VanMol on Alstott (so-called Yale) letter
July 19, 2022

We need to establish some background here before I launch into the Alstott letter.

The international standard of care is watchful waiting with strong emphasis on psychological evaluation and support of the child as well as the family.
This is based on two primary facts;

1. **There is the overwhelming probability of the presence of mental health issues, adverse childhood experiences, neurodevelopmental factors (autism spectrum), and family dynamic issues (parental problems, etc.). Dealing with these will often resolved the gender confusion.**
2. **Desistance is the normal for gender dysphoria by adulthood.**
3. **And a third is the irreversibility of GAT.**

Mental health co-morbidities. Note for all four studies here, the mental health diagnoses preceded that of gender dysphoria, not the other way around. Very significant.

- **2015 report from Finland's gender identity services found 75% of adolescents they saw were or had been undergoing psychiatric treatment for reasons other than GD. 26% had autism spectrum disorder. 87% female.[1]**
- **2014. Four nation European study found almost 70% of people with gender identity disorder had "a current and lifetime diagnosis."[2]**
- **Australia 2021.[3] Prospective study from a multidisciplinary pediatric gender service.**
    - **Children: n = 79; 8.42–15.92 yo; 33 bio males, 46 bio females.**
    - **High levels of distress (including GD), suicidal ideation (41.8%), self-harm (16.3%), and suicide attempts (10.1%).**
    - **High rates of comorbid mental health disorders: anxiety (63.3%), depression (62.0%), behavioural disorders (35.4%), and autism (13.9%).**
    - **High rates of adverse childhood experiences, with family conflict (65.8%), parental mental illness (63.3%), loss of important figures via separation (59.5%), and bullying (54.4%); and maltreatment (39.2%).**

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[1] Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. 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 (2015) 9:9.
[2] Heylens G, et al. "Psychiatric characteristics in transsexual individuals: multicentre study in four European countries," The British Journal of Psychiatry Feb 2014, 204 (2) 151-156; DOI: 10.1192/bjp.bp.112.121954.
[3] Kozlowska K, McClure G, Chudleigh C, et al. Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems*. **2021;1(1):70-95. doi:10.1177/26344041211010777**

  - **Key challenges faced by the clinicians: polarized discourses; pressures to abandon the holistic [biopsychosocial] model; the difficulties of untangling gender dysphoria from comorbid factors such as anxiety, depression, and sexual abuse.**
- **Kaiser-Permanente study 2018 (Becerra-Culqui): Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers.[4]**
  - **Gleaned from electronic medical records of 8.8M members in GA and CA.**
  - **High rates of psychiatric disorders and suicidal ideation before gender non-congruence in teens.**
  - **Rates (prevalence ratios/PR) in the 6 months before first findings of GNC compared to gender congruent peers: psych disorders 7 times higher overall, vast PR for certain ones, psych hospitalizations 22-44 times higher, self harm 70-144 times higher, suicidal ideation 25-54 times higher (Tables 3 & 4 of study).**
  - **Suicidal ideation during said 6 months before GNC findings: 7% in biological males and 5% in biological females. Far below rates claimed by activists, but still high.**

DESISTANCE is the norm for GD/GA, unless affirmed. Conservatively, 85% will desist by adulthood.

- **DSM-5 p.455: rates of persistence translate to rates of desistance in natal males from 70 to 97.8% and natal females from 50 to 88%. [5]**
- **American Psychological Association** *Handbook on Sexuality and Psychology,V1,744*: **[6]**
  - **"In no more than about one in four children does gender dysphoria persist from childhood to adolescence or adulthood…"**
    That represents a minimum 75% rate of desistance.
- **Singh, Bradley, Zucker, 2021, Front. Psychiatry. 87.8% desistance in "largest sample to date of boys clinic-referred for gender dysphoria."[7]**

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[4] Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. Pediatrics. 2018;141(5):e20173845.

[5] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing. P.455.

[6] Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology* **(2 volumes). Washington D.C.: American Psychological Association,** *1*: **744.)**

[7] Singh D, Bradley SJ and Zucker KJ (2021) A Follow-Up Study of Boys With Gender Identity Disorder. *Front. Psychiatry* **12:632784. doi: 10.3389/fpsyt.2021.632784**

- **Cohen-Kettenis, 2008, J SexMed: 80-95% of gender dysphoric pre-pubertal children desist by the end of adolescence.[8]**
- **Ristori, et al Int Rev Psychiatry 2016: Finding a desistance rate of 61-98% of GD cases by adulthood.[9]**
- **The pro-affirmation Endocrine Society Guidelines admit: "… the large majority (about 85%) of prepubertal children with a childhood diagnosis (of GD) did not remain gender dysphoric in adolescence."[10]**
- **U of Toronto psychologist Dr. Ken Zucker summarizes and defends the numerous studies showing desistance is common in his 2018 paper, "The myth of persistence."[11]**

P.1, para.2 & P.4.1. GAT considered experimental in Bell v Tavistock decision of a UK high court, and quality of pro-GAT evidence found to be very low in NICE 1 &2 and Swedish statements. Similarly, Finland and France have reversed course on GAT, as noted in GAPMS.

- **The UK's N.I.C.E. reviews, 2020 (The National Institute for Health and Care Excellence).[12]**
  - **2020 N.I.C.E. Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria.:**
    - **Conclusion: "The results of the studies that reported impact on the critical outcomes of gender dysphoria and mental health (depression, anger and anxiety), and the important outcomes of body image and psychosocial impact (global and psychosocial functioning), in children and adolescents with gender dysphoria are of very low certainty using modified GRADE. They suggest little change with GnRH analogues from baseline to follow-up."**
  - **2020 N.I.C.E. Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria.:**

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[8] Cohen-Kettenis PY, et al. "The treatment of adolescent transsexuals: changing insights." J Sex Med. 2008 Aug;5(8):1892-7. doi: 10.1111/j.1743-6109.2008.00870.x. Epub 2008 Jun 28.

[9] Ristori J, Steensma TD. Gender dysphoria in childhood. Int Rev Psychiatry. 2016;28(1):13-20.

[10] Hembree, W., Cohen-Kettenis, et al., (2017) Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guildeline. J Clin Endocrinol Metab,102:1–35.

[11] Zucker, K. J. (2018). The myth of persistence: response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender nonconforming children" by Temple Newhook et al. International Journal of Transgenderism, 19(2), 231–245. Published online May 29, 2018. http://doi.org/10.1080/15532739.2018.1468293

[12] https://arms.nice.org.uk/resources/hub/1070871/attachment and https://arms.nice.org.uk/resources/hub/1070905/attachment

  - **Conclusion: "Any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria."**
  - **"Results from 5 uncontrolled, observational studies suggest that, in children and adolescents with gender dysphoria, gender-affirming hormones are likely to improve symptoms of gender dysphoria, and may also improve depression, anxiety, quality of life, suicidality, and psychosocial functioning. The impact of treatment on body image is unclear. All results were of very low certainty using modified GRADE."**
  - **Very significantly: "Adverse events and discontinuation rates associated with gender-affirming hormones were only reported in 1 study, and no conclusions can be made on these outcomes."**
- **United Kingdom High Court case ruling in Bell vs. Tavistock Dec. 12, 2020.[13] Ruled that puberty blockers and cross-sex hormones constitute experimental treatments with limited evidence for efficacy and safety which cannot, in most cases, be given to children under 16 years of age without application to the court. Even for minors under aged 16-17, the High Court advised "clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment."**
- **Swedish Agency for Health Technology Assessment and Assessment of Social Services' 2019 literature review.[14] Found no scientific evidence to explain increase incidence of GD, the increase in minors seeking GAT, few studies on gender affirming surgery in minors, few studies on long-term effects, and "Almost all" studies were observational and "no relevant randomized controlled trials in children and adolescents were found."**
- **Sweden's Karolinska Hospital (affecting Astrid Lindgren Children's Hospital's pediatric gender services) issues a policy change effective April 1, 2021:[15] hormonal treatments (PBA and CSH) will not be allowed under age 16; patients 16-18 can only received hormonal treatment in a clinical trial setting; psychological and psychiatric care must continue under 18; and they cite both the UK High Court ruling in Bell v Tavistock and that "These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis."**

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[13] https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf

[14] https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/

[15] Karolinska Policyförändring K2021-3343 March 2021 (Swedish).pdf; Karolinska Policy Change K2021-3343 March 2021 (English, unofficial translation).pdf

P.4.1. Citing WPATH.
WPATH is an advocacy organization, neither medical nor scientific.
Their SOC 7 citations are about 80% from non-peer-reviewed sources.
Overwhelmingly not from peer-reviewed sources.
They call it Standards of Care (SOC) but that doesn't them so.

P.4. Final para going over to P.5 first para.
Citing organizations that support GAT. That is both eminence based and false authority.
The rank-and-file members do not get a vote, that is for the few dozen at the top.
The GAT supporting organizations usually have policies written by WPATH members.
So forget the number of members they represent, it's a few dozen on top who do this.

Again, with the repeated Endocrine Society regerence, yet…

- **The 2017 Endocrine Society Guidelines state their medical evidence rating for puberty blockers and cross-sex hormones in selected minors as "low" and adult genital surgery as "very low."** [16]
    - **Disclaimer p. 3895: "The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The guidelines are not intended to dictate the treatment of a particular patient."**

Consensus is not a proxy for truth. Group think is by consensus, too.
The pro-GAT/TAT party line is in part a Castro consensus.[17]

- **"A Castro Consensus is a near-unanimous show of agreement brought about by means other than the honest and uncoerced judgements of individuals."**
- **"…once dependence, polarization, and external pressure are introduced…the probability of a false consensus increases dramatically."**

P.5.2. Not only is the GAPMS easoning scientific, it includes the McMaster U review.

P.6. A. Says reasoning is not with peer-reviewed sources. Ignores the peer-reviewed article with Cantor's attachment, Transgender and Gender Diverse Chldren…, J of Sex & Marital Therapy. Also, the GAPMS and attachments is replete with peer-reviewed citations.

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[16] **Wylie C Hembree, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,** *The Journal of Clinical Endocrinology & Metabolism*, **Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658**

[17] **Understanding the Role of Dependence in Consensus Formation.** *Proceedings of the 2020 Truth and Trust Online (TTO 2020)*, **pages 12–20, Virtual, October 16-17, 2020. https://www.cs.hmc.edu/~montanez/pdfs/allen-2020-castro-consensus.pdf**

Alstott spends a lot of time issuing snark and ad hominem.

P.8.para 2. Calls SEGM an advocacy group. But WPATH?? SEGM is "an international medical society."

P.8. last para. So they don't like ADF either, the group that has played a strong hand in disproving things in high court.

P.10.2. "The BPW document violates scientific standards for evaluating medical evidence."
It did a pretty good job of exposing the lack of scientific standards in GAT, and Alstott is offended and angry.

P.11.para 4. "*The key point is that "low quality" in this context is a technical term and not a condemnation of the evidence, because "low quality" studies regularly guide important aspects of clinical practice."*
They and the Endocrine Society both used a lot of words to say this. Why have high quality is low quality is just fine? What does low quality and very low quality mean except nothing when the fix is in for pre-ordained standards of care that are actually not? Their explanation indicates GAT is simply not falsifiable. UK, Sweden, Finland, France, and others have found otherwise and did a turn about against it.

P.12. para 3. "The critical fact is that RCTs are not, and cannot be, the gold standard for medical research on gender dysphoria, due to strong ethical constraints."

- **Per Paul Hruz: "It is often argued that conducting randomized controlled trials in the field of gender medicine would be unethical. This is based upon the false premise that the control group would receive no specific therapy. However, in scientific investigation all variables except the independent variable being tested are kept constant in both experimental and control groups. Thus, although members of the control group do not receive the intervention being studied, they are provided with all other aspects of treatment indicated for the condition; that is, they receive standard care. There are numerous means of psychological support for anxiety, depression, and other comorbidities associated with gender dysphoria. Coping skills can be developed in both treatment arms." Paul Hruz, MD (e-mail 7/7/2022)**

P.13. para 3. "It is quite common for consensus medical practices to be supported only by technically "low quality" but respected observational studies – without RCTs."
Again, consensus is not a proxy for truth and is not in itself science. Group think is by consensus as well.

P. 13. B. "The June 2 Report disregards robust clinical research studies and instead relies on sources with no scientific credibility." The robustness has been called into question by NICE 1 & 2 from the UK, Bell v Tavistock, and sources from Sweden, Finland and France, with Swede and Fin sources representing medical, scientific, and governmental decisions.

Royal College of GPs Position Statement June 2019 "There is 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 GPs from helping patients and their families in making an informed decision."

https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2019/RCGP-transgender-care-position-statement-june-2019.ashx?la=en

Editor in chief of the BMJ Carl Heneghan wrote, "There are significant problems with how the evidence for Gender-affirming cross sex hormone has been collected and analyzed that prevents definitive conclusions to be drawn."
"An Archive of Diseases in Childhood letter referred to GnRH treatment as a momentous step in the dark. It set out three main concerns: 1) Young people are left in a state of developmental limbo without secondary sexual characteristics that might consolidate gender identity 2) use is likely to threaten the maturation of the adolescent mind, and 3) puberty blockers are being used in the context of profound scientific ignorance."
He concludes, "The current evidence does not support informed decision making and safe practice in children."

Heneghan, Carl. "Gender-Affirming Hormone in Children and Adolescents." BMJ EBM Spotlight, 21 May 2019, blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-inchildren-and-adolescents-evidence-review/.
Referencing: (Richards C, Maxwell J, McCune N. Use of puberty blockers for gender dysphoria: a momentous step in the dark. *Archives of Disease in Childhood* **2019;104:611-612.)**

p.15.para 2 brings up 2015 Costa from NHS GIDS trial.

- **Professor Michael Biggs of Oxford**
  Criticized the UK's NHS GIDS having produced only a single study (at that time) from their trial of puberty blockers, and showed no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. Furthermore, unpublished evidence showed puberty blockers worsened gender dysphoria."[18]
- **I think this deals with it too.**

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[18] Michael Biggs, The Tavistock's Experiment with Puberty Blockers, 29 July 2019, http://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf

Gender dysphoria in children: puberty blockers study draws further criticism. BMJ 2019; 366 doi: https://doi.org/

Here they make no mention of the Carmichal 2020 follow up study.

- **UK GIDS Tavistock study 2020.[19]**
  - **BMD and growth/height both showed "suppression of growth" precisely when they should be having the surge of the lifetime.**
    - **"As anticipated, pubertal suppression reduced growth that was dependent on puberty hormones, i.e. height and BMD. Height growth continued for those not yet at final height, but more slowly than for their peers so height z-score fell. Similarly for bone strength, BMD and BMC increased in the lumbar spine indicating greater bone strength, but more slowly than in peers so BMD z-score fell."**
  - **Self-harm did not improve and "no changes in psychological function," meaning no improvement. (Also, "YSR [Youth Self Report] data at 36 months (n = 6) were not analysed.")**
    - **"We found no differences between baseline and later outcomes for overall psychological distress as rated by parents and young people, nor for self-harm."**
    - **"We found no evidence of change in psychological function with GnRHa treatment as indicated by parent report (CBCL) or self-report (YSR) of overall problems, internalising or externalising problems or self-harm. This is in contrast to the Dutch study which reported improved psychological function across total problems, externalising and internalising scores for both CBCL and YSR and small improvements in CGAS."**

P.15.C. "The June 2 Report mistakenly claims that puberty blockers and hormones are experimental because they are used "off-label" and not approved by the FDA." That is a companion argument against PBs. Note that the off-label uses of other meds they cite rarely involves chemical sterilization, permanent sexual function deficit of otherwise healthy bodies.
PB use is considered experimental because of the dearth of evidence, noted repeatedly in the literature and, again, noted by several N. European nations.

P.16.D. Low rates of regret. Classic error.
"Studies and surveys commonly cited to prove that regret after transition (GAT) for gender dysphoria is exceedingly rare remarkably often demonstrate the same fatal flaws:

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[19] Polly Carmichael, Gary Butler, et al.. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK.
medRxiv 2020.12.01.20241653; doi:https://doi.org/10.1101/2020.12.01.20241653

- **Impressively high rates of loss to follow up, from over 20% to over 60%, which invalidate the findings.[20] Were those lost patients helped, hurt, or even still alive?[21]**
- **Exceedingly strict definitions for regret.**
- **Insufficient periods of follow up, usually only 6 months to 2 years post-transition, despite the existing evidence that post-surgical regret is known to manifest 8 years or so post-transition.[22] [23]**
- **Sampling usually taken from gender clinics, to which those with regret repeatedly report they do not return. Dr. Littman's 2021 survey of 100 detransitioners found that only 24% had informed their clinician of their detransition, thus 76% did not.[24]**
- **Data is gleaned from in house satisfaction surveys lacking clear and uniform definitions, metrics, and follow up. This low-quality data then gets pooled to create low quality, unreliable results."**

Source: Andre Van Mol, "Regretting Transition for Gender Dysphoria" CMDA 'The Point" blog, June 23, 2022. https://cmda.org/regretting-transition-for-gender-dysphoria/

Entwistle K. Debate: Reality check - Detransitioner's testimonies require us to rethink gender dysphoria. *Child Adolesc Ment Health*. **2021;26(1):15-16. doi:10.1111/camh.12380**

P.17. E. "The June 2 Report repeats discredited claims that "social contagion" is leading teens to become transgender. Scientific evidence refutes this claim, which is based on a single, discredited study whose results have not been replicated by more rigorous studies."

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[20] D'Angelo, R., Syrulnik, E., Ayad, S. *et al.* **One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria.** *Arch Sex Behav* **(2020). https://doi.org/10.1007/s10508-020-01844-2**
Citing: D'Angelo R. Psychiatry's ethical involvement in gender-affirming care. *Australasian Psychiatry*. **2018;26(5):460-463. doi:10.1177/1039856218775216**
[21] D'Angelo R. Psychiatry's ethical involvement in gender-affirming care. *Australasian Psychiatry*. **2018;26(5):460-463. doi:10.1177/1039856218775216**
[22] Dhejne C, Öberg K, Arver S, et al. An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: prevalence, incidence, and regrets. Arch Sex Behav. 2014;43:1535–1545.
[23] Wiepjes CM, Nota NM, de Blok CJM, et al. The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. J Sex Med. 2018;15:582–590.
[24] Littman, L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Arch Sex Behav* **50, 3353–3369 (2021). https://doi.org/10.1007/s10508-021-02163-w**

They are referring to Littman's ROGD parent survey. "A single study" is a confession the professional literature on the subject is deficient. "Discredited" means they were offended by it.

- Dr. Littman: **With exposure "Within friendship groups**, the average number of individuals who became transgender-identified was **3.5 per group.**" (citation below)
- "However, it is plausible that the following can be initiated, magnified, spread, and maintained via the mechanisms of social and peer contagion: (1) the belief that non-specific symptoms (including the symptoms associated with trauma, symptoms of psychiatric problems, and symptoms that are part of normal puberty) should be perceived as gender dysphoria and their presence as proof of being transgender; 2) the belief that the only path to happiness is transition; and 3) the belief that anyone who disagrees with the self-assessment of being transgender or the plan for transition is transphobic, abusive, and should be cut out of one's life." -- Littman.[25]
- **Dr. Lisa Littman**: "In other words, "**gender dysphoria**" may be used as a **catch-all explanation** for any kind of distress, psychological pain, and discomfort that an AYA is feeling while **transition** is being promoted as a **cure-all solution**." [26]

Here is another way of saying the literature on the subject is deficient.
Swedish Agency for Health Technology Assessment and Assessment of Social Services' 2019 literature review: "Gender dysphoria in children and adolescents: an inventory of the literature" (commissioned by the Swedish government).
https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/
"Conclusions

- We have not found any scientific studies which explains the increase in incidence in children and adolescents who seek the heath care because of gender dysphoria.

Neither disproves the very obvious social contagion element noted consistently by regretters and detransitioners. The literature will catch up.

P.19. G. "The June 2 Report speculates, without evidence, that psychotherapy alone is as effective as medical treatment for gender dysphoria. This claim contradicts the findings of solid scientific studies."
Again, please see the details of documents from UK, Sweden, Finland, and how explicit they are on the necessity of psychotherapy first and foremost in treatment of GD.
Miriam will have strong contribution here as well.

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[25] **Littman, L. "Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports," journals.plos.org, Aug. 16, 2018. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330.**
[26] **Littman, L. "Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports," journals.plos.org, Aug. 16, 2018. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330.**

Endocrine Society 2017 guidelines, which are pro-GAT, state that psychological intervention is all that is needed in some forms of gender dysphoria." "In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient."

> Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism* 2017; **102**(11): 3869-903.

Dr. **Kenneth Zucker**, long acknowledged as one of the foremost authorities on gender dysphoria in children, spent years helping his patients align their subjective gender identity with their objective biological sex. He **used psychosocial treatments (talk therapy, family counseling, etc.) to treat gender dysphoria and had much success.**

> (Kenneth J. Zucker et al., *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*, 59 J. of Homosexuality 369-97 (2012).)

Note also in the UK Tavistock Gender Identity Development Service (GIDS) Controversy.

- **35 psychologists resigned over 3 years.** [27]
  - Over-prescribing medicalization of kids with GD "with psychologists unable to properly assess patients over fears they will be branded 'transphobic…'"
  - "we fear that we have had front row seats to a medical scandal."

Even for adults: **"GD can remit in some [adult]cases** (Marks et al. 2000); **perhaps psychotherapy could facilitate such remission** – or a reduction in GD symptoms… in some subset of the diverse group of adults [who meet the diagnosis of] GD."
…"**Unfortunately, these possibilities have not yet been investigated, and such investigations are strongly discouraged in the SOC – 7**."

> Zucker KJ, Lawrence AA, Kreukels BP, Gender Dysphoria in Adults, Annual Rev of Clinical Psych, 2016. 12:20.1-20.31, p. 21.
> Citing:
> Marks I, Green R, Mataix-Cols D. Adult gender identity disorder can remit. *Comprehensive Psychiatry* 2000; **41**(4): 273-5.

"Since the widespread adoption of interventional strategies directed toward affirming transgender identity, **efforts to identify psychological approaches to mitigate dysphoria,** with or without desistance as a desired goal, **have largely been abandoned**."

> Hruz, P. W. (2020). Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *The Linacre Quarterly*, *87*(1), 34–42. https://doi.org/10.1177/0024363919873762

So that's what I have on the main body of the letter. I think attorneys, you all, will have little trouble dissection such letters as they step all over themselves, come across as condescending

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[27] **"NHS 'over-diagnosing' children having transgender treatment, former staff warn," news.sky.com, 12 Dec. 2019. https://news.sky.com/story/nhs-over-diagnosing-children-having-transgender-treatment-former-staff-warn-11875624**

and dismissive (just like they treat dissenting or questioning parents of kids with GD), and set themselves up to be exposed for inconsistency, contradiction, projection, and a remarkably refractory blindness to what is happening in northern Europe. And should it come up, northern Europe doing a U-turn on GAT cannot remotely be blamed on the influence of political conservatives or the religious right, now can it?

Andre Van Mol, MD