IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

DYLAN BRANDT, et al.,

PLAINTIFFS,

v. **No. 4:21-CV-00450-JM**

LESLIE RUTLEDGE, et al.,

DEFENDANTS.

REBUTTAL DECLARATION OF DR. MARK REGNERUS

Pursuant to 28 U.S.C. 1746, I declare:

1. My credentials, research, and professional qualification are detailed in my declaration in this matter dated December 10, 2021. Here, as there, my opinions are based upon my knowledge and research in the matters discussed. The materials I have used to research and write this report are the standard sources used by other experts in my field. I have actual knowledge of the matters stated in this declaration. My opinions as detailed in this report are based upon my knowledge and direct professional experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that other experts in my field rely upon when forming opinions on the subject. This declaration does not exhaust my opinions.

2. I have reviewed the newly submitted declarations by Dr. Deanna Adkins (dated December 9, 2021), Dr. Armand Antommaria (dated December 10, 2021), Dr. Jack Turban (dated December 10, 2021), as well as the declaration submitted by the plaintiffs' additional witness, Dr. Dan H. Karasic (dated December 10, 2021).

3. My primary discussion of the medicalization of adolescent gender dysphoria does not concern the pharmacological details of treatment plans. I am not a psychiatrist or pediatric

endocrinologist. Rather, my primary concerns are sociological. The main points of my rebuttal are as follows:

- The protocols for careful mental-health assessments and stringent criteria for eligibility repeatedly invoked by the plaintiffs' witnesses are, in practice, hardly occurring and are being diminished or removed entirely in favor of "informed consent" models in discussions of evolving professional standards of care.
- The plaintiffs' witnesses deny or downplay social and external factors, whereas these influences are undeniable in the recent surge of transgender identification.
- There are open debates, divisions, and concerns now being expressed within the field, even by some gender-affirmative clinicians within the United States, which are not even acknowledged by the plaintiffs' witnesses, much less the concerns and conclusions of vast national health system reviews of research and care that now are protecting youths from being subjected to these medical treatments.
- The medical protocols recommended in the United States for the treatment of adolescents with gender dysphoria are increasingly out of step with developments and changes in numerous countries with progressive policies and decades of research. Where these countries are limiting and/or prohibiting gender medicine for minors in order to protect vulnerable youth, advocates in the United States seek to do the opposite, as reflected by the ideological capture of the professional organizations cited by the plaintiffs' witnesses
- The plaintiffs' witnesses claim that hormonal treatments are largely reversible, and yet only a tiny fraction of patients opt out of subsequent treatment options. If that is true, we are indeed talking about very early decisions with (*de facto*) permanent consequences.

- Strong legal norms once protected minors from consenting to experimental and irreversible procedures. Children's inability to consent to treatments that result in sterilization at ages as young as 10 and 11 is one of the primary reasons that laws such as the SAFE Act are needed.
- The threat of suicide is inflated and increasingly employed to justify these drastic interventions. Meanwhile, the risk of regret over irreversible changes and/or detransition is minimized or ignored.
- In the end, the laws of the state either function as they always have—to protect children and minors from preventable harms—or the state shirks its obligation to them.

I. SOCIOLOGICAL ISSUES

4. My concerns are primarily sociological—that is, how social influences are demonstrably evident, but inexplicably ignored, in the rapid "evolution" of protocols, and the swift ideological capture of professional organizations, resulting in suppressed internal rifts now coming to light. Observable radical shifts (e.g., the surge in cases, sex-ratio reversal in cases, disappearing emphasis on psychotherapy in practice, diminishing barriers to medical treatment) are being ignored by many "professionals," including the plaintiffs' witnesses. None of them make reference to any of these troubling developments that are now openly haunting some of their professional peers.[1] They do not wish to debate it, but rather defend only one way forward. To borrow from Admiral Farragut's famous command, it's "Damn the surge. Full speed ahead."

5. Social norms are a basic building block of society and a common notion in sociology. They are patterns of behavior and internalized values that are socially enforced.

[1] Anderson, E. (2022). When it comes to trans youth, we're in danger of losing our way. *San Francisco Examiner,* January 3, https://www.sfexaminer.com/opinion/are-we-seeing-a-phenomenon-of-trans-youth-social-contagion/; Ghorayshi, A. (2022). Doctors debate whether trans teens need therapy before hormones. *The New York Times*, January 14, https://www.nytimes.com/2022/01/13/health/transgender-teens-hormones.html.

Norms simplify life and enable persons to classify (and hence understand) each other's actions, a process that contributes to social order.[2] While Dr. Karasic insists on page 6 that "[g]ender identity…is not a product of external influence and not subject to voluntary change," his description of the 2013 definition of "Gender Dysphoria in Children" as outlined in the Diagnostic and Statistical Manual Fifth Edition (DSM-5), highlights the profoundly social (and hence external) aspects of gender dysphoria. All but one of the seven criteria Dr. Karasic lists on page 6 concerns social norms: talk of "the other gender," "simulating female attire," "typical masculine clothing," "typical feminine clothing," "cross-gender roles," "activities stereotypically used or engaged in by the other gender," "playmates of the other gender," "typically masculine toys," and "typically feminine toys, games, and activities."

6. It's not just the DSM-5. Dr. Karasic himself makes reference to "typically male or typically female" when discussing the definition of gender identity on page 5. To suggest something is "typical" means to accord it a mental image or "type" socially considered common to most cases of a given phenomenon. This is what early sociologist Max Weber identifies as an "ideal type," or (socially) shared mental constructs that help us bring order to reality.[3] (The "ideal" language is no moral claim, but a reflection of wide agreement on key traits.) And yet Dr. Karasic, ignoring universal practice and usage, claims that "the terms biological sex and biological male or female…should be avoided" (page 5). His advice seeks to disable human societies from understanding and classifying each other—a process necessary for social stability.

7. My point is not to belabor what constitutes something that is masculine or feminine; rather, I am simply observing that these are all social judgments that vary within and

[2] Norms. (2013). *Oxford Bibliographies Online*, Sociology. doi: 10.1093/obo/9780199756384-0091.

[3] Britannica, T. Editors of Encyclopaedia (2018, October 10). *ideal type*. *Encyclopedia Britannica*. https://www.britannica.com/topic/ideal-type.

across societies. And yet they are not arbitrary, but instead helpful to shaping and predicting the behavior of other people. To Judith Butler, author of the book (and phrase) *Gender Trouble* and key contributor to what its critics call "the theory of gender," gender constitutes unconscious, culturally compelled "performance" and is thereby powerfully socially rooted, constructed, and hence malleable.[4] Her influence on contemporary gender matters, including the transgender movement, is extensive. To suggest, as Dr. Karasic does, that gender identity "is not a product of external influence" is to maintain—in the face of evidence to the contrary—that gender is *only* molded by biology, that is, dimorphic sex differences. In doing so, he denies and contradicts what even the draft version of WPATH's SOC 8 acknowledges: "The phenomenon of social influence on gender is salient…as some who have changed their thoughts about their own gender identity have described how social influence was relevant in their experience of their gender during adolescence."[5]

8. Some clinicians perceive a practical dilemma. That is, suppress puberty and treat those teens who identify as transgender with cross-sex hormones in order to avoid presumed distress of having gone through the endogenous (i.e., normal) puberty process of one's natal sex, or consider the possibility that endogenous puberty may alter the experience of gender dysphoria and lead—over time—to the acceptance of one's natal sex. The plaintiffs and their experts assume that a transgender identity is stable over time. (Hence, the vociferous pushback against observations of "rapid-onset" gender dysphoria.) But in a social milieu in which cases of "nonbinary" gender identity are similarly surging, it becomes increasingly difficult to defend the

[4] Butler, J. *Gender Trouble*. New York: Routledge, 1990.

[5] World Professional Association for Transgender Health. (2021). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* [DRAFT 8th Version: Adolescent Chapter].

idea of a stable gender identity—and with it a stable understanding of both (1) what is going on socially among a great many adolescents, and (2) what to do next.

9. In my December 2021 declaration, I claimed that ideological capture well explains the professional discussion of gender dysphoria in the United States. This ideological capture is a cousin to the regulatory capture that is occurring in the domain of gender medicine, since there are now strong material incentives to offer treatments that are loosely governed by professional statements and perceptions of legitimate authority (e.g., WPATH, Endocrine Society).[6] In other words, gender medicine is a new and lucrative line of medicine. Its origins are cultural, rooted in recent notions that men can become women and vice versa by way of social discourse and medical treatments. But the end is the same in both cases—the "capture" of authority by the successful co-opting of professional organizations to serve the aims of a particular interest group.

10. This process is accelerated by what could be described as *conceptual veiling*, that is, the construction of new (and extensive) narratives to both diffuse criticism and obtain professional organizations' support for new treatment norms—norms that as little as 10 years ago would have stunned most pediatricians, not to mention the families they serve.[7] Personal stories, not unlike those told by the plaintiffs in this case, are powerful material. And yet they "veil" what is fundamentally going on here—that is, the failure of medical and legal institutions to protect those who are particularly exposed and vulnerable to manipulation and influence by social media content. The evidence suggests this is in no small part responsible for the surge in

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[6] Kwak, J. (2013). Cultural capture and the financial crisis in preventing regulatory capture. In Carpenter, & Moss (Eds.), Preventing regulatory capture: Special interest influence, and how to limit it, pp. 72–98. Cambridge: Cambridge University Press.

[7] Palea, V. (2021). "'Unreliable accounts: How regulators fabricate conceptual narratives to diffuse criticism' by Karthik Ramanna: A comment on ideological capture." *Accounting, Economics, and Law*, November, 1-8, https://doi.org/10.1515/ael-2021-0054.

teen gender dysphoria. To lurch further in the direction of treatment on demand with mere consent and to enable minors' willful destruction of healthy body parts that are undergoing normal development and maturation is an unprecedented and stunning shift.

II. PROTOCOLS ENDORSED—THEN IGNORED

11. Hence, there is a very real gender medicine *industry* today, on a scale that is unparalleled. It is experiencing explosive growth, and there are now somewhere around 300 gender clinics in the United States.[8] Social media influencers and activists urge clinicians to offer services that self-identified transgender persons ask for, regardless of age. In turn, gender medicine providers and scholars supporting them now engage in what is, in effect even if not in intention, a bait-and-switch maneuver: sell the public on wide access to hormonal and surgical treatments for dysphoric teens based on study results employing the Dutch protocol's very different patient characteristics and far more rigorous mental health safeguards.

12. In reality, the Dutch protocol is now all but ignored. Even WPATH's current guidelines—which have evolved considerably away from the Dutch protocol—are increasingly bypassed in favor of an "affirmative" approach whose primary criterion for moving forward to treatment is simple informed consent. That approach no longer scrutinizes dysphoric patients' psychological co-morbidities but instead believes that its treatments can alleviate them. By age 18, this approach is a given. For example, Planned Parenthood Great Plains, whose clinics cover the state of Arkansas, requires no evidence of previous gender-related psychotherapy or a

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[8] E.g. "In 2019, there were over 200 Planned Parenthood facilities in 31 states providing services for patients who identify as transgender." Planned Parenthood. (2020). 2019-2020 Annual Report. Planned Parenthood Federation of America, https://www.plannedparenthood.org/uploads/filer_public/67/30/67305ea1-8da2-4cee-9191-19228c1d6f70/210219-annual-report-2019-2020-web-final.pdf, page 11; Society for Evidence-based Gender Medicine. (2021). "Gender-affirming" hormones and surgeries for gender-dysphoric US youth, *Spotlight Blog,* May 28, https://segm.org/ease_of_obtaining_hormones_surgeries_GD_US#:~:text=There%20are%20over%2060%20pediatric,currently%20estimated%20at%20over%20300.

documented history of gender dysphoria prior to supplying hormone prescriptions. Their website even reads, "You don't need to participate in therapy or provide information from a mental health provider to receive hormone therapy."[9]

13. Hence, there is a *de jure* protocol—the WPATH Standards of Care—which all of the plaintiff's experts have taken pains to carefully state and reiterate. But the evidence suggests a quite different *de facto* reality has now emerged, one that is increasingly tailored to patient demands.

14. WPATH is, as Dr. Karasic points out on page 8, an organization whose suggested protocols are "endorsed and cited as authoritative" by a series of medical professional organizations.

15. Repeatedly, Dr. Karasic suggests WPATH SOC7's ongoing authority:

a. Page 9: "The WPATH SOC 7 and Endocrine Society Guidelines do not recommend genital surgery until a patient has reached adulthood."

b. Page 9: "The WPATH SOC 7 states that '[b]efore any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken.'"

c. Page 9: "The WPATH SOC 7 makes clear that '[h]ormonal or surgical interventions are appropriate for some adolescents, but not for others.'"

d. Page 9: "After ongoing work with mental health professionals and when the adolescent has lived in accordance with their gender identity for a significant period of time, they may start treatment with hormones…if and when medically indicated."

[9] See: https://www.plannedparenthood.org/planned-parenthood-great-plains/patient-resources/gender-affirming-care.

e. Page 10: "The WPATH SOC 7 and the Endocrine Society Guideline further provide that before any medical or surgical interventions are provided to adolescents, a careful mental health assessment should be conducted to ascertain whether the diagnostic criteria for Gender Dysphoria in Adolescents and Adults are met, and the appropriateness of such care for the patient."

f. Page 12: "[T]here is the additional safeguard of the assessment by a mental health professional, who, in addition to diagnosing gender dysphoria, also reviews the risks and benefits of treatment with the youth and parents."

g. Page 15: "Gender-affirming medical interventions in accordance with the WPATH SOC 7 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many adolescents with gender dysphoria."

16. Dr. Adkins follows suit in her report, taking pains to reiterate the same claim: "The Endocrine Society and WPATH have published widely accepted guidelines for treating gender dysphoria…" (page 4). She also notes that "[b]efore any medical intervention is initiated, the Endocrine Society Guideline and the WPATH Standards of Care for the Treatment of Gender Dysphoria ("WPATH SOC") provide that extensive mental health evaluations should be conducted" (page 7). On page 8, she further remarks that WPATH SOC 7 maintains that "[b]efore any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken . . . . The duration of this exploration may vary considerably depending on the complexity of the situation."[10]

[10] World Professional Association for Transgender Health (WPATH). (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people [7th version] https://www.wpath.org/publications/soc. The quote is from p. 18.

17. The key word here, and in five other instances on the same page (8), is "should." Mental health evaluations "should" be conducted, she notes. It does not mean they are required to, or that they will. Dr. Adkins goes on to present (on page 9) the Endocrine Society Guideline's mental health qualifications for eligibility for pubertal suppression. Indeed, at least five pages of Dr. Adkins's report consist of a simple restatement of official protocols—how such organizations believe minors *should* be evaluated and how treatments *should* be administered. The reader is left to presume that this is how treatment happens everywhere. But that is nowhere stated.

18. Even Dr. Turban notes (on page 7 of his report) that "gender-affirming genital surgeries are not recommended until adulthood" under the guidelines of both the Endocrine Society and the WPATH's SOC 7. Does this mean he does not object to the SAFE Act's prohibiting these surgeries on minors? On the contrary, Dr. Turban approvingly discusses (on page 7) a study about the benefits of "masculinizing chest surgery" for the relief of what he labels "chest dysphoria" among a small sample of natal female "transmasculine" adolescents.[11] The average age of these post-surgical patients was just under 18 years old, for whom the average time-since-surgery was 19 months. In other words, the mean age at "top" surgery was around 16½ years old. These were minors who were approved for such surgeries in spite of the Endocrine Society and WPATH guidance to the contrary.

19. What difference does it make for the plaintiffs' witnesses to repeatedly cite the protocols of professional organizations if practitioners—including plaintiffs' own witnesses—are clearly not interested in adhering to them? It matters a lot, actually. Regulatory capture—the formal co-opting of professional organizations' recommended policy and practice about the

[11] Mehringer, J.E., Harrison, J.B., Quain, K.M., et al. (2021). Experience of chest dysphoria and masculinizing chest surgery in transmasculine youth. *Pediatrics*, 147(3):e2020013300.

hormonal and surgical treatment of minors—is not simply driven by material incentives (e.g., new, permanently-dependent patients). It is also driven by "expert knowledge" to help generate the social context for such a radical change, that is, the medical treatment of minors' gender dysphoria on demand, without counseling.[12] This historically unprecedented approach is, without a doubt, at stake in this case.

III. THE RAPID UPTAKE OF AN UNOFFICIAL TREATMENT PROTOCOL

20. None of the plaintiffs' witnesses admit that there is a debate among clinicians about whether psychological assessments—a core component of the Dutch protocol—are necessary before proceeding to treat someone with hormones and surgeries. The question is particularly poignant for adolescents. A *New York Times* feature article in January 2022 describes how clinicians are at odds with each other over whether adolescents should be allowed pubertal blockers and cross-gender hormones on demand rather than after a psychological evaluation and several years spent questioning their gender identity.[13] The *New York Times*'s illuminating probe reveals that a journalist is more comfortable with observing (and admitting) that teenagers may be more subject to "emotional distress" and "more vulnerable to peer influence" than the plaintiffs' witnesses have been.[14]

21. Indeed, there is now open conflict among practitioners of transgender medicine over whether gender dysphoria even need be diagnosed before moving to desired medical treatment.[15] Alex Keuroghlian, a frequent co-author with Dr. Turban and a clinical psychiatrist

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[12] Palea, *op. cit*.

[13] Ghorayshi, A. (2022). "Doctors Debate Whether Trans Teens Need Therapy Before Hormones," *New York Times*, January 13. https://www.nytimes.com/2022/01/13/health/transgender-teens-hormones.html.

[14] Ibid., paragraph 5.

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

and director of the Massachusetts General Hospital Psychiatry Gender Identity program, told the *Times* reporter that pre-treatment mental health assessment is unnecessary: "I'm really not a believer in requiring that for people," he stated when asked. "Being trans isn't a mental health problem," he later asserted. "To make that a requirement for everybody is inherently unnecessary gatekeeping and also stigmatizing and pathologizing and a waste of resources," Dr. Keuroghlian maintains.[16]

22. Minors now present themselves as transgender and ask that clinicians respect their self-identity and offer the medical treatments—pubertal blockers, cross-sex hormones, and subsequent surgical options—that they cannot access without the permission of these clinical "gatekeepers." It is the professionals (i.e., the gatekeepers) who are being pressured by patients and activists to offer care to those who ask for it.

23. For many practitioners, acquiescence is the path of least resistance. For example, while Dr. Karasic quotes Dr. Kenneth Zucker approvingly (on page 12 of his report), Karasic sought to ban Zucker from presenting his own research at the 2017 USPATH conference. Karasic, who chaired the conference and oversaw the program which included a pair of talks by Zucker, nevertheless gave way to activist critics *during the conference*, apologized to them, and proceeded to cancel Zucker's final scheduled talk.[17] Why? Because Zucker is consistently on record as supporting more rigorous conditions for subjecting minors to gender-transition procedures. Doctors, so the emerging protocol implies, should not be gatekeepers to medical treatment anymore. What are physicians for, then?

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[16] Ghorayshi, *op. cit.*, paragraph 33.

[17] Singal, J. (2016). How the fight over transgender kids got a leading sex researcher fired. *The Cut,* February 7, https://www.thecut.com/2016/02/fight-over-trans-kids-got-a-researcher-fired.html.

24. Already in a 2018 article appearing in the *AMA Journal of Ethics*, a series of practitioners advocated for a shift away from WPATH's SOC7 and toward "an informed consent approach to care as more patient centered and respectful of the patient's sense of agency."[18] The motivation for this is grounded in a conviction about "a person's right of self-determination—and the belief that clinicians will work to facilitate patients' decisions about the course of their own lives and care." This is the aggressively affirmative treatment pathway. It is demand-driven, with fewer "speed bumps."

25. Published research using clinic data reflects this shift away from WPATH's current standards toward even easier and faster treatment enrollment (which also disregards the lopsided sex-ratios that follow).[19] In other words, there is increasing support for informed consent as the only threshold for initiating hormone therapy in teenagers.

26. Even WPATH's new (draft) 8th Standards of Care mark a significant shift in the direction of an informed consent approach to care as more focused on the patient's sense of agency. More to the point, SOC8 suggests minimum ages that are demonstrably "lower than those in the previous version, for each treatment: 14 for starting hormone therapy, 15 for chest masculinization and at least 17 for more invasive genital operations."[20] That is, cross-sex hormones no later than age 14 and surgeries beginning at age 15. Why do the plaintiffs' expert witnesses spend so much ink restating old standards when newer ones are imminent?

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[18] Cavanaugh, T., Hopwood, R., & Lambert, C. (2016). Informed consent in the medical care of transgender and gender-nonconforming patients. *AMA Journal of Ethics*, *18*(11), 1147-1155.

[19] Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302–311, https://doi.org/10.1037/cpp0000288. On page 304, the authors note that their clinic does not require an in-house mental health evaluation prior to treatment: "To avoid unnecessary delays in medical care, our clinic does not require patients to be seen by one of our clinic's mental health professionals if they have an established GD diagnosis and referral from a community mental health professional."

[20] Ghorayshi, *op. cit.*, paragraph 30.

27. Perhaps anticipating that this shift in actual practice could jeopardize legal goodwill (in this case), the plaintiffs' witnesses go to great lengths to declare that the old protocols are still in place. For example, Dr. Turban repeats the mantra that "[p]rotocols for the provision of such care" have been made clear in the Endocrine Society Guideline and in WPATH's SOC 7 (page 3), and that the "WPATH SOC 7 highlight that an adolescent must be assessed by a mental health professional with specific qualifications prior to initiating any gender-affirming medical interventions" (page 4).

28. The plaintiff's expert witnesses still like to cite evidence from studies employing the Dutch protocol—as Dr. Turban does multiple times on pages 4 and 5.[21] (Dr. Antommaria does the same on pages 15 and 16 of his report.)[22] It is a bait-and-switch tactic. Such studies imposed rigorous requirements for study participation, but they are being employed in this case to defend newer and far looser protocols for hormonal treatments on a very different class of adolescents with demonstrable, co-occurring mental health problems.

29. Hence, Dr. Turban's citation (on page 5) of the de Vries et al. 2014 *Pediatrics* study, which "found steady improvement in mental health over the course of the study" should be put into context: the participants did not have the type of significant baseline mental health

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[21] The following studies cited on pages 4 and 5 of Dr. Turban's report each employ the Dutch protocol for treatment (and hence study enrollment) eligibility: 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; van der Miesen, A.I., Steensma, T.D., de Vries, A.L., et al. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, *66*(6), 699-704; de Vries, A.L., McGuire, J.K., Steensma, T.D., et al. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*(4), 696-704.

[22] The following studies cited on pages 15 and 16 of Dr. Antommaria's report each employ the Dutch protocol: de Vries et al. (2011) *op. cit.*; 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; Schagen S.E., Cohen-Kettenis P.T., Delemarre-van de Waal H.A., Hannema S.E. (2016). Efficacy and safety of gonadotropin releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *Journal of Sexual Medicine, 13*(7):1125-32.

problems that are consistent with the current surge in dysphoric adolescents presenting at gender clinics around the United States. The *Pediatrics* study sample consisted instead of those "adolescents (who) belonged to a group of 196 consecutively referred adolescents between 2000 and 2008, of whom 140 *had been considered eligible* for medical intervention" (emphasis mine).[23] Eligibility in the Dutch protocol for medical treatment is not by demand, but only after careful psychological scrutiny of the sort that many clinicians and researchers are now actively seeking to drop or disregard.

30. As an extension of this, Dr. Turban discusses transition regret (on page 11) among the history of patients in the Amsterdam cohort, and asserts that the regret rate for those who had undergone "gender-affirming surgery" was 0.6% for transgender women and 0.3% for transgender men.[24] For a discussion of the medical treatment of minors, this observation is irrelevant, because the Amsterdam cohort adheres to the Dutch protocol, and the 0.6% and 0.3% observations refer to adult gonadectomy regret rates. That is, these are observations made of adults, not minors.

31. On p. 13, Dr. Karasic cites a 2021 meta-review[25] which found regret rates of 1%. However, the primary studies reviewed were "inherently flawed due to loss to follow up." A more recent review out of the UK found that 20% of patients in the sample had stopped hormone treatment, with half of these citing "regret" or "detransition" as a reason.[26] One case note review

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[23] de Vries et al. (2014), *op. cit.*, p. 697.

[24] Wiepjes C.M., Nota, N.M., de Blok, C.J.M., et al. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, *15*:582–590.

[25] Bustos, V.P., Bustos, S.S., Mascaro, A., Del Corral, G., Forte, A.J., Ciudad, P., Kim, E.A., Langstein, H.N. and Manrique, O.J., 2021. Regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plastic and Reconstructive Surgery Global Open*, *9*(3): e3477.

[26] Boyd, I., Hackett, T., & Bewley, S. (2022). Care of transgender patients: A general practice quality improvement approach. *Healthcare*, *10*(1), 121. https://doi.org/10.3390/healthcare10010121.

found a detransition rate of 6.9% at one UK clinic.[27] Either regret rates have been underestimated in the past or they are increasing. In reality, both are true.

32. In the conclusion of Dr. Turban's report, he claims that reports of transition and treatment regrets are unusual, given the "1.4 million transgender people in the United States alone" (page 13). Turban leans on a study employing the (more rigorous) Dutch protocol for support of his claims about modest surgical regret rates, and yet that study claims a transgender prevalence rate of 1 in every 3,600 persons above age 16.[28] Meanwhile, Turban's 1.4 million estimate yields a ratio of 1 in every 235 Americans—reminding us again of the bait-and-switch tactic employed here. That is, draw upon conclusions based on a rigorous criterion of inclusion, but then apply its findings to a social setting—the contemporary United States—that now exhibits a baseline rate (of transgender self-identity) at least 15 times larger than that employed in the Dutch protocol-based study sample. And still neither Turban nor any of the other plaintiffs' expert witnesses address whether there is anything different about the two populations.[29]

33. In 2020, Dutch clinician Annelou de Vries acknowledged that the "new developmental pathway" seen in youth presenting as trans at or past puberty without a history of childhood gender dysphoria and often with mental health diagnoses "raises the question whether the positive outcomes of early medical interventions also apply to adolescents who more recently present in overwhelming large numbers for transgender care." Dr. de Vries expressed a need for

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[27] Hall, R.; Mitchell, L.; Sachdeva, J. Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: Retrospective case-note review. BJPsych Open 2021, 7, e184.

[28] Wiepjes et al. (2018), *op. cit*. The rate quoted is equivalent to the article's reference to 27.7 transgender persons per 100,000 people.

[29] Johns, M.M., Lowry, R., Andrzejewski, J., et al. (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*:67–71, http://dx.doi.org/10.15585/mmwr.mm6803a3.

"caution" and mentioned concern for those later-presenting adolescents that "may detransition."[30] Thomas Steensma warned that clinicians around the world were "blindly adopting" their research, stating that "we don't know whether studies we have done in the past can still be applied to this time" due to the novel type of presentation.[31]

34. Such an acknowledgement is not lost on other nations' decision-making. Indeed, Sweden's Karolinska Institute—along with four of the country's five other gender clinics—has recently moved away from the original Dutch protocol, allowing pediatric transitions only in strictly controlled trials going forward.

35. Similarly, Finland now recommends psychotherapy as the preferred initial treatment for youth presenting with gender dysphoria, even advising clinicians to wait until age 26 (after brain maturation has completed) before administering medical interventions. While still allowing pediatric transitions, Finland has now returned to a stricter adherence to the original Dutch protocol, requiring evidence of childhood onset gender dysphoria, no mental health co-morbidities, and "watchful waiting."[32] Thus, Finland's national recommendations now differ from what WPATH's SOC7 had already endorsed, and are worlds apart from the proposed SOC8 guidelines and the Informed Consent Model.

36. Meanwhile, in contrast to the Dutch protocol, a statement by the American Academy of Pediatrics proposes that mental health comorbidities are caused by gender dysphoria rather than the other way around. "[I]f a mental health issue exists, it most often stems from

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[30]de Vries, A. L. C. (2020). Challenges in timing puberty suppression for gender-nonconforming adolescents, *Pediatrics*, *146*(4), e2020010611. The quotes are from p. 1-2.

[31]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/.

[32] "Watchful waiting" was a key component of the original Dutch protocol. See page 61 of: Ehrensaft, D. (2017). Gender nonconforming youth: current perspectives. *Adolescent health, medicine and therapeutics*, *8*, 57-67.

stigma and negative experiences rather than being intrinsic to the child," wrote a small cadre of clinicians tasked with articulating policy for all pediatricians[33] In other words, the emerging scholarly mentality no longer wonders whether minors may come to the conclusion that they are transgender and need hormonal and (later) surgical treatments *because* they are unhappy. They have concluded instead that it is sufficient to take gender dysphoric teens at their word and deduce that they are unhappy *because* of social responses to being transgender. Hence, treatment will alleviate unhappiness by aligning their gender identity with their physical body. The closer the alignment—a socially- and culturally-attuned measure, of course—the better the expected outcome.

37. If there were not a concurrent explosion—and a reversal in the longstanding sex ratio—of cases of gender dysphoria and rates of self-identified transgender teenagers, this transition from a template of caution to one of haste might well have gone unnoticed.

IV. THE CENTRAL ROLE OF A NARRATIVE ABOUT SUICIDALITY

38. The specter of suicide is not simply a motivation undergirding the push toward "affirmative" medical treatment of minors at younger ages. It is the only thing that could possibly justify such drastic interventions. Hence, it is an absolutely essential component of the narrative. Dr. Adkins moves straight to the threat of suicide in her page 19 section on the harms of withholding or terminating transgender treatment among minors with gender dysphoria, and concludes her report (on page 21) by warning that "[w]e barely save some of these young people's lives by getting them on treatment; to take them off mid-treatment where the treatment is working could be life-threatening." This is a narrative widely employed by clinicians, who

[33] Rafferty, J., et al. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, *142*(4): e20182162. The quotes are from page 4.

pose the question, "Would you rather have a living son or a dead daughter?"[34] While none of the experts employ that particular claim in their reports, its use is widespread and an invention of the perception—as distinct from the reality—of a strong association between gender dysphoria and actual completed suicide (as distinct from suicidality or attempted suicide).

39. Throughout the entire seventh edition of WPATH's Standards of Care document, published in 2011 and amounting to 120 pages, the terms "suicide," "suicidal," and "suicidality" appear only four times total—two of which are in the same sentence. The terms appears in no references (i.e., in the titles of journal articles) at all. In the eighth edition, a draft of which is now circulating, the terms appear 31 times in the text of the document, and in 45 references. (For perspective, Dr. Turban uses the terms 21 times in his report's 13 total pages.) Why the skyrocketing interest? It is not because of any surge in actual suicides.

40. In a January 2022 article published in the *Archives of Sexual Behavior*, Oxford University sociologist Michael Biggs documents how reports of attempted suicide dramatically exceed the actual rate of completed suicides among adolescent transgender patients.[35] To be sure, Biggs notes that the suicide rate is in fact higher—5.5 times higher—than among that observed among adolescents ages 14 to 17 in the UK. And yet some perspective is in order: the actual number of adolescent suicides Biggs uncovers among patients at the UK's GIDS—the world's largest gender clinic—over a decade is four (or 0.03 percent of all patients), which the author notes "is orders of magnitude smaller than the proportion of transgender adolescents who report attempting suicide when surveyed."[36]

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[34] Soh, D. (2020). *The end of gender: debunking the myths about sex and identity in our society*. New York: Simon & Schuster. The quote is from page 160.

[35] Biggs, M. (2022). Suicide by clinic-referred transgender adolescents in the United Kingdom. *Archives of Sexual Behavior*. https://doi.org/10.1007/s10508-022-02287-7. The quote is from page 4.

[36] Ibid., page 4.

41. The disparity between suicide "risk" and actual completions is so dramatic that Biggs concludes that "[i]t is irresponsible to exaggerate the prevalence of suicide," adding that Bernadette Wren, a former senior clinician at the GIDS clinic, warned "when inaccurate data and alarmist opinion are conveyed very authoritatively to families we have to wonder what the impact would be on children's understanding of the kind of person they are…and their likely fate."[37]

42. Dr. Biggs notes that completed suicide rates were considerably higher at the Belgian pediatric clinic, despite better average patient psychological function there, as well as at the Amsterdam clinic, a finding he attributed to higher median age (25) at first visit there.[38] Suicide rates tend to peak in middle age, an observation that seems lost on participants in this debate. Instead, simple assumptions about the etiology of suicidality among self-identified transgender youth remain the preferred narrative of advocates.[39]

43. Biggs discusses the meaning of self-reporting suicide attempts, citing a pair of small-sample studies of non-heterosexual youth in which half of the studies' respondents who had initially reported a suicide attempt eventually clarified that their attempts had gone no further than imagining or planning suicide. The remainder of actual attempted suicides, he notes, did not typically involve life-threatening situations. The reported attempts, one of the original

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[37] Wren, B. (2015). Making up people. Presented at the meeting of the European Professional Association for Transgender Health, Ghent, Belgium. A selection of this presentation was quoted in Biggs (2022), page 4.

[38] Biggs (2022), *op. cit*.

[39] E.g. Brown, M. (2017). Suicides peak in middle age. So why do we call it a young person's tragedy? *The Guardian,* September 13, *https*://www.theguardian.com/commentisfree/2017/sep/13/suicide-middle-aged-young-people-death; Van Orden et al. (2010) Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, *117*(2), 575-600.

studies noted, instead reflected efforts “to communicate the hardships of lives or to identify with a gay community.”[40]

44. Biggs notes that elevated prevalence of other conditions, like eating disorders, depression, and autism spectrum conditions—the latter of which occurs at a rate 15 times higher than that found among UK students as a whole—are each known to increase the probability of suicide.[41] Despite Biggs’s observation of a profoundly disproportionate rate of autism among GIDS patients, Dr. Turban questioned the connection in print, claiming that “current research has not established an over-representation of GD in those with ASD [Autism Spectrum Disorder] or the converse.”[42] Even if there is a link between autism and gender dysphoria, Dr. Turban maintains that it doesn’t matter: “they should be provided with access to gender-affirming medical care.”[43] Thus, it seems that medical treatments are the go-to prescription. Maslow’s “law of the instrument,” a form of cognitive bias, is evident here: if the only tool you work with is a hammer, it’s tempting to treat everything as if it were a nail.[44]

45. Suicide is being weaponized in service to a political end. This is unsurprising. Indeed, it is part of the “conceptual veiling” that aids the capture of professional organizations and, with them, policy shifts and legal protections in practice. Refusing to subject minors with gender dysphoria to puberty blockers, cross-sex hormones, or any of a host of surgical procedures will not kill them—as many seem to imply. It is not akin to withholding insulin from

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[40] Savin-Williams, R. C. (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Consulting and Clinical Psychology*, *69*, 983–991. https://doi.org/10.1037/0022-006X.69.6.983. This is quoted in Biggs (2022), *op. cit.*, page 1.

[41] Ibid.

[42] Turban, J. L., & van Schalkwyk, G. I. (2018). “Gender dysphoria” and autism spectrum disorder: Is the link real? *Journal of the American Academy of Child & Adolescent Psychiatry, 57*(1), 8-9. The quote is from page 9.

[43] Turban, J. L., & van Schalkwyk, G. I. (2018). Drs. Turban and van Schalkwyk reply. *Journal of the American Academy of Child & Adolescent Psychiatry, 57*(11), 887–889, https://doi.org/10.1016/j.jaac.2018.07.881. The quote is from page 889.

[44] Maslow, A. (1966). *The psychology of science: a reconnaissance*. New York: Harper & Row, page 15.

a Type-I diabetic, a move which will indeed lead to death. The two are not comparable processes.

46. Similarly, Dr. Antommaria compares the possibility of adolescents' subsequent treatment-induced infertility with that prompted by cancer. "Parents of children with some types of malignancies may choose treatments that may damage their children's gonads and result in infertility," he writes on page 20 of his report. The same, he notes there and again on page 23, goes for decisions about DSDs (disorders of sex development). Gender dysphoria, however, is not a malignancy, the invasive medical treatment of which is absolutely necessary to preserve life. Nor is it a DSD. A dysphoria is, rather, a psychological state marked by distress, unease, and dissatisfaction. Cancer is not, at bottom, a psychological problem. An intersex condition is likewise physically demonstrable. Moreover, childhood cancers have been and remain extremely rare—affecting 1 in every 6,500 minors per year.[45] DSDs remain comparably rare.[46] The same can no longer be said of gender dysphoria.

V. CONSENT

47. Dr. Antommaria outlines the ethical principles about informed consent, assent, and adolescents' decision-making capacity, as asserted by the Endocrine Society (on page 21 of his report). Is there an age that is too young for informed consent? Small children have difficulty understanding quantity, quality, and time, as well as assigning "causal attributions," that is, understanding that occurrences have both proximal and distal causes. The same goes for reasoning, anticipating the future, the formation of identity, self-reflexivity (or the ability to

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[45] Ries, L.A.G., Eisner, M.P., Kosary, C.L., Hankey, B.F., Miller, B.A., Clegg, L., Edwards, B.K. (eds). (2002). SEER Cancer Statistics Review, 1973-1999. National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1973_1999/.

[46] Witchel, S. F. (2018). Disorders of sex development. *Best practice & research. Clinical obstetrics & gynaecology*, *48*, 90–102. https://doi.org/10.1016/j.bpobgyn.2017.11.005.

assess our own judgments), moral awareness, judgment, and truth seeking.[47] The capacity for each of these develops over time and is quicker in some than in others. Each is related to informed consent here, since adolescents are being asked to decide what their future will look like at a very young age.

48. Furthermore, Dr. Antommaria notes that a discussion of "fertility and options for fertility preservation" is recommended by the Endocrine Society as part of "the informed consent process for puberty blockers and sex hormones" (page 21). To speak with a minor about future fertility before beginning puberty blockers is to talk with them about it by around age 11. The Endocrine Society, he continues, "also advises delaying gender-affirming hormone treatment, which results in partly irreversible physical changes, until an adolescent is developmentally capable of providing informed consent." How old is "developmentally capable"? How insignificant is "partly irreversible"? Even the ability to have a serious conversation about the future is decreasingly possible given the move away from physician gatekeeping and toward earlier cross-sex hormone treatment. (WPATH SOC8 recommends age 14.)

49. Dr. Adkins discusses (on page 12 of her report) the process of acquiring informed consent from her adolescent patients, noting that those age 12 and over (and a parent or guardian) sign "line by line," but that "a visual presentation" is used "with patients who have limitations on their ability to absorb the information..." Perhaps this concerns minors' grasp of complex medical language. On the other hand, perhaps it signals that Dr. Adkins endorses puberty blockers and cross-sex hormone treatments for minors who either cannot read well or who are too young to understand concepts explained on the printed page. Either way, if pictures

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[47] Smith, C. (2011). *What is a person? Rethinking humanity, social life, and the moral good from the person up*. Chicago: University of Chicago Press.

must replace text, Dr. Adkins's criteria undermine confidence in the ability of minor patients to understand long-term treatment consequences and offer their informed consent.

50. Dr. Antommaria writes at some length about principles of informed consent and assent (pages 11-12). The matter of adolescent "medical decision-making capacity" remains central to the concern articulated in the SAFE Act. Antommaria cites Douglas Diekema's 2004 discussion of parental refusals of medical treatment for their minor children.[48] Diekema nevertheless commences his study with the proposition that minors "are generally considered incompetent to provide legally binding decisions regarding their health care."

51. Experimental medicine has historically reinforced the importance of consent and fostered greater protections of those considered most vulnerable—chief among them pregnant women and children. For example, the Institutional Review Board of the Children's Hospital of Philadelphia maintains that "[c]hildren are neither legally nor developmentally capable of consenting to their own treatment or participation in research."[49]

52. In discussing the purported absence of clinical equipoise, Dr. Antommaria observes that one particular challenge to conducting a randomized trial is the difficulty of locating a sufficient number of participants willing to risk being randomized into the control wing of the study (page 9). He considers this "inadequate sample size" to constitute an ethical problem. But given that so many studies in this domain rely on modest sample sizes, is Dr. Antommaria sure he wants to consider sample size an issue of ethics? If so, we could disregard perhaps over three-quarters of all published research in this domain. While we're at it, I consider drawing conclusions from recruited opt-in samples (like Dr. Turban does in his publications

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[48] Diekema, D.S. (2004). Parental refusals of medical treatment: The harm principle as threshold for state intervention. *Theoretical Medicine*, *25*(4):243-64.

[49] Children's Hospital of Philadelphia Research Institute, Criteria for IRB approval. https://irb.research.chop.edu/criteria-irb-approval. Retrieved: Feb. 10, 2022.

drawing upon the United States Transgender Study, or USTS) dubious at best and borderline unethical—especially if used to draw conclusions or propose policy about an underlying population—despite its large sample size.

53. While Dr. Antommaria discusses at length the varying quality of medical research, the General Assembly's findings that there is "a lack of 'long-term longitudinal studies' on puberty-blocking drugs and a lack of 'randomized clinical trials' of cross-sex hormone therapy" also remains accurate.

I. CONCLUSIONS

54. It is evident by now that there is a widening split between clinicians over how and when to introduce transgender medicine to minor patients. Protocols are shifting to favor younger timelines, and some clinicians are opting to overlook mental health comorbidities and gamble instead that treatments will alleviate them. Given the rapid shift to looser protocols aggressively promoted by many advocates today, what WPATH or the Endocrine Society does or does not currently recommend should be of little or no concern in this case, because the guidance will soon change, and the confederation of medical professional organizations seems very unlikely to contest loosened guidance.

55. In the end, this is not about asking a judge to mull over the merits of this or that study's methods, measurements, or conclusions. Debates are hardly unusual in the academy, nor is any single study beyond criticism. Rather, what I have sought to establish—primarily in my December 2021 report and in this rebuttal—is that what is going on in transgender medicine for teenagers is less about tweaking protocols and more about the ideological capture of professional organizations in service to ideas that were unthinkable up until a few years ago. Those ideas are: (1) that minors could consent to their own sterilization by age 14 and surgical removal of normal tissue by age 15, encouraged by strangers on social media; (2) that with the aid of social

collusion the human person can will their own sex change into existence; and (3) that major medical professional associations have—in service to purported respect for human agency—cooperated with activists to put patients in charge of their own diagnosis and treatment prescriptions. To justify all this, the threat of patient suicide has taken center stage, in spite of modest evidence.

56. The result is rightfully viewed as scandalous outside of the transgender medicine context. Ordinary Americans maintain critical opinions of treating transgender teenagers with hormones or surgery.[50] This is an example of "déformation professionnelle," or job "conditioning" in which training and socialization processes associated with a profession—in this case the emergence of "gender" medicine—have resulted in a distorted understanding of the human person as a unity of mind and body.[51] That this branch of medicine seems particularly prone to patient activists' emotional involvement in the development and revision of protocols—as compared to, say, cardiology or oncology—offers evidence of (and further fuel for) this professional distortion. As articulated in my own research, this case—and the medical treatment of adolescent gender dysphoria as a whole—has everything to do with a questionable ideological prioritizing of bodily autonomy over bodily integrity.[52] But this choice of values is rarely articulated or reflected upon, to the detriment of young people placed in the medical pipeline of transgender medicine.

57. The SAFE Act concerns minors. It makes no claims on the decisions adults wish to make. The law has long recognized the difference, and sought to protect minors from making

[50] Regnerus, M., Vermurlen, B. (2022). Attitudes in the U.S. toward hormonal and/or surgical interventions for adolescents experiencing gender dysphoria. Archives of Sexual Behavior, https://doi.org/10.1007/s10508-021-02214-2.

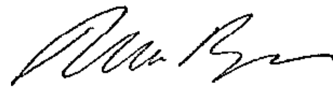
[51] The origin of the term is unclear, but is often attributed to the early Russian-American sociologist Pitirim Sorokin, who emigrated to the United States before becoming the inaugural professor of sociology at Harvard.

[52] Regnerus, Vermurlen (2022), *op. cit*.

premature judgments that come with strings attached, that is, unintended consequences, permanent changes, and altered life trajectories. Indeed, there is no shortage of things that the law prevents minors from doing, even if they wish to. The SAFE Act suggests there are grave misgivings about the ability of minors—especially but not only those who are very young, such as ages 11 and 12—to consent to the (rapidly evolving) medical interventions that constitute transgender medicine. Either the law will extend its protection to minors in these situations—telling them to wait—or it will leave them exposed to the subtly coercive claims of activists and their clinicians, whose rapid capture of professional organizations that once protected children is a stunning accomplishment. Hippocrates would be scandalized. Some priorities, he maintained, "may outweigh the surgeon's knife and the chemist's drug."

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

Executed on February 10, 2022.



Mark Regnerus, Ph.D.