(3) The affirmation therapy model (model #4)

45. While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be immediately accepted as decisive, and thoroughly affirmed by means of consistent use of clothing, toys, pronouns, etc., associated with the transgender identity to which the child expresses an attraction. These advocates treat any question about the causes of the child's transgender identification as inappropriate and assume that observed psychological co-morbidities in the children or their families are unrelated or will get better with transition and need not be addressed by the MHP who is providing supportive guidance concerning the child's gender identity.

46. Some advocates, indeed, assert that unquestioning affirmation of any claim of transgender identity in children is essential, and that the child will otherwise face a high risk of suicide or severe psychological damage. I address claims about suicide and health outcomes in Sections IV and V below.

47. The idea that social transition is the only accepted treatment for prepubertal children is not correct. On the contrary, one respected academic in the field has recently written that "almost all clinics and professional associations in the world" do not use "gender affirmation" for prepubescent children and instead "delay any transitions after the onset of puberty."[19] This approach is widely

[19] J. Cantor (2020), *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX & MARITAL THERAPY VOL. 46, NO. 4, 307-313.

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practiced because when the intrapsychic, biological, and social developmental processes of puberty are allowed to act unimpaired (but accompanied by supporting therapy), resolution of the gender dysphoria is by far the most common outcome.[20] Natural desistance offers a reasonable likelihood of sparing the individual the life-long physical, mental, and social stresses associated with living in a transgender identity, which I discuss in Section V.

48. It is notable that even the Standards of Care published by WPATH, an organization which in general leans strongly towards affirmation in the case of adults, do not specify affirmation of transgender identity as the indicated therapeutic response for young children. Instead, the WPATH Standards of Care recognize that social transition in early childhood "is a controversial issue, and divergent views are held by health professionals"; state that "[t]he current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood"; and acknowledge that "previously described relatively low persistence rates of childhood gender dysphoria" are "relevant" to the wisdom of social transition in childhood.[21]

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[20] D. Singh et al. (2021), *A Follow-Up Study of Boys With Gender Identity Disorder*, FRONTIERS IN PSYCHIATRY Vol. 12:632784 at 12 (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8039393/.)

[21] WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH (2011), *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (7th Version) at 17. I note that I regretfully resigned from the precursor organization of WPATH in 2002 after concluding that many of its positions of enthusiastic and unqualified support of transition for individuals suffering from gender dysphoria were dictated by politics and ideology, rather than by any scientific basis. WPATH is composed of a mix of practitioners and transgender activists with little or no scientific training, and its most recent self-designated "Standards of Care" are not reflective of the practices of a large number of psychiatrists and Ph.D. psychologists who practice in this area. For this reason, WPATH's cautious position with regard to transition of children who suffer from gender dysphoria is all the more notable.

49. In contrast to WPATH's cautious position with respect to children, in 2018 the American Academy of Pediatrics issued a statement asserting that "gender transition" "is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria."[22] But in a peer-reviewed paper, based on a careful review of the sources cited in the AAP statement, prominent researcher James Cantor concluded that "In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all," and described Rafferty 2018 as "a systematic exclusion and misrepresentation of entire literatures." (Cantor at 312.) Based on my professional expertise and my review of the literature, I agree with Dr. Cantor's evaluation of Rafferty 2018.

50. In fact, the DSM-5 added—for both children and adolescents—a requirement that a sense of incongruence between biological and felt gender must last at least six months as a precondition for a diagnosis of gender dysphoria, precisely because of the risk of "transitory" symptoms and "hasty" diagnosis that might lead to "inappropriate" treatments.[23]

51. I do not know what proportion of practitioners are using which model. However, in my opinion, in the case of young children, prompt and thorough

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[22] J. Rafferty (2018), *Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness*, PEDIATRICS 142(4): 2018-2162.

[23] K. Zucker (2015), *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. Trombetta et al. (eds.), MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH (Springer-Verlag Italia).

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affirmation of a transgender identity disregards the principles of child development and family dynamics and is not supported by science. Rather, the MHP must focus attention on the child's underlying internal and familial issues. Ongoing relationships between the MHP and the parents, and the MHP and the child, are vital to help the parents, child, other family members, and the MHP to understand over time the issues that need to be dealt with over time by each of them.

52. Likewise, since the child's sense of gender develops in interaction with his parents and their own gender roles and relationships, the responsible MHP will almost certainly need to delve into family and marital dynamics.

F. Patients differ widely and must be considered individually.

53. In my opinion, it is not possible to make a single, categorical statement about the proper treatment of children or adolescents presenting with gender dysphoria or other gender-related issues. There is no single pathway of development and outcomes governing transgender identity, nor one that predominates over the large majority of cases. Instead, as individuals grow up and age, depending on their differing psychological, social, familial, and life experiences, their outcomes differ widely.

54. As to causes in children and adolescents, details about the onset of gender dysphoria may be found in an understanding of family relationship dynamics. In particular, the relationship between the parents and each of the parents and the child, and each of the siblings and the child, should be well known by the MHP. Further, a disturbingly large proportion of children and adolescents who seek professional care in connection with gender issues have a wider history of

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psychiatric co-morbidities. (*See supra* n. 12.) A 2017 study from the Boston Children's Hospital Gender Management Service program reported that: "Consistent with the data reported from other sites, this investigation documented that 43.3% of patients presenting for services had significant psychiatric history, with 37.1% having been prescribed psychotropic medications, 20.6% with a history of self-injurious behavior, 9.3% with a prior psychiatric hospitalization, and 9.3% with a history of suicide attempts." (Edwards-Leeper at 375.) It seems likely that an even higher proportion will have had prior undiagnosed psychiatric conditions.

55. In the case of adolescents, as I have noted above, there is evidence that peer social influences through "friend groups" (Littman) or through the internet can increase the incidence of gender dysphoria or claims of transgender identity, so the responsible MHP will want to probe these potential influences to better understand what is truly deeply tied to the psychology of this particular individual, and what may instead be "tried on" by the youth as part of the adolescent process of self-exploration and self-definition.

III. GENDER IDENTITY, GENDER DYSPHORIA, AND THERAPIES FOR GENDER DYSPHORIA IN YOUNGER CHILDREN

A. Natural desistance is by far the most frequent resolution of gender dysphoria in young children absent social transition.

56. A distinctive and critical characteristic of juvenile gender dysphoria is that multiple studies from separate groups and at different times have reported that in the large majority of patients, absent a substantial intervention such as social transition and/or hormone therapy, the dysphoria does *not* persist through puberty. A recent article reviewed all existing follow-up studies that the author

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could identify of children diagnosed with gender dysphoria (11 studies) and reported that "every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition." (Cantor at 307.) Another author reviewed the existing studies and reported that in "prepubertal boys with gender discordance . . . the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance."[24] A third summarized the existing data as showing that "Symptoms of GID at prepubertal ages decrease or disappear in a considerable percentage of children (estimates range from 80-95%)."[25] As cited above, a 2021 extended follow-up of originally evaluated prepubertal boys found a persistence rate of only 12 percent. (Singh 2021.)

57. It is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist. (Levine, *Ethical Concerns*, at 9.)

58. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described "rapid onset gender disorder." I observe an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male gender identity at some

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[24] S. Adelson & American Academy of Child & Adolescent Psychiatry (2012), *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 51(9) 957 at 963 ("*Practice Parameter*").

[25] P. T. Cohen-Kettenis et al. (2008), *The Treatment of Adolescent Transsexuals: Changing Insights*, J. SEXUAL MED. 5(8) 1892 at 1895.

point during their teen years. However, data on outcomes for this age group with and without therapeutic interventions is not yet available to my knowledge.

B. Social transition of young children is a powerful psychotherapeutic intervention that changes outcomes.

59. In contrast, there is now data that suggests that a therapy that encourages social transition before or during puberty dramatically changes outcomes. A prominent group of authors has written that "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood," and "Youth with persistent TNG [transgender, nonbinary, or gender-nonconforming] identity into adulthood . . . are more likely to have experienced social transition, such as using a different name . . . which is stereotypically associated with another gender at some point during childhood."[26] Similarly, a comparison of recent and older studies suggests that when an "affirming" methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence—that is, achieved comfort identifying with their sex—instead persist in a transgender identity. (Zucker, *Myth of Persistence*, at 7).[27]

60. Indeed, a review of multiple studies of children treated for gender dysphoria across the last three decades found that early social transition to living as

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[26] C. Guss et al. (2015), *Transgender and gender nonconforming adolescent care: psychosocial and medical considerations*. CURR. OPIN. PEDIATR. 27(4):421 ("*TGN Adolescent Care*").

[27] One study found that social transition by the child was found to be strongly correlated with persistence for natal boys, but not for girls. (Zucker, *Myth of Persistence,* at 5 (citing T. D. Steensma, et al. (2013), *Factors Associated with Desistance & Persistence of Childhood Gender Dysphoria: A Qualitative Follow-up Study*, J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 52, 582.))

the opposite sex severely reduces the likelihood that the child will revert to identifying with the child's natal sex, at least in the case of boys. That is, while, as I review above, studies conducted before the widespread use of social transition for young children reported desistance rates in the range of 80-98%, a more recent study reported that fewer than 20% of boys who engaged in a partial or complete social transition before puberty had desisted when surveyed at age 15 or older. (Zucker, *Myth of Persistence*, at 7; Steensma (2013).)[28] Some vocal practitioners of prompt affirmation and social transition even claim that essentially *no* children who come to their clinics exhibiting gender dysphoria or cross-gender identification desist in that identification and return to a gender identity consistent with their biological sex. As one internationally prominent practitioner stated, "In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has 'desisted' and asked to return to his or her assigned gender."[29] Given the consensus that no method exists to reliably predict which children suffering from gender dysphoria will desist and which persist, and given the absence of any study demonstrating the validity of any such method, this is a disconcerting statement. Certainly, it reflects a very large change as compared to the desistance rates documented apart from social transition.

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[28] Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma (2013) at 584.

[29] D. Ehrensaft (2015), *Listening and Learning from Gender-Nonconforming Children,* THE PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34.

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61. Accordingly, I agree with noted researcher in the field Ken Zucker, who has written that social transition in children must be considered "a form of psychosocial treatment." (Zucker, *Debate,* at 1.)

62. I also agree with Dr. Zucker's further observation that "...we cannot rule out the possibility that early successful treatment of childhood GID [Gender Identity Disorder] will diminish the role of a continuation of GID into adulthood. If so, successful treatment would also reduce the need for the long and difficult process of sex reassignment which includes hormonal and surgical procedures with substantial medical risks and complications."[30]

63. By the same token, a therapeutic methodology for children that *increases* the likelihood that the child will continue to identify as the opposite gender into adulthood will *increase* the need for the long and potentially problematic processes of hormonal and genital and cosmetic surgical procedures.

64. Given these facts, it is the cross-gender affirming methods endorsed by gender identity advocates that are changing the identity outcomes that would otherwise naturally result for the large majority of prepubertal children who suffer from gender dysphoria. It is thus these methods that could most properly be described as "conversion therapy." By contrast, the watchful waiting approach which monitors the child's mental health while working to resolve co-morbidities and reduce life stress, and while allowing time for the natural psychosocial

[30] Zucker, *Myth of Persistence*, at 8 (citing H. Meyer-Bahlburg (2002), *Gender Identity Disorder in Young Boys: A Parent- & Peer-Based Treatment Protocol*, CLINICAL CHILD PSYCHOLOGY & PSYCHIATRY 7, 360 at 362.)

developmental processes of adolescence to shape the child's identity, is properly seen as the far less invasive therapeutic approach.

65. Not surprisingly, given these facts, encouraging social transition in children remains controversial. Supporters of such transition acknowledge that "Controversies among providers in the mental health and medical fields are abundant. . . . These include differing assumptions regarding . . . the age at which children . . . should be encouraged or permitted to socially transition . . . . These are complex and providers in the field continue to be at odds in their efforts to work in the best interests of the youth they serve."[31]

66. In sum, therapy for young children that encourages transition (including use of names, pronouns, clothing, and restrooms associated with the opposite sex) cannot be considered to be neutral, but instead is an experimental procedure that has a high likelihood of changing the life path of the child, with highly unpredictable effects on mental and physical health, suicidality, and life expectancy. Claims that a civil right is at stake do not change the fact that what is proposed is a social and medical experiment. (Levine, *Reflections,* at 241.) Ethically, then, it should be undertaken only subject to standards, protocols, and reviews appropriate to such experimentation. In my judgment, many gender clinics today are encouraging and assisting children to transition without following these ethically required procedures.

[31] A. Tishelman et al. (2015), *Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples*, PROF. PSYCHOL. RES. PR. at 11 ("*Serving TG Youth*") (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4719579/pdf/nihms706503.pdf).

67. Moreover, it is not clear how these clinics could create a legal, ethical, and practical informed consent process. Parents would need to understand the risks and benefits of the recommended therapy and of alternative approaches, and to grapple with the scientific deficiencies in this arena, including: the absence of randomized controlled studies, the absence of long follow-up studies of previous children who have undergone these interventions, and the rates of success and failure of the intervention. And it is a difficult question when either minors or parents can ethically (and perhaps legally) grant consent to a medical or therapeutic pathway that carries a high probability of leading to prescription of potentially sterilizing drugs while the child is still a minor. In every case, the professional has an ethical obligation to ensure that meaningful and legal informed consent is obtained.

C. The administration of puberty blockers to children as a treatment for gender dysphoria is experimental, presents obvious medical risks, and appears to affect identity outcomes.

68. Gender clinics are increasingly prescribing puberty blockers for children as young as ten, as a component of a regime that commonly includes social transition. Puberty blockers are often described as merely providing a completely reversible "pause," which supposedly gives the child additional time to determine his or her gender identity while avoiding distress which would be caused by pubertal development of the body consistent with the child's biological sex. The language used about puberty blockers often states or implies that this major hormonal disruption of some of the most basic aspects of ordinary human development is a small thing, and entirely benign.

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69. In fact, it is important to recognize that the available (limited) evidence suggests that clinically, puberty blockers administered to children at these ages, for this purpose, and in conjunction with social transition, do not operate as a "pause." After reviewing the evidence provided by experts from different perspectives, including an expert declaration that I submitted, the U.K. High Court recently concluded that "the vast majority of children who take [puberty blockers] move on to take cross-sex hormones," and thus that puberty blockers in practice act as a "stepping stone to cross-sex hormones."[32] In my opinion, this finding accurately summarizes the available data.

70. It is equally important to recognize that administration of puberty blockers as a treatment for gender dysphoria is an off-label use of these powerful drugs which is entirely experimental. This application can by no means be considered equivalent to the only application for which puberty blockers have been tested for efficacy and safety and approved—which is for the delay of precocious puberty until the normal time for pubertal development. The U. K. High Court panel accurately summarized the science when they described the use of puberty blockers as "experimental" and as putting children on a "clinical pathway" which is a "lifelong and life changing treatment . . . with very limited knowledge of the degree to which it will or will not benefit them." (*Tavistock*, ¶¶136, 143.)

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[32] Opinion of the United Kingdom High Court of Justice Administrative Court, Divisional Court (December 1, 2020), in *Bell and A. v. Tavistock and Portman NHS Trust and Others*, Case No: CO/60/2020, at ¶¶136-137 (available at https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf.)

71. This is a very profound experiment being conducted on children. It is well known that the hormonal changes associated with ordinary puberty drive not only the obvious physical and sexual changes in the adolescent, but also drive important steps in cognitive development—that is, in brain functioning—as well as increases in bone density. As the bodies and interests of peers change, the trans adolescent who—as a result of puberty blockade hormones— maintains a puerile appearance and development, risks isolation and social anxiety. This risk is not given adequate weight when the treatment is justified as creating merely a useful pause.

72. We simply do not have meaningful data concerning the long-term effects on brain, bone, and other organs of interrupting or preventing this natural developmental process between the ages of 10 and 16. Psychology likewise does not know the long-term effects on coping skills, interpersonal comfort, and intimate relationships of pubertal blockade and, as it were, standing on the sideline in the years when one's peers are undergoing their maturational gains in these vital arenas of future mental health.

73. A number of recent papers have claimed to report beneficent or at least neutral short-term effects of use of puberty blockers. None of these even purports to address long-term effects as the subjects mature into adulthood, and even as to short-term effects these studies suffer from methodological deficiencies that prevent them from supporting such conclusions. Recently, the British National Health Service commissioned the respected National Institute for Health and Care

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Excellence (NICE) to conduct a thorough evidence review of all available studies that touch on the efficacy and safety of use of puberty blockers for children with gender dysphoria. The exhaustive, 130-page results of this review were published in October 2020. While of course this report provides extensive detail, its overall summary was that, according to widely accepted criteria for measuring the reliability of clinical evidence, "The quality of evidence for [all claims concerning safety and efficacy of this use of puberty blockers] was assessed as very low certainty."[33] They found that "the studies all lack appropriate controls" and "were not reliable," that "the studies that reported safety outcomes provided very low certainty evidence," and that studies that claimed marginally positive outcomes "could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding bias or chance." (NICE at 13.)

74. So far as I am aware, no study yet reveals whether the life-course mental and physical health outcomes for the relatively new class of "persisters" (that is, those who would have desisted absent a transgender-affirming social and/or pharmaceutical intervention, but instead persisted as a result of such interventions) are more similar to those of the general non-transgender population, or to the notably worse outcomes exhibited by the transgender population generally.

[33] NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (2020), Evidence review: Gonadotrophin releasing hormone analogues for children and adolescence with gender dysphoria (available at https://arms.nice.org.uk/resources/hub/1070905/attachment.)

75. Taking into account the risks, the lack of any reliable evidence concerning long-term outcomes from the use of puberty blockers, and the inability of pre-adolescents and even adolescents to comprehend the physical, relational, and emotional significance of life as a sexually mature adult, I also agree with the conclusion of the U. K. High Court that "it is highly unlikely that a child age 13 or under would ever be . . . competent to give consent to being treated with [puberty blockers]," and that it is "very doubtful" that a child of 14 or 15 "could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent." (*Tavistock*, ¶ 145.)

IV. THE AVAILABLE DATA DOES NOT SUPPORT THE CONTENTION THAT "AFFIRMATION" OF TRANSGENDER IDENTITY IN CHILDREN AND ADOLESCENTS REDUCES SUICIDE OR RESULTS IN BETTER PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY.

76. I am aware that organizations including The Academy of Pediatrics and Parents and Friends of Lesbians and Gays (PFLAG) have published statements that suggest that all children who express a desire for a transgender identity should be promptly supported in that claimed identity. Recently, the governing counsel of the American Psychological Association adopted the *APA Resolution on Gender Identity Change Efforts*, which broadly (and wrongly) categorizes any approach to gender dysphoria other than gender affirming methods as unethical and dangerous. These positions appear to rest on the belief—which is widely promulgated by certain advocacy organizations—that science has already established that prompt "affirmance" is best for all patients, including all children and adolescents, who

present indicia of transgender identity.[34] As I have discussed above and further discuss later below, this belief is scientifically incorrect, and ignores both what is known and what is unknown.

77. The knowledge base concerning the causes and treatment of gender dysphoria has low scientific quality.

78. In evaluating claims of scientific or medical knowledge, it is important to understand that it is axiomatic in science that no knowledge is absolute, and to recognize the widely-accepted hierarchy of reliability when it comes to "knowledge" about medical or psychiatric phenomena and treatments. Unfortunately, in this field opinion is too often confused with knowledge, rather than clearly locating what exactly is scientifically known. In order of increasing confidence, such "knowledge" may be based upon data comprising:

a. Expert opinion—it is perhaps surprising to educated laypersons that expert opinion standing alone is the lowest form of knowledge, the least likely to be proven correct in the future, and therefore does not garner as much respect from professionals as what follows;

b. A single case or series of cases (what could be called anecdotal evidence) (Levine, *Reflections*, at 239.);

c. A series of cases with a control group;

d. A cohort study;

[34] The APA Resolution on Gender Identity Change Efforts (APA GICE Resolution) is available at https://www.apa.org/about/policy/ resolution-gender-identity-change-efforts.pdf.

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e. A randomized double-blind clinical trial;

f. A review of multiple trials;

g. A meta-analysis of multiple trials that maximizes the number of patients treated despite their methodological differences to detect trends from larger data sets.

79. The strongest forms of scientific knowledge emerge from the latter three types of research—randomized, blind trials; reviews of multiple randomized, blind trials, and meta-analyses. When the APA Task Force on Promotion and Dissemination of Psychological Procedures considered what criteria would empirically validate a treatment, the task force relied heavily on whether a procedure had been "tested in randomized controlled trials (RCT) with a specific population and implemented using a treatment manual."[35] Social affirmation of children, use of puberty blockers as a treatment for gender dysphoria, and administration of cross-sex hormones to adolescents, have never been clinically tested and validated in this way.

80. Critically, "there are no randomized control trials with regard to treatment of children with gender dysphoria." (Zucker, *Myth of Persistence,* at 8.) On numerous critical questions relating to cause, developmental path if untreated, and the effect of alternative treatments, the knowledge base remains primarily at the level of the practitioner's exposure to individual cases, or multiple individual

[35] Am. Psych. Assoc'n (2006), *Evidence-Based Practice in Psychology*, AM. PSYCHOLOGIST, Vol. 61, No. 4, 271 at 272.

cases. As a result, claims to certainty are not justifiable. (Levine, *Reflections*, at 239.)

81. Unfortunately, advocates of unquestioning affirmation further complicate efforts to understand the available science by speaking indistinctly, ignoring differences between approaches that are likely to be clinically important. For example, the recent APA resolution speaks of "individuals who have experienced pressure or coercion to conform to their sex assigned at birth." (APA GICE at 1.) "Pressure or coercion" does not describe either the "watchful waiting" or psychotherapy models I have described above, nor therapy structured around a patient's own desire to become comfortable with his or her natal sex. Nor is it possible to extrapolate from outcomes experienced by those who have been subjected to "coercive" techniques to predict outcomes for patients who receive responsible "watchful waiting" or psychotherapeutic care as I have described and as many experienced practitioners practice.

82. Unsurprisingly, prominent voices in the field have emphasized the severe lack of scientific knowledge in this field. The American Academy of Child and Adolescent Psychiatry has recognized that "Different clinical approaches have been advocated for childhood gender discordance. . . . There have been no randomized controlled trials of any treatment. . . . [T]he proposed benefits of treatment to eliminate gender discordance … must be carefully weighed against … possible deleterious effects." (Adelson et al., *Practice Parameter,* at 968–69.) Similarly, the APA has stated, "because no approach to working with [transgender and gender

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nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children."[36]

83. Contrary to the impression that statements in the recent APA GICE Resolution might leave, recent published research has not changed this situation. It remains the case that no randomized controlled trials of any treatment for gender dysphoria have been conducted, and recently published studies suffer from other serious methodological defects as well.

84. For example, the APA GICE Resolution cites Turban et al. (2020), *Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults*,[37] ("*Association*"), and this article has been cited to support claims that failing to affirm a transgender identity in children presenting with gender dysphoria results in a higher risk of their attempting suicide.

85. But the sample and methodology of Turban, *Association* (2020) are profoundly flawed and cannot support such a conclusion. A group of researchers has published a detailed critique of these defects,[38] which I will not attempt to replicate here. To highlight the most obvious defects, however, *Association* (2020) relied entirely on data drawn from an online convenience sampling of transgender-identified and genderqueer adults recruited from trans-affirming websites. It is well

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[36] Am. Psych. Assoc'n (2015), *Guidelines for Psychological Practice with Transgender & Gender Nonconforming People*, AM. PSYCHOLOGIST 70(9) 832 at 842.

[37] 77 JAMA PSYCHIATRY 77(1) 68-76.

[38] R. D'Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria* (2021), ARCH. SEX BEHAV. 50, 7-16.

known that one "cannot make statistical generalizations from research that relies on convenience sampling."[39] Nor did the authors of *Association* (2020) control for the subjects' mental health status prior to the reported exposure to what the study deemed a "gender identity change effort." I agree with D'Angelo et al. (2021) that "failure to control for the subjects' baseline mental health makes it impossible to determine whether the mental health or the suicidality of subjects worsened, stayed the same, or potentially even improved after the non-affirming encounter." (D'Angelo (2021) at 10.)

86. Looking at the literature in this area more broadly, a review of 28 studies of outcomes from hormonal therapy in connection with sex reassignment reported that these studies provided only "very low quality evidence" for a variety of reasons.[40] Large gaps exist in the medical community's knowledge regarding the long-term effects of sex-reassignment surgery (SRS) and other gender identity disorder treatments in relation to their positive or negative correlation to suicidal ideation, attempts, and completion.

87. What is known is not encouraging. With respect to suicide, individuals with gender dysphoria are well known to commit suicide or otherwise suffer increased mortality before and after not only social transition, but also before and

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[39] *Handbook of Survey Methodology for the Social Sciences* (2021) (Lior Gideon, ed. Springer).

[40] H. Murad et al. (2010), *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes.* CLINICAL ENDOCRINOLOGY; 72(2): 214-231. See also R. D'Angelo (2018), *Psychiatry's ethical involvement in gender-affirming care*, AUSTRALASIAN PSYCHIATRY Vol 26(5) 460-463, noting the large number of non-responders in follow-up outcome studies, and observing that "it is generally not known whether they are alive or dead," and that "it is . . . pure speculation to assume that none committed suicide."

after SRS. (Levine, *Reflections,* at 242.) For example, in the United States, the death rates of trans veterans are comparable to those with schizophrenia and bipolar diagnoses—20 years earlier than expected. These crude death rates include significantly elevated suicide rates. (Levine, *Ethical Concerns,* at 10.) Similarly, researchers in Sweden and Denmark have reported on almost all individuals who underwent sex-reassignment surgery over a 30-year period.[41] The Swedish follow-up study found a suicide rate in the post-SRS population 19.1 times greater than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions. (Levine, *Ethical Concerns,* at 10.)

88. Advocates of immediate and unquestioning affirmation of social transition in children who indicate a desire for a transgender identity sometimes assert that any other course will result in a high risk of suicide in the affected children and young people. Contrary to these assertions, no studies show that affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-term outcomes, as compared to either a "watchful waiting" or a psychotherapeutic model of response, as I have described above.[42]

89. In considering "suicide," mental health professionals distinguish between suicidal thoughts (ideation), suicide gestures, suicide attempts with a

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[41] C. Dhejne et al. (2011), *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS ONE 6(2) e16885 ("*Long Term*"); R. K. Simonsen et al. (2016), *Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality*, NORDIC J. OF PSYCHIATRY 70(4):241-7

[42] A recent article, J. Turban et al. (2020), *Puberty Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS 145(2), has been described in press reports as demonstrating that administration of puberty-suppressing hormones to transgender adolescents reduces suicide or suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.

lethal potential, and completed suicide. Numerous studies have found suicidal ideation to have been present at some time in life in ~40-50% of trans-identifying persons. This figure is approximately twice that reported in gay and lesbian communities. In the heteronormative communities, ideation is approximately 4%. Mental health professionals distinguish clearly between gestures and potentially lethal attempts, which often result in hospitalization.

90. I will also note that any discussion of suicide when considering younger children involves very long-range and very uncertain prediction. Suicide in pre-pubescent children is rare and the existing studies of gender identity issues in pre-pubescent children do not report significant incidents of suicide. The estimated suicide rate of trans adolescents is the same as teenagers who are in treatment for serious mental illness. What trans teenagers do demonstrate is more suicidal ideation and attempts (however serious) than other teenagers.[43] Their completed suicide rates are not known.

91. In sum, claims that affirmation will reduce the risk of suicide for children are not based on science. Such claims overlook the lack of even short-term supporting data as well as the lack of studies of long-term outcomes resulting from the affirmation or lack of affirmation of transgender identity in children. They also overlook the other tools that the profession does have for addressing depression and

[43] A. Perez-Brumer, et al. (2017), *Prevalence & Correlates of Suicidal Ideation Among Transgender Youth in Cal.: Findings from a Representative, Population-Based Sample of High Sch. Students*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 56(9) at 739.

suicidal thoughts in a patient once that risk is identified. (Levine, *Reflections*, at 242.)

92. A number of data sets have also indicated significant concerns about wider indicators of physical and mental health, including ongoing functional limitations;[44] substance abuse, depression, and psychiatric hospitalizations;[45] and increased cardiovascular disease, cancer, asthma, and COPD.[46] Worldwide estimates of HIV infection among transgendered individuals are up to 17-fold higher than the cisgender population. (Levine, *Informed Consent,* at 6.)

93. Meanwhile, no studies show that affirmation of pre-pubescent children or adolescents leads to more positive outcomes (mental, physical, social, or romantic) by, e.g., age 25 or older than does "watchful waiting" or ordinary therapy. Because affirmation and social transition for children and adolescents, and the use of puberty blockers for transgender children, are a recent phenomenon, it could hardly be otherwise.

94. Given what is known and what is not known about the incidence and causes of suicide attempts and suicide in children and adolescents who suffer from gender dysphoria, and what is known about the incidence of suicide attempts and suicide in individuals who have transitioned to live in a transgender identity, it is in

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[44] G. Zeluf, et al. (2016), *Health, Disability and Quality of Life Among Trans People in Sweden—A Web-Based Survey*, BMC PUBLIC HEALTH 16, 903.

[45] C. Dhejne, et al. (2016), *Mental Health & Gender Dysphoria: A Review of the Literature*, INT'L REV. OF PSYCHIATRY 28(1) 44.

[46] C. Dragon, et al. (2017), *Transgender Medicare Beneficiaries & Chronic Conditions: Exploring Fee-for-Service Claims Data*, LGBT HEALTH 4(6) 404.

my view unethical for a mental health professional to tell a young patient, or the parents of a young patient, that social transition, puberty blockers, or use of cross-sex hormones will reduce the likelihood that the young person will commit suicide.

95. Instead, transition of any sort must be justified, if at all, as a life-enhancing measure, not a lifesaving measure. (Levine, *Reflections,* at 242.) In my opinion, this is an important fact that patients, parents, and even many MHPs fail to understand.

V. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT ON MOVING QUICKLY TO "AFFIRM" TRANSGENDER IDENTITY IN CHILDREN AND ADOLESCENTS.

96. As I have detailed above, enabling and affirming social transition in a prepubescent child appears to be highly likely to increase the odds that the child will in time pursue pubertal suppression and persist in a transgender identity into adulthood. This means that the MHP, patient, and in the case of minors, parents must consider long-term as well as short-term implications of life as a transgender individual when deciding whether to permit or encourage a child to socially transition.

97. Indeed, given the very high rates of children who desist from desiring a trans identity through the course of uninterrupted puberty, it is efforts to "affirm" a sex-discordant gender identity in prepubescent children that should be understood as the therapeutic path that is most likely to "change" or "convert" the child's adult gender identification, diverting the child from his or her probable maturation away from trans-identification.

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98. The APA and other gender identity advocates argue that gender affirmation practices are safe and effective. (APA GICE Resolution at 3.) But if we consider the long term—a life course perspective— a great deal of data point in the opposite direction. The multiple studies from different nations (including societies which pride themselves on being actively inclusive of sexual minorities, such as Sweden and Denmark) that have documented the increased vulnerability of the adult transgender population to substance abuse, mood and anxiety disorders, suicidal ideation, and other health problems warn us that assisting the child or adolescent down the road to becoming a transgender adult is a very serious decision, and stand as a reminder that a casual assumption that transition will improve the young person's life is not justified based on numerous scientific snapshots of cohorts of trans adults and teenagers. American public health professionals repeatedly have published descriptions of trans populations as marginalized and vulnerable to many adversities.[47]

99. The possibility that steps along this pathway, while lessening the pain of gender dysphoria, could lead to additional sources of crippling emotional and psychological pain, are too often not considered by advocates of social transition and not considered at all by the trans child. (Levine, *Reflections,* at 243.)

100. I detail below several classes of predictable, likely, or possible harms to the patient associated with transitioning to live as a transgender individual.

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[47] K. L. Ard, & A. S. Keuroghlian (2018), *Training in Sexual and Gender Minority Health - Expanding Education to Reach All Clinicians*. NEW ENGLAND J. OF MED, 379(25), 2388–2391; W. Liszewski et al. (2018), *Persons of Nonbinary Gender - Awareness, Visibility, and Health Disparities*. NEW ENGLAND J. OF MED., 379(25), 2391–2393.