they recognize that silencing detransitioners "will undoubtedly raise questions regarding the objectivity of our field…"[119] Indeed, it has.

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[116] Shumer, #76, p. 19.
[117] Heath, L, & Bunn, S. (2023) Factors shaping gender incongruence and dysphoria, and impact on health services, Postbrief 53, August 2, UK Parliament Post, https://post.parliament.uk/research-briefings/post-pb-0053/.
[118] Singal, J. (2018). When children say they're trans. *The Atlantic Monthly*, July/August, https://www.theatlantic.com/magazine/archive/2018/07/when-a-child-says-shes-trans/561749/.
[119] Edwards-Leeper & Anderson, *op. cit.*, paragraph 6.

92. Dr. Olson-Kennedy has at times seemed unconcerned about possible future regrets. During a conference presentation in 2018 describing her discussion with a patient concerned about possible regret, she declared, "If you want breasts at a later point in your life, you can go and get them."[120]

93. For Dr. Olson-Kennedy, her practice of transgender medicine is tied to ideological commitments and a vision of the way the world should be. In a 2017 interview, she intimated that social justice was the most important aspect of her job. "More important than this just being pediatrics, this job to me is a rare opportunity to be able to play a role in a human rights issue. One of the things I had found disappointing about medicine is that there wasn't a lot of work in the area of social justice. Until now. .... It's an incredible feeling to help someone live his or her truth," she states. "If everyone could pursue authenticity the way transgender individuals do, we'd find ourselves in a much better world."[121]

94. In a 2022 *JAMA* pediatrics commentary decrying so-called "conversion therapy," Dr. Olson-Kennedy envisions what could lead to that "much better world."[122] She writes, "...perhaps humanity might redirect its reparative efforts toward dismantling the harmful hetero and cisgender normative chokehold that continues to asphyxiate social evolution." In her worldview, the transgender-identifying youth is not just a person in distress but is also a means to "social evolution" and "dismantling" stultifying sex and gender norms.

[120] Video clip: https://www.youtube.com/watch?v=5Y6espcXPJk; See also: Grossman, M. (2022) "The moral atrocity of "top surgery," *City Journal,* Feb. 25, https://www.city-journal.org/article/the-moral-atrocity-of-top-surgery.
[121] Villano, M. (2017). Surviving to thriving. Children's Hospital Los Angeles, March 7, https://www.chla.org/blog/work-matters/surviving-thriving.
[122] Olson-Kennedy J. (2022). When the human toll of conversion therapy is not enough. *JAMA pediatrics*, *176*(5), 450–451, https://doi.org/10.1001/jamapediatrics.2022.0049. The quote is from p.451.

95. The evidence demonstrates that desistance rates—that is, the share of adolescents who cease identifying as transgender and accept their natal sex—may have been around 90 percent for patients treated with a "watchful waiting" approach.[123] In a review of childhood gender dysphoria, prior studies demonstrated desistence rates ranging from 61% to 98%.[124] This approach, however, is now vigorously contested in the United States, Canada, Australia, and the UK. For dysphoric adolescents put on the "gender affirmation" schedule, the reverse has become true. Rather than pressing a pause button for time to think, 98 percent of the adolescents put on puberty blockers at the UK's Tavistock clinic proceeded to cross-sex hormones,[125] thereby triggering irreversible effects.[126] In other words, the "watchful waiting" method consistently predicted desistance because it hypothesized, and then recognized, the transience of cross-gender identification in minors. But taking an aggressively "affirmative" approach almost guarantees transition.

96. Does this shift in approach and outcomes reflect authentic patient satisfaction with "gender affirming" care? It is impossible to discern since pubertal blockers now prevent all but a small share of adolescent patients from knowing what it's like to have experienced the full course of natal puberty.

97. Transgender activists and their allies in the professions have sought to minimize the experiences of people who regret their transition and silence the voices of those who have detransitioned because of the challenges these present to the transgender identity narrative. Serious

[123] Singh, Bradley, and Zucker (2021) recently released a longitudinal study where the desistance rate was 88%. See: Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in psychiatry*, *12*, 1-18, https://doi.org/10.3389/fpsyt.2021.632784.
[124] Ristori, J., Steensma, T. D. (2016). Gender dysphoria in childhood, *International review of psychiatry*, *28*(1),13-20.
[125] Carmichael et al. *op. cit.*
[126] de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The journal of sexual medicine*, *8*(8), 2276-2283, https://doi.org/10.1111/j.1743-6109.2010.01943.x.

studies into this increasing phenomenon have been successfully squelched due to pressure from activists,[127] but the fact is that transition regret is real.[128] One recent study surveyed 237 detransitioners, both male and female, and noted that over half of the respondents had three mental health co-morbidities, a trait that once nixed their eligibility for aggressive treatments.[129] The majority of the sample, a full 70 percent, said a reason for detransitioning was due to realizing their "gender dysphoria was related to other issues." Additionally, 62 percent marked health concerns as a reason for detransitioning, 50 percent said they did not find transition beneficial for their dysphoria, and 45 percent found other ways of dealing with their dysphoria. "Lack of support from social surroundings (13%), financial concerns (12%) and discrimination (10%)" were the least compelling reasons for detransitioning.[130]

98. None of these reasons comport with the trans-affirmative narrative claiming that detransition is primarily due to social pressure or discrimination.[131] Much has been made of Jack Turban's study of survey data (gathered from an online, opt-in convenience sample) that reported far higher levels of "external" rather than "internal" reasons for detransitioning—meaning that motivation for detransitioning was thought to come from the respondent's social environment rather than from internal motivation. This conclusion, however, is a direct result of how the survey question was posed to respondents. External reasons for detransitioning dominated the answer

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[127] Hardy, R. (2017). How a psychotherapist who has backed transgender rights for years was plunged into a Kafkaesque nightmare after asking if young people changing sex might later regret it, October 13, *Daily mail,* https://www.dailymail.co.uk/news/article-4979498/James-Caspian-attacked-transgender-children-comments.html.
[128] Djordjevic, M. L., Bizic, M. R., Duisin, D., Bouman, M. B., & Buncamper, M. (2016). Reversal surgery in regretful male-to-female transsexuals after sex reassignment surgery. *The journal of sexual medicine*, *13*(6), 1000-1007, https://doi.org/10.1016/j.jsxm.2016.02.173; Entwistle, K. (2021). Debate: Reality check–Detransitioner's testimonies require us to rethink gender dysphoria. *Child and adolescent mental health*, *26*(1), 15-16, doi/epdf/10.1111/camh.12380.
[129] Vandenbussche, E. (2021). Detransition-related needs and support: A cross-sectional online survey. *Journal of homosexuality*, 1-19, https://doi.org/10.1080/00918369.2021.1919479.
[130] *Ibid*. The quote is from p. 5.
[131] Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors leading to "detransition" among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT health*, *8*(4), 273-280, https://doi.org/10.1089/lgbt.2020.0437.

options, including seven "pressure" answers (e.g., pressure from a parent, pressure from a spouse or partner, pressure from an employer, etc.). Only two vaguely-worded internal answer options were offered: "I realized that gender transition was not for me" and "It was just too hard for me." (While write-in options were allowed, they predictably revealed the lowest response frequency.)

99. Psychotherapists reacted to Turban's study by noting its use of a biased sample, measures of questionable validity, and failure to assess baseline mental health status, before asserting that Turban's conclusions are used to "justify the misguided the notion that anything other than 'affirmative' psychotherapy for gender dysphoria (GD) is harmful and should be banned."[132]

100. In a 2021 study published in the *Archives of Sexual Behavior*, public health scientist Lisa Littman surveyed a convenience sample of 100 detransitioners in order to better understand this population.[133] Her survey of detransitioners offered a far wider array of possible reasons for doing so than the U.S. Trangsender Survey (USTS) did, and revealed what the USTS could not, by design—namely that internal reasons were far more apt to be selected than external ones. Sixty percent of them became "more comfortable identifying as their natal sex," nearly half indicated concerns with "potential medical complications from transitioning," and 38% had come to view their dysphoria as "caused by something specific, such as trauma, abuse, or a mental health condition," each of which are—if the traditional pathway to treatment were followed—supposed to be probed prior to hormonal or medical treatments.[134]

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[132] D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, *50*, 7–16, https://doi.org/10.1007/s10508-020-01844-2.

[133] Littman L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of sexual behavior*, *50*(8), 3353–3369, https://doi.org/10.1007/s10508-021-02163-w.

[134] *Id*. The quote is from p. 3353.

101. In the USTS, and hence in Turban's published study of detransitioning, no answer options were offered that would recognize that dysphoria and initial transitioning might have involved "difficulty accepting themselves as homosexual," traumas (including but not limited to sexual trauma), mental health conditions, and peer effects. Littman's survey did not include the first of these—but nevertheless revealed its importance: "Despite the absence of any questions about this topic in the survey, nearly a quarter (23.0%) of the participants expressed the internalized homophobia and difficulty accepting oneself as lesbian, gay, or bisexual narrative by spontaneously describing that these experiences were instrumental to their gender dysphoria, their desire to transition, and their detransition."[135] This is hardly the only piece of evidence suggesting the possibility of a common underlying causal mechanism at work in both homosexuality and transgender (natal) males.[136]

102. Additionally, 37% of detransitioners reported feeling pressure—mostly external—to have transitioned in the first place. It seldom came from family, however. Open-response answers included: "My gender therapist acted like it [transition] was a panacea for everything;" "[My] [d]octor pushed drugs and surgery at every visit;" "I was dating a trans woman and she framed our relationship in a way that was contingent on my being trans;" "A couple of later trans friends kept insisting that I needed to stop delaying things;" "[My] best friend told me repeatedly that it [transition] was best for me;" "The forums and communities and internet friends."[137]

[135] *Id*. The quote is from p. 3362.
[136] Behzad S., Khorashad, M.D, et al. (2020). Birth order and sibling sex ratio in androphilic males and gynephilic females diagnosed with gender dysphoria from Iran. *The journal of sexual medicine*, *17*(6), 1195-1202, https://doi.org/10.1016/j.jsxm.2020.02.004.
[137] *Id*. The quote is from p. 3360.

103. By contrast, only seven percent (collectively) reported in Littman's study that a parent, spouse, or a family member had pressured them to detransition, far below the USTS's report of 36%, 18%, and 26%, respectively.

104. Notably, only 24% of those surveyed by Littman had informed the doctor or gender clinic of their detransition, which means that any "official" numbers on detransitioners are apt to be a significant undercount.

105. Further, not even all who experience regret or difficulties attributable to their transition will actually seek to physically detransition. There are many reports of individuals having regret but seeking to make the best of the irreversible changes and situation they find themselves in.[138] Consider the pioneer patient of the experimental Dutch protocol, "B," who was followed for 22 years until the age of 35. It was reported that "he indicated no regrets about his treatment."[139] However, B "scored high on the measure for depression. Owing to 'shame about his genital appearance and his feelings of inadequacy in sexual matters,' he could not sustain a romantic relationship."[140] One cannot help but wonder whether B could have enjoyed greater lifetime wellbeing if he had not been placed on the medicalized transgender trajectory at the age of 13.

106. The scholar/activist authors of a 2020 *JAMA Psychiatry* study, led by plaintiffs' witness Dr. Turban, paint an entire class of cautious therapeutic approaches as intrinsically harmful—conversion attempts—using survey language stated as follows: "Did any professional (such

[138] E.g.: Jax, R. (2017). *Don't get on the plane: Why a sex change will ruin your life*. CreateSpace Independent Publishing Platform.; Heyer, W. (2018). *Trans life survivors*. Bowker Identifier Services.; Teller Report. (2020). Aleksa Lundberg: "I am a gay feminine man with a female body," May 12, https://www.tellerreport.com/news/2020-05-12-aleksa-lundberg--%22i-am-a-gay-feminine-man-with-a-female-body%22.SyWGzCjDcU.html.

[139] Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L.C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of sexual behavior*, *40*(4), 843–847, p. 843.

[140] Biggs, M. (2023). The Dutch protocol for juvenile transsexuals: origins and evidence. *Journal of sex & marital therapy*, *49*(4), 348-368, DOI: 10.1080/0092623X.2022.2121238; Cohen-Kettenis et al., *op. cit.*, p. 845.

as a psychologist, counselor, or religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?" Given the hundreds of questions and items the USTS posed to its respondents six years ago, the fact that it lumps any scenario that does not involve unqualified affirmation (including "watchful waiting") into one imprecise, binary measure is psychometrically irresponsible.[141] In other words, it is foisting on people a one-size-fits-all definition. What one can learn from a poor-quality question posed to an opt-in sample of respondents motivated—even recruited—to participate is limited by definition. That such studies seem easily publishable today highlights the extent to which certain medical journals—officially sponsored by the same associations that have claimed a stake in the outcome here—have been "ideologically captured." They seem uninterested in holding transgender research to standards comparable to other divisions of medicine.

107. If counseling can be construed as conversion attempts, this sends a clear message to psychiatrists and psychotherapists alike about their role in the doctor-patient relationship here—as a supplier of whatever the patient wishes to do. In a marketplace where professionals, just like any business, are subject to public reviews of their work, the label of "transphobic" is unwelcome and may have serious adverse professional consequences.

[141] Turban et al. (2020). This study was thoroughly critiqued in: D'Angelo et al., *op. cit.*, whose authors concluded: "Turban et al.'s (2020) singular endorsement of "affirmative" therapies, which their data failed to substantiate, contributes to the alarming trend to frame any non-"affirming" approaches as harmful. We are deeply concerned that this false dichotomy, reinforced by Turban et al.'s unproven claims of the harms of GICE, will have a chilling effect on the ethical psychotherapists' willingness to take on complex GD patients, which will make it much harder for GD individuals to access quality mental health care. We maintain that availability of a broad range of non-coercive, ethical psychotherapies for individuals with GD is essential to meaningful informed consent, which requires consideration of the full range of treatment options, from highly invasive to non-invasive. Further, given the potential of agenda-free psychotherapy to ameliorate GD non-invasively among young people with GD, withholding this type of intervention, while promoting "affirmation" approaches that pave the way to medical transition, is ethically questionable. We believe that exploratory psychotherapy that is neither "affirmation" nor "conversion" should be the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures." The quote is from p. 13.

108. I concur with Dr. Levine, who has highlighted the quandary facing professionals attempting to provide "informed" counsel to patients about the biological, social, and psychological risks posed by any treatment approach.[142] Such risks are real and ought to be discussed—this is what ethical informed consent does. But a serious, ranging conversation—the "informed" part of obtaining informed consent—could be perceived as an attempt to "convert" the person from pursuing gender affirmation treatments (e.g., hormones, surgery).

109. The idea that it is a "conversion" for a person to become convinced that perhaps they may be able to live at peace with their body strains simple logic as well as the advice of pioneering clinicians that less invasive outcomes were preferable to more aggressive ones.[143] In any case, there is no defined psychotherapeutic method for treating gender dysphoria that can be widely characterized and consistently identified as "conversion therapy" in order to be banned. Nor has there been a clinical trial evaluating specific psychotherapeutic methods of counseling gender dysphoria that could potentially demonstrate whether one or more such methods are indeed helpful or harmful.

110. The central framework for understanding the treatment of adolescent transgender patients is not that of mental and physical flourishing, but rather has become that of securing bodily autonomy and patient choice. The ideological capture of much of this field of treatment makes for a very difficult environment for psychological treatment of gender dysphoria in minors.

111. Many other examples of undue pressure could be given, both within and outside the professions. Amazon's decision to withdraw from selling books that so much as suggest the

[142] Levine (2019).
[143] Smith, Y. L., van Goozen, S. H., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *40*(4), 472-481.

idea that gender dysphoria is (or had been associated with) a mental disorder is one. Public fora for legitimate debate are actively being curbed.[144] Even *reviews* of books are being retracted and withdrawn.[145] Certain conclusions are now penalized both professionally and in the wider social and economic marketplace. To suppose that such external social and political pressures do not affect basic social or medical research on transgender-related matters would be naïve.

E. Inconsistent Claims about Adolescents' Ability to Consent

112. A central and persistent concern about hormonal (and subsequent surgical) courses of treatment for gender dysphoria in adolescents is their ability to genuinely consent to treatments that will almost invariably lead to de facto sterilization. Parental consent to sterilization used to be unlawful in many locales, creating ethical dilemmas that commonly required judicial review.[146]

113. These are complicated matters, no doubt. Bernadette Wren, who was a senior clinician at the Tavistock until her retirement in 2020, admits in her diary of reflections to doubts about her field at the UK's gender clinic: "Can children and adolescents realistically consent to these treatments? If yes, how is their competence ensured? If no, is this decision within the scope of parental discretion? And if young people, with or without their parents, are deemed competent, where does the responsibility lie if there are subsequent feelings of regret?" If senior clinicians who have worked in this domain for decades have such fundamental questions, they are certainly worth considering.

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[144] Trachtenberg, J. A. (2018). Amazon won't sell books framing LGBTQ+ identities as mental illnesses. *Wall street journal,* March 11, https://www.wsj.com/articles/amazon-wont-sell-books-framing-lgbtq-identities-as-mental-illnesses-11615511380.

[145] Novella, S. & Gorski, D. (2021, June). Retraction notice for Hall, H. (2021). Book review: *Irreversible damage: The transgender craze seducing our daughters*, by Abigail Shrier. *Science-based medicine,* June 15, https://science-basedmedicine.org/irreversible-damage-the-transgender-craze-seducing-our-daughters/.

[146] For example, it remains illegal in Oregon to sterilize a person under age 15, regardless of parental permission. See also Boynton, M. (1994). Sterilization of minors. *Minn med. 77*(1):23-4, https://pubmed.ncbi.nlm.nih.gov/8127303/.

114. The stakes are high. The bar to informed consent for experimental medical treatments (of any sort) has long been elevated for minors. This is much less true in gender medicine. As gender therapist Diane Ehrensaft observes, "continuity of care in gender affirmation" from puberty blockers to cross-sex hormones results in "discontinuity in potential capacity to ever create progeny with their own genetic material."[147] In other words, affirmative care eventually means sterilization *as a minor*, under WPATH's proposed new guidance.

115. Even researchers and clinicians trained on the experimental Dutch protocol are signaling new allegiances to the "affirm without question" paradigm, after claiming that the recent surge in cases merely reflects hidden demand previously unsurfaced.[148] As an example of this, Dutch child and adolescent psychiatrist Annelou de Vries and six co-authors registered their disappointment with the (original) *Bell v Tavistock* decision, asserting that "minors as young as 12 years of age frequently possess this ability"—that is, the competency to understand the consequences of a decision to begin puberty blockers.[149]

116. In asserting this, de Vries and her colleagues claim to concur with "all the major medical associations." But even some medical associations offer reasons to doubt that adolescents are competent to consent. The APA recognizes that "adolescents can become intensely focused on their immediate desires, resulting in outward displays of frustration and resentment when faced with any delay in receiving the medical treatment from which they feel they would

[147] Ehrensaft, D. (2021). Fertility issues for transgender and nonbinary youth. Training presentation sponsored by the UC San Francisco Child and Adolescent Gender Center, April 7. Discussion and video links available at: https://4thwavenow.com/2021/04/13/tmi-genderqueer-11-year-olds-cant-handle-too-much-info-about-sterilizing-treatments-but-do-get-on-with-those-treatments/.

[148] Arnoldussen, M., Steensma, T.D., Popma, A. *et al.* (2020). Re-evaluation of the Dutch approach: Are recently referred transgender youth different compared to earlier referrals? *European child & adolescent psychiatry*, *29*, 803–811, https://doi.org/10.1007/s00787-019-01394-6.

[149] de Vries, A. L., Richards, C., Tishelman, A. C., Motmans, J., Hannema, S. E., Green, J., & Rosenthal, S. M. (2021). Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents, *International journal of transgender health*, doi: 10.1080/26895269.2021.1904330. The quote is from p. 5.

benefit and to which they feel entitled. This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering decisions to change their name or gender marker, begin hormone therapy (which may affect fertility), or pursue surgery."[150] For its part, the Endocrine Society guidelines recognize that "no objective tools to make such an assessment [i.e., of an adolescent's competence in decision making] are currently available" and notes that some "believe that . . . abilities (such as good risk assessment) do not develop until well after 18 years."[151]

117. The American Medical Association (AMA), on the other hand, appears to want it both ways with regard to consent. In an April 26, 2021, letter to the National Governors Association (NGA), the AMA wrote to urge the NGA to "oppose state legislation that would prohibit the provision of medically necessary gender transition-related care to minor patients."[152] But this statement is flatly inconsistent with the position the AMA has taken concerning adolescents' abilities in other contexts. In its 2005 amicus brief to the U.S. Supreme Court in *Roper v. Simmons*, a case that concerned capital punishment for crimes committed by minors, the AMA emphatically asserted that "[a]dolescents' behavioral immaturity mirrors the anatomical immaturity of their brains. To a degree never before understood, scientists can now demonstrate that adolescents are immature not only to the observer's naked eye, but in the very fibers of their brains."[153]

118. The AMA brief makes an additional pair of comparative claims about the adolescent brain: "First, adolescents rely for certain tasks, more than adults, on the amygdala, the area

[150] American Psychological Association (2015), p. 842.
[151] Hembree, *op. cit.,* p. 3884.
[152] Madara, J. L. (2021). Official AMA letter to legislators, April 26, https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.
[153] American Medical Association et al. (2005). Brief of Amici Curiae in *Roper v. Simmons*, (U.S. Sup. Ct.), 543 U.S. 551 (No. 03-633), 2004 WL 1633549, p. 10. The AMA was joined in their claims by the American Psychiatric Association, American Society for Adolescent Psychiatry, American Academy of Child & Adolescent Psychiatry, American Academy of Psychiatry and the Law, National Association of Social Workers, Missouri chapter of the National Association of Social Workers, and the National Mental Health Association.

of the brain associated with primitive impulses of aggression, anger, and fear. Adults, on the other hand, tend to process similar information through the frontal cortex, a cerebral area associated with impulse control and good judgment. Second, the regions of the brain associated with impulse control, risk assessment, and moral reasoning develop last, after late adolescence."[154] This is widely recognized today in the conventional wisdom that (prefrontal) brain development does not stabilize in human beings until around age 25.

119. One of the attorneys who penned the brief in *Roper* on behalf of the AMA and other organizations later reinforced—by referring to the brief itself—that the "ability of adolescents to make cost-benefit calculations, as compared to adults, is deficient. Additionally, their susceptibility to peer pressure is greater because of this impaired judgment. Moreover, adolescents are more volatile than adults, experiencing more extreme emotions that are not as regulated as they are in adults."[155]

120. When it comes to criminal activity, the AMA asserted that minors cannot be trusted to navigate peer pressure, weigh costs and benefits, make clear-minded judgments, and move ahead with life-altering decisions. But when it comes to transgender medicine and its life-altering consequences, the AMA asserts that minors are competent to make such decisions.

121. Is a child at the cusp of puberty competent to weigh the risks and consequences that transgender medicine entails? That was the question at stake in *Bell v Tavistock*. In 2020, Keira Bell petitioned the court to review the treatment given to minors and young people, saying she had been rushed to transition, was not given other therapeutic options, and lacked the capacity to understand the long-term implications of her decisions at the time. "I was an unhappy girl

[154] American Medical Association et al., p. 11.
[155] Haider, A. (2006). *Roper v. Simmons*: The role of the science brief. *Ohio state journal of criminal law 3*: 369-377, p. 372.

who needed help," Bell stated. "Instead, I was treated like an experiment."[156] In its December 2020 decision, the UK's highest court ruled that children could not give genuine consent to hormonal treatments offered at the National Health Service's gender clinic.

122. In its original verdict, the UK High Court also highlighted a "lack of clarity over the purpose of the treatment: in particular, whether it provides a "pause to think" in a "hormone neutral" state or is a treatment to limit the effects of puberty, and thus the need for greater surgical and chemical intervention later."[157]

123. When the initial judgment in *Bell v Tavistock* was announced, plaintiff Keira Bell responded, "I am delighted at the judgment of the court today. It was a judgment that will protect vulnerable young people. I wish that it had been made for me before I embarked on the devastating experiment of puberty blockers. My life would be very different today. This time last year I joined this case with no hesitation, knowing what I knew about what had and has been going on at the gender identity clinic. My hope was that outside of the noise of the culture wars the court would shine a light on this harmful experiment on vulnerable children and young people. These drugs seriously harmed me in more ways than one and they have harmed many more particularly young girls and women."[158] In the most recent ruling on the Tavistock's subsequent appeal, the Court of Appeals upheld a legal precedent favoring physicians' discernment of adolescent competence to consent, on a case-by-case basis.[159]

124. What is certainly clear is that the use of puberty blockers in the present is linked to the potential outcomes of future drugs and surgeries, thus revealing a presumption of medical

[156] Bell, K. (2021). Keira Bell: My story. *Persuasion*, April 7, https://www.persuasion.community/p/keira-bell-my-story.
[157] Bell & A v. Tavistock & Portman NHS Foundation Trust, *op. cit.*, paragraph 134.
[158] Bell, K. (2020) Keira Bell case: Statements from BBC interview. Transcript available here: https://our-duty.group/2020/12/02/keira-bell-case-statements/.
[159] http://www.bailii.org/uk/cases/UKHL/1985/7.html or https://www.judiciary.uk/judgments/bell-and-another-v-the-tavistock-and-portman-nhs-foundation-trust-and-others/

"path dependence" in these treatment protocols. That is why the UK court determined that puberty blockers and cross-sex hormones are essentially two parts of "one clinical pathway."[160] This is truer today than as recently as 10 years ago, given the very high rate of continuing treatment. Consequently, for minors to be competent to consent to blockers, they would have to adequately understand and consent to the effects of future cross-sex hormones as well.

125. The legal precedent, established in *Gillick v West Norfolk and Wisbech Area Health Authority*, presupposes that all clinicians are subject to professional regulation, with established review mechanisms. However, there is growing concern from within the transgender medical community that such established review mechanisms are increasingly disregarded. Wren recently reflected that the landscape for treating gender dysphoria in the UK had shifted. There is now "growing resistance from families toward…[a] slow-paced model of care. Young people and their parents, arriving at [Tavistock's GIDS clinic] many months after referral, were becoming more assertive in their demands for validation of their new gender identity and for faster, earlier and simpler access to puberty suspension and cross-sex hormones."[161] Social media sources add motivation, while external providers add competition. Caution and reflection, Wren observed, "were now pitted against online sources of anecdote, emotion and personal history. Private providers waited in the wings, willing to meet these requests with a minimal protocol."[162]

126. Hence, the September 2021 Court of Appeals deference to "Gillick competence," the precedent established in the 1985 case by that name, formally affirms an approach that is increasingly informally ignored—including at the Tavistock clinic, according to Wren.

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[160] Bell & A v. Tavistock & Portman NHS Foundation Trust. (2020), para. 136.
[161] Wren, B. (2021). Epistemic injustice. *London review of books*, *43* (23), December 2, https://www.lrb.co.uk/the-paper/v43/n23/bernadette-wren/diary, paragraph 12.
[162] *Ibid*.

127. The same observations are being made in the United States. A pair of clinical psychologists—one of whom identifies as transgender—who work with gender dysphoric adolescents, recently asserted that "we find evidence every single day, from our peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized and developmentally appropriate assessment process to one where every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery."[163] Formal standards, they claim, are being openly ignored in favor of believing the patient, no matter how young. This, the pair observes, is what gender-affirming medicine has become—skipping the psychological assessment and believing the patient is capable of making all decisions about their own body. They make reference to a popular physician and gender clinic director's claim that gender-affirming medicine means that "'you are best equipped to make decisions about your own body,' full stop."[164]

VI. ASSESSING THE RISK OF SUICIDE AS MOTIVATION FOR "AFFIRMATIVE" TREATMENT

128. Parents' fears about children's suicide are understandable and ought never to be dismissed. However, such fears should not override scholarly evaluations of suicidality—which the APA defines as risk of suicide indicated by ideation and intent—with suicide itself.[165] The association of the two (suicide and suicidality) varies notably in subpopulations.[166] Too often, however, suicidal "ideation" is equated with "attempted" suicide, and even seems to be treated as a proxy for suicide.

[163] Edwards-Leeper & Anderson, *op. cit.*, paragraph 6.
[164] *Id.,* paragraph 13.
[165] APA, *Dictionary of Psychology*, https://dictionary.apa.org/suicidality. Retrieved: Aug. 13, 2023.
[166] Han, B., Compton, W. M., Gfroerer, J., & McKeon, R. (2015). Prevalence and correlates of past 12-month suicide attempt among adults with past-year suicidal ideation in the United States. *The journal of clinical psychiatry*, *76*(3), 295–302, https://doi.org/10.4088/JCP.14m09287.

129. Plaintiffs' experts claim that gender-affirming medicine reduces the risk of suicide.[167] Just last month, Endocrine Society President Stephen Hammes, with insular references to only U.S. medical associations, wrote, "More than 2,000 studies published since 1975 form a clear picture: Gender-affirming care improves the well-being of transgender and gender-diverse people and reduces the risk of suicide."[168] Such a statement was so counter to the evidence gathered in repeated systematic reviews that 21 clinicians and researchers from nine countries wrote a reply challenging his statements as "not supported by the best evidence."[169] That letter stated, "Every systematic review of evidence to date, including one published in the Journal of the Endocrine Society, has found the evidence for mental-health benefits of hormonal interventions for minors to be of low or very low certainty.... Dr. Hammes's claim that gender transition reduces suicides is contradicted by every systematic review, including the review published by the Endocrine Society, which states, "We could not draw any conclusions about death by suicide. There is no reliable evidence to suggest that hormonal transition is an effective suicide-prevention measure."[170]

130. Dr. Turban, meanwhile, proposes suicidality as an important motivation for endorsing the "affirmative" approach to treating dysphoric adolescents.[171] Oxford University sociologist Michael Biggs, however, noted that "males who took estrogen are more likely to plan suicide, to attempt suicide, and to require hospitalization for a suicide attempt." His assessment of

[167] Shumer, #90, p. 23.
[168] Hammes, S. (2023) Endocrine Society responds on gender-affirming care, *Wall street journal,* July 5, https://www.wsj.com/articles/trans-gender-affirming-care-endocrine-society-evidence-fdb8562c?mod=article_inline.
[169] Kaltiala, R. et al. (2023) Youth gender transition is pushed without evidence, *Wall street journal*, July 13, https://www.wsj.com/articles/trans-gender-affirming-care-transition-hormone-surgery-evidence-c1961e27.
[170] *Ibid.*
[171] Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics, 145,* e20191725, https://doi.org/10.1542/ peds.2019-1725.

the same data evaluated by Turban revealed that "puberty suppression has no statistically significant effect on mental health."[172]

131. Suicidal ideation and suicidal behavior are not as tightly associated as some surmise. For example, young adults are at least three times as likely to report past-year thoughts of suicide than are adults age 50 and older.[173] But the actual suicide rate among older Americans remains well above that among young adults, and far above children below age 15.[174] New data, collected during the COVID-19 era, complicates matters further, given that young adults ages 18-24 reported suicidal thoughts in the past month at rates 12 times higher than that of respondents age 65 and over, and six times that reported by those between 45 and 64 years old (25.5, 3.8, and 2.0 percent, respectively).[175] Based on thoughts of suicide, then, it could be said that there is a crisis of suicidality among the young. But the crisis of actual suicide affects older Americans to a more significant degree.

132. One of the most recent evaluations of suicidal ideation using the CDC's 2019 Youth Risk Behavior Survey noted that 19 percent of Americans ages 14-18 report having seriously thought about suicide (i.e., had suicidal ideation) in 2019.[176] Nine percent reportedly attempted suicide. The CDC did not track such rates among youth identifying as transgender but

[172] Biggs, M. (2022). Estrogen is associated with greater suicidality among transgender males, and puberty suppression is not associated with better mental health outcomes for either sex, *PLoS One*, Comments, Jan 19: https://journals.plos.org/plosone/article/comment?id=10.1371/annotation/dcc6a58e-592a-49d4-9b65-ff65df2aa8f6.
[173] Lipari, R. N., Hughes, A., & Williams, M. (2016). State estimates of past year serious thoughts of suicide among young adults: 2013 and 2014. *The CBHSQ report*, 1-7, June 16, Substance Abuse and Mental Health Services Administration (US), PMID: 27854411.
[174] Hedegaard, H., Curtin, S. C., Warner, M. (2021). Suicide mortality in the United States, 1999–2019. *NCHS data brief, no. 398*. Hyattsville, MD: *National center for health statistics*, doi: https://dx.doi.org/10.15620/cdc:101761.
[175] Czeisler, M. É. , Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E. & Rajaratnam, S. M. W. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24–30. *MMWR Morbidity & mortality weekly report, 69*(32)*,* 1049–1057, doi: http://dx.doi.org/10.15585/mmwr.mm6932a1.
[176] Ivey-Stephenson, A. Z., Demissie, Z., Crosby, A. E, Stone, D. M., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020). Suicidal ideation and behaviors among high school students - Youth Risk Behavior Survey, United States, 2019. *MMWR Suppl., 69*(Suppl. 1), 47-55, doi: 10.15585/mmwr.su6901a6. See also: Gender Identity Development Service. (2021). Evidence base: Psychosocial difficulties. https://gids.nhs.uk/evidence-base.

did note elevated rates among individuals identifying as lesbian, gay, or bisexual. Previous research has noted that between 25 to 30 percent of adolescents identifying as transgender report having attempted suicide during their lifetimes.[177]

133. Localized estimates of suicidal ideation and attempts among transgender-identifying adolescents vary notably. A 2017 chart review from a Cincinnati gender clinic noted that among patients (ages 12-22) diagnosed with gender dysphoria, 30 percent reported at least one suicide attempt.[178] (Overall, 58 percent of the Cincinnati clinic patients exhibited at least one additional psychiatric diagnosis.) Two similar studies support these findings, with attempted suicide rates among transgender or dysphoric adolescents of between 26 and 31 percent.[179] Others note lower rates, including 14 percent in a Toronto clinic and 10 percent in an Australian clinic.[180]

134. The UK's Gender Identity Development Service (GIDS) observes that suicide remains "extremely rare" among dysphoric youth, even while noting their rates of self-harm are consonant with those among adolescents in the general population. The Tavistock report also revealed that after a year on puberty blockers, a significant increase was noted in responses to the

[177] Olson, J., Schrager, S. M., Belzer, M., Simons, L. K., & Clark, L. F. (2015). Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. *Journal of adolescent health, 57*(4), 374–380; Grossman, A.H., Park, J.Y., & Russell, S.T. (2016). Transgender youth and suicidal behaviors: Applying the interpersonal psychological theory of suicide. *Journal of gay & lesbian mental health, 20*(4), 329–349.
[178] Peterson, C. M., Matthews, A., Copps-Smith, E. and Conard, L. A. (2017). Suicidality, self-harm, and body dissatisfaction in transgender adolescents and emerging adults with gender dysphoria. *Suicide and life-threatening behavior*, *47*, 475-482, https://doi.org/10.1111/sltb.12289.
[179] Eisenberg, M. E., Gower, A. L., McMorris, B. J., Rider, G. N., Shea, G., & Coleman, E. (2017). Risk and protective factors in the lives of transgender/gender nonconforming adolescents. *Journal of adolescent health*, *61*(4), 521-526, https://doi.org/10.1016/j.jadohealth.2017.04.014; Grossman, A. H. & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and life-threatening behavior*, *37*(5), 527-537, https://guilfordjournals.com/doi/abs/10.1521/suli.2007.37.5.527.
[180] Sorbara, J. C., Chiniara, L. N., Thompson, S., & Palmert, M. R. (2020). Mental health and timing of gender-affirming care. *Pediatrics*, *146*(4), https://doi.org/10.1542/peds.2019-3600; Kozlowska et al., *op. cit.*

statement "I deliberately try to hurt or kill myself." This finding, however, was not replicated across the duration of the study.[181]

135. An extensive, longitudinal chart study of all 8,263 adult, adolescent, and child referrals to an Amsterdam gender clinic between 1972 and 2017 documented that 41 natal men (0.8 percent) and 8 natal women (0.3 percent) died by suicide.[182] Among the former, suicide deaths had decreased over time, while it did not change in natal women. Only four suicide deaths were observed among patients referred to the clinic before the age of 18 (0.2 percent), which was a lower risk than among adult patients (0.7 percent).

136. In 2020, the Swedish National Board of Health and Welfare reported that minors with gender dysphoria have a high incidence of "co-occurring psychiatric diagnoses, self-harm behaviors, and suicide attempts compared to the general population" and that suicide mortality rates are higher among people with gender dysphoria than in the general population. They also observe complications in figuring out what is to blame: "At the same time, people with gender dysphoria who commit suicide have a very high rate of co-occurring serious psychiatric diagnoses, which in themselves sharply increase risks of suicide. Therefore, it is not possible to ascertain to what extent gender dysphoria alone contributes to suicide, since these psychiatric diagnoses often precede suicide."[183]

[181] Biggs (2019). Britain's puberty blocking experiment. In: *Inventing Transgender Children and Young People*, ed. M. Moore, H. Brunskell-Evans, Cambridge Scholars Publishing, Newcastle upon Tyne, pp. 40-55.
[182] The median age at first visit, however, was 25. See: Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M, de Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam cohort of gender dysphoria study (1972–2017). *Acta psychiatrica Scandinavica, 141*(6), 486-491, https://doi.org/10.1111/acps.13164.
[183] Swedish National Board of Health and Welfare. (2020). The evolution of the diagnosis of gender dysphoria: Prevalence, co-occurring psychiatric diagnoses and mortality from suicide. *Socialstryrelsen*. The quote is from p. 11.

137. An earlier study of 55 transgender youth reported that "nearly half of the sample reported having seriously thought about taking their lives and one quarter reported suicide attempts."[184] Among them, however, "a significantly greater proportion of those who had attempted suicide expressed weight-related body dissatisfaction than those who had not," a finding observed in other studies as well.[185] They also tended to ruminate about how others evaluated their bodies.

138. Simply documenting elevated "suicidality" among self-identified transgender youth does not recommend a particular treatment approach.[186] As one psychoanalyst put it, "We treat suicide first of all by keeping people safe, and by helping them become more resilient."[187] Understanding the relationship between gender dysphoria and suicidality is complex; that is, there is an association, but the dysphoria may or may not be a central cause. Research has noted recently that particular aspects of body dissatisfaction may constitute independent risk factors for suicidality among patients with gender dysphoria.[188] In other words, dissatisfaction with appearance—all the more in the age of Instagram and the selfie—may play a factor in the elevated risk of attempted suicide. In the absence of data analyses that can control for the effects of other confounding and contributing factors, it becomes very difficult to establish that gender dysphoria is a solitary or primary driver of suicidality, all the more since the majority of gender dysphoric minors never attempt suicide.

139. Suicides and attempted suicides among the self-identified transgender population are indeed higher than those in the population at large. It is, however, difficult to determine this

[184] Grossman & D'Augelli, *op. cit.*, p. 527.
[185] Day, D. S., Saunders, J. J., & Matorin, A. (2019). Gender dysphoria and suicidal ideation: Clinical observations from a psychiatric emergency service. *Cureus*, *11*(11), e6132, https://doi.org/10.7759/cureus.6132. The quote is from p. 2; Grossman & D'Augelli, *op. cit.*
[186] Day, Saunders & Matorin, *op. cit.*
[187] Shrier, *op.cit.* The quote is from pp. 137-138.
[188] Peterson et al., *op. cit.*

subpopulation's scope of suicide risk with accuracy. Moreover, suicide rates have increased strikingly in the general population over the past decade.[189]

140. Hence, the actual suicide risk among gender dysphoric minors is simply unclear, and not just because completed suicides are far more apt to be documented in terms of demographic characteristics rather than sexual and gender-related ones. Rather, as one psychiatrist aptly notes, "Suicide is rare and noisy," that is, understanding particular causes is challenging. The white male suicide rate, for example, is the highest in the United States by a significant margin. But to suggest that race or sex plays a compelling motivation in suicidal decision-making does not make sense. Complicating matters here is the known, elevated frequency of "significant psychopathology" among dysphoric adolescents.[190] This makes direct, unmediated claims about the causes of suicidal ideation very difficult to defend.

141. The specter of suicide has nevertheless become a central narrative among supporters of the affirmative treatment approach. Some advocates compare puberty suppression to cancer treatments, claiming that these interventions are as "life-saving" for gender-dysphoric youth as oncology treatments are for those afflicted with cancer.[191] However, the science behind claims that such treatments lead to sustained improvement in mental health—improvement that cannot possibly occur in its absence—is remarkably weak.

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[189] Whalen, J. (2018). Youth suicidal behavior is on the rise, especially among girls. *Wall street journal,* May 15, https://www.wsj.com/articles/youth-suicidal-behavior-is-on-the-rise-especially-among-girls-1526443782.

[190] Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and adolescent psychiatry and mental health*, *9*(1), 1-9, https://doi.org/10.1186/s13034-015-0042-y.

[191] In the Tavistock study, children were barred from beginning GnRha treatment if their baseline bone density was too low or agreed to stop treatment if it fell below a certain threshold. In the original Dutch protocol, several participants had to discontinue treatment due to medical complications from the hormone therapy. Did these children die from lack of medicine? Was the progression of their natural puberty and release of sex congruent hormones akin to the progression of metastatic cancer? Of course not. One hopes that these children were rightly encouraged in resilience, rather than surmise that they were doomed to commit suicide because they could not tolerate living in their body apart from transgender medical interventions.

142. Affirmative clinicians Dr. Edwards-Leeper and her transgender co-author Dr. Erica Anderson have criticized advocates' weaponization of suicidality—a tool they believe to be wielded by the "affirm without question" wing of clinicians, whose argument can be summarized as follows: support the minor's self-diagnosis and put them on the pathway to transition, lest they take their own life. Edwards-Leeper and Anderson have heard enough; the "specter" of suicide "should not be used to push forward unrelated medical treatment without professional care or attention for each patient."[192]

VII. THE ROLE OF VALUES IN THE PRODUCTION OF SCIENCE

143. Many scientists have long asserted the reality and importance of the fact/value distinction. That is, there are facts—real things—and then there are values, our opinions or attitudes. The study of transgender medicine undermines any strong confidence in this distinction because what a person values shapes what they discern as facts.

144. Misunderstanding the place of values in science is not just an intellectual problem. It can have practical consequences, especially where science has implications for public health and policy. A trio of philosophers aptly note: "If values play a role in science, then the public and public officials cannot take scientific results as given and scientific authorities as beyond challenge. Responsible public policy will require responsible use of science; responsible use of science will require explicit critical awareness of its value assumptions."[193]

145. Although this report has focused on the scientific evidence, researcher behavior, and the culture of scientific organizations, it is nevertheless easy to observe how values saturate "affirmative" approaches to treating gender dysphoria. This is not a criticism per se. Values

[192] Edwards-Leeper & Anderson, E., *op. cit.*, paragraph 15.
[193] Kincaid, H., Dupré, J., & Wylie, A., (Eds.). (2007). *Value-free science? Ideals and illusions*. Oxford University Press. The quote is from pp. 4-5.

necessarily infuse the sciences, including the medical sciences as well. The Endocrine Society openly notes how particular values affect their counsel: "These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression."[194] In other words, the Endocrine Society is more concerned with helping young people achieve a certain subjective satisfaction with their physical appearance than it is avoiding possible harms of experimental medications, the threat of sterilization, or addressing the long-term health and well-being of its young patients.

146. The Endocrine Society is not alone here. Even Dr. de Vries and her colleagues, cited earlier as one-time representatives of the (less reckless but still experimental) Dutch protocol, make a play for the same privileging of physical appearance in their criticism of the UK court's *Tavistock* decision: "Our deep concern is that the High Court overlooked . . . the lifelong benefits of having a physical appearance which is congruent with one's gender identity (e.g., no or less breast development and less feminine body shape in an affirmed male and no low voice, Adam's apple, or masculine facial features in an affirmed female)."[195]

147. Indeed, value-laden questions may outnumber purely clinical ones in this domain. Is the physician's role one of granting the requests of patients in order to fulfill what the latter believe or want to be true, or is the physician's role to treat the gender dysphoria with as little longstanding harm to the wellbeing of the body and mind as possible? Are we to master our feelings and emotions or be subject to them?

148. The very experience of social, hormonal, and surgical "transition" is a value leap—the introduction of a new meaning of "life cycle." The "body and its meanings" are now

[194] Hembree et al., *op. cit*. The quote is from p. 3881.
[195] de Vries et al., *op. cit.* The quote is from p. 4.

considered "contingent."[196] The concept of "gender identity" requires body dissociation de facto, subjugating material reality to the subjective feelings of youth susceptible to suggestion.

149. Bernadette Wren, the retired senior clinician from the Tavistock clinic, wrote in 2014 how trendy postmodern ideas about gender had impacted clinicians' work with children and adolescents, namely, by adopting the idea of "all gender as fictional and artificial." After discussing the possible conundrums that arise when directing minors toward irreversible physical changes in light of these conceptions, Wren concluded: "the meaning of trans is constantly shaped and re-shaped, [and] rests on no foundation of truth. The therapist is not burdened with needing to be right or certain, but to offer a reflexive and thoughtful space to help clients explore the architecture and borders of their gendered world view."[197]

150. Wren recognizes the value-laden nature of gender medicine for minors: "We are concerned about overstepping what the current evidence can tell us about the safety of our interventions. And we are fully alive to the complexities of informed consent, especially with respect to irreversible bodily change and fertility—and to the possibility of young people having later misgivings around medical intervention. We see that these are not matters of narrow 'clinical' judgement, but relate to broader social acceptance of the challenges brought by new medical technologies, new ideologies of self-determination and new models of parental responsiveness and love."[198] Unquestionably, values saturate this domain.

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[196] Pyne, J. (2014). Gender independent kids: A paradigm shift in approaches to gender non-conforming children. *The Canadian journal of human sexuality, 23*(1), 1-8, https://doi.org/10.3138/cjhs.23.1.CO1. The quote is from p. 5.
[197] Wren, B. (2014). Thinking postmodern and practising in the enlightenment: Managing uncertainty in the treatment of children and adolescents. *Feminism & Psychology*, *24*(2), 271-291. The quotes are from p. 271 and p. 287, respectively.
[198] Wren, B. (2020). Debate: You can't take politics out of the debate on gender-diverse children. *Child and adolescent mental health*, *25*(1), 40-42, https://doi.org/10.1111/camh.12350. The quote is from p. 41.

VIII. CONCLUSION

151. The field of adolescent transgender medicine is saturated by conflict over competing values. High quality longitudinal research is rare. Randomized clinical trials research has not occurred. The distinction between researcher and affirmative-care activist is blurred. Careful practitioners are put in a position to only guess at what may result based on research conducted under quite different conditions. Bait-and-switch tactics are being employed—that is, conclusions from studies based on patients without psychological comorbidities are being applied to patients displaying anxiety disorders, autism spectrum disorders, suicidality, and self-harming behaviors. Protocols are becoming more permissive (and aggressive in "affirmation"), motivated by a market-driven medical culture in which emphasis is placed on liking what one sees in a mirror, or, increasingly, how others respond to photographs of themselves. To object, however, invites professional censure. Meanwhile, the basics of the explosion in gender dysphoria, especially among natal girls, remain understudied and undertheorized—perhaps now on purpose—even as minors' ability to consent is validated because minors (and their parents) are demanding the (experimental) treatments. This is not how healthy medical research operates.

152. A premature—and still evolving—"consensus" has been contrived among some professional organizations in this field of medicine. Activists and other interested parties have played a significant role in shaping medical policy, and researchers have taken steps to suppress public discussion and debate and to push medical practice in one direction. The pace and extent of ideological capture is staggering.

153. Bernadette Wren, the retired Tavistock senior clinician quoted earlier, helps articulate the dilemma here. "For some advocates," a term that certainly includes the plaintiffs in this case, "[a] justice-based approach extends to the demand that all gender-diverse people, including

the young, should have the unquestionable right to make fully autonomous treatment decisions – the full freedom, we might say, to make their own mistakes."[199]

154. Based on the current state of the science, giving minors the power to make "fully autonomous treatment decisions" and "make their own mistakes" here is to abdicate responsibility and to abandon them to the risks of irreversible and long-term consequences. Medical treatment protocols for youth gender dysphoria are becoming more aggressive, at earlier ages, even as interest in discerning the long-term presence and stability of the dysphoria before treatment is diminishing.

155. Given the state of disarray in the science, the activist capture of medical organizations, and the market motivations shaping medical decision-making in a surging domain, there are compelling reasons to protect young people by ensuring that they reach adulthood before submitting to experimental, life-altering gender transition treatments.

[199] Wren, (2021), *op. cit.* The quote is from paragraph 20.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on August 14, 2023.

DocuSigned by:
Mark Daniel Regnerus
7B9BE24BAA60493...

Dr. Mark Regnerus

STATE OF TEXAS §
§
COUNTY OF TRAVIS §

Before me, Lara Courtney, on this day personally appeared by means of an interactive two-way audio and video communication Mark Regnerus, who has provided satisfactory evidence of identity in accordance with Chapter 406, Texas Government Code to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed. This notarial act was an online notarization.

TO CERTIFY which, witness my hand and official seal on this August 14, 2023.

DocuSigned by:
Laura Courtney
D25A83836AC14E6...

8/14/2023 | 9:13 AM CDT

Laura Courtney
Notary Public in and for the State of Texas

Notary w/o bond

NOTARY PUBLIC STATE OF TEXAS

LAURA COURTNEY
Notary ID
13135672-6
My Commission Expires
1/4/2026

Notary Seal