



**Florida Boards of Medicine and Osteopathic Medicine
Joint Rules/Legislative Committee Rule Workshop**

**Hyatt Regency Orlando International Airport
9300 Jeff Fuqua Boulevard
Orlando, FL 32827
407-825-1234**

October 28, 2022

AGENDA

Participants in this public meeting should be aware that the proceedings are being recorded and that an audio file of the meeting will be posted to the Boards' websites.

Roll call will be at 8:00 a.m. or soon thereafter. The meeting will end no later than 1:00 p.m.

Rule Workshop:

Development of Rule Language..... 1

Rules 64B8-9.019 & 64B15-14.014, F.A.C. – Practice Standards for the Treatment of Gender Dysphoria

- **Roll call**
- **Opening Remarks and Administrative Matters**
- **Subject Matter Experts – Questions and Answers**
 - **Michael Biggs, PhD**
 - **Kristin Dayton, M.D.**
 - **Aron Janssen, M.D.**
 - **Riittakerttu Kaltiala, M.D.**
 - **Michael Laidlaw, M.D.**
 - **Meredithe McNamara, M.D.**
- **Discussion and Development of Rule Language**
- **Public Comments**
- **Closing Remarks and Administrative Matters**
- **Meeting Adjourns**

Notice of Meeting/Workshop Hearing

DEPARTMENT OF HEALTH BOARD OF MEDICINE

RULE NO.: RULE TITLE:
64B8-9.019 Practice Standards for the Treatment of Gender Dysphoria

The **Florida Boards of Medicine and Osteopathic Medicine Joint Rules/Legislative Committee** announce a workshop to which all persons are invited.

DATE AND TIME: Friday, October 28, 2022, 8:00 a.m. EDT and ending no later than 1:00 p.m. EDT

PLACE: Hyatt Regency Orlando International Airport, 9300 Jeff Fuqua Boulevard, Orlando, Florida 32827

GENERAL SUBJECT MATTER TO BE CONSIDERED: The Florida Boards of Medicine and Osteopathic Medicine Joint Rules/Legislative Committee will conduct a rule workshop and meeting to receive and consider presentations from subject matter experts and comments from the public, and to discuss and develop draft rule language related to practice standards for the treatment of gender dysphoria. A copy of the agenda may be obtained by contacting: Board of Medicine by email at BOM.MeetingMaterials@flhealth.gov or by calling the Board of Medicine at (850)245-4131. Written public comments should not be sent to this email address. Information regarding written public comment submissions is provided below.

Public comments presented at the workshop will be limited to no more than two hours in total. Any person who wants to make public comments must notify board staff in writing. Speaker cards will be available at the workshop for this purpose. Public comments will be limited to three minutes per person. This time will not include time spent by the public commenter responding to questions imposed by Committee members, staff, or board counsel. If a group or faction of persons consisting of five or more persons wishes to address the Committee, please identify one individual who will speak on behalf of the group. Public commenters may use pseudonyms if they do not wish to identify themselves on the record. All public comments received at the workshop will become part of the rulemaking record.

Written public comments may be submitted to the Committee between the publication of this notice until 24 hours following the conclusion of the workshop. The email address for such submissions is BOMPublicComment@flhealth.gov. All comments received at this email address, including the sender's email address, will become part of the rulemaking record and will be a public record.

Public participation is solicited without regard to race, color, national origin, age, sex, gender, religion, disability, or family status.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop is asked to advise the Committee at least seven days before the workshop by contacting the Board of Medicine by email at BOM.MeetingMaterials@flhealth.gov or by calling the Board of Medicine at (850)245-4131.

If you are hearing or speech impaired, please contact the Committee using the Florida Relay Service at 1(800)955-8771 (TDD) or (800) 955-8770 (Voice).

If any person decides to appeal any decision made by the Boards with respect to any matter considered at this meeting or hearing, they will need to ensure that a verbatim record of the proceeding is made, including the testimony and evidence from which the appeal is to be issued.

For more information, you may contact: Florida Board of Medicine by email at BOM.MeetingMaterials@flhealth.gov or by calling the Board at (850)245-4131.

Notice of Meeting/Workshop Hearing

DEPARTMENT OF HEALTH BOARD OF OSTEOPATHIC MEDICINE

RULE NO.: RULE TITLE:
64B15-14.014 Practice Standards for the Treatment of Gender Dysphoria

The **Florida Boards of Medicine and Osteopathic Medicine Joint Rules/Legislative Committee** announce a workshop to which all persons are invited.

DATE AND TIME: Friday, October 28, 2022, 8:00 a.m. EDT and ending no later than 1:00 p.m. EDT

PLACE: Hyatt Regency Orlando International Airport, 9300 Jeff Fuqua Boulevard, Orlando, Florida 32827

GENERAL SUBJECT MATTER TO BE CONSIDERED: The Florida Boards of Medicine and Osteopathic Medicine Joint Rules/Legislative Committee will conduct a rule workshop and meeting to receive and consider presentations from subject matter experts and comments from the public, and to discuss and develop draft rule language related to practice standards for the treatment of gender dysphoria. A copy of the agenda may be obtained by contacting: Board of Medicine by email at BOM.MeetingMaterials@flhealth.gov or by calling the Board of Medicine at (850)245-4131. Written public comments should not be sent to this email address. Information regarding written public comment submissions is provided below.

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Public participation is solicited without regard to race, color, national origin, age, sex, gender, religion, disability, or family status.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop is asked to advise the Committee at least seven days before the workshop by contacting the Board of Medicine by email at BOM.MeetingMaterials@flhealth.gov or by calling the Board of Medicine at (850)245-4131.

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For more information, you may contact: Florida Board of Medicine by email at BOM.MeetingMaterials@flhealth.gov or by calling the Board at (850)245-4131.

MICHAEL BIGGS

Employment

- 2006- Associate Professor (formerly Lecturer), Department of Sociology, University of Oxford; Fellow of St Cross College
- 2005-06 Lecturer, School of Sociology and Social Policy, Queen's University Belfast
- 2003-05 Assistant Professor, Department of Sociology, University of Illinois at Urbana-Champaign
- 2000-02 Junior Lecturer, Department of Sociology, University of Oxford

Education

- 2000 Doctor of Philosophy, Sociology, Harvard University: 'The Rise and Decline of a Mass Movement: American Workers and the Strike Wave of 1886' (Chair: Theda Skocpol)
- 1991 Bachelor of Arts—First Class Honours, History and Economic History, Victoria University of Wellington, New Zealand

Publications

- 'The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence', *Journal of Sex and Marital Therapy*, in press; DOI: 10.1080/0092623X.2022.2121238 (Stata program provided as DOI 10.7910/DVN/QPRCR1)
- 'Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom', *Archives of Sexual Behavior*, 2022; DOI 10.1007/s10508-022-02287-7 (supplement provides data)
- 'Queer Theory and the Transition from Sex to Gender in English Prisons', *Journal of Controversial Ideas*, vol. 2, 2022; DOI 10.35995/jci02010002
- 'Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria'. *Journal of Pediatric Endocrinology and Metabolism*, vol. 34, 2021, pp. 937–939; DOI 10.1515/jpem-2021-0180 (Stata program provided as DOI 10.7910/DVN/FSOMME)
- 'Gender Dysphoria and Psychological Functioning in Adolescents Treated with GnRHa: Comparing Dutch and English Prospective Studies', *Archives of Sexual Behavior*, vol. 49, 2020, pp. 2231–2236; DOI 10.1007/s10508-020-01764-1 (Stata program provided as DOI 10.7910/DVN/CB1IUH)
- 'Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria', *Archives of Sexual Behavior*, vol. 49, 2020, pp. 2227–29; DOI 10.1007/s10508-020-01743-6
- 'A Letter to the Editor Regarding the Original Article by Costa et al: Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria', *Journal of Sexual Medicine*, vol. 16, 2019, p. 2043; DOI 10.1016/j.jsxm.2019.09.002
- 'Britain's Experiment with Puberty Blockers', *Inventing Transgender Children and Young People*, ed. Michele Moore and Heather Brunskell-Evans, Newcastle: Cambridge Scholars Publishing, 2019, pp. 40–55

‘Did Local Civil Rights Protest Liberalize Whites’ Racial Attitudes?’ (with Christopher Barrie and Kenneth T. Andrews), *Research and Politics*, vol. 7, 2020, pp. 1–8; DOI 10.1177/2053168020914757 (data and Stata programs provided as DOI 10.7910/DVN/UIRLFC)

‘Size Matters: Quantifying Protest by Counting Participants’, *Sociological Methods and Research*, vol. 47, 2018, pp. 351–83; DOI 10.1177/0049124116629166 (supplement provides data and Stata programs)

(with Neil F. Ketchley) ‘The Educational Contexts of Islamist Activism: Elite Students and Religious Institutions in Egypt’, *Mobilization*, vol. 22, no. 1, 2017, pp. 57–76; DOI 10.17813/1086-671X-22-1-57

(with Juta Kawalerowicz) ‘Anarchy in the U.K.: Economic Deprivation, Social Disorganization, and Political Grievances in the London Riot of 2011’, *Social Forces*, vol. 94, no. 2, 2015, pp. 673–98; DOI 10.1093/sf/sov052

‘Protest Campaigns and Movement Success: Desegregating the U.S. South in the Early 1960s’ (with Kenneth T. Andrews), *American Sociological Review*, vol. 80, no. 2, 2015, pp. 416–43; DOI 10.1177/0003122415574328 (data provided as ICPSR 35630)

‘Has Protest Increased Since the 1970s? How a Survey Question Can Construct a Spurious Trend’, *British Journal of Sociology*, vol. 66, no. 1, 2015, pp. 141–62; DOI 10.1111/1468-4446.12099 (supplement provides data and Stata programs)

‘How Repertoires Evolve: The Diffusion of Suicide Protest in the Twentieth Century’, *Mobilization*, vol. 18, no. 4 (Frontiers in Social Movement Methodology), 2013, pp. 407–28

(with Raheel Dhattiwala) ‘The Political Logic of Ethnic Violence: The Anti-Muslim Pogrom in Gujarat, 2002’, *Politics and Society*, vol. 40, no. 4, 2012, pp. 481–514

‘Explaining Membership in the British National Party: A Multilevel Analysis of Contact and Threat’ (with Steven Knauss), *European Sociological Review*, vol. 28, no. 5, 2012, pp. 633–46

‘From Protest to Organization: The Impact of the 1960 Sit-Ins on Movement Organizations in the American South’ (with Kenneth T. Andrews), *The Diffusion of Social Movements: Actors, Frames, and Political Effects*, ed. Rebecca Kolins Givan, Sarah A. Soule, and Kenneth M. Roberts, Cambridge University Press, 2010, pp. 187–203 (data provided as ICPSR 35630)

‘Self-Fulfilling Prophecies’, *The Oxford Handbook of Analytical Sociology*, ed. Peter Bearman and Peter Hedström, Oxford University Press, 2009, pp. 294–314

‘Who Joined the Sit-ins and Why: Southern Black Students in the Early 1960s’, *Mobilization*, vol. 11, no. 3, 2006, pp. 241–56

(with Kenneth T. Andrews) ‘The Dynamics of Protest Diffusion: Movement Organizations, Social Networks, and News Media in the 1960 Sit-Ins’, *American Sociological Review*, vol. 71, no. 5, 2006, pp. 752–77 (data provided as ICPSR 35630)

‘Dying without Killing: Self-Immolations, 1963–2002’, *Making Sense of Suicide Missions*, ed. Diego Gambetta, Oxford University Press, 2005 (revised paperback ed. 2006), pp. 173–208, 320–24; Spanish translation: ‘Morir sin matar: las autoinmolaciones, 1963–2002’, *El sentido de las misiones suicidas*, Mexico City: Fondo de Cultura Económica, 2009

‘Strikes as Forest Fires: Chicago and Paris in the Late 19th Century’, *American Journal of Sociology*, vol. 110, no. 6, 2005, pp. 1684-1714

‘Positive Feedback in Collective Mobilization: The American Strike Wave of 1886’, *Theory and Society*, vol. 32, no. 2, 2003, pp. 217-54

‘Strikes as Sequences of Interaction: The American Strike Wave of 1886’, *Social Science History*, vol. 26, no. 3, 2002, pp. 583-617—awarded biennial prize for the best article by a graduate student published in *Social Science History*

‘Putting the State on the Map: Cartography, Territory, and European State Formation’, *Comparative Studies in Society and History*, vol. 41, no. 2, 1999, pp. 374-411

Under review

‘The Technology of Puberty Suppression’, *Sex and Gender Identity: A Reader*, ed. Alice Sullivan and Selina Todd, under contract with Routledge, manuscript submitted August 2022

‘How Protesting Depends on Peers: U.S. Students in the 1960s’, revise and resubmit

Conference presentations

Annual meeting of the American Sociological Association, 1995, 1997, 1999, 2002, 2003, 2005, 2006 (invited, thematic session), 2007, 2009, 2010 (presented by coauthor), 2011 (invited, thematic session), 2012 (presented by coauthor), 2013 (roundtable), 2016

Annual conference of the British Sociological Association, 2011, 2013, 2018

Annual meeting of the Social Science History Association, 1999, 2000, 2003, 2004 (also organized panel), 2013, 2016

1968-2018: Fifty Years After, Scuola Normale Superiore, Florence, 2018

Generational Experience / Transformational Experience of 1968, European Solidarity Centre, Gdańsk, 2018

Cultural Transmission and Social Norms, University of East Anglia, 2017

Conference of the European Consortium for Sociological Research (keynote), 2016

Annual conference of the Political Studies Association, 2014

Conference of the Political Studies Association’s Methodology Group, 2017

Social Movements and Protest, University of Brighton, 2016

‘Alternative Futures and Social Protest’, Manchester Metropolitan University, 2001, 2014, 2016, 2017

Annual workshop on Analytical Sociology / Conference of the International Network of Analytical Sociologists, 2008, 2010, 2016

Annual conference of the Social History Society, 2009

Annual meeting of the Irish Conference of Historians, 2009

Annual conference of the Women’s History Network, 2009

‘Imprisonment and the Irish’, Mater Dei Institute of Education, City University of Dublin, 2009

Michael Biggs

‘Crossing Borders’, Wissenschaftszentrum Berlin für Sozialforschung, 2006

‘Power Laws in the Social Sciences’, George Mason University, 2003

Invited seminars

Chinese University of Hong Kong, 2021

Charles University, Prague, 2018

Centre for Human and Social Sciences, Superior Council for Scientific Research, Madrid, 2018

Department of Social Sciences, Carlos III University, Madrid, 2018

Department of Sociology, University of Edinburgh, 2017

School of Sociology, University College Dublin, 2016

School of Social Sciences, Education and Social Work, Queen’s University Belfast, 2016

‘Interdisciplinary Perspectives on Modelling Conflict’, University of Essex, 2016 (keynote)

Auro University, Surat, India, 2016

‘Urban Insecurity and Civil Conflict’, Nuffield College, Oxford, 2015

Institute for Analytical Sociology, Linköping University, 2015

Forum for Civil Society and Social Movement Research, University of Gothenburg, 2015

Department of Sociology, University of Cambridge, 2015

Department of History, Victoria University of Wellington, 2015

‘The Power of the People: The Dynamics and Limits of Social Mobilization in South Eastern Europe’, St Antony’s College, Oxford, 2015 (keynote)

‘Hunger Striking and Medical Ethics: Historical and Modern Perspectives’, Centre for History of Medicine in Ireland, University of Ulster, 2015

‘Political Engagement and Political Alternatives in the Age of Austerity in Europe’, University of Birmingham, 2015

Contentious Politics Research Seminar, London School of Economics, 2013, 2015

Department of Sociology, University of Essex, 2013

‘Suicide Protest: Normative Intrusions’, Amherst College, 2013

Faculty of Sociology, Higher School of Economics Moscow, 2013

Summer School, University of Essex, 2012

‘Tibet is Burning: Self-immolations, Ritual or Political Protest’, Collège de France, 2012

Collegio Carlo Alberto, Turin, 2011

Centro Dondena, Università Bocconi, Milan, 2011

Institute for Social Change, University of Manchester, 2009

European Studies Center, University of Washington, 2009

Juan March Institute, Madrid, 2009

Social and Political Theory Group, Australian National University, 2008

Department of History, Victoria University of Wellington, 2008
 Department of Sociology, University of Surrey, 2008
 Department of Sociology, University of Kent at Canterbury, 2008
 Complexity Seminar, Brunel University, 2007
 ESRC Social Capital Seminar, University of Nottingham, 2006
 Department of Political and Social Sciences, Universidad Pompeu Fabra, Barcelona, 2004
 Department of Sociology, Illinois State University, 2004
 Comparative Politics Workshop, University of Chicago, 2003

Other publications

['Research evidence: Gender-Atypical Tots Likely to Become Gay or Lesbian'](#), 4thWaveNow, 7 August 2018

['The Open Society Foundations and the Transgender Movement'](#), 4thWaveNow, 25 May 2018

Review of Emily Beaulieu's *Electoral Protest and Democracy in the Developing World*, in *Mobilization*, vol. 21, no. 1, 2016, pp. 137-8

(with Kenneth T. Andrews) 'Sit-ins and Desegregation in the U.S. South in the Early 1960s', ICPSR 35630, Inter-university Consortium for Political and Social Research, 2015

(with Neil Ketchley) ['Who Actually Died in Egypt's Rabaa Massacre'](#), *Washington Post* Monkey Cage Blog, 14 August 2015

(with Neil Ketchley) ['What Is the Egyptian Anti-Coup Movement Protesting for?'](#), *Washington Post* Monkey Cage Blog, 4 April 2014

Review of Matthew Lange's *Educations in Ethnic Violence: Identity, Educational Bubbles, and Resource Mobilization*, in *British Journal of Sociology*, vol. 64, no. 1, 2013, pp. 184-85

'Prophecy, Self-Fulfilling/Self-Defeating', *Encyclopedia of Philosophy and the Social Sciences*, ed. Byron Kaldis, Thousand Oaks, Calif.: Sage Publications, 2013, vol. 2, pp. 765-6

'Self-Immolation in Context, 1963-2012', *Revue d'Etudes Tibétaines*, no. 25, 2012, pp. 143-50

'Storm in a Teacup? A Comment on Ullmann-Margalit', *Norms and Values: The Role of Social Norms as Instruments of Value Realisation*, ed. Michael Baumann, Geoffrey Brennan, Bob Goodin, and Nicholas Southwood, Baden-Baden: Nomos Verlagsgesellschaft, 2010, pp. 143-48

'Dying for a Cause—Alone?', *Contexts*, vol. 7, no. 2, 2008, pp. 22-27

Review of Matthias Reiss (ed.), *The Street as Stage: Protest Marches and Public Rallies since the Nineteenth Century*, in *Cultural and Social History*, vol. 6, no. 2, 2009, pp. 250-52

Review of Stathis N. Kalyvas, *The Logic of Violence in Civil War*, in *American Journal of Sociology*, vol. 113, no. 2, 2007, pp. 558-60

Review of Marek M. Kaminski, *Games Prisoners Play: The Tragicomic Worlds of Polish Prison*, in *American Journal of Sociology*, vol. 110, no. 6, 2005, pp. 1820-22

Review of Maryjane Osa, *Solidarity and Contention: Networks of Polish Opposition*, in *Social Forces*, vol. 83, no. 1, 2004, pp. 447-49

Review of Beverly J. Silver, *Forces of Labor: Workers' Movements and Globalization since 1870*, *Contemporary Sociology*, vol. 33, no. 4, 2004, pp. 467-69

'A Century of American Exceptionalism: Review Essay on Seymour Martin Lipset and Gary Marks, *It Didn't Happen Here: Why Socialism Failed in The United States*', *Thesis 11*, no. 68, 2002, pp. 110-21

Review of James C. Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, *Comparative Studies in Society and History*, vol. 44, no. 4, 2002, pp. 852-54

Review of Stephen K. Sanderson, *Social Transformations: A General Theory of Historical Development*, *Contemporary Sociology*, vol. 26, no. 1, 1997, pp. 47-48

Contributor to *New Zealand Historical Atlas*, ed. Malcolm McKinnon, Wellington: David Bateman in association with Historical Branch, Department of Internal Affairs, 1997

Kevin Hince, with Kerry Taylor, Jacqui Peace, and Michael Biggs, *Opening Hours: History of the Wellington Shop Employees Union*, Wellington: Wellington Shop Employees Union, 1990

Research grants

'Social Contexts of Islamist Activism in the United Kingdom', £2,483 awarded by the Economic and Social Research Council's Knowledge Exchange Dialogues Scheme, 2015

'Student Protest and Digital Media: The Campaign Against Tuition Fees', £6,914 awarded by the John Fell OUP Research Fund (102/671), 2011

'Protest Demonstrations in London over Two Centuries', £25,315 awarded by the John Fell OUP Research Fund (072/616), 2008-09

'Hunger Strikes by Suffragettes and Irish Republicans, 1909-1923: Compiling a Database of Individuals and Events', £71,873 awarded by the British Academy (LRG-45549), 2007-09

'Hunger Strikes Against British Rule, 1909-1933: Campaigns for Women's Suffrage, Irish Independence, and Indian Independence', \$12,335 awarded by the University of Illinois Research Board, 2004-05

'Self-immolation: A Global Dataset, 1963-2002', £4,216, awarded by the Economic and Social Research Council (000-22-033), 2002

Media

Online and newswire: BBC World News online; BBC News magazine; Associated Press; France 24 online; France TV; Inter Press Service news agency; Al Jazeera; *Foreign Policy*; *Washington Post*'s Monkey Cage

Radio: Outlook and Newshour on BBC World Service; Today on BBC Radio 4; Archive Hour on BBC Radio 4; All Things Considered, Talk of the Nation, The Takeaway, and Interfaith Voices on National Public Radio; Public Radio International; Voice of America; CBC Radio; The Wide Angle on Newstalk Radio Ireland; Rear Vision, Australian Broadcasting Corporation; The Wire, Australia

Television: BBC Newsnight; BBC London TV

Newspaper: *Daily Telegraph*; *Sunday Times*; *Toronto Star*; *Times of India*

PROFESSIONAL SERVICE

Editorial Board of *Mobilization* (from 2007), *Social Forces* (from 2012), *Irish Journal of Sociology* (from 2018); consulting editor for *American Journal of Sociology* (2012-14)

Reviewer for *American Journal of Sociology* (35), *Social Forces* (29), *Mobilization* (19), *American Sociological Review* (16), *British Journal of Sociology* (9), *Social Movement Studies* (9), *European Sociological Review* (5), *Social Science History* (5), *Sociological Methods and Research* (4), *Sociological Forum* (4), *Social Problems* (3), *Social Science Research* (3), *International Review for the Sociology of Sport* (3), *Sociological Theory* (2), *World Politics* (2), *Comparative Political Studies* (2), *Political Studies* (2), *Journal of Peace Research* (2), *Journal of Comparative Politics* (2), *Theory and Society* (2), *Ethnic and Racial Studies* (2), *Acta Sociologica* (2), *Environmental Science and Policy* (2), *Politics, Religion and Ideology* (2), *Journal of Early Adolescence* (2), *American Political Science Review*, *Proceedings of the National Academy of Sciences*, *British Journal of Political Science*, *Sociology*, *PLOS One*, *American Journal of Physics*, *Organization Studies*, *Political Behavior*, *British Politics*, *Journal of Policy History*, *Qualitative Sociology*, *Urban Studies*, *Journal of Historical Sociology*, *International Labor and Working-Class History*, *Sociological Compass*, *Social Currents*, *Sexuality and Culture*, *Archives of Sexual Behavior*, *American Journal of Physics*, *Journal of Political Philosophy*, *Research in Social Movements*, *Conflicts and Change*, *Research and Politics*, *European Societies*, *Security Studies*, *Policy and Politics*, *Journal of Women, Politics and Policy*, *Journal of Controversial Ideas*, *Journal of Medical Ethics*, *Transcultural Psychology*, Oxford Bibliographies

Reviewer for ESRC First Grant Scheme; Volkswagen Stiftung; Netherlands Organisation for Scientific Research; Wellcome Trust, Medical History and Humanities Fellowship; Swiss National Science Foundation; Israel Science Foundation; Irish Research Council

Reviewer for Routledge (2), Polity, Sage's Quantitative Applications in the Social Sciences, Zed Books

External member of committee to appoint Associate Professor of Sociology, University of Konstanz, 2020

Organizer, Sessions on Collective Behavior, annual meeting of the American Sociological Association, 2005 and 2013

TEACHING

Completed doctoral students

Sandra Gonzalez-Bailon, 'Mapping Civil Society on the Web: Networks, Alliances and Informational Landscapes' (2007); Associate Professor of Communication, Annenberg School for Communication, University of Pennsylvania

Thomas Grund, 'Antecedents and Consequences of Social Networks: Macro-Implications of Micro-Dynamics' (2010, jointly with Peter Hedström); Professor of the Chair of Methods of Empirical Social Research, RWTH Aachen University

Christina Fuhr, 'The Construction and Perpetuation of Jewish Identity in Contemporary Britain' (2013, jointly with Gabriella Elgenius)

Samina Luthfa, 'Confronting the Juggernaut of Extraction: Local, National, and Transnational Mobilization against the Phulbari Coal Mine in Bangladesh' (2013); Associate Professor of Sociology, University of Dhaka

Rebeca Ibarra Olivares, 'Social Mechanisms of Tax Behaviour' (2013)

Raheel Dhattiwala, 'Hindu-Muslim Violence in Gujarat, 2002: Political Logic, Spatial Configuration, and Communal Cooperation' (2013)

Fei Yan, 'The Politics of Factional Conflict and Collective Violence: The Cultural Revolution in Guangzhou, 1966-1968' (2014); Associate Professor of Sociology, Tsinghua University

Juta Kawalerowicz, 'How Social Context Influences Political Participation in 21st-Century Britain, from Rioting to Voting' (2016); Postdoctoral Researcher, Department of Human Geography, Stockholm University, Sweden

Rima Majed, 'The Shifting Salience of Sectarianism in Lebanon, 2000-2010' (2016); Assistant Professor of Sociology, American University of Beirut

Effrosyni Charitopoulou, 'The European Refugee Crisis in Greece: Understanding Host Communities' (2020); Postdoctoral Researcher, Department of Politics and International Relations, University of Oxford

Christopher Barrie, 'Dynamics of Conflict and Revolution in Iraq and Tunisia' (2020); Lecturer in Computational Sociology, University of Edinburgh

Adam Brodie, 'Why Parades Are Peaceful: A Study of Mobilisation, Segregation, and Authority in Northern Ireland, 2006-2006' (2020, jointly with Dr Robin Harding)

Nicholas Martindale, 'The Impact of Outsourcing on State School Systems: The Case of the Academies Programme in England' (2021); Postdoctoral Prize Research Fellow, Nuffield College, Oxford

Arun Frey, 'Them Against Us: Assessing the Causes and Consequences of Anti-Immigrant Violence During the German Refugee Crisis', 2021; Postdoctoral Fellow, Leverhulme Centre for Demographic Science, Department of Sociology, University of Oxford

Courses designed and taught

Social Movements: Illinois, undergraduate; Oxford, graduate

Introduction to Social Statistics: Illinois and Queen's, undergraduate

Classical Sociological Theory: Illinois, graduate (*ranked excellent, fall 2004*); Queen's, undergraduate

Analytical Sociological Theory: Oxford, graduate and undergraduate

Social Dynamics—Theories, Models, Methods: Illinois, graduate

Sociological Analysis: Oxford, graduate

Introduction to Sociology: Illinois, undergraduate

Explaining Knowledge: Harvard, undergraduate

(15 October 2022)



Department of Sociology

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Website: <http://users.ox.ac.uk/~sfos0060>

19 September 2022

Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Florida Board of Medicine,

This submission is made to assist your deliberation on the treatment of children and young people suffering from gender dysphoria, specifically on the use of ‘puberty blockers’.

I have published on the origin of this treatment in the Netherlands 1990s (Biggs 2022b) and on the initial British experiment in the 2010s (Biggs 2019b). I was the first to call on the British Tavistock and Portman NHS Foundation Trust’s Gender Identity Development Service (GIDS) to publish the results of its experiment (Tominey and Walsh 2019), and I was the first to publish preliminary results from the experiment (Biggs 2020a). Provoked by the poor quality of data and analysis in this field of medicine, I have published on the effects of puberty suppression on psychological functioning (Biggs 2019a), on suicidality (Biggs 2020b), and on bone density (Biggs 2021), as well as on the suicide rate of transgender adolescents (Biggs 2022a). This work has appeared in *Archives of Sexual Behavior*, *Journal of Sex and Marital Therapy*, *Journal of Sexual Medicine*, and *Journal of Pediatric Endocrinology and Metabolism*.

Puberty suppression as a treatment for gender dysphoria

1. Dutch clinicians started using Gonadotropin-Releasing Hormone agonist (GnRHa) to suppress puberty in children suffering from gender dysphoria—who they designated as ‘juvenile transsexuals’ (Gooren and Delemarre-van de Waal 1996)—in the 1990s. The Dutch protocol had three stages (Delemarre-van de Waal and Cohen-Kettenis 2006). GnRHa would be given from the age of 12, once the child had reached Tanner Stage 2: the first growth of pubic hair and for girls by budding breasts and for boys by growing testicles. Cross-sex hormones would be administered from 16, and surgeries would commence at 18. For this purpose, GnRHa is used off-label, for it has never been licensed to treat gender dysphoria, anywhere in the world. It is licensed to treat precocious puberty—when puberty commences before the age of 7 (approximately) in girls or 9 in boys. That treatment involves delaying a puberty that arrives abnormally early so that the child can undergo puberty at the normal age,

whereas puberty suppression for gender dysphoria entails stopping normal puberty in order to prepare the child for taking hormones of the opposite sex.

2. Puberty suppression as a treatment for gender dysphoria was never tested in any randomized clinical trial. Nor were there any preliminary experiments on non-human animals. Only two decades after this treatment was first used on children were any experiments conducted on sheep and mice (Hough, Bellingham, Haraldsen, McLaughlin, Rennie, et al. 2017; Hough, Bellingham, Haraldsen, McLaughlin, Robinson, et al. 2017; Anacker et al. 2021). The Dutch clinicians published outcomes from a longitudinal study of the first cohort of 70 children whose puberty was suppressed (de Vries et al. 2011; 2014). About half the psychological measures showed improvement. The reported improvement in gender dysphoria is flawed because the researchers switched the questionnaires used to construct the measure. A male who wanted to become a woman was given the male version at baseline and then the female version at follow-up, including irrelevant questions such as about menstruation (Levine, Abbruzzese, and Mason 2022). Notably, one teenager died during vaginoplasty—and so the death rate exceeded 1%. This cohort have not been followed up since their early twenties, just after surgery. Only one patient—the very first to receive puberty suppression for gender dysphoria—has been followed up in the long term. At the age of 35, he was depressed. Due to ‘shame about his genital appearance and his feelings of inadequacy in sexual matters’, he could not sustain a romantic relationship with a girlfriend (Cohen-Kettenis et al. 2011, 845). The clinicians concluded optimistically that ‘the negative side effects are limited’ (Cohen-Kettenis et al. 2011, 843).
3. While gender clinics in many other countries adopted the Dutch protocol from the late 2000s, they did not collect data on outcomes or decided not to publish it. The GIDS started puberty suppression as an experiment in 2011, involving 44 children aged 12 to 15 (Viner et al. 2010). Before the last subject had been recruited, it was pronounced a success by the Director of GIDS and used to justify a new policy of lowering the age of puberty suppression: ‘Now we’ve done the study and the results thus far have been positive we’ve decided to continue with it’ (Manning and Adams 2014). The lack of publication of the results led to my protracted campaign involving news media (e.g., Tominey and Walsh 2019), complaints to the NHS ethics committee (Health Research Authority 2019), and questions in Parliament (Blackwood of North Oxford 2019). The GIDS delayed publication until the day after the verdict was delivered in the judicial review launched by Keira Bell (Carmichael et al. 2020; 2021). The researchers acknowledge that puberty suppression, after two years, produced no positive effects. These results were significantly inferior to the Dutch results following puberty suppression (Biggs 2020a). The subjects of this experiment have not been followed up after cross-sex hormones; the GIDS admits that it loses track of its patients after the age of 18 (Butler et al. 2018). One of the subjects in the experiment appeared on Twitter (as @mediocredruid): she is deeply distressed by her treatment—GnRHa at 15 led to testosterone, double mastectomy, hysterectomy, vaginectomy, and metoidioplasty—but does not know whether to detransition because the physical changes have been so extreme that she might not be able to pass as a woman.
4. In the United States, puberty suppression became widely adopted from 2008 onwards (Biggs 2020b). Dozens of children’s gender clinics were established to tap into this new lucrative market. The National Institutes of Health awarded \$5.7 million for a prospective longitudinal

study of the effects of GnRHa and cross-sex hormones on children (Children’s Hospital Los Angeles 2015). Subjects were recruited between 2016 and 2018 (Olson-Kennedy et al. 2019). Outcomes after two years on GnRHa were thus collected by 2020, but the researchers have only published on the characteristics of the cohort *before* treatment (Chen et al. 2021; Lee et al. 2020) and on the respective merits of two brands of GnRHa (Olson-Kennedy et al. 2021). As in Britain, practitioners of gender medicine are curiously reluctant to publish the outcomes of puberty suppression for psychological functioning and gender dysphoria—even though those outcomes were the primary justification for the treatment.

The association of gender dysphoria with same-sex attraction and autism spectrum conditions

5. Puberty suppression is founded on the assumption that a child suffering from gender dysphoria at age 12—or even younger, if Tanner stage 2 is reached earlier—is a ‘juvenile transsexual’ whose destiny is fixed. This assumption was known to be false by the clinicians who invented the Dutch protocol, who initially recognized that ‘most GID [gender identity disorder, the precursor to gender dysphoria] children under 12 will not grow up to become transsexuals’ (Cohen-Kettenis and van Goozen 1997, 246). ‘Prospective studies of GID boys show that this phenomenon is more closely related to later homosexuality than to later transsexualism’ (Cohen-Kettenis and Gooren 1999, 319). One of the four studies cited is a famous study of ‘sissy boys’ who were selected because they were thought to be ‘pretranssexuals’; after fifteen years, however, two thirds of the 44 had become bisexual or homosexual men and only one was contemplating transsexuality (Green 1987). A representative longitudinal study of 14,000 children born in 1991–92 shows that those who as infants gravitated towards toys and activities typical of the opposite sex were far more likely by the age of 15 to grow up to be gay or lesbian (Li, Kung, and Hines 2017). All this evidence predates the promotion of transgenderism in healthcare and schools and on social media. The manifesto for the Dutch protocol fails to mention homosexuality and does not cite any of the studies of feminine boys (Delemarre-van de Waal and Cohen-Kettenis 2006). Unpublished data on 27 of the Dutch adolescents were given GnRHa reveals that 26 were homosexual and 1 was bisexual (de Vries 2010, 103). The suspicion must be that at least some of these children could have grown up to be typical gays and lesbians, without requiring lifetime medical treatment and without loss of fertility and sexual function.
6. The overlap between gender dysphoria and autistic spectrum conditions (ASC) is well documented (Socialstyrelsen 2020; Warrier et al. 2020). ‘GD [gender dysphoria] and ASD [autism spectrum disorder, another term for ASC] were found to co-occur frequently—sometimes characterized by atypical presentation of GD, which makes a correct diagnosis and determination of treatment options for GD difficult’ (van der Miesen, Hurley, and de Vries 2016, 70). Children on the autistic spectrum are more likely to face difficulties fitting in with their same-sex peers, which makes a transgender identity obviously appealing as both an explanation and a solution. From a sample of over 700 referrals to the GIDS in 2012 and 2015, 14–15% were diagnosed with ASC (Morandini et al. 2021). This was more than ten times greater than the rate for students in England, 0.8%–1.1% (Department for Education 2012; 2015). The proportion among those subjected to GnRHa could be even higher. Out of the first 30 subjects enrolled in the GIDS experiment on puberty suppression, almost half had

ASC traits: mid to moderate in 9 children, and severe in 5 (Gender Identity Development Service 2015).

The risk of suicide for children suffering from gender dysphoria

7. Surveys demonstrate that adolescents who identify as transgender are vulnerable to suicidal thoughts and self-harming behaviors (dickey and Budge 2020; Hatchel, Polanin, and Espelage 2021; Mann et al. 2019). In New Zealand, 20% of transgender students reported attempting suicide in the past 12 months, compared to 4% of all students (Clark et al. 2014). In the United States, 15% of transgender students reported a suicide attempt requiring medical treatment in the last 12 months, compared to 3% of all students (Centers for Disease Control and Prevention 2018; Jackman et al. 2021; Johns et al. 2019). In another American survey, 41% of transgender students reported having attempted suicide during their lifetime, compared to 14% of all students (Toomey, Syvertsen, and Shramko 2018).
8. Respondents who report suicide attempts are not necessarily indicating an intent to die. One survey of the American population found that almost half the respondents who reported attempting suicide subsequently stated that their action was a cry for help and not intended to be fatal (Nock and Kessler 2006). In two small samples of non-heterosexual youth, half the respondents who initially reported attempting suicide subsequently clarified that they went no further than imagining or planning it; for the remainder who did actually commit suicide, their actions were usually not life-threatening. To an extent, then, 'the reports were attempts to communicate the hardships of lives or to identify with a gay community' (Savin-Williams 2001). Such elaborate survey methods have not been used to study transgender populations, but there is anecdotal evidence for a disjuncture between self-harm and suicidal ideation on one hand and fatal suicide on the other. The pediatric endocrinologist who established the first clinic for transgender children in the United States stated that 'the majority of self-harmful actions that I see in my clinic are not real suicide attempts and are not usually life threatening' (Spack 2009, 312).
9. Two published studies have reported suicide fatalities among transgender adolescents. Belgium's pediatric gender clinic provided counselling to 172 youth aged from 12 and 18 years, who had been referred between 2007 and 2016: 5 of them (2.9%) committed suicide (Van Cauwenberg, Dhondt, and Motmans 2021). The mean age of referral was 15, implying a mean duration of 3 years before transition to an adult clinic, which translates to an annual suicide rate of 969 per 100,000.
10. At the Tavistock GIDS, which serves young people under 18 from England, Wales, and Northern Ireland, 4 patients were known or suspected to have died by suicide between 2010 and 2020. The clinic had referrals for approximately 15,000 patients in this period. To calculate the annual suicide rate, the total number of years spent by patients under the clinic's care is estimated at about 30,000. This yields an annual suicide rate of 13 per 100,000 (95% confidence interval: 4–34). Compared to the United Kingdom population of the same age and sexual composition, the suicide rate for patients at the GIDS was 5.5 times higher (Biggs 2022a). It is not clear what explains the enormous disparity in suicide rates at these two clinics; the Belgian rate is 70 times higher. The suicide rate at the Tavistock is much closer to the rate calculated from 8,000 adults who visited the Amsterdam clinic between 1972 and 2017, which was quadruple that of the Dutch population (Wiepjes et al. 2020).

11. The elevated suicide rate of children who identify as transgender could be explained by some combination of gender dysphoria, accompanying psychological conditions, and ensuing social disadvantages such as bullying. The association between ASC and gender dysphoria was pointed out above. Autism is known to increase the risk of suicide mortality, especially in females (Socialstyrelsen 2020; Hirvikoski et al. 2016; Kirby et al. 2019). To some extent, therefore, the elevated suicide rate for transgender youth compared to their peers reflects the higher incidence of ASC. The same holds for other psychiatric disorders associated with gender dysphoria (Dhejne et al. 2016).
12. The claim that puberty suppression reduces suicidality in children suffering from gender dysphoria is not implausible. Because the risk of suicide increases greatly from prepubescence to late adolescence, halting normal cognitive and emotional development with GnRHa could reduce the risk of suicide by preventing the child from maturing. As yet there is no evidence, however, that endocrinological interventions reduce the risk of suicide. At the GIDS from 2010 to 2020, there is no detectable difference between the suicide rate for patients on the waiting list and for patients who were being seen (Biggs 2022a). In the Belgian clinic which experienced the exceptionally high suicide rate, subsequent correspondence reveals that ‘suicide was related to many more (psychological) problems than their GD [gender dysphoria], and occurred mostly a few years after the start on hormonal treatment’ (email from Gaia Van Cauwenberg to Avi Ring, 27 May 2022).
13. One study claims that puberty suppression reduced subsequent suicidality in adults (Turban et al. 2020). This finding derives from a nonrepresentative survey of transgender adults in the United States, which included 89 respondents who reported taking puberty blockers. Six measures of suicidality and three other measures of mental health and substance abuse were examined, but only one yielded a statistically significant association after controlling for other factors: the respondents who reported taking puberty blockers were less likely to have thought about killing themselves than were the respondents who reported wanting blockers but not obtaining them. This study has numerous serious flaws (Biggs 2020b). Most fundamentally, without information on the respondents’ mental health during adolescence, the causal direction cannot be ascertained. The association could well be explained by clinicians refusing to prescribe GnRHa to adolescents with significant psychological problems, as indeed was then recommended by the Endocrine Society (Hembree et al. 2009). The study did not disclose the fact that one of its authors had been paid by Endo Pharmaceuticals, which manufactures a GnRHa drug (histrelin acetate under the brand Supprelin). At my insistence, the journal issued a correction to admit this conflict of interest (Pediatrics 2021).
14. There are anecdotal reports of children experiencing increased suicidal feelings after GnRHa. At the Leiden clinic, one teenager ‘stopped treatment because of an increase in mood problems and suicidal thoughts and confusion attributed to GnRHa treatment’ (Brik et al. 2020, 2614). One English teenager recalled that GnRHa led to suicidal feelings (Klotz 2022). The triptorelin formulations used in Britain—Gonapeptyl® Depot and Decapeptyl® SR—carry warnings that depression is a common side effect, affecting between 1% and 10% of patients (Ferring Pharmaceuticals Ltd 2016), and ‘may be severe’ (Ipsen Ltd 2017).

The effect of puberty suppression on mental health

15. The first Dutch cohort of 70 children given GnRHa reported generally positive outcomes, by age 16, when they graduated to cross-sex hormones (de Vries et al. 2011). (The actual number of observations ranged from 41 to 57, depending on measure.) Psychological functioning improved, depressive symptoms declined, and behavioural and emotional problems decreased. Gender dysphoria, however, worsened for females. Using the same measures as the Dutch, the first GIDS cohort of 44 children reported no improvement in psychological functioning or gender dysphoria after two years (Carmichael et al. 2021). There was a misleading earlier article from the GIDS which claimed that puberty suppression improved psychological functioning (Costa et al. 2015). It had an extraordinarily high attrition rate—almost half the subjects vanished over 12 months, without explanation—and the claimed effect was actually not statistically significant (Biggs 2019a). It nevertheless continues to be cited as credible evidence for the beneficial effects of puberty suppression.
16. According to a recent study from the Seattle Children’s Gender Clinic, 69 youth aged 13 to 16 experienced dramatically reduced rates of depression and of self-harm or suicidal thoughts after 12 months on GnRHa or cross-sex hormones (Tordoff et al. 2022). (The authors unfortunately do not differentiate these two interventions.) In fact the data for these youth showed no change over time (Singal 2022). The false claim was derived from statistical comparison with youth from the clinic who had not received these endocrinological interventions, whose mental health worsened over time. But this comparison group numbered only 6 patients after 12 months. One obvious explanation is that the clinicians were following the World Professional Association of Transgender Health’s recommendations against commencing medical intervention when an adolescent is experiencing an acute mental health crisis. (This is the same fallacy of causal inference that vitiated Turban et al.’s (2020) study of suicidality.)
17. A proper randomized control trial of the effect of suppressing puberty in mice using GnRHa demonstrated that it caused significantly higher levels of stress in males, and increased anxiety and despair-like behaviour in females (Anacker et al. 2021).

The effect of puberty suppression on bone density

18. The Dutch pioneers warned at the outset that patients could ‘end with a decreased bone density, which is associated with a high risk of osteoporosis’ (Delemarre-van de Waal and Cohen-Kettenis 2006, S134). The fact that GnRHa prevents the accrual of normal bone mass is well documented from Dutch and British studies (Klink et al. 2015; Schagen et al. 2020; Stoffers, de Vries, and Hannema 2019; Vlot et al. 2017; Joseph, Ting, and Butler 2019). In addition, children given GnRHa already have unusually low bone density, perhaps due to the high prevalence of eating disorders. The combined effect can be appreciated by looking at the proportion of adolescents who end up after treatment with severely low bone density, two standard deviations below the average—putting them at risk for osteoporosis. Reanalysis of 31 of the GIDS patients demonstrates that after two years on GnRHa, up to a third had reached this very low range, depending on the measure (hip or spine); only 2.3% of the population would be this low. Moreover, four patients (13%) had spine bone density over

three standard deviations from the mean; only 0.13% of the population would be so extremely low (Biggs 2021).

19. Whether such abnormally low bone density has increased the risk of fractures is unknown because clinics apparently do not collect data on fractures. Anecdotally, a British female patient who started GnRHa at age 12 then experienced four broken bones by the age of 16 (Bannerman 2019). A Swedish documentary highlighted the case of a female who was given GnRHa from age 11 to 15, and now suffers from severe osteoporosis, including continual skeletal pain (SVT 2021).

The effect of puberty suppression on sexual function

20. When GnRHa is used to treat prostate cancer, one side effect is that ‘sexual desire, sexual interest and sexual intercourse were totally annulled’ (Marumo, Baba, and Murai 1999, 19). This is why GnRHa is licensed to chemically castrate men who are sex offenders (Ho et al. 2012; Turner and Briken 2018). Clinicians who use GnRHa off-label to treat gender dysphoria have ignored its effects on sexuality. The Dutch studies, for example, included no measures for libido or capacity for orgasm (de Vries et al. 2011; 2014). The lead author recently described orgasm as ‘a very interesting and so far not studied question’ (Klotz 2022). A Californian surgeon who has performed over 2,000 vaginoplasties (and who is also transgender) recently acknowledged that ‘every single child who was, or adolescent, who was truly blocked at Tanner Stage 2, has never experienced orgasm. I mean, it’s really about zero’ (Bowers 2022). This remark refers to males. The effects of puberty suppression at such an early stage on females is unknown.

The effect of puberty suppression on subsequent medical transition

21. Dutch clinicians initially promoted puberty suppression as providing space for therapeutic exploration of gender identity, without the pressure of the physical changes accompanying puberty (Delemarre-van de Waal and Cohen-Kettenis 2006). This was plausible, perhaps, though it was also plausible that stopping normal sexual and cognitive development would impede such exploration. As the Dutch clinicians admitted at the time, ‘none of the [54] patients who were selected for pubertal suppression has decided to stop taking GnRHa’ (Delemarre-van de Waal and Cohen-Kettenis 2006, S136). It could have been argued that this was due to careful selection of a small number of adolescents for this experimental treatment.
22. Although the number of children subjected to puberty suppression has increased dramatically, they almost invariably continue to cross-sex hormones. Out of 333 children given GnRHa in the Amsterdam clinic to the end of 2015, 326 (98%) continued to cross-sex hormones (Wiepjes et al. 2018). Out of 133 children given GnRHa at the Leiden clinic in the Netherlands who attained the age of eligibility for cross-sex hormones, 128 (96%) continued (Brik et al. 2020). Out of 44 children enrolled in the GIDS experiment with GnRHa, 43 (98%) continued to cross-sex hormones (Carmichael et al. 2021). Out of 54 children given GnRHa by the Royal Children’s Hospital Gender Service in Australia, 53 (98%) continued to cross-sex hormones (Tollit et al. 2021). The suspicion is that puberty suppression reinforces gender dysphoria.
23. Given the fact that there are almost no cases of children ceasing GnRHa, the claim for reversibility is moot. The article that first proposed puberty suppression deemed it to be ‘fully

reversible; in other words, no lasting undesired effects are to be expected’ (Gooren and Delemarre-van de Waal 1996, 72). The phrasing acknowledged the lack of actual evidence. Suppressing puberty for just one month would have a negligible effect on a child’s development, of course, but the Dutch protocol entails suppression for up to four years (from age 12 to 16). It is simply incredible to claim that suppressing puberty for many years would have no lasting effect if the child were to stop GnRHa and restart their natal sex hormones. The manifesto for the Dutch protocol admitted as much: ‘It is not clear yet how pubertal suppression will influence brain development’ (Delemarre-van de Waal and Cohen-Kettenis 2006, S137). Randomized experiments with sheep now provide compelling evidence on this point: GnRHa impairs spatial memory, and this impairment remains after the treatment is stopped and puberty is restarted (Hough et al. 2017a; Hough et al. 2017b).

Recent evaluations of puberty suppression by the English and Swedish health systems

24. NHS England commissioned a systematic evaluation of every study on puberty suppression published up to July 2020. From detailed analysis spanning 131 pages, it concluded: ‘The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding, and all the results are of very low certainty using modified GRADE [Grading of Recommendations, Assessment, Development and Evaluations, a framework for summarizing medical evidence]. They all reported physical and mental health comorbidities and concomitant treatments very poorly’ (National Institute for Clinical Excellence 2020, 23).
25. The Swedish National Board of Health and Welfare updated its recommendations in February 2022, based on a systematic review of the scientific evidence by the Agency for Health Technology Assessment and Assessment of Social Services (Statens beredning för medicinsk och social utvärdering 2022). It states that ‘the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming [cross-sex] hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases’, in part due to the ‘continued lack of reliable scientific evidence concerning the efficacy and the safety of both treatments’ (Socialstyrelsen 2022, 3).

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Michael Biggs', with a stylized, cursive script.

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Appended

1. Michael Biggs. 2020b. 'Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria'. *Archives of Sexual Behavior* 49: 2227–29. <https://doi.org/10.1007/s10508-020-01743-6>.
2. Michael Biggs. 2021. 'Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria'. *Journal of Pediatric Endocrinology and Metabolism* 34: 937–39. <https://doi.org/10.1515/jpem-2021-0180>.
3. Michael Biggs. 2022a. 'Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom'. *Archives of Sexual Behavior* 51: 685–90. <https://doi.org/10.1007/s10508-022-02287-7>.
4. Michael Biggs. 2022b. 'The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence'. *Journal of Sex & Marital Therapy*, online. <https://doi.org/10.1080/0092623X.2022.2121238>.

References

- Anacker, Christoph, Ezra Sydnor, Briana K. Chen, Christina C. LaGamma, Josephine C. McGowan, Alessia Mastrodonato, Holly C. Hunsberger, et al. 2021. 'Behavioral and Neurobiological Effects of GnRH Agonist Treatment in Mice: Potential Implications for Puberty Suppression in Transgender Individuals'. *Neuropsychopharmacology* 46: 882–90. <https://doi.org/10.1038/s41386-020-00826-1>.
- Bannerman, Lucy. 2019. 'Puberty Blocking Drugs: "For the Past Four Years I've Been Stuck as a Child"'. *Times*, 26 July 2019. <https://www.thetimes.co.uk/article/transgender-children-puberty-blocking-drugs-for-the-past-four-years-i-ve-been-stuck-as-a-child-5s6tkh7z2>.
- Biggs, Michael. 2019a. 'A Letter to the Editor Regarding the Original Article by Costa et al: Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria'. *Journal of Sexual Medicine* 16: 2043. <https://doi.org/10.1016/j.jsxm.2019.09.002>.
- . 2019b. 'Britain's Experiment with Puberty Blockers'. In *Inventing Transgender Children and Young People*, edited by Michele Moore and Heather Brunskell-Evans, 40–55. Newcastle: Cambridge Scholars Publishing.
- . 2020a. 'Gender Dysphoria and Psychological Functioning in Adolescents Treated with GnRHa: Comparing Dutch and English Prospective Studies'. *Archives of Sexual Behavior* 49: 2231–36. <https://doi.org/10.1007/s10508-020-01764-1>.
- . 2020b. 'Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria'. *Archives of Sexual Behavior* 49: 2227–29. <https://doi.org/10.1007/s10508-020-01743-6>.
- . 2021. 'Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria'. *Journal of Pediatric Endocrinology and Metabolism* 34: 937–39. <https://doi.org/10.1515/jpem-2021-0180>.
- . 2022a. 'Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom'. *Archives of Sexual Behavior* 51: 685–90. <https://doi.org/10.1007/s10508-022-02287-7>.
- . 2022b. 'The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence'. *Journal of Sex & Marital Therapy*. <https://doi.org/10.1080/0092623X.2022.2121238>.
- Blackwood of North Oxford, Baroness. 2019. 'Answer to Written Question HL15681 Asked by Lord Lucas'. Presented at the United Kingdom Parliament, House of Lords, May 22.
- Bowers, Marci. 2022. 'Teen Transitions'. Presented at the Trans and Gender Diverse Policies, Care, Practices, and Wellbeing Symposium, Duke University, March 21. <https://www.facebook.com/dukesgmhealth/videos/704267637246585/>.
- Brik, Tessa, Lieke J.J.J. Vrouwenraets, Martine C. de Vries, and Sabine E. Hannema. 2020. 'Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria'. *Archives of Sexual Behavior* 49: 2611–18. <https://doi.org/10.1007/s10508-020-01660-8>.
- Butler, Gary, Nastasja De Graaf, Bernadette Wren, and Polly Carmichael. 2018. 'Assessment and Support of Children and Adolescents with Gender Dysphoria'. *Archives of Disease in Childhood* 103: 631–36. <https://doi.org/10.1136/archdischild-2018-314992>.
- Carmichael, Polly, Gary Butler, Una Masic, Tim J Cole, Bianca L De Stavola, Sarah Davidson, Elin M. Skageberg, Sophie Khadr, and Russell Viner. 2020. 'Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK'. Preprint. Sexual and Reproductive Health. <https://doi.org/10.1101/2020.12.01.20241653>.
- Carmichael, Polly, Gary Butler, Una Masic, Tim J. Cole, Bianca L. De Stavola, Sarah Davidson, Elin M. Skageberg, Sophie Khadr, and Russell Viner. 2021. 'Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK'. *PLoS ONE* 16: e0243894. <https://doi.org/10.1371/journal.pone.0243894>.
- Centers for Disease Control and Prevention. 2018. '2017 Youth Risk Behavior Survey'. <https://www.cdc.gov/healthyyouth/data/yrbs/data.htm>.
- Chen, Diane, Mere Abrams, Leslie Clark, Diane Ehrensaft, Amy C. Tishelman, Yee-Ming Chan, Robert Garofalo, Johanna Olson-Kennedy, Stephen M. Rosenthal, and Marco A. Hidalgo. 2021. 'Psychosocial Characteristics of Transgender Youth Seeking Gender-Affirming Medical Treatment: Baseline Findings from the Trans Youth Care Study'. *Journal of Adolescent Health* 68 (June): 1104–11. <https://doi.org/10.1016/j.jadohealth.2020.07.033>.

- Children's Hospital Los Angeles. 2015. 'NIH Funds First Ever Multi-Site Study of Transgender Youth in the US with a \$5.7 Million Award'. 14 August 2015. <https://www.newswise.com/articles/nih-funds-first-ever-multi-site-study-of-transgender-youth-in-the-us-with-a-5-7-million-award>.
- Clark, Terryann C., Mathijs F.G. Lucassen, Pat Bullen, Simon J. Denny, Theresa M. Fleming, Elizabeth M. Robinson, and Fiona V. Rossen. 2014. 'The Health and Well-Being of Transgender High School Students: Results from the New Zealand Adolescent Health Survey (Youth'12)'. *Journal of Adolescent Health* 55: 93–99. <https://doi.org/10.1016/j.jadohealth.2013.11.008>.
- Cohen-Kettenis, Peggy T., and Stephanie H.M. van Goozen. 1997. 'Sex Reassignment of Adolescent Transsexuals: A Follow-up Study'. *Journal of the American Academy of Child and Adolescent Psychiatry* 36: 263–71. <https://doi.org/10.1097/00004583-199702000-00017>.
- Cohen-Kettenis, Peggy T., Sebastiaan E.E. Schagen, Thomas D. Steensma, Annelou L.C. de Vries, and Henriette A. Delemarre-van de Waal. 2011. 'Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-Up'. *Archives of Sexual Behavior* 40: 843–47. <https://doi.org/10.1007/s10508-011-9758-9>.
- Cohen-Kettenis, P.T., and L.J.G. Gooren. 1999. 'Transsexualism: A Review of Etiology, Diagnosis and Treatment'. *Journal of Psychosomatic Research* 46: 315–33.
- Costa, Rosalia, Michael Dunsford, Elin Skagerberg, Victoria Holt, Polly Carmichael, and Marco Colizzi. 2015. 'Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria'. *Journal of Sexual Medicine* 12: 2206–14. <https://doi.org/10.1111/jsm.13034>.
- Delemarre-van de Waal, Henriette A., and Peggy T. Cohen-Kettenis. 2006. 'Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects'. *European Journal of Endocrinology* 155 (suppl_1): S131–37. <https://doi.org/10.1530/eje.1.02231>.
- Department for Education. 2012. 'Special Educational Needs in England, January 2012'. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2012>.
- . 2015. 'Special Educational Needs in England, January 2015'. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2015>.
- Dhejne, Cecilia, Roy Van Vlerken, Gunter Heylens, and Jon Arcelus. 2016. 'Mental Health and Gender Dysphoria: A Review of the Literature'. *International Review of Psychiatry* 28 (January): 44–57. <https://doi.org/10.3109/09540261.2015.1115753>.
- dickey, lore m., and Stephanie L. Budge. 2020. 'Suicide and the Transgender Experience: A Public Health Crisis'. *American Psychologist* 75: 380–90. <https://doi.org/10.1037/amp0000619>.
- Ferring Pharmaceuticals Ltd. 2016. 'Package Leaflet: ... Gonapeptyl® Depot 3.75mg'. <http://www.medicines.org.uk/emc/product/2229/pil>.
- Gender Identity Development Service. 2015. 'Preliminary Results from the Early Intervention Research'. In *Board of Directors Part One: Agenda and Papers ... 23rd June 2015*, 50–55.
- Gooren, Louis, and Henriette Delemarre-van de Waal. 1996. 'The Feasibility of Endocrine Interventions in Juvenile Transsexuals'. *Journal of Psychology and Human Sexuality* 8: 69–74. https://doi.org/10.1300/J056v08n04_05.
- Green, Richard. 1987. *The Sissy Boy Syndrome: The Development of Homosexuality*. Yale University Press.
- Hatchel, Tyler, Joshua R. Polanin, and Dorothy L. Espelage. 2021. 'Suicidal Thoughts and Behaviors among LGBTQ Youth: Meta-Analyses and a Systematic Review'. *Archives of Suicide Research* 25: 1–37. <https://doi.org/10.1080/13811118.2019.1663329>.
- Health Research Authority. 2019. 'Investigation into the Study "Early Pubertal Suppression in a Carefully Selected Group of Adolescents with Gender Identity Disorders"'. 14 October 2019. <https://www.hra.nhs.uk/about-us/governance/feedback-raising-concerns/investigation-study-early-pubertal-suppression-carefully-selected-group-adolescents-gender-identity-disorders/>.
- Hembree, Wylie C., Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, Walter J. Meyer, Norman P. Spack, Vin Tangpricha, and Victor M. Montori. 2009. 'Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline'. *Journal of Clinical Endocrinology and Metabolism* 94: 3132–54. <https://doi.org/10.1210/jc.2009-0345>.
- Hirvikoski, Tatja, Ellenor Mittendorfer-Rutz, Marcus Boman, Henrik Larsson, Paul Lichtenstein, and Sven Bölte. 2016. 'Premature Mortality in Autism Spectrum Disorder'. *British Journal of Psychiatry* 208 (March): 232–38. <https://doi.org/10.1192/bjp.bp.114.160192>.
- Ho, David K., Giriya Kottalgi, Callum C. Ross, Jose Romero-Ulceray, and Mrigendra Das. 2012. 'Treatment with Triptorelin in Mentally Disordered Sex Offenders: Experience From a Maximum-Security Hospital'. *Journal of Clinical Psychopharmacology* 32: 739–40. <https://doi.org/10.1097/JCP.0b013e318266c6f5>.

- Hough, D., M. Bellingham, I.R. Haraldsen, M. McLaughlin, J.E. Robinson, A.K. Solbakk, and N.P. Evans. 2017. 'A Reduction in Long-Term Spatial Memory Persists after Discontinuation of Peripubertal GnRH Agonist Treatment in Sheep'. *Psychoneuroendocrinology* 77: 1–8. <https://doi.org/10.1016/j.psyneuen.2016.11.029>.
- Hough, D., M. Bellingham, I.R.H. Haraldsen, M. McLaughlin, M. Rennie, J.E. Robinson, A.K. Solbakk, and N.P. Evans. 2017. 'Spatial Memory Is Impaired by Peripubertal GnRH Agonist Treatment and Testosterone Replacement in Sheep'. *Psychoneuroendocrinology* 75: 173–82. <https://doi.org/10.1016/j.psyneuen.2016.10.016>.
- Ipsen Ltd. 2017. 'Package Leaflet: ... Decapeptyl® SR 11.25 Mg'. <http://www.medicines.org.uk/emc/product/780/pil>.
- Jackman, Kasey B., Billy A. Caceres, Elizabeth J. Kreuze, and Walter O. Bockting. 2021. 'Suicidality among Gender Minority Youth: Analysis of 2017 Youth Risk Behavior Survey Data'. *Archives of Suicide Research* 25: 208–23. <https://doi.org/10.1080/13811118.2019.1678539>.
- Johns, Michelle M, Richard Lowry, Jack Andrzejewski, Lisa C Barrios, Zewditu Demissie, Timothy McManus, Catherine N Rasberry, Leah Robin, and J Michael Underwood. 2019. 'Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors among High School Students: 19 States and Large Urban School Districts, 2017'. *Morbidity and Mortality Weekly Report* 68: 69–71.
- Joseph, Tobin, Joanna Ting, and Gary Butler. 2019. 'The Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria: Findings from a Large National Cohort'. *Journal of Pediatric Endocrinology and Metabolism* 32: 1077–81. <https://doi.org/10.1515/jpem-2019-0046>.
- Kirby, Anne V., Amanda V. Bakian, Yue Zhang, Deborah A. Bilder, Brooks R. Keeshin, and Hilary Coon. 2019. 'A 20-year Study of Suicide Death in a Statewide Autism Population'. *Autism Research* 12 (April): 658–66. <https://doi.org/10.1002/aur.2076>.
- Klink, Daniel, Martine Caris, Annemieke Heijboer, Michael van Trotsenburg, and Joost Rotteveel. 2015. 'Bone Mass in Young Adulthood Following Gonadotropin-Releasing Hormone Analog Treatment and Cross-Sex Hormone Treatment in Adolescents with Gender Dysphoria'. *Journal of Clinical Endocrinology and Metabolism* 100: E270–75. <https://doi.org/10.1210/jc.2014-2439>.
- Klotz, Frieda. 2022. 'The Fractious Evolution of Pediatric Transgender Medicine'. *Undark Magazine*. 6 April 2022. <https://undark.org/2022/04/06/the-evolution-of-pediatric-transgender-medicine/>.
- Lee, Janet Y, Courtney Finlayson, Johanna Olson-Kennedy, Robert Garofalo, Yee-Ming Chan, David V Glidden, and Stephen M Rosenthal. 2020. 'Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study'. *Journal of the Endocrine Society* 4: bvaa065. <https://doi.org/10.1210/jendso/bvaa065>.
- Levine, Stephen B., E. Abbruzzese, and Julia M. Mason. 2022. 'Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults'. *Journal of Sex and Marital Therapy*. <https://doi.org/10.1080/0092623X.2022.2046221>.
- Li, Gu, Karson T. F. Kung, and Melissa Hines. 2017. 'Childhood Gender-Typed Behavior and Adolescent Sexual Orientation: A Longitudinal Population-Based Study'. *Developmental Psychology* 53: 764–77. <https://doi.org/10.1037/dev0000281>.
- Mann, Georgina E, Amelia Taylor, Bernadette Wren, and Nastasja de Graaf. 2019. 'Review of the Literature on Self-Injurious Thoughts and Behaviours in Gender-Diverse Children and Young People in the United Kingdom'. *Clinical Child Psychology and Psychiatry* 24: 304–21. <https://doi.org/10.1177/1359104518812724>.
- Manning, Sanchez, and Steven Adams. 2014. 'NHS to Give Sex Change Drugs to Nine-Year-Olds: Clinic Accused of "playing God" with Treatment That Stops Puberty'. *Mail on Sunday*, 17 May 2014. <https://www.dailymail.co.uk/news/article-2631472/NHS-sex-change-drugs-nine-year-olds-Clinic-accused-playing-God-treatment-stops-puberty.html>.
- Marumo, Ken, Shiro Baba, and Masaru Murai. 1999. 'Erectile Function and Nocturnal Penile Tumescence in Patients with Prostate Cancer Undergoing Luteinizing Hormone-releasing Hormone Agonist Therapy'. *International Journal of Urology* 6: 19–23. <https://doi.org/10.1046/j.1442-2042.1999.06128.x>.
- Miesen, Anna I.R. van der, Hannah Hurley, and Annelou L.C. de Vries. 2016. 'Gender Dysphoria and Autism Spectrum Disorder: A Narrative Review'. *International Review of Psychiatry* 28: 70–80. <https://doi.org/10.3109/09540261.2015.1111199>.
- Morandini, James S, Aidan Kelly, Nastasja M de Graaf, Polly Carmichael, and Ilan Dar-Nimrod. 2021. 'Shifts in Demographics and Mental Health Co-Morbidities among Gender Dysphoric Youth Referred to a Specialist Gender Dysphoria Service'. *Clinical Child Psychology and Psychiatry*, October. <https://doi.org/10.1177/13591045211046813>.

- National Institute for Clinical Excellence. 2020. 'Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria'.
- Nock, Matthew K, and Ronald C Kessler. 2006. 'Prevalence of and Risk Factors for Suicide Attempts versus Suicide Gestures: Analysis of the National Comorbidity Survey'. *Journal of Abnormal Psychology* 115: 616–23. <https://doi.org/10.1037/0021-843X.115.3.616>.
- Olson-Kennedy, Johanna, Yee-Ming Chan, Robert Garofalo, Norman Spack, Diane Chen, Leslie Clark, Diane Ehrensaft, Marco Hidalgo, Amy Tishelman, and Stephen Rosenthal. 2019. 'Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study'. *JMIR Research Protocols* 8 (July): e14434. <https://doi.org/10.2196/14434>.
- Olson-Kennedy, Johanna, Laer H. Streeter, Robert Garofalo, Yee-Ming Chan, and Stephen M. Rosenthal. 2021. 'Histrelin Implants for Suppression of Puberty in Youth with Gender Dysphoria: A Comparison of 50 Mcg/Day (Vantas) and 65 Mcg/Day (SupprelinLA)'. *Transgender Health* 6: 36–42. <https://doi.org/10.1089/trgh.2020.0055>.
- Pediatrics. 2021. 'Erratum for TURBAN 2019-1725'. *Pediatrics* 147: e2020049767. <https://doi.org/10.1542/peds.2020-049767>.
- Savin-Williams, Ritch C. 2001. 'Suicide Attempts among Sexual-Minority Youths: Population and Measurement Issues'. *Journal of Consulting and Clinical Psychology* 69: 983–91. <https://doi.org/10.1037/0022-006X.69.6.983>.
- Schagen, Sebastian E.E., Femke M. Wouters, Peggy T. Cohen-Kettenis, Louis J. Gooren, and Sabine E. Hannema. 2020. 'Bone Development in Transgender Adolescents Treated with GnRH Analogues and Subsequent Gender-Affirming Hormones'. *Journal of Clinical Endocrinology and Metabolism* 105: e4252–63. <https://doi.org/10.1210/clinem/dgaa604>.
- Singal, Jesse. 2022. 'Researchers Found Puberty Blockers and Hormones Didn't Improve Trans Kids' Mental Health at Their Clinic, Then They Published a Study Claiming the Opposite'. *Singal-Minded* (blog). 6 April 2022. <https://jessesingal.substack.com/p/researchers-found-puberty-blockers>.
- Socialstyrelsen. 2020. 'Utvecklingen av diagnosen könsdysfori [The evolution of the diagnosis of gender dysphoria]'. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6600.pdf>.
- . 2022. 'Care of Children and Adolescents with Gender Dysphoria: Summary'.
- Spack, Norman P. 2009. 'An Endocrine Perspective on the Care of Transgender Adolescents'. *Journal of Gay & Lesbian Mental Health* 13: 309–19. <https://doi.org/10.1080/19359700903165381>.
- Statens beredning för medicinsk och social utvärdering. 2022. 'Hormonbehandling vid könsdysfori - barn och unga'.
- Stoffers, Iris E., Martine C. de Vries, and Sabine E. Hannema. 2019. 'Physical Changes, Laboratory Parameters, and Bone Mineral Density during Testosterone Treatment in Adolescents with Gender Dysphoria'. *Journal of Sexual Medicine* 16: 1459–68. <https://doi.org/10.1016/j.jsxm.2019.06.014>.
- SVT, dir. 2021. 'Transbarnen [Trans Kids]'. *Uppdrag Granskning [Mission Investigate]*. Sveriges Television.
- Tollit, Michelle A., Tamara May, Tiba Maloof, Michelle M. Telfer, Denise Chew, Melanie Engel, and Ken Pang. 2021. 'The Clinical Profile of Patients Attending a Large, Australian Pediatric Gender Service: A 10-Year Review'.
- Tominey, Camilla, and Joani Walsh. 2019. 'NHS Transgender Clinic Accused of Covering up Negative Impacts of Puberty Blockers on Children by Oxford Professor'. *Telegraph*, 7 March 2019. <https://www.telegraph.co.uk/news/2019/03/07/nhs-transgender-clinic-accused-covering-negative-impacts-puberty/>.
- Toomey, Russell B., Amy K. Syvertsen, and Maura Shramko. 2018. 'Transgender Adolescent Suicide Behavior'. *Pediatrics* 142: e20174218. <https://doi.org/10.1542/peds.2017-4218>.
- Tordoff, Diana M., Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland, and Kym Ahrens. 2022. 'Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care'. *JAMA Network Open* 5: e220978. <https://doi.org/10.1001/jamanetworkopen.2022.0978>.
- Turban, Jack L., Dana King, Jeremi M. Carswell, and Alex S. Keuroghlian. 2020. 'Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation'. *Pediatrics* 145: e20191725. <https://doi.org/10.1542/peds.2019-1725>.
- Turner, Daniel, and Peer Briken. 2018. 'Treatment of Paraphilic Disorders in Sexual Offenders or Men with a Risk of Sexual Offending with Luteinizing Hormone-Releasing Hormone Agonists: An Updated Systematic Review'. *Journal of Sexual Medicine* 15: 77–93. <https://doi.org/10.1016/j.jsxm.2017.11.013>.

- Van Cauwenberg, Gaia, Karlien Dhondt, and Joz Motmans. 2021. 'Ten Years of Experience in Counseling Gender Diverse Youth in Flanders, Belgium: A Clinical Overview'. *International Journal of Impotence Research*. <https://doi.org/10.1038/s41443-021-00441-8>.
- Viner, Russell, Polly Carmichael, Domenico Di Ceglie, Gary Butler, Caroline Brain, Victoria Holt, Sophie Khadr, and Elin Skagerberg. 2010. 'An Evaluation of Early Pubertal Suppression in a Carefully Selected Group of Adolescents with Gender Identity Disorder (v1.0)'.
- Vlot, Mariska C., Daniel T. Klink, Martin den Heijer, Marinus A. Blankenstein, Joost Rotteveel, and Annemieke C. Heijboer. 2017. 'Effect of Pubertal Suppression and Cross-Sex Hormone Therapy on Bone Turnover Markers and Bone Mineral Apparent Density (BMAD) in Transgender Adolescents'. *Bone* 95: 11–19. <https://doi.org/10.1016/j.bone.2016.11.008>.
- Vries, Annelou L.C. de. 2010. 'Gender Dysphoria in Adolescents: Mental Health and Treatment Evaluation'. PhD, Vrije Universiteit Amsterdam. <https://research.vu.nl/en/publications/gender-dysphoria-in-adolescents-mental-health-and-treatment-evalu>.
- Vries, Annelou L.C. de, Jennifer K. McGuire, Thomas D. Steensma, Eva C.F. Wagenaar, Theo A.H. Doreleijers, and Peggy T. Cohen-Kettenis. 2014. 'Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment'. *Pediatrics* 134: 696–704. <https://doi.org/10.1542/peds.2013-2958>.
- Vries, Annelou L.C. de, Thomas D. Steensma, Theo A.H. Doreleijers, and Peggy T. Cohen-Kettenis. 2011. 'Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-up Study'. *Journal of Sexual Medicine* 8: 2276–83. <https://doi.org/10.1111/j.1743-6109.2010.01943.x>.
- Warrier, Varun, David M. Greenberg, Elizabeth Weir, Clara Buckingham, Paula Smith, Meng-Chuan Lai, Carrie Allison, and Simon Baron-Cohen. 2020. 'Elevated Rates of Autism, Other Neurodevelopmental and Psychiatric Diagnoses, and Autistic Traits in Transgender and Gender-Diverse Individuals'. *Nature Communications* 11 (3959). <https://doi.org/10.1038/s41467-020-17794-1>.
- Wiepjes, C. M., M. den Heijer, M. A. Bremmer, N. M. Nota, C. J. M. Blok, B. J. G. Coumou, and T. D. Steensma. 2020. 'Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972–2017)'. *Acta Psychiatrica Scandinavica* 141: 486–91. <https://doi.org/10.1111/acps.13164>.
- Wiepjes, Chantal M., Nienke M. Nota, Christel J.M. de Blok, Maartje Klaver, Annelou L.C. de Vries, S. Annelijn Wensing-Kruger, Renate T. de Jongh, et al. 2018. 'The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets'. *Journal of Sexual Medicine* 15: 582–90. <https://doi.org/10.1016/j.jsxm.2018.01.016>.



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Executive Director
Florida Board of Medicine

Dear Florida Board of Medicine,

This submission is made to assist your deliberation on the treatment of children and young people suffering from gender dysphoria, specifically on the use of ‘puberty blockers’.

I have published on the origin of this treatment in the Netherlands 1990s (Biggs 2022b) and on the initial British experiment in the 2010s (Biggs 2019b). I was the first to call on the British Tavistock and Portman NHS Foundation Trust’s Gender Identity Development Service (GIDS) to publish the results of its experiment (Tominey and Walsh 2019), and I was the first to publish preliminary results from the experiment (Biggs 2020a). Provoked by the poor quality of data and analysis in this field of medicine, I have published on the effects of puberty suppression on psychological functioning (Biggs 2019a), on suicidality (Biggs 2020b), and on bone density (Biggs 2021), as well as on the suicide rate of transgender adolescents (Biggs 2022a). This work has appeared in *Archives of Sexual Behavior*, *Journal of Sex and Marital Therapy*, *Journal of Sexual Medicine*, and *Journal of Pediatric Endocrinology and Metabolism*.

Puberty suppression as a treatment for gender dysphoria

1. Dutch clinicians started using Gonadotropin-Releasing Hormone agonist (GnRHa) to suppress puberty in children suffering from gender dysphoria—who they designated as ‘juvenile transsexuals’ (Gooren and Delemarre-van de Waal 1996)—in the 1990s. The Dutch protocol had three stages (Delemarre-van de Waal and Cohen-Kettenis 2006). GnRHa would be given from the age of 12, once the child had reached Tanner Stage 2: the first growth of pubic hair and for girls by budding breasts and for boys by growing testicles. Cross-sex hormones would be administered from 16, and surgeries would commence at 18. For this purpose, GnRHa is used off-label, for it has never been licensed to treat gender dysphoria, anywhere in the world. It is licensed to treat precocious puberty—when puberty commences before the age of 7 (approximately) in girls or 9 in boys. That treatment involves delaying a puberty that arrives abnormally early so that the child can undergo puberty at the normal age,

whereas puberty suppression for gender dysphoria entails stopping normal puberty in order to prepare the child for taking hormones of the opposite sex.

2. Puberty suppression as a treatment for gender dysphoria was never tested in any randomized clinical trial. Nor were there any preliminary experiments on non-human animals. Only two decades after this treatment was first used on children were any experiments conducted on sheep and mice (Hough, Bellingham, Haraldsen, McLaughlin, Rennie, et al. 2017; Hough, Bellingham, Haraldsen, McLaughlin, Robinson, et al. 2017; Anacker et al. 2021). The Dutch clinicians published outcomes from a longitudinal study of the first cohort of 70 children whose puberty was suppressed (de Vries et al. 2011; 2014). About half the psychological measures showed improvement. The reported improvement in gender dysphoria is flawed because the researchers switched the questionnaires used to construct the measure. A male who wanted to become a woman was given the male version at baseline and then the female version at follow-up, including irrelevant questions such as about menstruation (Levine, Abbruzzese, and Mason 2022). Notably, one teenager died during vaginoplasty—and so the death rate exceeded 1%. This cohort have not been followed up since their early twenties, just after surgery. Only one patient—the very first to receive puberty suppression for gender dysphoria—has been followed up in the long term. At the age of 35, he was depressed. Due to ‘shame about his genital appearance and his feelings of inadequacy in sexual matters’, he could not sustain a romantic relationship with a girlfriend (Cohen-Kettenis et al. 2011, 845). The clinicians concluded optimistically that ‘the negative side effects are limited’ (Cohen-Kettenis et al. 2011, 843).
3. While gender clinics in many other countries adopted the Dutch protocol from the late 2000s, they did not collect data on outcomes or decided not to publish it. The GIDS started puberty suppression as an experiment in 2011, involving 44 children aged 12 to 15 (Viner et al. 2010). Before the last subject had been recruited, it was pronounced a success by the Director of GIDS and used to justify a new policy of lowering the age of puberty suppression: ‘Now we’ve done the study and the results thus far have been positive we’ve decided to continue with it’ (Manning and Adams 2014). The lack of publication of the results led to my protracted campaign involving news media (e.g., Tominey and Walsh 2019), complaints to the NHS ethics committee (Health Research Authority 2019), and questions in Parliament (Blackwood of North Oxford 2019). The GIDS delayed publication until the day after the verdict was delivered in the judicial review launched by Keira Bell (Carmichael et al. 2020; 2021). The researchers acknowledge that puberty suppression, after two years, produced no positive effects. These results were significantly inferior to the Dutch results following puberty suppression (Biggs 2020a). The subjects of this experiment have not been followed up after cross-sex hormones; the GIDS admits that it loses track of its patients after the age of 18 (Butler et al. 2018). One of the subjects in the experiment appeared on Twitter (as @mediocredruid): she is deeply distressed by her treatment—GnRHa at 15 led to testosterone, double mastectomy, hysterectomy, vaginectomy, and metoidioplasty—but does not know whether to detransition because the physical changes have been so extreme that she might not be able to pass as a woman.
4. In the United States, puberty suppression became widely adopted from 2008 onwards (Biggs 2020b). Dozens of children’s gender clinics were established to tap into this new lucrative market. The National Institutes of Health awarded \$5.7 million for a prospective longitudinal

study of the effects of GnRHa and cross-sex hormones on children (Children’s Hospital Los Angeles 2015). Subjects were recruited between 2016 and 2018 (Olson-Kennedy et al. 2019). Outcomes after two years on GnRHa were thus collected by 2020, but the researchers have only published on the characteristics of the cohort *before* treatment (Chen et al. 2021; Lee et al. 2020) and on the respective merits of two brands of GnRHa (Olson-Kennedy et al. 2021). As in Britain, practitioners of gender medicine are curiously reluctant to publish the outcomes of puberty suppression for psychological functioning and gender dysphoria—even though those outcomes were the primary justification for the treatment.

The association of gender dysphoria with same-sex attraction and autism spectrum conditions

5. Puberty suppression is founded on the assumption that a child suffering from gender dysphoria at age 12—or even younger, if Tanner stage 2 is reached earlier—is a ‘juvenile transsexual’ whose destiny is fixed. This assumption was known to be false by the clinicians who invented the Dutch protocol, who initially recognized that ‘most GID [gender identity disorder, the precursor to gender dysphoria] children under 12 will not grow up to become transsexuals’ (Cohen-Kettenis and van Goozen 1997, 246). ‘Prospective studies of GID boys show that this phenomenon is more closely related to later homosexuality than to later transsexualism’ (Cohen-Kettenis and Gooren 1999, 319). One of the four studies cited is a famous study of ‘sissy boys’ who were selected because they were thought to be ‘pretranssexuals’; after fifteen years, however, two thirds of the 44 had become bisexual or homosexual men and only one was contemplating transsexuality (Green 1987). A representative longitudinal study of 14,000 children born in 1991–92 shows that those who as infants gravitated towards toys and activities typical of the opposite sex were far more likely by the age of 15 to grow up to be gay or lesbian (Li, Kung, and Hines 2017). All this evidence predates the promotion of transgenderism in healthcare and schools and on social media. The manifesto for the Dutch protocol fails to mention homosexuality and does not cite any of the studies of feminine boys (Delemarre-van de Waal and Cohen-Kettenis 2006). Unpublished data on 27 of the Dutch adolescents were given GnRHa reveals that 26 were homosexual and 1 was bisexual (de Vries 2010, 103). The suspicion must be that at least some of these children could have grown up to be typical gays and lesbians, without requiring lifetime medical treatment and without loss of fertility and sexual function.
6. The overlap between gender dysphoria and autistic spectrum conditions (ASC) is well documented (Socialstyrelsen 2020; Warrier et al. 2020). ‘GD [gender dysphoria] and ASD [autism spectrum disorder, another term for ASC] were found to co-occur frequently—sometimes characterized by atypical presentation of GD, which makes a correct diagnosis and determination of treatment options for GD difficult’ (van der Miesen, Hurley, and de Vries 2016, 70). Children on the autistic spectrum are more likely to face difficulties fitting in with their same-sex peers, which makes a transgender identity obviously appealing as both an explanation and a solution. From a sample of over 700 referrals to the GIDS in 2012 and 2015, 14–15% were diagnosed with ASC (Morandini et al. 2021). This was more than ten times greater than the rate for students in England, 0.8%–1.1% (Department for Education 2012; 2015). The proportion among those subjected to GnRHa could be even higher. Out of the first 30 subjects enrolled in the GIDS experiment on puberty suppression, almost half had

ASC traits: mid to moderate in 9 children, and severe in 5 (Gender Identity Development Service 2015).

The risk of suicide for children suffering from gender dysphoria

7. Surveys demonstrate that adolescents who identify as transgender are vulnerable to suicidal thoughts and self-harming behaviors (dickey and Budge 2020; Hatchel, Polanin, and Espelage 2021; Mann et al. 2019). In New Zealand, 20% of transgender students reported attempting suicide in the past 12 months, compared to 4% of all students (Clark et al. 2014). In the United States, 15% of transgender students reported a suicide attempt requiring medical treatment in the last 12 months, compared to 3% of all students (Centers for Disease Control and Prevention 2018; Jackman et al. 2021; Johns et al. 2019). In another American survey, 41% of transgender students reported having attempted suicide during their lifetime, compared to 14% of all students (Toomey, Syvertsen, and Shramko 2018).
8. Respondents who report suicide attempts are not necessarily indicating an intent to die. One survey of the American population found that almost half the respondents who reported attempting suicide subsequently stated that their action was a cry for help and not intended to be fatal (Nock and Kessler 2006). In two small samples of non-heterosexual youth, half the respondents who initially reported attempting suicide subsequently clarified that they went no further than imagining or planning it; for the remainder who did actually commit suicide, their actions were usually not life-threatening. To an extent, then, ‘the reports were attempts to communicate the hardships of lives or to identify with a gay community’ (Savin-Williams 2001). Such elaborate survey methods have not been used to study transgender populations, but there is anecdotal evidence for a disjuncture between self-harm and suicidal ideation on one hand and fatal suicide on the other. The pediatric endocrinologist who established the first clinic for transgender children in the United States stated that ‘the majority of self-harmful actions that I see in my clinic are not real suicide attempts and are not usually life threatening’ (Spack 2009, 312).
9. Two published studies have reported suicide fatalities among transgender adolescents. Belgium’s pediatric gender clinic provided counselling to 172 youth aged from 12 and 18 years, who had been referred between 2007 and 2016: 5 of them (2.9%) committed suicide (Van Cauwenberg, Dhondt, and Motmans 2021). The mean age of referral was 15, implying a mean duration of 3 years before transition to an adult clinic, which translates to an annual suicide rate of 969 per 100,000.
10. At the Tavistock GIDS, which serves young people under 18 from England, Wales, and Northern Ireland, 4 patients were known or suspected to have died by suicide between 2010 and 2020. The clinic had referrals for approximately 15,000 patients in this period. To calculate the annual suicide rate, the total number of years spent by patients under the clinic’s care is estimated at about 30,000. This yields an annual suicide rate of 13 per 100,000 (95% confidence interval: 4–34). Compared to the United Kingdom population of the same age and sexual composition, the suicide rate for patients at the GIDS was 5.5 times higher (Biggs 2022a). It is not clear what explains the enormous disparity in suicide rates at these two clinics; the Belgian rate is 70 times higher. The suicide rate at the Tavistock is much closer to the rate calculated from 8,000 adults who visited the Amsterdam clinic between 1972 and 2017, which was quadruple that of the Dutch population (Wiepjes et al. 2020).

11. The elevated suicide rate of children who identify as transgender could be explained by some combination of gender dysphoria, accompanying psychological conditions, and ensuing social disadvantages such as bullying. The association between ASC and gender dysphoria was pointed out above. Autism is known to increase the risk of suicide mortality, especially in females (Socialstyrelsen 2020; Hirvikoski et al. 2016; Kirby et al. 2019). To some extent, therefore, the elevated suicide rate for transgender youth compared to their peers reflects the higher incidence of ASC. The same holds for other psychiatric disorders associated with gender dysphoria (Dhejne et al. 2016).
12. The claim that puberty suppression reduces suicidality in children suffering from gender dysphoria is not implausible. Because the risk of suicide increases greatly from prepubescence to late adolescence, halting normal cognitive and emotional development with GnRHa could reduce the risk of suicide by preventing the child from maturing. As yet there is no evidence, however, that endocrinological interventions reduce the risk of suicide. At the GIDS from 2010 to 2020, there is no detectable difference between the suicide rate for patients on the waiting list and for patients who were being seen (Biggs 2022a). In the Belgian clinic which experienced the exceptionally high suicide rate, subsequent correspondence reveals that ‘suicide was related to many more (psychological) problems than their GD [gender dysphoria], and occurred mostly a few years after the start on hormonal treatment’ (email from Gaia Van Cauwenberg to Avi Ring, 27 May 2022).
13. One study claims that puberty suppression reduced subsequent suicidality in adults (Turban et al. 2020). This finding derives from a nonrepresentative survey of transgender adults in the United States, which included 89 respondents who reported taking puberty blockers. Six measures of suicidality and three other measures of mental health and substance abuse were examined, but only one yielded a statistically significant association after controlling for other factors: the respondents who reported taking puberty blockers were less likely to have thought about killing themselves than were the respondents who reported wanting blockers but not obtaining them. This study has numerous serious flaws (Biggs 2020b). Most fundamentally, without information on the respondents’ mental health during adolescence, the causal direction cannot be ascertained. The association could well be explained by clinicians refusing to prescribe GnRHa to adolescents with significant psychological problems, as indeed was then recommended by the Endocrine Society (Hembree et al. 2009). The study did not disclose the fact that one of its authors had been paid by Endo Pharmaceuticals, which manufactures a GnRHa drug (histrelin acetate under the brand Supprelin). At my insistence, the journal issued a correction to admit this conflict of interest (Pediatrics 2021).
14. There are anecdotal reports of children experiencing increased suicidal feelings after GnRHa. At the Leiden clinic, one teenager ‘stopped treatment because of an increase in mood problems and suicidal thoughts and confusion attributed to GnRHa treatment’ (Brik et al. 2020, 2614). One English teenager recalled that GnRHa led to suicidal feelings (Klotz 2022). The triptorelin formulations used in Britain—Gonapeptyl® Depot and Decapeptyl® SR—carry warnings that depression is a common side effect, affecting between 1% and 10% of patients (Ferring Pharmaceuticals Ltd 2016), and ‘may be severe’ (Ipsen Ltd 2017).

The effect of puberty suppression on mental health

15. The first Dutch cohort of 70 children given GnRHa reported generally positive outcomes, by age 16, when they graduated to cross-sex hormones (de Vries et al. 2011). (The actual number of observations ranged from 41 to 57, depending on measure.) Psychological functioning improved, depressive symptoms declined, and behavioural and emotional problems decreased. Gender dysphoria, however, worsened for females. Using the same measures as the Dutch, the first GIDS cohort of 44 children reported no improvement in psychological functioning or gender dysphoria after two years (Carmichael et al. 2021). There was a misleading earlier article from the GIDS which claimed that puberty suppression improved psychological functioning (Costa et al. 2015). It had an extraordinarily high attrition rate—almost half the subjects vanished over 12 months, without explanation—and the claimed effect was actually not statistically significant (Biggs 2019a). It nevertheless continues to be cited as credible evidence for the beneficial effects of puberty suppression.
16. According to a recent study from the Seattle Children’s Gender Clinic, 69 youth aged 13 to 16 experienced dramatically reduced rates of depression and of self-harm or suicidal thoughts after 12 months on GnRHa or cross-sex hormones (Tordoff et al. 2022). (The authors unfortunately do not differentiate these two interventions.) In fact the data for these youth showed no change over time (Singal 2022). The false claim was derived from statistical comparison with youth from the clinic who had not received these endocrinological interventions, whose mental health worsened over time. But this comparison group numbered only 6 patients after 12 months. One obvious explanation is that the clinicians were following the World Professional Association of Transgender Health’s recommendations against commencing medical intervention when an adolescent is experiencing an acute mental health crisis. (This is the same fallacy of causal inference that vitiated Turban et al.’s (2020) study of suicidality.)
17. A proper randomized control trial of the effect of suppressing puberty in mice using GnRHa demonstrated that it caused significantly higher levels of stress in males, and increased anxiety and despair-like behaviour in females (Anacker et al. 2021).

The effect of puberty suppression on bone density

18. The Dutch pioneers warned at the outset that patients could ‘end with a decreased bone density, which is associated with a high risk of osteoporosis’ (Delemarre-van de Waal and Cohen-Kettenis 2006, S134). The fact that GnRHa prevents the accrual of normal bone mass is well documented from Dutch and British studies (Klink et al. 2015; Schagen et al. 2020; Stoffers, de Vries, and Hannema 2019; Vlot et al. 2017; Joseph, Ting, and Butler 2019). In addition, children given GnRHa already have unusually low bone density, perhaps due to the high prevalence of eating disorders. The combined effect can be appreciated by looking at the proportion of adolescents who end up after treatment with severely low bone density, two standard deviations below the average—putting them at risk for osteoporosis. Reanalysis of 31 of the GIDS patients demonstrates that after two years on GnRHa, up to a third had reached this very low range, depending on the measure (hip or spine); only 2.3% of the population would be this low. Moreover, four patients (13%) had spine bone density over

three standard deviations from the mean; only 0.13% of the population would be so extremely low (Biggs 2021).

19. Whether such abnormally low bone density has increased the risk of fractures is unknown because clinics apparently do not collect data on fractures. Anecdotally, a British female patient who started GnRHa at age 12 then experienced four broken bones by the age of 16 (Bannerman 2019). A Swedish documentary highlighted the case of a female who was given GnRHa from age 11 to 15, and now suffers from severe osteoporosis, including continual skeletal pain (SVT 2021).

The effect of puberty suppression on sexual function

20. When GnRHa is used to treat prostate cancer, one side effect is that ‘sexual desire, sexual interest and sexual intercourse were totally annulled’ (Marumo, Baba, and Murai 1999, 19). This is why GnRHa is licensed to chemically castrate men who are sex offenders (Ho et al. 2012; Turner and Briken 2018). Clinicians who use GnRHa off-label to treat gender dysphoria have ignored its effects on sexuality. The Dutch studies, for example, included no measures for libido or capacity for orgasm (de Vries et al. 2011; 2014). The lead author recently described orgasm as ‘a very interesting and so far not studied question’ (Klotz 2022). A Californian surgeon who has performed over 2,000 vaginoplasties (and who is also transgender) recently acknowledged that ‘every single child who was, or adolescent, who was truly blocked at Tanner Stage 2, has never experienced orgasm. I mean, it’s really about zero’ (Bowers 2022). This remark refers to males. The effects of puberty suppression at such an early stage on females is unknown.

The effect of puberty suppression on subsequent medical transition

21. Dutch clinicians initially promoted puberty suppression as providing space for therapeutic exploration of gender identity, without the pressure of the physical changes accompanying puberty (Delemarre-van de Waal and Cohen-Kettenis 2006). This was plausible, perhaps, though it was also plausible that stopping normal sexual and cognitive development would impede such exploration. As the Dutch clinicians admitted at the time, ‘none of the [54] patients who were selected for pubertal suppression has decided to stop taking GnRHa’ (Delemarre-van de Waal and Cohen-Kettenis 2006, S136). It could have been argued that this was due to careful selection of a small number of adolescents for this experimental treatment.
22. Although the number of children subjected to puberty suppression has increased dramatically, they almost invariably continue to cross-sex hormones. Out of 333 children given GnRHa in the Amsterdam clinic to the end of 2015, 326 (98%) continued to cross-sex hormones (Wiepjes et al. 2018). Out of 133 children given GnRHa at the Leiden clinic in the Netherlands who attained the age of eligibility for cross-sex hormones, 128 (96%) continued (Brik et al. 2020). Out of 44 children enrolled in the GIDS experiment with GnRHa, 43 (98%) continued to cross-sex hormones (Carmichael et al. 2021). Out of 54 children given GnRHa by the Royal Children’s Hospital Gender Service in Australia, 53 (98%) continued to cross-sex hormones (Tollit et al. 2021). The suspicion is that puberty suppression reinforces gender dysphoria.
23. Given the fact that there are almost no cases of children ceasing GnRHa, the claim for reversibility is moot. The article that first proposed puberty suppression deemed it to be ‘fully

reversible; in other words, no lasting undesired effects are to be expected' (Gooren and Delemarre-van de Waal 1996, 72). The phrasing acknowledged the lack of actual evidence. Suppressing puberty for just one month would have a negligible effect on a child's development, of course, but the Dutch protocol entails suppression for up to four years (from age 12 to 16). It is simply incredible to claim that suppressing puberty for many years would have no lasting effect if the child were to stop GnRHa and restart their natal sex hormones. The manifesto for the Dutch protocol admitted as much: 'It is not clear yet how pubertal suppression will influence brain development' (Delemarre-van de Waal and Cohen-Kettenis 2006, S137). Randomized experiments with sheep now provide compelling evidence on this point: GnRHa impairs spatial memory, and this impairment remains after the treatment is stopped and puberty is restarted (Hough et al. 2017a; Hough et al. 2017b).

Recent evaluations of puberty suppression by the English and Swedish health systems

24. NHS England commissioned a systematic evaluation of every study on puberty suppression published up to July 2020. From detailed analysis spanning 131 pages, it concluded: 'The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding, and all the results are of very low certainty using modified GRADE [Grading of Recommendations, Assessment, Development and Evaluations, a framework for summarizing medical evidence]. They all reported physical and mental health comorbidities and concomitant treatments very poorly' (National Institute for Clinical Excellence 2020, 23).
25. The Swedish National Board of Health and Welfare updated its recommendations in February 2022, based on a systematic review of the scientific evidence by the Agency for Health Technology Assessment and Assessment of Social Services (Statens beredning för medicinsk och social utvärdering 2022). It states that 'the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming [cross-sex] hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases', in part due to the 'continued lack of reliable scientific evidence concerning the efficacy and the safety of both treatments' (Socialstyrelsen 2022, 3).

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Michael Biggs', with a stylized, cursive script.

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Appended

1. Michael Biggs. 2020b. 'Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria'. *Archives of Sexual Behavior* 49: 2227–29. <https://doi.org/10.1007/s10508-020-01743-6>.
2. Michael Biggs. 2021. 'Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria'. *Journal of Pediatric Endocrinology and Metabolism* 34: 937–39. <https://doi.org/10.1515/jpem-2021-0180>.
3. Michael Biggs. 2022a. 'Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom'. *Archives of Sexual Behavior* 51: 685–90. <https://doi.org/10.1007/s10508-022-02287-7>.
4. Michael Biggs. 2022b. 'The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence'. *Journal of Sex & Marital Therapy*, online. <https://doi.org/10.1080/0092623X.2022.2121238>.

References

- Anacker, Christoph, Ezra Sydnor, Briana K. Chen, Christina C. LaGamma, Josephine C. McGowan, Alessia Mastrodonato, Holly C. Hunsberger, et al. 2021. 'Behavioral and Neurobiological Effects of GnRH Agonist Treatment in Mice: Potential Implications for Puberty Suppression in Transgender Individuals'. *Neuropsychopharmacology* 46: 882–90. <https://doi.org/10.1038/s41386-020-00826-1>.
- Bannerman, Lucy. 2019. 'Puberty Blocking Drugs: "For the Past Four Years I've Been Stuck as a Child"'. *Times*, 26 July 2019. <https://www.thetimes.co.uk/article/transgender-children-puberty-blocking-drugs-for-the-past-four-years-i-ve-been-stuck-as-a-child-5s6tkh7z2>.
- Biggs, Michael. 2019a. 'A Letter to the Editor Regarding the Original Article by Costa et al: Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria'. *Journal of Sexual Medicine* 16: 2043. <https://doi.org/10.1016/j.jsxm.2019.09.002>.
- . 2019b. 'Britain's Experiment with Puberty Blockers'. In *Inventing Transgender Children and Young People*, edited by Michele Moore and Heather Brunskell-Evans, 40–55. Newcastle: Cambridge Scholars Publishing.
- . 2020a. 'Gender Dysphoria and Psychological Functioning in Adolescents Treated with GnRHa: Comparing Dutch and English Prospective Studies'. *Archives of Sexual Behavior* 49: 2231–36. <https://doi.org/10.1007/s10508-020-01764-1>.
- . 2020b. 'Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria'. *Archives of Sexual Behavior* 49: 2227–29. <https://doi.org/10.1007/s10508-020-01743-6>.
- . 2021. 'Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria'. *Journal of Pediatric Endocrinology and Metabolism* 34: 937–39. <https://doi.org/10.1515/jpem-2021-0180>.
- . 2022a. 'Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom'. *Archives of Sexual Behavior* 51: 685–90. <https://doi.org/10.1007/s10508-022-02287-7>.
- . 2022b. 'The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence'. *Journal of Sex & Marital Therapy*. <https://doi.org/10.1080/0092623X.2022.2121238>.
- Blackwood of North Oxford, Baroness. 2019. 'Answer to Written Question HL15681 Asked by Lord Lucas'. Presented at the United Kingdom Parliament, House of Lords, May 22.
- Bowers, Marci. 2022. 'Teen Transitions'. Presented at the Trans and Gender Diverse Policies, Care, Practices, and Wellbeing Symposium, Duke University, March 21. <https://www.facebook.com/dukesgmhealth/videos/704267637246585/>.
- Brik, Tessa, Lieke J.J.J. Vrouwenraets, Martine C. de Vries, and Sabine E. Hannema. 2020. 'Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria'. *Archives of Sexual Behavior* 49: 2611–18. <https://doi.org/10.1007/s10508-020-01660-8>.
- Butler, Gary, Nastasja De Graaf, Bernadette Wren, and Polly Carmichael. 2018. 'Assessment and Support of Children and Adolescents with Gender Dysphoria'. *Archives of Disease in Childhood* 103: 631–36. <https://doi.org/10.1136/archdischild-2018-314992>.
- Carmichael, Polly, Gary Butler, Una Masic, Tim J Cole, Bianca L De Stavola, Sarah Davidson, Elin M. Skageberg, Sophie Khadr, and Russell Viner. 2020. 'Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK'. Preprint. Sexual and Reproductive Health. <https://doi.org/10.1101/2020.12.01.20241653>.
- Carmichael, Polly, Gary Butler, Una Masic, Tim J. Cole, Bianca L. De Stavola, Sarah Davidson, Elin M. Skageberg, Sophie Khadr, and Russell Viner. 2021. 'Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK'. *PLoS ONE* 16: e0243894. <https://doi.org/10.1371/journal.pone.0243894>.
- Centers for Disease Control and Prevention. 2018. '2017 Youth Risk Behavior Survey'. <https://www.cdc.gov/healthyyouth/data/yrbs/data.htm>.
- Chen, Diane, Mere Abrams, Leslie Clark, Diane Ehrensaft, Amy C. Tishelman, Yee-Ming Chan, Robert Garofalo, Johanna Olson-Kennedy, Stephen M. Rosenthal, and Marco A. Hidalgo. 2021. 'Psychosocial Characteristics of Transgender Youth Seeking Gender-Affirming Medical Treatment: Baseline Findings from the Trans Youth Care Study'. *Journal of Adolescent Health* 68 (June): 1104–11. <https://doi.org/10.1016/j.jadohealth.2020.07.033>.

- Children's Hospital Los Angeles. 2015. 'NIH Funds First Ever Multi-Site Study of Transgender Youth in the US with a \$5.7 Million Award'. 14 August 2015. <https://www.newswise.com/articles/nih-funds-first-ever-multi-site-study-of-transgender-youth-in-the-us-with-a-5-7-million-award>.
- Clark, Terryann C., Mathijs F.G. Lucassen, Pat Bullen, Simon J. Denny, Theresa M. Fleming, Elizabeth M. Robinson, and Fiona V. Rossen. 2014. 'The Health and Well-Being of Transgender High School Students: Results from the New Zealand Adolescent Health Survey (Youth'12)'. *Journal of Adolescent Health* 55: 93–99. <https://doi.org/10.1016/j.jadohealth.2013.11.008>.
- Cohen-Kettenis, Peggy T., and Stephanie H.M. van Goozen. 1997. 'Sex Reassignment of Adolescent Transsexuals: A Follow-up Study'. *Journal of the American Academy of Child and Adolescent Psychiatry* 36: 263–71. <https://doi.org/10.1097/00004583-199702000-00017>.
- Cohen-Kettenis, Peggy T., Sebastiaan E.E. Schagen, Thomas D. Steensma, Annelou L.C. de Vries, and Henriette A. Delemarre-van de Waal. 2011. 'Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-Up'. *Archives of Sexual Behavior* 40: 843–47. <https://doi.org/10.1007/s10508-011-9758-9>.
- Cohen-Kettenis, P.T., and L.J.G. Gooren. 1999. 'Transsexualism: A Review of Etiology, Diagnosis and Treatment'. *Journal of Psychosomatic Research* 46: 315–33.
- Costa, Rosalia, Michael Dunsford, Elin Skagerberg, Victoria Holt, Polly Carmichael, and Marco Colizzi. 2015. 'Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria'. *Journal of Sexual Medicine* 12: 2206–14. <https://doi.org/10.1111/jsm.13034>.
- Delemarre-van de Waal, Henriette A., and Peggy T. Cohen-Kettenis. 2006. 'Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects'. *European Journal of Endocrinology* 155 (suppl_1): S131–37. <https://doi.org/10.1530/eje.1.02231>.
- Department for Education. 2012. 'Special Educational Needs in England, January 2012'. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2012>.
- . 2015. 'Special Educational Needs in England, January 2015'. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2015>.
- Dhejne, Cecilia, Roy Van Vlerken, Gunter Heylens, and Jon Arcelus. 2016. 'Mental Health and Gender Dysphoria: A Review of the Literature'. *International Review of Psychiatry* 28 (January): 44–57. <https://doi.org/10.3109/09540261.2015.1115753>.
- dickey, lore m., and Stephanie L. Budge. 2020. 'Suicide and the Transgender Experience: A Public Health Crisis'. *American Psychologist* 75: 380–90. <https://doi.org/10.1037/amp0000619>.
- Ferring Pharmaceuticals Ltd. 2016. 'Package Leaflet: ... Gonapeptyl® Depot 3.75mg'. <http://www.medicines.org.uk/emc/product/2229/pil>.
- Gender Identity Development Service. 2015. 'Preliminary Results from the Early Intervention Research'. In *Board of Directors Part One: Agenda and Papers ... 23rd June 2015*, 50–55.
- Gooren, Louis, and Henriette Delemarre-van de Waal. 1996. 'The Feasibility of Endocrine Interventions in Juvenile Transsexuals'. *Journal of Psychology and Human Sexuality* 8: 69–74. https://doi.org/10.1300/J056v08n04_05.
- Green, Richard. 1987. *The Sissy Boy Syndrome: The Development of Homosexuality*. Yale University Press.
- Hatchel, Tyler, Joshua R. Polanin, and Dorothy L. Espelage. 2021. 'Suicidal Thoughts and Behaviors among LGBTQ Youth: Meta-Analyses and a Systematic Review'. *Archives of Suicide Research* 25: 1–37. <https://doi.org/10.1080/13811118.2019.1663329>.
- Health Research Authority. 2019. 'Investigation into the Study "Early Pubertal Suppression in a Carefully Selected Group of Adolescents with Gender Identity Disorders"'. 14 October 2019. <https://www.hra.nhs.uk/about-us/governance/feedback-raising-concerns/investigation-study-early-pubertal-suppression-carefully-selected-group-adolescents-gender-identity-disorders/>.
- Hembree, Wylie C., Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, Walter J. Meyer, Norman P. Spack, Vin Tangpricha, and Victor M. Montori. 2009. 'Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline'. *Journal of Clinical Endocrinology and Metabolism* 94: 3132–54. <https://doi.org/10.1210/jc.2009-0345>.
- Hirvikoski, Tatja, Ellenor Mittendorfer-Rutz, Marcus Boman, Henrik Larsson, Paul Lichtenstein, and Sven Bölte. 2016. 'Premature Mortality in Autism Spectrum Disorder'. *British Journal of Psychiatry* 208 (March): 232–38. <https://doi.org/10.1192/bjp.bp.114.160192>.
- Ho, David K., Giriya Kottalgi, Callum C. Ross, Jose Romero-Ulceray, and Mrigendra Das. 2012. 'Treatment with Triptorelin in Mentally Disordered Sex Offenders: Experience From a Maximum-Security Hospital'. *Journal of Clinical Psychopharmacology* 32: 739–40. <https://doi.org/10.1097/JCP.0b013e318266c6f5>.

- Hough, D., M. Bellingham, I.R. Haraldsen, M. McLaughlin, J.E. Robinson, A.K. Solbakk, and N.P. Evans. 2017. 'A Reduction in Long-Term Spatial Memory Persists after Discontinuation of Peripubertal GnRH Agonist Treatment in Sheep'. *Psychoneuroendocrinology* 77: 1–8. <https://doi.org/10.1016/j.psyneuen.2016.11.029>.
- Hough, D., M. Bellingham, I.R.H. Haraldsen, M. McLaughlin, M. Rennie, J.E. Robinson, A.K. Solbakk, and N.P. Evans. 2017. 'Spatial Memory Is Impaired by Peripubertal GnRH Agonist Treatment and Testosterone Replacement in Sheep'. *Psychoneuroendocrinology* 75: 173–82. <https://doi.org/10.1016/j.psyneuen.2016.10.016>.
- Ipsen Ltd. 2017. 'Package Leaflet: ... Decapeptyl® SR 11.25 Mg'. <http://www.medicines.org.uk/emc/product/780/pil>.
- Jackman, Kasey B., Billy A. Caceres, Elizabeth J. Kreuze, and Walter O. Bockting. 2021. 'Suicidality among Gender Minority Youth: Analysis of 2017 Youth Risk Behavior Survey Data'. *Archives of Suicide Research* 25: 208–23. <https://doi.org/10.1080/13811118.2019.1678539>.
- Johns, Michelle M, Richard Lowry, Jack Andrzejewski, Lisa C Barrios, Zewditu Demissie, Timothy McManus, Catherine N Rasberry, Leah Robin, and J Michael Underwood. 2019. 'Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors among High School Students: 19 States and Large Urban School Districts, 2017'. *Morbidity and Mortality Weekly Report* 68: 69–71.
- Joseph, Tobin, Joanna Ting, and Gary Butler. 2019. 'The Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria: Findings from a Large National Cohort'. *Journal of Pediatric Endocrinology and Metabolism* 32: 1077–81. <https://doi.org/10.1515/jpem-2019-0046>.
- Kirby, Anne V., Amanda V. Bakian, Yue Zhang, Deborah A. Bilder, Brooks R. Keeshin, and Hilary Coon. 2019. 'A 20-year Study of Suicide Death in a Statewide Autism Population'. *Autism Research* 12 (April): 658–66. <https://doi.org/10.1002/aur.2076>.
- Klink, Daniel, Martine Caris, Annemieke Heijboer, Michael van Trotsenburg, and Joost Rotteveel. 2015. 'Bone Mass in Young Adulthood Following Gonadotropin-Releasing Hormone Analog Treatment and Cross-Sex Hormone Treatment in Adolescents with Gender Dysphoria'. *Journal of Clinical Endocrinology and Metabolism* 100: E270–75. <https://doi.org/10.1210/jc.2014-2439>.
- Klotz, Frieda. 2022. 'The Fractious Evolution of Pediatric Transgender Medicine'. *Undark Magazine*. 6 April 2022. <https://undark.org/2022/04/06/the-evolution-of-pediatric-transgender-medicine/>.
- Lee, Janet Y, Courtney Finlayson, Johanna Olson-Kennedy, Robert Garofalo, Yee-Ming Chan, David V Glidden, and Stephen M Rosenthal. 2020. 'Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study'. *Journal of the Endocrine Society* 4: bvaa065. <https://doi.org/10.1210/jendso/bvaa065>.
- Levine, Stephen B., E. Abbruzzese, and Julia M. Mason. 2022. 'Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults'. *Journal of Sex and Marital Therapy*. <https://doi.org/10.1080/0092623X.2022.2046221>.
- Li, Gu, Karson T. F. Kung, and Melissa Hines. 2017. 'Childhood Gender-Typed Behavior and Adolescent Sexual Orientation: A Longitudinal Population-Based Study'. *Developmental Psychology* 53: 764–77. <https://doi.org/10.1037/dev0000281>.
- Mann, Georgina E, Amelia Taylor, Bernadette Wren, and Nastasja de Graaf. 2019. 'Review of the Literature on Self-Injurious Thoughts and Behaviours in Gender-Diverse Children and Young People in the United Kingdom'. *Clinical Child Psychology and Psychiatry* 24: 304–21. <https://doi.org/10.1177/1359104518812724>.
- Manning, Sanchez, and Steven Adams. 2014. 'NHS to Give Sex Change Drugs to Nine-Year-Olds: Clinic Accused of "playing God" with Treatment That Stops Puberty'. *Mail on Sunday*, 17 May 2014. <https://www.dailymail.co.uk/news/article-2631472/NHS-sex-change-drugs-nine-year-olds-Clinic-accused-playing-God-treatment-stops-puberty.html>.
- Marumo, Ken, Shiro Baba, and Masaru Murai. 1999. 'Erectile Function and Nocturnal Penile Tumescence in Patients with Prostate Cancer Undergoing Luteinizing Hormone-releasing Hormone Agonist Therapy'. *International Journal of Urology* 6: 19–23. <https://doi.org/10.1046/j.1442-2042.1999.06128.x>.
- Miesen, Anna I.R. van der, Hannah Hurley, and Annelou L.C. de Vries. 2016. 'Gender Dysphoria and Autism Spectrum Disorder: A Narrative Review'. *International Review of Psychiatry* 28: 70–80. <https://doi.org/10.3109/09540261.2015.1111199>.
- Morandini, James S, Aidan Kelly, Nastasja M de Graaf, Polly Carmichael, and Ilan Dar-Nimrod. 2021. 'Shifts in Demographics and Mental Health Co-Morbidities among Gender Dysphoric Youth Referred to a Specialist Gender Dysphoria Service'. *Clinical Child Psychology and Psychiatry*, October. <https://doi.org/10.1177/13591045211046813>.

- National Institute for Clinical Excellence. 2020. 'Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria'.
- Nock, Matthew K, and Ronald C Kessler. 2006. 'Prevalence of and Risk Factors for Suicide Attempts versus Suicide Gestures: Analysis of the National Comorbidity Survey'. *Journal of Abnormal Psychology* 115: 616–23. <https://doi.org/10.1037/0021-843X.115.3.616>.
- Olson-Kennedy, Johanna, Yee-Ming Chan, Robert Garofalo, Norman Spack, Diane Chen, Leslie Clark, Diane Ehrensaft, Marco Hidalgo, Amy Tishelman, and Stephen Rosenthal. 2019. 'Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study'. *JMIR Research Protocols* 8 (July): e14434. <https://doi.org/10.2196/14434>.
- Olson-Kennedy, Johanna, Laer H. Streeter, Robert Garofalo, Yee-Ming Chan, and Stephen M. Rosenthal. 2021. 'Histrelin Implants for Suppression of Puberty in Youth with Gender Dysphoria: A Comparison of 50 Mcg/Day (Vantas) and 65 Mcg/Day (SupprelinLA)'. *Transgender Health* 6: 36–42. <https://doi.org/10.1089/trgh.2020.0055>.
- Pediatrics. 2021. 'Erratum for TURBAN 2019-1725'. *Pediatrics* 147: e2020049767. <https://doi.org/10.1542/peds.2020-049767>.
- Savin-Williams, Ritch C. 2001. 'Suicide Attempts among Sexual-Minority Youths: Population and Measurement Issues'. *Journal of Consulting and Clinical Psychology* 69: 983–91. <https://doi.org/10.1037/0022-006X.69.6.983>.
- Schagen, Sebastian E.E., Femke M. Wouters, Peggy T. Cohen-Kettenis, Louis J. Gooren, and Sabine E. Hannema. 2020. 'Bone Development in Transgender Adolescents Treated with GnRH Analogues and Subsequent Gender-Affirming Hormones'. *Journal of Clinical Endocrinology and Metabolism* 105: e4252–63. <https://doi.org/10.1210/clinem/dgaa604>.
- Singal, Jesse. 2022. 'Researchers Found Puberty Blockers and Hormones Didn't Improve Trans Kids' Mental Health at Their Clinic, Then They Published a Study Claiming the Opposite'. *Singal-Minded* (blog). 6 April 2022. <https://jessesingal.substack.com/p/researchers-found-puberty-blockers>.
- Socialstyrelsen. 2020. 'Utvecklingen av diagnosen könsdysfori [The evolution of the diagnosis of gender dysphoria]'. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6600.pdf>.
- . 2022. 'Care of Children and Adolescents with Gender Dysphoria: Summary'.
- Spack, Norman P. 2009. 'An Endocrine Perspective on the Care of Transgender Adolescents'. *Journal of Gay & Lesbian Mental Health* 13: 309–19. <https://doi.org/10.1080/19359700903165381>.
- Statens beredning för medicinsk och social utvärdering. 2022. 'Hormonbehandling vid könsdysfori - barn och unga'.
- Stoffers, Iris E., Martine C. de Vries, and Sabine E. Hannema. 2019. 'Physical Changes, Laboratory Parameters, and Bone Mineral Density during Testosterone Treatment in Adolescents with Gender Dysphoria'. *Journal of Sexual Medicine* 16: 1459–68. <https://doi.org/10.1016/j.jsxm.2019.06.014>.
- SVT, dir. 2021. 'Transbarnen [Trans Kids]'. *Uppdrag Granskning [Mission Investigate]*. Sveriges Television.
- Tollit, Michelle A., Tamara May, Tiba Maloof, Michelle M. Telfer, Denise Chew, Melanie Engel, and Ken Pang. 2021. 'The Clinical Profile of Patients Attending a Large, Australian Pediatric Gender Service: A 10-Year Review'.
- Tominey, Camilla, and Joani Walsh. 2019. 'NHS Transgender Clinic Accused of Covering up Negative Impacts of Puberty Blockers on Children by Oxford Professor'. *Telegraph*, 7 March 2019. <https://www.telegraph.co.uk/news/2019/03/07/nhs-transgender-clinic-accused-covering-negative-impacts-puberty/>.
- Toomey, Russell B., Amy K. Syvertsen, and Maura Shramko. 2018. 'Transgender Adolescent Suicide Behavior'. *Pediatrics* 142: e20174218. <https://doi.org/10.1542/peds.2017-4218>.
- Tordoff, Diana M., Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland, and Kym Ahrens. 2022. 'Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care'. *JAMA Network Open* 5: e220978. <https://doi.org/10.1001/jamanetworkopen.2022.0978>.
- Turban, Jack L., Dana King, Jeremi M. Carswell, and Alex S. Keuroghlian. 2020. 'Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation'. *Pediatrics* 145: e20191725. <https://doi.org/10.1542/peds.2019-1725>.
- Turner, Daniel, and Peer Briken. 2018. 'Treatment of Paraphilic Disorders in Sexual Offenders or Men with a Risk of Sexual Offending with Luteinizing Hormone-Releasing Hormone Agonists: An Updated Systematic Review'. *Journal of Sexual Medicine* 15: 77–93. <https://doi.org/10.1016/j.jsxm.2017.11.013>.

- Van Cauwenberg, Gaia, Karlien Dhondt, and Joz Motmans. 2021. 'Ten Years of Experience in Counseling Gender Diverse Youth in Flanders, Belgium: A Clinical Overview'. *International Journal of Impotence Research*. <https://doi.org/10.1038/s41443-021-00441-8>.
- Viner, Russell, Polly Carmichael, Domenico Di Ceglie, Gary Butler, Caroline Brain, Victoria Holt, Sophie Khadr, and Elin Skagerberg. 2010. 'An Evaluation of Early Pubertal Suppression in a Carefully Selected Group of Adolescents with Gender Identity Disorder (v1.0)'.
- Vlot, Mariska C., Daniel T. Klink, Martin den Heijer, Marinus A. Blankenstein, Joost Rotteveel, and Annemieke C. Heijboer. 2017. 'Effect of Pubertal Suppression and Cross-Sex Hormone Therapy on Bone Turnover Markers and Bone Mineral Apparent Density (BMAD) in Transgender Adolescents'. *Bone* 95: 11–19. <https://doi.org/10.1016/j.bone.2016.11.008>.
- Vries, Annelou L.C. de. 2010. 'Gender Dysphoria in Adolescents: Mental Health and Treatment Evaluation'. PhD, Vrije Universiteit Amsterdam. <https://research.vu.nl/en/publications/gender-dysphoria-in-adolescents-mental-health-and-treatment-evalu>.
- Vries, Annelou L.C. de, Jennifer K. McGuire, Thomas D. Steensma, Eva C.F. Wagenaar, Theo A.H. Doreleijers, and Peggy T. Cohen-Kettenis. 2014. 'Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment'. *Pediatrics* 134: 696–704. <https://doi.org/10.1542/peds.2013-2958>.
- Vries, Annelou L.C. de, Thomas D. Steensma, Theo A.H. Doreleijers, and Peggy T. Cohen-Kettenis. 2011. 'Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-up Study'. *Journal of Sexual Medicine* 8: 2276–83. <https://doi.org/10.1111/j.1743-6109.2010.01943.x>.
- Warrier, Varun, David M. Greenberg, Elizabeth Weir, Clara Buckingham, Paula Smith, Meng-Chuan Lai, Carrie Allison, and Simon Baron-Cohen. 2020. 'Elevated Rates of Autism, Other Neurodevelopmental and Psychiatric Diagnoses, and Autistic Traits in Transgender and Gender-Diverse Individuals'. *Nature Communications* 11 (3959). <https://doi.org/10.1038/s41467-020-17794-1>.
- Wiepjes, C. M., M. den Heijer, M. A. Bremmer, N. M. Nota, C. J. M. Blok, B. J. G. Coumou, and T. D. Steensma. 2020. 'Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972–2017)'. *Acta Psychiatrica Scandinavica* 141: 486–91. <https://doi.org/10.1111/acps.13164>.
- Wiepjes, Chantal M., Nienke M. Nota, Christel J.M. de Blok, Maartje Klaver, Annelou L.C. de Vries, S. Annelijn Wensing-Kruger, Renate T. de Jongh, et al. 2018. 'The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets'. *Journal of Sexual Medicine* 15: 582–90. <https://doi.org/10.1016/j.jsxm.2018.01.016>.

Letter to the Editor

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Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria

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To the Editors,

I write to respond to Joseph, Ting, and Butler's recent article, describing the effect of administering gonadotropin-releasing hormone analogue (GnRHa) to suppress puberty in adolescents diagnosed with gender dysphoria [1]. The mean of the patients' bone mineral density (BMD)—relative to the norm for their sex and age—declined significantly over 2 years. What really matters is the lower tail of the distribution, but this information was omitted by Joseph et al. This letter analyses individual data on 24 patients from Joseph et al.'s sample of 31 [2]. It finds that after 2 years of GnRHa, up to a third of patients had abnormally low bone density, in the lowest 2.3% of the distribution for their sex and age. A few patients recorded extremely low values, in the lowest 0.13% of the distribution. This finding undermines Joseph et al.'s conclusions.

The Dutch pioneers of this experimental treatment for gender dysphoria warned that patients could 'end with a decreased bone density, which is associated with a high risk of osteoporosis' [3]. The effects on bone density have been described by four Dutch studies [4–7], besides Joseph et al. BMD is measured by a dual energy X-ray absorptiometry (DXA) scan over the spine (lumbar) and the hip (femoral neck). The absolute value of BMD is standardized as a Z-score, expressing this individual's BMD relative to the population of the same sex and age. BMD can be adjusted for

height to derive the volumetric bone mineral apparent density (BMAD), which is likewise standardized as a Z-score.

A Z-score below -2 is considered low; it indicates bone density in the lowest 2.3% of the population of the same sex and age [8]. Joseph et al. argue that 'this is not the sole definition of low bone mass in children, nor is this criterion a recognized predictor of later fracture risk'. But this threshold was prominent in the experiment which introduced puberty suppression for gender dysphoria to Britain. The original experimental protocol (co-authored by Butler) in 2010 excluded any child with a spine or hip BMD Z-score below -2 . In 2012, however, this exclusion criterion was relaxed 'in exceptional circumstances'—if clinicians 'feel that on the balance of risks, pubertal suppression is an appropriate option despite risks of osteoporosis in later adult life' and patients 'understand the risks of GnRH analogue treatment for bone density (i.e., risks of later osteoporosis)' [9].

Information on the lower tail of the distribution of Z-scores—below -2 —is omitted by Joseph et al. and by three out of four Dutch studies. Describing distributions by mean (and standard deviation) is not sufficient when clinical concern focuses on very low values. This will be illustrated for patients experiencing 2 years of puberty suppression. Joseph et al.'s sample after 24 months on GnRHa comprised 31 patients. Data on 24 of these patients—or at least patients from the same clinic at University College London Hospital—have recently been released, though sex is unavailable [2]. These patients were enrolled in the British experiment which recruited patients from 2011 to 2015. The Stata do file to replicate the analysis is posted at <https://doi.org/10.7910/DVN/FSOMME>.

Table 1 shows mean Z-scores for Joseph et al.'s three measures of BMD, at baseline and at 24 months (the hip measure is missing for three patients). The 2011–15 sample is naturally similar to Joseph et al.'s. The decline in the mean of all three scores is statistically significant in both samples ($p \leq 0.004$ in every paired t-test).

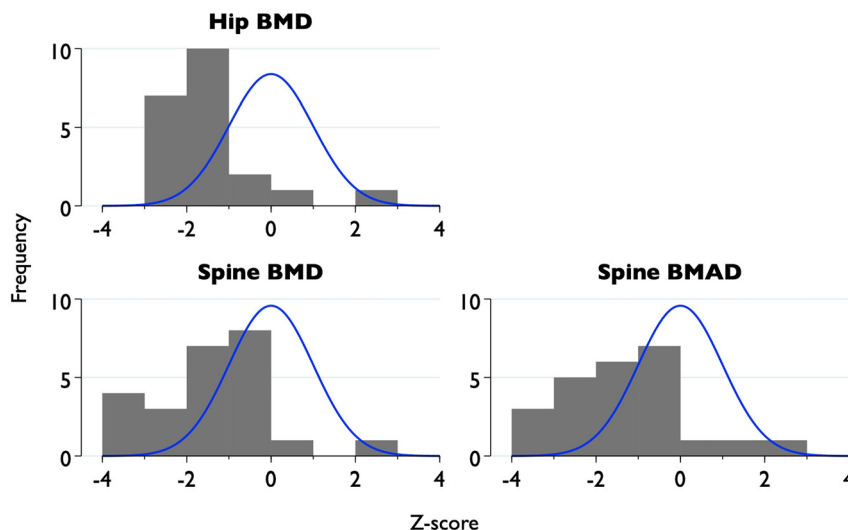
Using data from the 2011–15 sample, Figure 1 depicts the distributions of Z-scores at 24 months, along with the

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Table 1: Bone density in adolescents undergoing puberty suppression.

	Hip BMD		Spine BMD		Spine BMAD	
	Joseph et al.	2011–15	Joseph et al.	2011–15	Joseph et al.	2011–15
Mean Z-score at baseline	−0.58	−0.55	−0.44	−0.34	−0.09	−0.46
Mean Z-score at 24 months	−1.40	−1.45	−1.64	−1.46	−0.71	−1.28
Change in Z-score	−0.82	−0.90	−1.20	−1.12	−0.62	−0.81
p-value (two-tailed)	0.000	0.000	0.000	0.000	0.000	0.004
n	31	21	31	24	31	24

BMD, bone mineral density; BMAD, bone mineral apparent density.



n = 24 for spine, 21 for hip. BMAD, bone mineral apparent density; BMD, bone mineral density.

Figure 1: Bone density after 24 months of puberty suppression.

Normal distribution to compare with the population of the same sex and age. For hip BMD, a third of patients had a low Z-score, below −2. For spine BMD, more than a quarter of patients had low Z-scores. The lower tail extended far beyond. Indeed, four patients had Z-scores below −3, putting them in the bottom 0.13% of the population. Adjusting for height, by computing spine BMAD, does not shrink the lower tail.

Given that puberty suppression left up to a third of patients with abnormally low bone density, Joseph et al.'s recommendations are surprisingly complacent. One is to reduce DXA monitoring which 'can have significant financial implications for healthcare providers'. Another is to change the computation of Z-scores; 'reference ranges may need to be re-defined for this select patient cohort'. Rather than altering a measure that provides inconvenient findings, practitioners of puberty suppression must record fractures as adverse events. One British patient who started GnRHa at age 12 then experienced four broken bones by the age of 16 [10]. This history, if it were combined with BMD Z-scores below −2, would meet the diagnostic criteria for

paediatric osteoporosis [11]. Whether this case is exceptional is unknown because clinicians have failed to collect relevant data.

References

1. Joseph T, Ting J, Butler G. The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: findings from a large national cohort. *J Pediatr Endocrinol Metab* 2019;32:1077–81.
2. Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PloS One* 2021;16:e0243894.
3. Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *Eur J Endocrinol* 2006;155:S131–7.
4. Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab* 2015; 100:E270–5.

5. Schagen SEE, Wouters FM, Cohen-Kettenis PT, Gooren LJ, Hannema SE. Bone development in transgender adolescents treated with GnRH analogues and subsequent gender-affirming hormones. *J Clin Endocrinol Metab* 2020;105:e4252–63.
6. Stoffers IE, de Vries MC, Hannema SE. Physical changes, laboratory parameters, and bone mineral density during testosterone treatment in adolescents with gender dysphoria. *J Sex Med* 2019;16:1459–68.
7. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone* 2017;95:11–9.
8. Lee JY, Finlayson C, Olson-Kennedy J, Garofalo R, Chan Y-M, Glidden DV, et al. Low bone mineral density in early pubertal transgender/gender diverse youth: findings from the Trans Youth Care Study. *J Endocr Soc* 2020;4:bvaa065.
9. Viner R, Carmichael P, Ceglie DD, Butler G, Brain C, Holt V, et al. An evaluation of early pubertal suppression in a carefully selected group of adolescents with gender identity disorder (v1.2); 2012.
10. Bannerman L. Puberty blocking drugs: 'for the past four years I've been stuck as a child' (26 July 2019). *Times*; 2019. Available from: <https://www.thetimes.co.uk/article/transgender-children-puberty-blocking-drugs-for-the-past-four-years-i-ve-been-stuck-as-a-child-5s6tkh7z2>.
11. Bachrach LK, Gordon CM, AAP Section on Endocrinology. Bone densitometry in children and adolescents. *Pediatrics* 2016;138:e20162398.



Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom

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Introduction

Surveys show that adolescents who identify as transgender are vulnerable to suicidal thoughts and self-harming behaviors (Dickey & Budge, 2020; Hatchel et al., 2021; Mann et al., 2019). Little is known about death by suicide. This Letter presents data from the Gender Identity Development Service (GIDS), the publicly funded clinic for children and adolescents aged under 18 from England, Wales, and Northern Ireland. From 2010 to 2020, four patients were known or suspected to have died by suicide, out of about 15,000 patients (including those on the waiting list). To calculate the annual suicide rate, the total number of years spent by patients under the clinic's care is estimated at about 30,000. This yields an annual suicide rate of 13 per 100,000 (95% confidence interval: 4–34). Compared to the United Kingdom population of similar age and sexual composition, the suicide rate for patients at the GIDS was 5.5 times higher. The proportion of patients dying by suicide was far lower than in the only pediatric gender clinic which has published data, in Belgium (Van Cauwenberg et al., 2021).

Suicidality in Transgender Adolescents

“About half of young trans people...attempt suicide,” declared the United Kingdom Parliament's Women and Equalities Committee (2015). Similar figures are cited by news media and campaigning organizations. The *Guardian* reported Stonewall's statistic that “almost half” of transgender young people “have attempted to kill themselves” (Weale, 2017). “Fifty percent of transgender youth attempt suicide before they are at age 21” stated the mother of the most famous transgender youth in the English-speaking world (Jennings & Jennings, 2016). As a transgender theologian has

observed, “the statistic about suicide attempts has, in essence, developed a life of its own” (Tanis, 2016).

Representative surveys of students in high schools provide one source of evidence for this statistic. In New Zealand, 20% of transgender students reported attempting suicide in the past 12 months, compared to 4% of all students (Clark et al., 2014). In the United States, 15% of transgender students reported a suicide attempt requiring medical treatment in the last 12 months, compared to 3% of all students (Centers for Disease Control & Prevention, 2018; Jackman et al., 2021; Johns et al., 2019). In another American survey, 41% of transgender students reported having attempted suicide during their lifetime, compared to 14% of all students (Toomey et al., 2018).

To what extent are self-reported suicide attempts reflected in fatalities? The connection is not straightforward. Respondents who report suicide attempts are not necessarily indicating an intent to die. One survey of the American population found that almost half the respondents who reported attempting suicide subsequently stated that their action was a cry for help and not intended to be fatal (Nock & Kessler, 2006). In two small samples of non-heterosexual youth, half the respondents who initially reported attempting suicide subsequently clarified that they went no further than imagining or planning it; for the remainder who did actually attempt suicide, their actions were usually not life-threatening. To an extent, then, “the reports were attempts to communicate the hardships of lives or to identify with a gay community” (Savin-Williams, 2001). Although such elaborate survey methods have not been used to study transgender populations, there is anecdotal evidence for a similar disjuncture. The pediatric endocrinologist who established the first clinic for transgender children in the United States stated that “the majority of self-harmful actions that I see in my clinic are not real suicide attempts and are not usually life threatening” (Spack, 2009).

Suicide mortality has been studied in the transgender population using registry data. The annual suicide rate is calculated by dividing the number of suicides by the total number of years each person was at risk. An individual who was observed for 20 years, for instance, contributes 20 person-years to the denominator. The

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largest study covers over 8,000 patients who visited the gender clinic in Amsterdam from 1972 to 2017 (Wiepjes et al., 2020). The annual suicide rate was 29 per 100,000 for transmen, quadruple the rate for the female population, and 64 for transwomen, quadruple the rate for the male population. A Swedish study of 324 individuals who had undergone genital surgery between 1973 and 2003 found much higher annual suicide rates: 250 per 100,000 for transmen, 43 times the rate for matched female controls, and 285 for transwomen, 16 times the rate for matched male controls (M. Boman, personal communication, 12 April 2021; Dhejne et al., 2011). Only one published study has reported suicide fatalities among transgender adolescents. Belgium's pediatric gender clinic provided counseling to 177 youth aged from 12 to 18 years, who had been referred between 2007 and 2016: five of them (2.8%) committed suicide (Van Cauwenberg et al., 2021). The mean age of referral was 15, implying a mean duration of 3 years before transition to an adult clinic, which translates to an annual suicide rate of 942 per 100,000. This is the highest suicide mortality recorded for any transgender population.

Method

This Letter estimates the suicide rate at the world's largest pediatric gender clinic. Based in London, the GIDS is part of the Tavistock and Portman NHS Foundation Trust, and serves youth under 18 from England, Wales, and Northern Ireland who are "experiencing difficulties with their gender identity development" (Carmichael & Davidson, 2009). Like all such services throughout Western Europe and North America, it has experienced enormous growth; referrals increased from 100 in 2009 to a peak of 2700 in 2019. The waiting list in April 2021 exceeded 5300.

The GIDS patients manifest typically high rates of self-harming behavior. In a sample of 900 adolescents (aged from 13 to 17) admitted to the clinic from 2009 to 2017 and given the Youth Self-Report questionnaire, 44% answered that they sometimes or very often "deliberately try to hurt or kill myself" (de Graaf et al., 2020). Unfortunately, both behaviors are combined in this question. In a different sample of over 700 children and adolescents (aged from 4 to 17) assessed by the GIDS in 2012 and 2015, 10% were flagged by clinicians as having attempted suicide (Morandini et al., 2021).

Suicides

Since the early 2000s, the National Health Service has implemented mandatory reporting of "serious incidents" (Department of Health, 2001, 2010). The death of any patient—including those on the waiting list—suspected to be suicide is reported to the Tavistock's Board of Directors. The Tavistock cooperates with a comprehensive surveillance system for every death

classified as suicide or (after an open verdict by the coroner) probable suicide in the United Kingdom (National Confidential Inquiry into Suicide & Homicide by People with Mental Illness, 1999; National Confidential Inquiry into Suicide and Safety in Mental Health, 2019). Papers for the Tavistock's Board meetings are available from April 2007 onwards; those not on the Trust's website were acquired by a Freedom of Information request. The pdf files of the *Agenda and Papers* (through September 2021) were searched for the keyword "suicid"; all 442 instances were inspected. From 2007 to 2020, four patients of the GIDS died by suspected suicide: two on the waiting list, in 2016 and 2017; and two after having been seen, in 2017 and 2020. The last case was described as "likely" to be suicide, because the inquest has not yet been held. These figures were confirmed by Freedom of Information requests to the Tavistock.

Triangulation is possible from two sources. Comprehensive mortality data on all adolescents aged from 10 to 19 who committed suicide in the United Kingdom from 2014 to 2016 include five transgender individuals (Rodway et al., 2020). Due to confidentiality restrictions, it is not possible to disaggregate these further by age or by country. Presumably, one of these is the patient of GIDS who died in 2016. The remaining four might have been 18 or 19—the risk of suicide increases significantly in the late teens—or might have lived in Scotland. Alternatively, they might have been eligible for the GIDS but had not sought a clinical referral (made by the local Child and Adolescent Mental Health Service, the child's general practitioner, social worker, or teacher) or had not obtained it.

Another source is the Transgender Day of Remembrance website, which aims to record all deaths by suicide or violence (Metcalf, 2021). For the United Kingdom between 2007 and 2020, the website names 3 adolescents under the age of 18 who committed suicide. One was one of the GIDS patients (the match is certain because they were named in the *Agenda and Papers*). The other two had no involvement with the GIDS (or any other gender clinician), as was evident from their inquests, though one was under the psychiatric care of another NHS Trust (BBC News, 2021; Bunyan, 2008). In addition, the website lists suicides by two "young" transgender people, sourced from Twitter, without information on their name or age. In one case, it is not clear whether the person lived in the United Kingdom.

Patients

With suicides as numerator, two denominators are relevant. Because comprehensive data on patient numbers became available from 2010, the period will be the 11 years from 2010 to 2020. (These are financial years; thus, 2020 runs from April 2020 to March 2021.) The first denominator is the total number of individual patients, estimated by summing the annual number of referrals to the GIDS from 2010 to 2020—excluding those aged 18 or over, as they are not accepted. The total number is 15,032. This sum omits patients at the clinic who had been referred before

2010, and so is a slight underestimate. (The Online Supplement provides full details.)

The second denominator is the total number of patient-years: the sum of the number of years spent by each individual as a patient of the GIDS. The number of patients seen by the GIDS each year was available from 2014 to 2020. Before 2014 only the number of patients first seen was available. From 2014 to 2016, the number of patients seen was consistently double the number first seen, and so the former number for 2010 to 2013 was estimated by doubling the latter. All these numbers exclude patients on the waiting list. The number waiting at the beginning of each year from 2016 to 2020 was obtained by Freedom of Information request. Before then the number was not available, and so must be treated as zero. This leads to an underestimate, of course, but the waiting list became appreciable only from 2015. The total number of patient-years over this period is estimated as 30,080. In other words, patients spent on average 2 years at the GIDS (including time on the waiting list). Time on the waiting list contributed 41% of the total patient-years.

Results

From 2010 to 2020, the four suicide deaths equate to 0.03% of the 15,032 patients. Taking the denominator as 30,080 patient-years, the annual suicide rate is calculated as 13 per 100,000 (95% confidence interval: 4 to 34 per 100,000). For comparison, the annual suicide rate in England and Wales between 2010 and 2020 for adolescents aged from 15 to 19 years averaged 4.7 (Office for National Statistics, 2021). This does not quite correspond to the age range of the GIDS patients, however. At referral, the patients ranged in age from 3 to 17 years; only 7% were younger than 10. The mean was 14 years and the median 15. Most patients stay with the GIDS until transitioning to an adult service. Therefore, the average age of patients at any point in time will lie somewhere between 14 and 17. A better comparison is therefore the overall suicide rate for adolescents aged from 14 to 17 (available only for the entire United Kingdom for 2015–2017), which was 2.7 per 100,000 (Office for National Statistics, 2018; Rodway et al., 2020). Comparison should also account for the difference between the sexes, because males are more likely to commit suicide than females. Of the GIDS patients, 69% were female. Adjusting for sex, the GIDS patients were 5.5 times more likely to commit suicide than the overall population of adolescents aged 14 to 17.

Discussion

How reliable are these estimates? The chief uncertainty about the numerator is whether the fourth death will be ruled as suicide when the inquest is eventually held. It could be speculated that there were further suicides unknown to the Tavistock and

to the National Confidential Inquiry into Suicide and Safety in Mental Health. All that can be said is that the single suicide by a GIDS patient from 2014 to 2016 is not out of line with comprehensive mortality data on suicides by transgender adolescents in the United Kingdom which counted five suicides in a longer age range and wider geographical area. The denominator for the annual suicide rate, however, is pieced together from various series and so is inevitably approximate. Statistics from the early 2010s are less reliable, though they make only a small contribution to the grand total; the last three years contribute more than half of the total number of patient-years. The most significant limitation is the lack of information on the age and sex of all the patients who committed suicide.

Direct comparison can be made with the Belgian pediatric gender clinic (Van Cauwenberg et al., 2021). Its annual suicide rate was about 70 times greater than the rate at the GIDS. This is especially puzzling because patients at the Belgian clinic scored better, on average, than those at the GIDS on tests of psychological functioning (de Graaf et al., 2018). The explanation for the huge disparity in suicide is not clear. The Amsterdam's clinic annual suicide rate was four times greater than the rate at the GIDS. The higher rate is not surprising, however, because the Dutch clinical population was dominated by older adults: the median age at first visit was 25 (Wiepjes et al., 2020). Suicide rates peak in middle age, and so a population of older adults would be at higher risk than a population of adolescents.

The suicide rate of the GIDS patients is not necessarily indicative of the rate among all adolescents who identify as transgender. On the one hand, individuals with more serious problems (and their families) would be particularly motivated to seek referral and more likely to obtain it, and so the clinical subset would be more prone to suicide. One study suggests that a child who frequently attempted suicide was more readily referred to the GIDS (Carlile et al., 2021). On the other hand, young people facing hostility from their families would be less able to seek referral, and this hostility could make them especially vulnerable to suicide.

Taking into account these limitations, the estimated suicide rate at the GIDS provides the strongest evidence yet published that transgender adolescents are more likely to commit suicide than the overall adolescent population. The higher risk could have various causes: gender dysphoria, accompanying psychological conditions, and ensuing social disadvantages such as bullying. Studies of young people referred to the GIDS in 2012 and 2015 found a high prevalence of eating disorders, depression, and autism spectrum conditions (ASC) (Holt et al., 2016; Morandini et al., 2021)—all known to increase the probability of suicide (Simon & VonKorff, 1998; Smith et al., 2018). Eating disorders and depression could be consequences of transgender identity and its ensuing social repercussions, but this is implausible for ASC insofar as it originates in genes or the prenatal environment. From a sample of over 700 referrals to the GIDS in 2012 and 2015, 14–15% were diagnosed with ASC (Morandini

et al., 2021). This compared to 0.8–1.1% of students in England (Department for Education, 2012, 2015). The association between autism and gender dysphoria is found in many populations (Socialstyrelsen, 2020; Warrier et al., 2020). Autism is known to increase the risk of suicide mortality, especially in females (Hirvikoski et al., 2016; Kirby et al., 2019; Socialstyrelsen, 2020). To some extent, therefore, the elevated suicide rate for transgender youth compared to their peers reflects the higher incidence of ASC. The same holds for other psychiatric disorders associated with gender dysphoria (Dhejne et al., 2016). Ideally, the suicide rate for patients of the GIDS would be compared to the suicide rate for patients in contact with other NHS mental health services, but the latter rate is not available.

One final caveat is that these data shed no light on the question of whether counseling or endocrinological interventions—gonadotropin-releasing hormone agonist or cross-sex hormones—affect the risk of suicide (Biggs, 2020; Turban et al., 2020). Although two out of the four suicides were of patients on the waiting list, and thus would not have obtained treatment, this is not disproportionate: the waiting list contributed nearly half of the total patient-years.

Conclusion

Data from the world's largest clinic for transgender youth over 11 years yield an estimated annual suicide rate of 13 per 100,000. This rate was 5.5 times greater than the overall suicide rate of adolescents of similar age, adjusting for sex composition. The estimate demonstrates the elevated risk of suicide among adolescents who identify as transgender, albeit without adjusting for accompanying psychological conditions such as autism. The proportion of individual patients who died by suicide was 0.03%, which is orders of magnitude smaller than the proportion of transgender adolescents who report attempting suicide when surveyed. The fact that deaths were so rare should provide some reassurance to transgender youth and their families, though of course this does not detract from the distress caused by self-harming behaviors that are non-fatal. It is irresponsible to exaggerate the prevalence of suicide. Aside from anything else, this trope might exacerbate the vulnerability of transgender adolescents. As the former lead psychologist at the Tavistock has warned, “when inaccurate data and alarmist opinion are conveyed very authoritatively to families we have to wonder what the impact would be on children’s understanding of the kind of person they are...and their likely fate” (Wren, 2015).

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Declarations

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References

- BBC News. (2021, June 4). Ellis Murphy-Richards: NHS care questioned over suicide. *BBC News*. <https://www.bbc.com/news/uk-england-kent-57358063>
- Biggs, M. (2020). Puberty blockers and suicidality in adolescents suffering from gender dysphoria [Letter to the Editor]. *Archives of Sexual Behavior*, 49, 2227–2229. <https://doi.org/10.1007/s10508-020-01743-6>
- Bunyan, N. (2008, February 15). Boy, 10, hangs himself after talking to his mother about craze. *Daily Telegraph*.
- Carlile, A., Butteriss, E., & Sansfaçon, A. P. (2021). “It’s like my kid came back overnight”: Experiences of trans and non-binary young people and their families seeking, finding and engaging with clinical care in England. *International Journal of Transgender Health*, 22, 412–424. <https://doi.org/10.1080/26895269.2020.1870188>
- Carmichael, P., & Davidson, S. (2009). A gender identity development service. *Psychologist*, 22, 916–917.
- Centers for Disease Control and Prevention. (2018). *2017 Youth Risk Behavior Survey*. <https://www.cdc.gov/healthyyouth/data/yrbs/data.htm>
- Clark, T. C., Lucassen, M. F. G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. (2014). The health and well-being of transgender high school students: Results from the New Zealand Adolescent Health Survey (Youth’12). *Journal of Adolescent Health*, 55, 93–99. <https://doi.org/10.1016/j.jadohealth.2013.11.008>
- de Graaf, N. M., Cohen-Kettenis, P. T., Carmichael, P., de Vries, A. L. C., Dhondt, K., Laridaen, J., Pauli, D., Ball, J., & Steensma, T. D. (2018). Psychological functioning in adolescents referred to specialist gender identity clinics across Europe: A clinical comparison study between four clinics. *European Child & Adolescent Psychiatry*, 27, 909–919. <https://doi.org/10.1007/s00787-017-1098-4>
- de Graaf, N. M., Steensma, T. D., Carmichael, P., VanderLaan, D. P., Aitken, M., Cohen-Kettenis, P. T., de Vries, A. L. C., Kreukels, B. P. C., Wasserman, L., Wood, H., & Zucker, K. J. (2020). Suicidality in clinic-referred transgender adolescents. *European Child & Adolescent Psychiatry*. <https://doi.org/10.1007/s00787-020-01663-9>
- Department for Education. (2012). *Special educational needs in England, January 2012*. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2012>
- Department for Education. (2015). *Special educational needs in England, January 2015*. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2015>

- Department of Health. (2001). *Building a safer NHS for patients: Implementing 'an organisation with a memory'*.
- Department of Health. (2010). *National framework for reporting and learning from serious incidents requiring investigation*. <https://web.archive.org/web/20101126102908/http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=68464&type=full&servicetype=Attachment>
- Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE*, 6, e16885. <https://doi.org/10.1371/journal.pone.0016885>
- Dhejne, C., Van Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, 28, 44–57. <https://doi.org/10.3109/09540261.2015.1115753>
- dickey, I. M., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. *American Psychologist*, 75, 380–390. <https://doi.org/10.1037/amp0000619>
- Hatchel, T., Polanin, J. R., & Espelage, D. L. (2021). Suicidal thoughts and behaviors among LGBTQ youth: Meta-analyses and a systematic review. *Archives of Suicide Research*, 25, 1–37. <https://doi.org/10.1080/13811118.2019.1663329>
- Hirvikoski, T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *British Journal of Psychiatry*, 208, 232–238. <https://doi.org/10.1192/bjp.bp.114.160192>
- Holt, V., Skagerberg, E., & Dunsford, M. (2016). Young people with features of gender dysphoria: Demographics and associated difficulties. *Clinical Child Psychology & Psychiatry*, 21, 108–118. <https://doi.org/10.1177/1359104514558431>
- Jackman, K. B., Caceres, B. A., Kreuze, E. J., & Bockting, W. O. (2021). Suicidality among gender minority youth: Analysis of 2017 Youth Risk Behavior Survey data. *Archives of Suicide Research*, 25, 208–223. <https://doi.org/10.1080/13811118.2019.1678539>
- Jennings, J., & Jennings, J. (2016). Trans teen shares her story. *Pediatrics in Review*, 37, 99–100. <https://doi.org/10.1542/pir.2016-002>
- Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students: 19 states and large urban school districts, 2017. *Morbidity and Mortality Weekly Report*, 68, 69–71.
- Kirby, A. V., Bakian, A. V., Zhang, Y., Bilder, D. A., Keeshin, B. R., & Coon, H. (2019). A 20-year study of suicide death in a statewide autism population. *Autism Research*, 12, 658–666. <https://doi.org/10.1002/aur.2076>
- Mann, G. E., Taylor, A., Wren, B., & de Graaf, N. (2019). Review of the literature on self-injurious thoughts and behaviours in gender-diverse children and young people in the United Kingdom. *Clinical Child Psychology & Psychiatry*, 24, 304–321. <https://doi.org/10.1177/1359104518812724>
- Metcalf, A.-J. (2021). *Remembering our dead: Reports*. <https://tdor.translivesmatter.info/reports>
- Morandini, J. S., Kelly, A., de Graaf, N. M., Carmichael, P., & Dar-Nimrod, I. (2021). Shifts in demographics and mental health comorbidities among gender dysphoric youth referred to a specialist gender dysphoria service. *Clinical Child Psychology & Psychiatry*. <https://doi.org/10.1177/13591045211046813>
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (1999). *Safer services: National confidential inquiry into suicide and homicide by people with mental illness*.
- National Confidential Inquiry into Suicide and Safety in Mental Health. (2019). *Annual Report: England, Northern Ireland, Scotland and Wales*. Healthcare Quality Improvement Partnership. <https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-in-mental-health-annual-report-2019/#.YdQiOy-13KY>
- Nock, M. K., & Kessler, R. C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology*, 115, 616–623. <https://doi.org/10.1037/0021-843X.115.3.616>
- Office for National Statistics. (2018). *Population estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2012 to mid-2016*. <https://www.ons.gov.uk/file?uri=%2fpeoplepopulationandcommunity%2fpopulationandmigration%2fpopulationestimates%2fdatasets%2fpopulationestimatesforukenglandandwalesscotlandandnorthernireland%2fmid2012tomid2016>
- Office for National Statistics. (2021). *Suicides in England and Wales*. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables>
- Rodway, C., Tham, S.-G., Ibrahim, S., Turnbull, P., Kapur, N., & Appleby, L. (2020). Children and young people who die by suicide: Childhood-related antecedents, gender differences and service contact. *Bijpsych Open*, 6, e49. <https://doi.org/10.1192/bjo.2020.33>
- Savin-Williams, R. C. (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Consulting and Clinical Psychology*, 69, 983–991. <https://doi.org/10.1037/0022-006X.69.6.983>
- Simon, G. E., & VonKorff, M. (1998). Suicide mortality among patients treated for depression in an insured population. *American Journal of Epidemiology*, 147, 155–160. <https://doi.org/10.1093/oxfordjournals.aje.a009428>
- Smith, A. R., Zuromski, K. L., & Dodd, D. R. (2018). Eating disorders and suicidality: What we know, what we don't know, and suggestions for future research. *Current Opinion in Psychology*, 22, 63–67. <https://doi.org/10.1016/j.copsyc.2017.08.023>
- Socialstyrelsen. (2020). *Utvecklingen av diagnosen könsdysfori* [The evolution of the diagnosis of gender dysphoria]. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6600.pdf>
- Spack, N. P. (2009). An endocrine perspective on the care of transgender adolescents. *Journal of Gay & Lesbian Mental Health*, 13, 309–319. <https://doi.org/10.1080/19359700903165381>
- Tanis, J. (2016). The power of 41%: A glimpse into the life of a statistic. *American Journal of Orthopsychiatry*, 86, 373–377. <https://doi.org/10.1037/ort0000200>
- Toomey, R. B., Syvertsen, A. K., & Shramko, M. (2018). Transgender adolescent suicide behavior. *Pediatrics*, 142, e20174218. <https://doi.org/10.1542/peds.2017-4218>
- Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145, e20191725. <https://doi.org/10.1542/peds.2019-1725>
- Van Cauwenberg, G., Dhondt, K., & Motmans, J. (2021). Ten years of experience in counseling gender diverse youth in Flanders, Belgium: A clinical overview. *International Journal of Impotence Research*, 33, 671–678. <https://doi.org/10.1038/s41443-021-00441-8>
- Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M.-C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications*, 11(3959). <https://doi.org/10.1038/s41467-020-17794-1>
- Weale, S. (2017, June 27). Almost half of trans pupils in UK have attempted suicide, survey finds. *Guardian*. Retrieved from <https://www.theguardian.com/education/2017/jun/27/half-of-trans-pupils-in-the-uk-tried-to-take-their-own-lives-survey-finds>
- Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in

- suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica*, 141, 486–491. <https://doi.org/10.1111/acps.13164>
- Women and Equalities Committee, UK Parliament. (2015). *Transgender equality: First report of session 2015–16*. <https://publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf>
- Wren, B. (2015). *Making up people*. Presented at the meeting of the European Professional Association for Transgender Health, Ghent, Belgium.
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The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence

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ABSTRACT

It has been a quarter of a century since Dutch clinicians proposed puberty suppression as an intervention for “juvenile transsexuals,” which became the international standard for treating gender dysphoria. This paper reviews the history of this intervention and scrutinizes the evidence adduced to support it. The intervention was justified by claims that it was reversible and that it was a tool for diagnosis, but these claims are increasingly implausible. The main evidence for the Dutch protocol came from a longitudinal study of 70 adolescents who had been subjected to puberty suppression followed by cross-sex hormones and surgery. Their outcomes shortly after surgery appeared positive, except for the one patient who died, but these findings rested on a small number of observations and incommensurable measures of gender dysphoria. A replication study conducted in Britain found no improvement. While some effects of puberty suppression have been carefully studied, such as on bone density, others have been ignored, like on sexual functioning.

The use of Gonadotropin-Releasing Hormone agonist (GnRHa) drugs to suppress puberty in “juvenile transsexuals” was first proposed in print in the mid-1990s (Gooren & Delemarre-van de Waal, 1996). Developed by three clinicians at Utrecht and Amsterdam, this intervention became known as the Dutch protocol. It rapidly became standard practice in the treatment of adolescents diagnosed with gender dysphoria (HBIGDA, 2001). This intervention has been described in several manifestos by its proponents (e.g. de Vries & Cohen-Kettenis, 2012; Delemarre-van de Waal, 2014; Delemarre-van de Waal & Cohen-Kettenis, 2006) and subjected to brief critical commentaries (Byng et al., 2018; Laidlaw et al., 2019; Levine et al., 2022). The aim of this paper to provide an historical account of the invention of the Dutch protocol and a critical review of the evidence that has accumulated in the quarter of a century since it was proposed.

Before proceeding, some definitions are in order. Gender dysphoria will be used here to describe a persistent desire to become the opposite sex (Zucker, 2010). Medical terminology has changed over time, from “gender identity disorder” and “transsexualism” (both introduced in the *Diagnostic and Statistical Manual of Mental Disorders-III* in 1980) to “gender dysphoria” (as renamed in the 2013 *DSM-5*) and “gender incongruence” (as renamed in the 2019 *International Classification of Diseases-11*). There is no need to dwell on these diagnostic criteria because the condition in practice is defined by the patient’s wish for endocrinological and surgical interventions. In the nomenclature of transgender medicine, “puberty blockers” denote GnRHa drugs (alternatively known as Luteinizing Hormone-Releasing Hormone agonists) which stop the production of sex hormones.¹ Drugs in this class include triptorelin (branded Decapeptyl or

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Gonapeptyl), which is used in the Netherlands and Britain, and leuporelin (branded Lupron) in North America. GnRHa drugs are licensed to treat several medical conditions including precocious puberty in children; endometriosis and uterine fibroids in women; and advanced prostate cancer and sexual deviance in men. The drugs have never been licensed as a treatment for gender dysphoria.

The paper begins by describing how puberty suppression was invented, primarily by the psychologist Peggy Cohen-Kettenis, in the 1990s. It reveals the gap between the protocol described in formal manifestos and actual clinical practice. The second section examines the rationale for this intervention, focusing on two claims—that GnRHa is reversible and that it serves as diagnosis—and two omissions—the association between gender dysphoria and homosexuality and the effect of GnRHa on sexual development. The third section traces the international adoption of the Dutch protocol. The fourth section scrutinizes evidence from an early cohort of 70 adolescents subjected to puberty suppression at the Amsterdam clinic (de Vries et al., 2011, 2014). This cohort provides the only significant evidence that GnRHa followed by cross-sex hormones and surgery results in improved psychological function and reduced gender dysphoria. The evidence is less persuasive than it appears: the number of observations was considerably fewer than 70, the reported reduction in gender dysphoria depended on incommensurable scales, and the outcomes omit one patient who died because puberty suppression dictated a riskier vaginoplasty. The fifth section pursues the British study designed to replicate the Dutch one; it was withheld from publication for some years, presumably because puberty suppression in this sample failed to improve gender dysphoria or psychological functioning. The poor quality of American studies is also noted. The final section evaluates evidence for the side effects of GnRHa. The negative effect on the accrual of bone mass is well studied, while there is increasing evidence for negative effects on cognitive and emotional development and on sexual functioning.

Origins of the Dutch protocol

Transsexualism as a concept emerged in the mid-twentieth century, following the discovery of cross-sex hormones and advances in plastic surgery (Hausman, 1995). Novel physical interventions were justified by the new theoretical construct of “gender identity” invented by American psychologists and psychiatrists, most notably John Money (1994). Gender identity was conceived as developing in infancy (e.g. Green, 1968), but physical interventions for transsexuals under the age of 18 were vanishingly rare. Money in 1973 advised a doctor to prescribe testosterone to a 15-year-old girl and even to consider mastectomy—but he was unusually reckless and there is no evidence that his advice was followed (Gill-Peterson, 2018, pp. 163–164). Specialist clinics for children and adolescents with gender identity problems were founded in Toronto in 1975, in Utrecht in 1987, and in London in 1989. They provided counseling. Cross-sex hormones had to wait until the patient was referred to an adult clinic, at an age ranging from 16 to 18 (Bradley & Zucker, 1990). Surgeries were not performed under the age of 18 (Petersen & Dickey, 1995). Referrals of children were rare. The London clinic—the only specialized clinic for children with gender dysphoria in the United Kingdom—over its first decade accepted an annual average of 14 patients (Di Ceglie, 2018). In its first seven years the Utrecht clinic averaged 9 per year (Cohen-Kettenis, 1994).

Lowering the age of intervention was driven by the founder of the Utrecht children’s clinic, Peggy Cohen-Kettenis. She had established herself in the field of gender medicine in the 1980s, presenting research to international conferences of the Harry Benjamin International Gender Dysphoria Association (HBIGDA), which had been formed by clinicians and academics. She eventually became professor of psychology in the Department of Child and Adolescent Psychiatry at University Medical Center Utrecht (Everaerd et al., 2014). She was closely connected to clinicians at VU Medical Center Amsterdam (affiliated with Vrije Universiteit Amsterdam), which housed the country’s clinic for adult transsexuals.

Cohen-Kettenis believed that transsexuals would experience better outcomes if they started treatment before adulthood. By the mid-1990s, she was referring some patients aged 16 and 17 to the Amsterdam clinic for endocrinological intervention prior to cross-sex hormones (Cohen-Kettenis, 1994). Males were given an antiandrogen, cyproterone acetate, which prevented erections and caused breast tissue to grow; females were given progesterin to stop menstruation (Gooren & Delemarre-van de Waal, 1996). Johanna, for example, “fulfilled all necessary requirements for early treatment”: she did not favor girly things (though neither did her sisters), she was fond of soccer, she never dated in school (perhaps not surprising given that she was homosexual), and her parents discovered her wearing a tight t-shirt to conceal her breasts (Cohen-Kettenis et al., 1998, p. 124). Brought to the clinic at 17, she was prescribed progesterin for four months and then testosterone. Within two years Jaap (as Johanna had become) underwent mastectomy, hysterectomy, and oophorectomy, and obtained a new birth certificate. Evidence to support such early treatment came from the first 22 patients from the Utrecht clinic, interviewed in their twenties, from one to five years after surgery (Cohen-Kettenis & van Goozen, 1997; Kuiper & Cohen-Kettenis, 1988). They were compared to a larger group of transsexuals who had transitioned later in adulthood in previous decades (Kuiper and Cohen-Kettenis 1988). Her former patients showed better psychological functioning and “more easily pass in the desired gender role” (Cohen-Kettenis & van Goozen, 1997, p. 270). One problem with the comparison is that they had transitioned in a more tolerant era. Another is the fact that they were still young; most had no sexual partner. Moreover they had not reached an age at which they might regret their inability to conceive children. (This group has not since been followed up.) Cohen-Kettenis’ initiative was praised by Money: he singled out her contribution to a conference in London as “the bravest” (1998, p. xviii).

Cohen-Kettenis had two collaborators at Amsterdam. One was Henriette Delemarre-van de Waal, a pediatric endocrinologist. She had expertise using the new GnRHa drugs—developed in the 1980s—to treat precocious puberty and other conditions (e.g. Schroor et al. 1995). The other was Louis Gooren, a psychiatrist and endocrinologist who was installed as the world’s first professor of transsexuality in 1989. His inaugural professorial lecture was addressed by Cohen-Kettenis and by Money, who flew over from Johns Hopkins University (Nederlands Tijdschrift voor Geneeskunde 1989). Like the pioneering generation who created transsexualism, Gooren saw gender dysphoria as an intersex condition: “there is a contradiction between the genetic, gonadal and genital sex on the one hand, and the brain sex on the other” and therefore “we must provide them with reassignment treatment which meets their needs” (Gooren, 1993, p. 238). This hypothesis was apparently vindicated when he coauthored an article in *Nature* showing that the volume of the central subdivision of the bed nucleus of the stria terminalis in six male-to-female transsexuals was closer to the volume found in females than in males (Zhou et al., 1995). “Unfortunately,” as he recently acknowledged, “the research has never been replicated” (Gooren, 2021, p. 50; see also Kreukels & Burke, 2020).

GnRHa was introduced as a treatment for gender dysphoria in two articles. Gooren and Delemarre-van de Waal (1996) proposed the “Feasibility of Endocrine Interventions in Juvenile Transsexuals.” More influential was a case study of the first “adolescent transsexual” treated with GnRHa (Cohen-Kettenis and van Goozen 1998). From the age of 5, FG “had made it very clear that I was supposed to be a boy” (FG, 2021, p. 131). It later transpired that FG was sexually attracted to women. FG’s father, an Italian with traditional views on gender, disapproved of his daughter’s masculinity, and serious conflict ensued. Extensive psychotherapy did not improve matters; FG wrote a suicide note at the age of 12. When FG was 13, Delemarre-van de Waal prescribed triptorelin.² Three years later, around 1990, FG came to the Utrecht gender clinic, and Cohen-Kettenis was impressed by FG’s “boyish appearance” (Cohen-Kettenis, 2021, p. 115). The clinic provided therapy and introduced FG to other adolescent girls who identified as transsexual. (Whether FG was introduced to any adolescents who identified as lesbian is not recorded.) FG’s puberty suppression continued until the age of 18, when testosterone commenced, followed by multiple surgeries: mastectomy, hysterectomy, oophorectomy, and

metoidioplasty. Awaiting the last surgery at the age of 20, FG was “happy with his life” and “never felt any regrets”; gender dysphoria was apparently cured (Cohen-Kettenis & van Goozen, 1998, p. 247).

Puberty suppression remained exceptional for some years. By 2000, GnRHa had been administered to only 7 children under the age of 16 (Cohen-Kettenis et al., 2000). The new treatment regime was codified at VU Medical Center in Amsterdam, where Cohen-Kettenis was appointed professor of medical psychology in 2002, moving with her clinic. The “Dutch protocol” was published in an influential article in 2006, supported financially by Ferring Pharmaceuticals, the manufacturer of triptorelin (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. S137). GnRHa could be administered to transsexuals as young as Tanner stage 2—marked by the first growth of pubic hair and for girls by budding breasts and for boys by growing testicles—as long as they had reached the age of 12. The adolescent would usually then begin “to live permanently in the role of their desired sex” (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. S132). After some years of puberty suppression, the youth would start cross-sex hormones at the age of 16 and then surgeries at the age of 18. Eligibility criteria for puberty suppression appeared strict. First, gender dysphoria should have begun early in childhood, and dysphoria should have worsened with the onset of puberty. Second, the patient should be psychologically stable, and not suffer from other mental health problems. Third, the patient should have support from their family. As the protocol was formalized, the number of children undergoing puberty suppression increased markedly. Between 2000 and 2008, GnRHa was prescribed to 111 children, about one per month (de Vries et al., 2011). One of them was Valentijn de Hingh, the subject of a television documentary (Nietsch, 2007). After a teacher was disconcerted by the boy’s passion for dolls, de Hingh at the age of 5 was diagnosed with gender dysphoria by Cohen-Kettenis (de Hingh, 2021). GnRHa was administered from the age of 12 in 2002.

The protocol as published was not always strictly followed by the clinicians. The minimum age of 12 for puberty suppression was not observed in every case (de Vries, 2010, p. 104). De Hingh had regular endocrinological checkups from the age of 10, presumably so that puberty suppression could commence as soon as Tanner stage 2 was reached. Likewise, cross-sex hormones sometimes started before the age of 16, as young as 13.9 years (de Vries et al., 2011, p. 2278). Family support was not essential, as the clinic administered GnRHa to a 14-year-old—who was institutionalized due to a physical handicap—against the parents’ objections (Cohen-Kettenis and Pfäfflin 2003). A British television documentary from the mid-1990s provides a glimpse of actual practice (Morse, 1996). *The Wrong Body* took three English young people to Amsterdam and Utrecht, to see transgender medicine at its most advanced. Fredd Foley, aged 13, met Gooren to learn about puberty suppression; this was around the time it was proposed in the medical literature (Gooren & Delemarre-van de Waal 1996). After returning to England and being refused GnRHa by the London clinic, Foley’s mother telephoned Gooren who agreed to write a three-month prescription of triptorelin. “If your child knows for sure he is transsexual,” he said, “I would not let puberty happen.” Gooren’s willingness to prescribe drugs for a child in another country, met briefly in front of the cameras, against the wishes of the child’s own psychiatrist, hints that the assessment process was not always as rigorous as portrayed in the published literature. As Cohen-Kettenis said in the documentary, “it’s very difficult to give exact criteria, in some cases you have the feeling that the adolescent has thought about it and knows pretty well what she or he is doing.”

The Dutch protocol scrutinized

The Dutch protocol comprised not just a drug (GnRHa) and a treatment regime (from age 12 or Tanner stage 2) but also two discursive claims. The first was reversibility. The initial article declared GnRHa to be “fully reversible; in other words, no lasting undesired effects are to be expected” (Gooren & Delemarre-van de Waal, 1996, p. 72). The phrasing hinted at the lack of actual evidence. Suppressing puberty for a short time, on the order of months, might be expected

to have a negligible effect on a child's development. Yet the Dutch protocol entailed suppression for up to four years (from age 12 to 16); for FG it lasted at least five years (from 13 to 18). It was implausible to claim that suppressing puberty for so many years would have no lasting effect if the child were to stop GnRHa and restart their natal sex hormones. On occasion this was acknowledged, as when Delemarre-van de Waal and Cohen-Kettenis' (2006, p. S137) manifesto stated that "It is not clear yet how pubertal suppression will influence brain development." Ten years later, however, Cohen-Kettenis still claimed that puberty suppression was "completely reversible" (Cohen-Kettenis, 2016; see also de Vries et al., 2016). The postulate of reversibility, however implausible, helped to avoid the question of whether a child aged 12 (or below) could give consent to this endocrinological experiment. HBGDA's Standards of Care warned that cross-sex hormones "are not, or are not readily, reversible" (HBGDA, 1985, p. 83). By pronouncing GnRHa to be reversible, the Dutch protocol demarcated a boundary between one endocrinological intervention and another.

The second claim was that puberty suppression was a diagnostic tool. The case study of FG described GnRHa as an "aid in diagnosis and treatment" (Cohen-Kettenis & van Goozen, 1998). This echoed the conception of cross-sex hormones as "both therapeutic and diagnostic in that the patient requesting such therapy either reports satisfaction or dissatisfaction regarding the results" (HBGDA, 1985, p. 85). GnRHa was posited to provide space for therapeutic exploration of gender identity, without the pressure of the physical changes accompanying puberty (Delemarre-van de Waal & Cohen-Kettenis, 2006). This claim was plausible, though it was also plausible that stopping normal cognitive, emotional, and sexual development would impede such exploration. In the event, the Dutch clinicians found that the diagnostic test invariably yielded the same result: "none of the [54] patients who were selected for pubertal suppression has decided to stop taking GnRHa" (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. S136). This might be explained by a rigorous selection process. An alternative explanation is that puberty suppression becomes a self-fulfilling prophecy. Subsequent experience in the Netherlands and in other countries confirms the fact that 96%–98% of children who undergo puberty suppression continue to cross-sex hormones (Brik et al., 2020; Carmichael et al., 2021; Wiepjes et al., 2018).

The framing of GnRHa as diagnostic circumvented a problem recognized in the earliest articles. "Not all children with GID [Gender Identity Disorder] will turn out to be transsexuals after puberty," acknowledged Cohen-Kettenis and Gooren (1999, p. 319). "Prospective studies of GID boys show that this phenomenon is more closely related to later homosexuality than to later transsexualism." They cited three longitudinal studies of feminine boys (Green, 1987; Money & Russo, 1979; Zuger, 1984).³ The best known is Richard Green's attempt at "studying pretranssexuals" by selecting a group of "sissy boys" (Green, 1987, p. 12). After fifteen years, to his surprise, only one out of 44 was contemplating transsexuality, whereas two thirds had become bisexual or homosexual men. Given such studies, Cohen-Kettenis concluded that "most GID children under 12 will not grow up to become transsexuals" (Cohen-Kettenis & van Goozen, 1997, p. 246). These findings were downplayed in subsequent publications; the key manifestos for the Dutch protocol did not mention homosexuality and did not cite any study of feminine boys (Cohen-Kettenis et al., 2008; Delemarre-van de Waal & Cohen-Kettenis, 2006). The assertion that "GID persisting into early puberty appears to be highly persistent" rested on slender evidence (Cohen-Kettenis et al., 2008, p. 1895). The only relevant cited source described adolescents who had been first assessed at ages ranging from 13 to 18, a range extending well beyond early puberty (Smith et al., 2001). This source did not support the hypothesis that the probability of gender dysphoria persisting to adulthood jumped suddenly on the cusp of age 12, from under 50% to virtually 100%. What is known is that most adolescents subjected to puberty suppression were homosexual. Of the first 70 adolescents referred to the Amsterdam clinic from 2000 to 2008 and given GnRHa, 62 were homosexual while only 1 was heterosexual (de Vries et al., 2011).

The crucial advantage of puberty suppression was creating "individuals who more easily pass in to the opposite gender role" (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. 155). The emphasis was on external appearance, especially height.⁴ That word appears 23 times in

Delemarre-van de Waal's review of puberty suppression (Delemarre-van de Waal, 2014). There is one cursory reference to "loss of fertility." The words orgasm, libido, and sexuality do not appear. This is curious because it was well known that men taking GnRHa for prostate cancer experience complete loss of erotic interest (Marumo et al., 1999). The drug is therefore licensed to chemically castrate men with sexual obsessions. Gooren was an early advocate for this usage. He warned that the side effects "may be very uncomfortable" for men with paraphilias (Gijs & Gooren, 1996, p. 279); no such warning accompanied his recommendation of the same drug for adolescents experiencing gender dysphoria. The Dutch clinicians did not ask whether blocking the normal development of erotic desire would affect their patients' understanding of their own body and their interest in future sexual and romantic relationships.

One significant disadvantage of puberty suppression for males was not mentioned in the 2006 manifesto for the Dutch protocol, though it had been raised at a conference in the previous year (GIRES, 2005). Stopping sexual development meant the penis did not grow, and so "the genital tissue available for vaginoplasty may be less than optimal" (Cohen-Kettenis et al., 2008, p. 1895). This made it more likely that the orifice would need to be lined with a portion of the patient's intestine rather than the inverted penis (van de Grift et al., 2020). Out of 49 patients at Amsterdam who started GnRHa at Tanner stage 2 or 3, 71% required intestinal vaginoplasty (van der Sluis et al., 2021). This procedure is more invasive, requiring a second surgical site, and it entails greater risk of complications such as rectal fistula. Surgical techniques have been refined so that the "possible occurrence of intestinal discharge could be kept under control" (Bouman, 2021, p. 141), but one quarter of the patients need further corrective surgeries (Bouman et al., 2016).

International adoption of the Dutch protocol

The Dutch protocol immediately attracted interest in other countries. Cohen-Kettenis and Gooren were already prominent in the field of transgender medicine, exemplified by their election to the Board of Directors of HBGDA (the former served two four-year terms from 1995 and 2003, while the latter served one term from 1999). Puberty suppression soon entered HBGDA's Standards of Care in the Sixth Version, approved in 2001. It closely followed the Dutch protocol, but did not specify any minimum age. It was "recommended that the adolescent experience the onset of puberty in his or her biologic sex, at least to Tanner stage Two," while also allowing earlier intervention on the recommendation of more than one psychiatrist (HBGDA, 2001, p. 10). Recall that the published evidence for the benefits of puberty suppression then comprised a single case study of one patient—FG—awaiting final surgery.

In the United States, adoption was led by Norman Spack, a pediatric endocrinologist. More than once he recalled "salivating" at the prospect of treating patients with GnRHa (Hartocollis 2015; Spack 2008, xi). In 2007 he cofounded the Gender Management Service at Boston Children's Hospital, which was the first dedicated clinic for transgender children in America. Its program was based on the Dutch model; the hospital sent a psychologist to Amsterdam to be trained by Cohen-Kettenis (Tishelman et al., 2015). From the outset the Boston clinic offered GnRHa at Tanner stage 2 or 3 with no minimum age (Spack et al. 2012). Spack joined Cohen-Kettenis, Gooren, and Delemarre-van de Waal on the Endocrine Society's committee tasked with writing their first clinical guidelines for "transsexual persons," which recommended GnRHa for children at Tanner stage 2 or 3 (Hembree et al., 2009). "There was an attitudinal shift to be able to say that the Endocrine Society supports this," he later recalled (Ruttimann, 2013, p. 19). The shift is visible in data from 43 children's hospitals on prescriptions of one GnRHa drug (histrelin acetate): it was never prescribed for gender dysphoria between 2004 and 2009 and was then prescribed to 92 patients from 2010 to 2016, most in the final years of the period (Lopez et al., 2018).

Oprah Winfrey Television broadcast the documentary *I Am Jazz: A Family in Transition* in 2011 (Stocks, 2011). Its dramatic structure was similar to *The Wrong Body*, focusing on the

looming threat of puberty as Jazz Jennings reached the age of 11. Jennings had been diagnosed with gender dysphoria at the age of 3 and had appeared on national television at the age of 7, when the family created the TransKids Purple Rainbow Foundation (Jennings & Jennings, 2016). The documentary showed the family consulting with a pediatric endocrinologist, who confirmed that Tanner stage 2 had been reached. The denouement was not shown, but Jennings's mother was clear: "you have to kinda nip puberty in the bud, you want to block it" (Stocks, 2011). Jennings did indeed commence puberty suppression some months later. The number of clinics for "gender-nonconforming children and adolescents" multiplied, and within a few years 32 of them advertised puberty blockers (Hsieh & Leininger, 2014).

England provides an example of adoption driven by patients rather than clinicians. *The Wrong Body* had promoted the Dutch approach to 3 million viewers (Nataf, 1999). Dissatisfaction at the cautious policy of the London clinic—still headed by its founder, Domenico Di Ceglie—became increasingly vocal. Sustained pressure came from the parents of children who identified as transgender, organized in the Gender Identity Research and Education Society (GIRES) and Mermaids. GIRES obtained funding from medical charities to organize an international symposium in London in 2005 to develop consensus guidelines for endocrinological intervention, which was attended by Cohen-Kettenis, Delemarre-van de Waal, and Spack. GIRES (2006) warned that "those who can in any way afford to do so have to consider taking their children to the USA." The first was Susie Green, later the chief executive of Mermaids. In 2007 she took her son Jackie, aged 12, to Boston to obtain GnRHa from Spack (Sloan, 2011). A presentation at Mermaids instructed parents in this medical tourism (Mermaids, 2007). Spack treated seven more British children over the next few years (Glass, 2012). The conflict between parents and clinicians climaxed in 2008, with two clashing conferences. The Royal Society of Medicine organized a meeting on adolescent gender dysphoria, which drew criticism for the lack of overseas speakers advocating for puberty blockers, even though it had invited Delemarre-van de Waal. The cofounder of GIRES, whose child had transitioned in their late teens two decades earlier, used the new epithet "transphobic" to describe the cautious clinicians (Groskop, 2008). Richard Green—the author of *Sissy Boys*, then in London as a visiting professor—quickly organized a rival conference to demand puberty suppression (Green, 2008). Speakers included the usual cast of clinicians, including Spack, and also patients and their parents, including two Dutch transgender adolescents. The demand for puberty suppression was becoming irresistible.

Di Ceglie was soon replaced as director of the London clinic (renamed the Gender Identity Development Service and located at the Tavistock and Portman NHS Foundation Trust) by Polly Carmichael, a clinical psychologist. The clinic in 2011 began to offer GnRHa from the age of 12, initially as part of an experimental study (Biggs, 2019b, 2019c). Before any outcomes were published, Carmichael declared success: "Now we've done the study and the results thus far have been positive we've decided to continue with it" (Manning and Adams, 2014). She even appeared on BBC Children's Television to promote puberty suppression, in a documentary about a 13-year-old girl who wanted to be a boy, Leo. Carmichael reassured Leo about GnRHa: "the good thing about it is, if you stop the injections, it's like pressing a start button and the body just carries on developing as it would if you hadn't taken the injection" (Niland, 2014). In 2015 the National Health Service adopted a policy of offering GnRHa for adolescents at Tanner stage 2, without age restriction (NHS England, 2015).

Evidence from the Amsterdam clinic

By the mid-2010s, then, the Dutch protocol was established as the standard for transgender medicine. It was apparently vindicated when longitudinal data was published on a cohort of 70 adolescents referred to the clinic between 2000 and 2008 and then subjected to puberty suppression. The lead author, Annelou de Vries, received her doctorate under the supervision of Cohen-Kettenis. Outcomes were initially measured as the patient was transitioning from GnRHa to cross-sex hormones, at ages ranging from 14 to 19. "Behavioral and emotional problems and

depressive symptoms decreased, while general functioning improved” (de Vries et al., 2011, p. 2276). Outcomes were subsequently measured soon after the patient’s final surgery (vaginoplasty or mastectomy and hysterectomy with oophorectomy), at ages ranging from 19 to 22. The authors concluded that “gender dysphoria had resolved, psychological functioning had steadily improved, and well-being was comparable to same-age peers” (de Vries et al., 2014, p. 696).

When scrutinized, however, the evidence is less persuasive. The sample was small: final outcome measures were available for subsets of patients numbering between 32 and 55. The finding that gender dysphoria had resolved depended on the Utrecht Gender Dysphoria Scale and the Body Image Scale, which have separate questionnaires for each sex. The researchers switched versions over the course of the study (Levine et al., 2022). A boy who wanted to become a girl, for example, answered the male questionnaires at baseline before puberty suppression, and then the female versions following surgery—so would be rating agreement with the statement “I hate menstruating because it makes me feel like a girl” (C. Schneider et al., 2016) and satisfaction with “ovaries-uterus” (Lindgren & Pauly, 1975). The inclusion of such meaningless questions compromises the measurement of change in gender dysphoria. The results after surgery exclude eight patients who refused to participate in the follow-up or were ineligible for surgery, and one patient killed by necrotizing fasciitis during vaginoplasty. The authors did not mention the fact that this death was a consequence of puberty suppression: the patient’s penis, prevented from developing normally, was too small for the regular vaginoplasty and so surgery was attempted with a portion of the intestine, which became infected (Negenborn et al., 2017). A fatality rate exceeding 1% would surely halt any other experimental treatment on healthy teenagers.

One inevitable limitation of the study was the measurement of results soon after surgery, which repeated the problem with the first study of adolescent transsexuals (Cohen-Kettenis & van Goozen, 1997). As Cohen-Kettenis notes, “a truly proper follow-up needs to span a minimum period of 20 years” (Cohen-Kettenis, 2021, pp. 117–118). A subsequent follow-up of this cohort is in preparation (Bazelon, 2022). The only long-term outcome published in the literature is that of the very first patient, FG, who was followed up again at the age of 35. FG did not regret transition, but scored high on the measure for depression. Owing to “shame about his genital appearance and his feelings of inadequacy in sexual matters,” he could not sustain a romantic relationship with a girlfriend (Cohen-Kettenis et al., 2011, p. 845). Ironically, a “strong dislike of one’s sexual anatomy” is one of the diagnostic criteria for gender dysphoria in children (according to *DSM-5*), and so in this respect it is not clear how the dysphoria had been resolved. The clinicians were more interested in FG’s height, which they compared punctiliously to the Italian as well as the Dutch height distribution. Cohen-Kettenis concluded that “the negative side effects are limited” (Cohen-Kettenis et al., 2011, p. 843). Delemarre-van de Waal’s (2014, p. 194) summary was even more optimistic: “He was functioning well psychologically, intellectually, and socially.” Now aged 48, FG has given two recent interviews. FG’s situation seems to have improved, and he now has a serious girlfriend. He describes puberty suppression as “life-saving” in his case (FG, 2021, p. 132) but also recommends that it should require a significant assessment process (Bazelon, 2022). In a recent interview, Valentijn de Hingh, who at the age of 31 now identifies as non-binary, emphasizes that “diagnosis and treatment at a young age were not wrong.” At the same time, de Hingh wonders “wasn’t that very young? To have been seeing a psychologist, having been examined and diagnosed from the age of five” (de Hingh, 2021, p. 182).

Replicating the Dutch results

An international study of puberty suppression—involving London and Boston as well as Amsterdam—was first mooted in 2005 (GIRES, 2005). The Boston clinic dropped out, but eventually an experiment along Dutch lines was begun in London in 2010. The entry criteria were “consistent with the protocol used at the Amsterdam Gender Clinic” (Viner et al., 2010, p. 6) and the outcome measures replicated those used by the Amsterdam longitudinal study (de

Vries et al., 2011, 2014). From 2011 to 2014, 44 adolescents aged from 12 to 15 years commenced puberty suppression. Outcomes for all subjects after two years on GnRHa were thus collected by 2016. Preliminary results were presented to the World Professional Association for Transgender Health (as HBGDA had been renamed) in Amsterdam. In her keynote address, Carmichael observed that “our results have been different to the Dutch” (Carmichael, 2016). According to one presentation, adolescents after one year of GnRHa “report an increase in internalising problems and body dissatisfaction, especially natal girls” (Carmichael et al., 2016). Another presentation was also negative: “Expectations of improvement in functioning and relief of the dysphoria are not as extensive as anticipated, and psychometric indices do not always improve nor does the prevalence of measures of disturbance such as deliberate self harm improve” (Butler, 2016). These conference papers were not published as articles, following the typical fate of medical experiments that fail to produce positive results (Johnson & Dickersin, 2007).

Instead, the London clinic published an article claiming that “adolescents receiving also puberty suppression had significantly better psychosocial functioning after 12 months of GnRHa ... compared with when they had received only psychological support” (Costa et al., 2015, p. 2206). The group subjected to puberty suppression were aged between 13 and 17, and must have included some of the 44 experimental subjects. This group comprised 101 adolescents at the outset, diminishing to 35 after twelve months. This high rate of attrition was not explained in the article. Anyway, the data showed no statistically significant difference between the group given GnRHa and counseling and the group given only counseling (Biggs, 2019a).

The full outcomes from the experiment were published following a protracted campaign involving publicity in newspapers and television (e.g. Tominey & Walsh, 2019), complaints to the ethics committee which approved the research (Health Research Authority, 2019), a Parliamentary question (Blackwood of North Oxford, 2019), and a judicial review (Keira Bell and Mrs A v Tavistock NHS Trust, 2020). Out of the 44 subjects in the experiment, all but one transitioned to cross-sex hormones. Outcomes were taken after 12 months of puberty suppression for all patients, and after 24 months for the subset waiting to reach the age of 16 when they could start cross-sex hormones. The headline finding was that “GnRHa treatment brought no measurable benefit nor harm to psychological function in these young people,” and gender dysphoria likewise did not improve (Carmichael et al., 2021, p. 20). This is all the more surprising because a placebo response would be expected in patients who had volunteered to pioneer this intervention in Britain (Kirsch, 2019). There was no disaggregation by sex, which is unfortunate because outcomes were evidently worse for natal girls than for boys (Biggs, 2020; Carmichael et al., 2016).

The researchers did not compare their findings to the outcomes from the Amsterdam clinic after puberty suppression (de Vries et al., 2011). Comparison is undertaken here, using available data on two question batteries.⁵ The Youth Self-Report (YSR) enables the adolescent to describe their problems, while the Child Behavior Checklist (CBCL) provides a parent’s assessment. YSR and CBCL each yield three *T*-scores: one for Internalizing Problems like anxiety; one for Externalizing Problems like anger; and a Total Problem score, combining these two along with other problems such as social isolation (Achenbach & Rescorla, 2001). *T*-scores are normalized relative to reference scores (for males and for females aged 12–18), with a mean of 50 and standard deviation of 10. The Amsterdam clinic reported these measures for 54 subjects, compared to 41 for the London clinic. The two samples were similar at the outset of puberty suppression: the mean age at Amsterdam was 14.8, the median at London was 13.6; females comprised 53% of the Amsterdam sample, 43% of the London one. Figure 1 depicts the mean scores at baseline before the commencement of puberty suppression, along with the 95% confidence interval. There was no discernible difference between the Amsterdam and London samples in any component of CBCL or YSR. At the Amsterdam clinic, the subjects completed the questionnaires again when they transitioned to cross-sex hormones, after a mean of 1.9 years. At the London clinic, the questionnaires were completed at 12-month intervals, and so I take the latest available before the end of puberty suppression; the mean duration is 1.4 years. Figure 2

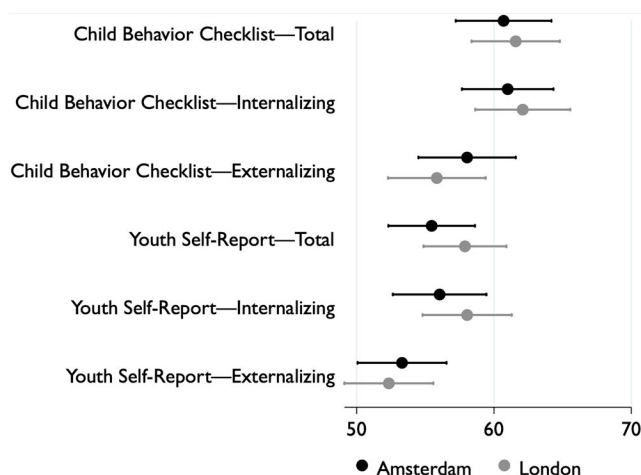


Figure 1. Psychological functioning before puberty suppression with GnRHa. The circle shows the mean *T*-score at baseline. The line traces the 95% confidence interval. *N* = 54 at Amsterdam, 41 at London. Data from de Vries et al. (2011, Table 2) and Carmichael et al. (2021).

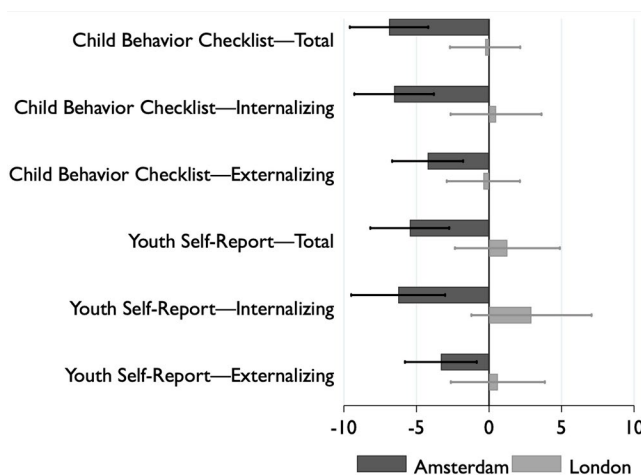


Figure 2. Change in psychological functioning after puberty suppression with GnRHa. The bar shows the change in *T*-score from baseline; negative values indicate reduced problems. The line traces the 95% confidence interval. *N* = 54 at Amsterdam, 41 at London. Data reported from de Vries et al. (2011, Table 2) and Carmichael et al. (2021).

shows how the scores changed since baseline. The Amsterdam sample improved—fewer problems were reported by the subjects and their parents—on all six measures ($p = .000004 \dots .003$). The London sample, by contrast, experienced no discernible change ($p = .16 \dots .82$). With one exception (YSR Externalizing Problems), the differences between the change in Amsterdam and the change in London are statistically significant ($p = .0006 \dots .03$, assuming equal variance).

The London clinic's failure to replicate the positive results found by the Amsterdam clinic after puberty suppression demonstrates that the Dutch results cannot be extrapolated to other countries. The reason for the failure to replicate could perhaps lie in the quality of care offered by the clinics or in the characteristics of their patients. Although the two samples had indistinguishable baseline scores on YSR and CBCL, on another measure of psychological functioning—the Children's Global Assessment Scale (CGAS), which is scored by the clinician—the adolescents attending the London clinic were significantly worse at the outset. This fits the general pattern in adolescents referred to European gender clinics: those at Amsterdam have fewer psychological problems and better peer relationships than those at London (de Graaf et al., 2018). The failure

to replicate could simply exemplify a general phenomenon in medicine (and science generally): a large effect found in a nonrandomized study with a small sample usually either declines in magnitude or disappears altogether in subsequent studies (e.g. Ioannidis, 2005). Given the London clinic's failure to find favorable results after puberty suppression, it has no incentive to follow up the 43 subjects who transitioned to cross-sex hormones and potential surgery. It loses track of all its patients after the age of 18, blaming "the frequent change in nominal and legal identity, including NHS number in those referred on to adult services" (Butler et al., 2018, p. 635).

One other clinic has published a comparable longitudinal study of puberty suppression. The Hamburg Gender Identity Service followed 11 adolescents who were administered GnRHa for an average of one year, but such a tiny sample provides insufficient statistical power for any conclusions (Becker-Hebly et al., 2021). Three American studies of puberty suppression have been published: from Stony Brook (Achille et al., 2020), Dallas (Kuper et al., 2020), and Seattle (Tordoff et al., 2022).⁶ None tried to replicate the Amsterdam and London longitudinal studies, choosing completely different measures, with one exception (BIS is used by Kuper et al., 2020). Each introduced a different set of measures: Quick Inventory of Depressive Symptoms, Screen for Child Anxiety Related Emotional Disorders, Center for Epidemiologic Studies Depression Scale, Quality of Life Enjoyment and Satisfaction Questionnaire, Generalized Anxiety Disorder 7-item scale, and the Patient Health Questionnaire 9-item scale. The last scale was common to two studies, but even they were not comparable: one used the version for teenagers, the other the adult version which the researchers chose to dichotomize. All the samples were tiny: 19, 23 (including an unspecified number of males given anti-androgens and females given medroxy-progesterone rather than GnRHa), and 25. Results were reported inconsistently: sometimes the outcomes for the sample subjected to puberty suppression were combined with a much larger sample on cross-sex hormones; sometimes the parameters of complex multivariate models were reported while the within-subject change during puberty suppression was concealed (Singal, 2022). Finally, some results were vitiated by high—and unexplained—rates of attrition: 47% of the subjects in one study were excluded because they failed to fill in the questionnaires at three points in time (Achille et al., 2020). What is frustrating is that if these researchers had simply followed the methods of de Vries et al. (2011), these three small samples would have contributed to cumulative knowledge. Finally, a large-scale American study recruited 90 subjects for puberty suppression—from Boston, Chicago, Los Angeles, and San Francisco—between 2016 and 2018 (Olson-Kennedy et al., 2019). Outcomes after 24 months have evidently been collected, but only baseline results have been published (Chen et al., 2021).

Evidence on side effects

On the side effects of puberty suppression, there is most evidence on bone density. That GnRHa would cause "an insufficient formation of bone mass" was initially dismissed "of no great concern" (Gooren & Delemarre-van de Waal, 1996, p. 72). Then it was recognized that patients could "end with a decreased bone density, which is associated with a high risk of osteoporosis" (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. S134). The detrimental effect of GnRHa on the accrual of normal bone mass has been documented in several longitudinal studies from the Amsterdam clinic (Klink et al., 2015; Schagen et al., 2020; Stoffers et al., 2019; Vlot et al., 2017), the London clinic (Biggs, 2021; Joseph et al., 2019), and a clinic in Ottawa (Navabi et al., 2021). Less obviously, adolescents who seek GnRHa for gender dysphoria have a lower distribution of bone density compared to the population of the same sex and age (see also Lee et al., 2020). This reflects in part the high prevalence of eating disorders.

Bone mineral density (BMD) is measured by a dual energy X-ray absorptiometry scan over the spine and the hip. The absolute value of BMD is standardized as a Z-score, expressing this individual's BMD relative to the population of the same sex and age. BMD can be adjusted for height to derive the volumetric bone mineral apparent density (BMAD), which is likewise standardized as a Z-score. A Z-score below -2 is considered low; it indicates bone density in the

lowest 2.3% of the population. The salience of this threshold is revealed by the London clinic's protocol which required both spine and hip Z-scores to exceed -2 to be eligible for GnRHa (Viner et al., 2010). This was subsequently relaxed "in exceptional circumstances" if clinicians "feel that on the balance of risks, pubertal suppression is an appropriate option despite risks of osteoporosis in later adult life" and patients "understand the risks of GnRH analogue treatment for bone density (i.e. risks of later osteoporosis)" (Viner et al., 2012).

Most studies of bone density after puberty suppression summarize the distribution of Z-scores by mean and standard deviation; only two provide information on the lower tail of the distribution, which is what matters clinically. At the Amsterdam clinic, 56 transgender adolescents were treated with GnRHa, commencing at ages ranging from 11 to 18, for an average duration of 1.7 years. After puberty suppression, the minimum Z-score for spine BMAD was -2.4 , and the minimum hip BMAD was -3.4 (Vlot et al., 2017). Normally we would expect to find a Z-score below -3 in only 0.13% of the population—1 in 741. At the London clinic, 24 adolescents were treated with GnRHa, commencing at ages ranging from 12 to 14, for a duration of 24 months. After puberty suppression, the hip BMD Z-score was below -2 for 7 patients. The spine BMD Z-score was below -2 for 7 patients, including 4 patients with Z-score below -3 ; the spine BMAD Z-score was below -2 for 8 patients, including 3 with Z-score below -3 (Biggs, 2021). Clearly, then, a significant minority of patients have abnormally low bone density after puberty suppression. The subsequent administration of cross-sex hormones increases bone mass, but Z-scores remain below the baseline recorded at the outset of puberty suppression (Klink et al., 2015; Stoffers et al., 2019; Vlot et al., 2017), with the possible exception of females who take testosterone after starting GnRHa early in puberty (Schagen et al., 2020).

What is not clear is the consequence of abnormally low bone density. Information on fractures, for example, has been published only for adults taking cross-sex hormones who had not undergone puberty suppression (Wiepjes et al., 2020). Anecdotally, a female patient at the London clinic who started GnRHa at age 12 then experienced four broken bones by the age of 16 (Bannerman, 2019). A Swedish television documentary discovered one female who was given GnRHa from age 11 to 15 by the Karolinska University Hospital in Stockholm, and now suffers from severe osteoporosis, including continual skeletal pain (SVT, 2022). This case—along with two others whose puberty suppression was terminated following concerns about bone density—led Sweden to restrict the use of GnRHa for adolescents with gender dysphoria.

The effects of puberty suppression on emotional and cognitive development are more difficult to ascertain, but more consequential as they could potentially affect the capacity to consent to cross-sex hormones and surgery. One case report of puberty suppression commencing just before age of 12 measured a drop in IQ by 10 points after 28 months (M. A. Schneider et al., 2017). A single case is insubstantial, of course, but there are similar findings from children treated with GnRHa for precocious puberty. A study of 25 children measured a drop of 7 points after two years (Mul et al., 2007); another study found a gap of 8 points between 15 treated children and a matched control group (Hayes, 2017; Wojniusz et al., 2016). Unfortunately the Amsterdam clinic's longitudinal study of puberty suppression measured IQ only at baseline and did not measure it again (de Vries et al., 2011, 2014). A small study from the clinic found that 8 adolescent males undergoing puberty suppression performed worse in a test of executive functioning than three control groups; the differences are statistically significant, but the samples are small (Staphorsius et al., 2015). Randomized control trials of non-human animals provide evidence of the substantial effects of puberty suppression. In sheep, GnRHa impairs spatial memory, and this effect remains after the treatment is stopped—thus demonstrating the irreversibility of puberty suppression (Hough et al. 2017a; 2017b). Counterintuitively, GnRHa also leads to greater differences between males and females in foraging behavior (Wojniusz et al., 2011). In mice, the effects of GnRHa vary by sex: males develop stronger preference for other males and an increased stress response; females exhibit increased anxiety and despair-like behavior (Anacker et al., 2021).

Even less is known about the effects of puberty suppression on sexual functioning. Jennings, who started on GnRHa at the age of 11, has no libido and cannot orgasm. Jennings' surgeon,

Marci Bowers, who has performed over 2,000 vaginoplasties, acknowledges that “every single child ... who was truly blocked at Tanner stage 2, has never experienced orgasm. I mean, it’s really about zero” (Bowers, 2022). This remark refers to males. The effects of puberty suppression at such an early stage on females is unknown. FG is reportedly able to orgasm (de Vries et al., 2011). One patient at the London clinic who took GnRHa from the age of 12 to 16 but did not continue to cross-sex hormones has experienced no sexual desire in the two years since ceasing GnRHa (Bannerman, 2022). According to de Vries, orgasm is “a very interesting and so far not studied question” (Klotz, 2022).

Conclusion

The use of GnRHa to suppress puberty has proved more popular than could have been envisaged in the mid-1990s. It has become the international standard for treating gender dysphoria and has attracted increasing numbers of patients. Down to 2015, the Amsterdam clinic administered GnRHa to a total of 333 youth aged under the age of 18 (Wiepjes et al., 2018). From 2012 to 2020, the London clinic administered GnRHa to 344 children under the age of 15. Both clinics were overwhelmed by referrals from the mid-2010s, and the lengthening waiting lists provided scope for unscrupulous commercial operations. GenderGP, for example, is a company registered in Singapore and owned by a Welsh doctor which will diagnose a 9-year-old with gender dysphoria over video and prescribe GnRHa on the same day (Medical Practitioners Tribunal Service, 2022). The total number of patients subjected to puberty suppression, worldwide, must run to several thousand. The proponents of GnRHa never reassessed the rationale for the intervention as the numbers multiplied. It is one thing to assert that very rare cases of extreme gender dysphoria—one per year in the Netherlands in the late 1990s—should be treated as juvenile transsexuals. It is another to make this claim for numerous adolescents—currently over a hundred a year in the Netherlands. Given the fact that gender dysphoria lacks an objective diagnosis, the potential for puberty suppression is expansive. When a recent survey in one American school district found 7% of students identifying as “gender diverse,” the authors urged that all receive “access to gender affirming care,” which in effect means giving GnRHa on request (Kidd et al., 2021, p. 3).⁷

Whether the availability of puberty suppression has increased demand is a question that should be raised. Taking GnRHa early in puberty promises a more passable resemblance to the opposite sex, and this is why it proved so fascinating to television audiences. It is no coincidence that media coverage of transgender youth focuses on those who suppressed puberty at a young age, most famously Jennings. Positive media coverage is known to increase referrals to gender clinics, at least over the short term (Indremo et al., 2022; Pang, de Graaf, et al., 2020). Although Dutch clinicians advise against “a complete social transition ... before the very early stages of puberty” (de Vries & Cohen-Kettenis, 2012, pp. 308–309), the availability of GnRHa now makes it feasible for parents to treat a young child as the opposite sex, which guarantees that the child will experience the onset of puberty as catastrophic and thus demand endocrinological intervention. For boys, social transition prior to puberty is a powerful predictor of gender dysphoria persisting into adolescence, even controlling for the degree of dysphoria in childhood (Steensma et al., 2013). This pathway is illustrated by interviews with 30 British parents who had started raising their children as the opposite sex between the ages of 3 and 10. According to one parent, “If you don’t give a child puberty-blockers there is a consequence—it’s not that nothing happens. There’s a massive consequence” (Horton, 2022, p. 13). Another candidly described their child’s attitude to counseling at the gender clinic: “at the end of the day, he’s just gonna say whatever it is, that makes you shut up, so that he can get the blocker” (Horton, 2022, p. 14).

What has happened to the majority of children with gender dysphoria who used to grow up into gay or lesbian adults? The original articles promoting GnRHa (Cohen-Kettenis & van Goozen, 1998; Gooren & Delemarre-van de Waal, 1996) hypothesized that children whose dysphoria persisted to the age of 12 were destined to become transsexual. This arbitrary age threshold

was soon forgotten. Outside the Netherlands, GnRHa was adopted with no minimum age, and has been prescribed to children as young as 8 years old.⁸ Delemarre-van de Waal eventually advocated for GnRHa to be administered before Tanner stage 2, “right at the onset of puberty,” followed quickly by cross-sex hormones (Delemarre-van de Waal, 2014, p. 202). And of course the transsexual pathway now begins long before puberty, with social transition and psychological diagnosis. As de Hingh observes, “a diagnosis says you’ve got a problem that needs to be treated ... The medical process, with pills and protocols, takes over the normal process of identification formation” (de Hingh, 2021, pp. 182–183). Clinicians need to explain how they are sure that some of the adolescents being prescribed GnRHa would not have grown into gay or lesbian adults, with their sexuality and fertility intact.

The article that introduced puberty suppression to the medical literature was accurately titled: this endocrinological intervention is designed for juvenile transsexuals (Gooren & Delemarre-van de Waal, 1996). This fact should not be obscured by claiming that puberty suppression is reversible and diagnostic. It is not diagnostic because over 95% of adolescents given GnRHa will continue to cross-sex hormones, and this fraction has not declined even as the number of youths subjected to GnRHa has multiplied by two orders of magnitude. The claim for reversibility was contradicted from the outset by the unknown effect of puberty suppression on brain development. Irreversibility has now been demonstrated by randomized control trials in non-human animals. The central justification for puberty suppression was that it increases outward resemblance to the opposite sex and requires less surgical intervention. Paradoxically, however, early puberty suppression for males will most likely make subsequent genital surgery more risky—this is what killed one of the initial Dutch cohort—with worse results.

Evidence for the benefits of puberty suppression must be acknowledged as slender. Decisions made by clinicians have prevented the collection of robust evidence. The Dutch proponents of GnRHa chose not to conduct a randomized control trial, giving two reasons (de Vries et al., 2011). Firstly, adolescents would have refused to participate, which does not make sense unless they could have obtained GnRHa from another source. Secondly, it would have been unethical to withhold GnRHa from the control group, because the clinicians believed the treatment to be beneficial—this rationale is circular because discovering whether a treatment is truly beneficial requires a randomized control trial. A lesson can be drawn from the use of GnRHa to pause precocious puberty. This was supposed to mitigate short stature, as was apparently shown by small uncontrolled studies (Hayes, 2016), but this effect was called into question by a randomized control trial (Cassio et al., 1999). When the London clinic designed a study to replicate the findings from Amsterdam, the same reasons for avoiding a randomized control study were repeated, along with an argument that subjects would soon realize whether they were receiving treatment or placebo (Viner et al., 2010). Yet this had been no impediment to the trial for children with early puberty.

The decision to rely on uncontrolled studies was exacerbated by other decisions. The Dutch clinicians chose incommensurable scales to measure gender dysphoria, which calls into question their finding that dysphoria declined following cross-sex hormones and surgery. Worse still, American clinicians eschewed the measures of psychological functioning used by the Amsterdam and London clinics (YSR, CBCL, and CGAS), thus ensuring that their tiny samples could not contribute to cumulative knowledge. One final point to remember in evaluating published studies is that the field of transgender medicine is subject to the same publication bias as every other field: unsuccessful results will not be published. This bias is illustrated by the London clinic’s attempt to replicate the Amsterdam clinic’s findings: the lack of improvement on GnRHa appeared in print only after the clinic was taken to the High Court of Justice for England and Wales.

While the use of GnRHa to suppress puberty helped to create the juvenile transsexual, it could now be creating another “new way of being a person” (Wren, 2020): a sexless adult. This follows from the premise that natal puberty can be a kind of disease, and therefore failure to prevent an “irreversible development of secondary sex characteristics ... may be considered unethical” (de Vries et al., 2011, p. 2282). Although the Dutch protocol envisages GnRHa as a

preparatory phase before cross-sex hormones—imagined as undergoing puberty of the opposite sex—the logical conclusion is that hormones of either sex can be treated as vectors of disease. An Australian girl, Phoenix, was socially transitioned into a nonbinary identity at the age of 5 and took GnRHa from age 11. Reaching the age of 16, Phoenix refused to take testosterone because “remaining in an androgynous, peripubertal state is the only way their body can truly reflect their non-binary gender identity” (Notini et al., 2020, p. 743). The clinicians agreed to provide perpetual puberty suppression, despite the known deleterious physical effects—most obviously on bone density—and despite the unknown effects on emotional and cognitive development—which would affect Phoenix’s capacity to consent. Phoenix is not the only individual seeking indefinite puberty suppression (Pang, Notini, et al., 2020). Such cases are still exceptional. But cases like FG also used to be exceptional.

Notes

1. The literature sometimes refers to GnRH (or LHRH) analogues, which is a broader classification comprising antagonists as well as agonists.
2. The pediatric endocrinologist was not named in the original article, but her identity is clear from later sources (e.g. Delemarre-van de Waal, 2014). FG is known as “B” in the published literature.
3. Bailey and Zucker (1995) had by then reviewed four additional prospective studies in the same vein as well as numerous retrospective ones. Later prospective studies demonstrated that girls who manifested cross-gender behavior as infants were also more likely to grow up as lesbian, though the association was weaker than for boys (e.g. Li et al., 2017).
4. Pediatric endocrinology’s obsession with height has motivated the use of artificial estrogen to accelerate puberty in girls judged as too tall (Cohen & Cosgrove, 2009) and the use of GnRHa to delay puberty in girls judged as too short (Hayes, 2016).
5. A previous comparison (Biggs, 2020) included only 30 subjects from the London clinic and measured outcomes after 12 months. The Stata do-file is posted on Harvard dataverse at <https://doi.org/10.7910/DVN/QPRCRI>.
6. De Vries (2022) also cites a study from Kansas City (Allen et al., 2019) which includes an unknown number of children subjected to GnRHa before cross-sex hormones, but it took no baseline measure before puberty suppression.
7. The authors calculate the “gender diverse” proportion as 9% because they omit students who skipped the question (Kidd et al., 2021). It is more plausible to include the latter in the denominator, which yields 7%.
8. The London clinic referred a 7-year-old for endocrinological intervention, but it is not known whether GnRHa was actually prescribed before she turned 8 (Butler et al., 2022).

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References

- Achenbach, T. M., & Rescorla, L. (2001). *Manual for the ASEBA school-age forms and profiles: An integrated system of multi-informant assessment*. Burlington, VT: ASEBA.
- Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. *International Journal of Pediatric Endocrinology*, 2020(8). doi:10.1186/s13633-020-00078-2
- Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, 7, 302–311. doi:10.1037/cpp0000288
- Anacker, C., Sydnor, E., Chen, B. K., LaGamma, C. C., McGowan, J. C., Mastrodonato, A., ... Denny, C. A. (2021). Behavioral and neurobiological effects of GnRH agonist treatment in mice: Potential implications for puberty suppression in transgender individuals. *Neuropsychopharmacology*, 46, 882–890. doi:10.1038/s41386-020-00826-1
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, 31, 43–55. doi:10.1037/0012-1649.31.1.43

- Bannerman, L. (2019, July 26). Puberty blocking drugs: 'For the past four years I've been stuck as a child'. *Times*. <https://www.thetimes.co.uk/article/transgender-children-puberty-blocking-drugs-for-the-past-four-years-i-ve-been-stuck-as-a-child-5s6tkh7z2>
- Bannerman, L. (2022, June 17). 'My puberty was chemically delayed: I was their guinea pig'. *Times*. <https://www.thetimes.co.uk/article/my-adolescence-was-chemically-delayed-i-was-their-guinea-pig-bbs3w00ph>
- Bazelon, E. (2022, June 15). The battle over gender therapy. *New York Times*. <https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html>
- Becker-Hebly, I., Fahrenkrug, S., Campion, F., Richter-Appelt, H., Schulte-Markwort, M., & Barkmann, C. (2021). Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: A descriptive study from the Hamburg Gender Identity Service. *European Child & Adolescent Psychiatry*, 30, 1755–1767. doi:10.1007/s00787-020-01640-2
- Biggs, M. (2019a). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 16, 2043. doi:10.1016/j.jsxm.2019.09.002
- Biggs, M. (2019b). Britain's experiment with puberty blockers. In M. Moore & H. Brunsell-Evans (Eds.), *Inventing Transgender Children and Young People* (pp. 40–55). UK: Cambridge Scholars Publishing.
- Biggs, M. (2019c). *The Tavistock's experiment with puberty blockers*. http://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf
- Biggs, M. (2020). Gender dysphoria and psychological functioning in adolescents treated with GnRHa: Comparing Dutch and English prospective studies. *Archives of Sexual Behavior*, 49, 2231–2236. doi:10.1007/s10508-020-01764-1
- Biggs, M. (2021). Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *Journal of Pediatric Endocrinology and Metabolism*, 34, 937–939. doi:10.1515/jpem-2021-0180
- Blackwood of North Oxford, B. (2019). *Answer to written question HL15681 asked by Lord Lucas*. UK: House of Lords.
- Bouman, M.-B. (2021). Interview. In A. Bakker (Ed.), *The Dutch approach: Fifty years of transgender health care at the VU Amsterdam gender clinic* (pp. 141–146). Los Angeles, CA: Boom.
- Bouman, M.-B., van der Sluis, W. B., Buncamper, M. E., Özer, M., Mullender, M. G., & Meijerink, W. J. H. J. (2016). Primary total laparoscopic sigmoid vaginoplasty in transgender women with penoscrotal hypoplasia: A prospective cohort study of surgical outcomes and follow-up of 42 patients. *Plastic and Reconstructive Surgery*, 138, 614e–623e. doi:10.1097/PRS.0000000000002549
- Bowers, M. (2022, March 21). Teen transitions. In *Trans and Gender Diverse Policies, Care, Practices, and Wellbeing Symposium*, Duke University. <https://www.facebook.com/dukesgmhealth/videos/704267637246585/>
- Bradley, S. J., & Zucker, K. J. (1990). Gender identity disorder and psychosexual problems in children and adolescents. *Canadian Journal of Psychiatry*, 35, 477–486. doi:10.1177/070674379003500603
- Brik, T., Vrouenraets, L. J. J., de Vries, M. C., & Hannema, S. E. (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. *Archives of Sexual Behavior*, 49, 2611–2618. doi:10.1007/s10508-020-01660-8
- Butler, G. (2016, June 19). *How effective is puberty suspension with GnRH analogues*. World Professional Association for Transgender Health. <http://wpath2016.conferencespot.org/62620-wpathv2-1.3138789/t001-1.3140111/f001-1.3140333/0706-000441-1.3140337>
- Butler, G., Adu-Gyamfi, K., Clarkson, K., El Khairi, R., Kleczewski, S., Roberts, A., ... Carmichael, P. (2022). Discharge outcome analysis of 1089 transgender young people referred to paediatric endocrine clinics in England 2008–2021. *Archives of Disease in Childhood*. doi:10.1136/archdischild-2022-324302
- Butler, G., De Graaf, N., Wren, B., & Carmichael, P. (2018). Assessment and support of children and adolescents with gender dysphoria. *Archives of Disease in Childhood*, 103, 631–636. doi:10.1136/archdischild-2018-314992
- Byng, R., Bewley, S., Clifford, D., & McCartney, M. (2018). Gender-questioning children deserve better science. *Lancet*, 392(10163), 2435. doi:10.1016/S0140-6736(18)32223-2
- Carmichael, P. (2016, June 18). *Time to reflect: Gender dysphoria in children and adolescents, defining best practice in a fast changing context*. World Professional Association for Transgender Health. <http://av-media.vu.nl/VUMedia/Play/581e58c338984dafb455c72c56c0bfa31d?catalog=2d190891-4e3f-4936-a4fa-2e9766ae0d0d>
- Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*, 16, e0243894. doi:10.1371/journal.pone.0243894
- Carmichael, P., Phillott, S., Dunsford, M., Taylor, A., & de Graaf, N. (2016, June 19). *Gender dysphoria in younger children: Support and care in an evolving context*. World Professional Association for Transgender Health. <http://wpath2016.conferencespot.org/62620-wpathv2-1.3138789/t001-1.3140111/f009a-1.3140266/0706-000523-1.3140268>
- Cassio, A., Cacciari, E., Balsamo, A., Bal, M., & Tassinari, D. (1999). Randomised trial of LHRH analogue treatment on final height in girls with onset of puberty aged 7.5–8.5 years. *Archives of Disease in Childhood*, 81, 329–332. doi:10.1136/ad.81.4.329
- Chen, D., Abrams, M., Clark, L., Ehrensaft, D., Tishelman, A. C., Chan, Y.-M., ... Hidalgo, M. A. (2021). Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: Baseline findings from the Trans Youth Care study. *Journal of Adolescent Health*, 68, 1104–1111. doi:10.1016/j.jadohealth.2020.07.033
- Cohen, S., & Cosgrove, C. (2009). *Normal at any cost: Tall girls, short boys, and the medical industry's quest to manipulate height*. New York, NY: Penguin Publishing Group.

- Cohen-Kettenis, P. (2021). Interview. In A. Bakker (Ed.), *The Dutch approach: Fifty years of transgender health care at the VU Amsterdam gender clinic* (pp. 112–118). Los Angeles, CA: Boom.
- Cohen-Kettenis, P., van Goozen, S. H. M., & Cohen, L. (1998). Transsexualism during adolescence. In D. Di Ceglie & D. Freedman (Eds.), *A stranger in my own body: Atypical gender identity development and mental health* (pp. 118–125). London: Karnac Books.
- Cohen-Kettenis, P. T. (1994). Die Behandlung von Kindern und Jugendlichen mit Geschlechtsidentitätsstörungen an der Universität Utrecht. *Zeitschrift für Sexualforschung*, 7, 231–239.
- Cohen-Kettenis, P. T. (2016, November 25). *Lessons Learned in 10+ Years of Experience Using Puberty Blockers at VUMC Amsterdam*. 10 ans de la Fondation Agnodice, Lausanne. <https://vimeo.com/241880094/46dd8a76af>
- Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. G. (2008). The treatment of adolescent transsexuals: Changing insights. *Journal of Sexual Medicine*, 5, 1892–1897. doi:10.1111/j.1743-6109.2008.00870.x
- Cohen-Kettenis, P. T., Dillen, C. M., & Gooren, L. J. (2000). De behandeling van jonge transseksuelen in Nederland. *Nederlands Tijdschrift voor Geneeskunde*, 144, 698–702.
- Cohen-Kettenis, P. T., & Gooren, L. J. G. (1999). Transsexualism: A review of etiology, diagnosis and treatment. *Journal of Psychosomatic Research*, 46, 315–333.
- Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage.
- Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior*, 40, 843–847. doi:10.1007/s10508-011-9758-9
- Cohen-Kettenis, P. T., & van Goozen, S. H. M. (1997). Sex reassignment of adolescent transsexuals: A follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 263–271. doi:10.1097/00004583-199702000-00017
- Cohen-Kettenis, P. T., & van Goozen, S. H. M. (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. *European Child and Adolescent Psychiatry*, 7, 246–248. doi:10.1007/s007870050073
- Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 12, 2206–2214. doi:10.1111/jsm.13034
- de Graaf, N. M., Cohen-Kettenis, P. T., Carmichael, P., de Vries, A. L. C., Dhondt, K., Laridaen, J., Pauli, D., Ball, J., & Steensma, T. D. (2018). Psychological functioning in adolescents referred to specialist gender identity clinics across Europe: A clinical comparison study between four clinics. *European Child and Adolescent Psychiatry*, 27, 909–919. doi:10.1007/s00787-017-1098-4
- de Hingh, V. (2021). Interview. In A. Bakker (Ed.), *The Dutch approach: Fifty years of transgender health care at the VU Amsterdam gender clinic* (pp. 112–118). Los Angeles, CA: Boom.
- de Vries, A. L. C. (2010). *Gender dysphoria in adolescents: Mental health and treatment evaluation* (PhD Thesis), Vrije Universiteit, Amsterdam. <https://research.vu.nl/en/publications/gender-dysphoria-in-adolescent-s-mental-health-and-treatment-evalu>
- de Vries, A. L. C. (2022). Ensuring care for transgender people who need it: Response to ‘reconsidering informed consent for trans-identified children, adolescents and young adults’. *Journal of Sex and Marital Therapy*. doi:10.1080/0092623X.2022.2084479
- de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59, 301–320. doi:10.1080/00918369.2012.653300
- de Vries, A. L. C., Klink, D., & Cohen-Kettenis, P. T. (2016). What the primary care pediatrician needs to know about gender incongruence and gender dysphoria in children and adolescents. *Pediatric Clinics of North America*, 63, 1121–1135. doi:10.1016/j.pcl.2016.07.011
- de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134, 696–704. doi:10.1542/peds.2013-2958
- de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine*, 8, 2276–2283. doi:10.1111/j.1743-6109.2010.01943.x
- Delemarre-van de Waal, H. A. (2014). Early medical intervention in adolescents with gender dysphoria. In B. P. C. Kreukels, T. D. Steensma, & A. L. C. de Vries (Eds.), *Gender dysphoria and disorders of sex development* (pp. 193–203). Berlin: Springer.
- Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155(suppl_1), S131–S137. doi:10.1530/eje.1.02231
- Di Ceglie, D. (2018). The use of metaphors in understanding atypical gender identity development and its psychosocial impact. *Journal of Child Psychotherapy*, 44, 5–28. doi:10.1080/0075417X.2018.1443151
- Everaerd, W., Swaab, H., Gooren, L., Megens, J., & van Trotsenburg, M. (2014). Preface. In B. P. C. Kreukels, T. D. Steensma, & A. L. C. De Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in care and knowledge* (pp. vii–xxi). Berlin: Springer.

- FG. (2021). Interview. In A. Bakker (Ed.), *The Dutch approach: Fifty years of transgender health care at the VU Amsterdam gender clinic* (pp. 131–132). Los Angeles, CA: Boom.
- Gender Identity Research and Education Society. (2005). *Consensus Report on Symposium in May 2005*. <https://www.gires.org.uk/consensus-report-on-symposium-in-may-2005/>
- Gender Identity Research and Education Society. (2006). *Final Report to the Nuffield Foundation*. <https://www.gires.org.uk/gires-final-report-to-the-nuffield-foundation/>
- Gijs, L., & Gooren, L. (1996). Hormonal and psychopharmacological interventions in the treatment of paraphilias: An update. *Journal of Sex Research*, 33, 273–290. doi:10.1080/00224499609551845
- Gill-Peterson, J. (2018). *Histories of the transgender child*. Minneapolis, MN: University of Minnesota Press.
- Glass, K. (2012, January 22). A boy's own story. *Sunday Times*. <https://www.thetimes.co.uk/article/a-boys-own-story-2wpctfb6pxt>
- Gooren, L. J. G. (1993). Closing speech. In *Transsexualism, medicine and law: Proceedings of the 23rd Colloquy on European Law* (pp. 233–238). Council of Europe Publishing.
- Gooren, L. (2021). Interview. In A. Bakker (Ed.), *The Dutch approach: Fifty years of transgender health care at the VU Amsterdam gender clinic*. Los Angeles, CA: Boom.
- Gooren, L., & Delemarre-van de Waal, H. (1996). The feasibility of endocrine interventions in juvenile transsexuals. *Journal of Psychology and Human Sexuality*, 8, 69–74. doi:10.1300/J056v08n04_05
- Green, R. (1968). Childhood cross-gender identification. *Journal of Nervous and Mental Disease*, 147, 500–509. doi:10.1097/00005053-196811000-00006
- Green, R. (1987). *The sissy boy syndrome: The development of homosexuality*. London: Yale University Press.
- Green, R. (2008, Autumn). A Tale of Two Conferences. *GT News*, 73.
- Groskopf, V. (2008, August 14). 'My body is wrong'. *Guardian*. <https://www.theguardian.com/society/2008/aug/14/children.youngpeople>
- Harry Benjamin International Gender Dysphoria Association. (1985). Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons. *Archives of Sexual Behavior*, 14, 79–90. doi:10.1007/BF01541354
- Harry Benjamin International Gender Dysphoria Association. (2001). *Standards of Care for Gender Identity Disorders, Sixth Version*. http://www.genderpsychology.org/transsexual/hbsoc_1990.html
- Hartocollis, A. (2015, June 17). The new girl in school: Transgender surgery at 18. *New York Times*. <https://www.nytimes.com/2015/06/17/nyregion/transgender-minors-gender-reassignment-surgery.html>
- Hausman, B. L. (1995). *Changing sex: Transsexuality, technology and the idea of gender*. Durham, NC: Duke University Press.
- Hayes, P. (2016). Early puberty, medicalisation and the ideology of normality. *Women's Studies International Forum*, 56, 9–18. doi:10.1016/j.wsif.2016.01.003
- Hayes, P. (2017). Commentary: Cognitive, emotional, and psychosocial functioning of girls treated with pharmacological puberty blockage for idiopathic central precocious puberty. *Frontiers in Psychology*, 8. doi:10.3389/fpsyg.2017.00044
- Health Research Authority. (2019, October 14). *Investigation into the study 'Early pubertal suppression in a carefully selected group of adolescents with gender identity disorders'*. <https://www.hra.nhs.uk/about-us/governance/feedback-raising-concerns/investigation-study-early-pubertal-suppression-carefully-selected-group-adolescents-gender-identity-disorders/>
- Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer, W. J., Spack, N. P., Tangpricha, V., & Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology and Metabolism*, 94, 3132–3154. doi:10.1210/jc.2009-0345
- Horton, C. (2022). "I didn't want him to disappear": Parental decision-making on access to puberty blockers for trans early adolescents. *Journal of Early Adolescence*. doi:10.1177/02724316221107076
- Hough, D., Bellingham, M., Haraldsen, I. R. H., McLaughlin, M., Rennie, M., Robinson, J. E., Solbakk, A. K., & Evans, N. P. (2017). Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. *Psychoneuroendocrinology*, 75, 173–182. doi:10.1016/j.psyneuen.2016.10.016
- Hough, D., Bellingham, M., Haraldsen, I. R., McLaughlin, M., Robinson, J. E., Solbakk, A. K., & Evans, N. P. (2017). A reduction in long-term spatial memory persists after discontinuation of peripubertal GnRH agonist treatment in sheep. *Psychoneuroendocrinology*, 77, 1–8. doi:10.1016/j.psyneuen.2016.11.029
- Hsieh, S., & Leininger, J. (2014). Resource list: Clinical care programs for gender-nonconforming children and adolescents. *Pediatric Annals*, 43, 238–244. doi:10.3928/00904481-20140522-11
- Indremo, M., Jodensvi, A. C., Arinell, H., Isaksson, J., & Papadopoulos, F. C. (2022). Association of media coverage on transgender health with referrals to child and adolescent gender identity clinics in Sweden. *JAMA Network Open*, 5, e2146531. doi:10.1001/jamanetworkopen.2021.46531
- Ioannidis, J. P. A. (2005). Contradicted and initially stronger effects in highly cited clinical research. *Journal of the American Medical Association*, 294, 218–228. doi:10.1001/jama.294.2.218
- Jennings, J., & Jennings, J. (2016). Trans teen shares her story. *Pediatrics in Review*, 37, 99–100. doi:10.1542/pir.2016-002
- Johnson, R. T., & Dickersin, K. (2007). Publication bias against negative results from clinical trials: Three of the seven deadly sins. *Nature Clinical Practice Neurology*, 3, 590–591. doi:10.1038/ncpneuro0618

- Joseph, T., Ting, J., & Butler, G. (2019). The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *Journal of Pediatric Endocrinology and Metabolism*, 32, 1077–1081. doi:10.1515/jpem-2019-0046
- Keira Bell and Mrs A v Tavistock NHS Trust (2020). Her Majesty's High Court of Justice in England. Case [2020] EWHC 3274 (Admin).
- Kidd, K. M., Sequeira, G. M., Douglas, C., Paglisotti, T., Inwards-Breland, D. J., Miller, E., & Coulter, R. W. S. (2021). Prevalence of gender-diverse youth in an urban school district. *Pediatrics*, 147, e2020049823. doi:10.1542/peds.2020-049823
- Kirsch, I. (2019). Placebo effect in the treatment of depression and anxiety. *Frontiers in Psychiatry*, 10, article 407. 10.3389/fpsy.2019.00407
- Klink, D., Caris, M., Heijboer, A., van Trotsenburg, M., & Rotteveel, J. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *Journal of Clinical Endocrinology and Metabolism*, 100, E270–E275. 10.1210/jc.2014-2439
- Klotz, F. (2022, April 6). The fractious evolution of pediatric transgender medicine. *Undark Magazine*. <https://undark.org/2022/04/06/the-evolution-of-pediatric-transgender-medicine/>
- Kreukels, B. P. C., & Burke, S. M. (2020). Neurobiology of pediatric gender identity. In M. Forcier, G. Van Schalkwyk, & J. L. Turban (Eds.), *Pediatric gender identity* (pp. 47–62). Berlin: Springer International Publishing. doi:10.1007/978-3-030-38909-3_4
- Kuiper, B., & Cohen-Kettenis, P. (1988). Sex reassignment surgery: A study of 141 Dutch transsexuals. *Archives of Sexual Behavior*, 17, 439–457.
- Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, 145, e20193006. doi:10.1542/peds.2019-3006
- Laidlaw, M. K., Van Meter, Q. L., Hruz, P. W., Van Mol, A., & Malone, W. J. (2019). Letter to the editor: "Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline". *Journal of Clinical Endocrinology and Metabolism*, 104, 686–687. 10.1210/jc.2018-01925
- Lee, J. Y., Finlayson, C., Olson-Kennedy, J., Garofalo, R., Chan, Y.-M., Glidden, D. V., & Rosenthal, S. M. (2020). Low bone mineral density in early pubertal transgender/gender diverse youth: Findings from the Trans Youth Care Study. *Journal of the Endocrine Society*, 4, bvaa065. doi:10.1210/jendso/bvaa065
- Levine, S. B., Abbruzzese, E., & Mason, J. M. (2022). Reconsidering informed consent for trans-identified children, adolescents, and young adults. *Journal of Sex and Marital Therapy*. doi:10.1080/0092623X.2022.2046221
- Li, G., Kung, K. T. F., & Hines, M. (2017). Childhood gender-typed behavior and adolescent sexual orientation: A longitudinal population-based study. *Developmental Psychology*, 53, 764–777. doi:10.1037/dev0000281
- Lindgren, T. W., & Pauly, I. B. (1975). A body image scale for evaluating transsexuals. *Archives of Sexual Behavior*, 4, 639–656. doi:10.1007/BF01544272
- Lopez, C. M., Solomon, D., Boulware, S. D., & Christison-Lagay, E. R. (2018). Trends in the use of puberty blockers among transgender children in the United States. *Journal of Pediatric Endocrinology and Metabolism*, 31, 665–670. doi:10.1515/jpem-2018-0048
- Manning, S., & Adams, S. (2014, May 17). NHS to give sex change drugs to nine-year-olds. *Mail on Sunday*. <https://www.dailymail.co.uk/news/article-2631472/NHS-sex-change-drugs-nine-year-olds-Clinic-accused-playing-God-treatment-stops-puberty.html>
- Marumo, K., Baba, S., & Murai, M. (1999). Erectile function and nocturnal penile tumescence in patients with prostate cancer undergoing luteinizing hormone-releasing hormone agonist therapy. *International Journal of Urology*, 6, 19–23. doi:10.1046/j.1442-2042.1999.06128.x
- Medical Practitioners Tribunal Service. (2022). *Record of Determinations: Dr Michael Webberley (2620107)*. <https://www.mpts-uk.org/-/media/mpts-rod-files/dr-michael-webberley-25-may-22.pdf>
- Mermaids. (2007). Obtaining help from the Children's Hospital Boston. In *Mermaids Annual Meeting*. <http://www.gires.org.uk/wp-content/uploads/2014/08/mermaids-presentation.ppt>
- Money, J. (1994). The Concept of gender identity disorder in childhood and adolescence after 39 years. *Journal of Sex and Marital Therapy*, 20, 163–177. doi:10.1080/00926239408403428
- Money, J. (1998). Foreword. In D. Di Ceglie & D. Freedman (Eds.), *A stranger in my own body: Atypical gender identity development and mental health* (pp. xvii–xviii). London: Karnac Books.
- Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology*, 4, 29–41. doi:10.1093/jpepsy/4.1.29
- Morse, O. (Director). (1996). The wrong body. In *The Decision*. London: Windfall Films (Channel 4).
- Mul, D., Versluis-den Bieman, H., Slijper, F., Oostdijk, W., Waelkens, J., & Drop, S. (2007). Psychological assessments before and after treatment of early puberty in adopted children. *Acta Paediatrica*, 90, 965–971. doi:10.1111/j.1651-2227.2001.tb01349.x
- Nataf, Z. (1999). *Interview*. <https://rainbowreeltokyo.com/99/English/interview/zacharynataf.html>
- Navabi, B., Tang, K., Khatchadourian, K., & Lawson, M. L. (2021). Pubertal suppression, bone mass, and body composition in youth with gender dysphoria. *Pediatrics*, 148, e2020039339. doi:10.1542/peds.2020-039339
- Nederlands Tijdschrift voor Geneeskunde. (1989). Transseksualiteit. *Nederlands Tijdschrift voor Geneeskunde*, 133, 1475.

- Negenborn, V. L., van der Sluis, W. B., Meijerink, W. J. H. J., & Bouman, M.-B. (2017). Lethal necrotizing cellulitis caused by ESBL-producing *E. coli* after laparoscopic intestinal vaginoplasty. *Journal of Pediatric and Adolescent Gynecology*, 30, e19–e21. doi:10.1016/j.jpog.2016.09.005
- NHS England. (2015). *NHS standard contract for Gender Identity Development Service for children and adolescents*.
- Nietsch, H. (Director). (2007). *Valentijn*. Amsterdam: VARA.
- Niland, P. (Director). (2014). *I Am Leo*. In *My Life*. London: CBBC.
- Notini, L., Earp, B. D., Gillam, L., McDougall, R. J., Savulescu, J., Telfer, M., & Pang, K. C. (2020). Forever young? The ethics of ongoing puberty suppression for non-binary adults. *Journal of Medical Ethics*, 46, 743–752. doi:10.1136/medethics-2019-106012
- Olson-Kennedy, J., Chan, Y.-M., Garofalo, R., Spack, N., Chen, D., Clark, L., ... Rosenthal, S. (2019). Impact of early medical treatment for transgender youth: Protocol for the longitudinal, observational Trans Youth Care Study. *JMIR Research Protocols*, 8, e14434. doi:10.2196/14434
- Pang, K. C., de Graaf, N. M., Chew, D., Hoq, M., Keith, D. R., Carmichael, P., & Steensma, T. D. (2020). Association of media coverage of transgender and gender diverse issues with rates of referral of transgender children and adolescents to specialist gender clinics in the UK and Australia. *JAMA Network Open*, 3, e2011161. doi:10.1001/jamanetworkopen.2020.11161
- Pang, K. C., Notini, L., McDougall, R., Gillam, L., Savulescu, J., Wilkinson, D., ... Lantos, J. D. (2020). Long-term puberty suppression for a nonbinary teenager. *Pediatrics*, 145, e20191606. doi:10.1542/peds.2019-1606
- Petersen, M. E., & Dickey, R. (1995). Surgical sex reassignment: A comparative survey of International centers. *Archives of Sexual Behavior*, 24, 135–156. doi:10.1007/BF01541578
- Ruttimann, J. (2013, January). Blocking puberty in transgender youth. *Endocrine News*, 16–20.
- Schagen, S. E. E., Wouters, F. M., Cohen-Kettenis, P. T., Gooren, L. J., & Hannema, S. E. (2020). Bone development in transgender adolescents treated with GnRH analogues and subsequent gender-affirming hormones. *Journal of Clinical Endocrinology and Metabolism*, 105, e2522–e2523. doi:10.1210/clinem/dgaa604
- Schneider, C., Cerwenka, S., Nieder, T. O., Briken, P., Cohen-Kettenis, P. T., De Cuypere, G., ... Richter-Appelt, H. (2016). Measuring gender dysphoria: A multicenter examination and comparison of the Utrecht gender dysphoria scale and the gender identity/gender dysphoria questionnaire for adolescents and adults. *Archives of Sexual Behavior*, 45, 551–558. doi:10.1007/s10508-016-0702-x
- Schneider, M. A., Spritzer, P. M., Soll, B. M. B., Fontanari, A. M. V., Carneiro, M., Tovar-Moll, F., ... Lobato, M. I. R. (2017). Brain maturation, cognition and voice pattern in a gender dysphoria case under pubertal suppression. *Frontiers in Human Neuroscience*, 11, article 528. doi:10.3389/fnhum.2017.00528
- Schroor, E. J., Van Weissenbruch, M. M., & Delemarre-van de Waal, H. A. (1995). Long-term GnRH-agonist treatment does not postpone central development of the GnRH pulse generator in girls with idiopathic precocious puberty. *Journal of Clinical Endocrinology and Metabolism*, 80, 1696–1701. doi:10.1210/jcem.80.5.7745021
- Singal, J. (2022, April 6). Researchers found puberty blockers and hormones didn't improve trans kids' mental health at their clinic, then they published a study claiming the opposite. *Singal-Minded*. <https://jessesingal.substack.com/p/researchers-found-puberty-blockers>
- Sloan, J. (2011, October 19). I had sex swap op on my 16th birthday. *Sun*. <https://www.thesun.co.uk/fabulous/51138/i-had-sex-swap-op-on-my-16th-birthday/>
- Smith, Y. L. S., van Goozen, S. H. M., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: A prospective follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 472–481. doi:10.1097/00004583-200104000-00017
- Spack, N. (2008). Foreword. In S. A. Brill & R. Pepper, *The transgender child: A handbook for families and professionals* (pp. ix–xi). Jersey City, NJ: Cleis Press.
- Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*, 129, 418–425. doi:10.1542/peds.2011-0907
- Staphorsius, A. S., Kreukels, B. P. C., Cohen-Kettenis, P. T., Veltman, D. J., Burke, S. M., Schagen, S. E. E., ... Bakker, J. (2015). Puberty suppression and executive functioning: An fMRI-study in adolescents with gender dysphoria. *Psychoneuroendocrinology*, 56, 190–199. doi:10.1016/j.psyneuen.2015.03.007
- Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistance and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 582–590. doi:10.1016/j.jaac.2013.03.016
- Stocks, J. (Director). (2011). *I am Jazz: A family in transition*. Los Angeles, CA: Oprah Winfrey Network.
- Stoffers, I. E., de Vries, M. C., & Hannema, S. E. (2019). Physical changes, laboratory parameters, and bone mineral density during testosterone treatment in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 16, 1459–1468. doi:10.1016/j.jsxm.2019.06.014
- SVT. (2022, February 23). *Uppdrag granskning avslöjar: Flera barn har fått skador i transvården*. SVT Nyheter. <https://www.svt.se/nyheter/granskning/ug/uppdag-granskning-avslor-flera-barn-har-fatt-skador-i-transvarden>
- Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel, F. H., Shumer, D. E., & Spack, N. P. (2015). Serving transgender youth: Challenges, dilemmas, and clinical examples. *Professional Psychology: Research and Practice*, 46, 37–45. doi:10.1037/a0037490

- Tominey, C., & Walsh, J. (2019, March 7). NHS transgender clinic accused of covering up negative impacts of puberty blockers on children by Oxford professor. *Telegraph*. <https://www.telegraph.co.uk/news/2019/03/07/nhs-transgender-clinic-accused-covering-negative-impacts-puberty/>
- Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open*, 5, e220978. doi:10.1001/jamanetworkopen.2022.0978
- van de Grift, T. C., van Gelder, Z. J., Mullender, M. G., Steensma, T. D., de Vries, A. L. C., & Bouman, M.-B. (2020). Timing of puberty suppression and surgical options for transgender youth. *Pediatrics*, 146, e20193653. doi:10.1542/peds.2019-3653
- van der Sluis, W. B., de Nie, I., Steensma, T. D., van Mello, N. M., Lissenberg-Witte, B. I., & Bouman, M.-B. (2021). Surgical and demographic trends in genital gender-affirming surgery in transgender women: 40 years of experience in Amsterdam. *British Journal of Surgery*, 109, 8–11. doi:10.1093/bjs/znab213
- Viner, R., Carmichael, P., Ceglie, D. D., Butler, G., Brain, C., Holt, V., ...Skagerberg, E. (2010). *An evaluation of early pubertal suppression in a carefully selected group of adolescents with gender identity disorder (v1.0)*.
- Viner, R., Carmichael, P., Ceglie, D. D., Butler, G., Brain, C., Holt, V., ...Skagerberg, E. (2012). *An evaluation of early pubertal suppression in a carefully selected group of adolescents with gender identity disorder (v1.2)*.
- Vlot, M. C., Klink, D. T., den Heijer, M., Blankenstein, M. A., Rottevel, J., & Heijboer, A. C. (2017). Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*, 95, 11–19. doi:10.1016/j.bone.2016.11.008
- Wiepjes, C. M., Blok, C. J., Staphorsius, A. S., Nota, N. M., Vlot, M. C., Jongh, R. T., & Heijer, M. (2020). Fracture risk in trans women and trans men using long-term gender-affirming hormonal treatment: A nationwide cohort study. *Journal of Bone and Mineral Research*, 35, 64–70. doi:10.1002/jbmr.3862
- Wiepjes, C. M., Nota, N. M., de Blok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., ...den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, 15, 582–590. doi:10.1016/j.jsxm.2018.01.016
- Wojnusz, S., Callens, N., Sütterlin, S., Andersson, S., De Schepper, J., Gies, I., ...Haraldsen, I. R. (2016). Cognitive, emotional, and psychosocial functioning of girls treated with pharmacological puberty blockage for idiopathic central precocious puberty. *Frontiers in Psychology*, 7, article 1053. doi:10.3389/fpsyg.2016.01053
- Wojnusz, S., Vögele, C., Ropstad, E., Evans, N., Robinson, J., Sütterlin, S., ...Haraldsen, I. R. H. (2011). Prepubertal gonadotropin-releasing hormone analog leads to exaggerated behavioral and emotional sex differences in sheep. *Hormones and Behavior*, 59, 22–27. doi:10.1016/j.yhbeh.2010.09.010
- Wren, B. (2020). New way of being a person? *Journal of Medical Ethics*, 46, 755–756. doi:10.1136/medethics-2020-106584
- Zhou, J.-N., Hofman, M. A., Gooren, L. J. G., & Swaab, D. F. (1995). A sex difference in the human brain and its relation to transsexuality. *Nature*, 378(6552), 68–70. doi:10.1038/378068a0
- Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior*, 39, 477–498. doi:10.1007/s10508-009-9540-4
- Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease*, 172, 90–97. doi:10.1097/00005053-198402000-00005

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Academic Appointments

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2017-present Clinical Associate Professor of Child and Adolescent Psychiatry
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Ann and Robert H. Lurie Children's Hospital of Chicago
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Education

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5/01	B.A.	Biochemistry	University of Colorado
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Licensure and Certification

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Academic Appointments

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2011-2017 Clinical Asst Professor, NYU Dept of Child and Adolescent Psychiatry
2017-2019 Clinical Assoc Professor, NYU Dept of Child and Adolescent Psychiatry
2011-2019 Clinical Director, NYU Gender and Sexuality Service
2015-2019 Co-Director, NYU Pediatric Consultation-Liaison Service
2019-present Associate Professor of Child and Adolescent Psychiatry, Northwestern University
2019-present Vice Chair of Clinical Affairs, Pritzker Department of Psychiatry and Behavioral

Major Committee Assignments

International, National and Regional

2021-present	Sexual Orientation and Gender Identity Committee, Chair, AACAP
2019-present	WPATH Standards of Care Revision Committee, Children
2019-present	WPATH Standards of Care Revision Committee, Adult Mental Health
2015-2019	Department of Child Psychiatry Diversity Ambassador
2013-2021	Sexual Orientation and Gender Identity Committee Member, AACAP
2012-2019	Founder and Director, Gender Variant Youth and Family Network
2012-present	Association of Gay and Lesbian Psychiatrists, Transgender Health Committee
2012-2019	NYULMC, Chair LGBTQ Advisory Council
2012-2019	NYULMC, Child Abuse and Protection Committee
2013-2015	NYULMC, Pediatric Palliative Care Team
2003-2004	American Association of Medical Colleges (AAMC), Medical Education Delegate
2004-2006	AAMC, Western Regional Chair

Psychiatry Residency

2006-2009	Resident Member, Education Committee
2007-2008	Resident Member, Veterans Affairs (VA) Committee

Medical School

2002-2006	Chair, Diversity Curriculum Development Committee
2002-2006	AAMC, Student Representative
2003-2004	American Medical Student Assoc. (AMSA) World AIDS Day Coordinator
2003-2004	AMSA, Primary Care Week Coordinator
2004-2006	Chair, Humanism in Medicine Committee

Memberships, Offices, and Committee Assignments in Professional Societies

2006-present	American Psychiatric Association (APA)
2009-present	American Academy of Child and Adolescent Psychiatry (AACAP)
2011-present	World Professional Association for Transgender Health (WPATH)
2011-2019	Director, Gender Variant Youth and Family Network, NYC
2013-2019	Chair, NYU Langone Medical Center LGBTQ Council

Editorial Positions

2016-2018	Clinical Assistant Editor, <i>Transgender Health</i>
2014-present	Ad Hoc Reviewer, <i>LGBT Health</i> .
2016-present	Ad Hoc Reviewer, <i>JAACAP</i>
2018-present	Associate Editor, <i>Transgender Health</i>
2020-present	Ad Hoc Reviewer, <i>Pediatrics</i>

Principal Clinical and Hospital Service Responsibilities

2011-2019	Staff Psychiatrist, Pediatric Consultation Liaison Service
2011-2019	Faculty Physician, NYU Child Study Center
2011-2019	Founder and Clinical Director, NYU Gender & Sexuality Service
2015-2019	Co-Director, Pediatric Consultation Liaison Service
2019-present	Vice Chair, Pritzker Dept of Psychiatry and Behavioral Health

2019-present	Chief Psychiatrist, Gender Development Program
2020-present	Medical Director, Outpatient Psychiatry Services

Relevant Program Development

Gender and Sexuality Service

- founded by Aron Janssen in 2011, who continues to direct the service
- first mental health service dedicated to transgender youth in NYC
- served over 200 families in consultation, with 2-3 referrals to the gender clinic per week
- trained over 500 mental health practitioners in transgender mental health – 1 or 2 full day trainings in partnership with the Ackerman Institute’s Gender and Family Project (GFP) and with WPATH Global Educational Initiative (GEI)
- New hires in Adolescent Medicine, Psychology, Plastic Surgery, Urology, Gynecology, Endocrinology, Social Work, Department of Population Health with focus on transgender care has led to expansion of available services for transgender youth at NYULMC in partnership with the Gender and Sexuality Service
- development of partnerships with Ackerman Institute, Callen-Lorde Health Center – both institutions have been granted access to our IRB and have agreed to develop shared research and clinical priorities with the Gender and Sexuality Service.
- multiple IRB research projects underway, including in partnership with national and international clinics
- model has been internationally recognized

Clinical Specialties/Interests

Gender and Sexual Identity Development
 Co-Occurring Mental Health Disorders in Transgender children, adolescents and adults
 Pediatric Consultation/Liaison Psychiatry
 Psychotherapy
 -Gender Affirmative Therapy, Supportive Psychotherapy, CBT, MI

Teaching Experience

2002-2006 Course Developer and Instructor, LGBT Health (University of Colorado School of Medicine)
 2011-2019 Instructor, Cultural Competency in Child Psychiatry (NYU Department of Child and Adolescent Psychiatry) – 4 hours per year
 2011-2019 Course Director, Instructor “Sex Matters: Identity, Behavior and Development” – 100 hours per year
 2011-2019 Course Director, LGBT Mental Health Elective (NYU Department of Psychiatry) - 50 hours of direct supervision/instruction per year
 2011-2019 Course Director, Transgender Mental Health (NYU Department of Child and Adolescent Psychiatry – course to begin in Spring 2018.
 2015-2019 Instructor, Gender & Health Selective (NYU School of Medicine) – 4 hours per year.

Academic Assignments/Course Development

New York University Department of Child and Adolescent Mental Health Studies
 -Teacher and Course Director: “Sex Matters: Identity, Behavior and Development.”
 A full semester 4 credit course, taught to approximately 50 student per year since

2011, with several students now in graduate school studying sexual and gender identity development as a result of my mentorship.

NYU Department of Child and Adolescent Psychiatry

-Instructor: Cultural Competency in Child and Adolescent Psychiatry

-Director: LGBTQ Mental Health Elective

World Professional Association of Transgender Health

-Official Trainer: Global Education Initiative – one of two child psychiatrists charged with training providers in care of transgender youth and adults.

Peer Reviewed Publications

1. Janssen, A., Erickson-Schroth, L., “A New Generation of Gender: Learning Patience from our Gender Non-Conforming Patients,” *Journal of the American Academy of Child and Adolescent Psychiatry*, Volume 52, Issue 10, pp. 995-997, October, 2013.
2. Janssen, A., et. al. “Theory of Mind and the Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning Autism Spectrum
3. Janssen A, Huang H, and Duncan C., *Transgender Health*. February 2016, “Gender Variance Among Youth with Autism: A Retrospective Chart Review.” 1(1): 63-68. doi:10.1089/trgh.2015.0007.
4. Goedel WC, Reisner SL, Janssen AC, Poteat TC, Regan SD, Kreski NT, Confident G, Duncan DT. (2017). Acceptability and Feasibility of Using a Novel Geospatial Method to Measure Neighborhood Contexts and Mobility Among Transgender Women in New York City. *Transgender Health*. July 2017, 2(1): 96-106.
5. Janssen A., et. al., “Gender Variance Among Youth with ADHD: A Retrospective Chart Review,” in review
6. Janssen A., et. al., “Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents,” *Journal of Child & Adolescent Psychology*, 105-115, January 2018.
7. Janssen A., et. al., “A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder,” *Transgender Health*, 3:1, 27–33, DOI: 10.1089/ trgh.2017.0037.
8. Janssen A., et. al., “The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study,” *Archives of Sexual Behavior*, 2019. # 3563492
9. Kimberly LL, Folkers KM, Friesen P, Sultan D, Quinn GP, Bateman-House A, Parent B, Konnoth C, Janssen A, Shah LD, Bluebond-Langner R, Salas-Humara C., “Ethical Issues in Gender-Affirming Care for Youth,” *Pediatrics*, 2018 Dec;142(6).
10. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, Shumer D, Register-Brown K, Sadikova E, Anthony LG., “Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals,” *Journal of the American Academy of Child and Adolescent Psychiatry*, 2018 Nov;57(11):885-887.
11. Goedel William C, Regan Seann D, Chaix Basile, Radix Asa, Reisner Sari L, Janssen Aron C, Duncan Dustin T, “Using global positioning system methods to explore mobility patterns and exposure to high HIV prevalence neighbourhoods among transgender women in New York City,” *Geospatial Health*, 2019 Jan; 14(2): 351-356.
12. Madora, M., Janssen, A., Junewicz, A., “Seizure-like episodes, but is it really epilepsy?” *Current Psychiatry*. 2019 Aug; 18(8): 42-47.

13. Janssen, A., Busa, S., Wernick, J., "The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study," *Archives of Sexual Behavior*. 2019 Oct; 48(7): 2003-2009.
14. Wernick Jeremy A, Busa Samantha, Matouk Kareen, Nicholson Joey, Janssen Aron, "A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery," *Urol Clin North Am*. 2019 Nov; 46(4): 475-486.
15. Strang, J.F., Knauss, M., van der Miesen, A.I.R., McGuire, J., Kenworthy, L., Caplan, R., Freeman, A.J., Sadikova, E., Zacks, Z., Pervez, N., Balleur, A., Rowlands, D.W., Sibarium, E., McCool, M.A., Ehrbar, R.D., Wyss, S.E., Wimms, H., Tobing, J., Thomas, J., Austen, J., Pine, E., Willing, L., Griffin, A.D., Janssen, A., Gomez-Lobo, A., Brandt, A., Morgan, C., Meagher, H., Gohari, D., Kirby, L., Russell, L., Powers, M., & Anthony, L.G., (in press 2020). A clinical program for transgender and gender-diverse autistic/neurodiverse adolescents developed through community-based participatory design. *Journal of Clinical Child and Adolescent Psychology*. DOI 10.1080/15374416.2020.1731817
16. Coyne, C. A., Poquiz, J. L., Janssen, A., & Chen, D. Evidence-based psychological practice for transgender and non-binary youth: Defining the need, framework for treatment adaptation, and future directions. *Evidence-based Practice in Child and Adolescent Mental Health*.
17. Janssen, A., Voss, R.. Policies sanctioning discrimination against transgender patients flout scientific evidence and threaten health and safety. *Transgender Health*.
18. Dubin, S., Cook, T., Liss, A., Doty, G., Moore, K., Janssen, A. (In press 2020). Comparing Electronic Health Records Domains' Utility to Identify Transgender Patients. *Transgender Health*, DOI 10.1089/trgh.2020.0069

Published Abstracts

1. Thrun, M., Janssen A., et. al. "Frequency of Patronage and Choice of Sexual Partners may Impact Likelihood of HIV Transmission in Bathhouses," original research poster presented at the 2007 Conference on Retroviruses and Opportunistic Infections, February, 2007.
2. Janssen, A., "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting, October 2012.
3. Janssen, A., "Gender Variance in Childhood and Adolescents: Training the Next Generation of Psychiatrists," 23rd Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, February 2014.
4. Janssen, A., "When Gender and Psychiatric Acuity/Comorbidities Overlap: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," AACAP Annual Meeting, October 2014.
5. Janssen, A., "Patient Experiences as Drivers of Change: A unique model for reducing transgender health disparities as an academic medical center," Philadelphia Transgender Health Conference, June 2016.
6. Janssen, A., "How much is too much? Assessments & the Affirmative Approach to TGNC Youth," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.

7. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
8. Janssen, A., "Gender Variance Among Youth with Autism: A Retrospective Chart Review," Research Poster, 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
9. Janssen, A., "Gender Fluidity and Gender Identity Development," Center for Disease Control – STD Prevention Conference, September 2016.
10. Janssen, A., "Transgender Identities Emerging During Adolescents' Struggles With Mental Health Problems," AACAP Annual Conference, October 2016.
11. Janssen, A., "How Much is Too Much? Assessments and the Affirmative Approach to Transgender and Gender Diverse Youth," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
12. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
13. Sutter ME, Bowman-Curci M, Nahata L, Tishelman AC, Janssen AC, Salas-Humara C, Quinn GP. Sexual and reproductive health among transgender and gender-expansive AYA: Implications for quality of life and cancer prevention. Oral presentation at the Oncofertility Consortium Conference, Chicago, IL. November 14, 2017.
14. Janssen, A., Sidhu, S., Gwynette, M., Turban, J., Myint, M., Petersen, D., "It's Complicated: Tackling Gender Dysphoria in Youth with Autism Spectrum Disorders from the Bible Belt to New York City," AACAP Annual Conference, October 2017.
15. May 2018: "A Primer in Working with Parents of Transgender Youth," APA Annual Meeting.
16. October 2018: "Gender Dysphoria Across Development" – Institute for AACAP Annual Conference.
17. November 2018: "Gender Variance Among Youth with Autism," World Professional Association for Transgender Health Biannual Conference.
18. March 2019: "Gender Trajectories in Child and Adolescent Development and Identity," Austin Riggs Grand Rounds.
19. Janssen, A., et. al., "Ethical Principles in Gender Affirming Care," AACAP Annual Conference, October 2019.
20. Janssen, A., "Gender Diversity and Gender Dysphoria in Youth," EPATH Conference, April 2019
21. Englander, E., Janssen A., et. al., "The Good, The Bad, and The Risky: Sexual Behaviors Online," AACAP Annual Conference, October 2020
22. Englander, E., Janssen, A., et. al., "Love in Quarantine," AACAP Annual Conference, October 2021
23. Janssen, A., Leibowitz, S., et. al., "The Evidence and Ethics for Transgender Youth Care: Updates on the International Standards of Care, 8th Edition," AACAP Annual Conference, October 2021
24. Turban, J., Janssen, A., et. al., "Transgender Youth: Understanding "Detransition," Nonlinear Gender Trajectories, and Dynamic Gender Identities," AACAP Annual Conference, October 2021

Books

1. Janssen, A., Leibowitz, S (editors), *Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook*, Springer Publishing, 2018.

Book Chapters

1. Janssen, A., Shatkin, J., “Atypical and Adjunctive Agents,” *Pharmacotherapy for Child and Adolescent Psychiatric Disorders*, 3rd Edition, Marcel Dekker, Inc, New York, 2012.
2. Janssen, A; Liaw, K: “Not by Convention: Working with People on the Sexual & Gender Continuum,” book chapter in *The Massachusetts General Hospital Textbook on Cultural Sensitivity and Diversity in Mental Health*. Humana Press, New York, Editor R. Parekh, January 2014.
3. Janssen, A; Glaeser, E., Liaw, K: “Paving their own paths: What kids & teens can teach us about sexual and gender identity,” book chapter in *Cultural Sensitivity in Child and Adolescent Mental Health*, MGH Psychiatry Academy Press, Editor R. Parekh, 2016
4. Janssen A., “Gender Identity,” *Textbook of Mental and Behavioral Disorders in Adolescence*, February 2018.
5. Busa S., Wernick, J., & Janssen, A. (In Review) *Gender Dysphoria in Childhood*. *Encyclopedia of Child and Adolescent Development*. Wiley, 2018.
6. Janssen A., Busa S., “Gender Dysphoria in Childhood and Adolescence,” *Complex Disorders in Pediatric Psychiatry: A Clinician’s Guide*, Elsevier, Editors Driver D., Thomas, S., 2018.
7. Wernick J.A., Busa S.M., Janssen A., Liaw K.R.L. “Not by Convention: Working with People on the Sexual and Gender Continuum.” Book chapter in *The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health*, editors Parekh R., Trinh NH. August, 2019.
8. Weis, R., Janssen, A., & Wernick, J. The implications of trauma for sexual and reproductive health in adolescence. In *Not Just a nightmare: Thinking beyond PTSD to help teens exposed to trauma*. 2019
9. Connors J., Irastorza, I., Janssen A., Kelly, B., “Child and Adolescent Medicine,” *The Equal Curriculum: The Student and Educator Guide to LGBTQ Health*, editors Lehman J., et al. November 2019.
10. Janssen, A., et. al., “Gender and Sexual Diversity in Childhood and Adolescence,” *Dulcan’s Textbook of Child and Adolescent Psychiatry*, 3rd edition, editor Dulcan, M., (in press)
11. Busa S., Wernick J, Janssen, A., “Gender Dysphoria,” *The Encyclopedia of Child and Adolescent Development*, DOI: 10.1002/9781119171492. Wiley, December 2020.

Invited Academic Seminars/Lectures

1. April 2006: “How to Talk to a Gay Medical Student” – presented at the National AAMC Meeting.
2. March 2011: “Kindling Inspiration: Two Model Curricula for Expanding the Role of Residents as Educators” – workshop presented at National AADPRT Meeting.
3. May 2011: Janssen, A., Shuster, A., “Sex Matters: Identity, Behavior and Development,” Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.

4. March 2012: Janssen, A., Lothringer, L., "Gender Variance in Children and Adolescents," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
5. June 2012: Janssen, A., "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, Woodhull Department of Psychiatry
6. October 2012: "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting.
7. March 2013: "Gender Variance in Childhood and Adolescence," Sexual Health Across the Lifespan: Practical Applications, Denver, CO.
8. October 18th, 2013: "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, NYU Department of Endocrinology.
9. October, 2014: GLMA Annual Conference: "Theory of Mind and Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning ASD," Invited Presentation
10. October 2014: New York Transgender Health Conference: "Mental Health Assessment in Gender Variant Children," Invited Presentation.
11. November, 2014: Gender Spectrum East: "Affirmative Clinical Work with Gender-Expansive Children and Youth: Complex Situations."
12. October 2015: "Gender Dysphoria and Complex Psychiatric Co-Morbidity," LGBT Health Conference, Invited Speaker
13. October 2015: "Transgender Health Disparities: Challenges and Opportunities," Grand Rounds, Illinois Masonic Department of Medicine
14. November 2015: "Autism and Gender Variance," Gender Conference East, Invited Speaker
15. February 2016: "Working with Gender Variant Youth," New York State Office of Mental Health State Wide Grand Rounds, Invited Speaker
16. March, 2016: "Working with Gender Variant Youth," National Council for Behavioral Health Annual Meeting, Invited Speaker
17. March 2016: "Gender Variance Among Youth with Autism: A Retrospective Chart Review and Case Presentation," Working Group on Gender, Columbia University, Invited Speaker.
18. September, 2016: "Best Practices in Transgender Mental Health: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell.
19. October, 2016: "LGBTQ Youth Psychiatric Care," Midwest LGBTQ Health Symposim
20. October, 2016: "Gender Fluidity and Gender Identity Development," NYU Health Disparities Conference.
21. February, 2017: "Best Practices in Transgender Mental Health," Maimonides Grand Rounds
22. March, 2017: "Transgender Health: Challenges and Opportunities," Invited speaker, Center for Disease Control STD Prevention Science Series.
23. September 2017: "Autism and Gender Dysphoria," Grand Rounds, NYU Department of Neurology.
24. November 2017: "Consent and Assent in Transgender Adolescents," Gender Conference East.

25. November 2017: “Transgender Mental Health: Challenges and Opportunities,” Grand Rounds, Lenox Hill Hospital.
26. April 2018: “Gender Trajectories in Childhood and Adolescent Development and Identity,” Sex, Sexuality and Gender Conference, Harvard Medical School.
27. September 2019: “Social and Psychological Challenges of Gender Diverse Youth,” Affirmative Mental Health Care for Gender Diverse Youth, University of Haifa.
28. October 2019: “Best Practices in Transgender Mental Health,” Grand Rounds, Rush Department of Psychiatry.
29. February 2020: “The Overlap of Autism and Gender Dysphoria,” Grand Rounds, Northwestern University Feinberg School of Medicine Department of Psychiatry
30. February 2020: “Gender Dysphoria and Autism,” Grand Rounds, University of Illinois at Chicago Department of Psychiatry
31. September 2021: “Gender Diversity and Autism,” Grand Rounds, Kaiser Permanente Department of Pediatrics
32. October 2021: Gender Dysphoria and Autism,” Grand Rounds, Case Western Reserve University Department of Psychiatry.

Selected Invited Community Seminars/Lectures

1. April 2012: “Gender and Sexuality in Childhood and Adolescence,” Commission on Race, Gender and Ethnicity, NYU Steinhardt Speakers Series.
2. February 2013: “Supporting Transgender Students in School,” NYC Independent School LGBT Educators Panel, New York, NY.
3. June 2013: “LGBT Health,” Presentation for Neuropsychology Department
4. August 2013: “Chronic Fatigue Syndrome: Etiology, Diagnosis and Management,” invited presentation.
5. September 2013: Panelist, “LGBTQ Inclusive Sex Education.”
6. April 2015: Transgender Children, BBC News, BBCTwo, invited expert
7. January 2016: Gender Dysphoria and Autism – Ackerman Podcast - <http://ackerman.podbean.com/e/the-ackerman-podcast-22-gender-dysphoria-autism-with-aron-janssen-md/>
8. February 2016: “Best Practices in Transgender Mental Health,” APA District Branch Meeting, Invited Speaker.
9. May 2016: “Best Practices in Transgender Mental Health,” Washington D.C., District Branch, APA, Invited Speaker
10. July 2016: “Transgender Youth,” Union Square West
11. November 2017: “Understanding Gender: Raising Open, Accepting and Diverse Children,” Heard in Rye, Conversations in Parenting.
12. January 2018: “The Emotional Life of Boys,” Saint David’s School Panel, Invited Speaker
13. June 2018: “Supporting Youth Engaged in Gender Affirming Care,” NYU Child Study Center Workshop.
14. October 2018: “Medicine in Transition: Advances in Transgender Mental Health,” NYCPS HIV Psychiatry and LGBT Committee Meeting.
15. October 2018: “Understanding Gender Fluidity in Kids,” NYU Slope Pediatrics.
16. October, 2021: Issues of Ethical Importance: Health Care for Pediatric LGBTQ+ Patients, American Medical Association, Invited Talk

Major Research Interests

Gender and Sexual Identity Development
 Member, Research Consortium for Gender Identity Development
 Delirium: Assessment, Treatment and Management
 Suicide Prevention

Research Studies

<u>Study Title</u>	<u>IRB Study#</u>	<u>Dates</u>
Suicide Attempts Identified in a Children's Hospital Before and During COVID-19	2021-4428	2/26/21-present
Lurie Children's Sex & Gender Development Program Clinical Measure Collection	2019-2898	2019-present
Adolescent Gender Identity Research Study (principal investigator) - unfunded	s15-00431	4/15-5/19
Co-Occurrence of Autism Spectrum Disorders and Gender Variance: Retrospective Chart Review (principal investigator) - unfunded	s14-01930	10/14-5/19
Expert Consensus on Social Transitioning Among Prepubertal Children Presenting with Transgender Identity and/or Gender Variance: A Delphi Procedure Study (principal investigator) - unfunded	s13-00576	3/16-5/19
Co-Occurrence of ADHD/Gender Dysphoria (principal investigator) - unfunded	s16-00001	1/16-5/19
PICU Early Mobility- unfunded	s16-02261	12/16-5/19
Metformin for Overweight and Obese Children and Adolescents with Bipolar Spectrum Disorders Treated with Second-Generation Antipsychotics – Funded by PCORI	s16-01571	8/16-5/19

Other

Grant Funding:
 Zero Suicide Initiative, PI Aron Janssen, M.D.
 Awarded by Cardinal Health Foundation, 9/2020
 Total amount: \$100,000

Catalyst Fund, PI Aron Janssen, M.D.
 Suicide Prevention in Pediatric Primary Care
 Total amount: \$750,000

Selected Media Appearances:

Guest Expert on Gender Identity on Anderson, “When Your Husband Becomes Your Wife,” Air
Date February 8th, 2012
Guest Host, NYU About Our Kids on Sirius XM, 2011
NYU Doctor Radio: LGBT Health, September 2013
NYU Doctor Radio: LGBT Kids, November 2013
NYU Doctor Radio: LGBT Health, July 2014
NYU Doctor Radio: Gender Variance in Childhood, December 2014
BBC Two: Transgender Youth, April 2015
NYU Doctor Radio: Transgender Youth, June 2015
Fox-5 News: Trump’s proposed military ban and Transgender Youth, July, 2017
Healthline.com: Mental Health Experts Call President’s Tweets ‘Devastating’ for Trans Teens,
July, 2017
Huffington Post: What the Military Ban Says to Our Transgender Youth: August, 2017
Metro: How to talk to your transgender kid about Trump, August 2017
NYU Doctor Radio: Transgender Youth, August 2017

Short CV Riittakerttu Kaltiala (updated 9/22)

1. Personal details

Kaltiala (Kaltiala-Heino, Kaltiala) Riittakerttu, orcid.org/0000-0002-2783-3892, born 1965, Finnish, www.riittakerttu.fi

2. Education and degrees completed

Docent in Forensic Psychiatry 2019, University of Turku; Specialist in forensic psychiatry 2016, University of Turku; Docent in adolescent psychiatry 2008, University of Oulu; Specialist in adolescent psychiatry 2004, University of Tampere; Docent in social psychiatry 2000, University of Tampere; Specialist in psychiatry 1999, University of Tampere; Bachelor of Social Sciences 2000, University of Tampere; Doctor of Medical Science 1995, University of Tampere; MD 1989, University of Tampere; Matriculation examination 1983, Tampereen lyseon lukio

3. Current employment

Currently: 1.4.2009 - Professor of Adolescent Psychiatry, Tampere University, Faculty of Medicine and Health Technology (Stage IV); 1.1.2005 - Director of Department of Adolescent Psychiatry, Tampere University Hospital; 1.1.2003- Chief psychiatrist in Adolescent Forensic unit, Tampere University Hospital.

4. Previous work experience

1.9.2014-31.12.2015 Chief psychiatrist, Tampere University Hospital, Forensic Psychiatric unit. 1.1.2000 – 31.12.2003 Acting professor of social psychiatry in Tampere School of Public Health. 1996-1999, senior assistant professor of social psychiatry ;1996-2002 Part-time senior consultant in Tampere University Hospital, Department of Consultation-liaison Psychiatry; 1994-1996, resident in the same department; 1992-1994 GP in Ylöjärvi health centre in 1992-1994; 1987-1991 GP in primary health care (Kangasala, Alajärvi and Ylöjärvi health centres), assistant doctor in Hattelmala and Pitkämäki psychiatric hospitals, in Hämeenlinna Mental Health Centre and Tampere City Hospital geriatric wards. Career breaks: I had maternity leaves of 12 months in 1991-2, 1994, 2002 and 2008

5. Research funding and grants

Current (2018-2021): Suomen Kulutturirahasto 40 000 e 2022, Lastentautien tutkimussäätiö 90 000 e 2021; Tays research infra 20 000 e 2021; Tays Tukisäätiö 26 666 e 2021; Wihurin rahasto 40 000 e 2020; Tays VTR 29106 e 2021, 17 537 e 2020, 18 833 e 2019; Earlier: various project fundings from Tays VTR, TYKS VTR (Vanha Vaasa Hospital), Tays koulutussäätiö, Suomen kulttuurirahasto, Jahnssonin säätiö, Academy of Finland, TERTTU 2004-2008 (applied as principal investigator)

6. Research supervision and leadership experience

Academic dissertations supervised: 13 (of these, 10 as main supervisor); undergraduate diplomas/ pro gradus supervised: >35; Currently supervising: academic dissertations 9, undergraduate theses 6

I am the responsible leader of three research branches: 1) Sexuality, gender identity and mental health in adolescence; 2) Aggression, violence and mental health in adolescence; 3) Adolescent mental health services and epidemiology

7. Teaching merits

Experience as professor 15 years; senior assistant professor 4 years; numerous doctoral courses; > 170 invited lectures in continuous professional education; >30 chapters in textbooks

8. Other key academic merits

Experience of organizing scientific meetings: 1996-2003 a member of the CME committee of Finnish Psychiatric association; participated in organizing a biannual 2-day CME meeting; Finnish graduate school in psychiatry, executive committee, member 2000 –2004; European Association for Child and Adolescent Forensic Psychiatry (EFCAP): chairperson in EFCAP Finland since 2006, responsible for organizing an annual CME meeting; board member in the EFCAP/EU since 2006 and member of the scientific committee for the biannual international scientific congress in 2010, 2012, 2014, 2016, 2018; Member of child and adolescent stream for the international congress of the European Professional Association for Transgender Health (EPATH) in 2017, 2019, 2021

External reviewer: **University of Oulu**, Anu Sauvola's dissertation 2001, Risto Ilomäki's dissertation, 2012; Tuula Hurtig's adjunct professorship 2012; **University of Helsinki**, Hanna Putkonen's dissertation 2003, Anna Keski-Rahkonen's adjunct professorship 2009, Elina Sihvola's dissertation 2009, Anu Castaneda's dissertation 2010, Marko Manninen's dissertation 2013, Taina Laajasalo's adjunct professorship 2015, Pauliina Mattila-Holappa's dissertation 2018, Anna-Sofia Urrila's adjunct professorship 2017; Olli Kiviruusu's adjunct professorship 2019; **Free University of Amsterdam**, Henny Lodewijks' dissertation 2008; Anna van der Miesen's dissertation 2021 **University of Turku**, Linnea Karlsson's adjunct professorship 2012, Kirsi Haapasalo-Pesu's adjunct professorship 2015; external review for tenure track assistant or associate professor in adolescent psychiatry, 2020; **University of Eastern Finland**, Helinä Häkkänen's and Tommi Tolmunen's adjunct professorships 2011; Anu Reavuori's adjunct professorship 2022 **University of Oslo**, Olav Nytingnes' dissertation 2018, Selma Overland Lie's dissertation 2022, Tore Hofstad's dissertation 2022; **University of Belfast**, Katrinn Lehmann's dissertation 2020; **Karolinska Institutet**, Thomas Masterman's position of adjunct senior lecturer (forensic psychiatry)

I have acted as opponent for academic dissertations in/ for whom: Free University of Amsterdam/ Henny Lodewijks (June 2008) (psychology) and Anna van der Miesen (June 2021)(medicine); University of Helsinki/ David Gyllenberg (April 2012) (medicine); Eerika Jalanko (February 2022) (medicine); University of Kuopio/ Virve Kekkonen (May 2016) (medicine); Karolinska Institutet/ Therese Åström (November 2016) (social work) and Hedvig Engberg (December 2016) (medicine) and Martin Larden (June 2021)(medicine); University of Oslo/ Olav Nytingnes (May 2018), Selma Lie (September 2022) (psychology); University of Belfast / Katrinn Lehmann 2020 (nursing science); University of Oulu/ Lauri Oulasmaa (medicine, June 2022);

9. Scientific and societal impact

Finnish Psychiatric Association, member 1994- ; member of educational committee 1996-2003 ; chairperson of trainees' section 1996-1999; Tampere Medical Association, member; Nordic Association of Psychiatric Epidemiology, member 1996-2002, course manager, 2000-2002; European Federation for all Psychiatric Trainees, delegate 1995, 1997, 1998; president 1998-1999, immediate past president 1999-2000; World Psychiatric Association, fellowship 1996; Young People's Committee, member 1998-1999; Network of Educational activities, member 1998; Psychiatric research consortium, vice member 1998-2000, member 2001 –2003; Finnish graduate school in psychiatry, executive committee, member 2000 –2004; European Association for Child and Adolescent Forensic Psychiatry (EFCAP), board member, 2005-2012; EFCAP Finland, member 2003-, chairperson 2006-; EFCAP / EU, Board member 2012 –2022; Lapsiasiain neuvottelukunta, member, 2012 – 2015 (Advisory board of Child ombudsman); Lasten ja nuorten terveyden ja hyvinvoinnin neuvottelukunta, member, 2011 – 2013 (Advisory board for child and adolescent health and welfare); Mannerheimin lastensuojeluliitto, valtuuskunta, member, 2012 –2014; Working group for revision of legislation on transgender health, member, 2013-14 and 2021-22; University Hospitals' child and adolescent psychiatry work group / Ministry of Health and Welfare, 2013-2016; Council for Choices in Health Care in Finland (COHERE Finland), section for sexual health, member 2018-2020. Finnish Medical Society Duodecim, working group for Current care guidelines in conduct disorder, 2016-2018; Advisory board for current care guidelines in psychiatry, member, 2021 - ; Numerous interviews and appearances in TV, radio, printed media.

10. Publications (C1)

Original articles > 215; books and reports 9; editorials and alike 17, chapters in books 31; abstracts about 100, and clinical and general communications

Publications

12/2020

Riittakerttu Kaltiala

Books & reports

1. Kaltiala-Heino R. Involuntary Psychiatric Hospitalization. A Comparison of Voluntarily and Involuntarily Admitted Psychotic Patients, their Experiences of and Attitude to Coercion in Psychiatry. Acta Universitatis Tamperensis Ser A vol 66, Vammalan kirjapaino, Vammala, 1995. (väitöskirja, monografia)
2. Kaltiala-Heino R, Välimäki M (toim.) Rajoitetaanko rajoittamista? Eristys ja lepositeet psykiatrisessa hoidossa. Julkaisuja 2, Tampereen yliopisto, Terveystieteen laitos. Tampereen yliopistopaino 1999
3. Välimäki M, Mäkitalo J, Eriksson J, Ala-Nissilä P, Nuutinen R, Nieminen J, Kaltiala-Heino R, Kulmala T, Leino-Olson K. Nuorten aikuisten kuntoutujien mielenterveyden edistäminen. Argumenttejä 6/2002. Mielenterveyden keskusliitto ry. Printway, Vantaa, 2002
4. Kaltiala-Heino R. Alaikäisten tahdosta riippumaton hoito. Mitä mielenterveyslain käsite vakava mielenterveydellinen häiriö alaikäisillä tarkoittaa? Sosiaali- ja terveystieteiden tutkimuskeskus, Selvityksiä 2003:7
5. Fröjd S, Laurila AM, Kilkku N, Kaltiala-Heino R. ARVO-mielenterveyspalveluarvio mielenterveyspalvelujen käyttäjien kokemusten kuvaajana. Pirkanmaan sairaanhoitopiiriin julkaisuja 19/2003, Tampereen yliopistopaino, Tampere, 2003
6. Fröjd S, Charpentier P, Luukkaala T, Pelkonen M, Ranta K, Ritakallio M, von der Pahlen B, Marttunen M, Kaltiala-Heino R. 9-luokkalaisten mielenterveys Tampereella ja Vantaalla. Peruseräraportti. Pirkanmaan sairaanhoitopiiriin julkaisuja 7/2004
7. Kangaspunta R, Kilkku N, Kaltiala-Heino R, Punamäki R-L. Lapsiperheiden psykososiaalinen tukeminen. Pirkanmaan mielenterveyshankkeen Peruspalvelutiimi- ja perheen hyvinvointineuvola-projektin loppuraportti 2002-2004. Pirkanmaan sairaanhoitopiiriin julkaisuja 1/2005. Tampereen yliopistopaino, Tampere, 2005
8. Fröjd S, Kaltiala-Heino R, Marttunen M. 9-luokkalaisten mielenterveys Tampereella ja Vantaalla, kaksivuotisseuranta. Pirkanmaan sairaanhoitopiiriin julkaisuja 6/2006. Tampereen yliopistopaino, Tampere, 2006
9. Kaltiala-Heino R, Welling J, Fröjd S. Tampereelaisten 9.-luokkalaisten mielenterveys lukuvuosina 2002-3 ja 2012-13. Pirkanmaan sairaanhoitopiiriin julkaisusarjan julkaisu 1/2014. (<http://www.pshp.fi/default.aspx?contentid=36894>)

Scientific articles

1. Kaltiala R., Sorri P. Lääkärien työnohjaus yleissairaalassa. *Suom Lääkäril* 1989;25:2454-2459
2. Kaltiala-Heino R., Salokangas R.K.R. Potilaiden kokemukset tahdosta riippumattomasta psykiatrisesta hoidosta. *Suom Lääkäril* 1990;28:2446-2453
3. Kaltiala-Heino R. Psykoosipotilaiden sekä heidän omaistensa ja hoitajiensa näkemys tahdosta riippumattomasta psykiatrisesta hoidosta. *Suom Lääkäril* 1995;36:3947-3952
4. Kaltiala-Heino R. Involuntary psychiatric treatment. A range of patients' attitudes. *Nord J Psychiatr* 1996;50:27-34
5. Kaltiala-Heino R. On coercion in psychiatry. *Psychiatria Fennica* 1996;68-78
6. Kaltiala-Heino R., Laippala P. Pakkotoimet ja rajoitukset psykiatrisessa sairaalahoidossa. *Suom Lääkäril* 1997;52:435-439
7. Rimpelä M, Rimpelä A, Vikat A, Hermansson E, Kaltiala-Heino R, Kosunen E, Savolainen A. Miten nuorten terveys on muuttunut 20 vuoden kuluessa? *Suom Lääkäril* 1997;52:2705-2712
8. Kaltiala-Heino R., Sorri P., Heikkinen M. Crisis treatment in a consultation-liaison unit. *Nord J Psychiatry* 1997;4:267-273
9. Kaltiala-Heino R. Suostumus, kieltäytyminen ja pakkohoito - psykiatrisen hoidon kipupisteitä. *niin&näin* 1997;2:42-45
10. Kaltiala-Heino R., Laippala P., Salokangas R.K.R. Impact of Coercion on Treatment Outcome. *Int J Law Psychiatry* 1997;20:311-322
11. Lukkari O, Kaltiala-Heino R, Rimpelä M, Rantanen P. Nuorten kokema avuntarve ja hoitoon hakeutuminen masentuneisuuden vuoksi. *Suom Lääkäril* 1998;53:1765-1768
12. Eronen M., Kaltiala-Heino R. Koulutettavien kokemuksia psykiatrian erikoislääkärikoulutuksesta. *Suomen mielenterveyden kenttä. Psychiatria Fennica reports* 115, Psykiatrian tutkimussäätiö, 1997
13. Kaltiala-Heino R, Rimpelä M, Rantanen P, Rimpelä A. Koulukiusaaminen, masentuneisuus ja itsetuhoajatukset. *Suom Lääkäril* 1998;53:2643-2549

14. Kaltiala-Heino R, Korkeila J, Isohanni M, Tuori T. Psychiatric services as seen by the GPs: A survey among primary care physicians in two Finnish cities. *Nord J Psychiatry* 1998;52:395-401
15. Kaltiala-Heino R. Tahdosta riippumattoman hoidon eettisistä ongelmista. *Suom Lääkäril* 1998;35:4099-4105
16. Kaltiala-Heino R, Rimpelä M, Rantanen P. School performance and self-reported depressive symptoms in middle adolescence. *Psychiatria Fennica* 1998;29:40-49
17. Kaltiala-Heino R, Rimpelä M, Rantanen P. Mielialakysely (R-BDI) Nuorten mielialan mittaaminen. *Suom Lääkäril* 1998;34:3891-3898
18. Kaltiala-Heino R. Methodological issues in measuring coercion in psychiatric treatment. In: Morrissey J, Monahan J (eds). *Research in Community and Mental Health vol 10. Coercion in Mental Health Services*. Stamford, Connecticut, JAI Press, 1999
19. Kaltiala-Heino R, Rimpelä M, Rantanen P, Laippala P Finnish modification of the 13-item Beck Depression Inventory in screening an adolescent population for depressiveness and positive mood. *Nord J Psychiatry*:1999;53:453-457
20. Kaltiala-Heino R, Rissanen A, Rantanen P, Rimpelä M. Bulimia and bulimic behaviour in middle adolescence: more common than thought? *Acta Psychiatr Scand* 1999;100:33-39
21. Kaltiala-Heino R, Rimpelä M, Marttunen M, Rimpelä A, Rantanen P. Bullying, depression, and suicidal ideation in Finnish adolescents: school survey. *BMJ* 1999;319:348-351
22. Kaltiala-Heino R, Rimpelä A. Are mental health promotion and prevention of mental disorders in adolescence worthwhile? *Psychiatria Fennica* 1999;30:225-243
23. Torikka A, Rimpelä M, Kaltiala-Heino R, Rantanen P. Masentuneisuus ja päihteiden käyttö nuoruusiässä. *Suom Lääkäril* 1999; 54:3377-3381
24. Kaltiala-Heino R, Välimäki M. Involuntary psychiatric treatment in the threshold of the 21st century. *Psychiatria Fennica* 1999;30:185-204
25. Kaltiala-Heino R, Korkeila J, Tuohimäki C, Lehtinen V, Tuori T. Coercion and restrictions in psychiatric inpatient treatment. *Eur Psychiatry* 2000;15:213-219
26. Kaltiala-Heino R, Rimpelä M, Rantanen P, Rimpelä A. Bullying at school-an indicator of adolescents at risk for mental disorders. *J Adol* 2000;23:661-674

27. Torikka A, Kaltiala-Heino R, Rimpelä M, Rantanen P. Depression, drinking and substance use among 14- to 16-year-old Finnish adolescents. *Nord J Psychiatry* 2001; 55:351-358
28. Tuohimäki C, Kaltiala-Heino R, Korkeila J, Protshenko J, Tuori T, Lehtinen V. Psychiatric inpatients' views on self-determination. *Int J Law Psychiatry* 2001;24:61-69
29. Kaltiala-Heino R, Rimpelä M, Rantanen P, Laippala P. Adolescent depression. The role of discontinuities in life course and social support. *J Aff Dis* 2001; 64(2-3): 155-166
30. Kaltiala-Heino R, Poutanen O, Välimäki M. Sairauden häpeällinen leima. *Duodecim* 2001;117:563-570
31. Kaltiala-Heino R, Rissanen A, Rimpelä M, Rantanen P. Early puberty and early sexual activity are associated with bulimic-type eating pathology in middle adolescence *J Adol Health* 2001;28:346-352
32. Ranta K, Kaltiala-Heino R, Marttunen M, Pelkonen M, Rantanen P. Nuorten ahdistuneisuushäiriöt. *Duodecim* 2001;117:1225-32
33. Kaltiala-Heino R, Laippala P, Joukamaa M. Has the attempt to reduce psychiatric inpatient treatment been successful in Finland? *Eur Psychiatry* 2001;16:215-221
34. Välimäki M, Taipale J, Kaltiala-Heino R. Deprivation of liberty in psychiatric treatment: a Finnish perspective. *Nursing Ethics* 2001;8(6): 522-532
35. Kaltiala-Heino R, Välimäki M. Involuntary commitment in health care –An analysis of the status and rights of involuntarily treated psychiatric patients in comparison with patients treated involuntarily under other acts. *Eur J Health Law* 2001;8:299-316
36. Korkeila J, Tuohimäki C, Kaltiala-Heino R, Lehtinen V, Joukamaa M. Predicting use of coercive measures in Finland. *Nord J Psychiatry* 2002;56:339-345
37. Höyer G, Kjellin L, Engberg M, Kaltiala-Heino R, Nilstun T, Sigurjonsdottir M, Syse S. Paternalism and autonomy – a presentation of a Nordic study on the use of coercion in the mental health care system. *Int J Law Psychiatry* 2002;25:93-108
38. Kaltiala-Heino R, Kautiainen S, Virtanen S, Rimpelä A, Rimpelä M. Has the adolescents' weight concern increased over 20 years? *Eur J Public Health* 2003;13:4-10
39. Kaltiala-Heino R, Laippala P, Joukamaa M. Inpatient treatment of mood disorders in the era of de-institutionalisation, depression awareness campaigns and development of new antidepressants. *J Aff Dis* 2003;76:31-37

40. Härmä AM, Kaltiala-Heino R, Rimpelä M, Rantanen P. Are adolescents with frequent pain symptoms more depressed? *Scand J Prim Care* 2002;20:92-96
41. Kaltiala-Heino R, Korkeila J, Tuohimäki C, Lehtinen V. Reasons for using seclusion and restraint in psychiatric inpatient care. *Int J Law Psychiatry* 2003;26:139-149
42. Kaltiala-Heino R, Rissanen A, Rimpelä M, Rantanen P. Bulimia and impulsive behaviour in middle adolescence. *Psychoter Psychosom* 2003;72:26-33
43. Torikka A, Kaltiala-Heino R, Marttunen M, Rimpelä A, Rantanen P, Rimpelä M. Drinking, other substance use and suicidal ideation in middle adolescence: a population study. *J Subst Use* 2002;7:237-243
44. Kaltiala-Heino R, Marttunen M, Rantanen P, Rimpelä M. Early puberty is associated with mental health problems in middle adolescence. *Soc Sci & Med* 2003;57:1055-1064
45. Kaltiala-Heino R, Poutanen P, Kilkku N, Rimpelä M. Runsaiden koulupoissaolojen yhteys mielenterveysongelmiin yläasteikäisillä nuorilla. *Suom Lääkäril* 2003;14:1677-1684
46. Ruuska J, Kaltiala-Heino R, Rantanen P, Koivisto AM. Puberty, sexual development and eating disorders in adolescence outpatients. *Eur Child Adol Psychiatry* 2003;12:214-220
47. Kaltiala-Heino R, Kosunen E, Rimpelä M. Pubertal timing, sexual behaviour and self-reported depression in middle adolescence. *J Adol* 2003;26:531-545
48. Kaltiala-Heino R, Lintonen T, Rimpelä A. Internet Addiction? Potentially problematic use of the Internet in a community sample of 12-18 year old adolescents. *Addiction Res* 2004;12:89-96
49. Kosunen E, K-H, Rimpelä M, Laippala P. Risk-taking sexual behaviour and self-reported depression in middle adolescence – a school-based survey. *Child: Care, Health and Development* 2003; 29:337-344
50. Tuohimäki C, Kaltiala-Heino R, Korkeila J, Tuori T, Lehtinen V, Joukamaa M. The use of harmful to others-criterion for involuntary treatment in Finland. *Eur J Health Law* 2003;10:183-199
51. Kaltiala-Heino R. Increase in involuntary psychiatric admission of minors: a register study. *Social Psychiatry & Psychiatric Epidemiology* 2004;39:53-59
52. Ritakallio M, Kaltiala-Heino R, Pelkonen M, Marttunen M. Miten ehkäistä nuorten käytöshäiriöitä? *Duodecim* 2003;119:1752-60

53. Välimäki M, Kaltiala-Heino R, Kjervik D. The rights of patients with mental problems in Finland. *J Nurs Law* 2003;9:17-28
54. Kaltiala-Heino R, Välimäki M, Korkeila J, Tuohimäki C, Protshenko J, Tuori T, Lehtinen V. Involuntary medication in psychiatric inpatient treatment. *Eur Psychiatry* 2003;18:290-295
55. Tuohimäki C, Kaltiala-Heino R, Korkeila J, Lehtinen V, Joukamaa M. Deprivation of liberty in Finnish psychiatric inpatients. *Int J Law Psychiatry* 2004;27:193-205
56. Lind M, Välimäki M, Kaltiala-Heino R, Suominen T, Leino-Kilpi H Nurses' ethical perceptions about coercion. *J Psych Mental Health Nurs* 2004;11:379-385
57. Rimpelä A, Rainio S, Pere L, Saarni L, Kautiainen S, Kaltiala-Heino R, Lintonen T, Rimpelä M. Suomalaisten nuorten terveys 1977-2003. *Suom Lääkäril* 2004;44:4229-4235
58. Kaltiala-Heino R, Työläjärvä M, Kahila K, Niemi S, Pilli M. Vaativien kiihtymystilanteiden evaluointi ja aggressionhallinnan parantaminen psykiatrisella osastolla. *Suomen Lääkärilehti* 2004;59:4017-4021
59. Putkonen H, Holi M, Kaltiala-Heino R, Korkeila J, Eronen M. Psychiatric Trainees in Finland 2001. *Nord J Psychiatry* 2005;59:148-151
60. von der Pahlen B, Kaltiala-Heino R, Marttunen M. Alcohol, aggression and gender differences in Finnish adolescence. *Alcoholism-clinical and Experimental Research* 2004;1: 28. DOI:10.1097/00000374-200408002-00252
61. Ritakallio M, Kaltiala-Heino R, Kivivuori J, Rimpelä M. Brief report: delinquent behaviour and depression in middle adolescence: a Finnish community sample. *J Adol* 2005;28:155-159
62. Ruuska J, Kaltiala-Heino R, Koivisto AM, Rantanen P. Are there differences in the attitudinal body image between adolescent anorexia nervosa and bulimia nervosa? *Eating and Weight Disorders* 2005;10:98-106
63. Ruuska J, Kaltiala-Heino R, Rantanen P, Koivisto AM. Psychopathological distress predicts suicidal ideation and self-harm in Adolescent Eating Disorder outpatients. *Eur Child Adol Psychiatry* 2005;15:276-281
64. Koski N, Kosunen E, Kaltiala-Heino R. Seksuaalielämä loppuraskaudessa – kyselytutkimus kahdessa Pirkanmaan äitiysneuvolassa. *Yleislääkäri* 2006;21:24-29
65. Kaltiala-Heino R, Kaivosoja M, Ritakallio M. Nuorten rikoksenteekijöiden mielenterveys ja psykiatrisen hoidon tarve. *Suom Lääkäril* 2006;61:971-977
66. Kaltiala Heino R, Kahila K. Forensic psychiatric inpatient treatment: creating a therapeutic milieu. *Child and Adolescent Psychiatric Clinics of North America* 2006;15:459-475

67. Kjellin L, Höyer G, Engberg M, Kaltiala-Heino R, Sigurjonsdottir M. Differences in perceived coercion at admission to psychiatric hospitals in the Nordic countries. *Soc Psychiatry Psychiatr Epidemiol* 2006;41:241-247
68. Ritakallio M, Kaltiala-Heino R, Kivivuori J, Rimpelä M. Delinquency and the profile of offences among depressed and non-depressed adolescents. *Criminal Beh & Mental Health* 2006;16:100-110
69. Kaltiala-Heino R, Fröjd S. Severe mental disorder as basic commitment criterion for minors. *Int J Law Psychiatry* 2007;30(1):81-94
70. Säkkinen P, Kaltiala-Heino R, Ranta K, Haataja R, Joukamaa M. Psychometric Properties of the 20-item Toronto Alexithymia Scale and Prevalence of Alexithymia in Finnish Adolescent Population. *Psychosomatics* 2007;48:154-161
71. Fröjd S, Kaltiala-Heino R, Rimpelä M. The association of parental monitoring and family structure with diverse maladjustment outcomes in middle adolescent boys and girls. *Nord J Psychiatry* 2007;61:296-303
72. Ruuska J, Rantanen P, Koivisto AM, Kaltiala-Heino R. Psychosocial Functioning Needs Attention in Adolescent Eating Disorders. *Nord J Psychiatry* 2007;61:452-8
73. Siponen U, Välimäki M, Kaivosoja M, Marttunen M, Kaltiala-Heino R. Increase in involuntary psychiatric treatment and child welfare placements in Finland 1996-2003: a nationwide register study. *Soc Psychiatry Psychiatr Epidemiol* 2007;42:146-152
74. Kaltiala-Heino R, Fröjd S, Autio V, Laukkanen E, Närhi P, Rantanen P. Transparent criteria for specialist level adolescent psychiatric care. *ECAP* 2007;16:260-270
75. Fröjd S, Marttunen M, Pelkonen M, Von der Pahlen B, Kaltiala-Heino R. Perceived financial difficulties and maladjustment outcomes in adolescence. *Eur J Public Health* 2006;16:542-548
76. Ranta K, Kaltiala-Heino R, Rantanen P, Tuomisto M, Marttunen M. Screening social phobia in adolescents from general population: the validity of the Social Phobia Inventory (SPIN) against a clinical interview. *European Psychiatry* 2007; 22:244-251
77. Ranta K, Kaltiala-Heino R, Koivisto AM, Tuomisto T, Pelkonen M, Marttunen M. Age and gender differences in social anxiety symptoms during adolescence: the Social Phobia Inventory (SPIN) as a measure. *Psychiatry Research* 2007;153:261-270
78. Aalto A, Kaltiala-Heino R. Äidin masennus ja vauvan temperamentti. *Sosiaalilääketieteellinen Aikakauslehti* 2007;44:29-38
79. Keski-Valkama A, Sailas E., Eronen M., Koivisto AM, Lönnqvist J & Kaltiala-Heino, R. legislation is not enough to reduce use of coercion in psychiatry. A nationwide study with a 15-year follow-up. *SPPE* 2007;42:747-752

80. Fröjd S, Nissinen E, Pelkonen M, Marttunen M, Koivisto AM, Kaltiala-Heino R. Depression and school performance in middle adolescent boys and girls. *J Adol* 2008;31:485-498
81. Isojoki I, Fröjd S, Rantanen P, Laukkanen E, Närhi P, Kaltiala-Heino R. Priority criteria tool for elective specialist level adolescent psychiatric care predicts treatment received. *ECAP* 2008;17:397-405
82. Kaltiala-Heino R, Berg J, Selander M, Työläjärvi M, Kahila K. Aggression management in an adolescent forensic unit. *Int J Forensic Mental Health* 2007; 6:185-196
83. Ritakallio M, Koivisto A, Pelkonen M, Marttunen M ja Kaltiala-Heino R: Continuity, comorbidity and longitudinal associations between adolescent depression and antisocial behaviour in middle adolescence: a 2-year prospective follow-up study. *Journal of Adolescence* 2008;31:355-370
84. Eronen M, Kaltiala-Heino R, Kotilainen I. Vaarallisuuden arviointi – missä tilanteissa ja miten väkivaltaisuuden vaaraa arvioidaan Suomessa? *Aikakauskirja Duodecim* 2007; 123:1752-1760
85. Kaltiala-Heino R, Eronen M, Gammelgård M. Alaikäisten oikeuspsykiatrian kysymyksiä. *Aikakauskirja Duodecim* 2007; 123:2381-2389
86. Fröjd S, Marttunen M, Kaltiala-Heino R. Perhe ja nuoren mielenterveyden häiriöt. *Suom Lääkäril* 2007;12:1249-1254
87. Fröjd S, Marttunen M, Pelkonen M, von de Pahlen B, Kaltiala-Heino R. Adult and peer involvement in help-seeking for depression in adolescent population: a two-year follow-up in Finland. *Soc Psychiatry Psychiatr Epidemiol* 2007;42:945-952
88. Gammelgård M, Koivisto AM, Weizmann-Henelius G, Eronen M, Kaltiala-Heino R. The short time predictive validity of Structured Assessment of Violence Risk in Youth in adolescent psychiatry and correctional schools. *J Forensic Psychiatry and Psychology* 2008;19:352-370
89. Isomaa A, Isomaa R, Marttunen M, Kaltiala-Heino R. Obesity and eating disturbances are common in 15-year old adolescents. A two-step interview study. *Nord J Psychiatry* 2010;64:123-129
90. Fröjd S, Kaltiala-Heino R, Pelkonen M, von der Pahlen B, Marttunen M. Significance of family life events in middle adolescence: a survey on Finnish community adolescents. *Nord J Psychiatry* 2009;63:78-86
91. Ritakallio M, Luukkaala T, Marttunen M, Pelkonen M, Kaltiala-Heino R: Comorbidity between depression and antisocial behaviour in middle adolescence: the role of perceived social support. *Nord J Psychiatry* 2010;64:164-171
92. Ranta K, Kaltiala-Heino R, Rantanen P, Marttunen M. Social phobia in Finnish general adolescent population: prevalence, comorbidity, individual and family correlates, and service use. *Depression and Anxiety* 2009;26:528-536

93. Kuosmanen L, Hätönen H, Kaltiala-Heino R, Kärkkäinen J, Suominen S, Holli T, Välimäki M. Patient Complaints in Finland 2000-2004: a retrospective register study. *Journal of Medical Ethics* 2008;34:788-792
94. Ranta K, Kaltiala-Heino R, Pelkonen M, Marttunen. Associations between peer victimization, self-reported depression, and social phobia among adolescents: the role of comorbidity. *Journal of Adolescence* 2009;32:77-93
95. Isomaa R, Isomaa A, Marttunen M, Kaltiala-Heino R, Björqvist Kaj. The Prevalence, Incidence and Development of Eating Disorders in Finnish Adolescents – A two-step 3-year Follow-up Study. *Eur Eat Dis Rev* 2009;17:199-207
96. Ranta K, Kaltiala-Heino R, Rantanen P, Marttunen M. Social phobia in Finnish general adolescent population: prevalence, comorbidity, individual and family correlates, and service use. *Depression and Anxiety* 2009;26:528-536
97. Kaltiala-Heino R, Ritakallio M, Lindberg N. Nuorten mielenterveyden häiriöt ja väkivaltainen käyttäytyminen. *Suom Lääkäril* 2008;49:4321-4329
98. Keski-Valkama A, Sailas E, Eronen M, Koivisto AM, Lönnqvist J, Kaltiala-Heino R. The reasons for using restraint and seclusion in psychiatric inpatient care: a nationwide 15-year study. *Nordic Journal of Psychiatry* 2010;64:136-144
99. Kaltiala-Heino R. Involuntary commitment and detainment in adolescent psychiatric inpatient care. *Soc Psychiatry Psychiatr Epidemiol* 2010;45:785-793
100. Turunen S, Välimäki M, Kaltiala-Heino R. Psychiatrists' views of compulsory psychiatric care of minors. *Int J Law Psychiatry* 2010;33:35-42
101. Kaltiala-Heino R, Fröjd S, Marttunen M. Involvement in bullying and depression in a 2-year follow-up in middle adolescence. *European Child Adolesc Psychiatry* 2010;19:45-55
102. Keski-Valkama A, Sailas E, Eronen M, Koivisto A-M, Lönnqvist J, & Kaltiala-Heino R. Who are the restrained and secluded patients: a 15-year nationwide study. *Soc Psychiatry Psychiatr Epidemiol* 2010;45:1087-1093
103. Keski-Valkama A, Koivisto AM, Eronen M, Kaltiala-Heino R. Forensic and general psychiatric patients' view of seclusion: a comparison study. *J Forensic Psychiatr Psychol* 2010;21(3):446-461
104. Isomaa R, Isomaa AL, Marttunen M, Kaltiala-Heino R, Björqvist K. Psychological distress and risk for eating disorders in subgroups of dieters. *Eur Eat Dis Rev* 2010;18:296-303

105. Siponen U, Välimäki M, Kaivosoja M, Marttunen M, Kaltiala-Heino R. A comparison of two hospital districts with low and high figures in the compulsory care of minors: an ecological study. *SPPE* 2011;46:661-670
106. Fröjd S, Kaltiala-Heino R, Marttunen M. Does problem behaviour affect attrition from a cohort study on adolescent mental health? *Eur J Public Health* 2011;21:306-301
107. Kaltiala-Heino R, Ranta K, Fröjd S. Nuorten mielenterveys koulumaailmassa. *Aikakauskirja Duodecim* 2010: 126:2033-2039
108. Gammelgård M, Weizmann-Henelius G, Koivisto AM, Eronen M, Kaltiala-Heino R. Violence risk and psychopathology in institutionalised adolescents. *J For Psychiatry Psychol* 2010;21:933-949
109. Kaltiala-Heino R, Fröjd S. Correlation between bullying and clinical depression in adolescent patients. *Adolescent Health, Medicine and Therapeutics* 2011;2:37-44
110. Isomaa R, Isomaa AL, Marttunen M, Kaltiala-heino R, Björkqvist K. Longitudinal concomitants of incorrect weight perception in female and male adolescents. *Body Image* 2011;8:58-63
111. Kaltiala-Heino R, Sailas E, Lindberg N. Nuorten väkivaltariskin arvioiminen. *Suom Lääkäril* 2011;66:643–50
112. Penttilä J, Rintahaka P, Kaltiala-Heino R. Aktiivisuuden ja tarkkaavuuden häiriön merkitys nuoren tulevaisuudelle. *Duodecim* 2011: 127:1433-1439
113. Kaltiala-Heino R, Koivisto AM, Marttunen M, Fröjd S. Pubertal timing and substance use in middle adolescence: a 2-year follow-up study. *J Youth Adolesc* 2011;40:1288-1301
114. Väänänen JM, Fröjd S, Ranta K, Marttunen M, Helminen M, Kaltiala-Heino R. Relationship between social phobia and depression differs between boys and girls in mid-adolescence. *J Affect Disord* 2011;133:97-104
115. Fröjd S, Ranta K, Kaltiala-Heino R, Marttunen M. Associations of social phobia and general anxiety with alcohol and drug use in a community sample of adolescents. *Alcohol Alcohol* 2011;46:192-199
116. Fröjd S, Marttunen M, Kaltiala-Heino R. The effect of adolescent- and parent-induced family transitions in middle adolescence. *Nord J Psychiatry* 2012;66(4)254-9
117. Berg J, Kaltiala-Heino R, Välimäki M. Management of aggressive behaviour among adolescents in forensic units: a four country perspective. *J Psych Mental Health Nurs* 2011;18:776-785

118. Ranta K, Kaltiala-heino R, Marttunen M. Sosiaalisten tilanteiden pelko ja sen hoito eri ikäusina. SLL 2011: 66:261-268
119. Ranta K, Kaltiala-Heino R, Rantanen P, Marttunen M. The mini-Social Phobia Inventory: psychometric properties in an adolescent general population sample. *Comprehensive Psychiatry* 2012;53:630-637
120. Viinamäki A, Marttunen M, Fröjd S, Ruuska J, Kaltiala-Heino R. Subclinical bulimia predicts conduct disorder in middle adolescent girls. *Eur Eat Dis Rev* **2013 Jan;21(1):38-44. doi: 10.1002/erv.2168.**
121. Gammelgård M, Weizmann-Henelius G, Koivisto AM, Eronen M, Kaltiala-Heino R. Gender difference in violence risk profiles. *J For Psychiatry & Psychology* 2012;23:76-94
122. Isomaa R, Väänänen JM, Fröjd S, Kaltiala-heino R, Marttunen M. How low is low? Low self-esteem as an indicator of internalizing psychopathology in adolescence. *Health Educ Behav* 2013;40(4):392-399
123. Lindberg N, Sailas E, Kaltiala-Heino R. The copycat phenomenon after two Finnish school shootings: an adolescent psychiatric perspective. *BMC Psychiatry* 2012: Jul 28;12(1):91
124. Berg J, Kaltiala-Heino R, Löyttyniemi V, Välinäki M. Staff's perception of adolescent aggressive behaviour in four European forensic units: A qualitative interview study. *Nord J psychiatry* 2013;67(2):124-131
125. Siponen U, Välimäki M, Kaltiala-Heino R. The use of coercive measures in adolescent psychiatric inpatient treatment: a nation-wide register study. *Soc Psychiatry Psychiatr Epidemiol* 2012;47:1401-1408
126. Heikkilä HK, Väänänen J, Helminen M, Fröjd S, Marttunen M, Kaltiala-Heino R. Involvement in bullying and suicidal ideation in middle adolescence: a 2-year follow-up study. *Eur Child Adolesc Psychiatry* 2013;22: 95-102
127. Ranta K, Kaltiala-Heino R, Fröjd S, Marttunen M. Peer victimization and social phobia: a follow-up study among adolescents. *Soc Psychiatry Psychiatr Epidemiol.* 2013;48(4):533-544
128. Lindberg N, Oksanen A, Sailas E, Kaltiala-Heino R. Adolescents expressing school massacre threats online: something to be extremely worried about? *Child and Adolescent Psychiatry and Mental Health* 2012, 6:39 doi:10.1186/1753-2000-6-39
129. Kaltiala-Heino R, Putkonen H, Eronen M Why do girls freak out? Exploring female rage among adolescents admitted to adolescent forensic psychiatric inpatient care *Journal of Forensic Psychiatry & Psychology* 2013;24:83-110

130. Fröjd S, Marttunen M, Kaltiala-Heino R. Nuorten aikuisten asunnottomuutta ennustavat tekijät peruskoulun viimeisellä luokalla. *Sosiaalilääketieteellinen aikakauslehti* Vol 49, Nro 3 (2012)
131. Lindfors PL, Kaltiala-Heino R, Rimpelä AH. Cyberbullying among Finnish adolescents -- a population-based study. *BMC Public Health* 2012;12(1):1027.
132. Kaltiala-Heino R, Lindberg N, Ranta K, Tainio V-M, Työläjärvä M. Sukupuoli-identiteetin häiriö lapsilla ja nuorilla. *Suom Lääkäril* 2013;11:819-825
133. Isomaa R, Isomaa AL, Marttunen M, Kaltiala-Heino R. Capturing clinically significant eating pathology in adolescence. *Eur J Psychiatry* 2013;27:122-128
134. Ranta K, Tuomisto M, Kaltiala-Heino R, Rantanen P, Marttunen M. Cognition, imagery and coping among adolescents with social anxiety and phobia. Testing the Clark and Wells model in population. *Clin Psychol Psychother*. 2014 May-Jun;21(3):252-63. doi: 10.1002/cpp.1833. Epub 2013 Jan 24.
135. Berg J, Öberg D, Haack MJ, Välimäki M, Kaltiala-Heino R. Provision of interventions in adolescent forensic units. *Int J Forensic Mental Health Serv* 2013; 3:155-164
136. Lindberg N, Sailas E, Kaltiala-Heino R. Kun nuori uhkaa koulusurmalla. *Duodecim* 2013;129(16):1695-700.
137. Fröjd S, Ala-Soini P, Marttunen M, Kaltiala-Heino R. Smoking predicts depression among adolescent girls but not among boys. *Child and Adolescent Behavior* 2013;1:3
138. Korhonen M., Luoma I., Salmelin R., Helminen M., Kaltiala-Heino R., Tamminen T. The Trajectories of Child's Internalizing and Externalizing Problems, Social Competence and Adolescent Self-reported Problems in a Finnish Normal Population Sample. *School Psychology International* 2014; 35:561-579 1-19. doi: 10.1177/0143034314525511.
139. Kaltiala-Heino R, Crowley R, Kraemer S. Children and young people's mental health services. *Eurohealth* 2014;20(1):16-19
140. Väänänen JM, Isomaa R, Kaltiala-Heino R, Fröjd S, Helminen M, Marttunen M. Decrease in self-esteem mediates the association between symptoms of social phobia and depression in middle adolescence in a sex-specific manner: a 2-year follow-up of a prospective population cohort study. *BMC Psychiatry*.2014; 14:79. DOI: 10.1186/1471-244X-14-79
141. Jormanainen E, Fröjd S, Marttunen M, Kaltiala-Heino R. Is pubertal timing associated with involvement in bullying in middle adolescence? *Health Psychology and Behavioral Medicine: an Open Access Journal* 2014;2 (1):144-159

142. Torikka A, Kaltiala-Heino R, Rimpelä A, Marttunen M, Luukkaala T, Rimpelä M. Self-reported depression is increasing among socio-economically disadvantaged adolescents - repeated cross-sectional surveys from Finland from 2000 to 2011. *BMC Public Health* 2014, 14:408 doi:10.1186/1471-2458-14-408
143. Gammelgård M, Koivisto AM, Eronen M, Kaltiala-Heino R. Predictive validity of the Structured Assessment of Violence Risk in Youth a 4 year follow-up". *Criminal Behaviour & Mental Health* 2015: 25(3):192-206
144. Kaltiala-Heino R, Eronen M, Putkonen H. Violent girls in adolescent forensic care are more often psychotic and traumatized than boys in the same level of care. *Journal of Forensic Psychiatry and Psychology*, published online 12 Aug 2014, DOI 10.1080/14789949.2014.943795
145. Väänänen JM, Marttunen M, Helminen M, Kaltiala-Heino R. Low perceived social support predicts later depression but not social phobia in middle adolescence. *Health Psychology and Behavioral Medicine: An Open Access Journal* 2014;2(1):1023-1037 adolescence, *Health Psychology and Behavioral Medicine: An Open Access Journal*, 2:1, 1023-1037, DOI:10.1080/21642850.2014.966716
146. Oksanen A, Kaltiala-Heino R, Kiilakoski T, Lindberg N. Bullying, romantic rejection, and conflicts with teachers: A Finnish perspective. Commentary on: Bullying, romantic rejection, and conflicts with teachers: The crucial role of social dynamics in the development of school shootings- a systematic review. *International Journal of Developmental Science* 2014;8 : 37–41 DOI 10.3233/DEV-1400141
147. Kaltiala-Heino R, Sumia M, Savioja H, Lindberg N. Seksuaaliterveyden kysymyksiä sukupuolen uudelleenmäärittelyn edellytysten arvioon hakeutuvilla nuorilla. *Seksologinen Aikakauskirja* 2014;1:15-28
148. Kaltiala-Heino R, Marttunen M, Fröjd S. Depression, conduct disorder, smoking and alcohol use as predictors of sexual activity in middle adolescence: a longitudinal study. *Health Psychology & Behavioural Medicine: An Open Access Journal* 2015;3 (1):25-39 DOI: 10.1080/21642850.2014.996887
149. Kaltiala-Heino R, Sumia M, Työläjärvä M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child Adolesc Psychiatry Ment Health*. 2015 Apr 9;9:9. doi: 10.1186/s13034-015-0042-y. eCollection 2015.
150. Kaltiala-Heino R, Eronen M, Työläjärvä M. Vahingoittavaan seksuaalikäyttäytymiseen syyllystyvät nuoret. *Duodecim* 2015;131:649-655
151. Kaltiala-Heino R, Mattila A, Kärnä T, Joutsenneimi K. Sukupuoli-identiteetin diagnosoiminen. *Duodecim* 2015;131(4):367-71

152. Oshukova S; Kaltiala-Heino R; Miettunen J; Marttila R; Tani P; Aronen ET; Marttunen M; Kaivosoja M; Lindberg N. Self-reported psychopathic traits among non-referred Finnish adolescents: psychometric properties of the Youth Psychopathic Traits Inventory and the Antisocial Process Screening Device. *Child and Adolescent Psychiatry and Mental Health* 2015;9:15
153. Savioja H, Sumia M, Kaltiala-Heino R. Seksuaalikokemukset ja mielenterveys nuoruusiässä *Suom Lääkäril* 2015;6:309-314
154. Sumia M, Savioja H, Lindberg N, Holttinen N, Kaltiala-Heino R. Sukupuoli- ja seksuaalivähemmistöihin kuuluvien nuorten mielenterveys. *Suom Lääkäril* 2015; 26-32:1919-1925
155. Kaltiala-Heino R, Marttunen M, Fröjd S. Lisääntyvätkö nuorten mielenterveyden ongelmat? *Suom Lääkäril* 2015;26-32:1908-1912
156. Ruuska J, Kaltiala-Heino R. Nuoruusiän syömishäiriöiden hoito erikoissairaanhoidossa. *Suom Lääkäril* 2015;24:1739-1744
157. Kaltiala-Heino R, Eronen M. Ethical issues in child and adolescent forensic psychiatry: A review. *Journal of Forensic Psychiatry and Psychology* 2015; 26:6, 759-780
<http://dx.doi.org/10.1080/14789949.2015.1062995>
158. Savioja H, Helminen M, Fröjd S, Marttunen M, Kaltiala-Heino R. Sexual experience and self-reported depression across adolescent years. *Health Psychology and Behavioral Medicine* 2015; 3(1): (337-347)
<http://www.tandfonline.com/action/doSearch?quickLinkJournal=&journalText=&AllField=savioja&publication=45004821>
159. Oksanen A, Kaltiala-Heino R, Holkeri E, Lindberg N. School shooting threats as a national phenomenon: comparison of police reports and psychiatric reports in Finland. *Journal of Scandinavian Studies in Criminology and Crime Prevention* 2015 16:2, 145-159, DOI: 10.1080/14043858.2015.1101823
160. Ranta K, La Greca AM, Kaltiala-Heino R, Marttunen M. Social Phobia and Educational and Interpersonal Impairments in Adolescence: A Prospective Study. *Child Psychiatry Hum Dev.* 2016 Aug;47(4):665-77. doi: 10.1007/s10578-015-0600-9.
161. Oshukova S, Kaltiala-Heino R, Hillege S, de Ruiter C, Joffe G, Miettunen J, Marttila R, Marttunen M, Kaivosoja M, Nina Lindberg N. Short report: self-reported psychopathic traits in Finnish and Dutch samples of non-referred adolescents: exploration of cultural differences. *Child Adolesc Psychiatry Ment Health* (2016) 10:3 DOI 10.1186/s13034-015-0090-3
<https://capmh.biomedcentral.com/articles/10.1186/s13034-015-0090-3>

162. Kaltiala-Heino R, Lankinen V, Marttunen M, Lindberg N, Fröjd S Overweight, perceived overweight and involvement in bullying in middle adolescence. *Child Abuse and Neglect* 2016;54:33-42
163. Waris P, Tani P, Lindberg N, Lipsanen J, Kettunen K, Kaltiala-Heino R, Saarimaa L-K, Reinvald O, Voutilainen A, Hokkanen L. Are There Differences in Neurocognition and Social Cognition Among Adolescents with Schizophrenia, a Pervasive Developmental Disorder, and Both Disorders? *Applied Neuropsychology: Child*, 2016 Oct-Dec;5(4):303-10. doi: 10.1080/21622965.2015.1064001.
164. Kaltiala-Heino R, Marttunen M, Fröjd S. Sexual harassment victimization in adolescence: associations with family background. *Child Abuse & Neglect* 2016;56:11-19 DOI: 10.1016/j.chiabu.2016.04.005
165. Kaltiala-Heino R, Fröjd S, Marttunen M. Sexual harassment and emotional and behavioural symptoms in adolescence: stronger associations among boys than girls. *Soc Psychiatry Psychiatr Epidemiol*. 2016; 51(8):1193-201. doi: 10.1007/s00127-016-1237-0
166. Turja T, Oksanen A, Kaakinen M, Sirola A, Kaltiala-Heino R, Räsänen P. Pro-eating disorder websites and subjective well-being: A four-country study on young people. *Int J Eat Disord*. 2016 Jul 21. doi: 10.1002/eat.22589. [Epub ahead of print]
167. Torikka A, Kaltiala-Heino R, Luukkaala T, Rimpelä A. Trends in Alcohol Use among Adolescents from 2000 to 2011: The Role of Socioeconomic Status and Depression. *Alcohol and Alcoholism* 2017 Jan;52(1):95-103 2016 doi: 10.1093/alcalc/agw048
168. Oshukova S, Kaltiala-Heino R, Kaivosoja M, Lindberg N. Self-assessed limited prosocial emotions do not distinguish community youth with psychosocial problems from those without them. *Nordic J Psychiatry* *Nordic J Psychiatry* 2017;71(2):126–130. 2016 (published online) <http://dx.doi.org/10.1080/08039488.2016.1241825>
169. Sumia M, Lindberg N, Työläjärvi M, Kaltiala-Heino R. Early pubertal timing is common among adolescent girl-to-boy sex reassignment applicants. *Eur J Contracept Reprod Health Care*. 2016; 3:1-3.
170. Litmanen J, Fröjd S, Marttunen M, Isomaa R, Kaltiala-Heino R. Are eating disorders and their symptoms increasing in prevalence among adolescent population? *Nord J Psychiatry*. 2016;14:1-6.

171. Reponen E, Väänänen J, Kaltiala-Heino R. Adolescents with their first episode of schizophrenia spectrum psychosis: a comparison with adolescents suffering from other severe mental disorders. *Psychiatria Fennica* 2016;47:128-148
172. Anis N, Isomaa R, Kaltiala-Heino R. Adolescent psychiatric in-patients with anorexia nervosa: can rehospitalisation be predicted by clinical features? *Psychiatria Fennica* 2016;47:76-94
173. Lindberg N, Oshukova S, Miettunen J, Kaltiala-Heino R. Do seriously offending girls differ from their age- and offence type-matched male counterparts on psychopathic traits or psychopathy-related background variables? *Child and Adolescent Psychiatry and Mental Health* 2016;10:38 DOI 10.1186/s13034-016-0128-1
<https://capmh.biomedcentral.com/articles/10.1186/s13034-016-0128-1>
174. Talonen S, Väänänen J, Kaltiala-Heino R. Gender differences in first onset Schizophrenia spectrum psychoses. *Nord J Psychiatry*. 2017 Feb;71(2):131-138
175. Oshukova S, Kaltiala-Heino R, Miettunen J, Marttila R, Aronen E, Marttunen M, Kaivosoja M, Lindberg N. Self-rated psychopathic traits in a sample of treatment-seeking adolescent girls with internalizing and externalizing disorders: comparisons to girls in the community. *Nord J Psychiatry*. 2017 Apr;71(3):210-216.
<http://dx.doi.org/10.1080/08039488.2016.1265583>
176. Sumia M, Lindberg N, Työläjärvä M, Kaltiala-Heino R. Current and recalled childhood gender identity in community youth in comparison to referred adolescents seeking sex reassignment. *Journal of Adolescence* 2017;56:34-39
177. Oshukova S, Kaltiala-Heino R, Miettunen J, Marttila R, Tani P, Aronen E, Marttunen M, Kaivosoja M, Lindberg N. The Relationship between Self-rated Psychopathic Traits and Psychopathology in a Sample of Finnish Community Youth: Exploration of Gender Differences *J Child Adolesc Behav* 2016, 4:5. DOI: [10.4172/2375-4494.1000314](https://doi.org/10.4172/2375-4494.1000314)
178. Lindberg N, Miettunen J, Heiskala A, Kaltiala-Heino R. Serious delinquency and later schizophrenia: A nationwide register-based follow-up study of Finnish pretrial 15- to 19-year-old offenders sent for a forensic psychiatric examination. *Eur J Psychiatry* 2017;44:173-178
179. Lindberg N, Miettunen J, Heiskala A, Kaltiala-Heino R.. Mortality of young offenders: a national register-based follow-up study of 15- to 19-year-old Finnish delinquents referred for forensic psychiatric examination between 1980 and 2010. *Child and Adolescent Psychiatry and Mental Health* 2017 Aug 8;11:37. doi: 10.1186/s13034-017-0174-3
180. Savioja H, Helminen M, Fröjd S, Marttunen M, Kaltiala-Heino R. Parental involvement, depression, and sexual experiences across adolescence: a cross-sectional survey among adolescents of different ages. *Health Psychology and Behavioral Medicine*, 5:1, 258-275, DOI: 10.1080/21642850.2017.1322908 To link to this article: <http://dx.doi.org/10.1080/21642850.2017.1322908>

181. Savioja H, Helminen M, Fröjd S, Marttunen M, Kaltiala-Heino R. Delinquency and sexual experiences across adolescence: does depression play a role? *Eur J Contracept Reprod Health Care*. 2017 Aug;22(4):298-304. doi: 10.1080/13625187.2017.1374361. Epub 2017 Sep 13.
182. Ranta K, Väänänen J, Fröjd S, Isomaa R, Kaltiala-Heino R, Marttunen M. Social phobia, depression and eating disorders during middle adolescence: Longitudinal associations and treatment seeking. *Nord J Psychiatry* 2017 Nov;71(8):605-613. doi: 10.1080/08039488.2017.1366548
183. Lankinen V, Fröjd S, Marttunen M, Kaltiala-Heino R. Perceived rather than actual overweight is associated with mental health problems in adolescence. *Nord J Psychiatry* 2018 Feb;72(2):89-96. doi: 10.1080/08039488.2017.1389987
184. Kaltiala-Heino R, Savioja H, Fröjd S, Marttunen M. Experiences of sexual harassment are associated with the sexual behavior of 14- to 18-year-old adolescents. *Child Abuse Negl*. 2018 Jan 2;77:46-57. doi: 10.1016/j.chiabu.2017.12.014.
185. Kaltiala-Heino R, Bergman H, Työlajärvi M, Frisén L. Gender dysphoria in adolescence: current perspectives. *Adolescent Health, Medicine and Therapeutics* 2018;9:31-41
186. Kurki-Kangas L, Marttunen M, Fröjd S, Kaltiala-Heino R. Sexual Orientation and Bullying Involvement in Adolescence: The Role of Gender, Age, and Mental Health. *Journal of School Violence*, published online 28 Jun 2018. DOI: [10.1080/15388220.2018.1488136](https://doi.org/10.1080/15388220.2018.1488136)
187. Kaltiala-Heino R, Työlajärvi M, Suomalainen L. Kun sukupuoli on nuorelle ongelma. *Duodecim* 2018;134:2941-2046
188. Knaappila N, Marttunen M, Fröjd S, Lindberg N, Kaltiala-Heino R. Socioeconomic Trends in School Bullying Among Finnish Adolescents from 2000 to 2015. *Child Abuse & Neglect* 2018;86:100-108
189. Tiirikainen K, Haravuori H, Ranta K, Kaltiala-Heino R, Marttunen M. Psychometric properties of the 7-item Generalized Anxiety Disorder Scale (GAD-7) in a large representative sample of Finnish adolescents. *Psychiatry Res* 2019; 272:30-35
doi:10.1016/j.psychres.2018.12.004.
190. Kaltiala-Heino R, Lindberg N. Gender identities in adolescent population: methodological issues and prevalence across age groups. *European Psychiatry* 2019;55:61-66
191. Kaltiala-Heino R, Työlajärvi M, Lindberg N. Sexual experiences of clinically referred adolescents with features of gender dysphoria. *Clinical Child Psychology and Psychiatry* 2019; 24(2): 365–378
192. Kaltiala-Heino R, Työlajärvi M, Lindberg N. Gender dysphoria in adolescent population: A 5-year replication study. *Clinical Child Psychology and Psychiatry* 2019; 24(2): 371-387

193. Apell S, Marttunen M, Fröjd S, Kaltiala R. Experiences of sexual harassment are associated with high self-esteem and social anxiety among adolescent girls, *Nordic Journal of Psychiatry*, 2019 Aug;73(6):365-371. doi: 10.1080/08039488.2019.1640790.
194. Knaappila N, Marttunen M, Fröjd S, Lindberg N, Kaltiala-Heino R. Socioeconomic Trends in Adolescent Smoking in Finland From 2000 to 2015. *J Adolesc Health* 2019;64:776-782
195. Souverein F, Dekkers T, Bulanoivaite E, Doreleijers T, Hales H, Kaltiala-Heino R, Oddo A, Popma A, Raschle N, Schmeck K, Zanoli M, van de Pol T. Overview of European forensic youth care: towards an integrative mission for prevention and intervention strategies for juvenile offenders. *Child Adolesc Psychiatry Ment Health* 2019;13;6. <https://doi.org/10.1186/s13034-019-0265-4>
196. Kaltiala-Heino R, Lindberg N, Fröjd S, Haravuori H, Marttunen M. Adolescents with same-sex interest: experiences of sexual harassment are more common among boys. *Health Psychology and Behavioral Medicine* 2019;7 (1):205-127. <https://doi.org/10.1080/21642850.2019.1598864>
197. Reinsalo P, Kaltiala R. Onko nuorisopsykiatrian poliklinikan potilaskunta muuttunut lähetemäärien kasvaessa? *Suom Lääkäril* 2019; 36: 1956-1959
198. Cacciatore R, Kortenien-Poikela E, Kaltiala R. The Steps of Sexuality—A Developmental, Emotion-Focused, Child-Centered Model of Sexual Development and Sexuality Education from Birth to Adulthood. *Int J Sexual Health* 2019;31(3):319-338, DOI: 10.1080/19317611.2019.1645783
199. Knaappila N, Marttunen M, Fröjd S, Lindberg N, Kaltiala-Heino R. Changes in delinquency according to socioeconomic status among Finnish adolescents from 2000 to 2015. *Scandinavian Journal of Child and Adolescent Psychiatry and Psychology* 2019;7(1): 52-59.
200. Kaltiala R, Bergman H, Carmichael P, de Graaf N, Egebjerg Rischel K, Frisén L, Schorkopf M, Suomalainen L, Waehre A. Time trends in referrals to child and adolescent gender identity services: a study in four Nordic countries and in the UK. *Nord J Psychiatry* 2020; 74(1):40-44. <https://doi.org/10.1080/08039488.2019.1667429>
201. Kaltiala R, Heino E, Työläjärvi M, Suomalainen L. Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*. 2020;74(3);213-219
202. Suokas K, Koivisto AM, Hakulinen C, Kaltiala R, Sund R, Lumme S, Kampman O, Pirkola S. Association of Income With the Incidence Rates of First Psychiatric Hospital Admissions in Finland, 1996-2014. *JAMA Psychiatry*. 2020;77(3):274-284. doi:10.1001/jamapsychiatry.2019.3647

203. Kurki-Kangas L, Fröjd S, Haravuori H, Marttunen M & Kaltiala R. Associations between Involvement in Bullying and Emotional and Behavioral Symptoms: Are there Differences between Heterosexual and Sexual Minority Youth? *Journal of School Violence* 2020;19:3:309-322, DOI: 10.1080/15388220.2019.1691009
204. Heino E, Ellonen N, Kaltiala R. Transgender identity is associated with involvement in bullying among Finnish adolescents. *Frontiers in Psychology Gender Sex and Sexualities*. Front. Psychol., 08 January 2021 | <https://doi.org/10.3389/fpsyg.2020.612424>
205. Eloranta S, Kaltiala R, Lindberg N, Kaivosoja M, Peltonen K. Validating measurement tools for mentalization, emotion regulation difficulties and identity diffusion among Finnish adolescents. *Nordic Psychology* 2020 (published online Dec 2020) 10.1080/19012276.2020.1863852 <https://doi.org/10.1080/19012276.2020.1863852>
206. Kaltiala R, Holttinen T, Lindberg N. Subsequent criminal participation among young people first admitted to psychiatric inpatient care during early and middle adolescence. *The Journal of Forensic Psychiatry & Psychology*, 2021. DOI: 10.1080/14789949.2020.1871499
207. Knaappila N, Marttunen M, Fröjd S, Lindberg N, Kaltiala R. Changes in cannabis use according to socioeconomic status among Finnish adolescents from 2000 to 2015. *Journal of Cannabis Research*. 2020 Dec;2(1):44. DOI: 10.1186/s42238-020-00052-y.
208. Heino E, Fröjd S, Marttunen M, Kaltiala R. Normative and negative sexual experiences of transgender identifying adolescents in the community. *Scand J Child Adolesc Psychiatr Psychol*. 2020 Nov 20;8:166-175. doi: 10.21307/sjcapp-2020-017.
209. Rimpelä A, Koivusilta L, Myöhänen A, Lindfors P, Kaltiala-Heino R. Does long-term disease in adolescence predict educational career? *European Journal of Public Health*, Volume 30, Issue Supplement_5, September 2020, ckaa166.285, <https://doi.org/10.1093/eurpub/ckaa166.285> Published: 30 September 2020
210. Cacciatore R, Ingman-Friberg S, Apter D, Kaltiala R. An alternative term to make comprehensive sexuality education more acceptable in childhood. *South African Journal of Childhood Education* 2020, vol 10, no 1, a857. <https://doi.org/10.4102/sajce.v10i1.857>
211. Holttinen T, Pirkola S, Rimpelä M, Kaltiala R. Factors behind a remarkable increase in adolescent psychiatric inpatient treatment between 1980 and 2010 – a nationwide register study. *Nord J Psychiatry* 2021, published online June 2021 <https://doi.org/10.1080/08039488.2021.1939780>
212. Knaappila N, Marttunen M, Fröjd S, Kaltiala R. Changes over time in mental health symptoms among adolescents in Tampere, Finland. *Scandinavian Journal of Child and Adolescent Psychiatry and Psychology* Vol. 9:96-104 (2021) DOI 10.21307/sjcapp-2021-011

213. Heino E, Fröjd S, Marttunen M, Kaltiala R. Transgender identity is associated with severe suicidal ideation among Finnish adolescents. *Int J Adolesc Med Health*. 2021 Aug 24. doi: 10.1515/ijamh-2021-0018. Online ahead of print.
214. Mohamad MS, Mahadir Naidu B, Kaltiala R, Virtanen SM, Lehtinen-Jacks S. Thinness, overweight and obesity among 6- to 17-year-old Malaysians: secular trends and sociodemographic determinants from 2006 to 2015. *Public Health Nutr*. 2021 Aug 5:1-14. doi: 10.1017/S1368980021003190. Online ahead of print.
215. Knaappila N, Kosola S, Kaltiala R. Nuorten ongelmakäyttäytyminen vähenee mutta ongelmat kasautuvat. *Suom Lääkäril* 2021;76(16):998 – 1002
216. Sumia M, Kaltiala R. Co-occurring gender dysphoria and autism spectrum disorder in adolescence. *Psychiatria Fennica* 2021;52:104-114
217. Hekali I, Kaltiala R. Sexual experiences and behaviours of adolescent psychiatric patients compared to those of age-peers in the general population. *Psychiatria Fennica* 2021;52: 88-102
218. Kaltiala R, Lindberg N. Personallisuushäiriöihin liittyvä väkivallalla uhkailu ja väkivallan uhka. *Duodecim* 2021: 137 (22):2467-73
219. Kaltiala R, Ellonen N. Transgender identity and experiences of sexual harassment in adolescence. *Child Abuse Review* 2022; e2748. <https://doi.org/10.1002/car.2748>
220. Kaltiala R. Aspects of gender and sexuality in relation to experiences of subjection to sexual harassment among adolescents in general population. *Int J Environ Res Public Health* 2022, 19, 9811. <https://doi.org/10.3390/ijerph19169811>
221. Melander K, Kortteisto T, Hermanson E, Kaltiala R, Mäki-Kokkila K, Kaila M, et al. (2022) The perceptions of different professionals on school absenteeism and the role of school health care: A focus group study conducted in Finland. *PLoS ONE* 17(2): e0264259. <https://doi.org/10.1371/journal.pone.0264259>
222. Kaltiala R, Holttinen T, Ellonen N. Sex offending among adolescents and young men with history of psychiatric inpatient care in adolescence. *Crim Behav Ment Health*. 2022;1–13.
223. Holttinen T, Lindberg N, Rissanen P, Kaltiala R. Educational attainment of adolescents treated in psychiatric inpatient care: a register study over 3 decades. *European Child & Adolescent Psychiatry* 2022: <https://doi.org/10.1007/s00787-022-02052-0>
224. Karvonen M, Goth K, Eloranta SJ, Kaltiala R. Identity Integration in Adolescents With Features of Gender Dysphoria Compared to Adolescents in General Population. *Frontiers in psychiatry* 2022: 13:848282
225. Karvonen M, Karukivi M, Kronstrom K, Kaltiala R. The nature of co- "

morbid psychopathology in adolescents with gender dysphoria, *Psychiatry Research* (2022), doi: <https://doi.org/10.1016/j.psychres.2022.114896>

Editorials and reviews discussing research, research policy and health care development

1. Reina T., Kaltiala-Heino R. Tietotekninen tietosuoja tutkimuksessa. *Suom Lääkäril* 1996;35:3789-3792
2. Kaltiala-Heino R, Rantanen P. Sosiaalipsykiatrinen tutkimus Tampereen yliopiston terveystieteen laitoksella. *Sosiaalilääketieteellinen aikakauslehti* 1998; 35: 188-190
3. Lehtinen V, Kaltiala-Heino R. Psykiatrinen tutkimus STAKESissa. *Sosiaalilääketieteellinen aikakauslehti* 1998; 35: 195-196
4. Kaltiala-Heino R, Välimäki M. Pohjoismainen tutkijakurssi mielenterveyden edistämisestä ja mielenterveyshäiriöiden ehkäisystä. *Suom Lääkäril* 2000;55:3146-3147
5. Kaltiala-Heino R, Jähi R, Hämäläinen P, Lönnqvist J. Tampere School of Public Health: social psychiatric research and mental health education. *Psychiatria Fennica* 2001

6. Kahila K, Kilkku N, Kaltiala-Heino R. Psychiatric Treatment and Research Unit for Adolescent Intensive Care - the first adolescent forensic psychiatric service in Finland. J Psych Mental Health Nurs 2004;11:240-244
7. Kangaspunta R, Kilkku N, Punamäki R-L, Kaltiala-Heino R. Psykososiaalisen tuen tarve äitiys- ja lastenneuvolatyön haasteena: Kokemuksia perheen hyvinvointineuvola -projektista. Suom Lääkäril 2004;38:3521-3525. Julkaistu uudelleen Terveystieteiden aikakauslehti 2005;4-5:26-29
8. Kaltiala-Heino R, Työläjä M, Selander M, Kahila K. Erityisen vaikeahoitoisten alaikäisten psykiatrisen tutkimus- ja hoitoyksikkö (EVA): ensimmäiset puolitoista vuotta. Suom Lääkäril 2005;5:569-572
9. Kaltiala-Heino R. Normaaliin nuoruuteen ei kuulu masennus. Suom Lääkäril 2005;27-29:2873
10. Ranta K, Kaltiala-Heino R, Rantanen P, Lindberg N, Marttunen M, Laukkanen E, Haapasalo-Pesu K-M. Nuorisopsykiatria – moderni lääketieteen erikoisala. Suom Lääkäril 2008;50:4408-4409
11. Salokangas RKR, Hietala J, Korkeila J, Karlsson H, Isohanni M, Laukkanen E, Marttunen M, Kaltiala-Heino R, Saarijärvi S. Psykiatrian erikoisalojen koulutus syytä uudistaa. Suom Lääkäril 2008; 4078
12. Kaltiala-Heino R, Pakkotoimia psykiatrisen hoidon aikana voi vähentää. Suom Lääkäril 2009;25:2268
13. Kaltiala-heino R, Sourander A. Lasten- ja nuorisopsykiatriassa isompi on vahvempaa. Suom Lääkäril 2012;67:28
14. Kaltiala-Heino R. Pelastakaa edes lapset. Kokonaisuudessa Alaikäisten transtutkimukset jakavat mielipiteitä. Suom Lääkäril 2011;26-31:2144
15. Kaltiala R, Kettula K, Tuisku K, Laukkala T. Toiveena sukupuolen korjaus. Tapauksen ratkaisu. Suome Lääkäril 2020;6:342-347
16. Uusi-Mäkelä N, Tuisku K, Puustinen N, Kaltiala R. Sukupuolidysforiasta kärsivä perusterveydenhuollon vastaanotolla. Suom Lääkäril 2020;37:1862-1864
17. Ranta K, Kaltiala R, Karvonen JT, Koskinen T, Kronström K. Nuorten varhaisia psykososiaalisia hoitoja tulee ottaa laajemmin käyttöön. Duodecim 2020;136(18):2044-6
18. Tuisku K, Kaltiala R. Sukupuolenkorjaushoitojen vaikutuksista itsetuhoisuuteen ei ole näyttöä. Suom Lääkäril 2021; 76 (34); 1711

Chapters in books

1. Kaltiala-Heino R. Eristys ja lepositeet psykiatrisessa hoidossa. Asiantuntijalausunto STAKESille 12/1997. Kirjassa: Ilkka Taipale (eds): Mielen valtaa. Psykiatrian yhteistyö ry. WSOY, Juva, 1999.
2. Kaltiala-Heino R. Nuorten masennus kouluterveydenhuollon haasteena. Kirjassa Terho ym (toim.) Kouluterveydenhuolto, Kustannus oy Duodecim, Gummerus kirjapaino Oy, Jyväskylä, 2000
3. Mäkitalo J, Välimäki M, Kaltiala-Heino R. Pakko ja psykiatrisen potilaan lääkekieltäytyminen. Kirjassa Kaltiala-Heino R, Välimäki M (toim.) Rajoitetaanko rajoittamista? Eristys ja lepositeet psykiatrisessa hoidossa. Julkaisuja 2, Tampereen yliopisto, Terveystieteen laitos. Tampereen yliopistopaino 1999
4. Kaltiala-Heino R. Eristys ja lepositeet psykiatrisessa hoidossa. Kirjassa Kaltiala-Heino R, Välimäki M (toim.) Rajoitetaanko rajoittamista? Eristys ja lepositeet psykiatrisessa hoidossa. Julkaisuja 2, Tampereen yliopisto, Terveystieteen laitos. Tampereen yliopistopaino 1999
5. Kaltiala-Heino R. Pakko psykiatrisessa hoidossa. Kirjassa Välimäki M, Holopainen A, Jokinen M (toim): Psykiatrisen hoitotyön oppikirja, WSOY, 2000
6. Kaltiala-Heino R. Alaikäisten tahdosta riippumaton hoito. Therapia Fennica 2002 (in press)
7. Kaltiala-Heino R. Ehkäisevä mielenterveystyö. Kirjassa: Kumpusalo E, Ahto M, Eskola K, ym. (toim) Yleislääketiede, ss. 384-396 Kustannus Oy Duodecim. Karisto Oy, Hämeenlinna, 2005.
8. Kaltiala-Heino R. Sukupuoli ja mielenterveys. Kirjassa: Luoto ym (toim) Sukupuoli ja terveys, ss.50-65. Vastapaino. Gummerus Kirjapaino OY, Jyväskylä 2003
9. Kaltiala-Heino R. National chapters: Finland. In: Salize HJ, Peitz M. Compulsory admission and involuntary treatment of mentally ill patients – legislation and practice in EU-member states. European Commission – Health & Consumer protection directorate-general research project, final report, Mannheim, 2002
10. Kaltiala-Heino R. Seksuaalisuus ja mielenterveys nuoruusiässä. Kirjassa: Kosunen E. Ritamo M (toim) Näkökulmia nuorten seksuaaliterveyteen. Raportteja 282. Sosiaali- ja terveystieteiden tutkimus- ja kehittämiskeskus STAKES, Helsinki, 2004
11. Kaltiala-Heino R, Rantanen P, Ruuska J, Laukkanen E, Närhi P, Tuominen T, Hiipakka A, Fröjd S. Oireiden ja toimintakyvyn perusteella arvioitu kiireetön erikoissairaanhoito diagnoosista riippumatta 13-22-vuotiailla nuorilla. Kirjassa: Oppaita 2005:5 Yhtenäisen kiireettömän hoidon perusteet, Sosiaali- ja terveysministeriö, Helsinki, 2005

12. Kaltiala-Heino R. Concepts and procedures in Member States. Finland. In: Salize HJ, Dressing H. Placement and treatment of mentally ill offenders – legislation and practice in the European Union. Pabst Science Publications, Lengerich, 2005
13. Marttunen M, Kaltiala-Heino R Nuorisopsykiatria. Kirjassa Lönnqvist ym. (toim) Psykiatria. Duodecim, Jyväskylä 2007
14. Kaltiala-Heino R, Fröjd S. Nuoruusikäisen itsemäärääminen ja pakolla auttaminen. Kirjassa: Ulla Ashorn, Juhani Lehto (toim): Tutkijapuheenvuoroja terveydenhuollosta, Gummerus Kirjapaino Oy, Jyväskylä 2008. ss 237-250
15. Kaltiala-Heino R. Concepts and procedures in European Countries. In: Salize J, Dressing H. mentally Disordered persons in European Prison Systems. Needs, programmes and Outcome. (EUPRIS). Research project, final report. Pabs Science Publishers, Lengerich, Germany, 2009
16. Kaltiala-Heino R. Lisääntyvätkö nuorten mielenterveyden ongelmat? Kirjassa Ståhl T, Rimpelä A (eds) Terveyden edistäminen tutkimuksen ja päätöksenteon haasteena. Terveyden ja hyvinvoinnin laitos. Yliopistopaino, Helsinki, 2010
17. Kaltiala-Heino R. Nuorten rikollisuus ja väkivalta. Kirjassa: Suomalainen lääkäriseura Duodecim ja Suomen Akatemia: Nuorten hyvin- ja pahoinvointi. Vammalan kirjapaino, Vammala, 2010
18. Karnik N, Vostanis P, Huemer J, Kjelsberg E. Kaltiala-Heino R, Steiner H. Epidemiology of psychiatric and substance use disorders among young offenders: Current research, Implications and Future Directions. In: Thomas C, Pope K (eds): The origins of antisocial behaviour. A developmental perspective. Oxford University Press New York, 2012
19. Kaltiala-Heino R. Lasten kaltoinkohtelu – oireet ja ongelmat nuoruusiässä. Kirjassa: Söderholm A, Kivittie-Kallio S. Lasten Kaltoinkohtelu. Kustannus Oy Duodecim, Helsinki, 2012
20. Kaltiala-Heino R, Makkonen P, Moring J. Turvallisuus psykiatrisessa avo- ja sairaalahoidossa. Kirjassa: Aaltonen L-M, Ronserberg P (toim): Potilasturvallisuuden perusteet. Duodecim, Helsinki, 2013
21. Kaltiala-Heino R. Involuntary Commitments. In: Levesque R (ed): Encyclopedia of adolescence, pp 1479-1489. ISBN: 978-1-4419-1694-5 (Print) 978-1-4419-1695-2 (Online). 2012
22. Kaltiala-Heino R. Aggressio lapsuudessa ja nuoruudessa. Kirjassa Nurmi P (toim): Lapsen ja nuoren viha. PS-kustannus, Helsinki, 2013
23. Kaltiala-Heino R. Väkivaltakäyttäytyminen. Kirjassa Nurmi P (toim): Lapsen ja nuoren viha. PS-kustannus, Helsinki, 2013

24. Crowley C, Kaltiala-Heino R, Kraemer S. Mental health and behavioural disorders. In: Wolfe I, McKee M (eds): European Child Health Services and Systems: Lessons without borders. MacGraw-Hill Education, Open University Press, New York, 2013
25. Marttunen M, Kaltiala-Heino R. Nuorisopsykiatria. Kirjassa: Lönnqvist ym. (toim): Psykiatria. Duodecim, Helsinki, 2014
26. Aronen E, Kaltiala-Heino R. Lasten ja nuorten oikeuspsykiatria erikoisalana. Kirjassa: Kumpulainen ym. (toim). Lastenpsykiatria ja nuorisopsykiatria. Kustannus Oy Duodecim, Helsinki, 2016.
27. Kaltiala-Heino R. Vahingoittavaan seksuaalikäyttäytymiseen syyllistyvät nuoret. Kirjassa: Kumpulainen ym. (toim). Lastenpsykiatria ja nuorisopsykiatria. Kustannus Oy Duodecim, Helsinki, 2016.
28. Kaltiala-Heino R, Tainio V-M. Sukupuolidysforia lapsilla ja nuorilla. Kirjassa: Kumpulainen ym. (toim). Lastenpsykiatria ja nuorisopsykiatria. Kustannus Oy Duodecim, Helsinki, 2016.
29. Kaltiala-Heino R. Tahdosta riippumaton hoito. Kirjassa: Kumpulainen ym. (toim). Lastenpsykiatria ja nuorisopsykiatria. Kustannus Oy Duodecim, Helsinki, 2016.
30. Kaltiala Heino R, Kaukonen P, Borg A-M. Tutkimuksiin lähettäminen ja kirjaaminen. Kirjassa: Kumpulainen ym. (toim). Lastenpsykiatria ja nuorisopsykiatria. Kustannus Oy Duodecim, Helsinki, 2016.

Abstracts

1. Kaltiala-Heino R., Salokangas R.K.R. Psykiatrinen pakkohoito potilaan kokemana. Tutkimus ja kansanterveys -symposiumi, abstraktit. Suomen akatemia, Helsinki 1990.
2. Kaltiala-Heino R., Salokangas R.K.R. Patienternas upplevelser av psykiatrisk tvångsvård. Tvång - autonomi - etik i psykiatri. Västerås 10.-12.09.1990

3. Kaltiala-Heino R., Salokangas R.K.R. Psykiatrisen hoidon kokeminen II. Tampereen lääkäripäivät 1991.
4. Kaltiala-Heino R. Pakon käyttö psykiatriassa henkilökunnan arvioimana. Tampereen lääkäripäivät 1993
5. Kaltiala-Heino R. Från hälsovårdscentral till mentalsjukhus. VIII Nordiska kongressen i allmänmedicin 11. - 14.08.1993, Seinäjoki, Finland
6. Kaltiala-Heino R. Hospitalized patients' experiences of and attitudes to coercion in psychiatry. World Psychiatric Association's Regional Symposium in Cologne, Germany 30.09. - 03.10.1993
7. Kaltiala-Heino R. Psykoosipotilaiden kokemuksia pakon käytöstä psykiatriassa. Lääketiede-Medicin-94, Helsinki
8. Kaltiala-Heino R. Kolme näkökulmaa pakkohoitoon. Tampereen lääkäripäivät 1994.
9. Kaltiala-Heino R. Patienternas, anhörigas och vårdpersonalens attityder till psykiatrisk tvångsvård. XXIV Nordiska psykiaterkongressen 16. - 19.05.1994, Linköping, Sverige
10. Kaltiala-Heino R. Coercion and outcome of inpatient treatment. XXI Congress on Law and Mental Health. 25.-29.6.1995, Tromsø, Norge.
11. Kaltiala-Heino R. Coercion in treatment of psychotic inpatients. XXI Congress on Law and Mental Health. 25.-29.6.1995, Tromsø, Norge.
12. Engberg M, Höyer G, Kaltiala-Heino R, Kjellin L. Paternalism and autonomy. A presentation of a planned Nordic study on coercion within psychiatric care. Part two: Reliability and validity of data on involuntary commitment. XXI Congress on Law and Mental Health. 25.-29.6.1995, Tromsø, Norge.
13. Kjellin L, Engberg M, Höyer G, Kaltiala-Heino R. Paternalism and autonomy. A planned Nordic study on coercion within psychiatric care. Level 3: Coercion as perceived by the patients. XXI Congress on Law and Mental Health. 25.-29.6.1995, Tromsø, Norge.
14. Kaltiala-Heino R., Laippala P. Coercion in psychiatric inpatient treatment. A pilot study. Role of Epidemiology in Psychiatry. Congress of AEP/Social Psychiatry, Cambridge 11.-13.4.1996
15. Kaltiala-Heino R, Laippala P. Deprivation of liberty in psychiatric treatment. Association of European Psychiatrists. European psychiatry: A force for future. London 7.-12.7.1996
16. Kaltiala-Heino R. Involuntary treatment in psychiatry: Occurrence and motivation. X World Congress of Psychiatry. World Psychiatric Association, Madrid, 22.-28.8.1996

17. Kaltiala-Heino R. Lääketieteen opiskelijoiden kuva ihmisestä ja lääkärintyöstä. Terveystieteiden tutkimuksen päivät. Sosiaalilääketieteen yhdistys, STAKES ym., Helsinki, 4.-5.10.1996
18. Kaltiala-Heino R, Korkeila J, Laippala P. Coercion and restrictions in psychiatric inpatient treatment. Nordic congress of psychiatry, Trondheim, Norway 7.-11.5.1997
19. Kaltiala-Heino R, Rantanen P, Rimpelä M. School Health Study: Depressiveness among adolescent population. A pilot analysis. Nordic Conference of Social Medicine, 10.-12.9.1997, Helsinki
20. Lukkari O, Kaltiala-Heino R, Rantanen P, Rimpelä M. Health seeking for depressiveness among adolescents. Nordic Association of Psychiatric Epidemiology, 20.-21.9.1997, Roskilde, Denmark
21. Kaltiala-Heino R, Rantanen P, Rimpelä M. Depressiveness among adolescent population. Nordic Congress of Social Medicine. 10.-13.9.1997, Helsinki
22. Kaltiala-Heino R, Rimpelä M, Rantanen P. Kouluterveys 1997: Masentuneisuus peruskoululaisten terveysongelmana. Terve Kunta-päivät, STAKES, 4.-5.12.1997, Helsinki
23. Kaltiala-Heino R, Lukkari O, Rimpelä M, Rantanen P. Saako masentunut nuori apua? Tampereen lääkäripäivät 19.-21.3.1998, Tampere
24. Kaltiala-Heino R. Tahdosta riippumattoman hoidon eettisiä ongelmia. Tampereen lääkäripäivät 19.-21.3.1998, Tampere
25. Kaltiala-Heino R, Eronen M. Expected competencies after psychiatric specialist training in Finland. Training in psychiatry and child psychiatry. The European Federation for all Psychiatric Trainees, Antwerp, 23.4.1998
26. Kaltiala-Heino R, Korkeila J, Tuohimäki C, Protshenko J, Tuori T, Lehtinen V: Psychiatric patients' perception of their legal status and possibilities to decide about their treatment. International Congress of Law and mental health, 1.-4.7.1998, Paris, France
27. Kaltiala-Heino R, Rimpelä M, Rantanen P. Depressiveness and bullying: a challenge to prevention. Nordic Congress on Health Promotion Research, Stockholm, 9.-11.9.1998
28. Kaltiala-Heino R, Rissanen A, Rimpelä M, Rantanen P. Prevalence of bulimia in middle adolescence. Association of European Psychiatrists, Copenhagen, 21.-24.9.1998
29. Kaltiala-Heino R. Psychiatric specialist training - real or formal competence ahead? Association of European Psychiatrists, Copenhagen, 21.-24.9.1998

30. Torikka A, Kaltiala-Heino R, Rimpelä M, Rantanen P. Masennukseen vai muuten vain? Nuorten masennus ja päihteiden käyttö. Yleislääketieteen päivät, Tampere, 23.10.1998
31. Kaltiala-Heino R, Rimpelä M, Rantanen P, Rimpelä A, Härmä AM, Torikka A. Bullying – a key to detect adolescents at risk for mental disorders. World Psychiatric Association, Regional Council: Preventive Psychiatry. 24.-28.2.1999, Athens, Greece
32. Kaltiala-Heino R. Preventive psychiatry in specialist training: A Nordic Perspective. World Psychiatric Association, Regional Council: Preventive Psychiatry. 24.-28.2.1999, Athens, Greece
33. Välimäki M, Kaltiala-Heino R. Self-determination and empowerment: the ways to mental health promotion? World Psychiatric Association, Regional Council: Preventive Psychiatry. 24.-28.2.1999, Athens, Greece
34. Kaltiala-Heino R, Laippala P, Joukamaa M. Fewer beds, fewer inpatient days? XI World Congress of Psychiatry, Hamburg, Germany 6.-11.8.1999
35. Joukamaa M, Kaltiala-Heino R, Laippala P. Child psychiatric inpatient treatment and deinstitutionalisation in Finland. 11th International congress, European Society for Child and Adolescent Psychiatry, 15.-19.9.1999, Hamburg, Germany
36. Kaltiala-Heino R. Millainen on suomalaisnuorten psyykkinen vointi? IV Kouluterveyspäivät 23.-24.8.1999, Tampere / Kouluterveys 2002-tiedotuslehti, STAKES
37. Kaltiala-Heino R, Rimpelä M, Karvonen S, Rimpelä A. Sosiaalinen liiikuvuus ja masennus 14-16-vuotiailla nuorilla. Sosiaalilääketieteen päivät 7.-8.10.1999, Tampere
38. Kaltiala-Heino R, Korkeila J, Tuohimäki C, Lehtinen V. Reasons for using seclusion and restraint in psychiatric inpatient care. 10th European symposium on psychiatry, psychiatric epidemiology and social psychiatry. Association of European Psychiatrists, 6.-8.4.2000, Budapest, Hungary
39. Engberg M, Höyer G, Kaltiala-Heino R, Kjellin L, Poulsen H, Sigurjonsdottir M. A presentation of the Nordic project on coercion in psychiatry in the Nordic countries. 10th European symposium on psychiatry, psychiatric epidemiology and social psychiatry. Association of European Psychiatrists, 6.-8.4.2000, Budapest, Hungary
40. Kaltiala-Heino R. Nuorten mielenterveyden edistäminen kouluissa. Terve-SOS 2000, STAKES, 22.-24.5.2000, Tampere. Abstraktit.
41. Kaltiala-Heino R, Rimpelä M, Kosunen E. Sexual activity and depression in middle adolescence. III Nordic Congress on Health Promotion Research. 6.-9.9.2000, Tampere, Finland

42. Kaltiala-Heino R. Saako masentunut nuori apua? Kouluterveyspäivät 28.8.2000, Abstraktit, Tampere
43. Kaltiala-Heino R, Rimpelä M, Rantanen P. Early maturation and emotional and behavioural symptoms in early adolescence. Nordic Association of Psychiatric Epidemiology, 22.-24.9.2000, Helsinki, Finland
44. Kaltiala-Heino R, Poutanen O, Pasternak A. Undergraduate studies in psychiatry in the problem-based learning medical curriculum at University of Tampere. 10TH Congress of Association of European Psychiatrists, 28.10.-3.11.2000, Prague, Czech Republic
45. Tuohimäki C, Kaltiala-Heino R, Engberg M, Höyer G, Kjellin L, Joukamaa M, Sigurjonsdottir M. Involuntarily committed patients in the Nordic countries. XXVI International Congress on Law and Mental Health. 3.-6.7.2001. Montreal, Canada.
46. Kjellin L, Höyer G, Engberg M, Kaltiala-Heino R, Sigurjonsdottir M. Legal status and patients' perceptions of being coerced at admission to psychiatric care in four Nordic countries. XXVI International Congress on Law and Mental Health. 3.-6.7.2001. Montreal, Canada.
47. Kaltiala-Heino R, Korkeila J, Tuohimäki C, Lehtinen V, Joukamaa M. Use of seclusion and restraints in psychiatric treatment. XXVI International Congress on Law and Mental Health. 3.-6.7.2001. Montreal, Canada.
48. Marianne Engberg, Riittakerttu Kaltiala-Heino, Georg Høyer, Lars Kjellin, Maria Sigurjónsdóttir. How valid are statistics on civil commitment rates in the Nordic countries? 11TH Congress of Association of European Psychiatrists, Stockholm, Sweden, 2002
49. Tuohimäki C, Kaltiala-Heino R, Engberg M, Höyer G, Kjellin L, Sigurjonsdottir M, Joukamaa M. Who are the committed psychiatric patients in the Nordic countries? 11TH Congress of Association of European Psychiatrists, Stockholm, Sweden, 2002
50. Høyer G, Engberg M, Kaltiala-Heino R, Kjellin L, Sigurjónsdóttir M. Background and design of the 'paternalism and autonomy' study. 11TH Congress of Association of European Psychiatrists, Stockholm, Sweden, 2002
51. Kjellin L, Engberg M, Høyer G, Kaltiala-Heino R, Sigurjónsdóttir M. Legal mode of admission and deprivation of liberty in psychiatric care in the nordic countries. 11TH Congress of Association of European Psychiatrists, Stockholm, Sweden, 2002
52. Høyer G, Lidz C, Engberg M, Kaltiala-Heino R, Kjellin L, Sigurjónsdóttir M. Measurements of perceived coercion, methodological problems. 11TH Congress of Association of European Psychiatrists, Stockholm, Sweden, 2002

53. Kaltiala-Heino R, Lintonen T, Rimpelä A. Internet addiction? Potentially problematic use of the internet in a population of 12-18 year-old adolescents. International Congress of Behavioural Medicine, 28.-31.8.2002, Helsinki, Finland
54. Fröjd S, Laurila AM, Kilkku N, Kaltiala-Heino R. Measuring patients' experiences of and expectations from mental health services: ARVO-questionnaire. Nordic Psychiatric Congress, Reykjavik, Iceland, 13.-17.8.2003
55. Kaltiala-heino R, Vermeiren R, Rimpelä M. Victimization by violence and antisocial behaviour and depression in 14-16 year old adolescents: a community study. The IACAPAP congress in Berlin, Germany, 22.-26.8.2004
56. Kaltiala-Heino R. Aggression management in an adolescent forensic unit. The IACAPAP congress in Berlin, Germany, 22.-26.8.2004
57. Berg J, Välimäki M, Kaltiala-Heino R. Psychiatric nursing staff's views of aggression management in the treatment of minor patients with aggression and impulse control problem. International Congress of Law and Mental Health, Paris, France, 4.-8.7.2005
58. Kaltiala-Heino R. Severe mental disorder as commitment criterion for minors. International Congress of Law and Mental Health, Paris, France, 4.-8.7.2005
59. Gammelgard M, Työläjärvä M, Kaltiala-Heino R. Short term predictive power of SAVRY violence risk assessment in Finnish adolescent forensic patients. International Congress of Law and Mental Health, Paris, France, 4.-8.7.2005, and NBordic Symposium of Forensic Psychiatry, Vaasa, Finland, 24.-26.8.2005
60. Siponen, U., Välimäki, M. & Kaltiala-Heino, R. Co-operation between mental health and social workers in the evaluation situation of the needs of involuntary treatment of conduct disordered adolescent. Poster-representation. Qualitative Research on Mental Health Conference 29.6-1.7.2006, Tampere, Finland
61. Berg J, Välimäki M, Kaltiala-Heino R. Staff's perception of adolescent aggression in forensic treatment in four European countries. Qualitative Research on Mental Health, Tampere, Finland, 29.6.-1.7.2006
62. Berg J, Välimäki M, Kaltiala-Heino R. Adolescent aggressive behaviour perceived by forensic care staff: comparison in four countries. International Academy of Law and Mental health, Padua, Italy, 2007
63. Gammelgård M, Koivisto AM, Eronen M, Kaltiala-Heino R. Violence risk and psychopathology among adolescents in psychiatric and child welfare care. International Academy of Law and Mental health, Padua, Italy, 2007
64. Turunen S, Välimäki M, Kaltiala-Heino R. Commitment to psychiatric care of minors: what justifies broader criteria? WPA Thematic Congress: Coercion in Psychiatry. Dresden, Germany, 6.-8.6.2007

65. Kaltiala-Heino R. Involuntary treatment and coercion in adolescent psychiatry. Keynote lecture. European Association for Forensic Child and Adolescent Psychiatry, Amsterdam, 22.-24.10.2008
66. Gammelgård M, Weizmann-Henelius G, Eronen M, Kaltiala-Heino R. What are the bad girls made of? Gender differences in the SAVRY. International Association for Forensic mental health services, Vienna 2008
67. Keski-Valkama A, Eronen M, Kaltiala-Heino R. Patients' experiences of seclusion - case reports. 7th Nordic Symposium of Forensic Psychiatry, Oslo, Norway, August 22-24, 2007
68. Keski-Valkama, A., Sailas, Koivisto, A., E., Eronen, M., Lönnqvist, J., Kaltiala-Heino, R. Clinical indications of restraint and seclusion in psychiatry: a nationwide 15-year time trend study in Finland. 8th Annual IAFMHS Conference, June 23-26, 2009, Edinburgh, Scotland
69. Keski-Valkama, A., Eronen, M., Kaltiala-Heino, R. The use of seclusion in the forensic psychiatry - secluded patients' view. 8th Nordic Symposium of Forensic Psychiatry, August 19-21, 2009, Elsinore, Denmark
70. Kaltiala-Heino R. Involuntary psychiatric treatment of minors. Nordic Congress of Psychiatry, Sep 22-24, 2009, Stockholm, Sweden
71. Kaltiala-Heino R. Violence risk and mental disorders in adolescents. Nordic Congress of Psychiatry, Sep 22-24, 2009, Stockholm, Sweden
72. Kaltiala-Heino R. Nuoren väkivaltariskien arvioiminen. Pohjolan lääkäripäivät 2010, abstraktit.
73. Fröjd S, Marttunen M, Kaltiala-Heino R. Why do late adolescents not seek professional help for mental health problems? European Psychiatric Association (EPA) 18th European Congress of Psychiatry February 27-March 2, 2010 | Munich, Germany
74. Kaltiala-Heino R, Fröjd S. Early puberty is associated with problematic drinking and substance use. European Association for Research on Adolescence EARA 2010 conference in Vilnius, Lithuania, May 12-15
75. Fröjd S, Marttunen M, Kaltiala-Heino R. Depressed adolescents at risk for educational exclusion. European Association for Research on Adolescence EARA 2010 conference in Vilnius, Lithuania, May 12-15
76. Kaltiala-Heino R. Comprehensive aggression management programme in an adolescent forensic unit. World Congress of Psychiatry, Buenos Aires, Argentina, 18.-23.9.2011
77. Kaltiala-Heino R. Ethical issues in adolescent forensic psychiatry. EFCAP congress, March 7-9 2012, Berlin, Germany
78. Fröjd S, Marttunen M, Kaltiala-Heino R. Psychiatric and psychosocial predictors of homelessness in Young adulthood. EARA, Spetses, Greece, 29.8-1.9.2012

79. Kaltiala-Heino R, Eronen M, Putkonen H. Why do girls freak out? A study of severely violent girls in adolescent forensic inpatient care. ESCAP, Dublin, Ireland, 6.-10.7.2013
80. Kaltiala-Heino R. Adolescent forensic psychiatric services in Finland. ESCAP, Dublin, Ireland, 6.-10.7.2013
81. Kaltiala-Heino R, Gammelgård M. Mad, bad and sad – how could we better help the most aggressive girls? IAFMHS, Maastricht, NL, 18.-21.6.2013.
82. Kaltiala-Heino R. Autonomy and self-determination in children and adolescents. EFCAP, Manchester, UK, 7.-9.5.2014
83. Kaltiala-Heino R. Implementing MDFT in adolescent psychiatric services in Finland. EFCAP, Manchester, UK, 7.-9.5.2014
84. Kaltiala-Heino R, Marttunen M, Fröjd S. Depression, conduct disorder, smoking and alcohol use as predictors of sexual activity in middle adolescence. ESCAP, Madrid, 20.-24.6.2015
85. Gammelgård M, Koivisto AM, Weizmann-Henelius G, Eronen M, Kaltiala-Heino R. Risk factors for violent and disruptive behaviours in adolescent institutionalized care. ESCAP, Madrid, 20.-24.6.2015
86. Kaltiala-Heino R, Kjellin L, Brunger M. Involuntary psychiatric treatment of minors in selected European countries. EFCAP, Porto, Portugal, 11.-13.5.2016
87. Kaltiala-Heino R, Turunen V, Röning T. Therapeutic cornerstones of an adolescent forensic unit. EFCAP, Porto, Portugal, 11.-13.5.2016
88. Kaltiala-Heino R, Fabrin K, Kivitela E, Setälä S, Väänänen J. Aggression management in an adolescent forensic unit. Violence in Clinical Psychiatry, Dublin, Ireland, 24.-26.10.2017
89. Gender variation in adolescent population – a 5-year replication study. Svensk Förening för Transsexuell Hälsa, Malmö, Sweden, 15.-17.11.2017
90. Riitakerttu Kaltiala-Heino & Nina Lindberg. Pathways to a school shooting rampage: Does fiction reflect scientific evidence? Nordic Congress of Psychiatry, Reykjavik, Iceland, 13.16.6.2018
91. Riitakerttu Kaltiala-Heino & Svetlana Oshukova. Harry Potter and a True Psychopath. EFCAP, Venice, Italy, 20.-22.6.2018
92. Progression of adolescent development after starting cross-sex hormones. Svensk Förening för Transsexuell Hälsa, Linköping, Sweden, 21.-23.11.2018
93. Sexual experiences of clinically referred adolescents with features of gender dysphoria. Svensk Förening för Transsexuell Hälsa, Linköping, Sweden, 21.-23.11.2018

94. Kaltiala R, Heino E. Sexual harassment and dating violence experiences in middle adolescence: a comparison of cis- and transgender identifying youth. Svensk Förening for Transpersoners Hälsa, Stockholm, Sweden, 20.-22.11.2019

Reports given for STAKES and the Ministry of Health and Welfare as permanent advisor in psychiatry

1. Eristys ja lepositeet psykiatrisessa hoidossa. 12/1997 (STAKES) (Seclusion and restraint in psychiatric care)
2. Alaikäisten tahdosta riippumaton psykiatrinen hoito- vakavan mielenterveyden häiriön diagnoosi ja muita ongelmakohtia. 2/1999 (STAKES) (Involuntary treatment of minor patients)
3. Lausunto euroopan neuvoston asiakirjasta ”White Paper” on the protection of human rights as dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment. 4 / 2000 (STAKES) (On White Paper – proposal of the European Council)
4. Alaikäisten tahdosta riippumaton hoito: mitä Mielenterveyslain käsite vakava mielenterveyden häiriö tarkoittaa? Sosiaali- ja terveysministeriön tilaama selvitystyö, loppuraportti, 2001 (How to interpret the concept “severe mental disorder” as basic criterion for involuntary treatment of minors)

Other professional publications

1. Kaltiala-Heino R. Junioripsykiatrit kansainvälisyyden puolesta. Suom Lääkäril 1995;28:2976
2. Kaltiala-Heino R. Pakon käyttö psykiatrisessa hoidossa on vähentynyt. Aamulehti, Alakerta, 18.3.1996
3. Kaltiala-Heino R. Kriisihoito yleissairaalapsykiatrian poliklinikalla. Kuriiri
4. Kaltiala-Heino R. EFPT - psykiatria erikoistuvat etujaan valvomassa. Nuorilääkäri 1997;7:21-22
5. Kaltiala-Heino R. Ankaraa aivovienttiä elleivät työolot tyydytä? Nuorilääkäri 1997;8:18-21
6. Kaltiala-Heino R. Eristys ja lepositeet psykiatrisessa hoidossa. STAKESin pyytämä asiantuntijalausunto 15.12.1997

7. Kaltiala-Heino R. Tieteenteosta ja lokikirjoista. Avoimuutta ja kohtuullisuutta erikoislääkärikoulutukseen. Suom Lääkäril 1997;26:3005-3005
8. Kaltiala-Heino R, Eronen M. Notes on the suggested new curriculum for psychiatric specialist training. Suomen mielenterveyden kenttä. Psychiatrica Fennica reports 115, Psykiatrian tutkimussäätiö, 1997
9. Kaltiala-Heino R. Laadunhallintaa terveyskeskuksessa. Nuorilääkäri 1998;4:41-43
10. Kaltiala-Heino R. Syntynyt: European Federation for all Psychiatric Trainees. Nuorilääkäri 1998;9:28-33
11. Kaltiala-Heino R. Koululaisten syömishäiriöt. Ravitsemuskatsaus 1998;2:14-15
12. Kaltiala-Heino R. La WPA e I giovani psichiatri: Io Young Psychiatrists Programme dell'XI Congresso mondiale di psichiatria. Studi di psichiatria 1999;1:111-112
13. Kaltiala-Heino R. Koulukiusaaminen ja mielenterveys. EST – ehkäisevän sosiaali- ja terveystieteiden verkostolehti 2000;1:4-5
14. Kaltiala-Heino R. Tahdosta riippumattoman hoidon ongelmia. Käytännön lääkäri 2001;44:64-68
15. Kaltiala-Heino R. Onko psykiatria yhteiskunnan moraalin vartija? Mediuutiset 24.1.2002
16. Kaltiala-Heino R. Itsemääräämisoikeus ei pelkästään hyväksi. Aamulehti, Alakerta 9.8.2002
17. Kaltiala-Heino R. Aggressio-ongelmat ja mielenterveys nuoruusiässä, osa 1. Neuvola ja kouluterveys 2006;4:23-25
18. Kaltiala-Heino R. Lisääntyvätkö nuorten mielenterveyden häiriöt? Neuvola & kouluterveys 1/2009
19. Kaltiala-Heino R. Koulu ja nuorten mielenterveys. Neuvola & kouluterveys 3/2009
20. Kaltiala-Heino R. Tarkkaavuuden ongelmat ja levottomuus. Neuvola & Kouluterveys 5/2009
21. Kaltiala-Heino R. Nuoruusiän haasteet Aspergerin oireyhtymässä. Neuvola & Kouluterveys 1/2010
22. Kaltiala-Heino R. Tulvavettä pidättelemässä? Neuvola & Kouluterveys 2/2010
23. Kaltiala-Heino R. Sinun lapsesi eivät ole sinun. Neuvola & Kouluterveys 3/2010
24. Kaltiala-Heino R. Miten nuori ilmentää jaksamattomuuttaan? Liikunnan ja terveystiedon opettaja – lehti Liito 4/2010

25. Kaltiala-Heino R. Neuvola & kouluterveys 1/2011
26. Kaltiala-Heino R. Neuvola & kouluterveys 2/2011
27. Kaltiala-Heino R. Toveripiirin hyljeksimäksi joutuminen ja väkivalta. Neuvola & kouluterveys 3/2011
28. Kaltiala-Heino R. Kiltit, hiljaiset tytöt. Neuvola & kouluterveys 4/2011
29. Kaltiala-Heino R. Ongelmana sukupuoli. Neuvola & kouluterveys 5/2011
30. Kaltiala-Heino R. Nuori seksuaalisen hyväksikäytön uhrina. Neuvola & kouluterveys 1/2012
31. Kaltiala-Heino R. Vanhemmat, vanhemmuus ja nuorten mielenterveys. Neuvola & kouluterveys 2/2012
32. Kaltiala-Heino R. Terve sielu terveessä ruumiissa? Neuvola & kouluterveys 3/2012
33. Kaltiala-Heino R. Kyllä jonkun pitää ottaa koppi! Neuvola & kouluterveys 4/2012

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Invited lectures

1. Pakon käytöstä psykiatrisessa hoidossa. Tilaisuudessa Lääkärit ja lehdistö. Suomen Lääkäriliitto, Hämeenlinnan paikallisosasto, 26.10.1995
2. Erikoislääkärikoulutuksen laadunvarmennus: Erikoistuvien näkökulma. Lääketiede-Medicin 1996 /Nuorten Lääkärien Yhdistys, 10.1.1996
3. Paternalismi ja autonomia - pakon käyttö psykiatrisessa hoidossa. Psykiatrian filosofia ja etiikka 17.-18.4.1996, Turku. Turun yliopiston täydennyskoulutuskeskus
4. Pakkohoito - teoriaa ja käytäntöä. Kellokosken sairaalan jatkokoulutusseminaari. 3.5.1996, Kellokoski
5. Pakolla kohti parempaa huomista? Oulun yliopiston psykiatrian klinikan jatkokoulutusseminaari, 15.1.1997, Oulu
6. Pakkohoidon ongelmia. Keski-Pohjanmaan sairaanhoitopiirin alueellinen koulutuspäivä laatuprojektin "Akuutin psykoosin hoito" luentosarjassa. 24.4.1997, Kokkola

7. Research Issues in Coercion in the Provision of Mental Health Services: Measuring coercion. Tutkimuskonferenssi, 2.-4.11.1997, Chapel Hill University, USA
8. How does specialist training prepare the young psychiatrists to co-operation with the GP's? Psykiatripäivät 1997, Suomen Psykiatriyhdistys, Helsinki
9. Tahdosta riippumattoman hoidon eettiset ongelmat. Tampereen lääkäripäivät, 22.3.1998, Tampere
10. Nuorten syömishäiriöt. Maito ja terveys, Valion koulutuspäivä 2.9.1998, Tampere.
11. Syömishäiriöt suomalaisnuorilla. Psykiatripäivät 23.10.1998, Suomen Psykiatriyhdistys, Helsinki
12. Depressiivisten nuorten avunhakemiskäyttäytyminen. Psykiatripäivät 23.10.1998, Suomen Psykiatriyhdistys, Helsinki
13. Preventive psychiatry in specialist training: A Nordic Perspective. WPA: Preventive Psychiatry, Athens, 24.-28.2.1999
14. Kaltiala-Heino R. Millainen on suomalaisnuorten psyykkinen vointi? IV Kouluterveyspäivät 23.-24.8.1999, Tampere / Kouluterveys 2002-tiedotuslehti, STAKES
15. Bullying, depression and suicidal ideation. Suomalainen depressiotutkimus tänään, 27.10.1999. Kansanterveyslaitos, Organon
16. Suomalaisnuorten mielenterveys- Kouluterveystudkimuksen tuloksia. Lapinlahden sairaalan tieteellinen meeting 16.11.1999
17. Miltä pakkohoito tuntuu? Lääkäripäivät, 11.1.2000, Helsinki: luento
18. Miltä pakkohoito tuntuu? Lääkäripäivät, 11.1.2000, Helsinki: lehdistötilaisuus
19. Syömishäiriöiden yleisyys. Lääkäripäivät, 12.1.2000, Helsinki
20. Syömishäiriöt suomalaisnuorilla: Kouluterveystudkimuksen tuloksia. Tampereen seudun syömishäiriöperheiden tuki ry. 26.4.2000, Tampere
21. Kaltiala-Heino R. Nuorten mielenterveyden edistäminen kouluissa. Terve-SOS 2000, 23.5.2000, Tampere.
22. Kaltiala-Heino R. Saako masentunut nuori apua? Kouluterveyspäivät 28.8.2000, Tampere
23. Kaltiala-Heino R. Psychoeducational treatment of schizophrenia and other psychoses. EFPT satellite symposium, 2.9.2000, Berlin, Germany

24. Eristys ja lepositeet psykiatrisessa hoidossa. Vanhan Vaasan sairaala, henkilökunnan koulutus. 7.11.2000, Vaasa
25. Kaltiala-Heino R. Kiusaaja ja kiusattu – mielenterveysnäkökulma koulukiusaamiseen. Mielenterveystapahtumat, 21.11.2000, Helsinki
26. Kaltiala-Heino R. Nuorten mielenterveys koulumaailmassa. Tuuleta mieltäsi. Mielenterveysviikon avajaistapahtuma. 19.11.2000, Tampere
27. Kaltiala-Heino R. Tahdosta riippumaton hoito pohjoismaissa. Psykiatripäivät 15.-16.3.2001, Helsinki
28. Kaltiala-Heino R. Puberteettikehitys, seksuaalisuus ja mielenterveys. Nuorten hyvinvointihankkeen koulutustilaisuus 21.3.2001, Pitkäniminen sairaala, Nokia
29. Kaltiala-Heino R. Kiusaaminen ja mielenterveys. Erikoislääkärikoulutusmeeting Pitkäniminen sairaala 9.10.2001, Nokia
30. Nuorten ongelmat ja ongelmanuoret. Nuorilääkäripäivät 19.10.2001, Helsinki
31. Koulupoissaolot ja mielenterveys. Kouluterveyspäivät 26.8.2002
32. Alaikäisten vakava mielenterveyden häiriö. Erikoislääkärimägilung, Päijät-Hämeen keskussairaala, 9.5.2003
33. Vakava mielenterveyden häiriö alaikäisillä ja erityisen vaikeahoitoisten alaikäisten uudet psykiatriset palvelut. Etelä-Pohjanmaan alueen lasten- ja nuorisopsykiatrit 13.6.2003
34. Väkilvalta terveydenhuollon haastena. Miten kohdata väkivaltainen potilas ja turvata oma työympäristö? Lääkärit ja lehdistö-seminääri, Suomen Lääkärilitto, 28.8.2003, Helsinki
35. Johtajan haasteet. V Mielenterveystyön johtamisen kurssi. Suomen Psykiatriyhdistys. Hanasaaren kurssikeskus, Espoo, 28.8.2003
36. Vakavasti oireilevien nuorten rikoksenteijöiden psykiatrisen hoidon ja kuntoutuksen tarve. Nuoret lainrikkojat -seminääri, Tampereen Poliisiopisto, 7.-8.8.2003
37. Nuorten rikoksenteijöiden psykiatrisen hoidon ja kuntoutuksen tarve. Lähipoliisiseminääri, Tampereen poliisiopisto, 5.11.2003
38. Nuorten käytöshäiriöt ja päihdeongelmat. Puolen päivän koulutus lastensuojelun toimijoille. Kalliola-opisto, Helsinki, 10.12.2003

39. Erityisen vaikeahoitoisten alaikäisten psykiatrinen tutkimus- ja hoitoyksikkö (EVA). Kokemuksia yksikön aloittamisesta. Lapinlahden sairaalan lääkärimmeeting, Helsinki, 7.12.2003
40. Pelottava nuoriso? Tieteen yö-tapahtuma, Tampereen yliopisto, Tampere, 4.1.2004
41. Alaikäisten vakava mielenterveyden häiriö. TAYSin psykiatrian toimialueen lääkärimmeeting, Pitkaniemen sairaala, 16.3.2004
42. The Psychiatric Treatment and Research Unit for Adolescent Intensive Care (EVA): the first adolescent forensic service in Finland. Ardenleigh Clinic, Birmingham, UK, 14.6.2004
43. Alaikäinen, seksuaalirikos ja mielenterveys. STAKESin SERI-hoitokoulutus, Helsinki, 27.10.2004
44. Nuorten päihdeongelmat nuorisopsykiatrian haasteena. KYSin päihdekoulutus, Kuopio, 8.12.2004
45. Pakon käyttö psykiatrisessa hoidossa: teoriaa, säädöksiä ja sovellutuksia. Hoitotyön koulutus, Pitkaniemen sairaala, Nokia, 13.12.2004 ja 14.3.2005
46. Paha, pahempi, pahin? Erityisen vaikeahoitoinen nuori. Lääkäripäivät, Helsinki, 13.1.2005
47. Nuorten hoitoon pääsyn kriteerit. Suomen Nuorisopsykiatrisen yhdistyksen seminaari, Tieteiden talo, Helsinki, 4.2.2005
48. Nuoret ja väkivalta. Tampereen Lääkäripäivät, Tampere, 17.3.2005
49. Nuoret ja väkivalta. OYS:n psykiatrian klinikkameeting, Oulu, 25.5.2005
50. Vaikeahoitoinen ja väkivaltainen? Auran sairaalan klinikkameeting, Helsinki, 6.10.2005
51. Pakon käyttö psykiatrisessa hoidossa. MAPA-kouluttajakoulutus, Laureat-instituutti, Hyvinkää, 25.10.2005
52. Nuorisopsykiatrisen erikoissairaanhoidon kriteerit. Psykiatripäivät, Helsinki, 27.10.2005
53. Nuoret ja väkivalta. Jorvin sairaalan klinikkameeting, Kauniainen, 28.10.2005
54. Päihdeongelmat nuorisopsykiatrian haasteena. Tampereen huumeosastoyhdistyksen seminaari, Tampere, 2.11.2005
55. Nuoret ja väkivalta. EFCAP koulutuspäivät, Kuopio, 17.11.2005

56. Nuorten rikoksentekijöiden mielenterveys, EFCAP koulutuspäivät, Kuopio, 17.11.2005
57. Seksuaalisuus ja mielenterveys nuoruusiässä. Seksuaalikasvatuksen kehittyvät käytännöt, Helsingin kaupungin opetusvirasto, Helsinki, 30.3.2006
58. Rajoitustoiminta psykiatriassa. Kymenlaakson sairaanhoitopiirin psykiatrian klinikan koulutustilaisuus, Kuusankoski, 19.10.2006
59. Nuorten väkivaltariskin arvioiminen. Erikoistuvien lääkärien päivät, Tampere, 21.10.2006
60. Pakon käyttö psykiatrisessa hoidossa. HUS Psykiatriakeskus, Helsinki, 20.12.2006
61. Nuoret seksuaalirikoksen tekijöinä ja uhreina. Wyethin koulutustilaisuus psykiatreille, Tampere, 22.11.2006
62. Pakon käyttö nuorisopsykiatrisessa hoidossa. TYKSin nuorisopsykiatrian klinikka, 28.11.2006
63. Adolescent forensic psychiatry: a European research project? EFCAP/ IALMH, Padua, 7/2007
64. Forensic Psychiatric Activities in Finland. EFCAP / ESCAP, Florence, Italy, 8/2007
65. Aggressionhallinta osastohoidossa. EFCAP ry:n koulutuspäivät 22.-23.11.2007, Tampere
66. Pakon käyttö psykiatrisessa hoidossa. MAPA-kouluttajakoulutus, 4.11.2008, Laurea-ammattikorkeakoulu
67. Nuorten mielenterveysongelmien kohtaaminen. Ehkäisevän päihdetyön viikko, 6.11.2008, Tampere
68. Coercion and restrictions in adolescent psychiatric treatment. Keynote lecture, EFCAP-congress, Amsterdam, 22.-24.10.2008
69. Pakon käyttö nuorisopsykiatrisessa hoidossa. Eettinen foorumi. Pohjois-Karjalan keskussairaala, Joensuu, 10.11.2008
70. Lisääntyvätkö nuorten mielenterveyden häiriöt? Väestön terveys ja terveyserot – seminaari, Säätytalo, Helsinki, 3.2.2009
71. Nuorten mielenterveystyö opiskeluhuollossa. Terveiden edistämisen seminaari, Pirkanmaan sairaanhoitopiiri, Tampere, 18.2.2009
72. Miksi mielenterveyden häiriöt lisääntyvät nuoruusiässä? Tampereen lääkäripäivät, Tampere, 20.3.2009

73. Nuorten mielenterveyden häiriöt ja väkivaltainen käyttäytymisen. Nuorisopsykiatrian juhlaseminaari, TAYS nuorisopsykiatrian vastuualue, Tampere, 12.8.2009
74. Lasten ja nuorten aggressioista -koulutuspäivä. OYS, Oulu, 3.9.2009
75. Mental disorders and violent behaviour in adolescence. ADAD-conference. FORUM - Research centre for adolescent psychosocial health, Karolinska institutet. Stockholm, 12.11.2009
76. Näkökulmia lasten ja nuorten väkivaltaisuuteen. MLL Tampereen paikallisosaston Lasten päivän aamukahvi 20.11.2009
77. Kurittomuutta vai pahoinvointia? Suomen nuorisokirjallisuuden instituutin Kurittomat lapset –seminaari, Tampere, 20.11.2009
78. Voiko nuori olla terveesti paha? Tampereen yliopiston lastenpsykiatrian oppiaineen Lasten päivän seminaari 20.11.2009
79. Väkivalta ja nuorten mielenterveys. Lapsenmieli ry:n koulutuspäivä 25.11.2009, Tampere
80. Riittävän hyvä teini-ikäisen vanhemmuus. Suomen Mielenetveysseura, Pulinapaja-projekti, Kaakkurin koulu, Oulu 19.1.2010; Säskylän koulukeskus, Säskylä 28.4.2010; Mikkeli 9.11.2010
81. Nuorten rikollisuus ja väkivalta. Suomen Akatemia ja suomalainen lääkäriseura Duodecim: Konsensuskokous 2010, Hanasaari, Helsinki, 1.2.2010
82. Nuoren väkivaltariskin arvioiminen. Pohjolan lääkäripäivät, Oulu, 25.2.2010
83. Lasten ja nuorten aggressioista –koulutuspäivä. Kehittyvä maakunta –kuntayhtymä, Kajaani, 19.3.2010
84. Millainen päihdekäyttö on huolestuttavaa nuorilla? SPR:n päihdetyön seminaari, Helsinki, 3.9.2010
85. Seksuaalisuus ja mielenterveys nuoruusiässä. Nuorten seksuaaliterveys – yhteinen asia, Terveiden ja hyvinvoinnin laitos, Paasitorni, Helsinki, 2.12.2010
86. Kuohuva nuoruus? Mikkelin mielenterveysseuran koulutustilaisuus sovittelijoille ja kriisipuhelintyön vapaaehtoisille. Mikkeli 9.12.2010
87. Mistä on tämän päivän nuoret tehty? Syömishäiriöpäivät. Syömishäiriöliitto, Turku, 12.1.2011
88. Nuoren väkivaltariskin arvioiminen. Lääkäripäivät, Helsinki, 13.1.2011

89. Häirikäivä / päihtynyt nuori vastaanotolla. Lääkäripäivät, Helsinki, 13.1.2011
90. Nuoren väkivaltariskin arvioiminen. Psykiatripäivät, maaliskuu 2011, Helsinki
91. Nuoren aggressiivinen käyttäytyminen: miten paha on paha? Psykiatrian alojen erikoistuvien runkokoulutuspäivä, Helsinki, 4.2.2011
92. Erityisen vaikeahoitoiset nuoret. Suomen Nuorisopsykiatrisen yhdistyksen koulutuspäivät, Helsinki 7.4.2011
93. Mielenterveyden häiriöt, väkivaltakäyttäytyminen ja väkivaltariski arvio nuoruusiässä. Oppilaitosturvallisuus-työryhmän seminaari, Opetus- ja kulttuuriministeriö, Helsinki, 23.5.2011
94. Hoitotakuu toimimaan prosesseja selkiyttämällä. HUS nuorisopsykiatrian vastuualue, klinikkameeting, 15.8.2011
95. Alaikäisten transtutkimukset. Psykiatripäivät, lokakuu 2011.
96. Ovatko nuoret väkivaltaisempia kuin ennen? Terveystiedon edistämisen päivät, Tampere, 10.10.2011
97. Mielenterveys ja sen häiriöt nuoruusiässä: milloin huolestua nuoresta? Koulutustilaisuus toisen asteen opettajille. Karkun evankelinen opisto, Karkku, 25.1.2012
98. Nuoret päihteiden ympäröiminä. Päihdehuoltopäivät, Professio Finland, Helsinki, helmikuu 2012
99. Ethical issues in adolescent forensic psychiatry. Keynote lecture. EFCAP congress, March 7-9 2012, Berlin, Germany
100. Mielenterveyden häiriöt ja rikollisuus nuoruusiässä. Tampereen Lääkäripäivät, maaliskuu 2012
101. Väkivaltariskin arvioiminen lapsilla ja nuorilla. Suomen Lastenpsykiatriyhdistyksen koulutuspäivä, Helsinki, maaliskuu 2012
102. Sukupuoli-identiteetin häiriöt lapsilla ja nuorilla. Slaghy ry:n koulutustilaisuus, Helsinki, 29.3.2012
103. Mielenterveysongelmat ja syrjäytyminen. Koulu- ja opiskelijaterveydenhuolto '12. Professio Finland, Helsinki, 16.4.2012
104. Mistä on tämän päivän nuoret tehty? Koulutustilaisuus toisen asteen opettajille, Valkeakosken ammattiopisto, Valkeakoski, 18.4.2012
105. Tyttöjen väkivaltakäyttäytymisen erityispiirteitä. Suomen ART ry, Helsinki, 20.4.2012

106. Seksuaalikäyttäytyminen ja mielenterveys nuoruusiässä. EFCAP ry, Tampere, 21.-22.11.2012
107. Nuorten sukupuoli-identiteetin tutkimuksen erityispiirteet. EFCAP ry, Tampere, 21.-22.11.2012
108. Nuoren väkivaltainen käyttäytyminen ja mielenterveyden häiriöt. Lasten- ja nuorisopsykiatria '13, Professio Finland, Helsinki, 15.2.2013
109. Milloin tarkkailulähete on tarpeen lapsen / nuoren sairaalaan lähettämässä ja miten se tehdään oikein? Lääkäripäivät, Helsinki, 10.1.2013
110. Kaltoinkohdellun lapsen oireet ja ongelmat nuoruusiässä. Lääkäripäivät, Helsinki, 11.1.2013
111. Paha, hullu vai normaali? Mieli 2013, Tampere, 8.2.2013
112. Aggressiivinen ja väkivaltainen nuori – mitä teen? Pohjolan Lääkäripäivät, Oulu, 21.2.2013
113. Kaltoinkohdellun lapsen oireet ja ongelmat nuoruusiässä. Espoon sosiaali-, terveys- ja sivistystoimen koulutuspäivä 6.3.2013, Espoo
114. Gender identity disorder in minors: ethical aspects. Nordic Committee on Bioethics, Copenhagen, Denmark, 18.4.2013
115. Päihdekäyttö ja mielenterveys nuoruusiässä. Sija ry, Tampere, 24.4.2013
116. Ethical issues in child and adolescent forensic psychiatry. Keynote lecture. Nordic Symposium of Forensic Psychiatry, Kuopio, 21.-23.8.2013
117. Sukupuolen moninaisuus lapsilla ja nuorilla. KYSin nuorisopsykiatrian alueellinen koulutus, Kuopio, 12.9.2013
118. Paha, hullu, normaali. Sijaishuollon päivät, Tampere, 1.10.2013
119. Are all adolescents gender confused? The assessment and treatment of the adolescent. Förening för transsexuell hälsa, Stockholm, Sweden, 7.11.2013
120. Sukupuoli-identiteetti: variaatiot ja hoidon tarve lapsuudessa ja nuoruudessa. Suomen nuorisopsykiatrinen yhdistys, Helsinki, 8.11.2013
121. Sukupuoli-identiteetin häiriö nuoruusiässä. Yleissairaalapsykiatrian meetingsarja, Tays, 2.12.2013
122. Väkivaltainen ja itsetuhoinen käyttäytyminen ja mielenterveyden häiriöt nuoruusiässä. Kohtaamisen taidot –hanke, Sosiaalikehitys, Tampere, 3.12.2013
123. Kun nuori viiltelee ja haluaa kuolla. Tampereen lääkäripäivät, Tampere, 21.3.2014

124. Nuorten transtutkimusten erityispiirteitä. Sukupuolen uudelleenmäärittelyn edellytysten arvioimiseen ja uudelleenmäärittelyn fyysisiin hoitoihin osallistuvien työryhmien tapaaminen, Töölön sairaala, Helsinki, 21.3.2014
125. Mitä yleislääkäriin tulee tietää nuorten syömishäiriöistä? Tampereen lääkäripäivät, Tampere, 21.3.2014
126. Puberteettikehitys ja mielenterveys. SLAGNYn koulutuspäivä, Helsinki, 27.3.2014
127. Eroaako tyttöjen väkivaltakäyttäytyminen poikien väkivaltaisuudesta? HUS nuorisopsykiatrian vastuualueen klinikkameeting, Helsinki 3.4.2014
128. Tyttöpojat ja poikatyöt eri ikävaiheissa – entä kun fyysinen sukupuoli ei tunnu omalta? Suomen lastenpsykiatriyhdistyksen kevätkoulutuspäivät, Tampere, 7.4.2014
129. Autonomy and self-determination in children and adolescents. EFCAP, Manchester, UK, 7.-9.5.2014
130. Violence and mental disorders in girls. EFCAP, Manchester, UK, 7.-9.5.2014
131. Harry Potter ja nuoruusiän kehitys. Suomen Lastenpsykiatriyhdistys, Helsinki, 10.11.2014
132. Aggressio-ongelmaisen nuoren osastohoito. EFCAP, Tampere, 20.-21.11.2014
133. Voiko nuori olla terveesti paha? Professori Nina Lindbergin juhlaseminaari 30.10.2015, Helsinki
134. Nuoruusikäisten kokema seksuaalinen häirintä. EFCAP, Tampere, 19.-20.11.2015
135. Clinical work with transgender adolescents. Tays lastenpsykiatrian vastuualueen alueellinen koulutuspäivä 15.1.2016
136. Harry Potter ja nuoruusiän kehitys. KYS nuorisopsykiatrian 30-vuotisjuhlaseminaari, Kuopio, 1.4.2016
137. Mielenterveyden häiriöt ja rikoskäyttäytyminen maahanmuuttajanuorilla. EFCAP, Tampere, 10.-11.11.2016
138. Kuinka kohdata aggressiivinen lapsi/ nuori? HUS Porvoon sairaalan lastenpsykiatrian poliklinikan koulutustilaisuus 29.9.2016
139. Könsidentitetsundersökningar med mindreåriga i Finland. Svensk Förening för Transsexuell Hälsa, Umeå, Sverig, 16.-18.11.2016
140. Könsidentitetsundersökningar med mindreåriga: Komplexa fall. Svensk Förening för Transsexuell Hälsa, Umeå, Sverige, 16.-18.11.2016

141. Mental disorders and violent behaviour in adolescence. Child and Adolescent Psychiatric Research Center, Karolinska Institute, Stockholm, Sverige, 1.12.2016
142. Sukupuoli-identiteetti nuoruusiässä. Oys nuorisopsykiatrian lääkärim meeting 15.12.16
143. Kuinka kohdata aggressiivinen lapsi/ nuori? Loviisan sivistystoimen koulutustilaisuus 6.2.17
144. Assessing risk for violent behaviour in adolescents - a psychiatric perspective. Metodutvecklings- och forskningsdagen 2017. BUP Stockholm, Stockholm, 21.2.2017
145. Vahingoittavaan seksuaalikäyttäytymiseen syyllistyvät nuoret – ilmiön tunnistaminen? Nuoret seksuaalirikolliset –koulutuspäivä, Terveiden ja hyvinvoinnin laitos, Helsinki, 19.5.2017
146. Vaikuttavuuden arviointi nuorisopsykiatriassa. Koulukotien kehittämisseminaari, Terveiden ja hyvinvoinnin laitos, Helsinki, 31.5.2017
147. Is he the next school shooter? Adolescent psychiatric perspective on adolescents who threaten with mass violence in school. Nordic Forensic Psychiatric symposium, Elsinore, Denmark, 22.8.2017
148. Mielenterveyslain soveltaminen alaikäisillä Suomessa. Psykiatripäivät, Helsinki, 2.11.2017
149. Nuoruusikäisen mielentilatutkimus. EFCAP, Tampere, 23.11.2017
150. Is he the next school shooter? Adolescent psychiatric perspective on adolescents who threaten with mass violence in school. The Ghent Group, Vanha Vaasa Hospital, Vaasa, 21.-22.9.2018
151. Gender dysphoria in adolescence: adolescent psychiatric perspective. ESPE meeting, Tavistock & Portman NHS Trust, London, 20.-21.9.2018
152. Pystyykö nuori kouluun, tukeeko koulu nuorta? TREDUn koulutustapahtuma toisen asteen ammatillisen koulutuksen opettajille. Tampere, 14.9.2018
153. Nuoruusikäisen mielentilatutkimuksen erityispiirteitä. Oikeuspsykiatrian neuvottelupäivä, Terveiden ja hyvinvoinnin laitos, Helsinki, 15.11.2018
154. Nuorten häiriö-/ väkivaltakäyttäytymisen arviointi ja hoitoonohjaus. Lääkäripäivät, Helsinki, 11.1.2019
155. Nuoren käytöshäiriö. Miten arvioida ja hoitaa? Pohjolan lääkäripäivät, Oulu, 22.2.2019
156. Sukupuoli-identiteetin määräytyminen. Kenen päätös ja milloin? Psykiatripäivät, Helsinki, 14.3.2019
157. Ketkä ja kuinka monet ovat sateenkaarinuoria? Psykiatripäivät, Helsinki, 14.3.2019

158. Voiko nuorella olla persoonallisuushäiriö? Nuorisolääkäripäivät, Espoo, 29.3.2019
159. Nuorten mielenterveys koulumaailmassa. Pirkanmaan ammatillisen erityisopetuksen koordinaatiokeskuksen koulutuspäivä, Tampere, 13.12.2019
160. Vyörykö masennusmassa – miksi nuorten psykiatrisen hoidon tarve kasvaa? Ylilääkäri Kirsi Haapasalo-Pesun juhlaseminaari, Satakunnan keskussairaala, 1.10.2019
161. Gender dysphoria in children and adolescents: Need for research. BrainBreak, Neurocenter Finland, 24.10.2020 online
162. Sukupuolen variaatiot ja sukupuolihadistus lapsuudessa ja nuoruusiässä. Alueellinen koulutuspäivä, Oulun yliopistollinen sairaala, 1.2.2021
163. Miksi nuorten mielenterveyspalveluiden kysyntä kasvaa? Mielenterveystmessut, online 15.11.2020
164. Sukupuoli- ja seksuaali-identiteetin rakentuminen nuoruusiässä. Ajankohtaisia haasteita. Naislääkäriyhdistyksen koulutustilaisuus, Helsinki, 15.6.2021
165. Mental health of transgender adolescents - what is known and not known? ISSM-WPATH Webinar on Transgender adolescent's health; the role of puberty suppression, online 24.6.2021
166. Year in review: Child and adolescent mental health. European Professional Association for Transgender Health, Göteborg, Sweden, 11.-13.8.2021
167. Seksuaalinen häirintä ja mielenterveys nuoruusiässä. Tutkijoiden yö, Tampere, 24.9.2021
168. Sukupuoli- ja seksuaali-identiteetin rakentuminen nuoruusiässä. SKLS syyskoulutuspäivät, Helsinki, 9.10.2021
169. Behandling av könsdysfori hos minderåriga i Finland. Konsultationsmöte med könsidentitetsteam i Lund. Online 14.10.2021
170. Recent updates in child and adolescent gender dysphoria and mental health. European Society for Pediatric Endocrinology, online, 23.9.2021
171. Väkivaltakäyttäytyminen nuoruusiässä. Terveyspsykologian päivät, Helsinki, 4.11.2021
172. Multidisciplinary assessments in gender identity units for minors in Finland: Why and how? Nemour's Children's Health, Orlando, Florida, USA. Online, 10.12.2021
173. Nuoruusikä, mielenterveys ja antisosiaalinen kehitys. Rikosseuraamusviraston koulutuspäivä 20.5.2022, online
174. Nuorten aggressio ja väkivallanteot. Tampereen lääkäripäivät, 24.8.2022, Tampere

175. Transgender identity, gender dysphoria and mental health in children and adolescents today. Tallinn Children's Hospital, 26.8.2022
176. Vaativahoitoisten nuoren arviointi moniammatillisessa yhteistyössä. Lastensuojelun Toivon seminaari, Helsingin kaupunki, Helsinki, 9.9.2022
177. Gender dysphoria in children and adolescents: the role of mental disorders. Denmark Southern Region CME day, 9.9.2022, online

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EMPLOYMENT

2006-Present Michael K Laidlaw, MD Inc. Private Practice – Endocrinology, Diabetes, and Metabolism. Rocklin, CA

EDUCATION

2004-2006 Endocrinology and Metabolism Fellowship - Los Angeles County/University of Southern California Keck School of Medicine
2001-2004 Internal Medicine Residency - Los Angeles County/University of Southern California Keck School of Medicine
1997-2001 University of Southern California Keck School of Medicine
Doctor of Medicine Degree May 2001
1990-1997 San Jose State University
Bachelor of Science Degree in Biology with a concentration in Molecular Biology, Cum Laude

LICENSURE

California Medical License – Physician and Surgeon: # A81060: Nov 6, 2002. Exp 5/31/2024.

PROFESSIONAL AFFILIATIONS

Endocrine Society 2006-2022
American Board of Internal Medicine - Endocrinology, Diabetes, and Metabolism – 2006
American Board of Internal Medicine - Internal Medicine - 2005
National Board of Physicians and Surgeons - Endocrinology, Diabetes, & Metabolism 2018-2024
National Board of Physicians and Surgeons - Internal Medicine 2018-2024

HONORS AND RECOGNITION

2010 Endocrine Society Harold Vigersky Practicing Physician Travel Award
2004-2005 Vice President - Joint Council of Interns and Residents
2002-2004 Council Member – Joint Council of Interns and Residents
1996, 1997 Dean's Scholar, San Jose State University
1995 Golden Key National Honor Society

RESEARCH AND PUBLICATIONS

- 2021 Publication – Michael K Laidlaw, Andre Van Mol, Quentin Van Meter, Jeffrey E Hansen. Letter to the Editor from M Laidlaw et al.: “Erythrocytosis in a Large Cohort of Trans Men Using Testosterone: A Long-Term Follow-Up Study on Prevalence, Determinants, and Exposure Years.” The Journal of Clinical Endocrinology & Metabolism, Volume 106, Issue 12, December 2021, Pages e5275–e5276, <https://doi.org/10.1210/clinem/dgab514>
- 2020 Publication – Van Mol A, Laidlaw MK, Grossman M, McHugh P. "Correction: Transgender Surgery Provides No Mental Health Benefit." Public Discourse, 13 Sep 2020. <https://www.thepublicdiscourse.com/2020/09/71296/>
- 2020 Publication – VanMol A, Laidlaw MK, Grossman M, McHugh P. "Gender-affirmation surgery conclusion lacks evidence (letter)". Am J Psychiatry 2020; 177:765–766.
- 2020 Publication – Laidlaw MK. "The Pediatric Endocrine Society’s Statement on Puberty Blockers Isn’t Just Deceptive. It’s Dangerous." Public Discourse. 13 Jan 2020. <https://www.thepublicdiscourse.com/2020/01/59422/>
- 2019 Speech to the U.K. House of Lords – Laidlaw MK. “Medical Harms Associated with the Hormonal and Surgical Therapy of Child and Adolescent Gender Dysphoria”. Parliament, London, U.K. 15 May 2019.
- 2019 Publication – Laidlaw MK, Cretella M, Donovan K. "The Right to Best Care for Children Does Not Include the Right to Medical Transition". The American Journal of Bioethics. Volume 19. Published online 20 Feb 2019. 75-77. <https://doi.org/10.1080/15265161.2018.1557288>
- 2018 Publication – Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline.” The Journal of Clinical Endocrinology & Metabolism, Volume 104, Issue 3, 1 March 2019, Pages 686–687, <https://doi.org/10.1210/jc.2018-01925> (first published on-line 11/2018)
- 2018 Publication – Laidlaw MK. "The Gender Identity Phantom". gdworkinggroup.org, 24 Oct 2018. <http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/>
- 2018 Publication – Laidlaw MK. “Gender Dysphoria and Children: An Endocrinologist’s Evaluation of ‘I am Jazz’”. Public Discourse, 5 Apr 2018. <https://www.thepublicdiscourse.com/2018/04/21220/>
- 2013 Abstract – Poster presentation Jun 2013. Endocrine Society Annual Meeting. A 12 Step Program for the Treatment of Type 2 Diabetes and Obesity.

- 2011 Abstract – Poster presentation Nov 2011. Journal of Diabetes Science and Technology. A Video Game Teaching Tool for the Prevention of Type 2 Diabetes and Obesity in Children and Young Adults.
- 2011 Abstract – Journal of Diabetes Science and Technology. A Web-Based Clinical Software Tool to Assist in Meeting Diabetes Guidelines and Documenting Patient Encounters.
- 2008 Abstract - Accepted to Endocrine Society Annual Meeting 2008. Hypercalcemia with an elevated 1,25 dihydroxy-Vitamin D level and low PTH due to granulomatous disease.
- 2005-2006 Clinical Research - University of Southern California – Utility of Thyroid Ultrasound in the Detection of Thyroid Cancer. Study involving the use of color flow/power doppler ultrasound and ultrasound guided biopsy to detect the recurrence of thyroid cancer in patients with total thyroidectomies.
- 2005 Certification - Certification in Diagnostic Thyroid Ultrasound and Biopsy – AACE 2005
- 2003 Certification - Understanding the Fundamentals: Responsibilities and Requirements for the Protection of Human Subjects in Research. University of Southern California. 29 Sep 2003 - 29 Sep 2006
- 2002-2005 Clinical Research - University of Southern California - Determining the Role of Magnesium in Osteoporosis. Study involved collecting and analyzing patient data related to patient characteristics, laboratory results, bone mineral density exams, nutrition analysis, and genetic analysis in order to determine a link between magnesium deficiency and osteoporosis.
- 1996 Research Assistant - San Jose State University - Role of the suprachiasmatic nucleus pacemaker in antelope ground squirrels.
- 1995-1996 Research Assistant - San Jose State University/NASA. Acoustic tolerance test and paste diet study for space shuttle rats.

EXPERT WITNESS WORK AND AMICUS BRIEFS

- 2022 Expert Witness – Laidlaw MK. AUGUST DEKKER, et al., Plaintiffs, v. SIMONE MARSTILLER, et al., Defendants. Case No. 4:22-cv-00325-RHMAF. Report October 3, 2022. Testified in court October 12, 2022.
- 2022 Expert Witness Report – Laidlaw MK. C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiff, vs. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendants. Case No. 3:20-cv-06145-RJB

- 2022 Expert Witness Report – Laidlaw MK. DISTRICT COURT OF TRAVIS COUNTY, TEXAS 459th JUDICIAL DISTRICT. PFLAG, INC., ET AL., Plaintiffs, v. GREG ABBOTT, ET AL., Defendants. NO. D-1-GN-22-002569. 3 July 2022.
- 2022 Expert Witness Report #2 – Laidlaw MK. United States District Court for the District of Arizona. DH and John Doe, Plaintiffs, vs. Jami Snyder, Director of the Arizona Health Care Cost Containment System, in her official capacity, Defendant. Case No. 4:20-cv-00335-SHR. 24 Jun 2022. (Sealed under Protective Order).
- 2022 Expert Witness Report – Laidlaw MK. United States District Court for the Middle District of Alabama Northern Division. REV. PAUL A. EKNES-TUCKER, et al., Plaintiffs, v. KAY IVEY, in her official capacity as Governor of Alabama, et al., Defendants. Civil Action No. 2:22-cv-184-LCB. 2 May 2022.
- 2021 Brief of Amicus Curiae – Bursch, John J., McCaleb, Gary S., Van Meter, Quentin L., Laidlaw, Michael K., Van Mol, Andre, Hansen, Jeffrey E. Brief of Amicus Curiae. United States Court of Appeals for the Eighth Circuit. DYLAN BRANDT, et al., Plaintiffs-Appellees v. LESLIE RUTLEDGE, in her official capacity as the Arkansas Attorney General, et. al. Defendants-Appellants. 23 Nov 2021.
- 2021 Expert Witness – JULIANA PAOLI v. JOSEPH HUDSON et al. heard in THE SUPERIOR COURT OF THE STATE OF CALIFORNIA, COUNTY OF TULARE. CASE NO. 279126. 2021.
- 2021 Brief of Amicus Curiae – Bursch, John J., McCaleb, Gary S., Grossman, Miriam, Van Meter, Quentin L., Laidlaw, Michael K., Van Mol, Andre, Hansen, Jeffrey E. Brief of Amicus Curiae. United States Court of Appeals for the Eleventh Circuit. DREW ADAMS, Plaintiffs-Appellee v. SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA, et. al. Defendants-Appellant. 26 Oct 2021.
- 2020 Expert Witness Affidavit 1 & 2 – Laidlaw MK. Supreme Court of British Columbia. File No. S2011599, Vancouver Registry. Between A.M. Plaintiff and Dr. F and Daniel McKee Defendants. 11/23/20 & 11/25/20.
- 2020 Brief of Amicus Curiae – Wenger, Randal L., McCaleb, Gary S., Grossman, Miriam, Laidlaw, Michael K., McCaleb, Gary S., Van Meter, Quentin L., Van Mol, Andre. Brief of Amicus Curiae. United States Court of Appeals for the Ninth Circuit. LINDSAY HECOX and JANE DOE, with her next friends Jean Doe and John Doe, Plaintiffs-Appellees v. BRADLEY LITTLE, in his official capacity as Governor of the State of Idaho, et. al. Defendant-Appellant. 19 Nov 2020
- 2020 Expert Witness Report – Laidlaw MK. United States District Court for the District of Arizona. DH and John Doe, Plaintiffs, vs. Jami Snyder, Director of the Arizona Health Care Cost Containment System, in her official capacity, Defendant. Case No. 4:20-cv-00335-SHR. 27 Sep 2020.

- 2019 Expert Witness Affidavit – Laidlaw MK. Court of Appeal File No. CA45940, Vancouver Registry. B.C. Supreme Court File No. E190334, between A.B. Respondent/Claimant, and C.D. Appellant/Respondent, and E.F. Respondent/Respondent. 24 Jun 2019.
- 2018 Brief of Amicus Curiae – Alliance Defending Freedom, Campbell, James A., Grossman, Miriam, Laidlaw, Michael K., McCaleb, Gary S., Van Meter, Quentin L., Van Mol, Andre. Brief of Amicus Curiae. United States Court of Appeals for the Eleventh Circuit. Drew Adams, Plaintiff-Appellee, v. School Board of St. Johns County, Florida, Defendant-Appellant. 12/27/2018.

PERSONAL

Languages: Conversational Spanish, French

Tutor: Biochemistry, computer science, High School mentor

Computers: Ruby, Rails, Javascript, C++, C, Java, and HTML programming

Medical Dangers of Gender Affirmative Therapy: What is known and unknown

Presented to the Florida Board of Medicine

**By Michael K. Laidlaw, MD
Endocrinologist. Rocklin, CA**

October 28, 2022

Letter to the Editor: “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline”

Michael K Laidlaw, Quentin Van Meter, Paul W Hruz, Andre Van Mol, William J Malone

The Journal of Clinical Endocrinology & Metabolism
Endocrine Society

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Accepted: November 20, 2018

First Online: November 23, 2018

Our criticism of gender affirmative therapy for minors was first published in 2018.

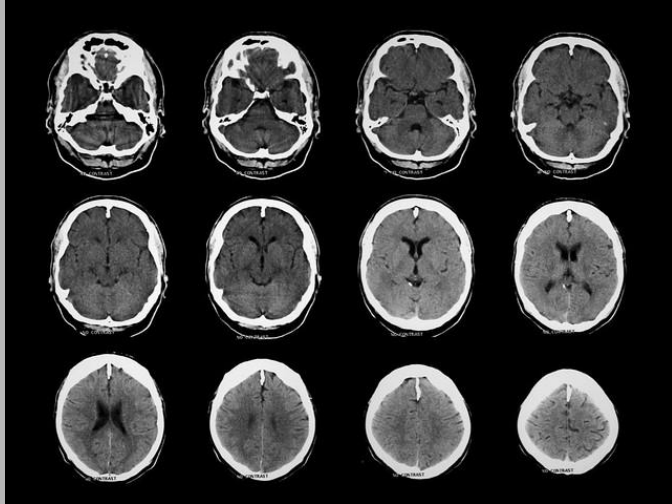
Definitions

- ❑ **Gender Identity - an internal feeling of being a boy, a girl, or some variation**
- ❑ **Gender Dysphoria - a discomfort with one's sex & perceived gender leading to significant distress and impairment of functioning lasting at least 6 months**
- ❑ **Desistance of Children by adulthood: 50-98%***

**Ristori J, Steensma TD. Gender dysphoria in childhood. Int Rev Psychiatry. 2016;28(1):13–20.*

Also From the DSM-5: “Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary...In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%” (American Psychiatric Association, 2013).

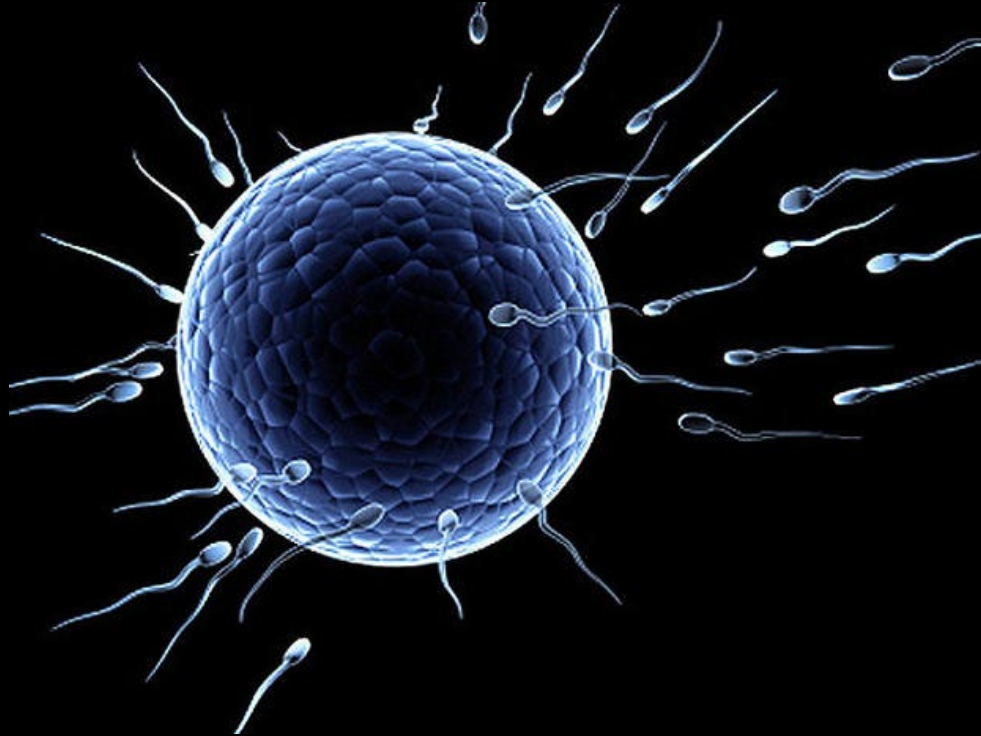
Where do I find the gender identity?



Q: CT, Ultrasound, Blood Test, MRI, Brain biopsy, genetic testing?

A: None of the above.

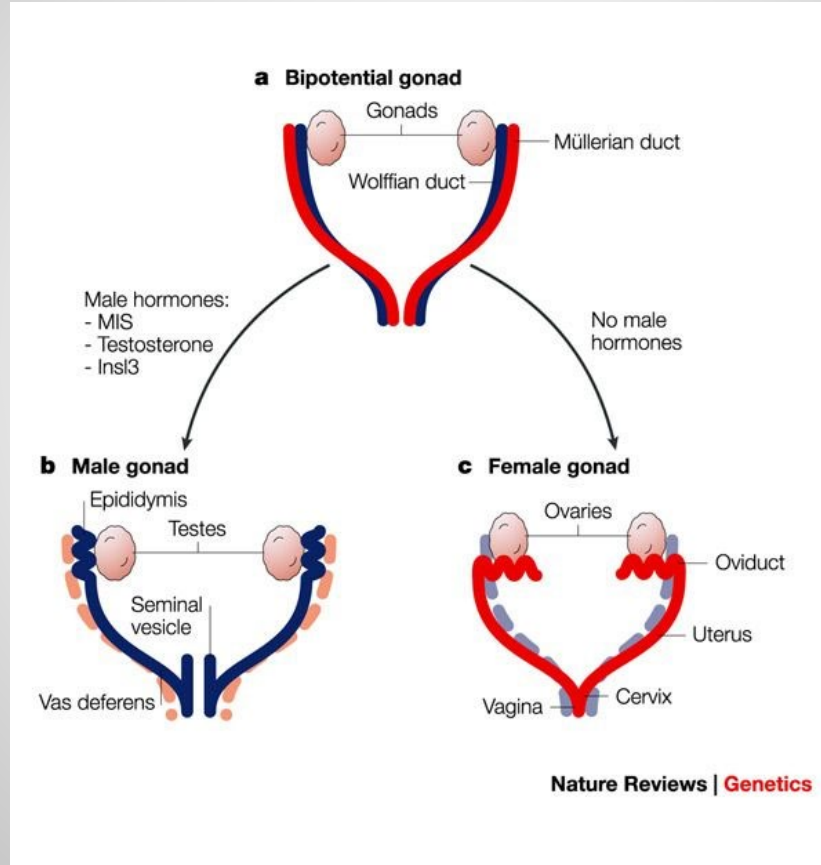
There are only two human sexes



*There are only two types of gametes each originating from either a male or a female. No other type of human gamete exists.

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Permanent Sexual Developmental Differentiation



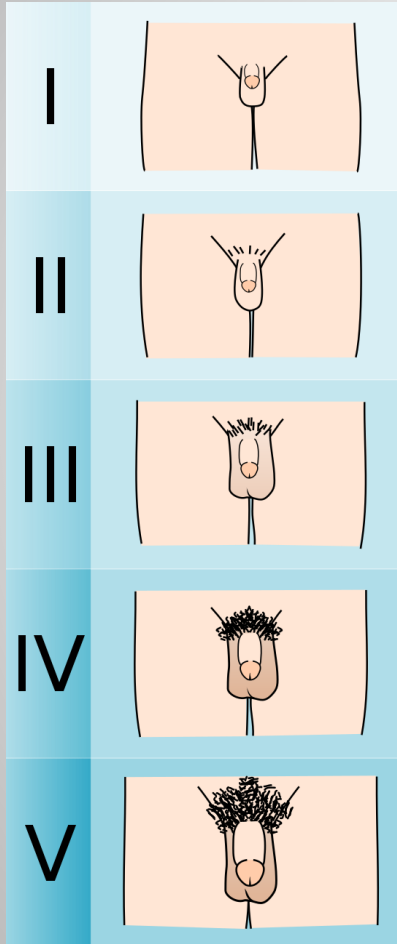
Sexual organ differentiation occurs between gestational weeks 8-12. There is a bifurcation in the pathway for males and females. Unique structures are created for each. The unused ductal system is obliterated. A person cannot change from one path to the other.

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Puberty - Tanner Stages

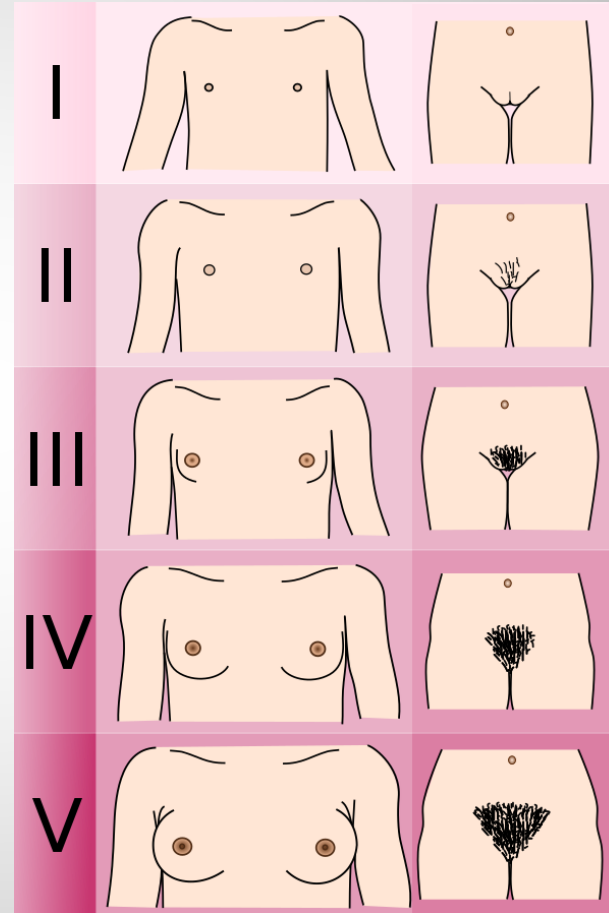
Male

M•Komorniczak,
polish wikipedist.
"Tanner scale-
male.svg"



Female

M•Komorniczak,
polish wikipedist.
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female.svg"



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What happens when you force a **Square Peg**



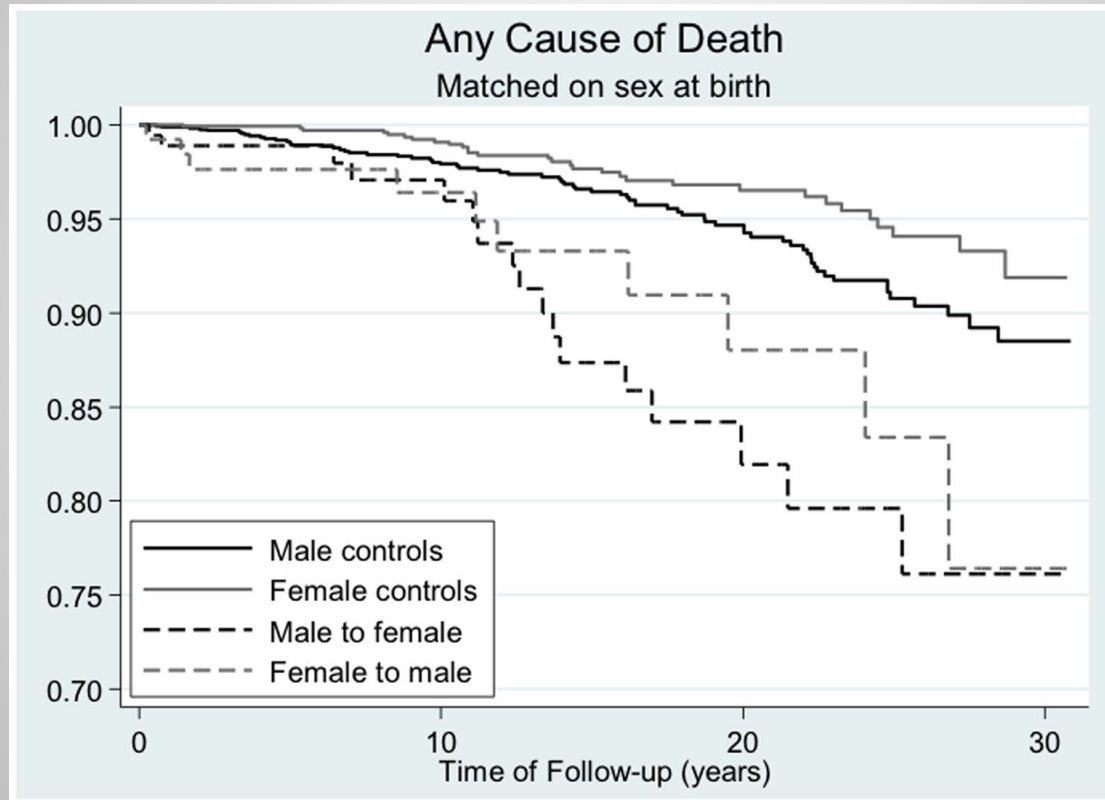
into a **Round hole?**

Gender Affirmative Therapy

- Social Transition
- Puberty Blockers
- Cross Sex Hormones
- Surgical Modifications

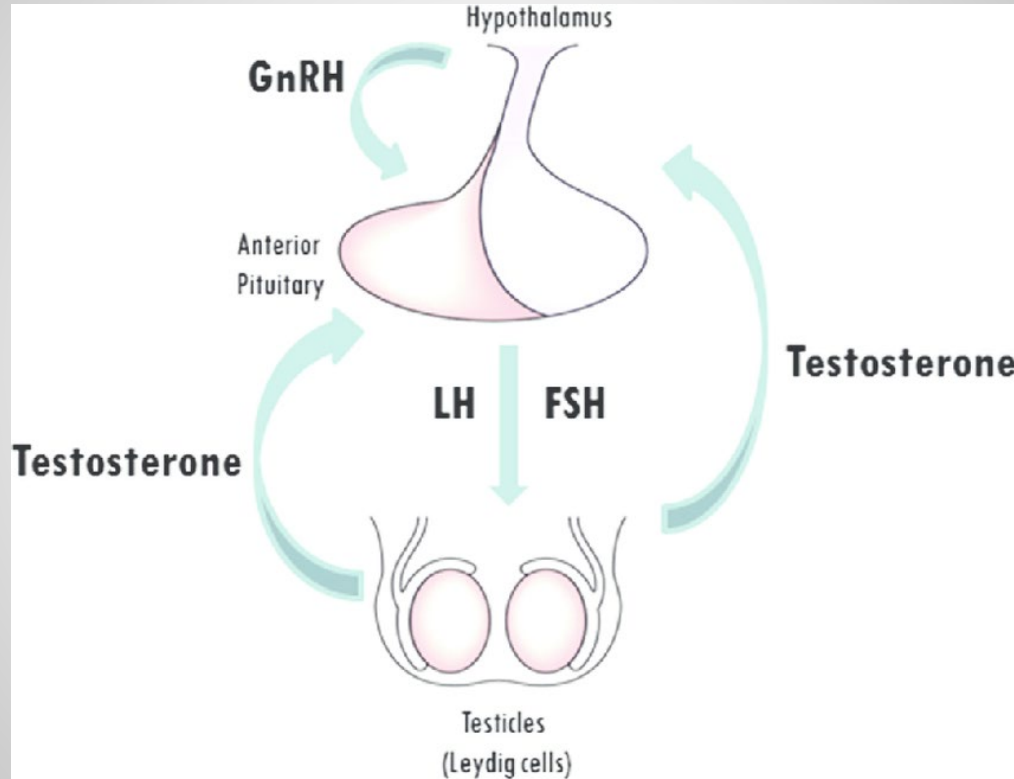
Long Term Mortality

Cross Sex Hormones and Surgery



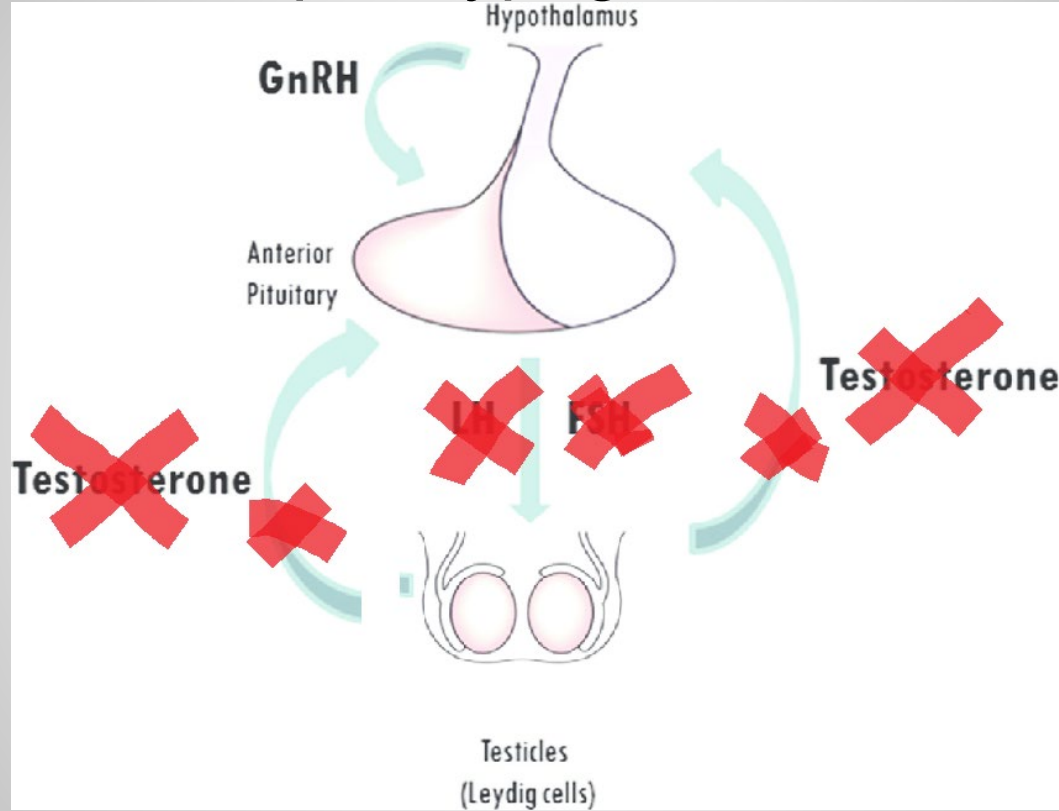
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Normal Pituitary Gonadal Function



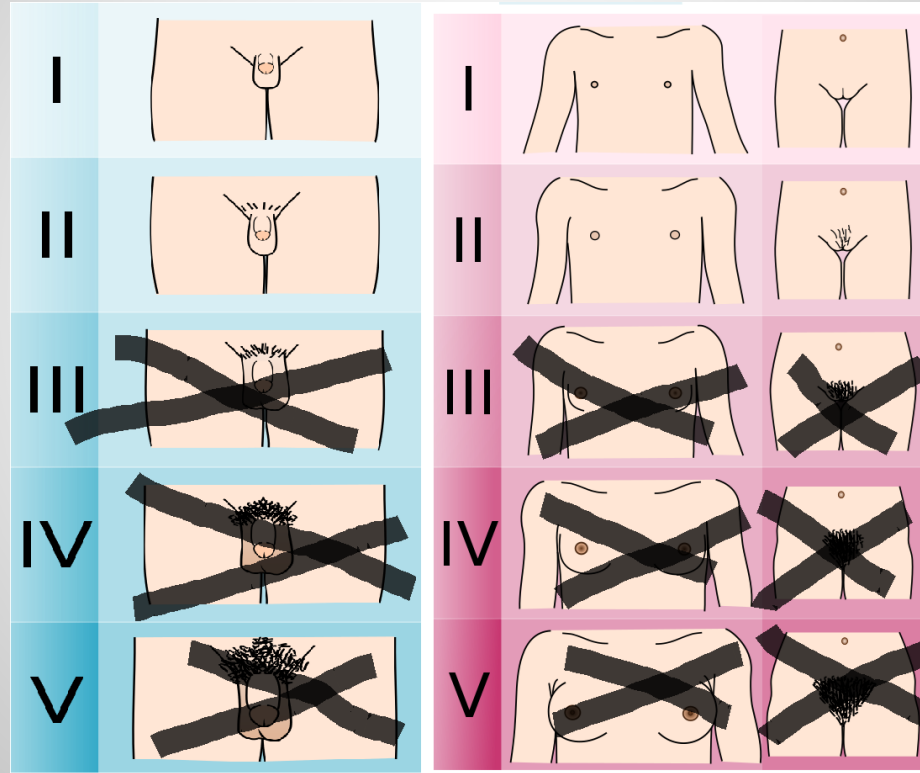
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Hypogonadotropic Hypogonadism - Iatrogenic*



*Caused by GnRH analogues such as Lupron

Effects of Puberty Blockers

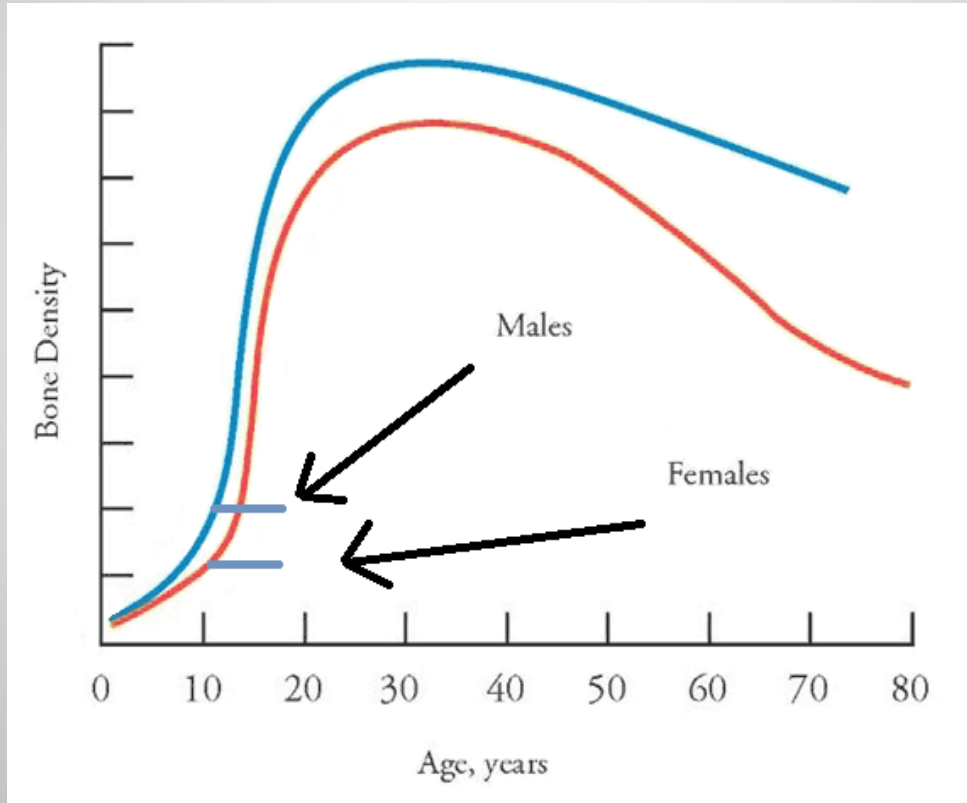


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Side Effects of Blockade of Normal Puberty

<i>Male</i>	<i>Female</i>
Stunting of penile and testicular growth	Menopause like state
	Blockade of normal breast development
Sexual dysfunction: Impairment of erection, orgasm, ejaculation	Decreased blood flow to vagina and vulva
	Sexual dysfunction: Thinning of vaginal epithelium, vaginal atrophy, anorgasmia
Prevention of spermatogenesis - infertility	Prevention of menses/ovulation - infertility
Disruption of normal brain development	Disruption of normal brain development
Disruption of normal bone development/strength	Disruption of normal bone development/strength

Flatline in Bone Density Accrual with GnRH analogues



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Cross Sex Hormones - Testosterone

6-100X higher than endogenous female levels

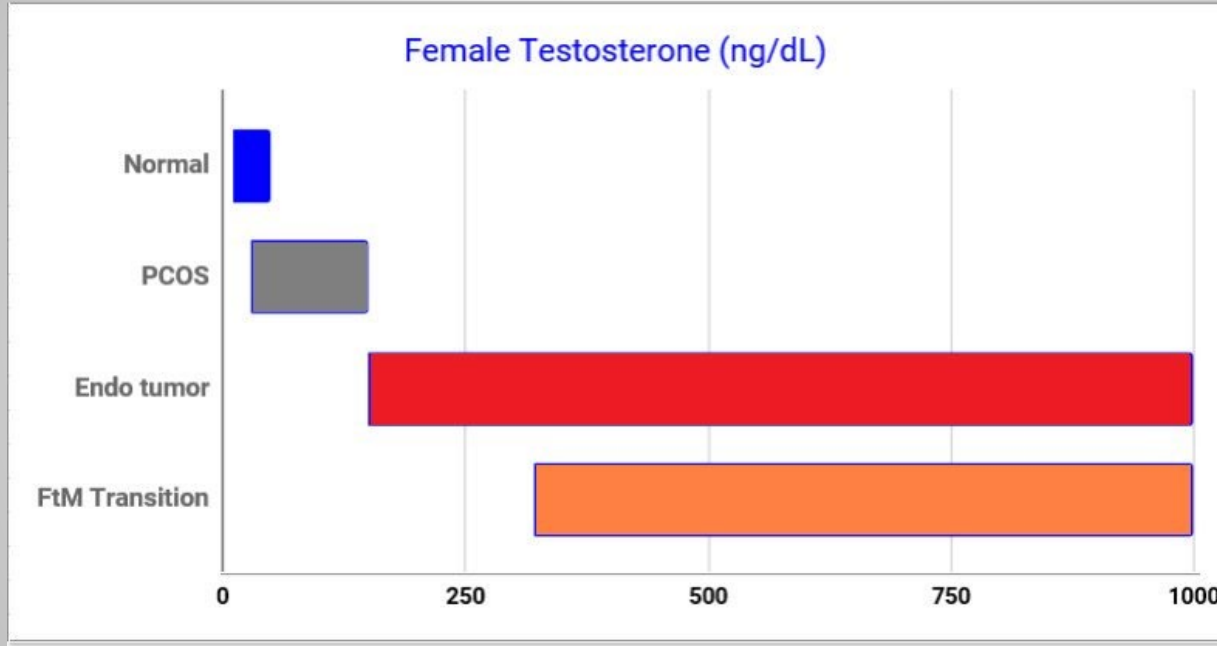


Image by Michael K Laidlaw, MD. Approximate total testosterone in ng/dL based on laboratory, etc. FtM transition from 2017 Endo Society Guidelines on Gender Dysphoria. With PCOS testosterone levels may be as high as 150. With endocrine tumors testosterone may be in the 150-1000 range. The recommendations of the Endocrine Society/WPATH are to bring levels into the 300-1000 range which is 6-100 times higher than normal endogenous adult female levels.

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Side Effects of Cross Sex Hormones

<i>Males on Estrogen</i>	<i>Females on testosterone</i>
increased risk of myocardial infarction and death due to cardiovascular disease*	increased risk of myocardial infarction and death due to cardiovascular disease*
Thromboembolism 5X Increased risk *	Erythrocytosis**
Gallstones**	Severe liver dysfunction**
Hypertriglyceridemia**	Hypertension**
Breast Cancer risk increased 46 X***	Breast, uterine, ovarian cancer risk **
Gynecomastia**	Hirsutism, deepening of the voice**
Sexual dsyfunction, infertility****	Sexual dsyfunction, infertility****

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*Irwig MS. "Cardiovascular health in transgender people." Rev Endocr Metab Disord. 2018;19(3):243–251. **Hembree WC, et al., "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," The Journal of Clinical Endocrinology & Metabolism, Volume 102, Issue 11 (Nov. 1, 2017). ***Christel J M de Blok, et al. "Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands" BMJ 2019; 365. (Published 14 May 2019). Laidlaw MK, Cretella M, Donovan K. "The Right to Best Care for Children Does Not Include the Right to Medical Transition". The American Journal of Bioethics. 19(2), Feb 2019.

Side Effects of High Dose Testosterone/ Anabolic Steroid Abuse

<i>Symptoms</i>
Irritability
Aggressiveness
Euphoria
Grandiose Beliefs
Hyperactivity
Reckless or Dangerous Behavior

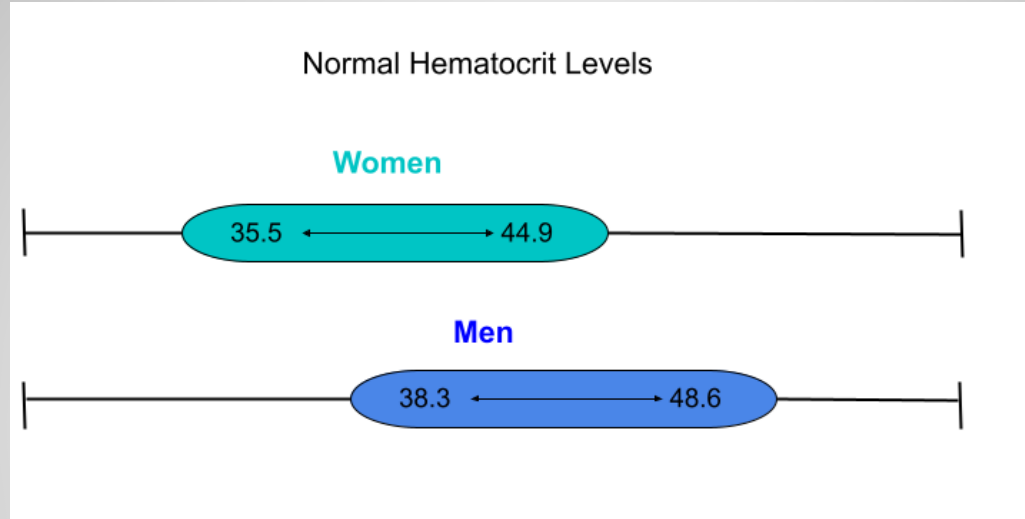
- **Psychiatric symptoms become more common and severe as the dose increases**

Studies have shown:

- **23% of subjects using high doses of steroids met DSM criteria for a major mood syndrome (mania, hypomania, and major depression)**
- **3.4-12% developed psychotic symptoms**

Hall Ryan CW, Hall Richard CW, Chapman MJ. "Psychiatric Complications of Anabolic Steroid Abuse". Psychosomatics 46:4, July-August 2005. Michael K. Laidlaw, MD. 28 Oct 2022

Laboratory Reference Ranges



Q. If a woman has a normal hematocrit of 36, but then identifies as a male (male gender identity), does she at that point become anemic because she has switched over to the reference range for males?

A. No, she does not become anemic. The gender identity is a psychological concept that has no direct bearing on human physiology. Conversely, an increase of hematocrit to 46, if she goes on to take testosterone, is consistent with erythrocytosis. <http://www.gendersanity.org/>

Surgical Conversion Therapy - Mastectomy

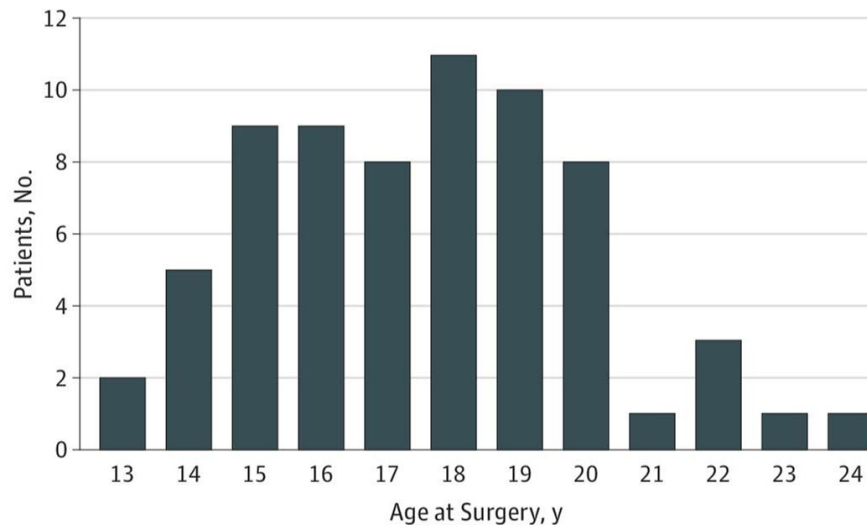


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"transgender man Jackson-Pratt drains after keyhole mastectomy"
author: Intellec7. File:Post-operative Jackson-Pratt Drains.JPGan with Jack

Mastectomy of Healthy Female Breasts for GD

Figure. Age at Chest Surgery in the Postsurgical Cohort



Graph includes all study participants who had undergone chest reconstruction (n = 68).

Surgeries occurring on girls as young as 13.

Age - num girls
13 yo - 2
14 yo - 5
15 yo - 9
16 yo - 9
17 yo - 8

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Surgical Conversion Therapy

Because of very small penis size due to puberty blockers, a segment of large bowel is used to extend the pseudo-vaginal cavity.

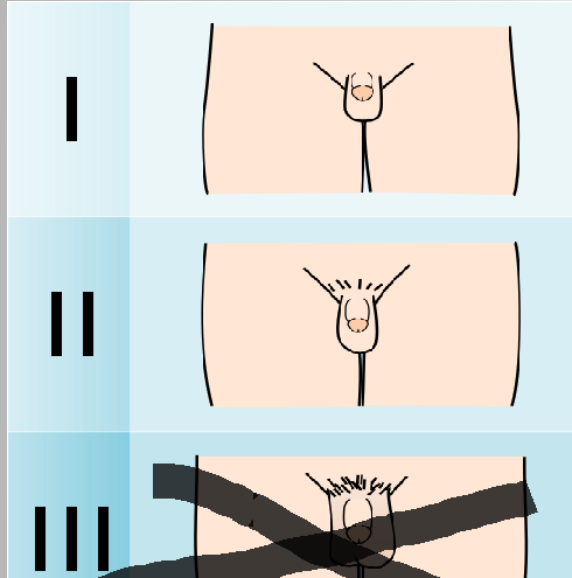
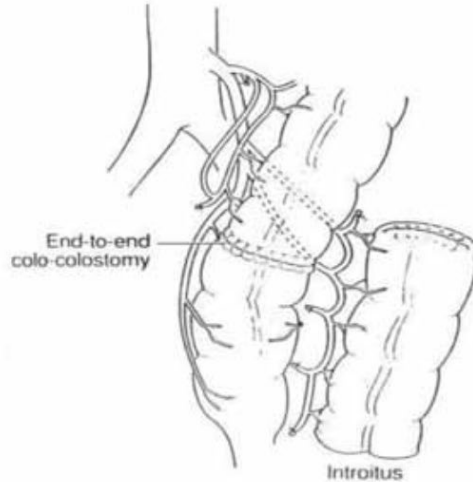


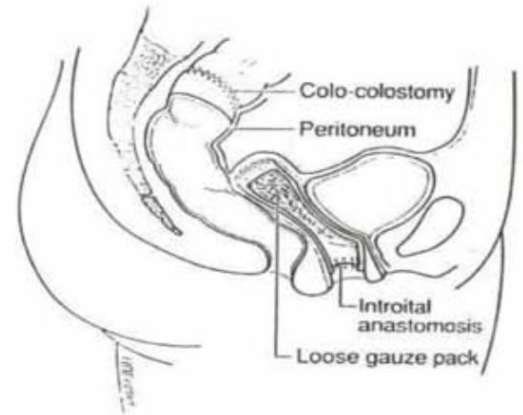
Figure 2 A and B - (A) Colocolostomy has been completed and the distal end of the colonic segment has been anastomosed to the opened rudimentary vaginal pit, (B): The peritoneum was closed above the transposed bowel and the neovagina was loosely packed with Vaseline gauze.

A

INTESTINAL VAGINOPLASTY



B



Surgical Conversion Therapy

Phalloplasty

A recent systematic review and meta-analysis of 1731 patients who underwent phalloplasty found very high rates of complications (76.5%) including a urethral fistula rate of 34.1% and urethral stricture rate of 25.4%.

Wang AMQ, Tsang V, Mankowski P, Demsey D, Kavanagh A, Genoway K. Outcomes Following Gender Affirming Phalloplasty: A Systematic Review and Meta-Analysis. Sex Med Rev. 2022 Aug 25:S2050-0521(22)00012-9. doi: 10.1016/j.sxmr.2022.03.002. E

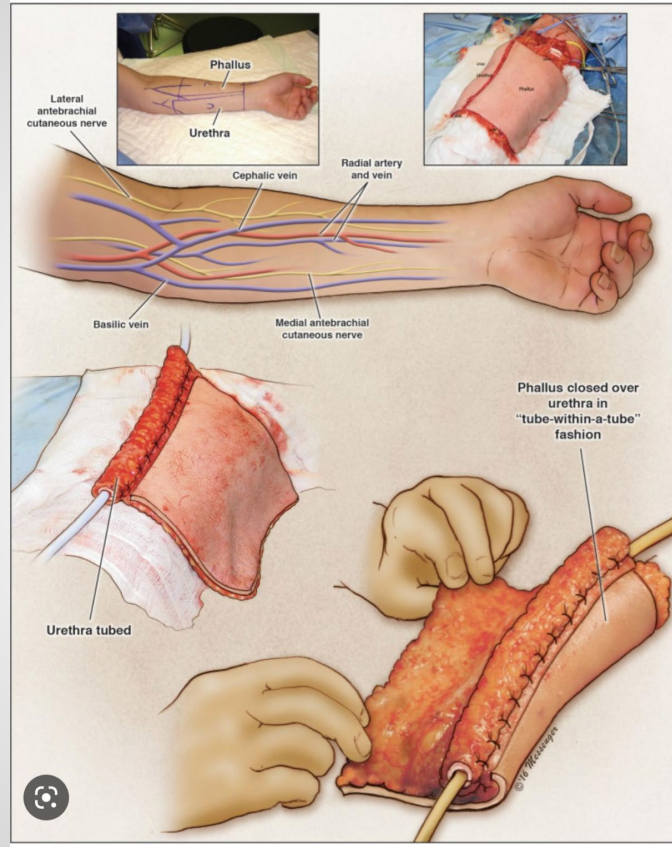


Image: Giulio Garaffa, David J. Ralph. Free Flap Phalloplasty For Female To Male Gender Dysphoria. The Journal of Sexual Medicine. Volume 13, Issue 12, 2016. p.1942-1947. <https://doi.org/10.1016/j.sxm.2016.10.004>.

Endocrine Society Gender Guidelines 2017

High Level of Conflict of Interest

CLINICAL PRACTICE GUIDELINE

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: **An Endocrine Society* Clinical Practice Guideline**

Wylie C. Hembree,¹ Peggy T. Cohen-Kettenis,² Louis Gooren,³ Sabine E. Hannema,⁴ Walter J. Meyer,⁵ M. Hassan Murad,⁶ Stephen M. Rosenthal,⁷ Joshua D. Safer,⁸ Vin Tangpricha,⁹ and Guy G. T'Sjoen¹⁰

Authors highlighted with WPATH relationship

-MKL

¹New York Presbyterian Hospital, Columbia University Medical Center, New York, New York 10032 (Retired); ²VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); ³VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); ⁴Leiden University Medical Center, 2300 RC Leiden, Netherlands; ⁵University of Texas Medical Branch, Galveston, Texas 77555; ⁶Mayo Clinic Evidence-Based Practice Center, Rochester, Minnesota 55905; ⁷University of California San Francisco, Benioff Children's Hospital, San Francisco, California 94143; ⁸Boston University School of Medicine, Boston, Massachusetts 02118; ⁹Emory University School of Medicine and the Atlanta VA Medical Center, Atlanta, Georgia 30322; and ¹⁰Ghent University Hospital, 9000 Ghent, Belgium

***Cosponsoring Associations:** American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and **World Professional Association for Transgender Health.**

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Endocrine Society Gender Guidelines 2017 - COI

Authors

- 9/10 WPATH members or worked on WPATH's scientific committee
- 7/9 WPATH leadership
- Only 1 with no known WPATH affiliation

Authors' WPATH role

Wylie Hembree - On scientific committee for WPATH 2009 XXI Biennial symposium

Peggy Cohen-Kettenis - WPATH Board of Directors 1995-1999

Louis Gooren - WPATH Board of Directors 1999-2003

Sabine E. Hannema - WPATH member

Walter J. Meyer - WPATH President 2003-2005

M. Hassan Murad - not found as WPATH member

Stephen M. Rosenthal - WPATH Board of Directors - (Members-at-large) 2020-2024

Joshua D. Safer - serves on WPATH's global education initiative committee and on WPATH's standards of care revision committee

Vin Tangpricha - WPATH president elect 2017, standards of care revision committee

Guy G. T'Sjoen - WPATH Board of Directors - (Members-at-large) EPATH representative 2020-2022

Endocrine Society Gender Guidelines 2017

Disclaimer: The Endocrine Society's clinical practice guidelines are developed to be of assistance to endocrinologists by providing guidance and recommendations for particular areas of practice. The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgement of healthcare providers and each patient's individual circumstances.

p. 3895

Not Standard of Care!!

Endocrine Society Guidelines 2017

2.0 Treatment of adolescents

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕○○)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 ⊕⊕○○)
- 2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕⊕○○)
- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has

confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 ⊕⊕○○).

- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 ⊕⊕○○)

recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase “we recommend” and the number 1, and weak recommendations use the phrase “we suggest” and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕○○○ denotes very low-quality evidence; ⊕⊕○○, low quality; ⊕⊕⊕○, moderate quality; and ⊕⊕⊕⊕, high quality. The task

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All of the guidelines for adolescents are low, very low quality or absent evidence.

WPATH SOC 8

- **In a correction to the SOC 8, all guidelines for minimum age of surgery were removed,** meaning a minor of any age could be referred for any of following GAT surgeries:
 - – Chest masculinization: had been 15 years old
 - – Breast augmentation, Facial Surgery: had been 16 years old
 - – Metoidioplasty, Orchiectomy, Vaginoplasty, Hysterectomy, Fronto-orbital remodeling: had been 17 years old
 - – Phalloplasty: had been 18 years old (WPATH SOC 8 Correction, p. S261).
- **All guidelines for minimum age of opposite sex hormones were also removed.**
- **The minimum age recommendations were retracted, it appears, *in contradiction to the recommendation of their own expert consensus*:** "On page S66, the following text was removed: 'Age recommendations for irreversible surgical procedures were determined by a review of existing literature and the expert consensus of mental health providers, medical providers, and surgeons highly experienced in providing care to TGD adolescents.'" (WPATH SOC 8 Correction, p. S260)

WPATH SOC 8 Correction, International Journal of Transgender Health, 23:sup1, S259- S261,
DOI: 10.1080/26895269.2022.2125695

WPATH SOC 8

- **The SOC8 used an aberrant form of the GRADE approach for systematic reviews that removed the grading of quality of evidence** (which should be categorized as very low, low, moderate, and high quality). Instead any recommendation of "recommend" is automatically assigned as high quality of evidence. (Coleman et. al, 2022, p. S250)
- **SOC 8 also failed to provide evidence profile tables which should include “an explicit judgment of each factor that determines the quality of evidence for each outcome”** (Guyatt et al., 2021).
- **A chapter regarding eunuchs was inserted into SOC 8 that gives recommendations for how to induce hypogonadism in men who have the eunuch "gender identity" by either orchiectomy [testicle removal] or chemical castration such as with GnRH analogues** (Coleman et al., 2022, p. S88).
- **WPATH SOC 8 is an extreme document and presents a grave danger to minors.**

Coleman E, et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8". International Journal of Transgender Health. 06 Sep 2022. International Journal of Transgender Health.

<https://doi.org/10.1080/26895269.2022.2100644>.

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Gender Dysphoria

How can these kids be helped?

- Investigate autism, depression, anxiety, bipolar disorder, physical or sexual abuse, self harm. Family problems - marital dissolution, interfamily conflict
- Identify and Properly Treat psychological comorbidities
- Individual Counseling
- Family Counseling

Child/Adolescent Affirmative Therapy

- This is not standard of care.
- We do not have the technology to make a male become a female, or a female become a male
- We do not know the long term outcomes of these medical/surgical interventions. No long term studies to assess the degree of harm in this age group.
- Medications are being used off-label and at high doses without proper FDA risk assessment profiles.
- The quality of evidence in the Endocrine Society's own guidelines for children and adolescents is low to very low quality or absent.
- WPATH SOC 8 is an extreme document and presents a grave danger to minors.
- Desisters have been ignored.

**Medical Dangers of Gender Affirmative Therapy:
What is known and unknown**

Thank You for Viewing.

**Michael K. Laidlaw, MD
Endocrinologist. Rocklin, CA**

Medical Dangers of Gender Affirmative Therapy: What is known and unknown

**Michael K. Laidlaw, MD
Endocrinologist. Rocklin, CA**

September 24, 2022

Introduction

- Because of the inherent risks and unknowns, several nations of the world are turning away from gender affirmative therapy for children and adolescents.
- These nations include the UK, Sweden, and Finland.
- On July 28, the UK's NHS announced that the Tavistock Gender Identity Development Service would be closed. Regional Clinics would handle cases.
- Why?
- The following should help provide answers.

[NHS to close Tavistock child gender identity clinic - BBC News](https://www.bbc.com/news/uk-62335665)

<https://www.bbc.com/news/uk-62335665>

Overview

- Objective reality vs. Subjective Feelings
- Definitions
- Identifying Sex
- Normal Sexual Development
- Gender Dysphoria
- Gender Affirmative Therapy
- Dangers of Hormones and Surgeries
- Nations question gender affirmative therapy (GAT)
- Assessment of the gender dysphoric child/adolescent

What does all of this hinge upon?

Objective Biology vs Subjective Feelings

“ 20. Gender identity—a person’s core internal sense of their own gender—is the *primary factor* in determining a person’s sex.”*

*Drew Adams vs. The School Board of St John’s Florida. First Amended Complaint. 9/7/2017

This is incorrect! What a person feels inside does not change the material reality of their sex.

Q. Can one defy the laws of physics* by their internal sense of self?

A. No.



*or biology?

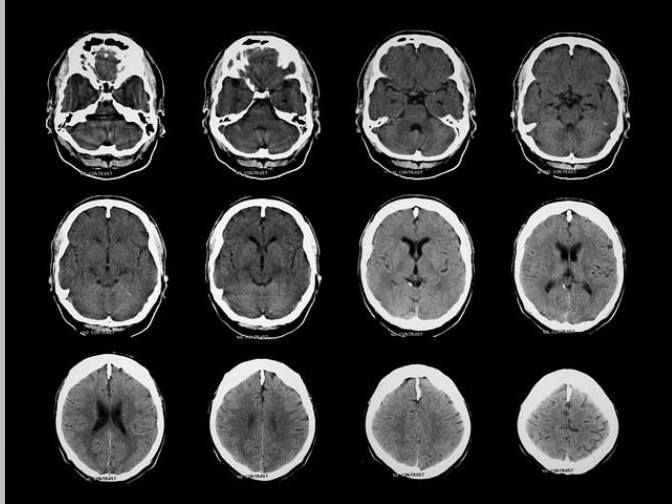
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Where do I find the gender identity?



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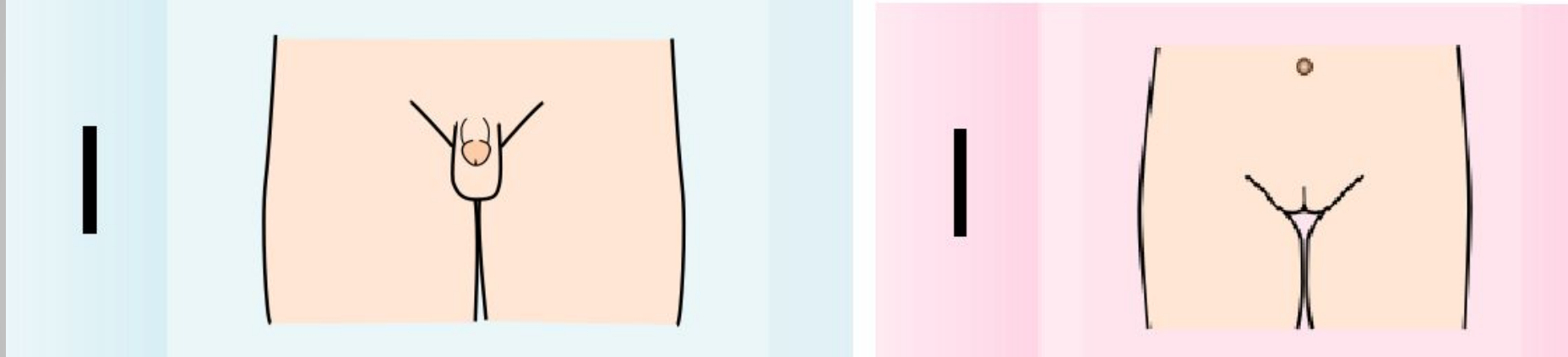
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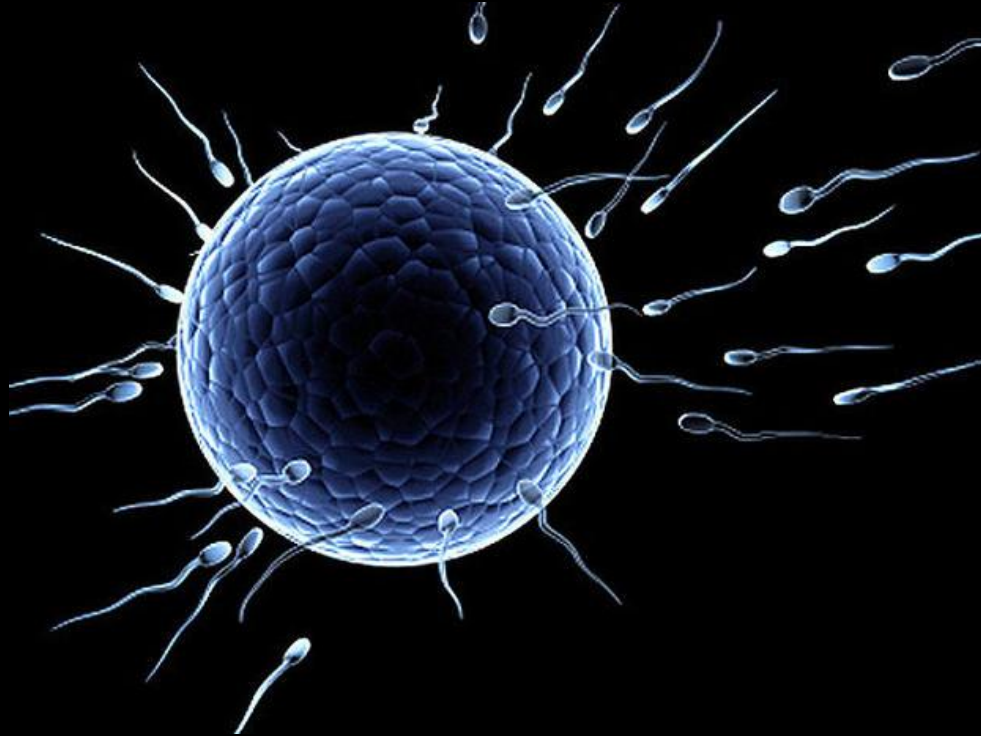
Our criticisms of gender affirmative therapy for minors was first published in 2018.

Sex is Identified* at Birth



*Sex is NOT assigned at Birth

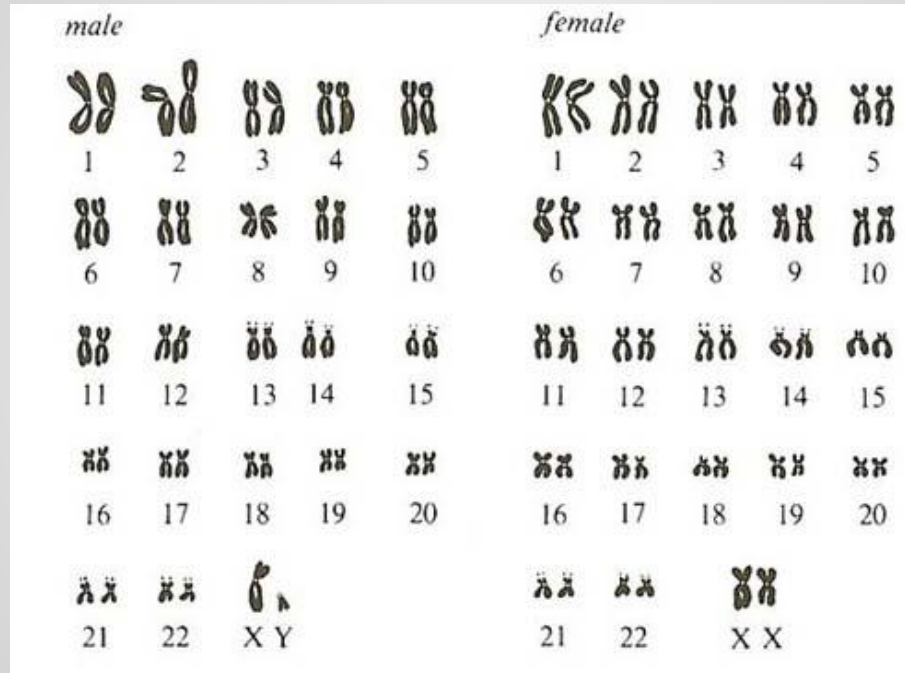
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Chromosomal Determination of Sex



Normal Development

Stages of human fetal development



Week 5



Week 6



Week 7



Week 8



Week 9



Week 10



Week 12

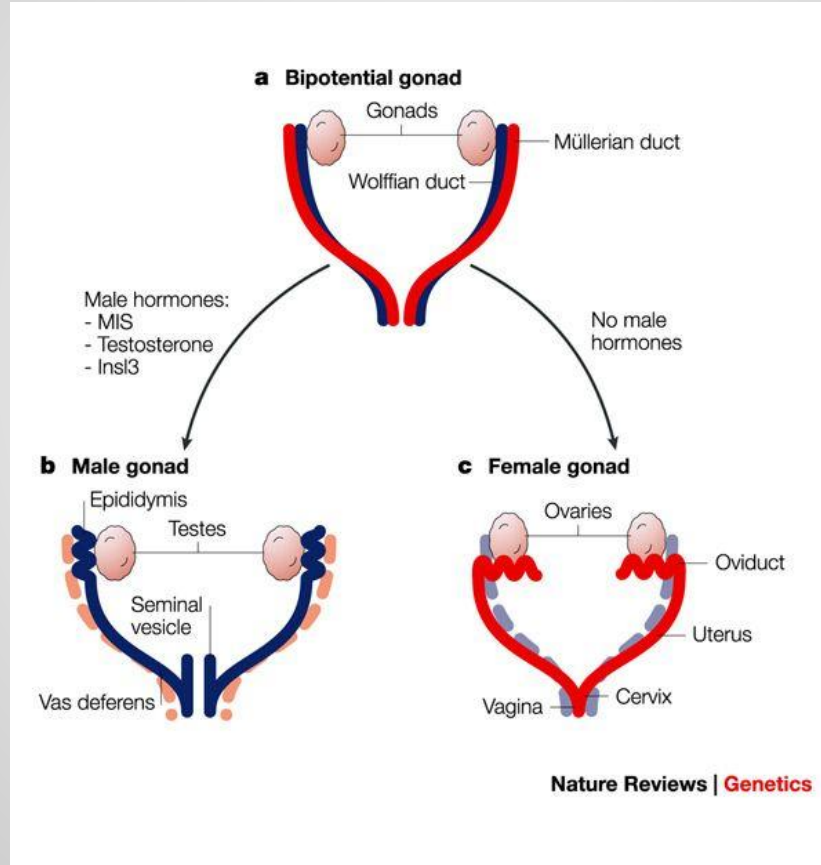


Week 21



Week 33

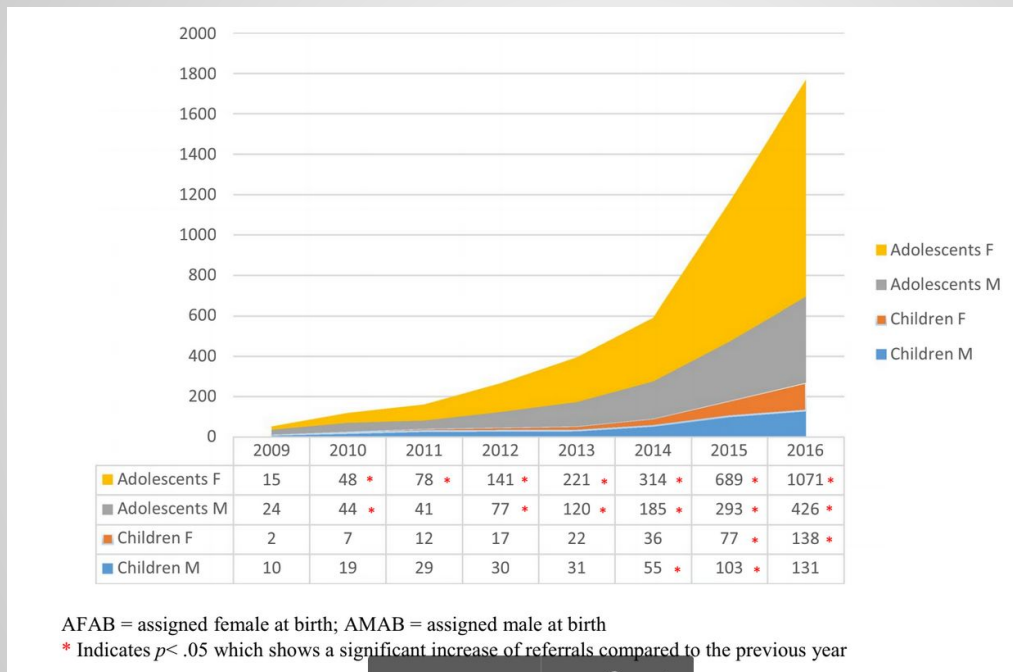
Permanent Sexual Developmental Differentiation



Sexual organ differentiation occurs between gestational weeks 8-12. There is a bifurcation in the pathway for males and females. Unique structures are created for each. The unused ductal system is obliterated. A person cannot change from one path to the other.

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Gender Dysphoria: Increase in Referrals GIDS UK, Change from predominantly male to female



Nastasja M. de Graaf¹, Guido Giovanardi¹, Claudia Zitz¹, Polly Carmichael. Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016). Archives of Sexual Behavior. Apr 2018.

Psychological Comorbidities and Preexisting Conditions

- In a study of the Finnish gender identity service, “75% of adolescents [assessed] had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria” (Kaltiala-Heino, 2015).
- In fact, “68% had their first contact with psychiatric services due to other reasons than gender identity issues.” The same study also showed that 26% percent had an autistic spectrum disorder and that a disproportionate number of females (87%) were presenting to the gender clinics compared to the past”. (Kaltiala-Heino, 2015).

Kaltiala-Heino R, Sumia M, Työläjäarvi M, Lindberg N. “Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development”. Child and Adolescent Psychiatry and Mental Health (2015) 9:9.

Social Contagion, Internet Use, Neurodevelopmental Disorders



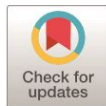
RESEARCH ARTICLE

Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports

Lisa Littman*

Department of Behavioral and Social Sciences, Brown University School of Public Health, Providence, Rhode Island, United States of America

* Lisa_Littman@brown.edu



Abstract

Purpose

In on-line forums, parents have been reporting that their children are experiencing what is described here as “rapid-onset gender dysphoria,” appearing for the first time during puberty or even after its completion. The onset of gender dysphoria seemed to occur in the context of belonging to a peer group where one, multiple, or even all of the friends have become gender dysphoric and transgender-identified during the same timeframe. Parents also report that their children exhibited an increase in social media/internet use prior to disclosure of a transgender identity. The purpose of this study was to document and explore these observations and describe the resulting presentation of gender dysphoria, which is inconsis-

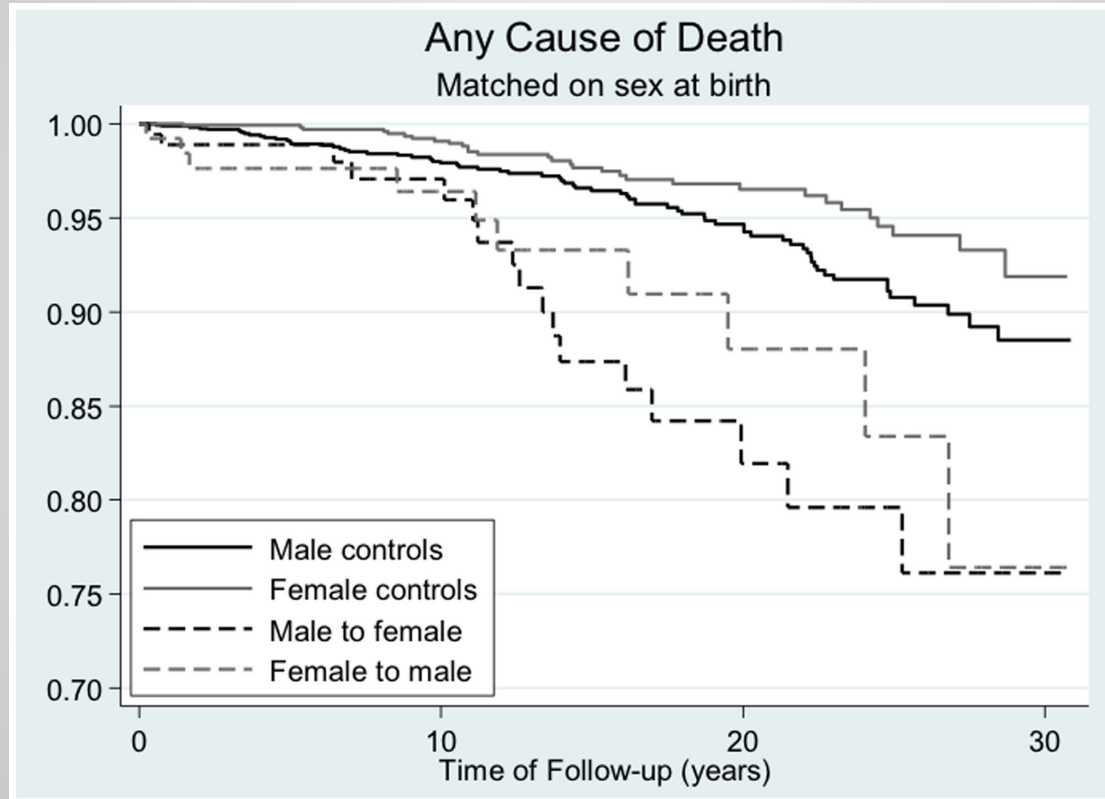
OPEN ACCESS

Citation: Littman L (2018) Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. PLoS ONE 13(8): e0202330. <https://doi.org/10.1371/journal.pone.0202330>

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24 Sep 2022

Long Term Mortality

Cross Sex Hormones and Surgery



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Sep 2022

1. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. PLoS One. 2011;6(2):e16885.

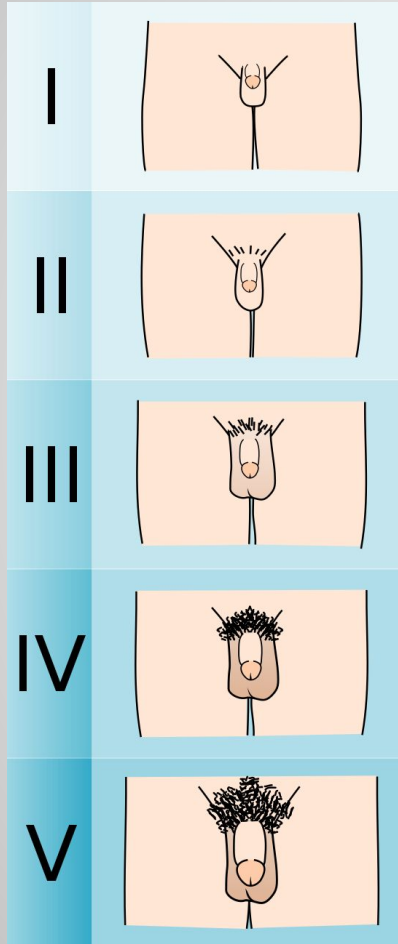
Gender Affirmative Therapy

- Social Transition
- Puberty Blockers
- Cross Sex Hormones
- Surgical Modifications

Puberty - Tanner Stages

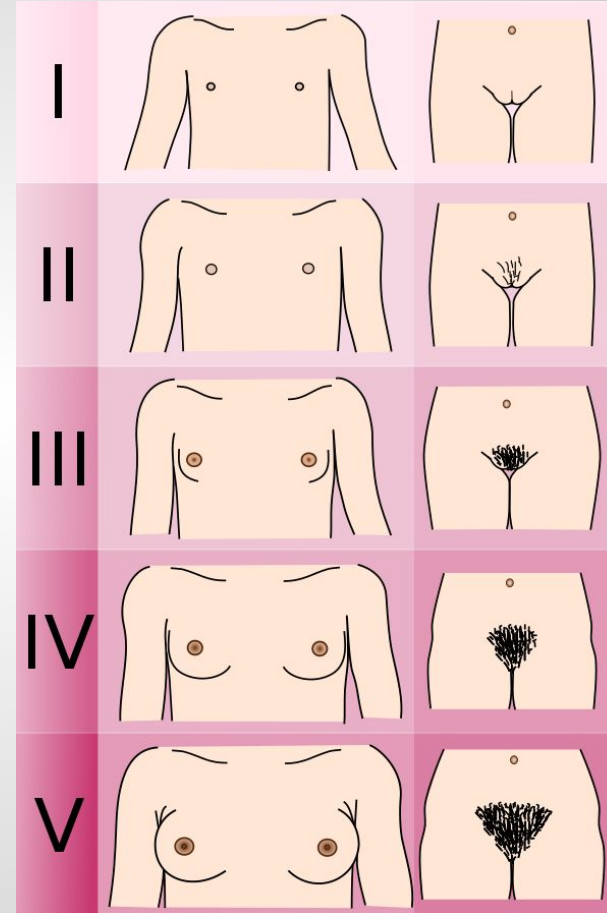
Male

M•Komorniczak,
polish wikipedist.
"Tanner
scale-male.svg"



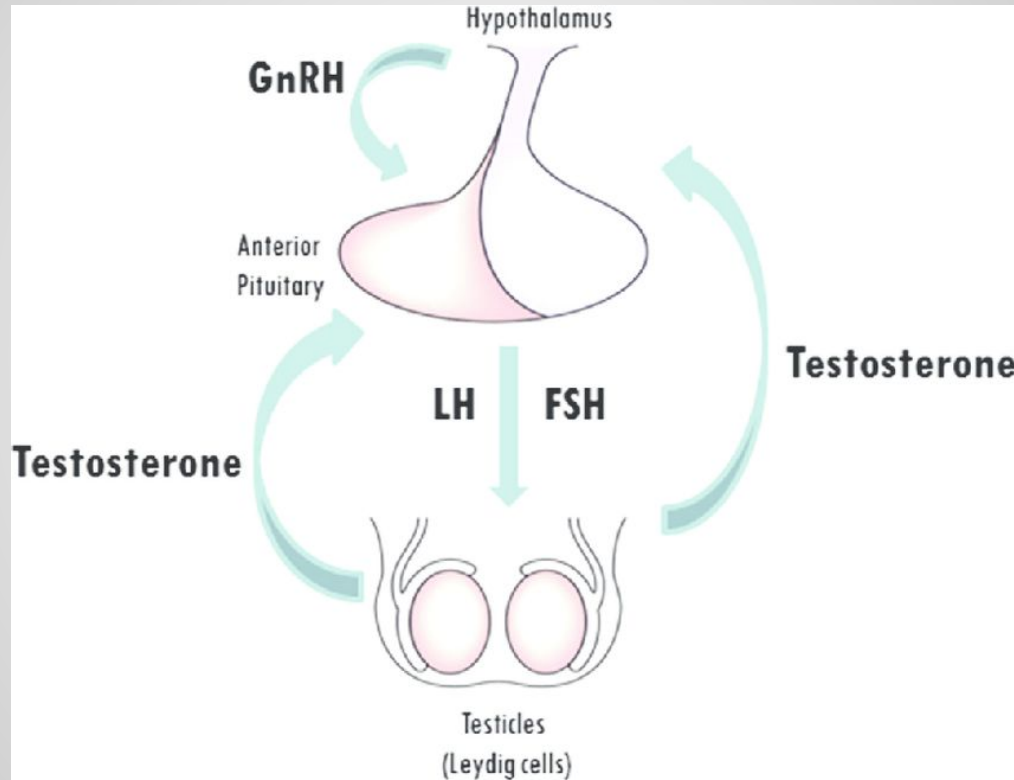
Female

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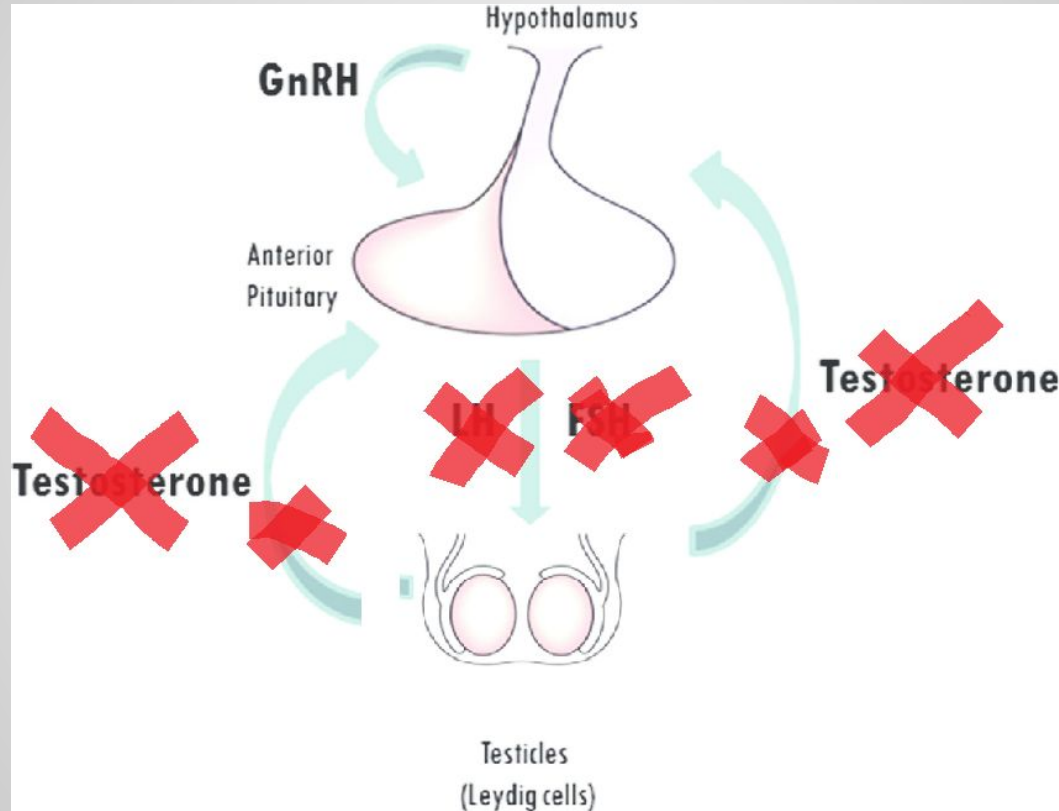
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Normal Pituitary Gonadal Function

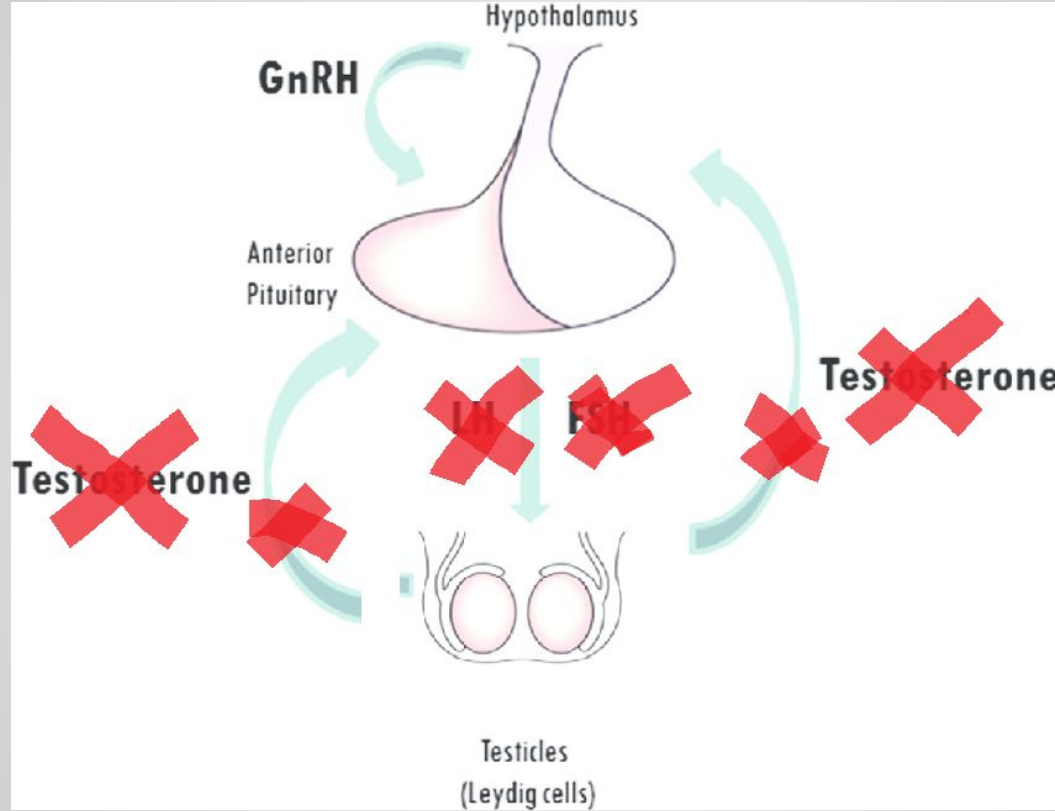


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Hypogonadotropic Hypogonadism

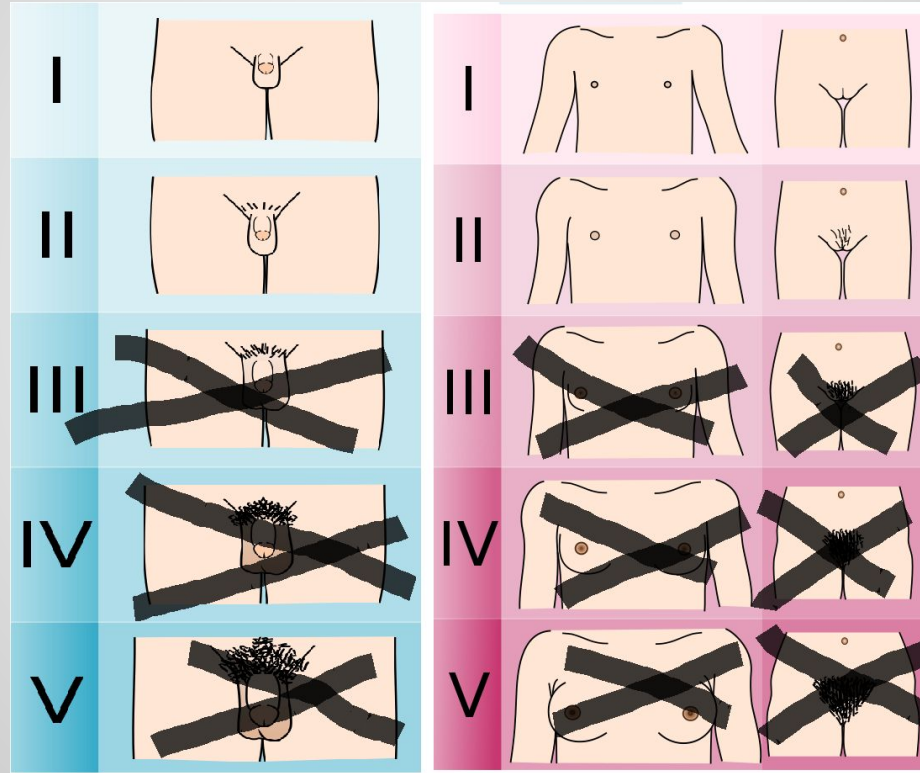


Hypogonadotropic Hypogonadism - Iatrogenic*



*Caused by GnRH analogues such as Lupron

Effects of Puberty Blockers



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How Young? Puberty Blockers as early as “age 8 or 9”



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Ilana Sherer, MD of UCSF at “Professional Session” of Gender Spectrum child transing organization.

Side Effects of Blockade of Normal Puberty

<i>Male</i>	<i>Female</i>
Stunting of penile and testicular growth	Menopause like state
	Blockade of normal breast development
Sexual dysfunction: Impairment of erection, orgasm, ejaculation	Decreased blood flow to vagina and vulva
	Sexual dysfunction: Thinning of vaginal epithelium, vaginal atrophy, anorgasmia
Prevention of spermatogenesis - infertility	Prevention of menses/ovulation - infertility
Disruption of normal brain development	Disruption of normal brain development
Disruption of normal bone development/strength	Disruption of normal bone development/strength

Neuropsychological Effects of Puberty Blockers

Emotional lability, mood changes, headaches*

Nervousness, anxiety, agitation, confusion, delusions, insomnia, depression*

“Monitor for development or worsening of psychiatric symptoms. Use with caution in patients with a history of psychiatric illness.” *

*Lupron Depot-Ped. Highlights of Prescribing Information. AbbVie Inc. Accessed May 1, 2022.

<https://www.rxabbvie.com/pdf/lupronpediatric.pdf>

Tavistock and Portman GIDS UK**

No statistically significant difference in psychosocial functioning in blockers vs support

Children reported greater self harm

Girls exhibited more behavioral and emotional problems, greater dissatisfaction with body

**Michael Biggs. "Tavistock's Experimentation with Puberty Blockers: Scrutinizing the Evidence". Transgender Trend. March 2, 2019

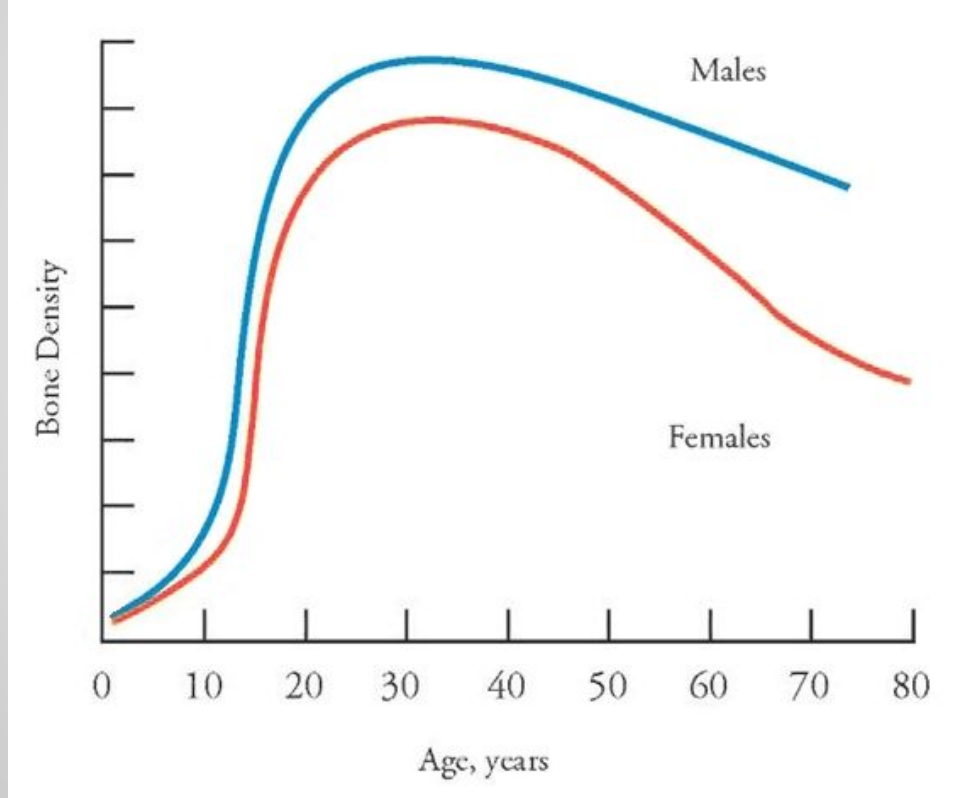
Puberty Blockers - Pathway to Sterilization

- In a Dutch study that included seventy adolescents who took puberty blockers, all seventy decided to go on to hormones of the opposite sex (de Vries, et al. 2011).
- In a follow-up study, the overwhelming majority went on to have sex reassignment surgery by either vaginoplasty for males or hysterectomy with ovariectomy for females (de Vries, et al. 2014).
- These surgeries resulted in sterilization. This is why puberty blockers, rather than being a “pause” to consider aspects of mental health, are instead a pathway towards future sterilizing surgeries.

de Vries AL, Steensma T, Doreleijers TA, Cohen-Kettenis PT. “Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study”. J Sex Med. 2011 Aug;8(8):2276-83.

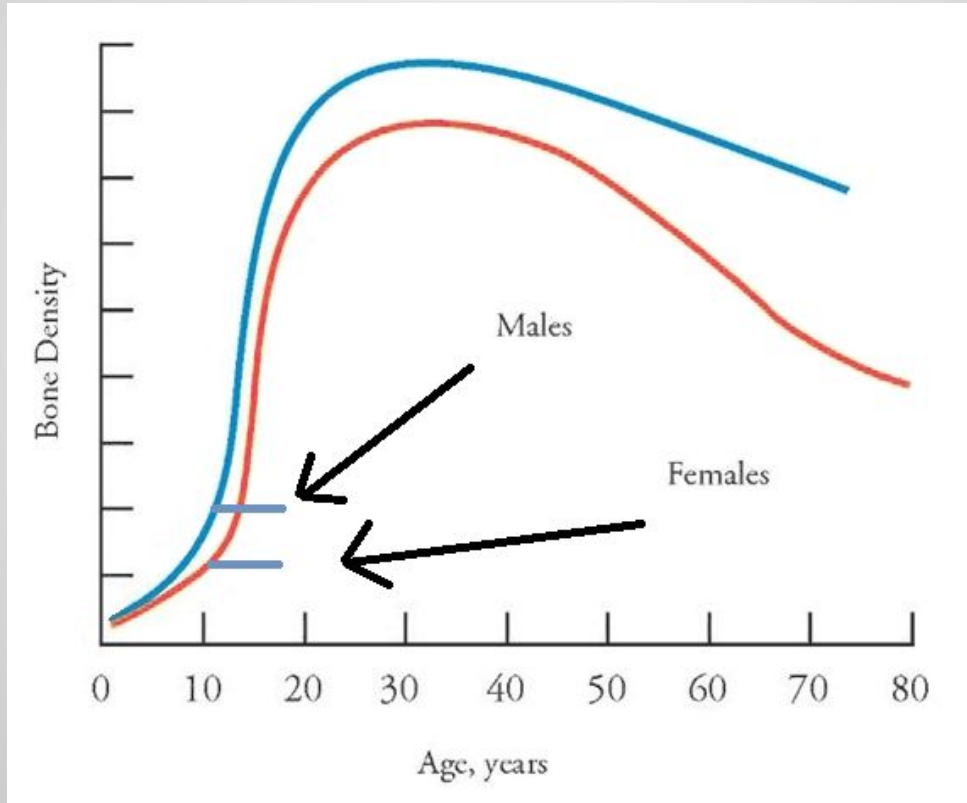
de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. “Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment”. Pediatrics (2014) 134 (4): 696–704.

Normal Increase in Bone Density During Adolescence



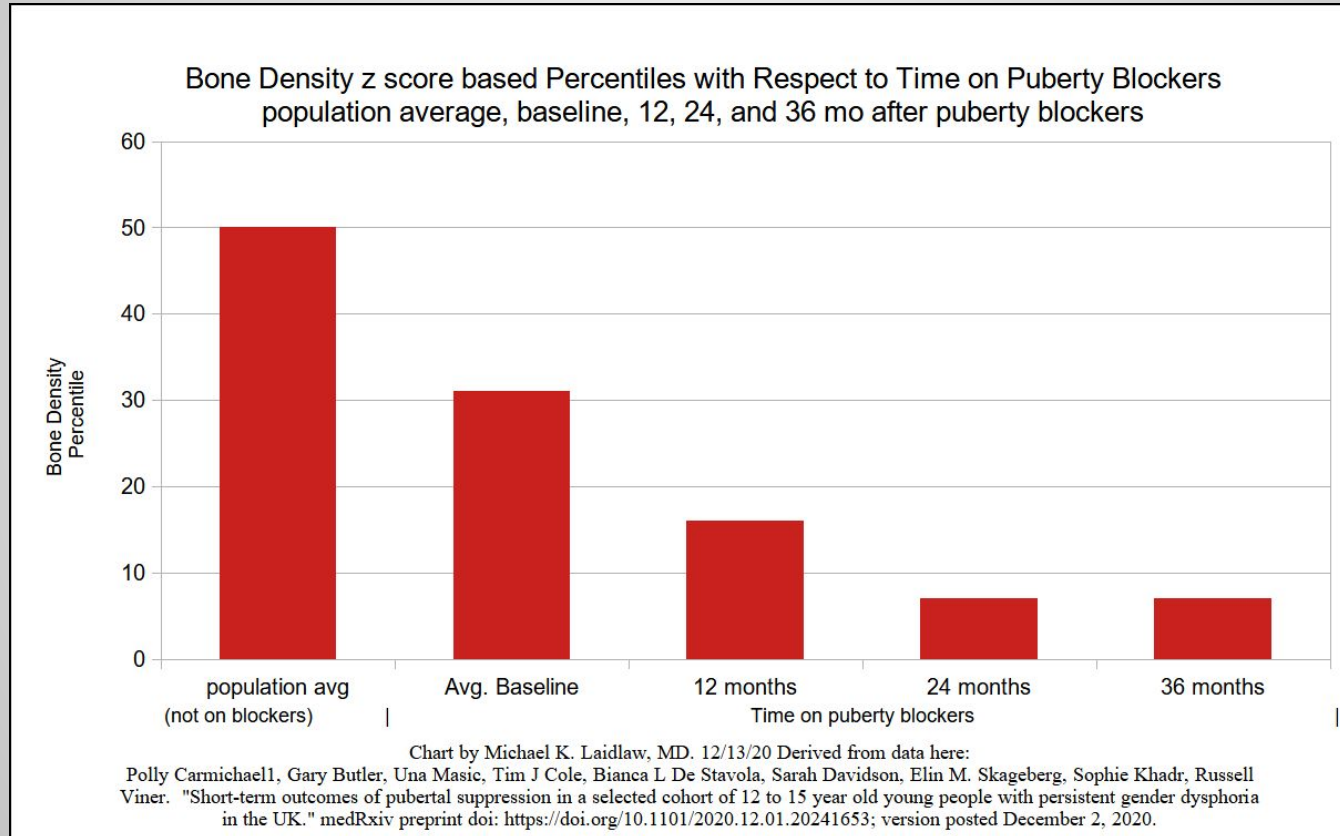
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Flatline in Bone Density Accrual with GnRH analogues



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Interference with normal bone development



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Side Effects of Cross Sex Hormones

<i>Males on Estrogen</i>	<i>Females on testosterone</i>
increased risk of myocardial infarction and death due to cardiovascular disease*	increased risk of myocardial infarction and death due to cardiovascular disease*
Thromboembolism 5X Increased risk *	Erythrocytosis**
Gallstones**	Severe liver dysfunction**
Hypertriglyceridemia**	Hypertension**
Breast Cancer risk increased 46 X***	Breast, uterine, ovarian cancer risk **
Gynecomastia**	Hirsutism, deepening of the voice**
Sexual dsyfunction, infertility****	Sexual dsyfunction, infertility****

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*Irwig MS. "Cardiovascular health in transgender people." Rev Endocr Metab Disord. 2018;19(3):243–251. **Hembree WC, et al., "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," The Journal of Clinical Endocrinology & Metabolism, Volume 102, Issue 11 (Nov. 1, 2017). ***Christel J M de Blok, et al. "Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands" BMJ 2019; 365. (Published 14 May 2019). Laidlaw MK, Cretella M, Donovan K. "The Right to Best Care for Children Does Not Include the Right to Medical Transition". The American Journal of Bioethics. 19(2), Feb 2019.

Cross Sex Hormones - Testosterone

6-100X higher than endogenous female levels

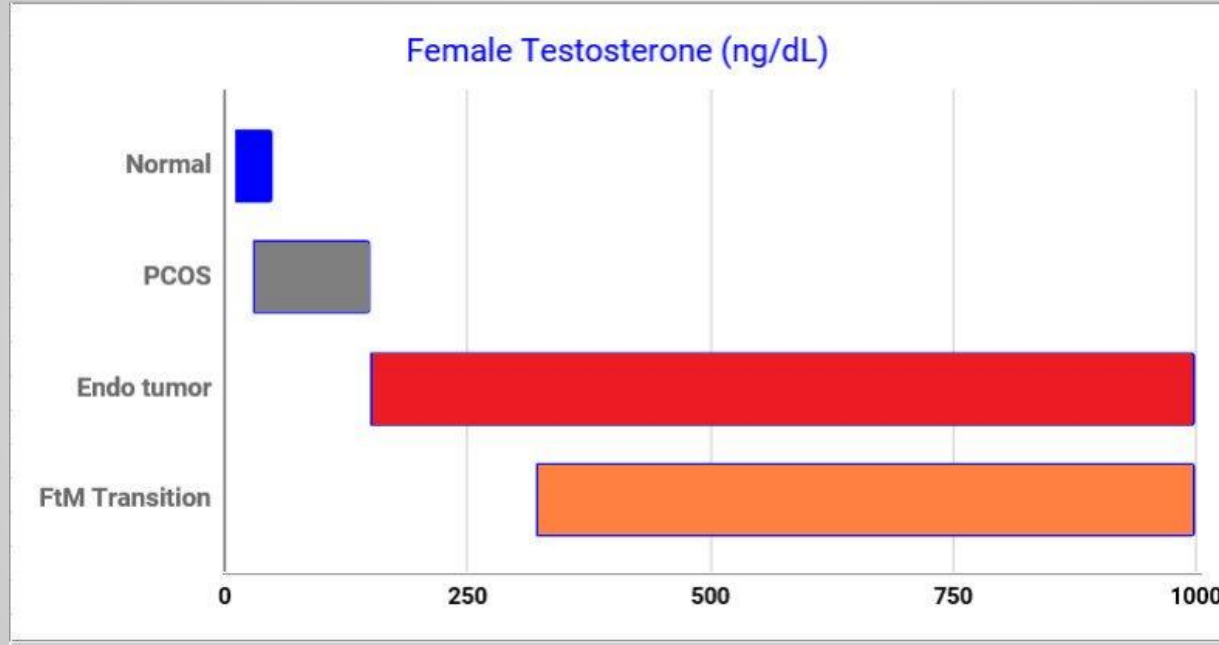


Image by Michael K Laidlaw, MD. Approximate total testosterone in ng/dL based on laboratory, etc. FtM transition from 2017 Endo Society Guidelines on Gender Dysphoria. With PCOS testosterone levels may be as high as 150. With endocrine tumors testosterone may be in the 150-1000 range. The recommendations of the Endocrine Society/WPATH are to bring levels into the 300-1000 range which is 6-100 times higher than normal endogenous adult female levels.

Testosterone - Controlled substance. Abuse Risk.

- Testosterone is an anabolic steroid of high potency.
- It is classified as a Schedule 3 controlled substance by the DEA: "Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence" (DEA, 2022).
- A licensed physician with a valid DEA registration is required to prescribe testosterone.
- "Testosterone has been subject to abuse, typically at doses higher than recommended for the approved indication" (Actavis Pharma, 2018)
- "Anabolic androgenic steroid abuse can lead to serious cardiovascular and psychiatric adverse reactions." *Id.*
- "Abuse and misuse of testosterone are seen in male and female adults and adolescents." *Id.*

DEA. Diversion Control Division. Controlled Substance Schedules. Accessed May 1, 2022. <https://www.deadiversion.usdoj.gov/schedules/>

Actavis Pharma, Inc. Testosterone Cypionate injection. Actavis Pharma, Inc., 2018. Accessed May 8, 2022 via <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d7b57b68-dca6-4df2-b3f2-7017d7b69f17&msclid=4ed2db18cd5411ecba911bd6e4bded62>

Side Effects of High Dose Testosterone/ Anabolic Steroid Abuse

<i>Symptoms</i>
Irritability
Aggressiveness
Euphoria
Grandiose Beliefs
Hyperactivity
Reckless or Dangerous Behavior

- **Psychiatric symptoms become more common and severe as the dose increases**

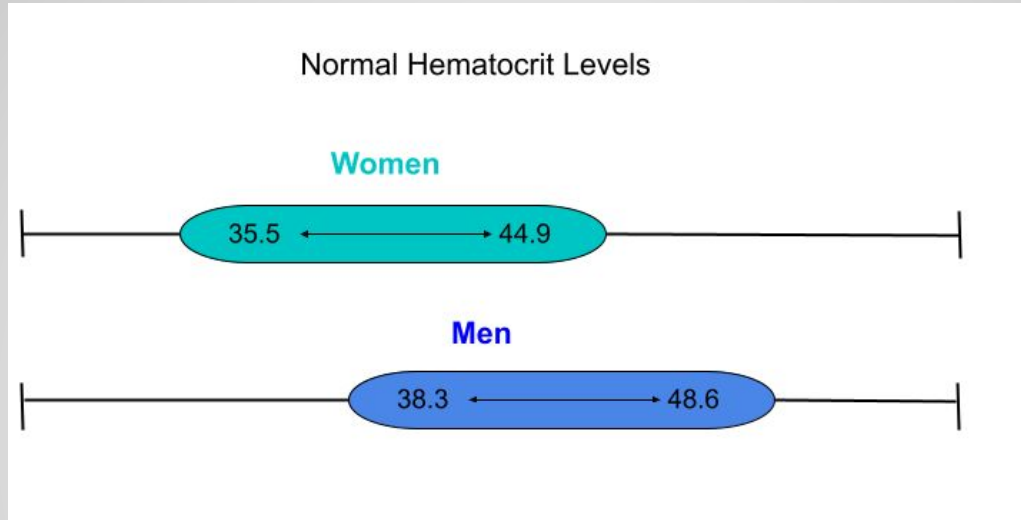
Studies have shown:

- **23% of subjects using high doses of steroids met DSM criteria for a major mood syndrome (mania, hypomania, and major depression)**
- **3.4-12% developed psychotic symptoms**

Hall Ryan CW, Hall Richard CW, Chapman MJ. "Psychiatric Complications of Anabolic Steroid Abuse".
Psychosomatics 46:4, July-August 2005.

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Laboratory Reference Ranges



Q. If a woman has a normal hematocrit of 36, but then identifies as a male (male gender identity), does she at that point become anemic because she has switched over to the reference range for males?


A. No, she does not become anemic. The gender identity is a psychological concept that has no direct bearing on human physiology. Conversely, an increase of hematocrit to 46, if she goes on to take testosterone, is consistent with erythrocytosis. <http://www.gendersanity.org/>

Testosterone - Erythrocytosis and CV Risk

- High dose Testosterone given to females causes erythrocytosis
- Having high red blood cell counts (erythrocytosis) puts females at increased risk of cardiovascular disease, coronary heart disease and death due to both as shown in the landmark [Framingham Study](#).
- Studies of trans males have already shown up to a [nearly five fold increased risk of myocardial](#) infarction compared to females not taking testosterone.*
- In the Framingham study, the younger female group (ages 35-64) at the highest range of hematocrit (above 45) had increased risk of cardiovascular disease, myocardial infarction and death due to both *.

*Alzahrani T, Nguyen T, Ryan A, Dwairy A, McCaffrey J, Yunus R, Forgione J, Krepp J, Nagy C, Mazhari R, Reiner J. Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population. Circ Cardiovasc Qual Outcomes. 2019 Apr;12(4):e005597. doi: 10.1161/CIRCOUTCOMES.119.005597. PMID: 30950651.

No FDA Approval of the GAT Medication Use



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Comprehensive Interdisciplinary Medical Services for Transgender, Non-Binary, and Gender-Expansive Transgender Children and Adolescents


Ongoing Research

UCSF has formed a research network consortium with Boston Children's Hospital (Harvard), Lurie Children's Hospital of Chicago (Northwestern University), and Children's Hospital Los Angeles (University of Southern California) -- The Trans Youth Network. We are presently engaged in a research project funded by the National Institutes of Health studying metabolic and quality of life issues for transgender youth undergoing treatment with puberty blockers or cross-sex hormones.


Gathering this data will also be important to encourage insurers to cover medical treatment for gender dysphoria, as **the drugs used do not have FDA approval for treatment of this condition.** In addition to increasing our knowledge, it is hoped that the research findings will impact the future of trans care for children and adolescents. We have applied for a second grant through the National Institute of Health to study prepubertal children exploring their gender, assessing developmental pathways and psychological outcomes.



[Diane Ehrensaft, PhD](#)
Clinical Child & Adolescent Psychology, Mental Health & Child Development



[Herbert Schreier, MD](#)
Child & Adolescent Psychiatry



[Ilana Sherer, MD](#)
Adolescent Medicine

Surgical Conversion Therapy - Mastectomy

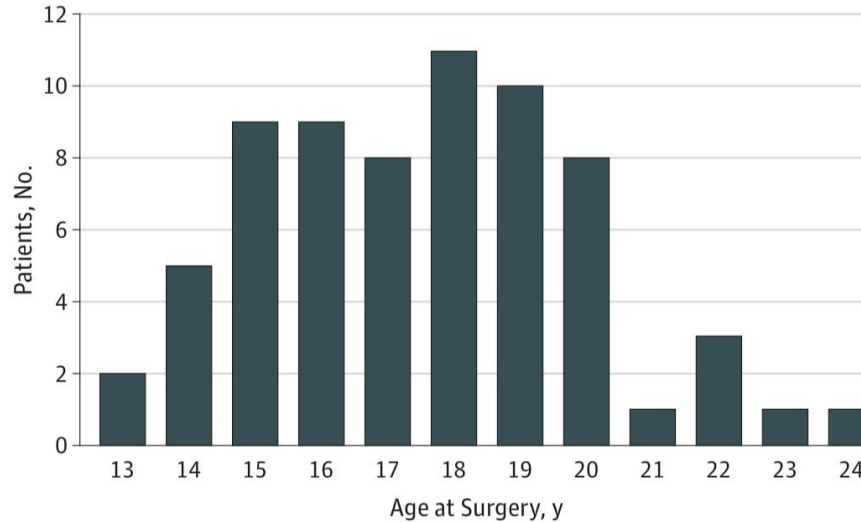


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"transgender man Jackson-Pratt drains after keyhole mastectomy"
author: Intellec7. File:Post-operative Jackson-Pratt Drains.JPGan with Jack

Mastectomy of Healthy Female Breasts for GD

Figure. Age at Chest Surgery in the Postsurgical Cohort



Graph includes all study participants who had undergone chest reconstruction (n = 68).

Surgeries occurring on girls as young as 13.

Age - num girls
13 yo - 2
14 yo - 5
15 yo - 9
16 yo - 9
17 yo - 8

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\$5.7 million dollar NIH Funded Researcher



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WPATH pediatrician/adolescent medicine - Johanna Olson Kennedy at Gender Spectrum. July 6, 2018. Moraga, CA.

\$5.7 million dollar NIH Funded Researcher



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WPATH pediatrician/adolescent medicine - Johanna Olson Kennedy at Gender Spectrum. July 6, 2018. Moraga, CA.

Surgery - Mastectomy

- The surgery results in a permanent loss of the ability to breastfeed and significant scarring of 7 to 10 inches.
- The scars are prone to widening and thickening due to the stresses of breathing and arm movement.
- Other potential complications include the loss of normal nipple sensation and difficulties with wound healing (American Cancer Society, 2022).
- It is important to note that this operation cannot be reversed. The female will never regain healthy breasts capable of producing milk to feed a child (Mayo Clinic, Top Surgery, 2022).

The American Cancer Society medical and editorial team. "Mastectomy". American Cancer Society.
<https://www.cancer.org/cancer/breast-cancer/treatment/surgery-for-breast-cancer/mastectomy.html>
accessed 06/24/22

Mayo Clinic. "Top surgery for transgender men and nonbinary people".
<https://www.mayoclinic.org/tests-procedures/top-surgery-for-transgender-men/about/pac-20469462>
accessed 06/24/2022.

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GAT Surgeries of the Male

- Removal of the testicles alone to permanently lower testosterone levels. This is by nature a sterilizing procedure.
- Further surgeries may be done in an attempt to create a pseudo-vagina which is called vaginoplasty. In this procedure, the penis is surgically opened and the erectile tissue is removed. The skin is then closed and inverted into a newly created cavity in order to simulate a vagina. A dilator must be placed in the new cavity for some time so that it does not naturally close.
- Potential surgical complications may include urethral strictures, infection, prolapse, fistulas and injury to the sensory nerves with partial or complete loss of erotic sensation (Mayo Clinic, Feminizing Surgery, 2022)

Mayo Clinic. “Feminizing Surgery”.

<https://www.mayoclinic.org/tests-procedures/feminizing-surgery/about/pac-20385102>

Accessed 07/01/2022

Surgical Conversion Therapy

Because of very small penis size due to puberty blockers, a segment of large bowel is used to extend the pseudo-vaginal cavity.

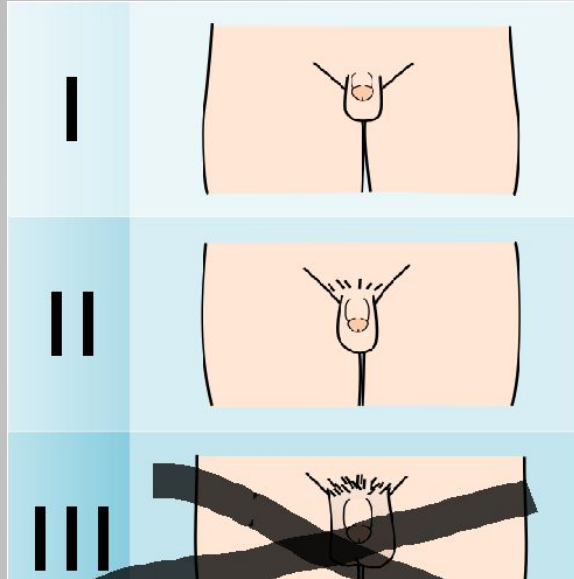
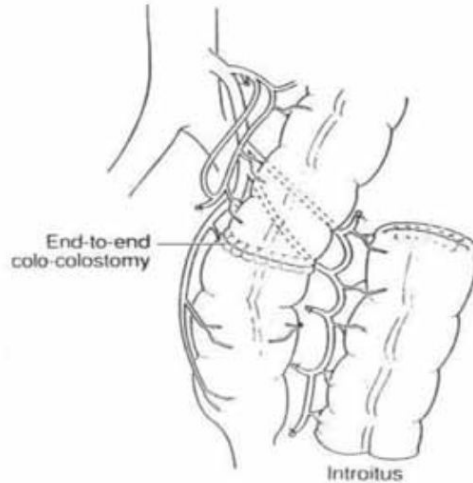


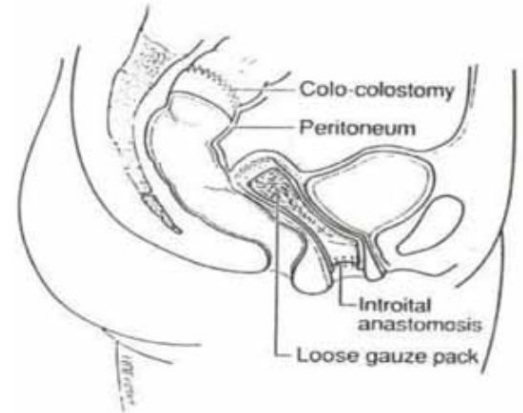
Figure 2 A and B - (A) Colocolostomy has been completed and the distal end of the colonic segment has been anastomosed to the opened rudimentary vaginal pit, (B): The peritoneum was closed above the transposed bowel and the neovagina was loosely packed with Vaseline gauze.

A

INTESTINAL VAGINOPLASTY



B



GAT Surgeries of the Female

- Other types of surgery for females include those of the genitalia and reproductive tract. For example, the ovaries, uterus, fallopian tubes, cervix and the vagina may be surgically removed. Removal of the ovaries results in sterilization.
- Phalloplasty: a roll of skin and subcutaneous tissue is removed from one area of the body, say the thigh or the forearm, and transplanted to the pelvis. Erectile devices such as rods or inflatable devices may be placed within the tube of transplanted tissue in order to simulate erection (Hembree, Endo Guidelines 2017). The labia may also be expanded to create a simulated scrotum containing prosthetic objects to provide the appearance of testicles.
- Complications of phalloplasty may include urinary stricture, problems with blood supply to the transplanted roll of tissue, large scarring to the forearm or thigh, infections including peritonitis, and possible injury to the sensory nerve of the clitoris (Mayo Clinic, Masculinizing Surgery, 2022).

Mayo Clinic. "Masculinizing Surgery".

<https://www.mayoclinic.org/tests-procedures/masculinizing-surgery/about/pac-20385105> accessed 06/24/2022

CMS - Evidence Inconclusive

- The Centers for Medicare and Medicaid Services (“CMS”) has found “inconclusive” clinical evidence regarding gender reassignment surgery.
- Specifically, the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (June 19, 2019) states: “The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population.”

Endocrine Society Gender Guidelines 2017

High Level of Conflict of Interest

CLINICAL PRACTICE GUIDELINE

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,¹ Peggy T. Cohen-Kettenis,² Louis Gooren,³ Sabine E. Hannema,⁴ Walter J. Meyer,⁵ M. Hassan Murad,⁶ Stephen M. Rosenthal,⁷ Joshua D. Safer,⁸ Vin Tangpricha,⁹ and Guy G. T'Sjoen¹⁰

Authors highlighted with WPATH relationship
-MKL

¹New York Presbyterian Hospital, Columbia University Medical Center, New York, New York 10032 (Retired); ²VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); ³VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); ⁴Leiden University Medical Center, 2300 RC Leiden, Netherlands; ⁵University of Texas Medical Branch, Galveston, Texas 77555; ⁶Mayo Clinic Evidence-Based Practice Center, Rochester, Minnesota 55905; ⁷University of California San Francisco, Benioff Children's Hospital, San Francisco, California 94143; ⁸Boston University School of Medicine, Boston, Massachusetts 02118; ⁹Emory University School of Medicine and the Atlanta VA Medical Center, Atlanta, Georgia 30322; and ¹⁰Ghent University Hospital, 9000 Ghent, Belgium

***Cosponsoring Associations:** American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and **World Professional Association for Transgender Health.**

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Endocrine Society Gender Guidelines 2017 - COI

Authors

- 9/10 WPATH members or worked on WPATH's scientific committee
- 7/9 WPATH leadership
- Only 1 with no known WPATH affiliation

Authors' WPATH role

Wylie Hembree - On scientific committee for WPATH 2009 XXI Biennial symposium

Peggy Cohen-Kettenis - WPATH Board of Directors 1995-1999

Louis Gooren - WPATH Board of Directors 1999-2003

Sabine E. Hannema - WPATH member

Walter J. Meyer - WPATH President 2003-2005

M. Hassan Murad - not found as WPATH member

Stephen M. Rosenthal - WPATH Board of Directors - (Members-at-large) 2020-2024

Joshua D. Safer - serves on WPATH's global education initiative committee and on WPATH's standards of care revision committee

Vin Tangpricha - WPATH president elect 2017, standards of care revision committee

Guy G. T'Sjoen - WPATH Board of Directors - (Members-at-large) EPATH representative 2020-2022

Endocrine Society Gender Guidelines 2017

Disclaimer: The Endocrine Society's clinical practice guidelines are developed to be of assistance to endocrinologists by providing guidance and recommendations for particular areas of practice. The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgement of healthcare providers and each patient's individual circumstances.

p. 3895

Not Standard of Care!!

Endocrine Society Guidelines 2017

2.0 Treatment of adolescents

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕○○)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 ⊕⊕○○)
- 2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕⊕○○)
- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has

confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 ⊕⊕○○).

- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 ⊕⊕○○)

mendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase “we recommend” and the number 1, and weak recommendations use the phrase “we suggest” and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕○○○ denotes very low-quality evidence; ⊕⊕○○, low quality; ⊕⊕⊕○, moderate quality; and ⊕⊕⊕⊕, high quality. The task

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All of the guidelines for adolescents are low, very low quality or absent evidence.

WPATH SOC 8

- **In a correction to the SOC 8, all guidelines for minimum age of surgery were removed,** meaning a minor of any age could be referred for any of following GAT surgeries:
 - – Chest masculinization: had been 15 years old
 - – Breast augmentation, Facial Surgery: had been 16 years old
 - – Metoidioplasty, Orchiectomy, Vaginoplasty, Hysterectomy, Fronto-orbital remodeling: had been 17 years old
 - – Phalloplasty: had been 18 years old (WPATH SOC 8 Correction, p. S261).
- **All guidelines for minimum age of opposite sex hormones were also removed.**
- **The minimum age recommendations were retracted,** it appears, ***in contradiction to the recommendation of their own expert consensus***: "On page S66, the following text was removed: 'Age recommendations for irreversible surgical procedures were determined by a review of existing literature and the expert consensus of mental health providers, medical providers, and surgeons highly experienced in providing care to TGD adolescents.'" (WPATH SOC 8 Correction, p. S260)

WPATH SOC 8 Correction, International Journal of Transgender Health, 23:sup1, S259- S261,
DOI: 10.1080/26895269.2022.2125695

WPATH SOC 8

- **The SOC8 used an aberrant form of the GRADE approach for systematic reviews that removed the grading of quality of evidence** (which should be categorized as very low, low, moderate, and high quality). Instead any recommendation of "recommend" is automatically assigned as high quality of evidence. (Coleman et. al, 2022, p. S250)
- **SOC 8 also failed to provide evidence profile tables which should include “an explicit judgment of each factor that determines the quality of evidence for each outcome”** (Guyatt et al., 2021).
- **A chapter regarding eunuchs was inserted into SOC 8 that gives recommendations for how to induce hypogonadism in men who have the eunuch "gender identity" by either orchiectomy [testicle removal] or chemical castration such as with GnRH analogues** (Coleman et al., 2022, p. S88).

Coleman E, et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8". International Journal of Transgender Health. 06 Sep 2022. International Journal of Transgender Health. <https://doi.org/10.1080/26895269.2022.2100644>.

WPATH SOC 8 is Dangerous

**For at least the reasons above, in my professional opinion,
WPATH SOC 8 represents a grave and immediate danger to
minors, young adults, and adults
and should not be followed by any physician, mental health care
provider, or other medical professional.**

Nations Question and Reverse Course on GAT

- Finland 2020 - recognized that “[r]esearch data on the treatment of dysphoria due to gender identity conflicts in minors is limited,” and recommended prioritizing psychotherapy for gender dysphoria and mental health comorbidities over medical gender affirmation (Council for Choices in Healthcare in Finland, 2020). Additionally, “[s]urgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors”.
- Sweden 2021 - the largest adolescent gender clinic announced that it would no longer prescribe puberty blockers or cross-sex hormones to youth under 18 years outside clinical trials (SEGM, 2021). "These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. This makes it challenging to assess the risk / benefit for the individual patient, and even more challenging for the minors or their guardians to be in a position of an informed stance regarding these treatments" (Gauffen and Norgren, 2021).

Society for Evidence Based Gender Medicine (SEGM). Sweden's Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies (May 5, 2021), https://bit.ly/SEGM_SwedenStopsHormones.

Gauffen D and Norgren S. "Policy Change Regarding Hormonal Treatment of Minors with Gender Dysphoria at Tema Barn - Astrid Lindgren Children's Hospital". 2021.

<https://segm.org/sites/default/files/Karolinska%20Guideline%20K2021-4144%20April%202021%20%28English%2C%20unofficial%20translation%29.pdf>

Nations Question and Reverse Course on GAT

- Dr Hilary Cass "was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020" (The Cass Review website, 2022). In her interim report dated February 2022, it states that "[e]vidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally" (Cass, 2022).

Cass, Hillary. The Cass Review Interim Report. Feb, 2022.
<https://cass.independent-review.uk/publications/interim-report/44>

Gender Dysphoria

How can these kids be helped?

- Investigate autism, depression, anxiety, bipolar disorder, physical or sexual abuse, self harm. Family problems - marital dissolution, interfamily conflict
- Identify and Properly Treat psychological comorbidities
- Individual Counseling
- Family Counseling

Child/Adolescent Affirmative Therapy

- This is not standard of care.
- We do not have the technology to make a male become a female, or a female become a male
- We do not know the long term outcomes of these medical/surgical interventions. No long term studies to assess the degree of harm in this age group.
- Medications are being used off-label and at high doses without proper FDA risk assessment profiles.
- The quality of evidence in the Endocrine Society's own guidelines for children and adolescents is low to very low quality or absent.
- WPATH SOC 8 is an extreme document and presents a grave danger to minors.
- Desisters have been ignored.

Assessment of the Patient with Gender dysphoria

In light of the very serious medical concerns and potential harms of gender affirmative therapy, there are several criteria that I believe would be important to fulfill before applying the Gender Affirmative Therapy model to a patient.

1. Patients should be evaluated to determine if they will follow the natural pattern of desistance which 50 to 98% of pediatric age children will follow.
2. Patients, parents and guardians should be made aware of other options for treatment of gender dysphoria including active psychosocial treatment or watching and waiting with support in order to help with natural desistance.
3. The patient should be provided an assessment by a qualified psychologist or psychiatrist who does not follow the WPATH GAT model. If underlying psychological conditions are diagnosed then these should be adequately evaluated and treated before proceeding to hormones and surgery.

Assessment of the Patient with Gender dysphoria

4. If a medicalized approach with hormones such as testosterone or medications to stop menstruation or puberty are being considered then a clear description of the risks and benefits needs to be conveyed to the minor and the parent or guardian. It needs to be verified that they fully understand these risks.

5. If surgical procedures such as mastectomy, hysterectomy, ovariectomy, orchiectomy, vaginoplasty, or phalloplasty are being considered then clear descriptions of the risks and benefits need to be conveyed to the minor and the parent or guardian.

However, even if a minor and their parents or guardian are made fully aware of the risks and benefits of hormones and surgeries, in my opinion, the minor does not have adequate maturity and judgment to make permanent changes to their body that may result in infertility/sterility and the permanent loss of organs such as breasts whose functions will not be fully utilized (such as breastfeeding) until adulthood.

**Medical Dangers of Gender Affirmative Therapy:
What is known and unknown**

Thank You for Viewing.

**Michael K. Laidlaw, MD
Endocrinologist. Rocklin, CA**

CURRICULUM VITAE

Date of Revision: 10/21/22

Name: Meredith McNamara, MD MS

Education:

B.A. Rutgers University (English Literature) 2007
M.S. Emory University (Clinical Research) 2013
M.D. Emory University 2013

Career/Academic Appointments:

07/13-06/16 Residency, Pediatrics, the University of Chicago, Chicago, IL
07/16-06/17 Fellowship, Leadership for Urban Primary Care Education and Transformation (LUCENT), Department of Medicine, the University of Chicago, Chicago, IL
07/17-06/18 Clinical Associate, Pediatrics, University of Chicago, Chicago, IL
07/18-06/21 Fellow, Adolescent Medicine, University of Illinois-Chicago, Chicago, IL
9/21- Assistant Professor, Pediatrics, Yale University, New Haven, CT

Board Certification:

American Board of Pediatrics, Pediatrics, 2016
American Board of Pediatrics, Adolescent Medicine, 2022

Professional Honors & Recognition:

International/National/Regional

2020: Semi-Finalist, U.S. State Department, Fulbright Scholar Award (Uganda)
2016: LUCENT Primary Care Fellowship, The University of Chicago
2011: NIH/Atlanta Clinical and Translational Science Institute TL1 Predoctoral Research Training Award

Grant/Clinical Trials History:

Past

6/2016-6/2017 Leadership for Urban Primary Care Education and Transformation Fellowship Grant – Full salary funding (50:50 research and clinical duties)
Mentor: Bradley Stolbach, PhD
\$5000 from the Health Resources & Services Administration (HRSA)
Taught trauma informed care workshops in Chicago healthcare settings

6/2015-6/2017 “Improving Trauma-Informed Care Practices for Pediatric Victims of Violence”
Co-PI: Bradley Stolbach, Ph.D.; Meredith McNamara, M.D.
\$80,000 for two years from the Bright Promises Foundation
Developed and taught a curriculum of hospital-based trauma informed care at Comer Children’s and John H. Stroger Hospitals

2/2012-9/2013 “Risk Factors for Obesity and Joint Disease in Persons with Hemophilia”
Mentor: Christine Kempton, MD
Funded by TL-1 grant, NIH pre-doctoral fellowship

Invited Speaking Engagements, Presentations, Symposia & Workshops:

International and National

1. "The Recovery of Adolescents and Young Adults from Firearm Violence," Grand Rounds at St. Joseph's Hospital, Paterson, NJ *upcoming* 9/27/2022
2. "Police-Free Schools: How Adolescent Providers Can Support Youth-Led Advocacy," Fenton R, **McNamara M.** University of Washington. Seattle, WA. 2/28/2022
3. "Police-Free Schools: How Adolescent Providers Can Support Youth-Led Advocacy," Fenton R, **McNamara M.** University of Washington. Seattle, WA. 5/28/2021
4. "Grand Rounds: Lessons from Police-Free Schools Advocacy in Chicago," Rush University. Chicago, IL. 5/28/2021.
5. "Preserving Adolescent Autonomy and Agency: Avoiding Reproductive Coercion," The University of Chicago. Chicago, IL. 1/14/2021
6. "Cross-Sector Collaboration for Police-Free Schools," Illinois Adverse Childhood Experiences Collaborative. Chicago, IL. 7/24/2020
7. "Sexually Transmitted Infections in Adolescents," Busitema University. Mbale, Uganda. 2/15/2020
8. "Menstrual Health and Hygiene," Busitema University. Mbale, Uganda. 2/14/2020
9. "Introduction to Adolescent Health," Busitema University. Mbale, Uganda. 2/12/2020
10. "Lessons in Trauma-Informed Care: A Panel Discussion with Youth Survivors of Violence," Windy City Emergency Medicine Conference. Chicago, IL. 9/21/2017
11. "Being a Champion of Trauma-Informed Care," Student National Medical Association Midwest Meeting. Springfield, IL. 10/05/2016

Local

1. "Heavy Menstrual Bleeding: High Yield Tips for the General Pediatrician." Connecticut AAP Conference. 5/17/2022
2. "Taking a Sexual and Menstrual History." Yale University, Pediatrics Residency. 5/5/2022
3. "Contraception Part 2: Medical Management." Yale University, Pediatrics Residency. 4/4/2022
4. "Contraception Part 1: Collaborative Counseling." Yale University, Pediatrics Residency. 3/30/2022
5. "Boosting Readiness for Eating Disorder Treatment in the Primary Care Setting." Pediatric Community Education Series, Bridgeport Hospital. 2/24/2022.
6. "The Design and Piloting of a Curriculum in Adolescent Health and Medicine: a course designed for Medical Trainees in Sub-Saharan Africa." Yale University, Pediatrics Residency Global Health Lecture Series. 10/20/2021
7. "Positive Youth Development: A Strengths-Based Approach to the Adolescent Psychosocial Interview." Yale University, Pediatrics Residency. 9/17/2021
8. "Innovation in Medical Education for Topics in Adolescent Health." University of Illinois-Chicago. Chicago, IL. 6/26/2021
9. "Mycoplasma genitalium: An Emerging STI." University of Illinois-Chicago. Chicago, IL. 7/6/2020
10. "Adolescent Sports Medicine: Athlete Wellness and Risk of Injury," University of Illinois-Chicago. Chicago, IL. 5/4/2020
11. "COVID-19 and Adolescent Wellness," Healing Hurt People-Chicago. Chicago, IL. 4/20/2020

Local – Recurring

1. "Eating Disorders." Yale University, Pediatrics Residency Primary Care Academic Half-Day: 3/8/2022, 2/23/2022, 2/9/2022
2. "Sexuality." Yale University, Pediatrics Residency Primary Care Academic Half-Day: 3/8/2022, 2/23/2022, 2/9/2022

3. "Approach to Abdominal Pain: Diagnosis and Management of Pelvic Inflammatory Disease." Yale University, Pediatrics Residency Senior Academic Half-Day. 2/10/2022
4. "Physician Bias and Non-specific Complaints in Adolescents: A Case Presentation," John H. Stroger Hospital: 10/5/2020, 10/26/2020; University of Illinois-Chicago. Chicago, IL. 10/14/2020
5. "The Pathogenesis and Sequelae of Sexually Transmitted Infection in Adolescents," University of Illinois-Chicago. Chicago, IL. 3/2020
6. "Patient Hand-offs in Residency: A Workshop for Fourth-Year Medical Students," University of Illinois-Chicago. Chicago, IL. 11/2019
7. "Health Maintenance of AYAs Affected by Violent Injury," John H. Stroger Hospital. Chicago, IL. 8/2019
8. "Health Maintenance of AYAs with Down Syndrome," University of Illinois-Chicago: 7/2019
9. "Care of the Adolescent Male," Comer Children's Hospital: 8/2016
10. "Communicating with Adolescents: An Interactive Session for Third-Year Medical Students", University of Illinois-Chicago. Chicago, IL. Monthly, 9/2020-
11. Resident Adolescent Health Curriculum, University of Illinois-Chicago. Chicago, IL. Monthly, 1/2019-
12. Complex Case Presentation, University of Illinois-Chicago. Chicago, IL. Biannually, 9/2019-
13. Adolescent Medicine Journal Club, University of Illinois-Chicago. Chicago, IL. Biannually, 10/2018-
14. "Trauma Informed Care: A Workshop for Medical Providers." Chicago, IL. Given 22 times from 5/2016-1/2019
15. Resident Adolescent Health Curriculum, Comer Children's Hospital: quarterly 7/2016-7/2018

Peer-Reviewed Presentations & Symposia

Oral Presentations

1. "When Science is Misused in Law: How to Address the Biased Science that Underlies Legal Bans on Gender-Affirming Care for Youth." World Professional Association of Transgender Health (WPATH) Conference, 9/18/22.
2. "A Curriculum in Adolescent Health and Medicine: Lessons from Mbale, Uganda." International Association of Adolescent Health. *Virtual*. 11/12/21.
3. "The Health Maintenance of Adolescents and Young Adults Affected by Violent Injury," Adolescent Health Initiative Conference. *Virtual*. 5/13/21.
4. "Police-Free Schools: How Adolescent Providers Can Support Youth-Led Advocacy," Fenton R, **McNamara M**: Society of Adolescent Health and Medicine. *Virtual*. 3/11/2021
5. "Training Hospital Personnel in Trauma-Informed Care: Assessing the Effectiveness of an Interprofessional Workshop with Patients as Teachers," Pediatric Academic Societies Annual Meeting. Baltimore, MD. 4/19/2019
6. "Trauma Informed Care: A Workshop for Medical Providers," Society for Adolescent Health and Medicine Annual Meeting. New Orleans, LO: 3/8/2017
7. "Hospital Care of the Violently Injured Patient," Grand Rounds: Emergency Medicine-Pediatrics. The University of Chicago. Chicago, IL. 4/1/2016
8. "The Role of Disease Severity in Influencing Body Mass Index in People with Hemophilia: A Single-Institutional Cross-Sectional Study," Striving for Excellence in Research and Critical Thinking: A Symposium for Pediatric Residents, Mead Johnson Foundation. Austin, TX. 4/14/2014
9. "Risk Factors for Obesity in Persons with Hemophilia," Clinical and Translational Science Awards National Predoctoral Programs Meeting, Mayo Health Systems. Rochester, MN. 5/8/2012

Poster Presentations

1. **McNamara M**, Wajarasi A, Brighton K, McMorris B, Safter M, Olupot-Olupot P, Miller K. "Implementation of an Adolescent Health and Medicine Course Designed for Medical Trainees in Low- and Middle-Income Countries: Results from a Pilot Study." International Association for Adolescent Health. *Virtual*. 11/2021
2. Miller K, **McNamara M**, McMorris B, Saftner M, Olupot-Olupot P. "An Adolescent Medicine Curriculum Designed for Low Income Countries: Results from Pilot Implementation at a Medical School in Easter Uganda." Society for Adolescent Health and Medicine. 3/2021.
3. Miller K, **McNamara M**, McMorris B, Saftner M, Olupot-Olupot P. "Pilot implementation of a curriculum in adolescent health and medicine: a course designed for medical trainees in low- and middle-income countries." Virtual poster presentation at the University of Minnesota – Pediatric Research, Education & Scholarship Symposium. *Winner – Best Fellow Research Award*. Minneapolis, Minnesota. 4/2020
4. Cane R, **McNamara M**, Schwartz A, Stolbach B. "Training Hospital Personnel in Trauma-Informed Care: Assessing the Effectiveness of an Interprofessional Workshop with Patients as Teachers." Pediatric Hospital Medicine Meeting. Seattle, Washington. 7/2019
5. **McNamara M**, Cane R, Schwartz A, Stolbach B. "Training Hospital Personnel in Trauma-Informed Care: Assessing the Effectiveness of an Interprofessional Workshop with Patients as Teachers." Pediatric Academic Societies Annual Meeting. Baltimore, Maryland. 4/2019
6. Tucker X, Dholakia A, **McNamara M**, Cane R, Hoffman Y, Stolbach B. "Building a Trauma-Informed Hospital: A Longitudinal Qualitative Study of Participants in a Trauma-Informed Care Training." American Association of Medical Colleges Meeting. Grand Rapids, Michigan. 3/2019
7. Dholakia A, Tucker X, **McNamara M**, Cane R, Hoffman Y, Stolbach B. "Expanding the Culture of Trauma-Informed Care: A Pilot Training Workshop for Medical Students." American Association of Medical Students Conference. Grand Rapids, Michigan. 3/2019
8. Tucker X, Dholakia A, **McNamara M**, Cane R, Hoffman Y, Stolbach B. "Building a Trauma-Informed Hospital: Preliminary Results from a Longitudinal Qualitative Study of Participants in a Trauma-Informed Care Training Workshop." The University of Chicago Medical Education Research Symposium. *Winner – Best Medical Student Presentation*. Chicago, Illinois. 9/2018
9. **McNamara M**, Cane R, Schuster L, Stolbach B. "Improving Trauma-Informed Care Practices for Pediatric Patients Affected by Violence." Leadership for Urban Primary Care Education and Transformation (LUCENT) Scholars Research Symposium. Chicago, Illinois. 6/2017
10. **McNamara M**, Cane R, Schuster L, Stolbach B. "Improving Trauma-Informed Care Practices for Pediatric Patients Affected by Violence." The University of Chicago Medical Education Research Symposium. Chicago, Illinois. 12/2016
11. **McNamara M**, Cane R, Stolbach B. "Healing Hurt People-Chicago: Creating a Hospital Culture of Trauma-Informed Care." University of Chicago Department of Pediatrics Research Symposium. Chicago, Illinois. 6/2016

Professional Service

Peer Review Groups/Grant Study Sections:

9/2016: Conference Planning Committee. Society of Adolescent Health and Medicine.

Public Service:

5/2015-6/2021 Healing Hurt People – Chicago, Illinois: Coordinating medical care for youth recovering from violent injury, co-leading trauma recovery workshops with youth clients, providing trauma-focused psychoeducation

2/2020	Atlas International – Mbale, Uganda: Fundraising and donations procurement of for Mbale Regional Referral Hospital and Busitema University
4/2019	Task Force, Cook County Health Systems – Chicago, Illinois: Provided confidential health screening and counseling to youth at social events
2/2015-9/2015	Care2Prevent Clinic – Chicago, Illinois: Provided medical care monthly to youth experiencing homelessness
8/2012	Georgia Migrant Farm Workers Project – Valdosta, Georgia: Delivered primary care to migrant farm workers and their families for one week
5/2009	House of Friendship – Copán, Honduras: Coordinated donations and medical supplies, volunteered with a pediatric medical team in rural clinics and schools for one week

Bibliography:

Peer-Reviewed Original Research

1. **McNamara M**, Kempton C, Antun A. "The Role of Disease Severity in Influencing Body Mass Index in People with Hemophilia: A Single Institution Cross-sectional Study." *Haemophilia*. 2013; 111th ser. 10.11 PMID: 24118577
2. **McNamara M**, Cane R, Hoffman Y, Reese C, Schwartz A, Stolbach B. "Training Hospital Personnel in Trauma-Informed Care: Assessing an Interprofessional Workshop with Patients as Teachers." *Academic Pediatrics*. 2020; S1876-2859 (20) 30190-X. PMID: 32492574
3. Miller K, Saftner M, **McNamara M**, McMorris B, Olupot-Olupot P. "Provision of adolescent health care in Resource-Limited Settings: Perceptions, practices and training needs of Ugandan health care workers." *Children and Youth Services Review*, Volume 132, 2022, 106310, ISSN 0190-7409, <https://doi.org/10.1016/j.childyouth.2021.106310>.

Chapters, Books, and Reviews

1. **McNamara M**, and Sharma J. Surgical Approaches to Endocrine Disorders. In Felner EI, Umpierrez G. *Endocrine Pathophysiology*. Lippincott Williams & Wilkins; 2013.
2. Cabral MD, Khan A, **McNamara M**, Dharmapuri S, Linares S, Cielo A. Renal manifestations of sexually transmitted infections. In Greydanus D, et al, eds: *Chronic Disease and Disability: The Pediatric Kidney*. 2nd edition, New York: Nova Science, 2021.

Case Reports, Technical Notes, Letters

1. Yano S, **McNamara M**, Halbach S, Waggoner D. "4q21 microdeletion in a patient with epilepsy and brain malformations." *American Journal of Medical Genetics*. 2015; 9999 A: 1-5. PMID: 25847229
2. Miller K, **McNamara M**, Pfeffer B, Kitaka S, Olupot-Olupot P. Capacity building in adolescent medicine: A collaborative curriculum for trainees in low- and middle-income countries. *American Academy of Pediatrics: Global Health Newsletter*. 2020:15-17.
3. **McNamara M**. "Gun Violence in Youth: A Syndemic Alongside COVID-19." Section of Adolescent Health, American Academy of Pediatrics Fall Newsletter. 2021.
4. Boulware S, Kamody R, Kuper L, **McNamara M**, Oleskeski C, Szilagyi N, Alstott A. "Biased Science: The Texas Attorney General's Legal Opinion on Medical Treatment for Transgender Children and Adolescents Relies on Inaccurate and Misleading Scientific Statements." 2022. Endorsed by: *The Endocrine Society, World Professional Association of Transgender Health, United States Professional Association of Transgender Health, Society of Adolescent Health and Medicine, North American Society of Pediatric and Adolescent Gynecology, American Medical Students Association and National Medical Students Pride Alliance*.

5. **McNamara M**, Abdul-Latif H, Boulware S, Kamody R, Kuper L, Olezeski C, Szilagyi N, Alstott A. “A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria.” 2022.
6. Lepore C, Alstott A, **McNamara M**. “Scientific misinformation is criminalizing the standard of care for transgender youth.” *Journal of the American Medical Association*. 2022. Article accepted, 2022.
7. Olezeski C, **McNamara M**, Alstott A. “Denying Trans Youth Gender Affirming Care is an Affront to Science and Medical Ethics” Los Angeles Times, June 13, 2022.
<https://www.latimes.com/opinion/story/2022-06-13/trans-youth-healthcare-state-bans>
8. **McNamara M**, Lepore C, Alstott A, Kamody R, Kuper L, Szilagyi N, Boulware S, Olezeski C. Scientific Misinformation and Gender Affirming Care: Tools for Providers on the Front Lines. *J Adolesc Health*. 2022 Jul 1:S1054-139X(22)00503-1. doi: 10.1016/j.jadohealth.2022.06.008. PMID: 35787819.
9. Lepore C, Alstott A, **McNamara M**. Scientific Misinformation Is Criminalizing the Standard of Care for Transgender Youth. *JAMA Pediatr*. 2022;176(10):965–966. doi:10.1001/jamapediatrics.2022.2959

From: [Vanessa Uphoff](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Petition to Initiate Rulemaking Setting the Standard of Care for Treatment of Gender Dysphoria
Date: Monday, August 1, 2022 10:13:47 PM

You don't often get email from vanessa.m.uphoff@gmail.com. [Learn why this is important](#)

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Greetings,

My name is Vanessa Uphoff. I wish to provide public commentary in opposition to the proposed rules on "Setting the Standard of Care for Treatment of Gender Dysphoria". It is my understanding that the hearing on this matter is taking place on August 5th at 8AM at Marriott Fort Lauderdale Airport, 166 North Compass Way, Dania Beach, FL 33004.

Please let me know who I should send a written request to so that I may make a public comment on this issue. Please also let me know if my understanding of the time and place for this hearing is correct.

Sincerely,

Vanessa Uphoff

From: [Kate Otero](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regarding Gender-affirming care and care for transgender youth
Date: Tuesday, August 2, 2022 4:25:19 PM

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Dear FBOM,

Another note to, again, ask that you vote to reject establishing an alternative standard of care that conflicts with medical consensus for children seeking gender-affirming treatment.

I am a pediatrician and member of the AAP and Florida Chapter of the AAP and agree with their summary regarding gender-affirming care:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

Please do no harm and do what is evidenced-based for transgender youth in Florida!

Thanks,
Kate Rooney-Otero, MD

From: [Elaine Donoghue](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Transgender medical care
Date: Tuesday, August 2, 2022 5:23:28 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Dr. Diamond-

I am writing to express concern about plans to politicize medical treatment of transgender youth. As a pediatrician, I feel that we need to keep the health and well-being of children as our highest priority. Some well-meaning groups have strong opinions about this, but we need to separate the emotions from the science. The major medical societies are in agreement that gender-affirming care supports better outcomes and children who receive evidence-based gender-affirming care experience sharply reduced incidence of mental health co-morbidities including anxiety, depression, and suicidal ideation.

Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk. Do you feel that a group of politicians should take on that role? Unfortunately, the Florida Department of Health has fallen victim to the politicization of medical treatment and would like to expose transgender children to this risk.

As a physician, I recognize my boundaries and try to stay within them. Regardless of strong beliefs, this country was founded on the principles that keep governments from interfering with people's lives. Please do not undermine the foundations of our country by allowing government to dictate things that should be within the boundaries of physicians and their patients/families. This is a dangerous path and holds great risk.

Sincerely-
Elaine Donoghue, MD

From: [Rebecca Plant](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Preserve Children's Rights and supporting Gender Affirming Care
Date: Wednesday, August 3, 2022 1:56:28 PM
Attachments: [Outlook-dkqlhut2.png](#)
[FBOM Letter.pdf](#)

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Hello,

Please find attached a letter I wholeheartedly agree with regarding the preservation of the rights of children to access gender-affirming care in our state. Below are some of the highlights:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

I ask that you continue to allow physicians to be able to provide gender-affirming care to the children of our state for their physical, mental, and emotional well-being.

Dr. Meredith Plant, MD

R. Meredith Plant, MD, FAAP
Assistant Professor of Pediatrics
Associate Program Director, Residency Program
Early Career Physician Committee Co-Chair, Florida Chapter of the AAP
University of South Florida Department of Pediatrics
South Tampa Center for Advanced Health Care
2 Tampa General Circle, 5007
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she/her/hers

I do not expect a reply on nights, weekends, or any personal time away from work.

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July 29, 2022

Dr. David Diamond, Chair
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

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Joseph L. Wright, MD, FAAP

Dear Dr Diamond,

The American Academy of Pediatrics (AAP), a nonprofit organization representing 67,000 pediatricians dedicated to the health, safety and well-being of all children and the Florida Chapter of American Academy of Pediatrics, Inc (FCAAP), a nonprofit organization representing more than 2,600 pediatricians committed to serving all children across the state, writes to express our concern regarding the request from the Florida Surgeon General for the Florida Board of Medicine to develop new standards of care for the treatment of gender dysphoria.

Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics;ⁱ the Florida Chapter of the American Academy of Pediatrics, Inc;ⁱⁱ the American Medical Association;ⁱⁱⁱ the American College of Obstetricians and Gynecologists;^{iv} the American College of Physicians;^v the American Psychiatric Association;^{vi} the American Psychological Association;^{vii} the American Academy of Family Physicians;^{viii} the American Academy of Child and Adolescent Psychiatry;^{ix} the Endocrine Society;^x the Society for Adolescent Health and Medicine;^{xi} the Pediatric Endocrine Society;^{xii} the World Professional Association for Transgender Health (WPATH);^{xiii} and many more medical organizations committed to providing the best evidence-based care.^{xiv}

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7^{xv} and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline^{xvi} (both are herein referenced as "standards of care") are well recognized and accepted among the medical community as the gold standard for treating gender dysphoria.

Included in the Board's meeting agenda to discuss the development of new standards of care for the treatment of gender dysphoria is the June 2, 2022 Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report (GAPMS)^{xvii}. The AAP and FCAAP provided in-depth comments in opposition of both the GAPMS report and the proposed Medicaid rule to ban coverage of gender-affirming care. Our joint comments are included in our communication to the Florida Board of Medicine and we encourage you to review them. The GAPMS report, which serves as the evidentiary basis for the attempt to develop new standards of care, fails to satisfy even the basic tenets of scientific

inquiry and research.^{xviii} Experts from Yale University recently released a critical review of the GAPMS report and found:

- Contrary to the June 2 Report's repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported "expert" reports that are biased, inexperienced, and full of errors. The claimed "expert" reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
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Thank you for your consideration of our comments.

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Moira Szilaygi, MD, PhD, FAAP
President, American Academy of Pediatrics



Lisa Gwynn, DO, MBA, MSPH, FAAP

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^{vi} American Psychiatric Association. Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. 2020. Accessed on June 23, 2022. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>

^{vii} American Psychological Association. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, December 2015. Vol. 70, No. 9, 832–864

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^{xiv} Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>

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From: [Camille Carre](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender-Affirming Care
Date: Wednesday, August 3, 2022 2:31:13 PM
Attachments: [FBOM Letter.pdf](#)

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Hello,

Please find attached a letter I wholeheartedly agree with regarding the preservation of the rights of children to access gender-affirming care in our state. Below are some of the highlights:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

I ask that you continue to allow physicians to be able to provide gender-affirming care to the children of our state for their physical, mental, and emotional well-being.

Camille Carre, MD
University of South Florida Chief Pediatric Resident

08/03/2022

American Academy of Pediatrics

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July 29, 2022

Dr. David Diamond, Chair
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

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Dear Dr Diamond,

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Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics;ⁱ the Florida Chapter of the American Academy of Pediatrics, Inc;ⁱⁱ the American Medical Association;ⁱⁱⁱ the American College of Obstetricians and Gynecologists;^{iv} the American College of Physicians;^v the American Psychiatric Association;^{vi} the American Psychological Association;^{vii} the American Academy of Family Physicians;^{viii} the American Academy of Child and Adolescent Psychiatry;^{ix} the Endocrine Society;^x the Society for Adolescent Health and Medicine;^{xi} the Pediatric Endocrine Society;^{xii} the World Professional Association for Transgender Health (WPATH);^{xiii} and many more medical organizations committed to providing the best evidence-based care.^{xiv}

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7^{xv} and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline^{xvi} (both are herein referenced as "standards of care") are well recognized and accepted among the medical community as the gold standard for treating gender dysphoria.

Included in the Board's meeting agenda to discuss the development of new standards of care for the treatment of gender dysphoria is the June 2, 2022 Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report (GAPMS)^{xvii}. The AAP and FCAAP provided in-depth comments in opposition of both the GAPMS report and the proposed Medicaid rule to ban coverage of gender-affirming care. Our joint comments are included in our communication to the Florida Board of Medicine and we encourage you to review them. The GAPMS report, which serves as the evidentiary basis for the attempt to develop new standards of care, fails to satisfy even the basic tenets of scientific

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From: [Jean-Claude Guidi](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Affirming Care
Date: Wednesday, August 3, 2022 5:00:14 PM
Attachments: [FBOM Letter.pdf](#)

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USF Internal Medicine - Pediatrics, PGY2



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www.aap.org

July 29, 2022

Dr. David Diamond, Chair
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4052 Bald Cypress Way Bin C-03
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Lisa Gwynn, DO, MBA, MSPH, FAAP

President, Florida Chapter of the American Academy of Pediatrics, Inc

ⁱ Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Gay, Lesbian, Bisexual and Transgender Health and Wellness. *Pediatrics*. Oct 2018; 142 (4) e20182162

ⁱⁱ Florida Chapter of the American Academy of Pediatrics, Inc. FCAAP Rejects New Florida Department of Health Guidelines on Gender-Affirming Care for Youth. 2022. Accessed on June 23, 2022. <https://www.fcaap.org/posts/news/press-releases/florida-chapter-of-the-american-academy-of-pediatrics-rejects-new-florida-department-of-health-guidelines-on-gender-affirming-care-for-youth/>

ⁱⁱⁱ American Medical Association. Health insurance coverage for gender-affirming care of transgender patients. 2019. Accessed on June 23, 2022. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>

^{iv} American College of Obstetricians and Gynecologists. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. 2021. Accessed on June 23, 2022. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>

^v Safer J, Tangpricha V. Care of the Transgender Patient. *Annals of Internal Medicine*. 2019 Jul 2;171(1):ITC1-ITC16.

^{vi} American Psychiatric Association. Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. 2020. Accessed on June 23, 2022. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>

^{vii} American Psychological Association. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, December 2015. Vol. 70, No. 9, 832–864

^{viii} American Academy of Family Physicians. Care for the Transgender and Gender Nonbinary Patient. 2020. Accessed on June 23, 2022. <https://www.aafp.org/about/policies/all/transgender-nonbinary.html>

^{ix} Adelson SL. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. *Jrnl of the American Academy of Child & Adolescent Psychiatry*. 2020; 957-974

^x Hembree W, Cohen-Kettenis P, Gooren L, Hannema S, Meyer W, Murad M, Rosenthal S, Safer J, Tangpricha V, T'Sjoen T. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2017; 102(11): 3869–3903

^{xi} Barkley L, Kodjo C, West KJ, et al. Promoting Health Equality and Nondiscrimination for Transgender and Gender-Diverse Youth. *Jrnl of Adolescent Health*. 2020; 66 (6): 804-807

^{xii} Lopez X, Marinkovic M, Rosenthal SM, et al. Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health. *Current Opinion in Pediatric*. 2017; 29(4). 475-480.

^{xiii} The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People 2011. Accessed on June 25, 2022. https://www.wpath.org/media/cms/Documents/SOC_v7/SOC_V7_English2012.pdf

^{xiv} Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>

^{xv} WPATH

^{xvi} Hembree et al

^{xvii} Florida Agency for Health Care Administration (ACHA), Division of Florida Medicaid. *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria (GAPMS)*. 2022. Accessed on June 22, 2022. https://ahca.myflorida.com/LetKidsBeKids/docs/AHCA_GAPMS_June_2022_Report.pdf

^{xviii} Alstott A, Boulware SD, Kamody R, Kuper L, Abdul-Latif H, McNamara M, Olezeski C, and Szilaygi N. Biased Science: A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria. July 8, 2022. Accessed on July 21, 2022. https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20ofinal%20july%208%202022%20accessible_443048_284_55174_v3.pdf

^{xix} Alstott et al

^{xx} Rafferty

^{xxi}Thoma BC, Salk RH, Choukas-Bradley , et al. Suicidality Disparities Between Transgender and Cisgender Adolescents. *Pediatrics*. 2019; 144(5)

^{xxii} Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 2018; 142(4)

From: [Richard Wilde](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Trans Youth
Date: Wednesday, August 3, 2022 5:01:08 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

I am writing to you in strong opposition to any proposed policy to limit or prohibit access to potentially lifesaving medical care for transgender youth. Here is why opposing such measures is so crucial:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

Sincerely,

Richard Wilde, MD, FAAP

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From: [Kristin Hoffschmidt](#)
To: [zzzz Feedback, Health](#); [zzzz Feedback, MQA Medicine](#)
Subject: For FL Board of Medicine
Date: Wednesday, August 3, 2022 8:58:59 AM

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Dear Members of the FL Board of Medicine,

I'm writing to urge you to vote against the proposal to bar physicians from providing treatment to transgender youth this Friday. A "standard of care" that denies care that is sought by a patient is unethical and contrary to the medical oath of physicians to do no harm. The proposed rule discriminates against transgender youth, limits their access to care, and contradicts the Board of Medicine's purpose of ensuring minimum requirements for the safe practice of medicine.

A report from Yale and other universities (<https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/>) debunk the scientific basis used by the FL Department of Health to deny gender-affirming care ("Flawed Medicaid Report in Florida" and "Biased Science in Texas & Alabama").

I urge you to not succumb to political pressure and to use valid and verifiable science as a basis for your decisions. The Board that licenses and regulates medical providers for the State of Florida must uphold the standards of the medical profession and not compromise its integrity by supporting policy based on disinformation.

Sincerely,
Kristin Hoffschmidt
232 Gulf Drive
Venice Florida 34285

From: [AOL SUPPORT](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: drjmark@rubpediatrics.com; drbeny@rubpediatrics.com
Subject: please consider a safe environment in schools for all children
Date: Thursday, August 4, 2022 10:26:39 AM

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August 3rd, 2022

Dr. David Diamond, Chair Florida Board of Medicine
4052 Bald Cypress Way Bin C-03 Tallahassee, FL 32399-3253

To the Board of Medicine

We would like you not to approve any legislation regarding the removal of gender-affirming care that will risk the lives and well beings of transgender youths.

They are Floridians and we must respect and uphold their rights to healthcare.

I invite you to examine the stance the Academy of Pediatrics Florida Chapter and the American Academy of Pediatrics take in support of gender-affirming care.

"Adolescentes with gender dysphoria face increased challenges in life compared to their cisgender peers. Bullying, discrimination, harassment, and a lack of social acceptance are issues adolescents with gender dysphoria deal with on a daily basis and all these issues lead to increased risks of suicide and other mental health conditions. In a study of more than 1,000 transgender adolescents, transgender adolescents had higher odds of all suicide outcomes compared to cisgender adolescents, and were at greater risk for suicidal ideations and attempts compared to their cisgender peers.

By proposing an alternative standard of care, Florida is ignoring the broad consensus among the medical community and the weight of peer reviewed medical literature. We call on the Florida Board of Medicine to reject the call for the development of new standards of care and ensure that the existing evidence-based standards of care are allowed to be used to care for children and adolescents with gender dysphoria. Only by doing so will the health and well-being of children and adolescents with gender dysphoria in Florida be preserved.

Thank you for your consideration.”

Sincerely,

Beny Rub MD

Rub Pediatrics

305-932-1007

www.rubpediatrics.com



August 4, 2022

Florida Department of Health
Board of Medicine
Marriott Fort Lauderdale Airport 166 North Compass Way
Dania Beach, FL 33004

Re: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Letter of Opposition from Latina Institute for Reproductive Justice Florida

Dear Chair Diamond, Vice-Chair Cairns, and members of the Florida Board of Medicine:

Latina Institute for Reproductive Justice Florida writes to express its strong opposition to the proposed rule to ban transgender medical care from the Florida Department of Health. A part of National Latina Institute for Reproductive Justice, we are a nonpartisan, non-profit organization that fights for equal access to reproductive health for Latina/x communities. The reproductive justice framework is rooted in the belief that all individuals and communities should have the resources and power they need to make their own decisions about their bodies, genders, sexualities, families, and lives.¹

This proposed rule would unnecessarily complicate healthcare, and cut off access to healthcare altogether, for Transgender and gender non-conforming/gender diverse Floridians. Transgender and gender non-conforming/gender diverse folks who are also “people of color, immigrants, sex workers, living with disabilities, or living with HIV face additional forms of marginalization, discrimination and violence.”² Study after study shows “that gender-affirming care—a medical and psychosocial health care designed to affirm individuals' gender identities—greatly improves the mental health and overall well-being of gender diverse, transgender, and nonbinary children and adolescents.”³ According to The Trevor Project's 2020 National Survey on LGBTQ Youth Mental Health, “54 percent of young people who identified as transgender or nonbinary reported having seriously considered suicide in the last year, and 29 percent have

¹ <https://healthlaw.org/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/>

² <https://www.pwn-usa.org/issues/policy-agenda/trans-rights-safety-justice/trans-centered-rj/>

³ <https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives#:~:text=Research%20demonstrates%20that%20gender%2Daffirming,and%20nonbinary%20children%20and%20adolescents.>



made an attempt to end their lives. In contrast, numerous research studies have found that gender-affirming care leads to improved mental health among TGNB youth.”⁴

In this current climate, Transgender and gender non-conforming/gender diverse folks already experience barriers in access accurate and compassionate healthcare.

- One in three Transgender and gender non-conforming/gender diverse people delayed or avoided preventive health care, like a pelvic exam or STI screening, out of fear of discrimination or disrespect. This number is even higher – almost one in two — for transgender men. (NRDS, 2015)⁵
- One in five Transgender and gender non-conforming/gender diverse people report having been turned away by a doctor because of their transgender or gender non-conforming status. (NRDS, 2015)⁶
- One half for Transgender and gender non-conforming/gender diverse people report having to teach their health care provider some aspect of transgender care. That number jumps to 62% for transgender men. (NRDS, 2015)⁷

The nation’s leading health organizations support gender-affirming care for Transgender and gender non-conforming/gender diverse people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others. (Equality Florida)

These continued attacks on Transgender and gender non-conforming/gender diverse Floridians, which are not based on science, medicine, and evidence-based approach from the U.S. Department of Health and Human Services (HHS), are dangerous, life-threatening, and abusive. “Rather than protect trans youth, all it does is aim to push them back into the closet, an approach which is tantamount to state-endorsed conversion therapy. Rather than affirm parental rights, all it does is deny parents the autonomy to make the best decisions for their children to support their development.”⁸

⁴ <https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives#:~:text=Research%20demonstrates%20that%20gender%2Daffirming,and%20nonbinary%20children%20and%20adolescents.>

⁵ <https://www.pwn-usa.org/issues/policy-agenda/trans-rights-safety-justice/trans-centered-rj/>

⁶ <https://www.pwn-usa.org/issues/policy-agenda/trans-rights-safety-justice/trans-centered-rj/>

⁷ <https://www.pwn-usa.org/issues/policy-agenda/trans-rights-safety-justice/trans-centered-rj/>

⁸ https://hrc-prod-requests.s3-us-west-2.amazonaws.com/FL-Dept-of-Health-Rebuttal_042122_v3.pdf



We urge you and fellow members of the Board of Medicine to reject this dangerous proposed rule. The actual harm is caused by the barriers to care and in the criminalization of our communities. We must ensure that Transgender and gender non-conforming/gender diverse Floridians are not targeted and criminalized simply for accessing healthcare, owning their bodies, and reclaiming control of their autonomy. If you should have any questions regarding Latina Institute's Florida opposition to this proposed rule, please contact Aurelie Colon Larrauri, FL State Policy Advocate, at aurelie@latinainstitute.org.

Sincerely,

Aurelie Colon Larrauri (she/they)
Florida State Policy Advocate
Latina Institute for Reproductive Justice Florida

From: [Allan Barsky](#)
To: [Alls, Wendy](#); [Strickland, Bettye C](#); [zzzz Feedback, MQA Medicine](#)
Subject: Today's Hearing
Date: Friday, August 5, 2022 10:30:05 AM

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Please support equal and full access to gender-affirming health care for transgender youths and adults. Medical care is a human right. The best people to determine what types of health care are needed and helpful are the patients, their parents (for minors), and their health care providers. Government should not bar physicians and other health care providers from providing services that can save lives and enhance the welfare of any group, particularly, groups that are more vulnerable to discrimination.

Thank you,
Allan Barsky, PhD

From: bruggemanbr@gmail.com
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comments for meeting today re: transgender youth
Date: Friday, August 5, 2022 8:48:41 AM

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To the Florida Board of Medicine,

I am planning to speak at the meeting today, but in the case that I am not able to speak I wanted to send my thoughts to you via email.

My name is Brittany Bruggeman, and I am a pediatric endocrinologist at the University of Florida. In my practice I see patients with endocrine disorders, with diabetes, and patients in our Youth Gender Program. I'm also an NIH-funded physician scientist. I was born and raised in Florida, attended UF for all of my 10 years of medical training in pediatric endocrinology, and am a member of the Gold Humanism Honor Society. It is an immense privilege for me to care for each of my patients with all of the empathy and art and science of medicine that this requires of us as physicians. I teach and mentor medical students and residents on a daily basis and have the honor of helping them to internalize their responsibility to provide the best evidence-based, compassionate, and patient-centric care.

Even prior to the pandemic, but especially now, as physicians we have withstood attacks on our training and expertise. However, as the Board of Medicine, my fellow physicians on the Board will understand the difficult decisions that we have to make every day. Every decision is a balance of risks and benefits, and as a pediatrician these risks and benefits must be weighed together by the medical team, the patient, and the family before a treatment decision is made.

Our current guidelines for the treatment of adolescents with gender dysphoria are supported by every major medical association including the AMA, AAP, Endocrine Society, and Pediatric Endocrine Society. Additionally, the level of evidence supporting this care is higher than the evidence that I use to start statins, ACE inhibitors, and even fast-acting insulin in my patients with diabetes. As you know, insulin especially is a medication with potentially severe and even fatal adverse events, but I must do what all physicians do: use the guidelines and evidence that I have, weigh the risks and benefits of treatment alongside the patient and family in front of me to make the best treatment decision for that patient.

The Board of Medicine's role is to ensure that every physician practicing in the state meets requirements for safe practice. Its role is not to overturn evidence-based medical guidelines to appease the whims and political agenda of the state.

Sincerely,

Brittany Bruggeman, MD

Sent from my iPhone

From: [Carreno Rijo, Elizabeth](#)
To: [zzzz Feedback, Health](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Diverse children/adolescents
Date: Friday, August 5, 2022 5:32:37 PM
Attachments: [Prohibiting gender.docx](#)

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August 5th 2022

Tom Wallace
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive
Mail Stop #8
Tallahassee, FL 32308
Dear Director Wallace,

I am an adolescent medicine physician, writing to express grave concern with regards to the rule that the Agency for Health Care Administration (AHCA) prohibiting coverage of gender-affirming care under the Medicaid program. Denying evidence-based, medically necessary standards of care to transgender adolescents constitutes a broad and sweeping discriminatory action by the State of Florida and its Medicaid program.

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- It is my experience that children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off

necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.

- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

Sincerely,

Elizabeth Carreno Rijo, MD MPH FAAP FSAHM
Medical Director Adolescent Medicine Clinic/Gender Clinic/Eating disorders Clinic at
Orlando Health

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August 5th 2022

Tom Wallace
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive
Mail Stop #8
Tallahassee, FL 32308

Dear Director Wallace,

I am an adolescent medicine physician, writing to express grave concern with regards to the rule that the Agency for Health Care Administration (AHCA) prohibiting coverage of gender-affirming care under the Medicaid program. Denying evidence-based, medically necessary standards of care to transgender adolescents constitutes a broad and sweeping discriminatory action by the State of Florida and its Medicaid program.

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- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
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- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

Sincerely,

Elizabeth Carreno Rijo, MD MPH FAAP FSAHM
Medical Director Adolescent Medicine Clinic/Gender Clinic/Eating disorders Clinic at
Orlando Health

From: [Jade Walter](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Access to healthcare
Date: Friday, August 5, 2022 10:32:37 AM
Attachments: [FBOM Letter.pdf](#)

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Hello,

Please find attached a letter I wholeheartedly agree with regarding the preservation of the rights of children to access gender-affirming care in our state. Below are some of the highlights:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
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- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government’s attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

I ask that you continue to allow physicians to be able to provide gender-affirming care to the children of our state for their physical, mental, and emotional well-being.



345 Park Blvd
Itasca, IL 60143
Phone: 630/626-6000
Fax: 847/434-8000
www.aap.org

July 29, 2022

Dr. David Diamond, Chair
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

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Constance S. Houck, MD, FAAP

At Large

Joseph L. Wright, MD, FAAP

Dear Dr Diamond,

The American Academy of Pediatrics (AAP), a nonprofit organization representing 67,000 pediatricians dedicated to the health, safety and well-being of all children and the Florida Chapter of American Academy of Pediatrics, Inc (FCAAP), a nonprofit organization representing more than 2,600 pediatricians committed to serving all children across the state, writes to express our concern regarding the request from the Florida Surgeon General for the Florida Board of Medicine to develop new standards of care for the treatment of gender dysphoria.

Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics;ⁱ the Florida Chapter of the American Academy of Pediatrics, Inc;ⁱⁱ the American Medical Association;ⁱⁱⁱ the American College of Obstetricians and Gynecologists;^{iv} the American College of Physicians;^v the American Psychiatric Association;^{vi} the American Psychological Association;^{vii} the American Academy of Family Physicians;^{viii} the American Academy of Child and Adolescent Psychiatry;^{ix} the Endocrine Society;^x the Society for Adolescent Health and Medicine;^{xi} the Pediatric Endocrine Society;^{xii} the World Professional Association for Transgender Health (WPATH);^{xiii} and many more medical organizations committed to providing the best evidence-based care.^{xiv}

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7^{xv} and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline^{xvi} (both are herein referenced as "standards of care") are well recognized and accepted among the medical community as the gold standard for treating gender dysphoria.

Included in the Board's meeting agenda to discuss the development of new standards of care for the treatment of gender dysphoria is the June 2, 2022 Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report (GAPMS)^{xvii}. The AAP and FCAAP provided in-depth comments in opposition of both the GAPMS report and the proposed Medicaid rule to ban coverage of gender-affirming care. Our joint comments are included in our communication to the Florida Board of Medicine and we encourage you to review them. The GAPMS report, which serves as the evidentiary basis for the attempt to develop new standards of care, fails to satisfy even the basic tenets of scientific

inquiry and research.^{xviii} Experts from Yale University recently released a critical review of the GAPMS report and found:

- Contrary to the June 2 Report's repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported "expert" reports that are biased, inexperienced, and full of errors. The claimed "expert" reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
- The linchpin of the June 2 Report is an analysis by two epidemiologists that claims to undermine the scientific evidence supporting medical care for gender dysphoria. Their analysis is extremely narrow in scope, inexperienced, and so flawed that it merits no scientific weight at all.
- The June 2 Report repeatedly and erroneously dismisses solid studies as "low quality." If Florida's Medicaid program applied the June 2 Report's approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.^{xix}

Adolescents with gender dysphoria face increased challenges in life compared to their cisgender peers. Bullying, discrimination, harassment, and a lack of social acceptance are issues adolescents with gender dysphoria deal with on a daily basis and all these issues lead to increased risks of suicide and other mental health conditions.^{xx} In a study of more than 1,000 transgender adolescents, transgender adolescents had higher odds of all suicide outcomes compared to cisgender adolescents, and were at greater risk for suicidal ideations and attempts compared to their cisgender peers.^{xxi} Additionally, in the first large scale (N = 120,670) study examining the relationship between transgender adolescents and suicide, the authors found that between 30-51% of transgender adolescents reported engaging in suicidal behavior, compared to between 10-18% of their cisgender peers.^{xxii}

By proposing an alternative standard of care, Florida is ignoring the broad consensus among the medical community and the weight of peer reviewed medical literature. We call on the Florida Board of Medicine to reject the call for the development of new standards of care and ensure that the existing evidence-based standards of care are allowed to be used to care for children and adolescents with gender dysphoria. Only by doing so will the health and well-being of children and adolescents with gender dysphoria in Florida be preserved.

Thank you for your consideration of our comments.

Sincerely,

A handwritten signature in cursive script that reads "Moira Szilaygi".

Moira Szilaygi, MD, PhD, FAAP
President, American Academy of Pediatrics



Lisa Gwynn, DO, MBA, MSPH, FAAP

President, Florida Chapter of the American Academy of Pediatrics, Inc

ⁱ Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Gay, Lesbian, Bisexual and Transgender Health and Wellness. *Pediatrics*. Oct 2018; 142 (4) e20182162

ⁱⁱ Florida Chapter of the American Academy of Pediatrics, Inc. FCAAP Rejects New Florida Department of Health Guidelines on Gender-Affirming Care for Youth. 2022. Accessed on June 23, 2022. <https://www.fcaap.org/posts/news/press-releases/florida-chapter-of-the-american-academy-of-pediatrics-rejects-new-florida-department-of-health-guidelines-on-gender-affirming-care-for-youth/>

ⁱⁱⁱ American Medical Association. Health insurance coverage for gender-affirming care of transgender patients. 2019. Accessed on June 23, 2022. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>

^{iv} American College of Obstetricians and Gynecologists. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. 2021. Accessed on June 23, 2022. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>

^v Safer J, Tangpricha V. Care of the Transgender Patient. *Annals of Internal Medicine*. 2019 Jul 2;171(1):ITC1-ITC16.

^{vi} American Psychiatric Association. Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. 2020. Accessed on June 23, 2022. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>

^{vii} American Psychological Association. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, December 2015. Vol. 70, No. 9, 832–864

^{viii} American Academy of Family Physicians. Care for the Transgender and Gender Nonbinary Patient. 2020. Accessed on June 23, 2022. <https://www.aafp.org/about/policies/all/transgender-nonbinary.html>

^{ix} Adelson SL. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. *Jrnl of the American Academy of Child & Adolescent Psychiatry*. 2020; 957-974

^x Hembree W, Cohen-Kettenis P, Gooren L, Hannema S, Meyer W, Murad M, Rosenthal S, Safer J, Tangpricha V, T'Sjoen T. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2017; 102(11): 3869–3903

^{xi} Barkley L, Kodjo C, West KJ, et al. Promoting Health Equality and Nondiscrimination for Transgender and Gender-Diverse Youth. *Jrnl of Adolescent Health*. 2020; 66 (6): 804-807

^{xii} Lopez X, Marinkovic M, Rosenthal SM, et al. Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health. *Current Opinion in Pediatric*. 2017; 29(4). 475-480.

^{xiii} The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People 2011. Accessed on June 25, 2022. https://www.wpath.org/media/cms/Documents/SOC_v7/SOC_V7_English2012.pdf

^{xiv} Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>

^{xv} WPATH

^{xvi} Hembree et al

^{xvii} Florida Agency for Health Care Administration (ACHA), Division of Florida Medicaid. *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria (GAPMS)*. 2022. Accessed on June 22, 2022. https://ahca.myflorida.com/LetKidsBeKids/docs/AHCA_GAPMS_June_2022_Report.pdf

^{xviii} Alstott A, Boulware SD, Kamody R, Kuper L, Abdul-Latif H, McNamara M, Olezeski C, and Szilaygi N. Biased Science: A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria. July 8, 2022. Accessed on July 21, 2022. https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20ofinal%20july%208%202022%20accessible_443048_284_55174_v3.pdf

^{xix} Alstott et al

^{xx} Rafferty

^{xxi}Thoma BC, Salk RH, Choukas-Bradley , et al. Suicidality Disparities Between Transgender and Cisgender Adolescents. *Pediatrics*. 2019; 144(5)

^{xxii} Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 2018; 142(4)



July 28, 2022

Dr. David Diamond, Chairperson
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

**Re: Human Rights Campaign Comments on the Surgeon General's July 2,
2022 Letter concerning gender affirming medical care**

Dear Dr. Diamond and Members of the Florida Board of Medicine:

On behalf of the Human Rights Campaign's more than three million members and supporters nationwide, we submit this comment in response to the letter from the Surgeon General of Florida recommending the creation of a standard of care that would ban or significantly curtail the ability of medical practitioners to provide standard and medically necessary gender affirming health care to minors.¹ As the nation's largest organization working on behalf of lesbian, gay, bisexual, transgender, and queer people, we are deeply troubled by this letter in which the Surgeon General disregards scientifically based standards set by numerous medical professional organizations including the American Academy of Pediatrics, the American Medical Association, and the Endocrine Society.² The creation of a standard of care in line with the Surgeon General's recommendations would cause confusion and chaos among medical professionals in the State as they attempt to comply with standards that contravene the majority scientific consensus. It would also potentially force many vulnerable young patients to either delay the start of treatment or suspend medically necessary care during the course of treatment. We implore the Board to disregard the unfounded recommendation by the Surgeon General of Florida or to ensure that any creation of a standard of care includes gender affirming healthcare as a viable treatment for medical practitioners to recommend and dispense in consultation with their patients and their families.

¹ Joseph A. Lapado, Letter to the Florida Board of Medicine, July 2, 2022, accessed July 28, 2022, at <https://www.documentcloud.org/documents/22050967-board-letter>.

² *Id.*

Denying access to safe, affirming, and age-appropriate medical care such as gender-affirming hormones or puberty-delaying medication is dangerous and can be life-threatening. There is a clear correlation between youth receiving gender-affirming care and a decrease in anxiety, depression, self harm, and suicidal ideation. A blanket denial of care by preventing medical practitioners from engaging in the practice would increase rates of adverse mental health outcomes among transgender young adults.³

Gender-affirming care for transgender youth and adolescents largely involves social transitioning – whereby a person adopts a name, pronouns, and gender expressions that are consistent with their gender identity. Additionally, youth are often supported by a host of medical practitioners in their social transition through therapy and later consultation regarding medical transition if the patient so desires it.⁴ Numerous studies have found that, after social transitioning, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. “Transitioning socially should not only be viewed as a form of treatment, but can be understood as a possibility for children to explore their own individual developmental pathways.”⁵ It is clear that these non-medical elements of transitioning help increase positive health outcomes. As stated, healthcare supporting social transitioning is sometimes only one part of a transgender individual’s healthcare plan to live fully as their whole selves.

For some people, medical transition is necessary. Gender-affirming medical care encompasses hormone therapy, puberty blockers or other medical procedures. And to be done properly and safely, there must be close consultation with medical practitioners. According to Williams Institute, there are approximately 16,200 transgender youth (ages 13-17) throughout the state of Florida.⁶ A standard banning or severely restricting gender affirming care would outright prevent these individuals from receiving care for gender affirming procedures within the State of Florida. For example, many transgender individuals report having to leave their home state (Florida included) in order to receive gender affirming care as the closest provider of such care resides outside of state lines.⁷ A new standard of care banning or severely restricting gender affirming care would push transgender youth across the State to either: 1) leave to a different, more welcoming state, to receive gender affirming care as there would remain no practitioner within the state that could provide them with said care, 2) suffer the mental health consequences as described above due to an inability to transition (due to financial, employment, familial, or other

³ “Use of GAHT [gender affirming health treatments] was associated with lower odds of recent depression and seriously considering suicide compared to those who wanted GAHT but did not receive it.” Amy E. Green, *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, Journal of Adolescent Health, (2021) <https://doi.org/10.1016/j.jadohealth.2021.10.036>.

⁴ American Psychiatric Association, *Gender Affirming Therapy, A Guide for Working With Transgender and Gender Nonconforming Patients* (accessed July 28, 2022), <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-affirming-therapy>.

⁵ Elisabeth DC Sievert and Katinka Schweizer, *Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria*, Clin Child Psychol Psychiatry (Oct. 19, 2020). P.92. <https://doi.org/10.1177/1359104520964530>.

⁶ Jody Herman, Andrew Flores, and Kathryn O’Neill, *How Many Adults and Youth Identity as Transgender in the United States*, UCLA School of Law Williams Institute (June 2022), <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>.

⁷ Puckett, J., Cleary, P., Rossman, K., Newcomb, M., and Mustanski, B., *Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals*, National Library of Medicine, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5842950/>.

restriction preventing them from crossing state lines), or 3) leave the state permanently with (or potentially without) their families to a state that is more welcoming and able to provide them with the standard and medically necessary treatments they need. Additionally, a new standard of care may lead to either the de-licensing of medical professionals throughout the state for having provided such care or the moving of medical professionals throughout the state because of a desire to provide such care. This could leave the State with a shortage of licensed medical professionals.

A new standard to prevent medical professionals from providing gender affirming care not only restricts access to necessary medical care, it also prevents parents from making decisions in the best interest of their children. This new standard would also prevent doctors from making medically sound determinations based on widely accepted and vetted standards of care and from working with their patients on how to provide the best care possible tailored to the individual for fear of losing their job and their license to practice medicine in the State. In a study of over 160 medical doctors, “[o]verall, 85.7 percent of clinicians were willing to provide routine care to transgender patients.”⁸ Although this number is encouraging, “willingness is not necessarily equivalent to competence or the ability to provide high-quality, sensitive care.”⁹ It is imperative to ensure that medical practitioners are able to provide gender affirming care not only for the benefit of youth throughout the State, but also to ensure that those same practitioners are keeping up to date with the latest in treatments made available by the scientific community.

A new standard also ignores the fact that the medical establishment has already spoken on this matter. The American Medical Association, representing millions of doctors across the United States, points out that the majority of medical associations throughout the nation include gender affirming care as part of their own treatment standards noting that:

The AMA opposes any discrimination based on an individual’s sex, sexual orientation or gender identity, opposes the denial of health insurance on the basis of sexual orientation or gender identity, and supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient’s physician....In addition, other medical associations, including the American Academy of Family Physicians, American College of Obstetricians and Gynecologists and American Psychiatric Association have stated that medically necessary transition-related care should be covered by insurance.¹⁰

Numerous fallacies underlie the Surgeon General’s letter recommending a new standard of care. The theory of rapid onset gender dysphoria has been debunked throughout the scientific and medical literature, and met with significant and substantial methodological critiques.¹¹ In fact, determining

⁸ Deirdre A. Shires, Daphna Stroumsa, Kim D. Jaffee and Michael R. Woodford, *Primary Care Clinicians’ Willingness to Care for Transgender Patients*, *The Annals of Family Medicine* (Nov. 2018) <https://doi.org/10.1370/afm.2298>.

⁹ *Id.*

¹⁰ American Medical Association and GLMA: Health Professionals Advancing LGBTQ Equality, *Health Insurance Coverage for gender-affirming care of transgender patients*, Issue Brief, <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>.

¹¹ Arjee Javellana Restar, *Methodological Critique of Littman’s (2018) Parental-Respondents Accounts of “Rapid-Onset Gender Dysphoria*, *National Library of Medicine* (Apr. 22, 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7012957/>; see also Greta R. Bauer, Margaret L. Lawson, and Daniel

treatment approaches (or, in this case, lack thereof) based on so-called rapid onset gender dysphoria would not meet the generally accepted professional medical standards determination, due to the lack of empirical support for this theory. This would make a new standard of care an outlier nationally. Indeed, in 2021, the American Psychological Association, the American Psychiatric Association, the Florida Psychological Association, and over 120 other medical associations issued a position statement calling for “eliminating the use of Rapid-Onset Gender Dysphoria and similar concepts for clinical and diagnostic application given the lack of rigorous empirical support for its existence and its likelihood of contributing to harm and mental health burden.”¹²

In addition, the overwhelming evidence supports the ability of medical professionals to provide gender affirming care due to the positive mental health impacts of treatments such as puberty blockers on transgender youth.¹³ For example, a systematic review of 13 studies found that receipt of puberty blockers had numerous positive psychosocial impacts, including “significant improvements in multiple psychological measures, including global functioning, depression, and overall behavioral and/or emotional problems.”¹⁴ Puberty blockers are both safe and fully reversible.¹⁵ According to the Endocrine Society, “Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD [gender dysphoric]/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/ gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains.”¹⁶

L. Metzger, *Do Clinical Data from Transgender Adolescents Support the Phenomenon of “Rapid Onset Gender Dysphoria”?*, *The Journal of Pediatrics* (Apr. 1, 2022), <https://www.jpeds.com/article/S0022-34762101085-4/fulltext>.

¹² Coalition for the Advancement & Application of Psychological Science, *CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD)*, Coalition for the Advancement & Application of Psychological Science (July 8, 2022), <https://www.caaps.co/rogd-statement>.

¹³ Denise Chew, *Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review*, *American Academy of Pediatrics*, (Apr. 1, 2018), <https://publications.aap.org/pediatrics/article/141/4/e20173742/37799/Hormonal-Treatment-in-Young-People-With-Gender?autologincheck=redirected>; see also Diana M. Tordoff, MPH, Jonathon W. Wanta, Arin Collin, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, *JAMA*, (Feb. 25, 2022), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423>; see also Jack Turban, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, *American Academy of Pediatrics*, (Feb. 01, 2020), <https://publications.aap.org/pediatrics/article/145/2/e20191725/68259/Pubertal-Suppression-for-Transgender-Youth-and>

[ender](https://publications.aap.org/pediatrics/article/141/4/e20173742/37799/Hormonal-Treatment-in-Young-People-With-Gender)

¹⁴ Denise Chew, *Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review*, *American Academy of Pediatrics* at 14. (Apr. 1, 2018), <https://publications.aap.org/pediatrics/article/141/4/e20173742/37799/Hormonal-Treatment-in-Young-People-With-Gender>

¹⁵ Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, *American Academy of Pediatrics*, (Oct. 1, 2018), <https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for> or; Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha, and Guy G T’Sjoen, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, *The Journal of Clinical Endocrinology & Metabolism* (July 13, 2018), <https://academic.oup.com/jcem/article/102/11/3869/4157558?login=false>

¹⁶ Hembree, Cohen-Kettenis, Gooren, Hannema, Meyer, Murad, Rosenthal, Safer, Tanpricha, T’Sjoen, *supra*.

‘Off label’ use does not mean experimental, illegal, or unsafe. Puberty blockers have been used safely and effectively with cisgender youth for decades under FDA approval, with minimal side effects.¹⁷ They have been used safely and effectively with transgender youth since the 1990s.¹⁸ As with puberty blockers, there is substantial evidence demonstrating positive mental health benefits associated with gender-affirming hormones, including lower rates of depression, anxiety, and suicidality.¹⁹ Any form of gender affirming care received by transgender youth is administered in consultation with medical and mental health professionals and their parents. The vast majority of transgender youth and adults remain consistent in their transgender identity.²⁰ Doctors must have the ability to choose safe and effective medical treatments for actual patients with actual health needs.

HRC reiterates our strong opposition to the Surgeon General of Florida’s letter recommending the creation of a standard of care banning or severely restricting the use of gender affirming care by medical practitioners. We urge the Board of Medicine to recognize the positive health benefits that gender-affirming care has on transgender individuals and the necessity of medical practitioners in that care. It is important to recognize that denial of transition-related care is damaging and has effects beyond access to gender-affirming medical procedures and medication, including resulting in a chilling effect on support for social transition and culturally sensitive healthcare for a person’s full range of medical needs. Medical professionals must be able to care for their patients using the full swath of care paths possible, not just those deemed politically acceptable by the government.

¹⁷ FDA Guidance for Administering Puberty Blockers https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020263s042lbl.pdf; see also Jason Lambrese, *Suppression of Puberty in Transgender Children*, AMA Journal of Ethics (Aug. 2010).

¹⁸ Jason Lambrese, *Suppression of Puberty in Transgender Children*, AMA Journal of Ethics (Aug. 2010). <https://journalofethics.ama-assn.org/article/suppression-puberty-transgender-children/2010-08>

¹⁹ Luke R. Allen, *Well-being and Suicidality Among Transgender Youth After Gender-affirming Hormones*, Clinical Practice in Pediatric Psychology (2019), <https://psycnet.apa.org/record/2019-52280-009>; see also Jack L. Turban, *Access to Gender-Affirming Hormones During Adolescents and Mental Health Outcomes Among Transgender Adults*, (Jan. 12, 2022), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039>; see also Amy E. Green, *Association of Gender-affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, Journal of Adolescent Health (2021), <https://www.jahonline.org/action/showPdf?pii=S1054-139X%2821%2900568-1>.

²⁰ Chantel M Wiepjes, *The Amsterdam Cohort of Gender Dysphoria Studies (1972-2015): Trends in Prevalence, Treatment, and Regrets*, J Sex Med (Apr. 15, 2018), <https://pubmed.ncbi.nlm.nih.gov/29463477/>; see also Valeria P. Bustos, *Regrets After Gender-affirming Surgery: A Systematic Review and Meta-analysis of Prevalence*, (Mar. 19, 2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8099405/>; see also Christina M. Roberts, *Continuation of Gender-affirming Hormones Among Transgender Adolescents and Adults*, The Journal of Clinical Endocrinology & Metabolism (Apr. 22, 2022), <https://doi.org/10.1210/clinem/dgac251>.

Testimony for FL Board of Medicine - 8/5/22

My name is Sujatha Prabhakaran and as a Florida physician practicing gender-affirming health care, I am here to express my opposition to the changes recommended for gender-affirming care. The Florida Surgeon General's recommendations are medically unsafe and cruel to transgender individuals and their families, and therefore must not be implemented.

I currently practice as an obstetrician-gynecologist in Sarasota, FL specializing in reproductive health care including supervising the initiation of a gender-affirming hormone therapy care program over five years ago. Since inception, the program has provided vital health care for over 3,000 patients, so I know firsthand the potentially devastating impacts that loss of care would have for transgender individuals.

Gender-affirming care is medically necessary and is often lifesaving for transgender patients. Blocking access to such care will increase the risk for suicidal ideation, suicide, depression, and anxiety for them.

Medical knowledge and compassion for each patient's individual circumstances must guide decisions about access to gender-affirming care. These medical decisions belong to individuals and their doctors. Yet, this proposal places itself between transgender individuals and the care they so desperately need. It is a dangerous intrusion into the practice of medicine and individuals' freedom.

I have personally treated transgender patients who came to us with severe depression and suicidal thoughts for years. They sought care with us after realizing they were not living as their true selves and that this might be the cause of their mental illness. A few months after being on gender-affirming hormone therapy, they began to see changes in their body that helped them feel more comfortable and happier in their body. They also noted that their depression and suicidal thoughts had gone away. If they had not received the care they needed, they almost certainly would be much less healthy today, and per their own admission might have committed suicide. This is just one of thousands of patients who would be hurt by this change.

This damaging recommendation will have tremendous and lasting negative effects on Floridians, affecting them at a time in their lives that are among the most personal and complicated. As a physician, it pains me to consider not providing my patients with the health care they need and desire to live their fullest life.

The standard of care recommended by the Florida Department of Health is not founded on science. Board of Medicine Chairman David Diamond and other board members, a group of professors and clinicians from Yale University, the University of Alabama at Birmingham and the University of Texas Southwestern, disputed the state's conclusions about treatments for gender dysphoria. They also said establishing a standard of care to prevent such treatments would violate legal protections "against discrimination and harm tens of thousands of Floridians."

We have an obligation to our patients, not politicians.

Please remember our ethical oath as physicians to do no harm. The LGBTQIA+ communities in Florida are also our valued patients and I urge you to oppose the standard of care recommended by the Florida Department of Health.

Sincerely,

Sujatha Prabhakaran, MD, MPH, FACOG

August 5, 2022

Florida Board of Medicine
4502 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Re: Petition to Initiate Rulemaking Setting the Standard of Care for Treatment of Gender Dysphoria

Dear Members of the Florida Board of Medicine:

Physicians for Reproductive Health (PRH) urges you to reject the petition from the Florida Department of Health to initiate rulemaking banning gender-affirming care for young people in Florida. PRH is a physician-led, national organization working to improve access to comprehensive reproductive health care, including gender-affirming care. Our network includes physicians of all specialties from across the country, including physicians of multiple specialties in Florida, committed to meeting the health care needs of the patients they care for.

Gender-affirming care is safe, essential, life-saving health care that allows for transgender and non-binary people to be able to live their full and authentic lives. Leading medical organizations including the [American Academy for Pediatrics](#), [American Medical Association](#), [American College of Obstetricians and Gynecologists](#), [Endocrine Society](#), [Pediatric Endocrine Society](#) and [World Professional Association for Transgender Youth](#) support gender-affirming care for transgender and gender non-binary people.

Barriers to essential health care makes patients and our communities less healthy, and denies them access to the full range of the quality, compassionate, health care they deserve. Bans like these disproportionately impact transgender youth of color, indigenous transgender youth, and immigrant transgender youth – populations who already face immense discrimination and access barriers to health care.

As physicians, we know that access to supportive, gender-affirming care is vital for transgender and non-binary, especially youth. Transgender and nonbinary youth have an increased risk of depression and suicidal ideation compared to other young people, with recent studies finding that between two-thirds to 72% of transgender youth are depressed and half considered suicide. However, research consistently proves that when transgender and nonbinary youth are affirmed by people around them and have access to gender-affirming care, rates of depression and suicide drop significantly. A [recent study](#) found that transgender youth who receive gender-affirming care are 60% less likely to be depressed and 73% less likely to have thoughts of suicide or self-harm compared to those who do not receive care. Sadly, this same study revealed that youth who are not able to access care experience a two- to threefold increase in depression and suicidal thoughts – indicating that delaying hormones and puberty blockers may in fact worsen mental health symptoms. It cannot be overstated that gender-affirming care is safe, essential, necessary health care that promotes adolescents' health and well-being. Transgender and nonbinary youth should not be subjected to a forced, unwanted form of puberty, particularly when it comes at the expense of their dignity and health.

The April 2020 guidance from the Florida Department of Health opposing gender-affirming care for youth ignores medical and scientific evidence and makes false claims about the health risks of gender-affirming care. This guidance not only interferes with the patient provider relationship and interferes with a provider's best medical judgment, but it also opposes social transition for transgender youth.

Anti-trans Florida politicians want to not only intervene in private health care decisions, but also prevent transgender youth from using the name, pronouns, and gender presentation that conforms to their identity.

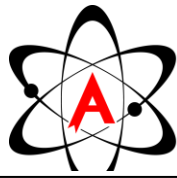
Banning access to care is clear government intrusion on personal decision making. The government should have no role interfering in private health care decisions, especially not decisions that dictate what a person's body should look like. Private medical and health care decisions should remain between the patient, and their trained, expert health care provider. These are personal, intimate decisions that people must be able to make for themselves. Patients need providers who will center their individual needs and provide individualized care – they do not need government control over their bodies. Gender-affirming care centers the interests and autonomy of the young person receiving care.

The Department of Health is out of step with the majority of Floridians. Over the past several years, public support for respecting the rights of transgender and nonbinary people has grown significantly, with large majorities of people across the political spectrum opposing discrimination against transgender people in health care and other parts of public life. Furthermore, discriminating against people based on their sexual orientation or gender identity is a violation of the non-discrimination provisions in the Affordable Care Act. No child deserves to be targeted by politicians for who they are. Instead of adopting a harmful rule to ban gender-affirming care for young people, the Florida Department of Health should listen to transgender people and the medical professionals who work directly with them, who understand the life-changing, positive impact of ensuring that they can access the gender-affirming care they need. Let transgender kids be who they are: kids who want to play, be with their friends and family, go to school, play sports, and access health care from compassionate, caring and competent providers.

The actions being undertaken by the Department of Health and its attempts to weaponize their authority is unprecedented and dangerous. I implore you, as The Board of Medicine, to exercise your professional judgement to reject the Department of Health's proposed rule. Transgender and nonbinary youth are depending on you to protect access to life-saving, safe, essential, gender-affirming health care. Everyone, including our young people, should be able to access the care they need. If you have any questions or would like additional information please reach out to Adrienne Ramcharan, Assistant Director of State Policy (aramcharan@prh.org).

Respectfully,

Jamila Perritt, MD, MPH, FACOG
President & CEO
Physicians for Reproductive Health



AMERICAN ATHEISTS

August 5, 2022

David Diamond, MD
Chair, Florida Board of Medicine
4052 Bald Cypress Way
Bin C-03
Tallahassee, Florida 32399

Re: OPPOSITION to Petition to Initiate Rulemaking regarding Standards of Care relating to Gender-Affirming Care

Dear Dr. Diamond and Members of the Florida Board of Medicine:

On behalf of its nearly 3,500 constituents in Florida, American Atheists stands in opposition to the petition to initiate rulemaking the Board of Medicine (“Board”) is considering,¹ which would result in the denial of critical, life-saving gender-affirming care to trans Floridians. We urge the Board to vote against this rulemaking and refuse to adopt this dangerous and harmful proposed standard of care.² This unfounded and malicious proposal will intensify systemic discrimination against trans people, undermine their access to life-saving health care, and unconstitutionally infringe their right to freedom of expression. The proposal asserts scientifically inaccurate claims and makes baseless arguments in a clumsy attack on scientifically based and medically sound gender-affirming health care, even going so far as to limit an individual’s ability to socially transition. We urge you to reject Surgeon General’s Ladapo’s petition to adopt a new “standard of care” in accordance with the Agency for Health Care Administration’s (“Agency”) guidance.

American Atheists is a national civil rights organization that works to achieve religious equality for all Americans by protecting what Thomas Jefferson called the “wall of separation” between government and religion created by the First Amendment. We strive to create an environment where atheism and atheists are accepted as members of our nation’s communities and where casual bigotry against our community is seen as abhorrent and unacceptable. We promote understanding of atheists through education, outreach, and community-building and work to end the stigma associated with being an atheist in America. As advocates for the health, safety, and

¹ Florida Board of Medicine, Gender Dysphoria Discussion Materials and Petition to Initiate Rulemaking, published Jun. 28, 2022. Available at: https://ww10.doh.state.fl.us/pub/medicine/Agenda_Info/Public_Information/Public_Books/2022/August/08052022_FB2_Publicbook.pdf.

² Florida Agency for Health Care Administration, General Medicaid Policy (proposed amendment), Fla. 59G-1.050, published Jun. 17, 2022. Available at: https://www.flrules.org/Gateway/View_notice.asp?id=25979915.

well-being of all Americans, American Atheists objects to efforts to subordinate the health and safety of all to the religious beliefs of a few.

Medical experts have conclusively established that gender affirming care is safe, clinically appropriate, and medically necessary for many individuals that experience gender dysphoria.³ Furthermore, legitimate and objective medical professional associations, such as the American Academy of Pediatrics, the American Medical Association, and the American Psychiatric Association, have long supported this care.⁴ These and other professional associations have expressly denounced the Agency's guidance, upon which this petition relies.⁵ The requested rulemaking and proposed guidance is not rooted in medical science, but instead social and religious bias against trans people. It seeks to deny them well-founded and necessary care, regardless of the impact on their health and well-being. Every claim the Agency asserted to support its guidance prohibiting coverage of gender-affirming care, and which is subsequently being used to support this petition, is inaccurate and misleading. The Board can and should ignore this politically driven so-called "science."

The materials and petition falsely assert that puberty suppression "leaves too many questions as to its effectiveness and medical necessity, especially considering how many children decide against transitioning," and therefore it should not be prescribed as doing so will "deny opportunities for adolescents to adapt and become comfortable with their natal sex." This deceptive claim intentionally disregards several published studies across the globe that have proven that detransition is rare. For example, a 2021 study showed that of 17,000 transgender-identifying adults, only 13% detransitioned.⁶ In that study, of the 13% of individuals who detransitioned:

- Approximately 32% detransitioned due to pressure from community or social stigma;

³ Dawson, L., Kates, J., & Musumeci, M. (2022, June 13). *Youth access to gender affirming care: The federal and state policy landscape*. KFF. Available at: <https://www.kff.org/other/issue-brief/youth-access-to-gender-affirming-care-the-federal-and-state-policy-landscape/>.

⁴ Rafferty, J. (2018, October 1). Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. American Academy of Pediatrics. Available at: <https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for?autologincheck=redirected>; AMA Reinforces Opposition to Restrictions on Transgender Medical Care. American Medical Association. (2021, June 15). Available at: <https://www.ama-assn.org/press-center/press-releases/ama-reinforces-opposition-restrictions-transgender-medical-care>; Physicians Oppose Texas Efforts to Interfere in the Patient-Physician Relationship and Criminalize Gender-Affirming Care. Psychiatry.org - Physicians Oppose Texas Efforts to Interfere in the Patient-Physician Relationship and Criminalize G. (2022, March 1). Available at: <https://www.psychiatry.org/newsroom/news-releases/physicians-oppose-texas-efforts-to-interfere-in-the-patient-physician-relationship-and-criminalize-gender-affirming-care>.

⁵ Dawson, L., Kates, J., & Musumeci, M. (2022, June 13). *Youth access to gender affirming care: The federal and state policy landscape*. KFF. Available at: <https://www.kff.org/other/issue-brief/youth-access-to-gender-affirming-care-the-federal-and-state-policy-landscape/>.

⁶ Turban, J. L., Loo, S. S., et al. (2021). Factors leading to "detransition" among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT Health*, 8(4), 273–280. <https://doi.org/10.1089/lgbt.2020.0437>

- Approximately 35% detransitioned due to parental pressure; and
- Only 2% (44 individuals) detransitioned due to “doubt around gender.”

Additional studies have shown that less than 2% of adolescents who underwent puberty suppression ceased treatment.⁷ In contrast, 78% of adolescents who received puberty suppression later surgically transitioned. Moreover, a 2021 study showed that of 7,900 transgender patients, only 77 patients (less than 1%) expressed regret, and many of those who did express regret did so as a result of lack of social acceptance.⁸

The materials and petition claims that there is no evidence to support providing gender-affirming medical care to trans people. This too is false, as there is overwhelming evidence demonstrating the positive impacts of gender-affirming medical care for those who need it. In fact, several studies have established that receiving gender-affirming care, such as hormone-replacement therapy, has significantly improved the mental and social health of trans people. In a study of 47 transgender youth who received gender-affirming hormones, these youth were 60% less likely to report depression and 73% less likely to report suffering from suicidal thoughts.⁹ Another relevant study showed that 83% of those who did not receive gender-affirming care experienced suicidal ideation and or engaged in self-harm.¹⁰ This is only a fraction of the robust research supporting gender-affirming care and confirming that it is medically necessary and appropriate health care for trans people.

Despite the overwhelming body of research supporting care for trans people, Surgeon General Ladapo, seemingly as a political extension of the DeSantis Administration, has sought to insert the Board of Medicine, and the entirety of the Florida government, into the relationships between trans patients and their doctors. The screening process and medical standards of care for trans people are well-established and medically conservative. In the event a doctor determines that it is in the best interest of their patient to provide gender-affirming care, that decision should remain with the patient, their parents if the patient is a minor, and the doctor. Instead, adopting a new standard of care denying affirming care would prohibit health care providers from acting in the best interest of their patients, regardless of their need or medical standards of care. Under other circumstances, failing to follow these standards would be considered negligent, opening the provider to liability, and yet that is what the petition seeks for all Florida health care providers.

⁷ Wiepjes, C. M., & de Blok, C. J. M., et al. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, 15(4), 582–590. <https://doi.org/10.1016/j.jsxm.2018.01.016>

⁸ Bustos, V. P., et. al. (2021). Regret after gender-affirmation surgery: A systematic review and meta-analysis of prevalence. *Plastic and Reconstructive Surgery - Global Open*, 9(3). <https://doi.org/10.1097/gox.00000000000003477>

⁹ Allen, L. R., et al. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302–311. <https://doi.org/10.1037/cpp0000288>

¹⁰ Tordoff, D. M., et. al (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open*, 5(2). <https://doi.org/10.1001/jamanetworkopen.2022.0978>

If adopted, this standard of care will cause immediate and irreparable harm. By denying basic health care services to trans people, the Board would subject trans and gender-diverse people to stigma and sanction government-mandated discrimination by health care providers. This will worsen the barriers to health care that trans people already face:

- 23% of trans and gender non-conforming people who informed health care providers of their gender identity were denied service altogether.¹¹
- Due to discrimination and disrespect, nearly 30% of trans and gender non-conforming people postponed or avoided medical treatment when they were sick or injured. Similarly, 33% of gender non-conforming and trans people did not seek needed preventative care.¹²

Instead of medical best practices, the origin of this proposed rulemaking traces to known anti-LGBTQ so-called “experts” and hate groups. One such “expert” relied upon by the Agency is the president of the American College of Pediatrics, a fringe anti-LGBTQ hate group that portrays itself as a mainstream professional organization.¹³ Another “expert” supporting this proposed rule is a deacon who has described an increase in trans identification as a “mass mutation.”¹⁴ A third “expert” supporting the proposed rulemaking has a history of ideologically biased research and anti-trans activities.¹⁵ In short, the guidance to support the adoption of a new standard of care is fueled by hatred against trans people, political opportunism, and religiously motivated disapproval of LGBTQ people rather than conclusive medical science. Adopting a new standard of care that limits gender-affirming care is unscientific and dangerous, and any authority that would adopt such a standard of care should be ashamed for letting itself be used as a political weapon to further a culture war at the expense of innocent lives.

Trans people already face significant stigma, and they are at higher risk for mental and physical harm as the result of not being able to access gender-affirming care. The vulnerable deserve to feel safe and supported by their State, not targeted for denial of health care. If passed, this proposed rulemaking would lead only to families fleeing the state to preserve the health and

¹¹ Grant, J., Mottet, L., & Tanis, J. (2016). (rep.). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Available at: https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.

¹² *Id.*

¹³ Zuckerman, J. (2020, February 5). *Conversion therapy is a discredited practice. Ohio hired its advocate as an expert witness*. Ohio Capital Journal. Available at: <https://ohiocapitaljournal.com/2020/02/05/conversion-therapy-is-a-discredited-practice-ohio-hired-its-advocate-as-an-expert-witness/>; American College of Pediatrics. Southern Poverty Law Center. (n.d.). Available at: <https://www.splcenter.org/fighting-hate/extremist-files/group/american-college-pediatricians>.

¹⁴ Lappert, D. P. W. (2021, May 14). *Doctor: Time for transgender treatment industry to "Follow the science"*. AL.com. Available at: <https://www.al.com/opinion/2021/05/doctor-time-for-transgender-treatment-industry-to-follow-the-science.html>.

¹⁵ *James Cantor vs. Transgender People*. Transgender Map. (2021, October 18). Available at: <https://www.transgendermap.com/politics/psychology/james-cantor/>.

well-being of their trans children, increased suicidality among trans children, discipline against doctors for trying to act in their patients' best interests, and rampant discrimination against trans people in the medical sector.

The petition for rulemaking is baseless, dangerous, and grossly discriminatory. The Board should not insert itself into the decisions between a patient, their parents, and their doctor, especially at the urging of "experts" whose only qualification is hatred against trans people. American Atheists strongly urges you to take a stand, reaffirm the integrity of Florida's health care system, and refuse to adopt a new standard of care limiting gender-affirming health care. Every patient, regardless of gender or gender identity deserves to receive adequate and medically necessary health care.

If you have any questions regarding American Atheists' opposition to the proposed rulemaking, please contact me at bwilliams@atheists.org.

Sincerely,



Brittany Williams
State Policy Counsel
American Atheists

From: [Jonathan Slimovitch](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender-Affirming Care
Date: Sunday, August 7, 2022 10:37:19 PM
Attachments: [FBOM Letter.pdf](#)

You don't often get email from jslimovitch@usf.edu. [Learn why this is important](#)

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To Whom This May Concern,

Please find attached a letter I wholeheartedly agree with regarding the preservation of the rights of children to access gender-affirming care in our state. Below are some of the highlights:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

I ask that you continue to allow physicians to be able to provide gender-affirming care to the children of our state for their physical, mental, and emotional well-being.

Sincerely,
Jonathan Slimovitch, MD



345 Park Blvd
Itasca, IL 60143
Phone: 630/626-6000
Fax: 847/434-8000
www.aap.org

July 29, 2022

Dr. David Diamond, Chair
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

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Dear Dr Diamond,

The American Academy of Pediatrics (AAP), a nonprofit organization representing 67,000 pediatricians dedicated to the health, safety and well-being of all children and the Florida Chapter of American Academy of Pediatrics, Inc (FCAAP), a nonprofit organization representing more than 2,600 pediatricians committed to serving all children across the state, writes to express our concern regarding the request from the Florida Surgeon General for the Florida Board of Medicine to develop new standards of care for the treatment of gender dysphoria.

Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics;ⁱ the Florida Chapter of the American Academy of Pediatrics, Inc;ⁱⁱ the American Medical Association;ⁱⁱⁱ the American College of Obstetricians and Gynecologists;^{iv} the American College of Physicians;^v the American Psychiatric Association;^{vi} the American Psychological Association;^{vii} the American Academy of Family Physicians;^{viii} the American Academy of Child and Adolescent Psychiatry;^{ix} the Endocrine Society;^x the Society for Adolescent Health and Medicine;^{xi} the Pediatric Endocrine Society;^{xii} the World Professional Association for Transgender Health (WPATH);^{xiii} and many more medical organizations committed to providing the best evidence-based care.^{xiv}

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7^{xv} and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline^{xvi} (both are herein referenced as "standards of care") are well recognized and accepted among the medical community as the gold standard for treating gender dysphoria.

Included in the Board's meeting agenda to discuss the development of new standards of care for the treatment of gender dysphoria is the June 2, 2022 Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report (GAPMS)^{xvii}. The AAP and FCAAP provided in-depth comments in opposition of both the GAPMS report and the proposed Medicaid rule to ban coverage of gender-affirming care. Our joint comments are included in our communication to the Florida Board of Medicine and we encourage you to review them. The GAPMS report, which serves as the evidentiary basis for the attempt to develop new standards of care, fails to satisfy even the basic tenets of scientific

inquiry and research.^{xviii} Experts from Yale University recently released a critical review of the GAPMS report and found:

- Contrary to the June 2 Report's repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported "expert" reports that are biased, inexperienced, and full of errors. The claimed "expert" reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
- The linchpin of the June 2 Report is an analysis by two epidemiologists that claims to undermine the scientific evidence supporting medical care for gender dysphoria. Their analysis is extremely narrow in scope, inexperienced, and so flawed that it merits no scientific weight at all.
- The June 2 Report repeatedly and erroneously dismisses solid studies as "low quality." If Florida's Medicaid program applied the June 2 Report's approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.^{xix}

Adolescents with gender dysphoria face increased challenges in life compared to their cisgender peers. Bullying, discrimination, harassment, and a lack of social acceptance are issues adolescents with gender dysphoria deal with on a daily basis and all these issues lead to increased risks of suicide and other mental health conditions.^{xx} In a study of more than 1,000 transgender adolescents, transgender adolescents had higher odds of all suicide outcomes compared to cisgender adolescents, and were at greater risk for suicidal ideations and attempts compared to their cisgender peers.^{xxi} Additionally, in the first large scale (N = 120,670) study examining the relationship between transgender adolescents and suicide, the authors found that between 30-51% of transgender adolescents reported engaging in suicidal behavior, compared to between 10-18% of their cisgender peers.^{xxii}

By proposing an alternative standard of care, Florida is ignoring the broad consensus among the medical community and the weight of peer reviewed medical literature. We call on the Florida Board of Medicine to reject the call for the development of new standards of care and ensure that the existing evidence-based standards of care are allowed to be used to care for children and adolescents with gender dysphoria. Only by doing so will the health and well-being of children and adolescents with gender dysphoria in Florida be preserved.

Thank you for your consideration of our comments.

Sincerely,

A handwritten signature in cursive script that reads "Moira Szilaygi".

Moira Szilaygi, MD, PhD, FAAP
President, American Academy of Pediatrics



Lisa Gwynn, DO, MBA, MSPH, FAAP

President, Florida Chapter of the American Academy of Pediatrics, Inc

ⁱ Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Gay, Lesbian, Bisexual and Transgender Health and Wellness. *Pediatrics*. Oct 2018; 142 (4) e20182162

ⁱⁱ Florida Chapter of the American Academy of Pediatrics, Inc. FCAAP Rejects New Florida Department of Health Guidelines on Gender-Affirming Care for Youth. 2022. Accessed on June 23, 2022. <https://www.fcaap.org/posts/news/press-releases/florida-chapter-of-the-american-academy-of-pediatrics-rejects-new-florida-department-of-health-guidelines-on-gender-affirming-care-for-youth/>

ⁱⁱⁱ American Medical Association. Health insurance coverage for gender-affirming care of transgender patients. 2019. Accessed on June 23, 2022. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>

^{iv} American College of Obstetricians and Gynecologists. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. 2021. Accessed on June 23, 2022. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>

^v Safer J, Tangpricha V. Care of the Transgender Patient. *Annals of Internal Medicine*. 2019 Jul 2;171(1):ITC1-ITC16.

^{vi} American Psychiatric Association. Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. 2020. Accessed on June 23, 2022. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>

^{vii} American Psychological Association. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, December 2015. Vol. 70, No. 9, 832–864

^{viii} American Academy of Family Physicians. Care for the Transgender and Gender Nonbinary Patient. 2020. Accessed on June 23, 2022. <https://www.aafp.org/about/policies/all/transgender-nonbinary.html>

^{ix} Adelson SL. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. *Jrnl of the American Academy of Child & Adolescent Psychiatry*. 2020; 957-974

^x Hembree W, Cohen-Kettenis P, Gooren L, Hannema S, Meyer W, Murad M, Rosenthal S, Safer J, Tangpricha V, T'Sjoen T. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2017; 102(11): 3869–3903

^{xi} Barkley L, Kodjo C, West KJ, et al. Promoting Health Equality and Nondiscrimination for Transgender and Gender-Diverse Youth. *Jrnl of Adolescent Health*. 2020; 66 (6): 804-807

^{xii} Lopez X, Marinkovic M, Rosenthal SM, et al. Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health. *Current Opinion in Pediatric*. 2017; 29(4). 475-480.

^{xiii} The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People 2011. Accessed on June 25, 2022. https://www.wpath.org/media/cms/Documents/SOC_v7/SOC_V7_English2012.pdf

^{xiv} Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>

^{xv} WPATH

^{xvi} Hembree et al

^{xvii} Florida Agency for Health Care Administration (ACHA), Division of Florida Medicaid. *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria (GAPMS)*. 2022. Accessed on June 22, 2022. https://ahca.myflorida.com/LetKidsBeKids/docs/AHCA_GAPMS_June_2022_Report.pdf

^{xviii} Alstott A, Boulware SD, Kamody R, Kuper L, Abdul-Latif H, McNamara M, Olezeski C, and Szilaygi N. Biased Science: A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria. July 8, 2022. Accessed on July 21, 2022. https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20ofinal%20july%208%202022%20accessible_443048_284_55174_v3.pdf

^{xix} Alstott et al

^{xx} Rafferty

^{xxi}Thoma BC, Salk RH, Choukas-Bradley , et al. Suicidality Disparities Between Transgender and Cisgender Adolescents. *Pediatrics*. 2019; 144(5)

^{xxii} Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 2018; 142(4)

From: [Eric Tragash](#)
To: [zzzz Feedback, MQA Medicine](#)
Subject: 2022-Aug-05 Hearing
Date: Sunday, August 7, 2022 7:42:18 AM

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Thank you for your service on this board. I attended today's meeting but had work responsibilities that kept me from being able to stay until the afternoon to provide a comment in person.

In preparation for this meeting started to review the over 1800 pages of documentation on the Medical Board's website. Obviously some group was paid handsomely to expound on why this panel should decide on the medical decisions of people they have never met.

I am willing to bet that if this Board tried, you could find 1800 or 18000 or even 180000 people willing to write 1 page each FOR FREE about how access to these therapies in question have positively affected them or their children PERSONALLY.

In fact, I know some portion of that record exists, as I **implore you to read Transitions of the Heart by Rachel Pepper**. It is an objective account unlike those 1800 pages living in the website.

It's truly unfortunate with all the issues, like the disciplinary issues and accounts of deplorable behavior I witnessed sitting in your hearing today, that need real problem solving, that pushing a discriminatory agenda is where this Board and our energies need to be focused. It's pretty clear there is an agenda being pushed for a course of action that really should be left to a patient, their physician and, for minors, the patient's guardian. The transrights issue we are taking about isn't something which needs to be legislated, it needs to be left to those intimately involved in the patient's life and protected under HIPAA.

We can all recognize that a person is more than the sum of their parts and must be treated as more than an X or Y chromosome.

Please don't discriminate against our citizens, even the minors. The lens of the future rarely looks back on those who discriminate favorably.

Thank you for your attention and good luck to all of us.

Sincerely a concerned parent and citizen.

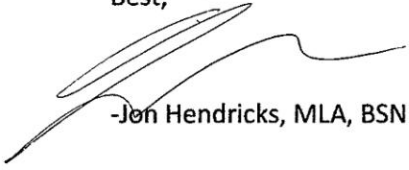
To the Florida board of medicine,

I understand that the surgeon general of the State of Florida has sent you a letter stating that under his view, gender-affirming care for treatment of gender dysphoria is something that the surgeon general of Florida wishes for the board of medicine to not endorse. I feel that this decision from the surgeon general is one of a politicized nature as the surgeon general has a track record of working with the state's governor in their quest to delegitimize vaccinations for COVID-19 and to instead promote illegitimate treatments for this disease.

The surgeon general vaguely states that there is not empirical evidence to suggest that treatment for gender affirming care is not of sound medical reasoning. Regardless, after performing a simple literature review, one can see that publications within the national institute of health database overwhelmingly suggest that gender affirming care is safe when prescribed in a clinical setting, and has the ability to improve the mental state of patients undergoing treatment for gender dysphoria. Moreover even though the surgeon general does not support the overwhelming literature and professional organizations that support gender affirming care (American association of pediatrics, world professional association for transgender health, the endocrine society, etc.), I would be hesitant to take medical advice from a person who sought to work with Governor Ron DeSantis to deed legitimize covid-19 vaccinations as well as to instead promote treatments for the disease that are not backed by credible empirical studies.

I implore the Florida board of medicine to not side with the politicized nature of the surgeon general's request, as I feel that this is simply an example of political posturing at the time when the governor is up for reelection. This is not a decision that is backed by evidence-based practice, empirical data, or even compassion for others. In effect, taking away gender affirming care from this population would be doing harm insofar as denying people access to treatment that has literally made their lives happier and in many instances prevented patients from completing suicide. As a nurse (recent BSN graduate), I will always fight for my transgender patients, as I would any of my other patients, to ensure that they have access to the care that they need to live a healthy and happy life.

Best,



-Jon Hendricks, MLA, BSN

11353 Stratton Park Drive

Temple Terrace FL 33617

2022 AUG 11 AM 11:57

PS - to the state reading this,
I Hope you like the sticker ☺

August 1, 2022

2022 AUG -4 PM 2: 04

BOM.MeetingMaterials@flhealth.gov

Department of Health, Board of Medicine,
4052 Bald Cypress Way, Bin C03,
Tallahassee, FL 32399

Re: Florida State Medical Board Meeting About the Non-binding AHCA Report

After the state's move to ban coverage for all transgender medical treatments for Medicaid became inconclusive (no vote), they struck again. Now, they seek to directly attack doctors via the state medical board for providing gender-affirming care.¹ By doing so, they (again) put that care within the grasp "of ... [state] officials"—not "withdraw[n] ... from the vicissitudes of political controversy[.]" *West Virginia Bd. of Ed. v. Barnette*, 319 U. S. 624, 638 (1943). Like with the Medicaid policy proposal, they use the same report, which has been rebutted by experts. Scientific standing is not the only problem here. I wrote in July that the proposed Medicaid "policy ... 'raise[s] the inevitable inference that the disadvantage imposed is born of animosity toward the class of persons affected.'" Response to Gen. Medicaid Pol. Propos. (quoting *Romer v. Evans*, 517 U.S. 620, 634 (1996)). That quote still holds water; it is not frivolous nor redundant. Indeed, state actions tell you everything you need to know: they only restrict the minority. It is illogical and perverse—it makes no sense to fulminate against transgender treatments while they could be equally applied to non-transgender individuals. And while the state is playing with the law, they are playing with trans people's lives and their liberty. This mistake should not be repeated by the Florida Medical Board. Accordingly, the medical board should not make any new rules or adjustments vis-à-vis transgender healthcare.

Absent any hiatus, the state is moving quickly to push flagrantly undermining rules to restrict (in all ways possible) transgender healthcare. To be clear, this is not the only state action in this area. On April 20, 2022, the Department of Health announced its new (non-binding) guidance opposing everything from "[s]ocial gender transition" to "puberty blockers or hormone therapy[]" for adolescents. Fla. Dept. of H. 2022. *Treatment of Gender Dysphoria for Children & Adolescents*. *Contra* Human Rights Campaign Rebuttal 2022, 1 (the guidance "dangerously cherry-pick[s] select research to assert their claims" while simultaneously "ignor[ing] the vast majority of the literature" supporting such treatments). And in June, the state's Health Care Administrative Agency sent a 46-letter claiming that "gender affirming" treatments are not safe or effective in the

¹ The meeting is set for August 5, 2022. See Florida Board of Medicine. n.d. "Meeting Information." Florida - Board of Medicine. <https://flboardofmedicine.gov/meeting-information/>

absence of “available medical literature[.]” DeSantis, Ron, and Simone Marstiller. 2022. *Fla. Medicaid-Gen. Acpted. Pro. Med. Std. Determ. on the Treatment of Gender Dysphoria* (hereinafter “AHCA Report”); see Florida Administrative Register 2022, pg. 2462 (a proposed medicaid rule barring Medicaid coverage for all medical treatments corresponding to “Gender Dysphoria[.]”) (unpub. rule).² Although the meeting has already finished (July 8), there still has not been a final decision. In its most recent move—and not even a month later—it seeks to have a new meeting with the medical board, consistent with the request by the surgeon general. This is particularly chilling given the statutory authority the Florida Medical Board possesses, and now it’s not just Medicaid—it’s every trans person at risk. Today, the medical board is at the center of the stage in the middle of a scientific and constitutional calamity.

Under Florida law, the Florida Medical Board has substantial power, including “disciplinary action” against physicians. Fla. Stat. § 458.331. Below are a few reasons for disciplinary action, clearly applying to gender-affirming treatments in the state’s dogma of them being, *inter alia*, “experimental” and not safe. AHCA Report, 38.

(q) it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs ... *inappropriately* or in excessive or inappropriate quantities *is not in the best interest of the patient* and is not in the course of the physician’s professional practice, without regard to his or her intent

(ee) prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs ...

Id., at 458.331 (1) (q)(ee) (emphasis added).³

If a physician violates those statutes above, the punishment could be, for example, “[r]estriction of practice or license,” “[s]uspension or permanent revocation of a license[.]” or even “an

² <https://www.flrules.org/notice/Proposedinfo.asp?id=25979915>

³ Surgeries for transgender individuals (more modest in usage than hormones or hormone blockers) may be also found within chapter 458. See Fla. Stat. § 458.328 (1) (h) (“...The board shall impose a fine of \$5,000 per day on a physician who performs a procedure or surgery in an office *that is not registered with the department*”) (emphasis added). Since the state is seeking to outlaw all transgender treatments, *see supra* ¶2, it is unlikely that it would be registered with the department. Even if we could surpass all of these statutes, “[t]he board has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it.” Fla. Stat. § 458.309 (1)

administrative fine[.]” Fla. Stat. § 456.072 (2) (b)(c)(d).⁴ The effect on the physicians is self-evident: many will be injured beyond just economic impairment. So too is the effect on transgender patients receiving (and needing) care. When treatment is diminished or stopped, the increase in the rates of suicide, suffering, and depression is not a mere question—it is a statement.⁵

The state’s actions today should not survive in the United States. When looking at the state’s actions relative to the AHCA Report, there’s no sheer concern about the “irreversible physical changes and side effects that can affect long-term health” related to treatments for gender dysphoria. 2. Nor could they: to this day, they have consistently failed to equally apply it to cisgender individuals, even when many treatments (as applied to cisgenders) are just as dangerous. *Compare* Fla. Dept. of Health guidance (opposing specifically gender-affirming care) *and* Florida Administrative Register 2022, 2462 (similar) *with* AHCA Report, 2–38 (similar). Indeed, “[i]f there is need to have [a] physician prescribe (and a pharmacist dispense) contraceptives, that need is as great for unmarried persons as for married persons.” *Eisenstadt v. Baird*, 405 U.S. 438, 450 (1972). Or, said another way, “[i]f there is a need to protect transgender youth from the purported risks of the banned treatments (there is not), then that need is as great for cisgender and/or intersex youth who receive the same medical treatments.” *Walker v. Marshall*, 2:22-cv-00167 (N.D. Ala. 2022), ECF 10, pg. 38 (hereinafter “*Walker*”). I will name a few examples. The state is fine with “chest surgery for [the] treatment of gynecomastia” as well as “chest-feminizing surgery” for non-transgenders. *Id.*, at 40. Similarly, gender dysphoria treatments, such as puberty blockers, “are also used to delay puberty in children with central precocious puberty[.]” *Id.*, at 39. The state says nothing about that. The same issue applies to hormone therapy: as for “nontransgender girls with primary ovarian insufficiency,” “hypogonadism,” and “Turner’s Syndrome,” for example, the state does not say anything about hormone treatment for those either. *Id.*, at 39–40. “[P]olycystic ovarian syndrome” may require testosterone blockers. *Id.*, at 40. Yet, the state bats no eye on blockers for that (nor any of the examples above)—even though apparently *all* medical treatments for gender dysphoria can cause “side effects that can affect long-term health[.]” AHCA Report, 2.

⁴ The medical board’s mission statement is far more candid: “The Florida Board of Medicine ... will license, monitor, discipline, educate, and when appropriate, rehabilitate physicians and other practitioners[.]” Florida Board of Medicine. n.d. Florida Board of Medicine - Healthcare Practitioner Licensing and Regulation. Accessed July 30, 2022. <https://flboardofmedicine.gov/>

⁵ See, e.g., Human Rights Campaign Rebuttal, *supra*, at 4–5 (listing six studies that demonstrate this); Olson, Kristina R. 2016. “Mental Health of Transgender Children Who Are Supported in Their Identities.” *Pediatrics* 137, no. 3 (March): 2015–3223 (stating that “[s]ocially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety”—albeit better than not getting treatment or being “supported.”); *infra* ¶7 (*Amicus Curiae* brief)

There's no legitimate concern by the state about the quality of evidence either—and it would be almost impossible for the state to carry their burden of making an “exceedingly persuasive” justification. *United States v. Virginia*, 518 U.S. 515, 524 (1996). Beyond the purported concern about “side effects,” the report also claims there is “weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures[.]” AHCA Report, 3. Thus, such treatments “are experimental and investigational.” *Id.* The public record demonstrates, however, that the state “tethers [transgender individuals] to sex stereotypes which, as a matter of medical necessity, they seek to reject.” *Kadel v. Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020). As a threshold matter, “the State cannot carry its burden to justify the[ir] [state actions] based on purported concerns about the quality of the evidence concerning the treatment for two reasons: (1) the consensus within the mainstream medical community is that the treatment is effective, and (2) even if there were limitations in the data supporting efficacy of the care, that would not explain why only this medical care—when provided to transgender [individuals]—is singled out for a uniquely high standard of evidence.” *Walker*, 44. All mainstream medical organizations, such as “the American Medical Association, the American Academy of Pediatrics, and the Endocrine Society,” have deduced and affirmed that gender-affirming treatment “is safe and effective.” *Id.* Even experts from Yale are on the same train: “If Florida[] ... applied the June 2 Report’s [low-quality concern] approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.”⁶ McNamara, Meredith et al. 2022. *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria*, pg. 3 (hereinafter “AHCA Review Report”); see *id.*, at 16; see also *id.*, at 5 (gender-affirming care “has been vetted and approved by international bodies of experts based on the scientific evidence.”) The state has failed to do so and subjects transgender individuals to an unusual standard of evidence vis-à-vis their non-transgender counterparts. Therefore, there are no legitimate state interests.

⁶ To continue with the “low quality” concern, the state mentions it many times—even at the start. See, e.g., AHCA Report, 2 (“Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality”). When readers surpass this deceptive language, however, they see that under the GRADE rating standards, even “low quality” studies “support a strong clinical treatment recommendation.” AHCA Review Report, 14; see Balshem, Howard, et al. 2011. “GRADE guidelines: 3. Rating the quality of evidence.” *J Clin. Epidemiol.* 64, no. 4 (Jan): 401-6. Randomized control trials would be considered “high quality” (AHCA Review Report, 13) while, conversely, observational proof, such as “studies [are] technically ranked as ‘low quality,’” *id.*, at 16 (citing Stone, Neil J. 2014. “2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults.” *Circulation* 129, no. 25 (June): S1-S45.) As stated above, medications, including statins and “common medical procedures like mammograms and routine surgeries,” rely on observational studies. AHCA Review Report, 3, 16 & n53. Thus, those studies are “low quality”—yet we don’t see the state sending a 46-page letter opposing any of those treatments, nor the other actions it has taken over the past couple of months. Either the state is hypocritical or it is discriminatory. It seems to be one or the other.

The state's dependence on faulty scientific findings does not rescue their claims. The state has sanctioned a reputedly "scientific report that so blatantly violates the basic tenets of scientific inquiry." *Id.*, at 2. It is "a document crafted to serve a political agenda." *Id.* In form and in effect, it endangers "adolescents with gender dysphoria access to medical interventions that alleviate suffering" by creating an unscientific report that spreads like a wildfire. Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, p. 19, *Eknes-Tucker v. Ivey*, 2:22-cv-184-LCB-SRW (M.D. Ala. 2022). And when "research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation," the state merely ducks. *Id.*⁷ Hereunder, I will go over the major findings in the AHCA Review Report.

First, five attachments (by "experts") to the AHCA Report disregard medical guidelines for the treatment of gender dysphoria and instead "recommend against the use of such interventions to treat what is categorized as a mental health disorder[.]" 2. *Contra* Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, 7–14 (20 major medical organizations listing the guidelines and affirming their effectiveness). However, the attachments could not be further afield. Not only do they go against the 20 major organizations listed above, but they also have underlying questions of bias and expertise. See AHCA Review Report, 6. Most notably, *none* are "peer-reviewed or published," a vital criterion by which scientific pieces may be publicly scrutinized. Nor do any of "the attachments provide a statement of funding and conflicts of interest." *Id.*, at 7. And *all* raise "flags" of bias. *Id.*, at 6. But first, turn to attachment E, which is by Quentin van Meter. He is the president of the American College of Pediatricians (ACP), a "political" organization "that opposes same-sex marriage, supports mental health providers practicing conversion therapy, and describes childhood gender dysphoria as 'confusion.'" *Id.*, at 7 (citations omitted); see *id.*, at n15, n16, n17. Meter has also been disqualified by a judge for being incapable of giving expert testimony about "the legal question of whether an adolescent transgender child should be administered puberty blockers and whether affirmation of an incongruent gender in a child is harmful or not[.]"⁸ Similarly, James Cantor (attachment D) in the report fares no better. There, "the Court gave

⁷ While "Cantor specifically notes that actual suicides are highly unlikely among gender dysphoric individuals, particularly trans-males[.]" the wall of medical experts (20 to be exact) seem to say otherwise. AHCA Report, 28. To be clear, "*more than one in three* transgender adolescents reported having attempted suicide in the preceding 12 months." Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, 6 (emphasis added); see *id.*, at n15. And even if Cantor and the state are true, they miss the point: Suicide attempts are a risk factor for completing suicide. Bostwick, Michael. 2016. "Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew." *Am J Psychiatry* 173, no. 11 (Nov): 1094–1100.

⁸ Caruso, Stephen. 2020. "A Texas judge ruled this doctor was not an expert. A Pennsylvania Republican invited him to testify on trans health care." *Pennsylvania Capital-Star*, September 15, 2020. <https://www.penncapital-star.com/government-politics/a-texas-judge-ruled-this-doctor-was-not-an-expert-a-pennsylvania-republican-invited-him-to-testify-on-trans-health-care/>

[Cantor's] testimony little weight because he admitted, *inter alia*, to having no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria.” *Id.*, at 8 (quoting Opinion and Order, *Eknes-Tucker v. Marshall*, 2:22-CV-184-LCB-SRW (M.D. Ala. 2022)). He could have been on the case because his “appearance in that case seems to have been funded by the Alliance Defending Freedom (‘ADF’), a religious and political organization that opposes legal protections for transgender people and same-sex marriage and defends the criminalization of sexual activity between partners of the same sex.” *Id.* (citations omitted); *see id.*, at n22, n23, n24. As for Attachment C (Romina Brignardello-Petersen & Wojtek Wiercioch), issues run the gamut, including inexperience. The first problem is quite simple—Brignardello-Petersen’s “only clinical experience appears to be in dentistry.” *Id.*, at 10.⁹ Apparently, we live in an alternate universe (“Florida”) where “dentistry” in lieu of endocrinology and mental health as applied to transgender care somehow passes as “expert.” Wiercioch, the other author, is a “postdoctoral fellow” who has “no prior research or clinical experience in” transgender care. *Id.* Indeed, the foregoing issues go against relevant guidelines; they require “expertise in the pertinent clinical content areas.”¹⁰ The study that the authors provide (Attachment C) is not peer-reviewed, nor are any of the studies in the attachments for that matter. As stated above, peer review is very important—it is not “merely window-dressing; they reflect bedrock commitments of the scientific method.” *Id.*, at 11. By failing to undertake basic peer-review, the authors (and most of the authors from the attachments) truncated ordinary procedures of scientific review. Furthermore, the authors include in their study a website called SEGM.org. *See id.* That citation crumbles upon examination; “the group’s website posts are not peer-reviewed or published, and its content is assembled by a small group of activists with few or no expert credentials[.]” *Id.* (quoting Boulware 2022).¹¹ Most notably, Brignardello-Petersen is connected to the group, having “conducted research” for them. *Id.*, at 8. The study provided by the authors suffers even more losses by further review. *See id.*, at 11–14 (evaluating the authors’ usage of certain rating systems and the absence of sufficient literature). Now, we turn to Patrick Lappert (Attachment F). Like Meter and Cantor, “evidence ... calls Lappert’s bias and reliability into serious question.” Memorandum Opinion and Order, *Kadel v. Folwell*, 1:19CV272 (M.D.N.C 2022), pg.

⁹ Brignardello-Petersen’s profile also states that she is a “Assistant Professor[of] Health Research Methods, Evidence, and Impact[.]” Brignardello, Romina. n.d. “Romina Brignardello Assistant Professor, Health Research Methods, Evidence, and Impact.” McMaster Experts. Accessed July 30, 2022. <https://experts.mcmaster.ca/display/brignarr>. But, as of July 30, 2022, her only contributions are in, *inter alia*, virology and epidemiology—both, again, inexpert for transgender care. *See id.*

¹⁰ Institute of Medicine, Board on Health Care Services, and Committee on Standards for Systematic Reviews of Comparative Effectiveness Research. 2011. *Finding What Works in Health Care: Standards for Systematic Reviews*. Edited by Alfred Berg, et al. N.p.: National Academies Press.

¹¹ Boulware, Susan D. 2022. “Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims.”

27. The court order also observed that “Lappert has worked closely with ADF” and had been to conferences that “asked whether they would be willing to participate as expert witnesses.” *id.* (quoting ECF No. 209-2 at 90:13–91:13).¹² The issues listed above are not mere hypothetical concerns; they are serious barriers posed, such as conflicts of interest and biases. Worse, the authors as listed in the attachments never address or mention them—or list them as every “scientific” report is supposed to do. *See* AHCA Review Report, 7 & n13.

Second, the AHCA Report attempts to dismiss various studies. However, by doing so, they trip over their own feet in the process—another fatal mistake. Below is a non-exhaustive list of those failed attempts. To begin, turn to page 15 of the report. There, the Costa study “relies heavily on self-assessments” so apparently the results “are likely biased and invalid.” AHCA Report, 15. The report also claims that the “short-term period of the study” warrants condemnation. *Id.* These points lack merit for two reasons. First, the “self-assessments” are from a test called the Children’s Global Assessment Scale. It is well-documented, well-regarded, and accepted, and is relied upon for psychological research. AHCA Review Report, 17. The scale is thus “carefully constructed and psychometrically validated.” *Id.* Lastly, one cannot solely criticize a medical study—that is, in this study, about the efficacy of puberty blockers—without looking into the vast array of other studies because “[s]cientific knowledge is ... cumulative.” *Id.*, at 18. The AHCA Report blindly attacks “a single study and fails to acknowledge that the weight of the literature as a whole strongly supports the same results that Costa et al. report.” *Id.*, at 17–18 (emphasis deleted). Continuing on to the other studies, the AHCA Report on the Chen article deludes the reader by misrepresenting the article’s contents. *See* AHCA Report 15–16 (stating, by use of the article, that the “the effects of pubertal suppression warrant further study”).¹³ *But see* AHCA Review Report, 18 (The article “is not a substantive study of the effects of puberty blockers”). The article is “a consensus parameter[]”—a type of “structured methodology” that enables experts to create a “research agenda for future studies.” *Id.* Thus, those types of opportunities are simply to pick out ways to research subjects and techniques—not to be cited in such a narrow manner by the state. The review report says it perfectly: the article’s “statements are not indictments of puberty blockers—they are conventional acknowledgments of the value of further study that drives scientific inquiry and innovation.” *Id.* The AHCA Report separately cites a case in which they say “puberty suppression causes side effects, some of which have the potential to be permanent.” 16. Interestingly, the report says that these “indicate that Gn-RH is safe” and that the majority of the “side effects associated

¹² He has also stated that physicians “should be ‘criminally prosecute[d]’ for giving gender-affirming care. *Kadel*, at 27 (quoting ECF No. 209-2 at 52:4-18, 54:7–55:2, 57:8-15, 61:16–64:20).

¹³ (quoting Chen, Diane. 2020. “Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth.” *Transgender Health* 5 (4): 246-257) (hereinafter “Chen et al”)

with Gn-RH are mild[.]” *Id.* One of the side effects the report digs into is “osteonecrosis.” *Id.* However, even it states that this side effect “is rare[.]” *Id.* From the state’s perspective, minor or moderate side effects (in its view, more solid than others) cause burdens—burdens that could be circumvented in toto if we strip away the right (and only the right) to gender-affirming care even though every medical organization opposes it. This is a strange way of looking at rights, and there is a good reason courts have not adopted this thinking. Further, it’s clear that gender-affirming care is not atypical for having specific side effects, so it makes no sense to only try to restrict and demean that care to a sole minority group. *See Walker*, 41–42 (rejecting the state’s concern of “risks” to justify banning gender-affirming care because there was nothing special tailored to those treatments).¹⁴

Third, the state again tries to negate the applicability of gender-affirming treatments to other treatments. Now, they try to assert that the “FDA did not approve [puberty blockers and hormone therapy] for treating gender dysphoria” and, as a result, it is classified as “off-label[.]” AHCA Report, 8. But the fact is, many drugs are used “off-label.” *See, e.g.*, AHCA Review Report, 20–21 (gabapentin is used off-label “for neuropathic or mixed pain”); (ketamine and fentanyl is used “off-label for pain relief”); (“[c]affeine is used off-label to treat apnea” including “phenobarbital is used off-label to treat neonatal seizures” in the NICU); (“pantoprazole is a proton pump inhibitor” and is also “used off-label in neonates with gastroesophageal reflux disease”); (“[o]ndansetron (Zofran) is used off-label for nausea and vomiting to prevent fluid loss”). As mentioned above, the state subjects transgender individuals to different standards of care in relation to their non-transgender counterparts. *See supra* ¶6.

Fourth, the AHCA Report claims that “the *majority* of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex[.]” 14 (emphasis added). Similar to Texas Attorney General Ken Paxton’s interpretations, the report uses the term “children” *Id.* “Actual scientific evidence on the course of gender dysphoria emphasizes the importance of distinguishing between prepubertal children and adolescents.”¹⁵ When the AHCA Report uses that

¹⁴ Also troubling, the letter cites studies that contradict its previous assertions, “in what looks like a circular firing squad.” *Equality Florida v. DeSantis*, 4:22-cv-0134-AW-MJ (N.D. Fla. 2022), ECF 81, pp. 13–14. *Compare* AHCA Report, 17 (“Prescribers ... de-emphasize that these drugs cause permanent physical changes and side effects that can lead to premature death”) with AHCA Report, 17 (the risk of long term effects are small, “most side effects associated ... are mild,” and “the authors indicate that Gn-RH is safe”) and Chen et al, 249 (“[s]uppressing puberty may reduce dysphoria and diminish risks for poor mental health in this population, thereby exerting *neuroprotective* effects.”) (emphasis added).

¹⁵ Boulware, Susan D. 2022. “Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims,” p. 18 (hereinafter “Texas and Alabama Report”).

terminology, it gives a false sense “that most or all children *and* teens diagnosed with dysphoria will cease identifying with the gender not assigned at birth.” Texas and Alabama Report, 18. Of course, that is wrong. Rather, studies paint a different picture: “[A]dolescents who are diagnosed with gender dysphoria will persist in their gender identity[.]” *Id.*; *see id.*, n63, n64, n65. Although the resolving rate *is* higher in prepubescent children suffering from gender dysphoria, “standard medical protocols do not treat prepubertal children with drug therapy or ... surgery.” *Id.*, at 18; *see* Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, 9. To defend its position, the state generally cites a study by Littman, but that goes awry.¹⁶ In the study, Littman “defines detransition as ‘discontinuing medications, having surgery to reverse the effects of transition, or both.’” AHCA Review Report, 22. This is obviously confusing because there are many reasons why people might want to stop medications. Applying her logic, her definition of a transgender individual could continue to be socially transitioned but be counted as a “detransition[er].” *Id.* Conversely, the state disregards important studies showing, *inter alia*, low regret and a detransition rate (findings were around $\leq 1\%$).¹⁷

Fifth (and lastly), the AHCA Report’s groundless statements about gender dysphoria being caused by “social and peer contagion.” 12. This so-called “peer contagion” in gender dysphoria may be caused by “rapid onset gender dysphoria[.]” *Id.* What is the pathology, or even the citations to back up this extraordinary claim? The former is not supported by any studies while the latter, is *her* study only. “Neither the American Psychiatric Association nor any other reputable professional organization” has actually validated ROGD. Texas and Alabama Report, 21. It could be because the study itself did not receive adequate feedback for it to be sufficient in the eyes of major organizations. The Texas and Alabama Report said

WPATH, among other authorities, has taken a skeptical view of Littman’s claim, and the study has been criticized for serious methodological errors, including the use of parent reports instead of clinical data and the recruitment of its sample of parents from anti-transgender websites. The journal of publication required an extensive correction of

¹⁶ Littman, Lisa. 2021. “Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners.” *Arch Sex Behav.* 50, no. 8 (Nov): 3353–69.

¹⁷ Bustos, Valeria et al P. 2021. “Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence.” *Plast Reconstr Surg Glob Open.* 9, no. 3 (Mar); Danker, Sara et al. 2018. “Abstract: A Survey Study of Surgeons’ Experience with Regret and/or Reversal of Gender-Confirmation Surgeries.” *Plastic and Reconstructive Surgery* 6, no. 9S (Sept); Wiepjes, Chantal M., et al. 2018. “The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets.” *J Sex Med.* 15, no. 4 (Apr): 582–90; *see also* Smith, Yolanda L. 2005. “Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals.” *Psychol Med.* 35, no. 1 (Jan): 89-99; Olson, Kristina R. 2022. “Gender Identity 5 Years After Social Transition.” *Pediatrics* 150, no. 2 (Aug).

the original Littman article because of its misstatements. Such a correction in reputable, peer reviewed academic journals is taken only when a panel of experts, in retrospect, came to recognize the methodological flaws of the original study and concluded that it would be unscientific to allow the originally published findings to stand.

Id., at 20–21.

Moreover, studies have rejected these notions of ROGD. When 173 youth arrived at Canadian gender clinics in 2022, they “found no evidence of rapid-onset dysphoria or social contagion” even when considering Littman’s hypothesis. AHCA Review Report, 24. And when another 173 youths were studied, they were also stumped with the same result: “no such correlations[]” materialized. *Id.*¹⁸ Data from the Williams Institute also supports those studies. The data simply “do[es] not show a massive wave of transgender identity even among teens.” *Id.* As of 2022, a study shows that 0.5% of adults and 1.4% of youth aged 13-17 identify as transgender (equivalent to 300,000 young individuals). *Id.*¹⁹ Collectively, the foregoing studies and resources join together to demonstrate the opposite of what the AHCA Report claims: there is no evidence of “rapid onset gender dysphoria” nor “social and peer contagion.” 12. Instead, it shows something else hidden under the cracked surface—stereotypes that transgender individuals “do not know[] their own gender identity and readily change their gender identity based on peer influence and social media.” AHCA Review Report, 24.

“[W]e are beyond the day when an [individual or] employer could evaluate [others] by assuming or insisting that they matched the stereotype associated with their group[.]” *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) (plurality op.). The state collapses under its own feet. “Nor is there an adequate remedy for preventable ‘life-long diminished well-being and life-functioning.’” *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1042 (7th Cir. 2017). When the state could eliminate discrimination, it chooses not to. The detrimental and irreparable effect is on the minority whom they have a compelling interest in protecting. *See Bd. of Dirs. of Rotary Int. v. Rotary Club of Duarte*, 481 U.S. 537, 549 (1987) (declaring the “State’s compelling interest in eliminating discrimination”); *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 252–53 (1964) (observing the systemic effects of discrimination); *id.*, at 274 (similar) (Black, J. concurring).

¹⁸ Bauer, Greta R., et al. 2022. “Do Clinical Data from Transgender Adolescents Support the Phenomenon of “Rapid Onset Gender Dysphoria?”” *J Pediatr.* (Apr), 224–27.

¹⁹ Herman, Jody L. 2022. “How Many Adults and Youth Identify as Transgender in the United States?” The Williams Institute.

Respectfully,

Michael Armstrong
Gay-Straight Alliance President
marmstrong321@msaschool.org

References:

1. Balshem, Howard. 2011. "GRADE guidelines: 3. Rating the quality of evidence." *J Clin. Epidemiol.* 64, no. 4 (Jan): 401–6. 10.1016.
2. Bauer, Greta R. 2022. "Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?" *J Pediatr.*, (Apr), 224–27. 10.1016.
3. Bostwick, Michael. 2016. "Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew." *Am J Psychiatry* 173, no. 11 (Nov): 1094–1100. 10.1176.
4. Boulware, Susan D. 2022. "Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims."
5. Brignardello, Romina. n.d. "Romina Brignardello Assistant Professor, Health Research Methods, Evidence, and Impact." McMaster Experts. Accessed July 30, 2022.
<https://experts.mcmaster.ca/display/brignarr>.
6. Bustos, Valeria P. 2021. "Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence." *Plast Reconstr Surg Glob Open.* 9, no. 3 (Mar). 10.1097.
7. Caruso, Stephen. 2020. "A Texas judge ruled this doctor was not an expert. A Pennsylvania Republican invited him to testify on trans

health care.” *Pennsylvania Capital-Star*, September 15, 2020.

<https://www.penncapital-star.com/government-politics/a-texas-judge-ruled-this-doctor-was-not-an-expert-a-pennsylvania-republican-invited-him-to-testify-on-trans-health-care/>.

8. Florida Administrative Register. 2022. “Florida Administrative Register.” 48, no. 118 (June): 2459–74.
9. Florida Department of Health. 2022. *Treatment of Gender Dysphoria for Children and Adolescents*.
10. Human Rights Campaign. 2022. *Florida Department of Health Memo Misleading the Public on the Science Behind Gender-Affirming Care*.
11. DeSantis, Ron, and Simone Marstiller. 2022. *Florida Medicaid - Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria*.
12. Chen, Diane. 2020. “Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth.” *Transgender Health* 5 (4): 246–57.
13. Danker, Sara. 2018. “Abstract: A Survey Study of Surgeons’ Experience with Regret and/or Reversal of Gender-Confirmation Surgeries.” *Plastic and Reconstructive Surgery* 6, no. 9S (Sept). 10.1097.
14. DeSanctis, Vincenzo. 2019. “Long-term effects and significant Adverse Drug Reactions (ADRs) associated with the use of Gonadotropin-Releasing Hormone analogs (GnRHa) for central precocious puberty: a brief review of literature.” *Acta Biomed*. 90, no. 3 (Sep): 345–59. 10.23750.

15. Florida Board of Medicine. n.d. Florida Board of Medicine - Healthcare Practitioner Licensing and Regulation. Accessed July 30, 2022. <https://flboardofmedicine.gov/>
16. Florida Board of Medicine. n.d. "Meeting Information." Florida - Board of Medicine. <https://flboardofmedicine.gov/meeting-information/>
17. Herman, Jody L. 2022. "How Many Adults and Youth Identify as Transgender in the United States?" The Williams Institute.
18. Institute of Medicine, Board on Health Care Services, and Committee on Standards for Systematic Reviews of Comparative Effectiveness Research. 2011. *Finding What Works in Health Care: Standards for Systematic Reviews*. Edited by Alfred Berg, Sally Morton, Laura Levit, and Jill Eden. N.p.: National Academies Press.
19. Littman, Lisa. 2021. "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners." *Arch Sex Behav*. 50, no. 8 (Nov): 3353–69. 10.1007.
20. McNamara, Meredith. 2022. *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria*.
21. Olson, Kristina R. 2016. "Mental Health of Transgender Children Who Are Supported in Their Identities." *Pediatrics* 137, no. 3 (March): 2015–3223.
22. Olson, Kristina R. 2022. "Gender Identity 5 Years After Social Transition." *Pediatrics* 150, no. 2 (Aug). 10.1542.

23. Smith, Yolanda L. 2005. "Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals." *Psychol Med.* 35, no. 1 (Jan): 89–99. 10.1017.
24. Stone, Neil J. 2014. "2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults." *Circulation* 129, no. 25 (June): S1–S45.
25. Wiepjes, Chantal M. Apr. "The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets." *J Sex Med.* 15, no. 4 (2018): 582–90. 10.1016.

Other References:

Cases:

1. *West Virginia Bd. of Ed. v. Barnette*, 319 U. S. 624 (1943)
2. *Romer v. Evans*, 517 U.S. 620 (1996)
3. *Eisenstadt v. Baird*, 405 U.S. 438 (1972)
4. *Walker v. Marshall*, 2:22-cv-00167 (N.D. Ala. 2022)
5. *United States v. Virginia*, 518 U.S. 515 (1996)
6. *Kadel v. Folwell*, 446 F. Supp. 3d 1 (M.D.N.C. 2020)
7. *Eknes-Tucker v. Marshall*, 2:22-CV-184-LCB-SRW (M.D. Ala. 2022)
8. Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, *Eknes-Tucker v. Ivey*, 2:22-cv-184-LCB-SRW (M.D. Ala. 2022)
9. *Equality Florida v. DeSantis*, 4:22-cv-0134-AW-MJ (N.D. Fla. 2022)
10. *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)
11. *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034 (7th Cir. 2017).
12. *Bd. of Dirs. of Rotary Int. v. Rotary Club of Duarte*, 481 U.S. 537 (1987)
13. *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964)

Statutes:

1. Fla. Stat. § 458.331
2. Fla. Stat. § 456.072
3. Fla. Stat. § 458.328
4. Fla. Stat. § 458.309

August 1, 2022
3641 NW 23rd Place
Gainesville, FL 32605

Dear Members of the Board,

In light of your recent guidance on the treatment of gender dysphoria for children and adolescents, as well as your Petition to Initiate Rulemaking on the same issue, I would strongly encourage you to at the very least issue guidance regarding another topic: infant male circumcision (circumcision).

I strongly believe circumcision is wrong and should not be permitted under Florida law. However, I only have a limited understanding of medicine, so I would highly encourage you to read this material about why it is wrong from a medical perspective, written by a highly qualified group of doctors: <https://www.doctorsopposingcircumcision.org/for-professionals/>. The medical case against it is comprehensive and overwhelming.

No medical association in the world recommends circumcision. Even the disreputable American Academy of Pediatrics cannot bring itself to issue a current statement on circumcision. The last statement it issued, in 2012, only states that families should be able to choose this for their children if they wish. No other medical association in the world takes a stance that is even remotely this pro-circumcision.

The scientific evidence supporting circumcision for alleged health benefits is incredibly weak. However, even if it were true, it would still not justify it. Circumcision is amputation of tissue and therefore must only be considered when conservative treatment for a diagnosed physical disease has failed. The vast majority of children do not have any diseases or conditions that would indicate the need for any treatment, much less circumcision. In addition, since the vast majority of circumcisions take place on minors who cannot give any consent, additional care must be taken. Proxy consent by parents is not sufficient.

The negatives of circumcision are numerous and obvious, but often denied. However, what is undeniable is that healthy tissue is removed. This by itself is enough reason for the procedure to be unethical. In no other circumstance is this considered acceptable in the state of Florida, and rightfully so. This is the main reason certain "gender affirming" procedures, such as castration and mastectomy, are unethical. The removal of healthy tissue, especially the genitals, especially from a child, should not be done. Either we live in a society which condones genital mutilation, or we do not.

Florida Statute 794.08 clearly and concisely bans female genital mutilation. This same protection should be provided to male children in Florida. It would be controversial, but the Department of Health has the authority to effectively ban circumcision. In addition to the Department's role in promoting the health of all Floridians, F.S. 458.331(1)(v) gives it the authority to establish standards of care. Requiring that informed consent be given by the patient on whom the circumcision is performed would eliminate almost all of the ethical problems with the procedure, and in my opinion be sufficient.

Your actions regarding circumcision would not follow the consensus in the United States medical community, but they would follow the consensus of the rest of the world. More importantly, it would be the moral and ethical stance to take. I applaud your recent actions opposing "gender affirming" care. You have been vilified, slandered, and threatened for these actions. Public opinion does not yet have quite the same negative view of circumcision as it does "gender affirming" surgeries, but that is rapidly changing. However, you should not base your decision upon public opinion in your decision making. Do what is right, not necessarily what is popular. Prove once more to the nation and the world that Florida is consistently dedicated to protecting the health and freedom of its citizens.

Sincerely,

A handwritten signature in cursive script that reads "Caleb Richard Duggan". The signature is written in dark ink and is positioned below the word "Sincerely,".

Caleb Richard Duggan

P.S. If you would like to watch a video lecture which gives a good overview of circumcision, I recommend this video: <https://youtu.be/XwZiQyFaAs0?t=264>.

Wendy Peale
8200 NW 105 Avenue
Tamarac, Florida 33321

MEDICINE BOARD
2022 AUG 18 AM 9:46

August 11, 2022

Dear Distinguished Members of the Board of Medicine,

I am writing this one letter to send to those of you who voted in favor of advancing the petition from the Florida Surgeon General for workshops and expert testimony on deciding the matter of care for transgender children and youth.

As a mom of a non-binary child, now a young adult, I am concerned there will be either a reduction of the current standard of care or a decision to disallow medical care such as hormone blockers for those transgender humans who are not yet considered an adult at 18. Gender affirming care is health care. Medical experts agree gender affirming care is medically necessary and can be life-saving. Gender affirming care helps youth who might otherwise kill themselves; that is a fact.

Why is there a need to create a separate standard of care for Florida when there is already a nationwide standard of care based upon the guidelines of several professional medical societies after years of research and vigorous scientific debate while taking care of patients to ensure harm is not done? Yet this care, **only this care**, is doubted and questioned by the current governor and surgeon general of this state.

Regarding the governor, we all know this attack is political and appealing to a base of voters with his eye toward a 2024 presidential run. The current surgeon general has shown himself to be on the fringe of the established medical associations on several health topics starting with the COVID-19 virus. The Florida Fact Checked information is not based on reality but bias and information taken out of context. (As a teacher, I am always explaining to my students about quoting without changing the meaning of the speaker.) What **is** blatantly false is stating "most children identifying as transgender will **detransition** following the onset of puberty." Current gender affirming care does not consist of "experimental and investigational medical treatments."

The speakers opposed to moving forward with changing or removing the current standard of care are living this and have lived it. The care they received was life-saving as many stated. One eloquent speaker toward the end of the discussion questioned why this matter is even before the members of the board when other types of standard medical practices are not questioned. It is just *this* about transgender care under the ruse of concern when it appears more along the line of transphobia. Doctors and patients are the ones who should do what is best. Supportive, loving parents are listening to their children and taking them for appropriate medical care and therapy. This is not abuse.

According to the Public Member List, there are two pediatricians on the board. I am surprised doctors treating children have not been guided by the existing standard of care for even one patient. Perhaps it is living in Milton and Tallahassee.

The speakers stating negative opinions and falsehoods were mostly those wearing Let Kids Be Kids stickers. They know nothing and are guided by ultra-conservative Christian religions, alarming non-news media, and conspiracy theories. Several people were spoken to for less than five minutes by someone wearing a sticker before they put on the sticker. It is doubtful they even

truly know one transgender person. One of those wearing a sticker went to a security person and asked him to move the person sitting near her! As at least one speaker opposed articulated, how can transgender kids "be kids" if they are forced to hide and deny who they are at the core based on their brains?

Trans (and non-binary) humans have always been here. They hid for decades, centuries even, desperate to live authentically and be seen.

I strongly recommend watching the following episode of *Through the Wormhole* on Discover+: *Are There More Than Two Sexes?* It is episode 3 of season 7.

This is directed at Dr. Diamond based on his comments, of which I took notes, just prior to the board members voting. I hope you were honest when you said this was *not about taking away* care. I hope it is to "ensure all" transgender youth in Florida get the "best care" and "care is given appropriately." That should not include removing life-saving hormone blockers for those kids prior to puberty. It should not remove hormone therapy for those past puberty. Social affirmation should not be stopped.

I beg you to listen to the experts such as Dr. Michael Haller, especially regarding debunking the idea that an increasing number of children are seeking puberty blockers or other medical interventions. Be mindful, these treatments are not handed out immediately like candy. Transgender children and youth go through therapy and are seen by physicians for many years. It is a journey taken by the transgender child and youth, usually with their parent(s) or guardian(s). Please obtain and carefully review all available data provided by medical experts involved with transgender care. Double-check sources to ensure the words are not taken out of context.

Regards,

A handwritten signature in black ink that reads "Wendy Peale". The script is fluid and cursive, with the first letters of "Wendy" and "Peale" being capitalized and prominent.

Wendy Peale

From: [Mitchell Stern](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Transgender care
Date: Saturday, August 6, 2022 3:58:05 PM

You don't often get email from neomd@aol.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine-

While I know that you met yesterday and likely have made your minds up, I wanted to write to you in opposition to any proposed policy to limit or prohibit access to potentially lifesaving medical care for transgender youth. Here are some points you may wish to consider in your decision:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms.

I hope that you make your decision with the patient's best interests in mind and that you do not succumb to political pressure. Thank you for your time and consideration.

Sincerely yours,

Mitchell E. Stern, MD
Medical Director, NICU
HCA FL University Hospital Davie.

From: Caroline Clark
To: zzzz.Feedback.BOM.MeetingMaterials
Subject: Fwd: One-minute pediatric advocacy
Date: Wednesday, August 3, 2022 8:49:45 PM
Attachments: Outlook-memoayr.png
FROM Letter.pdf

From: Rebecca Plant <rplant@usf.edu>

Sent: Wednesday, August 3, 2022 1:59:09 PM

To: Celisse Zabalo <czabalo@usf.edu>; Eric Smart <elsmart@usf.edu>; Roshini Pudhucode <roshini@usf.edu>; Taylor Tragesser <ttragesser@usf.edu>; Bini John <binijohn@usf.edu>; Nikhil Vallabhaneni <nikhilv109@usf.edu>; Jade Walter <jadewalter@usf.edu>; Jessica Hukill <jkeenan10@usf.edu>; Krizia Trasmonte <trasmonte@usf.edu>; Elizabeth Havlicek <ehavlicek@usf.edu>; Marion Martin <marionclaremartin@usf.edu>; Jasmin Shahrestani <jshahrestani@usf.edu>; Constance Blindernagel <cbindernagel@usf.edu>; Paola Blanco <blancop@usf.edu>; Sukjoo Cho <sjcho1989@gmail.com>; Cristina Del Valle Avila <cddelvalleavila@usf.edu>; Jasmine Jordan <jasmine6@usf.edu>; Denise Klein <deniseklein@usf.edu>; Andrea Lafnitzegger <alafnitz@usf.edu>; Matthew Lazzara <mvlazzara@usf.edu>; Selena Soviravong <ssoviravong@usf.edu>; Kaitlyn Steward <kmsteward1@usf.edu>; Ivy Wilson <ivyw@usf.edu>; Natasha Carrero Mercado <ncarreromercado@usf.edu>; Caroline Clark <cadark170@usf.edu>; Jessica Creech <creechj@usf.edu>; Stefanie D'Arrigo <sdarrigo2@usf.edu>; Kristin DeMayo <kdemayo@usf.edu>; Anggie Ferrer Estupinan <anggief@usf.edu>; Jennifer Markwood <jmarkwood@usf.edu>; Morsal Osmani <morsal@usf.edu>; Angela Pluguez <apluguez@usf.edu>; Avram Rago <avram@usf.edu>; Monica Singh <monicasingh@usf.edu>; Emily Vlasik <evlasik@usf.edu>; Nicole Dinescu <ndinescu@usf.edu>; Jameson Kuang <jkuang@usf.edu>; Richard Nguyen <rjnguyen@usf.edu>; Ethan Nowell <enowell@usf.edu>; Aubrey Schley <aschley@usf.edu>; Ha Shin <hyshin@usf.edu>; Benjamin Berthet <bberthet@usf.edu>; Isaac Cha <cei@usf.edu>; Katherine Finley <finleyk2@usf.edu>; Sherri Huang <huang22@usf.edu>; Ashley Perry <aperry2@usf.edu>; Fatimat Shotande <fatimatshotande@usf.edu>; Emily Shipley <eshiplay@usf.edu>; Jean-Claude Guidi <guidi@usf.edu>; Michelle Edward <edward57@usf.edu>; Timothy Bradley <bradley122@usf.edu>; Alaina Mui <abmui@usf.edu>; Jonathan Slimovitch <jslimovitch@usf.edu>; Miranda Sullivan <mirandasullivan@usf.edu>; Jayme Verdi <jverdi@usf.edu>

Cc: USF Health Pediatrics Chiefs <usfpedichiefs@usf.edu>

Subject: One-minute pediatric advocacy

Caroline Clark,DO

Please feel free to steal my email below and forward to bom.meetingmaterials@flhealth.gov. I attached the letter sent in this email as well. If you feel led to, please take 1 minute and forward this email and let's advocate to keep the state from deciding how we can care for our children in Florida.

Please find attached a letter I wholeheartedly agree with regarding the preservation of the rights of children to access gender-affirming care in our state. Below are some of the highlights:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

I ask that you continue to allow physicians to be able to provide gender-affirming care to the children of our state for their physical, mental, and emotional well-being.

From: Scott VanDeman <svandeman@fcaap.org>

Sent: Tuesday, August 2, 2022 4:15 PM

To: Rebecca Plant <rplant@usf.edu>

Subject: Act now to preserve health care rights for transgender children

FLORIDA BOARD OF MEDICINE TO CONSIDER PROHIBITING GENDER-AFFIRMING CARE FOR YOUTH

Act now to preserve health care rights for transgender children ...

Dear Rebecca M Plant,

Florida's children need pediatricians to act now ensure access to health care services free of government interference. The Florida Board of Medicine (FBOM) is scheduled to meet on **Friday, August 5**, and will consider establishing an alternative standard of care that conflicts with medical consensus for children seeking gender-affirming treatment.

This is the latest step in a series of efforts to block transgender youth from receiving appropriate, evidence-based medical care that started with the Florida Department of Health's April 20, 2022 [guidance](#) recommending against gender-affirming treatment of any kind for children and adolescents—including non-medical social transition. See FCAAP's statement [here](#).

On July 8, the Agency for Health Care Administration (AHCA) held a public hearing to consider a new rule prohibiting coverage of gender-affirming care under the Medicaid program (see the FCAAP/AAP joint [letter to AHCA](#)). During this hearing, the state heard testimony from "experts" from the American College of Pediatricians, a fringe organization classified by the Southern Poverty Law Center as an anti-LGBTQ [hate group](#).

This week, the FBOM will discuss enacting an alternative standard of care that could **limit or completely prohibit gender-affirming care for transgender youth in Florida**. See the FCAAP/AAP [joint letter](#) to FBOM Chairman David Diamond, MD.

How You Can Help

We are asking you to write to the FBOM in opposition to any proposed policy to limit or prohibit access to potentially lifesaving medical care for transgender youth. Here are some points you may wish to consider in your letter:

- Prohibiting gender-affirming care for children suffering from gender dysphoria runs counter to guidance from every major medical society, including the Florida Chapter of the American Academy of Pediatrics, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, and many more.
- Children who receive evidence-based gender-affirming care and support experience sharply reduced incidence of mental health comorbidities including anxiety, depression, and suicidal ideation.
- The current standard of care and clinical guidelines for gender-affirming care—developed by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—are evidence-based, well researched, and widely accepted as the gold standard for the care of children and adolescents with gender dysphoria.
- Overriding the established standard of care for transgender youth cuts off necessary treatment for transgender children and puts the physical and mental health of vulnerable children at risk.
- The Florida Department of Health study the state is using in its decision-making process fails to conform to established research methodologies and norms, as outlined in [this analysis](#) by the Yale School of Medicine.
- Physicians in all areas of practice should reject government's attempts to insert itself into the doctor-patient relationship and to enact one-size-fits-all rulemaking to the practice of medicine.

Please send your completed letters to born.meetingmaterials@flhealth.gov.

Thank you for your assistance as we continue to fight for equity in health care and equal rights for all children.

On Behalf of FCAAP,



Lisa Gwynn, DO, MBA, MSPH, FAAP
President

Florida Chapter of the American Academy of Pediatrics, Inc.
Email: info@fcaap.org
Text or Call: 850/224-3939
Fax: 912/452-9050
Postal Mail: 1400 Village Square Blvd., #3-87786, Tallahassee, Florida 32312

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[YouTube FloridaChapterAAP](https://www.youtube.com/channel/UCqj8K8K8K8K8K8K8K8K8K8K)

R. Meredith Plant, MD, FAAP
Assistant Professor of Pediatrics
Associate Program Director, Residency Program
Early Career Physician Committee Co-Chair, Florida Chapter of the AAP
University of South Florida Department of Pediatrics
South Tampa Center for Advanced Health Care
2 Tampa General Circle, 5007
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she/her/hers
I do not expect a reply on nights, weekends, or any personal time away from work.

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July 29, 2022

Dr. David Diamond, Chair
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

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Joseph L. Wright, MD, FAAP

Dear Dr Diamond,

The American Academy of Pediatrics (AAP), a nonprofit organization representing 67,000 pediatricians dedicated to the health, safety and well-being of all children and the Florida Chapter of American Academy of Pediatrics, Inc (FCAAP), a nonprofit organization representing more than 2,600 pediatricians committed to serving all children across the state, writes to express our concern regarding the request from the Florida Surgeon General for the Florida Board of Medicine to develop new standards of care for the treatment of gender dysphoria.

Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics;ⁱ the Florida Chapter of the American Academy of Pediatrics, Inc;ⁱⁱ the American Medical Association;ⁱⁱⁱ the American College of Obstetricians and Gynecologists;^{iv} the American College of Physicians;^v the American Psychiatric Association;^{vi} the American Psychological Association;^{vii} the American Academy of Family Physicians;^{viii} the American Academy of Child and Adolescent Psychiatry;^{ix} the Endocrine Society;^x the Society for Adolescent Health and Medicine;^{xi} the Pediatric Endocrine Society;^{xii} the World Professional Association for Transgender Health (WPATH);^{xiii} and many more medical organizations committed to providing the best evidence-based care.^{xiv}

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7^{xv} and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline^{xvi} (both are herein referenced as "standards of care") are well recognized and accepted among the medical community as the gold standard for treating gender dysphoria.

Included in the Board's meeting agenda to discuss the development of new standards of care for the treatment of gender dysphoria is the June 2, 2022 Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report (GAPMS)^{xvii}. The AAP and FCAAP provided in-depth comments in opposition of both the GAPMS report and the proposed Medicaid rule to ban coverage of gender-affirming care. Our joint comments are included in our communication to the Florida Board of Medicine and we encourage you to review them. The GAPMS report, which serves as the evidentiary basis for the attempt to develop new standards of care, fails to satisfy even the basic tenets of scientific

inquiry and research.^{xviii} Experts from Yale University recently released a critical review of the GAPMS report and found:

- Contrary to the June 2 Report's repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported "expert" reports that are biased, inexperienced, and full of errors. The claimed "expert" reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
- The linchpin of the June 2 Report is an analysis by two epidemiologists that claims to undermine the scientific evidence supporting medical care for gender dysphoria. Their analysis is extremely narrow in scope, inexperienced, and so flawed that it merits no scientific weight at all.
- The June 2 Report repeatedly and erroneously dismisses solid studies as "low quality." If Florida's Medicaid program applied the June 2 Report's approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.^{xix}

Adolescents with gender dysphoria face increased challenges in life compared to their cisgender peers. Bullying, discrimination, harassment, and a lack of social acceptance are issues adolescents with gender dysphoria deal with on a daily basis and all these issues lead to increased risks of suicide and other mental health conditions.^{xx} In a study of more than 1,000 transgender adolescents, transgender adolescents had higher odds of all suicide outcomes compared to cisgender adolescents, and were at greater risk for suicidal ideations and attempts compared to their cisgender peers.^{xxi} Additionally, in the first large scale (N = 120,670) study examining the relationship between transgender adolescents and suicide, the authors found that between 30-51% of transgender adolescents reported engaging in suicidal behavior, compared to between 10-18% of their cisgender peers.^{xxii}

By proposing an alternative standard of care, Florida is ignoring the broad consensus among the medical community and the weight of peer reviewed medical literature. We call on the Florida Board of Medicine to reject the call for the development of new standards of care and ensure that the existing evidence-based standards of care are allowed to be used to care for children and adolescents with gender dysphoria. Only by doing so will the health and well-being of children and adolescents with gender dysphoria in Florida be preserved.

Thank you for your consideration of our comments.

Sincerely,

A handwritten signature in cursive script that reads "Moira Szilaygi".

Moira Szilaygi, MD, PhD, FAAP
President, American Academy of Pediatrics



Lisa Gwynn, DO, MBA, MSPH, FAAP

President, Florida Chapter of the American Academy of Pediatrics, Inc

ⁱ Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Gay, Lesbian, Bisexual and Transgender Health and Wellness. *Pediatrics*. Oct 2018; 142 (4) e20182162

ⁱⁱ Florida Chapter of the American Academy of Pediatrics, Inc. FCAAP Rejects New Florida Department of Health Guidelines on Gender-Affirming Care for Youth. 2022. Accessed on June 23, 2022. <https://www.fcaap.org/posts/news/press-releases/florida-chapter-of-the-american-academy-of-pediatrics-rejects-new-florida-department-of-health-guidelines-on-gender-affirming-care-for-youth/>

ⁱⁱⁱ American Medical Association. Health insurance coverage for gender-affirming care of transgender patients. 2019. Accessed on June 23, 2022. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>

^{iv} American College of Obstetricians and Gynecologists. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. 2021. Accessed on June 23, 2022. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>

^v Safer J, Tangpricha V. Care of the Transgender Patient. *Annals of Internal Medicine*. 2019 Jul 2;171(1):ITC1-ITC16.

^{vi} American Psychiatric Association. Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. 2020. Accessed on June 23, 2022. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>

^{vii} American Psychological Association. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, December 2015. Vol. 70, No. 9, 832–864

^{viii} American Academy of Family Physicians. Care for the Transgender and Gender Nonbinary Patient. 2020. Accessed on June 23, 2022. <https://www.aafp.org/about/policies/all/transgender-nonbinary.html>

^{ix} Adelson SL. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. *Jrnl of the American Academy of Child & Adolescent Psychiatry*. 2020; 957-974

^x Hembree W, Cohen-Kettenis P, Gooren L, Hannema S, Meyer W, Murad M, Rosenthal S, Safer J, Tangpricha V, T'Sjoen T. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2017; 102(11): 3869–3903

^{xi} Barkley L, Kodjo C, West KJ, et al. Promoting Health Equality and Nondiscrimination for Transgender and Gender-Diverse Youth. *Jrnl of Adolescent Health*. 2020; 66 (6): 804-807

^{xii} Lopez X, Marinkovic M, Rosenthal SM, et al. Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health. *Current Opinion in Pediatric*. 2017; 29(4). 475-480.

^{xiii} The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People 2011. Accessed on June 25, 2022. https://www.wpath.org/media/cms/Documents/SOC_v7/SOC_V7_English2012.pdf

^{xiv} Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>

^{xv} WPATH

^{xvi} Hembree et al

^{xvii} Florida Agency for Health Care Administration (ACHA), Division of Florida Medicaid. *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria (GAPMS)*. 2022. Accessed on June 22, 2022. https://ahca.myflorida.com/LetKidsBeKids/docs/AHCA_GAPMS_June_2022_Report.pdf

^{xviii} Alstott A, Boulware SD, Kamody R, Kuper L, Abdul-Latif H, McNamara M, Olezeski C, and Szilaygi N. Biased Science: A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria. July 8, 2022. Accessed on July 21, 2022. https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20ofinal%20july%208%202022%20accessible_443048_284_55174_v3.pdf

^{xix} Alstott et al

^{xx} Rafferty

^{xxi}Thoma BC, Salk RH, Choukas-Bradley , et al. Suicidality Disparities Between Transgender and Cisgender Adolescents. *Pediatrics*. 2019; 144(5)

^{xxii} Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 2018; 142(4)

From: [Laura Becker](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Detransition Awareness
Date: Tuesday, September 13, 2022 8:09:41 AM

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Hello,

I am a detransitioner, this is a video essay I made reflecting on the double mastectomy I had to treat my gender dysphoria, which was really just undiagnosed CPTSD. I wish the board of medicine to know the experience I, and many other young women have had with gender-affirming surgeries, which I illustrate some of the effects and nuances of here. I have been invited to speak at the upcoming public meeting in Florida, but due to the nature of hostility in such meetings, it would not be wise for my health to attend in person.

I hope you will watch this video and understand better the realities of these surgeries and the population receiving them.

https://www.youtube.com/watch?v=wdRQGrBogVU&list=LLykvjF1bAGJjgJMr_Xx9aaA

Thank you,
Laura

--

Stay Groovy,
Laura Becker
funkgod.com

From: latrall79@everyactioncustom.com on behalf of [LaTrall Simon](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:40:58 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
LaTrall Simon
12458 Condor Dr Jacksonville, FL 32223-3711
latrall79@gmail.com

From: ocaballero@everyactioncustom.com on behalf of [Obed Caballero](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
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Please reject this proposal and keep Florida safe for all.

Sincerely,
Obed Caballero
1444 Windsor Ct Apt 4 Fort Lauderdale, FL 33304-1222
ocaballero@our-fund.org

From: Tera.Webb1979@everyactioncustom.com on behalf of [Tera Webb](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
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Please reject this proposal and keep Florida safe for all.

Sincerely,
Tera Webb
19 Seminole Dr Debary, FL 32713-3209
Tera.Webb1979@gmail.com

From: ddinmia@everyactioncustom.com on behalf of [Yma Corrales](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
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Please reject this proposal and keep Florida safe for all.

Sincerely,
Yma Corrales
15811 SW 79th Ter Miami, FL 33193-2960
ddinmia@aol.com

From: idadamnissen@everyactioncustom.com on behalf of [Ida Nissen](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ida Nissen
300 Bayou Blvd Apt 118 Pensacola, FL 32503-6301
idadamnissen@gmail.com

From: gfern224@everyactioncustom.com on behalf of [Grey Fernandez](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
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Please reject this proposal and keep Florida safe for all.

Sincerely,
Grey Fernandez
3818 Kumquat Ave Miami, FL 33133-5610
gfern224@fiu.edu

From: alinaoroz@everyactioncustom.com on behalf of [Alina Orozco](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
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Please reject this proposal and keep Florida safe for all.

Sincerely,
Alina Orozco
7801 SW 95th St Miami, FL 33156-7508
alinaoroz@aol.com

From: hankspatton@everyactioncustom.com on behalf of [Kristen Hanks](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:32:31 AM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Kristen Hanks
1622 Larmon Ct Cincinnati, OH 45224-3116
hankspatton@gmail.com

From: dubya0717@everyactioncustom.com on behalf of [Eric Farquhar](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:32:06 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Eric Farquhar
191 Carson Oaks Ln Santa Rosa Beach, FL 32459-7158
dubya0717@yahoo.com

From: davidtobolowsky@everyactioncustom.com on behalf of [David Tobolowsky](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:29:22 AM

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Dear Florida Board of Medicine,

As a psychiatrist practicing in Miami for 40 years, I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

(Ladapo has NO credentials in the field of transgender medicine. His California medical license is listed as delinquent, for failure to pay the renewal fee when it expired at the end of 2021, and the American Board of Internal Medicine site shows him as certified but NOT participating in the required maintenance of certification. He belongs to the fringe group "America's Frontline Doctors," which still endorses the debunked use of hydroxychloroquine for treating COVID-19.)

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Practice standards for treating any medical condition are determined by mainstream medical specialty societies whose members deal with those conditions and do not vary from state to state. They are NOT determined by maverick physicians pushing a political agenda.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
David Tobolowsky
9601 SW 123rd Ave Miami, FL 33186-2540
davidtobolowsky@gmail.com

From: Tmkennedy5@everyactioncustom.com on behalf of [Martha Kennedy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:29:14 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Martha Kennedy
40 NE Plantation Rd # Stuart Fl 308 Stuart, FL 34996
Tmkennedy5@yahoo.com

From: jrichardson59@everyactioncustom.com on behalf of [Jessica Pockey](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:29:05 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jessica Pockey
12643 Banting Ter Orlando, FL 32827-7646
jrichardson59@gmail.com

From: carolineabeckman@everyactioncustom.com on behalf of [Caroline Beckman](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:27:36 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Caroline Beckman
12 Greer Ct Hamilton, OH 45013-4135
carolineabeckman@gmail.com

From: blakeseangriffin22@everyactioncustom.com on behalf of [Blake Griffin](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:26:31 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Blake Griffin
1411 E 1st Ave Mount Dora, FL 32757-5851
blakeseangriffin22@gmail.com

From: tran.stephanie.marie@everyactioncustom.com on behalf of [Stephanie Tran](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:26:20 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Stephanie Tran
31551 Calle De Las Rosas Bonsall, CA 92003-3711
tran.stephanie.marie@gmail.com

From: rani28r@everyactioncustom.com on behalf of [Rani Richardson](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:24:24 AM

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Please reject this proposal and keep Florida safe for all.

Rani Richardson, BSN, RN, CCM

Sincerely,
Rani Richardson
2055 Golden Ivy Way Apopka, FL 32703-1318
rani28r@yahoo.com

From: kristie.hatcher-bolin@everyactioncustom.com on behalf of [Kristie Hatcher-Bolin](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:24:21 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kristie Hatcher-Bolin
1045 Fox Hunt Dr Winter Haven, FL 33880-5021
kristie.hatcher-bolin@gray-robinson.com

From: saraibowden@everyactioncustom.com on behalf of [Saraia Bowden](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:23:18 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Saraia Bowden
376 S Military Hwy Apt G Norfolk, VA 23502-5269
saraibowden@fmail.com

From: provost-draper@everyactioncustom.com on behalf of [Clifford Provost](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:22:20 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Clifford Provost
215 E 66th St Apt 3C New York, NY 10065-6431
provost-draper@earthlink.net

From: jtsaenz97@everyactioncustom.com on behalf of [Jesse Saenz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:21:21 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jesse Saenz
1722 Iris Ave Sebring, FL 33875-6022
jtsaenz97@gmail.com

From: krusso6994@everyactioncustom.com on behalf of [Karen Russo](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:21:13 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Karen Russo
6557 Creekview Ter N Pinellas Park, FL 33781-4818
krusso6994@aol.co

From: tedbat10@everyactioncustom.com on behalf of [Ted Battaglia](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:20:56 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ted Battaglia
301 29th St N Saint Petersburg, FL 33713-7716
tedbat10@tampabay.rr.com

From: cwmlbk1@everyactioncustom.com on behalf of [Claudia Mann](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:20:55 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Claudia Mann
3790 Lavilla Ave North Port, FL 34286-7457
cwmlbk1@comcast.net

From: debbadoo1@everyactioncustom.com on behalf of [Deborah Shafman](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:20:55 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Deborah Shafman
22120 Laramore Ave Port Charlotte, FL 33952-4502
debbadoo1@hotmail.com

From: cdaymaines@everyactioncustom.com on behalf of [Cathy Day](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:19:52 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Cathy Day
82000 TARSIER Ave New Port Richey, FL 34653
cdaymaines@gmail.com

From: carylkllose@everyactioncustom.com on behalf of [Caryl Klosr](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:19:29 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Caryl Klosr
550 Glen Way Miami Springs, FL 33166-5231
carylkllose@gmail.com

From: cpgriff8@everyactioncustom.com on behalf of [Chas Griffin](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:17:43 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Chas Griffin
1275 7 Lks N West End, NC 27376-9759
cpgriff8@nc.rr.com

From: mille112@everyactioncustom.com on behalf of [Mark Miller](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:15:19 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Mark Miller
211 NE 43rd St Oakland Park, FL 33334-1427
mille112@gmail.com

From: futurejd2025@everyactioncustom.com on behalf of [Sarah Wilson](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:15:00 AM

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Sincerely,
Sarah Wilson
18490 Nalle Rd North Fort Myers, FL 33917-5251
futurejd2025@gmail.com

From: jbcahill@everyactioncustom.com on behalf of [John Cahill](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:12:17 AM

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Sincerely,
John Cahill
720 NE 4th Ave Apt 507 Fort Lauderdale, FL 33304-2687
jbcahill@bellsouth.net

From: martinpow@everyactioncustom.com on behalf of [Martin Powell](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:11:21 AM

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Dear Florida Board of Medicine,

I am writing to you today to request that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. I am not trans, and I do not have family who is, but I have read much of the scientific research, and there are, without a single doubt people receiving this treatment who benefit from it. As long as that is the case, please let doctors and patients determine the best course of treatment.

Statements from the medical experts who conducted the studies cited in the Department's memo have established clearly and on the record that this rule is inconsistent with their research findings. This rule jumps beyond well-established peer-reviewed medical guidance and will have the impact of foreclosing life-saving options for Floridians.

Please use medical and scientific evidence, not because it is always right, but because it is the safest and best way we know how to move forward and save Floridian lives.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Martin Powell
403 E Georgia St Tallahassee, FL 32301-1251
martinpow@gmail.com

From: imade.borha@everyactioncustom.com on behalf of [Imadé Borha](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:10:16 AM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Imadé Borha
522 Kipling Way Durham, NC 27713-2173
imade.borha@gmail.com

From: nightshade89@everyactioncustom.com on behalf of [Kalen Carey](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:08:14 AM

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Sincerely,
Kalen Carey
5409 SW 80th St Gainesville, FL 32608-4485
nightshade89@gmail.com

From: drevey@everyactioncustom.com on behalf of [Evelyn Hernandez-Gonzalez](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:07:12 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Evelyn Hernandez-Gonzalez
27744 Sky Lake Cir Wesley Chapel, FL 33544-7647
drevey@aol.com

From: dietrichh@everyactioncustom.com on behalf of [Hayley Dietrich](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:07:04 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Hayley Dietrich
14624 Grenadine Dr Tampa, FL 33613-2988
dietrichh@usf.edu

From: amontanez@everyactioncustom.com on behalf of [Andrea Montanez](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:06:53 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Andrea Montanez
3477 Flossmoor Ave Orlando, FL 32822-4028
amontanez@hcc-offm.org

From: bwilliams@everyactioncustom.com on behalf of [Brittany Williams](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:06:07 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Brittany Williams
10181 SW 1st St Plantation, FL 33324-2223
bwilliams@atheists.org

From: mandybuffington@everyactioncustom.com on behalf of [Mandy Buffington](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:04:15 AM

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Sincerely,
Mandy Buffington
2999 NE Brogden St Hillsboro, OR 97124-6707
mandybuffington@gmail.com

From: koontzk87@everyactioncustom.com on behalf of [Kristan Koontz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:03:26 AM

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Sincerely,
Kristan Koontz
30207 N Course Vw Franklin, TN 37067-6175
koontzk87@gmail.com

From: kirstenwood@everyactioncustom.com on behalf of [Kirsten Wood](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:03:02 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kirsten Wood
5915 SW 79th St South Miami, FL 33143-5121
kirstenwood@protonmail.com

From: csfurnival@everyactioncustom.com on behalf of [Charles Furnival](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 8:54:51 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Charles Furnival
3101 N Bowden Rd Avon Park, FL 33825-8556
csfurnival@aol.com

From: fgurucharri@everyactioncustom.com on behalf of [Frank Gurucharri](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Thursday, August 4, 2022 9:40:58 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Frank Gurucharri
2731 NE 14Th Street Cswy Pompano Beach, FL 33062-3562
fgurucharri@gmail.com

From: tsalibrown@yahoo.com@mg.gospringboard.io on behalf of [Taylor Brown](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, August 26, 2022 9:11:21 AM

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Dear Florida Board of Medicine

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Care providers, doctors, and leading medical associations have been clear that gender-affirming care is safe, effective, and evidence-based, and that it's literally lifesaving.

The issued guidance by the Dept. of Health and the studies used by this board are inaccurate and dangerous. This guidance is nothing more than another tool for the Governor to express his opposition to transgender individuals' existence.

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The Board must provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

I urge you to reject this proposal.

Sincerely,

Taylor Brown

From: Fbaboolal@gmail.com@mg.gospringboard.io on behalf of Fa Ba
To: zzzz Feedback, BOM MeetingMaterials
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, August 26, 2022 9:11:19 AM

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The Board must provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

I urge you to reject this proposal.

Sincerely,

Fa Ba

From: indywind@gmail.com@mg.gospringboard.io on behalf of [JD Kennedy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, August 26, 2022 9:11:19 AM

You don't often get email from indywind@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Sincerely,

JD Kennedy

From: foxg9775@gmail.com on behalf of [Grace Fox](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, August 26, 2022 9:11:19 AM

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I urge you to reject this proposal.

Sincerely,

Grace Fox

From: dorritram@hotmail.com@mg.gospringboard.io on behalf of [Dorrit Ram](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, August 26, 2022 9:11:19 AM

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Sincerely,

Dorrit Ram

From: Cynthia=emergencecounseling.com@mg.gospringboard.io on behalf of [Cynthia Fisher](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Monday, August 22, 2022 11:54:19 AM

You don't often get email from cynthia@emergencecounseling.com. [Learn why this is important](#)

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I urge you to reject this proposal.

Sincerely,

Cynthia Fisher

From: judithr@umich.edu on behalf of [Judith Rose](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Thursday, August 4, 2022 10:18:44 PM

You don't often get email from judithr@umich.edu. [Learn why this is important](#)

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I urge you to reject this proposal.

Sincerely,

Judith Rose

From: tom.serwatka@unf.edu on behalf of [Thomas Serwatka](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Thursday, August 4, 2022 10:56:44 AM

You don't often get email from tom.serwatka@unf.edu. [Learn why this is important](#)

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The failure to address the needs of transgender children will lead to increase suicides. To say that we believe in the sanctity of life and then remove the care that some children need to build a stronger and better life is such a mockery. Please don't do that

Thomas S. Serwatka

I urge you to reject this proposal.

Sincerely,

Thomas Serwatka

From: kyla.byron@gmail.com@mq.gospringboard.io on behalf of [Kyla Byron](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Wednesday, August 3, 2022 6:55:46 PM

You don't often get email from kyla.byron@gmail.com. [Learn why this is important](#)

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I urge you to reject this proposal.

Sincerely,

Kyla Byron

From: revshepard=knology.net@mg.gospringboard.io on behalf of [Margaret Shepard](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Wednesday, August 3, 2022 6:39:45 PM

You don't often get email from revshepard@knology.net. [Learn why this is important](#)

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I urge you to reject this proposal.

Sincerely,

Margaret Shepard

From: j.clarvey@gmail.com on behalf of [JESSICA Harvey](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, August 26, 2022 9:11:22 AM

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I urge you to reject this proposal.

Sincerely,

JESSICA Harvey

From: yucaxpetition@hotmail.com@mg.gospringboard.io on behalf of [Yuisa Colon](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Tuesday, September 13, 2022 3:06:45 PM

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I urge you to reject this proposal.

Sincerely,

Yuisa Colon

Dear Board Members, thank you for your time,

I am a former “trans” kid.

As a child I was insistent, persistent, and consistent that I was a boy.

I have no doubt that if the option to take puberty-blockers and cross-sex hormones had been available, I would have done everything I could to obtain them, including threatening suicide, especially if I had others encouraging me to threaten suicide as children are today.

In the short-term I likely would have felt better.

Testosterone is a controlled substance. Like other controlled substances, it has high risks to health and well-being and has the potential for both addiction and abuse. Testosterone makes almost anyone who takes it initially feels a sense of euphoria. If I had taken it as a child it would have allowed me to completely dissociate from myself as a girl and create a new persona, someone who could pretend that the horrible trauma that triggered my gender dysphoria didn't happen to me.

When I first started taking it, it would have boosted my confidence and increased my energy and most importantly, I would have felt safer.

If I took testosterone, it would have been so much easier to pretend that I was not the little girl who was brutally sexually assaulted. A little girl who became convinced at the moment of the assault that I was not safe being a girl. That the only way I could keep it from happening again was by becoming a boy.

Despite feeling better in the short term, in the long term taking testosterone would have been profoundly damaging, potentially even more damaging than the sexual assault. I can't imagine the impact of being told by teachers, doctors, and other adults that I was born in the wrong body. That I was inherently flawed.

It would have reinforced all the mistaken beliefs I had that caused me to develop gender dysphoria in the first place:

That being a girl was bad.

That it was my fault that those men hurt me.

That my body was a mistake.

That it was too dangerous be a girl.

If I had been medically transitioned, I wouldn't have gotten the help I needed to work through my self-hatred and shame. I never would have realized that my transgender identity was a coping mechanism.

I am so thankful that my school psychologist put me on a healing path. I am grateful to other therapists who helped me understand that my transgender identity was a result of the sexual assault not because I was born in the wrong body.

I shudder to think at what my life would be like if I'd been encouraged to believe that I was a boy.

I would have lived my life hating myself.

Puberty blockers would have retarded my growth and development. Cross-sex hormones would have caused my otherwise healthy body to become dysfunctional. The combination of both puberty blockers and cross-sex hormones would have left me sterile.

Children who says they feel better because of puberty blockers and cross-sex hormones are likely telling the truth. In the short term, these interventions allow children to avoid the difficulties they are facing, whether that be grappling with internalized homophobia, struggling with autism, or trying to recover from a significant trauma.

We should not be giving children controlled substances in order to make them feel better. It is a horrible disservice to encouraging them to dissociate, to run away from their feelings, to run away from themselves and to take a drug that in the short term will help them to feel better by numbing their feelings but in the long term, permanently damage their bodies and in the long term, prevent them from getting the help that they need to understand the difficult feelings that they're having in the first place.

It is natural for children to do what they can to shut down difficult feelings which is why we work hard to stop children from using drugs and alcohol. We know that encouraging children to run away from their pain and struggles is not the solution even if it makes them feel better in the short term.

It is our job as adults to give children the message that no matter how intense and difficult their feelings are, they can work through them without dissociating from themselves to become a different person.

Because of loving, caring, and supportive therapists and teachers, I got the care I so desperately needed to process what happened to me.

Transgender activists often discount my story, saying I was never really transgender. They are right. I wasn't. And that is the point. Even though I was insistent, consistent, and persistent about being a boy, I wasn't a boy. Yet gender doctors admit that the only diagnostic criteria used to determine if a child should get puberty blockers, cross-sex hormones, and surgeries is if the child is insistent, consistent, and persistent with gender confusion.

It only takes one story like mine to show they are wrong. To show that children develop gender dysphoric feelings not because of being born in the wrong body, but as a coping mechanism.

The belief that a child can somehow be born in the wrong is a mystical view, not a medical view.

I have great respect for doctors. However, they have gotten it wrong in the past. We are still suffering from the consequences of the opioid epidemic, where doctors were told by pharmaceutical companies that treating pain with dangerous and addictive opioids was safe and effective. How many thousands of people died because doctors were following guidelines for pain management written by those who were profiting from the sale of opioids? How many people have wrestled with serious addictions after well-meaning doctors prescribed medications that they had been told were safe and effective only to find out later that they were misled by pharmaceutical companies willing to put dollars ahead of human lives?

The so called "treatments" for gender dysphoria that are being championed by activists will go down in history as being far worse than the opioid crisis unless regulation are passed to protect children from these experimental and harmful interventions. The only treatment proven to help manage and resolve gender dysphoria is therapy combined with allowing children to naturally progress through puberty.

Children struggling with confusion about their identity need love and support.

My teacher and therapist gave me the gift of time to heal and I am so incredibly grateful.

All children who are struggling with gender dysphoria deserve the same gift.

Thank you for your efforts to protect children from a dangerous ideology.

Erin Brewer

Billy Burleigh's Written Testimony to the Florida Board of Medicine

My name is Billy Burleigh and I used to be transgender.

As a child I had the reoccurring thought that, "God made a mistake, I'm a girl". I prayed before going to bed and, every time I prayed, I asked, "God, please make me a girl before I wake up". If I could have, I would have quickly chosen any path that would have transformed me into a girl.

In my early twenties, I sought help for the disconnect between my mind telling me I was a woman, and my body telling me I was a man. While going to therapy and doing my own research, the message I received was that I had to change my body to match my mind. After seeking any other path forward, I decided to take the therapists' and medical researchers' advice to change my body.

I started on a testosterone blocker and estrogen. My emotions were up and down, and my body was changing, but I was supposedly on this new road to happiness and that made me happy.

In my first surgery I had a penile inversion, an Adam's apple shave, and a brow shave. After the surgery, the doctor and nurses had difficulty stopping the bleeding from my new "vagina." My artificial vagina was packed with gauze and a sandbag was placed on my lower abdomen, but the bleeding did not stop. Later, mom told me that going into my hospital room was awful. The odor in the room was overpowering of stale blood. I received a blood transfusion and plasma and, eventually, the bleeding stopped. My two week stay in the hospital turned into a three week stay. But changing my penis to an artificial vagina required two surgeries, so about four months later I was back for part two, labioplasty. My money was low at that point, so I did not have any family or friends accompany me – I went through this second surgery on my own. I was desperate for the happiness I believed was ensured me.

After this, I had additional feminization surgeries, but no matter how many I had, every time I looked in the mirror, I saw a man staring back at me. I tried hard to resolve the conflict between my mind and my body but after seven years of trying, I had more problems at that point than I had when I started on the road of transition.

The bottom line is that the therapists and medical researchers were wrong – changing my body did not resolve my internal conflict and it did not make me happy, but what it did do was drain my financial resources and left a scarred body.

I have fully transitioned back to male, I am happily married, I have two beautiful stepdaughters, and I have peace of mind and body.

Lastly, I was a responsible adult and I made a horrible mistake. In hindsight, I am male and I was born into the right body. The therapists and medical researchers failed to help with my underlying problems. They identified me as transgender and they were wrong. How often are they wrong?

How were the therapists and medical researchers wrong?

I was led to believe that the cause of my gender dysphoria was, potentially, a birth defect - that my brain was washed in the wrong hormone and that the only path I had to happiness was to transition. This logic was wrong and it took me down the wrong path, but I did eventually find the right path to peace and freedom.

Later in life I heard it said that everyone has a need to be accepted, significant, and secure. Though I had not heard this before, I agreed with this statement, and I started thinking about how I had tried to satisfy these needs in my younger years. I had many problems as a child – I was very skinny, had a speech impediment, had learning difficulties, wasn't athletic, was sexually abused, and I didn't seem to fit in with the other boys. I did, however, seem to fit in well with the girls and I enjoyed playing with them more than I enjoyed playing with the boys. As a boy, I didn't feel accepted or secure, and I most certainly didn't feel significant. But if I were a girl, I believe I would have felt accepted and would have felt more secure. And, with my childhood distorted thinking, I thought I may have been more significant to my dad. In hindsight I see that I had several underlying problems that reinforced the false thought that I was a girl. The therapists never did explore these underlying issues, and my research on transgenderism failed to turn-up anything on these needs. The therapists and researchers, with respect to me, got it wrong.

I also learned that not all of our thoughts are actually our thoughts. Secular research and opinions on "What is a thought?" and "Where do thoughts come from?" seems to be in many different directions. The Bible says that they can ultimately come from God, ourselves, or the devil (and his minions). Here in the west, we are quick to dismiss the spiritual aspect of our well-being, but I had to dive into this spiritual component in order to find my freedom from this mental battle. Back in the first grade, I was standing in front of the school wondering where I belonged when the thought "God made a mistake, I'm a girl" came into my mind. From that point on, for decades, that was an intrusive reoccurring thought. I didn't know what to do with the thought; I didn't want the thought, and I did not share it with anyone, until I was having a breakdown and sought therapy in my early twenties. This started my road of transitioning to presenting as a woman.

The start of my road to transitioning back to male began when I gave my life to Jesus and started studying the Bible. I learned that we are all engaged in spiritual battles, whether we know it or not. The Bible talks about these battles, what we are up against, and about the provisions God has already provided to all of us, through Jesus, to overcome. My name is Billy Burleigh and I use to be transgender, but I am now a child of the Most High God; I was bought with a price and I belong to God. Knowing Who-I-Am makes a Huge difference!

The world has many ways, many means, of offering acceptance, significance, and security. However, the "ways" and "means" keep changing, just as the DSM has continued to change on what it says about transgenderism, or gender dysphoria, over the past many decades.

I believe that gender affirming therapy for any person of any age is wrong. I believe it is not gender dysphoria, but rather simply dysphoria. Per GoodTherapy.org, Dysphoria is defined as a state of generalized unhappiness, restlessness, dissatisfaction, or frustration, and it can be a symptom of several mental health conditions. As is my case, and as I have heard from others who have not de-transitioned and who have de-transitioned, there were many childhood issues that contributed to our dysphoria, and those issues were not explored nor dealt with in therapy. The media, the government, school systems, and other groups are telegraphing to children and teenagers that if they feel different, if they feel trapped in the wrong body, there is special help for them, that they will be embraced, helped, and protected. For kids who are struggling with many different issues, this is the wrong place to find acceptance, significance, and security – it does not cure, and it imparts lasting harm.

But as for me, Billy Burleigh, I am accepted, significant, and secure in Jesus of Nazareth, who is unchanging and who is a solid rock!

Thank you for your time today and for listening to my journey. I can make myself available later for questions. Thank you.

Addendum A to my testimony: When I was transitioning from identifying and presenting as a female back to male, I needed a medical document to change all my legal documents from Female to Male. Having a Phalloplasty would satisfy this requirement. Long story short – I asked the surgeon many times if I was a good candidate for this surgery and he assured me that I was. He said that I would be very happy with the outcome. I trusted him! He's a doctor, a surgeon, and he had my best interest in mind, or so I thought. Below are two pictures: the first is of my abdomen prior to the surgery and the second is about a year after the surgery. The surgery was so painful and the outcome horrified me. I later had the surgeon unfold the unsightly manmade penis and put the skin back onto my lower abdomen. The therapists and medical professionals say trust us, we care for you and we know what we are doing. Here again, the council I received failed me.

Before Phalloplasty

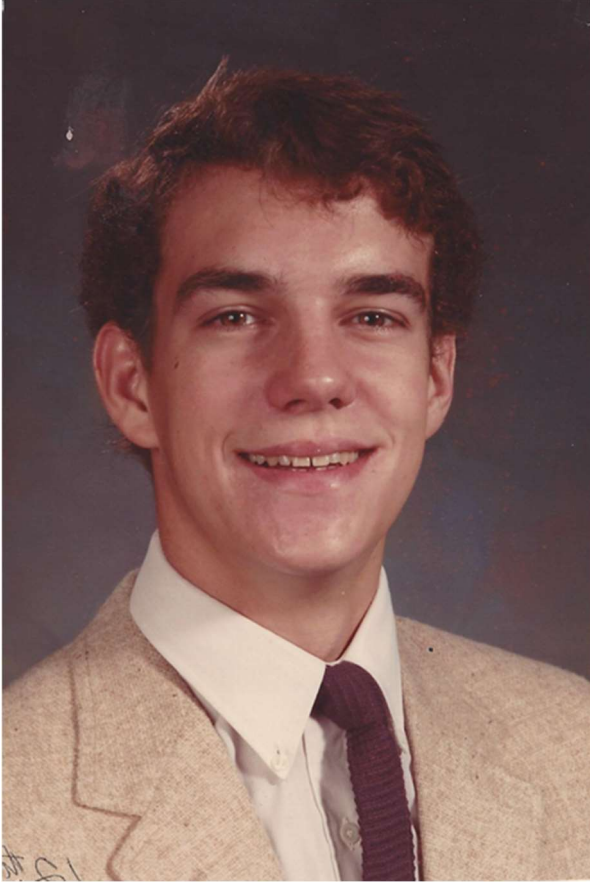


After Phalloplasty



Addendum B to my testimony: These are pictures of me at different times in my life:

- Me when I was 18, a senior in High School
- Presenting as female, about age ~35



- Presenting as female, about age ~34
- Transitioned back to male, married (that's Rachel), age ~52



From: Richard Sandler <rhsandler@gmail.com>
Sent: Thursday, September 1, 2022 8:59 PM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>
Subject: Challenging routine gender affirming therapy for children

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Richard H. Sandler, MD
4079 Conway Place Circle
Orlando, FL 32812
Cell: 407.575.3458
Email: rhsandler@gmail.com

September 1, 2022

Also sent via US mail to:
Paul Vazquez, Executive Director
Board of Medicine
State of Florida
4052 Bald Cypress Way, BIN C#
Tallahassee, Florida 32399

Dear Mr. Vazquez:

I'm writing today to express my concern for the welfare of teenagers being subjected to mutilating surgery and potentially dangerous hormonal medications as part of "Gender Affirming Therapy." After review of available data, and deep reflection, I completely concur with the Department of Health's finding that these therapies are "experimental", and as such should not be conducted outside of IRB-approved research studies. Our approach should be a process of discernment, not abrogation of professional judgement to the ever-changing views of teenagers. We don't give 'fatness affirming therapy' to teens with anorexia nervosa, nor 'suicide affirming therapy' to teens calling for help following their suicide gestures. Why should we think 'gender affirming therapy' (GAT) must be the only option for children questioning their gender identity?

There remain legitimate questions about the possible narrow indications for GAT. Properly conducted clinical research is the only way to help answer at least the scientific questions that arise, especially as to long-term outcomes. Of course, 'science' is not equipped to address the ethical and moral considerations, and these overriding concerns are also deserving of vigorous and open debate.

Thank you for your courageous efforts to protect Florida's children.

Sincerely,

Richard H. Sandler, MD
Fellow, American Academy of Pediatrics
Board Certified in General Pediatrics, and Gastroenterology, Hepatology and Nutrition
Nemours Children's Hospital
Professor of Pediatrics
Professor of Mechanical and Aerospace Engineering
University of Central Florida
Cell: 407.575.3458
Email: rhsandler@gmail.com

From: [Vazquez, Paul](#)
To: [Aaron Kimberly](#)
Cc: [Strickland, Bettye C](#)
Subject: FW: Regarding trans health reform
Date: Tuesday, September 6, 2022 8:23:41 AM
Attachments: [image002.png](#)
[image003.png](#)
[image004.png](#)
[image005.png](#)
[Florida Board of Medicine Aug2022.pdf](#)

Aaron:

Your comments have been received. They will be provided to the Committee for consideration and will become part of the rulemaking record.

Best regards,



Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine
Florida Department of Health
Phone: 850-245-4130

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: Aaron Kimberly <aaronk@genderdysphoriaalliance.com>
Sent: Friday, September 2, 2022 6:12 PM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>
Subject: Regarding trans health reform

You don't often get email from aaronk@genderdysphoriaalliance.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Mr Vazquez,

Please find a letter attached which we would like to submit into public record, in support of your plans to reform the treatment of gender dysphoria.

Thank-you.

Aaron Kimberly
Founder and Director



Dysphoria without ideology



The Florida Board of Medicine
Paul Vazquez, Executive Director
4052 Bald Cypress Way, BIN C#
Tallahassee, Florida 32399

Paul.Vazquez@flhealth.gov

August 29, 2022

Dear Mr Vazquez,

I am an adult who has medically transitioned and is happy with my own transition. If I had been asked five years ago what I thought of childhood transition, I probably would have thought it was great. It's easy to look back on my experience of childhood onset gender dysphoria (GD) and imagine the benefits of having undergone childhood transition: If I'd been put on puberty blockers, I probably wouldn't have needed a double mastectomy and therefore wouldn't have scars. If I'd socially transitioned and started testosterone as a teen, then maybe my GD wouldn't have interfered with my social development as it did.

Despite these possible benefits that some may argue they would have experienced via childhood transition (which of course is no more than a thought experiment), I am now of a different mind: I strongly disagree with childhood transition. I'd like to explain to you how I've arrived at this conclusion.

As a young adult, I became a part of the lesbian community through which I met many very masculine lesbians and effeminate gay men. I began to understand my GD as somehow related to being gay and to the masculinizing effects of the Ovotesticular Disorder of Sex Development (DSD) which I was diagnosed with at age nineteen. Though I struggled with GD, I didn't give it

much more thought. In the butch/femme lesbian subculture, butches often use male nicknames and are referred to by male pronouns though, to be clear, no one is confused about the biological sex of butch lesbians. “Stone Butch” is a term for such women whose GD is so severe they can’t tolerate being touched.

Then, in 2006 I saw a documentary on mainstream TV about “trans kids” whose described experience of GD and cross-sex identification was a near exact reflection of my experience growing up. The documentary framed the experience of GD as: if you experience x,y, z, then it means you are a transgender person. So that was it! I thought, I must be a transgender person because I certainly had all of those experiences. Looking back, I can see that I had exhibited all the classic signs of GD, which I found to be confusing and distressing, since the age of three. Prior to seeing this documentary, I didn’t have language or a framework through which to understand my experience of cross sex identification. My GD wasn’t something I had discussed with anyone. But after seeing this documentary, it seemed to me that I finally had a framework to explain my heretofore confusing and distressing experience – I was “trans”! After this revelation, I booked an appointment at the local gender clinic where I was assessed for Gender Identity Disorder (GID) over a period of several months, and I was started on testosterone. I was assessed again by a clinical psychologist prior to having any surgeries done. I personally found the assessment process helpful, because it required me to consider things I hadn’t thought of, and prevented me from making hasty decisions. The changes to my body, from testosterone and a double mastectomy, did relieve my distress and disconnect with my body. However, it’s also been a very complicated emotional, psychological, social and physical process, which I believe requires a great deal of stability, maturity and support to navigate well.

In 2008, two years after my diagnosis and the start of my hormonal treatment, I became a registered nurse with a specialization in mental health. I worked in the mental health department at St Paul’s Hospital in Vancouver, Canada, for 10 years. Initially I worked in the Psychiatric Stabilization Unit and then in the Provincial Eating Disorders Program. In 2017 I moved to Kelowna, Canada, to help launch a multidisciplinary youth clinic. By 2019, about 25%

of the youth presenting to our clinic were trans identified and requesting medical interventions. The clinic physician was interested in providing medical interventions, but she didn't have the sessional time with our program to provide (what we'd assumed would be) lengthy assessments and care planning. Since assessment is one of my professional strengths, I offered to do intake assessments and coordinate the trans health services. I was excited to cross the table and learn about GD from a clinical perspective. Working within a multidisciplinary clinic seemed like an ideal setting to do whole person care, since we had access to primary care, psychiatry, counselling, housing services, parent supports, employment services and partnerships with more intensive mental health and social services.

I consulted with the Provincial Health Services Authority (PHSA), which provides oversight and clinical training for trans healthcare services throughout British Columbia. PHSA's team (Trans Care BC, TCBC) came out to Kelowna twice to do training for us. Additionally, I was doing weekly mentorship calls with them. During this training and mentoring process with TCBC, I started to become confused and concerned about the current state of trans healthcare.

TCBC's in-person training was best described as cultural sensitivity training. They presented the Genderbread man diagram, personal narratives, and coached us to use certain language. TCBC's training did not include any peer reviewed studies. Rather, their "literature" relied solely on community-based surveys. Shockingly, there was no mention of GD. Further, TCBC's website claims that one doesn't have to be trans to medically transition.¹

I was informed by TCBC that the purpose of assessments is strictly for the purpose of determining a patient's capacity to consent, and that assessment could be completed in a single visit, using a one-page checklist created by TCBC, found in their Primary Care Toolkit.² In British Columbia, minors may consent to treatment without parental permission, under our Mature Minors Act.

I asked TCBC for peer reviewed studies about GD, and psychotherapeutic models that are helpful for supporting those with GD. They didn't point me to a single study.

During mentorship calls and on the clinical listserv, I heard from other clinicians that they were telling parents that their child would die by suicide if the parents did not support their medical transition. I learned that one well known psychologist, who works with youth in the foster care system, had told an audience during a public presentation to lie about being suicidal to get what they wanted.³

I'd known some of these clinicians for many years because some of them were my care providers. My experience in trans healthcare as a clinician and my experience 15 years earlier did not mesh. Consequently, I became very confused about the nature and/or clinical meaning of "trans" or "GD" and why clinical practice in trans care had changed so much.

The youth I had been seeing at my clinic were often highly complex and very few of them seemed to have the same experience of GD that I did. Between Aug 2019 - Dec 2020, I saw 52 clients for hormone readiness assessments. Of these clients, 71% were natal females. Of these female clients, 8% identified as heterosexual. (The boys were all heterosexual or bisexual). Of the 52 clients, 19% had an ASD diagnosis. 29% had an ADHD diagnosis. 14% were involved with child protection services or were adopted, and 15% reported significant trauma. A single visit assessment seemed grossly insufficient, so I wanted to take my time with my clients, to do more thorough assessments, care planning, and provide education.

By getting to know my clients, I learned that some of the youth had been very lonely through childhood. Some admitted that they never had any GD as children. One teen girl in particular stands out in my mind. She had initially been brought to our clinic by her parents to start testosterone. She wanted to be a boy and had already socially transitioned. Then, one day her parents brought her in to see me again. She seemed embarrassed and said she was happier back when she was a girl. She was ambivalent, because she stated that she'd have to "grow her hair long and start wearing girl clothes". I informed her that she could have whatever hairstyle and wear whatever she wanted to as a girl and asked if she'd considered exploring what kind of girl she was. She lit up like it was Christmas morning and seemed very relieved. She never came back to start hormones.

Meanwhile, some of my friends who had medically transitioned 20 years ago were starting to open up about their transitions. One very much regrets her transition and now understands that her decision to transition had been motivated by childhood sexual abuse. The consequences of her transition have been considerable. Significantly, she's resigned herself to a life without a romantic partnership, since she's attracted to lesbians, but lesbians are not attracted to her, since she looks like a man.

I became so disturbed and confused by what I was seeing in trans care that I started digging into the medical literature for answers. Surely there was evidence to explain why thorough assessment and psychotherapy had been eliminated, and why GD is no longer being discussed among clinicians. I found no such evidence. What I found were 11 studies all saying that most young people with childhood onset GD desist by or through puberty.⁴ I also read through studies by psychologists Drs. Blanchard⁵, Bailey⁶, Zucker⁷, and Vasey⁸. The information I learned from these high-quality studies was overwhelming, and that sense of overwhelm led me to crash. No one had ever informed me about the three known pathways to GD, all outlined in the DSM-5:⁹

- (1) Late onset - Transvestic disorder with Autogynephilia
- (2) Early onset – highly correlated with homosexuality
- (3) GD related to a Disorder of Sex Development

The aforementioned body of work regarding GD not only makes 100% sense regarding my personal experience of GD, but it also maps onto what I've seen in the trans population over the past 20 years. We are not all the same. We have experiences, and different needs.

When I raised my concerns about the state of care being provided to trans identified youth within the system of care (TCBC, listserv etc), the response was drastic and swift: complaints were made to my employer, I was removed from the clinical mentorship mailing list, I was accused of using the listserv for anti-trans activism, our clinic was boycotted, and I was moved to another program within the organization. The attacks didn't stop there: A trans woman who

works TCBC, and two of her friends began a smear campaign on social media and called the head office of the organization I work for, in an attempt to get me fired. The accusation levelled against me was that I was “gatekeeping”, “spreading misinformation” and advocating for hatred against trans people.

These reactions (shunning, smearing, attacks on my livelihood) on the part of the members of the trans care system in BC, prompted me to create the Gender Dysphoria Alliance (GDA) in January 2021. My goal for the GDA was for it to act as a lightning rod for like-minded trans people who understand or want to understand themselves from an evidence-based clinical lens, rather than activist led narratives.

The GDA has had many different stakeholders such as parents of children and youth with gender-related distress, trans people, clinicians, detransitioners, teachers and journalists, reach out to us. They’ve all noted that they did not know where else to turn for evidence-based support and information on trans related issues. One teacher told us that 50% of her classroom of pre-teens identified as something other than “cis gender” but she was afraid that voicing concerns would be seen as transphobic.

I believe the clinical community has failed in its obligation to provide evidence-based care and education about what GD is.

Kids are being socially and medically transitioned without any regard to the desistance studies.

I believe there is a social phenomenon occurring that is attracting young, vulnerable people into trans identities. Dr Lisa Littman, in a preliminary study, named this phenomenon Rapid Onset Gender Dysphoria.¹⁰ The influence of social media and Queer theory activism, which is a deliberate attempt to blur our understandings of male/female and gay/straight, is confusing kids and recruiting them into a political movement that doesn’t care whether the kids have GD or not. To date, there is no other plausible explanation for why we are not only seeing many

more young people flooding clinics, but ***a completely new presentation of young people: girls with no history of childhood gender non-conformity.*** Historically, the only natal females who sought transition were butch lesbians who's reported experiences of GD fit the childhood onset pathway to GD. Furthermore, until the recent shift in populations presenting to gender clinics, females have always been the minority of those presenting with GD. The reason for this is threefold: (1) there are fewer lesbians than gay men, and even fewer butch lesbians. (2) women rarely have paraphilias like transvestic disorders, and (3) DSD related GD is rare. This new cohort of girls (and some boys) is not accounted for in our current evidence-based understanding of GD. This should prompt concern, pause and investigation by the medical establishment, not faster pathways to medicalizing them.

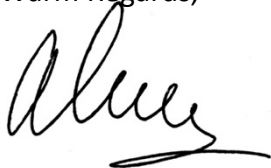
Knowing what I now know, I know I would have benefitted from the truth – that my GD is related to my DSD and sexual orientation.

I was lied to about the nature of my condition, and about my health and treatment options by the system. I will not participate in continuing that lie as a clinician.

I am very much in support of a return to evidence-based practices, including watchful waiting, psychotherapy, and comprehensive, whole-person assessment.

Thank-you Mr Vazquez, for your efforts to protect kids with one of the types of GD, as well as the kids who don't have GD, who would likely be harmed by hasty medicalization and misinformation.

Warm Regards,

A handwritten signature in black ink, appearing to read 'Aaron', with a stylized flourish at the end.

Aaron Kimberly, RN
Executive Director, Gender Dysphoria Alliance

References:

1. <http://www.phsa.ca/transcarebc/hormones/readiness>
2. <http://www.phsa.ca/transcarebc/Documents/HealthProf/Primary-Care-Toolkit.pdf>
3. <https://vimeo.com/326339802>
4. Singh D, Bradley SJ and Zucker KJ (2021) A Follow-Up Study of Boys With Gender Identity Disorder. *Front. Psychiatry* 12:632784. doi: 10.3389/fpsyt.2021.632784 [[LINK](#)]
5. Blanchard, R. , Clemmensen, L.H. , Steiner, B.W. Heterosexual and homosexual gender dysphoria. *Arch Sex Behav* 1987; 16: 139–152. [[LINK](#)]
6. Bailey, J. M. (2003). *The man who would be queen*. Washington DC: The Joseph Henry Press. [[LINK](#)]
7. Zucker KJ. Gender identity disorder in children and adolescents. *Annu Rev Clin Psychol.* 2005;1:467-92. doi: 10.1146/annurev.clinpsy.1.102803.144050. PMID: 17716096. [[LINK](#)]
8. Vasey PL, Bartlett NH. What can the Samoan "Fa'afafine" teach us about the Western concept of gender identity disorder in childhood? *Perspect Biol Med.* 2007 Autumn;50(4):481-90. doi: 10.1353/pbm.2007.0056. PMID: 17951883. [[LINK](#)]
9. American Psychiatric Association. (2013). Gender Dysphoria. In *Diagnostic and statistical manual of mental disorders* (5th ed.).
10. Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One.* 2018 Aug 16;13(8):e0202330. doi: 10.1371/journal.pone.0202330. Erratum in: *PLoS One.* 2019 Mar 19;14(3):e0214157. PMID: 30114286; PMCID: PMC6095578. [[LINK](#)]

Dear Chairman Diamond;

I WANT TO THANK THE BOARD FOR
Protecting minors from "Gender-Affirming"
Treatment. I AM GLAD THAT THE
BOARD RECOGNIZES CHILDREN WHO ARE
STRUGGLING WITH SEXUAL IDENTITY. NEED
COUNSELING NOT DRUGS AND SURGERY.

Sincerely Yours,

Robert P. Fernald

CAPT.

USAF (Ret.)

Dear Chair David Diamond,

We thank you and the state board for protecting minors from gender affirming treatments.

Our children and teens are not mature enough and this will protect them from making a decision they will regret later in life.

Thank you again and we are praying for you.

Sincerely,

Sandra Roberts

From: [Strickland, Bettye C](#)
To: [Strickland, Bettye C](#)
Subject: FW: Caring for children and youth with Gender Dysphoria
Date: Wednesday, September 14, 2022 3:19:52 PM

From: Jennifer Lahl <jennifer.lahl@cbc-network.org>
Sent: Wednesday, September 7, 2022 4:22 PM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>
Subject: Caring for children and youth with Gender Dysphoria

Dear Mr. Vazquez,

It has come to my attention that Florida will be having hearings about “gender affirmation care” vs a proper medical management of minors struggling with gender dysphoria.

I was a PICU nurse for over 15 years and am now the President of the Center for Bioethics and Culture. I have a keen interest in a “first do no harm” medical approach to minors who are unable to consent to permanent and harmful therapies.

As such, I’ve written and directed two documentaries on the subject:

Trans Mission: What’s the Rush to Reassign Gender?

The Detransition Diaries: Saving Our Sisters (release date Sept 19, 2022)

I wish to submit these films into the public record for the hearing.

Here are the links the film and trailer for the upcoming film.

<https://youtu.be/rUeqFoARKOA>

<https://youtu.be/NVhUoiXGWx8>

Can you confirm receipt of this email and if I’m allowed to do this?

Sincerely,

Jennifer Lahl R.N., B.S.N., M.A. (bioethics)

--

Jennifer Lahl
President
Center for Bioethics & Culture Network

www.cbc-network.org

<https://twitter.com/JenniferLahl>

Dear Chair David Diamond

Thank you for prohibiting children + teens
from receiving hormone therapy or undergoing
"gender" surgery. Thank you for protecting
~~our~~ our kids. We are so
appreciative for standing for our
kids. God bless you and
keep up the good works.

Sincerely
Cristina R. Orozco

Dear

Chair David Diamond

Just A Note of Thanks for
standing AGAINST the Evil
confusion that is trying to
destroy this nations inheritance
Pray for you to continue to
stand for truth.

Sincerely

Christ
Hend

Dear Chairman Diamond,

Thank you and the Board so very much for voting to protect our minors from these horrible "gender-affirming" treatments.

May God bless you and your efforts to protect our children.

Sincerely,

Bonita Chase

CHAIRMAN DIAMOND -

THANK YOU FOR STANDING
STRONG AGAINST EXPERIMENTING
WITH THE CHILDREN OF
FLORIDA!!

BRYAN ROSENTHAL

Dear Sir,

This is to thank you as well as the state board for working so hard to protect our minors from gender-affirming treatments.

Your work and dedication are greatly appreciated.

We will continue to pray for you - God's blessings will abound -

Jody Kelly

Chairman David Diamond

Thank you and your team for your all
commitment in protecting our children.
It brings me great appreciation knowing
that we have someone like you and
your team can make a difference for
the better.

Rita Senquis

Dear Chairman Diamond,

Thank you for protecting of kids and families from these evil agendas trying to push into thing we don't want. Keep fighting this fight. I pray God strengthens you and protects you.

God bless you!

Sincerely,

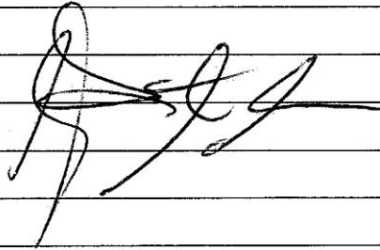
Robert Just

DEAR: CHAIR DAVID DIAMOND

THANK YOU FOR PROTECTING OUR MINORS

FROM THESE "gender-affirming"

TREATMENTS.

A handwritten signature in black ink, appearing to be 'R. S. J.', written on lined paper.

Dear David Diamond,

Thank you for protecting our
minors from these "GENDER AFFIRMING"

TREATMENTS.

Roger Banksen

Dear Mr Diamond,

Thank you and the
State Board for taking a stand to
protect our precious children from
gender-affirming treatments. We truly
appreciate your hard work and love
for our children. Keep up this great
fight.

Sincerely,

Parbatie Dial

Chairman Diamond

Thanks so much for standing
& protecting minors from gender-
affirming treatments. We appreciate
you helping to protect our children.

Jack Mat

Dear Chairman Diamond,

Thank you so much for all
you've done to protect our minors
from gender assignment
treatments.

We will continue to pray for
our state in this matter.

Sincerely,

Michelle Wolff

David Diamond,

Thank you for protecting our
minors from the gender -
affirming treatments.

Ernest & Adela Morgan

Dear Chairman Diamond,
Thank you and the
State board for protecting our
minors from the gender affirming
treatments.

Sincerely
Allen R. S.

Dear Chairman Diamond,

Thank you for protecting
minors from the "so called"
"gender affirming care".

We must protect our children
from this crazy ideology.
Children are born male or
female ~~and~~ determined by God and
we should not be doing life-altering
procedures or medicines. Thank you! Barry Webster

Dear Chairman Diamond,

Thank you for your work in
protecting minors from receiving
inappropriate gender treatments and
surgeries.

Sincerely,

Chris Roddy

Dear Chairman Diamond,

thank you so much for protecting our
youth from 'Gender-affirming' treatments.
God bless you, we are praying for you.

David + Teresa Sawyer

Dear David Diamond,

I am so thankful for you and
the state board for protecting
our minors from these "gender-
affirming treatments.

God bless you,

Louise Simmons

Dear Chairman Diamond,

Thank you for holding our stance on the protection of our minors from these treatments. We are greatly appreciative of your help in standing up for these rights for our children.

Sincerely,

Green D. Lee

Chair David Diamond,

Knows that our thoughts
→ Prayers are with
you. Thank you for
protecting our minors from
gender affirming

Thank you for advancing the
new rule prohibiting children
+ teens from receiving hormone
therapy.

M. Deber

Dear Chairman Diamond,

I wanted to take a moment to thank you + the State Board for protecting our minors from the horrific "gender-affirming" treatments!

God bless you as you continue to fight for the well-being of our children.

I'm praying for your continued success in these efforts!

Sincerely,
Kelli Banks

Dear Chair David Diamond

Thank you for protecting
our Minors from these
"gender-affirming" treatments
God bless you.

Kind regards
Mrs Laverne Brown

Dear Chairman Diamond,
Thank you the board's protecting
minors from so-called "gender affirming"
treatments.

I believe your decision reflects both
a moral + ethical outlook on this subject
and is just good common sense.

Our children should **(NOT)** be used as
experiments by special interest groups!
Keep up the good work! Kind Regards,
Cliff Evans

Chairman Diamond,

Thank you and the State board of
medicine for protecting our miners
from these "gender-affirming
treatment."

I appreciate all your hard work.

Sincerely,

Mrs. Stacy Nock
Ocoee Fl.

Dear David,

Thank you for protecting our rights from gender theory. It's really sad
that there is so much whining in some-sev. Hopefully it gets more
faded away.

Love, David,

David

Dear Chair David Diamond

I congratulate you and state board for
protecting minors from gender affirming
treatment.

Our children and teens are not mature
enough and this will protect them from
making a decision they will regret later
in life. Thank you so much.

Sincerely
James Roberts

From: [zzzz Feedback, BOM_MeetingMaterials](#)
To: [Strickland, Bettye C](#)
Subject: FW: HHS Statement
Date: Friday, September 16, 2022 10:25:29 AM

From: Kathleen M. <motb2004@gmail.com>
Sent: Thursday, September 15, 2022 10:51 PM
To: zzzz Feedback, BOM_MeetingMaterials <BOM.MeetingMaterials@flhealth.gov>
Subject: HHS Statement

You don't often get email from motb2004@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear all,

I am a mom in California, a life-long Democrat. I am the parent of a son who at age 15 was convinced that he was a transgirl. He did not come by this belief organically. He was a rough and tumble boy who came to his identity after being cut from the high school baseball team. His dream. He was lost and started spending hours online and watching anime. He knew none of the girls in elementary school and in middle school he wondered how he would ever date girls because he had nothing in common with them.

He also decided he was trans with another boy from Boy Scouts. After he told us this we started seeing it everywhere.

As soon as he announced his trans identity, his mental health plummeted. He barely got out of bed. He lost 30 pounds. He started failing his classes at school. He was diagnosed with severe depression and anxiety. His online friends instructed him that his parents are abusive. His teacher in school also affirmed this belief and actively tried to help him move out of our safe home into a LGBT center.

My son is now 18 and moved out of our house while we were at work and we have no idea where he is.

Over and over, the media presents desperate trans-identifying children, abandoned by their families, but the hundreds of parents I know — parents like me — don't reject their gender questioning children. They reject us.

My son's first therapist offered a single option, immediately affirming his trans identity, insisting that we use his desired female name and pronouns. The therapist warned us that our son had a 44% chance of committing suicide if we did not celebrate our newdaughter. The 44% that the therapist quoted was lifted from a headline. The study it came from stated that this was an extreme overestimate, but this therapist had never bothered to read the study. Recent studies show the number to be magnitudes lower, and similar to rates for the comorbidities many trans-identifying children have.

As I watched my son change from a loving child to an unrecognizable kid — vicious, angry and sullen— my gut told me that the therapist was wrong. I read everything that I could on this new crop of teenagers that suddenly announce a trans-identity. Lisa Littman is spot on with her description of rapid onset of gender dysphoria.

I know that my story is not unique because I have heard 100s of stories like mine. The patterns are clear – these ROGD kids are into anime and cosplay. They spend too much time on social media. Many have internalized homophobia. They are socially awkward, intellectually advanced but emotionally immature, on the spectrum, have eating disorders, AND all of them have comorbid mental health issues that are not alleviated by gender affirming care. Forcing the affirmation model as the only treatment for gender dysphoria or incongruence will harm millions of children and youth in our country, leading them toward a lifetime of medications and surgery — treatments with no evidence base to support their safety or efficacy. Affirmation is not life-saving; it is life destroying.

From: [zzzz Feedback, BOM_MeetingMaterials](#)
To: [Strickland, Bettye C](#)
Subject: FW: Please regulate access to "affirmative care" for people under age 25
Date: Friday, September 16, 2022 10:26:30 AM

From: Mary Laval <marylavalgenspect@gmail.com>
Sent: Friday, September 16, 2022 9:36 AM
To: zzzz Feedback, BOM_MeetingMaterials <BOM.MeetingMaterials@flhealth.gov>; Vazquez, Paul <Paul.Vazquez@flhealth.gov>
Subject: Please regulate access to "affirmative care" for people under age 25

Some people who received this message don't often get email from marylavalgenspect@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Paul Vazquez and the Florida Medical Board,

I urge you to create sensible and European-style regulations for care for gender-questioning young people under the age of 25, which is when science now knows the brain completes development.

[Finland](#) was the first country to do it, based on the evidence. They realize the importance of the age of 25.

This was followed by [Sweden](#) and the [UK](#).

The [exploding numbers of detransitioners](#) are the canary in the coal mine. Clearly young people are being socially influenced to identify as trans - even [France's National Academy of Medicine](#) realizes it, [as do clinicians who are themselves trans](#). A minority probably are, based on historical evidence, and probably a bit more than the past, given growing societal acceptance.

However, many are realizing they are not, with very costly consequences, including lifelong health problems, sexual dysfunction, and infertility.

Please read some of their testimonies here:

<https://nypost.com/2022/06/18/detransitioned-teens-explain-why-they-regret-changing-genders/>
<https://somenuanceplease.substack.com/p/some-reflections-on-the-hysterectomy>
<https://www.dailymail.co.uk/news/article-10953157/Man-suing-NHS-trans-surgery-regrets-bravely-waived-anonymity-share-ordeal.html>
<https://genspect.org/how-internalized-misogyny-contributed-to-my-transition/>
<https://www.newsweek.com/theres-no-standard-care-when-it-comes-trans-medicine-opinion-1603450>

And we don't even know how many detransitioners there are. One [recent study](#) says as many as 75%

of detransitioners don't return to their clinicians to tell them they are stopping their medicalization.

Please also read the testimonies of trans people who are very concerned about what is happening to children with undeveloped brains:

<https://www.newsweek.com/we-need-balance-when-it-comes-gender-dysphoric-kids-i-would-know-opinion-1567277>

<https://www.washingtonpost.com/opinions/2022/04/11/i-was-too-young-to-decide-about-transgender-surgery-at-nineteen/>

<https://bust.com/sex/195055-trans-man-gyneologist-advice-buck-angel.html>

Parents are understandably alarmed at what is happening to children: kids being influenced away from their families, [affirmed often in secret by schools](#) and friends, and then fast-tracked to medicalize by the medical establishment, some of them with clear monetary motives and no concern about ethics ([this one performed a double mastectomy on a 13-year-old girl](#) - in Florida!).

I urge you to set the standard in the United States - which will also make an impact beyond the US.

Thank you.

From: [zzzz Feedback, BOM_MeetingMaterials](#)
To: [Strickland, Bettye C](#)
Subject: FW: Letter for your review and discussion
Date: Friday, September 16, 2022 10:25:34 AM
Attachments: [Florida Medical Board Letter.pdf](#)

From: Beatriz Martinez <b@beatrizmartinez.org>
Sent: Thursday, September 15, 2022 11:47 AM
To: zzzz Feedback, BOM_MeetingMaterials <BOM.MeetingMaterials@flhealth.gov>
Subject: Letter for your review and discussion

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Greetings,

Please accept the attached letter for discussion at your upcoming September 30th meeting.

With gratitude,



Beatriz Martinez-Peñalver, L.M.H.C

Founder, [Triumph Steps, Inc](#)

[Healthy Connections, CMHC](#)

Featured on [NBC](#), [CBS](#), [Univision](#)

What we focus on the longest, grows the strongest.

Emotional literacy in all schools. Transformative coaching.

Office: [305.646.0112](tel:305.646.0112)

Greetings to all,

We are writing to The Board of Medicine because the mental health of our children is our most significant concern.

My husband and I have a combined mental health experience of almost 70 years. I am a psychotherapist who has had a mental health center for the past 21 years, serving our community with a team of over 20 professionals. My husband is a psychiatrist who holds medical licenses in 34 states and presently practices in 120 emergency rooms around the nation.

In the past 30 years in the field, I've had one adult male patient who had partially transitioned to be a female. My husband remembers having no more than 4-5 transgender cases in his career (none children) until about three years ago. Now, he sees 5-10 children with gender dysphoria per month in emergency rooms. In my clinic, not long ago, we received a phone call from a mother, and in that call, we identified ten preteen girls experiencing gender dysphoria—her daughter and four girls in her class, as well as five friends from another school. None of the clients who have come to us with gender dysphoria have presented with a history of childhood gender dysphoria. Instead, parents describe a sudden onset of their symptoms. This rapid onset is a clear picture of peer contagion. Historically, there has always been a small number of children who present with gender dysphoria, and 80% of them outgrow it.

Many say that the rise in gender dysphoria visits to mental health professionals like us has to do with increased acceptance which helps the clients not feel marginalized. However, we have not seen an increase in adults exploring transitioning. It is solely children seeking it. There is an increase of 4,400% in kids identifying with gender dysphoria, and we need the help of The Florida Board of Medicine not to harm these children permanently. Many psychotherapists explore other factors affecting the child's mental wellbeing, not affirm, and have found great success.

We can learn a lot from looking at the history of John Money, the psychologist who originally introduced terms such as gender identity, sexual orientation, and gender roles that are now adding to our current mental health crisis.

Money stated that pedophilia is not always pathological. He argued that there are affectional pedophilia and sadistic pedophilia. According to Money, affectional pedophilia was about having too much love for a child. Money had considerable research on sexual identity and the biology of gender based on the case of the Reimer twin brothers. One of the twins had a condition that was attempted to be corrected by circumcision. The procedure went wrong, and the boy lost his penis. Money suggested raising the boy as a girl, and the parents did. He often brought the two kids to his office to do therapy and show them how they needed to perform sex acts. Both twins killed themselves when they were in their 30s. In the 1960s, John Hopkins pioneered sex reassignment procedures, and in 1979 the clinic was closed because they realized that reassignment procedures did not bring happiness or any of the benefits they were looking to find.

Transitioning does not bring wholeness and happiness. We have already traveled those waters. Many young women who transitioned in adolescence later regretted it and de-transitioned. We can read about many of them. "What we focus on the longest grows the strongest" is a phrase I often use with my clients and students. Social media and academia are creating a climate that propagates gender confusion at unprecedented rates. They do it by putting pressure on young children to identify with a gender, introducing books about gender identity at an early age, and more.

Our children need the help of the Florida Board of Medicine to protect them and do no harm. Please do not allow the medical transition of minors with hormones, puberty blockers, or gender surgeries. Our current mental health crisis merits it. Our children deserve it.

Respectfully yours,

A handwritten signature in black ink, appearing to read 'B. Martinez-Penalver', with a stylized flourish at the end.

Beatriz Martinez-Penalver, LMHC Florida Lic. MH4158

From: [zzzz Feedback, BOM_MeetingMaterials](#)
To: [Strickland, Bettye C](#)
Subject: FW: Regarding Regulations for Transitioning Minors
Date: Friday, September 16, 2022 10:25:47 AM

From: Studio o <clockworkegg@hotmail.com>
Sent: Friday, September 16, 2022 7:33 AM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>
Cc: zzzz Feedback, BOM_MeetingMaterials <BOM.MeetingMaterials@flhealth.gov>
Subject: Regarding Regulations for Transitioning Minors

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Dear Paul

I am a mother in The United Kingdom with a son who told me, age 14 that he was 'a girl' in June 2020. He wanted puberty blockers, cross sex hormones, name and pronoun change.

Currently and as of February 2022 he no longer believes himself to be the opposite sex and no longer wants hormones.

When he first told me, I was supportive and reassured him we would get through this together, he knows that I have several medically transitioned adult friends and could never be classed as 'transphobic'. Confusingly, I had never seen any behaviour from him that made me think he was *not* male.

I joined the parents forum of UK 'Children's Charity' Mermaids where I was informed: 'this is not a phase they grow out of', use his chosen female name and pronouns and see a doctor asap to arrange puberty blockers and to avoid our '*daughter*' self-harming or *worse*.

Strangely, I saw that the forum was receiving multiple new members every day, all like us and all the teenagers were saying exactly the same things, almost word for word. Many of them, like my son are somewhere on the Autism Spectrum and had started puberty earlier than their peers just before the isolation of Covid Lockdown. They had also accessed pornography at an early age. These similarities are key.

My husband and I looked at all the information available regarding this condition and found the description of 'R.O.D.G.' (Rapid Onset Gender Dysphoria). Studies and surveys showed that this was a phase, one that around 80% of teenagers grow out of **if** not affirmed in their belief, normal, talk

therapy can help, online influencers and social contagion play a big part in convincing vulnerable young teenagers their normal feelings of puberty mean something else.

We did not have a big confrontation. We spent more time together, never changed his pronouns or name and found a non-affirming therapist.

My son is happier than he's ever been, he got high marks in his exams this Summer, got a girlfriend, is enjoying his new college, plays guitar, meets up with friends and most importantly has a healthy body - his only body.

I have seen what happens to children who were given puberty blockers - they all go onto cross-sex hormones, it is a non-stop path. I have nightmares that we gave into the pressure at the beginning and pretended he was a girl like we were advised to. Thankfully we didn't sign our child up to stunted cognitive and bone development and a life-long medical reliance based on what he read on the internet.

Watchful waiting, the most cost-efficient response is actually the safest and most likely to lead to a happy child. Even socially transitioning them or altering pronouns helps to reinforce their feelings of being the opposite sex, remaining neutral is important.

Give these children **time** (2-3 years) not GnRH agonists, that were originally developed for adults with prostate cancer, endometriosis and uterine fibroids, and to chemically castrate sex offenders. Normal, talk therapy is a very helpful, safe space for them to discuss their feelings and any other issues with experienced professionals.

I know there is relentless pressure from lobby groups to recognise 'trans kids' but I know from experience that they are just kids going through the process of finding their identity. There is no such thing as 'the wrong puberty', natural puberty helps these young people find themselves.

Yours sincerely

J. Derbyshire

From: [zzzz Feedback, BOM_MeetingMaterials](#)
To: [Strickland, Bettye C](#)
Subject: FW: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, September 16, 2022 10:26:53 AM

From: Ashsoch@gmail.com@mg.gospringboard.io <Ashsoch@gmail.com@mg.gospringboard.io> **On Behalf Of** Asher Sochaczewski
Sent: Wednesday, September 14, 2022 6:21 PM
To: zzzz Feedback, BOM_MeetingMaterials <BOM.MeetingMaterials@flhealth.gov>
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Care providers, doctors, and leading medical associations have been clear that gender-affirming care is safe, effective, and evidence-based, and that it's literally lifesaving.

The issued guidance by the Dept. of Health and the studies used by this board are inaccurate and dangerous. This guidance is nothing more than another tool for the Governor to express his opposition to transgender individuals' existence.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people, including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving

treatment.

The Board must provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

I urge you to reject this proposal.

Sincerely,

Asher Sochaczewski

From: [zzzz Feedback, BOM_MeetingMaterials](#)
To: [Strickland, Bettye C](#)
Subject: FW: Comment on gender "affirmative care"
Date: Friday, September 16, 2022 11:08:51 AM

From: Jen <lavend3rlazuli@gmail.com>
Sent: Friday, September 16, 2022 10:34 AM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>; zzzz Feedback, BOM_MeetingMaterials <BOM.MeetingMaterials@flhealth.gov>
Subject: Comment on gender "affirmative care"

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

To Paul A. Vazquez and the Florida Board of Medicine,

I want to support your move to restrict the so called "affirmative care" of children who identify as transgender. Around the age of thirteen, my daughter and several of her classmates came to the conclusion that they are transgender. When my daughter came out to us at fourteen, we were shocked as she had been a typical girl who had in no way demonstrated that she was unhappy with her body or the sex that she is. We are an educated, left leaning family (my husband is a professor) and have never embraced gendered social stereotypes. The boys in our family have long hair. Our eldest daughter is a lesbian in a loving relationship.

We thought that our daughter's distress should be explored and so made an appointment at a gender clinic. Outrageously, after one appointment, the "affirmative care" counsellor recommended that our young teen be put on experimental opposite sex hormones (ie. testosterone). We felt that was moving forward too quickly and I began to research everything I could about transgender teens. Four years later, I've made many eye-opening discoveries. I firmly believe that the recent outbreak of transgender identities in this new and different cohort of young people is the result of social contagion, as Dr. Erica E. Anderson (trans woman, and former president of the United States Professional Association for Transgender Health, and former board member of WPATH) has written here: https://www.sfexaminer.com/archives/opinion-when-it-comes-to-trans-youth-we-re-in-danger-of-losing-our-way/article_833f674f-3d88-5edf-900c-7142ef691f1a.html.

We must protect these young people from making irreversible medical and surgical changes on their bodies. You are well aware of the global shift regarding the transitioning of children and adolescents. Progressive countries such as Sweden, Finland, the UK and France have realized the harm that can come from the "affirmative care" model of treatment for trans kids and are now revamping their policies and programs for these patients. There are increasing numbers of detransitioners who are unhappy/angry with the healthcare they have received in the name of transgender care.

As a family we have not allowed our daughter to take testosterone though she begged that she needed it "for her mental health". Instead we have found a good psychologist who is helping our child deal with her anxieties. We are trying to educate our daughter about the realities of medical transition and how it is fraught with complications, both physical and psychological. We try to affirm her in her healthy body instead. She has recently stated that you don't need to take hormones to be trans. I hope that means she is backing away from medicalizing her perfect body.

Thank you for caring for and protecting the health of our children and youth. I support your search for the best treatment practices for these vulnerable kids. Please include mental health resources in your policies.

Sincerely,
Lavender Li

Dear Mr. Diamond.

Thank you for protecting
minors from gender-
affirming treatments.

Sincerely
Barbara Kliffel

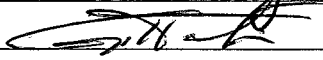
Dear Mr Diamond

Thank you for protecting our minors from
from these "enders" offering treatments

Carol S. Muller

DEAR DAVID Diamond

I want to personally thank you for
looking out for the well being of all
Florida children by working to ban trans-
gender treatments for minors. Keep up the
fight & DON'T BACK DOWN!!

Sincerely


From: [William Malone](#)
To: [BOM Public Comment](#)
Subject: Re: Practice Standards for the Treatment of Gender Dysphoria: Rule Number 64B8-9.019
Date: Saturday, September 17, 2022 1:27:28 PM
Attachments: [Florida_Medical_Board_9_17_2022_Letter Form.pdf](#)

You don't often get email from malone.will@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

My apologies, please disregard the attachment on the previous email. The version attached to this email is the correct and updated version of my submission.

On Sep 17, 2022, at 11:17 AM, William Malone <malone.will@gmail.com> wrote:

Dear Florida Board of Medicine:

Please find attached commentary regarding the upcoming meeting concerning treatments for gender dysphoria.

Sincerely,

William Malone, MD

Endocrinologist

<Florida_Medical_Board_9_17_2022_Letter Form.pdf>

From the desk of : William J. Malone, MD, Endocrinologist, Twin Falls, ID

9/17/2022

Dear Chairman of the Board:

I'm an endocrinologist practicing in Twin Falls, ID, via Stanford University, NYU School of Medicine and Los Angeles County/University of Southern California Medical Center. I'm also a Board Member of a nonprofit international organization of clinicians and researchers which evaluates current interventions for gender dysphoria and promotes evidence-based care for children, adolescents, and young adults. I've published articles in The Journal of Clinical Endocrinology and Metabolism, The Lancet, Child and Adolescent Health, and Medscape on this subject. My views are my own, and do not represent the positions of any organization with whom I am affiliated. I am providing the following comments, annotated from public remarks I made recently to HHS, and copies of articles I have written on the topic of gender medicine, in the hopes the medical board will find them helpful as it deliberates next steps in gender care in the state of Florida.

1. Gender-affirmative care is a euphemism for a highly invasive treatment protocol for minors. To illustrate this point:

A 10-year-old feminine boy is teased for being gender-non-conforming, and determines that his interest in dolls and makeup indicates that he is transgender. Under the affirmative care paradigm, clinicians would have to affirm this child's belief and begin preparing him for transition starting with puberty blockers. Puberty blockers will halt his genital development—his genitalia will stay very small—prepubertal size, only slightly larger than infant sized genitalia. It will also stop accrual of bone

density, and alter his brain development, and impact the development of every part of his body in ways that we do not fully understand. In nearly 100% of cases, puberty blocked kids proceed to cross sex hormones. This means that puberty blockers should not be considered a pause button, nor stand-alone treatment. They represent the first step in a pathway of cross-sex hormones and possible surgeries that can cause permanent physical changes and sterility.

At around age 14, estrogen will be given, which results in the destruction of future sperm producing potential, rendering sterility. This young person will be dependent on estrogen life-long which will increase the risks of strokes and blood clots by several fold and may increase the risk of cancer.

At age 17, a surgeon will remove the pre-pubertal sized and non-functional testes. At age 18, a surgeon will create a neovagina from the penile tissue, but because the penis is the same small size that it was at age 10, a section of colon will need to be used. This neovagina may carry the odor of colon tissue, and will be susceptible to developing diseases of the bowel such as colitis. It is not clear whether this young person will ever experience sexual desire or be able to have an orgasm. What is clear is that the young person will never be able to reproduce and will face a life time of medical patient-hood.

Today, kids like the one I described are presenting in record numbers seeking sex reassignment. As many as 10% of youth identify as transgender. Affirmative care asks that children make life-changing decisions that carry irreversible consequences at an age when the ability to provide meaningful consent is questionable.

2. Interventions of such impact should only be provided when the evidence of benefit outweighs the risk of harm. In our highly politicized environment, it is claimed this is the case. However, every credible systematic review of evidence conducted to date—from the US to Finland to Sweden and the UK, has failed to demonstrate any lasting or credible benefits of these interventions while noting very significant risks. While the often-heard statement that “puberty blockers save lives” is catchy, and has been successful at shutting down dialogue, the statement has never been scientifically proven. Specifically, there is no evidence that puberty blockers reduce suicide rates in gender dysphoric youth.
3. Females who take testosterone have increased odds of developing heart disease. Other risks include: liver dysfunction, hypertension, vaginal atrophy, menopausal symptoms, and uterine pain. Irreversible masculinizing changes to the female body occurs -- deepening of the voice, facial structure changes, male pattern hair loss, enlargement of the clitoris. Males who take estrogen have increased risks of strokes and blood clots, as well as increased risks of male breast cancer.
4. Mastectomies remove healthy breast tissue from women, which prevents future breastfeeding, and can lead to scarring and permanent nerve damage.
5. Because of the low quality of evidence, no established standard of care for the treatment of youth with gender dysphoria currently exists. The World Professional Association for Transgender Health (WPATH) acknowledges that despite the misleading name, WPATH Standards of Care 7 and recently released 8 are also practice guidelines, not standards of care. Even the Endocrine Society’s guidelines admit that they “cannot guarantee any specific outcome, nor do they establish a standard of care”.

6. In the last 24 months, multiple guidelines have been developed by health authorities worldwide (UK, Sweden, Finland) which are increasingly divergent from US Guidelines regarding who should be treated, how they should be treated, when they should be treated, and whether medical interventions for minors can be ethically initiated outside of clinical trials.
7. Dr. Carl Heneghan, the Editor in Chief of the BMJ-Evidence Based Medicine division has written that the administration of puberty blockers and cross sex hormones to children and adolescents represents an “unregulated live experiment”. Dr. Christopher Gillberg, a Swedish psychiatrist and world’s expert in autism calls the current unregulated administration of puberty blockers and cross-sex hormones to children and adolescents the greatest medical scandal of modern medical times.
8. Unfortunately, the history of medicine has many examples of well-meaning interventions that resulted in widespread pain and suffering because they were not adequately studied prior to their adoption. Thalidomide and the recent opioid epidemic are such examples. Two decades ago, physicians were instructed, against their better judgment, to treat pain as the fifth vital sign and to liberally prescribe opioids. The short-term relief that patients experienced backfired into the biggest medical scandal of modern times, the current the opioid crisis. I, and great many of my physician colleagues are concerned that we are in the midst of a similar or perhaps even greater epidemic of harm directly resulting from physician actions, where there is no consensus as to how to determine medical necessity for treatment within a very large and diverse population of patients. The long-term medical harm at a massive scale will be unavoidable.

Sincerely,

A handwritten signature in black ink that reads "William J. Malone". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

William Malone, MD

Endocrinologist

Twin Falls, ID

Please find below copies of articles that I have authored or co-authored on this topic:

COMMENTARY

Time to Hit Pause on 'Pausing' Puberty in Gender-Dysphoric Youth

William Malone, MD

September 17, 2021

Teens are identifying as transgender in record numbers. In 2017, [3-4 in 100 teens in the United States](#) reported that they are or may be transgender. A more recent 2021 study suggests that the rate of transgender identification among America's youth may be as high as [9 in 100](#). All of the major gender centers in the world have reported a several-thousand-percent increase in youth presenting with gender distress.

How do we reconcile these numbers with 2013 [data](#) reporting the prevalence of adult gender dysphoria to be a rare 2-14 in 100,000? Reflection is warranted because many US medical societies support providing youth who have transgender identification (over 1 million children and adolescents, using the latest estimates) with access to powerful endocrine interventions.

GnRH analogues (colloquially known as "puberty blockers") are now available at Tanner stage 2 of puberty — a threshold crossed by females as young as 8-9 years old. Cross-sex hormones and surgeries follow, and mastectomies are now available to children [as young as 13](#). Genital-altering surgeries, as well as the removal of the ovaries, uterus, and testes, can be obtained [as soon as a patient turns 18](#).

What's driving this massive increase in trans-identified youth? What are the risks, benefits, and uncertainties associated with hormonal and surgical interventions? Do such interventions improve the long-term psychological health of gender-dysphoric youth? How many will regret the irreversible changes made to their bodies during what may have been a temporary phase in their development?

We don't know the answers to these questions, but we need to figure them out before offering such interventions. Frontline clinicians — especially those working with youth — will not be able to remain on the sidelines of this issue for much longer. Each clinician considering writing a prescription for puberty blockers or cross-sex hormones, or generating a referral for surgery, will need to answer for themselves: *Just because I can, does it mean I should?*

What's Contributing to the Rapid Rise of Gender-Dysphoric Youth?

The etiology of the rapid rise of transgender identifications in young people is vigorously debated. Proponents of hormonal and surgical interventions for youth argue that the several-thousand-percent increase in the numbers of youth seeking gender reassignment is a reflection of more social acceptance of transgender identities, allowing more young people to "come out." But closer examination of this claim reveals several inconsistencies.

Because [adolescent](#) and young adult females now account for [6-8 in 10 of the presenting cases](#) (previously, prepubertal males were more common), one would expect a commensurate increase in the rate of transgender identification in older females. This has not occurred. In addition, [more than three quarters](#) of currently presenting cases have significant mental health problems or suffer from neurocognitive comorbidities such as [autism spectrum disorder or attention-deficit/hyperactivity disorder](#) — a much higher burden of mental health comorbidities than the historical cohort with gender dysphoria.

There is legitimate concern that these comorbid mental health conditions, as well as the influence of social groups and online immersion into transgender topics, may be playing a role in the rapidly growing rate of transgender identification among these particularly vulnerable youth.

The initial study [positing the theory](#) that social influence is playing a role in the increased incidence of "late" or adolescent-onset (vs childhood-onset) transgender-identified youth was harshly attacked by proponents of medical transitioning of youth, despite the fact that the study utilized [similar methods](#) used in other areas of health research. The study underwent an unprecedented second peer review and emerged with largely unchanged conclusions.

Since the study's publication, a [number of mental health clinicians working directly with gender-distressed youth](#) have corroborated a rapid onset of transgender identification among teens with previously gender-normative childhoods.

Pioneers in Gender Dysphoria Treatment Are Changing Course

Several European countries that were pioneers in pediatric medical transition are now reversing course toward far more caution after their own evidence evaluations failed to show that medically transitioning gender-distressed youth improves mental health outcomes. In Sweden, following [Karolinska Hospital's announcement](#) that it will no longer transition people under 18 outside of strictly regulated clinical trials, a number of other pediatric gender clinics followed suit and [made the same decision](#).

In the UK, Keira Bell — a young woman who was treated with "affirmative" hormonal and surgical interventions before detransitioning — brought a challenge against the national gender clinic. Her landmark case and the [UK High Court's original judgement](#) against the clinic have highlighted the urgency to reassess treatment approaches for the increasingly varied presentations of gender dysphoria in young people. As this article went to press, the UK's national gender clinic [won](#) its appeal against Keira Bell, meaning that doctors there will once again be able to decide whether their patients under 16 can properly consent to puberty blockers. Keira Bell said she is disappointed with this decision and will be seeking permission to appeal to the Supreme Court. She said the medical service had become "politicized," and added: "A global conversation has begun and has been shaped by this case. It has shone a light into the dark corners of a medical scandal that is harming children and harmed me. There is more to be done."

And the UK National Health Service (NHS) has already commissioned an [independent systematic review](#) of data, which concluded that the evidence of benefit of hormonal interventions in gender dysphoric youth is of very low certainty and must be carefully weighed against the risks. An [independent taskforce has also been convened](#) to reassess the country's approach to treating gender dysphoric youth.

Finland has arguably undertaken the biggest change of all. An early adopter of pediatric medical transition, researchers there noticed that adolescents who had mental health struggles at baseline [failed to improve after transition](#). The Finnish national Gender Identity Development services issued [new treatment guidelines in 2020](#) stating that psychotherapy, rather than gender reassignment, should be the first line of treatment for gender-dysphoric youth.

The leadership of America's medical societies have been slower to respond. Last month, the [Society for Evidence-Based Gender Medicine](#) applied to share information about youth gender transitions at the yearly meeting of the American Academy of Pediatrics (AAP). The application was denied without explanation, despite the fact that [80% of rank-and-file pediatricians](#) who voted on AAP resolutions days earlier endorsed a resolution calling for a reassessment of the evidence and more caution regarding gender transitions of minors.

The AAP leadership apparently ignored the resounding support for this resolution, but the clear message from that vote is that frontline pediatricians do not agree with the "one size fits all" approach of automatically affirming gender-distressed youth as transgender and proceeding to gender reassignment.

What We Know and Don't Know

There is now growing evidence that the "gender-affirming" model, based on the unproven assumption that gender reassignment is the best way to help gender-distressed youth, is not living up to its promise. This should not be surprising. Despite more than 50 years of experience with mature adult gender transitions, there is a lack of convincing evidence that transitions improve the psychological functioning of those with gender dysphoria, and studies on regret have been plagued by high dropout rates that prevent meaningful conclusions for practitioners and patients alike. Pediatric transitions are a much more recent phenomenon, with little to no quality data to guide decision-making.

We are witnessing a growing number of [vocal regretters](#) who underwent gender reassignment as teens and young adults under "gender-affirming" care protocols in recent years. A review of [stories on the subreddit r/detrans](#), which counts over 20,000 members (not all are detransitioners, as the forum is open to those fully detransitioned, partially detransitioned, desisted [those who identified as transgender for a period of time in their youth but no longer do], and questioning their transition) is flush with first-hand accounts of regret and should be mandatory reading for any clinician who is considering becoming a prescriber of gender-affirmative care.

Here is a brief outline of what we know — and more importantly, what we don't know — about the practice of medically transitioning minors.

- **Most cases of early childhood-onset gender dysphoria self-resolve.** [Eleven out of 11 studies](#) that followed the trajectory of gender-variant youth show that the most common outcome is natural resolution of gender dysphoria [around or after puberty](#). Among those diagnosed as having gender identity disorder, 67% no longer met the diagnostic criteria as adults; among those subthreshold for diagnosis, [93% were not gender dysphoric](#) as adults. Gender dysphoria in childhood is a far better predictor of future homosexuality than of future trans identity.

- **The future trajectory of people whose transgender identity emerged during or after puberty is entirely unknown.** No one has studied future trajectories of patients whose transgender identity emerged for the first time after the onset of puberty — a previously rare but now increasingly common presentation. Growing numbers of young detransitioners and desisters are precisely from this demographic, suggesting that a transgender identity that emerges in adolescence may not be durable.
- **Social transition does not improve mental health outcomes.** Recent studies show that while socially transitioned children can thrive in the short term, they **do not fare any better** than their non-socially transitioned dysphoric peers. It appears that **peer relations**, not the social transition status, predict mental health in gender-dysphoric children. We don't yet know the long-term trajectories of socially transitioned minors, but **emerging evidence** suggests that they may **be more likely to persist** with gender-related distress rather than outgrow it, as previously observed. This in turn necessitates decades of invasive and risky medical interventions. In fact, the Dutch researchers who pioneered the protocol used to medically transition minors (see Box) **explicitly and strongly discouraged** social transition of children and early adolescents.
- **Nearly 100% of children who begin puberty blockers will proceed to cross-sex hormones and surgeries.** The two main studies that have **evaluated the effects of puberty blockers** on mental health found **no improvements** or **improvements of marginal clinical significance**. Both studies are also at critical risk of bias due to the absence of control groups. **Four additional studies** looking at the mental health effects of puberty blockers were plagued by **design limitations** and also **failed** to show any convincing positive effects on psychological health. However, one effect of puberty blockers has been consistently replicated: **At least four studies show** that **virtually all of the children who start puberty blockers proceed to cross-sex hormones**. This suggests that rather than being a pause button, puberty blockers may serve as the "gas pedal" for gender transition.
- **Most of the long-term health risks are largely unknown.** No long-term studies exist of patients who underwent medical transition as teens or young adults. Therefore, our ability to assess risks vs benefits is limited. Puberty blockers have been demonstrated to **significantly impair bone health**, and it is not clear whether this will result in future osteoporosis. Cross-sex hormones are associated with **roughly 3-5 times the risk for heart attacks and strokes**, though long-term studies are of insufficient quality for accurate risk assessments. Other risks associated with these endocrine interventions will come to light as the practice continues to scale and as young people spend years and decades on these interventions. The risks to fertility are largely unknown, but it is almost certain that if puberty blockers are given at the early stages of puberty and followed by cross-sex hormones, sterility will result.
- **The medical pathway of "affirmative care" rests on a single Dutch study that is not applicable to the current populations of gender-dysphoric youth.** Most of the youth presenting for care today would have been explicitly disqualified by the original Dutch protocol, as most have significant mental health comorbidities and post-puberty onset of trans identities. This fact has been recognized by the principal investigators of the Dutch protocol itself, who have **recently begun to sound the alarm** about the **potential misapplication of their protocol** and who suggest that psychotherapy — rather than gender reassignment — is more appropriate for many of the currently presenting cases.

On Suicidality

The urgency to put gender-dysphoric youth through gender reassignment despite the dearth of evidence appears to stem from the notion that if we don't intervene medically and in short order, these youth will commit suicide. However, studies using quality data reveal a markedly different reality.

While gender-dysphoric youth do have elevated rates of suicidality, it's not uniquely high. In fact, it's **roughly similar** to the rate of suicidality found in populations of youth referred for other mental health conditions. Quality long-term studies that explored whether transition leads to reduced suicidality **have not been able to demonstrate** a reduction.

Medicine has a pattern of enthusiastically embracing unproven medical interventions, only to find out years or decades later that the harms from those interventions outweigh the benefits. We owe it to our patients to be transparent about the limits of our knowledge and the fact that the "affirmative care" pathway is largely irreversible.

When the benefits of an intervention have not been shown to outweigh the risks, medical ethics dictate that such interventions should not occur outside of clinical trials. We must not conflate medical care for gender-dysphoric youth with experimental and risky interventions that are based on low-quality evidence. It's time to hit pause on gender transitions for youth.

A Brief History of the Dutch Protocol

Before the mid-1990s, medical transition was primarily reserved for mature adults. However, noting the "[never-disappearing masculine appearance](#)" of many adult male transitioners, a team of Dutch researchers hypothesized that it might be appropriate to provide early intervention to a carefully selected group of adolescents before the irreversible physical changes of puberty occur.

To differentiate the majority of gender-dysphoric children who would outgrow their cross-sex identification by adulthood from the few who would probably not have resolution and would wish to transition later in life, the Dutch gender clinic designed a [rigorous screening protocol](#), with multidisciplinary teams closely following prospective candidates for several years.

To qualify for early intervention, the adolescents had to have had persistent and severe cross-sex identification from early childhood (cases of adolescent-onset trans identity were disqualified); the distress had to worsen during puberty; and the adolescents had to be free from any other significant mental health conditions. For qualifying adolescents, puberty blockers were initiated no earlier than 12 years of age, cross-sex hormones at 16, and surgeries upon turning 18. Ongoing psychotherapy was provided through the entire assessment and intervention period.

The Dutch team published the [final results](#) of their research in 2014. The authors reported that at the average age of 21 (approximately 1.5 years post-surgery), the young people were free from gender dysphoria and functioning well. Despite a postsurgical death from infection, several new diagnoses of metabolic illness, and multiple dropouts, the Western world enthusiastically embraced the early-intervention model. Concerningly, the only attempt to replicate the Dutch protocol outside of the Netherlands [failed to show any psychological improvements](#), and to date, no long-term outcome data are available for the cohort of the 55 treated Dutch adolescents.

These progressively irreversible interventions form the basis of the "Dutch Protocol." Currently, this protocol is being scaled in ways it was never designed for. For example, it strongly discouraged childhood social transition and did not transition adolescents with postpubertal onset of transgender identity or those with significant mental health comorbidities. Yet, treating such cases with the interventions outlined in the Dutch protocol is now common, and the age of eligibility for hormonal and surgical interventions has progressively lowered, with children as young as 8 now eligible to begin puberty blockers.

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LETTER TO THE EDITOR



Puberty blockers for gender dysphoric youth: A lack of sound science

Dear Editor,

The medical transition of children and adolescents with gender dysphoria remains highly debated and there is significant divergence in policy internationally.¹⁻⁷ Mills and colleagues' review the interventions that comprise the "gender-affirmative" care pathway, an approach currently promoted by many medical organizations in North America.⁶⁻⁸ We strongly agree with the authors that pharmacists have a responsibility to "understand the evidence," and "place the well-being of the patient over any personal cultural beliefs."⁸ However, we think the use of evidence to support the authors' claim that gonadotropin releasing hormone (GnRH)-analogs are fully reversible and have been shown to improve mental health, requires critical appraisal.

GnRH-analogs have been used for decades to successfully delay the early onset of puberty in children with precocious puberty.⁹ While generally considered safe for this indication, recent concern about impacts on polycystic ovarian disease, metabolic syndrome, and future bone density, have been raised.¹⁰ Even less is known about the use of GnRH-analogs to halt normally timed puberty in youth with gender dysphoria; no long-term, longitudinal studies of GnRH-analogs for this indication exist.

Puberty-related hormones have wide ranging effects on brain structure, function, and connectivity.¹¹ Concerns have been raised that hormonal suppression of puberty may permanently alter neurodevelopment.^{2,11-13} The possible impact of puberty blockade on a young person's cognition has important implications for the decision to initiate exogenous cross-sex hormones and the capacity to give informed consent.¹⁴ Moreover, it has been suggested that pubertal suppression may alter the course of gender identity development, essentially "locking in" a gender identity that may have reconciled with biological sex during the natural course of puberty.¹³ Over 95% of youth treated with GnRH-analogs go on to receive cross-sex hormones.¹⁵ By contrast, 61-98% of those managed with psychological support alone reconcile their gender identity with their biological sex during puberty.¹⁶⁻¹⁸ This lack of evidence to support the durability of a transgender identification is conceptually consistent with significant psychosocial determinants of cross-sex identity, while the belief in immutable biological influences can best be described as a "current hypothesis."¹⁹

There are also concerns that GnRH-analogs may have irreversible effects on sexual function and bone development. In some youth

pubertal blockade at Tanner stage 2 followed by exogenous cross-sex hormones has resulted in a complete absence of adult sexual function.²⁰ Profound effects on future sexual function may even occur when puberty is paused and later allowed to proceed, since the precise timing of hormone exposure during the peripubertal window is a determinative factor in adult sexual function.²¹ Finally, several studies have found that the expected pattern of bone mass accrual during adolescence does not occur when puberty is halted.²²⁻²⁵ The long-term clinical consequences of failure to accrue normal bone mass are unknown.

Uncertainties about long-term risks of medical transition are often overshadowed by the most potent argument provided by advocates of the affirmative model: failure to affirm a young person's transgender identity may result in suicide. Suicidal ideation and self-harming behaviors have been found to be higher than age-matched peers, but comparable to nongender dysphoric youth referred for management of other mental health diagnoses.²⁶ However, the relevant question is whether affirmative care reduces suicide risk. Mills and colleagues' assertion that GnRH-analogs have been shown to decrease lifetime suicidal ideation stems from a nonrepresentative, low-quality survey of transgender adults that has been thoroughly critiqued by others.^{27,28} Moreover, their claim that these drugs are effective for other mental health outcomes is at odds with recent systematic reviews that concluded there is little change from baseline to follow-up in depression, anxiety, body image, gender dysphoria, or psychosocial functioning.^{2,12,29} A seminal Dutch case-series of children with early-onset gender dysphoria is cited to support the assertion that GnRH-analogs improve psychological functioning.¹⁵ The magnitude of posttreatment improvement in mental health outcomes in this study was small and of questionable clinical significance. Furthermore, the applicability of results to the most common demographic presenting today, that is, adolescent females with pre-existing mental health problems or neurodevelopmental conditions and no prior history of gender dysphoria, is questionable.^{4,30} A recent attempt to replicate the results of the Dutch study in the United Kingdom found no psychological benefit with GnRH-analogs, but treatment was associated with adverse effects on bone development.³¹

Multiple European countries that were pioneers in youth medical transition are now adopting a more cautious approach to the use of

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GnRH-analogs and cross-sex hormones after their own evidence reviews failed to show mental health benefits and highlighted a profound lack of knowledge about harms. The UK's Cass review emphasized the paucity of data in their interim report stating, "it is important that it is not assumed that outcomes for, and side effects in, children treated for precocious puberty will necessarily be the same in children or young people with gender dysphoria."¹³ The NHS updated guidance on treatment of gender dysphoria removed statements about the reversibility of GnRH-analogs and now states, "little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria."⁴ The Swedish Health Authority no longer offers GnRH-analogs to minors except in exceptional cases stating, "the risks of puberty suppressing treatment with GnRH-analogues and gender affirming hormonal treatment currently outweigh the possible benefits."³ Finland has severely restricted their use and now recommend psychotherapy as first-line treatment for gender-dysphoric youth.² Lastly, the French Académie Nationale de Médecine recently issued a press release stating, "great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause."⁵ Although puberty-blockers and cross-sex hormones will still be available, the Académie emphasized, "the greatest reserve is required in their use, given side effects such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause."⁵

In summary, we believe the authors' review does not present a balanced assessment of the evidence and betrays a bias toward uncritically promoting medical transition. The widespread methodological weaknesses in the research coupled with the lack of certainty that benefits outweigh harms, should raise questions about affirmation being positioned as the "standard of care" in the United States and Canada.²⁹ Patients and their families rely on pharmacists to resist ideological influence and communicate transparently. To this end, we call on Mills and colleagues to revisit their important review and provide a more nuanced discussion of the evidentiary basis for gender-affirming care.

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CONFLICT OF INTEREST

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REFERENCES

1. The World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. 7th version; https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20v7_English.pdf
2. Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland) Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. 2020. Society for evidence based gender medicine unofficial translation. https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf
3. SOCIALSTYRELSEN. The National Board of Health and Welfare (NBHW). Care of children and adolescents with gender dysphoria. 2022. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>
4. National Health Service (NHS). Treatment—Gender dysphoria; 2020. <https://www.nhs.uk/conditions/gender-dysphoria/treatment/#:~:text=Puberty%20blockers%20and%20cross%20sex%20hormones&text=Little%20is%20known%20about%20the,the%20psychological%20effects%20may%20be>
5. Académie Nationale de Médecine. Communiqué. La médecine face à la transidentité de genre chez les enfants et les adolescents; 2022. https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en#_ftn1
6. Office of Population Affairs. Gender-affirming care and young people. <https://opa.hhs.gov/sites/default/files/2022-03/gender-affirming-care-young-people-march-2022.pdf>
7. Bonifacio JH, Maser C, Stadelman K, Palmert M. Management of gender dysphoria in adolescents in primary care. *CMAJ*. 2019;3:E69–E75.
8. Mills AR, Astle K, Frazier CC. "Affirming" journey: Narrative review and practice considerations on gender affirming care. *JACCP: Journal of the American College of Clinical Pharmacy*. 2022;5:697–706.
9. Carel JC, Eugster EA, Rogol A, Ghizzoni L, Palmert MR, ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;4:e752–e762.
10. De Sanctis V, Soliman AT, Di Maio S, Soliman N, Elsedfy H. Long-term effects and significant adverse drug reactions (ADRs) associated with the use of gonadotropin-releasing hormone analogs (GnRHa) for central precocious puberty: A brief review of literature. *Acta Biomed*. 2019;3:345–359.

11. Chen D, Strang JF, Kolbuck VD, et al. Consensus parameter: Research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. *Transgend Health*. 2020;4:246–257.
12. National Institute for Health and Care Excellence (NICE). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria; 2020.
13. Cass Review. Independent review of gender identity services for children and young people. Interim report; 2022 <https://cass.independent-review.uk/publications/interim-report/>
14. Levine SB, Abbruzzese E, Mason JW. Reconsidering informed consent for trans-identified children, adolescents, and young adults. *J Sex Marital Ther*. 2022;1–22. <https://doi.org/10.1080/0092623X.2022.2046221>
15. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med*. 2011;8:2276–2283.
16. Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ. A follow-up study of girls with gender identity disorder. *Dev Psychol*. 2008;1:34–45.
17. Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;1:13–20.
18. Singh D, Bradley SJ, Zucker KJ. A follow-up study of boys with gender identity disorder. *Front Psychiatry*. 2021;12:632784.
19. Saraswat A, Weinand JD, Safer JD. Evidence supporting the biologic nature of gender identity. *Endocr Pract*. 2015;2:199–204.
20. Blum B. Would you give up an orgasm? Opinion. The Jerusalem Post. June 2, 2022. <https://www.jpost.com/opinion/article-708397> Video recording from Women's Voices <https://twitter.com/WomenReadWomen/status/1521692875242688512>.
21. Shirazi TN, Self H, Dawood K, et al. Pubertal timing predicts adult psychosexuality: Evidence from typically developing adults and adults with isolated GnRH deficiency. *Psychoneuroendocrinology*. 2020;104733:104733.
22. Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. 2021;7:937–939.
23. Joseph T, Ting J, Butler G. The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *J Pediatr Endocrinol Metab*. 2019;10:1077–1081.
24. Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab*. 2015;2:E270–E275.
25. Viot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*. 2017;95:11–19.
26. Zucker KJ. Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Arch Sex Behav*. 2019;7:1983–1992.
27. Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*. 2020;145:e20191725.
28. Biggs M. Puberty blockers and suicidality in adolescents suffering from gender dysphoria. *Arch Sex Behav*. 2020;7:2227–2229.
29. Brignardello-Peterson R, Wiercioch W. Effects of gender affirming therapies in people with gender dysphoria: Evaluation of the best available evidence. May 16, 2022. https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Attachment_C.pdf
30. Strang JF, Meagher H, Kenworthy L, et al. Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *J Clin Child Adolesc Psychol*. 2018;1:105–115.
31. Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*. 2021;2:e0243894.



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No One Is Born in 'The Wrong Body'



William J. Malone, Colin M. Wright, and Julia D. Robertson

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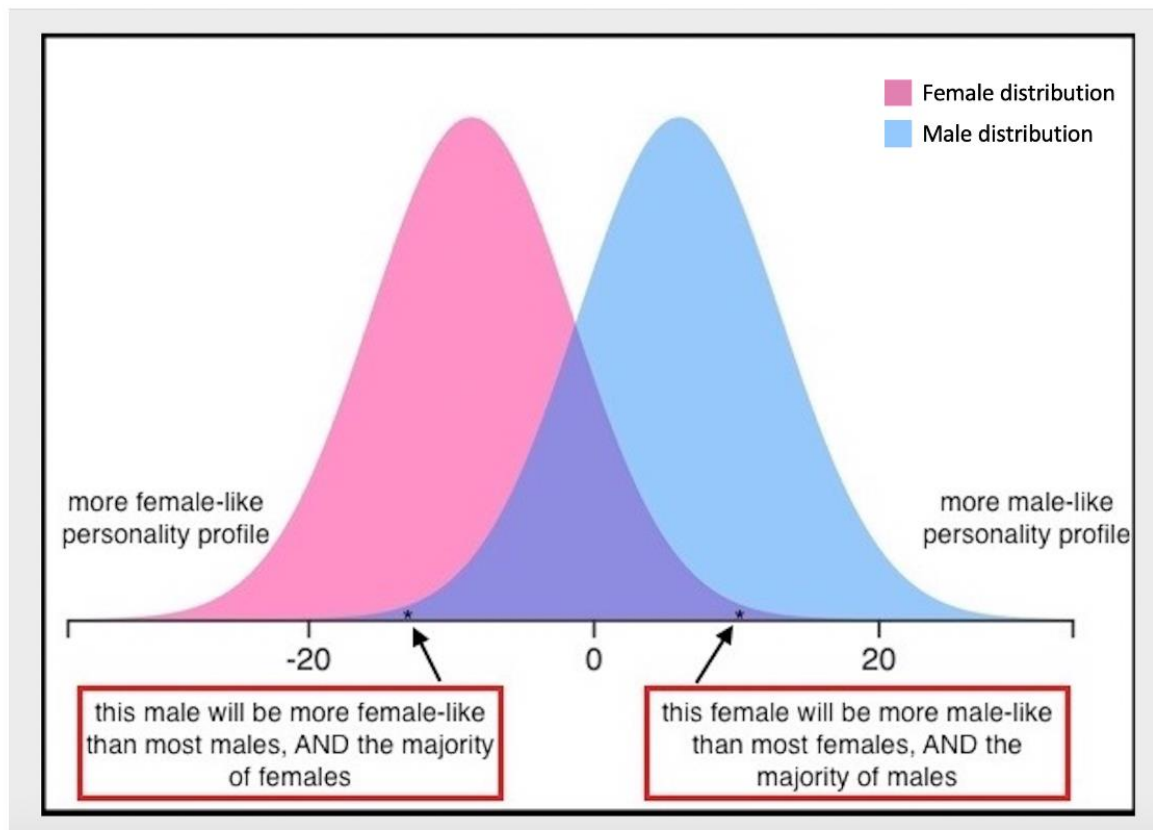
The idea that all people have an innate “gender identity” recently has been endorsed by many health-care professionals and mainstream medical organizations. This term commonly is defined to mean the “internal, deeply held” sense of whether one is a man or a woman (or, in the case of children, a boy or a girl), both, or neither. It also has become common to claim that this sense of identity may be reliably articulated by children as young as three years old.

While these claims about gender identity did not attract systematic scrutiny at first, they now have become the subject of criticism from a growing number of scientists, philosophers and health workers. Developmental studies show that young children have only a superficial understanding of sex and gender (at best). For instance, up until age seven, many children often believe that if a boy puts on a dress, he becomes a girl. This gives us reason to doubt whether a coherent concept of gender identity exists *at all* in young children. To such extent as any such identity may exist, the concept relies on stereotypes that encourage the conflation of gender with sex.

However, starting at a young age, children do tend to exhibit preferences and behaviors that we associate with *sex* (as distinct from *gender*). For example, male children display more aggressive behavior than female children. In addition, “cross-sex” behavior—or, more accurately, cross-sex stereotypical behavior—often is predictive of later same-sex attraction.

Can all of these findings be integrated? To start, just as sex influences the development of bodies, it also influences brains. There are in-utero differences in hormone exposures (male testosterone surges at eight weeks gestation, for example), and distinct developmental pathways are triggered based on the XX (typically female) or XY (typically male) chromosomal make-up of neurons. The integration of these sex-related and other developmental processes with environmental pressures gives rise to an individual’s unique personality and preferences.

It comes as no surprise then that population-based studies have demonstrated sex-related differences in personality and preferences that are independent of social influences. When social influences are weakened (in more egalitarian societies such as the Nordic countries of Europe), the sex-related differences in personality and preferences actually increase (the opposite of what one would expect if men and women were wired in an identical fashion). This suggests that as environmental pressures become relaxed, innate sex-specific preferences surface.



A closer look at personality traits shows that when data is analyzed in aggregate, there is a roughly 30% overlap between sexes, as schematized in the accompanying figure. The consequence of this overlap is that adolescent males who fall on the left end of the male (blue “masculine”) curve, and adolescent females who fall on the right end of the female (pink “feminine”) curve, will exhibit personality traits that diverge from the majority of other members of their own sex. In fact, due to the overlap of personality traits between males and females, *the personality traits of some females will be more “male-like” than those exhibited by some, or even most males’ and vice versa.*

In the case of an adolescent female whose behavior, personality traits and preferences are more “masculine” than most girls *and* most boys, she could be led to incorrectly conclude that she is really a male, born in the wrong body. That child’s parents could become confused as well, noticing how “different” their child’s behavior is from their own, or from that of their peers. In reality, that child simply exists at the end of a behavioral spectrum, and “sex-atypical” behavior is part of the natural variation exhibited both within and between the sexes. *Personality and behavior do not define one’s sex.*

There are approximately 40-million children in the United States between the ages of four and fourteen. The distribution curve above would suggest that roughly four-million of them have personality profiles that are “sex atypical,” but which are still part of the natural distribution of personalities within each sex.

The broad, but normal distribution of personality traits also explains studies showing a 28% concordance of transgender identity in twins. Twins have identical chromosomes, and so likely will have similar sex-related behaviors, as well as experience similar environmental influences in regard to those behaviors. Using twin adolescent males as an example: If their behaviors are at the “feminine” end of the male-typical distribution, they could both become confused as to what their behaviors and preferences mean about their sex.

In most cases, the thing that is now called “gender identity” likely is simply an individual’s perception of how their own sex-related and environmentally influenced personality compares to same and opposite sexed people. Put another way, it’s a self-assessment of one’s stereotypical degree of “masculinity” or “femininity,” and it’s wrongly being conflated with biological sex. This conflation stems from a cultural failure to understand the broad distribution of personalities and preferences *within* sexes and the overlap *between* sexes.

When a girl reports that she “feels like a boy” or “is a boy,” that sentiment may reflect her perception of how her personality and preferences compare to the rest of her peers. If the girl has an autism spectrum condition, she may even perceive “sex-atypical” behavior that does not actually exist, and thereby falsely self-diagnose as male even without experiencing any actual male personality traits.

It should be noted that these scenarios don’t apply to all cases of gender dysphoria, as many other triggers are described in the literature. But in most cases, counseling can help gender dysphoric adolescents resolve any trauma or thought processes that have caused them to desire an opposite sexed body.

Historical data suggests that about 0.5% of children develop gender dysphoria—distress caused by a perceived incongruence between one’s biological sex and gender presentation. Reinforcing studies in the medical literature show that, as children get older, childhood-onset gender dysphoria resolves (i.e. ends) in most cases. As two authors put it in a 2016 *International Review of Psychiatry* article, “the conclusion from these studies is that childhood GD [gender dysphoria] is strongly associated with a lesbian, gay or bisexual outcome and that for the majority of the children (85.2%; 270 out of 317 [studied individuals]) the gender dysphoric feelings remitted around or after puberty.”

Yet instead of offering counseling, medical professionals now are commonly telling children that they may have been “born in the wrong body.” This new approach, called “gender affirmation,” makes gender dysphoria less likely to resolve, pushing children down the path toward irreversible medical and surgical interventions. If aggressive transition options are pursued early in puberty, the combination of puberty-blocking drugs, followed by cross sex hormones, will result in permanent infertility.

The growing population of transgender-identifying high school students now is estimated to comprise about 2% of all students—a three-fold increase over the baseline 0.5% figure cited above. Many adolescents now are presenting to gender clinics, with some clinics seeing a 10-fold increase in new cases. Many of these adolescents have no history of childhood gender dysphoria. Higher rates of autism-spectrum conditions have been described in many of these adolescents, and the controversial “affirmation model” is being applied to this unstudied cohort as well. Not surprisingly, reports of transition regret, and de-transition, are growing in number.

To summarize, a lack of understanding regarding the distribution of sex-related personality and behavioral differences has led to confusion that impacts children who fall at the extreme tail-ends of the distribution, and who would be statistically more likely to grow up to be gay, lesbian or bisexual adults if allowed to experience uninterrupted puberty. Additionally, telling a child that he or she was born in the wrong body pathologizes “gender non-conforming” behavior and makes gender dysphoria less likely to resolve.

The fact is, *no child is actually born in the wrong body*. Adults should expand their understanding of what normal male and female behavior and preferences look like—which would lead them to appreciate that being male or female comes with a wider range of personalities preferences, and possibilities than old stereotypes would have us believe.

Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline"

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Childhood gender dysphoria (GD) is not an endocrine condition, but it becomes one through iatrogenic puberty blockade (PB) and high-dose cross-sex (HDCS) hormones. The consequences of this gender-affirmative therapy (GAT) are not trivial and include potential sterility, sexual dysfunction, thromboembolic and cardiovascular disease, and malignancy (1, 2).

There are no laboratory, imaging, or other objective tests to diagnose a "true transgender" child. Children with GD will outgrow this condition in 61% to 98% of cases by adulthood (3). There is currently no way to predict who will desist and who will remain dysphoric. The degree to which GAT has contributed to the rapidly increasing prevalence of GD in children is unknown. The recent phenomenon of teenage girls suddenly developing GD (rapid onset GD) without prior history through social contagion is particularly concerning (4).

GnRH agonists are used in precocious puberty to delay the abnormally early onset of puberty to a physiologically normal age. The goal of PB in the healthy child, however, is to induce hypogonadotropic hypogonadism to "buy time" to confirm gender incongruence. In a study of PB in adolescents aged 11 to 17 years, 100% desired to continue GAT. They simply "bought" themselves lower bone density and the need for lifelong medical therapy (5).

Studies show that <5% of adolescents receiving GAT even attempt fertility preservation (6). Those started on PB at

Tanner stage II, as recommended by current guidelines, will be blocked prior to sperm maturation and ovum release. They will have no prospect of biological offspring while on HDCS hormones and continuing on to gonadectomy.

The Endocrine Society's guidelines recommend elevating females' testosterone levels from a normal of 10 to 50 ng/dL to 300 to 1000 ng/dL, values typically found with androgen-secreting tumors. The ovaries of women given testosterone correspond to those found in PCOS, which itself is associated with increased ovarian cancer risk and metabolic abnormalities (1). Venous thromboembolism risk is elevated fivefold in males taking estrogen (2).

The health consequences of GAT are highly detrimental, the stated quality of evidence in the guidelines is low, and diagnostic certainty is poor. Furthermore, limited long-term outcome data fail to demonstrate long-term success in suicide prevention (7). How can a child, adolescent, or even parent provide genuine consent to such a treatment? How can the physician ethically administer GAT knowing that a significant number of patients will be irreversibly harmed?

Hypothesis-driven randomized controlled clinical trials are needed to establish and validate the safety and efficacy of alternate treatment approaches for this vulnerable patient population. Existing care models based on

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psychological therapy have been shown to alleviate GD in children, thus avoiding the radical changes and health risks of GAT (8). This is an obvious and preferred therapy, as it does the least harm with the most benefit.

In our opinion, physicians need to start examining GAT through the objective eye of the scientist-clinician rather than the ideological lens of the social activist. Far more children with gender dysphoria will ultimately be helped by this approach.

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References

1. Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869–3903.
2. Irwig MS. Cardiovascular health in transgender people. *Rev Endocr Metab Disord*. 2018;19(3):243–251.
3. Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;28(1):13–20.
4. Littman L. Rapid-onset gender dysphoria in adolescents and young adults: a study of parental reports. *PLoS One*. 2018;13(8):e0202330.
5. de Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011;8(8):2276–2283.
6. Nahata L, Tishelman AC, Caltabellotta NM, Quinn GP. Low fertility preservation utilization among transgender youth. *J Adolesc Health*. 2017;61(1):40–44.
7. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885.
8. Zucker KJ, Wood H, Singh D, Bradley SJA. A developmental, biopsychosocial model for the treatment of children with gender identity disorder. *J Homosex*. 2012;59(3):369–397.



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Letter to the Editor from William J. Malone et al:

“Proper Care of Transgender and Gender-diverse Persons in the Setting of Proposed Discrimination: A Policy Perspective”

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We agree with Walch et al that medical treatments should be based on scientific evidence rather than becoming political matters (1). However, Walch et al endorse a position statement by the Endocrine Society (ES) that is unsupported by the available evidence.

Walch et al endorse the ES position that puberty suppression (PS), cross-sex hormones (CSH), and surgeries are “effective,” “relatively safe,” and have been “established as the standard of care” (2). However, the ES clearly states that its practice guidelines “cannot guarantee any specific outcome, nor do they establish a standard of care” (3). The World Professional Organization for Transgender Health (WPATH) also acknowledges that despite the misleading name, WPATH Standards of Care 7 are also *practice guidelines*, not standards of care (4). Unlike standards of care, which should be authoritative, unbiased consensus positions designed to produce optimal outcomes, practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased. In addition, the ES claim of effectiveness of these interventions is at odds with several systematic reviews, including a recent Cochrane review of evidence (5), and a now corrected population-based study that found no evidence that hormones or surgery improve long-term psychological well-being (6). Lastly, the claim of relative safety of these interventions ignores the growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret.

Walch et al also endorse the ES position, claiming there is an established “durable biological underpinning” to gender identity (GI) (2). However, the first citation supplied by the ES for this position highlights contradictory studies and describes the biological origin of gender dysphoria

(GD) as simply a “current hypothesis” (7). The other citation describes GI as a “complex interplay of biological, environmental, and cultural factors” (8). Further, the concept of “durability” is challenged by the fact that most cases of GD in children naturally resolve by adulthood. It is precisely this lack of durability that should give pause to administering potentially harmful and often irreversible medical interventions to young patients with GD.

The ES position statement also overlooks a key fact that the existing body of evidence regarding treatment outcomes for GD was not only graded as “low quality,” but has been derived from a vastly different population than the one presenting with GD today. Currently, GD predominantly presents in adolescent females with no childhood history, in contrast to the prior predominantly male and childhood-onset GD presentation. It is not yet known whether this novel patient segment, which remains poorly understood and largely unstudied, will benefit or be harmed by hormonal and surgical interventions.

We concur with the 3rd ES position calling for more research. However, we are concerned that bias and politicization are preventing an honest scientific debate about interventions that carry lifelong implications for young people. There is a need for increased funding not only to better understand the natural history of this condition and its sharp increase in adolescent females, but also to help determine the optimal care of youth with GD.

Additional Information

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References

1. Walch A, Davidge-Pitts C, Safer JD, Lopez X, Tangpricha V, Iwamoto SJ. Proper care of transgender and gender diverse persons in the setting of proposed discrimination: a policy perspective. *J Clin Endocrinol Metab*. 2021;**106**(2):305-308.
2. *Transgender Health: An Endocrine Society Position Statement*. December 15, 2020. Accessed January 6, 2021. <https://www.endocrine.org/advocacy/position-statements/transgender-health>.
3. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline [published correction appears in *J Clin Endocrinol Metab*. 2018;**103**(2):699] [published correction appears in *J Clin Endocrinol Metab*. 2018;**103**(7):2758-2759]. *J Clin Endocrinol Metab*. 2017;**102**(11):3869-3903.
4. *WPATH Statement Regarding Medical Affirming Treatment including Puberty Blockers for Transgender Adolescents*. December 1, 2020. Accessed January 28, 2021. https://www.wpath.org/media/cms/Documents/Public%20Policies/2020/FINAL%20Statement%20Regarding%20Informed%20Consent%20Court%20Case_Dec%2016%202020.docx.pdf?t=1608225376.
5. Haupt C, Henke M, Kutschmar A, et al. Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane Database Syst Rev*. 2020;**11**:CD013138.
6. Correction to Bränström and Pachankis. *Am J Psychiatry*. 2020;**177**(8):734.
7. Saraswat A, Weinand JD, Safer JD. Evidence supporting the biologic nature of gender identity. *Endocr Pract*. 2015;**21**(2):199-204.
8. Rosenthal SM. Approach to the patient: transgender youth: endocrine considerations. *J Clin Endocrinol Metab*. 2014;**99**(12):4379-4389.

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Commentary: The Signal and the Noise—questioning the benefits of puberty blockers for youth with gender dysphoria—a commentary on Rew et al. (2021)

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In less than a decade, there has been a sharp rise in the numbers of young people presenting with gender dysphoria (GD). Today, the majority are adolescents, many with post-puberty adolescent-onset transgender histories, and suffering from mental health and neurodevelopmental comorbidities (De Vries, 2020; Zucker, 2019). Furthermore, there is controversy and heated debate in the literature on this topic (Dubicka, 2021). This lack of scientific consensus highlights the need for any published literature on the topic of GD to be carefully evaluated.

In this commentary, we critically examine a systematic review of the evidence for puberty blockers for GD youth that was recently published in this journal (Rew, Young, Monge, & Bogucka, 2021). Our aim is to highlight problems with this review that compromise its findings and conclusions.

Brief description of Rew et al.'s (2021) study

Rew et al. described undertaking a "critical" and "systematic" literature review on the topic of puberty blockers for GD youth. They identified nine studies for review and, on the basis of these, concluded that puberty blockers have "few serious adverse outcomes," and "several potential positive ones." Rew et al.'s abstract highlighted two key conclusions: the "potentially life-saving benefits" of puberty blockers; and a need for rigorous research. Their "implications," "conclusion," and "key practitioner message" sections appeared to claim that the literature supports the use of puberty blockers for the early puberty subgroup of GD youth.

Overview of our concerns

We agree with Rew et al.'s conclusion that more rigorous research is required in the area of management of GD in youth. However, in our view, their review suffers from methodological oversights, including the omission of relevant studies and suboptimal analysis of the quality of the included studies. As a result, the authors overstate the certainty of the potential positive outcomes and minimize the potential adverse outcomes of puberty blockers. Importantly, their statement, that a "positive

outcome" of puberty blockers is "decreased suicidality in adulthood," is a misinterpretation of a single cross-sectional study. This study's design was incapable of determining causation, and adult suicidality was not one of the measured outcomes (Turban, King, Carswell, & Keuroghlian, 2020).

Contrast Rew et al.'s (2021) conclusions with another recently completed systematic review of puberty blockers for GD youth, commissioned by England's NHS and conducted by The National Institute for Health and Care Excellence (NICE) (2020). The NICE review concluded that studies investigating the benefits or adverse effects of GnRH analogs (puberty blockers) were of "very low certainty using modified GRADE." They noted that any outcome differences that were found could have represented changes of "questionable clinical value," or, as the studies themselves were "not reliable," could have been "due to confounding, bias or chance." They suggest that if controlled studies are not possible, then reliable comparative studies are required.

These findings came just after NHS England suspended the use of puberty blockers for new patients under the age of 16, following the High Court's judgment that children so young could not consent to the unknown risks of these drugs. The Karolinska Institute in Sweden suspended the use of puberty blockers as treatment for GD youth outside of clinical trials following this review, citing multiple physical risks, including to bone development (Nainggolan, 2021). Finland also sharply curtailed the use of these drugs after their systematic review arrived at similar conclusions about the uncertain risk/benefit profile (COHERE, 2020).

We are concerned that Rew et al.'s review will mislead clinicians unfamiliar with the literature into prescribing puberty blockers to GD youth with confidence, when the only clinical stance supported by the evidence is that of extreme caution. This is also underscored by the fact that the research literature in this field is rapidly evolving. For example, a recently published study, that attempted to demonstrate the benefits of the Dutch puberty suppression protocol in the UK setting, failed to show any psychological benefit (Carmichael et al., 2021).

Limitations in study selection strategy

The review published by Rew et al. has important limitations that compromise its usefulness for clinical decision-making. Rew et al. identified only 151 potentially eligible studies, while the NICE review found 525 studies. One possible explanation for this could be their limited study search strategy. Another possible explanation is that Rew et al. did not conduct a comprehensive search so that, in omitting one of the largest electronic databases—EMBASE, they may have overlooked relevant evidence.

Notably, the final set of nine studies reviewed by Rew et al. is missing at least one key study on puberty blockers and psychosocial functioning (Costa et al., 2015), and two other studies examining the risks of puberty blockers on bone density (Joseph, Ting, & Butler, 2019; Klink, Caris, Heijboer, van Trotsenburg, & Rotteveel, 2015). It is unclear to us whether these studies were omitted due to the limited database search or whether the evaluators decided to exclude these studies, and if so for what reason. These three studies were all included in the NICE (2020) review. Although it has to be kept in mind that all the NICE reviewed studies' findings were assessed as "very low certainty," the Costa et al. study provided comparative evidence and found no significant difference in psychosocial functioning between a group of adolescents receiving puberty blockers plus psychosocial support, and a group receiving only psychosocial support, at eighteen months (the study end period) (Biggs, 2019). In addition, the Costa study was cited by the Finnish gender identity services in their policy change, which now recommends psychotherapy alone as first-line treatment.

Failure to adequately assess certainty of the study findings

It is our contention that the reviewers did not adequately assess the certainty of the reviewed studies' findings. For example, they used the Joanna Briggs Institute checklist to assess Turban et al. (2020), the study from which their message that puberty blockers reduce adult suicidality and have "potentially life-saving benefits" derives. This checklist can overemphasize whether studies report information and underemphasize the assessment of study validity. Below, we show how Rew et al. applied this tool to Turban et al. (2020), and the important study limitations it overlooked.

Was the exposure measured in a valid and reliable way? (Q3) Rew et al. answered "yes" to this question. We believe it should be "no." The exposure to puberty blockers was based on a self-report, with 73% of those respondents, who answered yes, claiming they began to use puberty blockers after the age of 18. It was noted that the respondents likely confused puberty blockers with other hormonal interventions (Biggs, 2020; D'Angelo et al., 2020). Although Turban et al. attempted to reduce the effects of this confusion by excluding certain participants from the sample, no adequate correction was possible. This introduced a significant risk of bias.

Were confounding factors identified and strategies to deal with them stated? (Q5, Q6) Rew et al. answered "yes" to both questions. We believe the answer to the latter question should be "no." For example, while one key confounding factor—prior mental health status—was indeed correctly identified by Turban et al., no strategy

was articulated to deal with it. When discussing their finding that puberty suppression is associated with lower lifetime suicidality, they acknowledged that "reverse causation cannot be ruled out: it is plausible that those without suicidal ideation had better mental health when seeking care and thus were more likely to be considered eligible for pubertal suppression" (Turban et al., 2020). This is one of the most serious limitations of the study, introducing a high risk of bias, and reducing the certainty of the findings.

In addition, while two questions ask about the subject selection criteria and whether the subjects and the setting were described in detail (Q1, Q2), these questions do not attempt to assess the impact of the sample composition. Affirmative ("yes") and "not applicable" answers to these questions, respectively, masked the fact that the study participants were not required to have a diagnosis of GD, and that the participant demographics were markedly different from the US population of transgender adults (D'Angelo et al., 2020), which negatively impacts the study's applicability/generalizability.

Rew et al. aggregated the answers to the checklist questions, with the Turban et al.'s study earning an 86% mark and a "good quality" rating. Even if we sideline the issue of any scoring inaccuracy, using such a simplistic scoring category is misleading since it implies that all questions are equally important, which is clearly not the case.

We also note, what appears to be, at least one error in Rew et al.'s assessment and reporting of study outcomes. In Table 2, they reported that Turban et al.'s positive outcome findings included decreased past-month psychological distress, past-month binge drinking, and lifetime illicit drug use. However, Turban et al.'s univariate analysis showed only one of these three outcomes, past-month psychological distress, showed any significant difference, and this significance disappeared once demographic variables were controlled for in the multivariable analysis.

A more rigorous tool to assess Turban et al.'s study would be ROBINS-I (The Risk of Bias of Non-randomized Studies of Interventions) (Sterne et al., 2016). This tool focuses on confounding, selection bias, classification and deviations from intervention, measurement of outcome, missing data, and selective reporting, and the extent to which the study design minimized biases and yielded trustworthy results. Given this, applying the ROBINS-I tool would find that the Turban et al.'s study is at a critical risk of bias.

Misleading statements regarding puberty blockers and suicidality

We are concerned that Rew et al.'s discussion of evidence about suicidality is unbalanced and misleading. Reading that puberty blockers had "positive outcomes [of] decreased suicidality in adulthood" will likely be understood as indicating causation. However, Turban et al. (2020), where this claim originates, noted that their study design did not allow for determination of causation, and "reverse causation" (individuals without suicidal ideation had better mental health and were more likely to be considered eligible for puberty blockers) was a plausible alternative explanation.

Further, there is a critical difference in meaning between "lifetime," and "adulthood." Not only does the

latter erroneously imply a pre-post effect (i.e., access to puberty blockers in childhood reduces suicidality in adults), which was not detectable in the study, but a measure of “adulthood suicidality,” which Rew et al. claim was impacted, was never included in the original study (Turban et al., 2020).

There is also unclear use of the term suicidality, which exaggerates the implication of Turban et al.’s findings. Suicidality is a broad term, which is comprised of suicide attempts, plans, and ideation, and indeed this was the manner it was used by Turban et al. It is also important to note that Turban et al. made no assessment of completed suicides. Turban et al. assessed six areas of suicidality (including recent and lifetime suicide attempts, recent ideation with plans, recent and lifetime ideation) and found no association between puberty blockers and suicidality measures on five of the six areas. The only association was with “lifetime suicidal ideation.” Of course, any suicidal ideation is concerning, but suicide attempts are generally considered of higher concern, in terms of suicide risk assessment, than suicidal ideation (Ryan & Oquendo, 2020).

Rew et al.’s inaccurate language further intensifies in the final sentence of their abstract, which described puberty blockers as “potentially life-saving.” This exaggerated claim is misleading, since there is no evidence to support it.

Absence of an appropriate process for making clinical recommendations

Finally, the authors appear to recommend the use of puberty blockers in the “key practitioner messages” box and in the “implications” section of their paper. Making recommendations requires not only evidence about benefits and harms on all health outcomes that are important for decision-making (which this review provides in a suboptimal way), but also considerations about patients values and preferences, ethics, acceptability, resources, costs, etc. (Andrews et al., 2013). All these considerations are balanced by making value judgments, which should be documented and reported explicitly and transparently. Rew et al. failed to do this, which, in our view, further undermines the credibility of their clinical practice recommendations.

Clinician reflections on the state of the GD literature

Rew et al.’s review illustrates a concerning trend, that we have observed in the GD literature, to overstate the evidence underpinning clinical practice recommendations for youth with GD. New publications reference prior ones with increasing and unwarranted confidence, and with the risk of misleading clinicians regarding the state of evidence. There is also a marked asymmetry in outcomes reporting: findings of positive outcomes of medical interventions are trumpeted in abstracts, while their profound limitations remain behind the paywall, thus, below the radar of busy clinicians.

Rew et al.’s paper demonstrates these types of issues. To start, the Turban et al.’s paper described a noncausal association between puberty blockers and “lifetime suicidal ideation,” carefully avoiding making a causal claim (although, arguably, implying it). Then, Rew et al., whose findings on suicidality are based solely on this Turban et al.’ study, rewrite this finding to create the strong

impression of causality—that puberty blockers reduce adult suicidality and are “potentially life-saving.” Subsequently, a recent Commentary and Editorial in the *Lancet* both directly state that puberty blockers reduce suicidality, and the latter adds the extraordinary claim that “removing these treatments is to deny life.” The only reference provided for these claims is the Rew et al. (2021) paper (Baams, 2021; *Lancet* editorial, 2021).

This resembles the game of “Telephone,” in which a message is whispered from person to person distorting the original meaning of the message. However, this is not a game, and these types of errors can cause harm. Clinicians relying on Rew et al.’s review are likely to misinform patients and families about the risk/benefit profile of puberty blockers. Can such patients really be considered as giving informed consent?

The clear signals emerging from the various reviews of the available evidence of the use of puberty blockers for GD youth are that there is very low certainty of the benefits of puberty blockers, an unknown risk of harm and there is need for more rigorous research. The clinically prudent thing to do, if we aim to “first, do no harm,” is proceed with extreme caution, especially given the rapidly rising case numbers and novel GD presentations. We must also, collectively, raise the bar on the quality of publications, in order to accurately educate clinicians and help patients make truly informed decisions that may impact for the rest of their lives.

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Ethical information

No ethical approval was required for this commentary.

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References

- Andrews, J.C., Schünemann, H.J., Oxman, A.D., Pottie, K., Meerpohl, J.J., Coello, P.A., ... & Guyatt, G. (2013). GRADE guidelines: 15. Going from evidence to recommendation—Determinants of a recommendation’s direction and strength. *Journal of Clinical Epidemiology*, 66, 726–735.
- Baams, L. (2021). Equity in paediatric care for sexual and gender minority adolescents. *The Lancet Child & Adolescent Health*, 5, 389–391.
- Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 16, 2043.

- Biggs, M. (2020). Puberty blockers and suicidality in adolescents suffering from gender dysphoria. *Archives of Sexual Behavior*, 49, 2227–2229.
- Carmichael, P., Butler, G., Masic, U., Cole, T.J., De Stavola, B.L., Davidson, S., ... & Viner, R.M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*, 16, e0243894.
- COHERE. (2020). Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation. Palveluvalikoimaneuvosto. Available from: <https://palveluvalikoima.fi/en/recommendations> [last accessed 23 May 2021].
- Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The Journal of Sexual Medicine*, 12, 2206–2214.
- D'Angelo, R., Syrułnik, E., Ayad, S., Marchiano, L., Kenny, D.T., & Clarke, P. (2020). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50, 7–16.
- de Vries, A.L.C. (2020). Challenges in timing puberty suppression for gender-nonconforming adolescents. *Pediatrics*, 146, e2020010611.
- Dubicka, B. (2021). Editorial: Evidence, policy and practice – gold standard, good enough or doing it differently? *Child and Adolescent Mental Health*, 26, 1–2.
- Joseph, T., Ting, J., & Butler, G. (2019). The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *Journal of Pediatric Endocrinology and Metabolism*, 32, 1077–1081.
- Klink, D., Caris, M., Heijboer, A., van Trotsenburg, M., & Rotteveel, J. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *The Journal of Clinical Endocrinology & Metabolism*, 100, E270–E275.
- Nainggolan, L. (2021). Hormonal Tx of youth with gender dysphoria stops in Sweden. *Medscape*. Available from: <https://medscape.com>
- National Institute for Health and Care Excellence (NICE). (2020). Evidence Review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Available from: <http://evidence.nhs.uk>
- Rew, L., Young, C., Monge, M., & Bogucka, R. (2021). Review: Puberty blockers for transgender and gender diverse youth – a critical review of the literature. *Child and Adolescent Mental Health*, 26, 3–14.
- Ryan, E.P., & Oquendo, M.A. (2020). Suicide risk assessment and prevention: Challenges and opportunities. *Focus*, 18, 88–99.
- Sterne, J.A.C., Hernán, M.A., Reeves, B.C., Savović, J., Berkman, N.D., Viswanathan, M., ... & Higgins, J.P.T. (2016). ROBINS-I: A tool for assessing risk of bias in non-randomised studies of interventions. *BMJ*, 355, i4919.
- The Lancet Child Adolescent Health. (2021). A flawed agenda for trans youth. *The Lancet Child & Adolescent Health*, 5, 385.
- Turban, J.L., King, D., Carswell, J.M., & Keuroghlian, A.S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145, e20191725.
- Zucker, K.J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*, 48, 1983–1992.

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The Karolinska Institute in Sweden, long considered gold-standard in providing transgender health care, no longer uses puberty blockers;⁶ nor does Finland promote their use.⁷ Additionally, a judicial review in the UK found puberty blockers to be an inappropriate option for most children younger than 16 years.⁸

We urge *The Lancet Child & Adolescent Health* to take this opportunity to engage with this issue, rather than publishing, in our opinion, inaccurate and careless Editorials.

We declare no competing interests.

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- 1 The Lancet Child & Adolescent Health. A flawed agenda for trans youth. *Lancet Child Adolesc Health* 2021; 5: 385.
- 2 Bustos V, Bustos S, Mascaro A, et al. Regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plast Reconstr Surg Glob Open* 2021; 9: e3477.
- 3 Gender Identity Development Service. Referrals to GIDS, financial years 2010–11 to 2020–21. <https://gids.nhs.uk/number-referrals> (accessed June 30, 2021).
- 4 Stock K. Material girls: why reality matters for feminism. London: Fleet Publishing, 2012.
- 5 Heneghan C, Jefferson T. Gender-affirming hormone in children and adolescents. *Blog BMJ EBM Spotlight* 2019. <https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/> (accessed June 30, 2021).
- 6 Naiingolan L. Hormonal Tx of youth with gender dysphoria stops in Sweden. *Medscape Medical News*, May 12, 2021. <https://www.medscape.com/viewarticle/950964>.
- 7 Palveluvalikoima. Summary of a recommendation by Council for Choices in Health Care, Finland. Medical treatment methods for dysphoria associated with variations in gender identity in minors—recommendation. 2020. https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abadfae46f2e/Summary_minors_en.pdf (accessed June 30, 2021).
- 8 McCall B, Naiingolan L. Transgender teens: is the tide starting to turn? *Medscape Medical News*, April 26, 2021. <https://www.medscape.com/viewarticle/949842>.

Puberty blockers for gender dysphoria: the science is far from settled

The Editorial in *The Lancet Child & Adolescent Health*¹ stated that trans youth “have the same right to health and wellbeing as all humans”. However, what constitutes good health care for this population is far from clear based on the available evidence.

From the Editorial¹ and Baams' related Comment,² readers might perceive that administering gonadotropin hormone-releasing hormone (GnRH) analogues (also known as puberty blockers) to young people with gender dysphoria is a proven, life-saving treatment akin to giving insulin to type 1 diabetics. Baams' assertion that puberty blockers prevent suicidality can be traced to a paper by Turban and colleagues,³ which has been thoroughly critiqued by others,⁴ so instead we ask: what is the evidence that the benefits of puberty blockers outweigh the harms?

The statement that puberty blockers improve the mental health of young people with gender dysphoria stems from a seminal study by de Vries and colleagues in 2011.⁵ However, the population studied—ie, youth with gender dysphoria beginning in early childhood and no significant co-occurring mental health difficulties—markedly differs from the population today, which is characterised by post-pubescent young people reporting a trans identity for the first time, often in the context of significant mental health problems. This difference raises the question of whether this study is still applicable to the majority of currently presenting cases.⁶

Further, the magnitude of the post-treatment improvements in mental health was small. The depression (Beck Depression Inventory) scores

improved by around 3 out of 63 points, and the global function (Children's Global Assessment Scale) scores improved by around 4 out of 100 points, and other measures of psychological health had similar improvements of marginal clinical significance—or no improvement at all.⁵ Such modest gains have to be carefully weighed against the risks of puberty blockers to bone health and fertility, and the uncertainty of the long-term health effects of interrupting puberty.

The absence of a control group in de Vries's study⁵ made it impossible to determine whether the reported psychological improvements were related to the medical interventions or the psychological interventions that all study participants received (or other factors, such as time). A study of 14 young people with gender dysphoria who were rejected from puberty suppression due to “psychological or environmental factors” found that at follow-up 1–7 years after the original application, 11 of 14 did not feel any regret about not undergoing gender confirmation.⁷ This result is significant, because most youth who receive puberty blockers proceed to the full medical protocol of gender-affirming care; for example, one UK study⁷ showed that 43 (98%) of 44 patients aged 12–15 years proceeded to start hormone therapy after 3 years of taking puberty blockers. This same study, which to date is the only attempt to replicate de Vries and colleagues,⁵ found “no evidence of change in psychological function with GnRHa treatment”, including measures of distress and self-harm.⁸

There is growing acknowledgment worldwide that the practice of providing gender-affirming care for youth is far from settled science.⁹ A systematic review by UK's National Institute for Health and Care Excellence found that in youth with gender dysphoria there was “little change with GnRH analogues from baseline to

follow-up” in gender dysphoria, mental health, body image, and psychosocial impact. The study concluded that the reported psychological improvements are “either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance”.¹⁰

All authors are board members of the Society for Evidence Based Gender Medicine. ME was a witness in the Keira Bell judicial review; his wife Susan Evans initiated the review and was a witness. Neither received any financial benefit from involvement in the case.

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- 1 The Lancet Child & Adolescent Health. A flawed agenda for trans youth. *Lancet Child Adolesc Health* 2021; 5: 385.
- 2 Baams L. Equity in paediatric care for sexual and gender minority adolescents. *Lancet Child Adolesc Health* 2021; 5: 389–91.
- 3 Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics* 2020; 145: e20191725.
- 4 Biggs M. Puberty blockers and suicidality in adolescents suffering from gender dysphoria. *Arch Sex Behav* 2020; 49: 2227–29.
- 5 de Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med* 2011; 8: 2276–83.
- 6 de Vries ALC. Challenges in timing puberty suppression for gender-nonconforming adolescents. *Pediatrics* 2020; 146: e2020010611.
- 7 Smith YLS, Van Goozen SHM, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry* 2001; 40: 472–81.
- 8 Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One* 2021; 16: e0243894.
- 9 Bewley S, Clifford D, McCartney M, Byng R. Gender incongruence in children, adolescents, and adults. *Br J Gen Pract* 2019; 69: 170–71.
- 10 National Institute for Health and Care Excellence. Evidence review: gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. 2021. <https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3fq%3dtransgender%26%3dDatec> (accessed July 25, 2021).

From: riazenlife@gmail.com
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Please Stop Medicalization
Date: Friday, September 16, 2022 1:36:08 PM

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I am yet another mom with daughter who declared Transgender identity after medical trauma, covid isolation, excessive time online and followed a group of other girls who identify as such as well.

This has been two years and my fear is as she turns 18 she will freely dangerous and harmful medicalization.

Please hear parents voices as the transgender activists are more powerful and stronger.

Our kids need more mental health assistance and not affirmation. These kids need help mental health not medicalization.

Thank you.

Ria DesRose

Sent from my iPhone

From: [A Rizzo](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: affirmative care
Date: Saturday, September 17, 2022 10:34:46 PM

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Dear Mr. Vazquez and Board of Health,

I am writing regarding the efforts being taken to protect children, adolescents and vulnerable people from the one size fits all approach of affirmative care. I am a married mother (lesbian) and my wife and I are parents.

During the pandemic one of our children, 13, began to struggle with depression and announced a transgender identity. It was very challenging to find appropriate care for our son. We were fortunate that his pediatrician and psychologist were very experienced but it was obvious that they felt they could not be straight forward with us after our son announced a trans identity. Interpreting advice from these medical professionals was akin to communicating in a foreign language. However, they did make clear to my son they did not believe he should rush into transitioning. Neither doctor encouraged my son to socially transition or visit a gender clinic. Our son, however, was adamant that transitioning was what he needed to do, and that his life depended on it.

The school, operating on guidelines developed in conjunction with a local children's hospital, affirmed our son's transgender identity. We didn't know until months later that our child had been presenting as a girl at school and had changed his name and gender. When we contacted the school, they were operating in the dark regarding our son's mental health status. They agreed to revert to referring to our son by his birth name.

A couple of months later, roughly 2 years after announcing a transgender identity, our son quietly and suddenly told us he no longer saw himself as transgender. It is now 9 months later and our son continues to present as a young man. The last nine months have been challenging. As my son's depression improved he realized he pushed friendships away and spent his early high school years believing he was a trans girl. Returning to school where he presented as a girl has been deeply embarrassing. To say that we have been concerned would be an extreme understatement. What the school did in implementing a social transition without our knowledge endangered our son's life.

Social and medical transition, with children and teens should not be rushed.

What if we had taken our son to a gender clinic?

What if he had been put on a puberty blocker?

What if the school had continued to use my son's preferred name?

What if, instead of waiting patiently, we had followed our young teen's lead?

Teenagers should not be diagnosing themselves as having gender dysphoria and embarking on lifelong, irreversible changes. I truly hope knowledge of child and adolescent psychology and common sense drive the board's decision making process, and that Florida leads our nation in protecting gender distressed youth from harm.

Sincerely,

Amy Pellini
Illinois

From: [Ritchie Herron](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Written Witness Statement - R.T Herron
Date: Friday, September 16, 2022 12:27:55 PM
Attachments: [Written Witness Statement for Florida Board of Medicine.docx](#)

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Good Afternoon

My name is Ritchie, I'm a detransitioner and I would like to have my testimony registered for the upcoming Florida Board hearing on 30/09/2022.

I would be grateful if you could acknowledge receipt of this.

Warm regards,

R.T Herron

<https://twitter.com/TullipR>

Written Testimony for the Florida Board of Medicine

Richard Trevor Herron 16/09/2022

Testimony

My name is Ritchie, I'm 35 years old and live in the United Kingdom, I represent a large group of male detransitioners whose voices have until now, been left unheard in the matter of Gender affirmation.

In 2014, despite having serious mental health issues, under the care of the United Kingdoms Gender Identity Clinics, I transitioned into a female identity at the age of 26. I adopted a woman's name, took an anti-androgen known as Zoladex Goserelin. I would later take Estradiol, a feminising cross sex hormone.

In 2018 I underwent major surgery called a penile inversion with scrotal graft. I had not initially intended to have surgery, I was unsure and weary. I quizzed medical professionals, they reassured me that complications were extremely rare but what I would be getting would more or less mimic a natal female's vagina.

I refused the surgery multiple times, putting it on hold until eventually being driven in 2017 to agree to be referred. During this time, multiple alarms were raised due to the state of my mental health and wellbeing. I had severe mental health issues and was abusing substances.

Despite this, I was permitted to have surgery and during which I experienced severe blood loss (1600ml), resulting in a blood transfusion days after surgery. My suture popped open days after surgery, which has left a gaping scar near the site. Inside, the passage way is narrow and numb, with only the prostate allowing partial pleasure. Climax is possible with great difficulty, however with a partner it is almost impossible due to the angle, structure and narrowness. Additionally, I left the hospital with a catheter and have been experiencing severe urethral constriction, which now requires constant medical attention.

Not long after surgery, I experienced intense regret. I blamed myself at first, then began bringing it up with the Gender Clinic, where instead of my regret being listened too, I was coached to believe this was a response to anaesthetic and related to my mental health rather than actual regret.

My trans identity was not up for question, it was a predesignated certainty and the idea of regret was constantly challenged and blamed on an obsessive compulsive rumination. I was then referred for treatment for Obsessive Compulsive Disorder, as they believed I was not experiencing regret but was instead suffering from a new manifestation of OCD.

Now years later, I continue to deal with incontinence and pain. My sexual function is but a fraction of what it was before transition. Even if I had not experienced those complications, the hormones have left me without a sex drive, low energy and short term memory loss.

As an adult, I am left ruined and shattered, with only myself to pick up the pieces. In doing so I have met with many 100's of others online who share the same reality, and the most concerning theme is; the younger a person starts hormones and has surgery; the worse the impact on wellbeing and health. I do not presume this is everyone's experience, but it is an experience that deserves to be heard. There are a sea of silent voices who are too ashamed to speak out, out of fear of losing their community, friends and being further socially alienated.

Many of us, myself included come from single parent households, experience varying degrees of autism and ADHD, OCD and experience major depressive, anxiety and cluster b personality disorders such as unstable personality and bipolar disorder. These issues were used as evidence of our trans status, but in reality, these are evidence of poor mental health. They are never resolved, but instead intensify with hormones and surgeries.

Whether the amount of people similar like me is low or not, irreversible damage is occurring under the name of medical care and it is your duty to ensure no harm is being done.

I hope the correct decisions are made.

Yours faithfully,

R.T Herron

From: [Alison Murray](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comment re Affirmative Care for Gender Questioning Youth
Date: Saturday, September 17, 2022 12:01:44 PM

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"The State of Florida's Medical Board is meeting in a few days to discuss a new rule about "affirmative care." There is a good chance that this medical board will move to restrict these interventions in order to safeguard youth from harm.

I write to you to share my first hand experience for you to consider when weighing this issue.

I have seen first hand just how social contagion works with kids choosing gender dysphoria as a way to express their distress, in the same way that for example anorexia was spread through social contagion in the 90s. My daughter entered a school with a lot of trans kids and adopted a trans identity over the course of a week, and then we discovered she had been consuming the content of "trans influencers" online via social media during the pandemic. There was no "authentic self" blossoming - it was a mix of social pressure, confusion around puberty, questions around sexual preferences (is she gay? does that mean she has to be a man ?) and a cry for help around anxiety.

I reject the new gender ideology that is based on restrictive stereotypes and tells girls that if they are 'tomboys' they need to cut their breasts off, take testosterone and become infertile, and become men. My daughter was sucked into this ideology and her school were her cheerleaders, changing her pronouns and addressing her with a male name without our knowledge.

Like many kids, she has come out of her gender dysphoria now, thank goodness with her healthy body intact. Many kids aren't so lucky and there

is a huge industry waiting in the wings to make \$\$\$\$ off of these vulnerable kids. Schools are well intentioned but teachers are not licensed or trained to accompany children in this profound identity shift that is taking on a different gender. A gender doctor in BC Canada announces proudly that most of his 'clients' are kids who have come through the foster care system. A disproportionate number of these kids are neurodiverse.

I support the right of adults to change their gender identities but we have to acknowledge there is something going on here, with something like a 500% increase in young women now identifying as trans. Social media and the presence of trans activists promoting the ideology - and the interventions - is a huge part of this. As is this well meaning "inclusiveness" wave in schools and teaching kids they can choose their gender. We should be teaching them they can be whoever they want without having to change their gender. Let's expand the definitions of being a girl . I celebrate girls !

In the UK they have closed the Tavistock Gender Clinic and the lawsuits are beginning - young people whose bodies were changed without any deeper psychological analysis, who now want their breasts back, or their testicles, or their fertility. Canada where I live is behind the curve on this issue.

I submit my comments in support of a slow and cautious approach that leaves medicalization out of the equation. Gender Dysphoria is a genuine mental health condition which requires kind, listening mental health support, not "affirmation" and medicalisation.

Best regards ,

Alison Murray

From: [Rachel Bordoli](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Comments regarding new rule about "affirmative care"
Date: Sunday, September 18, 2022 8:05:00 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Paul A. Vazquez, J.D., Executive Director Florida Board of Medicine,

I am a parent of a 14 year old girl who identifies as transgender. I very much hope that the Florida Board of Medicine will lead the way on pushing back against gender affirmative care and am providing **comments in support of a slow and cautious approach that leaves medicalization out of the equation.**

Our daughter is not transgender: she is a natural tomboy who has recently latched on to this identity, as have several of her friends. I fully believe that if we did not live in the grip of gender ideology (which has infected our schools in California) my daughter would still identify as a girl and I would not be writing this letter. There are, after all, many ways to be a girl.

I was trained as a biological scientist and have been stunned by many people's willingness to actively deny the reality of biological differences between the sexes. I am adamantly opposed to the gender affirmation model and to the medicalization youth experiencing this condition. These models of diagnosis and treatment are not based on science or ethics and do not consider the long term health of this new trans-identifying population of teenage girls, many of whom are becoming collateral damage in the culture wars.

The UK recently commissioned a highly distinguished public health and pediatric expert, Dr. Hilary Cass, to reconsider the affirmative model. I grew up in the UK and while I've lived all my adult life in the US and am a US citizen, I continue to pay close attention to developments there and believe the US can learn from a recent report called the Cass Review interim report.

Please consider with care its findings, summarized below along with some relevant background.

What is the Cass Review interim report?

The Cass Review is an Independent Review of Gender Identity Services for Children and Young People. It was 'commissioned by NHS England and NHS Improvement in Autumn 2020 to make recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence [1].' In March 2022, the Cass Review submitted an interim report to NHS England. This interim report '[set] out [the] work to date, what [had] been learnt so far and the approach going forward [2].'

Who is Dr. Hilary Cass?

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020.

A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020).

Although retired from clinical practice, she remains an honorary Consultant Paediatrician at Evelina London Children's Hospital, Guy's & St Thomas's NHS Foundation Trust, where she was also previously Director of Education and Workforce.

Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah's Ark Children's Hospice. She is also leading work on how to address the challenges for both families and professionals in supporting the rising numbers of children with complex medical conditions and disability.

Other recent roles include acting as the Senior Clinical Advisor for Child Health for Health Education England.

Prior to this Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Paediatrics in London. Her consultant clinical practice was as a tertiary neurodisability consultant from 1992 to 2018 in three very different specialist centres and she has published widely in this area.

In addition to her neurodisability practice, Dr Cass was closely involved in the development of paediatric palliative care services at Evelina London Children's Hospital.

Dr Cass was awarded the OBE for services to child health in 2015. She was also awarded an honorary fellowship by the Royal College of Nursing in 2015, and by RCGP in 2016.

Background

The United Kingdom has seen a significant increase in the number of children seeking help for distress in relation to their biological sex. Many school staff first started noticing the phenomenon of children – predominantly teenaged girls – wanting to change sex during the last decade.

In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (para. 1.1).

From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment (para 3.10).

This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender and gender identity.

Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus (para. 2.4).

No consensus

This being a new phenomenon, research is limited and no consensus exists (within the scientific community) about possible causes and most appropriate treatment options.

At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual (para. 1.7).

We must secure a balanced treatment of political issues, they must take a child-centred, evidence-based approach, and take care not to express personal beliefs in ways which could exploit pupils' vulnerabilities. We should not for example, present, as fact, childhood gender incongruence as an inherent and immutable phenomenon as this is a contested idea rather than an established evidence-based fact.

Low quality evidence

The Cass Review interim report acknowledges that '[over] the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial' (para. 2.4). Many of us feel confused or conflicted about approaching the issues of sex and gender identity with adolescents. The above-mentioned rise in referrals to GIDS has been accompanied by an increasing number of news reports claiming that some teachers and/or schools are promoting the idea that gender identity supersedes sex. However, there is insufficient high quality, longitudinal data (relating to gender-questioning children) from which to draw robust conclusions. There is a notable gap in the evidence base pertaining to the surge in female teenagers seeking support from gender identity services.

Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint (para. 1.29).

Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally (para. 3.21).

It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group (para. 3.23).

Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing (para. 5.10).

This is an area of research where no scientific consensus exists. Schools must be aware that any claims made about the reasons behind the increase in gender-questioning children are speculative and cannot be treated as established evidence-based facts.

Changing epidemiology

Early childhood gender dysphoria is not a new phenomenon. However, the existing literature on treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female and often presenting with a range of neurodevelopmental and mental health co-morbidities.

In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS (para 3.10).

This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years (para. 3.11).

The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress (para. 1.10).

Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes (para. 1.28).

Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group (para. 5.10).

The Cass Review interim report highlights the difficulties faced by clinicians responsible for making diagnoses and recommending treatment. Teachers are neither qualified nor capable of critically evaluating existing evidence. They must carry out their duties within statutory and non-statutory frameworks. This included ensuring that any necessary referrals are made as specified by their schools' safeguarding protocols.

Diagnostic overshadowing

Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria (para.

4.10).

School staff must be clear that they are not qualified to offer students advice in this area. Moreover, the promotion of specific beliefs about the source(s) of gender-related distress could influence children's attitudes toward the diagnostic process before meeting with a clinically trained professional. Guidance from the Department for Education states that teachers "are in a position of authority and will typically be respected and trusted by the pupils they teach, giving their personal opinions greater weight and credibility. As a general principle, they should avoid expressing their own personal political views to pupils unless they are confident this will not amount to promoting that view to pupils [4]."

Affirmative vs developmental models

Broadly speaking, there are two approaches to treating children with gender-related distress: the gender-affirmative approach and the developmentally-informed approach. The gender-affirmative approach is based on the theory that a child's gender identity is innate. The developmentally-informed approach is based on the theory that a complex interaction of multiple factors underlie gender-related distress. The Cass Review interim report acknowledges that some clinicians report being under pressure to adopt a gender-affirmative approach.

Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach (para. 4.15).

Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach (para 4.20).

There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies (para. 5.8).

School staff are unqualified to evaluate the merits of these approaches. Moreover, they have an obligation to remain politically impartial. This means not supporting one approach over another.

Social transition

Social transitions (the act of treating children as if belonging to the opposite sex) are performed by some schools in England. A social transition is a powerful psychological treatment that affects a child's psychological development. Not only are school staff unqualified to judge the appropriateness of such interventions, the outcomes are poorly

understood.

Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes (para. 5.19).

Pressure

The Cass Review interim report acknowledges the pressures clinicians are under to adopt an unquestioning affirmative approach. Similarly, there is an acknowledgement that children are under pressure to identify with societal stereotyping. Schools cannot erase the pressures that children are under from, for example, social media and peers. However, teachers should promote acceptance for children's non-stereotypical behaviour (boys and girls exhibiting stereotypically 'feminine' and 'masculine' behaviour, respectively) and avoid reinforcing harmful stereotypes.

Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters (para. 1.14).

From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision (para. 1.18).

It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services (para. 2.5).

We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long children and young people are waiting to access services (para 4.13).

These will be considered further during the lifetime of the Review and include: . . . The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years (para. 4.14).

Safeguarding

Children with gender-related distress may pose specific safeguarding concerns. They have a higher incidence of comorbid psychiatric and/or developmental difficulties. Teachers need to be aware of possible harms such as breast binding or tucking (of male genitals). Children may

also be subjected to grooming and/or coaching, and encouraged to deceive parents, clinicians and teachers in order to secure particular outcomes such as clinical diagnoses of gender dysphoria. They may also be receiving cross-sex hormones from unregulated sources.

In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children (para. 3.11).

We have also heard about the distress experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts (para. 4.3).

Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria (para. 4.4).

We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation (para. 4.5).

We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment (para. 4.7).

Summary

There has been a huge increase in the number of children (predominantly female teenagers) seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making diagnoses and recommending treatment. School staff who now affirm my daughter are neither qualified to evaluate existing research nor clinically trained. Therefore, they cannot judge the appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development. The Cass Review interim report outlines some of the specific safeguarding issues that surround gender-questioning children.

Thank you most sincerely for your time and consideration.

Yours sincerely,

Rachel Bordoli
San Francisco, California

From: [Avery Kennedy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Care
Date: Sunday, September 18, 2022 4:01:04 PM

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Paul A. Vazquez, J.D.

Executive Director Florida Board of Medicine

BOM.MeetingMaterials@flhealth.gov

Dear Mr. Vasquez,

I am writing in regards to the proposed regulations on “gender-affirming” care currently under review in Florida. I am a California attorney who is watching gender issues closely across the US.

I believe I have the best interest of children in mind, not only because my 17-year-old daughter is obsessed with transition but also because I know 36 kids - organically from family relationships- who also self-identify as “trans.”

One of these children is my best friend’s son. Another is my sister-in-law’s daughter. The numbers defy logic. Sadly, most of the children I know are on the spectrum, including mine.

My child suffers greatly from depression and anxiety. I took her to a psychiatrist who immediately told my daughter and I that she would kill herself if she doesn’t get immediate gender medical care. Can you imagine someone saying that to your child?

I could write chapters on gender medicine and mental health but I’ll stick to my short letter. Please be rational when dealing with our kids’ health. They’re so precious and shouldn’t be experiments.

Best regards,

Avery Kennedy

From: thebergeys24@gmail.com on behalf of [Amy Bergey](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Monday, September 19, 2022 11:50:50 AM

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Dear Florida Board of Medicine

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Care providers, doctors, and leading medical associations have been clear that gender-affirming care is safe, effective, and evidence-based, and that it's literally lifesaving.

The issued guidance by the Dept. of Health and the studies used by this board are inaccurate and dangerous. This guidance is nothing more than another tool for the Governor to express his opposition to transgender individuals' existence.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people, including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

The Board must provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Stop discriminating against people for any reason. You are medically discriminating against these people.

I urge you to reject this proposal.

Sincerely,

Amy Bergey

From: rgrosse77@gmail.com
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care / Florida Board of Medicine
Date: Sunday, September 18, 2022 4:02:17 AM
Importance: High

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Dear Paul A. Vazquez, J.D. (Executive Director Florida Board of Medicine)

I am a parent of a teenage old girl, who identifies as transgender. Our daughter is not transgender: she has struggled all her life with mental health challenges and with her social anxiety. We are constitutionally opposed to the affirmation model and with hormonal and surgical interventions. These are not based on science or ethics for this new population of teenage girls. A very vulnerable population.

Great Britain recently commissioned a highly distinguished public health and pediatric expert to reconsider the affirmative model in the United Kingdom. Please consider with care the findings of the Cass Review interim report.

What is the Cass Review interim report?

The Cass Review is an Independent Review of Gender Identity Services for Children and Young People. It was 'commissioned by NHS England and NHS Improvement in Autumn 2020 to make recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence [1].' In March 2022, the Cass Review submitted an interim report to NHS England. This interim report '[set] out [the] work to date, what [had] been learnt so far and the approach going forward [2].'

Who is Dr. Hilary Cass

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020. A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020). Although retired from clinical practice, she remains an honorary Consultant Paediatrician at Evelina London Children's Hospital, Guy's & St Thomas's NHS Foundation Trust, where she was also previously Director of Education and Workforce. Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah's Ark Children's Hospice. She is also leading work on how to address the challenges for both families and professionals in supporting the rising numbers of children

with complex medical conditions and disability. Other recent roles include acting as the Senior Clinical Advisor for Child Health for Health Education England. Prior to this, Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Paediatrics in London. Her consultant clinical practice was as a tertiary neurodisability consultant from 1992 to 2018 in three very different specialist centres and she has published widely in this area. In addition to her neurodisability practice, Dr Cass was closely involved in the development of paediatric palliative care services at Evelina London Children's Hospital. Dr Cass was awarded the OBE for services to child health in 2015. She was also awarded an honorary fellowship by the Royal College of Nursing in 2015, and by RCGP in 2016.

Background

The United Kingdom has seen a significant increase in the number of children seeking help for distress in relation to their biological sex. Many school staff first started noticing the phenomenon of children – predominantly teenaged girls – wanting to change sex during the last decade. In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (para. 1.1). From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020, there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment (para 3.10).

This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender and gender identity. Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus (para. 2.4).

No consensus

This being a new phenomenon, research is limited and no consensus exists (within the scientific community) about possible causes and most appropriate treatment options. At primary, secondary and specialist level, there is a lack of agreement, and in many instances, a lack of open discussion about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the

individual (para. 1.7).

We must secure a balanced treatment of political issues, they must take a child-centred, evidence-based approach, and take care not to express personal beliefs in ways which could exploit pupils' vulnerabilities. We should not, for example, present as fact childhood gender incongruence as an inherent and immutable phenomenon as this is a contested idea rather than an established evidence-based fact.

Low quality evidence

The Cass Review interim report acknowledges that '[over] the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial' (para. 2.4). Many of us feel confused or conflicted about approaching the issues of sex and gender identity with adolescents. The above-mentioned rise in referrals to GIDS has been accompanied by an increasing number of news reports claiming that some teachers and/or schools are promoting the idea that gender identity supersedes sex. However, there is insufficient high quality, longitudinal data (relating to gender-questioning children) from which to draw robust conclusions. There is a notable gap in the evidence base pertaining to the surge in female teenagers seeking support from gender identity services.

Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint (para. 1.29).

Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally (para. 3.21).

It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people **may** not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group (para. 3.23). Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing (para. 5.10).

This is an area of research where no scientific consensus exists. Schools must be aware that any claims made about the reasons behind the increase in gender-questioning children are speculative and cannot be treated as established evidence-based facts.

Changing epidemiology

Early childhood gender dysphoria is not a new phenomenon. However, **the existing literature on treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female and often presenting with a range of neurodevelopmental and mental health co-morbidities.**

In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS (para 3.10). This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years (para. 3.11). The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress (para. 1.10).

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Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria (para. 4.10).

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societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long children and young people are waiting to access services (para 4.13).

These will be considered further during the lifetime of the Review and include: . . . The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years (para. 4.14).

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Summary

There has been a huge increase in the number of children (predominantly female teenagers) seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making diagnoses and recommending treatment. School staff who now affirm my daughter are neither qualified to evaluate existing research nor clinically trained. Therefore, they cannot judge the appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development. The Cass Review interim report outlines some of the specific safeguarding issues that surround gender-questioning children.

Thank you most sincerely for your time and consideration.

Yours sincerely,

Linda Grosse



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From: [Amy Dunphy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulations for gender medicalization
Date: Sunday, September 18, 2022 7:44:17 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,

Thank you for taking up the vital question of regulating the so-called "gender-affirming" hormones and surgeries for young people.

My family has gone through so much trying to help our son who never showed any sign of gender confusion his entire life. It has been extremely difficult to find anyone that will help us without immediately saying that he is "transgender" and needs to be affirmed by everyone.

As parents of these children, we have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions sometimes on the first or second visit. The myth that our children are getting "assessments" is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society's recommendations.

Older adolescents can get hormones with no assessments at all, and have their healthy body parts amputated by eager surgeons on little more than self-declaration of "trans identity." Many of our children are gay and autistic and have come to believe their very real distress is explained by the fact that they are "transgender" and that hormones and surgeries will help. They do not. We have seen our children's mental and physical health plummet following "gender-affirmation."

We also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation."

Thank you for doing what you can to regulate this experiment on our vulnerable children.

From: [ROBERT&J FRAMINGHAM](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Please Stop the Medical Transitioning of Minors in Florida
Date: Sunday, September 18, 2022 5:32:36 PM

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Dear Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

I am the mother of a 28-year-old man, who has been identifying as transgender for the past six years. While there are undoubtedly various contributing factors responsible for the alarming increase in our youth and young adults being drawn to it, I ask that the Board of Medicine please consider that transgender ideology offers only a temporary reprieve to individuals experiencing psychological distress and more serious mental disorders. In my son's case, he was diagnosed with borderline personality disorder by a licensed Florida therapist when he was still in college. My son has loathed himself since he was in high school, and transgenderism is merely an escape from his self-hatred. He has also become anorexic. I knew he was extremely depressed, but I did not understand the severity of his disorder until it was too late to exercise any control over his treatment. It's hard for me to believe that my son was once a healthy, muscular, young man who was even an Eagle Scout. He began taking cross-sex hormones and his depression and anxiety worsened to the point that he dropped out of Florida State University and never completed his bachelor's degree in computer science. He has worked in minimum wage jobs consequently. He has refused to get therapy even though he acknowledges that the therapist, previously mentioned, was helpful.

My son, like so many other young people, has been persuaded by transgender activists that all his problems are due to him being "born in the wrong body". The problem is that there are now thousands of young people like him who have spent years trying to pass as the opposite sex only to realize that this ideology did not resolve their underlying psychological issues (just look at Reddit's Detrans group of well over 30,000 members). In fact, it did not matter how many changes they undertook (e.g., cross-sex hormones, orchiectomies, vaginoplasties, mastectomies), the euphoria of each change would wear off after a short while and they returned to feeling like they did not before the intervention.

This is the reason why European countries such as Sweden, Finland, France, and England have started to put breaks on puberty blockers, cross-sex hormones, and surgeries for minors. There are now several large studies that confirm that medical interventions did not alleviate the psychological distress and mental disorders of these unfortunate individuals. For example, one Swedish study found that the risk of suicide is actually 19 times higher in individuals after receiving a medical intervention. It also suggested that this is one of the reasons that so many of these individuals are

lost to follow-up. (I am assuming other parents will be sending you links to many relevant studies, but I can provide complete source citations if you are interested in reading more). I also want to share this suicide note left on Twitter in July 2015 from a young man who used the handle "Trans Malpracticed" (@Trans Malpr) and wrote that "I'll miss this beautiful, amazing world. I wanted to live a long, full life. Everyone dies someday. I love you. I want to apologize most to my parents. I let this destroy your healthy, promising child. I'm sorry. I'm so very, very sorry. Doc thought he was doing me favors, removing barriers I didn't even know... I didn't ask for favors, not when my life was at stake!" I can't tell you how terrible this makes me feel as the parent of a young man who has also been led down this same path. I can only pray that he will get the kind of behavioral health treatment he needs to realize that it is a mistake to try and change his body to deal with his distress.

In closing, I want to say thank you for giving parents and other relatives the opportunity to express our concerns about what has been happening to our families over the past several years. Transgender activists would have everyone believe that transgender individuals are the most marginalized in society, but it is really the families of these individuals who have been the most marginalized. We are treated terribly for affirming biology rather than pathology. It's simply awful knowing that this is probably the greatest medical scandal of our current era, and our culture isn't listening to us and there is little that we can do to prevent serious harm to confused youth who are experiencing severe psychological distress and mental illness.

Sincerely,

Julie Framingham

3925 Ming Tree Dr

New Port Richey, FL 34652

(850) 559-3342

jframingham@comcast.net

From: [Robert B Bennett](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: I'm a Florida voter and am 100% against childhood gender grooming and gender reassignment in Florida. I have three kids and find it unconscionable that such would be allowed in our nation or our state. Please prevent such atrocities from happening in ou
Date: Friday, September 16, 2022 12:39:11 PM

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I'm a Florida voter and am 100% against childhood gender grooming and gender reassignment in Florida. I have three kids and find it unconscionable that such would be allowed in our nation or our state. Please prevent such atrocities from happening in our State.

Thank you,

Robert B. Bennett, Esq.

Partner

Bennett, Jacobs & Adams, P.A.

P.O. Box 3300 Tampa, FL 33601

Tampa Tel: 813.272.1400 Fax: 813.272.1401

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From: [Annie Smith](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comment to the Florida Medical Board - MINORS SHOULD NOT RECEIVE GENDER TREATMENTS
Date: Monday, September 19, 2022 5:45:47 PM

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Dear Dr. Vazquez and Florida Board of Medicine members,

I am a parent of a 17 year old son who came out to me as transgender 3 years ago. He is one of the children that has "ROGD" - Rapid Onset of Gender Dysphoria, meaning coming out as trans "out of the blue" due to social contagion and mental illness. He has been very determined about taking cross sex hormones since day one he came out because he has been indoctrinated by the social media and trans activists that cross sex hormones will give him a new life and make him happy. He also believes that the health consequences such as infertile, sex function dysfunction, from medical transition are reversible.

Our family has been negatively impacted by his gender ideology. My relationship with him was very close before all this happened. However, as coached by his online "friends" and social media, he hates me and his family who disagrees with his gender identity and I'm one of them so he sees me as a stranger and enemy because I have been trying to do everything to prevent him from medical transition. Sadly I only have 6 months left before he turns 18 when he does not need parent consent to obtain hormone therapy. I live with extremely terrified feelings everyday because I know that I will not be able to do anything to stop him from harming his healthy body in 6 months. I am also horrified to even think that it will be too late when he discovers that medical transition did little to relieve his dysphoria and mental illnesses, but damages have already been made to his body permanently.

I am one of the parents in a parent support group where we parents all have similar stories about our kids who came out as trans. All of us support each other because we are not able to find trustworthy non-affirming therapists and doctors to help our vulnerable and naive kids. We are all facing a strong force of politicians, therapists, schools, friends and even family members that we need to affirm our kids and let them be the lead. When I told our pediatrician that my son identified as trans three years ago, her first reaction was referred us to a gender clinic, where the specialist affirmed my son in the first meeting and told us that we should support him to take cross sex hormones, without even asked any other questions regarding his mental health condition. Had I listened to the gender clinic and decided to let my son medicalize himself, my son would have been sterilized and there was no way back.

NO one is born in the wrong body and we all should accept who we are and should not do anything to damage our healthy body.

Respectfully,
Annie

From: [Angela Baalman](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Comments on Sex-Based Medicine
Date: Monday, September 19, 2022 10:07:18 PM

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Hello,

I am a pharmacist working in the US healthcare field. I strongly encourage the Florida Board of Medicine to restrict the misguided interventions aimed at "re-assigning" the gender of the youth in Florida.

Those who identify as transgender deserve holistic, evidence-based care that is in accordance with human reality and will offer them a real hope at happiness and fulfillment. None of this can be found in the attempts of medical providers to assist in "transitioning" of their patients.

Please restrict these practices to protect the youth in Florida and prevent the healthcare field from turning into a trade of goods and services, rather than retaining its essential mission of healing and "doing no harm" to individuals.

Thank you,

Angela

From: [Derek Faulk](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Date: Tuesday, September 20, 2022 2:25:25 PM

Some people who received this message don't often get email from dgfaulk@gmail.com. [Learn why this is important](#)

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I beg you to ban "Affirmative Care" for minors. I am the father of an adult child who suffers from Rapid On-Set Gender Dysphoria and who started down this path as a teenager. Over the past several years, counselors, doctors, college professors, and college administrators did not question my child's gender confusion.

I believe "Affirmative Care" should be banned for all ages. The only long-term study that followed all participants showed that those who medically transition are 19 times more likely to commit suicide than those in the general public. Authors of a recent study had to correct their conclusions to accurately reflect that data showed there is no evidence that puberty blockers, cross-sex hormones, or gender-affirming surgeries improve mental health.

We desperately need professionals to stand up and stop this insanity. The brain doesn't completely mature until a person is at least 25 years old. Yet minor children are being allowed to make decisions that will affect them for the rest of their lives while counselors, doctors, and school administrators ignore the wishes and directions of parents.

All of the procedures considered "Affirmative Care" are experimental. None are being tracked and no long-term research is being conducted following any of these procedures; therefore, we will never know the depth of how devastating the outcomes are. At this point, we can only rely on the testimony of the tens of thousands of detransitioners. The common theme among them is that they were led/coerced down the path of medical transitioning. Once they realized they had made a mistake, the same people who encouraged them viciously turned their backs on them, including the doctors and mental health professionals.

Once again, I ask that you ban "Affirmative Care" for gender-confused minors.

Thank you,
Derek Faulk

From: [Christopher Snyder](#)
To: [Vazquez, Paul](#)
Cc: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comments re: gender dysphoria
Date: Monday, September 19, 2022 7:57:36 PM

Some people who received this message don't often get email from chris.w.snyder@gmail.com.

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Dear Dr. Vazquez and Members of the Board,

I am a practicing pediatric general surgeon in St. Petersburg.

I do NOT support alteration of secondary sexual characteristics with medications or surgical procedures for minors with gender dysphoria. Evidence for such treatments is poor, the long-term outcomes are unknown, and the harms may well outweigh any benefits. Altering normal anatomy and physiology for minors, who are unable to understand the long-term implications of such decisions, is ethically problematic.

I DO support access to appropriate mental health care and counseling for minors suffering from gender dysphoria.

Please contact me if there are any questions.

Respectfully,
Christopher Snyder, MD, MSPH
FL license #ME118285

From: [Charles Kelley](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Date: Monday, September 19, 2022 1:14:07 PM

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I do not support gender transitioning!

From: BB
To: Vazquez, Paul; zzzz Feedback, BOM MeetingMaterials
Subject: "Gender Affirming" care for young people
Date: Tuesday, September 20, 2022 10:27:21 AM

Some people who received this message don't often get email from sweetjilln63@gmail.com. [Learn why this is important](#)

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Thank you for taking up the vital question of regulating the "gender-affirming" hormone and surgeries for our children.

I am a parent of one of these children, we've seen some well-meaning but misinformed doctors, therapists, and other adults recommend these radical life-changing interventions. I know in my family's case my 13 year old daughter was offered Testosterone at our first visit to a prestigious gender clinic within a 2 hour visit, with NO follow up to her personal therapist.

As we, her parents, declined this intervention my daughter thought she would die, because of on-line influence of the internet's pushing the suicide narrative. That was years ago now, and she hasn't died of suicide she in fact now believes her parent's have her back and tell her the truth of medical interventions that would lead to long term effects and sterilization. She is close to now desisting and living as the woman she was born as.

We encourage you to require explorator psychotherapy and issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children need safe non-invasive alternatives to radical gender theory which is an experiment on children or adults as there is no long term studies.

Thank you for doing what you can on this dangerous experiment on vulnerable children
Beth

From: [Turnock, Adam R](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: An Appeal in Regards to Sex-Based Medicine
Date: Monday, September 19, 2022 6:23:32 PM

Some people who received this message don't often get email from aturnock@tulane.edu. [Learn why this is important](#)

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To The Florida Board of Medicine,

I am writing in regards to the upcoming meeting to determine the implementation of regulations related to "sex-based medicine". I implore you, in the name of sanity and reason, to **VOTE FOR STRICT REGULATIONS** in regards to so-called "sex-based medicine". Particularly when it comes to children and patients under the age of legal consent (18 years of age).

I am sure that your inbox is being flooded with misguided physicians, parents and patients who are pleading just the opposite and in a spirit of charity I will assume that they are doing so from a place of love and care for those poor individuals who truly struggle with gender dysphoria. However, as I stated, they are misguided. As physicians we rely on objective facts, science, logic and reason in our practice of medicine to best care for our patients; when we fail to do so, we do a disservice to our patients and our profession. While the concept of objectivity is one that has largely been abandoned by the mainstream culture, it is imperative that we as physicians do not follow suit. It is quite simply the case that neither facts, logic or reason undergird the concept of "gender affirming care" or gender ideology at large. Instead, it is a movement that is based solely on subjectivity and appeals to emotion. In fact, the strongest argument put forward by those who support "gender affirming care" amounts to little more than emotional blackmail, "They'll hurt themselves if we don't let them transition". While this might seem like a compelling impetus to comply with the wishes of the underaged patient and their parent; it does not take a vivid imagination to conceive of numerous similar scenarios in the varied fields of medical practice where we as physicians would never acquiesce to similar threats. So why do we blindly accept them when they are placed under the aegis of "sex and gender"? Instead of cowing to the loudest voices in the room, we as physicians ought to allow ourselves to be guided by reason and ask if there are not alternative treatment strategies we might investigate. Surely, we are not limited to radical and unalterable surgical procedures or experimental drug regimens which thwart natural human development.

The proponents of "gender ideology" are very skilled at the conflation of words and terms in order to obfuscate these issues. The truth is that the term "gender" has no place in the medical vocabulary. Gender is a property of language as it pertains to those which utilize masculine and feminine forms of words (Spanish for example). Sex is a property of human beings. Physicians treat human beings, not words and human beings have a sex not a gender.

A sex that can be objectively determined by biologic characteristics, namely the presence of the Y chromosome. The belief that an individual is a member of the opposite sex, despite all objective scientific evidence to the contrary, is not in accordance with reality. It is false. It is a false belief. Should an individual persist in this belief, it would be a fixed false belief. A fixed false belief is known as a delusion. You don't treat delusions by indulging in them.

Thank you for your consideration and I once again implore you to **VOTE FOR STRICT REGULATIONS** in regards to so-called "sex-based medicine".

Adam Turnock, MD FAAD

Florida Medical License: [ME156996](#)

From: [Vander Griend, Robert A](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comments to Florida Medical board
Date: Monday, September 19, 2022 5:28:44 PM

You don't often get email from vander@ortho.ufl.edu. [Learn why this is important](#)

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The Florida Medical Board is considering several issues relating to medical transition for minors suffering from gender dysphoria.

This is a very medical complex issue often overshadowed by gender issue driven politics. Regardless of ones personal beliefs it is clear that the medical and psychological aspects of medical/hormonal transition in minors has not been studied objectively. Neither the short term or longer term effects are known.

We do, however, know that medical transitions in adults are associated with number of medical problems and complications-some of which are not reversible. Children and young adults would be expected to be even more susceptible.

I would urge the Florida Medical Board to proceed slowly and cautiously on permitting medical transitions for minors who have been "diagnosed" as gender identity issues

Thankyou

Bob Vander Griend MD

From: [Gregory Coffman](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Affirmative Care
Date: Monday, September 19, 2022 7:46:31 PM

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Dear Members of the Florida Board of Medicine,

I am a pediatrician in the Central Florida area and have practiced for 28 years. I am gravely concerned that “Affirmative Care “ is detrimental to the children of Florida. In all my years of practice, I have never had any discussions with parents regarding their children’s gender identity until the past 2 to 3 years. This explosion of gender dysphoria came out of nowhere and is very much a socially driven issue. I know that some children truly struggle with gender dysphoria, but for most, it is transitory.

Children during development go through many stages of trying to define who they are, where they fit into their family, society and their own bodies. There is a natural progression and struggle in all these areas. Giving a child the power to make a life altering decision at such a young age is malpractice! Most children end up comfortable with their gender. The few that don’t, can as adults with full knowledge undergo gender reassignment.

We need to be compassionate and provide psychological support for these children as they struggle, but affirming their decision and providing them medical intervention that is irreversible is maleficence. We are called as physicians to “First Do No Harm“ as stated in the Hippocratic Oath.

I strongly encourage the Florida Board of Medicine to protect the children of Florida from this misguided , detrimental Affirmative Care model.

Sincerely,

Gregory J. Coffman, M.D
Vice Chair Orlando Health Physician Associates
Department of Pediatrics

From: [Pax AMDG](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: advice against so called gender-affirming care
Date: Monday, September 19, 2022 5:40:14 PM

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To whom this may concern,

As a practicing physician, I believe it is detrimental to children, especially those under 13, that they be protected from so-called gender-affirming care. Most children do not know what they want to do with their lives, how could they possibly understand all the risks associated with long-term and permanent changes with gender-affirming care, especially surgical ones.

It is in their best interest to not assume that they have the full capacity of an adult to make such a life-changing decision, where the data is still unclear of how many of these transition treatments have benefited them, whether that be meta-analysis or prospective studies.

Peace be with thee,
HP

From: [Jeanne Holup](#)
To: Paul.vasquez@flhealth.gov; [zzzz Feedback, BOM MeetingMaterials](#)
Subject: comments on "gender-affirming care"
Date: Monday, September 19, 2022 5:50:20 PM

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As a psychiatrist, I am obliged to comment on the practice of "gender-transitioning", especially our youth. This is malpractice, it amounts to child-abuse, is reprehensible and is of satanic origin. Our children deserve protection from such perverse ideas, and not exploitation!

Respectfully,

Jeanne M. Holup

Sent from [Mail](#) for Windows

From: [Julie Angus](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Affirmation 'care'
Date: Friday, September 16, 2022 8:43:46 PM

You don't often get email from angusjulie@hotmail.com. [Learn why this is important](#)

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I am horrified to see that trusted doctors, psychologists and psychiatrists are promoting the idea that children are born in the wrong body. This is quite clearly a recent trend with many children suddenly rejecting their gender and wanting to appear as the opposite. Where is the evidence of these kids that were suicidal about their gender in the history books? Why do these children only have a certain personality type? It is not healthy to affirm these kids without question and promote a lifestyle of surgeries and cross sex hormones. Many of the kids have autism or complex mental or emotional issues and should not be pushed into permanently altering their bodies. Look at the companies promoting trans as a lifestyle and will benefit from the huge sums of money involved.

A child believing they are 'trans' is more like being anorexic than being gay, with gay being a sexual preference and trans involving sterilization and amputation of healthy body parts. Most questioning kids will, if left alone, come to accept their birth gender. On Reddit chat boards alone there are 38,000 destransitioners and the number increases weekly.

Please uphold the spirit of 'first, do no harm' and stop automatically affirming children who are too young to vote, drink alcohol or drive, yet are guiding medical professionals into butchery.

Julie Angus
Concerned parent.

Sent from my iPad

From: Angeles
To: zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul
Subject: Fwd: End the transitioning of children
Date: Monday, September 19, 2022 4:12:49 PM

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Dear Paul A. Vazquez, J.D. ,

>

> I am the parent of a teen who became confused about his gender a few months after covid first hit. However, we did not find out about his "new" identity until last year. My child never showed any signs of gender confusion in his childhood. He was what we call the typical boy who loved everything that had to do with boys. He loved playing outdoor and getting dirty. Never showed any distress with the clothes he wore and always loved playing with boy toys (cars, trucks, trains, etc). His gender confusion came after the amount of time he spent on the internet during covid lockdown.

> In the last year we have tried helping our child by removing social media and blocking certain sites from his phone and computer. We also tried finding him a therapist. However, after doing some research and speaking with other parents who are in this same situation as us, we came to the conclusion that no therapist is better than a bad one. You see, once the gender topic comes up, therapist and other specialists now put everything else aside and just focus on that. Then they send kids/young adults to a gender clinic where they are placed on crossed-sex hormones and then have irreversible surgeries. But of course you know all that. That is now what these children and young adults need. We need stop putting them into a path of irreversible damages.

> A lot of this children suffer from anxiety, depression, ADHD, autism, and bullying. Some were sexually assaulted and have not been able to speak about it.

> Our child, for example, was a victim of bullying while he was in middle school. Sadly we did not find about it until he no longer attended the school and he refuses to tell us what happened to him.

> Although we do not affirm his new identity, we love our child and nothing will ever change that. We worry about him and his future if he continues on this path. For now, he has only come out to his closed friends at school who celebrate his new identity and affirm him. Friends of which most are also calling themselves trans or non-binary.

>

> I don't understand how professionals like yourself are blinded by what is happening out there. In the past few years, we have seen an enormous increase of children identifying as trans, specially after covid lockdown. Children are being told that if they feel a certain way, it is because they were born in the wrong body. What kind of nonsense is that? This ideology makes it seem like we walk into a store that sells infant parts and we put them together just like we do with the Mr. Potato Head toy. It's ridiculous. We all know no child is born in the wrong body.

>

> I ask you, actually I beg you to please put a stop to this medical malpractice happening with children and young adults. We need you to create a rule that will prevent doctors from bring able to prescribe experimental puberty blockers, cross sex hormones and perform any type of gender affirming surgeries such as double mastectomies, vaginoplasty or phalloplasty on minors. Below you will find reasons why we need to put a stop to this.

>

> - There is a lack of high-quality rigorous evidence surrounding these treatment procedures, which make them experimental in nature since the long-term consequences of these drugs being used on children/teens are relatively unknown. There is also a lack of debate among medical professionals in this area because doctors that speak out against these treatments being used on children are silenced. Alternate treatment options are not being considered or even presented at this point in medicine. It appears activism has infiltrated our medical community on this issue and biological reality is being ignored.

> - The side effects we are aware of often times lead to the sterilization of these individuals and the loss of any future sexual function when puberty blockers are used.

> - Children and teen brains are not fully developed until age 25 and therefore they cannot give informed consent because they don't have the ability to fully understand the consequences of these treatments. Parents are also not

being given the full picture and all treatment options available to them like the watchful waiting approach. They are being told to only affirm or their child will commit suicide. They are also not told that through the watchful waiting treatment approach, many of these children, upwards of 80%, would resolve their distress during or shortly after puberty. There is also no evidence that medical transitioning children actual improves mental health outcomes.

> - Proper assessments are not being done and there is little to no safeguarding in place before a child is placed on a medical pathway. Many of this new cohort of children/teens do not even meet criteria for gender dysphoria, yet they are being treated medically for the “feeling” in their mind that they should be the opposite sex. They are experiencing normal discomfort with their pubescent body, but are being convinced that any amount of discomfort with their body is an indication that they are “transgender.” There is currently no coherent definition of the word transgender in the medical field.

> - Co-morbid issues are being unchecked and unresolved in the name of gender affirming care and patients and parents are being told that medical transitioning will fix their child’s distress.

> - We are now seeing the population of detransitioners increase every day because they come to the realization that medical transitioning did not fix their pain and many are stating their co-occurring mental health issues were ignored or not explored.

> - Medical organizations and associations are blindly adopting guidelines from WPATH without doing a proper review of the evidence being used for these guidelines. These guidelines are being pushed as actual standards of care, which is a gross misrepresentation of what these guidelines are. Further, professionals that are speaking out against these guidelines or advocating for a review of existing literature are silenced through gaslighting or simply ignored as in the case of the American Academy of Pediatrics.

> - Other countries like the UK, Sweden, Finland and France are re-evaluating these medical treatments for children because they have done a rigorous review of existing literature and research and have come to the conclusion that the risks do not outweigh the benefits in children and there is just so much we don’t know about the long-term consequences of these irreversible interventions. These countries have either stopped medical transitioning minors or are advocating for great caution when medically treating children for gender dysphoria. They are all stating mental health treatment should be the first line of defense, which is not currently happening in the US.

> - Despite what the media reports, these surgeries are occurring on children. Many hospitals state openly they are performing double mastectomies on children ages 16 and up and sometimes as young as 15, as stated in the new WPATH guidelines that were set to be released this month. In addition to the pediatric gender clinics in Florida hospitals providing these medical interventions, there are many private plastic surgeons, OBGYN offices, private endocrinologist offices and pediatricians prescribing puberty blockers, cross sex hormones and operating on minors. They claim parents give consent, but should a parent be allowed to consent to experimental medical treatments for their child for a mental health issue? Should parents be able to consent to amputating healthy body parts for their children and taking away their fertility and ability to have a child as an adult?

>

> Again, I ask you to please help put a stop to this by creating a rule that will protect our children from being used as experiments.

>

> Sincerely,

>

> J.C.

>

From: [Kathleen Quigley](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Date: Sunday, September 18, 2022 7:32:31 PM

You don't often get email from kathquig@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Paul A. Vazquez, J.D.

Executive Director Florida Board of Medicine

I am a parent of a 19 year old girl, and a 23 year old young man who identify as transgender.

Our daughter is not transgender: she and more than a dozen of her school mates transitioned at the same time. This is adolescent social confusion.

My son has been hospitalized with mental health issues before falling for the trans-fix all cure for struggle- you can leave it all behind in a new body! In fact he was given estrogen not 6 months after his second of two hospitalizations for psychosis last year, in which he stopped all meds and refused psychiatric follow up and with no checking in with his history or other health care providers. We were in fact not 3 weeks before in an hour long appt with his primary urgently seeking mental health care and looking at the possibility of bi-polar or schizophrenia that emerges in your men typically at this age. The affirming care does not care about this if you want hormones and surgeries you can just have them. This is harmful. This is malpractice.

We are constitutionally opposed to the affirmation model and with hormonal and surgical interventions. These are not based on science or ethics Great Britain recently commissioned a highly distinguished public health and pediatric expert to reconsider the affirmative model in the United Kingdom. Please consider with care the findings of the Cass Review interim report. This shift toward evidence based ethical practice will be coming to America.

What is the Cass Review interim report?

The Cass Review is an Independent Review of Gender Identity Services for Children and Young People. It was 'commissioned by NHS England and NHS Improvement in Autumn 2020 to make recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence [1].' In March 2022, the Cass Review submitted an interim report to NHS England. This interim report '[set] out [the] work to date, what [had] been learnt so far and the approach going forward [2].'

Who is Dr. Hilary Cass

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020.

A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020).

Although retired from clinical practice, she remains an honorary Consultant Paediatrician at Evelina London Children's Hospital, Guy's & St Thomas's NHS Foundation Trust, where she was also previously Director of Education and Workforce. Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah's Ark Children's Hospice. She is also leading work on how to address the challenges for both families and professionals in supporting the rising numbers of children with complex medical conditions and disability.

Other recent roles include acting as the Senior Clinical Advisor for Child Health for Health Education England.

Prior to this Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Pediatrics in London. Her consultant clinical practice was as a tertiary neuro-disability consultant from 1992 to 2018 in three very different specialist centers and she has published widely in this area.

In addition to her neuro-disability practice, Dr Cass was closely involved in the development of pediatric palliative care services at Evelina London Children's Hospital.

Dr Cass was awarded the OBE for services to child health in 2015. She was also awarded an honorary fellowship by the Royal College of Nursing in 2015, and by RCGP in 2016.

Background

The United Kingdom has seen a significant increase in the number of children seeking help for distress in relation to their biological sex. Many school staff first started noticing the phenomenon of children – predominantly teenaged girls – wanting

to change sex during the last decade.

In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (para. 1.1).

From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment (para 3.10).

This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender and gender identity.

Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus (para. 2.4).

No consensus

This being a new phenomenon, research is limited and no consensus exists (within the scientific community) about possible causes and most appropriate treatment options.

At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual (para. 1.7).

We must secure a balanced treatment of political issues, they must take a child-centred, evidence-based approach, and take care not to express personal beliefs in ways which could exploit pupils' vulnerabilities. We should not for example, present, as fact, childhood gender incongruence as an inherent and immutable phenomenon as this is a contested idea rather than an established evidence-based fact.

Low quality evidence

The Cass Review interim report acknowledges that '[over] the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarized and adversarial' (para. 2.4). Many of us feel confused or conflicted about approaching the issues of sex and gender identity with adolescents. The above-mentioned rise in referrals to GIDS has been accompanied by an increasing number of news reports claiming that some teachers and/or schools are promoting the idea that gender identity supersedes sex. However, there is insufficient high quality, longitudinal data (relating to gender-questioning children) from which to draw robust conclusions. There is a notable gap in the evidence base pertaining to the surge in female teenagers seeking support from gender identity services.

Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint (para. 1.29).

Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally (para. 3.21).

It is also important to note that any data that are available do not relate to the current predominant cohort of laterpresenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group (para. 3.23).

Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing (para. 5.10).

This is an area of research where no scientific consensus exists. Schools must be aware that any claims made about the reasons behind the increase in gender-questioning children are speculative and cannot be treated as established evidence-based facts.

Changing epidemiology

Early childhood gender dysphoria is not a new phenomenon. However, the existing literature on treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female and often presenting with a range of neurodevelopmental and mental health co-morbidities.

In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS (para 3.10).

This increase in referrals has been accompanied by a change in the case-mix from predominantly birthregistered males presenting with gender incongruence from an early age, to predominantly birthregistered females presenting with later onset of reported gender incongruence in early teen years (para. 3.11).

The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with genderrelated distress (para. 1.10).

Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and

outcomes (para. 1.28).

Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group (para. 5.10).

The Cass Review interim report highlights the difficulties faced by clinicians responsible for making diagnoses and recommending treatment. Teachers are neither qualified nor capable of critically evaluating existing evidence. They must carry out their duties within statutory and non-statutory frameworks. This included ensuring that any necessary referrals are made as specified by their schools' safeguarding protocols.

Diagnostic overshadowing

Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria (para. 4.10).

School staff must be clear that they are not qualified to offer students advice in this area. Moreover, the promotion of specific beliefs about the source(s) of gender-related distress could influence children's attitudes toward the diagnostic process before meeting with a clinically trained professional. Guidance from the Department for Education states that teachers "are in a position of authority and will typically be respected and trusted by the pupils they teach, giving their personal opinions greater weight and credibility. As a general principle, they should avoid expressing their own personal political views to pupils unless they are confident this will not amount to promoting that view to pupils [4]."

Affirmative vs developmental models

Broadly speaking, there are two approaches to treating children with gender-related distress: the gender-affirmative approach and the developmentally-informed approach. The gender-affirmative approach is based on the theory that a child's gender identity is innate. The developmentally-informed approach is based on the theory that a complex interaction of multiple factors underlie gender-related distress. The Cass Review interim report acknowledges that some clinicians report being under pressure to adopt a gender-affirmative approach.

Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach (para. 4.15). Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach (para 4.20).

There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies (para. 5.8).

School staff are unqualified to evaluate the merits of these approaches. Moreover, they have an obligation to remain politically impartial. This means not supporting one approach over another.

Social transition

Social transitions (the act of treating children as if belonging to the opposite sex) are performed by some schools in England. A social transition is a powerful psychological treatment that affects a child's psychological development. Not only are school staff unqualified to judge the appropriateness of such interventions, the outcomes are poorly understood.

Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes (para. 5.19).

Pressure

The Cass Review interim report acknowledges the pressures clinicians are under to adopt an unquestioning affirmative approach. Similarly, there is an acknowledgement that children are under pressure to identify with societal stereotyping. Schools cannot erase the pressures that children are under from, for example, social media and peers. However, teachers should promote acceptance for children's non-stereotypical behaviour (boys and girls exhibiting stereotypically 'feminine' and 'masculine' behaviour, respectively) and avoid reinforcing harmful stereotypes.

Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters (para. 1.14).

From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision (para. 1.18).

It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services (para. 2.5). We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long children and young people are waiting to access services (para 4.13).

These will be considered further during the lifetime of the Review and include: . . . The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years (para. 4.14).

Safeguarding

Children with gender-related distress may pose specific safeguarding concerns. They have a higher incidence of comorbid psychiatric and/or developmental difficulties. They are also more likely to be looked after children. Teachers need to be aware of possible harms such as breast binding or tucking (of male genitals). Children may also be subjected to grooming and/or coaching, and encouraged to deceive parents, clinicians and teachers in order to secure particular outcomes such as clinical diagnoses of gender dysphoria. They may also be receiving cross-sex hormones from unregulated sources.

In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children (para. 3.11).

We have also heard about the distress experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts (para. 4.3).

Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria (para. 4.4).

We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation (para. 4.5).

We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment (para. 4.7).

Summary

There has been a huge increase in the number of children (predominantly female teenagers) seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making diagnoses and recommending treatment. School staff who now affirm my daughter are neither qualified to evaluate existing research nor clinically trained. Therefore, they cannot judge the appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development. The Cass Review interim report outlines some of the specific safeguarding issues that surround gender-questioning children.

Thank you most sincerely for your time and consideration.

Yours sincerely,

Kathleen

I would be happy to discuss this further with you.

From: [Neal Gerwitz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Banning important
Date: Tuesday, September 20, 2022 1:57:11 PM

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I am a Florida resident and I am totally against any transitioning of minors in Florida as regards the medical community. We ask for a ban on gender-affirming care for minors.

Please record my comments against any gender-affirming surgeries or "health care" for minors.

Thanks,
Neal

From: [MarieP19](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Doctors Do No Harm to minors who are gender confused.
Date: Monday, September 19, 2022 8:14:58 PM

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Dear Florida Board of Medicine,

We thank you for taking up the vital question of regulating the so-called "gender-affirming" hormones and surgeries for young people.

As parents of these children, we have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions sometimes on the first or second visit. The myth that our children are getting "assessments" is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society's recommendations.

Older adolescents can get hormones with no assessments at all, and have their healthy body parts amputated by eager surgeons on little more than self-declaration of "trans identity." Many of our children are gay and autistic and have come to believe their very real distress is explained by the fact that they are "transgender" and that hormones and surgeries will help. They do not. We have seen our children's mental and physical health plummet following "gender-affirmation."

We also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation."

Thank you for doing what you can to regulate this experiment on our vulnerable children.

Marie Moran

South Carolina

Sent with [Proton Mail](#) secure email.

From: [michael page](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Comment on proposed legislation for youth transitioning and informed consent
Date: Monday, September 19, 2022 5:35:44 PM

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To The Florida Board of Medicine,

September 19th 2022

The profession of Medicine is the profession that seeks to restore the bodily integrity of the human person when illness or injury has caused this integrity to be compromised. This is what I do daily as an Emergency Medicine Physician. I also help facilitate the healing of persons psyche when they are damaged from trauma and illness as well. I participate in this process by employing tried and true methods of restoring wholeness to the human person that have been subjected to peer review and scientific scrutiny.

Gender ideology is an ideology and not medicine. Ideology that seeks to destroy the bodily integrity of the human person by removing or diminishing normal functioning parts of the human person is the antitheses of medicine and should not be allowed to tout itself as medicine. It is ideology that hopes to use the tools of medicine to diminish and not restore the human persons integrity without subjecting itself to broad based peer review.

From the time of Hippocrates to today it has been well understood that castration of a male, as was the custom in some ancient cultures and even amongst some peoples until recently does not make a female but makes a Eunuch. The same could be said for mutilation of female genitalia. This does not make a male but a traumatized female. The subjection of children to any of these experimental practices would be a gross violation of the fiduciary responsibility of physicians to preserve and restore bodily integrity to patients. How can a child possibly participate in a decision that will alter their body permanently when the very thought is being seriously questioned across the globe. Look at events in England and Sweden who have been at this experiment for longer and have not found it to be the panacea they had hoped for. Assisting in this ideology by adopting laws to facilitate its practice should be considered a dereliction of due diligence.

Sincerely,

Michael Page, MD

Holland, Michigan

From: [Richard Florentine](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Oppose Gender Affirmative treatments that lack sufficient evidence base in science not ideology
Date: Tuesday, September 20, 2022 12:56:29 PM

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My name is Dr. Richard Florentine, MD.

I am a licensed board certified physician of Internal Medicine in Massachusetts. I am writing to you about my strong concerns about the attempt in your state to advance the practice of “gender affirming care” for vulnerable patients with gender dysphoria despite the lack of good quality evidence on the benefits of this method of treatment and it's highly likely life- long and irreversible harm to vulnerable, young children and adolescents who do not have adequate brain maturation to be able to give fully informed consent.

The impetus for this push for “gender affirming care” seems to be mostly motivated by ideology and politics rather than medical facts and supportive evidence based proposals. This is very DANGEROUS for the practice of medicine and for some of the most vulnerable patients in our society. This practice needs to be halted until further study and adequate and well designed studies can protect these vulnerable children from a profit driven, ideologically dominated medical complex which is NOT founded on a sufficiently sound high quality evidence base to support it's claims. High quality evidence is required of every other kind of medical practice. The even more vulnerable children with gender dysphoria should not be subjected to irreversible harm to their bodies and brains without the usual medical practice of extensive study of new treatment possibilities.

The ideological foundations of this type of proposed medical care was proposed by Dr. John Money at Johns Hopkins University in Baltimore, whose experiment on an unfortunate male patient, David Reimer, who was not intersex but had a damaged penis from a botched circumcision, and was raised by his parents, at the recommendation of Dr. Money, as a girl. His treatment included both surgical and hormonal interventions to ensure that he would develop female-typical sex characteristics. This conformed with Money's theory that gender was a social construct that could be altered by the conditions under which a child was raised. However, the attempt to conceal from the child what had happened to him was not successful—the child self identified as a boy. Eventually, with the guidance from his psychiatrist, his parents informed him of what had happened to him at birth and he decided to reverse the hormonal and surgical interventions that had been performed to feminize his body. He continued to be tormented by his childhood ordeal and took his on wife at the age of 38.

David 's life story is an example of the harm wrought by theories that gender identity can socially and medically be reassigned in children.

Previous medical literature had shown that in young male patients (the majority of the cases of GD) (in the past) with prepubescent gender dysphoria showed a high rate of natural resolution with 61-98% of the children reidentifying with their biological sex during the experience of their own puberty with psychological support. (work of Zucker).

Currently there has been a complete reversal of this pattern of gender dysphoria with a NEW (?Epidemic) form of non childhood initiated gender dysphoria in genetic adolescent girls, which has increased by 5000%. In addition, many of these patients have comorbid conditions such as autism/ASD and Attention Deficit/ Hyperactivity Disorder. The reasons for this new phenomena has not been fully explained. But since the recent introduction of “gender affirming treatment” on this subgroup of patients, has lead to 100 % of these patients have pursuing "gender transition" treatments.

In the US, the thrust for this kind of “gender affirming care” has been ideologically motivated, with an effort to

“silence’ all debate or oppositional voices.

In Europe, however, there has been a movement at reassessment after the leading Gender Identity Development Service, called Tavistock and Portman Trust’s Gender Identity Development Service clinic in London were closed after a “damning report on ideological malpractice”. On July 29,2022, the World’s Largest Pediatric Gender Clinic was shut down due to Poor Evidence , Risk of Harm and Operational Failures. These concerns have also been recognized increasingly in Western Europe, where more thorough medical records are kept, Thus Sweden has made the decision to no longer offer gender transition to minors outside of clinical trials. Finland has also now sharply restricted eligibility for gender transition to minors with a classic, early childhood onset gender dysphoria and no mental health comorbidities, and has stated that “psychotherapy” should be the first line of treatment.

At the Federal level of the USA, the US continues to assert that “gender-affirming” care is safe and effective, despite the findings of multiple systemic reviews of evidence that found that the benefits of gender transition are highly uncertain while the risks may be significant. Specifically, the Endocrine Society’s treatment guidelines for gender-dysphoric youth are followed, a minor’s future sterility is likely. Other health risks include compromised bone health, brain development, cardiovascular complications and a number of other, as yet unknown risks.

For these and other reasons, I strongly urge you to oppose supporting medical treatments that are not sufficiently evidence based, especially when irreversible harms is great and informed consent is not possible.

Sincerely yours,

Richard Florentine, MD
Massachusetts

From: [Sarah Toates](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comments on gender affirming care - proposed changes
Date: Monday, September 19, 2022 1:11:46 PM

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Dear Florida Board of Medicine,

As a current medical student and future physician, I firmly believe that "gender-affirming care," when defined as providing chemical and surgical methods of transition to children and adolescents, are not only harmful, but unproven and experimental treatments that should not be available to minors. The evidence-based medicine is clear: there are negative short- and long-term psychological, emotional, social, and medical consequences of these so-called therapies. I strongly urge you to carefully evaluate the available science before making any decisions which have irreversible effects on Florida's youth, and to prevent harm to children.

Sincerely,

Sarah E. Toates

Oakland University William Beaumont School of Medicine
M3 Student | Class of 2024
sarahbecker@oakland.edu
Phone: (763)-400-0697

From: [Laurie Samuelson](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); [Vazquez, Paul](#)
Subject: "Affirmative" care for gender diversity
Date: Monday, September 19, 2022 8:44:28 PM

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Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Florida Board of Medicine,

I am not a doctor or psychologist, I am a parent, a mom.

There's no stronger instinct than a parent's need to protect his or her child.

Last year, a California woman fought off a mountain lion—with her bare hands. Why? Because the predator was dragging away her 5-year-old son. She heard a commotion, ran outside and immediately began punching the mountain lion. It fled, and she saved her son's life.

The Florida Board of Medicine must use its authority to protect children and adolescents from misinformed and dangerous actions and must allow its members to render evidence-based professional care. Minors cannot provide informed consent to irreversible and unknown harms of so-called "gender affirmative" medical treatments and surgeries. Gender confusion and body dysphoria require psychoeducation while comorbid psychopathology may require psychotherapy and psychopharmacology. "Puberty-blocking" drugs are misrepresented as "reversible pause buttons" while interfering with growth, sexual development, fertility, and multi-system functioning. The meteoric expansion of gender clinics is a preventable medical scandal in the making.

What is the treatment doing, other than sterilizing people; placing them at increased risk of various cardiovascular problems, osteoporosis, and cancers; destroying their sexual response; and limiting their future dating and partner pools?

Transgenderism is an ideology that values artificiality, medical experimentation, image obsession, and mutilation; and devalues health and self-acceptance.

Worse, promoting and protecting content that encourages gender transition can lead

to irreversible harm. The chemical and surgical interventions used for gender transition cause health problems like cardiovascular disease, reduced bone density, and, ultimately, sterilization. They don't even improve mental health in the long run: Those who surgically transition are 19 times more likely to commit suicide than their peers, and teen suicide rates are found to be higher in states where minors can access these interventions with greater ease.

You're assuming these kids need these medical interventions. The evidence does not support this. Every evidence review has found the evidence behind these interventions to be low quality, meaning you can't predict outcomes reliably (in particular if the intervention will help). Maybe kids who are trans identifying shouldn't be given these surgeries and drugs this young, as it's not clear when it is temporary or not (kids before puberty in the past, if not socially transitioned, grew out of it most of the time, and older people have found in many cases that their trans identification stemmed from being gay, depression, separation anxiety, being on the spectrum, trauma, etc.). That is why many countries are actually protecting "trans" kids by not rushing them to permanent dangerous interventions until they understand themselves better--that is, not giving them puberty blockers (which seem to almost always lead to taking hormones), hormone and surgeries, except in very very special cases, and in research settings. Trans identification is poorly understood and in many cases temporary. This is not at all like being gay. This isn't a right wing issue, it's a medical issue. You can look at the Cass Review in the UK, the French National Academy of Medicine, Finland, Sweden...the US has gone anti-science.

Stop the affirmation only policy. There is no biological test for gender identity disorder, it is a mental disorder. No one is born in the wrong body. "Born in the wrong body" is like saying one was born with the wrong liver, heart, kidney, brain, or other organ. It's just not possible, and thinking one is born in the wrong body is a mental illness, and "gender affirming medicine" does not solve a mental illness. It does no long term good and is purely and simply abuse (child abuse if practiced on minors) and should be stopped!

The message we must send to our children is that we do not need a label. We do not need irreversible medication. We do not need surgery. We are fine just the way we are.

Thank-you, and Do No Harm!

Sincerely,
Laurie Samuelson, 65 year Florida resident

From: [R Kirby](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Date: Monday, September 19, 2022 6:46:49 PM

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Dear Florida Board of Medicine members,

It has come to my attention that you are reviewing the regulations for **youth transition** and the **informed consent process**. As a parent, a tax-payer and Doctor of Education, I strongly request that you limit puberty blockers, surgeries, and any other hormone therapies for children. These medical procedures do not correct the real issues, which are mental health related. Issues of fitting in, being accepted and loving themselves cannot be satisfied with surgery. These children need a stringent therapy program. In addition, children often say things they don't understand, or mean and often regret. When my daughter was young, she wanted to be Cinderella, but I knew she would grow out of that and she did. I did not go and get surgery to make her look like Cinderella. They are extremely impressionable, and unable to fully understand the lifelong impacts of these decisions. It is very apparent the adults in their lives are also in need of therapy and are not acting in the best interest of these children. Gender is a feeling, Biology is a fact. Please use your authority to save these children from a lifetime of pain and confusion. These children should be given coping mechanisms to help them through adolescence and the awkwardness that comes with it. Once they turn 18, they should be free to decide on surgery.

Thank you very much for your time.

Rachel Kirby, Ed.D.
321.439.8231

From: [Matthew Muller](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Matthew Muller](#)
Subject: concern about trans-gender care
Date: Monday, September 19, 2022 10:28:50 PM

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Hello, I am a certified/licensed anesthesia provider in Ohio and also a devout Catholic and member of the Catholic Medical Association. I understand that the State of Florida is soon going to be considering regulations for "youth transition" and the "informed consent process".

The destruction of a person's reproductive organs is not health care and only fuels a lie, namely that a person can become something other than what Almighty God has destined them to be. It is simply not possible to transition to a new gender by cosmetically changing reproductive organs with medicine and surgery. We all need to stand up and say "no" to this ridiculous fad we are going through.

You probably have read the story by Hans Christian Anderson, "The Emperor's New Clothes". In this story, everyone in town believes a lie and by not speaking up and promoting the truth this farce continues. It is the innocent child that finally stops the madness: "the king is naked !!" We need to all get our heads out of the sand and speak up: "TRANSGENDER MEDICINE IS NOT HEALTHCARE !!".

I would be happy to discuss this issue on the phone.

Best regards,
~Matt
419-304-7356

--

Matthew D. Muller, Ph.D.

Assistant Professor of Anesthesiology & Perioperative Medicine
Case Western Reserve University School of Medicine

--[Muller Academic Website](#)

--[CWRU Master of Science in Anesthesia Program](#)

Certified Anesthesiologist Assistant
University Hospitals Cleveland Medical Center
matthew.muller2@uhhospitals.org

From: [Art Trish Weber](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: "Youth transition" and "informed consent"
Date: Tuesday, September 20, 2022 1:09:00 PM

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Dear Florida Board of Medicine Members,

I am writing to encourage you to not legalize "gender affirmation surgery" for children, in Florida. Children need time for full neurologic development before making decisions regarding this surgery, unless they were born with a chromosomal disorder of sexual development. Then, the decisions of surgery should be made in the best interest of the child, with parental consent. These guidelines would help prevent unnecessary surgeries which may be made because of peer or societal pressures. Thank you for your consideration.

Patricia Weber, MD

From: [Robert McDonald](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Date: Monday, September 19, 2022 1:21:44 PM

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To whom it may concern,

Please do not allow transgender surgery or medical treatment to be practiced in Florida.

These treatments permanently harm innocent children.

I am very concerned about allowing this medical practice.

Thank you,

Robert McDonald, M.D.

From: [Tyler Tominello](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comments for Florida Board of Medicine Regarding Sex-based Medicine Regulation
Date: Monday, September 19, 2022 8:19:10 PM

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Dear Board Members,

I stand with the Catholic Medical Association (CMA) to voice my support for regulating sex-based medicine practices in the state of Florida in light of medical evidence and the highest ethical standards that safeguard the dignity of each human being. I especially support restricting “gender-affirming care,” which seeks rapid gender transition for children and adolescents. Now is the time to set things right and an example for the rest of the country. Now is the time to return to medical evidence, parental authority in their children’s healthcare, and to protect children and adolescents from barbaric mutilation and puberty suppression being pushed in the name of political ideology.

Sincerely,
Tyler Tominello
Medical Student
Catholic Medical Association (CMA)

Dear Charmon Diamond,
Thank you and State Board for protecting our
miners from these gender-affirming treatments.

Sincerely,
A. Brown

Chairman David Diamond

I greatly appreciate all the hard work and commitment that you have done in protecting children and the righteousness of God.

It's through your unwavering perseverance that there is hope for the future.

Mother & Grandmother

Carol. P. P.

Chairman David Diamond Sept 12-2022
To chair ~~David~~ Diamond

I want to thank you

Thanking the state board for

Protecting our minors from

these genders affirming treatments

Elida Garcia

Hello Mr. David Dromend,

I am Sending my Personal Thanks
to you for your care and
concern for the well being of
all children in Florida.

Your work to BAN Transgender
Treatments & Surgery on Minors
is so appreciated.

Don't Give Up or Back Down!

With Heartfelt Appreciation!

Debra Tachina

To Chairman Diamond · Sept 12-2022

I want to thank you.

Thanking the state board for

protecting our minors from

these gender-affirming treatments

deeply
appreciated

From: [D.H](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: STOP "trans" medical treatment for minors
Date: Tuesday, September 20, 2022 8:18:20 AM

You don't often get email from donine.henshaw@gmail.com. [Learn why this is important](#)

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I am writing to voice my strongest possible objection to any medical treatment for people under 18 for "transgenderism" under the guise of "gender-affirming care."

This is an ideologically-driven abomination. It's medical malpractice and needs to be immediately outlawed. No child can consent to any of this:

Puberty blockers are NOT a "temporary pause button." Puberty blockers cause: infertility, chemical castration in sex offenders, are being used off-label with no studies on safety or efficacy, cause stunted growth, reduced brain size, IQ & cognition, osteopenia, osteoporosis, bone fractures & lifelong reduced bone density, an INCREASE in anxiety/depression/suicidal ideation, micropenis in males, just to name a few.

All of this transgender nonsense is being funded by pharmaceutical billionaires. Young girls are having their healthy breasts cut off before they can vote, legally sign a contract or join the military or buy a drink. Girls are having their healthy uteruses & ovaries removed. Boys are having their testicles & penises cut off. It's barbaric and sickening and the state of Florida has a LEGAL & MORAL responsibility to stop it and protect these vulnerable children from predatory doctors, surgeons and their mentally ill parents.

Trans medical care should be outlawed for people under age 25, when the brain is fully formed. The drinking age is 21. Because kids don't have the mental ability to have good judgment and weigh consequences. Please stop this to the oldest age possible.

The most notorious butcher surgeon in the country butchers children in FL, Sidhbh Gallagher, MD, of Gallagher Plastic Surgery. She needs to lose her license in FL. FL needs to outlaw the practice of doctors advertising these surgeries to children on social media, if you legally can. Dr. Gallagher does this better and more than anyone on Facebook & Instagram.

Thank you for doing this.

Best regards,
Ms. Donine Henshaw
Tucson, AZ 85718

Sincerely,

Donine S. Henshaw, M.A.

From: [Elizabeth Giddings](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulation of Pediatric Gender medicine
Date: Tuesday, September 20, 2022 10:22:07 AM

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Good morning,

I am writing today to send my strong encouragement to the Florida Board of Health in the matter of the regulation and restriction of pediatric gender affirming care. I am writing as the mother of an ROGD teen girl, and as a Registered Nurse of almost 20 years.

In the past 5 years, I have watched as more and more young people, mostly young women have declared a trans identity. I see this in my practice both as an emergency RN and as a Forensic Sexual Assault Nurse Examiner. The girls that are identifying this way are largely suffering from childhood trauma, autism, and other mental health issues, and many of them are typically gender nonconforming, lesbian or bisexual, and somewhat socially awkward, with difficulty fitting in with their peers.

This is my experience with my own daughter as well. Autistic, recovering from a childhood sexual assault, depression, anxiety, an eating disorder, and desperate for acceptance from the peers that have tormented her for her entire school career. She never showed any signs of gender dysphoria or discomfort with her natal sex until her middle school introduced a unit on gender identity. Shortly after that, every single one of her friends began identifying as some letter under the LGBTQ+ umbrella and she herself declared a non-binary identity. This was almost four years ago, and my own daughter has since declared that she is a lesbian, bisexual, back to lesbian, and now demanding the use of her preferred pronouns. I have always loved and supported my children. I am what you would call a classic liberal, I campaigned for marriage equality and have a son who is gay. I told my daughter that I will always love and support her, but that I didn't know what non-binary meant, as there are two sexes and a billion+ different ways to express oneself. My daughter's mental health has steadily declined since she made this identity declaration, and she has spent the past 3 months in various treatment facilities after two suicide attempts. Affirming her, using preferred pronouns, telling her she is separate from her body will not help her. She needs therapy to work through her trauma, coping skills to deal with life's hardships, treatment for her anxiety and depression, and a healthcare system that does not misdiagnose her autism as transgenderism.

I have grave concerns as an RN about the use of puberty blockers in children, and I am horrified at the number of photos I see circulating on social media of young girls post double mastectomy. Even worse, I am appalled at the number of physicians who have taken to using social media as a way of advertising double mastectomies and genital reconstruction surgeries to children.

I have serious concerns that basic medical ethics are being overlooked, and I am shocked that my own professional organizations have stayed silent. Although it is not law, the Nuremberg Code is the gold standard for medical ethics regarding human experimentation and it is the framework used to teach nursing students about ethical issues in institutions across this country. The Nuremberg Code states that a patient must be able to give informed consent to any treatment for it to be considered ethical. There are no long term clinical trials on the use of puberty blockers in otherwise healthy children for extended periods, and the short term evidence points to issues with cognitive development, bone loss, osteoporosis, brain swelling, vision loss, and so much more. These effects are permanent and not reversible, as the public has been told.

There are no long term clinical trials on how children who have been effectively sterilized during puberty do in the long term in regards to mental health, but we do know that the suicide rate for transgender individuals, contrary to popular belief, is much higher approximately 7-10 years post transition, indicating that this is not in any way a form of suicide prevention as the public has been told.

There are no long term clinical trials on the use of wrong sex hormones long term and the impacts this has on every other body system. The public has been told that transgender individuals have a much shorter lifespan than the average American, and we are told this is because of high suicide rates and transphobia, but the fact that some of these people have destroyed their bodies by taking years of wrong sex hormones is always, conveniently, left out of the discussion.

With every issue listed above, how can we even begin to say that parents and children are being given appropriate information, or that they could even begin to give informed consent? There are far too many unknowns to consider any of this informed, and as the lawsuits of the detransitioners start to roll in, we will see how well that holds up in court.

It seems that medical providers have stopped following evidenced based guidelines in pursuit of activist interests, and the harm being done is impacting our most vulnerable population, our children. As a healthcare professional, I am ashamed of my colleagues for perpetuating these lies about this so called gender affirming care, and as a mother I have lost all trust in the healthcare system. I will no longer use a primary care provider for myself or my family, CVS minute clinic check ups all around when necessary, otherwise I manage from home. I have no faith or trust in the medical community anymore. I do not trust activist physicians or nurses who are so eager to throw away evidence based practice and ethics in search of gaining internet or social media fame, or to make a name for themselves.

As an RN, I am called to provide holistic care to all of my patients, to facilitate healing of body, mind, and spirit. How can I do that when society is pushing a ridiculous notion that somehow a person's body is separate from their mind and spirit and physicians who seem to have lost their ability to think critically are endorsing such a notion?

As a mother, I am called to advocate for and protect my child at all costs, how am I to do that when unethical physicians disregard every concern I have or somehow label me bigoted and non affirming for expressing these concerns? As a mother, I look to physicians to assist me in maintaining my children's physical and mental health, not to brainwash them into thinking humans can magically change sex, or that all of their mental anguish will be solved by elective cosmetic surgeries and procedures.

I am appalled and disgusted by the behavior of social media activist physicians, I believe that the medical transitioning of children is the largest medical scandal of all time, more so than lobotomies, thalidomide, or Tuskegee. I am begging you today, as both a nurse and a mother, to be the first of what will hopefully turn out to be a landslide of reasonable medical agencies, to restore sanity and urge caution in performing unnecessary elective procedures on minors that will not solve their mental health issues, only turn them into lifelong patients dependent on the medical and pharmaceutical industry for survival.

Please help return the focus of healthcare to HEALTH, not identity politics, not customer service, not political activism.

Thank you for your consideration,

Elizabeth N.G. Watson RN, BSN, PHN

Sent from my iPad

From: [Jeanne Southard](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Affirming Vote
Date: Tuesday, September 20, 2022 10:54:39 AM

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I hope I'm in time to to stop your voting to give you my thoughts so you may make an objective decision. I am writing as a concerned voter who wants you to know that I believe this is NOT your decision to make! Consulting with a minor without their parents present goes against everything our Country is built on. By changing legislation to allow doctors the ability to council, prescribe medication to, or help minors to change their appearance because the minor may think they are something else will be opening doors that will hurt others in the future.

Examples:

1. This could change laws regarding under age sex, let's say a 15 yr old and someone who is 18. Right now Parents can have the 18 year old arrested. The fact that this piece of legislation is excluding the parents may take the parents rights away for all future events!
2. How will pornography is look in legal system if this piece of legislation passes?

These questions do need to be asked because children shouldn't be making major decisions about their bodies alone, without parents present or parental consent. Our uniformed police officer's across the United States cannot question minors without their parents present, so why would this be any different? And if you change this will you be changing this protection for our children?

Thank you,

Jeanne Southard

Sent from my iPad

From: [David Musielewicz](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulation of Transgender Medical Practice
Date: Tuesday, September 20, 2022 12:48:56 PM

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Dear Florida Board of Medical Practice,

I understand that the Florida BOMP is considering regulation of transgender medical practice.

My concern is that National Medical Associations and the current practice standards have adopted an unproven and experimental approach to transgender treatment called "affirmation" as opposed to an evidence based and scientifically grounded approach to the treatment of the diagnosis of "gender dysphoria."

I support the Florida BOMP adopting a scientific and evidence-based regulation of the treatment of gender dysphoria.

Medical atrocities are being committed on youth and young adults in the name of a transgender ideology that has no basis in science. Florida can lead the nation by joining the United Kingdom and other European countries that are beginning to recognize the affirmation model coupled with medical intervention as truly harming people. My best wishes to you if you take this on. Transgender activists will attack the reliance of science and evidence supported medicine for treatment of gender dysphoria and transgender persons mercilessly. Good luck.

Sincerely,

David Musielewicz

From: [ELIZONDO VEGA MD, Heather](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: gender-affirming medical care
Date: Tuesday, September 20, 2022 10:18:56 AM

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Hello,

My name is Heather Elizondo Vega. I am a member of both the American Academy of Pediatrics and the Christian Medical Dental Association. I am board-certified through the American Board of Pediatrics in both General Pediatrics and Adolescent Medicine.

I learned from the president of the CMDA that you all were allowing comment through 20 September 2022 regarding the issues surrounding gender-affirming medical care, particularly for youth. Thus, I am writing to you in response to that.

First, I would like to express my concern that your organizations did not make this information (about the inquiry) publicly available. I only learned because I met with the CMDA President at a recent conference. I am disappointed that there was not any sort of mass e-mail sent out from either the Dept of Health or the Board of Medicine about this opportunity for comment through 20 September 2022. Thus, I am concerned that you are going to receive a skewed representation of the population of Florida physicians due to many individuals being unaware of the opportunity to comment at this time.

I have mixed opinions regarding the medical care for youth to provide "gender affirmation". I have heard the arguments on both sides. I do very much have ethical and medical concerns about gender-affirming medical interventions. However, at the same time, I cannot support a state-wide ban on such services. Here is how I came to that conclusion: I am concerned that children are rushing into treatment too early. I am also concerned about longterm ramifications such as irreversible physical attributes that, in some cases are later regretted, and I am particularly concerned about infertility. However, I also support individual autonomy and parental rights to make decisions for their children.

I think that there need to be protections put into place to ensure that children are evaluated by a qualified mental health professional over a period of time before they enter into any sort of gender-affirming medical treatment. Perhaps, some sort of extra protections such as having a child meet with two independent mental health providers for consensus would be a good idea. Secondly, there should never be a situation in which a child receives gender-affirming medical interventions without parental consent.

Again, while I do have ethical and medical concerns about gender-affirming medical care, I think that the decision should be left to the patient/parent/medical provider/psychological provider group, should be individualized, and should be made with much discussion in relationships. I am generally

opposed to the idea of outright government bans, as this becomes an infringement upon patient rights and parental rights.

Meanwhile, as I do have concerns about the medical ramifications of gender-affirming medical care, I think we need to support long-term studies regarding the risks and benefits. I would support a Florida-wide education campaign to help the medical and lay community to know that there is more to this argument than suicide prevention. Most studies and policy statements that have been made by the “major medical organizations” discuss gender-affirming medical care in the context of either suicide prevention or prevention of patients seeking “street drugs”. The voices of the counterpoint are not loud enough or widespread enough. We need more education to the medical and the lay community about the reality that there is a lack of long-term data regarding suicide prevention and regarding the rates of persistence versus desistence. More information is also needed by the medical and lay community about fertility considerations, particularly since most teens who identify as transgender do not make attempts to preserve their fertility before entering treatment, whereas it is my understanding that the rates of adults who identify as transgender who desire fertility is much higher.

So, ultimately, I would like to advocate for more education, a strong policy regarding the need for parental consent, and a strong policy regarding the need for a high-quality psychological intervention before entering into decisions about gender-affirming medical interventions. But, because of my concerns about the politicization surrounding this issue as well as infringements upon individual and parental rights, I cannot support an outright ban on such services for youth in Florida nor can I support any sort of criminalization of either parents who undertake this treatment for their children or of medical providers who provide such services. Generally speaking, medical decision-making is best left between patient/parent/provider and best left out of the government’s hands. However, if the Department of Health and the Florida Medical Board are concerned about the ethical and medical concerns related to this issue, as am I, I would whole-heartedly support a stronger education campaign for both the lay and medical community so that everyone has a better understanding of both the pros and the cons of such treatment.

Thank you for your consideration.

Sincerely,

Heather

Heather Elizondo Vega MD

AdventHealth Medical Group | Central Florida Division

Adolescent Medicine Physician | Pediatric and Adolescent Medicine Winter Garden

O 407-656-0042

F 407-656-0633

M 210-287-7243

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From: [John M](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: True health for youth
Date: Tuesday, September 20, 2022 10:20:59 AM

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Good morning,

As a medical doctor board-certified in General Preventive Medicine and Public Health and concerned for the true health of children, I want to give my professional recommendation that the Florida Board of Medicine **not** support any gender-affirming actions, rapid gender transition or other putative gender-altering interventions on children as these actions do not constitute care, medicine or evidence-based practice.

Best,
John W. Kieffer, MD, MPH
San Antonio, TX

From: [JUSTINE MERCEDES](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Regulations for youth transition and the informed consent process.
Date: Tuesday, September 20, 2022 9:32:26 AM

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I am writing to urge you to adopt these measures to protect children from dangerous medical transitioning through prohibiting both informed consent and banning Puberty Blockers, Wrong/Cross-Sex Hormones and all surgeries related to gender transition.

As you are aware the use of Puberty Blockers, wrong-sex hormones, and surgeries such as double mastectomies and penectomies are all experimental with no long-term studies. Research shows that there is no shown improvement in mental health as a result of any of these procedures. Minors do not have the capacity to make lifelong decisions, especially when the decision could sterilize them. This is evident by the number of detransitioners coming forward and telling their stories about their regret over medically transitioning. Their numbers are growing rapidly, but most are too afraid to speak up. .

My daughter suffers from Rapid On-Set Gender Dysphoria, ROGD, and has all the typical traits of this phenomenon. Her college pushed and aided her down the path of transitioning. Sadly, she estranged herself from us in the spring of 2020. That July she started taking wrong sex hormones. In April of 2021 she travelled to Florida and had a double mastectomy at the age of 22. A 22-year-old does not have the capacity to truly understand the lifelong implications of such a decision. Yet much younger children are being allowed to make such decisions and that is unacceptable and child abuse.

I am the Indiana leader of Parents of ROGD Kids and a leader a Christian support group. I spend a lot of time speaking with parents dealing with a child that suddenly comes out as Trans. All of the children have the usual traits of ROGD such as trauma or mental health comorbidities. Most of these children are still minors. The parents are scared to death and don't know where to turn. Trying to find a therapist that won't affirm their child's belief they were "born in the wrong body" is almost impossible. The schools are ignoring their parental rights. Even more frustrating, doctors are affirming their child in front of the parents.

When I give presentations, the audience is shocked when they find out the only provider of gender care for minors in Indiana is Riley Children's Hospital in Indianapolis. Up until two years ago, Dr. Sidhbh Gallagher was on staff at Riley and the Eskenazi gender clinic. She would post pictures on Facebook of herself posing with young woman right after she had amputated their healthy breasts. As I'm sure you are aware, she relocated her practice to Florida. She now includes posts on TikTok where she refers to herself as the "Tit Wizard" and the procedure as "Teetus Deletus" and "Yeet the Teets".

Dr. Gallagher is just one example of the many mental health and medical professionals acting in unethical manners and, instead of being reprimanded, are being applauded. It is mind boggling that we have come to a place where it is acceptable to ignore mental health history, cut off healthy body parts, and inject dangerous off label drugs, which are creating lifelong medical patients. Worse yet, these so-called professionals are turning their backs on the individuals who now regret what they were coerced into doing to their bodies.

I ask that you adopt these guidelines and protect our children from these experimental, unproven, and dangerous procedures. Let Kids be Kids.

-

Thank you for your time.

Justine Mercedes

--

Justine Mercedes

Parents of ROGD Kids

Indiana Leader

260-444-6610

From: [Jon Ward](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care
Date: Tuesday, September 20, 2022 10:16:03 AM

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Dear Board of Medicine

I am a Florida licensed physician writing this letter in support of the rulemaking request by Surgeon General Joseph Ladapo. As you are aware, the data upon which gender affirming care has been recommended is of low quality and there is no objective high quality data that would justify the expense or the known risks of this path that sets up these patients for a lifetime of medical problems.

The explosion of new adolescent girls who are seeking these treatments is a social contagion that is being fueled by predatory clinicians and we need to put an end to this in Florida.

Best Regards,

Jon Ward, MD

From: [Susan Illg](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulation of Transgender Medicine
Date: Monday, September 19, 2022 11:45:18 PM

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Dear Members of the Florida Board of Medicine:

I understand you are evaluating the need for regulation of gender-related health care. Based on my experience with my own trans-identified child plus extensive reading on this topic, I believe regulation is badly needed.

When my child came out as trans I interviewed a couple dozen therapists in search of one who would do a thorough assessment and standard psychotherapy with my child. All I could find were therapists who believed in immediately affirming a child's trans identity. I finally found a therapist in another state who my child could see online. I have had to pay out-of-pocket for this treatment, but it has been worth every penny. Over time my child has built a trusting relationship with this therapist; my child's anxiety has decreased; her confidence has increased; she is no longer pursuing medical transition; and her relationship with us has improved immensely. Simply affirming her trans identity would not have fostered this growth.

When I began researching medical transition treatments, I was truly stunned to learn about the types of treatments being offered to children and young people. The female body has not evolved to process large amounts of testosterone. Doctors consider high testosterone levels in girls with polycystic ovary syndrome to be dangerous, but testosterone magically becomes safe and therapeutic as soon as a girl declares a trans identity. Doctors tell athletes that using anabolic steroids will damage their cardiovascular systems but now hand out the original anabolic steroid, testosterone, freely to girls and young women. Minors are receiving double mastectomies because they don't like their bodies. Many if not most adolescents go through periods of disliking their bodies, but we used to let them grow out of that discomfort instead of cutting them up. Traditionally, doctors have been very reluctant to perform hysterectomies on women under 35 because it can increase the risk of stroke, bone loss, heart attacks, and urinary issues, but now hysterectomies are okay for young women as long as they identify as transgender. Phalloplasties should simply be banned based on their complication rate, but women whose prefrontal cortices are not yet fully developed can get them. It seems that in the realm of gender medicine, all common sense, conventional wisdom, and medical knowledge fly out the window, and anything goes. It truly feels like the wild west.

I hope you will follow the lead of the United Kingdom where the National Health Services is conducting a thorough review of the scientific literature around transition treatments and plans to revamp their pediatric gender services based on their findings.

Please regulate gender medicine for the sake of our children, adolescents and young adults.

Sincerely,

Susan Nagel

From: [Suzanne Greenquist](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex based medicine regulations
Date: Tuesday, September 20, 2022 11:41:15 AM

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Hello! I am a family medicine physician from Nebraska and am writing to encourage you to take a strong stand for the youth of your state as you consider regulations regarding sex based medicine. Rapid gender transition therapy is child abuse. The medical and evidence-based studies of these methods demonstrate both short and long term harm of these interventions and they should not be allowed. Psychosocial support models, which other countries are moving back to after seeing the negative effects of surgical and hormonal "therapies", are safer and offer our children the opportunity to grow and mature as they are intended. Always consider the Hippocratic oath in which medical professionals vow to "first, do no harm". These therapies are most certainly causing harm to the young people being subjected to them.

Thank you for your consideration and leadership.

Suzanne M. Greenquist, D.O.
Family Medicine-Nebraska

From: [Mark Casebolt](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: gender altering surgery for minors
Date: Tuesday, September 20, 2022 9:41:51 AM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

My name is Mark Casebolt

I am a general surgeon in Ocala, Florida

I am writing to you because I am concerned about upcoming recommendation concerning surgical alteration of external sexual characteristics for minors who suffers from gender dysphoria.

As a father of 4 grown children, I have a hard time believing that any minor has the mental acuity and emotional maturity to make such a monumental and irreversible decision.

With the evidence being inconclusive I do not see any compelling reason to recommend that the surgery be done. I would err on the side of conservative management.

I think the decision about gender altering surgery should only be made after an individual reaches the age where they have the emotional maturity to make such a decision.

Where is the harm in having them wait?

From: [Paul Camarata](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Treatments for Gender Dysphoria
Date: Tuesday, September 20, 2022 5:58:42 AM

You don't often get email from pcamarata@kumc.edu. [Learn why this is important](#)

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Paul Vazquez, JD, Executive Director
Florida Board of Medicine

Dear Director Vazquez,

I am writing as a concerned physician and surgeon to encourage the Florida Board of Medicine to restrict the use of hormonal and surgical therapies to treat gender dysphoria in children.

Despite the popular narrative, there are no high-quality, long-term studies that show that the mental health state or suicide rate is any different following transition of children. The fact that many of these irreversible treatments are currently being proposed for and even administered to children who have barely reached the age of puberty is unconscionable.

In fact peer-reviewed studies show that a “watch and wait” approach to gender dysphoria in children will result in a realignment of gender identity with biological sex in up to 85% of these same children.

Even the revered Tavistock Center in the United Kingdom has been forced to close its doors and cease treating children with gender dysphoria for a variety of reasons, including the health staff felt under pressure to adopt an ‘unquestionably affirmative approach.’”

I believe it is premature to move forward with such experimental therapy without the informed consent of these children, who very commonly will begin down an irreversible path which many will regret. We owe our children more than this. Please continue to urge caution and withhold such experimental therapy from our precious children.

Thank you.

Paul J. Camarata, MD, FAANS, FACS
Overland Park, KS

Sent from my iPad

From: [Aime Nuar](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender-Affirming Care
Date: Tuesday, September 20, 2022 9:38:19 AM

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Dear Members:

I am concerned about the youth transition and informed consent process being considered by the Florida Board of Medicine.

"Gender-Affirming Care," including rapid gender transition for children and adolescents, is neither caring nor affirming. Medical and evidence-based studies show that significant short and long term harm is done by such interventions.

Let your vote be guided by reason and truth, not emotions. Vote NO for "Gender - Affirming Care."

Sincerely,
Aime L Nuar, MD
9213 Stonewall Road
Manassas, VA 20110
703-773-3672

From: inkwoman@gmail.com
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender-Affirming Care - Florida Board of Medicine
Date: Monday, September 19, 2022 11:10:54 PM

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To Members of the Florida Board of Medicine:

As the Board seeks to understand the evidence, efficacy and the ethics of gender care - and in particular the "affirmative approach" involving hormonal and surgical transition - I am compelled to submit my comments.

I'm a liberal and a Democratic, a social worker by profession, and the mother of a 16-year-old girl who has been caught up in the trend of young girls suddenly embracing a transgender identity. I supported (and still support) gay marriage, I applaud and stand for peoples' rights to express their chosen sexual identity, and, I support people to live, including to physically transition *if they are adults who have considered the pros and cons over a period of time*, as the gender they feel expresses their "true" selves.

I am, however, dismayed that the school curriculum in this country, apparently along with the American Academy of Pediatrics, endorses the unscientific notion that gender is "an internal sense" and not a biological reality. Please see [here](#), [here](#), and [here](#) for more information. The number of girls claiming a transgender identity has [skyrocketed](#) in recent years.

The summer that my daughter turned nine, we moved across the country from New Jersey to California so my husband could start a new job. Until then we had been a family who had limited internet contact to less than two hours a day, (again, as per recommendation of the AAP, who we formerly thought of as a reliable resource for health and children).

When we moved, without school in session, and with fewer friends and social outlets in our new town, our daughter turned to more time on the computer. When she took up coding via the MIT-organized website Scratch.org, I figured if she was going to spend more time online, at least it would be "educational". Several weeks later, our daughter announced "I've realized I'm transgender". My husband and I were confused, as there was no indication at all of these thoughts until she said this. Although we were confused, we were not alarmed. Why would we be? Kids are impressionable. They "try on" different identities as part of their development. Over the years, my daughter presented herself as depending on the days, a kitten, a bunny, and a ballet dancer.

As we met more people in our new town, I was astonished to discover that other adults, including my daughter's new pediatrician and her schoolteachers, were not only eager to embrace my daughter's 'transgender identity', but they were disapproving when I commented that I thought this was a phase. While we were happy, we told our daughter and anyone else who would listen, to have our daughter dress however she wanted, cut her long hair, even call

herself a different name since she "hated" her own name...this did not, we reiterated, mean that she was actually a boy.

The pediatrician, who had met my daughter once, insisted on "respecting my daughter's gender identity" and proceeded to call her by a boy's name my daughter had chosen for herself. I then switched to a different pediatrician, who repeated the need to "respect and support" my daughter's sudden, seemingly random, recognition that she was "actually a boy". She also recommended that my 9-year-old attend support groups for transgender children, run by the local lgbtq center. They had support groups for parents too, so that the parents could "learn to embrace the transition".

Meanwhile, in the wake of her newly found trans identity, my daughter's mental health became severely compromised. She (ten years old now) was diagnosed with depression. She started cutting herself. She spoke of thoughts of suicide, that she thought would disappear if she could only be medically transitioned to be a boy.

When we approached mental health practitioners (a first, then a second, then a third!) they all repeated that not affirming my child's gender identity was putting her at a higher risk of suicide. The second one was actually the person to introduce my child, without my knowledge, when I was out of the room, to the idea of puberty blockers. All three of them said some version of "would you rather have a dead daughter or a live son"?

In brief, after five years of insisting she "knows herself", pleading for puberty blockers, and attempting several times to have professionals convince us, her parents, of the need for medicalization...she stopped. It wasn't sudden. First she grew her hair out a little longer. She got interested in lip gloss. She read graphic novels and books about what we used to call "tomboys". Over time, she has thought this through for herself and now realizes she was, in her words, "confused." If we had succumbed to the pressure (and that is indeed what we felt - pressured!) of doctors, school counselors, mental health professionals, and other parents who barely knew our child., all of whom insisted that my child knew best...my child would already have been on a path to medical transition. Some effects of this transition (her voice, facial hair) would be irreversible. Her fertility, at age 10, would have been compromised...perhaps permanently.

I know (too many) parents that have experienced almost exactly the same circumstances as did our family. In some cases, their kids were older and the parents were unable to intervene in medical decisions. In some cases, CPS was called in by school officials who thought the parents were damaging their children by not 'affirming their gender identity'

And in some cases, as often happens, their kids matured and changed their minds. After all, we now know the brain is not fully developed into one's mid-20's. If my daughter was 25 when she first announced her trans identity, I probably would have considered it a more measured declaration. I'm glad we questioned her at nine.

I implore the members of this board to carefully consider the potentially disastrous consequences of allowing children (and adults who don't have much history with them) to make life-changing medical alterations.

Thank you for your consideration of this matter.
Rina Davis

From: [C.G.](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Stop Medical Transitioning of Minors
Date: Tuesday, September 20, 2022 12:09:01 AM

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Greetings,

I am writing to you as a parent of a trans-identified child, who did not have any discomfort with their biological sex until being exposed to information regarding gender identity on the internet. Our child is intellectually gifted and on the autism spectrum. It is well known that children on the spectrum are at greater risk of being emotionally manipulated by peers and adults. I believe that the confluence of social media and normal adolescent insecurity during the pubertal process is creating a perfect storm among our youth who are just trying to make sense of the world. Parents like me are counting on the grown-ups in the room to look at the evidence, and to recognize the social contagion that is before us.

So called "gender affirming care" sounds like an altruistic endeavor, however what that care involves is chemical castration with puberty blockers, followed by wrong sex hormones, which leaves an individual sterile and most likely without the ability to have full sexual function. Surgically, for females, it involves the removal of healthy breast tissue, and after a few years on testosterone, the removal of the reproductive organs. For males, it involves the removal of the testicals and an inversion of the penis to create a pseudo-vagina, which is really just an open wound that requires constant maintenance to keep the wound from closing. These are not life "affirming" or life saving procedures, they are life altering, permanent changes that will create a lifetime of frustration for individuals who will no longer be able to experience sexual pleasure. It also creates individuals who are dependent on synthetic hormones for the rest of their life. The pharmaceutical companies stand to make huge profits off of vulnerable people. This is the second dope sick of our time.

This is a psychic epidemic that has been perpetuated by propaganda that children are being exposed to not only on the internet, but also within schools across our nation with the teaching of the pseudoscientific concept of gender identity. This is a faulty belief system that people can be born in the wrong body based on regressive, sexist stereotypes. It is not bigoted or transphobic to denounce this concept.

One of the big lies around this movement is the risk of suicide. I hope you and your fellow physicians understand that this is a false, misleading and emotionally manipulative lie. There is a long term study from another country that shows the suicide rate actually increases by nearly 20 percent after people have medicalized.

More and more detransitioners, individuals who no longer believe they are the opposite sex, are starting to come forward to tell the stories of how they have been harmed, and currently it seems that the medical community and our governmental institutions are treating them like an anomaly. The truth is their numbers are growing because a different cohort of individuals are being "affirmed" without any safeguarding or long term psychoanalysis to unpack an individual's ideations. We are at risk of pathologizing childhood.

Please be brave in renouncing these unethical, and unscientific practices.

Respectfully,

Chris, a concerned parent

From: [Connie](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: State of Florida medical board
Date: Monday, September 19, 2022 11:16:10 PM

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Dear Florida Board of Medicine,

Thank you for questioning the regulation of so-called "gender-affirming" hormones and surgeries for young people. I can guarantee that this is one of the most important issues of our lifetime.

As a parent of one of these children, I have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions sometimes on the first or second visit. The myth that our children are getting "assessments" is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society's recommendations. Even with an older child, there is often social dysmorphia and extreme OCD that should be addressed before anything having to do with gender is even talked about. My son is one of those older youth who was coerced into going on hormones and eventually ending up with an orchiectomy. The physicians and mental health "experts" did not fix his social anxiety or his TOCD. He is in a much worse place than he has ever been in. We are really struggling right now and worry every day about his mental state.

Older adolescents can get hormones with no assessments at all, and have their healthy body parts amputated by eager surgeons on little more than self-declaration of "trans identity." I suspect that my child may be gay with autistic traits and has come to believe his very real distress is explained by the fact that he is "transgender" and that hormones and surgeries will help. They will not. I have seen my child's mental and physical health plummet following "gender-affirmation."

I also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation."

Thank you for doing what you can to regulate this social experiment on our vulnerable children. I believe that this is going to go down as the largest medical scandal ever in the history of bad medicine. It's time to pick a side. I hope you pick the side of children.

Thank you,

Connie Hahn

From: [Edward Loniewski](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Reassignment Procedures and Proper Informed Consent
Date: Tuesday, September 20, 2022 9:33:18 AM

You don't often get email from eloniewski@gmail.com. [Learn why this is important](#)

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Dear Members of Florida Health Board:

Good morning , and I hope this email finds you and your families in good health and spirits. I am dropping a very short note to encourage you not to adopt any rapid processes of so called gender affirmation procedures or chemical processes. As we all know, the published research and personal empirical experiences regarding these procedures is less than optimal and many sources and personal experiences tell us that these procedures cause tremendous harm with some irreversible effects. The complication rates after surgical transformation has led to multiple readmissions for an abnormally high rate of postoperative morbidity. The rates of suicide have been reported to escalate over 400% compared to a control group. Our hospital systems can not handle this growing number of easily preventable morbidities and mortalities. These patients require very careful selection of these patients with clear informed consent of these complications. The other item to consider is the fact that informed consent should clearly state that these procedures and drug treatments do not change the genetic code of the individual and as thus, the claim that they change the gender of the individual is false and misleading. In addition, there are many, many potential side effects we do not know such as the rates of specific hormone sensitive cancers and the destructive nature of long term hormone treatment on the musculoskeletal system. I have personally seen numerous patients who are currently receiving hormone blocking and stimulating treatment for gender dysphoria and most have severe changes within their major joints such as knees, hips and shoulders. Yet, none of them have had any informed consent that this is a known and probable side effect with irreversible damage.

Thus, I am asking you to adhere to the basic principles of informed consent and ensure that all of the patients undergoing these procedures are properly informed of the potential risks (there are hundreds) as well as the published benefits (which there are none) so we can treat these precious individuals with the respect they deserve.

May God continue to bless all of you and the important work you do everyday.

--

Happy Healing;
Edward G. Loniewski, DO,FACOS, FAOAO
Compassionate Use Medical Officer
AVM Biotechnology
eloniewski@avmbiotech.com

From: [Fr Glenn Kohrman](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Medical Interventions
Date: Tuesday, September 20, 2022 9:58:17 AM

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To whom it may concern,

I understand the doctor who pioneered some of the gender surgeries no longer supports such interventions because it did not resolve the psychological challenges that he had hope to remedy through such radical interventions. It seems grossly irresponsible to allow such interventions to occur on children. Please be guided by sound science and not ideology.

Fr. Glenn Kohrman, B.S.M.E., M.S.M.E., MDiv., MA

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Holy Family Parish - ***Guiding Families to Pursue the Truth and Live It!***

St. John the Baptist -***Preparing the way for Disciples to love the True, the Good and the Beautiful!***

From: [Katrina Nguyen](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex-based practice of medicine
Date: Tuesday, September 20, 2022 12:24:03 PM

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To whom this may concern:

I am pediatric GI physician in Illinois and have evaluated patients since 2020 for side effects following hormone treatment for gender transition services that were provided by Gender Clinics elsewhere. Some of the side effects included migraine headaches, intractable vomiting, intractable diarrhea, and chronic abdominal pain. These symptoms got worse as the hormone doses increased. These symptoms were not present before hormone treatment. Parents reported that despite signing a consent form, they were not aware that these were the potential side effects of hormone treatment.

All the patients I have evaluated have a history of mental illness, physical or sexual abuse, or being bullied at school. Many of them are having family discord with parents going through separation or divorce. Many of the patients did not feel that the mental illness, bullying, abuse or family discord received adequate attention or treatment.

Parents stated that teachers and principals told them that the children wanted to identify as the opposite gender and that the parents have to support their wishes. Parents felt bullied into accepting their child's wishes rather than being given an opportunity to talk to their children without interference from teachers or principals.

I hope that you will take my shared experience into consideration as you consider sex-based practice of medicine in Florida.

Sincerely,
Katrina Nguyen, MD

From: [Michael Jaquith](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender transition opposition
Date: Monday, September 19, 2022 4:43:11 PM

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Would encourage you to vote against gender transitioning treatment for children and adolescents. These treatments harm children. Gender dysphoria is a treatable condition. No state funding should be used to encourage this condition.

Sincerely,

Michael H. Jaquith, M.D.

Sent from my Verizon, Samsung Galaxy smartphone
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From: [sallison25](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Trans youth health care
Date: Monday, September 19, 2022 9:04:44 PM

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Florida Board of Medicine Members

I am writing to you today to voice my concerns about the current state of affirmative only health care for transgender youth and young adults in the United States. I am not an activist. I wish to convey my thoughts on this matter as a mother of a biological son who identifies as a female. I am a democrat. I do not see this as a right vs left issue despite what the media and trans activists would like you to believe.

The problem that I see with the current affirmative only trans healthcare for youth and young adults is that doctors seem to think there is only one approach and that approach leads their patients down a medical path that they will need to follow the rest of their lives. This one size fits all approach is immediate affirmation only, socially and medically with little regard to the individual patient's health background and childhood social history. There is little to no psychotherapy for these individuals before approving cross sex hormone medication. Trans activists call any sort of psychotherapy conversion therapy. This is absolutely wrong! Psychotherapy is meant to explore the underlying reasons that a child declares he or she is trans and help guide the patient and their family in making the right decision for each individual. Many of these trans identified children and young adults are neuro-diverse. They have histories of ASD, ADHD, OCD, are socially awkward, have poor executive function skills, have slow processing speeds, have sensory integration issues and/or trauma. Still others will grow up to be homosexual and identify as trans due to internalized homophobia. Yet others are influenced by friend groups, social media and teachers. There are many ways into identifying as trans and there should be many options for these patients of how to deal with their feelings instead of just one path that will make them a medical patient for the rest of their lives.

Sweden, Finland and the UK have recently restricted hormone therapy and surgeries for transgender youth because studies have shown that the risks outweigh the benefits for most patients. Studies show that left alone to mature, many trans identifying youth (65-80%) will re-identify as their birth sex. Misinformation, is all that lay people and some doctors know due to the media and trans activists. My hope is that the Florida Board of Medicine can realize that they have the power to do what is best for patients and their families. Patients and their families need to be fully informed of all possible side effects and complications of cross sex hormones and surgeries. They do not need to be rushed into medical care. They need a thoughtful well managed plan of care that includes mental health exploratory therapy. They need the truth that these young people are not at higher risk of suicide. They need to be aware that there are no long term studies to prove that transition is the best option to all. They need to be followed for several years throughout their childhood and adolescence to assess their mental health and their feelings about being trans. Cross sex hormones should only be given under the guidance of strict clinical trials. Cross sex hormones are not benign. Genital surgeries are permanent. Patients need to be followed for a prolonged time after transition also ... 20 years or more. Please do your diligence and research and discuss with the trans doctors of Sweden, Finland and review the Cass Report on Tavistock of the UK to understand why they have pulled back on the affirmation only treatment. Those countries have been doing transitions for much longer than the United States and we should learn from them.

Gender non-conforming youth and young adults are very vulnerable. They deserve love and respect. They deserve to explore their nonconformity without risking permanent damage to their body. Families deserve to do what they feel is best for their children and young adults without fear of being called transphobic or being accused of abuse. After all parents know their kids best of all. Doctors need to discuss all options with patients and their families, the pros, the cons, and potential complications and life altering experience. Surgical procedures and cross sex hormones should never be promised to fix the patients feelings. They should never be promised to make their life better. Doctors need to inform patients about all the potential complications and not be driven by money. This is a person's life that you hold in your hands and you should First Do No Harm!

**Sincerely,
Sandi Allison**

Sent with [Proton Mail](#) secure email.

From: [Alfred Cioffi](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Alfred Cioffi](#)
Subject: GENDER TRANSITIONING AND TEENS
Date: Monday, September 19, 2022 4:37:18 PM

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Dear Sirs, I hope this email finds you well and in good health.

My name is Alfred Cioffi. Academically, I have a Doctorate in Bioethics (Gregorian U, Rome) and a Doctorate in Genetics (Purdue U). I am an Associate Professor of Biology and Bioethics at St. Thomas University, Miami Gardens, Florida.

In re. teenagers and gender transitioning, a few points to consider:

First, it is well known that the vast majority of gender questioning self-resolves as children transition through the teen years into adulthood. This is within the range of normal psycho-sexual development.

Second, teens -like any of us- are also influenceable by peer pressures and beliefs; but teens generally more influenceable, due to their immature mind.

Third, many parents do not necessarily possess in-depth knowledge of human psycho-sexual development. Therefore, when one of their children tells them that they want to "transition" -perhaps because his/her best friend at school is transitioning-, parents may feel pressured to allow their child to transition too, but without realizing the full life-long implications of this.

Fourth, it has also been published that the suicide rate of transitioned people is at least 15x higher than those who do not transition. I know that Drs. Mayer and McHugh's data (Johns Hopkins) has been challenged and disputed -it starts getting ideological. Even so, even if it's only twice or three times the background suicide rate, that is sufficient reason for pause. And, we can't just keep blaming societal non-acceptance for the discontent, since there's plenty of acceptance in society today.

Fifth, since a full transition is essentially irreversible (loss of genitalia and therefore fertility), we really should wait at least until adulthood, when the person, on average, will have a more mature mind to make this drastic decision. Repressing puberty artificially on teens is cruel, abusive and ethically unjustifiable. Teens deserve at least the chance to finish their biological sexual development before considering this issue.

In sum, I ask you to please refrain from allowing teens to transition, and from parents consenting to their children's transition. This is an extremely serious decision, and should be strictly adult fare.

Respectfully submitted,

Alfred Cioffi, SThD, PhD

From: [Joseph Schrandt](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex based medical practice
Date: Monday, September 19, 2022 8:32:45 PM

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Dear Doctors,

As a practicing physician, I appreciate the opportunity to testify about these matters. Many young people clearly suffer in their experience of sexuality. And, of course, well-meaning people want to help.

But regardless of how one conceives of gender, that person IS male or female, as defined by genotype, a biological reality.

Therefore, both common sense and scientific data tell us that infusing non-physiological hormones or surgically altering the body is NOT a solution for distress.

No pre-adult could possibly give proper informed consent to permanent sterilization or to the permanent alteration in body image, giving rise to a shocking rate of suicide and depression.

It is no wonder that Europe has put the brakes on all of this.

Please do whatever you can to exercise prudence in limiting such irreversible medical practice on our vulnerable young people.

Thank you so much.

Sincerely yours,

N. Joseph Schrandt, M.D.

Diplomate, American Board of Neurology

From: [DR ANTHONY DARDANO](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Dr Diane Gowski](#); [Dr Felix Rodriguez](#)
Subject: Gender transitioning
Date: Monday, September 19, 2022 9:16:55 PM

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Dear Members of the Board:

I entered the medical profession in 1963 and at age 80 am still practicing as medical director of a large hospital in South Florida and an associate Dean at our local medical school. Prior to this, I have delivered thousands of babies and have first hand experience of the family unit with children. Mothers have never told me they were faced with such issues. It's a known fact that the great majority of these children with these thoughts, normally outgrown them. I must say I am highly disappointed that members of our esteemed profession would even consider such atrocities as any gender transformation procedures on our children.

Moreover, enacting such atrocities, without input from geneticists, endocrinologists, pediatricians, psychiatrists, and most importantly, the parents, makes this tantamount to medical misconduct and child abuse. Yes, that thump you just heard was Hippocrates turning over in his grave.

Therefore, I urge the Board to oppose any such legislation. Thank you in advance for analyzing the issue and voting your conscience. Our noble profession needs to adhere to our basic principle "primum non nocere" (do no harm).

Respectfully submitted,
Anthony N Dardano, MD, FACS, FACOG

From: [Coral Lancaster](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Florida Medical Board decision on affirmative care for gender-questioning youth
Date: Monday, September 19, 2022 6:15:51 PM

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Dear Sir / Madam

I am writing as parent of a teenager who began to question their gender during the 2020 pandemic. My daughter was 15, had no prior history of gender confusion, but had experienced social anxiety and had been bullied at high school. She experienced a traumatic (possibly sexual) incident with her boyfriend and began to identify as transgender soon afterwards. He also began to identify as transgender at the same time along with a close circle of their friends. All of these teenagers, including my daughter, developed mental health issues during the school lockdowns and were struggling in multiple ways. Some parents have been using the new names and pronouns and others have been proceeding more reluctantly, but all of us love our children and want the best for them.

My daughter has since been diagnosed with high-functioning autism and has been gradually improving in her mental health. Her ex-boyfriend has now desisted and returned to identifying as his birth Sex.

I strongly believe that for many teenagers, their gender-exploration is not an organically-arising awareness that requires adults to immediately agree and affirm an identity. It is something that arises from emotional pain and can be peer-influenced.

These young people require compassion and support that affirms them as valuable and loved human beings, but there should be no rush to cement a transgender identity.

My daughter is currently happy dressing in a gender non-conforming way and has received CBT counselling to help her manage her black-and-white thinking patterns. She is 17 now, and I believe it is right to safeguard her from damaging her future fertility and sexual-functioning by taking opposite-sex hormones. This would be irresponsible in my opinion.

Huge numbers of gender-questioning teenagers are autistic - why on earth does anyone think autistic young people ought to be sterilised and have mastectomies? I am looking to my daughter's longer term health and am very happy for her to be dress as she wishes and be gender non-conforming.

I would urge the state of Florida to safeguard young people's bodies and provide ethical and evidence-based medical care.

Yours sincerely
Coral Lancaster

Sent from my iPhone

From: [David Kosnosky](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: regulations about sex based medicine practices
Date: Monday, September 19, 2022 9:37:07 PM

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Dear Sirs: I am a primary care physician who has been in practice for over 40 years. I have seen many changes and advances in the practice of medicine. both good and bad. However, I am shocked by the rapid attempts to normalize gender transition for children and adolescents. As you know the medical and evidence based studies of these methods do not support these claims. It's clear to me that there are multiple factors in society that are leading to the desire for these "treatments." but I appeal to your medical expertise and courage to do the right thing for children and the medical profession.

Sincerely,

David P. Kosnosky,D.O.

From: [Brian Christine](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Gender Dysphoria in youth
Date: Monday, September 19, 2022 5:52:11 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Sirs and Madams,

As a member of the Catholic Medical Association and a practicing Urologic surgeon who specializes in men's health, I fully understand that gender dysphoria is a real condition. Patients with gender dysphoria truly suffer, and they all deserve compassion and effective, evidence based treatment. Some adults with gender dysphoria may elect to alter their bodies with hormones and surgery; as adults, this is their prerogative. The use of hormonal manipulation and surgery that permanently, drastically changes the body is not appropriate, however, in children and minors.

The use of hormones such as testosterone and puberty blocking drugs is increasingly advocated to "affirm" the feelings of gender in minors. Surgery is also advocated to change the outward appearance of these young patients. The undeniable fact is that chemicals and surgery do not, can not, and never will change a child's gender. Their sex chromosomes are fixed. They are male or female, and that is not mutable.

If the use of drugs and body altering surgery cannot truly change a child's sex, can they cure gender dysphoria? The medical literature tells us the answer is "no". An extensive review of research papers from 1946- 2017 has been published in the journal Pediatrics. The authors found that drugs and surgery do not appear to resolve gender dysphoria in children. Studies also show the changes to their bodies brought on by hormonal manipulation and surgery do not meet most of these children's hopes and needs. What medical evidence does show, is that when treated with appropriate, caring counseling 85-90% of minors with gender dysphoria will ultimately resolve these feelings and no longer identify with the opposite sex. Further, it is fact that some of these children who have been "transitioned" are regretful and wish to return to their original body. That they can not is a tragedy. The human brain and emotional self take years to fully develop; to assert that a child can truly know he or she would be more comfortable assuming the appearance of the opposite sex and undergoing permanent, life altering treatment is not supported by evidence and is foolhardy.

Since there is a lack of robust, long term medical research that proves puberty blocking drugs, hormones, and irreversible, so-called gender reassignment surgery actually cure gender dysphoria in minors, they should be avoided. Time, therapeutic counseling, and if the parents wish, pastoral and religious counseling, are the best treatments. Florida's legislature should act to protect these vulnerable patients by passing and advancing to Governor DeSantis legislation preventing the use of puberty blockers, hormones, and body altering surgery in minors with gender dysphoria.

Brian S. Christine, MD

--

Dr. Brian Christine

From: [Anne Nealen](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Your upcoming discussion regarding "youth transition" and "informed Consent process" in Florida
Date: Monday, September 19, 2022 7:31:52 PM

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To Members of the Florida Board of Medicine:

The current trend in the country, and in mainstream medicine has been to push for hormonal "treatment" that alters pubertal development in children who, for whatever reason, are experiencing gender dysphoria. There is furthermore a trend toward pushing for surgical alteration of children who identify themselves as the opposite of their biological sex. This is a very concerning development.

As a pediatrician, my goal has always been to DO NO HARM. There is good evidence that 80-95% of children who experience some gender dysphoria will not have persistence of this problem past adolescence, if they are left alone, or get appropriate counseling for any mental health problems. Children are not capable of understanding the long term effects of puberty blocking hormones or surgery, and therefore cannot give appropriate informed consent to these procedures. The use of these procedures leaves these children with long term side effects, including sterility. Even transgender affirming groups have questioned these treatments, as they are beginning to see the harm done both physically and psychologically to individuals who have undergone these procedures.

An exhaustive review of the evidence was published in the Fall 2016 issue of The New Atlantis. The entire article would give you a much better picture of the state of research in this area at that time. Further studies are ongoing, but it is very important to look very carefully at methods, as many of the studies have been very biased, or have been so small as to be statistically insignificant. Decisions regarding these issues should be based on solid scientific evidence, not emotion. I quote the summary conclusion from part 3 of this study. (pp112-113):

"The scientific evidence summarized suggests we take a skeptical view toward the claim that sex-reassignment procedures provide the hoped for benefits or resolve the underlying issues that contribute to elevated mental health risks among the transgender population. While we work to stop maltreatment and misunderstanding, we should also work to study and understand whatever factors may contribute to the high rates of suicide and other psychological and behavioral health problems among the transgender population, and to think more clearly about the treatment options that are available." There is a further, more lengthy conclusion to the whole article that follows.

Rather than pushing medical therapies fraught with unwanted side effects and dangerous long-term risks (some quite dangerous to long term health), and disfiguring and irreversible surgical procedures, particularly on children and adolescents whose brain maturity precludes them from being able to truly anticipate the long term consequences, it would be much better to address the serious mental health challenges that some of these children face, and to guide them to an

appropriate but much safer solution to their problems.

I sincerely hope that you will choose to do what is truly best for children: to provide compassionate care for all, regardless of sexual orientation, but to refrain from procedures that are harmful from both a physical and psychological standpoint.

Sincerely,

Anne M. Nealen, M.D., F.A.A.P., F.A.C.P.

Board Certified in Pediatrics

From: [Bonita Jude](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: FW: Gender Transition
Date: Monday, September 19, 2022 9:21:14 PM

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Sent from [Mail](#) for Windows

From: [Bonita Jude](#)
Sent: Monday, September 19, 2022 9:19 PM
To: Paul.Vazquez@flhealth.gov; BOM.MeetingMaterais@flhealth.gov
Subject: Gender Transition

September 19, 2022

To whom it may concern,

I have been a Board-certified Pediatrician for over two and a half decades. I have never been so disturbed by a policy involving the pediatrician population as I am now with the "Gender transition affirming treatments".

The great Psychologist, Dr. Erik Erikson's theory on the stages of psychosocial development categorizes the very stage of a child's development in question (12-19 years old), as the transition years. His theory states that the crisis this age group faces is questions about Identity vs Inferiority. Erikson states a favorable outcome is when the adolescent can see himself or herself as a unique and integrated person. An unfavorable outcome is when the adolescent has confusion over who and what one really is.

I am tired of seeing kids make life long, permanent decisions due to their irrational, developing brain, as they mitigate this transient stage of life. It should be a criminal offense if mature, board certified, adult physicians are allowing a "child" to determine their gender. I am not naïve to believe this is not a challenging time for kids, but if parents would step in and reaffirm their children for who they are and covered them in love and NOT have a child make "adult" decision, this crisis would blow over. In addition, couple parental support with intense psychosocial therapy for a year or so and then readdress the issue.

I am embarrassed to be associated with a profession who is allowing mutilation of our future. As scientists, our profession deals with "evidence-based" practices. Where is the data that shows the mental, emotional, and physical stability of a child ten years from now, who had been mutilated, is stable, happy, and contributing to society.

This "Gender transition affirming treatment "is CHILD ABUSE.

I tell the parents, that if a child cannot decide that eating vegetables is good for their health, how can I trust their future gender to an adolescent?.

I know I am not living in the twilight zone.

Dr. Bonita Jude, MD, FAAP,

Sent from [Mail](#) for Windows

From: macaulay.brian
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Gender transitioning is destructive to our children
Date: Monday, September 19, 2022 10:08:33 PM

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As a practicing physician, I am strongly against "gender affirming care". These interventions destroy our children by subjecting them to often irreversible medicines and surgeries at a time when children are vulnerable and easily influenced. There is no science to support it - the studies that are available are extremely poorly designed and do not show any benefit, while causing great harm physically and psychologically. I am completely against these practices and strongly urge you to oppose them.

Brian Macaulay, MD.
Littleton, Colorado
720.854.9711

Sent with [Proton Mail](#) secure email.

From: [Sharon Merritt](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Restrict Gender Affirmative Care for Minors
Date: Monday, September 19, 2022 8:28:46 PM

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To whom it may concern,

It seems as though there are shortcuts taken and children are being rushed into transitions, why?

I agree with the State of Florida's Medical Board's proposed new rule to restrict affirmative care interventions on children.

Are the following questions being asked and/or answered?

- Why are parents being rushed and pressured into making these life changing decisions for their children?
- What are the long term effects from the numerous drugs, is this being studied?
- Are the Children's full range mental-health issues taken into consideration before the decision is made?
- Do the doctors and/or staff feel pressured to adopt an "unquestioning affirmative approach"?
- What are the long term effects from the numerous surgeries associated with this, is this being studied?
- Research?
- Science?
- How much money is being made from this?

These are CHILDREN, made in the image and likeness of God.

Thank you for bringing this to light.

Sharon Merritt.

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From: [Silvio Melo](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: No medical need
Date: Monday, September 19, 2022 8:12:55 PM

You don't often get email from silviomelo@sbcglobal.net. [Learn why this is important](#)

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Dear colleagues,

I am a physician for 21 years and never in my mind I thought I was going to I had to write an email to protect the rights of children.

It is absolutely insane what's going on now. We are physicians, we protect life, we protect innocence. And we do not act on crazy movements.

There is no role for Florida to allow for any children or adolescents to have access to any form of castration. This is not medicine. This is not align of our Hypocratic oath. This is wrong!!

I am absolutely against it and I hope this is now allowed in Florida!

Respectfully

Silvio de Melo, MD FACG AGAF

[Sent from AT&T Yahoo Mail for iPhone](#)

From: [Janette](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Affirming Care
Date: Monday, September 19, 2022 7:57:11 PM

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To Whom It May Concern :

I am very worried about our young people and the so called gender affirming care. As we all know , young people is still growing and developing. Why causing sterilizations , castrations and mutilations; all permanent bodily changes , when it is well known , that about 80% might change their mind ! Our Children need to know the truth about this figures , what are they doing to their bodies, and what impact that might have in their lives later on. Studies show that about half of the patients with gender dysphoria suffer from mental illnesses, and treating the mental illness (depression, adjustment disorders , etc,) may resolve the gender dysphoria too . One out of five patients , regret having surgery after gender reassignment or transition. Science tells us is not right , is not good medicine for our Children , then let's protect them and help them ! Let's have them informed of this staggering figures ; talk to their doctors, their therapists , their families, their ministers , other patients that had gone through same experiences. Let's have them grow , develop ,mature and them with all this information make the best decisions.

Sincerely

Dr. Janette Serrano de Malavet

Sent from my iPhone

From: [Heidi Zimmerman](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Transition Affirming Treatments
Date: Monday, September 19, 2022 5:41:39 PM

Some people who received this message don't often get email from hlzmd58@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

I am writing as a practicing central Florida family physician. I was not aware until this weekend that the board was seeking public comment on proposed legislation for Gender Transition Affirming Treatments. My concern is specifically for treatments (medical/hormonal and especially surgical) for gender reassignment for individuals under the age of 18. These treatments can be permanently life altering and the decision is being made by or for young people under the age of 18. Is it really possible at this young stage in their life that they can truly be making a fully informed consent about a very adult decision? This is not to say I think we should deny help and support to children and teens struggling with their sexual identity. But I do not think this drastic step is necessary before they are fully of age and even then pursued only with careful and thoughtful informed consent.

Thank you,
Heidi L. Zimmerman, MD

From: [Eugenio Erquiaga](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex Based Medicine
Date: Monday, September 19, 2022 8:14:27 PM

You don't often get email from erquiaga1@verizon.net. [Learn why this is important](#)

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Good evening Florida Board of Medicine,

As a physician licensed in Florida for over thirty years I was happy to learn that the Board of Medicine has decided to address medical and surgical treatments for patients with gender dysphoria. Florida's approach to the recently ended Covid-19 pandemic was reassuring to me because it was evidence-based. I saw news reports about how Governor DeSantis and Dr. Ladapo read studies in the peer-reviewed infectious disease and epidemiology journals to help formulate the appropriate response to the pandemic from the state health agencies. Our health leaders were able to correctly identify that our older patients were at highest risk and warranted the most aggressive preventative and therapeutic methods. Similarly, our youngest patients were at the least risk from the virus but at greatest risk from the side effects of the mitigating strategies that kept them socially isolated and uneducated.

A similar evidence-based approach is warranted for our patients with gender dysphoria. Sadly, the conversation about what appropriate care is has been dominated by a very small but very adamant and very vocal group. I have listened to the arguments about so-called "gender affirming care" and find them lacking in scientific evidence. There really aren't any studies that show that medical hormonal therapy or plastic surgery improve the outcomes for patients with gender dysphoria. I recall that in 1979 the Johns Hopkins Hospital stopped performing what was then called sex reassignment procedures because the psychological outcomes and more importantly the suicide rates were the same in groups that received and didn't receive the surgery.

Our newest Supreme Court Justice, Ketanji Brown-Jackson, has been

roundly mocked for stating that she could not define a woman because she was not a biologist. However, the ridicule is misplaced. She correctly realizes that gender is biological. That certainly has been the understanding of biologists, physicians and ordinary people forever. Now we are being told by that small, loud group that we can be whatever gender we feel we are. That just isn't true. Many people who share my science-based view are routinely bullied, mocked and cancelled. That doesn't make my view any less true.

There is nothing that a physician can do to change someone's gender. Stating otherwise is an affront to medical science. The only possible gender-affirming care is to tell a boy that he is a boy and a girl that she is a girl. Anything else is a disservice to patients suffering from gender dysphoria and makes me question whether those physicians should be allowed to practice our medical profession.

We have seen over the past few years a spike in the number of patients who announce that they are of the opposite gender. The prevalence is particularly high in teenage girls. Rather than being offered psychotherapy, most of these patients are directed to irreversible hormone therapy, plastic surgery and sterilization. Parents consent for fear of losing their child to suicide. The stories of regret grow each day. Thousands of children are harmed each year by treatments to which they cannot adequately give informed consent.

As you deliberate what the appropriate policies should be for Florida's physicians I encourage you to study the evidence. I encourage you to pursue a policy of "First, do no harm." I encourage you to allow scientific debate and not buckle to the demands of the loudest in the room. I encourage you to require appropriate psychiatric and psychological treatment to patients suffering from gender dysphoria before allowing irreversible treatments. And finally, I encourage you to follow the science. It's hard to believe that the discovery of DNA is less than seventy years old. And yet, we seem to have understood the reality of our genetically determined gender for far longer.

Eugenio Erquiaga, MD
FL ME58937

From: [Marcia Vandermus](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: youth transition" and the "informed consent process"
Date: Monday, September 19, 2022 4:59:11 PM

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It is a crime to mutilate children this way and also your job in your positions to prevent undue harm to our children in regards to these processes. It shouldn't be about the money and business side of these lucrative and surgical procedures. Please restrict all misguided interventions and protect the youth of your state from unnecessary and lifelong harm.

There is scientific evidence that the human brain doesn't stop growing and decision making isn't mature until age 25.

I'm not sure what is wrong with the parents and adults in this convoluted process, but it's worth further scientific investigation- don't you think?

Mrs. Marcia Vandermus

--

Marcia

From: [Jeanne Holup](#)
To: Paul.vasquez@flhealth.gov; [zzzz Feedback, BOM MeetingMaterials](#)
Subject: comments on "gender-affirming care"
Date: Monday, September 19, 2022 5:50:20 PM

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As a psychiatrist, I am obliged to comment on the practice of "gender-transitioning", especially our youth. This is malpractice, it amounts to child-abuse, is reprehensible and is of satanic origin. Our children deserve protection from such perverse ideas, and not exploitation!

Respectfully,

Jeanne M. Holup

Sent from [Mail](#) for Windows

From: [Mary Nave](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Youth Transition and authentic informed consent
Date: Monday, September 19, 2022 6:47:31 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Sirs ,

The issues regarding youth transition and informed consent are very concerning for medicine. In the medical practice where we struggle to do what is best for children, we can not ask children and their parents to consent to medications and procedures that will cause the young patients irreversible physical and mental harm. A child and a teen are unable to consent to these types of treatment as they do not have the cognitive capacity or experience to know what it truly means. The permanence of the operations and the lifelong hormonal treatment is not something to experiment with in children. Most children who suffer from gender dysphoria will outgrow it by the time they complete puberty. The best treatment is good mental health services that can actually diagnose the root cause of the situation which in some cases may be early schizophrenia or child abuse. The parent relies on the medical personnel to honestly tell them the truth of what is known about the risks and benefits and many are consenting based on the fear their child will commit suicide. They are not told that there is no evidence that these treatments/procedures decreases the risk of suicide. Countries where they have been doing transgender care for much longer than we have, have not seen a decrease in the suicide rate nor a decrease in the mental health issues of this fragile population. These countries have also stopped doing teen and early childhood medical/procedural treatments as they have seen the lack of good outcomes. In view of the scientific information available now, these treatments are a violation of the Hippocratic Oath. It is experimentation on children which mutilates their normally functioning sexual body parts and medicalizes them for life.

Here are some statements that are well footnoted with scientific references from the American College of Pediatricians which support my statements.

<https://acpeds.org/topics/sexuality-issues-of-youth/gender-confusion-and-transgender-identity/deconstructing-transgender-pediatrics>

<https://acpeds.org/position-statements/gender-dysphoria-in-children>

Please do not allow treatment and procedures which harm the minds, bodies and souls of our future citizens and medicalize them for life. Children and their families deserve better than costume transitions which will affect their future ability to live healthy lives and to have children if they desire to be a parent.

Thank you for your time deciding this matter. I know we are all trying to do what is truly best for children.
Sincerely,

Mary M Nave, MD, FACP
Pediatric Medicine, Child Abuse/SART examiner

From: [Jason Phillips](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Transgender affirmative care
Date: Monday, September 19, 2022 7:59:06 PM

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To whom it may concern:

I am writing as a board-certified obstetrician/gynecologist who is opposed to the proposed gender-affirming care. This is especially harmful to the youth, who need our protection as medical professionals from this social phenomenon. The claim that gender affirmation is the only thing that can prevent these teenagers from committing suicide is not backed-up by the best available data.

As a physician, I have treated several patients who identify as transgender and the phenomenon is becoming increasingly common. Spending some time talking with these patients, several things become apparent. Firstly, these people need to be treated with love and respect and gentleness, just like all of us. Perhaps even more so, as these patients frequently struggle with feelings of anxiety and lack of self-worth. Secondly, these people often possess a deep sense of incompleteness – and the sense that their completeness and happiness are just around the corner. If only they could attain the “next thing”, hormonal treatments, surgical management, or wide societal acceptance, then they would finally feel whole.

Contrarily, however, the best available evidence suggests the opposite is true. In a study published in 2011, a cohort of 324 patients who underwent “sex-reassignment surgery” were examined over a 30-year period. They were found to have an increased incidence of inpatient psychiatric treatment, criminal activity, cardiovascular disease, and perhaps most shockingly, a rate of suicide 19.1 times more likely. Notably, the suicidality of these patients did not manifest until about 10 years postoperatively. None of the studies suggesting that surgical management results in improved psychiatric status look at long-term outcomes.

In fact, almost all of the data suggesting cross-sex hormone treatment and surgical gender reassignments actually benefit patients are low-quality and poorly powered. Indeed, the Centers of Medicare and Medicaid, in a document defending its decision to not have a national policy covering these treatments, stated, “the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding...small sample sizes, lack of validated assessment tools, and

considerable lost to follow-up”.

The largest study to date looking at the effects of transgender surgical procedures and cross-sex hormone administration was published in the *American Journal of Psychiatry* in 2019. Based on data obtained from Sweden (the country that seems to have the widest acceptance of, and treatment for, gender dysphoria), there is no improvement in mental health with the administration of cross-sex hormones over time. Furthermore, completed suicides were not even tracked in this study, which is apparently the very reason why we as a society must urgently mutilate and sterilize our children.

I hope everyone in positions of power will carefully and objectively consider these issues, rather than being swayed by political influence or passing trends.

Sincerely,

Jason Phillips, MD FACOG
Department Head, Obstetrics and Gynecology St. Vincent's Clay
President, Jacksonville Catholic Medical Association

From: [maria gray](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Re: Gender Affirming Care in minors
Date: Monday, September 19, 2022 5:23:11 PM

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Hello Mr. Vasquez,

I am writing with respect to the issue of the Florida Board of Medicine's consideration of regulating gender affirming care.

I am a parent of two teenagers. I live in California. I was a lifelong Democrat until my youngest child, now age 17, was swept up by gender ideology at age 13.

I beg the Florida Board of Medicine to regulate this area of what is nothing short of medical experimentation on our youth.

My daughter was by all accounts a happy and typically developing young girl with traditionally feminine interests. She is gifted and highly creative. Up until the 7th grade, she showed absolutely zero signs of wanting to be something other than a girl.

At the point puberty started, we saw a massive change in her demeanor, her academic performance, her manner of dress and hygiene, and much more. She did not want to discuss puberty in any way, shape or form with me. At the start of 8th grade, she fell into a deep depression, began failing most of her classes, stopped showering or caring for her appearance, began wearing baggy clothes. We immediately sought counseling for her and she was put on antidepressants for both anxiety and depression. We still do not understand the source of these issues - they seemingly came out of nowhere.

She then came out as "non binary" to us, which we really didn't understand. As her parents, we love her unconditionally, and told her as much. She asked us to call her by they/them pronouns and did not want to be referred to as our daughter. She asked to bind her breasts. She stated she wanted to have her breasts removed as soon as it was feasible.

I researched "how to support a non binary child" on Google. What I read scared me: article after article told me I must affirm my child's new identity or she would likely commit suicide. On the fifth page of Google search results, I found a site that presented a contrary view: a view that outlined for me that thousands of girls were coming out in this manner, all very similar to my own, with no history of dysphoria. It talked about the dangers of breast binding, puberty blockers, and hormones. It educated me that mastectomy might not be the only surgery my daughter might pursue: if she came out as a "full boy" we could expect to be asked to approve a genital surgery. All of this sounds horribly wrong to me.

Little did I know that by this point, her school and her friends and everyone around her had already been calling her a different name and pronouns for at least a year. It was all hidden from us. I took her for educational psychological testing. She has no ADHD/ADD, no autism,

nothing but a high level of giftedness and a risk for bipolar disorder.

Instead of maturing into a different worldview and embracing her developing body as she moved through puberty, my daughter has become more entrenched by the day with this idea that she was born in the wrong body. She may go away to college next year, and I cry at the thought that as soon as she leaves our home, she will head immediately to Planned Parenthood and do all of the things that we as parents could never in our right minds approve. She is going to jeopardize her health, and she will have no idea how this might permanently impact her future.

We have had extreme difficulties finding therapists who can explore the source of her body hatred, and her anxiety and depression, who don't jump to affirmation or push us to affirm. I haven't taken her to a pediatrician in 3 years because I'm afraid she will talk to the physician privately and ask for these treatments. I have spent the last four years immersed in the science on this. I cannot understand how our country is not just allowing, but encouraging and celebrating the interruption of normal puberty, administration of cross sex hormones, or "affirming" surgeries when so many of these children have either physical or mental health comorbidities or both.

There are no long-term studies on the effects of these treatments on adolescents. We know that 80% of youth desist out of dysphoria or a trans identity IF they are not placed on a medical pathway. So why would we rush them down that very pathway? You can read the stories of detransitioners whose lives and health have been seriously damaged by having been rushed to these treatments with no safeguarding. In the state of Florida, you have a plastic surgeon, Dr. Gallagher, who advertises "yeeting the teets" and glamorizing mastectomies as easy as getting one's nails done. It is so dangerous to be manipulating vulnerable youth in this manner and taking away the opportunities they have as adults to have normal sex lives, bear children, and not be injecting cross-sex hormones into their bodies for the rest of their lives.

If these policies were regulated, fewer devastating mistakes might be made. Fewer lives might be ruined. The FL BOM can't save my daughter, but you can save hundreds just like her. Please, save our children.

Sincerely,
Maria Gray

From: mdepie6302@aol.com
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender transition surgery
Date: Monday, September 19, 2022 4:33:23 PM

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Dear Mr Vazquez

I am a physician and member of the Catholic Medical Association, board certified in internal medicine, pulmonary disease and critical care. I am well versed in evidence based medicine having been an author or coauthor on over 60 papers or poster presentations presented at medical meetings. In that capacity I am writing to comment on the Florida Board of Medicines policy considerations for gender transition therapy for Children.

In short the board should regard this at best as experimental therapy that is potentially dangerous and has almost no medical evidence in its favor.

It is known that the puberty blocking drugs are associated with a number of complications. For example there are changes in bone mineral density that may be associated with increased osteoporosis risk as noted here

[Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones - PubMed \(nih.gov\)](#)

The package insert for these drugs includes risks for psychiatric disturbance, seizures and pseudotumor cerebri. (a disorder in which the intracranial pressure of the cerebrospinal fluid around the brain is increased, and which if untreated can cause blindness.)

There are basically no long term well controlled studies for this off label use of puberty blockers to treat gender dysphoria. Still less is there evidence for cross hormone therapy.

Surgical treatments such as mastectomy, or phalloplasty, penectomy and the rest of it are associated with permanent sterility, loss of sexual function and surgical wound complications.

The evidence such as it is supporting such treatments is mostly produced by transgender activists who have created their own medical journals to publish in. It is rather as if a pharmaceutical company created its own journal to publish its own pivotal trial data. This would obviously reflect unacceptable bias.

At the very least the physicians and activists defending this kind of treatment in children who do not show long term, well controlled data, with hard endpoints have no business proceeding to subjecting children to a therapy they can not themselves consent to. Obviously the consent to the extent their is consent would be through a guardian and it is not clear the guardian would be acting in the child's best interests where they to subject them to therapy with so little scientific support and obvious known risks.

If doctors do proceed with this, the legislature should life the statue of limitations on any negligence claims resulting from injury related to subjecting the kids to this, and any claim related to lack of informed consent should be automatically escalated to a gross negligence claim , because the unless a child and guardian were told this is very poorly studied the advocates of this kind of medical intervention are being dishonest.

Thank you

Michael DePietro MD
Hockessin Delaware

From: [Harolyn Bean](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Please stop medical transition of children
Date: Monday, September 19, 2022 10:56:47 PM

Some people who received this message don't often get email from harolynbean@gmail.com.
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I am a grandparent of a 16 year old girl, who identifies as transgender. She might be a lesbian, but she is not transgender. She has struggled with mental health issues. My family is opposed to the affirmation model and hormonal/surgical interventions for my granddaughter. Historically, teenage females are plagued by social contagion issues including anorexia, bulimia, and cutting. We believe our granddaughter has been caught up in this latest social contagion like many other teens. She has always struggled socially, and gender ideology with its social justice aspect, has proved to be the answer for her to longing to belong and have friends. Nearly 25% of kids in her high school have recently claimed a trans identity.

Research is limited, and no consensus exists within the scientific community about possible causes of gender dysphoria and the most appropriate treatment options. We must secure a balanced treatment of political issues, which must take a child-centered, evidence-based approach, and take care not to express personal beliefs in ways that could exploit vulnerabilities. We should not for example, present childhood gender incongruence as an inherent and immutable phenomenon, as this is a contested idea not an established evidence-based fact.

The number of people who regret transition is unknown. Most who “desist” simply stop treatment and do not report their desistance to their providers. According to the ever-increasing numbers of people involved in online forums and groups of detransitioners, they do not have support from the medical or transgender communities. Many say they did not fully understand the magnitude of side effects, adverse outcomes, and risks involved in their transitions.

The human brain is not considered fully developed until approximately 25 years of age. According to psychological developmental stages of children and teenagers, forming identity is an important process. Erik Erikson’s psychosocial developmental stage of ‘Identity vs Role Confusion’ speaks perfectly to the normalcy of teens questioning their identities. Self-exploration is a normal part of growing up for everyone. The problem with claiming a trans identity is the irreversible damage that can be done with medical and surgical interventions. Children and teenagers are unable to provide true informed consent for such treatment. They are unable to fully understand the lifelong consequences of these decisions. Please consider this and protect children from irreversible damage. When they are adults who can provide true informed consent, they can make these decisions for themselves.

Thank you most sincerely for your time and consideration.
Harolyn Bean

From: mhabib@tampabay.rr.com
To: Vazquez, Paul; zzzz Feedback, BOM MeetingMaterials; "dianetg@aol.com"
Subject: RE: Transgender issue in FL - email deadline tomorrow please help out
Date: Monday, September 19, 2022 5:12:46 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Sir, Madame

I am a retired Pediatrician that continue to practice in the state of Florida as volunteering for the poor. In my long years of practicing Medicine in three different continents! I believe that the issue of Youth transition and the Informed consent process is a very complex sensitive subject to reach a solution for.

Our role as Physician is to do "NO HARM", do our best to focus on the well being not only of our children, but also parents, relatives, friends, society & the world. In order to reach an agreement between those who are not for and those who are for this above issue, we must analyze well the detrimental consequences that will impact the children, & the families of the world.

As we all know well that the maturity of the human brain occur at the age 24 -25 . Why do we want to mislead ourselves blindly by following our children desires & thoughts ? Adults are to be responsible of showing the right path to their children not the opposite. Can a parent give his car key to a twelve years old and tell him go and drive my car to get some groceries? The answer is No of course. The child brain is not mature yet. The car is not a toy. Also! In our legal system, judging the children whether delinquent, thieves, murderers, criminals etc... is quite different than the procedure for adults. Why that? Because they are Children /Youth/Not mature yet .The media effects on the children was very well studied and how it cause harm to our children. Recently a study done about "IGD " Internet Gaming Disorder" associated with anxiety, insomnia, isolation, social dysfunctional behavior, violence and academic failure. Isn't the media? Well all of us see well how the media can be harmful to our children embedding in their pure brain fantasies that are not fruitful or productive or even realistic about the outcome. Unfortunately the media doesn't show the irreversible damage and harm they can trigger with this fashion. The media shows them clearly that everything is okay, everything is good for you, it is the normal, it is okay to do so and so. Is this the right thing to follow ?Is this good for our children? The answer is No. There is no supervision or guidance. There is lack of educating our children about all these ideas early in their life before they get exposed to the wrong unnatural ones.

Some medical studies showed for a fact that the rate of Anxiety, Depression & suicides are at a higher % in those transgenders ? Is that what we want for our families? the answer is No. Children have the right to live their childhood with their normal brain. It's okay for a boy to play with a doll ? or a girl to play with a truck? What's wrong with that? is it harming anyone? Children have the right to explore, they will find their way. It doesn't mean they are suffering ? Children are our future. They are our most precious gifts of Life. Lastly, for their well being we advice them no alcohol until 21 years old, we can do as well and tell them no transition until you mature and your brain is fully developed my child.

Thank you for reading my mail. May God guide you in the " No Harm" Path.

Best Regards,

Marcelle G. Habib, MD

From: dianetg@aol.com

To: "mhabib@tampabay.rr.com", "robert_pelaez@msn.com", "ruizmds@gmail.com"

Cc:

Sent: Monday September 19 2022 1:21:27PM

Subject: Transgender issue in FL - email deadline tomorrow please help out

I would like to request help (a brief email) from each of you, as pediatricians,
regarding **TRANSGENDER ISSUE in FL:**

I. FL BOM is meeting Sept 30 to discuss a new rule about "affirmative care"
(gender-affirming care) and what changes need to be implemented;

specifically, the areas of the transgender issue being focused on are:

- 1- Youth transition
- 2- Informed consent process

***** TOMORROW Tues. Sept. 20 is the deadline to send a brief email
for the FL BOM** to consider your input about regulation of the practice of medicine
to protect children/ FL citizens. You can address one or both of these areas.

***** PLEASE SEND YOUR CONCISE EMAIL TO BOTH OF THESE EMAIL ADDRESSES:**

- * 1- Paul.Vazquez@flhealth.gov
- * 2- BOM.MeetingMaterials@flhealth.gov

II. In-person expert, patient and parent testimony are also needed at FL BOM hearings;
(register at meeting; 3 minutes max speech);

- Sept.30: 8 am to 12 noon in Tallahassee; FL BOM Rules Committee workshop to gather info
to help craft a rule regulating gender care

- Oct 6; 4-6 pm (may end later) in Tampa; FL BOM 's Rules Committee second meeting
- Oct 7; 8 am to 5 pm in Tampa; full FL BOM meeting to discuss and possibly vote on
any rule brought for the from the Rules committee

Thank you in advance for your input !

Appreciate any feedback; please forward to like-minded colleagues who might be also interested to help;
I am very sorry for the last-minute notice!!

Diane Gowski, MD
727-480-7574. if any questions or concerns
dianetg@aol.com
=====

((note; if you would like to send me a bcc copy of your email, for feedback to me to update please do so
)

From: [Florence BeGole](#)
To: paul.vazques@flhealth.gov
Cc: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Parental concern about medicalization of minors
Date: Saturday, September 17, 2022 2:48:40 PM

[You don't often get email from florence.begole@icloud.com. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Good afternoon Mr. Vazquez

I am writing to express my concern as a parent and teacher regarding the medicalization of minors (particularly those with rapid onset of gender dysphoria).

My own teenage daughter , caught up in the social media promoted trans ideology now wants to take testosterone (a class 3 drug) in addition to getting a mastectomy and eventual phalloplasty. The devastating , permanent effects of testosterone are now known from testimony and physical evidence of more and more de-transitioners. We know a youth's brain is not fully developed until the age of 25. Permitting such medicalization of minors is unconscionable. As a parent and teacher, I ask you to protect this generation of children.

Sincerely

Florence BeGole

Comments to the Florida Department of Health and Florida Board of Medicine on the “Affirmative Care Model” and Standards of Care for Youth Gender Transition

Catherine Saxbe, M.D., Diplomate, American Board of Psychiatry & Neurology

The following professional comments are based on medical understanding of the neurological and endocrine development of the human body, the healthy psychosocial development of the adolescent, and the presentations, manifestations, and treatments of psychological distress, including depression and dysphoria. None of the conclusions are informed by personal opinion, a political, moral, social, or religious agenda; but are strictly in the interest of determining the best, evidence-based medical care for youth expressing gender dysphoria or gender incongruence. The recommendations in this statement are the result of an extensive review of relevant published research and over a decade of clinical experience as a child and adolescent psychiatrist and child advocate.

“Gender Dysphoria” is a relatively new diagnostic term in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). In editions prior to 2013, the diagnosis “Gender Identity Disorder” described patients with fantasies of and prolonged insistence on being or becoming the opposite sex, and experiencing emotional distress over the discrepancy between one’s natal sex and one’s desired sex. Gender dysphoria recasts the disorder not as inner psychological conflict but as a de facto difference in “assigned” sex and subjective gender identity. This is also referred to as “gender incongruence”.

The White House, The Department of Justice, and the Department of Health and Human Services have recently promoted the practice of “gender-affirming care” in opposition to “conversion therapy”.

“My Administration must safeguard LGBTQI+ youth from dangerous practices like so-called “conversion therapy” — efforts to suppress or change an individual’s sexual orientation, gender identity, or gender expression — a discredited practice that research indicates can cause significant harm, including higher rates of suicide-related thoughts and behaviors by LGBTQI+ youth.”¹

The above description of conversion therapy is misleading and inaccurate. Conversion therapy has traditionally meant intervention to “treat” homosexual orientation and convert same-sex

¹ Executive Order on Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals, signed by President Biden on June 15, 2022

attraction to opposite-sex attraction. It is indeed harmful, as the above White House Executive Order states. Radical gender identity theory activists and lobbyists who drafted the Executive Order have reclassified standard psychotherapeutic approaches to gender dysphoria with supportive therapy and exploring the origins of the gender-questioning feelings as so-called “conversion therapy”. Patients may present with self-loathing and self-rejection resulting in depression and dysphoria. Gender dysphoria is dissatisfaction with how one’s body is made and develops, a rejection of one’s own physical self and a yearning - often obsession - to become the opposite sex. Since biological sex is coded in our cells, it cannot be changed. What could be more of a *conversion* than giving exogenous hormones to force the body to resemble the opposite sex? Only an approximation to the appearance of the opposite sex can be achieved, through lifelong ingestion of cross-sex hormones, organ removal, and cosmetic surgeries. This extreme medical intervention has direct effects and side effects that must not be undervalued and are often irreversible.

While puberty blockers used to halt early (precocious) puberty have been shown to be reversible, no such studies exist for puberty blockers administered to stop normally timed puberty. . . they may harm bone development, may permanently alter the brain, and that it is not yet known how they affect other vital organs, all of which undergo significant structural changes during uninterrupted puberty.²

“Gender-affirming care” for children and adolescents sounds like a wholly positive term because caregivers (parents, therapists, and doctors) want to affirm the validity of adolescent distress and alleviate it. However, the “affirmation” in this treatment approach is agreement with the patient's belief that incongruent gender identity is the sole source of their dysphoria and that the patient is actually the opposite gender, or even the opposite biological sex, though no treatment can change the X and Y chromosomes present in the body’s cells. The female and male biological sexes are not equivalent to gender identities of feminine and masculine, though this distinction is frequently confounded.

The medical model of so-called gender-affirming care is to start children in puberty at Tanner Stage II (typically from 9 to 12) on “puberty blockers” which chemically interfere with the natural, normal, and healthy development of puberty. The theory is that puberty-blockers (chemical castration of males and chemical menopause for girls) “buy time” or “pause puberty” for these distressed children to figure out which gender they “really” are. However, by blocking the normal development of puberty, the endocrine process which plays the essential and primary role in

² <https://segm.org/fact-checking-gender-affirming-care-and-young-people-HHS>

coming to terms with sex and gender, is prevented. Puberty blockers do not freeze time. Children continue to grow and time moves on, but powerful chemicals have arrested the psychological and biological evolution that their bodies are programmed to begin. After the profound effect of puberty arresting drugs, children who've thwarted their development will very likely not identify as their biological sex nor typical gender because the exogenous hormones they've received have severed that physiologic relationship. Following off-label high dose synthetic hormones, the majority of patients, encouraged by gender-affirming therapists and doctors, begin cross-sex hormones^{3,4} (girls take high doses of testosterone and boys take high doses of estrogen) so that girls grow beards and hairy arms and legs, their voices deepen, their jaw and facial features widen to look more masculine, their vaginal tissue desiccates, and they may become infertile. The changes wrought by high dose hormones on the developing body are mostly permanent.

Suppression of puberty with gonadotropin-releasing hormone agonist analogs (GnRHa) in the pediatric transgender patient can pause the maturation of germ cells, and thus, affect fertility potential. Testosterone therapy in transgender men can suppress ovulation and alter ovarian histology, while estrogen therapy in transgender women can lead to impaired spermatogenesis and testicular atrophy⁵

These patients may next choose to have cosmetic surgeries to amputate breasts and harden the lines of their facial bone structure to appear more masculine. In boys on estrogen, their penis remains childlike, sperm production never starts or stops, and they may grow breast tissue. Cosmetic surgeons add breast implants to natal males and shave their jaw bones and Adam's apple to approach the appearance of the opposite sex so that they can "pass" as their non-biological sex. Some trans-feminine patients may amputate their penises and scrotum, and plastic surgeons may construct a pseudo "vagina" out of tissue taken from the colon. Girls on testosterone may develop (non-functional) micro-penises after puberty blockers and cross-sex hormones cause the clitoris to enlarge. However, since they have not developed these secondary sex characteristics naturally and require lifetime hormones to maintain the appearance but not the function, they are unlikely to experience orgasm ever in their adult lives. Females on cross-hormones are at greater risk for heart disease (double that of men) and bone loss as well as other complications. Males with high estrogen levels are at higher risk for depression, deep vein thrombosis and pulmonary embolism, diabetes, and other complications.

³ Brik T, Vrouenraets LJ, de Vries MC, Hannema SE. Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. *Arch Sex Behav*. 2020;49(7):2611-2618

⁴ de Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis PT. Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study. *The Journal of Sexual Medicine*. 2011;8(8):2276-2283

⁵ Cheng, et al, 2019:<https://pubmed.ncbi.nlm.nih.gov/31380227/>

Pro-“affirmative care” providers cite a statistic that this intervention saves lives by preventing suicide in transgender teens. They quote a suicide risk as high as 41% or more for those with gender dysphoria who do not transition.⁶ This is not evidence-based, has never been shown in a double-blind controlled study, and a careful reading of the statistical analysis of the scant articles that cite this figure reveal the actual risk factor to be much lower. The oft-touted claim that puberty blockers reduce suicide has quite simply not been shown. There is no established, causal relationship. When it comes to gender dysphoric children, there is little evidence that medical transition decreases suicide rates.⁷ There are also conflicting published conclusions about the benefit vs. risk ratio in treating children with puberty blockers and in 2019 the National Health Services in England commissioned a full scale, evidence based review of the current treatment, led by pediatrician Dr. Hilary Cass, and known as the *Cass Review*.

The context for the commissioning of this broader review was the weak evidence base underpinning the current practice of prescribing gonadotropin-releasing hormone analogues to pause puberty in children and young people with gender dysphoria, as well as the uncertainties about the subsequent prescription of cross-sex hormones.⁸

The assertion that such a radical intervention on a healthy child is life-saving is a reflection of misleading but persistent misinformation and is repeated by doctors, medical societies, and politicians, despite lacking evidence-based support. A long-term Swedish study found post-operative transgender people have “considerably higher risks” for suicidal behavior, and a study in the *European Journal of Endocrinology* showed that suicide rates among post-surgical transgender male-to-females were 51% *higher* than the general population.^{9,10}

A prominent study published by the *Journal of the American Psychiatric Association* erroneously claiming that medical transition alleviated suicidality was corrected to clarify that it demonstrated “**no** advantage of surgery” in this regard.¹¹ The false statistical conclusions in that study had been used to manipulate parents into consenting to hormones and surgery for their minor

⁶ Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry* 77 (1): 68-76

⁷ Biggs, M. (2020). Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria. *Archives of Sexual Behavior* (49): 2227–2229.

⁸ Review of gender identity services for children and young people. *BMJ* 2022; 376 March 2022

⁹ Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). ‘Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden’. *PLoS ONE*, 6(2)

¹⁰ Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A. & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology* 164 (4)

¹¹ American Journal of Psychiatry (2020). Correction to Bränström and Pachankis. Published online: 1 August 2020

children under threat that withholding transition would lead their children to commit suicide. This study and others with similar inaccurate conclusions have been the basis for states to dub any withholding of transition aimed treatment - so-called “gender-affirming care”, which includes social transition, to be considered child abuse. The state of Maryland has removed children from parents and legal guardians who do not use a child’s preferred pronouns under the auspices of a hate crime and child abuse.

There is one approach to childhood onset gender dysphoria that has been the standard of care for decades and practiced by clinicians and that is to without medical intervention and provide supportive therapy in a watchful waiting approach.¹² The majority of childhood onset gender dysphoria resolves by adulthood, is not correlated by suicide rates higher than other mood disorders in children, and in most cases results in a same-sex orientation. So, returning to the Executive Order to fight conversion therapy, “gender-affirming care” is thwarting the natural process by which homosexual teens come to terms with themselves as accept themselves for who they really are, without the influence of lifelong cross-sex hormones that lead to sexual dysfunction and infertility. In openly homophobic governments such as Saudi Arabia and Iran, homosexuality is a crime punishable by death, and sex-reassignment treatment with hormones and surgery is considered a cure and subsidized by the state. They are true victims of “conversion therapy”.

Medical gender transition is not quality health care. It does not improve physical health; it deteriorates it. Despite claims to the contrary interventions to approximate the appearance of the opposite sex do not improve mental health, but instead encourage a depressed patient’s belief that the or she was made in the wrong body, and promises an outcome that is impossible. In psychiatry and psychology, the goal of treatment for self-loathing and self-rejection is self-love and self-acceptance, not affirmation of perceived defects requiring risky surgeries, lifelong hormones, and amputation of healthy, especially developing, body parts.

In our society, we have laws that recognize the immaturity and lower accountability of minors. These laws are to protect them and others from harm. For example, driver’s licenses, voting, tattoos, and other elective procedures for underage citizens are limited by law. It is a well-established truth, verifiable by neuroanatomy and behavior, that impulse control and long term planning by adolescents is impaired compared to adults. The pre-frontal cortex commands executive functioning (reasoning, problem solving, comprehension, impulse control, creativity,

¹² D’Angelo, R., Sylulnik, E., Ayad, S., Marchiano, L., Kenny, D.T. & Clarke, P. (2021). One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria. *Arch Sex Behav* 50: 7-16

and perseverance) and does not fully develop until age 25. All of those qualities are essential in giving truly informed consent for a combination of radical medical procedures to impose on a 9 to 12 year old who may have idealized ideas of what it means to be the opposite sex. They can't possibly know nor project what infertility and permanent anatomical changes will mean to their 25, 35, and 65 year old selves.

It is normal, natural, and common for pre-teens and teenagers to have a sense of invincibility, passionate conviction, and high risk tolerance. They are undergoing an important psychological process known as individuation, which is typified by extreme emotions, parental (and to some degree, societal) rebellion, rapidly shifting displays of self-expression from clothing to make-up to hobbies to music and peer groups, and experimentation with their personae, emerging sexual identities, and coming to terms with their developing bodies. To lock in a gender-questioning eleven or twelve year-old child to a concretized "gender identity" defies everything known about child development. Going through discomfort and negative self-regard is part of growing up. Emotional resilience as an adult comes through the destabilizing and re-stabilizing developmental stages of maturation and experience. Authentic selves are not fully formed at Tanner Stage 2. This is a time of significant transition characterized by self-consciousness, anxiety, awkwardness, and emotional lability. One does not need to be a mental health professional to know this. The stages of psychosocial development, from infancy to old age, first described by Erik Erikson in the 1940s and still taught in psychiatry, psychology, social work, and counseling education, defined adolescence from ages 12 to 18 as a time of Identity vs. Role Confusion. It is when adolescents explore a sense of self. It is not when a sense of self is finalized, but when the journey begins in earnest. This social and emotional development is derailed by the use of puberty blockers at the moment when the influence of natal hormones is key. It is typical, normal, and developmentally appropriate for children during this stage to be confused about who they are and who they are becoming, and to cycle through various "identities" in order to mature and discover who they are and want to be. This observable child-to-young-adult process is recognized by various rites of passage and modes of expression in every culture on Earth. It is a global human experience examined by endocrinologists, psychologists, psychiatrists, neurologists, pediatricians, sociologists, anatomists, philosophers, writers, lawmakers, educators, and other chroniclers of development. This is precisely the age when the medico-socio-politico gender-identity concept of "affirmative care" is meant to be implemented. And it is a potential disaster for gender-questioning children biologically and psychologically. During this

phase, social acceptance and social interactions reach a pinnacle of importance, and the parental influence recedes. Social groups determine in large part the self-expression and self-worth of individuals in a peer group. In recent years, as gender identity theory is discussed and promoted among younger audiences via schools and social media, teachers, parents, and mental health providers have observed groups of peers socially transition together to opposite sex pronouns, and seek gender-affirming medical care as a result of peer influence and social relationships.¹³

Stages and phases of adolescent angst often have generational expressions, such as an epidemic of anorexia in the 1980s and 1990s, replaced by a high rate of cutting behaviors in the 2000s and 2010s, and now a widely observed gender dysphoria. Children around the country who still believe in Santa Claus are being transitioned socially by parents who view atypical gender behavior (girls who refuse to wear dresses) as confirmation of a mismatch in gender identity and biological sex. This social trend is a major public health phenomenon and needs serious scholarly research to understand what has been a several thousand percent increase in youth presenting with gender dysphoria, compared to fifteen or twenty years ago.

Conclusion

I strongly urge parents, professionals, and the state of Florida to reject the theory of this “affirmative-care model”, to respect and allow the normal physical, psychological, and neurological development of adolescence, and to treat dysphoria and depression with compassionate, supportive therapy, and/or appropriate medications that do not alter one’s intrinsic physiology and anatomy. When troubled teens reach the age of legal maturity, or better, neurological maturity at age 25, they may decide for themselves what medical interventions they would like to pursue if they have persistent gender dysphoria - many will not - and their adult selves will be in better place intellectually and emotionally to give truly informed consent.

¹³ Littman, L. Rapid Onset of Gender Dysphoria in Adolescents and Young Adults: a Descriptive Study (2017) *Journal of Adolescent Health*. Volume 60, Issue 2, Supplement 1, S95-S96

From: [Erin Friday](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comment to the Florida Medical Board - MINORS SHOULD NOT RECEIVE GENDER TREATMENTS
Date: Friday, September 16, 2022 5:25:34 PM
Attachments: [Florida Medical Board.pdf](#)

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Dr. Vazquez and others:

Please see my comments related to transgender interventions on minors.

I am a parent of a child who had thought she was trans, but changed her mind.

Respectfully,

Erin Friday, Esq.
Co-Lead Our Duty

C. Erin Friday, Esq.
California

September 16, 2022

Florida Board of Medicine

I am an attorney in California, a life-long Democrat who voted for same-sex marriage and a mother of two. I am the parent of daughter who at age 13 was convinced that she was a trans boy. She did not come by this belief organically. She was indoctrinated by an older trans-identifying girl and people she met online. She was influenced by TikTok, Youtube, Instagram and Twitter. She came to her identity after spending hours online during the COVID lockdown. She was sent porn by groomers — homemade porn by her minor groomer friend, as well as Hentai — anime porn with gender bending themes, incest and sadomasochism. She listened to erotica read aloud on Youtube. She was taught how to dissociate from her body and was encouraged to sell provocative pictures to a sugar daddy online, being told that it's really not her body that she is showing because she is actually a boy.

I watched as close to 50% of her girl scout troop -7/16— came out as trans or non-binary.

As soon as she announced her trans identity, her mental health plummeted. She barely got out of bed. Brushing her teeth was a feat. She copied her older trans-identified friend and limited her calorie intake. She imitated this girl and others online — cutting her hair, dying it different colors, donning binders, piercing her nose, decorating her room in a goth motif. She started failing her classes at school. She was diagnosed with severe depression and anxiety. Her online friends instructed her to distance herself from me — to hate me. They told her to call me by my first name, to state that I was just her birth mom and that I am a bigot since I wouldn't accept her trans-identity. She was coached on how to emancipate and run away to an LGBTQ shelter. At their instruction, she was told to kick me head in.

Over and over, the media presents desperate trans-identifying children, abandoned by their families, but the hundreds of parents I know — parents like me — don't reject their gender questioning children. They are coached to reject us. This is a cult-like method- remove those who love and care from the person.

My daughter's first therapist offered a single option, immediately affirming her trans identity, insisting the we use her desired male name and pronouns, and treat her as a boy. The therapist warned us that our daughter had a 41% chance of committing suicide if we did not forget our little girl, and celebrate our new son. The 41% that therapist quoted was lifted from a headline. The study it came from stated that this was an extreme overestimate, but this

therapist had never bothered to read the study. Recent studies show the number to be magnitudes lower, and similar to rates for the comorbidities many trans-identifying children have. We went through a number of other therapists all who affirmed or would not take my daughter on as client because of “conversion therapy” laws.

As I watched my daughter change from a loving child to an unrecognizable kid — vicious, angry and sullen— my gut told me to swim upstream, ignore all of the medical providers. I quit my law practice and read everything that I could on this new crop of teenagers that suddenly announce a trans-identity. Lisa Littman is spot on with her description of rapid onset of gender dysphoria.

I pulled my daughter from the public school, that without parent input, changed her name and sent CPS to my home when I complained. I took away her phone and all social media. I fired the therapist. After rejecting many other mental health providers who would also only affirm and had no interest in my daughter’s addiction to porn or her depression and anxiety, I finally found one willing to explore the causality of her trans identity. I worked tirelessly to show her how amazing her natural body is, how periods are a part of life and discomforts are part of the human condition. I showered her with love and compassion and took all of her daily vitriol, enduring her insults hours on end.

I am happy to say that after about 2 years of love and support, my daughter is now comfortable in her body. She joined the track team, wore a ballroom gown at her uncle’s wedding and spent the summer in a bikini. Had I followed the myopic and unscientific affirmation model, my little girl, would have had her breasts removed and her body pumped with testosterone. This is the affirmative model.

As a lead of a parent of a Rapid On set of Gender Dysphoric Kids support group, I know that my story is not unique because I have heard now 100s like mine. When new parents onboard — which they do almost every week — I can predict their stories whether they have a son or a daughter. The patterns are clear — these ROGD kids are into anime and cosplay. They spend too much time on social media. Many have internalized homophobia. They are socially awkward, intellectually advanced but emotionally immature, on the spectrum, have eating disorders, AND all of them have comorbid mental health issues that are not alleviated by gender affirming care. Forcing the affirmation model as the only treatment for gender dysphoria or incongruence will harm millions of children and youth in our country, leading them toward a lifetime of medications and surgery — treatments with no evidence base to support their safety or efficacy. Affirmation is not life-saving; it is life destroying.

The parents of desisted kids know that once the companion mental health issue resolves, so does the gender dysphoria. Dysphoria is the manifestation of the mental issue, similar to anorexia. People who overeat and look to surgery for the quick fix, still need to resolve what the root cause of their over-indulgence in food.

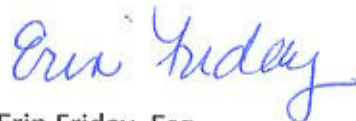
I no longer take my daughter to a pediatrician for the school sports health forms. You see, our pediatrician who knew her since she was born, changed her name to be male without my permission – just following orders - was her excuse. I will never recover from my disdain towards the medical community for failing my daughter and not only abandoning my family, but pushing her towards a delusion.

We, parents, in this space can clearly see the social contagion, the marketing to our kids, and the indoctrination of the schools. Sex-ed curriculum hits the kids 3 times with a the false statements that we have a gender-essence – that one can have a brain of a male and body of female. These kids “acquire” gender dysphoria, they do not have it. We are sterilizing a generation of children.

In closing, I help detransitioners and other parents caught in the web. I know how the gender ideology is ripping apart families and leaving regret in its wake. I have read every study on this issue – likely 3 times over – the science does not support pumping bodies with cross-sex hormones. I have yet to meet a well-adjusted “trans” person, I live in San Francisco. More studies aren’t needed, they are there. Surgeries do not alleviate body dysphoria. Age is the greatest predictor of tubal ligation regret. (40% of women under the age of 24 will regret tubal ligation.) Puberty blockers harmed a number of young girls who used them for precocious puberty. 19% suicide rate POST-surgery and transition. Mental health issues are not cured by plastic surgeries. None of this is new. What is new, is that we have changed biological reality and we have decided that somehow maturation related to gender identity (which is fluid per the ideologues) is the exception to the rule that most humans mature at age 25, with no basis in science. Actuaries understand maturation – this is why kids cannot rent a car until 25, or rent a vacation home.

Had I sent my daughter to a gender clinic, she would be preparing for a life as a medical patient even if she detransitioned. No one is born in the wrong body.

Respectfully,



Erin Friday, Esq.
Co-Lead of Our Duty
Norcal parent lead of Parents of Rapid
Onset Gender Dysphoric Kids
Mother to two Teenagers

From: [Mayssa Toppino](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Vazquez, Paul](#)
Subject: gender medicine for minors. PLEASE SAY NO
Date: Friday, September 16, 2022 2:33:27 PM

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Hello, I am writing today as a parent as well as a physician. I have two teenage children, one is currently identifying as transgender. I can tell you my child is not anxious or depressed (her psychiatrist agrees), she is certainly not suicidal. I doubt that many of the growing numbers of similar children are. They are just kids. They copy each other (and internet peers), they look for attention, they get confused, and they definitely make mistakes.

I have been in leadership positions and I know how difficult it is to say no when colleagues want to expand privileges or services. I know how there is frequently more dissenting voices for what is wrong for our patients, than for what is really right; remember our creed is first "Do no harm"

The fact remains that any minor person simply does not understand enough about life, interpersonal relationships, or their future to make medical decisions that will affect the rest of their lives. Today's kids may seem more savvy and grown up because they are exposed to a lot, but seeing things and internalizing the meaning to our lives and future are very different. We all understand teenage invincibility, car accidents, fashion fads and certain phases. Why don't we see how hormones and surgery are setting most of these kids up for potential disaster?

The U.K., Sweden and Norway have all closed gender clinics and have stopped offering gender medicine to minors.

We seem to have no trouble recognizing that Tourette's and Dissociative Identity disorder are being spread via social media, with a similar 2000-4000% increase in diagnosis rate. Yet no one is willing to say that social media has anything to do with the burgeoning number of "transgender youths".

There is also a growing epidemic of detransitioners. These people are truly depressed and suffering. And they have no voice, they receive vitriol and hate. Let's not add to their numbers. They all say that they felt happy **while pursuing** transition, which is expected when one has goals to set, work toward and attain; but that once they got there, they found it did not actually solve any of their problems and in fact created new ones.

The best data available actually shows the highest suicide rates among transgender people at 8-10 year POST transition. If we wait that long our problems will truly be epidemic and epic.

The most reliable data we have say that about 80% of kids with gender dysphoria will desist before adulthood.

Please, let us not pathologize normal variation of gender expression into something unacceptable that has to be changed through life long treatment. We are telling future gay adults and tomboys and not so masculine boys that they are not ok the way they are. This will lead to an actual psychological crisis. How many of us nerdy doctors would have been led down the same path when we were kids?? Where would we be now?

An argument used for early transition is better physical outcomes down the road. However, most actual transgender ADULTS do not feel that waiting has impacted their results. Further, early treatment does not allow sufficient development of genitalia to provide tissue for good outcomes. As far as secondary sex characteristics hormone manipulation will make changes no matter when

they are started.

Physicians should be the voice of reason in society, not contributors to and creator of psycho-social pathology. We can support our youth with love and guidance and encouragement. We can lay out future potential options. Many parents who are advocating for transition for their children have been frightened into believing there is only one answer, they are frightened and feel that supporting their child means going along with anything. Early treatment may be beneficial for a very small number of individuals but the vast majority of kids presenting as transgender today will be hurt by it. Parents consult the internet and it is very hard to find more than one answer on the internet. Even I initially fell for the idea that my child might need hormones and feared for my child's well being. I was distraught due to cognitive dissonance; it did not feel like the right thing but I was told it was the right thing. After many lengthy discussions with my child and many hours of research I have a far better understanding of what is actually best for my child; even when she does not. But this is a lot of parenting in general is about, guiding kids to adulthood when they will be ready to make decisions for themselves.

My personal phone is 352-267-3770. I would be happy to answer any questions. Thank you for your time and attention to this matter most critical to our youth and their futures.

Dr. Mayssa Aziz Toppino, M.D., P.A., F.A.C.S

Dr. Mayssa Aziz Toppino

1804 Oakley Seaver Dr., Suite B

Clermont, FL 34711

Office: 352.243.8704

TOPPINO EYE CARE LOGO



From: [Eileen Lovenstein](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Transgender Ideology
Date: Friday, September 16, 2022 7:17:28 PM

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I am an Aunt in Florida, a life-long Democrat. My nephew at age 15 was convinced that he was a transgirl. He did not come by this belief organically. He was a rough and tumble boy. He was socially awkward. He was lost and started spending hours online and watching anime. He knew none of the girls in elementary school and in middle school he wondered how he would ever date girls because he had nothing in common with them. He also decided he was trans with another boy from Boy Scouts. After he told us this we started seeing it everywhere.

As soon as he announced his trans identity, his mental health plummeted. He barely got out of bed. He lost 30 pounds. He started failing his classes at school. He was diagnosed with severe depression and anxiety. His online friends instructed him that his parents are abusive. His teacher in school also affirmed this belief and actively tried to help him move out of our safe home into a LGBT center.

My nephew is now 18 and moved out of their house while they were at work and they have no idea where he is. Over and over, the media presents desperate trans-identifying children, abandoned by their families, but the hundreds of parents I know — children like my nephew's parents — don't reject their gender questioning children. They reject them.

My Nephew's first therapist offered a single option, immediately affirming his trans identity, insisting that his parents use his desired female name and pronouns. The therapist warned them that their son had a 41% chance of committing suicide if they did not celebrate their new daughter. The 41% that the therapist quoted was lifted from a headline. The study it came from stated that this was an extreme overestimate, but this therapist had never bothered to read the study. Recent studies show the number to be magnitudes lower, and similar to rates for the comorbidities many trans-identifying children have. The suicide statistic is higher after transitioning.

As I watched their son change from a loving child to an unrecognizable kid — vicious, angry and sullen— my gut told me that the therapist was wrong. I read everything that I could on this new crop of teenagers that suddenly announce a trans-identity. Lisa Littman is spot on with her description of rapid onset of gender dysphoria.

I know that my story is not unique because I have heard 100s of stories like theirs. The patterns are clear — these ROGD kids are into anime and cosplay. They spend too much time on social media. Many have internalized homophobia. They are socially awkward, intellectually advanced but emotionally immature, on the spectrum, have eating disorders, AND all of them have comorbid mental health issues that are not alleviated by gender affirming care. Forcing

the affirmation model as the only treatment for gender dysphoria or incongruence will harm millions of children and youth in our country, leading them toward a lifetime of medications and surgery — treatments with no evidence base to support their safety or efficacy. Affirmation is not life saving - it is life destroying.

Eileen Lovenstein
Age 65

Sent from my iPhone

From: [Chan Kulatunga-Moruzi](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Florida Board on Transgender care for youth
Date: Friday, September 16, 2022 8:59:28 PM

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Paul A. Vazquez, J.D., Executive Director

Florida Board of Medicine

I am writing to ask that you carefully consider the [exponential rise](#) of gender dysphoria and trans identification in young people, particularly teen girls beginning in 2015. As an academic, I have spent the last 18 months studying this phenomenon, and although there is much left to be answered, I concur with health policy analysts in [Finland](#), [Sweden](#), [UK](#) and [France](#) as well as prominent concerned figures of [WPATH](#) & [USPATH](#) that the affirmation model of care currently in place is ushering many young people to seek irreversible medical treatment for what may be transitory distress. As the [Cass Report](#) highlights, there are many etiological pathways to and out of gender dysphoria. Gender dysphoria is not prima facie evidence of being transgender as demonstrated by the growing [narratives](#) of those who have [detransitioned](#); trauma, internalized misogyny and homophobia, peer/social contagion, and being on the autism spectrum, for example, can lead to dysphoria. Further several studies have shown that sexuality may be related to the experience of [gender dysphoria, as 60-90%](#) of those with childhood gender dysphoria align with their biological sex and grow up to be LGB. It is imprudent and unethical to treat these youth with irreversible treatments without letting them fully understand their sexuality.

We need to [uncouple LGB from T in order to understand](#) why affirmation and conversion therapy bans may be an [impediment to sound psychological support](#) for gender dysphoria. We need discussion of the ethics around [informed consent](#) for medical treatment that is based on poor quality evidence. We need legislation that support parents who love and want the best for their children. The current state of affirmation medicine triangulates families and leaves young people particularly vulnerable.

I support the practice of Dialectical Behavioural Therapy and open-ended psychotherapy for youth with gender dysphoria. I support the more traditional “watchful waiting” approach that takes into account what we know about gender dysphoria and child and adolescent development. I support a family centered approach where the rights of parents, who know their children, and long-term well-being are centred. We do not know enough about the potential risks and benefits of hormonal and surgical treatments. Considering that our brains do not fully mature until the mid 20’s, and it is impossible for an adolescent to fully

understand the risk to future fertility and sexual function. Given that these treatments are poorly researched, these irreversible treatments should not be available to those under the age of 25.

I implore you to be prudent in your decisions.

Best regards,

C. K. Moruzi, Msc., PhD.

Chan Kulatunga-Moruzi, M.Sc, Ph.D



September 16, 2022

To: Paul A. Vazquez, J.D. Executive Director Florida Board of Medicine Paul.Vazquez

I am a child advocate parent member of Cardinal Support Network of Ohio. We are a volunteer network of families of gender confused children and young adults who are suffering. We love our kids. We support any protections put in place that would align with science and evidence-based care of children who suffer from gender dysphoria. Ohio also needs to protect minors from the experimental practices of the gender clinics. We hope that this Florida resolution will encourage the Ohio Medical board to investigate the medical harms happening in our own clinics and separate themselves from WPATH members associating with this organization that has been radicalized by activists, creating a billion dollar industry and state sponsored child abuse.

1. There is absolutely no scientific evidence that you can be born in the wrong body and the burden of proof sits on the shoulders of every gender clinic director the hospitals that employ them, not the parents.
2. State medical boards should protect minors from unnecessary interventions that have become popular and mainstream, and as we witness a growing media induced social contagion of teenage girls with low self-esteem desiring bilateral mastectomies marketed as top surgery by clinics and public hospitals.
3. The majority of these children resolve their issues and accept their bodies after natural puberty is complete and do not pursue transition as adults. Many of them would grow up to be gay, lesbian or bisexual adults.
4. These interventions on minors have NOT met the lowest GRADE of evidence common in every other area of medicine for minors. Finland, Sweden, France and other countries have stopped transitioning children.
5. Detransitioners, those that regret these decisions are telling their stories and we are concerned for our own children's futures. We need to listen and learn from detransitioners and protect them.
6. There is a drastic imbalance between the benefits and harms of these procedures. The recommendations of gender clinics lack any long-term study and rely on adult biased surveys when treating children.
7. We do know that the majority of youth who are given supportive non-medical resources resolve their issues with gender identity, even some gender clinics state this on their websites for years prior to the drastic intervention changes taking place.
8. There is no way to know who will benefit from transition and who will be harmed. Parents who want watchful waiting are looked down upon by clinics as unaccepting and even transphobic.
9. The state medical board should stop the grooming of our children into believing anyone can be born in the wrong body. We have human sexed bodies, defined in every cell of our body as male or female. Removing reproductive organs does not change this reality. Neutering a male child does not make him female. We believe we are victims of medical malpractice. Of the 580 parents who have completed our survey:
 - A. 80% of their children are female, mostly between the ages of 12-21 (average = 14)
 - B. 67% had one or more friends come out at the same time (average = 3)
 - C. 55% had a formal mental health diagnosis prior to "coming out" as transgender (most common diagnoses were anxiety, (74%), depression (65%), ADHD (30%) and ASD (16%))
 - D. 70% reported their child had experienced a major stressful event prior to onset of GD (e.g. death or divorce of parents, suicide of friend or sibling, sexual or physical trauma, or received serious medical diagnosis)
 - E. Parents overwhelmingly reported that social transition had a negative effect on their child's socialization, emotional wellbeing and family relationships.

10. These clinic directors have stated without evidence, that unless parents go along with these unnecessary interventions, our kids will kill themselves. Many parents go along against their better judgment and are coerced into social and medical interventions. It's not their fault.
11. Parents are concerned about medical malpractice with regards to misdiagnosis and surgical errors resulting in the creation of lifelong medical patients. Our children have normal endocrine systems that are being destroyed by wrong sex hormones.
12. Allowing children as young as 4 to self-diagnose as transgender and accepting delusion as true by any adult is just one element of malpractice. Hospitals can be held liable for injuries caused by doctors. In order to be accredited, every hospital has to have rules in place that protect the safety of patients. Evidence based care has been replaced by activist-based care and these clinics partner with activist groups (HRC, GLSEN, PFLAG, Living With Change and Planned Parenthood). These groups promote misinformation and profit from the gender industry. In Ohio as an example there are 7 gender wings in these Children's hospitals.
13. It is important to note that the new WPATH guidelines include doing eunuch surgeries on minors and believe this is an identity that needs to be supported with surgeries. WPATH has been dropped by Finland as it has been radicalized by activists.

Nationwide's Director's Statements, 2021 Pride Podcast , Dr. Liebowitz, Thrive Director

WPATH Adolescent Chapter Lead of the 8th Addition standards of Care is your typical, radicalized gender clinic director. He assisted in writing the new WPATH guidelines that include surgeries for eunuch identities. He has treated over 2,000 patients. **These are some of the many troubling statements he believes in.**

"We have to go on what the young person bases their experience on... and that (it) is actually a good thing for everyone, which eliminates gender boxes and which eliminates just 2 gender boxes and it allows young people to be authentic no matter how they express themselves. It's important to affirm without questioning it is a phase. It's okay to validate without.

Curricula should include gender identity and sexual orientation. I know there is curricula that schools can turn to such as GLSEN, HRC are developmentally appropriate and it benefits all youth and all families.

Referring to natural puberty calling it "irreversible puberty". Nationwide Director states: **"As a child gets older for young adolescents as their body starts to go through irreversible puberty if you think about it by definition for a transgender person going through the puberty that is not associated with their gender identity can be pretty devastating."**

And **(natural puberty) that leads to really irreversible, devastating outcomes** for the rest of their lives that can be very challenging to undo should a transgender person go through their first puberty, and go through a second puberty, parents often tell me how difficult one puberty is let alone 2, therefore, we ascribe to using puberty blockers which is a medicine that halts puberty. It is largely reversible.

We are suppressing puberty to buy time for that young person to be older and become more mature and better able to be in a place to make decisions about more irreversible treatments which include the gender affirming hormone treatments such as testosterone or estrogen.

What gender affirming hormones would do for a more mature adolescent is they would produce the affects that would create a puberty of the gender associated with their desired assigned sex at birth. So, for example, in a transgender boy, it would deepen their voice, it would create a perhaps facial hair in the future, it would perhaps change their muscle mass in a way that is more consistent with the secondary characteristics of boys or men.

And for a transgender girl, **estrogen would create a development of breasts, it would create a softening of their skin, redistribute fat in a way that is more typical of women**

The decisions on surgery are largely based on emotional maturity of the young person, how long that they have been experiencing their own gender dysphoria, how impaired their life is as a result of not obtaining surgery

(NOTE FAILURE RATES OF THESE SURGERIES ON THE REFERENCE PAGE)

(Surgery) is more likely to be recommended for a person who is still a minor would be a top surgery or a chest reconstruction, masculinization surgery, for a transgender boy simply because for a boy who has been living as a boy (57:43), and on testosterone for years at this point and their entire life identity is being perceived as the gender they identify in." The WPATH guidelines and are currently revising since the evidence and research have been evolving since the last guidelines were issued in 2011.

Because they are receiving gender affirming medical care, them to be expected to use a bathroom that a cisgender kid needs to accept it and include cisgender students as well.

The more we talk the more we normalize and the more we can act and support all kids.

It is important for a pediatrician to **meet with them alone** and ask them in an open-ended way that does not presume that the faith-based organization is harmful but what religion and spiritually means to them and how the institution they are going to makes them feel as far as comfort around gender roles, gender identity and sexual orientation.

We are seeing higher rates of suicide in this group, it's not inherent in this group. There is research on anxiety, depression and being transgender that is contingent on family support.

Family acceptance and support is helpful in reducing negative outcomes in transgender youth.

We should be screening for sexual orientation, gender identity and gender expression alongside mental health challenges in everyone and not make assumptions. This should be introduced as young as a child is able to speak a language by not enforcing that a child has to be a certain way.

We start with less irreversible going up to more going up to irreversible depending on emotional maturity and age. **We follow WPATH Standards**

Dr. Liebowitz stated seeing 1,000 patients in 2020 alone.

Cincinnati Children's Transgender Clinic Summary

Since 2013, Cincinnati's Trans Clinic has been aggressively transitioning over 2,000 children referencing an adult transgender survey as proof that if you do not actively transition your child, that child will be homeless or commit suicide later in life. Cincinnati Children's transgender clinic, court custody against parents, **the director stated that 100% of the patients were candidates for medical interventions for gender affirmation.**

It is funded by a transgender lobby, Living with Change (LWC). The founders are publicly transitioning their own biological son presenting a conflict of interest, donating \$2 million from sales of sex toys (Pure Romance), sells breast binders to young girls and legal name changes for minors as "gender affirmation".

Dr. Conard stated "it's not my job to worry about these kids' adult lives and the long-term effects, I am just trying to get them through puberty alive" Parents in CSN have reported that the gender clinic staff typically ask: "Would you rather have a dead son or an alive daughter?" when they question these drugs, such as testosterone for females, a Class A controlled substance with many risks and not approved by the FDA for this purpose.

Admits testosterone is given to biological females and for puberty suppression: Leuprolide acetate is an injection given monthly or quarterly. Histrelin is an implant that lasts 12 to 18 months. The choice, Conard said, depends on how, or if, insurance will pay for the treatment. **In puberty suppression, the child does not develop functioning sperm or eggs. If the child wants to have biological children, then the child must progress through a normal puberty to get mature sperm or eggs for preservation and then go on the suppressing hormones. When an older transgender adolescent has already gone through puberty, the clinic offers the possibility of sperm or egg preservation before starting the gender transition with hormones. "But that's hard for a 15- or 16-year-old to think about," Conard said.**



r/detrans

Welcome all detransitioners/desisters and self-questioners. Please self-identify your detrans status with user flair, or your content will be removed (medical or legal professionals, please message mods for an exception). Post anything about gender detransition. Ask questions, share memes, inspire, vent, wonder, etc. Abide by our rules (listed in the right rail below on If you are in urgent need of an area of detrans support please visit and join our discord server: <https://discord.gg/VE5SNCjKnx>

29.4k
Members

125
Online

The Detrans Reddit page has 29.5 Members, transition as minors.

reacnyrium3 · 6 days ago 🇺🇸

detrans female

Your story, and that of my own and others if why I fight so hard against the toxic positivity of this movement by the lgbt. We need mental healthcare, not hormone shots. I wish you all the best

detrans female

This is a great perspective to have! I really appreciate it. You're right that it's proof we thought we were doing what was best for us. When I started transitioning, pretty much no one talked about regret or detransition, and a lot of people even insisted it didn't happen at all. Instead I only heard stories of people who went decades suppressing their dysphoria just to eventually transition anyway and wishing they had done it sooner, so I understandably thought it would last forever. Thank you so much <3



2



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I am so sorry for how you are feeling right now. I know that things like your voice are difficult to accept (I still struggle with accepting mine at times..) and even though you may not be able to sing at the pitch you'd like it shouldn't stop you from singing in general. I'm not good about following through with it usually but there is also voice training for at least speaking voice... I understand how you feel about not getting to experience being a young woman I definitely feel the same on that as I came out as trans at 13, started T at 14 and had a mastectomy at 16 and a legal name change.. lived that way until around age 21 when I realized the mistake of it all. It is hard and it's hard not to want to relive those times without the alterations we had made to our bodies and life to fit what we wanted at the time. All we can do is try to support each other here and keep moving forward. Buy and wear the things that make you feel pretty, if you're worried about your hair right now then maybe some wigs would be an option for you or some extensions or something.. I would speak with someone who does hair who might be able to help on that. May even be some products that would help with the hairline.

I wish the best for you. You are not alone.

References to above testimony available upon request:

FAILURE RATES FOR SURGERIES:

https://www.theepochtimes.com/when-gender-surgery-goes-wrong_4452260.html?est=UB4z5am1W1xD4x2M72igEQnyGwwJOGi7wSiXv8CW1Rzk44MQaykumGexzWX18w%3D%3D
www.CardinalSupportNetwork.com
<https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/>
www.Pediacastcme.org
<https://www.eurekalert.org/news-releases/474759>
<https://4thwavenow.com/2018/02/17/cincinnati-trans-teen-custody-decision-more-than-meets-the-eye/>
<https://littmanresearch.com/publications>
<https://segm.org/studies>
https://segm.org/trans_youth_suicide_study
https://segm.org/detransition_case_study_questions_affirmative_care_model
<https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey>
<https://bmcp psychiatry.biomedcentral.com/articles/10.1186/s12888-021-03056-x>
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC428525/>
<https://thepostmillennial.com/watch-doctor-suggests-children-who-regret-gender-affirming-surgery->

From: [Bill Mahon](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); [Vazquez, Paul](#)
Cc: [Bill Mahon](#)
Subject: Our story about the harm caused by gender medical treatments and the harm done to minors
Date: Friday, September 16, 2022 1:55:46 PM

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September 15, 2022

Dear Florida Board of Medicine,

My daughter has been seriously harmed by the gender medical community in California where we live, and she has been encouraged to pursue irreversible medical treatments including testosterone therapy and the removal of her female organs/hysterectomy.

Our story is similar to many other families, but it has been devastating for our child and our entire family. Our daughter told us she was confused about her gender identity during the first summer of the pandemic, in August of 2020. We reached out to parents and therapists in our community and everyone, following the Gender Affirming Care initiative, told us how they affirmed their daughters and took them to support groups and the Gender Center.

Our daughter had already been struggling for a long time with serious depression, anxiety and she is autistic. She became so obsessed with the idea of removing her female body parts that she resorted to hitting herself in the stomach with full force, pulling her hair out and breaking things. She told us if we wouldn't get her a hysterectomy she would give herself one, realizing this meant she would cut herself open and she would die. We tried to find her help from therapists, but she was so agitated and hysterical that she really couldn't get benefit from talk therapy. We went to a doctor to get help with stopping her period and the doctor told her that if we would consent, she could get a hysterectomy. My daughter cannot forget these words and she plays them over and over in her head. She is not rational and cannot be soothed or comforted.

We had to call 911 and take our daughter to the psychiatric emergency room twice over the past year after she fell apart and couldn't recover from her obsessive

thoughts about removing her female body parts. She was put on a 5150 hold the second time because she was a threat to herself and others. She also had to go to a psychiatric hospital for a 6 week stay to stabilize this summer.

I am asking you, Florida Board of Medicine to please consider changing the age of consent for gender medical treatments to at least the age of 25. Children should not be told by doctors that they can surgically remove healthy body parts as a way to feel better about themselves.

Thank you,

William Mahon

From: [Karen Mahon](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); [Vazquez, Paul](#)
Subject: My daughter was harmed by Gender Affirming Care and Gender Medicine
Date: Friday, September 16, 2022 1:15:54 PM

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September 15, 2022

Dear Florida Board of Medicine,

I am the mom of a child in Northern, California who has been harmed by the Gender Affirming Care model and who has been encouraged to pursue harmful medical interventions including Testosterone therapy and a Radical Hysterectomy by medical practitioners at UCSF Pediatric and Adolescent Gender Center and UCSF Division of Gynecology.

My request to the Florida Medical Board is that the minimum age for gender-related medical interventions be changed to 25 since it is widely documented by the scientific community that maturation of the prefrontal cortex, responsible for executive functioning and critical decision making in the adolescent brain, is not accomplished until the age of 25.

The development and maturation of the prefrontal cortex occurs primarily during adolescence and is fully accomplished at the age of 25 years. The development of the prefrontal cortex is very important for complex behavioral performance, as this region of the brain helps accomplish executive brain functions. - ["Maturation of the Adolescent Brain," Pub Med](#)

Here's my story. My daughter is now 16 years old. She is autistic and has co-existing serious mental health conditions including acute anxiety and clinical depression, making her extremely vulnerable.

When my daughter became confused about her gender identity in the summer of 2020, she was encouraged by Internet influencers to take immediate action to change her body. The gender affirming care model told us as parents that we had to support her. Her first request was to medically suppress her period using hormones. Our pediatrician was able to help with this initially, but my daughter's high level of distress about break through bleeding, which inevitably occurs with menstruation suppression, led us to speak to UCSF Child and Adolescent Gender Center via telehealth. My daughter was so distressed that she struggled to focus on any of her preferred interests or activities, including school, leaving the house, interacting with peers or

basic self care. During this time, my daughter continued her obsessive Internet research on the topic and became fixated on the solution of demanding a radical hysterectomy to remove her ovaries, uterus, fallopian tubes and external female genitals. The pediatric nurse at the UCSF Gender Center referred us to an OBGYN at UCSF for support with the menstruation management and because she was known to be reassuring to distressed kids.

During the consult with the UCSF doctor, my then 15 year old daughter was told that Testosterone therapy would “induce amenorrhea” or effectively suppress her period. I objected and stated my concerns about my daughter’s significant development delays due to Autism and her inability to make informed decisions for herself in addition to her extreme emotion dysregulation, tendency to become aggressive and her anxiety and clinical depression. The doctor already had this history on my daughter, so I believe it was unethical to discuss this treatment option with my daughter. The doctor also discussed with daughter the opportunity to get “gender affirming gynecologic procedures,” and told her that while surgeries were usually done on people over the age of 18, she could get a radical hysterectomy if she could get her mom to consent. This offer from a UCSF doctor has been the single most harmful aspect of the gender affirming care model for my daughter. Her obsessive fixation on getting me to consent to surgery at a young age has lead her to extreme dysregulation, school refusal, self harming behavior and multiple psychiatric hospitalizations.

My daughter has been hospitalized twice at the psychiatric emergency rooms in Northern California after she decompensated into self-injurious behavior while obsessively demanding a radical hysterectomy. She was placed on a 5150 hold after the second psychiatric hospitalization and stayed in a psychiatric hospital for 7 days. Later that month she was transported to a Psychiatric Hospital for a 6 week stabilization stay.

Many Autistic children share common traits that make them uniquely vulnerable to the gender ideology and to the suggestion by medical professionals that they will experience immediate relief from irreversible medical interventions. For Autistic kids who have often felt marginalized in the classroom, in their communities and even at home, their blame is often directed inward toward their bodies, and the suggestion of changing their bodies to find relief is very powerful. Hallmarks of Autism include rigid, black and white thinking, challenges with understanding the social world, tendencies toward [perseveration](#) and difficulties with regulating emotions, to name a few. The prevalence of co-borbid mental health issues among Autistics is widely documented, with extremely high rates of ADHD, anxiety and depression. While each of these issues can be challenging to manage in themselves, the combination of ASD qualities with additional issues such as impulsivity and difficulty shifting attention, and unhealthy thinking patterns that emerge from anxiety and depression, can lead to extreme dysregulation and explosiveness. When combined with an obsessive fixation

on medical interventions, these co-borbid mental health conditions make it impossible for a child to think rationally.

Parents are often blindsided by [Rapid Onset Gender Dysphoria](#) when it shows up in their young teenage children. Most kids will move on through this phase of identity exploration if we don't make it concrete for them. Parents deserve to know there are other ways to support our kids rather than buying into the 'affirm and medicalize' model currently in place in our country. Our children were not born in the wrong bodies and no one in the medical community should be saying they were.

Thank you for considering this perspective.

Respectfully,

Karen Mahon

From: [K Clark](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Youth transition testimony from a parent
Date: Friday, September 16, 2022 2:01:54 PM

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Here is my story and I now know I am not alone. I live in California but grew up in Florida. My teen daughter suddenly came out as trans 1 ½ years ago. There is a life pattern and a path to transness that is almost comical to hear. This is NOT normal. Many of these trans identifying teens are girls. This is new. They fit into a pattern identified as ROGD. Read Dr. Lisa Littman's [studies](#) because they are spot on. These teens are the average age of 16 when they come out. They have struggled with mental illness their entire lives. They have been bullied as children. They have struggled socially to fit in their entire lives. They never mentioned gender or sex as ever being an issue their entire lives. They hung out on Youtube or other social media that lean heavily on algorithms to suggest the next thing to watch. They often came out as lesbian a year prior. And as we now know, they are often on the Spectrum. And then they dropped a bomb on our house that we're still trying to dig out from.

Here's what else is going on in our lives: We seek help and we're only told of the 'affirming' therapists. We're put on waiting lists because there aren't enough therapists. After months of waiting, we take whatever therapist we can find. They tell us to 'trust the process.' We see things moving too fast but realize too late that we're caught in an agenda that we want no part of. Some of us still don't realize this. We're told our teen will kill themselves at any moment if we don't give them medical treatment right away. The endocrinologist creates a disease to list in our teen's medical chart to treat them with testosterone so the insurance will cover treatment. Our child has no such disease and yet, it's on her chart: "Unspecified Endocrine Disorder". Meanwhile, they fail to point out to us that our child is suffering from severe to extreme anorexia (we were told our child just needed to 'gain some weight') when in a rational medical world, they would have been immediately hospitalized. The severe anxiety that the therapist didn't treat at all before referring us to the gender clinic gets worse. We want what is best for our child but medically torturing our child while not first acknowledging and addressing these severe mental health issues first is medical malpractice. And we go on. Eventually, we wake up and seek care at several eating clinics to help treat our daughter. All of them affirm. None of them know how to treat eating disorders caused by Autism. So we stay at home, suddenly becoming medical experts ourselves because we can no longer safely seek care for our daughter within the medical establishment. We are now seeking life outside of the US. It is not safe to take your child to the doctor anymore. It's that simple. How on earth did we come to this?!

Please stop the medicalization of trans children. Many of these children are often girls who have many co-morbidities such as eating disorders, depression and anxiety that often have simply manifested due to undiagnosed or diagnosed Autism. It is often the autism that is speaking, not because they were 'born in the wrong body.' We all know it is physically impossible to be 'born in the wrong body.' Everyone is born simply biologically male or female with a tiny contingent of people who are intersex. Children reach true maturity at age 25 and we know that children on the Spectrum often lag behind with maturation, which is closer to 30. Parents are being turned away as not trustworthy when they are the ones who know their own children. The 4000% increase in girls identifying as trans should not be normalized, especially when 48% of the patients at Tavistock were considered on the Spectrum. Medicalizing these children with cross sex hormones and puberty blockers will likely lead to surgery and it will lead to infertility. It will also make their co-morbidities amplified. This we can see early signs of and yet, trans centers are not fully explaining this to the families who enter these clinics. The 'affirmation only' model is pushing these vulnerable children and families into a future life being tied to the medical industry. They will make a fortune off of these children. As a parent, I'm appalled that I can no longer take my child to a doctor and trust that they won't push them towards this ideology. We are looking into leaving the US now because the entire industry has been co-opted and I now trust no doctor. None!. I've been burned four times already in the past year by 'affirmation only' care. Please, please heed parents warnings and stop this insanity. There will be reckoning one day on all of this but in the meantime, so many families are suffering as are these children.

From: [Jane Clarke](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Protection of children
Date: Saturday, September 17, 2022 10:04:07 AM

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Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Executive Director,

I am writing to you as a parent of an autistic child. My son has been thoroughly indoctrinated to believe that all his social problems will be solved by changing sex. He reads the propaganda printed by gender clinicians and believe hormones and surgeries to be completely safe. Due to his autism he doesn't see the harms. How will he feel when he's had irreversible hormones and surgeries and realises he's still socially awkward? I plead with you to protect vulnerable children like my son.

Kind Regards,
Jane Clarke

From: [Kathleen Dooley](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); [Vazquez, Paul](#)
Subject: Affirmative Care
Date: Friday, September 16, 2022 4:14:15 PM

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To Whom It May Concern

I am writing to express my deep concerns about the current state of affirmative care for gender questioning youth and adolescents.

I am the mother of an 18 Year Old daughter who decided 3 years ago - completely out of the blue - that she was "trans". Her entire circle of friends also identified as trans. It has made our life a living hell. After she decided she was trans, her mental state plummeted. She became depressed, anxious, suffered panic attacks and began cutting herself. She also suffered from suicidal ideation.

The pediatrician I took her to just before she turned 16 told me to affirm her or she would suffer harm. In March 2020, one clinic asked me if I wanted a dead daughter or living son. My husband and I were not having it. We found a good psychologist who specializes in body dysmorphia and she treats kids who claim to be trans or "born in the wrong body". That made perfect sense because when she was placed in my arms at 13 months old, she was only 15 lbs. She didn't cry and couldn't even hold a bottle, let alone crawl. She was subsequently seen by world renowned orphan specialist, Dr. Jane Aronson, who diagnosed her as a failure to thrive baby and said we got her "just in time." Her toddler years were filled with night terrors and flashbacks. At 8 years old she told us that a piece of her heart was missing and she needed to know who she was.

The psychologist has diagnosed our child with pre-adoption trauma, depression, anxiety and suicidal ideation. One year later she confirmed that our child is not transgender. She's just fearful of her future, has abandonment issues, and needs to focus on what she does well outside of her gender space. One of our daughter's friends started testosterone in 2019. She went off to college last year and had to come home. She has decided she is not trans after all and has declared herself to be "non-binary" and changed her boy name to a gender neutral one.

Our daughter has been diagnosed with borderline personality disorder this year. We have never affirmed her male identity and were able to convince her highschool and most of the adults in our lives to not affirm her. We see some improvement in her self esteem and are told that this may take a while for her to work through, but as long as she works at therapy, she will have the tools needed to cope with her issues. We believe in watchful waiting and not medicalization for children. Puberty blockers and cross-sex hormones have too many harmful side effects and we refused to be complicit in what we see as experimentation with children's bodies. I have personal experience with Lupron which we used during IVF in the 90's and had to stop because it gave me a heart rhythm issue that I am still dealing with today. When I was in my 20's I was put on the Pill to deal with painful menstrual cycles. After one month, I was rushed to a specialist in NYC, Dr. Porges, who told me that I was on the verge of a heart

attack or stroke and he cautioned me that hormones, regardless how low the dose, were a danger to me. So I know what hormones are capable of doing to an adult body.

Last year I spoke to a mother whose 15 Year old gender dysphoric/autistic daughter was diagnosed with osteopenia after two years on puberty blockers. The doctors strongly urged her to continue with testosterone. She refused. Today her daughter is mentally better and showing signs of desistance.

My husband and I (and we are Liberals by the way) support a slow and cautious approach that leaves medicalization entirely out of the equation. We have seen no good reason why children should be allowed to self-identify - before their brains are fully formed - and placed on a path of medical misery. History will not look kindly on what was done to this generation of vulnerable youth.

Thank you for reading this.

Sincerely,

Robert and Kathleen (Dooley) Breslin

From: julie.drjuliehamilton.com
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Florida Board of Medicine Rules Committee
Date: Saturday, September 17, 2022 3:06:35 PM
Attachments: [Letter to Florida Board of Medicine.pdf](#)

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Dear Mr. Vasquez and Colleagues,

Thank you for evaluating the treatment needs of children and teenagers who experience gender dysphoria. I have attached a letter for consideration prior to your September 30th meeting.

Thank you again,

Julie Hamilton, Ph.D., LMFT
Licensed Marriage and Family Therapist

Julie Hamilton, Ph.D., LMFT

Licensed Marriage and Family Therapist

julie@drjuliehamilton.com, www.homosexuality101.com, 561-312-7041

September 14, 2022

Dear Florida Board of Medicine,

I am writing to you regarding the needs of children and teenagers who struggle with gender dysphoria. As you may know, some children begin experiencing gender dysphoria as early as age 3. For others, gender dysphoria suddenly appears in adolescence. In either case, there are usually many underlying reasons why children and teenagers report discomfort with their biological sex.

As a marriage and family therapist for the past 27 years, and as someone who has educated on gender identity for nearly 20 years, I want to emphasize to you the importance of directing these children and their families to get the help that they are needing – psychological help for the root issues – rather than simply treating surface symptoms with experimental medical treatments. For children who begin experiencing gender incongruence by the age of three, there are often attachment issues that need to be addressed. For adolescents who define themselves as transgender, though not previously demonstrating gender incongruence, there are usually other issues. Often these adolescents and teenagers with no prior history of gender incongruence have other emotional, relational, or mental health issues. These individuals often encounter cultural messages encouraging cross-gender behaviors and identities, and for some of these young people, adopting a transgender identity becomes a welcome distraction from their emotional or mental turmoil. Many teens become fixated on a transition as a solution to all of their problems. Without proper psychological intervention, they develop tunnel vision around transitioning, and as they find encouragement from culture and even the medical establishment, their obsession grows until they finally begin taking steps. Unfortunately, however, years after transition these young people are likely to find that their emotional, relational, and/or mental health issues remain, and the transition did not resolve their problems. Many will regret the transition and feel even more hopeless and suicidal after accomplishing their goal of transition and finding they are still as depressed as they were years earlier, before embarking on their journey of hormones and surgery.

As a therapist, I have assisted children and teens in exploring their underlying issues, addressing the deeper needs, and making peace with their biological sex. As one who understands the root issues, I am writing to ask you to recommend therapy instead of hormones to these very confused individuals who are unhappy in their own skin. They often have attachment issues, trauma, family dynamics, and other issues to work through. If they are to become truly healthy and productive adults, they need encouragement to deal with root issues rather than move down an impossible path of trying to change their biology. These children and teens need help addressing their *psychological* make-up not changing their *biological* make-up.

Thank you for considering the deeper issues and needs of these children,

Julie Hamilton, Ph.D., LMFT
Licensed Marriage and Family Therapist

From: [Heather Duffie](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Concerned Parent Speaks to "Affirmative Care" Approach
Date: Friday, September 16, 2022 12:35:52 PM

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Good afternoon,

I heard that the Florida Board of Medicine is meeting to consider regulations regarding the practice of gender medicine.

As a concerned parent living in the state of Georgia, I wanted to briefly share my family's experience with my now 16 yr old daughter as it relates to affirmative care.

In 2020 our daughter told us she thought she was trans and wanted us to use different pronouns than she/her, consider allowing her to wear a binder, and consider the use of testosterone or puberty blockers. At 14, she was already well into the stages of puberty, so halting that for what was described as feeling like she was born in the wrong body felt dangerous. In addition, what we knew as her parents was that she had been sexually abused by a teenage neighbor two years prior, just as she was starting puberty. Touched in sensitive areas, she now wanted to bind those areas and ultimately make them disappear. As parents we felt like this was a coping mechanism to deal with the trauma from the abuse. Why would she want to be a girl if girls are abused?

My husband and I decided not to use her preferred pronouns and not to allow the use of binders or testosterone. She was not happy with us for a year and a half, but she was confident in our love for her and the strong relationship that we had with her. Fast forward to June of 2022 when she went to a father-daughter camp still thinking she was trans. Halfway through the week she, by herself with no prompting from my husband, came to the realization that she had been discounting her value as a girl. She arrived home to tell me that the trans identity was a coping mechanism for the abuse, but while she was within the coping mechanism she couldn't admit that that is what it was all about. Now, she is free from this belief and is growing in her confidence as a female.

Imagine if we had taken her to a doctor or gender therapist who took her at her word of being born in the wrong body. She could have been put on a path to body mutilation. Imagine waking up and realizing that it had been a coping mechanism, but it was too late bc she had already taken too many steps to reverse where she was. We are so thankful that did not happen. We are so thankful we decided to encourage her to wait. We always knew it was a coping mechanism, but to her we said wait bc you never know how you might feel a few years down the road.

We believe this is the only "affirmative care" approach that should be allowed for these kids. We affirmed the struggle that she was going through. We affirmed our love for her. And now we still have our daughter, with her body and mind completely intact and experiencing a

freedom she had not experienced for the last 4 years since the abuse.

Our hope is that our story can help other parents advocate for their children, because maybe they know of something in the child's history that might be contributing to their desire to change their gender. And our hope is that our story can encourage the Florida Board of Medicine to seriously consider the dangerous effects of blindly affirming these kids who need adults to help them become healthy instead of affirming their ultimate demise.

Sincerely,
Heather Duffie
Georgia Parent

From: [Kathryn Handelman](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); [Vazquez, Paul](#)
Subject: My experience with gender "care"
Date: Friday, September 16, 2022 12:29:11 PM

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Hi -

I am the parent of a 15 year old daughter who has been identifying as a boy for a year and a half now. Our daughter's announcement came out of the blue 9 months into lockdown here in New Jersey and with no previous identity issues.

I would like to write to urge you to recommend using the utmost caution, setting guardrails around this issue. We are loving parents of 2 older children too, both of whom are in college now. We were pushed to agree to medicalization very quickly. Our daughter was said to be a good candidate for puberty blockers after 1 visit to a psychiatrist. We zoomed into a "trans parent support group" where we were told that our child should be in charge (who was 13 at the time). We were urged to make an appointment with an endocrinologist, just to investigate. We did that and within 15 minutes were being shown a puberty blocker that could be implanted which was described as "totally reversible" and "safe". (blockers are not safe or reversible- I will leave others to tell you why) We left that appointment after I accused the doctor of violating her hippocratic oath. This was 6 months into our child's new identity. We were warned by all that if we didn't affirm our child and medicalize immediately our child had a good chance of suicide. That suicide statistic is a lie.

In the time since then we have cycled through a number of psychiatric nurses. Our child takes focallin for ADHD and sertraline for anxiety and depression. I am always suspicious of clinicians as they are always referring up to the endocrinologist and surgeon. We fear a clinician will call CPS on us for not agreeing to medicalize our teen. There is a disconnect. The psychologists don't deal with the medicalizing so won't take responsibility for what happens if a child medicalizes unnecessarily (and they don't know the medical risks) and the doctors/surgeons will say they aren't the ones making the assessment. It's kind of like do it yourself gender medicine- with children/teenagers driving the bus and big pharma and the many gender clinics getting rich. The trans activists are masterful at marketing. Please lurk on the Trevor Project. Go in and pretend to be a 14 year old who thinks they might be trans. You will see how they "help" the kids and encourage them to hide things from their parents. Unfortunately it is very hard to get up to speed on this quickly. If I had been up to speed we never would have gone to that endo who devastated my family. I have spent more than a thousand hours researching this and think this is the scandal of the century, worse than the scandal which was the lobotomy and satanic panic/recovered memories/multiple personality disorder. They ask parents to sign informed consent because it is considered experimental medicine. Think about that. They want parents to consent to experimental medicine being practiced on their children. This medicine will sterilize the child and in many cases leave them without sexual function. They don't know what puberty blockers do to the brain. It is a human rights violation in plain sight. No adult can or should consent to this for a child!

Please recognize that gender identity is more of a religion (unfortunately being taught in public schools here in NJ) . It is not a sexual orientation and shouldn't be conflated with being gay or lesbian. In fact, lots of LGB people are waking up to this and feel that gender medicine

is harming children and teens who would grow up to be gay or lesbian otherwise. Our teen is still ID'ing a boy but no longer wants blockers. We continue to support and love her - and even use her chosen name. I avoid pronouns. There are countless stories of detransitioners. There is a detrans subreddit with 38,000 in it now. That's a lot of medical harm and evidence that identity is fluid. We will wait and see. There is a 4000-5000% increase in teenage girls showing up at gender clinics in the last 10 years. Does that make sense? Thanks for listening. I wrote more than I thought I would. I am happy Florida is considering what is best for children and parents. Please question what trans activists and large charitable organizations say the truth is.

Sincerely,
Kathryn Handelman

From: [Leonore Tiefer](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: State of Florida's Medical Board consideration of "Affirmative Care"
Date: Saturday, September 17, 2022 2:24:56 AM

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The Florida Board of Medicine must use its authority to protect children and adolescents from misinformed and dangerous actions and must allow its members to render evidence-based professional care. Minors cannot provide informed consent to irreversible and unknown harms of so-called “gender affirmative” medical treatments and surgeries. Gender confusion and body dysphoria require psychoeducation while comorbid psychopathology may require psychotherapy and psychopharmacology. “Puberty-blocking” drugs are misrepresented as “reversible pause buttons” while interfering with growth, sexual and brain development, fertility, and multi-system functioning. The meteoric expansion of gender clinics is a preventable medical scandal in the making.

(Signed)

Leonore Tiefer, PhD
NYS licensed Clinical Psychologist and former co-Director of Montefiore Medical Center
Department of Psychiatry Sex and Gender Clinic

.....
Leonore Tiefer, PhD
646 279 2248 (C)
ltiefer@mindspring.com

From: [Kierstin Swanson](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); Paul.vasquez@flhealth.gov
Subject: Parent of formerly transgender identified child - recommendation for caution and safe-guarding
Date: Friday, September 16, 2022 12:51:53 PM

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Dear Board of Health,

I am asking as a parent that the Florida Medical Board listen to the testimonies of detransitioners and consider that "gender-affirming" medical care crystalizes an identity, that without the committing aspect of medical intervention, many more transgender identifying persons would likely have desisted fully and physically intact. Unfortunately, the affirmative approach in general is not in anyway neutral -it tends to push a child toward a path of medicalization without allowing for the child to change their mind easily.

I know this well because I have a daughter who identified for a year as a boy at her school and did not feel like she could change back to being a girl for fear of the social ramifications. It was too embarrassing and difficult for her. We decided to move for year for her to go back to being a girl -her biological sex and she agreed to try this in her new environment. She now understands that she is simply a girl with boy interests. What was once called a tom-boy. But in today's "gender-affirming" environment, she was genuinely confused by all the information she was receiving online and in her school. The move and ability to go back to her true self identifying with her biological sex-helped to pull her out of her confusion and she is now thriving. Unfortunately, most families are not able to take such drastic measures to support their child. We think that if she would have stayed, she would have continued to be severely confused.

Most importantly, through this experience, which rocked our entire family, we have now learned of the flood of detransition's coming out of this gender-affirming care approach. We believe that 100% of children deserve to go through puberty and into adulthood with their fertility intact and their brains and bodies unaltered by synthetic hormones. It is developmentally appropriate for children to experiment with different identities. But the "gender-affirmative" model solidifies these otherwise transient identities. An intact body that has gone through a biologically appropriate puberty is a human right that all children deserve. Yet we know that the current model of "gender-affirming" care causes many cases of regret and detransition. These are children whose fertility, bodies, voices, breasts, and penises, and wombs have been sacrificed to allow others to supposedly "truly transgender kids" to receive care that is really nothing more than a medical experiment.

We need to find a way to support kids who identify as transgender without shaming them and

yet without any medical intervention. I believe this is possible and many adult transgender persons testify to the gratitude they felt by a cautious approach that centered around their mental health needs being met and a process that allowed them to be sure that the decisions they were making as an adult were the right ones for them.

We also need to have exploratory therapy available to all children impacted with gender-identity issues and to not conflate this with "conversion" therapy. This should be made available and also be a requirement before any adult medical care.

Thanks for taking the cautious approach that honors your oath to "First, Do No Harm".

Sincerely, Kierstin Swanson

From: [lynn chadwick](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender "affirmative care" rulings
Date: Friday, September 16, 2022 11:58:09 AM

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Hello I'm writing as a parent of two children who have undergone medical gender transition.

Recent years have shown an explosion in the numbers of young people who claim a transgender identity and medical and surgical interventions which are irreversible and potentially serious.

The Florida Board of Health must use its authority to protect children from misguided, misinformed, and dangerous interventions. Children deserve careful, evidence based, quality care at all times. It's past time for an open, honest, rigorous debate centering children rather than political or activist agendas.

There is not a single shred of evidence that interventions such as puberty blockers, cross sex hormones, surgeries, or even social transition improve long term mental health, or that they decrease suicide risk. On the contrary, the best studies show the worst outcomes.

Search the Cochrane base, and you will find that there is no quality evidence for these interventions. More study is desperately needed. In the meantime, these children deserve open, unbiased exploratory therapy to help them deal with underlying co-morbidities.

Thank you for your attention to this matter. I hope that you will courageously stand for children such as mine and so many others.

Warmly, Lynn Chadwick.

Sent from my iPhone

From: [Michelle Vessey](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender medicine
Date: Saturday, September 17, 2022 11:35:55 AM

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As the Florida Board of Medicine meets to consider regulations around gender medicine, I am writing to express my strong support for a slow and cautious approach that does not medicalize our kids for the rest of their lives.

There is serious risk of harm to our vulnerable youth in the so-called “affirmative care” model, which includes puberty blockers, surgery, and cross sex hormones. And there is an absolute shocking lack of medical knowledge about the outcomes of this “one-size fits all” type of treatment plan. See this editorial in the BC Medical Journal: <https://bcmj.org/letters/informed-consent-gender-questioning-youth-seeking-gender-affirmative-care-complex-issue>

Based on systematic reviews of the literature, Sweden, Finland, France, and the UK have concluded that the risks outweigh potential benefits and now tightly regulate medical interventions for youth under 18, in favor of psychological treatments. The interim report of the UK’s Cass Review outlines some of these concerns.[2]

Medical professionals are bound to “do no harm”, and I applaud the courage of the Board in assessing the current state of gender medicine and ensuring that it does not harm our kids.

My daughter has expressed discomfort in her body, and school officials have lied and hid from us her efforts to socially transition. We are her parents and we love her unconditionally, as most parents do. Any social transition counselling (which is simply a first step towards irreversible medicalization of children) and medical interventions must require parental knowledge and consent.

Some people think that parents are causing harm if they do not support medicalization of their children, when in fact the reverse is true. It is important that parents are not cut out of the discussion by school and medical personnel, because maintaining a strong and healthy connection to family is crucial and in the best long term interest of the child. A loving parent can support their child through their feelings of gender dysphoria, while at the same time not supporting irreversible medicalization.

I encourage you to also consider data on the sharp increase in the number of adolescent girls presenting gender dysphoria. This could point to a social contagion for which medicalization of these girls would be a terrible and irrevocable outcome.

Also, the increasing numbers of desisters and detransitioners shows that gender identity changes - which makes permanent medical treatment so very harmful. See Littman L.

Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. Arch Sex Behav 2021;50:~~3353-3369~~.

Instead of the so-called “affirmative care” model, I support less invasive and non medical treatments such as watchful waiting, treating underlying psychiatric conditions and exploratory therapy. These treatments are more individualized to each person, and do not harm the child permanently. Treating underlying causes is especially important when you consider the high percentage of kids experiencing gender dysphoria who have autism.

Michelle Vessey

From: [Morag](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulations regarding the practice of youth medicine submission of comments
Date: Friday, September 16, 2022 10:36:20 PM

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Dear BOM Meeting,

I am pleased to see you are considering implementing regulations regarding the practice of gender medicine.

I have a son who believes he is a woman. If he is pressed into gender reassignment surgery without any and all medical professionals making sure he knows the full ramifications and risks around this experimental procedure, then the medical profession will open itself up to serious consequences for their actions. Equally if he is given powerful drugs to facilitate his transition process without fully informed consent of the full range of side effects that have the potential to cause him harm, again the medical professionals who neglect to do this open themselves up for litigation.

My son is under 18 years of age and he is aware of proper procedure as far as informed consent is concerned and he is also aware of the process of gathering evidence to support him if he is harmed by not being given full disclosure and fully informed consent.

I am sure more and more youth are realising they need to take precautionary measures as they see their peers in the transgender community suffering when they were not fully informed and as a result had no idea what they were really allowing doctors to inflict on them; a life long condition that has robbed them of many healthy aspects of their lives without any way to hold these medical professionals to account. So youth are now learning how to gather information they are given in preparation for any possible harm that occurs so that they can take this information to court to not only get recompense but to ensure case law is created to protect others.

However this can all be avoided if competent and thorough regulations are put in place around this issue.

The medical profession that is capable of giving prescriptions and performing operations, need to be the last step after serious in depth counselling that includes informing the patient of any potential harm of allowing doctors and other professionals to prescribe powerful drugs and/or to carry out experimental operating procedures.

Regulations need to cover this aspect thoroughly so that anyone involved in the care of youth with transphobia or any other gender related condition are made fully aware of their responsibilities and the ramifications for them if these responsibilities around patient care are neglected. If this is done then doctors and clients dealing with gender issues of any kind will be in a much safer and more caring environment with professionals taking the care that is seriously lacking in some negligent medical practises.

The regulations put in place need to state the step by step procedures health professionals need to follow to ensure client and medical professional alike are protected.

Eg

1. Ensure the client has had in depth counselling with a counsellor who will help them question if this is the right path for them.
2. Ensure the client has written examples of what potential side effects can occur with any prescription for hormone treatment (puberty blockers, testosterone, progesterone etc) before they give their consent so there is no doubt that they have been fully informed
2. Ensure the client has written examples of what potential side effects can occur with any operational procedure before they give their consent so there is no doubt that they have been fully informed

Kind Regards
Morag Lorigan
14 Evan Street
Nightcaps
Southland
NZ

From: pbrinkley@comcast.net
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Pediatrician input on gender affirming care for youth
Date: Saturday, September 17, 2022 10:30:16 PM

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To the Florida Board of Medicine:

I am so very grateful that you are closely examining this difficult topic of gender affirming care for young people. As a pediatrician, I have seen several children and teens in recent years struggling with gender dysphoria and the numbers are increasing.

When I first started seeing these patients, I would typically refer such a patient to the local gender clinic, assuming they would receive a full evaluation, including mental health assessment, before initiating any kind of medical treatment. Over time, however, I have come to realize that the default approach of gender affirming care is simply that— just to affirm. Meaning to simply take at face value whatever the child says about their own gender, regardless of age, history of gender incongruence, state of mental health, other diagnoses (such as autism), or the perspective of their parents. I attended a talk a few months ago by Diane Ehrensaft, Director of Mental Health for the UCSF Gender Center and one of the main proponents of gender affirming medicine, and this is how she described the major tenets of this approach (bolded below and verbatim from her slide):

- **Gender variations are not disorders; there are infinite pathways of gender; cisgender is only one of many; each gender pathway is positive; no one pathway is privileged over another**
- **gender is not fixed at a moment in time, but is a lifelong process**
- **co-occurring psychological issues, if present at all, are typically related to interpersonal and cultural reactions to a child, not internal pathology**
- **therefore, pathology more likely lies in the culture rather than in the child**
- **essential therapeutic tenet: it is not for us to say, but for the children to tell**

While it may sound reasonable from a social justice perspective to say all gender pathways are equally valid, what that often translates into in practice is that kids are rather quickly medicalized (meaning puberty blockers, cross sex hormones, and/or surgery) sooner rather than later, and often with very little exploration of any possible underlying issues. In fact, such exploratory therapy is often discouraged by gender-affirming doctors/therapists as 'conversion therapy' -- because if all possible genders are equally valid, regardless of one's natal biology, and we should accept whatever the child says at face value, then it logically follows that any therapeutic exploration is unnecessary 'gatekeeping'.

I personally find this very troubling-- the 'natural history' of gender dysphoria prior to the last decade was that most kids who felt gender dysphoric as young children would get past it once they hit puberty (puberty itself is often the cue which facilitates that process-- making puberty blockers much more significant than just the pause button it is claimed to be). Many studies have shown these kids with childhood onset gender dysphoria often turn out to be gay later, some go on to be cis, and a small minority do continue to be trans into adulthood. So to me, what makes sense is to leave those kids alone and allow them to come to terms with their bodies over time if that's possible, rather than "overtreating" what even proponents admit may be a temporary or 'fluid' condition. I don't think it's "transphobic" at all to "privilege" the pathway which allows the child to keep all their original body parts and avoid irrevocable consequences (like possible sterility) and a lifetime of mandatory medication. Moreover, how can such a young person possibly understand the potential consequences of what they are 'agreeing' to-- among others, the potential risks of not being able to have an orgasm, a biological child, or not being able to breastfeed? Indeed the rapidly growing number of detransitioners suggests that many of these young people truly did not understand the implications of such decisions (the detrans subreddit-- <https://www.reddit.com/r/detrans/> -is now up to over 38,000 members and full of heartbreaking stories).

Of course many of the kids being seen now do not have childhood onset gender dysphoria-- more commonly these days gender dysphoria shows up near puberty, without signs noted earlier in childhood. This has been dubbed 'rapid onset gender dysphoria' (ROGD) and is a radically different phenomenon (not just with age of onset, but also that it affects mostly natal girls; childhood onset historically affected mainly natal boys), but these types are often completely conflated. The reason this matters so much is because the original Dutch study (on which the whole approach of gender affirming care is based) consisted of only 55 kids with only childhood onset GD; there really is NO long term follow up data on outcomes for this new population of older ROGD kids. The Dutch study also specifically excluded any kids with mental health diagnoses, though the population currently presenting itself for care has been shown to have 2-3 times the risk of various mental health problems (anxiety, depression, self harm, etc). This again calls into question whether the Dutch protocol should even be applied to them. And if it doesn't apply, then there is truly minimal evidence to support current practice. Indeed this is exactly what many other countries around the world have concluded, leading them to step back from gender affirming care in the last year (e.g. UK, France, Sweden, Finland).

Despite the concurrence of the AAP with gender-affirming medical care, there are clearly serious problems with the current approach and more long term research is urgently needed. Every U.S. gender clinic should be collecting data on the various interventions received by all of their patients, as well as outcomes with respect to physical and mental health over time, including an attempt to determine outcomes for those who don't return to the clinic.

I believe it is the responsibility of all physicians, especially pediatricians, to keep always foremost in our minds the long term best interest of our young patients and

their families. Medical guidelines should not be driven by activists or political factors, but by medical considerations and scientific evidence. Until we have more definitive data, I believe our staunch commitment as physicians to 'first, do no harm', prescribes a pause to the medicalization of gender dysphoria in youth.

Sincerely,
Paula Brinkley, MD, MPH, FAAP
Berkeley CA

From: [Miriam Berlow-Jackson](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Affirmative care is dangerous
Date: Saturday, September 17, 2022 5:39:23 AM

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Dear Florida adults

I am from the UK and we have been struggling with our children being caught up in this social contagion.

It's a terrible choice to push young children down a medicalised path without trying talking therapies or watchful waiting.

86% of children desist. Puberty blockers and hormones for children are so dangerous and cause long term damage.

Don't let it ruin your Floridian children who are beautiful and confused. No one is born in the wrong body. I strongly feel children should not be pushed down the affirmation path.

Love your children as they are

I recommend you read this

[76% of referees to The Tavistock & Portman Gender Identity Service \(GIDS\) are adolescent girls, and we also know from The Tavistock's statistics that 48% either have a diagnosis of, or show traits of Autism. 1](#)

Love

Miriam Berlow-Jackson
Scotland UK

From: [nancy.cowen](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Caution for Trans Medicalization - Irreversible Harm
Date: Friday, September 16, 2022 11:50:22 AM

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Adults are there to protect children not to lead them into irreversible harm. Adolescence is a time of exploration, impulsivity, and search for identity. Biological sex is real. Gender Ideology has no basis in science. These are Facts.

Please lead the USA, adopt a cautious, slower and safer approach to treating children with gender questioning.

That affirmation, social transition, smothering the voices of mothers. and irreversible medicalization is the only treatment given to kids lost is insanity.

Please protect our children.

Mother of 15 year old daughter who thinks being a boy will solve the sexual trauma she experienced as child.

From: [Maurice Day Lawson](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care / Florida Board of Medicine
Date: Saturday, September 17, 2022 8:01:12 AM

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Dear Paul A. Vazquez, J.D.

Executive Director Florida Board of Medicine

I am the uncle of a teenage old girl, who identifies as transgender.

My niece is not transgender: she has struggled all her life with mental health challenges and

with her social anxiety.

We are constitutionally opposed to the affirmation model and with hormonal and surgical interventions. These are not based on science or ethics for this new population of teenage girls. A very vulnerable population.

Great Britain recently commissioned a highly distinguished public health and pediatric expert to

reconsider the affirmative model in the United Kingdom.

Please consider with care the findings of the Cass Review interim report.

What is the Cass Review interim report?

The Cass Review is an Independent Review of Gender Identity Services for Children and Young People. It was 'commissioned by NHS England and NHS Improvement in Autumn 2020 to make recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence [1].' In March 2022, the Cass Review submitted an interim report to NHS England. This interim report '[set] out [the] work to date, what [had] been learnt so far and the approach going forward [2].'

Who is Dr. Hilary Cass

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020.

A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020).

Although retired from clinical practice, she remains an honorary Consultant Paediatrician at Evelina London Children's Hospital, Guy's & St Thomas's NHS Foundation Trust, where she was also previously Director of Education and Workforce.

Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah's Ark Children's Hospice. She is also leading work on how to address the challenges for both families and professionals in supporting the rising numbers of children with complex medical conditions and disability.

Other recent roles include acting as the Senior Clinical Advisor for Child Health for Health Education England.

Prior to this Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Paediatrics in London. Her consultant clinical practice was as a tertiary neurodisability consultant from 1992 to 2018 in three very different specialist centres and she has published widely in this area.

In addition to her neurodisability practice, Dr Cass was closely involved in the development of paediatric palliative care services at Evelina London Children's Hospital.

Dr Cass was awarded the OBE for services to child health in 2015. She was also awarded an honorary fellowship by the Royal College of Nursing in 2015, and by RCGP in 2016.

Background

The United Kingdom has seen a significant increase in the number of children seeking help for distress in relation to their biological sex. Many school staff first started noticing the phenomenon of children – predominantly teenaged

girls – wanting to change sex during the last decade.

In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (para. 1.1).

From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment (para 3.10).

This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender and gender identity.

Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus (para. 2.4).

No consensus

This being a new phenomenon, research is limited and no consensus exists (within the scientific community) about possible causes and most appropriate treatment options.

At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual (para. 1.7).

We must secure a balanced treatment of political issues, they must take a child-centred, evidence-based approach, and take care not to express personal beliefs in ways which could exploit pupils' vulnerabilities. We should not for example, present, as fact, childhood gender incongruence as an inherent and immutable phenomenon as this is a contested idea rather than an established evidence-based fact.

Low quality evidence

The Cass Review interim report acknowledges that ‘[over] the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial’ (para. 2.4). Many of us feel confused or conflicted about approaching the issues of sex and gender identity with adolescents. The above-mentioned rise in referrals to GIDS has been accompanied by an increasing number of news reports claiming that some teachers and/or schools are promoting the idea that gender identity supersedes sex. However, there is insufficient high quality, longitudinal data (relating to gender-questioning children) from which to draw robust conclusions. There is a notable gap in the evidence base pertaining to the surge in female teenagers seeking support from gender identity services.

Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint (para. 1.29).

Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally (para. 3.21).

It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people **may** not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group (para. 3.23).

Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing (para. 5.10).

This is an area of research where no scientific consensus exists. Schools must be aware that any claims made about the reasons behind the increase in gender-questioning children are speculative and cannot be treated as established evidence-based facts.

Changing epidemiology

Early childhood gender dysphoria is not a new phenomenon. However, **the**

existing literature on treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female and often presenting with a range of neurodevelopmental and mental health co-morbidities.

In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS (para 3.10).

This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years (para. 3.11).

The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress (para. 1.10).

Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes (para. 1.28).

Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group (para. 5.10).

The Cass Review interim report highlights the difficulties faced by clinicians responsible for making diagnoses and recommending treatment. Teachers are neither qualified nor capable of critically evaluating existing evidence. They must carry out their duties within statutory and non-statutory frameworks. This included ensuring that any necessary referrals are made as specified by their schools' safeguarding protocols.

Diagnostic overshadowing

Another significant issue raised with us is one of diagnostic overshadowing –

many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria (para. 4.10).

School staff must be clear that they are not qualified to offer students advice in this area. Moreover, the promotion of specific beliefs about the source(s) of gender-related distress could influence children's attitudes toward the diagnostic process before meeting with a clinically trained professional. Guidance from the Department for Education states that teachers "are in a position of authority and will typically be respected and trusted by the pupils they teach, giving their personal opinions greater weight and credibility. As a general principle, they should avoid expressing their own personal political views to pupils unless they are confident this will not amount to promoting that view to pupils [4]."

Affirmative vs developmental models

Broadly speaking, there are two approaches to treating children with gender-related distress: the gender-affirmative approach and the developmentally-informed approach. The gender-affirmative approach is based on the theory that a child's gender identity is innate. The developmentally-informed approach is based on the theory that a complex interaction of multiple factors underlie gender-related distress. The Cass Review interim report acknowledges that some clinicians report being under pressure to adopt a gender-affirmative approach.

Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach (para. 4.15).

Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach (para 4.20).

There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be

highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies (para. 5.8).

School staff are unqualified to evaluate the merits of these approaches. Moreover, they have an obligation to remain politically impartial. This means not supporting one approach over another.

Social transition

Social transitions (the act of treating children as if belonging to the opposite sex) are performed by some schools in England. A social transition is a powerful psychological treatment that affects a child's psychological development. Not only are school staff unqualified to judge the appropriateness of such interventions, the outcomes are poorly understood.

Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes (para. 5.19).

Pressure

The Cass Review interim report acknowledges the pressures clinicians are under to adopt an unquestioning affirmative approach. Similarly, there is an acknowledgement that children are under pressure to identify with societal stereotyping. Schools cannot erase the pressures that children are under from, for example, social media and peers. However, teachers should promote acceptance for children's non-stereotypical behaviour (boys and girls exhibiting stereotypically 'feminine' and 'masculine' behaviour, respectively) and avoid reinforcing harmful stereotypes.

Primary and secondary care staff have told us that they feel under pressure to

adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters (para. 1.14).

From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision (para. 1.18).

It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services (para. 2.5).

We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long children and young people are waiting to access services (para 4.13).

These will be considered further during the lifetime of the Review and include: . . . The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years (para. 4.14).

Safeguarding

Children with gender-related distress may pose specific safeguarding concerns. They have a higher incidence of comorbid psychiatric and/or developmental difficulties. They are also more likely to be looked after children. Teachers need to be aware of possible harms such as breast binding or tucking (of male genitals). Children may also be subjected to grooming and/or coaching, and encouraged to deceive parents, clinicians and teachers in order to secure particular outcomes such as clinical diagnoses of gender dysphoria. They may also be receiving cross-sex hormones from unregulated sources.

In addition, approximately one third of children and young people referred to

GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children (para. 3.11).

We have also heard about the distress experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts (para. 4.3).

Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria (para. 4.4).

We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation (para. 4.5).

We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment (para. 4.7).

Summary

There has been a huge increase in the number of children (predominantly female teenagers) seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making diagnoses and recommending treatment. School staff who now affirm my daughter are neither qualified to evaluate existing research nor clinically trained. Therefore, they cannot judge the appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development. The Cass Review interim report outlines some of the specific safeguarding issues that surround gender-questioning children.

Thank you most sincerely for your time and consideration.

Yours sincerely,

Maurice Lawson

From: [Peter O'Brien](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Comment on "affirmative care"
Date: Friday, September 16, 2022 4:34:50 PM

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In view of the many testimonies of individuals and families and including medical data regarding "transgener" thinking, it is ostensibly obvious that thoughts/feelings about gender and transitioning from one's biological gender to another, changes over time. Over 90% embrace their own birth gender. This is especially true for children through young adulthood. Parents, as legal guardians and responsible for the health and welfare of their children must be included in any care or decisions regarding medical intervention. Funding for transgender procedures must not be provided by insurance or government subsidy as this type of treatment is not necessary for the physical health of the person and it can actually cause permanent harm.

Any treatments should be limited to adult age individuals who initiate the procedures after having received full-spectrum information for informed consent.

Anyone imposing influence to encourage a child toward transitioning must be held accountable for psychological and emotional abuse.

From: [Martha Shoultz](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Story from parents in Texas
Date: Saturday, September 17, 2022 6:30:03 PM
Attachments: [Jake-story - short Sept 2022.docx](#)

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For the Florida hearings, here is a short summary of what happened to my son when he found a trans identity online.

Please contact me if you have any questions.

Thank you,
Martha

Jake's story

My son was a typical, very happy boy for most of his childhood. His interests started with construction at age 2, Superheroes at 3, then Ninjas and martial arts, tanks and ancient weapons, and hockey in Middle School. When he was 16 his personality changed after a series of sinus infections that we later learned had affected his brain, and he experienced trauma upon the sudden death of his close friend.

That same year my son experienced racial dysphoria – he is Caucasian but truly believed he was black. After the death of his friend, my son did not want to discuss it and immersed himself in research on the computer, where he apparently found a transgender Reddit group. A few months later, he announced that he was “trans.” On the advice of our pediatrician, who believed this was mental illness, we took him to Dallas Children’s Hospital for evaluation by their gender clinic. Our pediatrician was as shocked as we were that despite my son's history of trauma, brain illness and racial confusion all beginning the year before his transgender announcement, the gender clinic in Dallas diagnosed our son with gender dysphoria, and advised us to start our 16-year-old on cross-sex hormones and blockers. This was outrageous to us, considering that our son had no history whatsoever of gender dysphoria or hatred of his boy body. My husband and I would not consent to the treatment and luckily in Texas parental consent is still required, but the surprising diagnosis and “affirmation” of his trans-identity set the stage for our son to start hormones as soon as he went off to college. Since no one affirmed my son's racial confusion, he recovered from that as soon as his brain got a break from the infection, but since many doctors and therapists, as well as my son's girlfriend, have AFFIRMED his gender confusion, he has not recovered from the dysphoria.

We are terrified for our son after having read accounts from numerous detransitioners about the hideous and permanent side effects from the treatments prescribed to “trans” young adults, even without the gruesome surgeries that often follow. We pray every day that we’ll find a cure for our son’s mental illness before he allows greedy doctors to completely destroy his chances of ever having a normal sex life (or a normal life at all).

From: [Tim McNicoll](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: gender affirming care
Date: Monday, September 19, 2022 4:28:32 PM

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I am grateful for the opportunity to provide comments regarding the Florida board of medicine evaluation of gender affirming care. My name is Tim McNicoll MD, I am board certified in family practice since 1984 with an additional year of residency training in Pediatrics, a certificate of added qualifications in geriatrics from the AAFP and ABIM and a masters degree in bioethics. I also practiced OB early in my career and have cared for patients from conception to death.

I have watched with some dismay over the last few years the rapid progression from gender insecurity to permanent gender transition in many youths. I have cared for children for the last 40 years and have witnessed how quickly they can progress through developmental stages acquiring and vacillating between new physical, psychological, emotional, and sexual identities. They are constantly and rapidly acquiring new skills but have mastered none of them. Their search for themselves often involves different clothing, different hair styles or color, different speech, and different peer groups. Some more potentially permanent or damaging changes include tattoos, anorexia, overeating, alcohol, smoking, drugs, self-harming behaviors, suicidal ideation and even suicide. These are often aggravated by anxiety, depression, and family dysfunction.

Gender insecurity seems to be another manifestation of the almost cataclysmic changes that result from general adolescent identity insecurity. One could conceive of this almost as a living suicide as you destroy a major part of who you have been throughout your life – and unlike the other developmental experiments listed above, you may never be able to return from this gender experiment. There are always exceptions to rules, and likely there are some who may always desire transition, but the tremendous recent increase in gender dysphoria seems to be more of a social trend rather than an inherent human characteristic. Hopefully, like anorexia, it will regress to a much smaller fraction of the adolescent population in 20 years. In the meantime, one has to wonder how many regrettable and irreversible changes will be made.

Other body altering surgeries such as bariatric surgery are rarely offered to adolescents and usually only after prolonged counseling and non-surgical medical treatments. Even adults must go through rigorous counseling and non-surgical weight loss treatments before undergoing such surgery. Breast augmentation again is rarely offered to adolescents and we now know after 50 years of the risks of autoimmune disease, potential cancer risks, difficulty with cancer detection, infection and prosthetic rupture associated with various breast implants.

It is likely a universal human characteristic that at times we all imagine being somebody or somewhere different. A place where all our troubles in life vanish. This is likely a more common and more powerful feeling in adolescence as we try to determine who we are and where we fit in. However, because of the rapid developmental changes that adolescents are constantly experiencing, we should take a long pause before embarking on gender transition treatments. As with driving, smoking, alcohol consumption, leaving high school campus without authorization, and even adults having sex with a minor, there are some activities that we should strictly limit or proscribe until adolescents have successfully navigated through a good part of their development. This is the least we can do for our children before they permanently alter the rest of their long life.

Grateful for your public service,

Tim McNicoll M.D., M.S. Bioethics

From: [Sister Edith Hart](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Upcoming meeting
Date: Monday, September 19, 2022 3:55:26 PM

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To the Board of Directors:

I am writing to express my deep concern about the consideration of the Florida Board of Medicines gender affirming care. This push to accept such care is clearly ideologically driven and not based in either reason or sound medical evidence.

There is excellent evidence coming from our European colleagues that such treatment fails to show improvement in youth experiencing gender dysphoria. In the UK an Independent systematic review of the data concluded that evidence was very low regarding hormonal interventions in gender dysphoric youth disorder. Finland, as a country, adopted a position of early transitioning of pediatric patients and they too showed a lack of improvement in mental health and have now moved to psychotherapy as first line therapy.

As a recent Medscape article pointed out by Dr William Malone Endocrinologist

- “Most cases of early childhood-onset gender dysphoria self-resolve. [Eleven out of 11 studies](#) that followed the trajectory of gender-variant youth show that the most common outcome is natural resolution of gender dysphoria [around or after puberty](#). Among those diagnosed as having gender identity disorder, 67% no longer met the diagnostic criteria as adults; among those subthreshold for diagnosis, [93% were not gender dysphoric](#) as adults. Gender dysphoria in childhood is a far better predictor of future homosexuality than of future trans identity.
- The future trajectory of people whose transgender identity emerged during or after puberty is entirely unknown. No one has studied future trajectories of patients whose transgender identity emerged for the first time after the onset of puberty — a previously rare but now increasingly common presentation. Growing numbers of young detransitioners and

desisters are precisely from this demographic, suggesting that a transgender identity that emerges in adolescence may not be durable.

- Social transition does not improve mental health outcomes. Recent studies show that while socially transitioned children can thrive in the short term, they [do not fare any better](#) than their non-socially transitioned dysphoric peers. It appears that [peer relations](#), not the social transition status, predict mental health in gender-dysphoric children. We don't yet know the long-term trajectories of socially transitioned minors, but [emerging evidence](#) suggests that they may [be more likely to persist](#) with gender-related distress rather than outgrow it, as previously observed. This in turn necessitates decades of invasive and risky medical interventions. In fact, the Dutch researchers who pioneered the protocol used to medically transition minors (see Box) [explicitly and strongly discouraged](#) social transition of children and early adolescents.
- Nearly 100% of children who begin puberty blockers will proceed to cross-sex hormones and surgeries. The two main studies that have [evaluated the effects of puberty blockers](#) on mental health found [no improvements](#) or [improvements of marginal clinical significance](#). Both studies are also at critical risk of bias due to the absence of control groups. [Four additional studies looking](#) at the mental health effects of puberty blockers were plagued by [design limitations](#) and also [failed](#) to show any convincing positive effects on psychological health. However, one effect of puberty blockers has been consistently replicated: [At least four studies show](#) that [virtually all of the children who start puberty blockers proceed to cross-sex hormones](#). This suggests that rather than being a pause button, puberty blockers may serve as the "gas pedal" for gender transition.
- Most of the long-term health risks are largely unknown. No long-term studies exist of patients who underwent medical transition as teens or young adults. Therefore, our ability to assess risks vs benefits is limited. Puberty blockers have been demonstrated to [significantly impair bone health](#), and it is not clear whether this will result in future [osteoporosis](#). Cross-sex hormones are associated with [roughly 3-5 times the risk](#) for [heart attacks and strokes](#), though long-term studies are of insufficient quality for accurate risk assessments. Other risks associated

with these endocrine interventions will come to light as the practice continues to scale and as young people spend years and decades on these interventions. The risks to fertility are largely unknown, but it is almost certain that if puberty blockers are given at the early stages of puberty and followed by cross-sex hormones, sterility will result.

- The medical pathway of "affirmative care" rests on a single Dutch study that is not applicable to the current populations of gender-dysphoric youth. Most of the youth presenting for care today would have been explicitly disqualified by the original Dutch protocol, as most have significant mental health comorbidities and post-puberty onset of trans identities. This fact has been recognized by the principal investigators of the Dutch protocol itself, who have [recently begun to sound the alarm](#) about the [potential misapplication of their protocol](#) and who suggest that psychotherapy — rather than gender reassignment — is more appropriate for many of the currently presenting cases.”

The fundamental principle in good medical practice is “do no harm”. The evidence clearly shows that harm is being done by these hormonal transitions and should not be encouraged or promoted. An individual is born either male or female and this accords with both reason and common sense. We as physicians should be working for the wholeness and well being of your patients and not contributing to further distress.

I appreciate your consideration of my comments in your deliberations.

Sincerely,

Margaret J. Hart, DO, FAAFP

Chandler, Arizona

https://www.medscape.com/viewarticle/958742#vp_4

From: [Neroli Lacey](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care / Florida Board of Medicine
Date: Saturday, September 17, 2022 6:44:46 AM

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Dear Paul A. Vazquez, J.D.

Executive Director Florida Board of Medicine

I am a parent of a 17 year old girl, who identifies as transgender.

Our daughter is not transgender: she has struggled all her life with mental health challenges and with her social anxiety.

We are constitutionally opposed to the affirmation model and with hormonal and surgical interventions. These are not based on science or ethics for this new population of teenage girls. A very vulnerable population.

Great Britain recently commissioned a highly distinguished public health and pediatric expert to

reconsider the affirmative model in the United Kingdom.

Please consider with care the findings of the Cass Review interim report.

What is the Cass Review interim report?

The Cass Review is an Independent Review of Gender Identity Services for Children and Young People. It was 'commissioned by NHS England and NHS Improvement in Autumn 2020 to make recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence [1].' In March 2022, the Cass Review submitted an interim report to NHS England. This interim report '[set] out [the] work to date, what [had] been learnt so far and the approach going forward [2].'

Who is Dr. Hilary Cass

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020.

A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020).

Although retired from clinical practice, she remains an honorary Consultant Paediatrician at Evelina London Children's Hospital, Guy's & St Thomas's NHS Foundation Trust, where she was also previously Director of Education

and Workforce.

Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah's Ark Children's Hospice. She is also leading work on how to address the challenges for both families and professionals in supporting the rising numbers of children with complex medical conditions and disability.

Other recent roles include acting as the Senior Clinical Advisor for Child Health for Health Education England.

Prior to this Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Paediatrics in London. Her consultant clinical practice was as a tertiary neurodisability consultant from 1992 to 2018 in three very different specialist centres and she has published widely in this area.

In addition to her neurodisability practice, Dr Cass was closely involved in the development of paediatric palliative care services at Evelina London Children's Hospital.

Dr Cass was awarded the OBE for services to child health in 2015. She was also awarded an honorary fellowship by the Royal College of Nursing in 2015, and by RCGP in 2016.

Background

The United Kingdom has seen a significant increase in the number of children seeking help for distress in relation to their biological sex. Many school staff first started noticing the phenomenon of children – predominantly teenaged girls – wanting to change sex during the last decade.

In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (para. 1.1).

From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment (para 3.10).

This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender and gender identity.

Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus (para. 2.4).

No consensus

This being a new phenomenon, research is limited and no consensus exists (within the scientific community) about possible causes and most appropriate treatment options.

At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual (para. 1.7).

We must secure a balanced treatment of political issues, they must take a child-centred, evidence-based approach, and take care not to express personal beliefs in ways which could exploit pupils' vulnerabilities. We should not for example, present, as fact, childhood gender incongruence as an inherent and immutable phenomenon as this is a contested idea rather than an established evidence-based fact.

Low quality evidence

The Cass Review interim report acknowledges that '[over] the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial' (para. 2.4). Many of us feel confused or conflicted about approaching the issues of sex and gender identity with adolescents. The above-mentioned rise in referrals to GIDS has been accompanied by an increasing number of news reports claiming that some teachers and/or schools are promoting the idea that gender identity supersedes sex. However, there is insufficient high quality, longitudinal data (relating to gender-questioning children) from which to draw robust conclusions. There is a notable gap in the evidence base pertaining to the surge in female teenagers seeking support from gender identity services.

Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint (para. 1.29).

Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally (para. 3.21).

It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people **may** not reach a settled gender expression

until their mid-20s, it is too early to assess the longer-term outcomes of this group (para. 3.23).

Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing (para. 5.10).

This is an area of research where no scientific consensus exists. Schools must be aware that any claims made about the reasons behind the increase in gender-questioning children are speculative and cannot be treated as established evidence-based facts.

Changing epidemiology

Early childhood gender dysphoria is not a new phenomenon. However, **the existing literature on treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female and often presenting with a range of neurodevelopmental and mental health co-morbidities.**

In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS (para 3.10). This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years (para. 3.11).

The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress (para. 1.10).

Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes (para. 1.28).

Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group (para. 5.10).

The Cass Review interim report highlights the difficulties faced by clinicians responsible for making diagnoses and recommending treatment. Teachers are

neither qualified nor capable of critically evaluating existing evidence. They must carry out their duties within statutory and non-statutory frameworks. This included ensuring that any necessary referrals are made as specified by their schools' safeguarding protocols.

Diagnostic overshadowing

Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria (para. 4.10).

School staff must be clear that they are not qualified to offer students advice in this area. Moreover, the promotion of specific beliefs about the source(s) of gender-related distress could influence children's attitudes toward the diagnostic process before meeting with a clinically trained professional.

Guidance from the Department for Education states that teachers “are in a position of authority and will typically be respected and trusted by the pupils they teach, giving their personal opinions greater weight and credibility. As a general principle, they should avoid expressing their own personal political views to pupils unless they are confident this will not amount to promoting that view to pupils [4].”

Affirmative vs developmental models

Broadly speaking, there are two approaches to treating children with gender-related distress: the gender-affirmative approach and the developmentally-informed approach. The gender-affirmative approach is based on the theory that a child's gender identity is innate. The developmentally-informed approach is based on the theory that a complex interaction of multiple factors underlie gender-related distress. The Cass Review interim report acknowledges that some clinicians report being under pressure to adopt a gender-affirmative approach.

Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach (para. 4.15).

Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach (para 4.20).

There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies (para. 5.8).

School staff are unqualified to evaluate the merits of these approaches. Moreover, they have an obligation to remain politically impartial. This means not supporting one approach over another.

Social transition

Social transitions (the act of treating children as if belonging to the opposite sex) are performed by some schools in England. A social transition is a powerful psychological treatment that affects a child's psychological development. Not only are school staff unqualified to judge the appropriateness of such interventions, the outcomes are poorly understood.

Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes (para. 5.19).

Pressure

The Cass Review interim report acknowledges the pressures clinicians are under to adopt an unquestioning affirmative approach. Similarly, there is an acknowledgement that children are under pressure to identify with societal stereotyping. Schools cannot erase the pressures that children are under from, for example, social media and peers. However, teachers should promote acceptance for children's non-stereotypical behaviour (boys and girls exhibiting stereotypically 'feminine' and 'masculine' behaviour, respectively) and avoid reinforcing harmful stereotypes.

Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters (para. 1.14).

From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision (para. 1.18).

It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services (para. 2.5).

We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long children and young people are waiting to access services (para 4.13).

These will be considered further during the lifetime of the Review and include: . . . The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years (para. 4.14).

Safeguarding

Children with gender-related distress may pose specific safeguarding concerns. They have a higher incidence of comorbid psychiatric and/or developmental difficulties. They are also more likely to be looked after children. Teachers need to be aware of possible harms such as breast binding or tucking (of male genitals). Children may also be subjected to grooming and/or coaching, and encouraged to deceive parents, clinicians and teachers in order to secure particular outcomes such as clinical diagnoses of gender dysphoria. They may also be receiving cross-sex hormones from unregulated sources.

In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children (para. 3.11).

We have also heard about the distress experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts (para. 4.3).

Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage

with clinical services and receive a medical diagnosis of gender dysphoria (para. 4.4).

We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation (para. 4.5).

We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment (para. 4.7).

Summary

There has been a huge increase in the number of children (predominantly female teenagers) seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making diagnoses and recommending treatment. School staff who now affirm my daughter are neither qualified to evaluate existing research nor clinically trained. Therefore, they cannot judge the appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development. The Cass Review interim report outlines some of the specific safeguarding issues that surround gender-questioning children.

Thank you most sincerely for your time and consideration.

Yours sincerely,

Neroli Lacey

neroli@beyondcommunications.com

I would be happy to discuss this further with you.

From: [William Faris](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: "innate gender identity"
Date: Friday, September 16, 2022 12:18:03 PM

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Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

This is a comment on regulations for gender medicine.

Discussions of this topic focus on "gender" and on "gender identity". My request is that these concepts be given precise definition in any regulations.

The word "gender" can mean "sex". Or it can mean "gender role". Or it can mean "gender identity". For this reason, the word "gender" by itself is best avoided.

The expression "gender identity" is also ambiguous. Any discussion should make sure to specify whether or not gender identity is implicitly assumed to be permanent, or whether it can be temporary. It should also give a list of possible gender identities. Are these possible gender identities "sex" (male or female) or are they "gender role" (masculine, feminine, neutral, etc.)? Finally, there should be a precise specification of how "gender identity" for an individual at a particular point in time is to be determined.

Most important of all, there should be a distinction between "declared gender identity" and "innate gender identity". These expressions should be used instead of the uninformative "gender identity". The phrase "declared gender identity" could in some cases refer to a "gender identity" that is a belief or preference, declared by the individual. The term "innate gender identity" is more specific; it is a declared gender identity that purports to be an intrinsic property of the individual, possibly even present throughout the entire course of life. This could include a male with a female gender identity, or a female with a male gender identity. It could also possibly include a male or female with a neutral gender identity. An "innate gender identity" is presumably permanent, or at least immune to external efforts to change it.

The notion of "innate gender identity" is central to discussions of medicalization; it needs to be made explicit and explored in detail. In particular, "innate gender identity" is more likely to be associated with "affirmative therapy", while the broader category of "declared gender identity" might lend itself to "exploratory therapy".

Thank you for your attention. I hope this contribution can make it into the record of your proceedings. The results will be important and have national impact.

Sincerely yours,

William Faris
Tucson, Arizona

From: [Richard Manning](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Opposing Gender dfeaturctive care
Date: Monday, September 19, 2022 2:57:56 PM

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Dear Members of the Florida Board of Medicine,

As a surgeon and physician, I am writing to ask you to oppose any efforts to implement medical practices and surgery that seek to offer so-called “gender-affirming care”, including rapid gender transition for children and adolescents. As we all know, the medical and evidence-based studies of these methods do not support such medical practice. Rather, the short and long-term harm of these interventions is clear, and this distinction needs to be emphasized and upheld by the Florida Board of Medicine.

Rick Manning
President & CEO



Office: (717) 200-2020
Mobile: (717) 712-6005
www.beteamintl.org

From: [Andrew Mullally](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Gender Affirming Care Is Not Evidence Based
Date: Monday, September 19, 2022 4:33:16 PM

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To whom it may concern,

My name is Andrew Mullally and I am a family physician. I am concerned about your upcoming meeting regarding sex based medicine practices in Florida.

Gender affirming care is not evidence based. If anything, there is growing evidence of the short term and long term harms that this treatment strategy confers on patients. As you are likely aware there is a significant increase in suicide and depression in patients even after gender affirming care and a large majority of those with this treatment regret their transition as they age. Gender dysphoria is showing itself to largely be a self limited condition for most patients. Additionally, it is well documented that this diagnosis is very regional and not consistent in a population. For these reasons and others, many of the European countries that pioneered this treatment strategy are moving away from gender affirming models -- it is bad medicine.

Please do not move to advance the gender affirming care model in Florida.

Thank you,

Andrew Mullally, MD

From: [Burkey, Brian](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care and surgery
Date: Monday, September 19, 2022 4:11:10 PM
Importance: High

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To whom it may concern, and colleagues,

As a licensee of the State of Florida, and a conscientious physician and surgeon, I am writing to express my concerns over enacting laws in FL that would facilitate rapid care for gender affirming care and surgery, especially amongst our young. Medical literature does not support this type of care for children and adolescents, and the push to do this is strictly based on emotion and politics. I would ask that you protect our developing and vulnerable young people and allow this type of care for adults who have affirmed these decisions after extensive counselling. Many patients change their minds on these unalterable treatments, and are done irreparable harm by it, even after care consideration, much less facilitated and rapid care.

My best,

Brian Burkey MD

Brian Burkey, MD, MEd, FACS

Chair, Regional Institute for Surgical Subspecialties
Professor and Chair, Otolaryngology-Head and Neck Surgery
Cleveland Clinic Indian River Hospital
Scully Welsh Cancer Center
3555 10th Court, Vero Beach, FL 32960
Assistant: Patty Selent, 772-563-4758

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From: [Peter Rosario](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Vazquez, Paul](#)
Subject: Youth and sex-based medicine
Date: Monday, September 19, 2022 4:03:20 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,

Although I do not practice medicine in Florida, I have been made aware of the Board's upcoming discussions on transgender issues especially regarding transitioning of youth away from their biological sex identified at birth. You are at the forefront of what every state medical association will be facing in the near future. You may well set a precedent. For this reason, I am writing you this short email.

I am not in favor of the chemical and physical mutilation of children. It makes no sense to allow youths to make life-altering decisions with mental complications (19-fold increase in suicides) and reproductive complications (permanent infertility), to name a few. And this at a point when the decision-making capacity of the brain is woefully underdeveloped and will remain so for several more years.

The medical literature is clear about the harmful effects and that over 90% of children and adolescents adopt their biological sex as they mature. Additionally, the experiences in European countries have caused, in recent times, more reticence in offering transition therapies. I pray the guiding principle of 'do no harm,' be the basis of your decisions.

Thank you. Sincerely,

Peter Rosario MD

From: [Karen Landmeier](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Please STOP rapid gender transition
Date: Monday, September 19, 2022 3:11:15 PM

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As a Developmental and Behavioral Pediatrician, I have been trained to understand both the physiology and the psychology of children. That is why I implore you to please RESTRICT rapid gender transition for children and adolescents. Most children who have gender dysphoria resolve their struggles and uncertainty by the end of adolescence, and thus it is essential that we allow them to work through this struggle in the proper timeline before making a permanent decision that involves hormone disruption and/or surgical intervention.

In fact, many European nations are CLOSING their gender transition clinics because their long-term, real life experience is that many who transition at a young age return with immense regret and a desire to transition back to their biological sex.

I am happy to be of assistance if you would like further explanation of how the process of gender dysphoria proceeds.

Sincerely,
Karen Landmeier, MD

From: [FRED DE MIRANDA](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Youth transition and the informed consent process
Date: Monday, September 19, 2022 4:07:02 PM

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To: Paul.Vazquez@flhealth.gov
Subject: Youth transition and the informed consent process

TO: Paul Vazquez

There have been very rapid developments in Florida that are worrisome to me as a pediatrician . As you are aware, your Florida Board of Medicine will be meeting very soon to consider implementing regulations related to sex based medicine practices in Florida. The Board is specifically concerned about “youth transition” and the “informed consent process”.

It is my understanding, I those who support so-called “gender-affirming care,” including rapid gender transition for children and adolescents, have inundated the Board of Medicine with their comments. As medical professionals (CMA), we feel compelled to make sure you are aware the medical and evidence-based studies of these methods do not support such claims. Rather, the short and long term harm of these interventions is clear.

I am a Cuban American. My father was a pediatrician in Camaguey. I went to schools in Miami for over 3 yrs before moving to West Virginia. I even swam in the Florida Jr Olympics qualifying meet. I practiced general pediatrics for 37 yrs prior to retirement.

I strongly believe children are incapable of making life long decisions till mid twenties. Much medical evidence proves this. Please allow children to be children. Don't allow the approval of politically driven, unethical, child experimentation procedures or drug treatments with lifetime consequences.

Sadly, if allowed, we'll live to regret it, and many children will have to live with the horrible consequences, physical and emotional.

Federico de Miranda MD

From: [drscottent](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender dysphoria
Date: Monday, September 19, 2022 4:01:41 PM

[You don't often get email from drscottent@gmail.com. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

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Dear Sirs,

This letter is to reject gender identification process being considered before you. In my medical opinion with a degree of medical certainty, gender dysphoria corrects in due time and any interference in medical or surgical treatment is irreversible and counterproductive to natural health. Thank you for your consideration.

Scott E. Manthei,DO,FOCOO

From: [DAVID MARTINEZ](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender "transition" regulations
Date: Monday, September 19, 2022 3:40:41 PM

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To whom it may concern:

The field of transgenderism is very new and so there is much that is unknown regarding its foundational ideology. Especially unknown are the psychological and corporal effects of the so called "therapies" because there is little data. Therefore great care must be taken when applying these therapies to minors and young adults because they are the most likely to not fully understand the consequences of the chemical and surgical interventions involved in "transitioning". It is almost certain they do not realize that the effects of many of these interventions are permanent and will irrevocably alter their lives. I believe that is why we are now seeing young individuals who have gone through all or part of this "transitioning" now regret what they did and are desperately trying to reverse the effects. I earnestly ask you to be very slow and deliberate in your study of this issue and not to rush any decisions. I ask you to make a thorough study of the results of those youth who have participated both in the U.S. and abroad to see how they have fared especially those who are speaking out in regret. Please do not affirm any "rapid transition" plans until you have completed your study. The very lives of our children are at stake.

Sincerely,

David P. Martinez M.D.

Lakewood Colorado

From: [H Krishnamurthy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Harmful effects of Estrogen in Male Brains, commentary on harmful effects of Hormonal treatment.
Date: Saturday, September 17, 2022 10:37:09 PM

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Our article in PITT substack details it well. Based on extensive research by Dr Guillamon it is clear that exogenous Estrogen leaches water from Astrocytes damaging synaptic formation and causing downstream effects like Schizophrenia, Dementia and other harmful effects

<https://pitt.substack.com/p/transgender-medical-interventions>

Recently Dr Guillamon was interviewed about his brain research and he clarified that wrong sex hormones are harmful to natal male brains. The hormones do the exact opposite of what the intended outcome is. He responds to the safety of these treatments here based on his extensive cause effect research. No other group has done such extensive cause effect work. Most research presented are low quality statistical chicanery without randomization and cannot reach conclusions they claim to reach.

Are gender-affirming treatments safe?

A. After puberty, hormonal treatment with testosterone (transgender boys) or estradiol (transgender girls) is not harmless; like any treatment, it can have adverse effects. In the brain, for example, we see enlarged ventricles. The first study on the effects of hormonal treatments on the brain dates from 2006. We did a second, broader study in 2014, which we published in the Journal of Sexual Medicine, and we offered an explanatory hypothesis. In the case of androgenization for a trans man, what happens is the same thing that occurs with the muscles when one takes an anabolic, the same anabolic and anti-catabolizing effects of the androgens in the rest of the body happen in the brain. In feminization, what we observe is that, as the thickness of the cerebral cortex and subcortical nuclei decrease, the ventricles expand. We recently showed that this happens because estradiol affects water metabolism in the cerebral cortex, not because the neurons shrink. We study the effects of the treatment in order to improve care for transgender people. We have proposed that a brain scan be included in the protocols every two years.

But absolutely nothing is known about the treatment of children with blockers on the brain. We have just been granted a ministry project to study them.

if we look at recent large cohort statistically significant studies they all point to much worse mental health (as expected since astrocytes are damaged) in natal males post Estrogen treatment.

Here is an analysis by Biggs et al.

Estrogen is associated with greater suicidality among transgender males, and puberty suppression is not associated with better mental health outcomes for either sex | PLOS ONE
<https://journals.plos.org/plosone/article/comment?id=10.1371/annotation/dcc6a58e-592a-49d4-9b65-ff65df2aa8f6>

Regards
Shyam

From: [T.K](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: "Gender" is not a medical condition. Puberty is not a medical condition. Teen angst is not a medical condition.
Date: Friday, September 16, 2022 1:53:56 PM

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Please define succinctly what is meant by "gender" and how is it differentiated from a human's reproductive state/sex. Sex has two meanings, the reproductive state humans are born into, either male or female, and, sex means, fornicating. Gender only means the reproductive state/sex humans are born into. That is why polite society uses the word, gender, to denote one's sex. The use of the word, gender, differentiates our sexed state from the sex act. That is why we have gender reveal parties for babies and not sex reveal parties. Sex and gender can have different connotation.

BIG PHARMA "trans" activists are deliberately obfuscating the meaning of words to push an incoherent - and highly profitable - agenda. "Gender" is not a medical condition. Puberty is not a medical condition. Teen angst is not a medical condition. No human being can change another human's sex. No drugs or surgeries can "trans" a little boy's body into a girl-body, or vice versa. Our sex is embedded in our DNA, apparent in blood and saliva samples, and easily observed at birth.

No human has the right to deceive the public about their sex in situation where it matters, such as, who showers in the women's locker room, how plays in female-only sports, who gets a pap smear, who needs a prostate exam, who gets pregnant, who show up when I request a woman care-giver to bathe my elderly mother, or when I request a female-only chaperone. Women and girls, FEMALES, needs the privacy, dignity and safe-guarding of single-sex spaces AND the accurate language to describe and protect our sexed rights and realities. We don't need "Trans" activists corrupting the medical community to deliberately erase women and harm children.

There are only 2 sexes as humans need only 2 gametes to reproduce. Females produce the gamete, ova. Males produce the gamete, sperm. Intersex is a birth defect not a 3rd sex. No person with the intersex condition produces a 3rd kind of gamete. "Trans" is not a sex at all. "Trans" is a deliberately pushed trend, a sexual fetish, or a body dissociative disorder. We don't perform anorexic affirming care on starving young girls, why deliberately deceive, destabilize and victimize CHILDREN with predatory "Trans" ideology? How is this not a CRIME?

Thank you for respecting biology and protecting children from "trans" predators.
T. Keefe
Woman, adult human of the female sex.

From: [Victoria G](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Vazquez, Paul](#)
Subject: Sept. 30, Oct. 6 + 7 meetings on gender care
Date: Friday, September 16, 2022 12:39:31 PM
Attachments: [Formal Complaint C.pdf](#)

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Dear Board Members,

I am writing to you as a parent of a daughter who was approved by a gender clinic in a Canadian Children's Hospital, for testosterone injections and a double mastectomy to treat gender dysphoria when she was 17 years old. As she was approved after only two appointments with a psychologist and a brief physical examination by an endocrinologist my husband and I did not feel she had been assessed thoroughly enough for such severe interventions and did not return to the clinic.

Despite what they had told us (that gender dysphoria never goes away) our daughter's distress around her gender gradually resolved on its own over a two year period without any chemical or surgical interventions. Today as an adult she is grateful she did not receive those treatments. While gender affirming interventions may be beneficial to some, my daughter is an example that a one size fits all approach can potentially result in overtreatment.

The dangers of false positive results, diagnostic overshadowing and overtreatment appear to occur anywhere where the affirmation model is used with adolescents, regardless of the type of healthcare system in which it is being used.

Recently in the BCMJ (British Columbia Medical Journal) three guest editors wrote a letter defending gender affirming care with youth, based on their belief that interventions were only administered after comprehensive psychosocial assessments were completed. This is the link to their letter:

<https://bcmj.org/letters/guest-editors-reply-drs-sinai-regenstreif-and-leising#a7>

After reading their letter, I had several questions which I passed on to the BCMJ. They forwarded my questions to one of the guest editors who declined to answer them. I have included my questions below and ask that your board review them and consider whether those who are promoting the affirmation model in Florida would be able to answer them.

1. Under what circumstances would gender affirming hormones and surgeries not be administered to an adolescent diagnosed with gender dysphoria?
2. If the only criteria is a diagnosis of gender dysphoria, what are the sensitivity and specificity of the assessment tools used in the comprehensive psychosocial assessment?
3. Can the psychosocial assessment determine cases of gender dysphoria that may ease or resolve over time without medical interventions?

4. Are there types of gender dysphoria? If so, does the psychosocial assessment determine which type?
5. Can the psychosocial assessment determine severity levels of gender dysphoria?
6. Are non pharmacological interventions the first line of treatment in cases of mild to moderate gender dysphoria?
7. Are hormones and surgeries only offered to patients after non pharmacological interventions have failed to ease the distress of gender dysphoria?
8. Are the waiting lists for gender affirming surgeries based on the patient's level or type of gender dysphoria?
9. Are outcomes of medical interventions better with certain types of gender dysphoria?
10. How is competency to provide informed consent determined in youth?
11. Is a health literacy precautions approach taken with adolescents when reviewing the risks of interventions?
12. Is it not also compassionate to consider the risks of overtreatment, the long term health outcomes of young patients and the lifelong medical burden these interventions create?

I hope that your board will also consider the fact that North American gender clinics have not appeared to be following up on adolescent patients to determine long term outcomes and these experimental treatments have been administered outside of regulated experimental trials. The gender clinic where my daughter was seen only found out that her gender dysphoria had resolved on its own after I filed a formal complaint. I have attached that complaint (with names redacted) to this email to provide you with an example of the gaps of care that occur with the use of the affirmation model with adolescents.

I hope your board will take the time to review what I have written and recognize that it is not political in nature, but has been sent to you in the interest of safeguarding adolescents.

Sincerely,

Victoria G.

Formal Complaint C

Introduction:

My complaint concerns the hormone readiness assessment that the team at _____ Children's Endocrinology and Gender clinic accepted and used to determine that my child, _____, had undergone a sufficient amount of evaluation to begin cross sex hormone treatments. A consent form for those treatments was given to my child at the clinic on _____.

Description of complaint:

1. Inadequate assessment process resulted in the approval of unnecessary testosterone injections and the delayed diagnosis and treatment of co occurring conditions.
2. The clinic did not evaluate or have checks and balances in place to ensure that the clinician, Dr. _____, who the clinic had recommended, had conducted a comprehensive assessment.
3. Concern that the _____ checklist for hormone readiness was not followed. Two items in particular do not appear to have been addressed.

The first checklist item is # 6 "Baseline blood work". To my knowledge my child never had any blood work done in relation to the hormone readiness assessment. Nor did the endocrinologist advise my child to get blood work done before the start of treatment. When my child eventually did get blood work done after withdrawing from the care of the Endocrinology clinic, the results showed very low levels of iron, increased levels of TSH and the presence of PCOS which are all conditions linked with depressive symptoms.

The second checklist item is #10 "Exclude rare differential diagnoses". I do not know if the psychologist made an attempt to screen or assess for co occurring conditions. It appears not, because three years later my child was diagnosed with autism by a psychiatrist. Neither the psychologist nor _____ Children's Gender Clinic recommended or made the referral for that assessment to take place. That is a concern given that an adolescent with ASD would possibly require additional support and a different communication style when discussing the effects of hormone therapy and issues surrounding informed consent. The information that there is an overlap between gender dysphoria and autism was withheld from me even after I mentioned my concerns that my child may be dealing with another condition that was contributing to the gender dysphoria and I gave examples of black and white thinking that I had observed my child exhibiting. In addition, sexual orientation was not adequately explored despite the association that gender dysphoria in youth is strongly associated with a lesbian, gay or bisexual outcome in adulthood. This vital information was withheld from me by both Dr. _____ and the Clinic and I did not learn of it till some time after our visit at the clinic. This information should be included prior to patients and parents making decisions about irreversible chemical interventions. My child is an example of this as her gender dysphoria diminished and eventually resolved without testosterone injections as she began to accept her same sex attraction, bisexuality and gender non conforming behaviour.

4. The assessment did not appear to include an evaluation process to help determine the level of my child's distress and if the most extreme treatment option which involves chemical and surgical interventions was the best option. My child was experiencing a significant amount of distress at the time of the assessment and while she was not functioning optimally, she was still functioning with family support. She was going to school, volunteering and preparing for post secondary. She did appear depressed but had not expressed suicidal ideations nor had she harmed herself physically. Nor were my husband or I ever told that she had. Yet she was approved for testosterone injections and a double mastectomy based on her self diagnosis. An option that was once only reserved for adults.
5. The lack of transparency and acknowledgment by both Dr. _____ and the clinic that there is no evidence base for clinicians to use to be able to predict which patients will truly benefit and which patients may regret irreversible changes to their bodies. Not enough research has been done on the new demographic seeking gender affirming medical interventions, adolescent biological females. Despite this, as a parent I was told my child's self diagnosis was accurate and should not be explored by Dr. _____. This was corroborated by the clinic as they were prepared to administer testosterone injections based on Dr. _____ report.
6. The statement that the clinic provided to the National Post recently, "Treatment with hormones and surgery only occurs after considerable assessment that involves families." was not what my daughter and I experienced. My daughter would have received testosterone injections based on two appointments with Dr. _____ who did not follow the recommended checklist by _____ with the exception of affirming my child's self diagnosis. The examples that I gave to the psychologist about my concerns that my child's gender dysphoria may be complicated by another condition were dismissed. As a parent I expected my child would receive a thorough evaluation and that the clinic would check that one had been done since they had recommended the psychologist involved. In addition, I was expecting further assessment at the clinic given the fact that psychologists do not prescribe medications and therefore was anticipating that the evaluation process would continue at the clinic.
7. My child never received a considerable assessment nor was family input encouraged. It was not explained to me that the "considerable assessment" would only include affirmation of my child's self diagnosis for medical interventions. Nor was I told why there would not be an exploration, evaluation or attempts at differential diagnosis. It is not fair to patients and families for the clinic to use the phrase "considerable assessment" if that is not what all of their patients receive. It misleads parents and the public into thinking that an evaluation process took place that examined less invasive options for dealing with the distress of gender dysphoria prior to settling on chemical interventions. My child was not provided with other options nor does it appear that any exploration or evaluation took place.
8. My daughter and I were not given a precise definition of what the evaluation process includes. Which items on the checklist are mandatory? Who is responsible for checking that baseline bloodwork is done? The GP, psychologist or endocrinologist?

9. The team did not attempt to assess my child's understanding of the possible side effects of testosterone injections that were read out loud to her during the clinic appointment (_____). No attempt was made to determine if my child had reasonable expectations concerning what the injections could or could not do.
9. The assessment process did not attempt to determine whether my child's gender dysphoria was secondary to another condition and therefore would require an extended diagnostic timeframe. As mentioned earlier my child was eventually diagnosed with ASD. Children with ASD experience gender identity development differently than neurotypical children and therefore require clinicians to take more time before clinical decisions concerning gender affirming procedures are made.
10. The clinic did not make an attempt to record the eventual outcome of my daughter's gender dysphoria. Therefore, it appears that despite the experimental nature of gender affirming chemical interventions for children and adolescents there is no attempt being made to keep track of short- and long-term outcomes. My daughter's gender dysphoria resolved without the implementation of testosterone injections. If cases like my daughter's are not recorded the data will be skewed and opportunities for clinicians and researchers to better understand which type of patient can benefit from an affirmation only approach versus an extended clinical assessment is lost. My child narrowly escaped receiving unnecessary treatment that would have resulted in irreversible changes and possible regret. Perhaps if the outcomes of previous patients had been followed, studied and recorded it would have helped clinicians recognize how my child's presentation differed from those individuals who have benefitted from gender affirming medical interventions. Instead, my child was offered a one size fits all solution despite the potential consequences of irreversible treatments. Understanding adolescents like my daughter whose gender dysphoria was secondary to another condition will not only help patients who may not need medical interventions but also those for whom medical intervention is beneficial.

Recommended Outcome:

Patients and parents are provided with a clear definition of what will or will not be done during a cross sex hormone readiness assessment. Parents are informed of the recommended guidelines and checklists for hormone readiness assessments. Parents are informed which guidelines are mandatory and which are optional for a clinician to address.

Patients and parents are provided with the information that in some cases gender dysphoria resolves without medical interventions.

_____ Children's Endocrinology and Gender Clinic reviews the practice of outsourcing the assessment process for cross sex hormone therapy and considers the challenges of such a practice which can result in inconsistent, substandard and varying levels of care, leaving patients such as my child who had co occurring conditions, unprotected.

Patients and parents are provided with the option of a psychosocial assessment that includes ASD screening. Given the overlap between gender dysphoria and ASD and the fact that neurodiverse patients may not have a diagnosis, autism screening has become part of the regular assessment process at Seattle Children's Hospital to ensure that communication is enhanced with this demographic that presents with both conditions. My daughter did not receive this added protection from _____ Children's Hospital Gender clinic.

Patients with previously diagnosed ASD are provided with additional support to help address the communication needs and executive function complexities of this demographic. Patients without a diagnosis but who exhibit signs of neurodiversity are also provided with this support.

The short- and long-term outcomes of patients who sought chemical interventions are recorded and analyzed even when the patient stopped pursuing hormonal interventions.

The cross-sex hormone readiness assessment for adolescents should allow the parent to provide the clinician with an extensive childhood history if the adolescent has given permission.

Parental questions and concerns regarding medical interventions should be considered with an open mind. These are experimental and irreversible treatments that were once only done on adults. This is a developing field where more research is sorely needed so it should not be surprising that parents instinctively will want to ask questions about procedures that can potentially negatively impact cardiovascular health, sexual function and fertility.

Clinicians at the gender clinic should be open to examining what is happening in other countries that treat minors with gender dysphoria and offer options to patients. Finland changed its approach in 2020 and now prioritizes psychotherapeutic non-invasive options and recognizes adolescence as a time of identity exploration. The experiences of desisters and detransitioners should also be taken into consideration and academic articles on this topic should be reviewed. The following article is an example of the need to address this issue. Pablo Expósito-Campos (2021) A Typology of Gender Detransition and Its Implications for Healthcare Providers, Journal of Sex & Marital Therapy, DOI: [10.1080/0092623X.2020.1869126](https://doi.org/10.1080/0092623X.2020.1869126)

Summary:

The assessment process for cross sex hormone readiness that my child received was inadequate. The purpose of this complaint is to communicate to the clinic the gaps of care that my child experienced in order to improve the system for future patients who may be experiencing gender dysphoria secondary to other conditions.

Sincerely,

From: [Melody](#)
To: BOM.MeetingMaterial@flhealth.gov; [Vazquez, Paul](#)
Subject: Comments on youth transition
Date: Sunday, September 18, 2022 3:35:11 PM

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Dear Florida Board of Medicine,

Thank you for taking up the vital question of regulating the so-called “gender-affirming” hormones and surgeries for young people.

As a parent of three teenagers, I have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions sometimes on the first or second visit. The myth that our children are getting “assessments” is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society’s recommendations.

Older adolescents can get hormones with no assessments at all, and have their healthy body parts amputated by eager surgeons on little more than self-declaration of “trans identity.” Many of our children are gay, autistic and many have experienced abuse or other trauma. They have come to believe their very real distress is explained by the fact that they are “transgender” and that hormones and surgeries will help. They do not. We have seen our children’s mental and physical health plummet following “gender-affirmation.”

We also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as “gender affirmation.”

Thank you for doing what you can to regulate this experiment on our vulnerable children.

Sincerely,
Melody Dunn

From: [Avery Kennedy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Care
Date: Sunday, September 18, 2022 4:01:04 PM

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Paul A. Vazquez, J.D.

Executive Director Florida Board of Medicine

BOM.MeetingMaterials@flhealth.gov

Dear Mr. Vasquez,

I am writing in regards to the proposed regulations on “gender-affirming” care currently under review in Florida. I am a California attorney who is watching gender issues closely across the US.

I believe I have the best interest of children in mind, not only because my 17-year-old daughter is obsessed with transition but also because I know 36 kids - organically from family relationships- who also self-identify as “trans.”

One of these children is my best friend’s son. Another is my sister-in-law’s daughter. The numbers defy logic. Sadly, most of the children I know are on the spectrum, including mine.

My child suffers greatly from depression and anxiety. I took her to a psychiatrist who immediately told my daughter and I that she would kill herself if she doesn’t get immediate gender medical care. Can you imagine someone saying that to your child?

I could write chapters on gender medicine and mental health but I’ll stick to my short letter. Please be rational when dealing with our kids’ health. They’re so precious and shouldn’t be experiments.

Best regards,

Avery Kennedy

From: [Diane](#)
To: [Vazquez, Paul](#)
Subject: Transgender
Date: Sunday, September 18, 2022 2:19:06 AM

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I am very upset over what is happening with gender ideologies. PLEASE do not teach my child she can change her sex...but that's what our school did and my daughter is now permanently altered and cut off from her family. BECAUSE the schools went along with her name change and pronouns...so they became the heroes and she hated on her parents for not going along with it.

We know our children best. She told me she was glad God made her a girl...loved dolls, dresses, babysitting, etc. but Im guessing did not feel feminine enough for her friends. Met someone at school who was on hormones and it made her curious. She becomes so obsessed over things. Decided she felt more comfortable when people THOUGHT she was a dude.

We love her. We can use a nickname but she will never be my son...always daddys little girl. She does not like that so she has lost contact. Its what the activists tell them to do...LOSE CONTACT. We miss her more than words can say. We beg her to come home...but she listens to all of the voices out there telling her we are her enemy. It's sick. Her dad is dying from a lung disease. She said she would care for him but wanted him to use her pronouns...He won't...she will not care for him.

I believe these kids will live with huge regrets later in life.

D Beck

From: [Joy Dot](#)
To: [Vazquez, Paul](#)
Subject: Endocrinology, regulation of transing kids fad
Date: Sunday, September 18, 2022 4:35:05 AM

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Hi paul.

18 years Hashis patient here - acquired via childbirth ptsd (previously full health)

I'm a uni educated (psych/ comm), reasonably progressive woman with 2 (young) adult children, female eldest having had thyroid cancer treatment at 20 immed post uni grad. It has changed/ restricted our lives beyond measure. I refer to this new reality as 'locked in syndrome' - my brain says DO THiS (fun, high energy activity as normal before) then body goes NOPE, nap time. We will never enjoy the energy, health or independence as prior, we are now dependent on worst the medical field can throw at us. And it's pretty overwhelming how substandard the field of endocrinology is if you are a patient with a brain.

During period living in Munich I underwent careful, detailed EXPENSIVE health testing for private insurance - doc stated I would not have any issue as retention from earlier athletics (rowing/ tennis) meant despite hashis I was still well above average health wise. Imagine surprise when every German insurer rejected me on basis endocrinology is such a mess patients are untouchables, subject to early, rapid decline. This is future of these children, travel restrictions, activity restrictions, employment limitations & health issues that will escalate rapidly & for which there is no solution.

In bluntest terms possible, endocrinology is a field full of charlatans. Their "science" is ephemera based on individual opinion - I have no idea how they get away with it. The idea you can artificially hormonally medicalise children is ludicrous. Any decent medic knows you cant, unfortunately at this point being a decent medic appears to intersect with cowardice. This is a fad. funding for ongoing medications will inevitably be withdrawn & I have no idea how

these new endo+ patients will get through. I have lived in multiple “top” countries with “excellent” healthcare - no system is set up for basics never mind this crap.

The people pushing it are reprehensible. Do not fall for their hubris - or that of delusional parents who deserve to be criminalised. Spare impressionable children the toxicity of these failed human adults, hold fast & regulate this industry into annals of horrible histories where it belongs. Have fun, these health terrorists are intent on making every Halloween slasher/zombie film come to life, you're going to need serious backbone.

Best -

Leslie Renfrew

Sent from my iPhone

From: [K Clark](#)
To: [Vazquez, Paul](#)
Subject: Youth transition testimony from a parent
Date: Friday, September 16, 2022 1:59:09 PM

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Here is my story and I now know I am not alone. I live in California but grew up in Florida. My teen daughter suddenly came out as trans 1 ½ years ago. There is a life pattern and a path to transness that is almost comical to hear. This is NOT normal. Many of these trans identifying teens are girls. This is new. They fit into a pattern identified as ROGD. Read Dr. Lisa Littman's [studies](#) because they are spot on. These teens are the average age of 16 when they come out. They have struggled with mental illness their entire lives. They have been bullied as children. They have struggled socially to fit in their entire lives. They never mentioned gender or sex as ever being an issue their entire lives. They hung out on Youtube or other social media that lean heavily on algorithms to suggest the next thing to watch. They often came out as lesbian a year prior. And as we now know, they are often on the Spectrum. And then they dropped a bomb on our house that we're still trying to dig out from.

Here's what else is going on in our lives: We seek help and we're only told of the 'affirming' therapists. We're put on waiting lists because there aren't enough therapists. After months of waiting, we take whatever therapist we can find. They tell us to 'trust the process.' We see things moving too fast but realize too late that we're caught in an agenda that we want no part of. Some of us still don't realize this. We're told our teen will kill themselves at any moment if we don't give them medical treatment right away. The endocrinologist creates a disease to list in our teen's medical chart to treat them with testosterone so the insurance will cover treatment. Our child has no such disease and yet, it's on her chart: "Unspecified Endocrine Disorder". Meanwhile, they fail to point out to us that our child is suffering from severe to extreme anorexia (we were told our child just needed to 'gain some weight') when in a rational medical world, they would have been immediately hospitalized. The severe anxiety that the therapist didn't treat at all before referring us to the gender clinic gets worse. We want what is best for our child but medically torturing our child while not first acknowledging and addressing these severe mental health issues first is medical malpractice. And we go on. Eventually, we wake up and seek care at several eating clinics to help treat our daughter. All of them affirm. None of them know how to treat eating disorders caused by Autism. So we stay at home, suddenly becoming medical experts ourselves because we can no longer safely seek care for our daughter within the medical

establishment. We are now seeking life outside of the US. It is not safe to take your child to the doctor anymore. It's that simple. How on earth did we come to this?!

Please stop the medicalization of trans children. Many of these children are often girls who have many co-morbidities such as eating disorders, depression and anxiety that often have simply manifested due to undiagnosed or diagnosed Autism. It is often the autism that is speaking, not because they were 'born in the wrong body.' We all know it is physically impossible to be 'born in the wrong body.' Everyone is born simply biologically male or female with a tiny contingent of people who are intersex. Children reach true maturity at age 25 and we know that children on the Spectrum often lag behind with maturation, which is closer to 30. Parents are being turned away as not trustworthy when they are the ones who know their own children. The 4000% increase in girls identifying as trans should not be normalized, especially when 48% of the patients at Tavistock were considered on the Spectrum. Medicalizing these children with cross sex hormones and puberty blockers will likely lead to surgery and it will lead to infertility. It will also make their co-morbidities amplified. This we can see early signs of and yet, trans centers are not fully explaining this to the families who enter these clinics. The 'affirmation only' model is pushing these vulnerable children and families into a future life being tied to the medical industry. They will make a fortune off of these children. As a parent, I'm appalled that I can no longer take my child to a doctor and trust that they won't push them towards this ideology. We are looking into leaving the US now because the entire industry has been co-opted and I now trust no doctor. None!. I've been burned four times already in the past year by 'affirmation only' care. Please, please heed parents warnings and stop this insanity. There will be reckoning one day on all of this but in the meantime, so many families are suffering as are these children.

From: [Linda Hayden](#)
To: [Vazquez, Paul](#)
Subject: Gender transition for youth / "informed" consent
Date: Friday, September 16, 2022 12:20:40 PM

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To whom it may concern,

We already know the facts. Children do not understand what they are consenting to. My friend has a child who is gender questioning...When her mother told her being put on puberty blockers can leave a person unable to have an orgasm the 16 yr old said "who cares about having orgasms?!?" In other words, she hadn't had one so how can she EVEN understand what she is leaving behind!

The idea of consent REQUIRES understanding the consequences of actions. These children have under developed frontal cortex's (the thoughtful decision making part of the brain) and are being put in the driver seat on making radical life long changes to their bodies. They haven't had their first kiss, but they are being led to sterilization and removal of healthy flesh! How is this NOT a major medical scandal waiting to explode.

We already know the facts. Parents all over the world are being told that transition will save their kids lives which we now know from UK's Cass review is not actually true. Suicide rates go UP after transition!

We already know that the children have no idea what they are ACTUALLY doing to their bodies, or how to assess the consequences, or how to consent. How can you consent to something you do not understand?

Transition, obviously, can sometimes aid a person in feeling more comfortable in their bodies. But shouldn't that decision, since it has such extraordinary repercussions, be made once the person can actually consent? The brain is completely developed around age 26/27....Can we see a way towards compassionately providing mental health support, therapy that explores why someone might feel uncomfortable with their birth sex? Autism, OCD, trauma, being gay, having internalized homophobia, internalized misogyny....these can all explain why a child may suffer from these feelings...but currently they are not allowed exploring. That's absurd!

Please. Let's create a space where children can become comfortable in their bodies over time and not rush to mutilation. Then, at age 26/27 when they're fully cognizant of what their sexuality is, what the actual transition will actually mean, THEN they can pursue it! Children require safeguarding. It's our duty as parents and adults.

Thank you,
Linda Hayden

From: [nmallett2](#)
To: [Vazquez, Paul](#)
Subject: Affirmative Care?
Date: Sunday, September 18, 2022 5:41:41 AM

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To whom it may concern,

I would like to put my voice towards this very serious issue of young vulnerable adults with underlying comorbidities being able to transition without thorough medical investigations.

I am very hopeful, thankful and encouraged that The State of Florida Medical Board is considering implementing regulations regarding the practice of gender medicine. We live in Queensland, Australia. Last year (2021) my adult son who suffers from Functional Neurological Disorder (FND), Depression and Anxiety was given Spironolactone and Estradiol. The prescription was given after just over an hour appointment with a General Practitioner. My son has been and continues to be under the care of a Psychiatrist since 2015. He suffers from dissociative episodes, full body and limb tremors, confusion and fatigue. After only 6 months on the medications he developed breasts, his testicles shrunk and he is left unable to ever father children. He regularly attends hospital because he is now suicidal, mostly bed ridden and unable to work. In fact, I clean his unit, wash his dishes and launder his clothes, shop for groceries and subsidise his rent. I made an appointment with the General Practitioner that prescribed the medication to explain how unwell my son is as this had been his first appointment with this Doctor. The doctor had not even read the years of clinical notes taken by his treating Psychiatrist. My whole family cannot understand the injustice that has occurred as there were no signs of gender dysphoria throughout his life. We are in shock and left reeling with dismay and devastation.

I truly do not feel this is "Affirmative Care" or "Informed Consent" as it is called in Australia, but instead butchery and mutilation of our beautiful young people. My son's body is irreversibly damaged. Vulnerable people need protecting. Doctor's take an oath to "first do no harm", my son is truly harmed.

Thank you for taking the time to read my email. I eagerly await your findings. Best of luck.

Kind regards Naomi Green

Villa 34/29 Harbour rd Hamilton

Queensland Australia 4007

(0402433851).

Sent from my Galaxy

From: [Morag](#)
To: [Vazquez, Paul](#)
Subject: Regulations regarding the practice of youth medicine submission of comments
Date: Friday, September 16, 2022 10:36:32 PM

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Dear Paul,

I am pleased to see you are considering implementing regulations regarding the practice of gender medicine.

I have a son who believes he is a woman. If he is pressed into gender reassignment surgery without any and all medical professionals making sure he knows the full ramifications and risks around this experimental procedure, then the medical profession will open itself up to serious consequences for their actions. Equally if he is given powerful drugs to facilitate his transition process without fully informed consent of the full range of side effects that have the potential to cause him harm, again the medical professionals who neglect to do this open themselves up for litigation.

My son is under 18 years of age and he is aware of proper procedure as far as informed consent is concerned and he is also aware of the process of gathering evidence to support him if he is harmed by not being given full disclosure and fully informed consent. I am sure more and more youth are realising they need to take precautionary measures as they see their peers in the transgender community suffering when they were not fully informed and as a result had no idea what they were really allowing doctors to inflict on them, a life long condition that has robbed them of many healthy aspects of their lives without any way to hold these medical professionals to account. So youth are now learning how to gather information they are given in preparation for any possible harm that occurs so that they can take this information to court to not only get recompense but to ensure case law is created to protect others. However this can all be avoided if competent and thorough regulations are put in place around this issue.

The medical profession that is capable of giving prescriptions and performing operations, need to be the last step after serious in depth counselling that includes informing the patient of any potential harm of allowing doctors and other professionals to prescribe powerful drugs and/or to carry out experimental operating procedures.

Regulations need to cover this aspect thoroughly so that anyone involved in the care of youth with transphobia or any other gender related condition are made fully aware of their responsibilities and the ramifications for them if these responsibilities around patient care are neglected. If this is done then doctors and clients dealing with gender issues of any kind will be in a much safer and more caring environment with professionals taking the care that is seriously lacking in some medical practises.

The regulations put in place need to state the step by step procedures health professionals need to follow to ensure client and medical professional alike are protected.

Eg

1. Ensure the client has had in depth counselling with a counsellor who will help them question if this is the right path for them.
2. Ensure the client has written examples of what potential side effects can occur with any prescription for hormone treatment (puberty blockers, testosterone, progesterone etc) before they give their consent so there is no doubt that they have been fully informed
2. Ensure the client has written examples of what potential side effects can occur with any operational procedure before they give their consent so there is no doubt that they have been fully informed

Kind Regards
Morag Lorigan
14 Evan Street
Nightcaps
Southland
NZ

From: [Miriam Berlow-Jackson](#)
To: BOM.comMeetingMaterials@flhealth.gov
Cc: [Vazquez, Paul](#)
Subject: Affirmative care
Date: Friday, September 16, 2022 3:00:00 PM

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Dear Florida adults

I am from the UK and we have been struggling with our children being caught up in this social contagion.

It's a terrible choice to push young children down a medicalised path without trying talking therapies or watchful waiting.

86% of children desist. Puberty blockers and hormones for children are so dangerous and cause long term damage.

Don't let it ruin your Floridian children who are beautiful and confused. No one is born in the wrong body. I strongly feel children should not be pushed down the affirmation path.

Love your children as they are

I recommend you read this

[76% of referees to The Tavistock & Portman Gender Identity Service \(GIDS\) are adolescent girls, and we also know from The Tavistock's statistics that 48% either have a diagnosis of, or show traits of Autism. 1](#)

Love

Miriam Berlow-Jackson
Scotland UK

From: [Pene Ferguson](#)
To: [Vazquez, Paul](#)
Subject: Impacts of Affirmative Care - Comment
Date: Sunday, September 18, 2022 12:17:43 PM

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Mr. Vazquez,

I have a daughter with mental health problems who has been pulled into dangerous beliefs that gender dysphoria equates always to being "transgender" (when in fact it has always been common in the gay community), that sex is not binary (the biology of sex is binary. If it were not, then we would not have a fight over transition from one sex to the other sex), and that sex is "assigned". This narrative has as much scientific basis as the belief that COVID vaccines will turn recipients into zombies. Children who are vulnerable and in distress hear false narratives constantly on social media, teaching that their self-image pain, or sexual orientation confusion, will be cured by joining the trans community. But the most terrifying fact is that they hear it from physicians, and therapists, the very people we as parents have trusted to guide us when our children are in distress. After my daughter announced to me that she had gender dysphoria (which she equates to be transgender), I learned that a therapist had brought this up to her when she was only 13, without ever discussing it with me. I have spent two hellish years researching and trying to understand this phenomenon, and it's impact on my daughter. **One of her psychologists, and her psychiatrist, told me in confidence that they don't believe my daughter is really transgender, but that they HAD to use the affirmative care model (meaning that they immediately used her "chosen" pronouns and name) with her. Their recommended path forward was to affirm, but try to slow her attempts to medicalize. HOW IS THIS RESPONSIBLE MEDICAL PRACTICE?** We know that the use of a new name and identity can alter a person's sense of self; that the longer they are in that identity, the more it solidifies. We know this from cult research, for one. So these professionals helped to lead my daughter down a path they did not believe to be right, hoping that by slowing her down, she would find for herself that the path was not right. Isn't it their job to explain that to her?? But these professionals have been bullied into this therapy, which appears in the standards of care. And the kids are the victims of it. They are instantly affirmed in their "choice" of gender, then hear that surgery and off-label use of drugs to "change" sex is a safe and necessary therapy, when in fact we have very little historical data of the outcomes and side effects of medical transition. Unlike any other condition treated by the medical community, they are allowed to self-diagnosis as having gender dysphoria and being transgender, and receive instant affirmation and treatment. And the rampant advocacy of affirmation and transition by the medical community is destroying families. I am not speaking as someone who reads this on the internet, but as a mother with first-hand knowledge of the tragedy taking place.

If you have any power to alter the course of this train, please use it. Not every child is susceptible to this ideology, but a great many are. And the medical community is doing a huge disservice to the most vulnerable.

Pene S. Ferguson
Mother

Gender specialists
questionnaire

conducted December
2021 – January 2022

Summary of responses

The Cass Review

Introduction

Context

About the Cass Review

The Independent Review of Gender Identity Services for Children and Young People (the Cass Review) was [commissioned by NHS England](#) to make recommendations about how to develop and improve the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence.

The scope of the review is broad and will look at different aspects of gender identity services from primary care through to specialist services with a focus on how care can be improved.

Background

In May this year, the Review Chair, Dr Hilary Cass [wrote to NHS England](#) setting out some of the immediate issues with current provision of services and suggesting how the Cass Review team might help with the challenging problem of establishing infrastructure outside of the specialist Gender Identity Development Service (GIDS).

In Autumn 2021, the Review worked with an independent research and engagement organisation to create an online multi-professional panel of primary and secondary care clinicians and social care staff to explore their views on how to build and sustain the capacity, capability and confidence of the wider workforce.

You can read the report of this activity on the Cass Review website: <https://cass.independent-review.uk/>

About the gender specialists survey

Having concluded the professional panel exercise, the Review wanted to triangulate what it had heard with the thoughts and views of professionals working predominantly or exclusively with gender questioning children and young people.

To do this in a systematic way we conducted an online survey which contained some service specific questions, but also reflected and sought to test some of what we had heard from specialists through our listening sessions and from primary and secondary care professionals engaged in the professional panel activities. Some of the questions posed were therefore deliberately provocative to stimulate discussion of some of the key issues. The survey included a mixture of quantitative and qualitative questions.

The survey was conducted between 14 December 2021 and 16 January 2022. The survey link was sent by email to current staff working in the Gender Identity Development Service (GIDS). It was also circulated to a number of former GIDS clinicians who had previously been in touch with the Review. The purpose of the exercise was explained to the participants, and they were informed about how the material collected would be used (including the use of quotes).

A total of 33 responses were received from current and former gender specialists. While this is a relatively small sample, the quality and fullness of the responses received was very high and the exercise yielded valuable insight and feedback. We are immensely grateful to all those who took the time to respond to the survey with such thoughtful and full answers.

About this report

This report presents summary thematic findings from the online research survey seeking the views and thoughts of clinicians and associated professionals working predominantly with children and young people needing support around their gender identity. All quotes have been anonymised.

The information gathered represents the views and insights of the survey respondents at a moment in time and findings should be read in the context of a developing narrative on the subject, where perspectives may evolve. This relates to both the experiences of professionals, but also the extent to which this subject matter is discussed in the public sphere.

Where comments have been made that relate to the quantitative questions these have been used to illustrate the insight from those questions. On a couple of occasions within the report, longer quotes have been shortened to allow as many different perspectives to be represented as possible. Where this is the case three dots (...) have been used. Every effort has been made not to change the meaning of the comment made. If a word has been added for ease of reading, this is represented in square brackets [].

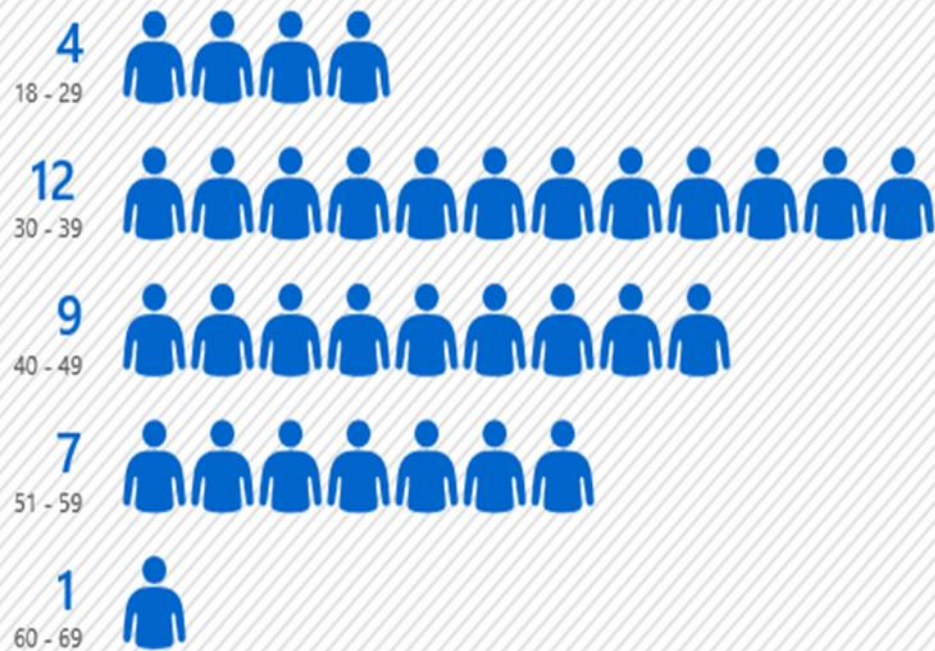
The report represents a sample of the specialist workforce and cannot be considered to represent the position of all specialists who are currently working or have previously worked in this field.

This is one part of the work that the Cass Review is undertaking to understand the experiences and views of those involved and/or engaging with health services for gender questioning children and young people.

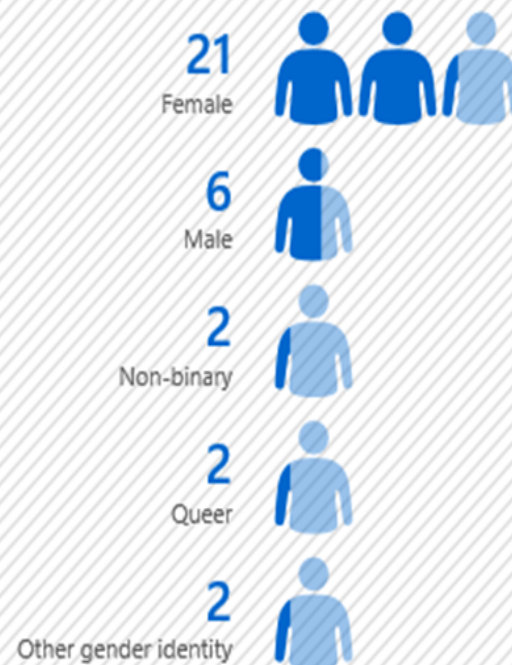
Respondent profile

Respondent profile

Age

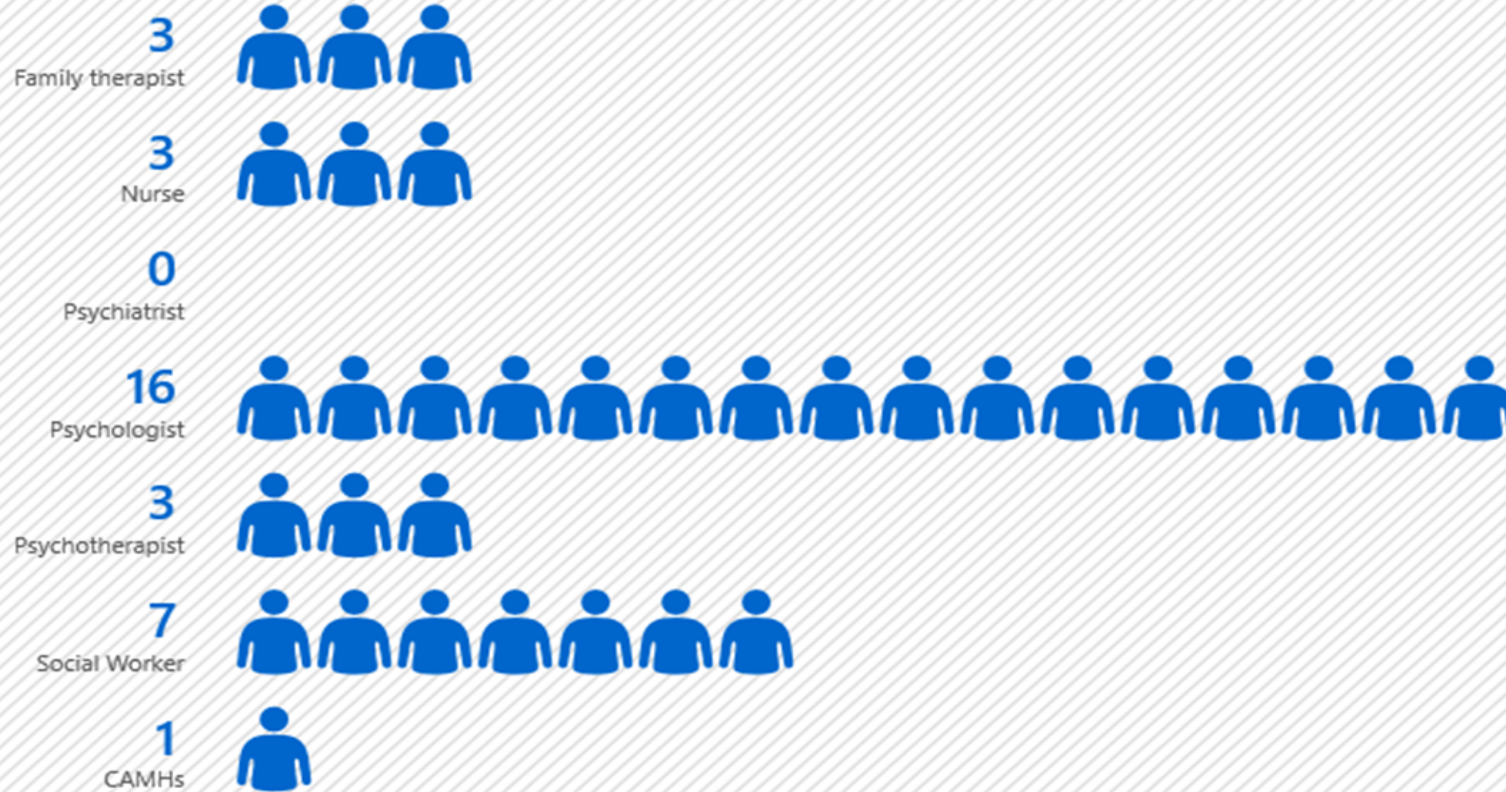


Identified gender

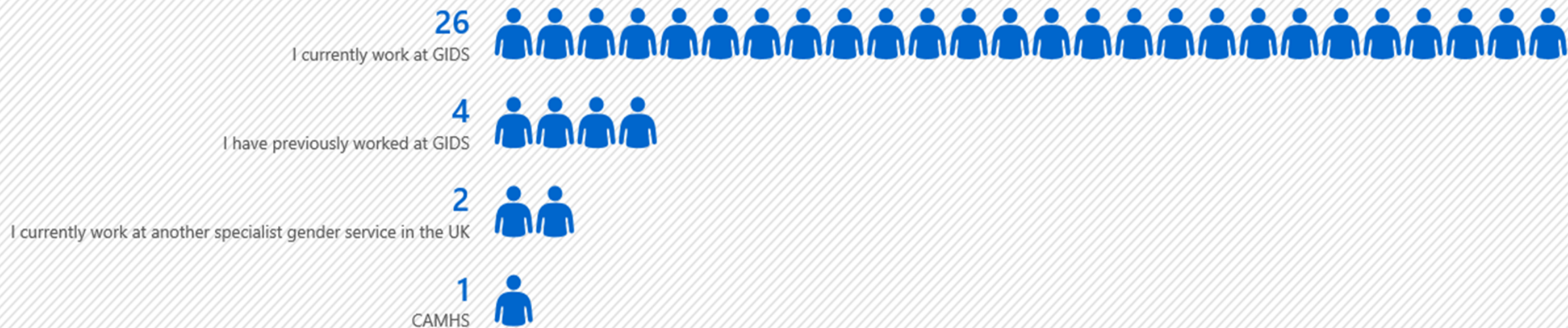


Respondent profile

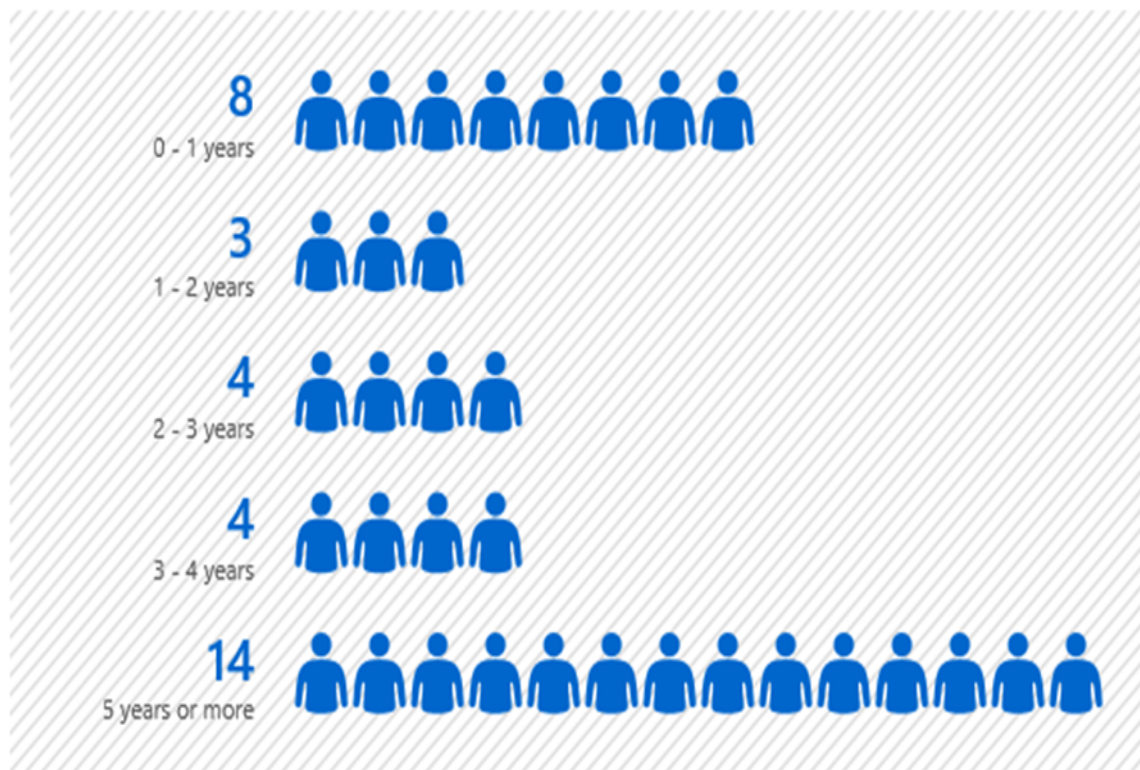
Profession



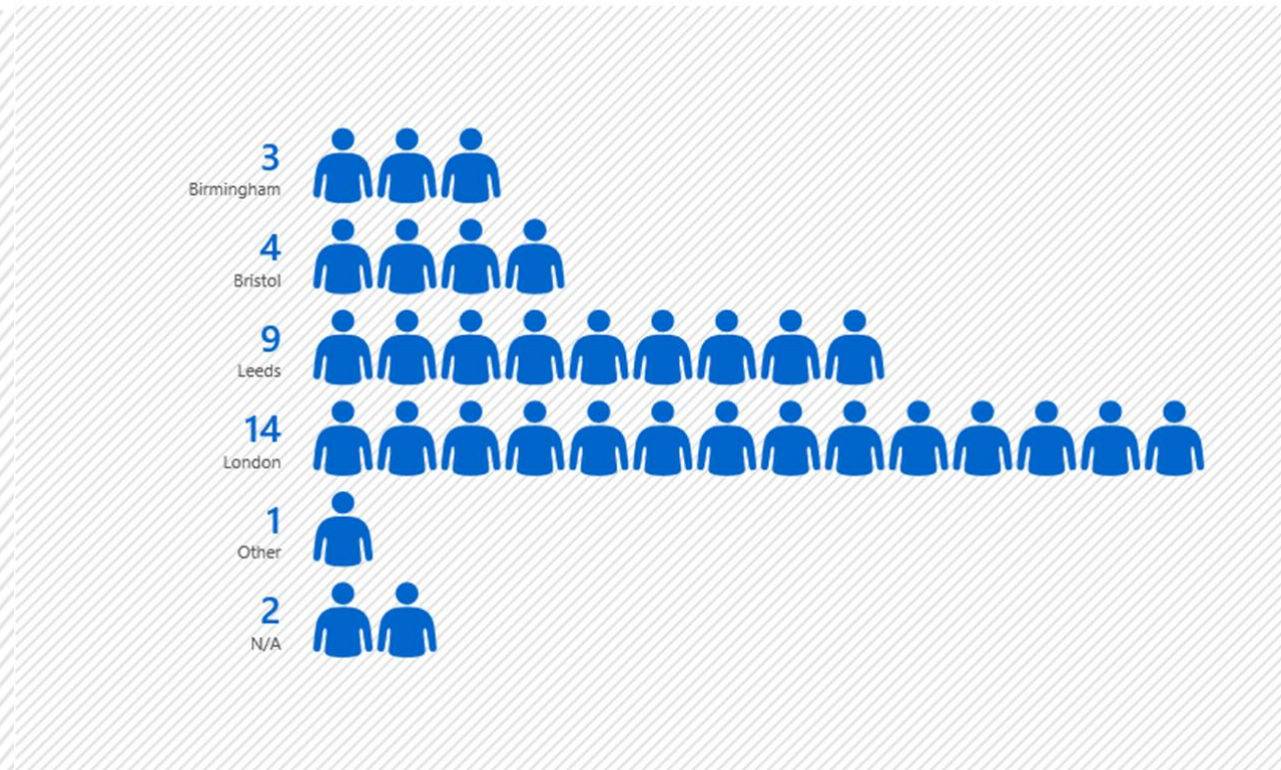
Employment



Years working at GIDS (if relevant)



Base if currently work / previously worked at GIDS



Overview of responses

Summary of findings

There are a number of consistent themes arising from the survey:

- The specialty is a rewarding but challenging field to work in, particularly given the waiting list pressures and level of external scrutiny of the service.
- The detrimental impact of the long wait to be seen by the specialist service can be seen both in terms of the mental health and wellbeing of the child/young person and their openness and ability to engage with assessment when they are seen at GIDS.
- There needs to be better links between specialist services and local services such as CAMHs to ensure the Child/young person receives a timely and holistic assessment and support.
- For the service offer to improve there needs to be more workforce capacity not just within specialist services but within the wider system, different pathway options and clear clinical guidelines.

However, there are also a number of areas where there is less consensus:

- There is not a clear agreed view about the primary purpose of puberty blockers, which may be different depending on the young person's age and stage of puberty.
- There is not a clear view amongst the specialists who responded to the survey as to the purpose of the assessment. Some respondents felt that assessment should be focused on whether medical interventions are an appropriate course of action for the individual. Other respondents believe that assessment should seek to make a differential diagnosis, ruling out other potential causes of the child or young person's distress.
- There are different perspectives on what the role of the specialist service should be within the wider care pathway.
- While there was general consensus that diagnostic or psychological formulation needs to form part of the assessment process, there were differing views as to whether a mental state assessment is needed, and should it be, where in the pathway and by whom this should be done

Detailed Responses

About the service user cohort

Respondents were asked what they consider to be the differences or commonalities when providing a service for a child or young person who needs support around their gender identity compared to another child or young person experiencing non-gender-related distress.

Commonalities: Some respondents felt that there were many commonalities between this patient cohort and other children and young people experiencing non-gender related distress.

"In many ways [there are] more commonalities than differences - dealing with developmental issues, relationships and systemic issues."

Among the commonalities cited were:

- **The nature of young people themselves.**

"Young people questioning their gender identity and those who are not are similar in having a great many personal resources and resilience, as well as often having had very difficult early experiences in their lives (such as trauma)."

"Young people and families in distress are young people and families in distress. I feel that what often gets lost on the wider political debates is how to actually support the individual young people and their families who are in high states of distress who are locating that distress in gender."

- **The professional skills needed.**

"All of the usual skills for providing a service for young people and families are the same - e.g. engagement, compassion, curiosity, being responsive, and conducting appropriate assessments, formulations and intervention plans."

"There are lots of commonalities, in that you would be looking at all parts of a young person's life to understand their distress and how to support them best. You would be listening to the child or young person and really trying to understand their feelings and ideas about the world, and their understanding of themselves. You would be encouraging them to explore and question. You would be helping them to improve their confidence and self-esteem. Cultural competence and an open mind would hopefully be a commonality."

"Some of the commonalities are having an open and honest approach, empathy and caring. Multi disciplinary working, clinical skills."

- **The need to provide a safe space to discuss concerns.**

"Supporting young people and family to discuss difficult/complex/multi layered topics is a transferable from gender to non gender related distress. This involves creating spaces that feel safe, creating new ways of talking or thinking about things, helping families to navigate topics they are stuck with or find hard to talk about without support."

"The importance of building a therapeutic relationship to enable engagement and communication. A safe space and time to discuss concerns/distress is a desire for young people whether they are experiencing gender related distress or not."

- **The need for a (non-directive) thoughtful approach and assessment.**

"I think all young people experiencing gender related distress could benefit from the same kind of therapeutic approaches as their cis counterparts managing distress, such as ACT, CFT, mindfulness and DBT techniques for managing distress, and trauma-focussed and systemic interventions."

"If it weren't for the availability of the medical pathway then I would argue that there is little difference in working with a child who is distressed about their gender as compared to any other child. For any distressed child you would need to do a full assessment, develop a formulation to help explain their particular distress, and then use interventions to try and alleviate that distress."

"All children experiencing psychological and physical distress should access thorough assessment and formulation to ensure that we can be clear about what intervention should be offered"

- **The need to work with the young person's family and the wider network.**

"Commonalities are that we work with the young person within their family and systems - school, CAMHS etc, we are interested in their experience of their gender identity as well as what other people around that have observed and heard."

"Involvement of families/parent/carers to support the young person."

About the service user cohort

Respondents were asked what they consider to be the differences or commonalities when providing a service for a child or young person who needs support around their gender identity compared to another child or young person experiencing non-gender-related distress. Continued.

Differences: Other respondents felt that there are more differences than commonalities between this patient cohort and other young people experiencing non-gender related distress.

"As well as there being commonalities, I would say the differences outweigh them."

Among the differences cited were:

- **The need for clinicians to have specialist knowledge about gender identity.**

"A thorough understanding of gender diversity is needed by the clinicians, alongside knowledge of the difference between gender identity and expression, the available pathways and what these involve (especially that there is more than one pathway - there is a need to invite uncertainty and curiosity into the conversation - just because someone is trans does not mean that medical transition at this time is the right thing for them)."

"I think it is important to be as knowledgeable as possible about trans and queer identities, and conversations about gender which young people have...I think coming to the work with a general understanding of terminologies, 'debates', multiple perspectives on gender is important when having therapeutic conversations with young people, in order to clearly position yourself as not aiming to change their gender identity but hoping to help them to better manage gender based distress."

- **Societal contexts including systemic and societal transphobia.**

"Social contexts can be very challenging for someone presenting with gender related distress. Young people presenting with gender related distress can seem to provoke strong reactions - both for and against - in others close by. I do not seem to have witnessed this to the same extent for other young people presenting with non-gender related distress."

"Experiences of transphobia - such as bullying at school, or systemic transphobia in terms of lack of funding for services or systemic barriers to care."

"Young people with gender-related distress often experience societal discrimination/bullying, needs to be taken into account within the work and addressed on a wider level."

- **The need to be non-directive.**

"There needs to be a nuanced, education and thoughtful approach to support young people accessing gender services with no preconceived ideas as to what the young person may want. This differs to other areas of healthcare where there may be somewhat of an expectation that the medical professional will direct the appropriate clinical pathway."

"You aim to reduce distress that some young trans and non-binary people experience by supporting them with their mental health and wellbeing; promoting self-acceptance, esteem, confidence etc. all of which can suffer due to minority stress and dysphoria. It's hard work and there isn't much evidence to let us know the most effective psychotherapeutic ways of alleviating distress in this group."

- **Availability of local services / support for co-occurring conditions.**

"The GIDS model does not allow treatment for Mental Health problems to be provided at GIDS so we rely heavily on the local Network... It is becoming increasingly difficult to obtain support from CAMHS unless the young person is self-harming or suicidal, and even then the support offered is short-term and increasingly not fit for purpose...GIDS staff are left 'holding' these young people who do not have local support, which is inappropriate and unsafe/risky."

"At present when there [are] associated Mental Health difficulties, I would not carry out the therapeutic work around this but rely on local services, however local CAMHS services are under resourced and the required work does not take place."

- **The competence and confidence of clinicians outside GIDS to work with these young people.**

"I suppose one of the main differences is that mental health services think they know how to support young people experiencing things like low mood, anxiety, self-harm - and there are plenty of evidence-based therapies they can offer...I think with gender, people can feel very out of their depth. They worry about saying or doing the wrong thing, and there is a distinct lack of training on professional courses about helping people with gendered distress. This means that generally these young people will end up at specialist services, even if they have co-occurring needs that should have been met locally."

"There is a lack of knowledge, understanding and expertise to support young people with gender related distress within mainstream services."

"It is different in that other services have positioned gender as being so expert that only GIDS can manage it - with other difficulties often having gone untreated and worsening during the long waiting time."

- **The medical model and medical interventions.**

"To work with gender related distress at the moment, you are constantly aware of the pressure of the medical model. A child/family can fixate on this being the only solution to the suffering and that makes them less likely to engage in the regular psychotherapeutic techniques described above."

"Physical interventions for gender feel like a more long-term medical intervention than most other medical interventions offered to distressed young people."

"The medical interventions we provide are not well-researched or evidence based, and they also have potentially life-long and life-altering impacts, which means the work we do is inherently more difficult, complex and thoughtful"

- **The focus on Gender alone and risk of diagnostic overshadowing.**

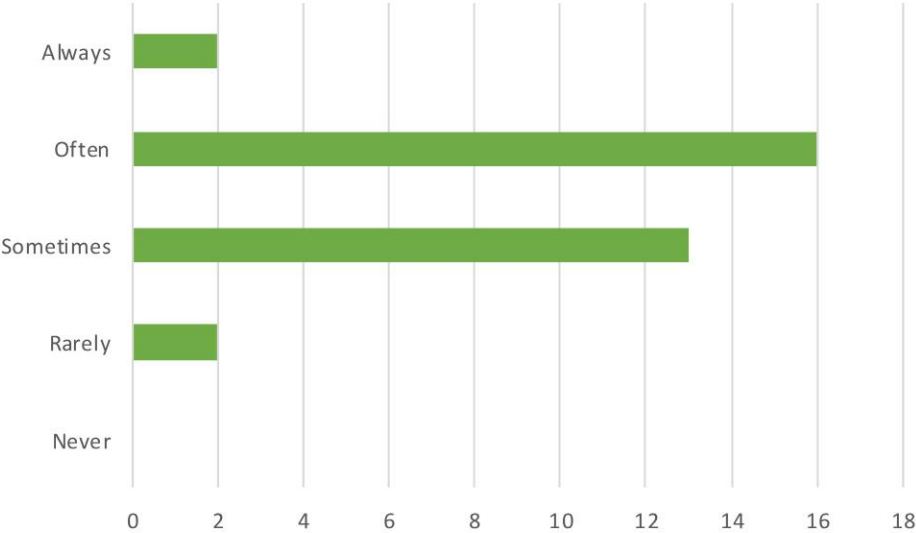
"Gender tends to be seen as the unique factor responsible of the young person's difficulties and distress, and it is much more difficult to hold in mind the possibility of addressing other needs, both for young people and their families, but also for other professional support services like CAMHS or GP."

Gender tends to be seen as the unique factor responsible of the young person's difficulties and distress, and it is much more difficult to hold in mind the possibility of addressing other needs, both for young people and their families, but also for other professional support services like CAMHS or GP."

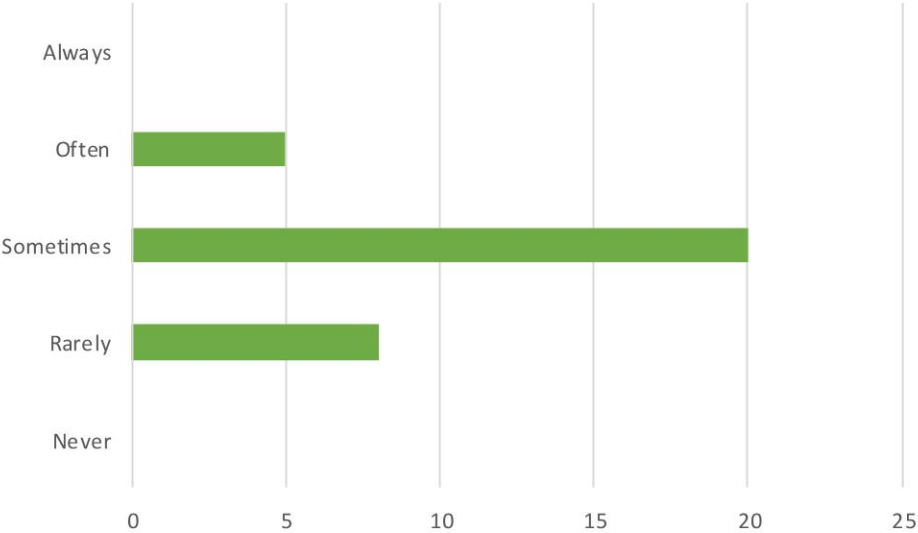
About the service user cohort

Respondents were asked the extent to which they agreed or disagreed with a series of statements:

In your professional experience, children and young people who need support around their gender identity have already obtained information about potential interventions and care pathways available to them



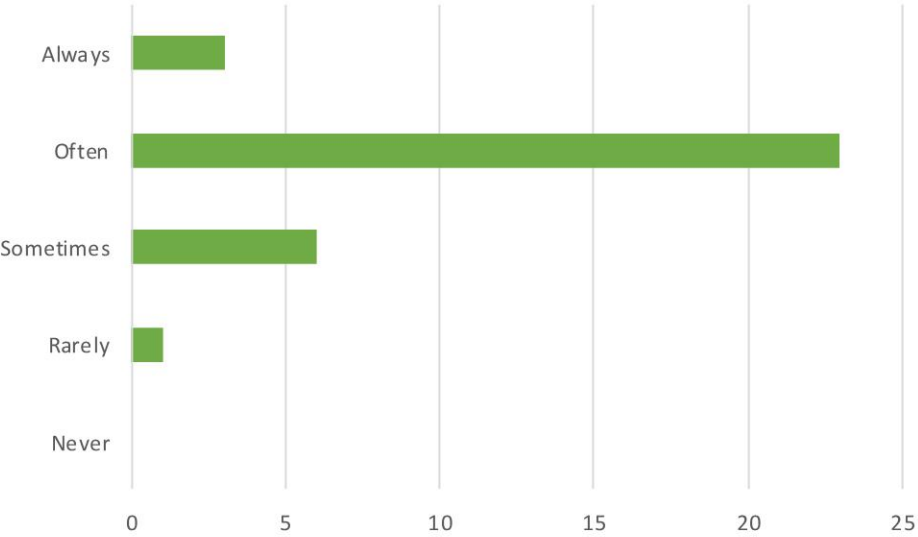
In your professional experience, children and young people who need support around their gender identity are well informed about their options



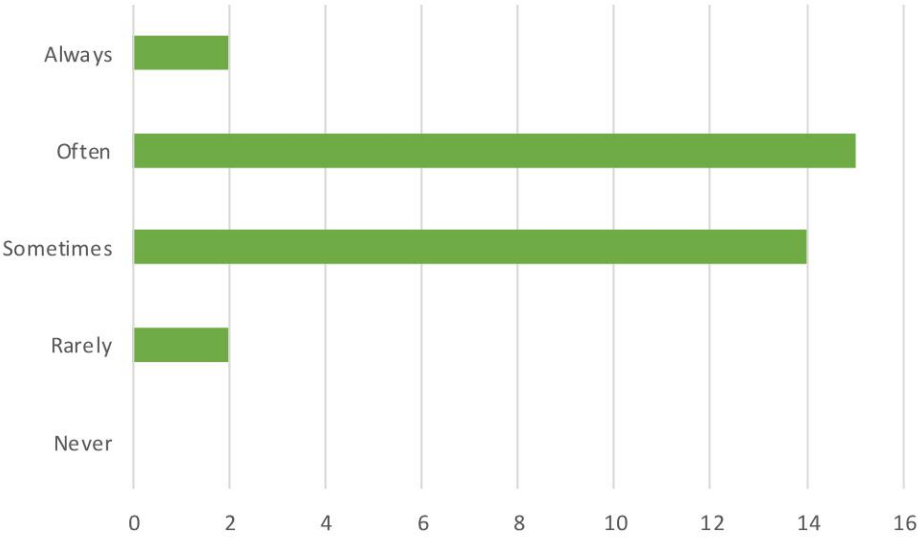
About the service user cohort

Respondents were asked the extent to which they agreed or disagreed with a series of statements:

In your professional experience, children and young people who need support around their gender identity arrive with a pre-determined preferred intervention/pathway in mind



In your professional experience, parents/carers of children and young people who need support around their gender identity arrive with a pre-determined preferred intervention/pathway in mind



About the service user cohort

Overview of findings:

- While a majority (87.5%) of respondents felt that children and young people often (48.5%) or sometimes (39%) arrived with some level of information about potential interventions and pathways there was less confidence that they were well-informed about their options on arrival with 24% of respondents stating that this was rarely the case and 61% suggesting this was sometimes the case.
- A majority (70%) of respondents felt that children and young people and to a lesser extent their parents/carers (45%) often arrived at clinic with a pre-determined preferred intervention in mind.

Comments made to other questions in the survey add more context to this and how it can affect the work GIDS does:

"In general, I regularly see children and parents who would have done extensive research on what is available to them in relation to gender related and therefore sometimes it can be a barrier to the exploration and assessment work if they have a fixed idea on what they want/feel they should receive. I would add that this is not the case for every family and even some who have perhaps set ideas when they arrive at GIDS do engage well with exploration."

"Young people and families often came with very definite views of the 'solution', which largely lies in physical interventions. Unlike in other services, GIDS were often seen as withholding something that private services were selling as the cure. This meant a higher proportion of people coming in with quite antagonistic attitudes towards the clinicians and armed with a very challenging approach."

"Often young people and parents have a fixed idea in their mind about the cause of the young person's distress, and the intervention needed to manage this (medical intervention)."

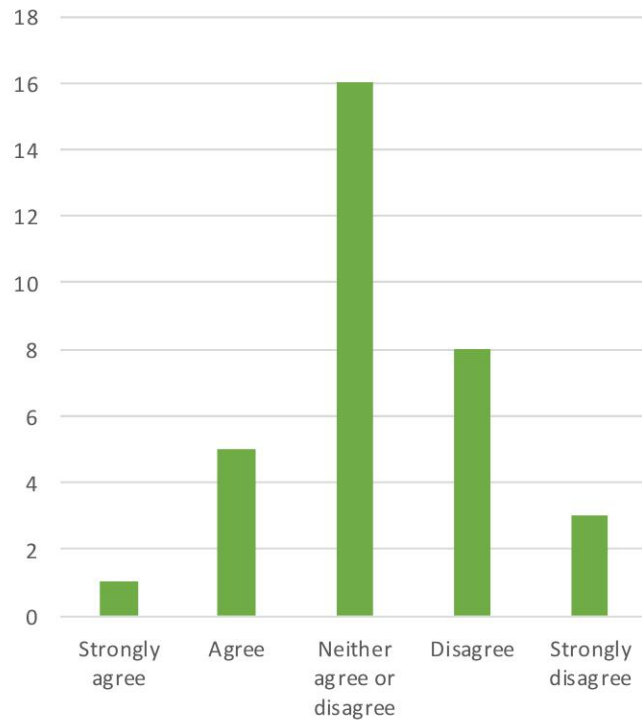
"I have found that initially young people present with very similar narratives to one another and events in [the] family tend to have unfolded in very similar ways however over time it becomes clear that the reasons why a particular adolescent has become immersed in online transgender spaces and has become drawn to the belief that they are trans do tend to be rather idiosyncratic."

"Families and clinicians often constitute polar opposites of [an] unhelpful dynamic. Parents and young people very often demand physical interventions, and do not see the need to engage in talking therapy; clinicians attempt to do their jobs, but often there is very little scope, the whole assessment being structured around deciding whether a young person will be referred to access endocrinology services by the end of it."

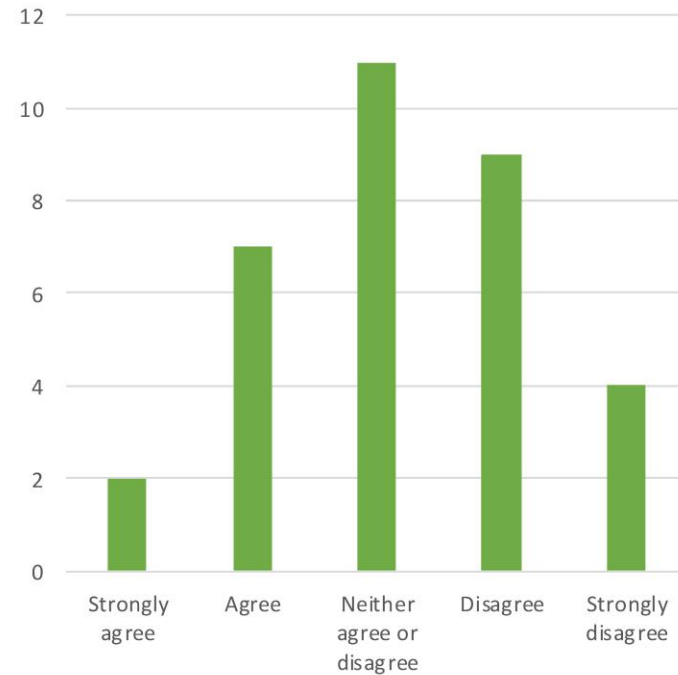
Assessment

Respondents were asked the extent to which they agreed or disagreed with a number of statements regarding the purpose of assessment of children and young people experiencing gender dysphoria.

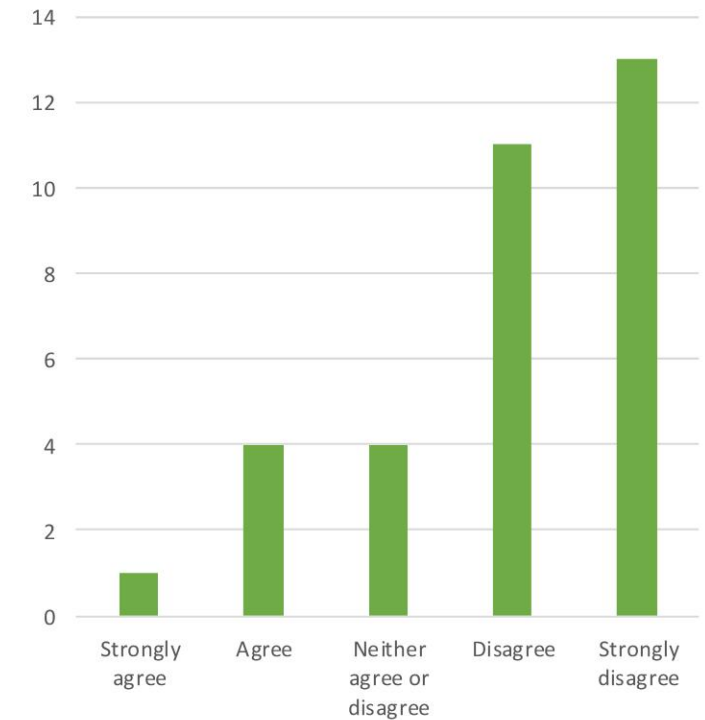
Children with gender dysphoria know their mind, and the purpose of assessment is to determine whether they wish to have medical intervention and their readiness for this.



Gender Dysphoria in children and young people is a symptom, and it is important to make a differential diagnosis as to whether transition is the right option or whether there is another way to address their gender-related distress.



Gender dysphoria is always an indicator of another underlying problem and assessment should focus on understanding the causes of their distress.



Assessment

Respondents were asked the extent to which they agreed or disagreed with a number of statements regarding the purpose of assessment of children and young people experiencing gender dysphoria

There was no clear consensus for any of the given statements regarding the purpose of assessment.

For all three of the given statements, more respondents disagreed than agreed.

It should be noted that several respondents commented that these statements were overly simplistic, which may be reflected in the numbers selecting “neither agree or disagree”.

The strongest consensus was disagreement with the statement *“Gender dysphoria is always an indicator of another underlying problem and assessment should focus on understanding the causes of their distress.”* (39.4% strongly disagreed and 33.3% disagreed with this statement).

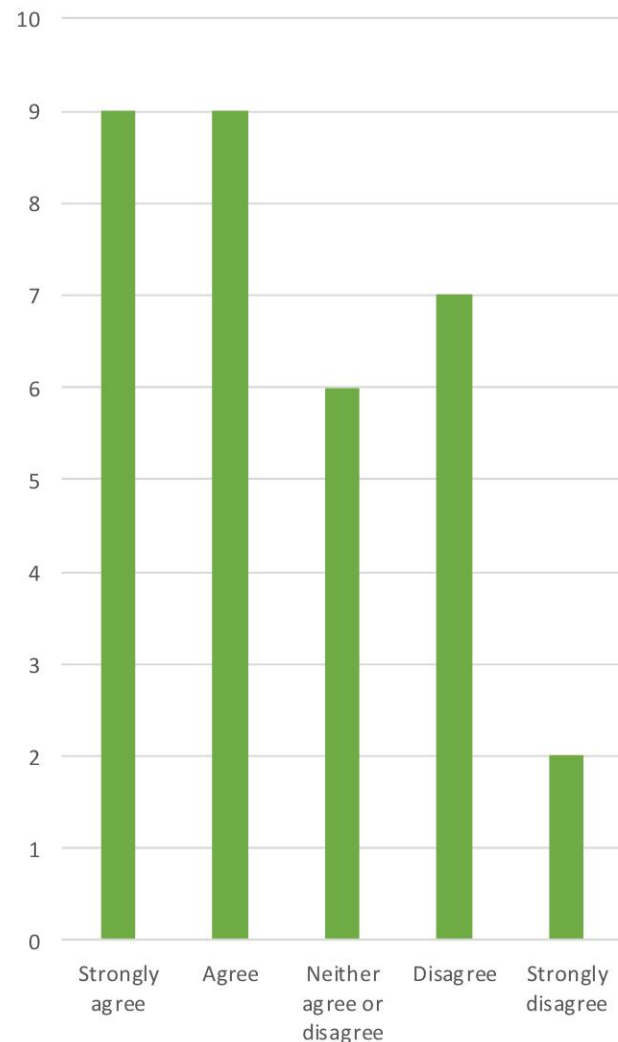
The statement receiving highest level of agreement was *“Gender Dysphoria in children and young people is a symptom, and it is important to make a differential diagnosis as to whether transition is the right option or whether there is another way to address their gender related distress.”* (6% strongly agreed and 21.2% agreed with this statement).

However, even in this case, more respondents disagreed (27.7%) or strongly disagreed (12%) with the statement than agreed.

Assessment

Respondents were asked the extent to which they agree or disagree that it can be helpful to undertake a mental state assessment on children and young people presenting at their clinic.

They were also asked what role they think a mental state assessment has in the care of children and young people needing support around their gender identity.



- **A majority (55%) of respondents agreed or strongly agreed that a mental state assessment would be helpful in assessing the children they were seeing at their clinic. However, a notable minority (27%) did not agree with this.**

- **Respondents who agreed that a mental state assessment would be helpful reasoned that it would provide a fuller picture of the young person and was helpful in managing risk.**

"It is helpful to understand risks and enable a multi-professional response within the YP [young person's] network. It is also helpful to understand the YP functioning so that assessment and intervention is tailored to the YP needs and level of understanding."

"I think it is imperative that young people receive a mental state as well as risk assessment in order to ensure all of their mental health needs are met and to reduce/manage risk. Living with gender dysphoria for a number of years (whilst on the waiting list) without the intervention of a specialist service can impact someone's mental health and increase their risk greatly."

- **Some respondents suggested that it can be helpful but only part of a broader assessment process.**

"I think mental state assessments are important, but only a (small) part of a broader assessment around gender development. It doesn't cover gender identity development over time and context, developing an understanding, family perspectives, hopes for future, developmental assessment, etc.."

- **A smaller number of respondents felt that a mental state assessment had no role in the care of children and young people needing support around their gender identity and doing so risked pathologizing the young person unnecessarily.**

"None. It is a snapshot of someone's presentation on that particular day at a particular time. It is a psychiatry tool that risks undermining the validity of patient experience and the ongoing, dynamic, and relational nature of the therapeutic relationship between client and clinician."

"None. This would be irrelevant for the young people I see. The tool lacks depth and complexity, and I would be unsure of the purpose of using it. The tool is part of psychiatry and has no place in GIDS."

- **Some clinicians said that a mental state assessment should be undertaken only when clinically indicated but that it should be done by local CAMHS and was not the role of GIDS.**

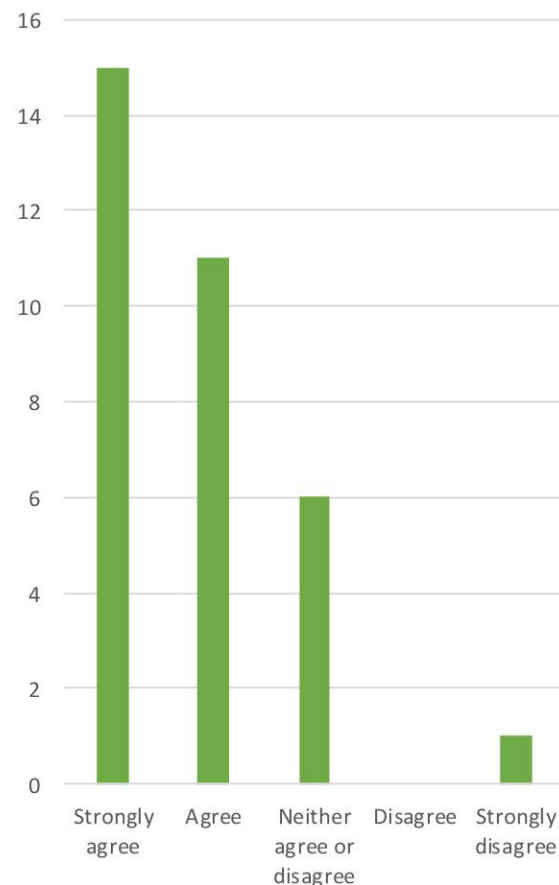
"The same as in any service, that if someone is presenting in acute distress/mentally acutely unwell then a mental state assessment would be appropriate but would be done by their local network and not in GIDS."

"As gender dysphoria isn't considered a mental health condition, it is unclear what role a mental state assessment would play. If there were concerns regarding mental health needs, my view is that it would be the responsibility of the local CAMHS team to undertake a mental health assessment."

Assessment

Respondents were asked the extent to which they agree or disagree that it can be helpful to use psychological formulation* with children and young people presenting at their clinic.

They were also asked what role they think psychological formulation has in the care of children and young people needing support around their gender identity.



- The majority (79%) of respondents agreed or strongly agreed that psychological formulation can be helpful in assessing children and young people needing support around their gender identity. 18% neither agreed or disagreed and 3% (1 respondent) strongly disagreed.
- Those respondents that agreed that psychological formulation is helpful reasoned that it can provide a structured process for understanding the child or young person's distress and provides a more holistic picture of the young person which can be helpful in developing an appropriate care plan.

"The process can build an understanding around the factors underlying any distress. This may identify those related to gender or those not and can enable exploration with the young person and build an understanding and picture. This can also enable signposting to other services if required, i.e. CAMHS, GP etc."

"Bringing together all relevant aspects of someone's life and context to make sense of their current experiences and indicate possible helpful ways forward. When co-created this can be one of the most powerful interventions when working with children, young people, and families. With gender-related distress, the aim is to explore and understand, rather than explain away, someone's experiences"

"It's key - how can you know how to help someone if you haven't got an individualised hypothesis as to why they are suffering? If you just use diagnostic assessments then you lose the individual details and so the differences between children's experiences - which are vast - and you are at risk of both confirmation bias and a one size fits all treatment approach, which we know inevitably won't work for everyone."

- Other respondents, while recognising psychological formulation can be helpful in some circumstances, were concerned that it could serve to further stigmatise the young person.

"I don't think it's fair to use gender dysphoria as a psychological formulation as a way to further stigmatise young people as it's not a mental health condition. Some young people and family may internalise having gender dysphoria as having something wrong with them."

"It depends what you're formulating. If you're formulating distress, then yes absolutely. If you're formulating someone's trans or non-binary identity, then no as that feels discriminatory. We don't formulate why a person is cisgender or straight... We need to be constantly self-reflective to detect and interrogate these underlying assumptions that might underpin our desire to formulate a person's gender identity."

"A psychological formulation may be useful in understanding the emotional and relational aspects of existing as a trans person in society. However, it is not appropriate to understanding the aetiology of why someone may turn out to be trans or gay for that matter."

- A couple of respondents felt that it was not possible to have formulation and diagnosis.

"...you can't really have a formulation and a diagnosis, so if a diagnosis is essential for progress through the system the diagnosis trumps the formulation. Some clinicians and the young people do not want a formulation they want diagnosis to go onto treatment, that's what they come for."

* Diagnostic Formulation: A structured approach to understanding the factors underlying distressing states in a way that informs the changes needed and the therapeutic intervention for these changes to occur.

Assessment

Respondents were asked if there was anything else they wanted to say about assessment of children and young people needing support around their gender identity.

- **The assessment process needs to be tailored to the individual.**

"The assessment of children and young people has to be tailored to the individual child and families circumstances, this includes when certain topics are asked and the pace of the assessment. It is also dependent on their communication needs and readiness to speak about gender. Speaking about gender and the pertinent issues (relationship to the body, gender identity development over time, puberty, sexuality) is emotive and has to be done with respect and sensitivity."

"I believe it is crucial to be able to respond to an individual young person and their circumstances, which means as a clinician I need to retain flexibility and manoeuvrability in response to the young person."

- **Many respondents said that there needs to be adequate time and space given to holistically explore with the child and their family based on their individual needs.**

"What is needed is a space whereby people's understandings of themselves are valued, whilst also providing an open space for exploration of what this means to the individual, and what support they need in order to live a happy and fulfilled life."

"It needs to be done carefully and take as much time as required. It must be conducted in an ethical, purposeful way, that respects the needs of the young person and their families. It should be accountable and open to challenge."

"As a development service, we should be just that. A service that enables a young person space and time to explore, rather than feeling the pressure (clinicians feeling the pressure) to diagnose a young person and place them on a medical pathway."

- **The extensive waiting list has hampered GIDS staff's ability to take this approach.**

"[The] wait has changed the work that we do with families considerably. When we can see young people soon after they seek a referral, we are able to do some exploratory work with them, some of them come to us wanting to explore gender or think about possibly socially transitioning. We are also then able to provide timely and appropriate interventions to [them]. However, now, young people have waited several years, have sought support elsewhere and now mainly come to us wanting to access physical interventions, however for many of them it is too late and we just do an onward referral to an adult GIC [Gender Identity Clinic]."

- **While some respondents feel the current GIDS assessment is robust and thorough they have suggestions on how it could be improved.**

"I think GIDS assessment process is robust, holistic and thorough, which I fully believe is the best way to be conducting these assessments at the current time. I would hope that going forwards, there would be more treatment options available for young people experiencing gender-based distress as well as physical interventions, such as third wave CBT, family therapy or psychotherapy at GIDS"

"I really value the assessment process in GIDS and see this as a cornerstone of the work. It is an intervention unto itself. It is generally a very helpful collaborative process which can support gender diverse young people and their families/carers in a range of ways. I do think the format could be somewhat different perhaps allowing for more flexibility in terms of times between sessions and longer sessions utilizing more creative methods in terms of assessment."

- **Better links between specialist services and CAMHS is needed to ensure the CYP receive a timely and holistic assessment and support.**

"Having worked at both GIDS and CAMHS, I strongly feel that there is a need to change the way in which young people are assessed to ensure they receive a timely and holistic assessment and support. I believe GIDS clinicians should be linked to all CAMHS services in order to support more localised holistic assessments."

"I cannot stress enough the importance of the local support for co-occurring mental health problems, and how it's almost non-existent in many parts of the country... I would very much like to be able to offer therapy to young people at GIDS as I think we might be able to make a difference. A group of us at GIDS are interested in using 3rd wave CBT therapies such as CFT and ACT to alleviate distress and build self-compassion in our trans and NB young people."

- **There is variation of practice in how assessments are carried out.**

"I think the service has tried to be open to different perspectives on the role of adverse life experiences but this results in variations in practice in how assessments are carried out. I think these variations in practice mean that different clinicians end up having different ideas about how common complexity is amongst the population we are seeing (to what extent the developmental history is explored depends on the belief of the clinician about the importance of the developmental history)."

- **The assessment should not be rooted in pathology.**

"The assessment should not be rooted in pathologising young people and/or their experiences. Assessment and outcomes should be holistic- extending to family members, members of network such as GPs and schools."

"We need to be creating gender services that listen to and respect the experiences of young trans people. And that help to normalise those experiences rather than pathologise them."

Respondents were asked what they think the role of the specialist service should be.

- To be specialist in their specific area of expertise**

"Offer specialist intervention, support and knowledge to those it works with. To add to and develop the research base for the specific area of specialism. To advocate for this area of expertise and for the people who use services in this area. Be a beacon for knowledge, skills and training. To have a national presence to add to the discussion in this area."

"To be the lead in assessing and care planning around gender identity."

"The service should have specialist knowledge and training."

- To provide a fuller assessment, including addressing other cooccurring conditions.**

"Detailed assessment of all areas of health before 17-year-olds go to adult services."

"To provide a fuller specialist assessment and advise [the] young person/family on options for the future - including addressing co-existing mental health issues and watchful waiting."

- To upskill local services, provide expert consultation and manage more complex cases**

"Ideally local services should be available to young people where they can discuss and explore their gender, be supported to try out social transition etc. If this was the case a specialist service would only be needed if they wanted assessment for physical interventions or there were multiple factors at play that local services felt unable to support with."

"GIDS should move to a consultation only model with all work around gender carried out locally. I think young people are not well served by having gender-based distress separated out from broader thinking about their mental wellbeing. Often, I have felt young people could benefit from more intensive therapeutic support that it is not possible for our service to manage due to current waiting times and the distance that families would have to travel for more regular appointments."

"Primarily consulting with and skilling up local services, to enable them to feel much more confident and capable to manage gender distress within their daily work. Alongside this there would need to be more funding for local services though... I feel that GIDS could then only see the more complex cases rather than any case where gender or sexuality is just mentioned."

"To liaise with a wider network and to educate local services who can support that person in a more robust way"

- To review and support a young person and family to explore gender and have a safe space to do so.**

"A service that enables children/young people and/or their parents/carers [to have] a safe space to explore around gender. For them to feel supported and listened to, and [have] time to build the therapeutic relationship. For the clinician(s) to adapt their approach to enable accessibility to the service and provide [the] child/young person and/or their parents/carers with appropriate information around this area to enable them to make informed choices."

"To support young people who are experiencing gender related distress, both through therapeutic discussions and [to] support them in thinking about medical interventions and if this is the right path for them."

- To explore whether physical interventions are appropriate for the individual**

"To hold a curious, open, safe, reflective, informed and knowledgeable space to think broadly around gender identity [and] gender development with young people and their families. If a young person would like to access a medical pathway, to support a young person with this process via an assessment and as part of this [give] further consideration to the medical pathway to fully support the young person to make an informed decision without having an opinion either way whilst bearing in mind we are working with a community that experience systemic oppression and there is a need to ensure that the work we do is collaborative and gentle and without judgment."

"Providing gender related advice and support to young people and explore whether physical intervention (hormone blockers and cross sex hormones) is an option for the young person, and [if] it's not support and exploration of other pathways should be given. Support around managing gender dysphoria, and young people feeling validated and supported. Managing uncertainty around the future and providing support on how to manage this. Offering a space for reflection for the young person and family. Also liaising with school, CAMHS, GP and other organisations to ensure the young person's holistic needs are met."

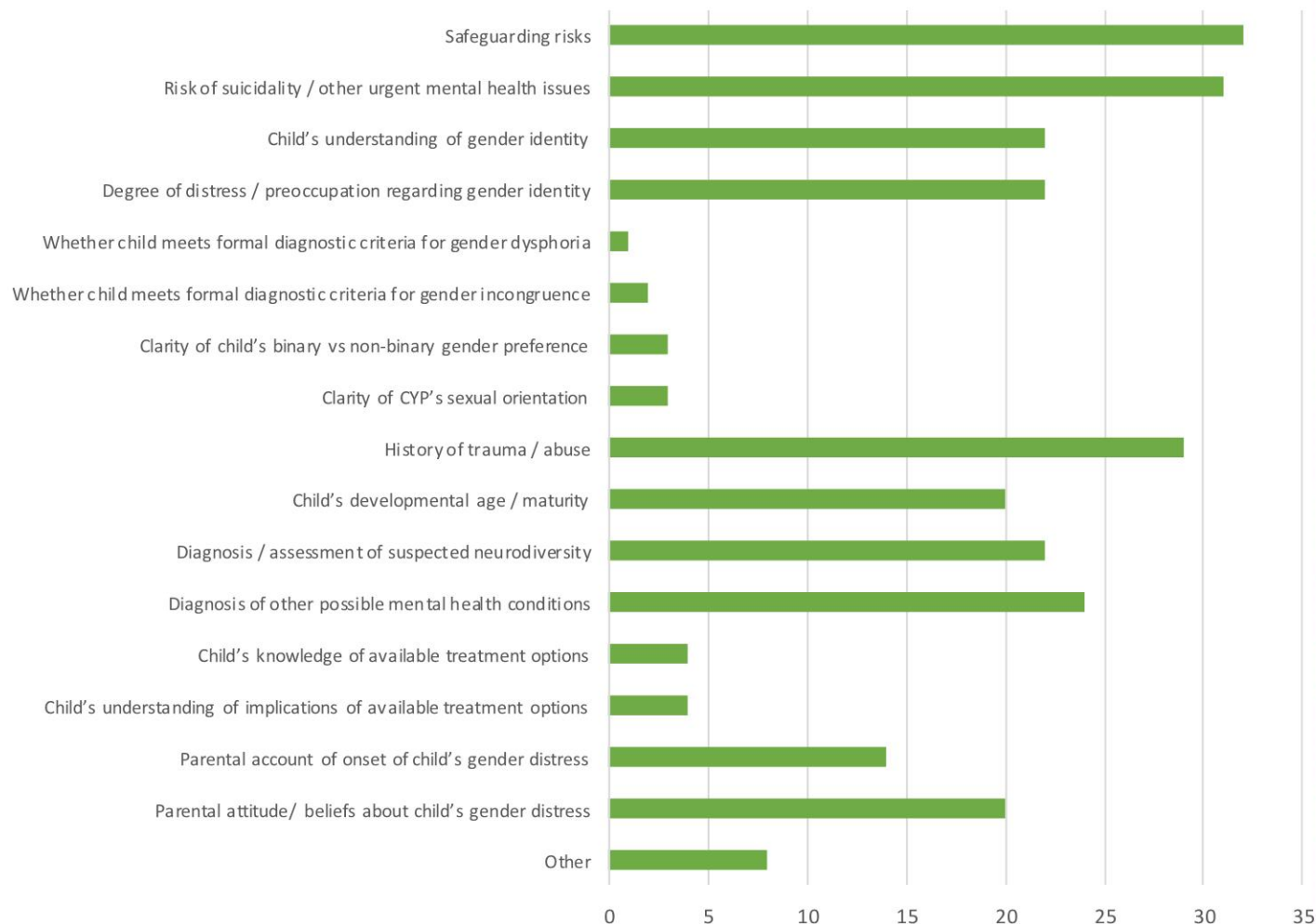
- It should contribute to research and thinking**

"To research and publish treatment findings, as well as reflective and sociological pieces."

"To develop a coherent and evidence-based understanding of the massive increase in adolescents identifying as transgender and develop a therapeutic psychological model for helping children and young people to feel comfortable with themselves and with their bodies that can then eventually be disseminated across local services."

Care Pathways

Respondents were asked about their minimum expectation of the support other agencies should have offered to young people and their families before they are referred to GIDS



- **The top responses were:**

- Safeguarding risks.
- Risk of suicide and other urgent mental health issues.
- History of trauma or abuse.
- Diagnosis of other possible mental health conditions.
- Diagnosis or assessment of suspected neurodiversity.
- The child's understanding of gender identity.
- Degree of distress / preoccupation regarding gender identity.

- **Respondents added a couple of "other" types of support or information they would expect other agencies to have offered prior to referral to GIDS:**

- Physical health and whether they are on any medical treatments.
- Who is involved in the [young person's] network.
- Broader mental health support to manage a range of associated difficulties.

- **In addition, general comments made were:**

"None of these are support, they are assessments."

"I have ticked the above in terms of what I would like to see provided to us, but we struggle to get GPs to do risk assessments of young people let alone more detailed assessments"

"Professionals completing referrals and children/parents need an awareness, understanding and knowledge that each person's gender journey is individual (even a heteronormative one) and there is no right way to transition, if indeed one does choose to transition. Not all people experiencing gender and/or sexual diverse identities need or want to access a specialist service or treatments."

"This all really depends on what model of understanding – [as to] why a child identifies as transgender - is underpinning the professional's approach."

"The above depends on the role the service should take. I have answered based on the way GIDS works at the moment."

Care Pathways

Respondents were asked what factors might indicate that a child or young person would not be appropriate for GIDS referral.

- **If the child is not experiencing significant levels of distress a GIDS referral would not be appropriate.**

"No significant distress or impairment in relation to gender."

"If they are not experiencing gender related distress. If there is no impact on their daily functioning because of gender."

"In terms of how services stand at present I would say the only factor would be that gender is not a concern for the young person, sometimes referers don't understand the difference between gender and sexuality."

- **However, any distress relating to gender made a referral to GIDS necessary.**

"If there is distress in relation to gender then all referrals for GIDS are appropriate"

"I think that anyone who is experiencing distress related to their gender should be eligible for a GIDS referral. I don't think a referral should be delayed by input for any other needs as the waiting list is 3+ years, however if other needs are identified at the point of the referral they should be addressed and updates sent to GIDS while the young person is on the waiting list."

- **If the child or young person's gender identity is newly formed or still evolving.**

"If the young person had recently started exploring their gender and there was low levels of distress (i.e. if there was trained/competent staff in CAMHS they could be supported by CAMHS in consultation with GIDS if needed)."

"Very recent onset of gender questioning/gender-based distress/self-reporting thoughts about gender."

"A young person who has only been presenting with gender incongruence for a very short period of time and little exploration has been done locally."

- **If there are safeguarding concerns that would affect ability to engage.**

"Safeguarding issues that mean it may be unsafe to engage [the] child in work relating to gender before these issues have been resolved"

"Experiencing a level of distress that poses an immediate risk to their safety or prevents them from being able to meaningfully weigh-up decisions (e.g. eating disorder, psychosis, significant self-harm or suicidality)."

"Where the young person does not have sufficient stability (housing, risk, mental health, addiction, etc.) to engage in intensive psychosocial exploration."

- **Lack of a full formulation/general support from local services.**

"If there are other underlying issues that have not been addressed, a referral to GIDS in its current form would not be appropriate. Either GIDS clinicians need adequate training to work with co-morbid or underlying mental health issues, or these issues need addressing elsewhere first."

"Significant additional mental health difficulties that have not been managed locally"

"Unclear formulation from mental health service in relation to complexity, risk, unmet mental health needs, or safeguarding; evidence that the need can be met by local support services"

"A high level of risk that is not being managed. A young person being in the midst of complex trauma work and perhaps not being able to engage with two processes at one time."

- **If the referral is more about supporting the parents than the young person.**

"[If the] young person [is] not expressing any distress about gender (we receive referrals which are more about a parent's worry than a young person's)."

"[Where] parents [are] not aware of the referral."

"Their age - sometimes we get referrals for 3, 4, 5 year olds. Young children that have no true comprehension of gender identity at all. Here it is more the parent that needs support on holding options open for their child, but I'm not sure this should come from a national specialist service."

"Concerned parents more focused on gender issues than [the] young person."

- **If the child / young person is already accessing treatment privately.**

"That they [the child or young person] are already seeking medical intervention from a private provider for gender related distress."

"[If the] young person [is] already accessing treatment privately and [has] been assessed in the private sector - the young person will have to go through another assessment at GIDS which may cause distress."

"If they accessed private [treatment] which meant there was no way for them to come back into NHS protocol (e.g. cross-sex hormones under 16)."

Referral for medical intervention

Respondents were asked what factors they take into consideration when deciding suitability for puberty blocking treatment.

- A full exploration of gender identity, level of distress around puberty and understanding of general development is needed.**

"Full exploration of gender identity including discussion about puberty/relationship to body and fertility - consideration around distress and the benefit of the blocker to reduce this."

"Gender Development History: strong narrative/ weak narrative/Binary/Non Binary/Consistent"

"Exploration of sexuality and how this is or not linked to gender identity development."

"Young person's gender development history, current gender identification. Consistency of gender identification, understanding of gender identity as separate from gender roles etc."

- The young person and parent/carer's understanding of the medical treatment.**

"That it is what a young person wants and has expressed independently that this is what they would like to access, having been informed in detail of what Puberty Blockers do and don't do, expectations and side effects etc."

"Parental consent, as well as parents having a robust understanding of [the] risks/benefits of hormone blockers."

"Psychological and physical wellbeing. Ability to make an informed decision. i.e. to understand information relevant to the decision, retain this over time, weigh up and communicate their decision."

"Young person's and family understanding of [the] treatment pathway, and a ability to manage with uncertainty around the future, and also their expectations."

"[Whether the child or young person has] realistic expectations around treatment [and] realistic ideas about the outcome of accessing a medical treatment."

- Understanding of external factors/influences.**

"[Getting a] sense of life in school, friends and broad wellbeing."

"[The need to] understand the relationship to online communities and any risk issues."

"[The need to] understand family context and history, key attachments [and] parent/carers stance towards issues."

"[The need to] understand spiritual, religious and cultural beliefs."

"[The need to understand any] coercion – ensuring [the] young person isn't coercing [the] parent and visa versa - individual sessions [held] with both parties."

- The extent to which alternative approaches have been explored.**

"How much they have explored alternatives and are aware of risks and benefits and whether they have thought about what they want in the future, areas such as fertility or their body."

"Exploration of alternative approaches (non-medical). Exploring how they [the child/young person] would see their life if they did not go down the medical route."

"Distress around the body (needs to be significant distress, and other attempts to alleviate distress have not been successful before we can consider blocker)."

"Clear indication that gender is a pressing issue and has been present as such for some time. That the child/young person and their family have been provided with access to and considered alternative options to puberty blockers. that shared decision making is based on informed choice, and a demonstrated ability to weigh up options."

- Mental health and general stability.**

"Relative stability in mental health and all other domains of life - or a ability of accessing treatment being a factor in achieving stability."

"If there are mental health problems, how well the person is supported by local services. [The] level of functioning across the different areas in the young person's life."

"Get a thorough grasp of the nature of any additional difficulties and the impact of these on life and functioning."

"If there are mental health problems, how well the person is supported by local services."

"Stability around decision-making - is there sufficient stability and has the young person communicated a desire for this intervention for a prolonged period of time."

- A small number of respondents expressed the view that blocking puberty should not be practiced due to unknown long-term effects and young people's ability to give fully informed consent.**

"Blocking puberty isn't safe because we don't know what the long-term impact is on brain development and it also means that male adolescents will require more invasive genital surgery if they continue with gender transition as adults and if they don't continue, they will be stuck with immature genitals."

"It is my experience that the vast majority of children and young people under 18 do not have the emotional maturity to discuss issues around fertility preservation, the possibility of wanting to have children in the future... etc. Hence, as I do not think under 18 young people should be in a position to actually decide about these treatments."

Referral for medical intervention

Respondents were asked what factors they take into consideration when deciding suitability for feminising/masculinising (cross-sex) hormones.

- **Young person's ability to consent.**

"Their chronological age (need to be 16+), do they have capacity/can give consent."

"Consideration if the young person requires any adaptation to understand and retaining information and if there is any conflict with parents/ carers [regarding] access to medical pathway."

"Current age/stage of development - level of maturity."

- **Young person/parent/carer's understanding of the treatment and side effects.**

"Young person/parents or carer's ability to understand, weigh and retain information about the treatment."

"Awareness of irreversible effects and exploring this with the young person and their parent/carer."

"Opportunity to consider fertility and fertility preservation options."

"When considering gender affirming hormones consideration [should be] given to [whether] it is what a young person independently wants and has been informed in detail of what GAH [gender affirming hormones] do, side effects, expectations etc."

"The potential benefit of starting [hormones] in the slow graded way at UCLH – University College London Hospital - (slowly increasing to an adult dose) versus starting on a full adult dose in adult services."

- **Exploration of different pathway options and understanding of potential outcomes.**

"[That the young person has the] opportunity to consider multiple gender pathways, potential for gender development and change."

"The degree of therapeutic engagement that has been possible. How much do I feel I have been able to think with this young person in a meaningful way?"

"[That the young person has the] opportunity to consider a range of influences on experiences of gender and distress if they wish (e.g. trauma, family relationships, gendered experiences growing up, heteronormativity and patriarchy, sexuality)"

"The young person's thoughts on how they would manage if they came to a different idea about their gender in the future - whether the young person understands possibility of regret."

- **The young person has a holistic view of what it means to transition and the impact of taking hormones.**

"How well a young person is doing in their life in a broader way. Is there evidence that a young person has been able to meaningfully engage in life whilst presenting in another gender."

"A young person's experience of relationships - friendships as well as romantic/sexual relationships, their sexuality and how they currently identify."

"Plans for the future in relation to gender."

"Able to think to the future about impact on life, relationships, medical care, openness vs secrecy."

"How the young person has responded to hormone blocking treatment."

"That they hope to move toward something rather than/alongside escape from something, e.g. not just trying to escape societal expectations regarding women."

- **Mental health and general stability.**

"Their mental health and if they need/are getting any support."

"[That the child/young person has had] stable and consistent mental health for at least six months."

"Consideration around mood/mental health and if there is any further support needed alongside support from GIDS."

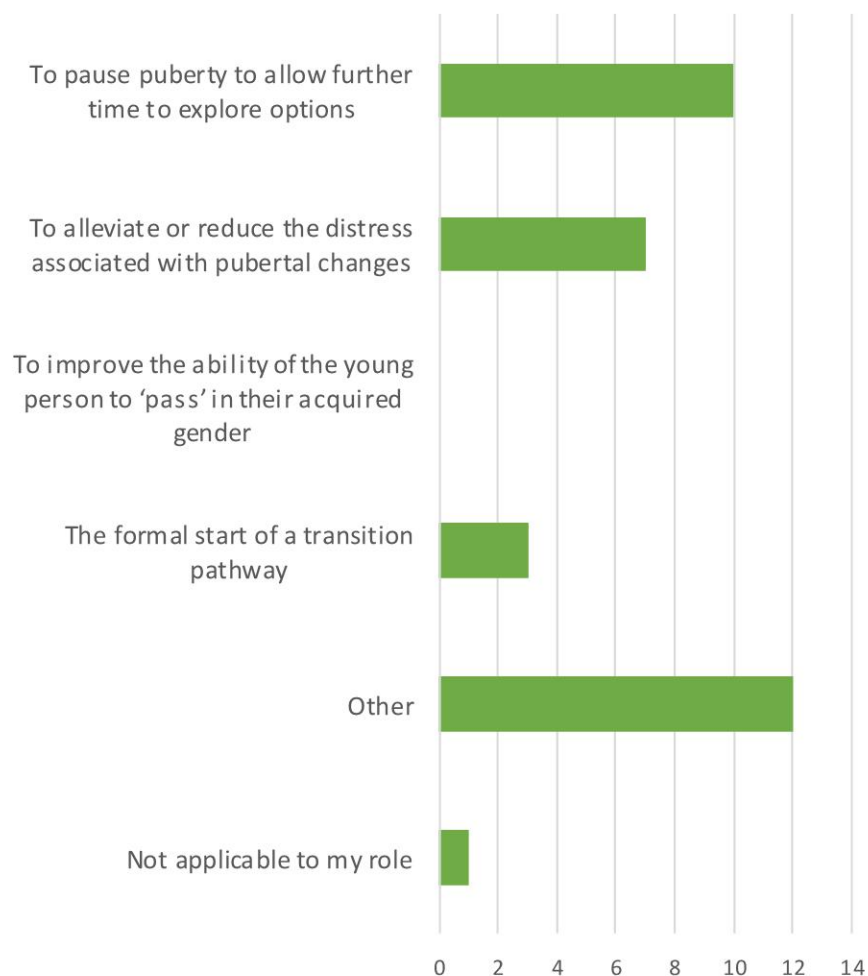
- **A small number of respondents expressed that cross-sex hormones are not safe for adolescents.**

"It's not possible to predict in adolescents who will continue to identify as transgender into adulthood and the risks of harm are profound."

"Adult issues are being 'thought about' with children who simply do not have the emotional development to be able to really think about it all."

Referral for medical intervention

Respondents were asked how they would describe the main purpose of puberty blockers when discussing treatment options with a child/young person.



- **The top responses for the given statements were:**

- To pause puberty to allow further time to explore options (30.3%)
- To alleviate or reduce distress associated with pubertal changes (21.2%)
- The formal start of a transition pathway (9%)

- **Several respondents indicated that there are multiple purposes.**

"I think the puberty blockers main use is more than just one answer. I think it is to firstly pause puberty to allow a young person space to explore whilst hopefully reducing distress associated with the pubertal changes."

"To both pause puberty in younger children and create space for further exploration, and/ or alleviate distress associated with pubertal changes."

- **Several respondents said that it depends on the individual's age and stage of development.**

"This is hard because the answer depends on age and stage of puberty, it would allow further time to explore in perhaps older young people who have mostly been through puberty."

"There isn't one main purpose, it really depends on where a young person is at and what they want. For younger children [it] is to reduce any anxiety about further pubertal changes which can in itself give more time to think - these points go together, they are not separate. For older teenagers many of them want the blocker because it enables them to access hormones, this is a fault with our service pathway as the blocker has very little use to them when they are post puberty."

- **Others said that it is important to understand the young person's expectation of what the blocker will achieve.**

"I think it's much more helpful to explore what the young person and family hope for hormone blockers to achieve so that this can be explored."

"This will be individual to the young person. Providing the young person with an understanding around why other young people may access these pathways could help build understanding. But also acknowledging not all young people access medical pathways, and exploring what they would like and what this would mean to them."

- **Some respondents mentioned the uncertainty around the purpose and impacts of puberty blockers.**

"I speak about the purpose as being the first [statement] but talk about how there is a possibility that going on the blocker may close down thinking for some young people. Note that people who do not take the blocker are less likely to take further physical interventions in the future. I explain how we don't know whether this is because we are only letting the "right" people go on the blocker or whether this is because there is something about the blocker that prevents young people from considering different pathways."

"I'm not actually sure what the purpose of the blocker is for us as a service right now. I would state the potential benefits to young people as being about pausing puberty, preventing further development of sex characteristics (which may prevent further intervention later on), and an experience of being on medical intervention and a medical pathway can also be useful"

Referral for medical intervention

Respondents were asked to describe the most challenging aspect of supporting children and young people in relation to informed consent to puberty blockers.

- **Concerns about the ability of young people to consent to treatments when they may not fully understand the consequences.**

"Assessing competence to make a decision now about something which may have life long future consequences, which are hard for young person to understand or imagine."

"Ensuring that enough information has been provided given that we are drawing from a limited amount of research, especially of long-term effects. And balancing that with how much of a positive difference they can make to some young people."

"Aware of the side effects - like hot flushes, and that the young person may need to be able to leave a class at times to manage hot flushes."

"[There is a] worry that young people can not meaningfully think about what it means to risk their potential for future satisfying sexual relationships and fertility"

- **Difficulties if the child is non-communicative due to distress or other factors.**

"[It] can be challenging if young people have learning difficulties/ASD/high levels of anxiety so say very little in their sessions."

"It can be difficult if young people have additional significant needs that make conversations and assessment of understanding difficult, especially if parents or guardians are unable to support with this."

"[There are] lots of difficulties/challenges when children/young people present as very distressed but are unable to engage in assessment process because of this."

- **A focus on accessing hormone treatment can limit exploration of other options.**

"The expectation from young people and families that this is the one and only answer to the difficulties being experienced. This forces clinicians into a gatekeeping role which obscures the options for exploration and psycho-social support."

"Another challenge is that young people/their parents are usually very focused on accessing the hormone blocker. While we can get informed consent, there is still often little alternative."

"The bind young people find themselves in where they have to both show that they could consider different options and could think about other ways of managing puberty at the same time as demonstrating that they are adequately distressed by puberty."

- **The friction between needing to do a full and complete assessment and a desire to resolve the child/young person's distress quickly.**

"Increased parental anxiety hoping for the assessment to speed up when more space/time is required to explore."

"Often due to distress, young people and [their] parent/carer request the process to be 'quick', however, thorough assessment is required to enable the informed consent to be obtained. Complexity of this can increase when a young person and/or parent/carer is unable to verbally consent/engage in the assessment either due to other complexities or distress - and alternative methods are used/extended time is required = to ensure the young person and/or parent/carer voice is heard and deemed informed."

"The tension between the child's puberty development and processes/waiting lists/assessments which means it is a tightrope of timings."

- **The additional scrutiny decisions around decision to refer for puberty blockers.**

"The process following on from the judicial review has significantly lengthened the process for young people accessing a medical pathway and caused in many cases extreme amounts of distress and for many young people traumatic experiences of going through pubertal changes that has negatively impacted their experience of themselves, their body and overall wellbeing."

"The bureaucracy, scrutiny and challenges of carefully considered and formulated clinical decision making [that] the service and professionals working in it experience, which disadvantages service users of GIDS and people waiting to become service users of GIDS."

- **The impact of external influences/factors.**

"The fact of their life stage - that they are at an adolescent stage of development and therefore forming their identity, of which gender is a major part. Societal pressures to conform to the gender binary, particularly when many are at secondary school. Bullying in the form of name calling."

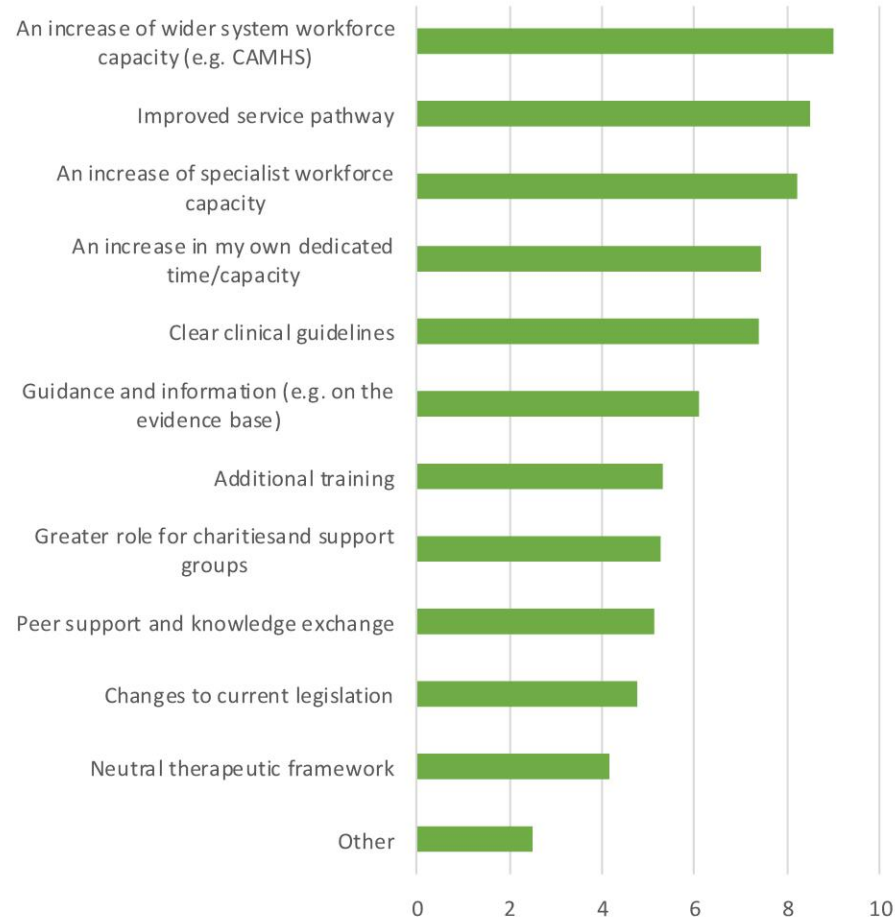
"There is so much peer pressure. The teens are all comparing themselves and their transitions to that of their peers. It makes it hard for them to think clearly about their individual needs and long-term health I think."

"The most challenging aspect at the moment are the layers of systemic transphobic barriers to care that the young people experience."

"When everyone around you (media, other staff in GIDS, people in the Tavistock etc.) are so anxious and fixated on possible regret. We do not see the level of focus on regret in other areas of medicine, even when the regret rates are known to be much higher. The current media frenzy sometimes makes it hard to think clearly."

About your role

Respondents were asked what would make their role supporting children and young people around their gender identity easier. They were given a number of options and asked to rank the options from most helpful to least helpful. The list of options was constructed from feedback from the primary and secondary professionals' panel (see introduction).



- The top responses were:**

- An increase in wider system capacity.
- Improved service pathway.
- An increase in specialist workforce capacity.
- An increase in clinician's own time/capacity.
- Clear clinical guidelines.

- Respondents indicated a number of other aspects that would make their role easier:**

- A reduction in time spent doing administrative tasks.
- An upskilling of the wider workforce.
- Research into epidemiological changes.
- Consensus on how GIDS works as a service.
- A transformed societal understanding of what gender means.
- Safeguarding in relation to gender.
- Exploratory therapeutic support to be seen as primary intervention.
- To have GIDS clinical work properly valued, respected and supported.
- Removal of the endocrine pathway.

- Additional comments made included:**

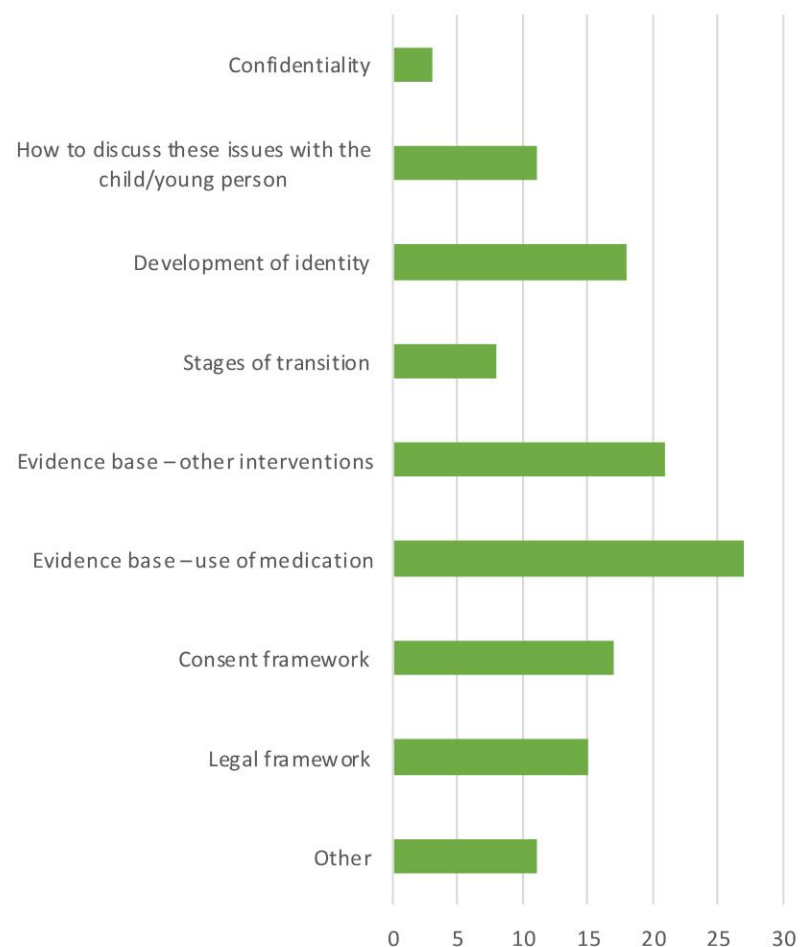
"To have GIDS clinical work properly valued, respected and supported."

"I don't think we need more staff, I think we need consensus as a service on how we work, what we offer and why, and clearer guidelines. As well as reduced case/workloads so we have time for the thought and reflection this work requires"

"We need to increase capacity. Fiddling about with the waiting list or making referral criteria is not the way to approach this. We are massively under resourced. Either invest properly in specialist services. Or open up the protocols to ensure treatment pathways, including endocrinology, can be accessed via primary and secondary care."

About your role

Respondents were asked, in their professional interaction supporting children and young people around their gender identity, on which of the following areas would it be helpful to have more information to guide their thinking on appropriate care/management – respondents could tick multiple answers. The list of options was constructed from feedback from the primary and secondary professionals' panel (see introduction).



- **The top responses were:**

- Evidence base around the use of medication.
- Evidence base around other interventions.
- Information/training on development of identity.
- The consent framework.

- **Respondents indicated a number of other aspects where more information would be useful:**

- How people develop an understanding about their relationship to their body.
- Training in the induction about gender affirming hormones/puberty blockers and their mode of action.
- Safeguarding in relation to gender.
- Ethics.
- Sexuality, detransitioners/long term outcomes.
- Long term studies with follow-ups of psychological/psychotherapeutic work with young people who presented with gender dysphoria.
- Working effectively with neurodiverse and Autistic people who are also gender diverse.

- **Additional comments included:**

"I believe all of the above are in place already. Improvement and ease of access, including clinicians' capacity to review and continued professional development inclusive of the above would be beneficial for all disciplines."

"It is not really a question of more information. It is more a question of creating a climate in which different therapeutic approaches can be discussed and developed without fear of vilification, legal action or complaints being brought. I believe the Cass review has a role to play here."

"I think we do have a lot of the above already. I am not clear about what 'other interventions' refers to, do you mean how safe binding is, or how useful psychosocial support is?"

General comments

Respondents were invited to add any further comments about services for children and young people needing support around their gender identity.

• Thoughts on the current service.

"It's been a tough few years in our service and young trans people are the ones who have suffered in terms of treatment being halted and huge waiting lists."

"The [GIDS] team offer a very unique service and that it is impossible to compare it to another service within this country, therefore it is very hard to review its success or its failures. That staff shortages should be looked at as a priority and recruitment and retention drives [should] be at the centre of change and also ensuring training is available. The image of GIDS to the wider arena may need to change for this to happen."

"I really enjoy working at GIDS- I like working with the client group and their families, I like working with my colleagues."

"We are drowning in paperwork at GIDS and overwhelmed with high caseloads of increasingly complex young people... It is no wonder people have left GIDS in droves. If many more people leave there won't be enough expertise to manage the current patient numbers and certainly no capacity to train newly hired staff- so the waiting list will remain in the dire state it's currently in."

"I feel disheartened and disappointed by the long waiting lists and the fact that these young people are not receiving the support they so desperately need in a timely manner."

"There continues to be a climate of fear and intimidation when discussing the issues connected to children and adolescents who identify as transgender. Our profession needs support or some kind of intervention that enables Clinical Psychologists to think and speak freely about our professional experiences, theories and concerns."

• Thoughts on a future service model.

"With the current numbers, the model of a single national service that treats this matter as a 'specialist service' is no longer sustainable. After more than 5 years working at GIDS, I have come to the conclusion that the matters needs to be addressed locally through CAMHS and other TIER 2-3 services, in the context of the other difficulties that these young people inevitably experience. We have to face this is no longer a specialist issue, but a wide-spread experience amongst young people, and local services should be equipped to address this as such."

"I think that services should be completely overhauled and the focus should be on reduction of waiting times."

"In my previous role at CAMHS I was attempting to set up a specific pathway at a local level as I felt it was very much needed. I still do."

"We need to maintain our clinical excellence and develop it further on all fronts. We also need to be able to offer more psycho-social interventions alongside the known medical interventions."

• Thoughts on pathway options.

"Differentiation of pathways within GIDS for [different] age groups, different associated difficulties (LD/ASC/MH) and a differentiation for those AMAB [assigned male at birth] and AFAB [assigned female at birth] would be beneficial - especially in the case of AMAB where stigma, safety and risk in wider society are most problematic."

"I believe there should be a range of therapeutic and medical options for young people, including psychological therapy for gender diverse young people, and non-blocker pathways for those who have completed puberty."

"To be able to offer a non-blocker pathway to the older adolescents. Lots of older trans boys want the blocker so they can have [testosterone], it has very little physical benefit to them but can result in side effects. It is more ethical to offer them a non-blocker pathway."

"I think the main thing that is needed over and above everything is a clear pathway for young people to be offered meaningful psychological therapy in order to explore what is going on. Currently we offer people physical interventions or very sporadic sessions... I feel that we are failing these young people by not at least offering this as an option."

"I believe there should be more specific provision for 17-20 year olds who are often lost in the gap between children and adult services."

The Review is grateful to all the participants for sharing their time and expertise and for their thoughtful consideration in responding to the survey.

The Review will build on the work undertaken and, alongside our academic research, will continue with a programme of engagement with professionals, service users and their families, which will help to further develop the evidence base.

JOURNAL

Entry 7 – Research

July 28, 2022



Hilary Cass (<https://cass.independent-review.uk/author/hilary-cass/>).

“

Without data, you're just another person with an opinion.”

W. Edwards Deming

Last week I sent a **[letter to NHS England](https://cass.independent-review.uk/publications/)** (<https://cass.independent-review.uk/publications/>), expanding on the advice in my interim report, and giving more detail about the proposed new regionalised model of care for children and young people questioning their gender identity or experiencing gender related distress. I recognise that it will take time before the staff and structures of the proposed regional services are in place. More immediately, I know that NHS England is setting in place interim arrangements to ensure the continuity and safety of current services.

NHS England also asked for advice on how to address the gaps in the evidence base that were flagged in my interim report, and I want to say a little more about that here.

I have explained previously the three components of the research commissioned by the Review: a comprehensive literature review focused on the questions that were set out in our terms of reference from NHS England; a qualitative study to understand more about the experiences of service users, parents and carers, and professionals, including young adults up to age 30; and a quantitative study to try and fill some of the gaps in follow-up data for the approximately 9,000 young people who have been through the Gender Identity Development Service (GIDS), many of whom are now adults.

Over the last few weeks, I have been concerned about the distress generated by the laying of the statutory instrument (SI) which was required before the proposed quantitative study commissioned by the Review could be considered by the Research Ethics Committee (REC) and the Confidentiality Advisory Group (CAG). Unfortunately, there was a lot of misinformation about both the purpose of the SI and of the research itself. Concern was also expressed that the research might not be subject to the proper ethical scrutiny and approval processes. During the last month we have had discussions with members of the community and advocacy groups to address the questions that have been raised about this. The most important points to share are that:

- The purpose of the research study is to understand the range of service use and outcomes of young people who have been through the GIDS, and there will be involvement of service users in interpreting any data that is generated.
- We were unfortunately not able to discuss the SI in advance because it was Department of Health and Social Care policy in development; however, our webpages now give detailed information about the reasons for the SI, the protection of data, and the very tight limitations on access and use.
- The research will go through all normal ethical and research approvals, and no records will be accessed until and unless those approvals are received.

- Subject to approval from REC and CAG the full protocol will be published on our website along with details about how you can opt out of the study should you wish to do so.

Fuller details can be found on our [research pages](#)

(<https://cass.independent-review.uk/cass-review-quantitative-research/>).

Obviously looking at pre-existing data (retrospective research) is never as good as planning research going forward (prospective research); in prospective studies it is much easier to agree the research questions, involve service users in designing the studies, obtain consent and collect the necessary data. In my letter to NHS England I have highlighted some of the questions that we need to address prospectively and have emphasised the collaborative work that will need to be undertaken to incorporate these into a comprehensive research programme.

As Edward Deming said, “*scientific data are not taken for museum purposes; they are taken as a basis for doing something.*” Improving the level and quality of evidence will enable young people seeking NHS support, their families and carers, and clinicians to have better information to help them determine the best support and interventions for them as individuals.

Next post

[Entry 8 – Beyond the Headlines](https://cass.independent-review.uk/entry-8-beyond-the-headlines/) (<https://cass.independent-review.uk/entry-8-beyond-the-headlines/>).

Previous post

[Entry 6 – Following the interim report \(March 2022\)](https://cass.independent-review.uk/entry-6-following-the-interim-report-march-2022/) (<https://cass.independent-review.uk/entry-6-following-the-interim-report-march-2022/>).

Cass Review

Independent Review of Gender Identity
Services for Children and Young People

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JOURNAL

Entry 8 – Beyond the Headlines

August 18, 2022



Hilary Cass (<https://cass.independent-review.uk/author/hilary-cass/>).

“

Medicine is the science of uncertainty and the art of probability”

William Osler

There has been wide-spread reporting of NHS England’s decision to establish two early adopter services and as a result bring the contract for the Gender Identity Development Service (GIDS) at the Tavistock and Portman clinic to a managed close next Spring. Within this coverage I feel that some of the detail about the key components of the future regionalised service delivery model, that I set out in my [latest advice to NHS England](https://cass.independent-review.uk/publications/) (<https://cass.independent-review.uk/publications/>), has sometimes been overlooked.

Medicine is a science of uncertainty in a world where we all want clarity and black and white answers. In medicine, when there is controversy or doubt about treatment decisions, the immediate reaction is to blame individuals, and sometimes organisations. However, the most important

way to reduce risk, improve decision-making and manage uncertainty is through safe systems. The purpose of my Review is to be forward-looking and define what a safe system of care should look like, and how to support that care with the best evidence.

In my interim report I said that a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand. The purpose of the regionalised model is to improve access, networked care, research capacity and workforce development.

I have previously said that the care of gender-questioning children and young people needs to be everyone's business, with responsibility taken throughout the health system rather than resting solely with a small expert workforce. The staff working at GIDS have demonstrated compassion and a strong professional commitment towards their patient population. Their experience and continued engagement will be essential in ensuring a smooth progression to the new service model. At the same time, we need to encourage, grow and develop the future workforce that will be key to the delivery of regionalised services.

This challenge is not unique to the NHS; speaking to colleagues in Finland, they describe a similar picture. When they opened their tertiary level gender identity service, others were reluctant or did not feel they had the capability to work with individuals with gender identity issues. Across schools, social services and local children's mental health services, staff did not feel that they had sufficient knowledge or expertise to explore gender identity or even address other issues that these young people might be struggling with. I am told that this has now changed completely; other professionals recognise that it is not helpful to exceptionalise gender identity issues, and that they have the transferrable skills to work in this area. There are useful lessons that we can take from their experiences.

The regionalised services that I have described will be direct service providers, assessing and treating children and young people who may

need specialist care, as part of a wider pathway. Alongside this, the regional centres will support networks of designated local services, in what is known in the NHS as an Operational Delivery Network (ODN). I have set out the functions of an ODN in my letter. This model will give the opportunity to provide targeted training, upskilling and additional staffing to a more manageable number of centres within a geography. For children and young people, this will mean improved access to services with flexible pathways that better respond to their individual needs.

Advancement in medicine is all about reducing uncertainty and risk through research, clinical experience, peer review and clinical networks. I have advised that the regional centres should also come together to form a national provider collaborative to ensure consistency of standards and data collection across all providers, as well as providing opportunities for peer review and a forum for discussion of complex cases and/or decisions about medical care. This will mean that whichever centre a young person attends they can expect the same standard of care and better information upon which to base their decisions.

There is still a lot of work to do in addition to the ongoing research programme, which I spoke about in my [previous journal entry](https://cass.independent-review.uk/entry-7-research/) (<https://cass.independent-review.uk/entry-7-research/>). I have always been clear that the Review will be an iterative process and that we will release information and advice when it becomes available so that improvement work can begin as soon as there is a clear direction of travel. I am pleased that NHS England has taken on board the Review's advice to date and has set out the [interim arrangements](https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/) (<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/>) being put in place to move towards the new delivery model. We will continue to work with them and all our stakeholders as the longer-term service model is established.

Previous post

[Entry 7 – Research \(https://cass.independent-review.uk/entry-7-research/\)](https://cass.independent-review.uk/entry-7-research/)

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LETTER TO THE EDITOR



Puberty blockers for gender dysphoric youth: A lack of sound science

Dear Editor,

The medical transition of children and adolescents with gender dysphoria remains highly debated and there is significant divergence in policy internationally.¹⁻⁷ Mills and colleagues' review the interventions that comprise the "gender-affirmative" care pathway, an approach currently promoted by many medical organizations in North America.⁶⁻⁸ We strongly agree with the authors that pharmacists have a responsibility to "understand the evidence," and "place the well-being of the patient over any personal cultural beliefs."⁸ However, we think the use of evidence to support the authors' claim that gonadotropin releasing hormone (GnRH)-analogs are fully reversible and have been shown to improve mental health, requires critical appraisal.

GnRH-analogs have been used for decades to successfully delay the *early* onset of puberty in children with precocious puberty.⁹ While generally considered safe for this indication, recent concern about impacts on polycystic ovarian disease, metabolic syndrome, and future bone density, have been raised.¹⁰ Even less is known about the use of GnRH-analogs to halt *normally* timed puberty in youth with gender dysphoria; no long-term, longitudinal studies of GnRH-analogs for this indication exist.

Puberty-related hormones have wide ranging effects on brain structure, function, and connectivity.¹¹ Concerns have been raised that hormonal suppression of puberty may permanently alter neurodevelopment.^{2,11-13} The possible impact of puberty blockade on a young person's cognition has important implications for the decision to initiate exogenous cross-sex hormones and the capacity to give informed consent.¹⁴ Moreover, it has been suggested that pubertal suppression may alter the course of gender identity development, essentially "locking in" a gender identity that may have reconciled with biological sex during the natural course of puberty.¹³ Over 95% of youth treated with GnRH-analogs go on to receive cross-sex hormones.¹⁵ By contrast, 61-98% of those managed with psychological support alone reconcile their gender identity with their biological sex during puberty.¹⁶⁻¹⁸ This lack of evidence to support the durability of a transgender identification is conceptually consistent with significant psychosocial determinants of cross-sex identity, while the belief in immutable biological influences can best be described as a "current hypothesis."¹⁹

There are also concerns that GnRH-analogs may have irreversible effects on sexual function and bone development. In some youth

pubertal blockade at Tanner stage 2 followed by exogenous cross-sex hormones has resulted in a complete absence of adult sexual function.²⁰ Profound effects on future sexual function may even occur when puberty is paused and later allowed to proceed, since the precise timing of hormone exposure during the peripubertal window is a determinative factor in adult sexual function.²¹ Finally, several studies have found that the expected pattern of bone mass accrual during adolescence does not occur when puberty is halted.²²⁻²⁵ The long-term clinical consequences of failure to accrue normal bone mass are unknown.

Uncertainties about long-term risks of medical transition are often overshadowed by the most potent argument provided by advocates of the affirmative model: failure to affirm a young person's transgender identity may result in suicide. Suicidal ideation and self-harming behaviors have been found to be higher than age-matched peers, but comparable to nongender dysphoric youth referred for management of other mental health diagnoses.²⁶ However, the relevant question is whether affirmative care reduces suicide risk. Mills and colleagues assertion that GnRH-analogs have been shown to decrease lifetime suicidal ideation stems from a nonrepresentative, low-quality survey of transgender adults that has been thoroughly critiqued by others.^{27,28} Moreover, their claim that these drugs are effective for other mental health outcomes is at odds with recent systematic reviews that concluded there is little change from baseline to follow-up in depression, anxiety, body image, gender dysphoria, or psychosocial functioning.^{2,12,29} A seminal Dutch case-series of children with early-onset gender dysphoria is cited to support the assertion that GnRH-analogs improve psychological functioning.¹⁵ The magnitude of posttreatment improvement in mental health outcomes in this study was small and of questionable clinical significance. Furthermore, the applicability of results to the most common demographic presenting today, that is, adolescent females with pre-existing mental health problems or neurodevelopmental conditions and no prior history of gender dysphoria, is questionable.^{4,30} A recent attempt to replicate the results of the Dutch study in the United Kingdom found no psychological benefit with GnRH-analogs, but treatment was associated with adverse effects on bone development.³¹

Multiple European countries that were pioneers in youth medical transition are now adopting a more cautious approach to the use of

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GnRH-analogs and cross-sex hormones after their own evidence reviews failed to show mental health benefits and highlighted a profound lack of knowledge about harms. The UK's Cass review emphasized the paucity of data in their interim report stating, "it is important that it is not assumed that outcomes for, and side effects in, children treated for precocious puberty will necessarily be the same in children or young people with gender dysphoria."¹³ The NHS updated guidance on treatment of gender dysphoria removed statements about the reversibility of GnRH-analogs and now states, "little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria."⁴ The Swedish Health Authority no longer offers GnRH-analogs to minors except in exceptional cases stating, "the risks of puberty suppressing treatment with GnRH-analogues and gender affirming hormonal treatment currently outweigh the possible benefits."³ Finland has severely restricted their use and now recommend psychotherapy as first-line treatment for gender-dysphoric youth.² Lastly, the French Académie Nationale de Médecine recently issued a press release stating, "great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause."⁵ Although puberty-blockers and cross-sex hormones will still be available, the Académie emphasized, "the greatest reserve is required in their use, given side effects such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause."⁵

In summary, we believe the authors' review does not present a balanced assessment of the evidence and betrays a bias toward uncritically promoting medical transition. The widespread methodological weaknesses in the research coupled with the lack of certainty that benefits outweigh harms, should raise questions about affirmation being positioned as the "standard of care" in the United States and Canada.²⁹ Patients and their families rely on pharmacists to resist ideological influence and communicate transparently. To this end, we call on Mills and colleagues to revisit their important review and provide a more nuanced discussion of the evidentiary basis for gender-affirming care.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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REFERENCES

1. The World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. 7th version; https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf
2. Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland) Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. 2020. Society for evidence based gender medicine unofficial translation. https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf
3. SOCIALSTYRELSEN. The National Board of Health and Welfare (NBHW). Care of children and adolescents with gender dysphoria. 2022. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>
4. National Health Service (NHS). Treatment—Gender dysphoria; 2020. <https://www.nhs.uk/conditions/gender-dysphoria/treatment/#:~:text=Puberty%20blockers%20and%20cross%2Dsex%20hormones&text=Little%20is%20known%20about%20the,the%20psychological%20effects%20may%20be>
5. Académie Nationale de Médecine. Communiqué. La médecine face à la transidentité de genre chez les enfants et les adolescents; 2022. https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en#_ftn1
6. Office of Population Affairs. Gender-affirming care and young people. <https://opa.hhs.gov/sites/default/files/2022-03/gender-affirming-care-young-people-march-2022.pdf>
7. Bonifacio JH, Maser C, Stadelman K, Palmert M. Management of gender dysphoria in adolescents in primary care. *CMAJ*. 2019;3:E69–E75.
8. Mills AR, Astle K, Frazier CC. "Affirming" journey: Narrative review and practice considerations on gender affirming care. *JACCP: Journal of the American College of Clinical Pharmacy*. 2022;5:697–706.
9. Carel JC, Eugster EA, Rogol A, Ghizzoni L, Palmert MR, ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;4:e752–e762.
10. De Sanctis V, Soliman AT, Di Maio S, Soliman N, Elsedfy H. Long-term effects and significant adverse drug reactions (ADRs) associated with the use of gonadotropin-releasing hormone analogs (GnRHa) for central precocious puberty: A brief review of literature. *Acta Biomed*. 2019;3:345–359.

11. Chen D, Strang JF, Kolbuck VD, et al. Consensus parameter: Research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. *Transgend Health*. 2020;4:246–257.
12. National Institute for Health and Care Excellence (NICE). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria; 2020.
13. Cass Review. Independent review of gender identity services for children and young people. Interim report; 2022 <https://cass.independent-review.uk/publications/interim-report/>
14. Levine SB, Abbruzzese E, Mason JW. Reconsidering informed consent for trans-identified children, adolescents, and young adults. *J Sex Marital Ther*. 2022;1–22. <https://doi.org/10.1080/0092623X.2022.2046221>
15. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med*. 2011;8:2276–2283.
16. Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ. A follow-up study of girls with gender identity disorder. *Dev Psychol*. 2008;1:34–45.
17. Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;1:13–20.
18. Singh D, Bradley SJ, Zucker KJ. A follow-up study of boys with gender identity disorder. *Front Psychiatry*. 2021;12:632784.
19. Saraswat A, Weinand JD, Safer JD. Evidence supporting the biologic nature of gender identity. *Endocr Pract*. 2015;2:199–204.
20. Blum B. Would you give up an orgasm? Opinion. The Jerusalem Post. June 2, 2022. <https://www.jpost.com/opinion/article-708397> Video recording from Women's Voices <https://twitter.com/WomenReadWomen/status/1521692875242688512>.
21. Shirazi TN, Self H, Dawood K, et al. Pubertal timing predicts adult psychosexuality: Evidence from typically developing adults and adults with isolated GnRH deficiency. *Psychoneuroendocrinology*. 2020;104733:104733.
22. Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. 2021;7:937–939.
23. Joseph T, Ting J, Butler G. The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *J Pediatr Endocrinol Metab*. 2019;10:1077–1081.
24. Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab*. 2015;2:E270–E275.
25. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*. 2017;95:11–19.
26. Zucker KJ. Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Arch Sex Behav*. 2019;7:1983–1992.
27. Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*. 2020;145:e20191725.
28. Biggs M. Puberty blockers and suicidality in adolescents suffering from gender dysphoria. *Arch Sex Behav*. 2020;7:2227–2229.
29. Brignardello-Peterson R, Wiercioch W. Effects of gender affirming therapies in people with gender dysphoria: Evaluation of the best available evidence. May 16, 2022. https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Attachment_C.pdf
30. Strang JF, Meagher H, Kenworthy L, et al. Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *J Clin Child Adolesc Psychol*. 2018;1:105–115.
31. Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*. 2021;2:e0243894.

Stories by transitioners and detransitioners

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We Need Balance When It Comes To Gender Dysphoric Kids. I Would Know

Scott Newgent, Newsweek

<https://www.newsweek.com/we-need-balance-when-it-comes-gender-dysphoric-kids-i-would-know-opinion-1567277>

Scott Newgent

On 2/9/21 at 7:30 AM EST

I am a 48-year-old transgender man. I was thrilled when the medical community told me six years ago that I could change from a woman to a man. I was informed about all the wonderful things that would happen due to medical transition, but all the negatives were glossed over. Since then, I have suffered tremendously, including seven surgeries, a pulmonary embolism, an induced stress heart attack, sepsis, a 17-month recurring infection, 16 rounds of antibiotics, three weeks of daily IV antibiotics, arm reconstructive surgery, lung, heart and bladder damage, insomnia, hallucinations, PTSD, [\\$1 million](#) in medical expenses, and loss of home, car, career and marriage. All this, and yet I cannot sue the surgeon responsible—in part because there is no structured, tested or widely accepted baseline for transgender health care.

Read that again: *There is no structured, tested, or widely accepted baseline for transgender health care.* Not for 42-year-olds, and not for the many minors embarking on medical transition in record numbers. It is not transphobic or discriminatory to discuss this—we as a society need to fully understand what we are encouraging our children to do to their bodies.

Throughout transition, I second-guessed my decisions, but each counseling session and doctor's appointment amounted to one more push convincing me I could be cured of being born in the wrong body. The truth was that I didn't fit in as a dominant, aggressive, assertive lesbian. The dream of finally fitting in dangled like a carrot: The idea that I could fit in catapulted me to a time much like adolescence, with its drive for acceptance, inclusive peers and the fantasy of being normal.

During my post-operation 17 months of sheer survival, I discovered that transgender health care is experimental and that large swaths of the medical industry encourage minors to transition due, at least in part, to [fat profit margins](#). I was gobsmacked. Each day I researched more and became increasingly appalled. As I jumped from ER to ER desperately seeking help, I realized that nobody knew what to do. Each physician told me to return to the original surgeon. I was trapped like a child with an abusive parent.

My recurring bladder infection not only demolished my body; it started to ravage my mind, too. I stopped being able to problem-solve, and then lost my health insurance when I couldn't work. I spent many nights in the bathroom in too much pain to even make it to the toilet, forced to

urinate on the floor, screaming as what felt like razor blades left my body. Rest came only in 45-minute increments that I induced with four shots of vodka, six Benadryl pills and a handful of melatonin—with only sleep-deprived hallucinations for my trouble.

One night I simply couldn't take it. I wanted to die. I crawled to bed and had another hallucination. My children's lives flashed before my eyes, and I saw the devastation my death would cause them. Right then, I made a deal with God, the universe, whatever you call it, that if my life were spared, if I were allowed to be here for my kids, I would help other kids by ensuring people knew what the experimentation of transgender health care really entails. I remember my whimpers: "God, an eye for an eye—in reverse. I will fight with a mother's passion for others if I can be here for my kids."

So here I am, a trans man, sifting through my good and bad decisions, and for the first time embracing who I am—what I have created, and the life I now lead. It took me 48 years to realize I transitioned because I never wholeheartedly accepted being a lesbian. Our children don't have a prayer to embrace the reality of something it takes a lifetime to understand. That's *our job*, as parents: to protect them from foolish, lifelong mistakes.

Here's what I could not comprehend before transitioning and what I honestly believe no child is capable of consenting to:

- [Decreased life expectancy](#)
- [Increased risk of premature death from heart attacks and pulmonary embolisms](#)
- [Bone damage](#)
- [Possible liver damage](#)
- [Increased mental health complications](#)
- [Increased chances of mood-syndrome symptoms](#)
- [Higher suicide rates than non-trans population](#)
- [12 percent higher chance than non-trans population to develop symptoms of psychosis](#)
- [Chance of stunted brain development](#)
- [Much reduced chance for lifelong sexual pleasure](#)
- [Higher chance of sterility and infertility](#)
- [No improved mental health outcomes](#)
- [Not completely reversible](#)

Trans activists tout studies that say medically transitioning gender-questioning children improves mental health. But those studies have often been [retracted](#) (and those retractions underreported by the media).



Transgender rights activists in New York City in 2018 Drew Angerer/Getty Images

Moreover, no *long-term* studies have been conducted on children who grow up without the benefit of natural puberty. No studies at all have been done on de-transitioners (people who return to identifying as their natal sex). What are the psychological effects? No one has a clue, and researchers are too often [shut down by cancel culture](#) for even raising the questions.

Peer-reviewed studies show a shocking correlation between gender dysphoria and [autism](#), depression, anxiety, eating disorders and [other co-morbidities](#). Additionally, it seems that many of these children are simply [gay](#). Could pushing people on a one-way path to medical transition be a different form of "conversion therapy?" We need to ask and study these hard questions—for the good of all children. But we're not—not in the mainstream media, and certainly not in President [Joe Biden](#)'s new administration.

America is proceeding down its path of total affirmation just as other countries are restoring greater balance. This past December, [the U.K. High Court of Justice](#) ruled that puberty blockers for minors are both experimental and a one-way ticket to permanent transition. [Finland](#) in 2020 completely overhauled its approach to treating minors with gender dysphoria, prioritizing psychotherapeutic non-invasive interventions and recognizing adolescence as a time of major identity exploration. [Sweden](#) is conducting a systematic literature review of the scientific basis of the long-term effects on physical and mental health of puberty blockers and hormones. The researcher who championed the "[Dutch protocol](#)" recently called [for a rethink](#), while other research is beginning to show that [the current one-size-fits-all status quo](#) is too limited.

So if we are now waking up to the fact that gender dysphoria is over-simplistically [conflated](#) with transgenderism, medical treatments have understudied long-term consequences, some are getting rich off transgender medicine and [de-transitioners](#) are speaking up in skyrocketing numbers, why are we only making it *easier* for children to unquestioningly transition?

We now have the obligation to work together to slow trans medicalization of minors until they are adults and have the capacity to truly understand the lifelong consequences of transitioning. As a former lesbian and current trans man, I maintain this is *not* transphobic. It is actually sensitive and caring to recognize that not just one treatment or pathway is right for all kids.

Therefore, I am currently building a bipartisan army to protect our children, hold the medical industry accountable and educate our president and the rest of society about the dangers of transgender extremism. We must throw our differences aside for a moment; I promise you, once children are safe, we can resume fighting. But until children are safe, nothing else matters.

So, endocrinologists and pediatricians, moderate [Democrats](#) and moderate [Republicans](#), radical feminists and evangelicals, lawyers and psychologists, parents and teachers: My hand is out. I will grab yours and turn down no one. Together, we can build a circle around our most precious resource: our children. Help me fulfill the promise I made on the night I almost gave up, to be here for my children—and now yours. Who's with me?

Scott Newgent is active with Trans Rational Educational Voices (www.TReVoices.com). Twitter: [@ScottNewgent](https://twitter.com/ScottNewgent).

What I wish I'd known when I was 19 and had sex reassignment surgery

Corinna Cohn, Washington Post

<https://www.washingtonpost.com/opinions/2022/04/11/i-was-too-young-to-decide-about-transgender-surgery-at-nineteen/>

By Corinna Cohn

April 11, 2022 at 1:05 p.m. EDT

Corinna Cohn, a software developer in Indianapolis, is an officer in the Gender Care Consumer Advocacy Network.

When I was 19, I had surgery for sex reassignment, or what is now called gender affirmation surgery. The callow young man who was obsessed with transitioning to womanhood could not have imagined reaching middle age. But now I'm closer to 50, keeping a watchful eye on my 401(k), and dieting and exercising in the hope that I'll have a healthy retirement.

In terms of my priorities and interests today, that younger incarnation of myself might as well have been a different person — yet that was the person who committed me to a lifetime set apart from my peers.

There is much debate today about transgender treatment, especially for young people. Others might feel differently about their choices, but I know now that I wasn't old enough to make that decision. Given the strong cultural forces today casting a benign light on these matters, I thought it might be helpful for young people, and their parents, to hear what I wish I had known.

I once believed that I would be more successful finding love as a woman than as a man, but in truth, few straight men are interested in having a physical relationship with a person who was born the same sex as them. In high school, when I experienced crushes on my male classmates, I believed that the only way those feelings could be requited was if I altered my body.

It turned out that several of those crushes were also gay. If I had confessed my interest, what might have developed? Alas, the rampant homophobia in my school during the AIDS crisis smothered any such notions. Today, I have resigned myself to never finding a partner. That's tough to admit, but it's the healthiest thing I can do.

As a teenager, I was repelled by the thought of having biological children, but in my vision of the adult future, I imagined marrying a man and adopting a child. It was easy to sacrifice my ability to reproduce in pursuit of fulfilling my dream. Years later, I was surprised by the pangs I felt as my friends and younger sister started families of their own.

The sacrifices I made seemed irrelevant to the teenager I was: someone with gender dysphoria, yes, but also anxiety and depression. The most severe cause of dread came from my own body. I was not prepared for puberty, nor for the strong sexual drive typical for my age and sex.

Surgery unshackled me from my body's urges, but the destruction of my gonads introduced a different type of bondage. From the day of my surgery, I became a medical patient and will remain one for the rest of my life. I must choose between the risks of taking exogenous estrogen, which [include](#) venous thromboembolism and stroke, or the risks of taking nothing, which includes [degeneration](#) of bone health. In either case, my [risk of dementia](#) is higher, a side effect of eschewing testosterone.

What was I seeking for my sacrifice? A feeling of wholeness and perfection. I was still a virgin when I went in for surgery. I mistakenly believed that this made my choice more serious and authentic. I chose an irreversible change before I'd even begun to understand my sexuality. The surgeon deemed my operation a good outcome, but intercourse never became pleasurable. When I tell friends, they're saddened by the loss, but it's abstract to me — I cannot grieve the absence of a thing I've never had.

The Equality Act is a positive step forward for the LGBTQ community. But it came with swift backlash from conservative lawmakers. (Video: Monica Rodman, Sarah Hashemi/The Washington Post)

Where were my parents in all this? They were aware of what I was doing, but by that point, I had pushed them out of my life. I didn't need parents questioning me or establishing realistic expectations — especially when I found all I needed online. In the early 1990s, something called Internet Relay Chat, a rudimentary online forum, allowed me to meet like-minded strangers who offered an inexhaustible source of validation and acceptance.

I shudder to think of how distorting today's social media is for confused teenagers. I'm also alarmed by how readily authority figures facilitate transition. I had to persuade two therapists, an endocrinologist and a surgeon to give me what I wanted. None of them were under crushing professional pressure, as they now would be, to "affirm" my choice.

I may well have transitioned even after waiting a few years. If I hadn't transitioned, I likely would have suffered from the world in other ways. In other words, I'm still working out how much regret to feel, but I'm comfortable with the ambiguity.

What advice would I pass on to young people seeking transition? Learning to fit in your body is a common struggle. Fad diets, body-shaping clothing and cosmetic surgery are all signs that countless millions of people at some point have a hard time accepting their own reflection. The prospect of sex can be intimidating. But sex is essential in healthy relationships. Give it a chance before permanently altering your body.

Most of all, slow down. You may yet decide to make the change. But if you explore the world by inhabiting your body as it is, perhaps you'll find that you love it more than you thought possible.

Keira Bell: My Story

Keira Bell, Persuasion

<https://www.persuasion.community/p/keira-bell-my-story>

As a teen, she transitioned to male but came to regret it. Here's how it felt to enter history in the trans debate.

[Keira Bell](#)

Apr 7, 2021

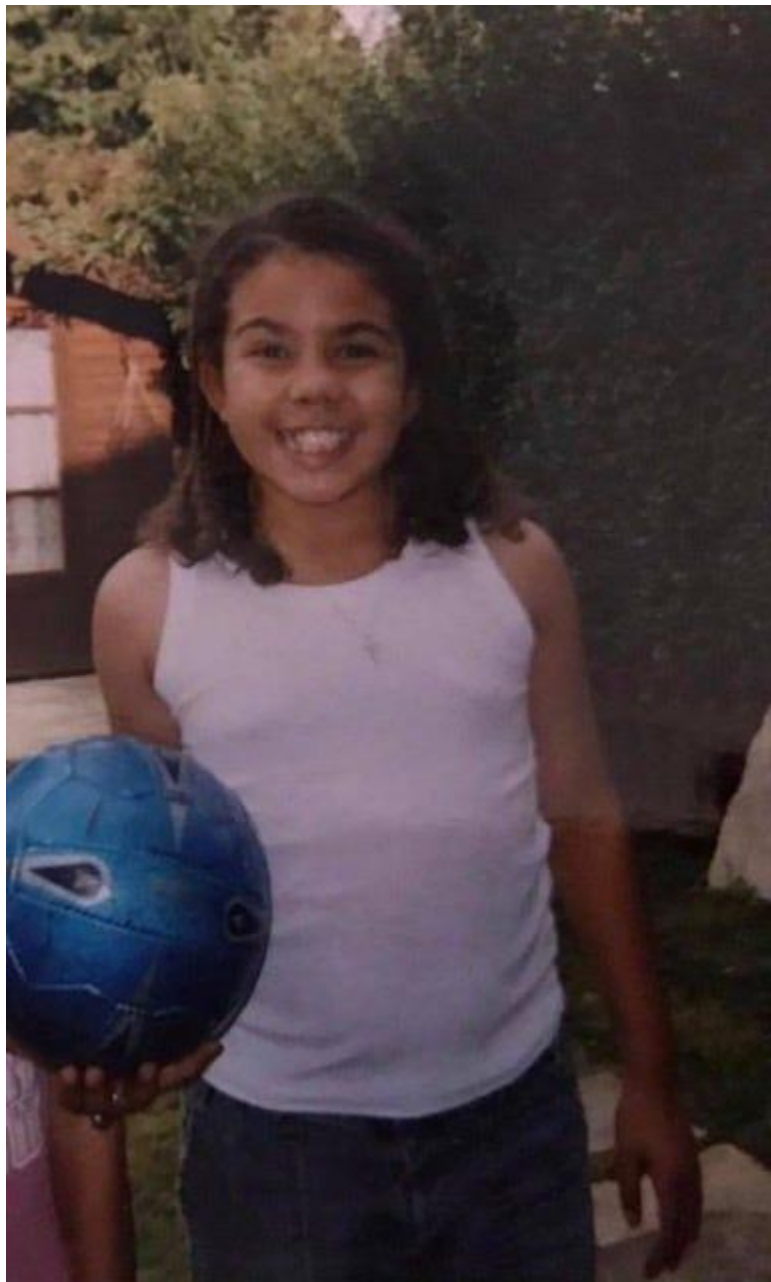


After a landmark court ruling in December, the name “Keira Bell” was cited worldwide, admiringly by some, with hostility by others. (Photo: Paul Cooper/Shutterstock)

By Keira Bell

From the earliest days, my home life was unhappy. My parents—a white Englishwoman and a black American who got together while he was in Britain with the U.S. Air Force—divorced when I was about 5. My mother, who was on welfare, descended into alcoholism and mental illness. Although my father remained in England, he was emotionally distant to me and my younger sister.

I was a classic tomboy, which was one of the healthier parts of my early life in Letchworth, a town of about 30,000 people, an hour outside London. Early in childhood, I was accepted by the boys—I dressed in typically boy clothing and was athletic. I never had an issue with my gender; it wasn't on my mind.



(Courtesy: Keira Bell)

Then puberty hit, and everything changed for the worse. A lot of teenagers, especially girls, have a hard time with puberty, but I didn't know this. I thought I was the only one who hated how my hips and breasts were growing. Then my periods started, and they were disabling. I was often in pain and drained of energy.

Also, I could no longer pass as “one of the boys,” so lost my community of male friends. But I didn’t feel I really belonged with the girls either. My mother’s alcoholism had gotten so bad that I didn’t want to bring friends home. Eventually, I had no friends to invite. I became more alienated and solitary. I had been moving a lot too, and I had to start over at different schools, which compounded my problems.

By the time I was 14, I was severely depressed and had given up: I stopped going to school; I stopped going outside. I just stayed in my room, avoiding my mother, playing video games, getting lost in my favorite music, and surfing the internet.

Something else was happening: I became attracted to girls. I had never had a positive association with the term “lesbian” or the idea that two girls could be in a relationship. This made me wonder if there was something inherently wrong with me. Around this time, out of the blue, my mother asked if I wanted to be a boy, something that hadn’t even crossed my mind. I then found some websites about females transitioning to male. Shortly after, I moved in with my father and his then-partner. She asked me the same question my mother had. I told her that I thought I was a boy and that I wanted to become one.

As I look back, I see how everything led me to conclude it would be best if I stopped becoming a woman. My thinking was that, if I took hormones, I’d grow taller and wouldn’t look much different from biological men.

I began seeing a psychologist through the National Health Service, or NHS. When I was 15—because I kept insisting that I wanted to be a boy—I was referred to the Gender Identity Development Service, at the Tavistock and Portman clinic in London. There, I was diagnosed with gender dysphoria, which is psychological distress because of a mismatch between your biological sex and your perceived gender identity.

By the time I got to the Tavistock, I was adamant that I needed to transition. It was the kind of brash assertion that’s typical of teenagers. What was really going on was that I was a girl insecure in my body who had experienced parental abandonment, felt alienated from my peers, suffered from anxiety and depression, and struggled with my sexual orientation.

After a series of superficial conversations with social workers, I was put on puberty blockers at age 16. A year later, I was receiving testosterone shots. When 20, I had a double mastectomy. By then, I appeared to have a more masculine build, as well as a man’s voice, a man’s beard, and a man’s name: Quincy, after Quincy Jones.



(Courtesy: Keira Bell)

But the further my transition went, the more I realized that I wasn't a man, and never would be. We are told these days that when someone presents with gender dysphoria, this reflects a person's "real" or "true" self, that the desire to change genders is set. But this was not the case for me. As I matured, I recognized that gender dysphoria was a symptom of my overall misery, not its cause.

Five years after beginning my medical transition to becoming male, I began the process of detransitioning. A lot of trans men talk about how you can't cry with a high dose of testosterone in your body, and this affected me too: I couldn't release my emotions. One of the first signs that

I was becoming Keira again was that—thankfully, at last—I was able to cry. And I had a lot to cry about.

The consequences of what happened to me have been profound: possible infertility, loss of my breasts and inability to breastfeed, atrophied genitals, a permanently changed voice, facial hair. When I was seen at the Tavistock clinic, I had so many issues that it was comforting to think I really had only one that needed solving: I was a male in a female body. But it was the job of the professionals to consider all my co-morbidities, not just to affirm my naïve hope that everything could be solved with hormones and surgery.

Last year, I became a claimant against the Tavistock and Portman NHS Foundation Trust in a judicial-review case, which allows petitioners in Britain to bring action against a public body they deem to have violated its legal duties. Few judicial reviews get [anywhere](#); only a fraction obtain a full hearing. But ours did, with a panel of three High Court judges considering whether youths under treatment at the clinic could meaningfully consent to such medical interventions.



Bell in January 2020, after she brought legal action against the clinic. (Photo: Sam Tobin/PA Wire)

My team argued that the Tavistock had failed to protect young patients who sought its services, and that—instead of careful, individualized treatment—the clinic had conducted what amounted to uncontrolled experiments on us. Last December, we won [a unanimous verdict](#). The judges expressed serious doubts that the clinic's youngest patients could understand the implications of what amounted to experimental treatment with life-altering outcomes.

In their ruling, the judges repeatedly expressed surprise at what had been going on at the Tavistock, particularly its failure to gather basic data on its patients. They noted the lack of evidence for putting children as young as 10 years old on drugs to block puberty, a treatment that is [almost universally followed](#) by cross-sex hormones, which must be taken for life to maintain the transition. They also had concerns about the lack of follow-up data, given “the experimental nature of the treatment and the profound impact that it has.”

Notably, a growing wave of girls has been seeking treatment for gender dysphoria. In 2009-10, [77 children](#) were referred to the Gender Identity Development Service, 52% of whom were boys. That ratio started to reverse a few years later as the overall number of referrals soared. In England in [2018-19](#), 624 boys were referred and 1,740 girls, or 74% of the total. Over half of referrals were for those aged 14 or under; some were as young as 3 years old. The court noted the practitioners at the Tavistock did not put forward “any clinical explanation” for the dramatic rise in girls, and expressed surprise at its failure to collate data on the age of patients when they began puberty blockers.

The ruling does not completely prevent a minor from beginning a medical transition. But the judges recommended that doctors consider getting court permission before starting such treatment for those 16 to 17; they concluded it was “very doubtful” that patients aged 14 and 15 could have sufficient understanding of the consequences of the treatment to give consent; and that it was “highly unlikely” for those aged 13 and under.

In response, [the NHS said](#) that the Tavistock had “immediately suspended new referrals for puberty blockers and cross-sex hormones for the under-16s, which in future will only be permitted where a court specifically authorizes it.” The Tavistock appealed the ruling, and the court will hear its appeal in June.

The puberty blockers that I received at 16 were designed to stop my sexual maturation: The idea was that this would give me a “pause” to think about whether I wanted to continue to a further gender transition. This so-called “pause” put me into what felt like menopause, with hot flushes, night sweats, and brain fog. All this made it more difficult to think clearly about what I should do.

By the end of a year of this treatment, when I was presented with the option of moving on to testosterone, I jumped at it—I wanted to feel like a young man, not an old woman. I was eager for the shots to start, and the changes this would bring. At first, the testosterone gave me a big boost in confidence. One of the earliest effects was that my voice dropped, which made me feel more commanding.

Over the next couple of years, my voice deepened further, my beard came in, and my fat redistributed. I continued to wear my breast binder every day, especially now that I was completely passing as male, but it was painful and obstructed my breathing. By the time I was 20, I was being treated at the adult clinic. The testosterone and the binder affected the

appearance of my breasts, and I hated them even more. I also wanted to align my face and my body, so got a referral for a double mastectomy.

My relationship with my parents continued to be difficult. I was no longer speaking to my mother. My father had kicked me out of his apartment shortly after I turned 17, and I went to live in a youth hostel. He and I were still in touch, though he was adamantly opposed to my transition. Reluctantly, he took me for the surgery. I was a legal adult when it took place, and I don't relieve myself of responsibility. But I had been put on a pathway—puberty blockers to testosterone to surgery—when I was a troubled teen. As a result of the surgery, there's nerve damage to my chest, and I don't have sensation the way I used to. If I am able to have children, I will never breastfeed them.

Around the end of that first year post-surgery, something started happening: My brain was maturing. I thought about how I'd gotten where I was, and gave myself questions to contemplate. A big one was: "What makes me a man?"

I started realizing how many flaws there had been in my thought process, and how they had interacted with claims about gender that are increasingly found in the larger culture and that have been adopted at the Tavistock. I remembered my idea as a 14-year-old, that hormones and surgery would turn me into someone who appeared to be a man. Now, I was that person. But I recognized that I was very physically different from men. Living as a trans man helped me acknowledge that I was still a woman.

I also started to see what I was living out was based on stereotypes, that I was trying to assume the narrow identity of "masculine guy." It was all making less and less sense. I was also concerned about the effect my transition would have on my ability to find a sexual partner.

Then there was the fact that no one really knew the long-term effects of the treatment. For instance, the puberty blockers and testosterone caused me to have to deal with [vaginal atrophy](#), a thinning and fragility of the vaginal walls that normally occurs after menopause. I started feeling really bad about myself again.

I decided to stop, cold turkey. When I was due for my next testosterone shot, I canceled the appointment.

After I came to this decision, I found a subreddit for detransitioners. The number of people on it started rising, as if all these young women had come to a collective realization of the medical scandal we had been a part of. It was a place we could talk about our experiences and support each other. I felt liberated.

What happened to me is happening across the Western world. Little of my case was a surprise to those paying attention to the Tavistock whistle-blowers who in recent years have [spoken out](#) in alarm to the media, sometimes anonymously. Some have [left the service](#) because

of these concerns. But the transgender issue is now highly political and wrapped up in questions of identity politics. It can be perilous to raise questions or doubts about young people's medical gender transitions. Some who have done so have been vilified and had their careers threatened.

At the Tavistock, practitioners provide "gender affirmative care"—in practice, this means that when children and teens declare a desire to transition, their assertions are typically accepted as conclusive. Affirmative care is being adopted as a model in many places. In 2018, the American Academy of Pediatrics released [a policy statement](#) on the treatment of young people who identify as transgender and gender diverse that advocated for "gender-affirmative care."

But former Tavistock practitioners have [cited varied problems](#) suffered by the kids who sought help, such as sexual abuse, trauma, parental abandonment, homophobia in the family or at school, depression, anxiety, being on the autism spectrum, having ADHD. These profound issues, and how they might be tied up with feelings of dysphoria, have often been ignored in favor of making transition the all-purpose solution.

As the High Court found, much of the clinic's treatment is not even based on solid evidence. At the time our case was accepted, the NHS was asserting that the effects of puberty blockers are "fully reversible." But recently, the NHS [reversed itself](#), acknowledging "that 'little is known about the long-term side-effects' on a teenager's body or brain." That didn't stop them from prescribing these drugs to people like me.

Dr. Christopher Gillberg, a professor of child and adolescent psychiatry at Gothenburg University in Sweden and a specialist in autism, was an expert witness for our case. Gillberg said in his court statement that over his 45 years of treating children with autism, it was rare to have patients with gender dysphoria—but their numbers started exploding in 2013, and most were biological girls. Gillberg told the court that what was happening at the Tavistock was a ["live experiment"](#) on children and adolescents.

Parents who are reluctant or even alarmed about starting their children on a medical transition may be [warned](#), "Would you rather have a dead daughter or a live son?" (Or vice versa.) I had suicidal thoughts as a teen. Suicidal thoughts indicate serious mental health problems that need assessment and proper care. When I told them at the Tavistock about these thoughts, that became another reason to put me on hormones quickly to improve my well-being. But after the court ruling, the Tavistock released an internal study of a group of 44 patients who had started taking puberty blockers at ages 12 to 15. It [said](#) that this treatment had failed to improve the mental state of patients, having "no significant effect on their psychological function, thoughts of self-harm, or body image." Additionally, of those 44 patients, [43 went on to cross-sex hormones](#). This suggests blocking puberty isn't providing a pause. It is giving a push.

Before beginning on testosterone, I was asked if I wanted children, or if I wanted to consider freezing my eggs because of the possibility that transition would make me infertile. As a teenager, I couldn't imagine having kids, and the procedure wouldn't have been covered by the NHS. I said I was fine if I couldn't, and I didn't need to freeze my eggs. But now as a young

adult, I see that I didn't truly understand back then the implications of infertility. Having children is a basic right, and I don't know if that has been taken from me.

As part of its defense, the Tavistock put forth statements from a few young trans people who are happy with their care. One is S, a 13-year-old trans boy who got puberty blockers from a private provider because the waiting list at the Gender Identity Development Service was so long. S told the court that he had "no idea what me in the future is going to think" about being able to have children and that since he has never been in "a romantic relationship," the idea of one is not "on my radar at the moment."

Lots of teenagers, when contemplating future sexual relationships, feel baffled and even disturbed at the thought. Those same people, when adults, often feel very differently. I know, because this happened to me. I'd never been in a sexual relationship at the time of my transition, so I didn't truly understand what the transition would mean sexually.

S's statement demonstrates how difficult it is for minors to give consent for procedures they can't yet understand. As the judges [wrote](#), "There is no age-appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years."



Bell speaking to the media after the court ruling last December. (Photo: Sam Tobin/PA Wire)

Today, at 24, I'm in my first serious relationship. My partner is very supportive of everything I do, and I am the same for her. She has a large group of female friends who accept me; it's been very healing. For now, I don't speak to either of my parents or have a relationship with them.

I still get taken for male sometimes. I expect that, and I'm not angry about it. I know that I will live with that for the rest of my life. What I am angry about is how my body was changed at such a young age. People want to know if I'm going to have reconstructive surgery of my breasts or do other things to make me look more female. But I haven't fully processed the surgery I had to remove my breasts. For now, I want to avoid more such surgical procedures.

When I joined the case, I didn't realize how big it would become. What has happened since the ruling has been a rollercoaster. Many people have thanked me. I have also been [attacked online](#). If you're someone who regrets transitioning and decides to speak out about your experiences, you're considered a bigot. You may be told that you're trying to take away trans rights, that children know what's best for themselves and their bodies, and that you're ruining kids' lives.

But I am focused on what is best for distressed young people. A lot of girls are transitioning because they're in pain, whether it's from mental-health disorders, or life trauma, or other reasons. I know what it's like to get caught up in dreaming that transitioning will fix all of this.

Although sharing my story has been cathartic, I still struggle, and have yet to receive appropriate therapy. As I go on with my life, I plan to continue to be an activist on behalf of this cause. I want the message of cases like mine to help protect other kids from taking a mistaken path. This year, I helped create the first [Detrans Awareness Day](#), on March 12. I hope that, in years to come, this day can be a beacon to empower others.

I do not believe in rigid gender expression. People should be comfortable and feel accepted if they explore different ways of presenting themselves. As I said in my statement after the ruling, this means stopping the homophobia, the misogyny, and the bullying of those who are different.

I also call on professionals and clinicians to create better mental health services and models to help those dealing with gender dysphoria. I do not want any other young person who is distressed, confused, and lonely as I was to be driven to conclude transition is the only possible answer.

I was an unhappy girl who needed help. Instead, I was treated like an experiment.

Keira Bell is a British activist.

Top Surgery Regret

Grace Lidinsky-Smith, <https://hormonehangover.substack.com/p/top-surgery-regret-part-1>

Part One: The Post-Surgery Bad Feelings, Expectations Vs. Reality, and Grief



[Hormone Hangover](#)

Feb 15, 2021



This is a three part essay series about detransition/regret after top surgery, or double mastectomy.

[This essay was influenced and inspired by Carey Callahan's great essay about detransition.](#) If you're a detransitioner or know someone who is, give that a read. It's a great balm. I wrote this in collaboration with [Carol](#) and [Jamie](#), who contributed their post-op detransition experiences and wisdom. You'll be hearing quotes from them in the next two essays. Thank you so much to Carol and Jamie!

This, the first section, is about being my experience of being surprised with grief and pain after top surgery.

What it's like to regret your mastectomy

"You arrive at the place

It is not what you want

But it is what you chased"

-[The Spine Song](#), by Cake Bake Betty

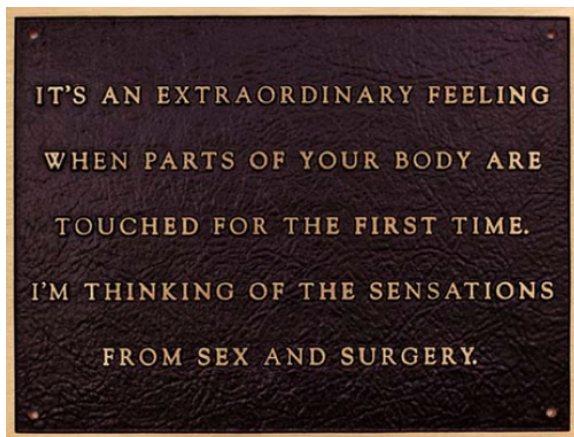
I've made a lot of mistakes in my life. But none have impacted me so indelibly, or caused as profound regret, as my 2017 decision to transition FTM: female-to-male. As I write this, the mastectomy scars are twinging on my chest. 4 years later, I've grown older, wiser, and way more cautious. But the scars remain.

When I realized that being a trans man wasn't what I wanted anymore, I fell into despair. My body was permanently changed. The surgery was the hardest thing to deal with. The scars hurt. I missed the feeling of having an intact, unscarred body. I was convinced my life had been ruined.

As a detransitioner, regret can be crushing. But somehow, eventually, even after the most catastrophic of mistakes, life goes on. It's still your only life, and you still have to figure out how to survive. It took me a while, and I learned I could survive.

Above all, I just want to say: you can come back from this. People have lived through a lot more. I am not a guide, I have no special wisdom, but I come to you humbled, scarred, and holding out my hand. You can get through this, and build a life.

Top Surgery, Expectations Vs. Reality



by Jenny Holzer

If you've never had a body part removed, or at least a major surgery, it's hard to understand what it feels like to have "top surgery." I used to romanticize it. The removal of the breasts leaves a smooth, flat chest with two sexy, mysterious slashes. The scars themselves were like a testament to suffering and transformation. I wanted it really bad. And more than the physical

results, I wanted what it represented. It was freedom from binding, it was the first step to truly, powerfully reshaping my body with my own will. It was freedom from the physical sensations of having breasts. I fixated on it as the quasi-religious ceremony of my becoming.

It was what I thought I wanted. As the date got closer, ragged jolts of fear started to come through me. But I persisted, and bolstered my belief by reading happy stories of post-op trans people.

During our brief pre-op consultation, [my surgeon](#) said that this was an easy surgery. Quick recovery, back to normal in no time, really. She glanced over my body and told me that I would look great. I was imagining a transformative and spiritual experience when I went in for surgery. I'd hyped myself up to believe that this was going to be a beautiful turning point to becoming the real me. Of course I knew in an intellectual way, it was going to be tough to have surgery. Nonetheless, I expected powerful relief from my dysphoria.

I had no idea how bad it was going to be. But once I got the surgery, I found out for myself.

After my mastectomy, I felt sewn up, aching, ghastly. My sutures oozed blood, my abdomen was swollen and grotesque. My chest didn't feel at all natural. A disturbing, never-abating sensation of numbness and occasional pain had replaced what I now realized was the natural feeling of my intact body. And almost immediately after the surgery, the dread of regret started to sink in. Whatever I thought I was getting into, I had failed to contend with the fleshy reality.

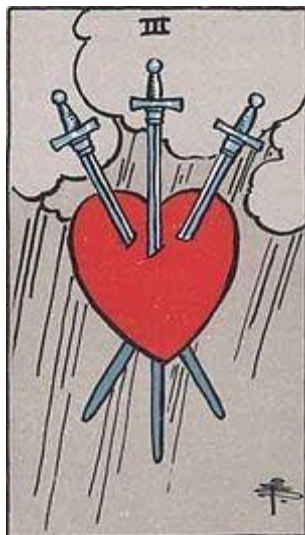
Lesson learned, younger me. Don't let the pushy, glitzy Instagram "before and after" photos fool you- a mastectomy is ALWAYS a big deal.

I felt like I might be crazy having this kind of reaction to the surgery. I had binged on smiling, triumphant pictures of post-op trans men. The gore and the pain and sadness were not what I had expected. I posted on the ftm reddit about feeling a strange sense of grief at the surgery, and asked if anyone felt the same. Many other members of the forum came out of the woodwork to agree. Even if they were happy with the end results, they still felt loss and pain.

Not only that, but my feelings of gender dysphoria increased. My obsession migrated to my hips, my voice, and my very mannerisms. The top half of my body looked okay, but what was I going to do about my hips? The way I moved? I was more obsessed than ever before with monitoring myself. I told myself I was being liberated, but really it felt like I was stacking the bricks to my own prison walls.

I had this nagging feeling - that nothing would ever be enough, that I could just keep cutting and cutting my body but I'd still be the same increasingly-wounded me underneath it all. That feeling grew and grew. When it got loud enough, I began to realize I would have to detransition. I stopped T, and then my hormone-dampened sadness came flooding back.

Loss and Grief



ouch (Ryder-Waite tarot deck)

I was taken aback by the deep, serious loss I felt. I tried to connect to other people who were struggling with the same feelings, and searched for more information about mastectomies. In *The Cancer Journals*, Audre Lorde said that losing a breast (from a mastectomy for cancer) was as viscerally painful as losing her own mother. Another friend described the post-op feeling as being like she had been placed on a strange planet and she could never go home. I think if you haven't experienced it, it's hard to convey the feeling.

There was also the psychological fallout of having body parts missing. I felt a harrowing feeling that something was wrong with my body, something was missing. Alarm-signals went off in my brain constantly. In a bleak way, it was fascinating - I had discovered a whole new range of bad feelings I had never felt before. I fantasized feverishly about turning back the clock. Life as I knew it seemed to be over.

It was also really upsetting to cope with the difference between what I hoped the surgery would do for me, and what it actually was. It's easy to think top surgery will fix your life in some magical way. It's supposed to help you pass as a man or be androgynous. It's a huge step on your transition journey. To have those expectations fall through for whatever reason and end up regretting is really hard.

When I realized my mastectomy had been a mistake, I felt betrayed, disoriented, and confused. My fantasies of what transition would do for me, the road map I had structured my future on, dissolved into meaninglessness. How did I get in this situation? Why did I think this awful, awful surgery would help me? Why didn't I run screaming away from the surgeon's table?

And on top of all of that, if you end up reverting to a female gender identity, there's the entire collapse of your understanding of yourself to deal with. While detransitioning is different from transitioning, they share the feature of reckoning with the nature of your life and identity. What's

your new name? Who are you after all this? What does it mean to be yourself, now? To a large extent, you have to find your own way out of the wilderness.

So: this was hard. Especially the first year, especially the first six months. It got worse after I realized I needed to detransition and make peace with my body, because that also involved accepting that my natural body would never be restored.

If you had top surgery and you're taking the loss of your breasts really hard, I'm sorry. You're not alone. You are entitled to healing and relief. You can find it. I'll talk about that more in the next essay.

The next essay will be about physical and emotional healing, forgiveness, and reconstruction surgery.

Edit: I deleted a line joking that I would be playing Tennis 2 weeks after top surgery. It was a joke, but I'm worried it didn't come across correctly and don't want to misrepresent my surgeon. My surgeon did say about 2 weeks would be recovery time for most activity post-surgery.

My Letter to the Surgeon Who Performed My Double Mastectomy

Laura, <https://pitt.substack.com/p/my-letter-to-the-surgeon-who-performed>
Aug 10



This is a copy of the letter I mailed to the surgeon who performed my double mastectomy or “top surgery” when I was 20 years old. This letter, addressed as a “Notification of Detransition” was mailed to the cosmetic surgeon. I wrote this letter to inform the doctor and his staff that a former patient of his 100% regrets the operation performed on her, and has detransitioned and is now living as a biological female with no functioning breasts.

I kept the letter short and emotionally detached and, despite my traumatic feelings around this loss of self and body parts in my private life, knew it was crucial to maintain a rational composure in stating the facts of my situation. I described how my gender dysphoria was not cured by surgery or medical transition, but instead was fully resolved within 2 years through cognitive behavioral therapy, because the “gender dysphoria” was in reality, complex post-traumatic stress disorder. I described how I realized, only 2 years later at age 22, that the surgery had been a mistake, and that I didn’t receive proper mental health treatment when I was obtaining the surgery, the supposedly necessary gatekeeping he required to perform the operation.

This was important to include because, although I doubt as a cosmetic surgeon who has made his career entirely dedicated to performing double mastectomies on young women and girls as young as 16, that he cares about the mental wellbeing of his cliental, he advertises his practice as being a legitimate medical service by insisting that he follows the “WPATH Standards of Care”, the leading organization of trans medicine which requires at least 2 letters of referral from mental health providers for a patient to receive medical transition. The Standards of Care

advocate for thorough screening for mental wellness, and selecting only appropriate patients who would truly benefit from transition.

It was crucial to inform the doctor that, in my case, the Standards were not met, as the mental health care I was receiving, and the subsequent referral letters, were negligent in providing assessment of my mental health situation, and therefore, his practice was not actually following the WPATH Standards of Care. Furthermore, what I did not include in the letter due to a desire to preserve my anonymity, was the fact that I openly discussed being suicidal with the doctor during our consultation, and feeling suicidal on the day of the actual surgery. Regardless of the recommendation letters, I presented to my doctor as not of sound mind to make a major elective surgical decision, but he performed the operation anyway.

After relaying my personal beliefs that this treatment was unethical in my case, I made it known to my doctor that I am far from the only former FTM patient who regrets medical transition, and cited Dr. Lisa Littman's study of detransitioners showing how high the comorbidity rates are of various mental disorders in the FTM population, and how this issue is not just a personal error, but a growingly widespread phenomenon. I closed the letter with a call to action for the doctor to reconsider what his practice views as 'medical treatment' to treat mental disorders. I plainly asked him to confront the reality that he removes young women's and even minor children's breasts to treat problems inside their minds, and if he truly believes that is following the medical oath to "Do No Harm."

My story is similar to many detransitioners who share why they felt they needed to transition. I grew up on the autism spectrum, experienced verbal, emotional, and psychosocial abuse from family resulting in PTSD, depression, and anxiety, had severe depression from attachment issues and hormonal dysregulation from PCOS, felt chronically othered and different as a girl, young woman, and person, suffered with relationship difficulties with romance, sex, and friendship due to undiagnosed trauma, and latched onto "gender dysphoria" as the cause of most of my difficulties.

I sought treatment for my gender related distress and learned online that the only solution was to accept being transgender and transition to live as a gay man. I followed the usual coaching of the process to "healing", first, to socially transition and come out as nonbinary and transgender, second, to receive hormones from an informed-consent clinic, with no mental health evaluation or gatekeeping, and finally to have top surgery, the greatest rite of passage for the FTM cult. Throughout this process I saw multiple doctors, a psychiatrist, and therapists, none of whom questioned my identity, traumas, or provided help for my complex mental health issues. I had just turned 20 and was fresh out of an inpatient psychiatric ward for suicidal ideation when I desperately made my appointment to try and heal my depression through altering my body with surgery.

There is no need for further explanation. I was 20, developmentally immature, mentally ill, suicidal, had PTSD, and not in a rational state of consciousness, yet the mental health system failed to provide its due service, and my doctor and other cosmetic surgeons hungrily leapt at

the opportunity for fresh meat to profit from operating on, in this unchecked, wild west market for “gender medicine.”

I share this letter with you to showcase real-life consequences of trans medical propaganda, and the repercussions our young people and children are facing. The last I checked; my doctor operates on girls as young as 16. I’ve done my soul-searching, grieving, extensive therapy, and self-punishment for the mistakes of my childhood self, but am healed enough to have progressed into self-forgiveness, acceptance, and upholding unrelenting boundaries around my peace, sanity, and healing process. I did not provide a return address on the letter I mailed, as I did not want to endure excuses or shaming correspondences.

The letter remains a rallying cry from the young women of the detrans movement to advocate for better medical treatment, no placation or bullshit apologies desired. I don’t claim to speak on behalf of anyone else, but unfortunately appreciate that my story is identical to countless other girls, and I hope that sharing this will somehow help them heal, or better yet, prevent the need for their healing in the first place.

Dear Dr. XXXX and Top Surgery Clinicians,

I am a former patient who you performed a double incision mastectomy on in 2017 while I was 20 years old. I am writing to inform you and your office that I have detransitioned and no longer identify as male/transgender and have returned to living fully as my biological female sex. I want to inform you that I fully regret having the surgery to have my breasts removed. My symptoms of gender dysphoria were the result of CPTSD from childhood abuse and my transgender identity was a maladaptive coping mechanism to deal with the reality of the trauma.

I have fully resolved my feelings of gender dysphoria through cognitive behavioral therapy and view the surgery and transition as a placebo that gave me only false hope of feeling better about myself. I 100% regret the surgical outcome of my body and miss having my healthy breasts. I was 20 when I had my identity crisis and detransitioned 2 years later at 22. I believe I did not receive proper mental health screening by my psychiatrists who wrote my surgery recommendation letters because they said I was mentally stable while I was actually suicidal and exhibiting symptoms of undiagnosed PTSD.

I have found healing and community within the online population of other detransitioned women with similar experiences of trauma, and I want to inform you that I do not believe removing the breasts of young women, especially minors, is medically ethical given the severe rates of comorbid mental health issues in the FTM population. I do not believe I was stable or mature at 20 to transition and I don’t think a minor child under 18 in any circumstance is stable or mature to consent to having her breasts removed.

There is a rising number of detransition cases just like mine as evidenced by the rapid increase of detrans stories on Youtube, and the Subreddit r/detrans. There has also been a recent study

by Lisa Littman at littmanresearch.com on detransition which shows that 60% of the detrans study participants transitioned due to underlying mental health and trauma reasons, and 25% due to being lesbian or gay.

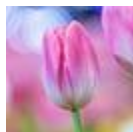
I ask you to consider my story and the stories of others as your ethical duty as a clinician to first do no harm, and rethink if removing healthy breasts of women and children so they can pretend to be men is physically or mentally doing no harm.

Your patient, Laura

Trans to Detrans

Ritchie Herron/TullipR, <https://tullipr.substack.com/p/trans-to-detrans>

From a detransitioning males perspective



[@TullipR Detrans Male](#)

Mar 21

If "trans" means "to cross" then "detrans" means "to come back" - to come home.

There's a reason why people sometimes refer to their trans identities in the third person, because it is such a disconnect within yourself that you start to create a character.

You give that character a name, and you try and take the image of what you envisage that character to look like into reality through a skewed, deeply controlled and filtered perspective.

You take 100 photos, delete 97 and then post it as if you didn't spend hours getting it right. *"Wow you look amazing, oh my god" "you look cis" "100% pass!" "imagine what HRT would do to you"*

The affirmation becomes intoxicating.

You then start to really change the way your character sends messages, becoming aware of not using enough emotive speech in my character's instance. Saying phrases like "awwwwww" or anything I felt would resemble a woman talking rather than a man.

Your 'unique' character becomes a clichéd stereotype, following the grain of what is considered right or wrong at the time by your fellow trans peers.

You then seek out other characters, who reinforce and refine your own character.

Then you tell your entire family that you are this character now and that's the way its always been.

You tell your bank, driving insurance, energy supplier, mobile phone provider of your characters name. You now have proof your character exists.

You tell your doctors that it is their duty to make this character come to life and you demand a referral to the gender clinic.

You get bored of waiting and go your own way. You know what you need, you need HRT! You book a private assessment and you get two separate opinions for £500.

Congratulations! You have a diagnosis, don't worry that its full of errors and they clearly wrote it quickly knowing you just wanted HRT and you probably wouldn't correct them anyway.

You're still waiting for the gender clinic, but because you now meet the criteria, you can start HRT on bridging hormones! Heyyyy!! Success!

All the other characters gather round and tell you how happy they are that you have finally be given the *'right'* HRT.

This is the best day of your character's life.

Your family tell you its just a character.

They worry endlessly that you will do something stupid, they tell you; come on, this isn't you, this is a character!!

“NO! I AM THE CHARACTER! IT WAS ME ALL LONG. BIGOT!”

Some family don't know what to do. They cut you out. They can't bear to sit and watch. They know what's going to happen. Some family stick by – they'd rather be there then lose you.

You are not well. You go back online and tell people "hey, maybe I'm not this character after all?"

“...THEY are the problem...” “this is internalised transphobia from your transphobic family, I'm sorry”

You are getting so much attention for your suffering, you finally are being heard, you tell them about all the awful homophobic things that happened. All the other characters sit and hug, validate and affirm.

They say all the things that a salesman will tell you about a broken car, obscuring the truth and focusing on the fact 'hey it's got wheels don't it?'

You work hard with a therapist, and you begin to see the character you've created.

You are so desperate not to lose it, you know what you could do to keep in the service, even though you really don't want to.

You ask to be referred for SRS.

They tell you to go for hair removal. You drag it out as long as you can, you defer appointments and make up excuses.

What should have taken 12 months took 2.5 years.

It's the day before surgery, there's something ticking in your mind trying to break through a formidable defence of cognitive dissonance.

You neatly lay your character on the bed, ready for the surgery you're convinced will make you better and save your life.

You wake up in a hospital bed. Your character was just that all along, it was you. This is the big reveal, the curtain call – the gravity of what you've just done hits you so hard.

It's not what you thought it would be and it's full of hidden terms and conditions; incontinence, discharge, areas of no sensation, some sensation, pain, UTIs, infections, low energy, varicose veins...

You become demoralised and realise this wasn't worth it all.

You can climax, that's great, but actually you've started to realise your dysphoria down below wasn't even that bad to begin with, and in fact the idea of being with another male is quite a nice idea in your head.

Then you realise actually you wrote your character all wrong to begin with, and no one really helped with that.

You're gay, and you're traumatised from a life of severe homophobia.

You realise there is no undoing any of this.

But you do realise you can come home.

You can detransition, which means throw away the character. Scrap it, it never was you to begin with, it was an idealised fiction that never met the test of reality.

You were always a feminine soul, but that doesn't mean you're a woman, it just means you're a feminine man. And that's okay! In fact it's freeing.

I feel like the shackles have come off, and I am myself again, I am back in the room.

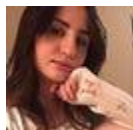
I realise it was always just a character to begin with.

-TR

By Any Other Name

Helena, <https://lacroicsz.substack.com/p/by-any-other-name>

The story of my transition and detransition.



[Helena](#)

Feb 19

My name is Helena, and as of this writing I'm a 23-year-old woman who, as a teenager, believed I was transgender. In the years since detransitioning (stopping testosterone treatment and no longer seeing myself as transgender), I've become interested in exploring why, in the last decade, nearly every English-speaking country has seen a meteoric rise in adolescents believing they are transgender and pursuing cosmetic medical and surgical interventions. Here, I'd like to go over how and why I came to see myself as transgender, the process of transitioning, and the events leading up to and following my detransition.

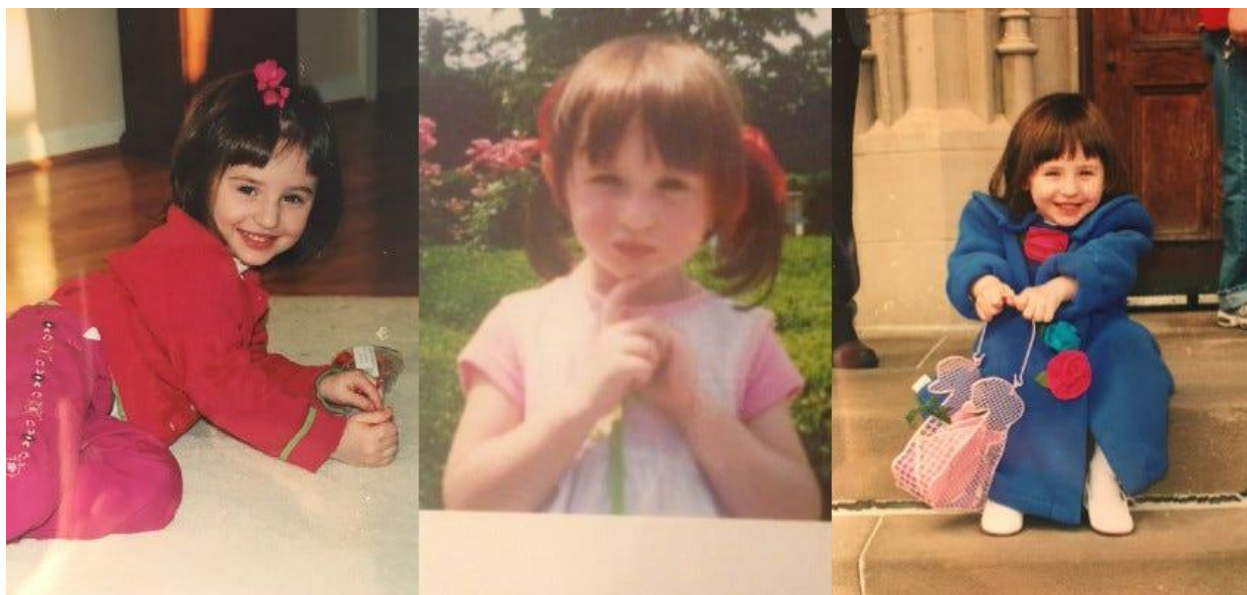
The short version of my detransition story for those who want the bare details is that when I was fifteen, I was introduced to gender ideology on Tumblr and began to call myself nonbinary. Over the next few years, I would continue to go deeper and deeper down the trans identity rabbit hole, and by the time I was eighteen, I saw myself as a "trans man", otherwise known as "FtM". Shortly after my eighteenth birthday, I made an appointment at a Planned Parenthood to begin a testosterone regimen. At my first appointment, I was prescribed testosterone, and I would remain on this regimen for a year and a half. It had an extremely negative effect on my mental health, and I finally admitted what a disaster it had been when I was 19, sometime around February or March 2018. When the disillusionment fully set in, I stopped the testosterone treatment and began the process of getting my life back on track. It has not been easy, and the whole experience seriously derailed my life in ways I could never have foreseen when I was that fifteen-year-old kid playing with pronouns on Tumblr.

But what leads a girl with no history of discomfort with stereotypical "girl" toys and clothes, or even the slightest desire to be a boy in childhood, to want to be a "man" through hormonal injections as she approached adulthood? In a vacuum, such a profound confusion leading to such drastic measures sounds like it should be rare and a sign of some sort of severe mental disturbance. Was I a fluke? Was I some kind of idiot who mistakenly believed I was trans because I'm crazy or just downright irresponsible?

The truth is that there has been an extreme rise in adolescents, especially girls, believing they are transgender. UK NHS referral data shows a [4000% increase](#) in pediatric gender service referrals (not a typo). So-called "gender dysphoria", which was once a very rare diagnosis that

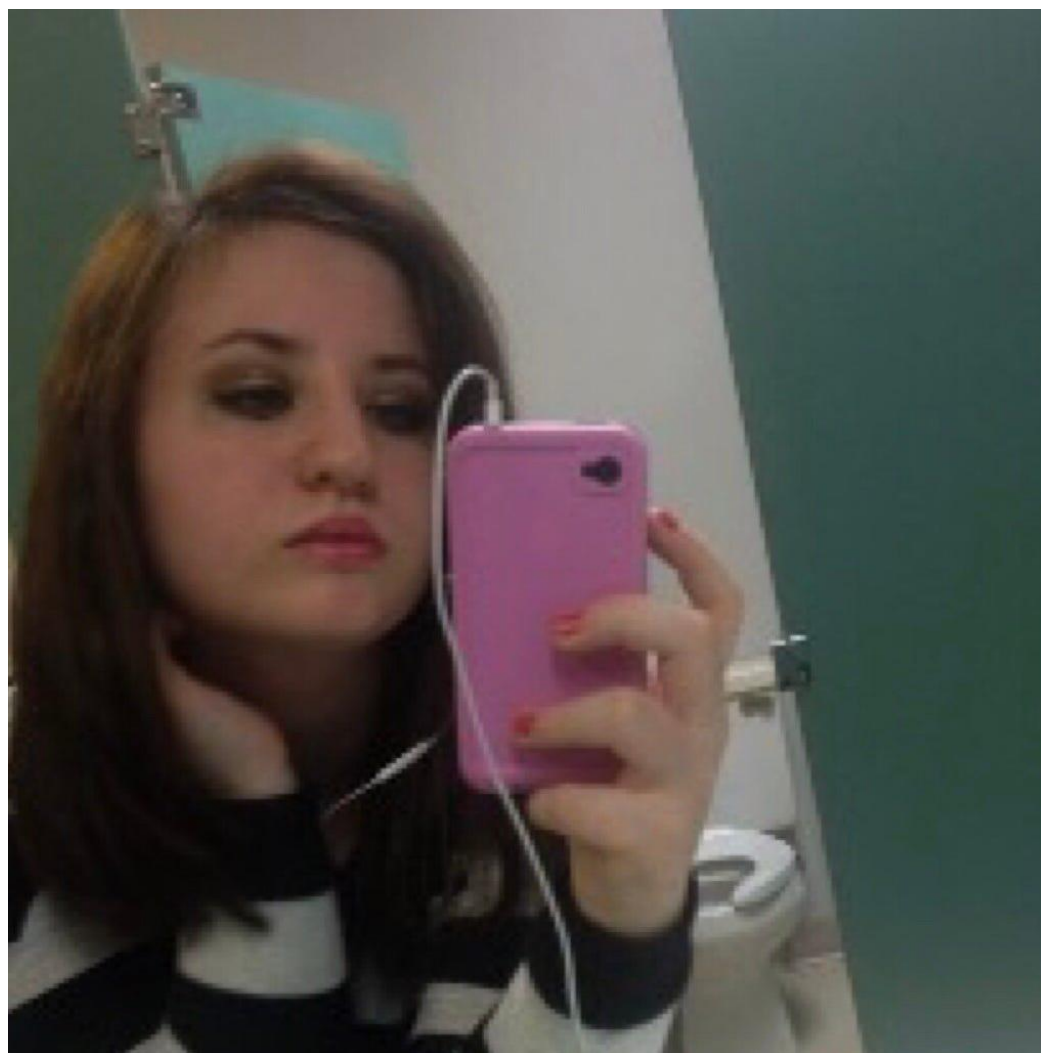
described mostly prepubescent boys and adult men, is now most commonly diagnosed in teenage girls. Activists will argue that these explosive numbers are a result of increased societal acceptance, and that at long last trans people are coming out of hiding and living as their authentic selves. If this were true, one might expect to see comparable rates of transgender identity across all age groups and between both sexes, but its disproportionately adolescent females feeling that warm and fuzzy inclusive acceptance. Considering “acceptance” now implies supraphysiological doses of cross sex hormones and having healthy body organs surgically rearranged, it’s worth a deeper look into what kinds of factors are driving this population clamoring to go under the knife.

How did it happen?



As a child, nobody would have pegged me as a future transitioner; I was never particularly masculine or even tomboyish. I hated sports, roughhousing, and getting dirty. I liked Barbies, playing dress up, and getting toy makeup sets for Christmas. Of course, nobody is a walking sex stereotype so there were certainly “boy” things I enjoyed, but my point is that neither female-typical activities nor being seen as a girl caused any distress for me before I was introduced to gender ideology. On the other hand, even at a young age I was beginning to experience some deep emotional difficulties unrelated to gender that would get more urgent over time. I suffered a serious loss when I was seven, and the rest of my family took the “don’t talk about it” approach, so my grief festered like an infected wound. My family was also very preoccupied with image, especially dieting and weight, and this began to have a pronounced effect on how I saw myself (and on my brother, too). By the time I was thirteen, I was isolating myself, self-harming, and had developed an eating disorder. In eighth grade, I lost touch with most of my school friends, and was too self-conscious and preoccupied with my eating disorder to put myself out there again. I started skipping school, spending lunch in the bathroom, and in general just keeping my head down, trying to get through the day unnoticed.

During this time, I developed an obsession with classic rock, and while searching the internet for photos of young Elvis Presley I found a website called Tumblr. I immediately noticed that on Tumblr, there were many accounts posting about 50s, 60s, and 70s artists and that best of all, they were other teenage girls. I made an account and began posting scans of some vintage pop magazines I had bought off eBay, and soon enough, these accounts were following me back. Between sharing photos, drawings, and fanfiction, these girls were posting about their lives and going into deep detail about their struggles. Many were social outcasts like me, also struggling with things like self-harm and eating disorders. Finding a community of such like minded people felt amazing, and I quickly began spending nearly every waking moment on Tumblr or messaging some friend I had met on there. If I had any remaining motivation to integrate myself into real life, I lost that here. At school, I would sit in the back of the class, scrolling Tumblr and talking to Tumblr friends without engaging in class. When I returned home, I would open Tumblr on my laptop or hop on Skype to voice call with girls halfway across the planet, ignoring homework and studying all the while. As you can imagine, my high school GPA was abysmal. Tumblr would stick with me as I moved through various interests, from classic rock to Harry Potter, to One Direction and Justin Bieber, each iteration subsumed in a community of countless other intense, obsessive girls like me. I was in love with my new world, and even now I look back on some of these times spent on Tumblr, and the girls I met, with incredible fondness.



Me at 15; not identifying as trans yet but well into Tumblr, eating disorder, and being sad all the time.

Tumblr, though, wasn't only a place to post art and make friends. Being such a secluded platform with a fairly homogenous user base not only

demographically (mostly teenage girls, many of whom white and middle to upper middle class), but especially in terms of personality type, it developed its own culture, distinct from the youth culture of the general population. Because many of its users were like me, using Tumblr as an all-day alternate reality escape from the real world, this “culture” should be understood in the most literal sense of the word. One should think of Tumblr, especially from 2009-2016, as a secluded island nation whose people rarely interact with the outside world, and thus have language, customs, hierarchy, and history that is entirely unique and at first incomprehensible to people from other nations visiting the island. There’s something about it that almost selects for a particular type of person, and I’ve heard so many times from normal people (for lack of a better word) that they “tried Tumblr, but couldn’t figure it out.”

We’ve all read *Lord of the Flies*, right? A bunch of tween boys get stranded on an island and all of their deepest, most repressed urges surface as they desperately attempt to organize and manage the tiny preteen society they’ve found themselves in. The novel ends in bloodshed, as the author theorizes that the immaturity, communication breakdown, and decision making difficulties one would find in a group of adolescent boys would create a chamber of destruction. How would it have ended differently, some have asked, if the story was one of a stranded group of girls? What would happen if every troubled, isolated, self-loathing, depressed, and emotionally overwrought teenage girl in the world wound up alone on an island?

Tumblr. Tumblr would happen.

~A quote from [this series](#) I began long ago, and unfortunately have yet to finish.

A major aspect of Tumblr culture has always been social justice ideology. Things that are now being played out and witnessed by the general public on platforms like Twitter and TikTok, like dissociative identity disorder LARPers, demisexuals, neopronouns, otherkin, and everything you see on @LibsOfTikTok, have long existed in an uncannily identical form on tumblr.com. The oppression hierarchy of racial and gender identities now being written into law in many of our once serious nations was the state religion of the People’s Republic of Tumblr long before your political junkie uncle knew the term “CRT”. As cultish religions tend to operate, open devotion to the religion is mandatory. Perhaps the outsiders most likely to understand the way social dynamics worked on that website would be survivors of Scientology or the Jehovah’s Witnesses. On Tumblr, the situation was such that any claim to being “oppressed” would accumulate social credibility, while any unfortunate “privileged” status was justification for verbal abuse. As a “privileged” person, you were expected to constantly grovel and apologize, you had no right to speak on any issue involving the group you were “oppressing”, and you could not object in any way to any mistreatment hurled against you because of your race, gender, or sexuality.

I found myself in a bit of a double bind. On one hand, I had found what felt like the perfect group of friends who understood me on an intuitive level, who I was able to talk to openly about the things I liked and made me “weird” in real life, but on the other hand I was a “cishet white girl” in an environment where that was one of the worst things to be. Since Tumblr users are mostly

biological females, the “cishet white girl” holds the position of most privileged and therefore most inherently bad group. In this climate, you are made to feel guilty and responsible for all the horrors and atrocities in the world. No hardship you could possibly go through could ever be as bad as the prejudice and genocide POC and LGBT people face every. Single. Day. Insert clap emoji. LGBT people and POC can’t even walk out of their houses without being murdered by cishet white people just like you!

Its understandable that any young person exposed to this kind of belief system would grow to deeply resent being white, “cis”, straight, or (biologically) male. The beauty of gender ideology is it provides a way to game this system, so that you can get some of those targets off your back and enjoy the camaraderie of like-minded youths. You can’t change your race, pretending to have a different sexuality would be very uncomfortable in practice, but you can absolutely change your gender, and it’s as easy as putting a “she/they” in your bio. Instantly you are transformed from an oppressing, entitled, evil, bigoted, selfish, disgusting cishet white scum into a valid trans person who deserves celebration and special coddling to make up for the marginalization and oppression you supposedly now face. Now not expected to do *as much* groveling and reaffirming to everyone how much you love checking your privilege, you can relax a little and talk about your life without wondering if you are distracting from the struggles of or speaking over marginalized groups, because you are marginalized too. With the new pronouns often comes a wave of positive affirmation from friends and followers, and the subconscious picks up quickly that there’s a way to make the deal of being on Tumblr even sweeter.

This is the incentive I felt to comb through my thoughts and memories for things that might be further evidence that deep down, I wasn’t really a girl. I hated my body; it must be because I don’t like that its female. Boys have never been interested in me like they are with other girls; well, maybe I would be attractive as a boy, and then I could be like all these cute “gay trans boys” I saw dating each other online. I didn’t have many friends, it must be because being a girl isn’t my “authentic self”, and that was getting in the way of my social life. Plus, people were nicer to me since I said I was trans so that must be an indication that being trans is the right thing to do to make friends. Female sexuality is hypersexualized and pornified, yet it’s supposed to be “empowering” for women to do porn, be prostitutes, or have dangerous, kinky, scary sounding sex with many different men. I heard that my discomfort with this made me “vanilla”, and a girl who is vanilla has no chance of really pleasing a man when competing with “empowered” women. I must not have really been meant to be a girl, because if I was, this wouldn’t all be so scary and confusing. I felt like my family didn’t care about me or pay attention to me, it must be because they subconsciously have always known I’m trans and they’re transphobic. I mean, they did make fun of Caitlyn Jenner that one time. They hate me! Just wait until I tell them I’m going to start testosterone; they’ll *have* to pay attention to me then.

I was also certified boy-crazy, but in the weird nerdy stalker way, not the actually dating boys way. I always had a crush on some boy I would never talk to, whether he was a celebrity, fictional character, or someone I just saw around at school. When I had a crush, it would utterly dominate my mind. I would become infatuated with every little detail of how they looked, spoke, laughed, and moved. I had elaborate fantasy worlds in my head down to the minutia of what we

would talk to each other about on the drive back from delivering our third baby at the hospital. I had a one-track mind and I craved an intense fantasy element. This led me to the world of fanfiction, mostly male/male pairings. What could be better than boys? Double boys! But they're written by girls so they make sense and feel familiar instead of different and intimidating. I loved the unlimited amount of creative and exciting content other girls were writing about my favorite characters. I wasn't super into erotic fanfiction, and if I did read it, it was always within the context of a longer, more relationship-oriented story, but pure erotica was popular too (often carrying heavy kinky themes...). I began to identify with these representations of boys written by other young females, and the themes within male/male fanfiction were so much more titillating than anything in mainstream, professionally produced media, or even heterosexual fanfiction for that matter. The pairing being same sex seemed to give writers and readers the freedom to explore these characters and their relationships without being constricted by the norms that come with heterosexual dynamics. It became this liminal space where I could explore what interested me about boys and fantasies about relationships, connecting it to whatever my media obsession was at the time, without the pressure of interacting with real boys, as real boys made me painfully bashful.

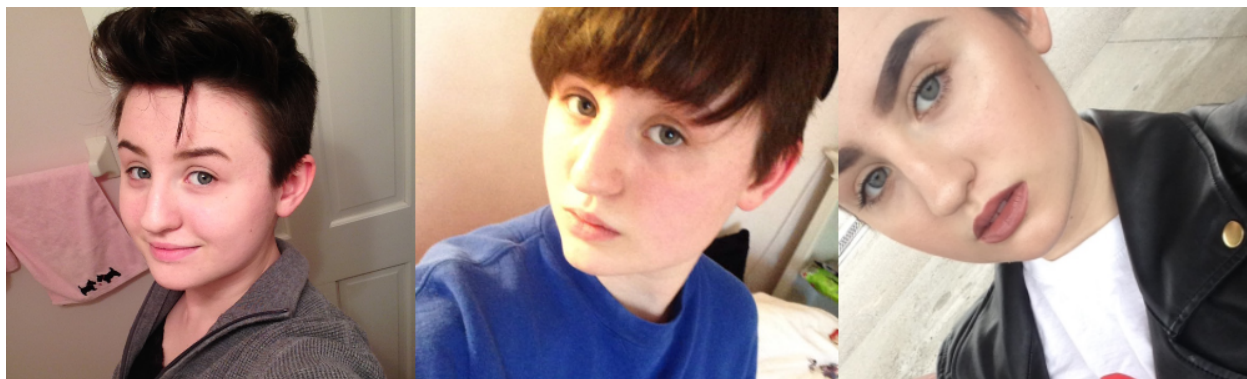
I wasn't alone in these mental and emotional traits that led me to shipping and fanfiction, and I *certainly* wasn't alone in wanting to be a boy after immersing myself in this kind of content. "Shipping" is the word for being interested in a pairing between two characters or people, and each "ship" has a community comprised of devoted shippers as well as people with a casual interest in the pairing. Being involved in these communities, comprised of mostly other trans-identified teenage girls, created a feedback loop in which we would obsess over these male characters or celebrities, share fantasies, art, and writing, and affirm and engage each other over these interests. One last aspect that bears discussion is the concept of "head canons". In a story, the "canon" is the timeline and facts of the story as the official author or historical evidence relays. A "head canon" is anywhere where one's personal perception of or preferences for the story deviates from the official canon. For example, if in the canonical Harry Potter story Harry is an English teenage boy attending wizard school, one might have a head canon that Harry is actually black, nonbinary, and drops out of Hogwarts to become a professional chef. The concept of head canons opens a whole world of possibilities for projecting onto a character and muddling the fantasy of one's personal identity or desired reality with the fantasy of the identity and life of an entirely fictional character in a fictional universe. In my head canon, Harry Potter, who I related to and was a meaningful character to me, was born female and was either nonbinary or a trans man depending on what point in my life you would have asked me. When I watched the Harry Potter movies, where Harry is obviously played by a male actor, or read the books, where nowhere in the text does J.K. Rowling state Harry is transgender, I would still kind of interpret the story through my own lens in which he was, and thus further see myself in him.

The adolescent brain is in a developmental stage primed to incorporate experiences into the process of identity formation, and spending so much time in fantasy without building much of an identity through real social and life experiences can lead to the identity and fantasy elements becoming indistinguishable.

My perception of myself as trans formed in the intersection between overwhelming emotional struggles, heavy fantasy, emotional and intellectual infatuation with males (real people, fictional characters, and the idea of males generally), fanfiction, social and ideological incentives to be trans, and insulation from experiences and perspectives that might have challenged the views I was developing about myself and the world. Each individual girl's story will vary, give or take a few factors, but in the broadest sense these are the basic factors that comprise the trans "social contagion" described by people like researcher Lisa Littman and Abigail Shrier in her book, *Irreversible Damage*, particularly when we are talking about male-attracted girls. What I've said here barely scratches the surface.

From fantasy to reality

Over the three years that I identified as trans prior to reaching legal adulthood, I kept this huge aspect of my self-perception to the confines of Tumblr and the few school friends I met after switching high schools, also avid Tumblr users, and all but one also identified as trans. I cut my hair, wore baggy clothes to hide my body, and was gifted a breast binder by a friend from Tumblr that I would wear out and about, but I didn't talk to my parents about any of this until late into my senior year of high school. By this time, I fully identified as a "trans boy", wished I had a male body, and wanted to medically transition.



Some examples of how I looked in high school after beginning to identify as trans. I would alternate between wearing a lot of makeup, long fake nails, and other very "feminine" things and making awkward attempts at looking more boyish.

When I told my mother about all this it was on an impulse. I had a whole spiel planned out where I would tell her all about how I was always trans, I just didn't know it, and hand her a big packet of printed out articles from pro-trans organizations about what different words meant and why I needed to transition. For some reason I still don't quite understand, on one gloomy day we were driving back from the grocery store and I just blurted it out mid conversation, telling her that I was going by a male name, male pronouns, and was going to transition. I immediately wanted to stuff my foot into my mouth, but it was too late, and the dead awkward silence was setting in. For what seemed like eternity, she drove in silence. I stared at the headboard, eyes wide and heart thumping. Finally, she responded with a word: "No."

"No, I am not going to call you that. You are Helena and you are a girl," she said, maintaining her glare at the road before us.

Deflated and conflict avoidant, I remember saying something meek and passive aggressive like "if you feel that way, I guess..." and we finished our drive in silence.

The next day, I went to the school library and printed out all those articles I had saved for my planned "coming out". When I got home, I scrawled a long-winded letter on loose leaf paper with what was originally going to be my "coming out" spiel, stapled it all together, waited for her to get home late and head to bed, then I slipped it under her bedroom door at night as she slept. The following day, I anxiously awaited speaking to her, wondering what she thought of all the articles. Had they convinced her? They had to, right? I was showing her that experts clearly agreed that trans people like me are valid.

When I returned from school that day, the packet was face down in the kitchen trash.

Distraught, I agonized over what would happen when she got home. Would she yell at me? What did she think of the packet? I wondered if she had already read "transphobic" material that countered the articles I sent her. Hopefully she read my letter and could see past any transphobia and realize that this was the real me. She didn't yell at me though. Instead, we mostly avoided each other for a few days and then both acted like nothing ever happened.

This would continue for months until another fateful confrontation, ironically at the same grocery store we were driving home from the first time. I don't remember how the argument started, but somehow, we got into it over my conviction that I was transgender.

"I don't understand why you can't just be a masculine woman," she said.

I responded, "Because I'm not a masculine woman! I'm a trans boy!"

She didn't understand that the issue wasn't of repressed masculinity itching to be let loose, it was a conviction that I was a part of the transgender identity group, and any masculinity I engaged in was a conscious supplement to that end.

Yelling and crying between us ensued, very classy for the middle of the dairy aisle at Kroger. She told me I had lost my mind and needed to see a psychiatrist. I told her she was a hateful person who wanted trans people to die. We went back to not talking much after that.

I was heartbroken. Now that I'm older and on the other side of this, I understand why my mom was struggling so much with her reactions to what I was demanding of her. We never had a relationship where we confided in each other often, and she can be somewhat emotionally distant. I don't demonize her for it anymore, but at the time I interpreted her unwillingness to entertain my identity as a disregard for what I was feeling and a rejection of who I was. To me at the time, being trans and wanting to transition was a desperate attempt to do something about my misery, and when she rejected my trans identity, it felt to me like she was telling me I didn't

deserve to feel better, and she wanted me to continue feeling the way I was, which was suicidal, lonely, and self-loathing. I do wish she had responded with more compassion and curiosity, but she was doing the best with the skills she had. It's an unreasonable expectation for most parents to respond perfectly to something as outlandish as an unexpected transgender identity and the possibility of irreversible medical interventions, especially when teenagers like I once was are under the influence of a noxious ideology that makes authentic communication nearly impossible.

To add fuel to the fire, I went to my school guidance counselor and told her I was very depressed (true) because my parents wouldn't accept me as trans (not so true). She completely affirmed my perception and told me how sorry she was that my parents weren't more supportive. She looked online with me at the local children's hospital gender clinic and said she would call to see how long their waiting list was. We also came up with a budget plan for how I would pay for testosterone using an informed consent clinic if I waited until I turned eighteen. In the meantime, she said I should talk to the school psychologist to help me deal with my family being so transphobic. I asked my mom if I could stop seeing the therapist I had been seeing occasionally and switch to the school psychologist. My mom, having no idea that the school was affirming me and helping me put together plans to transition behind her back, agreed.

The psychologist was also very affirming, and again told me how sad it was that my parents weren't supportive and that I was a real and valid boy. After years of self-harm, depression, and struggling with an eating disorder in silence, it felt nice to have all these adults suddenly take such an interest in my "mental health". It was just further proof to me that being trans was my ticket to happiness, anybody who urged caution only wanted to hurt me and hold me back. The psychologist brought up the idea of a family session to work things out between me and my mom, and once I felt assured that she would take my side in the matter, I agreed. I hoped coming face to face with a psychologist would finally convince my mom to take the fact that I was transgender seriously. In our session, the therapist and I all but ganged up on my mom, telling her that I needed to transition to be happy, and that trans youth are at a high risk of suicide if they are not given "access" to hormones and surgeries. Predictably, my mom did not respond well and we both left the session feeling bitter.

Some time over the summer, my mom told my dad about my "trans thing" and he told me calmly that he didn't think I was a boy, but he wasn't going to fight me on it either because he could see it wasn't going so well for my mom. He even took me out to drive his stick shift car thinking I might like to do something "manly". I couldn't figure out how to do it and got really upset that I wasn't able to easily do something he considered "manly". I think he was trying to show me that I didn't need to be trans to enjoy "guy things", but that was sadly missing the point. It was this weird belief system I found on the internet that made me want to be trans, not a repressed yearning to do "guy things". I had never been all that interested in "guy things". My dad and I didn't talk about it much other than that.

Soon after, I turned eighteen. I have a July birthday, and over that summer after graduation I began to put more intention into "passing" as male in preparation for testosterone and my plan to "live as male" in college. I went out and bought what I thought were "boy" clothes that would

fit my curvy, slightly overweight female body. Joggers, basketball shorts, and hoodies. Ugh, I cringe just thinking about it. So not my style, but I wanted people to think I was a boy. I believed once the testosterone transformed my body, I could be more creative with my outfits.

I want to take some time to explore what my expectations were for how testosterone would change my body. I am a female, 5'3 and a half, and at the time probably weighed about 150lbs. I don't have the curviest body, but I certainly carry a lot of my weight in my legs and arms and almost none in my waist. Even with the fat redistribution caused by testosterone, there's no way that a testosterone regimen could give me what I wanted: a tall, lanky, bony male physique. During puberty in natal males, testosterone is able to sculpt the male body while bones are still growing, which is part of the reason why this kind of physique was unrealistic. Testosterone also cannot change a female's height, or elongate leg bones, so no matter what I did I would never be tall or have long, spindly extremities. I also have long struggled with my weight, so my expectation to look bony was unrealistic in that regard too. I would look at male "thinspo" (pro-anorexia term for imagery of very thin people that is used as inspiration to restrict food) and "transition goals" (a similar concept in trans circles where people look at photos of the opposite sex that they want to emulate through style, hormones, and surgeries), which caused a massive disconnect between how my body really looked and what I thought could by some magic happen in the future. This kind of unrealistic fantasy obsession over body changes is one of the many ways in which trans identity resembles anorexia, which also involves an unhealthy obsession with unrealistic body goals and shifting goal posts. I spent much of my time before being trans looking at pro-anorexia content and chasing the ideal of an ultra-thin, androgynous [female] body. My restrictive dieting led to binge eating, and I convinced myself testosterone would do what I never could myself through starvation.



These are examples of the kinds of images I was perusing daily which formed my "transition goals". Notice the cropped faces in each picture; the images are objectifying in a similar way to anorexia "thinspo" images. This allows the viewer to enmesh their self-perception with the bodies in the images. Anime and Tumblr art were also hugely influential. Search terms like "tumblr boy aesthetic outfits" or "tumblr soft boy art" will show countless additional examples of this aesthetic which is popular among young trans identified girls. Incidentally, these

androgynous, pretty boy types are also the kinds of young men that adolescent girls tend to be attracted to.

Now a legal adult, I could pursue testosterone without my parents or laws holding me back. I searched around in my area, but back in 2016 there weren't any informed consent model gender clinics around. Informed consent is the model of treatment whereby someone of the legal age according to their state (in the US) who desires an intervention must only sign their name on a legal disclaimer informing them of certain risks in order to acquire those interventions. There is no therapy, psychological screening, or in my case even physical health screening involved in the informed consent model. At most, a provider could decline a candidate for some reason at their personal discretion. Whereas in the past, people who wanted to transition often had to be in treatment with specialists for years before being prescribed hormones or operated on, informed consent is now the most popular methods of distributing cross sex hormones and surgeries to people old enough to give medical consent in their state of the US today. There are even online telehealth services that will ship you hormones so you don't even have to leave your house to get them. Don't you love innovation?

Since there were no informed consent clinics in my area that I could find in a quick Google search, I decided to see which Planned Parenthoods offered it, as I had heard raving things about Planned Parenthood from people on Tumblr. The closest location to me offering informed consent HRT (hormone replacement therapy) was all the way in Chicago, a six-hour drive from my home town. I figured I could tell my parents I was out with friends and would make the drives to and from Chicago in one day. I had only gotten my drivers license a few months before, and had never attempted such a long drive. On the drive back, I got caught in a terrifying thunderstorm so bad that I couldn't see 10 feet in front of me and the winds were shaking my car. Now that I'm older and have done many long drives, I recognize this was a stupid thing to do. But I was doing a lot of stupid things.

My appointment, and first injection of testosterone, was on August 15th, 2016. I had just turned eighteen.



Me at 18; putting more effort into “passing” as male. I wore that hat all the time because I had no idea how to do or cut my hair in a way that resembled a typical man. I was too scared to go to a barber or men’s hairstylist. Also, because people have made this comment before, the thing on my shirt isn’t a confederate flag, its the logo of a local pirate themed laser tag place my brother used to go to and I stole the shirt from him.

I woke up early on the morning of the appointment, which I believe was for some time around noon, got together my couple hundred dollars in cash, put on my uniform of basketball shorts

and hoodie, and got in my car. I was banking on my parents waking up and leaving for work without coming to my room and would text them I was heading over to a friend's house at some point during the day. My mom called me during my drive, at which point I remembered I had actually been supposed to attend a dentist appointment that day, and I made up a story to her about how I was on my way to the dentist appointment and would head to a friend's house after. She wished me luck at the dentist, and we said goodbye. I still have always been too scared to admit to her what I was really doing that day, and that I didn't get that cavity taken care of for an embarrassingly long time.

This was my second time in Chicago (the first was for my high school senior trip), and as I merged onto Lake Shore Drive, the urban landscape excited me. I felt affection towards the city, believing that this place with its ultramodern lifestyle and progressive values was going to deliver me into a whole new life. As I exited onto LaSalle, I was met with several posters and signs related to LGBT, and felt my affections confirmed. This place was welcoming me. Validating me. I couldn't wait to get to my appointment.

I was probably late because I didn't factor in the whole issue of finding parking, and if you've ever been to Chicago its always a disaster. Directly through the door was a woman behind plexiglass next to a locked door. She asked for my identification, and I remember thinking how great it was that Planned Parenthood was keeping women and trans people safe from violent haters who might try to get into the clinic. Upon confirming my identity and appointment, she buzzed me in and I proceeded to the reception area. As I completed my intake forms, I looked around me at the people in the room with me, mostly women and a few couples, mostly black and Hispanic. I remember thinking how cool it was to see so much diversity in such a great and helpful place like Planned Parenthood. Being a Tumblr SJW from a mostly white area, I was euphoric at the thought of a place that affirms trans people and caters to a poor black and brown people. I think I was feeling that this connection confirmed my status as "marginalized", as this was still very important to me.

Before long, my (trans) name was called and I looked up to see a tall, heavy woman with shoulder length brown hair and a clipboard. As we walked back through the halls of the clinic, she introduced herself as a social worker and told me we would do a brief intake to understand what I was looking to get out of the services at Planned Parenthood. I told her that I had drove six hours all the way from my hometown, and I think she responded with some comment about how I must be so determined. When we arrived at our room, she motioned for me to sit and she began the intake process. This process consisted of a handful of basic questions, which you can see below, along with her notes on my answers.

Social Work Intake Form

TODAY'S DATE: 8/15/16	PATIENT #: 4 [REDACTED]	DATE OF BIRTH: 07/24/1998
PREFERRED NAME: [REDACTED]	LEGAL NAME: Helena [REDACTED]	PRONOUN(S): Male
GENDER: Male	SEX ASSIGNED AT BIRTH: Female	SEX LISTED W/ INSURANCE: N/A

<p>What do you know about Hormone Therapy? What are you hoping Hormone Therapy will do for you?</p> <p>Patient was well versed and knowledgeable about hormone therapy. Patient reports that he has thought about using hormones for some time, especially over the last 2 years. Patient states that turning 18 is why he was able to start the process.</p>	<p>Who knows about your plans to start hormones?</p> <p>Patient states that he is "out to everyone" and identifies trans. Patient states that he has told one friend about starting hormones and is also connected to online communities for support.</p>
	<p>Do you live alone or with other people? If with others, does it feel like a safe place to transition? (consider coping methods if they do not know or may have negative reactions)</p> <p>Patient does live with his family; however he is going to college in Columbus in 2 days. Patient states that his family is not supportive of his transition; however he does indicate that his mother and father have started to come around more. They refuse to identify him by his preferred name or pronoun in the home and with family, but have made a commitment to do so at college. Patient feels that once his family sees how truly happy he is once he transitions; he feels they will come around and be more supportive.</p>
<p>Why hormones now (vs. past/future)?</p> <p>Patient states that he is now 18 and can initiate the process himself.</p>	<p>Do you work and/or go to school? If so, are you out at work/school or considering talking to your employer/school?</p> <p>Patient does not work currently. Patient going to college in a couple days and would like to study biochemistry.</p>
<p>Aside from hormones, are there other changes you are considering or thinking about making?</p> <p>Patient states that he is 100% confident that he will get top surgery in the future. Patient states that he has considered some facial masculinization work as well, but states that he wants to see what the hormones will do first. Patient states that he would consider bottom surgery if the options that he would like for a penis became available, but he is not interested with the current options.</p>	<p>Do you date or have a partner? Thoughts about how you might talk to partner/dates about your identity?</p> <p>Patient is not in a relationship currently. Patient states that he has no fears about this as he believes that he will only connect with other trans people or an individual who is supportive of his process.</p>
<p>How are you thinking about coping with stressors from the changes you will experience?</p> <p>Patient states that he feels like he will be much happier. Patient states that he has struggled with depression currently and in the past. Patient states that this summer was tough for him with depression and suicidal thoughts. Patient states that since he has been able to make this appointment, his depression has already started to improve. Patient expects that his whole life will be quite different and he will be very happy when he starts to change.</p>	<p>General Screen:</p> <p>Oriented to person/place/time/situation: YES / NO</p> <p>Mood and affect appropriate to situation: YES / NO</p> <p>Suicidal ideation or thoughts of self-harm: YES / NO</p> <p>Patient endorses a hx of depression and SI. Patient denies any current SI, plan or intent. Patient states that his most recent thought was about 2 weeks ago. Patient states that he was very suicidal over the summer and it was tough for him. Patient states that now that he has started his transition, his depression is significantly improving.</p> <p>Client can make informed consent: YES / NO</p>

Feminizing: How do you handle depression when you get sad?

Masculinizing: How do you handle anger when it happens?

Patient states that he feels that he will be able to manage his emotions. As stated, patient feels that his mood will significantly improve.

In most of the records I share here, certain information is redacted, because at the time I took these photos I was speaking to a lawyer who advised me against naming Planned Parenthood publicly, or releasing other information. Nothing came of those pursuits, and I am now more

open about these things. My real name, Helena, is also used on the Planned Parenthood records because their policy was to use my legal name on official records, but my clinicians called me by my preferred name, and on some of the records my preferred name was also listed.

I remember the intake process taking about 20 minutes, at which point the social worker told me she would talk over my intake with the nurse practitioner, and they would decide if I was a good candidate for testosterone. I waited anxiously by myself for a couple of minutes, and then the social worker came back. She told me that I was a perfect candidate for testosterone, and since I had traveled so far, and seemed “so sure”, that they would even work around their typical policy of taking blood samples and waiting for test results to prescribe the hormones, and give me my prescription that very day.

Ecstatic, I burst into tears of joy and called my friend who was also trans (at the time, she isn't anymore) that they were going to give me my first injection that day. My friend and I squealed to each other over the phone and when we calmed down, we hung up and the social worker motioned me into a new room. There, I met the nurse practitioner who handed me the informed consent document and asked me to read it over. I gave it a glance, knowing that I had already made my decision and some silly formality wouldn't stop me. I and the professionals already knew what was best for me. I signed the document.

The image shows two copies of a document titled "Client Information for Informed Consent: Masculinizing Hormone (Female to Male) Therapy". The document is dated "Revised June 2016". The left copy is a scan of the original document, and the right copy is a scan of the signed version. The signed version has "Helena" written in the signature line and "8-15-16" written in the date line. The document includes sections on "What is masculinizing hormone therapy?", "What is testosterone?", "What are the benefits?", "What are the risks?", "What are the side effects?", "How long does it take to work?", "How long do I need to take testosterone?", "Can I get pregnant?", and "Proprietary property".

My full informed consent document. My main criticism is that testosterone as a hormone and testosterone as a treatment are presented as primarily cosmetic, when in fact testosterone is involved in many physiological processes, and healthy in different amounts for men and women. I took a closer look at the contents of this document in [this thread](#).

Now that all that legal liability nonsense was taken care of, it was time to get to the exciting part: dosage. Typically, females beginning a masculinizing testosterone regimen are started on a relatively low dose and monitored for a few weeks or months, at which point the dose may be

increased. Considering I hadn't even had blood work, in hindsight this would have been the more responsible way to do it. That is not what happened in my case, though. When the nurse practitioner suggested a lower dose to start, I objected, saying I believed I had "higher estrogen than most AFABs" (people "assigned female at birth"), citing the size of my thighs and breasts as evidence. This was acceptable to the nurse practitioner, and she asked me what dose I would like to start at. Nervously, I said something along the lines of, "well what's the highest we can go?"

Most female transitioners I've known have told me they started at 25mg, or even less. Some of my FtM friends who are still on testosterone and look remarkably like natal males, are only on 50mg. I was prescribed 100mg of testosterone, to be self-injected into my thigh muscle weekly, starting that very day.

There were no words that could have prepared me for what was about to come.

PATIENT: Helena [REDACTED]
 BIRTH SEX: Unknown
 GENDER IDENTITY: TransMale/TransMan
 DATE OF BIRTH / AGE: 07/24/1998 / 18 Years
 MEDICAL RECORD: 417847
 DATE: 08/15/2016 1:25 PM
 LOCATION: [REDACTED]
 VISIT TYPE: Office Visit
 PATIENT STATUS: New patient

SUBJECTIVE
 Medication Review Details
 Medication Reconciliation
 Medications reconciled today.

ASSESSMENT
 Diagnoses with Plan

#	Detail Type	Description
1.	Assessment	Endocrine disorder, unspecified (E34.9).

PLAN
 Birth control method at end of visit: Unknown.
 Meds Prescribed During this Visit
 IL PMP check(Unexpected Value)

Medication	Strength	Sig	#Ord	Avail Refills	Ordered by	Transaction Category	Rx Notes
NEEDLE	22 gauge X 1 1/2"	1 needle per use for drawing up and administering IM #20	20	0	[REDACTED]	External Rx	
TESTOSTERONE CYPIONATE	200 mg/mL	0.5 mL IM q week, #1 10 mL vial	1	1	[REDACTED]	External Rx	

Table 1. Hormone preparations and dosing (Grading: T O M)

Androgen	Initial - low dose ^b	Initial - typical	Maximum - typical ^c	Comment
Testosterone Cypionate ^a	20 mg/week IM/SQ	50mg/week IM/SQ	100mg/week IM/SQ	For q 2 wk dosing, double each dose

My medical record showing that I was prescribed testosterone cypionate on my first appointment, without blood work (results take at least a few days), and that my dosage was the maximum recommended dosage per the [UCSF dosing guidelines](#).

Shit, meet fan

Two days after I started testosterone was my first day of college. The weekend prior, I told my mom that I had requested for the university to list me under the male name I had chosen, and that to avoid confusion she should use this name if only when interacting with the school. She agreed to use the name and male pronouns when she and my dad dropped me off at my dorm so that at least I could start my first day of college on one page, even if she wasn't on that page herself. I was content with this, and felt like I was finally getting her to understand.

On August 17th, 2016, my parents and brother dropped me off at college and helped me carry all my new college stuff into my dorm, unaware of my testosterone expedition. I hid my vials and needles deep in the recesses of a bag of clothes, which I insisted my parents let me unpack later. My bed sheets were standard red and navy-blue plaid from Walmart, my school supplies were all some mix of grey and navy blue, and my only dorm decoration was a Star Wars poster. My wardrobe was a handful of sweatpants, hoodies, and t-shirts, all mostly from Walmart or the men's section of TJ Maxx. Gone were the days of glitter gel pens, notebooks covered in cat stickers, my cozy bedroom with a plush, floral comforter, fluffy rug, and One Direction poster. It was now time to "act like a boy", because if I acted like myself, nobody would believe I was trans.

My roommate was another trans guy (whom I will call "he", because that is how I remember him), who I later learned was one of the youngest people in my state to have gone on puberty blockers and testosterone. My school had a "self-ID" policy, and I was originally supposed to be placed with an actual male, but when I looked him up on Facebook, he was some massive ripped sports guy and the idea of sleeping next to him scared the living hell out of me. I'm sure he wouldn't have appreciated coming to school and finding out he was rooming with a girl, either. I chickened out of rooming with him and asked an administrator if they could find me another trans person to live with. That first day, I was simultaneously intimidated to meet another trans guy and feeling incredibly awkward introducing my parents into this whole new trans world when just a few months ago they'd had no idea I wanted to be trans at all. We all went through the motions of pretending everything was normal until my mom accidentally called me "she" to my roommate and he locked eyes with me apologetically, signaling to me he witnessed the incredible violence that had just occurred. My mood soured for the rest of my parent's visit, and I gave them both attitude until they left for the drive back home. That night, my roommate and I got to talking, and he said he was sorry that my parents were so transphobic and unaccepting. He told me that his mom was very supportive of him being trans, and fought tooth and nail to get him "access" to transition at a record setting age. I was seething with jealousy.

That week was eventful, and I made a bunch of new trans friends. My roommate introduced me to his ex that he was still friends with, who at the time was also trans and eventually became my

closest relationship for nearly four years (I will call her “Jamie”, and “she”, because that is how I know her now). She and I clicked immediately and would be inseparable for years, even long after any resemblance of a romantic relationship fizzled away. I consider myself heterosexual and would not date a trans man now, but at the time as a “gay trans man” under the influence of gender ideology, which tells you biological sex isn’t real, and experiencing surges of testosterone, I convinced myself I was attracted to this girl who looked like a boy at the time and had rapidly become my closest friend. Since in the back of my mind I knew she was a biological female, she didn’t intimidate me as much as actual men did.

In a classic *me* maneuver, I had forgotten one of most important items: my laptop. The first week was just orientation week, so I didn’t need it, but I would need to drive back down to my home town to retrieve my laptop before Monday. On Friday or Saturday, I said goodbye to my friends and drove the two hours back to my parent’s house. As I pulled up to the house, I saw my mom had just arrived home from work. Stiffly, we greeted each other and entered the house through the garage. I nervously wondered if either of my parents would be able to guess that I had started testosterone, even though a week is hardly long enough for there to be visible effects.

As I walked from the kitchen to the stairs, my mom called me “Helena” and I whipped around, snapping back at her that she needed to respect me now and use my “real name” (my trans name). She yelled after me as I stomped upstairs to my room, and as I was collecting my laptop and charger cable, she stormed in behind me. Six months of pent-up frustration and rage spilled out of her, and she tore into me in a tirade that felt eternal as it was in progress. I don’t say these details to demonize her, I understand why things happened the way they did, but it’s an important part of the story. The tirade reached some dark places, and she said things I won’t repeat here but hurt me deeply. As she yelled, I sat on my bed staring at the floor and whispering “okay, okay” over and over. One of the last things she said was that I shouldn’t come back until I realized I was a girl. Whether she meant this literally or not, I already had a narrative in my head that transphobic parents disown their trans kids, so that’s how I took it. Plus, I thought I would never stop being trans.

She left the room, and I began panicking. Hyperventilating, I grabbed my laptop, a few extra things I meant to retrieve, and headed for the door. As I went to walk out, my sweet old cat, Puff, was standing in the doorway like he always would when he came upstairs around the time I went to bed. He was my little buddy, and always slept next to me. The night before I left for college I cried and told him that I would be back to sleep next to him all the time, but I never got to again.

Tears welling, I patted Puff on the head, and gave him a little kiss goodbye.

I was properly shaking by the time I started my car and drove it to a near by gas station. There, I allowed myself to break down and called a [trans] Tumblr friend of mine. I cried to her and told her that my mom had just disowned me, and I didn’t know what to do. She helped me remember that I had left money in a box in my room, and told me to call a family friend to retrieve it for me, which I did. Once I had the money, I began the drive back to my university, getting in at one in the morning, throwing my belongings on the floor and crashing to sleep in my top bunk bed.

The Dark Days

Everything that followed this altercation with my mother was dark, and things were dark for a long time. I won't bore you with every story, but let's just say there was a succession of demotivating, stressful, and painful events in quick succession. There was a lot of drama, I lost nearly all my new friends, and I started to feel really, really down again. Within a month, I moved into the campus LGBT house due to issues with the room mate and the three other people who lived there with me were my entire social circle. We mostly sat around smoking weed and drinking, and my academic performance plummeted. I was also advised to financially emancipate myself by one of the campus gender studies professors who was "helping" me navigate being "disowned" by my parents, which just created financial issues for me down the line that added to the stress. I remember feeling numb for months, and when I wasn't numb and checked out, I was angry. I'm still not sure how much of that was due to the testosterone or the general state of my life.

The anger started as a smoldering anger at first. I found myself feeling more irritable, less able to put up with the little things that bothered me about other people. I was uncomfortable with my newfound tendency to get bent out of shape at everybody so I started isolating myself, trying to hide this awful person I thought I was turning out to be. I didn't make the connection between this and the testosterone, I just thought I was a bad person. I didn't feel like being around people, and when I was, I felt so unlike myself that I didn't know how to relate to them. Even five years after the fact, I still feel like this experienced has damaged my self esteem and social capabilities in a major way. It definitely changed me as a person.

These next few years of my life are still incredibly hard for me to think about, much less write about for everyone else to see. The one redeeming quality of this dreadful time period is that I adopted my cat, Corndog (yes that's his name) early in 2017, and he has been by my side through all of it. I remember myself as a shell of a person, a monster, someone who didn't recognize the feelings in her own body anymore. To make things worse, the testosterone injections themselves were causing significant distress for both me and Jamie; it would take us hours of crying and hyperventilating to drive the needles into our flesh once a week. I had always had emotional problems, but this was different. In high school, I had always banked on the future where I would be in college, transitioning, and part of me genuinely thought testosterone would somehow make me into this outgoing male jock archetype and I would be handsome, have lots of friends, and love life. That wasn't really panning out. I was lonely, enmeshed in toxic and stressful relationships, on academic probation, in legal trouble due to substance use, and feeling possessed by some sort of demon I now recognize was at least partially the testosterone's worsening grip on my mind. With the reality of my old future fantasy having rapidly deteriorated, but not yet realizing the fundamental issues with my life, I set my sights on another route of escape.

Jamie, who was in a similar position of plummeting mental state, still maladaptively coping with the trauma of growing up in a severely dysfunctional family, one night suggested that we run away; just take what little stuff we can fit in the car and move to a whole new city, one that will

embrace our transness and will allow us to realize our true potential. I told her I knew just the place...

Chicago.

And so not long before the end of that school year, we told the few acquaintances we had that we were moving and they wished us luck, excited to hear we were getting out of suburbia and moving on to better things. I remember feeling awkward telling them, like there was some cognitive dissonance between the fact that chasing trans had only made my life worse, and the fact that I was making another drastic life decision to chase trans once more.

I quit my crappy fast food job, unenrolled from the university, which was going to kick me out anyway, paid a visit to my mother to let her know of my plans (we were on strained speaking terms at this point), and soon enough I was en route to Chicago. We had managed to rent a small studio apartment, and both applied to schools in the city. I didn't end up attending school, though, because not long after getting settled in to the new apartment my mental health would get even worse.

What I thought would be a fresh start turned out to be more of the same. I isolated, too uncomfortable with myself to even make eye contact with other people. I didn't get a job, didn't go to school, didn't meet any people, and for the most part, didn't even get out of bed. It was around this time that something really weird started happening to me, and this part I largely do contribute to the testosterone.

When they tell you about testosterone, they mostly frame it as a cosmetic thing. Sure, you might feel more irritable, you'll probably have a higher sex drive, and there is that whole thing about increased risk for heart disease and cancer, but for the most part its all about fat redistribution and getting a deep, commanding voice. My informed consent document even generously warned me about "mood changes". But I don't know if anything would have prepared me for what it actually felt like.

During the initial months following my first shot, I recall a general feeling of suffocating numbness and inability to identify my emotions, with bouts of anger that were easy to trigger dispersed throughout. Something that before would have made me mostly sad, or even frustrated, made every cell in my body overflow with rage. The anger was also of a different quality than the kind of anger I experienced before. Previously, I might have gotten so angry that I cried, or yelled, or very occasionally slammed a door, but I rarely if ever felt much more of an urge to externalize it physically beyond that. While I was on testosterone, the anger demanded to be externalized. I felt like my body would explode if I couldn't hit or throw something, and this scared me. Crying was no longer an option, at least at first, as crying was nearly impossible to achieve. When I was emotionally overwhelmed, instead of easily crying like before I would start to feel extremely angry, and instead of hitting others or anything in my surroundings, I resorted to hitting myself. I would struggle against the anger by punching myself and eventually, after there was enough pain, I could cry and when I cried I'd cry for hours, often falling asleep and not

remembering much when I'd wake up. I had these kinds of meltdowns about once a week or so, and regularly had bruises on my head and body from where I would hit myself.

One day, I had a meltdown like this and instead of hitting myself I hurt myself quite seriously with a kitchen knife, and when I calmed down enough to be spoken to I was coaxed into going to the emergency room by Jamie. I can only imagine how traumatic it was for her to be around me during this time. I still, at this point, made no connection to the testosterone. We both just thought I was a severely mentally ill person; even though I had never experienced anything remotely like this before testosterone (and never again since!).

I was checked into the hospital psychiatric ward that night and remained for seven days. There, no inquiry was made into my high testosterone dosage or whether it might have been having an impact on my behavior. Instead, I was diagnosed with borderline personality disorder, depression, and acute psychosis, for which I was prescribed four separate psychiatric medications. Upon my discharge, I dutifully took my prescribed medications and even felt validated by my being prescribed an "anti-psychotic". I was thankful that I had finally been diagnosed as severely mentally ill and given strong medications that would fix my faulty brain chemistry and allow me to live a better life. For the next few weeks, I was to attend a thrice weekly outpatient group therapy program that was three hours a day. In this intensive group therapy, we talked about mindfulness and how to manage the demands of work while living with "mental illness", but deeper psychological work was absent, and once again the fact that I was a young biological female on a supraphysiological dosage of synthetic testosterone remained completely unaddressed. Throughout every experience in any mental health treatment during my trans identification, my testosterone treatment was never identified as a potential source of mental health symptoms, and my desire to be a "boy" was never questioned as possibly a result of pre-existing emotional issues. My "preferred name and pronouns" were always used without hesitation or question, and I was "affirmed" by every professional I saw during this time. I had still not developed the skepticism of the mental health and medical industries that I have now, so I saw this as even more reason to not question my identity as trans.

While I was enrolled in the outpatient program, I was not improving. I was still unemployed, using substances (including some of my prescribed medications), unable to get out of bed most days, talking about suicide in group, and having "episodes". Eventually, the psychiatrists and therapists at the outpatient program sat me down and told me I needed to go back into inpatient. I did, and this time stayed for about half a week. When I got out, I decided these programs were not helping me and that once I unenrolled from them, I was going to get a different therapist (at the local LGBT center), get a job, and try making some friends, the latter of which didn't happen until after I detransitioned.

For the next six months or so, I worked in a small cookie shop where I often worked ridiculous hours, including relatively frequent 10 hour solitary night shifts, not returning home until nearly 5 am. Needless to say, this wasn't fantastic for my mental wellbeing either, but its where some changes started to take place. I started interacting with people regularly, and though I didn't make any long-term friends, it was helpful just to know some names and faces and be a fly on the wall listening to the drama in the lives of my coworkers. A trans coworker of mine clued me

in to an organization that issued grants that paid for trans surgeries, as my insurance at the time didn't cover them. My coworker showed me the website to apply, but I always procrastinated it. Strange, considering I would publicly talk about how badly I wanted the surgery. So I never got any surgeries, something for which I am extremely grateful.

During some of the late night, solitary shifts, I had a lot of time to reflect. In some ways, it was a bit maddening, but dispersed within the general neuroticism were moments of clarity. I remember deciding to take my chest binder off at work for the first time, because it was just me and one other worker who always sat in the back, and that fucking thing hurt. It felt so much more natural not to have anything constricting my chest underneath my work shirt. I started skipping testosterone injections because they made me so anxious, so I was only injecting once or twice a month. With this, my "episodes" dramatically decreased. I remember browsing trans subreddits in hopes I would get some answers for what to do if transitioning wasn't improving my mental health. There were many posts asking this question, and by far the most common answer was to "just keep going" and that one day, when you passed well enough, it would all be worth it. There were times when I sat back and questioned nearly every choice in my life, like the relationship I was in and moving to Chicago. I thought about how all these things I desperately jumped into thinking they would save me had not don't anything of the sort. The only thing I didn't outright question was my choice to be transgender. That would require a more up-front reality check.

The call is coming from inside the house

Not everyone has an "a-ha!" moment when they realize they want to detransition, but I did. Mine was after a few weeks of occasionally thinking back to before I had transitioned, the comfortable clothes I used to wear and how I didn't worry about whether or not the "feminine" stuff I liked would make people "doubt I was trans". I thought about how much I loathed the way men's clothes fit me and the way masculine styles looked on me in general, and I remember wishing society was more accepting of "gender non-conforming men like me". I also wished I "wasn't trans", and even recall making a reddit post to this effect, lamenting how even though "being trans" was making me miserable, I knew it was who I really was and after I got surgeries it would be right for me.

This kind of thinking, I now realize after talking to so many detransitioners, is common in the weeks or months leading up to detransition. My "a-ha!" moment happened in February of 2018, when Jamie made a video montage consisting of photos of us chronologically from the day we met (2 days after I started testosterone) until recently, set to music. As I watched the video, I saw the way my face changed from so young, hopeful, and most of all, recognizable, to weary, deadpan, and foreign.



Top row: Photos of me from the first month of my transition. Bottom row: Photos of me from the final months before detransitioning.

I began to sob uncontrollably. At first, Jamie thought I was crying because I loved the video so much, but I quickly informed her it was something else, but I wouldn't say what. I cried, and cried, and cried. Every memory those photos evoked was flashing before my eyes, all the pain I knew was behind my eyes was emerging vividly. I saw innocence turn to anguish and I knew I had been on the wrong path for a long, long time. I didn't know. I didn't know it would be this way. I was just a kid.

How could I have been so stupid?

I couldn't bring myself to tell Jamie what I was truly thinking. I knew that she would probably freak out and try to make me rationalize away these feelings, but it was too late for that now. The dam had broken. Instead, I silently berated myself and catastrophized internally until I mustered the courage to tell my very pro-LGBT therapist: being trans had been a massive mistake.

I remember her response clear as day: "But you always tell me about your terrible dysphoria!"

"I know, but I... I don't think that's what it is" I replied, and started to tell her my still developing thoughts on how I had developed the "dysphoria" after finding out about gender identities online as a teenager, when I had been struggling with so many other emotional issues for a long time, and that in retrospect I must have gotten carried away, thinking that being trans was the explanation and solution for all of my problems. She wasn't really hearing me, and questioned the things I said from the angle of "you're trying to talk yourself out of being trans because transphobia is making you hate yourself." Ironical that nobody ever questioned my desire to be trans that way.

This was the first moment I started realizing something was off about the trans movement, and institutions in general. I had experienced this massive realization, and it was agonizing but at least it was finally something real, and here I was being met with all these rationalizations for why this of all things was a psychological symptom. Not the effects of the testosterone, not my belief that all of my problems would be solved by transitioning, not my aversion to being female, but the fact that I now knew transitioning had been a mistake.

I left this session feeling frustrated, and I don't think I ever went back. Sitting in the car outside the building, I told Jamie that I was regretting my transition and questioning my trans identity in general, and predictably she was extremely upset. She reacted in anger, saying I must be confused and, like my therapist, accusing me of having these thoughts due to some underlying psychological issue, like only an insane person would ever regret being trans.

She was not being uniquely harsh here, this is a common occurrence in the trans community. In one direction, there's a desire to encourage gender questioning in others who have not questioned their gender yet (some people call this "cracking an egg"). In the other direction, there is an intense fear of others changing their minds about being trans or wanting to transition. Once someone is questioning their gender, there's a push to encourage them to take steps towards social and medical transition, which, once initiated, makes changing one's mind more complicated and going back to living as they did before more difficult. I personally have gotten very angry and desperate when friends in the past would voice doubts about identifying as transgender, and I have also encouraged gender questioning and trans identity in friends of mine who did not yet identify as trans. I regret this very much now, as some of these friends have gone on to medically transition, and I no longer believe this was remotely in their best interest. But in the trans community, people cope with the inherent doubts and cognitive dissonance of pretending to be someone they are not by encouraging others to do the same. This is also why so many adult trans people advocate for child transition. If an innocent, pure child can "be trans", that validates their identity and belief system too. An enormous amount of

mental energy is devoted to the crowdsourcing of validation and firefighting of anything that triggers internal conflict, which is always nagging in the back of the mind.

When a person is at peace with themselves and expressing themselves naturally, they don't desperately micromanage everything and everyone around them.

Around this time, Jamie and I were preparing for a trip my mom had invited us on with herself and my brother. Now finally on cordial terms, we agreed to go, and our dramatic conversation in the car occurred in the week before. We both felt pressure to act like everything was fine because I had worked so hard to get my mom to tolerate my transition, and I was feeling guilty and humiliated. Being somewhere else kind of felt like a neutral ground where we could have conversations more freely with less judgement. We took many long walks to talk about our transitions, trans identities, and reflect on our lives up to this point. During these walks, Jamie also admitted to herself and to me that she didn't want to be trans anymore. We felt crushed, scared, confused, and regretful, but so much more free.

Back in Chicago, we now had to figure out what to do next. Neither of our families knew what we were thinking, and we were both scared to tell them. There's an enormous amount of shame in realizing how much hurt and chaos has been inflicted on others in your pursuit of ideas you now think were ridiculous and destructive. You think of all the decisions you made that weren't directly related to your transition, but were made in the effort of chasing the fantasy more broadly, and you feel like you've just woken up in a pit of your own digging, too deep to climb out of. You feel trapped, cornered, panicked, and deeply ashamed. Regret comes with a lot of self flagellation, and at the time, there wasn't the big detransition community there is today to let us know that we weren't alone. I remember looking up transition regret online, and I found one essay by an older lesbian. While we did have detransition in common, everything else about her experiences were different and I couldn't see myself in that story. I felt an incredible emotional whiplash, like I had just woken up from a five-year spell and was suffering amnesia about how I'd gotten to where I was. I was hungry for clues that would help me make sense of my position.

I began to search online with key words like "regret", looking for anything that might resonate with what I was experiencing. I knew the standard trans narrative was wrong, at least in my case, but looking at other perspectives still scared me. In fact, I called myself nonbinary, and picked a "gender-neutral" name to go by, because I was still reflexively averse to being myself, a filthy "cis girl". It felt incredibly uncomfortable -- more uncomfortable even than being FtM -- and I dropped that pretty quickly. Once the dam broke, the same old tricks of self-deception were no longer tolerable to me. I remember finding the reddit r/detrans forum, which at the time had only around 100 subscribers, if memory serves me (it now has tens of thousands). This clued me in to the fact that at least a handful of people out there were feeling regret too.

When I had my detransition realization, I immediately wanted to go back to looking like a girl. The men's clothes, short hair, and my wispy little testosterone moustache made me sick to look at. I bought some basic clothes, like leggings and long sleeved, women's cut shirts, simple things I used to like wearing before I transitioned. I also bought some cheap make-up and a wig. Though these made my reflection in the mirror less jarring, I felt kind of like a man in drag. It was

a really gross, uncomfortable feeling. I didn't know if I would ever feel normal. The realization that my escapist fantasy I had hoped would save me from my teenage misery was a fraud sucked me right back into that old misery. The consequences of my decisions compounded it further. I felt utterly, hopelessly trapped.

Somehow, I kept picking jobs where I'd end up doing entire shifts alone, which once again made things more difficult in some ways, but also allowed me to do lots of internet searching, and it was during these lonely shifts that I found a subreddit called r/GenderCritical. At first, the "transphobic" language (such as calling trans women "men") horrified me. I felt so incredibly guilty for even reading the words in front of me, but I couldn't look away. It was my first exposure to a perspective towards trans issues that wasn't the mainstream narrative, which I now knew was at least not true for me. I searched the subreddit for topics of detransition and regret, and I saw other young women posting similar stories to mine. I made a post, and was met with a surge of positive, encouraging comments. Somebody recommended me the book *Female Erasure* by Ruth Barrett, which presented me with both illuminating facts that contradicted the trans narrative and an alternative, positive image of womanhood. I still remember the exact moment, standing crouched over the work iPad alone in my smoothie store, when I had the mind-bending realization that not only was I not the only one going through this, but it was a full fledged phenomenon. I had been manipulated, taken advantage of, and involved in a cult-like community.

For a short time, I became enthused by radical feminism, and the gender critical feminist perspective greatly appealed to me. I was still very confused and used to receiving external validation, so I tried to fit myself into the "lesbian who transitions due to internalized homophobia and misogyny" narrative that I found was common in gender critical circles. With time, I would grow to form my own beliefs and understandings of myself and I gradually distanced myself from radical feminism, but it was a stepping stone away from gender ideology.

From r/GenderCritical, I found out about parent groups and advocates like 4thWaveNow and Lily Maynard (who I wrote [this essay](#) for early on in my detransition). Here, I could read a lot of thoroughly researched information on trans activism, corruption, regulatory and institutional capture, and more non-ideological critiques of the trans movement that weren't from a strong feminist angle. I found out about "Rapid Onset Gender Dysphoria" (ROGD), which is a term coined by researcher Lisa Littman. It describes certain patterns parents have reported that preceded the sudden declaration by their adolescent children that they are transgender, most notably in adolescents who showed no pronounced gender incongruence in childhood. I read her study, and I just about ticked every box.

Pre-existing mental health issues, check. A friend group where multiple people began identifying as trans around the same time, check. Decline in mental health and parent-child relationship since identifying as trans, check. Expressing distrust/dislike of non-transgender people and spending less time around non-transgender friends, check. Isolating self from family, check. Only trusting information about gender from pro-transgender sources, check. Increased social media use directly preceding the identification as trans, check.

I was in shock. This was... me! Perhaps more importantly, this was... EVERYONE! All of those young biological females I had been friends with online and offline who identified as trans also fit this *exact* description.

While researching this phenomenon, I also learned that in the years that I began identifying as trans, the demographics of people seeking to transition had changed dramatically. I learned that gender dysphoria was once seen primarily in pre-pubescent boys and adult men. I learned that there had already been research into these men, and that they had completely different histories and motivations to myself and the other girls who fit the description of ROGD.

Finally... I saw that Dr. Littman had been targeted for her research. Targeted by activists infuriated by her evidence that contradicted the trans narrative they were so emotionally dependent on, her institution turned its back on her, unwilling to stand up to the activists.

I was pissed.

I was angry about having this kind of information kept from me by the community, which I now understood exhibits information control dynamics similar to that of cults or extreme religious sects. I was angry that clinicians either didn't understand or didn't make the effort to read this information about demographics and gender dysphoria. I was angry that I had been affirmed every step of the way, and only questioned when I was starting to express regret. I was angry that people who seemed to be making a genuine attempt to understand this new phenomenon were being targeted, and I was angry that I would have targeted them too if I had known about this not long ago.

This inspired me to boot up that old 25 follower twitter account I had made in college and subsequently abandoned. Furiously, I began typing away a thread defending the idea of ROGD, and offering details of my own life trajectory to back it up. I didn't know if anybody would see my post, but I wanted to get these thoughts out. People did see it though, and I began to interact with other detransitioners, parents, and gender critical people. Hearing how deeply so many people were being affected by this phenomenon that had been so damaging to me too was invigorating, and I became passionate about understanding it (and my experiences) as thoroughly as I could and exchanging ideas with others who were lost in the confusion with me.

As I began to feel strengthened by the knowledge that this was a phenomenon and not a personal failing, I decided I would tell my parents when I saw them next. Sometime in the spring of 2018, they invited me to visit them back in my hometown. I felt myself growing more and more nervous as the day of my flight approached, and on that day, I was a wreck. The airport in my hometown has a long hallway that requires maybe 10 minutes to traverse from the terminal to baggage claim. I distinctly remember my walk down this corridor and seeing my parents as two little dots at the very end. The dots grew and their image came into focus, and with every step I felt more afraid, my heart pounding in my chest, stomach churning, and a dizziness overcoming my body. At about 50 meters away, my vision blacked out for a few seconds! That's how terrified I was to admit to my parents what I had realized!

When I told them, it was that night at dinner when they asked me “what’s new?” It was an awkward conversation, but at least they didn’t say “I told you so”. They didn’t say much; maybe they didn’t know what to say. They did say they were glad to hear it though and that they thought detransitioning was the right decision. My brother was fairly silent throughout, and later that night I heard him say to his gaming friends on Discord, “Sooo, my sister isn’t trans anymore.”

The hardest thing about detransitioning in my case has thankfully not been living with permanent damage to my body, something many other young people with similar histories to mine cannot say. It has been coming to terms with the bad decisions I made that made my emotional struggles much more painful, my ability to socially adjust and have healthy relationships much more difficult, and generally took my life in an unexpected direction that has been very hard to climb out of. In many ways I am still climbing out of it. The years following my initial decision to detransition have been fraught with challenges that, with each overcoming, have required me to mature beyond my age. I am very thankful for that, and am growing to truly enjoy and respect myself, but it has also made finding my place in the world difficult. I have continued to struggle with many of the original problems that lead me to identify as trans in the first place, like social weaknesses, anxieties about not fitting in, poor body image, unresolved childhood grief, shame, and conflicts in my family.

Living life by delusion and going to such extreme lengths to chase a falsehood steer one away from true resolution of such natural human issues. Even if the testosterone itself hadn’t had such a damaging effect on my mind and my life, the very act of trans identity and transition was, for me, an act of immense self-harm. Emotions are a way for the unconscious, all sensing body to communicate to the part of us that experiences conscious thought information about how our environment and the people around us affect us. In order to move through and overcome painful emotions, we must first acknowledge the core emotion that is occurring and have compassion towards ourselves for feeling the emotion in the context within which it is occurring. Trans identity took me far away from this into blaming and punishing my body for the emotions I was feeling. It resulted in an even wider disconnect from understanding the conditions that led me to feel such sadness, fear, and grief. Transitioning made my mental health much, much worse. Not better. It was a “fuck you” to the hurting child inside of me. It was telling her that she didn’t matter. It was telling her that I hated her and wanted to annihilate her. It was an act of war against myself.

War against yourself comes with a cost. In the aftermath, there are fires to put out, ashes and debris to clean up, towns to rebuild and ground to fertilize so that life may exist once again. Having just been at war, these necessities of the aftermath feel insurmountable; the body and mind is too exhausted. I had to begin not with action but with turning inward and finally respecting the emotions I had tried to cast away and smother. With each level of depth into compassion with myself, I could then turn to one step of action that would move me forward in the outside world. That has been my back and forth process of healing and recovery from years that not only were wasted, but pulled me down so deep I nearly drowned.

I often felt that upon waking up from “the spell”, I was transported backwards in time into the consciousness of my fifteen-year-old self. Like all the years of being trans were not really me,

and the real me lied dormant under it all, finally able to come forward once the false persona disintegrated. Being the “real me” again, years out from detransitioning at this point, I still can’t fully wrap my head around having been consumed by that false persona. It doesn’t really feel like that was me. And it makes me sad that I did feel the need to reject myself to such a degree as to completely dissociate from who I was, because I quite like myself now, actually. I recognize that many of my qualities that have made certain aspects of life more difficult also make me unique in a very powerful way.



Photo 1: about 6 months after I quit testosterone. Photo 2: About a year post detransition. Photo 3: About 2 years post detransition. Photo 4: About 2.5 years post detransition, I still was really not doing well up until the time of the next photo. Photo 5: About 3 years post detransition. 2021 was a big year for me because I made some major strides in my emotional wellbeing and

started practicing far better nutrition. Photo 6: About 3.5 years post detransition. My mental and physical health are better than they have ever been, but there is still much work to be done!

I firmly believe now that overcoming adversity is the only way a human being can truly come to enjoy and feel proud of themselves, but there is such a thing as unnecessary harm. I am undecided on whether my experiences constitute this, and I guess I just hope the reward is sweet when I more fully overcome the challenges I have been dealt.

My story is not a fluke, and I am not uniquely troubled or irresponsible. What I am though, is fortunate, because there are others for whom the harm has been exponentially worse. Though there is much strength to be found in overcoming, the fact is that today, any young person who remotely struggles with self-esteem, making friends, fitting in to common gender roles, or body image is now vulnerable to being subjected to what amount to medical experiments that may permanently destroy the prior functioning of their bodies before they have had the chance to build identity and strength through the normal means of overcoming life's challenges. I have seen firsthand that for some people, the medical and psychological damage is far beyond what could be considered a healthy amount of adversity.

Transition was easy...Detransition was not

Abel, <https://pitt.substack.com/p/detransitioner-perspective-transition-1f1>

Aug 17



My name is Abel Garcia, I was born in 1997 to a Mexican family who came to the US illegally. Due to my parents' illegal status, I was raised by my grandparents because my parents were working non-stop so they could support me. Growing up I was a very shy, quiet, and timid boy, I was and still am an over-thinker. With my father working non-stop, I did not have a male role model in my life growing up. As a kid, I did not feel comfortable as a boy because of my overthinking and also because I was not the most masculine boy growing up. My feeling that I was not a typical boy led to my belief that I must be a girl.

Even though I had issues with what it meant to be a boy or a man while confusing my different nature as a girl/woman, I did not know what the word "transgender" was until I was much older and found the word through YouTube. Not knowing much and assuming that was what I was, especially with my childhood, I believed I was transgender. But because I was a minor I did not move forward on those thoughts, and I just put them in the back of my mind. It was not until after I left high school that I decided to transition from male to female.

I came out as transgender to my friends who were all supportive of my decision, I then came out to my mother a few months later in December of 2015. My mother broke down crying when I came out to her as transgender, she then asked me many questions mostly regarding what if I made a mistake or what if I realized I wasn't transgender, I informed my mother then that I knew this is what I wanted and that I could not be wrong regarding this. A few months later I went to see a therapist regarding my identity as a transgender woman at my local LGBT center, I received a female therapist. This therapist did not know how to handle transgender patients so, after three sessions with her, she then transferred me to her supervisor who had more experience with transgender patients.

The next therapist that I spoke with, immediately affirmed me as a transgender woman and informed me that she had my letter to transition during my first session with her. When I asked her why she felt comfortable recommending this during my first session with her, I was informed that she did not want to gatekeep me from my transition. Even though I wanted to transition then I waited a couple of months before I accepted the letter to transition— a part of me knew that this could be irreversible and due to that possibility, I took a bit longer to start my transition and gave myself a plan regarding surgeries. My original plan was to wait five years before I received top surgery (aka breast implants) and ten years before I got bottom surgery aka penile inversion/neo-vagina.

Before accepting my letter to start hormones, my father had learned about my plans to transition from male to female. My father being Mexican did not approve of my choice and decided to fix me because, at this point in my life, I had not been in a relationship with a woman. My father's idea to fix me was for me to have a relationship with a woman. In 2016, my father took me to Mexicali under the pretense that he needed a backup driver to return from Mexico to the United States. Later in the day after completing his business in Mexico, we parked in a parking lot, and my father then brought me into a "restaurant" for a bite to eat.

The building was painted black both inside and outside, and had tinted windows. I had a horrible gut feeling but I went along with my father because I was in a country where I did not know nor knew how to stand up for myself. After a few minutes of sitting down, I heard my father's voice telling me to stand up and pick a woman. At that moment I realized that I was not at a restaurant but instead at a brothel.

I looked up and noticed a row of women who looked to be in their 20s. My father told me to pick one of the ladies and, not knowing what to do, I picked a random lady from the group. Before she had a chance to lead me inside, my father told the woman that I had picked that he wanted to speak with her alone. I was told to go on ahead without her, but instead I hid around the corner, and I overheard my father informing the young lady "take care of him, it's his first time". After my father and the woman who I was supposed to have intercourse with finished their conversation, the woman walked toward me, and together we walked into a room.

I do not recall most of what happened next, not because I was drugged or anything, but because I have chosen to repress those traumatic memories. From what I do recall, after entering the room, I was told to undress and that she was going to give me a massage. Eventually, we went from the massage table to the bed. While I do not recall exactly what happened next, I could not perform with her, and eventually, our time ended. But before we left the room and went back to my father, I asked her to lie to my father that we had a great time and that it went very well, which she did. I was utterly disgusted by the event but, for my father's sake I acted like I enjoyed the experience. My father seemed proud of me—he believed he had fixed me with this encounter.

Actually though, this experience had the opposite effect. It was the pivotal moment that led to my decision to continue with transition, and to go down a path of self-destruction. I eventually spoke with my therapist informing her of the incident in Mexico but, because she was a

gender-affirming therapist who worked with transgender patients, she did not see my recent trauma as a causal event and continued to affirm me as a transgender woman.

I continued to see my therapist for five more months before I finally moved out of my parents' house and, a month later, I started hormones, after obtaining medical clearance from a doctor who lied to me in saying that I could become a woman, I just needed hormones and surgeries. The doctor even brought in a transgender activist to inform me that I was not just a feminine man, but I was a transgender woman—and he could tell this by the proportions of my body. I sadly believed the lies that I was told.

Once I started hormones, I was happy that I was finally able to be my true authentic self. I was affirmed by everyone who knew that I was transgender. A few months later I got my name and sex marker changed on all my documents and was recognized as a woman legally. A year after I started hormones, I got my letter to get both top and bottom surgery approved. During that session I only requested top surgery, but I did not want to get bottom surgery yet. I did not know it at the time, but I was given both letters of approval at that appointment. I only found out when I got a letter from my insurance company saying that I was cleared to meet up with my surgeons for both top and bottom surgery. I ignored the letter for the bottom surgery at that time.

In May 2018, I had breast implants. Initially, I was very happy with the results of my surgery. Three months after I got surgery, however, I realized that I made a mistake and that this was not for me. I had to then accept that I had damaged my body, but that I would always be a man even if I continued to go down this path of self-destruction. I was just a man—a man who was in the process of being mutilated to appear as a woman—and I was now a decoy or caricature of what I believed a woman looked like.

When I reached out for help to detransition from the therapist who signed off on my transition, I was met with pushback. My therapist informed me that my desire to detransition was caused by childhood trauma. I realized that this therapist would only affirm my transgender delusion, and would never give me the proper help I needed. I looked for a new therapist through my medical clinic—but this new therapist was as worse as the last one maybe even worse.

This was late 2018. In early 2019 I decided that joining the military was the only or best way to get a therapist to sign off on my detransition, because at the time you could not enlist in the military if you were trans unless you detransitioned or finished your transition. My new therapist did not like that I was willing to throw away my progress regarding my transition because of the military and instead told me to look at other avenues that did not require me to detransition. He informed me that I should not be too cavalier regarding my detransition as it could have irreversible damage to my body and be dangerous. I again tried to find another therapist but instead, I found a detransitioner by the name of [Walt Heyer](#).

Mr. Heyer is a detransitioner in his 80s but when I reached out to him, I told him that I had nowhere to look for help and I felt hopeless. After telling Heyer my story and where I lived, he informed me that he had a friend and therapist in my area who could help me fix my life. A few months later I was finally able to see Walt's friend, my final therapist and the one who was able

to help me detransition. During the first session I had with this therapist, he informed me that because we were in California, everything we were talking about and doing, was of my own free choice and not of his doing, because if the state were to find out they would accuse him of conversion therapy and strip him of his license.

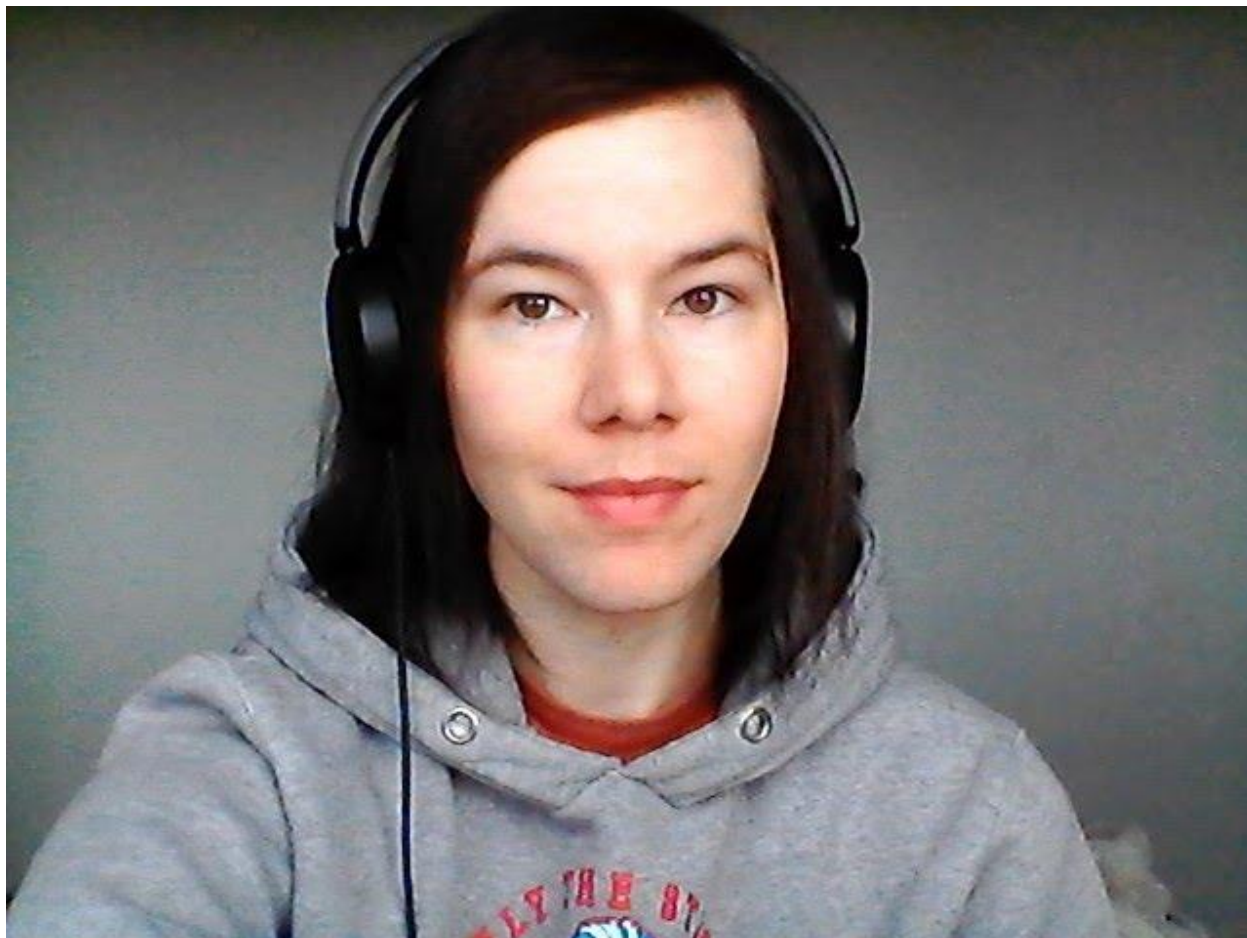
A few months later I started my transition back to being a man. As you will see, this process was infinitely more involved, time consuming and difficult than the cavalier sign off of my original transition—the exact opposite of the way it should be. The process required me to find two medical professionals to sign off on my detransition, submit it to my health insurance and then find a surgeon who would remove my implants. Months passed and I was eventually able to find a second medical professional to sign off on my detransition, but this was after pinpointing who was covered by my insurance and explaining my story to the medical professional and his staff until I was given an appointment. It was an ordeal. Once we secured both letters for my detransition, next we had to submit them to my insurance company which was easier said than done.

Once we submitted the documents to my insurance company, we waited—and then, finally, I was denied! Fortunately, I was able to appeal the decision, which I did and after thirty days I was approved. My implants were removed (by the original surgeon!) in December of 2020. I had to then fight the state of California to allow me to change all my documents back to male, which took a total of 6 months. I then spent the next year and two months wearing a chest binder—the same product that young women wear to transition from female to male to make their chest appear flat. For me the binder was necessary because I had developed gynecomastia from the cross sex hormones I took, from the trauma to my body of having implants added and removed, and because I was overweight. Fast forward to February of 2022 I had one final surgery to finalize my detransition, I had my chest reconstructed to be flat and removed all the excess skin that I had developed. Unfortunately, I could not reverse everything done to my chest, I now have a chest with scars that will forever serve as a reminder of the choices I made.

Looking back to these last seven years, I am a young man in his mid-twenties who has damaged his body for a lie. Amongst the many negative side effects of my “trans journey”, many of which may only be revealed later in my life, my genitals have atrophied and shrunk. I have difficulties relieving myself in the bathroom, and pain when I urinate. I do not know my fertility status, but I do not suspect to be fertile after being on estrogen for two and a half years while compressing my genitals with tight clothes and because of the atrophy I now suffer from. I have also developed a shake on the left side of my body, mostly affecting my shoulder and face. I’ve been told it is more than likely Multiple Sclerosis—which estrogen put me at a much higher risk for. I also have numbness in my chest due to the multiple surgeries I underwent.

I am now speaking out—I think it’s long past time that others learn about the costs of transition, which I am now, sadly, paying. It’s not as advertised, to say the least.

Note: For more on Abel, follow him on twitter at [@officialAbelG](https://twitter.com/officialAbelG)



An open letter

Watson and Others, plus Angus Fox, <https://genspect.org/an-open-letter/>

By [Angus Fox](#) / 22 September 2021

This letter was recently tweeted out by Genspect advisor Sinéad Watson. We continue to be inspired by Sinéad's commitment, and the depth of her understanding of the trans phenomenon. Sinéad's kindness and thoughtfulness shine through, as ever, and we are proud to count her among our team.

Dear Professor Shashank V. Joshi,

I am writing to you on behalf of a group of detransitioned women regarding your fellow Dr Jack Turban. We are deeply concerned with Dr Turban's disparagement of psychiatric intervention

and exploratory psychotherapy, his singular endorsement of affirmative therapies for people with gender dysphoria, and his dismissive and derogatory treatment of those of us who detransitioned due to transition regret.

We are but a few of many that have been the victims of this type of cavalier attitude. We all suffered from gender dysphoria at one point (and some still do), and were led to believe that our best chance of treating our dysphoria was to medically transition. As it turned out, this was not the case. As a result, we now have to live with bodies and voices that have been irreversibly changed (and in some cases damaged) by hormones and surgeries, when what we needed was a compassionate and thoughtful exploration of our gender distress through talk therapy. Some of us will now never be able to have children and many of us live with great distress and regret every day.

Not only did physicians like Dr Turban fail us by sending us down a singular path of transition, they are now letting us down once again by disparaging our experiences and even our existence, when they should be providing us with support to help us heal from our unnecessary medical transitions. The fact that Dr Turban is a psychiatrist at Stanford and uses his credentials to promote his reckless approach is especially troubling, as he has been granted a large and influential media platform. As we see more and more distressed young people following in our footsteps of a rushed medical gender transition, in a few years, we fear the consequences of Dr Turban's activism will be catastrophic and visible to all.

Dr Turban does not hide his disregard for the role of psychotherapy in treating gender distress, and his singular belief in medical and surgical approaches to treating gender dysphoria, whatever its cause may be. Appearing on the GenderGP Podcast episode 'Exploring Detransition with Dr Jack Turban' (2021), hosted by Dr Helen Webberley, a UK physician criminally-convicted for running an illegal clinic, Dr Turban says:

"There's no psychiatric intervention for gender dysphoria. There are medical interventions for gender dysphoria, if you will. And it's not the rule like right, how the psychiatrist's going to treat gender dysphoria, they're not like they're not going to make that go away. The only way that it's ever been proposed that psychiatry can do that was through conversion therapy, which obviously doesn't work."

As you will read later in this letter, many detransitioners report that they strongly wish they had received exploratory psychotherapy rather than affirmation, thus Dr Turban's insinuation that this would be tantamount to conversion therapy is highly disturbing.

Dr Turban describes detransition, in the GenderGP podcast, as having "*become this really awful word... I feel like 90% of the time when you read it, it's really being weaponized.*" The claim that discussing detransition is problematic due to the topic being "weaponized" has been used to shame and silence detransitioners who try to tell our stories. This bullying of a very vulnerable group is unacceptable, and we find it incredibly worrying that Dr Turban would participate in the accusation that detransition is "being weaponized," furthering the bullying of detransitioned individuals. This is not only a matter of rhetoric. Many of us are unable to receive any

meaningful support from the mental health community. Instead of helping us heal, many mental health professionals informed by the likes of Dr. Turban continue to steer us toward medical transition, unable to accept our lived experience. There are more and more people like us sharing their stories of transition regret openly online, and we implore you to look these up.

Dr Turban goes on to say:

“when you say detransition people usually think that means like transition regret. It brings up this idea that somebody transitioned, then realize like, oh my god, that was a huge mistake. I’m actually cisgender, I regret every domain of gender affirmation I’ve ever had. And as I’m sure you know, that’s not the reality of the situation.”

Dr Turban is, again, completely dismissing those of us who have experienced transition regret. As detransitioned woman, we are deeply hurt that Dr Turban would find it appropriate to suggest that our pain and distress is not a reality. We do, in fact, regret every domain of gender affirmation we ever had and the irreversible changes that medical transition did to us that we must now live with for the rest of our lives. It is, therefore, highly unprofessional and deeply offensive to see comments like this from a fellow at Stanford.

At the same time as Dr Turban dismisses our existence, he also claims to represent us in research, but his bias is clear: the goal is to minimize detransition because it contradicts Dr. Turban’s professional aspirations to promote transgender medical and surgical interventions. In the GenderGP podcast he also says:

“We have a paper that hopefully is coming out soon, where we took the data from the 2015 US Transgender Survey. So this was a survey of over 27,000 transgender adults in the United States. And we found that of those who had transitioned in some way, don’t quote me on that exact number, but it’s something like 13% of them said that at some point in their life, they had detransitioned. And when we looked at why they did that, the vast majority of them, like close to 90%, I think, had detransitioned due to some external factor.”

We bring to your attention that the 2015 USTS survey that Dr Turban repeatedly uses for his research is an online convenience survey that was promoted by transition advocacy sites. We believe in and support transgender rights and trans people, but respectfully submit that this survey, subtitled “Injustice at Every Turn,” which is full of biased questions that promote a political agenda, serves as a poor base for respectable research. Dr Turban previously attempted to use this survey to claim that psychotherapy leads to suicide; his problematic analysis and conclusions were thoroughly outlined in a rebuttal by Roberto D’Angelo et al. in ‘One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria’ (2020), to which Dr. Turban never replied, even though he had the chance to do so. Instead, he attacked the researchers on Twitter. Dr Turban also used the same survey to attempt to show that puberty blockers saved lives. Another rebuttal showed just how flawed that piece of research was (‘Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria’ (2020) by

Michael Biggs). Dr Turban failed to respond to that critique in the scientific area, but did go on media circuit to promote his deeply flawed conclusions.

Most recently, Dr Turban misused this problematic sample to discredit detransition experiences in his research, 'Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis' (2021). Dr. Turban did not seem troubled by the fact that 100% of the respondents were transgender-identified and did not identify as detransitioners. This is an expert from his study:

These [detransition due to internal factors] experiences did not necessarily reflect regret regarding past gender affirmation, and were presumably temporary, as all of these respondents subsequently identified as TGD, an eligibility requirement for study participation.

Dr. Turban's conclusions were that detransition is largely a temporary phenomenon, happens in response to external pressures, and does not really represent a problem for those who detransitioned. These conclusions are highly flawed and ignore those of us who have detransitioned due to transition regret, and who were excluded from the survey for no longer being transgender-identified.

In comparison, recent detransition research conducted within the actual detransition community ('Detransition-Related Needs and Support: A Cross-Sectional Online Survey' (2021) by Elie Vandebussche) found very different results: that most of us detransition due to the internal realization that transition was not what we needed, that transition did not help and can actually make things worse for us, and that we found other non-invasive ways to alleviate our dysphoria. Further, the research showed that detransitioners expressed the need to find alternative treatments to deal with their gender dysphoria, but reported that it was nearly impossible to talk about it within LGBT+ spaces and in the medical sphere.

Vandebussche found that most detransitioners currently are in dire need of psychological support on matters such as gender dysphoria, co-morbid conditions, feelings of regret, social/physical changes and internalized homophobic or sexist prejudices. The research confirmed that detransitioners experience prejudice when working with medical and mental health systems, which Dr. Turban's vocal activism directly emboldens and reinforces.

We feel it important to add that in May 2021, the Karolinska Hospital in Sweden issued a new policy statement regarding the treatment of gender-dysphoric minors. This policy has ended the practice of prescribing puberty blockers and cross-sex hormones to gender-dysphoric patients under the age of 18. Finland also revised its treatment guidelines in June 2020, prioritizing psychological interventions and support over medical interventions. Major changes are also underway in the UK, as the NHS has convened a "Cass Review" to examine the practice of transition for young people and the evidence that underlies it.

Thus, it seems evident that there is a growing concern over the proliferation of medical interventions that have a low certainty of benefits, while carrying a significant potential for

medical harm. It is worrying that Dr Turban does not seem to demonstrate the professional curiosity to rethink his endorsement of medical transition for minors and his dismay at psychotherapy and its role in the care of gender dysphoric individuals of all ages.

We are also deeply concerned by Dr Turban's activism to suppress the debate on the proper care for gender dysphoria in the public arena. On May 25, 2021, Dr Turban tweeted the following:

"When I spoke with @60Minutes about their "detransition" story and asked where they found the people to profile – they refused to tell me and became defensive. We still don't know if they searched for people on TERF forums, and transparency would be appreciated."

We bring to your attention that "TERF" (an acronym for "trans-exclusionary radical feminist") is a pejorative term, and that Dr Turban's use of it to smear and dismiss the experiences of the detransitioners who appeared on 60 Minutes is incredibly hurtful. That a fellow at Stanford would criticise 60 Minutes for having a brief segment featuring detransitioners has many of us very concerned that, should one of his patients experience transition regret and subsequently decide to detransition, Dr Turban would be unfit to help them due to his hostility towards the subject.

Therefore, we are deeply concerned with how Dr Turban may practice as a clinician, specifically how he may treat a transgender person struggling with transition regret or a detransitioner seeking to discuss their regret or reverse their transition. His comments on the GenderGP podcast, his flawed use of the USTS, and his hostility towards any discussion of transition regret are all highly problematic and in need of addressing. We ask Stanford to speak out for more thoughtful approaches because, as it stands now, Stanford appears to be silently endorsing Dr Turban's harmful claims that exploratory psychotherapy is tantamount to conversion therapy and that hormones and surgeries are the only appropriate treatment for people with gender dysphoria.

I received affirmative care at my gender clinic. I received no exploratory talk therapy. I injected myself with cross-sex hormones and underwent a double mastectomy. I now suffer from transition regret, and have detransitioned as a result. The distress and harm that I have endured because of the knee-jerk affirmative approach that people like Dr Turban advocates for has been immense. I implore you, on behalf of the detransitioned women who co-signed this letter and myself, to please consider its contents carefully – we wish only to help the many others like us.

Sincerely,

Sinéad Watson

Keira Bell

Rachel Marie Foster

Carol Freitas, co-founder of DetransVoices.org

Cited:

U.S. Transgender Survey Report (2015): [USTS-Full-Report-Dec17.pdf \(transequality.org\)](#)

Exploring Detransition with Dr Jack Turban (2021): [Exploring Detransition with Dr Jack Turban \(gendergp.com\)](#)

One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria (2020): [One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria | SpringerLink](#)

Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis (2021): [Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis – PubMed \(nih.gov\)](#)

Detransition-Related Needs and Support: A Cross-Sectional Online Survey (2021): [Full article: Detransition-Related Needs and Support: A Cross-Sectional Online Survey \(tandfonline.com\)](#)

Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation (2020): [Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation | American Academy of Pediatrics \(aappublications.org\)](#)

Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria (2020): [Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria | SpringerLink](#)

[Angus Fox](#)

Actually, I was just crazy the whole time.

(And honestly, it's really hard to trust anyone after that.)

Michelle Alleva,

<https://somenuanceplease.substack.com/p/some-reflections-on-the-hysterectomy>



[Michelle Alleva](#)

Aug 24

My sudden desire to transition in young adulthood felt like an epiphany. I came across this concept—transgenderism—which, as I heard it explained over and over, increasingly sounded like something that might apply to me. The visualization I had of the moment I made the decision (because there is a moment in time I can pinpoint) was completely cinematic in my head and has an epic soundtrack.

The part of me that likes to see the positive in everything commends my younger self's flair for the dramatic. I want everything in my life to go like a movie. I want everyone in it to automatically know what I'm thinking and how I'm feeling, I want everything in it to go exactly how I've visualized it a hundred times before, and I want my story to *mean* something because what's the point of suffering this life if it doesn't *mean* anything. (Sorry. Apparently my present self also has a flair for the dramatic.)

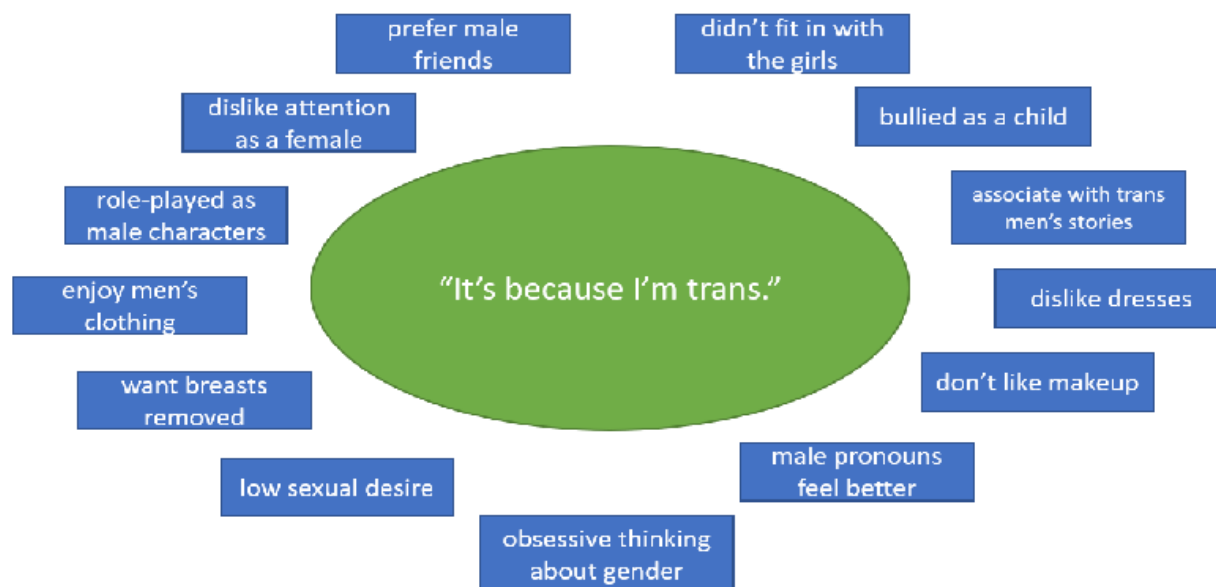
Otherwise, though, having the benefit of what I know today, remembering this moment is kind of sobering. I now understand all the moving parts that make up the so-called epiphany. I now understand how they all went together in a way that gave me the wrong answer. And I've also now learned a word for what I was experiencing: apophenia.

"Apophenia is the tendency to perceive meaningful connections between unrelated things."¹ It's over-interpreting patterns from what is essentially just random noise. It's the same concept that leads people to believe in conspiracy theories. At an extreme, it's a type of delusional thinking... you know, like believing you're not a woman when all of the credible evidence points to the contrary?

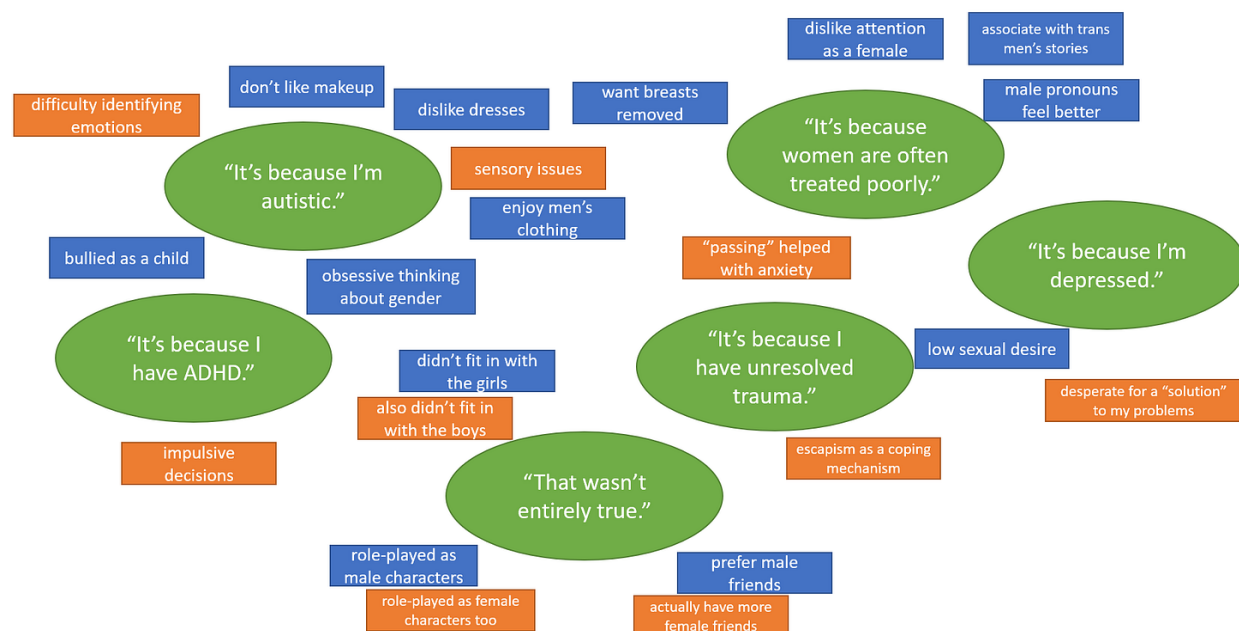
I didn't have an epiphany. I had an apopheny.

When I was making the decision to transition, I came up with a list of evidence that I felt explained why I was not a woman (and was somehow a man instead). I now have better explanations for everything on that list.

I went from something that looked like this:



...to something that looks like this:



I hear frequently that I am meant to take “personal responsibility” for my decision to transition, particularly because I was an adult. This is my take on the situation: I became completely convinced about something that was ultimately untrue. It was a delusional belief. I brought that belief to health professionals who had been taught that it was kinder to affirm the belief than to question it. As a result, I was prescribed cross-sex hormones which caused irreversible changes to my body, and with my belief affirmed, I continued further, having surgeries that disconnected me even further from the reality of my femaleness.

I believe it was medical negligence for them to have failed to properly investigate my delusional belief. My argument is three-fold: “gender identity” is a faith-based belief, not an empirically-recognized condition, and when it comes to medicalization, it is unethical for health professionals to simply accept such a belief at face value; the evidence base for medical transition does not present a straightforward narrative where the benefits always outweigh the risks; and my consent could never have been informed without a proper and thorough exploration of what was affecting my mental health—particularly egregious was the failure to screen for developmental disabilities.

I’ve also written about how [social influence](#) and [developmental disability](#) played parts.

I don’t place blame in one single place. I don’t understand the purpose of yelling “personal responsibility” at me when it is clear that the health professionals who facilitated my transition had their own responsibility towards me. Particularly, I believe they had a responsibility to offer me the type of therapy that would have led to an understanding as in the second diagram above before proceeding to an invasive treatment with permanent effects.

I do have to take responsibility for *something*, though. Of course I do. I may have been delusional, but coming to the wrong conclusion was still my mistake. I have the responsibility of figuring out how I was able to make such a massive mistake. I have to learn from the process. I have to teach myself what critical thinking looks like. I have to recognize logical fallacies. I have to be able to identify abusive behaviour. I have to see red flags for what they are and not what I want them to be. I have to acknowledge that my voice of reason sometimes says things I don’t want to hear but which are true.

I think nearly everyone who transitions experiences that voice of reason. At least, when I experienced doubts about transition, people were certainly happy to remind me that everyone who transitions does. It’s just internalized transphobia. Maybe young transitioners don’t hear it as often, especially if they have a regular routine of people affirming them. As a transitioning adult, though, it’s a lot harder to live in the real world. It’s a lot harder to establish yourself in society. It’s a lot harder to find satisfying relationships. Over time, it gets harder and harder to ignore the fact that it feels like everything you’ve invested into this identity has been for absolutely nothing. All transition does is create virilized women and feminized men, and we have so few long-term studies about what lifelong synthetic cross-sex hormones does to a person. The whole thing is just one giant experiment.

Doubt is why so many true believers, when confronted with biology or the existence of detransition, feel like they have been traumatized by the interaction instead of being able to laugh it off. People who transition are invariably prone to rumination, and doubt can cause a spiral. Imagine the devastation if you are wrong. What's been done to you. What's been done to thousands of others. What we're happily doing to naive little children. The thought would send anyone into a tailspin. Of course it's easier to believe everything's fine.

Imagine feeling your whole life like you're "crazy" until you find a community who assures you that you aren't and enables you on a journey of self-discovery, only to find at the end that... hey, you actually were crazy the whole time. It's a bummer.

I don't know if I'm succeeding at critical thinking. I have a difficult time taking hard positions on anything nowadays. Some days I'll be really firm on one thing, and other days I'll start to loosen up a bit. I'm worried about overcommitting... what if I make a mistake again? I second guess whether I'm doing the right thing. Sometimes when assessing people, I wonder if I'm giving them the benefit of the doubt or just ignoring red flags.

This whole ordeal has left me feeling like I can't trust anyone, including myself. I had a hard time asking for help *before* I transitioned. Health care professionals felt a little safer. Now I don't know if I'll ever be able to forget the kind of recklessness they had with my life. People who loved me cheered me on as I nullified every body function that identified me as a woman, then berated me and claimed I had been radicalized when I shared that I felt like I'd been brainwashed.

How am I supposed to know who has my best intentions in mind? How do I know which authorities to believe? How do I know if the people I think are my friends actually care about my well-being? Which of these people just want me for my story? Who is safe to be vulnerable in front of?

Transition was a form of escapism for me, and escapism is still my coping method of preference. I'm still chronically online. I feel like most of my existence is just a concept on the Internet. Otherwise I'm just electricity auto-piloting a meatsack that barely feels a thing. Most days, it is so difficult to just be present.

I value material reality because it keeps me grounded. It's good to have things that you feel you can safely put your faith in. I trust empiricism. I don't trust me. I've let myself down too many times. But I'll get there.

¹<https://en.wikipedia.org/wiki/Apophenia>

The Boy Who Shifted Shapes: A Detransitioner's Story

Shape Shifter, <https://reduxx.info/opinion-the-boy-who-shifted-shapes/>

By

Shape Shifter

June 22, 2022

I call myself Shape Shifter.

While the name is not my own, I feel it describes me well. I have traversed the darkest reaches of the so-called “gender spectrum” in search for what – who – I was, and transformed myself in the process multiple times.

I can say now that I am a 31-year-old gay male who lived life as a transgender woman for a decade.

I grew up in predominantly Muslim country in Eastern Europe. From the youngest years of my life, I was ‘gender non-conforming,’ and even before I hit puberty I knew I wasn’t like the other boys. But as I got older, I realized that my sexuality and desire to present myself the way I felt most comfortable was not accepted by the society I had been born into. I was rejected both at school and in the home. Bullied by peers, and treated as a burden by my family for my femininity.

My father would tell me I “wasn’t a real man.”

My mother expressed shame over my height and physical attributes.

It doesn’t take long to drown when you’re thrown into a sea of resentment with no lifejacket.

Slowly but surely, I began to hate everything about myself. My “feminine” body and mannerisms were a burden, as was my sexuality. Still, all I could focus on was improving my English with the dream I could leave my country and move to the West.

When I was 20-years-old, that dream became a reality. I moved to the United States to begin graduate school, and for a moment breathed the fresh air of a liberation I’d never before known. I was finally able to grow out my hair and dress in the manner I preferred, and I could be openly gay without fear of persecution.

But that moment was tragically brief.

A question from a well-meaning classmate would put the breaks to the freedom I was enjoying.

“What are your pronouns?”

I was confused, uninitiated. I'd never been exposed to the concepts present in contemporary gender ideology before, and began to research into it like any curious person would. Little did I know at the time, every page I scrolled through and concept I learned was tugging me farther and farther away from the liberation I had just barely begun to enjoy.

Faced with an avalanche of testaments to affirmation and validation, I began to convince myself I was a “straight woman” trapped in a man's body. After the life I had lived, wrought with such repression and condemnation, it almost made sense.

It explained everything, in fact. The reasons why I never fit in or felt comfortable with my body suddenly became crystal clear. The logic behind it also promised an escape, something I had been desperately searching for my whole life.

I could be free from the homosexuality that I had been shamed for since my earliest years. I could be free from being a “feminine” man. I could be a heterosexual woman. Then I could be accepted, find love, and live a normal life.

In my excitement, I almost immediately began presenting myself as a transgender woman. I distanced myself from my gayness and my maleness. I changed my pronouns and quickly changed my name and legal documents.

But despite my initial feelings I had done the right thing, the escape – the freedom – I sought continued to elude me.

While I had been told while I was growing up that I was too “feminine,” male sexual partners were now telling me I was too “masculine,” and not womanly enough. I decided it must have been because my “wrong body” still needed medical correction.

I was able to get feminizing hormones rather quickly through Fenway Health in Boston, Massachusetts, which only required me to tell them I was living as a woman and “felt” like a girl on the inside. Soon after, I got facial feminization surgery and breast implants.

While my dating pool initially increased, I was told by members of my transgender community that men who were comfortable with my penis were “tranny chasers” who didn't see me as a real woman. This, coupled with the fact these men often didn't want anything to do with me out of the bedroom, made me feel like I would never find true love until I had completed all of the surgeries associated with transitioning. My mental health began to deteriorate, and I decided that I needed bottom surgery in order to feel happy.

I ended up getting two letters from mental health professionals at Fenway Health stating that I had gender identity disorder and that I was a good candidate for sex reassignment surgery. At no point was I asked about my childhood trauma, the repression of my sexuality in my home

country, or even whether I had any co-morbid mental health concerns. They assumed that my depression and anxiety issues were due to gender identity disorder, and that radical medical intervention would be the solution.

I had my surgery in 2015, and my life has been a living hell since then.

The “neo-vagina” the surgeon had constructed was too tight for comfortable penetrative sex, and I started rapidly losing depth despite rigorous and painful dilations because my body was treating the tunnel as a wound and was constantly trying to heal itself.

Within a few months, I was back on the operating table to widen the constructed passage. The surgeon blamed me for not dilating enough, though I had followed the instructions he’d given. Even after I left the hospital, I lost one inch of the canal’s depth in the drive from Pennsylvania to Massachusetts as my body continued to treat the surgical creation as a wound that needed to be closed.

Despite all of my efforts, most of which resulted in extreme discomfort during urination, the canal was narrowing once again.

My second revision was done with a different surgeon, one who harvested tissue from my colon in order to add it to the constructed canal. Within one month, the passage had tightened once again and dilation was painful.

Shape Shifter in a 2017 YouTube video documenting the aftermath of one of his neo-vagina revisions.

By my third revision surgery, I had done so much research that I was begging the surgical team to order certain supplies to keep my passage from closing again. During this surgery, my pelvic bone was shaved down to make the entrance to my hole wider. But after I removed the inflatable stent I had inserted during surgery, I discovered I had developed a colorectal fistula — an abscess-like infection. I had to be scheduled for fistula repair surgery.

The fourth revision to my neo-vagina resulted in the fistula tearing back open.

It was then that I realized no one had known what they were doing. Everything was experimental. All of it was being made up as they went along — and I was nothing more than a guinea pig.

I later discovered the surgeon, Dr. Salgado, who had done my last three revisions was let go from the University of Miami for taking pictures of his patients while they were under anesthesia and posting them to Instagram.

Currently, my neo-vagina is only 1 inch deep. I have spent thousands of dollars flying across the United States trying to find a surgeon with a solution, but I have been told that due to the

amount of revisions I have had, any attempts would likely result in me having to wear a colostomy bag.

I realize now that in my search for freedom... I have mutilated myself.

I lost my perfectly healthy genitals. I lost my 20s. I lost family and friends. I lost my chance at a comfortable, fulfilling sex life.

My insurance, however, has paid out over \$250,000 to surgeons and hospitals for the various hack-jobs that had been performed on my body. Everyone made out like a bandit, yet I had nothing to show for it. Not one of the surgeons who lined their pockets off of my trauma has ever called to check up on me, ask about my quality of life, or see if I was still alive.

In 2018, I made my first YouTube video discussing my complications. At the time, I was still living as a "woman," and I had thought I would document my thoughts and experiences as I believed they were rare.

But after I uploaded my first videos, I had many trans-identified individuals write me and explain they were in similar positions. I realized there were a lot of people with complications, but they weren't included in any official statistics or data.

Just as my journey had started, it would end with research.

I realized hormone treatments were not even FDA approved for treatment of gender dysphoria. That there were no studies proving that hormone replacement therapy was safe in the long run. And, just as I had thought, all of the surgeries were experimental.

But more than anything else, I realized I was not a "woman." I was a gay man who had been sold a lie.

After everything I have been through. I realize medical transition destroyed my mental and physical health, and lowered my quality of life substantially.

At 31-years-old, I have osteoporosis and scoliosis from the impact of hormone replacement therapy. In fact, my testosterone was so low that in January I began taking it to improve my bone density. My T-levels increasing resulted in a slew of extreme emotions towards my transition. It was as though a part of my brain that had been dormant was activated, and I was suddenly wrought with the full depth of the realization that I had made a mistake I could never take back.

I was at my breaking point, and experienced suicidal ideations. Entering therapy helped me realize I had heavy childhood trauma that should have been addressed prior to ever allowing me to proceed with an irreversible medical intervention. I discovered I had borderline personality

disorder as well as body dysmorphia, and no matter how far I took my surgical modifications, I would have never felt “at home” in my body.

Since I have come out as a detransitioner, I have spoken to so many people like me whose stories are important and deserve to be heard. In fact, I believe the detransitioner community will be growing exponentially in the coming years. It is tragic to think about the parents who will one day realize they ruined their child’s body by jumping to “affirm” how they perceived themselves at one moment in time — kids who may have just been gay or gender-nonconforming like myself.

I have also met criticism from those who still subscribe to gender ideology who claim that me speaking on my experiences will take away “life saving” care from trans people.

But I got that care. And where is my life?

Sometimes I feel like I am in a nightmare I will wake up from. My eyes will open and I will have my original body and have my whole life ahead of me to make decisions. Since beginning testosterone, I also sometimes get ‘phantom penis’ symptoms which are extremely traumatic.

Medical detransitioning is even more experimental than medical transitioning, but I am not rushing into anything anymore. One thing is for sure, I will never again identify as transgender woman — a label that not only endorses questionable medical experimentation, but also has a negative impact on the rights and dignity of females.

My idea of freedom is different now than it was those years ago, but the challenges are, ironically, the same.

In addition to the criticism from those who champion gender ideology, I also get flak for having long hair and nails but identifying as a man. Yet again I am being criticized for not fitting certain rigid definitions of masculinity — the very thing that set me down this path in the first place.

But I am done trying to ‘correct’ myself to please others.

I am done shifting shapes.

Shape Shifter

Shape is a guest opinion contributor at Reduxx. He is a recently detransitioned male who now advocates for the rights of gender nonconforming people to be protected from medical transition.

What they took from us

Ritchie Herron, Twitter: <https://archive.ph/dA1wn>




Thread






TullipR 🌈🏳️‍🌈🏳️‍🌈
 @TullipR

I want to tell everyone what they took from us, what irreversible really means, and what that reality looks like for us.

No one told me any of what I'm going to tell you now.



6:57 PM · Jun 13, 2022 · Twitter Web App

4,001 Retweets 1,868 Quote Tweets 10.9K Likes








TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h
 Replying to @TullipR

I have no sensation in my crotch region at all.


You could stab me with a knife and I wouldn't know. The entire area is numb, like it's shell shocked and unable to comprehend what happened, even 4 years on.

 24
  279
  2,426
 




TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h

I tore a sutra 4 days post recovery, they promised to address it, i begged them in emails to fix it, they scorned me instead.



New to Twitter?


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
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Relevant people



TullipR 🌈🏳️‍🌈🏳️‍🌈
 @TullipR




Detransitioned Adult Male |
 HRT is 🍌 | JK is based |
 Team Member @genspect |
 Detransition support is
 available at
reddit.com/r/detrans

What's happening

MLB · LIVE

Braves at Nationals



Years later, I have what looks like a chunk of missing flesh next to my neo-vagina, it literally looks like someone hacked at me.

They still wont fix it



7



186



2,056



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h ...

No one told me that the base area of your penis is left, it can't be removed - meaning you're left with a literal stump inside that twitches.

When you take Testosterone and your libido returns, you wake up with morning wood, without the tree.

I wish this was a joke



25



311



2,383



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h ...

And if you do take testosterone after being post op, you run the risk of internal hair in the neo-vagina. Imagine dealing with internal hair growth after everything?

What a choice... be healthy on Testosterone and a freak, or remain a sexless eunuch.



10



196



2,093



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h ...

And thats something that will never come back and one of the reason why i got surgery.

My sex drive died about 6 months on HRT and at the time I was glad to be rid of it, but now 10 years later, Im realising what im missing out on and what I won't get back.



5



178



2,021



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h ...

Because even if i had a sex drive, my neo vagina is so narrow and small, i wouldn't even be able to have sex if i wanted too.

And when I do use a small dilator, I have random pockets of sensation that only seem to pick up pain, rather than pleasure.



6



151



1,836



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h

...

Any pleasure I do get comes from the Prostate that was moved forward and wrapped in glands from the penis, meaning anal sex isn't possible and can risk further damage.



3



133



1,680



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h

...

Then there's the dreams. I dream often, that I have both sets of genitals, in the dream I'm distressed I have both, why both I think? I tell myself to wake up because I know it's just a dream.

And I awaken into a living nightmare.



5



142



1,834



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h

...

In those moments of amnesia as I would wake, I would reach down to my crotch area expecting something that was there for 3 decades, and it's not.

My heart skips a beat, every single damn time.



10



142



1,794



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h

...

Then there's the act of going to the toilet. It takes me about 10 minutes to empty my bladder, it's extremely slow, painful and because it dribbles no matter how much I relax, it will then just go all over that entire area, leaving me soaked.



6



155



1,754



TullipR 🌈🏳️‍🌈🏳️‍🌈 @TullipR · 4h

...

So after cleaning myself up, I will find moments later that my underwear is wet - no matter how much I wiped, it slowly drips out for the best part of an hour.

I never knew at 35 I ran the risk like smelling like piss everywhere I went.

11

145

1,827



TullipR 🌈🏳️‍♂️ @TullipR · 4h

...

Now i get to the point where im detransitioned and the realisation that this is permanent is catching up with me.

During transition, I was obsessive and deeply unwell, I cannot believe they were allowed to do this to me, even after all the red flags.

13

331

2,639



TullipR/Ritchie 🌈🏳️‍♂️ @TullipR · 13 Jun

...

I wasn't even asked if I wanted to freeze sperm or want kids. In my obsessive, deeply unwell state they just nodded along and didnt tell me the realities, what life would be like.

70

844

7,365



TullipR/Ritchie 🌈🏳️‍♂️ @TullipR · 13 Jun

...

And finally, theres dilation, which is like some sort of demonic ceremony where you impale yourself for 20 agonising minutes to remind you of your own stupidity.

41

580

5,976



TullipR/Ritchie 🌈🏳️‍♂️ @TullipR · 13 Jun

...

This isn't even the half of it. And this isn't regret either, this is grief and anger.

Fuck everyone who let this happen.

697

1,181

11.9K



TullipR/Ritchie 🌈🏳️‍♂️ @TullipR · 14 Jun

...

Replying to @TullipR

I haven't deleted anything btw. Thread got mass reported.

242

539

5,905



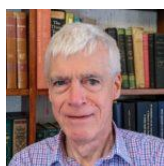
Chloe's story: puberty blockers at 13, a double mastectomy at 15

Chloe Cole & Michael Cook, MercatorNet,

<https://mercatornet.com/chloe-cole-gender-transition/80073/>

Note: most of Chloe's remarks were originally from a speech in the public forum of the California State Assembly.

Laying bare the iniquity of doctors and psychologists who exploit the confusion of children and adolescents.



by

Jul 27, 2022 / 3 mins

[Michael Cook](#)

/ 12



Chloe Cole / Facebook screenshot

The California State Assembly has been studying a bill, [SB 107](#), to declare the state a sanctuary for minors who have been denied transgender -affirming medicine and surgery elsewhere.

SB 107 would permit insurance companies, physicians, and contractors to disregard subpoenas about child custody if the child is being medically treated for gender dysphoria. It would also ban health care providers from providing medical information requested from another state if that state has a policy allowing civil action to be taken against individuals who perform “gender-affirming health care” on children.

A young California woman, Chloe Cole, has testified before legislators in her own state, in Louisiana, and in Florida about her experience at the hands of gender-affirming doctors. She began to transition to a male at 13; she had a double mastectomy at 15; and she detransitioned at 17. Her brief speech lays bare the iniquity of doctors and psychologists who exploit the confusion of children and adolescents.

This is [the text of her address in Louisiana](#). It is heart-breaking.

My name is Chloe Cole, and I am from the Central Valley of California and a former transgender child patient. I am currently 17 years old and was medically transitioning from ages 13-16.

After I came out to my parents as a transgender boy at 12, I consulted a pediatric therapist in July of 2017 and was diagnosed with dysphoria by a ‘gender specialist’ the following month. The healthcare workers are trained to strictly follow the affirmative care system, even for child patients, in part because of California’s ‘conversion therapy’ ban. There was very little gatekeeping or other treatments suggested for my dysphoria.

When my parents asked about the efficacy of hormonal, surgical, and otherwise ‘affirming’ treatments in dysphoric children, their concerns were very quickly brushed aside by medical professionals. I didn’t even know [detransitioners](#) existed until I was one.

The only person who didn’t affirm me was the first endocrinologist I met. He refused to put me on blockers and expressed concerns for my cognitive development. However, it was easy to see another endocrinologist to get a prescription for blockers and testosterone, just like getting a second opinion for any other medical concern. After only two or three appointments with the second endocrinologist, I was given paperwork and consent forms for puberty blockers (Lupron) and androgens (Depo-Testosterone), respectively. I began blockers in February of 2018, and one month later, I received my first testosterone shot. I received Lupron shots for about a year.

After two years on testosterone, I expressed to my therapist that I was seeking top surgery, or the removal of my breasts. I was recommended to another gender specialist, who then sent me to a gender-affirming surgeon. After my first consultation with the surgeon, my parents and I were encouraged to attend a ‘top surgery’ class, which had about 12 Female-to-Male (FTM) kids. I was immediately struck by how early some of them seemed in their transition and how

some were much younger than I was; I was 15 at the time and had been transitioning for 3 years.

In retrospect, the class inadvertently helped to affirm my decision because of the sense of community provided by seeing girls like me going through the same thing. Despite all these consultations and classes, I don't feel like I understood all the ramifications that came with any of the medical decisions I was making. I didn't realize how traumatic the recovery would be, and it wasn't until I was almost a year post-op, that I realized I may want to breastfeed my future children; I will never be able to do that as a mother.

The worst part about my transition would be the long-term health effects that I didn't knowingly consent to at the time. I developed urinary tract issues during my transition that seem to have gotten worse since stopping testosterone. I have been getting blood clots in my urine and have an inability to fully empty my bladder. Because my reproductive system was still developing while I was on testosterone, the overall function of it is completely unknown. I have irreversible changes, and I may face complications for the rest of my life.

I was failed by modern medicine."

Did Chloe give informed consent to these life-changing procedures? Is her experience really different from the atrocities committed by German doctors at Auschwitz or American doctors in the Tuskegee syphilis studies?



Michael Cook

Purification Rites

Cut Down Tree, <https://cutdowntree.substack.com/p/purification-rites>

An autobiographical essay



[Steven A Richards](#)

Apr 26

There's a concept which I was exposed to a lot while I was transitioning: "testosterone poisoning". It's talked about online and in trans spaces, and is pretty common; I've seen multiple trans women wearing "I survived testosterone poisoning" t-shirts.

The idea is that, for male-to-female trans people, the testosterone naturally produced by their bodies is toxic. It makes them grow hair, causes their bodies to develop in a masculine direction during puberty, deepens their voices, changes how they smell, increases their libido, and often makes them more aggressive and prone to anger. Later in life, it can cause male-pattern baldness. These changes are upsetting and confusing to many young boys as they enter puberty, but most of them learn to cope with, and even appreciate, the changes that come to their body as they grow into adults.

I didn't get that chance, and never will.



I was terrified of what testosterone was doing to me. I didn't want to be a man. I didn't want to be big and hairy. Men scared me. I'd seen my mom assaulted when I was young, and I didn't want to be like the man who'd done that to her. The idea of testosterone poisoning made sense to me because maleness itself terrified me. I'd been bullied a lot in school by other boys, and a lot of that bullying involved sexual abuse—groping, inappropriate touching, striking my butt and genitals, and verbal harassment (wolf-whistling and yelling sexual comments at me). These, I felt, weren't the sorts of things that happened to men. My suffering was only legible if I was a woman.

This background made me vulnerable to the ideology of transgenderism. I had no friends in high school and spent a lot of time online, and I was exposed to the burgeoning social justice/woke movement before it entered the mainstream. When I connected to the internet, I was inundated with messages about the violence of maleness. This wasn't just "toxic masculinity"—I saw feminists saying *all* masculinity was toxic, that all men were rapists, all men were oppressors, all men should be killed. As a white man, I was directly responsible for all of the oppression experienced by women and people of color. I was fourteen years old and had never been in a fight in my life or said a racist or misogynistic word to anyone, but I believed that the circumstances of my birth made me a monster. I wasn't mentally mature enough to think critically about these ideas, or to take them as anything but literal fact. (Literal thinking is common among autistic people, and I would be diagnosed with autism a few years later.) I believed, all the way down to my core, that all men were evil and all women were unimpeachably virtuous. This was black-and-white thinking; it's one of the reasons why so many autistic people are transitioning. I believed that my very existence was sinful.

I picked up these messages from the internet because I was a chronically online loner. Now this stuff is everywhere, online and off. Is it any surprise that teenagers (frequently autistic teenagers who take everything literally) want to transition when they're exposed to societal messages telling them "men are bad, men are dangerous to women, only men have power" and "you can change your gender if you want to"? Young boys will want to transition to escape the masculinity they're being told is harmful and toxic; and while I can't speak with authority on the subject, I imagine young girls will want to transition to escape the violence they're being told is around every corner, in the eyes of every man who looks at them, and to access the power they're being told they're denied. These hyperbolic, oversimplified distortions of a complicated reality are neither healthy nor empowering, and hurt more than they help. Add that onto the fact that puberty is often a miserable experience, and you have an epidemic of child transition. The same pressures that made me want to transition are everywhere now.

I wanted to transition because my body was my enemy, and my body was the enemy of the world. I hated myself and wanted to punish myself. It was the same feeling that motivates cutting, binge-eating, anorexia, and lashing oneself. My very nature meant I deserved pain. I couldn't remove my whiteness from myself, but maybe I could remove my maleness. The first step was to get rid of the poison coursing through my body: testosterone, the hormone turning me into an animal and a brute. I needed to purify myself.

When you're being poisoned by a chemical which makes your mind and body monstrous—when your very soul is at risk—you'll do anything to make it stop. For me, that meant transitioning. I didn't have any particular reason to want to be female except that women were better than men—in my mind women were smarter, kinder, more empathetic, more beautiful, more moral. I was attracted to women, and felt guilty about that attraction—straight male sexuality, I was told, was repulsive and rapey and objectifying. If I were a woman, I could be attracted to other women in a virtuous way. Maybe I was fetishizing lesbians, but there was nothing leering about it—I simply believed the things that women online were saying about themselves.

Women also, in my perspective as a confused and traumatized fourteen-year-old, were valuable and worthy of consideration in a way that men were not. When women were sexually victimized by men, they seemed to receive sympathy and caring. People moved mountains to protect them. When I told my dad about the sexual harassment I faced at school, he told me I should punch the next person who did something like that to me. My whole life I'd been told that violence was never the answer, and I believed that. I was a gentle soul. Now, because of my sex, I was expected to use violence to protect myself in a way I had no idea how to do. I didn't, and if I had I suspect I would've been suspended for defending myself and the bullying would've gotten exponentially worse when I returned. I didn't receive any protection. If I couldn't handle it myself, I deserved what I got.

I perceived that society viewed women as having inherent value (“women and children first!”) and I envied that, because in my life I felt that no one valued me. My transition wasn't driven by fetishism or misogyny. I was just a lonely, wounded child. All I really wanted was to be loved.

Still, teenagers try on a lot of different identities and beliefs. I'd already had a militant atheist phase. This trans phase might have also passed on its own—if it weren't for the Queer Youth Center. An organization in my area offered resources for “queer youth”, including community groups and sex ed. Opting into a trans identity didn't just mean aligning myself with some vague concept of female goodness, it also gave me a community of friends when I had none. I met my first girlfriend (she called herself a lesbian) at the Queer Youth Center. I went from being utterly alone to being surrounded with love. Adults at the Queer Youth Center affirmed my identity, introduced me to trans activists, and encouraged me to engage in activism myself. (The activism is a central part of the trans movement—these people don't want you to *just* transition, they also want you to spread the ideology. This moral drive to proselytize is part of how the movement has spread so quickly.) While I can't remember if I was ever urged to medically transition, there was definitely a sense that medical transition was the “next step” after adopting a trans identity. I didn't even need that much motivation. People cared about me. I had friends. I was sold.

So I had to transition, which meant I had to convince my parents and doctors to let me transition. Remember, I had been convinced by online hyper-left rhetoric that my soul was on the line here, so nothing was off the table. Adult trans people online gave scripts for how to talk to parents and doctors when you wanted to access trans medical care. I dug through my memories, searching for evidence of a good, gentle female soul buried deep inside my awful, twisted male body. When I was a kid I tried on my mom's sandals. I wore nail polish with my mom and sister. When my mom was nursing my sister, I tried to mimic what she was doing by

holding a doll to my chest. I didn't like haircuts that made me look too masculine. I used these isolated incidents to construct a narrative, and I even convinced myself it was true. I also convinced myself—following the guidance of online transsexuals—that I'd kill myself if I didn't transition. I made suicide threats. I claimed that I'd buy hormones off the black market (again, adult trans women on the internet told me how I could do this if I needed to). I begged, pleaded, and threw fits. Health care providers told my parents that I was trans, that transitioning was the best thing for me, that it would be good for my health. I got my mom on my side, and together we talked my dad into letting me start puberty blockers at 15, after I'd banked sperm (thank God they made me preserve my fertility, because I wouldn't have done it myself) and estrogen at 16. Even this was too slow for me. Every day, my body was masculinizing. Every day, that slow drip of poison was mutating me into a bestial horror.

I wasn't old enough to understand what I was doing to myself. I didn't realize what I was giving up, how permanent these changes I was making were. But I hadn't yet made the worst decision of my life. That would come a few years later, when I decided to have myself castrated.

I was about 20. (I remember being 21 when I got the surgery, while my mom remembers me being 19, and I really don't want to dig up medical records to check—even writing about it conjures traumatic memories.) I no longer cared about being female, but the fundamental self-hatred was still there. I'd chosen a new name—I'd chosen a lot of new names, and none of them stuck—and was telling people to use "they/them" pronouns for me. I wanted to have my testicles removed. They were the source of testosterone, the source of the poison I had to take medication to block. They were symbolic of everything I hated about myself.

No responsible doctor should have performed this surgery. I was frequently changing my name and identity. I had no clear conception of who I was or what I wanted. The delusional thinking which began with me believing I was a woman deep down had morphed into something stranger and darker, encouraged by a trans woman who'd struck up a friendship with me when I was fifteen and they were in their mid-twenties. I saw myself as a being of water and light, an angel imprisoned in a filthy human body. I resented having to eat, sleep, piss, and shit. I particularly hated having sexual desires and wanted to be rid of them. I'd been diagnosed with autism, and would later be diagnosed with OCD. That OCD manifested as a constant fear that my testicles would get tangled up and somehow kill me in my sleep (I told the doctors about this and it didn't raise any red flags). Shortly before the surgery, I'd briefly tried to detransition in a moment of lucidity, but I didn't have a supportive community waiting on the other side to welcome me. After a few months of loneliness, scary changes to my body, and a significantly increased libido that didn't know how to handle, I fled back to the neutering medication and the open arms of my local trans community. All of this should have screamed to any sane person that I wasn't in a mental state where I could understand what this surgery meant or fully consent to it. I needed serious psychiatric help and deprogramming, not to have my balls cut off so I could more closely resemble the sexless angel I wanted to be.

I saw the surgery as a rite of purification. I felt that by removing a part of myself I would become whole. Years of online grooming and ideological brainwashing had made me delusional, but no one pushed back on it. I heard, through my mom, that my dad was worried about me, but we

never spoke about it. I can't remember if he tried; if he did, I'm sure I wasn't receptive. What did he know? The doctors were happy to go through with it, and they had medical degrees. So I took two weeks off work, went into the hospital, and had my balls cut off.

They called the surgery an "orchiectomy", but these days I think of it as a castration. I sometimes have nightmares about waking up afterwards. In my dreams I scream and scream, I run through the hallways howling and begging for them to undo it, to fix me, to make me right again. In reality, I stuffed all my feelings of grief, regret, and horror as far down as they would go. My testicles were gone. My healthy endocrine system, which would have begun to function again if I'd ever gone off medication, had been destroyed. For several years I lived with severe cognitive dissonance, constantly pushing away any negative feelings about the surgery, but eventually I had to admit to myself what had happened.

I hadn't cleansed myself, I'd ruined myself, and I'll never get back what I lost. I've made myself permanently reliant on the pharmaceutical industry for artificial testosterone which will never be as good as the real thing and which can be taken away in a heartbeat if I ever lose my insurance or there are problems with the supply chain. I still have phantom pains, and probably always will, as well as intense cramping in my groin when I do certain exercises. I wasn't warned about any of this by the doctor who performed my surgery.

For many people, transition is an obsessive quest to compulsively eradicate one's own sexed characteristics. It's born from ideology, self-hatred, trauma, and grooming by online strangers. Gay, autistic, mentally disabled, and gender non-conforming teenagers, as well as victims of sexual violence, are the most affected. Pharmaceuticals and plastic surgery investors are getting rich off of the butchery, mutilation, and mass sterilization of these vulnerable and traumatized populations. Doctors and therapists who assist people in transition aren't providing care, they're enabling self-harm and practicing eugenics.

A transition is never done. There's always more surgeries, new treatments, more work to do. You can never carve away enough pieces of yourself to be satisfied. You can never rid yourself of the fundamental facts of your own biology. You can never be cleansed of sin.

The end goal of transition isn't self-actualization. It's self-annihilation.

From: [LGB Alliance USA](#)
To: [Vazquez, Paul](#)
Subject: LGB Alliance USA Statement To The Florida Board of Medicine
Date: Tuesday, September 20, 2022 4:51:26 PM
Attachments: [Outlook-m4a0zcqa.png](#)

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

We are LGB Alliance USA, an organization that represents the interests of lesbian, gay, and bisexual individuals across the United States. We are writing in anticipation of the September 30th meeting of the Florida Board of Medicine regarding proposed rule changes for the medical treatment of gender dysphoric minors. This is an important issue for us, as some of our members are detransitioners and desisters who have been harmed by so-called "gender affirming care."

Here are some reasons we oppose the current trend of affirming and medicalizing trans identities in youth:

- [Most trans-identifying children](#) desist by adulthood and grow up to be lesbian, gay, or bisexual, making "transition" a new self-appointed form of conversion therapy.
- [Over half](#) of detransitioners cited internalized homophobia as a reason for transition.
- People with suicidal ideation need psychological treatment, not medicalization and affirmation.

The fact that many trans-identifying youth may be suicidal does not make medicalized transition "lifesaving care." The lifesaving care they need is counseling, not bodily modification. When did it become "hatred" and "bigotry" to learn bodily acceptance? As gender dysphoria is a psychological issue, it should be treated with psychological care. Doctors do not give diet pills to young people with anorexia. Psychological distress over one's physical body deserves psychological care. Physical intervention may provide a superficial or temporary solution but will not and cannot resolve the underlying issue because the underlying issue is psychological. People with eating disorders do not suddenly love their bodies when they lose weight because, like dysphoria, the underlying issue is body image perception.

To examine this issue at the root, we must examine the reality of raising children in a sexist and homophobic society. Children are being raised in a culture full of hyper-sexualized influencers and celebrities, where the exploitation of women in pornography is normalized, where gender constructs are inherent in nearly everything children consume: books, movies, TV, advertising, their peers, their households, their families, even their school textbooks. Virtually all imagery, narratives, and words they are exposed to are heteronormative and reinforce gender roles (masculinity/femininity as inherent to the sexes). From the misogyny in religions in which children are indoctrinated, to the hyper-

masculinity of sports culture, to self-proclaimed “feminists” declaring makeup and high heels are “empowering choices,” regressive gender roles are everywhere, all the time—and now many of them are being rebranded “progressive.” In the digital age, we are bombarded by it every waking hour. Combined with the cult contagion of social media, this is where gender dysphoria is born.

Thank you for considering our input



Leading the Fight for Same-Sex Rights

info@lgbausa.org | LGBAUSA.org

From: [Sarah Jorgensen](#)
To: [Vazquez, Paul](#)
Subject: Florida board of medicine: puberty blockers for gender dysphoric youth
Date: Friday, September 16, 2022 1:33:57 PM
Attachments: [JACCP JOURNAL OF THE AMERICAN COLLEGE OF CLINICAL PHARMACY - 2022 - Jorgensen - Puberty blockers for gender dysphoric.pdf](#)

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Mr. Vazquez,

I'd like to submit our recent letter, published in the Journal of the American College of Clinical Pharmacists, titled "Puberty blockers for gender dysphoric youth: a lack of sound science," for the Florida Board of Medicine's consideration on this issue.

Best regards,
Sarah

*Sarah Jorgensen, PharmD MPH BCIDP
Institute of Medical Science
University of Toronto*

18 September 2022

Paul A. Vazquez, J. D., Executive Director
Florida Board of Medicine
BOM.meetingmaterials@flhealth.gov
Paul.Vazquez@flhealth.gov

Sir,

Please accept this message in testimony from 2 pediatricians from Miami FL.

Gender dysphoria (GD) in children is diagnosed when children show gender confusion. When GD occurs in the pre-pubertal child, it resolves spontaneously in 80-90% after the children naturally develop through puberty. A high proportion of children with GD have other neuropsychiatric disorders such as autism and anorexia. GD is considered a body integrity disorder and ought to be treated by a mental health specialist.

The treatment recommended for this disorder is affirmation of the confusion exhibited by the child, suppression of puberty with hormones, high dose cross hormones (testosterone for the girls estrogen for the boys) and mutilating surgeries.

Puberty is an essential milestone in the development of the child. Puberty blocking medications like Lupron (most used) cause a disease state. Harms include impaired brain maturation, decreased bone density with risk of later fractures, sexual dysfunction, and infertility. Are puberty blocking effects reversible? No. Time lost from developing together with peers and reaching important milestones can never be regained.

High dose cross hormones can result in heart disease, hypertension, diabetes, and cancer.

Once a child is given a puberty blocker, the majority go on to mutilating surgeries. Girls as young as 14 have had completely healthy breasts removed. Surgeries for males include dissecting the penis and inverting into a pelvic wound. For girls, removal of skin of the forearm and attachment to the pelvis to simulate a penis.

There are no long-term studies that show that gender changing therapies done to children have any beneficial effects. Suicide risk among trans-identified youth is the same as for other at-risk groups, such as depression, autism, and anorexia.

Prevention of suicide ought to be the same as for other youth: talk therapy and FDA approved psychiatric medications. Psychiatrists in the US and Europe agree that there is no evidence that gender transition reduces gender dysphoric children likelihood of killing themselves.

Studies of transgender adults show a high incidence of depression and suicide. In Sweden, a 30 year follow up of sex-reassigned adults showed rates of suicide 20 times greater than the general population.

Acts which are performed by doctors which mutilate, sterilize or otherwise harm children such as blocking puberty, high dose cross sex hormones, and sex organ removal are not healthcare, but are atrocities. *Especially when the children diagnosed with GD resolve their confusion as they grow naturally through puberty and align their perceived gender with their biological sex by late adolescence.* Our children are the victims of this terrible experiment, as confused adults impose their disordered ideology onto the most innocent and vulnerable.

Felipe E Vizcarrondo MD, MA
Faculty, Institute for Bioethics and Social Policy
Miller School of Medicine. University of Miami
President, Miami Guild
Catholic Medical Association

Norman Ruiz Castaneda, MD
Attending pediatrician in private practice
Nicklaus Children's Hospital, Miami FL
Vice President, Miami Guild
Catholic Medical Association

From: [Beatriz Martinez](#)
To: [Vazquez, Paul](#)
Subject: Florida Board Meeting
Date: Thursday, September 15, 2022 11:29:13 AM
Attachments: [Florida Medical Board Letter.pdf](#)

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Greetings,

Please accept the attached letter for discussion at your upcoming September 30th meeting.

With gratitude,



Beatriz Martinez-Peñalver, L.M.H.C

Founder, [Triumph Steps, Inc](#)

[Healthy Connections, CMHC](#)

Featured on [NBC](#), [CBS](#), [Univision](#)

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Greetings to all,

We are writing to The Board of Medicine because the mental health of our children is our most significant concern.

My husband and I have a combined mental health experience of almost 70 years. I am a psychotherapist who has had a mental health center for the past 21 years, serving our community with a team of over 20 professionals. My husband is a psychiatrist who holds medical licenses in 34 states and presently practices in 120 emergency rooms around the nation.

In the past 30 years in the field, I've had one adult male patient who had partially transitioned to be a female. My husband remembers having no more than 4-5 transgender cases in his career (none children) until about three years ago. Now, he sees 5-10 children with gender dysphoria per month in emergency rooms. In my clinic, not long ago, we received a phone call from a mother, and in that call, we identified ten preteen girls experiencing gender dysphoria—her daughter and four girls in her class, as well as five friends from another school. None of the clients who have come to us with gender dysphoria have presented with a history of childhood gender dysphoria. Instead, parents describe a sudden onset of their symptoms. This rapid onset is a clear picture of peer contagion. Historically, there has always been a small number of children who present with gender dysphoria, and 80% of them outgrow it.

Many say that the rise in gender dysphoria visits to mental health professionals like us has to do with increased acceptance which helps the clients not feel marginalized. However, we have not seen an increase in adults exploring transitioning. It is solely children seeking it. There is an increase of 4,400% in kids identifying with gender dysphoria, and we need the help of The Florida Board of Medicine not to harm these children permanently. Many psychotherapists explore other factors affecting the child's mental wellbeing, not affirm, and have found great success.


We can learn a lot from looking at the history of John Money, the psychologist who originally introduced terms such as gender identity, sexual orientation, and gender roles that are now adding to our current mental health crisis.

Money stated that pedophilia is not always pathological. He argued that there are affectional pedophilia and sadistic pedophilia. According to Money, affectional pedophilia was about having too much love for a child. Money had considerable research on sexual identity and the biology of gender based on the case of the Reimer twin brothers. One of the twins had a condition that was attempted to be corrected by circumcision. The procedure went wrong, and the boy lost his penis. Money suggested raising the boy as a girl, and the parents did. He often brought the two kids to his office to do therapy and show them how they needed to perform sex acts. Both twins killed themselves when they were in their 30s. In the 1960s, John Hopkins pioneered sex reassignment procedures, and in 1979 the clinic was closed because they realized that reassignment procedures did not bring happiness or any of the benefits they were looking to find.

Transitioning does not bring wholeness and happiness. We have already traveled those waters. Many young women who transitioned in adolescence later regretted it and de-transitioned. We can read about many of them. "What we focus on the longest grows the strongest" is a phrase I often use with my clients and students. Social media and academia are creating a climate that propagates gender confusion at unprecedented rates. They do it by putting pressure on young children to identify with a gender, introducing books about gender identity at an early age, and more.

Our children need the help of the Florida Board of Medicine to protect them and do no harm. Please do not allow the medical transition of minors with hormones, puberty blockers, or gender surgeries. Our current mental health crisis merits it. Our children deserve it.

Respectfully yours,



Beatriz Martinez-Penalver, LMHC Florida Lic. MH4158

From: [Ruth Muir](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Identity- Florida Board of Health
Date: Monday, September 19, 2022 11:31:04 AM

Some people who received this message don't often get email from ruthpaterson78@hotmail.com.
[Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,

I write to you as a concerned Mother of a 15 year old girl who is biologically female but identifies as Transgender, A trans boy, and everyday there are safeguarding issues. E,g she either doesn't use the toilet at all, or if need be uses the Men's Toilet. You Tube and online influencers have guided her throughout this journey, and it is the same for so many other young people, many who have spent more time online due to lockdown.

Parents need better guidelines to help their Children, and I believe Teachers and Medical professionals also need better guidance on this new and pressing issue.

Additionally to being a Mum of a Trans identifying teen I am a registered Art therapist working with Children and Young people, and am concerned at the amount of young people who are self diagnosing, and self-identifying. Often they are heavily influenced by social media.

Since identifying as Trans I have seen my child's mental health deteriorate drastically. The one thing that has helped is limiting social media time.

My Child is waiting on an autism assessment. In the meantime she is very focused on things that I don't believe a 15 year old should even be contemplating.

She plans to 'Go on T' – (Testosterone), and have 'Top Surgery'- (A double masectomy)

As a Mum and a practising Art Therapist, I wholeheartedly believe that the best approach for Children and Adolescents questioning their gender is a watchful waiting one.

I would not recommend the affirmative approach as I have seen first hand how it can narrow their options. Once a child has socially transitioned and 'come out' to friends, family, and their School, it is very difficult for them to backtrack if they are having doubts. This means that many Children are going on hormones, drugs, and having life changing procedures which they often go on to regret, This is morally and ethically wrong.

I advocate for a compassionate approach for gender questioning young people.

A slowing down, of this often fast track to sex change, which is completely inappropriate for young people who are still growing and developing.

It is time to stand up to the Trans Activists and Influencers, and those in the positions of power, money and greed, and do the right thing for this generation.

For my teenage daughter, and for the many, many young people caught up in gender ideology, please be part of a movement that allows them the space to grow up, healthy in their own bodies and minds.

Should they wish to transition as an experienced well informed Adult then that is another matter.

I recommend a holistic approach for gender questioning young people, and would be happy to correspond with you on this matter.

With Best Wishes,

Ruth Muir

HCPC registered Art Therapist

From: [Michael Moloney](#)
To: [Vazquez, Paul](#)
Subject: gender transition
Date: Monday, September 19, 2022 4:35:20 PM

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To whom it concerns

Please do not promote children and youth and their well intentioned parents from doing real permanent sterilizing harm to the reproductive systems of their bodies and to their future happiness because what is being promoted (sterility) cannot be reversed.

Dr. Michael Moloney MD, MPH,

Sent from my iPhone

From: [Stacy Riddle](#)
To: [Vazquez, Paul](#)
Subject: Affirmative Care and Minors
Date: Friday, September 16, 2022 7:50:31 AM

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Dear Health Board of Florida

As the mother of a trans identifying teenage girl I am writing to encourage you to protect children in Florida by stopping the affirmative care model for trans health.

My daughter was an outgoing, funny, loving girly girl growing up. She loved all things that were stereotypically girl. This was not something her father or I pushed. As she got to middle school we started to notice changes that concerned us. She was sad all the time, spent too much time online, hardly talked to people and mumbled when she did, had very complicated friend issues, and started hiding herself behind dark, very baggy clothing. She attended a small middle school. Her friends were a group of six socially awkward but highly intelligent young ladies. My daughter and one other girl went on to identify as nonbinary and transgender respectively in eighth grade.

Being highly gifted in art, we allowed my daughter to apply to a gifted high school with a focus on art and technology. We knew that there would be many other trans identifying students there, but also believed it would be a chance for her to be with other kids who were intelligent, awkward and gifted in art. In short, we thought she would find a place to belong. In this ultra affirming school my daughter quickly went from identifying as nonbinary to trans.

Since high school my daughter has pushed hard for testosterone and a double mastectomy. Teachers, society, social media and our government have encouraged her to pursue these medical interventions. It has been impossible to find a therapist that would do the deep work of exploratory therapy. Her first psychologist in eighth grade thought she only needed support in learning how to live as nonbinary, after only one test that she skipped multiple questions on, and one other meeting. Two therapists since have dropped her. When I talk to a doctor or therapist about gender, puberty, menstruations etc. I have try to find a way to secretly contact them and make sure they won't encourage her to make permanent changes she may later regret. Many of these conversations are tense and hushed because doctors and therapists are worried about losing licenses due to conversion therapy laws.

Last year she was diagnosed as autistic. The psychologists she worked with and a teacher we contract to help develop social skills and transition to college, have both told us that they are seeing an epidemic of patients/students who identify as trans. The teacher told me I was the fourth parent in two weeks to tell her their child identified as trans.

We have told our daughter all along that we will love and support her no matter what. We have made her wait until adulthood to pursue any medical interventions. She will be 18 in a little under a year. She has been on this path for four years. Some may ask, since this has been persistent, why we don't allow testosterone. But for a child that was never gender non-

conforming until the most difficult time of her life and has had no one but us try to figure out why, to suddenly take on this persona, while being bullied, an undiagnosed autistic, and having every other authority in her life encourage her to transition, it is absolutely crazy to think testosterone is a good choice. And with years of affirmation without real exploration of her issues, it doesn't make sense that she will be prepared to transition next year either!

There are thousands of kids like mine out there. The Tavistock in the UK recorded a 4000% increase in adolescent females identifying as trans over a ten year period in the late 2000s to the late 2010s. This issue can't be described as anything but a social contagion. We have seen it before as suicide attempts, anorexia, cutting, goth, but at no other point in history have we taken an adolescent girl who is stressed, depressed and confused and encouraged her to follow her heart and hurt herself.

You must stand up for the children of Florida and stop all medical transitioning of children and young adults. Give them time for their brains to mature. Make sure that true exploratory therapy is done before medical interventions are pursued. Protect thousands from a lifetime of regret.

Respectfully,
Stacy Riddle

From: [Sharon P. Glaab](#)
To: [Vazquez, Paul](#)
Subject: Hormone therapy / gender dysphoria in young people
Date: Sunday, September 18, 2022 9:13:24 AM

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Dear Florida Board of Medicine,

Thank you for taking up the vital question of regulating the so-called "gender-affirming" hormones and surgeries for young people.

As a parent of one of these children, I have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions on the first or second visit. The myth that our children are getting "assessments" is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society's recommendations.

My son is high functioning ASD (what used to be called Aspergers). He never had a lot of friends. In his last year of high school, he made friends with a classmate who went through various stages of gender / sexual confusion, ultimately deciding that she wanted to be a male. Soon after, my son expressed feelings of gender dysphoria. His pediatrician recommended that we talk to an endocrinologist and indicated that there would be at least two years of therapy required before any interventions were prescribed. However, the endocrinologist discussed gender affecting hormones on the first visit, recommending to my son that he consider freezing his sperm because he would be sterilized (he was 16 at the time). I took him to a therapist who wrote him a letter after only a few weeks' time. The therapist told me not to worry because the cost of the drugs would be prohibitive and that would delay his implementation of gender therapy. My son was prescribed these hormones a few months later, on his second visit to the endocrinologist, and was easily able to afford the monthly cost of them, as all three drugs he was prescribed cost under \$12 total per month.

Along the way, we relied on professionals who were well intentioned, but woefully misinformed. The pediatrician was shocked when we followed up with him and told him what had actually occurred. His therapist wrote the letter in order to 1) keep a patient and 2) build a patient's trust in her, all the while thinking that she had many months to continue therapy with him before any permanent biological changes would happen. At no point did the therapist try to work with my child on the cause of his dysphoria - her entire focus was on helping him "adjust" to living as a female.

Many young people have gender questions around the time of puberty. Some simply need a few years to get used to the changes in their bodies. The swift medicalization of "addressing" issues that are often a normal part of progressing to adulthood is robbing these children of the opportunity to work through their questions in a non-harmful way.

Older adolescents can get hormones with no assessments at all, and have their healthy body

parts amputated by eager surgeons on little more than self-declaration of "trans identity." Many of our children are gay and autistic and have come to believe their very real distress is explained by the fact that they are "transgender" and that hormones and surgeries will help. They do not. We have seen our children's mental and physical health plummet following "gender-affirmation."

We also encourage you to require in depth psychotherapy to address the feelings of dysphoria, and to issue a clear statement that psychotherapy for gender dysphoria is not "conversion". Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation."

Thank you for doing what you can to regulate this experiment on our vulnerable children.

Sherry Glaab

From: [mary.ellen5](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Ban Gender Affirming
Date: Sunday, September 18, 2022 4:45:15 PM

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Please do not cave to this erroneous effort to change our America The Beautiful - One Nation Under God, Indivisible, with liberty and justice for all into an unruly garbage pit. The proposal for Gender affirmation has no scientific basis and No Religious basis whatsoever. Our forefathers have sweated blood and tears to gift our nation with the values and dignity we have been enjoying until most recent years of Marxist influence. It is heartbreaking to see our government and country compromised by the corrupt leadership that proposes those sort of evil and calls it "rights" and Gender affirming. It sure does not affirm Gender of male and female as God created us.

Say no to Gender affirmation and say yes to true American values.

Sent from my Verizon, Samsung Galaxy smartphone

From: [Melanie Tiwari](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Affirmative care appeal
Date: Sunday, September 18, 2022 5:02:01 PM

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Good afternoon. I am aware that the state of Florida is considering limiting affirmative care in terms of youth transition and informed consent process. I urge you to consider banning or stricting limiting surgical youth transition and encouraging parental consent for any medical procedures. Children under 18 are not aware of their family's medical history and may be consenting to medical procedures that could be complicated by hereditary conditions that they may not be aware of, which can change response to procedures, recovery and risk their lives. Minors may also have other undiagnosed mental health issues that can affect their decision-making as well and may very well be the cause of their desire to change themselves. All other federal and state laws for making decisions regarding the human body and property in general involve decisions to be made by adults over 18, like getting a tattoo or piercing, voting, buying or renting property and more. Besides this regarding minors, it's also against the fundamental nature of the medical profession to "first do no harm," which cutting off perfectly functioning organs and body parts would be doing.

With such an intense, life-changing process of multiple surgeries--one surgery may not be enough to complete gender transition--also creates a medical customer/client for life who lives dependent on hormones, doctors for continuing body changes and adjustments and mental health professionals to help them deal with all of the social, physical, emotional and mental changes they experiences. Young children and teens, all under 18, do not have the brain development necessary to make such lasting decisions, which is why in every other area of our country and government they are limited from doing so. It is common knowledge and medical consensus that the adolescent brain doesn't finish developing until the early 20's. Parents have historically been the protection for these children and trusted with their medical well-being, which they have done with vaccinations for school, managing allergies, getting emergency care as well as wellness care, among normally daily care. Limiting parents involvement and help with decision-making would put children in the face of very real danger to themselves. It is abhorrent that the medical community would consider risking the live, health and function of children and their bodies in the face of political pressure. It undermines their very sole purpose in helping our children grow in health.

Please consider this as you all make your decision. Although I didn't include links and pages of research, I am stating facts that we have sealed in law right now and have depended on as foundational scientific facts for centuries and decades. Thank you.

Melanie

From: pgb@igc.org
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: I support Stephanie Will's comments on gender affirming care
Date: Sunday, September 18, 2022 5:44:47 PM

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Dear Mr. Vazquez:

I am writing to say I agree with Stephanie Winn's recent comments on "gender affirming care". I want to be very clear that I am a lifelong progressive and defender of human rights, and I am appalled by the ways the political right has responded to this issue. At the same time, Ms. Winn makes an extremely strong and compelling case against "gender affirming care". It is a myth that all liberals and progressives support this perspective; actually, many, many of us find it poorly thought out, frightening, and dangerous to children.

Ms Winn presents many strong points in her letter. I will only add that health services and organizations in Europe that originally promoted "gender affirming care" are now advising extreme caution in this area. Britain recently closed the Tavistock clinic, which focused on "gender affirming care."

Thank you, and please look at this issue thoughtfully and carefully.

Paul Belz

Chico, Ca.

From: [Saramichelle Stultz](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Comment on Affirmation Model for Transcare
Date: Sunday, September 18, 2022 7:54:32 PM

Some people who received this message don't often get email from saramerelli7@gmail.com.
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Dear Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

I am a parent and a concerned citizen and educator. I am vehemently opposed to the affirmation model and with hormonal and surgical interventions without thoughtful, informed and cautious decision making by an adult and a team of up-to-date experts, including in the field of mental health. Currently in the US, we are seeing a social contagion with the numbers of teenagers and young adults identifying as trans and non-binary having risen (and continuing to rise) at alarming rates in the past year. At the same time, the number of desisters and detransitioners are increasing at incredible rates in a short period of time. The World's largest Gender Clinic, Tavistock, recently closed down and there are over 1,000 lawsuits of malpractice. Great Britain recently commissioned a highly distinguished public health and pediatric expert to reconsider the affirmative model in the United Kingdom. Other nations are following suit, such as France, Sweden and Finland. Additionally if you review the original intent from the Dutch model and sole study, which is what the US is based off of, it was and still is, supportive of a slow, intense intervention at the mental health level to ensure that the adolescent is receiving the best possible care and informed of the risks involved. This is NOT happening in the US as it has become a political and economic issue. Many people are profiting off our youth and duped parents, who are the newest form of guinea pigs for social justice advocates. I am a life-long liberal and now find myself completely and utterly perplexed and disgusted as to why we, in the US, would ever allow this to happen. But if you look at our history, this has happened before. It is time to change things immediately and stop the harm that is being done to children. We can stop this now, instead of having to look back and say, well, we didn't know. We DO know the harms and this is the biggest scam that has ever entered western society. Vulnerable kids of being rushed to hormones and surgeries with life-long adverse effects to their health, including 100% sterilization. I also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation."

Please consider with care the findings of the Cass Review interim report.

What is the Cass Review interim report?

The Cass Review is an Independent Review of Gender Identity Services for Children and Young

People. It was 'commissioned by NHS England and NHS Improvement in Autumn 2020 to make

recommendations about the services provided by the NHS to children and young people who are

questioning their gender identity or experiencing gender incongruence [1].' In March 2022, the

Cass Review submitted an interim report to NHS England. This interim report '[set] out [the] work to date, what [had] been learnt so far and the approach going forward [2].'

Who is Dr. Hilary Cass

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent

Review of Gender Identity Services for children and young people in late 2020.

A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr

Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020).

Although retired from clinical practice, she remains an honorary Consultant Paediatrician at Evelina London Children's Hospital, Guy's & St Thomas's NHS Foundation Trust, where she was also previously Director of Education and Workforce.

Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah's Ark Children's

Hospice. She is also leading work on how to address the challenges for both families and professionals in supporting the rising numbers of children with complex medical conditions and disability.

Other recent roles include acting as the Senior Clinical Advisor for Child Health for Health Education England. Prior to this Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Paediatrics in London.

Her

consultant clinical practice was as a tertiary neurodisability consultant from 1992 to 2018 in three very different specialist centres and she has published widely in this area.

In addition to her neurodisability practice, Dr Cass was closely involved in the development of

paediatric palliative care services at Evelina London Children's Hospital.

Dr Cass was awarded the OBE for services to child health in 2015. She was also awarded an honorary fellowship by the Royal College of Nursing in 2015, and by RCGP in 2016.

Background

The United Kingdom has seen a significant increase in the number of children seeking help for distress in relation to their biological sex. Many school staff first started noticing the phenomenon of children – predominantly teenaged girls – wanting to change sex during the last decade.

In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (para. 1.1).

From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment (para 3.10).

This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender and gender identity. Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus (para. 2.4).

No consensus

This being a new phenomenon, research is limited and no consensus exists (within the scientific community) about possible causes and most appropriate treatment options. At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in

childhood and

adolescence can be an inherent and immutable phenomenon for which transition is the best

option for the individual (para. 1.7).

We must secure a balanced treatment of political issues, they must take a child-centred, evidence-based approach, and take care not to express personal beliefs in ways which could

exploit pupils' vulnerabilities. We should not for example, present, as fact, childhood gender incongruence as an inherent and immutable phenomenon as this is a contested idea rather than an established evidence-based fact.

Low quality evidence

The Cass Review interim report acknowledges that '[over] the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial' (para. 2.4). Many of us feel confused or conflicted about approaching the issues of sex and gender identity with adolescents. The above-mentioned rise in referrals to GIDS has been accompanied by an increasing number of news reports claiming that some teachers and/or schools are promoting the idea that gender identity supersedes sex. However, there is insufficient high quality, longitudinal data (relating to gender-questioning children) from which to draw robust conclusions. There is a notable gap in the evidence base pertaining to the surge in female teenagers seeking support from gender identity services.

Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some

authors interpret their data from a particular ideological and/or theoretical standpoint (para. 1.29).

Decisions need to be informed by long-term data on the range of outcomes, from satisfaction

with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally (para. 3.21).

It is also important to note that any data that are available do not relate to the current predominant cohort of laterpresenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group (para. 3.23).

Since the rapid increase in this group began around 2015, they will not reach late 20s for another

5+ years, which would be the best time to assess longer-term wellbeing (para. 5.10).

This is an area of research where no scientific consensus exists. Schools must be aware

that any claims made about the reasons behind the increase in gender-questioning children are speculative and cannot be treated as established evidence-based facts.

Changing epidemiology

Early childhood gender dysphoria is not a new phenomenon. However, the existing literature on

treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female and often presenting with a range of neurodevelopmental and mental health co-morbidities.

In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS (para 3.10).

This increase in referrals has been accompanied by a change in the case-mix from predominantly birth registered males presenting with gender incongruence from an early age, to predominantly birth registered females presenting with later onset of reported gender incongruence in early teen years (para. 3.11).

The mix of young people presenting to the service is more complex than seen previously, with

many being neurodiverse and/or having a wide range of psychosocial and mental health needs.

The largest group currently comprises birth-registered females first presenting in adolescence

with gender related distress (para. 1.10).

Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes (para. 1.28).

Secondly, the cohort that the original Dutch Approach was based on is different from the current

more complex NHS cohort, and also from the current case-mix internationally, and therefore it is

difficult to extrapolate from older literature to this current group (para. 5.10).

The Cass Review interim report highlights the difficulties faced by clinicians responsible for making diagnoses and recommending treatment. Teachers are neither qualified nor capable of

critically evaluating existing evidence. They must carry out their duties within statutory and non-

statutory frameworks. This included ensuring that any necessary referrals are made as specified by their schools' safeguarding protocols.

Diagnostic overshadowing

Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria (para. 4.10).

School staff must be clear that they are not qualified to offer students advice in this area. Moreover, the promotion of specific beliefs about the source(s) of gender-related distress could

influence children's attitudes toward the diagnostic process before meeting with a clinically trained professional. Guidance from the Department for Education states that teachers "are in a

position of authority and will typically be respected and trusted by the pupils they teach, giving

their personal opinions greater weight and credibility. As a general principle, they should avoid

expressing their own personal political views to pupils unless they are confident this will not amount to promoting that view to pupils [4]."

Affirmative vs developmental models

Broadly speaking, there are two approaches to treating children with gender-related distress: the

gender-affirmative approach and the developmentally-informed approach. The gender-affirmative approach is based on the theory that a child's gender identity is innate. The developmentally-informed approach is based on the theory that a complex interaction of multiple

factors underlie gender-related distress. The Cass Review interim report acknowledges that some clinicians report being under pressure to adopt a gender-affirmative approach.

Following directly from this is a spectrum of opinion about the correct clinical approach, ranging

broadly between those who take a more gender-affirmative approach to those who take a more

cautious, developmentally-informed approach (para. 4.15).

Some secondary care providers told us that their training and professional standards dictate that

when working with a child or young person they should be taking a mental health approach to

formulating a differential diagnosis of the child or young person's problems. However, they

are
afraid of the consequences of doing so in relation to gender distress because of the
pressure to
take a purely affirmative approach (para 4.20).
There is a spectrum of academic, clinical and societal opinion on this. At one end are those
who
believe that gender identity can fluctuate over time and be highly mutable and that,
because
gender incongruence or gender-related distress may be a response to many psychosocial
factors, identity may sometimes change or the distress may resolve in later adolescence or
early adulthood, even in those whose early incongruence or distress was quite marked. At
the other end are those who believe that gender incongruence or dysphoria in childhood or
adolescence is generally a clear indicator of that child or young person being transgender
and question the methodology of some of the desistance studies (para. 5.8).
School staff are unqualified to evaluate the merits of these approaches. Moreover, they
have an
obligation to remain politically impartial. This means not supporting one approach over
another.

Social transition

Social transitions (the act of treating children as if belonging to the opposite sex) are
performed
by some schools in England. A social transition is a powerful psychological treatment that
affects a child's psychological development. Not only are school staff unqualified to judge
the
appropriateness of such interventions, the outcomes are poorly understood.
Social transition – this may not be thought of as an intervention or treatment, because it is
not
something that happens within health services. However, it is important to view it as an
active
intervention because it may have significant effects on the child or young person in terms of
their psychological functioning. There are different views on the benefits versus the harms
of early social transition. Whatever position one takes, it is important to acknowledge that it
is not a
neutral act, and better information is needed about outcomes (para. 5.19).

Pressure

The Cass Review interim report acknowledges the pressures clinicians are under to adopt
an
unquestioning affirmative approach. Similarly, there is an acknowledgement that children
are
under pressure to identify with societal stereotyping. Schools cannot erase the pressures

that

children are under from, for example, social media and peers. However, teachers should promote acceptance for children's non-stereotypical behaviour (boys and girls exhibiting stereotypically 'feminine' and 'masculine' behaviour, respectively) and avoid reinforcing harmful stereotypes.

Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical

assessment and diagnosis that they have been trained to undertake in all other clinical encounters

(para. 1.14).

From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision (para. 1.18).

It is not the role of this Review to take any position on the cultural and societal debates relating

to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services (para. 2.5).

We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long children and young people are waiting to access services (para 4.13).

These will be considered further during the lifetime of the Review and include: . . . The complex

interaction between sexuality and gender identity, and societal responses to both; for example,

we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years (para. 4.14).

Safeguarding

Children with gender-related distress may pose specific safeguarding concerns. They have a

higher incidence of comorbid psychiatric and/or developmental difficulties. They are also more

likely to be looked after children. Teachers need to be aware of possible harms such as breast

binding or tucking (of male genitals). Children may also be subjected to grooming and/or

coaching, and encouraged to deceive parents, clinicians and teachers in order to secure particular outcomes such as clinical diagnoses of gender dysphoria. They may also be receiving cross-sex hormones from unregulated sources.

In addition, approximately one third of children and young people referred to GIDS have autism

or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children (para. 3.11).

We have also heard about the distress experienced by birth-registered females as they reach

puberty, including the use of painful, and potentially harmful, binding processes to conceal their

breasts (para. 4.3).

Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and

receive a medical diagnosis of gender dysphoria (para. 4.4).

We have heard that some young people learn through peers and social media what they should

and should not say to therapy staff in order to access hormone treatment; for example, that they

are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation

(para. 4.5).

We have heard about families trying to balance the risks of obtaining unregulated and potentially

dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment (para. 4.7).

Summary

There has been a huge increase in the number of children (predominantly female teenagers)

seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing

epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making

diagnoses and recommending treatment. School staff who now affirm are neither qualified to evaluate existing research nor clinically trained. Therefore, they cannot judge the

appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development. The Cass Review interim report outlines some of the specific safeguarding issues that surround gender-questioning children.

Thank you most sincerely for your time and consideration.

Yours sincerely,

Sara Stultz

I am an academic researcher at a top U.S. university. Let me start by saying that I am a lifelong, staunch supporter of LGB rights. Like most progressives, when “T” was added to the acronym, I assumed that represented something good. The little I knew suggested that transsexuals (at the time) were a tiny, marginalized group treated poorly by society. I still believe that, in a way, but over the past three years I have discovered that the issue is much more complex in 2022 than I had previously understood.

My daughter, a highly intelligent, sensitive, creative child, was always lost in her own fantasy world. She loved stuffed animals, Angelina Ballerina, Fancy Nancy, Calico Critters, My Little Ponies, American Girl dolls and books, Disney princesses, books about fairies and elves and dragons, and horses. She was obsessed with horses – real ones, figurines, stories of horses – and still takes lessons. She begged to take ballet because she loved the pink tutu and the slippers. She loved to play dress-up, and I would have to talk her out of wearing her holiday dress with sequins to a family picnic at the park. As a female scientist, I would try unsuccessfully to interest her in STEM topics. I would sign her up for soccer and science camp and outdoor adventure camp. She liked some of those things, but creative, artsy, and imaginative activities were always her favorites. She was young for her age.

When she was 11, my daughter hit puberty. Her chest blossomed, and she kept outgrowing bras every few months. Also at 13, she received her first smart phone for her birthday. At age 14, she came to us and said she was *literally not a girl* but rather identified as “nonbinary”. My husband and I were taken aback. The idea that someone with a female body as well as lifelong adherence to all the stereotypical “girly” attributes and interests was “not a girl” was puzzling. She asked for and got a very short haircut. She was upset coming home because it wasn’t short enough in her view. I was finally able to get a little clarity: she told me it was her hope that a very short haircut could help offset the very obviously female shape of the rest of her.

My daughter is, as I said, highly sensitive, which is a [common characteristic of gifted kids](#). Asynchronous development, which is a mismatch between cognitive, emotional, and physical development, [is also common](#). So I don’t doubt she was feeling agony at the effects of puberty, which catapulted her into the body of an 18-year-old when she was struggling to hold on to childhood. But what happens when such a girl goes online and searches “I hate my breasts”? The answer she found was to label herself “nonbinary.” My daughter, [immature like so many modern adolescents](#), and seeking a definitive solution to her social anxiety, swiftly got pulled into this narrative. It seemed to solve everything, especially since one key step for a nonbinary or trans-identified natal female is to get a double mastectomy – something that is euphemistically known as “top surgery” – and to which my daughter aspired.

I found this solution quite extreme, and I started doing some research. Adolescence, from age 12 to 25, is a period of life in which [the brain is entirely rewired](#). Synapses are pruned, neural pathways that are often used are strengthened, and the [brain is bathed in pubescent hormones](#). The [developmental goal](#) is to emerge at the end of the process having formed an occupational identity and a sexual identity. Part of a fulfilling adulthood is a sense of self-actualization: having a set of goals and a drive to pursue them. When a person spends the better part of adolescence pondering and performing gender and expending energy getting others to validate it, it seems likely that this activity could replace any more concrete goal. I worry about this for my daughter and for all of the teens caught up in this narrative who have a similar story of [adolescent awkwardness](#) pathologized. This, more than anything, is why I do believe those who draw the association between adolescent transgender identification and internet use: social media encourages us to perform to others rather than to just live our lives.

The internet, along with academia, our school district, and most other mainstream sources, was very clear about what my husband and I should have done as parents: affirm our daughter as a nonbinary person, start using different pronouns and another name, buy her a binder to squeeze her breast tissue, and start working

on reducing our bigotry. We should agree that yes, there is something missing in you, a “female” feeling that you apparently lack. But I found that idea disturbing and regressive, and I dug further for answers that made more sense to me. So I can tell you that this advice is not the only advice out there. Other thoughtful, nuanced advice says to acknowledge that your child is truly experiencing extreme distress, and to ask questions, listen carefully and empathetically, and work on identifying the true source of that distress.

In my daughter’s case, the answers weren’t hard to identify. She is extremely self-conscious, socially anxious, and a perfectionist. That last trait, in adolescents, often causes them to resist trying new things in case of failure; how much more problematic to have a new sexualized body that you didn’t ask for, and how tempting to opt out of it with a trendy label and a checklist of steps to complete to rid yourself of the problem. I will never forget that when I first took my daughter to a therapist specializing in gifted kids, the therapist told me that about half her caseload had some type of gender issue. Think about that for a minute. A therapist who sees only gifted kids, which are the top 2-3% of the population according to IQ, says *half her caseload* is questioning their gender. There is a lot of overlap between giftedness and autism spectrum, including what used to be called Asperger’s Syndrome. Interestingly, one well-known fact about autistic people is that they tend to be confused by or impatient with gender norms.

We have been working on building my daughter’s self-esteem and providing more real-life experiences that can help her become comfortable inhabiting her body. These things are working. She is much happier and is slowly maturing, and she no longer fixates on gender.

I do not pretend to know what’s best for other families and other kids, but I have spent a lot of time in parent support groups online and I can tell you that there are many, many kids like my daughter, who have been swept up into the trans narrative for other reasons but then cling to it hard for a long time. I personally know of two of my daughter’s friends and three of my older son’s friends, all natal girls and all academically gifted, who believe they are nonbinary or trans. And I know that there are many parents who swallow feelings of whiplash and disorientation because the “experts” say that this is what they must do.

Nothing that I have read gives me confidence that the clinicians at gender clinics are willing to recognize this, that essentially it is now their job to try to sort out who are the very few kids with such extreme gender dysphoria that arose organically and cannot be remedied in some other way than to sign up for a lifetime as a medical patient, versus all of the kids with sundry other mental health and neurodevelopmental issues who have read on the internet that gender services are the solution to their distress. And once they are 18, there appears to be no care taken *at all* to get to root causes in any of the cases that I personally know about.

I heard that there was a question about this being a made-up issue, that Republicans are being hateful and stirring up political controversy where there is no real concern, so I decided to write. I don’t know their motives, but I am very grateful that this issue is now getting public scrutiny. There *is* real concern. I have shared my story with many friends and relatives, and even a few colleagues, and the concern is uniform. Most people know a kid like my daughter and are dubious about the whole idea of gender identity being helpful to kids. Several people confessed that they had always thought it made no sense, but felt guilty saying so. Outside of politics, people do understand that childhood and adolescence are times of imagination, experimentation, rejection of cultural norms, and identity formation, and they tend to agree that permanent, irreversible changes to the body with lifelong health implications should not be made on the basis of what a child or adolescent believes at a point in time along that developmental journey.

-- worried mother/scientist

From: [Stephanie O'Brien](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Written testimony for Florida Board of Medicine Committee
Date: Sunday, September 18, 2022 9:40:00 PM

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Florida Board of Medicine Committee testimony

I am the mother of a daughter, who as of recently identified as transgender. It started suddenly a few months shy of her 15th birthday, out of the blue and with no prior manifestation of gender dysphoria or incongruence. At least 2 years prior to the transgender announcement she was suffering from social anxiety and depression. In 9th grade she was introduced to gender concepts at school and then on the internet. She became withdrawn, isolated herself and suicidal. We sought help for her in the form of psychotherapy from a psychologist and psychiatrist. Both immediately affirmed her trans identity without any exploration of her prior co-morbidities or issues. We (her parents) were shut out of all conversations surrounding this sudden onset of gender incongruence. We were told that this was her "authentic self" and that we needed to be on board with her new identity and if we didn't the chances of suicide were exceptionally high.

Our daughter at the age of 16 expressed a desire for "top surgery" and was exploring the route of opposite sex hormones. My husband and I were absolutely opposed to this and expressed our concern. Her therapist continued to affirm and the affirmation model of gender care was the only model employed. We were shut out of sessions and communication with the therapist so we decided to take our daughter out of therapy because of the lack of communication and the fact that we were becoming the enemy. We told our daughter that at this age we would not consent to these irreversible surgeries and treatments but that we understood that at 18 she could make her own decisions. We counseled her to wait until she was at least 25 years old to make these decision and we talked about the science of brain development and how the frontal lobe was not fully mature until at least 25 and sometimes later. She agreed to take a wait and see approach until at least 18. We told her that no matter what we would always love and care for her and if at 25 she still felt this way that we would cross that bridge and be there for her.

She is now 18 years of age and no longer identifies as transgender. During the years that she identified as transgender we let her have time and space to explore her feelings and to present as masculine as she wanted. She cut her hair and took her senior pictures in a tuxedo. We did not allow for social transition as a teenager knowing full well that when a child socially transitions it is very hard to walk back and can confirm and cement gender incongruence. We wanted to give her space and time to explore without anything becoming permanent at this young age. I recently posed the question of "what if we had agreed to the double mastectomy and testosterone that you wanted? Do you think it would have helped or hurt you?" She expressed that she was glad that we let her take her time to get more comfortable with her body and herself and that she knows that it would have hurt and not helped and most likely would have made her worse.

As I write this, I look back and am thankful for the group of parents I found that are going through this. Almost all our stories are the same and the only model of care we and these kids are offered is the affirmative care model. I can think of no other mental health diagnosis where the only model offered is to affirm. This is a completely new, unstudied cohort of teenagers and young adults that are being affirmed and being told that they are born in the wrong body and that surgery and hormone treatment will "fix" them. We ask ourselves daily, what if we had followed the professionals advice? What if we allowed our underage, suffering from depression and anxiety, highly gifted, sensitive daughter to cut off her breasts and take testosterone?

I urge you all to consider the ramifications of allowing underage children who cannot possibly understand or consent to irreversible surgeries and hormone treatments. Please give these kids the gift of time and help that will allow them to explore, without the permanence that takes place with gender affirming care only. Gender affirming

care is a one way street than does not allow for questions, reflexion, exploration or space in which to safely investigate feelings and expression.

Thank you for your time and consideration,
Stephanie and Jeff O'Brien

Mrs Sharon Davies

8 Borrowdale Close

Narellan NSW

Australia

20.09.22

Dear Mr Vazquez

I'm writing out of concern for young people who are considering surgical or hormonal gender transition and the ease of which it seems, they can currently access this. I believe it is important to consider that for many this is happening during a period of their lives where so many things are confusing, in a world where there is so much turmoil around them and in an era where they can access all sorts of highly influential information, some credible, but much non-credible and possibly damaging while not even having complete brain development yet. I am also concerned about the possible negative impacts long term for these teenagers. I am aware of some who realise a few years after transitioning that their choice to transition they regret due to the permanency of many of the physical and chemical changes to their body.

I have a daughter who is 17 years old. Following 15 years of being a very content child to teenager she began showing signs of severe mental illness. A number of factors including grief of a well-loved pet, long-term low-level bullying by a close friend and increasing school pressure seemed to trigger this. In the last 8 months she has revealed that she feels that "she is in the wrong body" but thankfully at this stage she has no intention of making physical or hormonal changes. I am very grateful that we have a very caring and alert psychiatrist who recognises that Gender Dysphoria is becoming increasingly common and often exists in patients who are displaying signs of mental illness. She has spent a good number of hours talking to myself and my daughter and asking questions relating to her childhood and has recognised Obsessive Compulsive Disorder (OCD) as one of the main underlying illnesses which is impacting my daughter.

An illness such as OCD can play a major part in something such as gender dysphoria as the patient spends a lot of time ruminating on things that bother them. I expect that other illnesses such as Autism Spectrum Disorder, Post Traumatic Stress Disorder and even Anxiety and Depression could play a significant part in the lives of many experiencing Gender Dysphoria. It is very easy to blame the way we feel, particularly dissatisfaction with ourselves and our bodies on a problem that we can come up with a quick fix solution for.

I am concerned that many young patients who are undergoing gender transitioning procedures are not receiving the medical investigations they need to help them identify possibly underlying causes of their dissatisfaction in themselves or the counselling which they deserve to adequately inform them of the likely impacts the changes may have on their adult lives.

I personally suffered 8 years of infertility and had the best treatment available at the time to enable me to conceive a baby. I would not wish that suffering on anyone else but gender transitioning procedures I understand could *cause* problems such as this. The last thing that a gender dysphoric

patient needs is to be given a quick fix solution when they are possibly too young to know if they will still feel the same way once their brain has fully developed and which will likely predisposition them to impacts such as infertility, inability to breastfeed, certain cancers, hair loss and other impacts; all ramifications which they may need medical help and/or counselling for in the future and which will potentially lead to mental illness if they are not already experiencing this.

I believe the best use of financial resources and best care for gender dysphoric patients is that they are listened to and cared for, that they are given opportunities to have mental illnesses diagnosed and treated and that they and their carers are given extensive and thorough counselling on how to best help them manage the difficulties that they are dealing with. I believe that this should be available to them until the time when their brain has fully developed. If at that stage they completely understand the consequences of transitioning their bodies, then they are in a much better position to choose to go ahead with this.

From: [Machado, Ronald](#)
To: [Vazquez, Paul](#)
Cc: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: RE: The availability of medical transition for minors suffering from gender dysphoria
Date: Monday, September 19, 2022 10:05:51 AM

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Dear Sirs:

There is a lack of quality evidence supporting efforts to medically alter secondary sexual characteristics in minors with gender dysphoria. The Florida Medical Board needs to consider proper evidence-based medicine standards in all decisions and defer decisions on issues without such proper evidence. Expert opinions on a medical issue such as this are best evaluate at the individual practice/practitioner level and should not enter into the state arena of decisionmaking.

Sincerely,

-RM

[Ron Machado, M.D.](#)

[Florida ME#74507](#)

Tallahassee, Florida

UF College of Medicine- M.D. Class of 1996

Florida State University – B.S. Biochemistry 1992 – Summa Cum Laude

Jupiter High School – Class of 1988

From: [Mike Bean](#)
To: [Vazquez, Paul](#)
Subject: Protection for Our Youth
Date: Sunday, September 18, 2022 8:37:03 PM

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Dear Florida Board of Medicine,

Thank you for considering young people's health regarding hormone treatments and surgeries. The use of hormones, if administered according to the Endocrine Society's recommendations, will sterilize young people in a distressed state.

In many places in our country, older adolescents can easily get both hormones and life-altering surgeries. They are told that these interventions will solve their distress; however, the data does not support this claim.

In addition, many parents are seeking exploratory therapy for their children. I have spoken to clinicians who want to offer this service but face obstacles. Families deserve safe alternatives to the current model of medical experimentation.

Please protect our youth.

Mike Bean

From: [Michael Jaquith](#)
To: [Vazquez, Paul](#)
Subject: Gender transition opposition
Date: Monday, September 19, 2022 4:41:40 PM

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Would encourage you to vote against gender transitioning treatment for children and adolescents. These treatments harm children. Gender dysphoria is a treatable condition. No state funding should be used to encourage this condition.

Sincerely,

Michael H. Jaquith, M.D.

Sent from my Verizon, Samsung Galaxy smartphone
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From: [Rachel Murphy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Transgender medical treatment on minors
Date: Monday, September 19, 2022 12:48:14 PM

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To whom it may concern:

I am writing to express my concerns regarding the transgender medical treatment of minors. It seems that the treatment of these minors is done very quickly with no concern to the long-term effects either physically or psychologically. Seeing that many of these children come from broken homes and have endured some form of trauma in their short lives, I think it would be prudent to first have them go through a series of counseling sessions to help them think through their feelings before making such a drastic and life changing decision. What are the possibilities of increased risk of cancer given that the natural function (DNA) of the sexual organs have been altered? The bodies DNA knows the true sex of the child and how will artificial hormones react in the body long term? Again, possible cancer risks because of the artificial hormones. I do hope the oath of "Do no harm," is still the number one priority. With that in mind there should be no rush to permanently alter a child's sex when the appropriate research of the physical and psychological health of the child has not been extensively researched.

Sincerely,
Rachel Murphy

--

["Nothing great is ever achieved without enduring much." St. Catherine of Siena](#)

From: [Lisa Pleskach](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: No Scientific Evidence!
Date: Monday, September 19, 2022 12:06:51 AM

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Children are in our care and we need to ensure a cautious slow approach that takes medicalization out of the picture.

The options being pushed are unethical with no scientific backing.

The risk of harm is huge when there is an absolute lack of knowledge about the outcomes of our future generation.

Please protect our children.

Lisa Pleskach

From: [Linda criswell](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Medical, transitioning and minors
Date: Monday, September 19, 2022 11:24:41 AM

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To be brief, I do not feel that this is a good or ethical idea for the following reasons.

1. although transgenderism is present in only a minority of the population, there has recently been a huge increase in the number of school children claiming to be transgender, up to 30% in some schools. This is thought to be because this is the current “in” thing to do and a way to stand out and get attention, even though gender dysphoria has not been present since a very young age.
 2. There is data indicating that a large percentage of people who do transition regret it, and have to live with this decision, or find a way to transition back. Since they often do not return to the original surgeon, who participated in their transition, this is not well documented.
 3. Although much has been said about gender, dysphoria, causing people to commit suicide, I believe that there is an equal amount of suicide after transitioning when the person finds that this does not solve their problems.
 4. About 80% of children who do say they want to change their gender change their minds by the time they become an adult. I think many of us can remember, wanting to belong to the other gender for various superficial reasons when we were children But this was transient and luckily, our parents did not take it seriously. Before drastic measures are taken there needs to be in-depth counseling of the child and the parent to determine what is at the root of this desire and in most cases surgery should wait until the child is an adult and can make more informed decisions.
 5. Children are not capable of foreseeing the long range consequences of such a decision.
- Sent from my iPhone

From: [Lisa Nainggolan](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Written submission from parent prior to Florida Board of Medicine Meeting
Date: Monday, September 19, 2022 7:49:16 AM

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I write to you as the parent of a trans-identifying teen, aged 17, from the UK. A girl who says she is a boy and who requested the use of male pronouns and a male name at school two years ago (when only 15), a request to which the school agreed without the knowledge of us, her parents. In fact, they hid the fact from us for two months, and paid no heed to my pleas when we did find out, to consider reversing the change. They - without any specialist knowledge in this field - seemed to believe that 'social transition' was a harmless concept. It is not.

Luckily, we live in the UK and my child has not requested any hormones to transition, or any surgery. Of course, this may all change when she becomes an adult (age 18) , next July. But for the time being we are 'safe'.

I have talked to my daughter extensively about this and said, "If you still feel this way when your brain has matured, around your mid-20s, then lets talk again.

But in the meantime, you are a biological female (a fact that, to be fair, she acknowledges) and you cannot ever BE male. All you can do is take opposite sex hormones and 'pass' as the opposite sex and have body-altering surgeries, should you so wish. I have emphasized to her the side-effects of cross-hormone therapy, many irreversible, and the obvious irreversibility of any surgeries. I have said, "You'd better be damn sure before you do any of this, that it's what you really want. And that you will be able to sustain this life-long adherence to such medical treatment."

I do not believe that the vast majority of 'gender experts' in the world are acting in the best interests of children. They are 'affirming' a self-diagnosis of 'being trans' which they would not DO in any other condition (eg anorexia). I believe that gender dysphoria is first and foremost a body dysmorphia. My daughter was incredibly girly growing up, but after she started her period, that's when she became uncomfortable in her female body. I do not believe that she wants to 'be' a male, rather I'm convinced that she is just not ready yet to be a woman.

I would strongly urge you, at the Florida Board of Medicine, to severely restrict all prescribing of puberty blockers, or cross-sex hormones, to under 18s. In cases where parents truly believe such treatment would be in the best interest of their child, I would suggest the conduct of a proper clinical trial, where the children are followed long-term (most youth receiving hormones and getting 'gender' affirmative surgeries are not followed anywhere in the world).

Also, in the case of youth aged 18 to 25, I would strongly implore you to look at the 'informed consent' model used to justify 'gender-affirming' care - again, I don't believe these young people are sufficiently mature to understand the implications of what they are undertaking. Surgeons have not historically performed hysterectomies on young women under 25 - even if they have begged for them for example due to severely painful endometriosis. The young woman claiming that she doesn't want children at that age is deemed not reliable, as they may change their mind as they get older. Why should this be any different for a young woman who wants her womb removed because she wants to pass as male??

Thanks for considering my submission

From: [Siggy](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Dysphoria Recommendations
Date: Monday, September 19, 2022 11:26:54 AM

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Dear Board of Medicine members,

As a physician dealing with patients of all walks of life, including transgender patients, I would like to remind you that we all have a most important responsibility: Protect our children from “well meant” but utterly misguided attempts to change their gender and feed into their “gender confusion”.

Children are NOT mature enough to make these decisions on surgeries and drugs. Just because we can do a thing doesn't mean we should. I have seen many several adult patients with previous gender changing measures and their lives have been misery. I will refer you to an article that does make it real of what we do not want:

<https://thefederalist.com/2019/10/24/it-should-be-illegal-to-give-children-transgender-hormones-and-surgery/>

Scientifically, I just want to reference the recent extensive review of the literature in the United Kingdom by Dr. Hilary Cass. The conclusion was that the quality of evidence supporting medical transition was deficient. Just to remind you that these findings have caused the UK, Sweden and Finland to change their approach to minors with gender dysphoria. Certainly, Florida should also undertake a slow and cautious approach to gender dysphoria in minors, emphasizing mental health evaluations rather than jumping quickly to medical transition. (<https://cass.independent-review.uk/publications/interim-report/>)

It is your and our societal responsibility to not allow treatments that are “experiments” on minors.

Thank you,

Siegfried O.F. Schmidt M.D., Ph.D., FAAFP

Sent with [Proton Mail](#) secure email.

From: [Lana H](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Care for Children
Date: Monday, September 19, 2022 1:39:54 AM

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To: Paul A. Vazquez, J.D.

Dear Sir -

I am writing to you both as a parent and a trauma informed healing practitioner as you consider regulating gender care.

I strongly urge you and the Florida government to set an important precedent by

- regulating medicalized gender care, especially for minors
- bringing focus back to science-based, holistic methods.

As a mother raising two teenagers, I understand how difficult it is for young people growing up and going through puberty at a time when so much is changing socially, economically, politically and globally.

Many young people from different backgrounds are struggling with their well being post lockdown, and have depression, anxiety, and various mental health challenges.

As a trauma specialist, I have learned that trauma can alienate us from our bodies, which is why so many young people begin to hate their bodies and self harm (cutting, anorexia, identifying as trans). The pathway to healing trauma is to work with our autonomic nervous systems in order to find ease in ourselves again (see references below signature line). Children in distress need somatic, body based therapy in order to heal the trauma from the inside out. They need to have their bodies as whole and as healthy as possible so that they have someplace to come home to when they are ready to heal.

Medicalizing an otherwise healthy body, poisoning it with wrong sex hormones and removing healthy body parts increases trauma rather than relieves it. It also creates medical problems that will continue to compound the existing trauma.

It is hard for me to comprehend, given what we know about children's development, teens, and trauma, that we are even entertaining any other pathway than psychotherapy and holistic care for young people.

I urge you to do the right thing by young people and the parents who are desperate to protect them. Please bring sanity into gender care and put a stop to knee-jerk 'affirmation' and medical harm.

Sincerely,
Lana A. Harel, ScD, PCC, SEP
Mountain View, CA

Sources on trauma and trauma resolution

[Gabor Mate](#)

[Peter Levine](#)

[Bessel Van der Kolk](#)

From: [John Lane](#)
To: [Vazquez, Paul](#)
Subject: Youth Transition
Date: Monday, September 19, 2022 4:12:11 PM

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Dear Dr. Vazquez,

The clinical research in support of youth transition uniformly falls into the lowest rank order of reliability. Given that these interventions are often being performed in patients who, because of their age, are unable to give full informed consent, these practices should be limited to strictly controlled studies under IRB review only. Thank you for your time and attention to this matter.

John I. Lane, MD

Sent from my iPhone

From: [Robert Cranston](#)
To: [Vazquez, Paul](#)
Subject: Upcoming Legislation
Date: Monday, September 19, 2022 5:06:39 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Mr. Vazquez:

There is a lack of quality evidence supporting efforts to medically or surgically alter secondary sexual characteristics in minors with gender dysphoria. In a recent extensive review of the literature in the United Kingdom by Dr. Hilary Cass, the conclusion was that the quality of evidence supporting medical transition was deficient. These findings have caused the UK, Sweden and Finland to change their approach to minors with gender dysphoria. Florida should also undertake a slow and cautious approach to gender dysphoria in minors, emphasizing mental health evaluations rather than jumping quickly to medical transition.

To perform surgeries or other procedures, the issue of informed consent in minors comes up. There is no way that these minors or their parents can fully comprehend the long-term impact that utilizing these experimental drugs or surgeries will be. There is an increasing number of persons who are attempting to undo what was done to them medically or surgically at an earlier point in their lives. Contrary to what some say, many of the changes brought about medically or surgically can never be adequately undone.

Please protect our children.

Sincerely,

Robert E. Cranston, MD, MA (Ethics), MSHA, FAAN
Florida License # ME1516682

From: [Christna Miller](#)
To: [Vazquez, Paul](#)
Subject: Bill regarding affirmation of transgenderism
Date: Tuesday, September 20, 2022 9:52:07 AM

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Hello,

It has come to my attention that there is a bill that will be considered regarding whether or not to affirm the choices of transgender youth, and that the Florida government is looking for input from medical professionals. Feel free to share the statement below.

I am a registered nurse and I work in an Emergency Department. I have cared for numerous individuals who identify as transgender. It is my experience that they do not have a healthy view of themselves. When we consider the actual biology of a human, it is impossible to change from a male to a female, or vice versa. Each cell of the body codes for XX or XY, regardless of what hormones are used to flood the body, or what surgeries are performed. Transgenderism views the body as the problem, but bodies cannot lie. Perhaps the problem is with the thinking of the one who cannot accept his or her birth assigned gender. To try to change this is to damage the body severely. Healthcare providers would do better to explore why such a person has this level of self-hatred, and try to treat that, rather than permanently mutilate bodies. I do not believe a person will ever be at peace or be able to accept himself or herself, if he or she cannot accept who and what they are on this very fundamental level.

Thank you very much for your consideration.

Christina Miller, BSN, RN

From: [Alfred Cioffi](#)
To: [Vazquez, Paul](#)
Cc: [Alfred Cioffi](#)
Subject: FL-BOM AND GENDER TRANSITIONING BY TEENS
Date: Monday, September 19, 2022 4:36:01 PM

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Dear Dr. Vazquez, I hope this email finds you well and in good health.

My name is Alfred Cioffi. Academically, I have a Doctorate in Bioethics (Gregorian U, Rome) and a Doctorate in Genetics (Purdue U). I am an Associate Professor of Biology and Bioethics at St. Thomas University, Miami Gardens, Florida.

In re. teenagers and gender transitioning, a few points to consider:

First, it is well known that the vast majority of gender questioning self-resolves as children transition through the teen years into adulthood. This is within the range of normal psycho-sexual development.

Second, teens -like any of us- are also influenceable by peer pressures and beliefs; but teens generally more influenceable, due to their immature mind.

Third, many parents do not necessarily possess in-depth knowledge of human psycho-sexual development. Therefore, when one of their children tells them that they want to "transition" -perhaps because his/her best friend at school is transitioning-, parents may feel pressured to allow their child to transition too, but without realizing the full life-long implications of this.

Fourth, it has also been published that the suicide rate of transitioned people is at least 15x higher than those who do not transition. I know that Drs. Mayer and McHugh's data (Johns Hopkins) has been challenged and disputed -it starts getting ideological. Even so, even if it's only twice or three times the background suicide rate, that is sufficient reason for pause. And, we can't just keep blaming societal non-acceptance for the discontent, since there's plenty of acceptance in society today.

Fifth, since a full transition is essentially irreversible (loss of genitalia and therefore fertility), we really should wait at least until adulthood, when the person, on average, will have a more mature mind to make this drastic decision. Repressing puberty artificially on teens is cruel, abusive and ethically unjustifiable. Teens deserve at least the chance to finish their biological sexual development before considering this issue.

In sum, I ask you to please refrain from allowing teens to transition, and from parents consenting to their children's transition. This is an extremely serious decision, and should be strictly adult fare.

Respectfully submitted,

Alfred Cioffi, SThD, PhD

From: [Thomas W. Ballard](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Dysphoria
Date: Monday, September 19, 2022 12:30:41 PM

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I believe that there is insufficient evidence to support altering secondary sexual characteristics in minors with gender dysphoria. The extensive literature review of the issue performed by Dr. Hilary Cass concluded that the quality of evidence supporting medical transition was deficient.

Furthermore, I do not believe that minors have the experience or maturity to make gender altering decisions, with or without parental support.

I urge the Board to recommend against making medical transition available to minors suffering from gender dysphoria.

Thomas W. Ballard, MD
206 Baywind Dr
Niceville, FL 32578

From: [joanne.c](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Statement for Florida Board hearing about regulations regarding the practice of gender medicine.
Date: Monday, September 19, 2022 12:37:00 AM

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Dear Dr. Vasquez and Florida Medical Board,
I would like to comment on medical intervention for gender dysphoria and its regulation, for your upcoming hearings.

Normally, I would not want the government to interfere between the physician-patient relationship. However, in spite of the medical interventions for gender dysphoria not being demonstrated to help (as in your own evidence review and those in Sweden, the UK, Finland and even the Endocrine Society finding low quality evidence behind recommendations), the US has adopted the affirmative model for treatment, recklessly and without evidence to back it.

I'm sure you'll get lots of letters saying that major (US) medical societies agree that the affirmative model is appropriate, but I'm sure you also know that the AAP adoption was not based upon evidence ("Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.", Cantor, Journal of Sex and Marital Therapy, 2020) and the Endocrine Society's current position statement also departs from the evidence (claiming gender identity does not respond to external influences, that medical intervention has been established to help, etc., see one rebuttal by Malone et al., 2021). This area of medical practice is full of misinformation (e.g., see Levine et al, 2022), with many clinicians, patients and their families completely unaware that trans identification can be temporary. Treating a temporary condition with interventions which are serious, irreversible and inappropriate once the condition resolves is iatrogenic harm. There is no clear test to determine when trans identification is not the temporary, so caution is crucial. It is also known that many comorbidities might be contributing to a transgender identification, which is why several countries recommend or have put into policy that mental health support should be first line. The misinformation in the US is so bad that even some American clinicians who are supposedly expert, e.g. a new UCSF gender professor, don't know therapy can help gender dysphoria resolve for some (<https://www.gendergp.com/exploring-detransition-with-dr-jack-turban/>). Most people don't seem to realize that long term outcomes are unknown, that even the number of detransitioners are unknown! (The commonly quoted < 4% or < 1% numbers are either from measuring regret too soon, losing track of people who were likely to regret, and/or measuring something besides regret and calling it regret, no one is really keeping track right now, again, how is large scale serious intervention like this happening when even this most basic information is missing??) There is a honeymoon period, regret studies find regret happening at 4,8, even 10 years on average, depending upon the study, so many of the people who will write you saying it is helping them...check back with them later. I believe there is going to be a horrifying flood of detransitioners shortly.

Given the enormous ignorance found in yours and other reviews, it is unclear why these drastic (including interruption of puberty, sterilization of young people and removal of healthy body parts, some of them key parts of the endocrine and reproductive systems) are being done outside of research studies, being done without extensive informed consent and oversight.

By informed consent, I mean factual informed consent, rather than what many young people and even some clinicians believe. In particular, many clinicians follow the affirmative model, which assumes that mental health issues are likely due to minority stress, and which assumes that medical intervention will be beneficial for mental health, gender dysphoria and quality of life, long term. This has not been shown to be true. The model's stance of quickly providing medical intervention as "care" instead of starting with exploratory therapy is also not supported by the evidence, but instead in conflict with it, given that many variants of gender dysphoria resolve with mental health support alone. The "informed consent" model where no mental health evaluation is also used in the US for people over the age of consent; it is appallingly irresponsible as well.

I know many clinicians are aware and afraid to speak up, I know journalists who have tried to speak up and have either been cancelled or gagged. I know many well meaning but misinformed people who think they are supporting trans-identified individuals by trying to get them medical intervention, not realizing that they are in fact working hard to provide inappropriate care which will recklessly interfere with the bodies of many distressed young people in irreversible and damaging ways which will cause them lifelong harm. It is horrifying that this has gone on so long.

The medical profession is not regulating itself on these interventions, so I think it is absolutely appropriate that the state do so instead.

Please support these young people with evidence based care. These interventions should be treated as experimental for people under 25 or who are for other reasons developmentally immature, and be restricted to only extreme cases in highly regulated research studies. It is a travesty that the medical profession is not doing this already, but if they won't do their job, please step in--regulate the medical treatments until the medical profession treats these young people's bodies and futures with respect! Right now, instead, terrible harm is being done.

Thank you for looking into this serious and important medical question,
Joanne

From: [Susan Albon](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Medicalization of Minors
Date: Sunday, September 18, 2022 8:49:59 PM

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First off, thank you for being willing to examine the extremely nuanced issue of transgender medicine in a non-political forum.

I would like to express my deep concern for the current trend in “affirmation care” for transgender youth. Recently our 13 year-old daughter suddenly told us that she feels like a boy. She showed no signs of gender dysphoria prior to her declaration. Since her announcement I have learned that 80% of the girls in her friend group claim a trans-ID and a review of her social media activity revealed an almost exclusive interest in the trans community. To us, there is an obvious social contagion aspect to the explosive rise in transgender identified youth.

In an effort to seek assistance in identifying the root cause of our daughter’s sudden discomfort, we immediately sought professional medical guidance. We were aware of many external influences that were affecting the overall mental health of our daughter and explained these to the professionals assuming they would ask deep questions and address all relevant factors contributing to our daughter’s distress. Unfortunately that was not the case. Once gender is mentioned the child is identified as exceptional and the pathways to healing narrow to ‘affirmation care’ only. The first professional we visited was an adolescent specialist MD who explained to our child that if she “felt trans, then she was trans” and began to explain the steps toward medical transition. All this was covered in our first visit. The second professional we visited was a counselor who immediately labeled our child as gender dysphoric and advised that we support social transition by using her preferred name and pronouns in order to reduce the risk of suicide.

My concern is that we are pathologizing and medicalizing puberty without sufficiently addressing serious mental health concerns. Yes, puberty is a most unpleasant phase of life, but nonetheless it is a very natural phase. We do our children a great disservice when we encourage them to ignore or run away from discomfort rather than teaching them ways to cope and accept themselves. I understand the allure of thinking that a medical intervention will take away one’s feelings of discomfort, but I find it unlikely that a radical physical change will ever satisfy a mental stress. These young people are hurting. It is a strange and complicated world they are growing up in. But what they need from us is encouragement to accept themselves and reality, not pills and surgeries. Please examine robust, peer reviewed data and seriously consider implementing safeguards to protect minor children.

Thank you for your time and consideration,
Susan Albon

From: [Kayla Biltucci](#)
To: [Vazquez, Paul](#)
Subject: MEDICAL TRANSITION OF MINORS
Date: Monday, September 19, 2022 4:52:08 PM

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ATTN: Paul A. Vazquez, J.D. Executive Director Florida Board of Medicine

Dear Director Vazquez,

My 26 year old daughter was caught in the web of social contagion that emerged insidiously into our society while she was an easily influenced adolescent. The influence continued into her late teens and early twenties, and there was little support for any parents to stop it. In fact, most professionals and anyone I spoke with didn't seem alarmed, let her find herself, she is going to be who she is intended to be. Fortunately, although she is socially transitioned, she has not gone any further. My hope is that she will go no further down this road. She never wanted to be a boy/man, and of this I am certain.

This social contagion has caused a tremendous amount of undue pain and anguish for our family, and it continues each and every day of my life. I know this is the case for many many more families with adult children of this generation who were influenced and supported in the most insidious ways by teachers and medical professionals. It will go down as the single most devastating and dangerous social contagion to ever plague our children. It needs to stop and I plead with you and all government leaders within your influence to put a stop to it now.

I am deeply troubled by the continued promotion and advocacy of this insanity from media and professionals who think it is a perfectly sound idea to follow the whims of a child and allow them to make permanent and irreversible decisions to mutilate their bodies to assuage typical adolescent insecurities. Very very few people truly are "born in the wrong body." Very very few...

We need your help to stand up against this social contagion and prohibit medical and educational professionals from pushing this agenda any further. Big money is promoting it and there is no concern for children, their welfare, nor the destruction to so many families.

Please help.

Regards,
Kay Biltucci
Naples, FL

From: [Diane McCarthy](#)
To: [Vazquez, Paul](#)
Subject: No to Gender alteration in pediatric patients
Date: Tuesday, September 20, 2022 8:18:15 AM

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Good morning,

For the sake of the children, please say NO to gender alteration. Parents and doctors, by the sake of their dominion, can lead youth to life-long interventions that complicate their lives rather than enhance their lives, an unjust proposition for the youth of our society.

Diane McCarthy, MD

Sent from my iPhone

From: [Jackie Lopez](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: First Do No Harm. Please stop experimental transgender "medicine" on children and adolescents
Date: Monday, September 19, 2022 2:13:58 AM

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Dear Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

I am a parent of a 16 year old girl, who identifies as transgender.
Our daughter is not transgender: she has struggled since she was 11 with mental health challenges and
with her social anxiety, not to mention low self esteem.
We are constitutionally opposed to the affirmation model and with hormonal and surgical interventions. These are not based on science or ethics for this new population of teenage girls. A very vulnerable population.
Great Britain recently commissioned a highly distinguished public health and pediatric expert to
reconsider the affirmative model in the United Kingdom.
Please consider with care the findings of the Cass Review interim report.
What is the Cass Review interim report?
The Cass Review is an Independent Review of Gender Identity Services for Children and Young People. It was 'commissioned by NHS England and NHS Improvement in Autumn 2020 to make recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence [1].' In March 2022, the Cass Review submitted an interim report to NHS England. This interim report '[set] out [the] work to date, what [had] been learnt so far and the approach going forward [2].'

Who is Dr. Hilary Cass

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020.

A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020).

Although retired from clinical practice, she remains an honorary Consultant Paediatrician at Evelina London Children's Hospital, Guy's & St Thomas's NHS Foundation Trust, where

she was also previously Director of Education and Workforce.

Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah's Ark Children's Hospice. She is also leading work on how to address the challenges for both families and professionals in supporting the rising numbers of children with complex medical conditions and disability.

Other recent roles include acting as the Senior Clinical Advisor for Child Health for Health Education England.

Prior to this Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Paediatrics in London. Her consultant clinical practice was as a tertiary neurodisability consultant from 1992 to 2018 in three very different specialist centres and she has published widely in this area.

In addition to her neurodisability practice, Dr Cass was closely involved in the development of paediatric palliative care services at Evelina London Children's Hospital.

Dr Cass was awarded the OBE for services to child health in 2015. She was also awarded an honorary fellowship by the Royal College of Nursing in 2015, and by RCGP in 2016.

Background

The United Kingdom has seen a significant increase in the number of children seeking help for distress in relation to their biological sex. Many school staff first started noticing the phenomenon of children – predominantly teenaged girls – wanting to change sex during the last decade.

In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (para. 1.1).

From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment (para 3.10).

This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender and gender identity.

Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus (para. 2.4).

No consensus

This being a new phenomenon, research is limited and no consensus exists (within the scientific community) about possible causes and most appropriate treatment options.

At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in

childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual (para. 1.7).

We must secure a balanced treatment of political issues, they must take a child-centred, evidence-based approach, and take care not to express personal beliefs in ways which could exploit pupils' vulnerabilities. We should not for example, present, as fact, childhood gender incongruence as an inherent and immutable phenomenon as this is a contested idea rather than an established evidence-based fact.

Low quality evidence

The Cass Review interim report acknowledges that '[over] the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial' (para. 2.4). Many of us feel confused or conflicted about approaching the issues of sex and gender identity with adolescents. The above-mentioned rise in referrals to GIDS has been accompanied by an increasing number of news reports claiming that some teachers and/or schools are promoting the idea that gender identity supersedes sex. However, there is insufficient high quality, longitudinal data (relating to gender-questioning children) from which to draw robust conclusions. There is a notable gap in the evidence base pertaining to the surge in female teenagers seeking support from gender identity services.

Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint (para. 1.29).

Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally (para. 3.21). It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group (para. 3.23).

Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing (para. 5.10).

This is an area of research where no scientific consensus exists. Schools must be aware that any claims made about the reasons behind the increase in gender-questioning children are speculative and cannot be treated as established evidence-based facts.

Changing epidemiology

Early childhood gender dysphoria is not a new phenomenon. However, the existing literature on treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female and often presenting with a range of neurodevelopmental

and mental health co-morbidities.

In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS (para 3.10).

This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years (para. 3.11).

The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress (para. 1.10).

Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes (para. 1.28).

Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group (para. 5.10).

The Cass Review interim report highlights the difficulties faced by clinicians responsible for making diagnoses and recommending treatment. Teachers are neither qualified nor capable of critically evaluating existing evidence. They must carry out their duties within statutory and non-statutory frameworks. This included ensuring that any necessary referrals are made as specified by their schools' safeguarding protocols.

Diagnostic overshadowing

Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria (para. 4.10).

School staff must be clear that they are not qualified to offer students advice in this area. Moreover, the promotion of specific beliefs about the source(s) of gender-related distress could influence children's attitudes toward the diagnostic process before meeting with a clinically trained professional. Guidance from the Department for Education states that teachers "are in a position of authority and will typically be respected and trusted by the pupils they teach, giving their personal opinions greater weight and credibility. As a general principle, they should avoid expressing their own personal political views to pupils unless they are confident this will not amount to promoting that view to pupils [4]."

Affirmative vs developmental models

Broadly speaking, there are two approaches to treating children with gender-related distress: the gender-affirmative approach and the developmentally-informed approach. The

gender-affirmative approach is based on the theory that a child's gender identity is innate. The developmentally-informed approach is based on the theory that a complex interaction of multiple factors underlie gender-related distress. The Cass Review interim report acknowledges that some clinicians report being under pressure to adopt a gender-affirmative approach.

Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach (para. 4.15).

Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach (para 4.20).

There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies (para. 5.8).

School staff are unqualified to evaluate the merits of these approaches. Moreover, they have an obligation to remain politically impartial. This means not supporting one approach over another.

Social transition

Social transitions (the act of treating children as if belonging to the opposite sex) are performed by some schools in England. A social transition is a powerful psychological treatment that affects a child's psychological development. Not only are school staff unqualified to judge the appropriateness of such interventions, the outcomes are poorly understood.

Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes (para. 5.19).

Pressure

The Cass Review interim report acknowledges the pressures clinicians are under to adopt an unquestioning affirmative approach. Similarly, there is an acknowledgement that children are under pressure to identify with societal stereotyping. Schools cannot erase the

pressures that children are under from, for example, social media and peers. However, teachers should promote acceptance for children's non-stereotypical behaviour (boys and girls exhibiting stereotypically 'feminine' and 'masculine' behaviour, respectively) and avoid reinforcing harmful stereotypes.

Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters (para. 1.14).

From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision (para. 1.18).

It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services (para. 2.5).

We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long children and young people are waiting to access services (para 4.13).

These will be considered further during the lifetime of the Review and include: . . . The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years (para. 4.14).

Safeguarding

Children with gender-related distress may pose specific safeguarding concerns. They have a higher incidence of comorbid psychiatric and/or developmental difficulties. They are also more likely to be looked after children. Teachers need to be aware of possible harms such as breast binding or tucking (of male genitals). Children may also be subjected to grooming and/or coaching, and encouraged to deceive parents, clinicians and teachers in order to secure particular outcomes such as clinical diagnoses of gender dysphoria. They may also be receiving cross-sex hormones from unregulated sources.

In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children (para. 3.11).

We have also heard about the distress experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts (para. 4.3).

Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria (para. 4.4).

We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation (para. 4.5).

We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment (para. 4.7).

Summary

There has been a huge increase in the number of children (predominantly female teenagers) seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making diagnoses and recommending treatment. School staff who now affirm my daughter are neither qualified to evaluate existing research nor clinically trained.

Therefore, they cannot judge the appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development. The Cass Review interim report outlines some of the specific safeguarding issues that surround gender-questioning children.

Thank you most sincerely for your time and consideration.

Kind regards,
JackalynnLopez
714-585-1446

I would be happy to discuss this further with you.

From: [Kelly](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming
Date: Sunday, September 18, 2022 8:01:08 PM

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Please, please, please do NOT consider gender affirming CARE. It's not care; it's destructive. Please don't buy into the Transgender ideology that has trapped many youth including my daughter who are so vulnerable. They are too young to be making harmful medical decisions. And medical gender affirming treatment is harm, long lasting harm, destructive harm that can't be taken back.

Stop gender affirming for youth and children!!!
Please !!!!

Kelly Rummler
Sent from my iPhone

Florida Medical Board Affirmative Therapy Submission

We are an Australian family. We love and respect our 23 year old daughter who identifies as a transgender male and is in the process of transitioning. She was prescribed testosterone injections by a medical practitioner, which she is now self administering and will be doing so for the rest of her life. It is difficult to express the heartache that this has caused her father and myself. We are not satisfied that the path that she is currently on is the best way for her to deal with her gender issues and we are worried about her future health both physically and mentally.

At no stage in the process of gender identification and transition has she consulted with a psychologist, something that has been of great concern for us. We have urged her to seek psychological counselling to deal with underlying mental health issues that may be associated with the body dysmorphia and gender dysphoria she has been experiencing.

As deeply concerned parents, we researched transgenderism and found that not only is gender dysphoria included as a mental disorder in the DSM4, studies have shown that there is a potential higher prevalence of ADHD and ASD among transgender individuals. It is clear that transgenderism is a psychological disorder. Our belief is that surgery and hormone therapy is not the way to properly treat the problem. There is nothing wrong with the body of a transgender person, there is a disconnect with the person's perceptions of their body and this is where treatment should be first directed.

Our daughter has symptoms of ADHD and has through adolescence experienced trichotillomania (compulsive hair pulling) and tics, therefore, it appears that our daughter's anxiety regarding her gender may be ameliorated by rational psychological approaches instead of the life altering and potentially dangerous avenue of gender affirmation treatment. To our thinking, it makes sense that treatment for associated conditions such as ADHD or OCD and anxiety/depression, should be the first strategy in treating transgender individuals; hormone therapy and surgery should be considered only after a careful psychological and complete medical evaluation.

Another concern we have as parents is that the long term negative impact of testosterone on the body of female to male transitioners has not been evaluated, especially in cases of polycystic ovary syndrome. Transgender males have a higher than average rate of polycystic ovary syndrome and a case has occurred where a transgender male developed ovarian cancer while receiving testosterone as part of their transition. While this is only one reported case, there is little evidence to show that long term testosterone injections have a benign impact on ovarian tissue. The five year survival rate for ovarian cancer is 45.7 percent, an alarming statistic that should not be ignored when it is clear that testosterone is being indiscriminantly injected into healthy female bodies, and all that an individual has to do to have this hormone prescribed is to state that they have a belief that they have been assigned the incorrect gender at birth.

Testosterone was prescribed to our daughter by a practitioner without any other medical or psychological evaluation having been presented. We find this highly irresponsible and frankly,

dangerous to her future health and well being.

As parents of a daughter who is transgender, our worries revolve around the activity of those members of the medical profession who see fit to, and profit from, indiscriminantly prescribing gender affirming drugs, as well as performing life altering surgeries on transgender individuals, who research has shown are suffering from a mental disorder that is being allowed to go unevaluated and untreated.

Diane and John,

Adelaide (South Australia)

Sept. 20, 2022

From: Angeles
To: Vazquez, Paul; BOM.MeetingMaterial@flhealth.gov
Subject: End the transitioning of children
Date: Monday, September 19, 2022 4:10:04 PM

[You don't often get email from rosegold200123@gmail.com. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Paul A. Vazquez, J.D. ,

I am the parent of a teen who became confused about his gender a few months after covid first hit. However, we did not find out about his "new" identity until last year. My child never showed any signs of gender confusion in his childhood. He was what we call the typical boy who loved everything that had to do with boys. He loved playing outdoor and getting dirty. Never showed any distress with the clothes he wore and always loved playing with boy toys (cars, trucks, trains, etc). His gender confusion came after the amount of time he spent on the internet during covid lockdown.

In the last year we have tried helping our child by removing social media and blocking certain sites from his phone and computer. We also tried finding him a therapist. However, after doing some research and speaking with other parents who are in this same situation as us, we came to the conclusion that no therapist is better than a bad one. You see, once the gender topic comes up, therapist and other specialists now put everything else aside and just focus on that. Then they send kids/young adults to a gender clinic where they are placed on crossed-sex hormones and then have irreversible surgeries. But of course you know all that. That is now what these children and young adults need. We need stop putting them into a path of irreversible damages.

A lot of this children suffer from anxiety, depression, ADHD, autism, and bullying. Some were sexually assaulted and have not been able to speak about it.

Our child, for example, was a victim of bullying while he was in middle school. Sadly we did not find about it until he no longer attended the school and he refuses to tell us what happened to him.

Although we do not affirm his new identity, we love our child and nothing will ever change that. We worry about him and his future if he continues on this path. For now, he has only come out to his closed friends at school who celebrate his new identity and affirm him. Friends of which most are also calling themselves trans or non-binary.

I don't understand how professionals like yourself are blinded by what is happening out there. In the past few years, we have seen an enormous increase of children identifying as trans, specially after covid lockdown. Children are being told that if they feel a certain way, it is because they were born in the wrong body. What kind of nonsense is that? This ideology makes it seem like we walk into a store that sells infant parts and we put them together just like we do with the Mr. Potato Head toy. It's ridiculous. We all know no child is born in the wrong body.

I ask you, actually I beg you to please put a stop to this medical malpractice happening with children and young adults. We need you to create a rule that will prevent doctors from bring able to prescribe experimental puberty blockers, cross sex hormones and perform any type of gender affirming surgeries such as double mastectomies, vaginoplasty or phalloplasty on minors. Below you will find reasons why we need to put a stop to this.

- There is a lack of high-quality rigorous evidence surrounding these treatment procedures, which make them experimental in nature since the long-term consequences of these drugs being used on children/teens are relatively unknown. There is also a lack of debate among medical professionals in this area because doctors that speak out against these treatments being used on children are silenced. Alternate treatment options are not being considered or even presented at this point in medicine. It appears activism has infiltrated our medical community on this issue and biological reality is being ignored.
- The side effects we are aware of often times lead to the sterilization of these individuals and the loss of any future sexual function when puberty blockers are used.
- Children and teen brains are not fully developed until age 25 and therefore they cannot give informed consent because they don't have the ability to fully understand the consequences of these treatments. Parents are also not

being given the full picture and all treatment options available to them like the watchful waiting approach. They are being told to only affirm or their child will commit suicide. They are also not told that through the watchful waiting treatment approach, many of these children, upwards of 80%, would resolve their distress during or shortly after puberty. There is also no evidence that medical transitioning children actual improves mental health outcomes.

- Proper assessments are not being done and there is little to no safeguarding in place before a child is placed on a medical pathway. Many of this new cohort of children/teens do not even meet criteria for gender dysphoria, yet they are being treated medically for the “feeling” in their mind that they should be the opposite sex. They are experiencing normal discomfort with their pubescent body, but are being convinced that any amount of discomfort with their body is an indication that they are “transgender.” There is currently no coherent definition of the word transgender in the medical field.

- Co-morbid issues are being unchecked and unresolved in the name of gender affirming care and patients and parents are being told that medical transitioning will fix their child’s distress.

- We are now seeing the population of detransitioners increase every day because they come to the realization that medical transitioning did not fix their pain and many are stating their co-occurring mental health issues were ignored or not explored.

- Medical organizations and associations are blindly adopting guidelines from WPATH without doing a proper review of the evidence being used for these guidelines. These guidelines are being pushed as actual standards of care, which is a gross misrepresentation of what these guidelines are. Further, professionals that are speaking out against these guidelines or advocating for a review of existing literature are silenced through gaslighting or simply ignored as in the case of the American Academy of Pediatrics.

- Other countries like the UK, Sweden, Finland and France are re-evaluating these medical treatments for children because they have done a rigorous review of existing literature and research and have come to the conclusion that the risks do not outweigh the benefits in children and there is just so much we don’t know about the long-term consequences of these irreversible interventions. These countries have either stopped medical transitioning minors or are advocating for great caution when medically treating children for gender dysphoria. They are all stating mental health treatment should be the first line of defense, which is not currently happening in the US.

- Despite what the media reports, these surgeries are occurring on children. Many hospitals state openly they are performing double mastectomies on children ages 16 and up and sometimes as young as 15, as stated in the new WPATH guidelines that were set to be released this month. In addition to the pediatric gender clinics in Florida hospitals providing these medical interventions, there are many private plastic surgeons, OBGYN offices, private endocrinologist offices and pediatricians prescribing puberty blockers, cross sex hormones and operating on minors. They claim parents give consent, but should a parent be allowed to consent to experimental medical treatments for their child for a mental health issue? Should parents be able to consent to amputating healthy body parts for their children and taking away their fertility and ability to have a child as an adult?

Again, I ask you to please help put a stop to this by creating a rule that will protect our children from being used as experiments.

Sincerely,

J.C.

Ted Hudacko

3030 Clinton Ave.
Richmond, California
C: (408) 482-0412
thudacko@rocketsciencesystems.com

September 18, 2022

Paul Vazquez,
Executive Director of the Florida Board of Medicine
Tallahassee, Florida

Subject: Necessary Regulations on “Gender-Affirming” Care

Dear Mr. Vazquez,

I am writing to provide input to the Florida Board of Medicine as it considers regulations around so-called “gender-affirming” care, especially as it pertains to minors and intersects with parental rights.

I am the father of two sons, including a now-18-year-old who is being seen by Dr. Stephen Rosenthal and Dr. Diane Ehrensaft, the co-directors of UCSF Child and Adolescent Gender Center (CAGC). My family’s story was the subject of investigative journalism stories earlier during 2022 that went viral worldwide:

- <https://www.city-journal.org/child-custody-gender-gauntlet>
- <https://www.dailymail.co.uk/news/article-10489717/California-father-denied-custody-trans-son-wouldnt-consent-therapy.html>

Dr. Rosenthal also is an expert witness retained by the Plaintiffs in *Eknes-Tucker v. Marshall* federal lawsuit challenging Alabama’s Vulnerable Child Compassion and Protection Act (VCCAP).

I have read Dr. Rosenthal’s Declaration against VCCAP. I can testify that his statements regarding the standard of care for transgender children, and particularly his claims that parents have the opportunity to exercise informed consent regarding medical interventions for their child are not true with regard to my son when he was a minor.

Dr. Rosenthal claims that medical treatment is done in consultation with the patient's family. In my case this is not true. Dr. Rosenthal's institution (UCSF CAGC) has actively worked to prevent my son's care to the point of providing information to the attorney representing my son in family court aimed at stripping me of custody because I would not affirm my son in a discordant gender identity. Some of the information provided was untrue.

In fact, I knew nothing about my son receiving life-altering medical interventions until I received a statement from my insurance carrier showing that it had paid more than \$200,000 to a child and adolescent gender clinic at UCSF. Even then, I did not know what the payment was for until I asked my ex-wife. She emailed me that she was "happy" to report that our son had been given an implant of Supprelin (used to suppress testosterone) and was receiving estradiol (estrogen) pills.

My research on these substances showed that they chemically castrate patients and are even used specifically for that purpose in some cases for sex offenders. Yet here my 17-year-old son was receiving these drugs from Dr. Rosenthal ostensibly to improve his health and well-being.

I have learned that Supprelin is Dr. Rosenthal's preferred method for administering puberty blockers for adolescents like my son. Supprelin requires surgical implantation, meaning that it is a surgical intervention administered to children under the age of 18, which is contrary to Dr. Rosenthal's testimony that surgical interventions are not prescribed to minors and not recommended by the "Standards of Care."

According to Breitbart News, Dr. Rosenthal has received more money from pharmaceutical manufacturers of the puberty blockers he dispenses than any other doctor: <https://www.breitbart.com/health/2022/07/26/childrens-gender-clinic-founder-was-consultant-puberty-blocker-manufacturers/>

Dr. Rosenthal's testimony also contradicts his actions with my son in that after UCSF implanted my 17-year-old son with Supprelin LA (without my knowledge or consent but paid for by my health insurance), Dr. Rosenthal discussed follow-up surgical options with him without at least one parent present. Dr. Rosenthal discussed breast implants, facial feminization, and bottom surgery with my son at age 17 years and 5 months.

Rosenthal claims to "provide the patient and their family the information they need to make an informed decision about whether to proceed with the treatment." Again that is not true regarding the treatment prescribed for my son. When I sought

information about alternatives, such as “watchful waiting,” and whether patients are assessed by Ray Blanchard’s typology of transsexuals, instead of receiving an answer I was subjected to actions in the family court aimed at stripping me of custody because of my questioning of the protocols at UCSF.

Similarly, when I provided Dr. Rosenthal with research that I had found which suggests that puberty blockers can cause cognitive harm and asked questions I received no response, contrary to his testimony that parents are involved to ensure everyone involved has the information they need to make an informed decision.

Further contradicting his claim of “informed” decision-making is seen in the form presented to and discussed with my then 16-year-old son. The form did not indicate that permanent and irreversible sterility is a potential and likely outcome of the recommended treatment, particularly when puberty blockers are combined with estrogen.

Dr. Rosenthal’s actions with regard to the treatment of my son differ significantly from the “safe and effective” protocols that he claims are part of “gender-affirming” treatments. His refusal to respond to my questions as the concerned father of his patient belie his testimony about the information-rich and collaborative environment he claims is part of the “gender-affirming” care he provides.

My experiences with Dr. Rosenthal instead point to an ideologically-driven conveyor belt onto which vulnerable children like my son are placed and processed without the safeguards usually inherent in medical procedures.

Parental participation is tolerated only so long as it is affirming of the ideology. If, as in my case, the parent asks questions instead of immediately affirming the agenda, then that parent is disregarded even to the point, as in my case, of having their rights stripped away.

The availability of “gender-affirming” medical interventions for vulnerable children experiencing distress about changes in their bodies enables the ideological conveyor belt to proceed unhindered, leaving in its wake sterilized, drug-dependent and dysfunctional young adults, shattered relationships, and distrust in the medical profession.

The Florida Medical Board’s efforts to ban these treatments for minors is necessary to prevent the irreversible and incalculable harms caused by the unchecked gender medicine machine and save Florida families from similar devastation.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Edward H. Hudacko".

Ted Hudacko

CC: Erin Friday, Esq., Our Duty

Candice Jackson, Esq.

Patricia Campbell, Esq.

From: [Torren Danowski](#)
To: [Vazquez, Paul](#); BOM.MeetingMaterial@flhealth.gov
Subject: Board of Medicine Meeting- Re: Youth Transition and Informed Consent Process
Date: Sunday, September 18, 2022 6:57:30 PM

You don't often get email from torren.danowski@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

To the Florida Board of Medicine:

My name is Torren Danowski and I am a 33 year old male who has desisted from a transgender identity. I prefer the term desisted because thankfully, I never "completed" a full transition process. I am grateful that at my age, I had the self-awareness and introspection to see that affirmative care for my gender dysphoria was nothing more than treating a symptom of much deeper issues. It was as though I was being given morphine for the pain of a broken leg, without the leg itself being treated.

I write to urge your consideration that the current informed consent model being touted by trans activists is incredibly dangerous, especially for younger children. The medical codes used during my treatment that allowed for my prescription for cross-sex hormones indicated that I had a, "disorder of the endocrine system." No such disorder existed. My endocrine system was producing the correct sex hormones based on my biology. However, the informed consent model allowed me to self-diagnose a physical condition that did not exist and be administered drugs that needlessly altered an otherwise healthy body.

I am thankful that because of my age and my community, I was able to continue wrestling with my decisions until I found freedom from the real underlying condition- my mental health and my own self-hatred. Had I not continued to wrestle with my decision, I would have never gotten healing from what actually ailed me and would have continued on trying to live life as transwoman when what I really needed was to learn to love myself as I was.

Informed consent implies that the individual undergoing treatment understands the costs and benefits of the desired treatment. I would argue that under no circumstances can an individual truly know all the costs of attempting a gender transition. I desisted when I realized I had a desire for biological children. I'm 33. No youth will be able to accurately assess their desire for such things until they are much older. This is why doctors often rightfully will not perform sterilization surgeries on young adults. In no circumstances should sterilization, chemical or surgical, be performed on someone not even old enough to vote.

Instead of either supporting or blanket-banning gender-affirmative care such as youth transition or informed consent, I would humbly ask that the board of medicine and all doctors and scientists involved would do more research on what actually causes gender dysphoria as well as potential alternative treatments. There is quite a bit of anecdotal evidence that both Cognitive Behavioral Therapy and psychedelic-assisted therapy can go a long way towards easing and even eliminating gender dysphoria.

Seeking to treat and cure the cause of dysphoria should always be the first option, with transition only being a last resort. If seeking to treat the cause is the first step, that leaves very

little room for an informed consent model, especially for youth.

Thank you,

Torren Danowski

From: [Yiotula Shilland](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Fwd: Gender Care
Date: Monday, September 19, 2022 12:13:44 AM

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Begin forwarded message:

From: Yiotula Shilland <yiotula@gmail.com>
Subject: Gender Care
Date: September 19, 2022 at 1:08:15 PM GMT+9
To: BOM.Meeting.Materials@flhealth.gov

Dear Mr. Vazquez,

I understand Florida is considering regulating gender medicine. I know that every story is different, but I feel that you need to hear our perspective. We are a Military Family stationed in Seoul, South Korea (residents of Florida). When we arrived in Seoul she was gender conforming. Always wore skirts to school, did her nails, wore dresses most of the time out of school. She liked singing and art. She's academically gifted. It was a hard transition. Girls in Korea are super thin with no curves. Our daughter struggled with puberty, growing into her adult female body was painful. She started hanging out with some kids in our neighborhood and suddenly the whole group was identifying as trans. It didn't sit right with me, this child at this point it just didn't make sense. We decided as her parents to take a loving, but stern approach. We did not allow binders, we did not allow social transition at school, we did allow haircuts (shaved head), and she could choose her own clothes. She got very sad, she hated us, she often wrote in her journal that we were bigots and horrible people. We talked about life, that it's long and teenagers don't always have the answers, we talked about medical complications from transition, we got her involved in activities that didn't allow her to wallow in self pity. We also said we accept whoever you become as an adult but now is the time to play with your clothes, your hair, your hobbies, your schoolwork, and everything with sexuality (and gender) will fall into place eventually.

I won't lie the 18 months were terribly difficult, we were often at odds with each other. Friends questioned whether we were being supportive enough. Luckily, schools in Korea are quite conservative so she didn't get much validation at school of this "identity". Living in Korea is not easy for any of us because of various circumstances, but I am grateful every day that my child didn't have an adult concretizing her teenage

"identity". In the past adults never really got involved in a kid's life. There was a separation that I think is healthy. Our teachers didn't obsess over our personal lives. We were free to try things to experiment and grow and learn without the

pressure of an adult cheering or jeering our social choices. My teen did have validation from friends and I feel that she knows that we accept her no matter what but, happened to be skeptical that medical care was necessary for her current situation.

The friends moved away, as they do in military life, and my daughter came back to us. She came to me and said she felt like she woke up from a bad dream, that the trans things she had dedicated her life too didn't sit well with her, she said she felt like she was leaving a cult and that she felt better and happier then she had in the last two years. That's what can happen when you sit with something for a while, when you aren't pushed, when you have time and perspective.

I read the stories of other parents who are not so lucky. The "Glitter Family" grabs these kids and tells them x will make you better, then it does for a while, until you need more and more and in a lot of cases it's never enough. You have to come to peace with who you are. No one should be affirming children especially Counselors and Therapists. If anything they should ask them to question everything and saying that stereotypes don't matter. They shouldn't tell them they aren't trans either, that's not the job of a counselor or therapist. They should only explore and allow the person to make their own decisions. I truly believe that most cases of gender dysphoria resolve naturally after adulthood. Some kids will end up gay, some won't and a very few will have to take further steps to relieve this dysphoria, but what's the rush?

Please take steps to save our children, to let them have time and perspective before they do irreversible damage to their perfect bodies.

Thanks for your time,
Yiotula Shilland

Sep 2022

Dear Chairman Diamond,

Thank you and the Board of
medicine for protecting minors from
"gender affirming" treatment. It's
even hard to think that children
would be put through such
treatments and schools, counselors, et
encourage such. We're killing + injuring
our greatest assets with experimental vaccine
and crazy treatments - all due to politics.
Thank you for standing firm - Kent + Cathy Seland

Dear Board Members,

I would like to tell you about why I believe a slower approach should be taken in regards to gender transition versus affirmative care.

My 21 year old son, "B" went to Planned Parenthood and was prescribed male to female hormones on his first visit.

B has a genetic mutation; SDHB which is called c.287-1g>c. This type of SDHB mutation can cause renal and papillary thyroid cancers, pituitary adenomas and also, an increased risk of developing paragangliomas or pheochromocytomas. These types of tumors are more likely to be malignant. Studies have shown that there is a **77-100% chance** of B **developing cancer** between 30-50 years of age. *See attached for additional information in regards to this mutation.*

Given that Estradiol is a hormone that is known for causing cancers, and with my sons predisposition of developing cancer/s (***in organs, that produce and regulate hormones!***), it seems like common sense that taking Estradiol and/or other similar hormones could be very dangerous to him. Yet, **he was prescribed Estradiol** on his very first visit **without any consultation** of his **Endocrinologist, Oncologist, Primary Care Physician nor his Genetic Counselor.**

Here is a bit of our family health history:

- B's father was diagnosed with **kidney cancer at age 32!** One of B's cousins was diagnosed with **kidney cancer and paraganglioma tumors, also at age 32**, and he **passed away within four years** of diagnosis! A second cousin developed **cancer at the age of 21 and died by the age 24!!** There have been many other family members with cancer and it is assumed they also had/have the genetic mutation. ****Estradiol can cause cancer!***
- There is a **very strong history** of heart disease in our family! B's father had a **heart attack at 47** years old, his maternal grandfather had a **heart attack at 34** and died on the fourth heart attack at 38 years old. Also, a second cousin died of a **heart attack at 31** years old! ****Estradiol can cause cardiovascular disease!***
- **Blood clots** (which can be hereditary) are also common in **both sides of our family!** Uncle's on from each side have had more than one blood clot at young ages. ****Estradiol can cause blood clots!***
- **Brain aneurysms** run in his family too! B's **grandmother had a brain aneurysm** that ruptured causing a hemorrhagic stroke. Her aneurysm lead to other family members being checked for aneurysms. **Myself and B's aunt also have/had brain aneurysms.** ****Estradiol can cause strokes!***
- Many family members have Diabetes. ***Estradiol can cause Type 2 Diabetes!***

****Link to estradiol side effects according to Mayo clinic:** <https://www.mayoclinic.org/tests-procedures/feminizing-hormone-therapy/about/pac-20385096>*

B suffers from **depression** and has been diagnosed with **ADHD** too. I do not believe that B was of sound mind and psychology stable when he went to Planned Parenthood but a Psychiatrist, nor Therapist, nor any mental health professional did an evaluation of him before prescribing hormones to him. Perhaps if B worked with professionals for his depression and ADHD he might feel differently about transitioning but this was not offered as a solution. Wouldn't it be smarter to first try a non-invasive treatment, especially with B's medical history?!

There needs to be more time for these doctors to thoroughly determine whether the patient should proceed down the path of medicalization. Synthetic hormones can have many detrimental side effects and everything should to be taken into consideration before patients are prescribed hormones.

Patients should be required to submit medical records, have family and friends testify that they are mentally stable and have a proper psychological evaluation done. Additionally, the doctor should provided proper statistics about people that have detransitioned and patients should be **fully** taken through the **risks of hormones, surgeries, etc.** They should not just given a consent form to sign with a bunch of legal information that no one ever reads. Especially, when working with a minor or a young adults whose brains are not yet fully developed to process all the ramifications.

With B's health history and the long list of family member's serious health issues, B should have been required to consult with an Endocrinologist, Oncologist, Primary Care Physician, Genetic Counselor, Neurosurgeon, Urologist, Cardiologist and a Psychiatrist prior to starting any hormones.

Instead, a **gynecologist** prescribed hormones to **my son** and within **four months** he ended up with **two brain tumors**, one in the pituitary gland the other in the left frontal lobe. I can provide mri scans from year prior to him taking hormones and mri 4 months after starting hormones. I am happy to provide medical records as well if you would like to see.

Mom of B

From: [McGovern, Jeffrey \(AHN\)](#)
To: [Vazquez, Paul](#)
Subject: gender issue
Date: Wednesday, September 21, 2022 11:30:06 AM

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Dear Dr Vazquez:

As a physician for well over 30 years, I want to voice my concern about the danger of rapid gender transition of youth. The rapid process in my professional opinion leaves this vulnerable population in danger. In addition, the lack of informed consent in this population and the absence of input from the families of these minors is outrageous. I ask the State health Department to take a mature view and to tone down the ideological volume voiced by those who prefer ideology over science. Thank you for your timr.

Jeffrey McGovern, MD

From: [Joanne Castillo](#)
To: [Vazquez, Paul](#)
Subject: Gender dysphoria
Date: Tuesday, September 20, 2022 11:55:59 PM

You don't often get email from joanne.e.castillo@gmail.com. [Learn why this is important](#)

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Dear Florida Board of Medicine:

I am a Board certified Family medicine physician, and recently read that you will have meeting to consider implementing regulations related to sex based medicine practices. I am deeply concerned about “gender transition” of minors and the importance of informed consent and parental consent, especially when there is medical evidence of the long term harmful effects of those treatments, and that simple waiting and counseling help the gender confused patient. It is of utmost importance to restrict these misguided interventions and protect the youth of the state of Florida from unnecessary and lifelong harm that results from surgical and hormonal treatment, including physical and chemical castration, and the sterilization of minors which should be considered permanent. There is medical evidence that “gender-affirming care” treatments have dangerous and harmful effects that include cancer, osteoporosis, depression and increased risk of suicide. The vast majority of children with gender dysphoria will have a resolution of symptoms over time, with observation and counseling. We now know that in identical twin studies, the tendencies to have same sex attraction correlate with the sociocultural influences and the environment, and not with genetic information, and that over time there is a high probability of resolution. Our goal as physician is to help with healing and do no harm, and the “gender affirming care” is not a cure, but a harmful path of lifelong suffering.

Sincerely,
Joanne E. Castillo Rivera, MD

From: [Mary McCrossan](#)
To: [Vazquez, Paul](#)
Subject: Sex based medical practice
Date: Tuesday, September 20, 2022 9:09:46 PM

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I am writing to support best care for children by protecting them from medicines and surgical procedures that would purport to help them affirm their true gender.

With more study and data, physicians have become increasingly aware that the effects of these therapeutics can be deleterious and not reversible as previously believed.

This is especially tragic, given that the majority of young people with feelings of gender dysphoria will eventually become comfortable with their biological sex.

Thank you,

Mary McCrossan, M.D.
Board certified family physician

From: [Lily Ding](#)
To: [Vazquez, Paul](#)
Subject: Florida Board of Medicine: regulations regarding the practice of gender medicine
Date: Tuesday, September 20, 2022 11:32:44 PM

You don't often get email from lilyding@gmail.com. [Learn why this is important](#)

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Hi, Mr. Vazquez,

I am writing to you about gender affirming care and the lack of scientific approach associated with the whole process.

My 20 year old son was captured by the gender cult right before he celebrated his 19th birthday. Since then our family has been torn apart, my son's mental health deteriorated, quit his dream college and lost / cutoff almost all of his childhood friends. My husband and I also suffered mentally, physically and financially, so did his 14 year-old brother who had been caught in the crossfire. Thankfully, my son is finally sobering up after more than one year of psychotherapy and medication. He is examining his comorbid conditions and doing gender exploration therapy. As a result, he becomes more human vs. previously a gender ideation rhetoric repeating machine. While I am encouraged by his progress, I think nobody should have gone through this kind of excruciating pain trying to help your beloved child make a well-informed vs. impulsive decision, while the whole world seemed to be against you. The schools, the media, the medical professionals all blindly affirm. It's as if, the minute the word "gender" was mentioned, everyone turned into a machine that can only affirm no questions asked. I don't think this is scientific and I don't believe public funds should be spent as blindly and politically as this. But, you don't have to take my words for it. This research said it all. Please read this scientific paper.

" the outcomes omit one patient who died because puberty suppression dictated a riskier vaginoplasty. The fifth section pursues the British study designed to replicate the Dutch one; it was withheld from publication for some years, presumably because puberty suppression in this sample failed to improve gender dysphoria or psychological functioning. The poor quality of American studies is also noted. The final section evaluates evidence for the side effects of GnRHa. The negative effect on the accrual of bone mass is well studied, while there is increasing evidence for negative effects on cognitive and emotional development and on sexual functioning." <https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2121238?scroll=top&needAccess=true>

Thanks for your time!

Lily

From: [vince.dodge](#)
To: [Vazquez, Paul](#)
Subject: How to treat gender dysphoria
Date: Tuesday, September 20, 2022 10:59:57 PM

You don't often get email from vbird62@hotmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Sirs,

As a board-certified Emergency Physician with a masters in psychiatric nursing living in Pensacola I strongly encourage you to be conservative in the physical and hormonal interventions with these dysphoric youth. Chemical transitioning is adding greater confusion and in fact often great regret for many youth who are in no position to make these lifelong decisions while suffering dysphoria. For the last 15 years I have seen many of these regretful cases in the emergency room suffering worsening mental conditions, anxieties, depression and suicidality.

There is a lack of quality evidence to support transitioning and a strong research bias has prevented reporting on the long-term damage of these procedures. What you can find is that these unfortunate patients and their parents are currently suing the institutions and doctors who have so poorly informed and consented them for this treatment.

Sincerely

Vincent Dodge MD, MSN, FACEP

From: [John Hamill](#)
To: BOM.meetingmaterials@flhealth.gov
Cc: [Vazquez, Paul](#)
Subject: Doctor Opposes Gender Changing Therapies
Date: Tuesday, September 20, 2022 10:27:28 PM

You don't often get email from jrhamill51@gmail.com. [Learn why this is important](#)

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Dear Paul Vazquez ,J.D.
Executive Director
Florida Board of Medicine

I have been a practicing Physician in Florida since 1982 that opposes Gender changing therapies. There are no long term evidence based studies that support this permanent medical and /or surgical treatment for children.

Thank you.
John Robert Hamill jr M.D.

From: [Peter Schwabe](#)
To: [Vazquez, Paul](#)
Subject: Gender Affirming Care for youth
Date: Tuesday, September 20, 2022 9:42:25 PM

You don't often get email from twodomers@mac.com. [Learn why this is important](#)

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I recently learned of Florida's BOM considering Gender Affirming Care for youth. I strongly encourage you to review the studies and data that show that not only is this based upon scientific opinion and not data, but in fact it is detrimental to the long term health of the child.

Peter J Schwabe
Member of Wisconsin CMA

506 W Wisconsin Ave
Oconomowoc, WI 53066
(262)853-3332
twodomers@mac.com
<https://www.linkedin.com/in/peterschwabe/>

From: [Philip Morris](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Vazquez, Paul](#)
Subject: Fwd: The Australian National Association of Practising Psychiatrists Guide to Management of Gender Dysphoria in Young People
Date: Friday, September 16, 2022 9:39:08 PM
Attachments: [Managing Gender Dysphoria in Young People – The NAPP Guide.pdf](#)

Some people who received this message don't often get email from plpmorris1@gmail.com. [Learn why this is important](#)

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FYI

Begin forwarded message:

From: Philip Morris <plpmorris1@gmail.com>
Subject: The Australian National Association of Practising Psychiatrists Guide to Management of Gender Dysphoria in Young People
Date: 17 September 2022 at 10:44:01 am AEST
To: Paul.Vazquez@flhealth.gov

Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Mr Vazquez,
the Australian National Association of Practising Psychiatrists (NAPP) published on our website (napp.org.au) in July 2020 our Guide to managing gender dysphoria in young people (see attached). This Guide was developed with contributions from child and adolescent psychiatrists, psychotherapists, paediatricians, and general adult psychiatrists. It is informed by the medical literature available on this clinical topic and has been updated with new information as the field has developed. We believe it provides a compassionate, respectful, cautious, contemporary and evidence-based approach to the care of children and adolescents presenting with gender dysphoria. I hope you might take it into account when your Board is reviewing the guidelines for the management of gender dysphoria in Florida.

Yours sincerely,
Prof Philip Morris AM
President NAPP

From: Philip Morris
To: zzzz Feedback, BOM_MeetingMaterials; Vazquez, Paul
Subject: Fwd: WPATH Standards of Care
Date: Friday, September 16, 2022 11:57:27 PM
Attachments: Screen Shot 2022-09-17 at 12.23.55 pm.png
Screen Shot 2022-09-17 at 12.23.22 pm.png
Screen Shot 2022-09-17 at 12.39.31 pm.png
Screen Shot 2022-09-17 at 12.51.56 pm.png
Screen Shot 2022-09-17 at 12.57.51 pm.png
Screen Shot 2022-09-17 at 12.58.24 pm.png
Screen Shot 2022-09-17 at 12.59.55 pm.png
Managing Gender Dysphoria in Young People – The NAPP Guide.pdf

Some people who received this message don't often get email from plpmorris1@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Mr Paul Vazquez and the Florida Board of Medicine, you may be interested in this email to Australian medical colleagues concerning developments in the treatment approach to gender dysphoria/incongruence in children and adolescents. The information contained may inform your review of the guidelines for clinicians in Florida working in this clinical area. Yours sincerely, Prof Philip Morris AM (president Australian National Association of Practising Psychiatrists - NAPP)

From: Philip Morris <plpmorris1@gmail.com>
Subject: Re: WPATH Standards of Care
Date: 17 September 2022 at 1:45:16 pm AEST

Dear All, perhaps the president of the American Academy of Pediatrics, Dr Szilagyi, might be given a copy of the NAPP Guide, given her pronouncements in her letter response to the Op-Ed in the Wall Street Journal in the screenshot below. Notice now how the term 'affirm' now means to 'de-stigmatise gender variance and promote the child's self worth', not affirm the child's demand to be or appear like a gender different to their birth-assigned gender. It seems to me, from what Dr Szilagyi said about the AAP advice that it does not push medical treatments or surgery, and for the vast majority of children, it recommends the opposite, the NAPP Guide could now become the policy of the American Academy of Pediatrics.

I also note the new edition of the WPATH guidelines include more cautious recommendations about use of medically affirming treatments in adolescents (see screenshots below), acknowledges the potential adverse effects on cognitive development of prolonged puberty blockade (see screenshot below), and the benefit of psychotherapy for children that addresses gender exploration, rather than gender affirmation (see screenshots below). Perhaps this last recommendation can be shown to the Queensland, ACT and Victorian governments with a request to make this recommendation part of their conversion therapy legislation.

Also, these issues are covered in my two interviews with ABC radio hosts (Paul Turton and Josh Szepe) on this topic available on the NAPP website (napp.org.au). Philip Morris.

OPINION | LETTERS

Academy of Pediatrics Responds on Trans Treatment for Kids

To 'affirm' a child or teen means destigmatizing gender variance and promoting the child's self-worth.

Aug. 21, 2022 12:37 pm ET



Regarding Julia Mason and Leor Sapir's op-ed "[The American Academy of Pediatrics' Dubious Transgender Science](#)" (Aug. 18): In its recommendations for caring for transgender and gender-diverse young people, the AAP advises pediatricians to offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. This care is nonjudgmental, includes families and allows questions and concerns to be raised in a supportive environment. This is what it means to "affirm" a child or teen; it means destigmatizing gender variance and promoting a child's self-worth. Gender-affirming care can be lifesaving. It doesn't push medical treatments or surgery; for the vast majority of children, it recommends the opposite.

WPATH guidelines

The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):

- 6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:
- 6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.
- 6.12.b- The experience of gender diversity/incongruence is marked and sustained over time.
- 6.12.c- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
- 6.12.d- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.
- 6.12.e- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
- 6.12.f- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
- 6.12.g- The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

(Hembree et al., 2017). A compelling reason for earlier initiation of GAHT, for example, might be to avoid prolonged pubertal suppression, given potential bone health concerns and the psychosocial implications of delaying puberty as described in more detail in Chapter 12—Hormone Therapy (Klink, Caris et al., 2015; Schagen et al., 2020; Vlot et al., 2017; Zhu & Chan, 2017). Puberty is a time of significant brain and cognitive development. The potential neurodevelopmental impact of extended pubertal suppression in gender diverse youth has been specifically identified as an area in need of continued study (Chen et al., 2020). While GnRH

Statement 7.8

We recommend health care professionals consider consultation, psychotherapy, or both for a gender diverse child and family/caregivers when families and health care professionals believe this would benefit the well-being and development of a child and/or family.

Society, 2020; Telfer et al., 2018). Nevertheless, it is often appropriate and helpful to seek psychotherapy when there is distress or concerns are expressed by parents to improve psychosocial health and prevent further distress (APA, 2015). Some of the common reasons for considering psychotherapy for a gender diverse child and family include the following 1) A child is demonstrating significant conflicts, confusion, stress or distress about their gender identity or needs a protected space to explore their gender (Ehrensaft, 2018; Spivey and Edwards-Leeper, 2019); 2) A child is experiencing external pressure to express their gender in a way that conflicts with their self-knowledge, desires, and beliefs (APA, 2015); 3) A child is struggling with mental health concerns, related to or independent of their gender

Tishelman, 2018); and 4) provide the child an opportunity to further understand their internal gender experiences (APA, 2015; Barrow & Apostle, 2018; Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). It is helpful for HCPs

Gender dysphoria/incongruence in young people is a contested area of medical practice. This approach avoids political, social, religious and ideological positions.

This approach to developing guidelines for managing gender dysphoria [1] or gender incongruence [2] in children and adolescents aims to protect and safeguard the health, safety and welfare of the child. This guide prioritises the best interests of the child in accordance with human rights obligations under the International Convention of the Rights of the Child [3].

Specifically, this guide:

While respecting young people's views about their gender identity, it does so as part of the totality of their developmental and holistic clinical picture, and incorporates these into the clinical formulation. This approach requires that a comprehensive bio-psycho-social assessment of the young individual and their family be conducted before recommending specific treatment.

Acknowledges that childhood and adolescence is a time of rapid physical and psycho-social growth and profound personal development, during which young people may question their identity, sexual orientation and gender. As the child matures and progresses through puberty this questioning usually transforms and resolves, and the young person, in the majority of cases, accepts his/her biological sex and adult body [4, 5].

Understands that gender dysphoria/incongruence can be both a symptom and a syndrome. For a young person to have the syndrome of gender dysphoria/incongruence there must be a significant, established and prolonged pattern [2] of desire and behaviour that indicates the person insists they are a gender different to their biological sex and natal (birth assigned) gender.

Recognises that gender dysphoria/incongruence can often be a manifestation of complex pre-existing family, social, psychological, or psychiatric conditions or predisposing factors [6]. A holistic approach to assessment includes a comprehensive exploration for these potential conditions in order to more fully understand a child presenting with gender dysphoria/incongruence [7,8]. Where these conditions are presenting as gender dysphoria/incongruence, the treatment of the underlying condition is a priority.

Individualised psychosocial interventions (e.g., psychoeducation, individual therapy, school-home liaison, family therapy) should be first-line treatments for young people with gender dysphoria/incongruence. Exploratory psychotherapy should be offered to all gender-questioning young people to identify the many potential sources of distress in their lives in addition to their gender concerns. Clinicians can apply a range of psychological interventions (e.g., supportive psychotherapy, CBT, dynamic psychotherapy, and family therapy) to assist the young person clarify and resolve these contributory factors. Such approaches are consistent with established principles of comprehensive, systemic youth health care [7]. They should be undertaken before experimental puberty-blocking drugs [9] and other medical interventions (e.g., cross-sex hormones, sex reassignment surgery) are considered.

Psychotherapy for gender dysphoria in children and adolescents is a respectful, supportive and exploratory process that does not seek any particular outcome in relation to gender identity or sexual orientation. It seeks to understand the nature and meaning of the young person's gender distress and the context in which it has arisen. Psychotherapy addresses the multiple factors that contribute to the young person's difficulties, helping to address issues that resolve distress and support ongoing development and maturation. Conversion therapies, on the other hand, aim to achieve a pre-determined outcome, such as gender normativity or heterosexual orientation. Psychotherapy for gender dysphoria must NOT be conflated with conversion therapies.

Medical interventions to block puberty and cross-hormone treatment to achieve feminization and masculinization according to the young person's perceived gender are not fully reversible and can cause significant adverse effects on physical, cognitive, reproductive and psychosexual development [9,10,11,12,13,14,15,16].

Currently, while some individuals report a successful transition, we are not aware of published long-term outcome studies that have followed up adults who have undergone childhood or adolescent transition that show substantial benefit. As a consequence, there is no consensus that medical treatments such as the use of puberty-blocking drugs, cross-sex hormones or sexual reassignment surgery lead to better future psychosocial adjustment [17,18,19,20].

Increasing numbers of individuals who have undergone hormonal treatment and surgical interventions subsequently report experiencing regret and a wish to de-transition [21]. They describe significant psychological and physical suffering, including loss of fertility and sexual function as a consequence of decisions made when younger [22,23,24,25,26,27].

Medico legal considerations must be fully appreciated in this area of clinical practice. Health professionals are exposed to significant legal risk:

- If a child or adolescent is found not to have been competent to give an informed consent,
- If in children under age 16 years both parents have not agreed to puberty suppression and cross-hormone treatment,
- If gender affirming treatment is not preceded by a comprehensive psycho-social assessment, that considers and excludes alternate diagnoses, or
- If the patient was not informed of all the risks of puberty blockers and cross-hormone treatment including their experimental nature [9].

Clinicians should therefore reflect carefully before recommending treatments for gender dysphoria/incongruence.

The still unproven risks and benefits of gender reassignment interventions make it imperative that parents and children under 18 years and young people over 18 years are made aware of the current evidence of potential harm regarding gender transition and provide fully informed consent before potentially damaging and irreversible treatment is commenced.

This cautious approach is also mirrored in general clinical guidance by national treatment advisory bodies in Finland, Sweden, France and the United Kingdom that recommend treatment methods for gender dysphoria in minors [28, 29, 30, 31]. In Finland, the recommendation is that among young people with gender dysphoria and significant psychiatric comorbidity no conclusions can be drawn on the stability of the gender identity of the child [28]. In the UK, the one specialised clinic in England (Tavistock Clinic) offering an affirmation approach to management of gender dysphoria in children and adolescents will be closed and replaced by regional clinics offering a more holistic model of care [32]. The author of the report that led to this decision (Dr Hilary Cass) raised substantial concerns about the effect of puberty blockers on developmental maturation and decision-making [32].

This guide adopts a personalised, non-ideological approach to the care of youth with gender dysphoria. As Dr Hilary Cass notes [33], the diagnostic process required by doctors who prescribe treatment for young individuals with this condition must include a diagnosis and differential diagnosis:

"I have also noticed some debate around the inclusion of the need for a diagnosis and differential diagnosis, and whether that means we are pathologising gender identity or seeing it as a mental health problem. I think it is worth clarifying what is meant by these terms.

Applying medical thinking to gender identity isn't required until and unless a young person needs treatment. The regulations are particularly tightly defined when a doctor is considering prescribing medication, and especially medication that may have some life-long effects. Doctors then have a professional obligation to go through a process of ensuring that it is appropriate for the health needs of the individual, which means making a positive diagnosis (what the condition is) and a differential diagnosis (what the condition isn't). This applies in all areas of medicine.

The process of differential diagnosis is neutral in terms of outcome - it's not about preferring one diagnosis over another; it's just about getting it right. It isn't about trying to rule out every conceivable explanation before confirming any particular diagnosis - only about ruling out other diagnoses that might be likely for that individual, or where getting it wrong and missing another diagnosis could have serious consequences. Achieving this involves taking a holistic, considered approach to each individual about the possible causes of their distress and identifying the most appropriate pathway for them. This must always be done with sensitivity and in partnership with the young person and their family.

This same requirement is reflected in the internationally developed Endocrine Society gender dysphoria/gender incongruence guidance which recommends that health professionals responsible for diagnosing gender dysphoria should meet a range of criteria including "the ability to make a distinction between GD [gender dysphoria] /gender incongruence and conditions that have similar features".

In preparing this guide, advice was obtained from a number of senior medical colleagues in child and adolescent psychiatry, adult psychiatry, and forensic psychiatry, as well as from physicians and psychologists who have cared for young people experiencing gender dysphoria/incongruence, and legal practitioners who have experience in this field.

References

1. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.
2. World Health Organization. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision). Retrieved from <https://icd.who.int/browse11/l-m/en>
3. UN Commission on Human Rights, Convention on the Rights of the Child., 7 March 1990, E/CN.4/RES/1990/74, available at: <https://www.refworld.org/docid/3b00f03d30.html> [accessed 3 November 2020]
4. Entwistle K. Debate: Reality check – Detransitioners' testimonies require us to rethink gender dysphoria. Child Adolesc Ment Health. 2020. doi:10.1111/camh.12380
5. Ristori J, Steensma T. Gender dysphoria in childhood. International Review of Psychiatry. 2016;28(1):13-20. doi:10.3109/09540261.2015.1115754
6. Kozłowska K, et al. Attachment patterns in children and adolescents with gender dysphoria. Frontiers in Psychology, 12 January 2021.
7. Kozłowska K, et al. Australian Children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments, 22 April 2021.
8. Kosky R. Gender-disordered children: does inpatient treatment help? Medical Journal of Australia 1987;146:565-69 (June 1, 1987). doi: 10.5694/j.1326-5377.1987.tb120415.x
9. <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>
10. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. Bone. 2017;95:11-19. doi: S8756-3282(16)30333-7 [pii].
11. Vlot MC, Wiepjes CM, de Jongh RT, T'Sjoen G, Heijboer AC, den Heijer M. Gender-affirming hormone treatment decreases bone turnover in transwomen and older transmen. J Bone Miner Res. 2019;34(10):1862-1872. doi: 10.1002/jbmr.3762 [doi].
12. Schneider M, Spritzer P, Soll B et al. Brain Maturation, Cognition and Voice Pattern in a Gender Dysphoria Case under Pubertal Suppression. Front Hum Neurosci. 2017;11. doi:10.3389/fnhum.2017.00528
13. Auer MK, Ebert T, Pietzner M, et al. Effects of sex hormone treatment on the metabolic syndrome in transgender individuals: Focus on metabolic cytokines. J Clin Endocrinol Metab. 2018;103(2):790-802. doi: 10.1210/jc.2017- 01559 [doi].
14. Alzahrani T, Nguyen T, Ryan A, et al. Cardiovascular disease risk factors and myocardial infarction in the transgender population. Circ Cardiovasc Qual Outcomes. 2019;12(4):e005597. doi: 10.1161/CIRCOUTCOMES.119.005597 [doi].
15. Nota NM, Wiepjes CM, de Blok, C. J. M., Gooren LJG, Kreukels BPC, den Heijer M. Occurrence of acute cardiovascular events in transgender individuals receiving hormone therapy. Circulation. 2019;139(11):1461-1462. doi: 10.1161/CIRCULATIONAHA.118.038584 [doi].

16. Goodman M, Nash R. Examining health outcomes for people who are transgender. <https://www.pcori.org/research-results/2013/examining-health-outcomes-people-who-are-transgender>. Updated 2014. Accessed Nov 7, 2019.
17. ²² Dhejne C, Lichtenstein P, Boman M, Johansson AL, Langstrom N, Landen M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One*. 2011;6(2):e16885. doi: 10.1371/journal.pone.0016885 [doi].
18. Bränström, R., & Pachankis, Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *American Journal of Psychiatry*. 2019;177(8), 727- 734. <https://doi.org/10.1176/appi.ajp.2019.19010080>
19. Correction to Bränström and Pachankis. *American Journal Of Psychiatry*. 2020;177(8), 734-734. <https://doi.org/10.1176/appi.ajp.2020.1778correction>
20. Kalin, N. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender Affirming Surgeries: A Comment by the Editor on the Process. *American Journal Of Psychiatry*. 2020;177(8), 764- 764. <https://doi.org/10.1176/appi.ajp.2020.20060803>
21. Vandebussche E. Detransition-related needs and support: a cross-sectional online survey. *Journal of homosexuality*. 2021 Apr 30; 1-19. Doi: 10.1080/00918369.2021.1919479.
22. Lesbian Strength 2019 – Charlie Evans. YouTube. <https://www.youtube.com/watch?v=-JazgA3AdUE>. Published 2019. Accessed November 1, 2019.
23. Female detransition and reidentification: Survey results and interpretation. archive Web site. <https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey>. Accessed Nov 7, 2019.
24. Pique resilience project. PIQUE RESILIENCE PROJECT Web site. <https://www.piqueresproject.com/>. Accessed Nov 7, 2019.
25. Subreddit survey update! : detrans. Reddit.com. https://www.reddit.com/r/detrans/comments/azj8xd/subreddit_survey_update/. Published 2019. Accessed November 1, 2019.
26. Reddit.com. Has anyone been to gender therapy? What was your experience?: detrans. [online]:https://www.reddit.com/r/detrans/comments/aeo5zd/has_anyone_been_to_gender_therapy_what_was_your/ Published 2019. Accessed November 1, 2019.
27. Tumblr: Guide on raging stars. Female detransition and reidentification survey. Available: <https://tinyurl.com/female-detrans-survey>. Published 2016. Accessed November 1, 2019.
28. Recommendation of the Council for Choices in Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors. Health Care in Finland (PALKO / COHERE Finland), 11 June 2020.
29. Linden T, MD PhD Director/Government Chief Medical Officer. The National Board of Health and Welfare, Sweden 2022.
30. https://segm.org/sites/default/files/English%20Translation_22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf
31. <https://cass.independent-review.uk/publications/interim-report/>
32. <https://cass.independent-review.uk/publications/>
33. <https://cass.independent-review.uk/entry-6-following-the-interim-report-march-2022/>

Dr Philip Morris AM
President National Association of Practising Psychiatrists

Dr Vivienne Elton
Vice-president National Association of Practising Psychiatrists

Prof Dianna Kenny
Consulting Psychologist

Dr Roberto D'Angelo
Psychiatrist and Psychoanalyst

Dr George Halasz
Consultant Child and Adolescent Psychiatrist

Dr Cary Breakey
Consultant Child and Adolescent Psychiatrist

From: [DENISE HUESO](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 10:10:30 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about medical care belong within the sanctity of the patient-physician relationship.”

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of

WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

DENISE HUESO
DHUESO@ATT.NET

Miami, Florida 33173

Dear Chair Diamond:

Thank you and the Florida Board of Medicine
for protecting Florida minors which prohibits children
and teens from receiving hormone therapy or
undergoing "gender" surgery. Your efforts, however
controversial they may seem to some people, are being
applauded in heaven by God almighty.
God will richly bless you for your efforts!

again thank you
Julien Stelly

Dear Chair Diamond:

Thank you and the Florida Board of Medicine
for protecting Florida minors without
prohibiting children and teens from receiving
hormone therapy or undergoing "gender surgery".
Your efforts, however controversial they may
be, people are being applauded for today
by God almighty.

God will richly bless you for your
efforts! -

Again Thank You

Mike B. Stebbins

From: [Andrea pedroza](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 10:49:37 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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Andrea pedroza

andrea.pl.1234@gmail.com

,

From: [Tena Zara](#)
To: [Vazquez, Paul](#)
Cc: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Youth Transition and the Informed Consent Process
Date: Monday, September 19, 2022 11:05:33 AM

Some people who received this message don't often get email from tena.b.zara@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Mr. Vazquez and the Florida Board of Medicine Rules Committee:

As a native Floridian who has recently returned to live in my home state, I'm exceedingly proud to know that the Board will be considering the vital issues regarding the practice of gender medicine at its upcoming meeting.

I'm hopeful that FL will lead the way and be on the right side of history regarding the worst medical catastrophe since the opioid crisis. The sterilization and mutilation of our youngest and brightest in the name of "affirmative care" for gender dysphoria.

My son, who has ADHD, OCD, who is extremely bright, socially awkward and has experienced trauma (all characteristics of youth presenting with gender dysphoria) told me four years ago that he was born in the wrong body. Not only that, he said that if I did not affirm that identity he may be taken from me (a crazy threat that turns out has happened to parents) or commit suicide. I did not know then that is a "script" that such youth are told my transgender activists. Needless to say, it knocks parents off their feet.

I took him to the pediatrician he had seen since birth, who told me to stay away from Boston Children's hospital and tried to help by referring me to non-affirming therapists, but those therapists were not taking new patients. This pediatrician is Harvard trained and did her residency at Massachusetts General hospital. She also cared for my older daughters since birth (33 years in total), lived in the same town as me, and my daughter and her daughter were friends. Thus, she knows my family intimately. She helped when my daughter had anorexia for which she was treated and is now recovered. She knew that the dramatic increase in youth presenting with gender dysphoria was not normal and she knew that I should not pursue transition for my child. I mention this because it seems like all pediatricians support transition. This is not true. **Many highly-trained pediatricians do not support transition but they are silenced by a society and a medical establishment that names anything other than full support "transphobic."**

My psychiatrist, a physician at Massachusetts General Hospital, immediately said my son was having an identity crisis when I told him about his sudden announcement of being transgender. He admits that one of the premiere gender doctors at MGH is an advocate for transgender people. Letting politics influence his medical advice. My

psychiatrist also finds it incredulous that many of these youth have autism and that the issue of social contagion is not being raised and examined in the medical field. He is incredulous that a clinic in Chicago diagnoses perfectly healthy males as having an endocrine disorder requiring cross-gender hormones as equivalent to saying that they have chromosome disorders. That same physician, who is now "brainwashed" by the hospital he works for that is making hundreds of thousands of dollars (maybe millions) off transgender care, has stepped back from that position and is now saying he is "remaining curious." **Many highly-trained psychiatrists do not support transition but they are silenced by a society and a medical establishment that names anything other than full support "transphobic."**

The individuals who "diagnosed" my son as having gender dysphoria were his high school guidance counselor and a very new therapist. They did so immediately after his declaration and immediately referred him to Boston Children's Hospital for puberty blockers. We never went.

There is scientific evidence that the male brain does not mature until age 25. Yet, we are listening to youth (who we freely say do stupid stuff in high school and college) that they need to medicalize themselves for life to escape mental anguish now.

I am a lawyer. I've already helped one detransitioner file suit against a major hospital and a group of doctors. This is the start of these lawsuits.

I am fighting for my child and the hundreds of thousands like him who have been influenced through the internet, peers, and some well-meaning adults that they are the other gender. Other progressive countries such as Finland, Sweden and the UK have woken up. We are like Iran who forces homosexual individuals to transition.

No youth can consent to elective, experimental treatments that will sterilize and medicalize them for life. No parent can consent on behalf of their minor children to elective, experimental treatments that will sterilize and medicalize them for life. Full stop.

I hope that the Florida Board of Medicine will do the right thing and prohibit transitioning care for gender non-conforming youth. I hope that it does so using science. Medicine should not be political. The treatments are irreversible. One better have high-quality longitudinal evidence that such treatments are necessary. There is none.

Best,
Tena Zara Herlihy
1615 Meridian Avenue, Unit 401
Miami Beach, FL 33139
617-699-3849

From: [Vanessa Perez](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 7:36:18 AM

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Vanessa Perez
vanessa.dc.perez@gmail.com

New York, New York 10473

From: [Strickland, Bettye C](#)
To: [Strickland, Bettye C](#)
Subject: FW: Please stop medically transitioning children
Date: Thursday, September 29, 2022 2:16:50 PM

-----Original Message-----

From: Jennifer <jenniferkrhn@yahoo.com>
Sent: Wednesday, September 28, 2022 11:40 PM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>
Subject: Please stop medically transitioning children

Hello Paul,

I am the mother of a previously trans identifying child. I was terrified to learn of the medical potential children are lead to by medical and mental health professionals. Puberty blockers, hormones and surgeries all have irreversible and very harmful effects on a child.

When we pulled our daughter away from all of the affirming influences in her life she desisted. I do not believe this would have happened had we not removed the influences from her life (internet, affirming friends, affirming school). She may have gone down a medical path that would have been wrong for her. In the old watchful waiting protocol most children grew to be comfortable with their sex. With all the influences in our culture today, (internet, friends, school, etc.) I believe there is no longer such a thing as watchful waiting.

Children are too young to consent to irreversible medical harms. There are now 40k in a detransitioner Reddit. This should be enough evidence that we need to pull back on these medical procedures.

We were lucky that we were able to help our child be comfortable with her sex. These are mistakes that children should not be allowed to make. The medical profession needs to hold to its oath to first do no harm. Please consider ending the medicalization of children in Florida.

Thank you,
Jennifer Krohn

Sent from my iPhone

From: [Hope Lemos](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 9:00:23 AM

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Hope Lemos

hjthompson22@yahoo.com

Greensboro, North Carolina 27408

From: [Ilaria Valenzuela](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 9:38:45 AM

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Ilaria Valenzuela

ilariacacopardo@me.com

137 Harbor Dr

Key Biscayne, Florida 33149

From: [Shanna L](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: September 30th meeting, Affirmative care for youth
Date: Monday, September 19, 2022 10:23:15 AM

You don't often get email from shanna.lindstrom@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Hello,

I am sending this email as a licensed mental health provider. I am in charge of a mental health agency in Utah with locations in three cities.

I have seen a tremendous increase in the number of adolescent girls seeking care at my agency over the last two years. The parents of these girls have brought them in after their daughters have suddenly wanted to use masculine names and shown confusion about their gender.

After these girls begin mental health therapy, we are seeing several underlying concerns such as: body image concerns, self-harm, anxiety, and depression.

Last year my own daughter suddenly chose a male sounding name and became confused about her gender after some others girls at school she associated with did the same thing.

As a mental health clinician (and also a mother) who is responsible for creating programs and cares about the mental well-being of these girls, I started to do some research.

Unfortunately, the increase in adolescent girls identifying as transgender is relatively new. Due to this, there is a surprisingly small amount of research on it.

I read some articles, including one in psychology today, which advocated for transitioning a youth as soon as they become gender dysphoric. In this same publication, they did acknowledge the increase in adolescents identifying as transgender has increased significantly in the past few years. In the same publication the researchers discussed how personality changes over time and we are not the same person in childhood, adolescence, and even through adulthood.

In addition, I read about the Supreme Court case in England for Kiera Bell, the banning of hormone treatments for youth in Finland and Sweden, as well the closure of Travistock for a more holistic approach to gender dysphoria in youth.

When I looked at the medical research, I saw that what is being used as a puberty blocker, has traditionally been used as chemical castration for sex offenders and in children with precocious puberty. I could not find any long term studies on the results of halting healthy puberty and having it return to normal in later adulthood when the medications were stopped. The closest thing I was able to find were cases where an adolescent had used puberty blockers then proceeded to cross sex hormones and became infertile.

I would like to encourage those with the authority to decide in Florida, to take a cautious

approach when it comes to affirmative care.

When one looks at all of the facts with regard to adolescent gender dysphoria, there is still much more research to be done. There are many unanswered questions. Why the sudden increase in gender dysphoric youth? Why do the vast majority of them have underlying mental health concerns? Why does it seem to appear in groups of girls? Why after exposure to gender oriented lessons/presentations, trans advocates online, or peers do adolescent girls seem to realize they were born in the wrong body? As well as many more questions.

When it comes to medical interventions, informed care is paramount. Even more so, permanent or possibly permanent inventions should be used with extreme caution. We do not allow minors to get tattoos or sign contracts. We do not schedule a hysterectomy as soon as an adolescent girl with painful periods decides she doesn't want to have them anymore and is convinced she won't want children later.

Every medication and every medical intervention has side effects. Every single one has pros and cons with it's use. In the cases of medical intervention with regard to affirmative care, we are halting a healthy and functioning process. We are interfering with the normal functioning of an adolescent's body. In my state, I have seen adolescent girls go to a gender clinic and get a prescription for hormones that same day without a note from that person's mental health therapist.

I don't have all the answers, but something is going on for our adolescents and, particularly, our adolescent girls. Please help the medical community to do it's due diligence in ensuring the research is conducted, evidence based inventions are used, and caution is used when providing treatment to minors for anything, but especially for something that could have lifelong consequences for them.

Thank you for your time in reading what I have written here today.

Shanna Lindstrom, LCSW

From: [jose ospina](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 4, 2022 3:25:47 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Florida Board of Medicine

Please be fair and recognize rights of all citizens and Florida residents- no one person should have more access to healthcare than another. stop trying to discriminate against Lesbian Gay and especially Transgender and Nonbinary citizens.

Your proposals and upcoming bills to deny citizens healthcare is not upholding relevant constitutional and national laws and guidelines. Using old outdated and debunked research is bogus attempt to sow fear and misinformation. Stop prejudice discrimination and hate + just stop attacking some citizens and showing favoritism to others. it is immoral and cruel to deny best practices in healthcare and to deny appropriate privacy between doctors and patients. Shame on you.

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jose ospina
jose.ospina@live.com

Venice, Florida 34285

From: [Claudia Thomas](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 7:35:33 PM

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Claudia Thomas
guitarchick@duck.com

Sanford, Florida 32771

From: [anna feiler](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 9:22:06 PM

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anna feiler
amf226@yahoo.com

Coral Gables, Florida 33134

From: [Midnight Moon](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 10:35:28 AM

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Midnight Moon

themidnightssystem@gmail.com

Pompano Beach, Florida 33060

From: [Rev. Allen B. Mullinax, Ph.D.](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 2:14:47 PM

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Rev. Allen B. Mullinax, Ph.D.
amullinax@bellsouth.net

, Florida 32304

From: [Allison Goodman](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 8:18:32 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about medical care belong within the sanctity of the patient-physician relationship.”

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of

WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Allison Goodman
alcrgo@gmail.com

Pinecrest, Florida 33156

From: [Jaesun Chong](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 2:24:00 PM

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As someone who cares about trans healthcare, I want the Florida Board of Medicine to abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Jaesun Chong
jessicrumb.chong@gmail.com

Austin, Texas 78739

From: [elizabeth schwartz](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Friday, September 30, 2022 1:31:31 PM

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As a lawyer in Florida, I stand for facts and reason. The Florida Board of Medicine's efforts to restrict access to gender-affirming care is illogical and unconstitutional. We must ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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elizabeth schwartz

liz@elizabethschwartz.com

Miami, Florida 33137

From: [Christen Lancaster](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Friday, September 30, 2022 12:55:13 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Christen Lancaster
lancaster.christen@yahoo.com

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From: [Ann Pasquale](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 4:12:35 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, and a pediatric nurse practitioner I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Ann Pasquale
apasquale62@comcast.net

Pinecrest, Florida 33156

From: [Aris Keshav](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 8:36:29 AM

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I ask that the Florida Board of Medicine abandons all efforts to restrict access to gender-affirming care and ensures uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Aris Keshav

ariskeshav@gmail.com

,

From: [Ailsa Hermann-Wu](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:17:23 PM

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As a supporter of equality, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Ailsa Hermann-Wu
bostonian71@gmail.com

Waltham, Massachusetts 02451

From: [Angel D'Angelo](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 6:54:45 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Angel D'Angelo
archangeladvocacy@gmail.com
9660 Kona Village Dr Apt 110
Riverview, Florida 33578

From: [Anja Jensen](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 6:22:50 AM

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Anja Jensen
belladonnakatty@gmail.com

Portland, Oregon 97209

From: [Cornell Staples](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 9:58:10 AM

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Carnell Staples

cj@dreamdefenders.org

Fort Lauderdale, Florida 33311

From: [Benjamin Davis](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:02:20 PM

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Benjamin Davis

bendavis22@gmail.com

,

From: [Alex X](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:32:00 PM

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Gender affirming care saves children's' lives. Please leave these decisions for the families and their physicians. Thank you.

Alex X
alexX@email.com

, Saint Croix Island 53701

From: [Amanda Cooke](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 5:45:44 PM

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Amanda Cooke

acooke304@gmail.com

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From: [Elina Fernandez](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 11:26:45 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Elina Fernandez
scullyk@comcast.net

, Saint Croix Island 3333-

From: [Chloe Bauer](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:26:41 PM

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Chloe Bauer
chlo3bauer@gmail.com

,

From: [DALILA AGUILAR, MD](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 6:49:54 PM

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DALILA AGUILAR, MD
dalila_y@yahoo.com
7600 COLLINS AVE APT 1206
MIAMI BEACH, Florida 33141

From: [Elena Sch.](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 10:46:34 AM

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Elena Sch.
eschi018@fiu.edu

Miami, Florida 33174

From: [Daniel Del Papa](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 12:13:15 AM

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Daniel Del Papa
ddelpapa23@gmail.com

Balwyn North, Victoria 3104

From: [Casey Stone](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 9:40:34 PM

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Casey Stone
teambunnygirl@gmail.com

Lecanto, Florida 34461

From: [Claire Hannah](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 6:08:38 AM

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Claire Hannah
hannah694@gmail.com

, Oregon 97532

From: [chloe k](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 12:15:46 AM

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chloe k
63b4745q.5df1q@8shield.net

Melbourne, Victoria 3000

From: [Daniella Kolomijez](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 6:12:40 AM

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I was in the meeting on August 5 2022. There was one detransitioner that spoke. ONE. There were 50+ transgender people in the room that I personally know & have been able to solve this issue in their lives. This has been given the label of 'concern for well-being', whilst ACTING in a non-concerning manner. Their actions do not match 'do no harm'. Denying people healthcare DOES harm.

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Daniella Kolomijez
dani.kolomijez@gmail.com

Pompano Beach, Florida 33069

From: [Elizabeth Rothwell](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 8:42:56 AM

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Elizabeth Rothwell
bethrain@gmail.com

,

From: [Jennifer Abeloff](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:01:19 PM

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Jennifer Abeloff
abeloffj@atlanticbb.net

Miami, Florida 33143

From: [Erica Musser](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:34:47 PM

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Erica Musser
emusser@fiu.edu

Coral Gables, Florida 33134

From: [Gold Cummins](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:12:05 PM

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Gold Cummins

gold.cummins@gmail.com

,

From: [Jennifer Solomon](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 9:26:14 AM

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Jennifer Solomon
mommysolomon@aol.com

Pinecrest, Florida 33156

From: [jennifer Knight](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:13:32 PM

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jennifer Knight
victorianhousewife@yahoo.com

,

From: [Jeff Agron](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 10:04:22 PM

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Jeff Agron

jeffreyagron@me.com

6545 SW 133 DRIVE NA

PINECREST, Florida 33156

From: [Jamie Diaz](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:14:23 PM

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I am not a citizen of Florida, but I am the parent of a transgender child and I've seen and experienced, first-hand, the positive outcomes of providing gender-affirming care for kids.

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Jamie Diaz
diaz.r.jamie@gmail.com

Santa Rosa, California 95404

From: [Jeff Big](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 6:00:22 PM

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A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Jeff Big
jeffc31@yahoo.com

Fort Lauderdale, Florida 33311

From: [Jessica Daly](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 10:40:05 PM

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I am writing to implore the Florida Board of Medicine to abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Jessica Daly
heyitsjessicadaly@gmail.com

Buffalo Grove, Illinois 60089

From: [Jessica Robertson](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:52:33 PM

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Jessica Robertson
jessie0223@aol.com

,

From: [Juniper Lake](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:02:45 PM

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Juniper Lake
junlake440482@gmail.com

Titusville, Florida 32780

From: [JUDITH ECHEVERRIA](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 1:30:27 PM

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JUDITH ECHEVERRIA
judyecheverria@gmail.com

Miami, Florida 33196

From: [Kandice OToole](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 7:26:06 PM

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Kandice OToole

kandyotoole@yahoo.com

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From: [Juan del Hierro](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 9:18:16 AM

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Juan del Hierro
delhierrojuan@gmail.com

North Miami Beach, Florida 33162

From: [Kat Duesterhaus](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 1:45:43 PM

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Kat Duesterhaus
katduesterhaus@gmail.com
10220 SW 4th Street
Miami, Florida 33174

From: [Julie Seaver](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:10:50 PM

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As a citizen of Florida, and a direct service provider to transgender children and their families, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state. Equitable access to affirming care to transgender children does not threaten other patients' body autonomy or their rights!

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Julie Seaver

julie@compassglcc.com

Lake Worth, Florida 33460

From: [Jowharah Sanders](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:56:14 PM

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Jowharah Sanders
JowharahSanders@gmail.com

Coral Springs, Florida 33071

From: [Joe Mahma](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 10:06:17 PM

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Joe Mahma

jlfepccocyxqplqfh@kvhrw.com

, Saint Croix Island 32007

From: [Kristi Cowles](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 9:45:33 PM

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Kristi Cowles
onewolfsings@gmail.com

,

From: [Kayce Compton](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:01:02 PM

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Kayce Compton
kaycecompton@gmail.com

Alexandria, Virginia 22301

From: [Lauren Fox](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 1:25:27 AM

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Lauren Fox
foxlauren96@gmail.com

Windsor Gardens, South Australia 5087

From: [Laurence Ford](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:04:25 PM

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Laurence Ford
lfordtampa@gmail.com

,

From: [Leon Light](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 1:37:25 PM

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Leon Light
leonlight@icloud.com

,

From: [Liam Westgate](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:57:20 PM

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Liam Westgate
lwestgate002@gmail.com

Baltimore, Maryland 21212

From: [Lola Insun](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 6:21:24 AM

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Lola Insun
lsun67@aol.com

Boynton Beach, Florida 33472

From: [Loretta Di Tocco](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:01:41 PM

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Loretta Di Tocco
lorettamdt@gmail.com
1018 James street
Key West, Florida 33040

From: [Luna Plaza](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 1:27:21 PM

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Luna Plaza
lunaplaza@protonmail.com

Pittsburgh, Pennsylvania 15212

From: [MARIA MANDRY](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 11:44:43 PM

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MARIA MANDRY

mcm11012003@yahoo.com

,

From: [Marie Luce Suckle](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 6:05:33 AM

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Marie Luce Suckle
marielu5@aol.com
3941 Crawford avenue
Coconut Grove, Florida 33133

From: [Mary Smith](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 9:54:42 PM

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A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Mary Smith
marys996@aol.com

Iona, Florida 33908

From: [Mar Garcia](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:02:50 PM

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Mar Garcia
gserena080502@gmail.com

,

From: [Marthe Hjortshøj](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:31:36 PM

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Marthe Hjortshoj
marthe.hjortshoj@gmail.com

,

From: [Lorenzo Canizares](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 10:34:05 PM

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Lorenzo Canizares
l.canizares@aol.com

Miami, Florida 33196

From: [Marcela Howell](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 10:52:29 AM

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Even though I am not a citizen of Florida, I am appalled that the Florida Board of Medicine would take this step to restrict access to gender-affirming care rather than ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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While Florida currently does not have state-specific standards for providing gender-affirming care, the Florida Board of Medicine should at least take the position to DO NO HARM.

If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Sincerely,
Marcela Howell

Marcela Howell
marcela@blackrj.org

Washington, District of Columbia 20005

From: mathimugil@gmail.com
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 11:05:50 AM

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mathimugil@gmail.com

,

From: [miriam Lopez](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 11:10:36 PM

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miriam Lopez
miriamlopez@mac.com
20 Island Av
Miami Beach, Florida 33139

From: [MICHELE DRUCKER](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 7:41:19 PM

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As a married mother of three children and thriving transgender daughter, I am horrified by this harmful and bigoted targeting of transyouth and families in Florida.

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MICHELE DRUCKER
michele.drucker@gmail.com
1101 PALERMO AVENUE
CORAL GABLES, Florida 33134

From: [Michelle Patricios](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 10:30:44 AM

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How could a medical board ignore the professional opinion of doctors and listen to hateful politicians instead? Ignore the AMA?

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I have two friends with trans adult children, who were suicidal as minors until they received mental health care and hormone therapy. It was under constant care by a physician, and with much care and concern.

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Michelle Patricios
michelle_ramirez@bellsouth.net

Pinecrest, Florida 33156

From: [Nicole Leidesdorf](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:26:24 PM

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Nicole Leidesdorf
neltrent@gmail.com

Palm Beach, Florida 33480

From: [nastasia.nastic](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:12:14 PM

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nastasia nastic

nastasia.nastic@gmail.com

,

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May Thach
maythach@live.com

St. Petersburg, Florida 33710

From: [Matthias Tang](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 8:35:37 PM

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WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Matthias Tang

cynthian.wordsmith@yahoo.com

,

From: [Reminé Benniefield](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 2:17:28 AM

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I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about medical care belong within the sanctity of the patient-physician relationship.”

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

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If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Reminé Benniefield
benniefieldr@arizona.edu

Tucson, Arizona 85730

From: [Phillip Whitt](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 4:00:29 AM

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If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Phillip Whitt
pmw7159@aol.com

Boynton Beach, Florida 33437

From: [River Petley](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:41:35 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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serves and does not need any adjustment.

If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

River Petley
turtle0verl0rd.jpeg@gmail.com

Coconut Creek, Florida 33073

From: [Riley Brannian](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:32:26 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Riley Brannian
rebrannian@gmail.com

,

From: [Robert Lee](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 10:47:00 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Robert Lee
leer321@gmail.com

, Florida 32303

From: [Ross Evans](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:07:01 PM

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A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Ross Evans
rosstherottenapple@yahoo.com

Miami, Florida 33143

From: [Samael Terebessy](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:14:40 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Samael Terebessy
samterebessy@gmail.com

Jacksonville, Florida 32224

From: [Stephanie Burton](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 12:25:23 AM

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As a member of the transgender community, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Stephanie Burton
stephanieburton1988@gmail.com

Colwick, Nottinghamshire NG4 2GJ

From: [Tatum Bent](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 2:00:09 AM

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As a citizen of Washington, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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If Florida-specific standards of care are adopted, they must reflect the most current version of

WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Tatum Bent
bentat06@gmail.com

Olympia, Washington 98502

From: [Stacy Frazier](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 10:26:14 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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Stacy Frazier
slfrazi@fiu.edu

Weston, Florida 33326

From: [Telene Thomas](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 4:34:10 AM

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A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Telene Thomas
telenejacobs@gmail.com

Delray Beach, Florida 33484

From: [Terry Lowman](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 11:09:58 AM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

One of my best friends came out as a transman. Henry is as precious as he ever was. It started with "if I had my life to do over again", but three years later he chose top surgery. He is so happy--a smile on his face all the time. I'd go very long way to do whatever I can to affirm his humanity.

We are talking about human beings here, not some abstraction or even an enemy. And if you haven't noticed, there are lots more transpeople coming out. You need to get on the right side of history. I would assume you are educated--which makes your sin even worse--you should know better.

Terry Lowman
terryLeeLowman@gmail.com

Miami Beach, Florida 33139

From: [Shannon Fortner](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:04:41 PM

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Shannon Fortner
shannon.fortner@fabaf.org

,

From: auditor.thunder.0z@icloud.com
To: [BOM Public Comment](#)
Subject: Standard of care for minors with sex/body dysmorphia
Date: Monday, September 26, 2022 3:53:48 PM

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To Whom It May Concern,

Minors suffering from sex dysphoria (that is, they feel they were “born in the sexed wrong body”) are at great risk of being victims of medical exploitation and malpractice. Puberty blockers completely block puberty from occurring and are being prescribed to physically healthy children as young as 10 years old, some even younger. Lupron, the commonly used puberty-blocking drug was given FDA approval to treat prostate cancer in men and endometriosis in women, not childhood psychological issues.

There have been no long-term clinical studies done on children. Puberty blockers are being used ‘off label’ to block kids’ healthy, natural development, with grave physical consequences. The few small studies we do have show that they don’t even provide any psychological benefit, and in fact may make things worse. The studies we do have show clearly that of these children (provided they go through puberty), 4 out of 5 experience complete alleviation of psychological distress. Most discover that they are same-sex attracted. Furthermore, over 90% of children who are put on puberty blockers move forward with cross-sex hormones. It is now clear that suicidality significantly *increases* in those who have been “affirmed” in this way. In addition, the long term effects of these drugs and hormones have sweeping deleterious effects on health and chain patients to a lifetime of medical intervention and drugs.

Gender ideology is a pseudo-religious movement which claims that children can be born in the wrong body. It teaches that we all have a ‘gender identity’ which takes precedence over our biological sex. It is entirely based on regressive stereotypes: Children are taught that it is their interests, hobbies, likes and dislikes which determine their gender. School materials literally say: if boys like Barbie dolls and dancing, they might actually be a girl. Girls struggling with adolescence, with puberty, with anxiety, etc. are especially vulnerable to this craze, as covered so well in Abigail Shrier’s book, ‘Irreversible Damage: The Transgender Craze Seducing Our Daughters’.

Instead of encouraging gender nonconformity, and rejecting regressive gender stereotypes, children are now taught to embrace the stereotypes to the point of physically harming their bodies. They are taught that they have boy brains or girl brains, or a gendered soul. This is wholly unscientific nonsense. Thousands of children are now being sent to gender clinics, where they receive ONLY affirmation of this idea, and they are quickly sent on a medical pathway which includes puberty blockers, opposite-sex hormones, and surgery.

State and federal governments must take a firm stand against pediatric “affirmative care” and the gender ideology being aggressively taught in schools (many starting in pre-K). It’s the biggest medical scandal in history and it’s being committed against our most precious

population — our children.

Thank you for your consideration of my opinion.

Best,
Suzy

From: [zachary hoskins](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:17:25 PM

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zachary hoskins

ladyvonhresvelg@gmail.com

, Kentucky 40019

From: [Weston Lucas](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, September 27, 2022 8:09:18 AM

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Weston Lucas
westy3028@gmail.com

Dallas, Texas 75231

From: [William Fisk](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:27:46 PM

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William Fisk
wafisk61@gmail.com
2105 Redwood Cir NE
Palm Bay, Florida 32905

From: [Victoria Benson](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:19:54 PM

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Victoria Benson
vabenson01@gmail.com

, Saint Croix Island 33736

From: [Tony Cooper](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 7:20:37 PM

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Do not continue down this path of transphobia.

Tony Cooper
carlsagan31@ymail.com

, Kansas carlsagan31@ymail.com

From: [Susan Nasrani](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, September 26, 2022 8:54:31 PM

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Susan Nasrani
susannasrani@gmail.com

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From: [Meredith Mechanik](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 3, 2022 5:33:07 PM

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Meredith Mechanik
mmechanik@usf.edu

,

From: [Heather Eslien](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 4, 2022 10:49:26 AM

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Heather Eslien

heather.d.eslien@gmail.com

, 34236

From: [MATTHEW BURCH](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 3, 2022 7:46:02 AM

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MATTHEW BURCH
MATT.W.BURCH@GMAIL.COM

,

From: [sue evans](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Statement for Florida Medical Board regarding Childhood Gender Dysphoria Treatments
Date: Thursday, September 22, 2022 12:05:50 PM
Attachments: [Florida Medical Board letter.docx](#)

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Dear Mr Vazquez,

I am an experienced mentally health practitioner who also specialises in the area of the psychological treatment of children and young adults with GD. It was suggested that I should write to you with some of my experiences and knowledge for your upcoming meeting regarding the evidence base and ethical treatment models for children experiencing gender dysphoria.

Please let me know if this is sufficient, and if required for the Board I can supply substantially more information, research data and references.

Yours sincerely

Susan Evans

Evanspsychotherapy.co.uk

6 Elm Rd
Beckenham
Kent BR3 4 JB

Practice number 0208650017

CV and Experience

I am trained as a Psychoanalytic Psychotherapist and currently work in private practice in the UK seeing children with gender identity issues. I am retired from the NHS which has allowed me to speak more freely regarding this issue.

I worked in the Tavistock Gender Identity Service in the NHS for several years. I trained as a state registered nurse and psychiatric nurse and have experience in many specialist areas of psychiatry/mental health since the 1980s. I was a Senior Clinical Lecturer at the Tavistock and Portman National Health Service Foundation Trust and Senior Fellow in Education, University of East London.

The Tavistock GIDS has recently been permanently closed, following many concerns raised by staff, parents, the law and the media. It received a poor report from the Care Quality Commission, which oversees standards of care in the NHS. NHS England in response, commissioned a report by Dr Hilary Cass, a consultant paediatrician and her team concerned with the evidence base, standards, and efficacy of approaches to the medical treatment and care of gender dysphoria in children.

Marcus Evans and I have authored a book on Gender Dysphoria which offers a potential holistic psychological understanding and treatment model to support children with gender dysphoria in their time of distress.

My involvement

Between 2004 and 2007 I became very concerned that the children who were presenting as patients in the GIDS were, in most cases, psychologically complex and many with co-morbidities. (It is estimated approximately 30% are on the autistic spectrum). I witnessed some being recommended for medicalised treatments on hormones, after as few as 4 assessment meetings, during which time very little psychological support or treatment could have occurred. In my clinical experience it takes much longer to make a full assessment of children and adolescents and a therapeutic alliance can take months to build. I was shocked by this superficial psychological approach, as it led to irreversible changes, both physical and mental, some of which, as yet, are unknown, due to the paucity of follow up data on the children receiving these treatments.

The UK Judicial review ‘Bell versus Tavistock

By 2019 the service had grown from approximately 80 referrals nationally per year to over 3,000 per annum. Certain staff at the unit whistle blew to Dr David Bell who was at the time a staff governor for the Tavistock Trust. He made a report for the Tavistock trust board, but the board decided to conduct their own review and many of the staff concerns were diminished or ignored. Meanwhile there was a growing awareness in the UK that all was not well in the growing political influence on medical and psychological approaches to treatment of gender dysphoria in children. There was a meeting organised by Lord Moonie in the House of Lords and from this several previously separate but concerned individuals came together. Following this I agreed with Mrs A, the mother of a teenage girl, with autism on the waiting list for the Tavistock GIDS, that we would take a judicial review to question whether children can give informed consent to this experimental form of medical treatment. Our team gathered witness statements from experts throughout the world and also from Keira Bell, a female who had been treated at GIDS as a 16-year-old, but subsequently de-transitioned. She became the main claimant in the Case.

At 23, Keira Bell felt that she should not have been able to embark on such a procedure because, in retrospect, she realised she had not had the maturity and understanding to give informed consent to the medicalised procedures. Mrs A, the other claimant, did not consider her daughter capable of understanding the attendant risks of undertaking gender reassignment treatment due to her autism diagnosis and other emotional conditions. The judicial review in the UK High Court was to challenge policies and practices based on unconditional “affirmation”

and the prescription of puberty blockers to children under 18 with gender dysphoria at the Gender Identity Development Service (GIDS), part of the Tavistock and Portman NHS Foundation Trust.

Our team submitted a huge amount of evidence which 3 high court judges were able to read prior to the hearing, along with any evidence that the Tavistock GIDS submitted.

In December 2020, three judges in the High Court ruled that it is doubtful that children under the age of 16 years are able to consent to treatment with hormone blockers

The 3 High Court judges stated "There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication." The judgement said it was "doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences" of this treatment. It further ruled that it was "highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers."

They also considered the 16-18 group and said that most young people aged 16 or 17 will be able to consent to medical treatment. Some young people under 16 can also consent to their medical treatment. **However, competence to consent to a treatment is specific to the nature of that treatment.**

"There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication."

In my clinical experience of working with this group of children, I have learned that many of these children are managing their anxieties through a system of rigid psychological defences. They often struggle to be able to think about their internal emotional world and their conflicts and confusions. It may feel anxiety provoking to explore this with the child, but a holistic empathetic approach can be utilised to help the child begin to be curious about themselves. If however, they are not supported to do so, the psychic discomfort is often channelled into the idea of making concrete changes to the body as if this will get rid of the difficult issues. The idea of 'puberty blockers' may be very appealing to put a stop to this adolescent development. (to the patients, parents and clinicians

because it appears to be an easier route out of the chaos and disturbance) The task of us all in life is to develop from a child into an adult. Adolescence and the accompanying chaos this age brings, is a very normal human experience. The anxieties which some children are hoping to avoid is often around their adolescent physical development and maturation, associated with a difficulty in negotiating sexuality and relationships. (I will not say more here but hope this offers the board some ideas for why puberty blocking is perhaps not only physically harmful but psychologically harmful as it interferes with ordinary human development in all areas).

The recent ICD11 has, in my view bowed to certain political pressures over diagnostic terms.

One small example is observing 'Insistence, Consistence and Persistence' taken to be diagnostic confirmations of gender dysphoria, and this might indeed describe the state of mind witnessed by the clinician, but for me these particular states of mind wave a red flag when I encounter them in children. As I said earlier, many of these children find themselves caught up in rigid psychic defence systems where there is no room for ordinary questioning or doubt about the huge decisions they are making for their future life. It is ordinary good mental health to question or have concerns and doubts about a serious life changing course of action. The lack of anxiety and doubt is of huge concern, not a green light of diagnostic confirmation in my opinion.

The Cass interim report found that gender identity involves a "complex range of issues", which are not sufficiently recognised in the WPATH Standards of Care.

Regret desistance and detransition

There is a very high level of desistance (between 75-95%) in children with gender dysphoria, if they are offered 'watchful waiting' but early evidence is suggesting that this rate lowers if children are socially and medically affirmed.

We have no true idea of the number of children who have given 'informed consent' to this medicalised route, received hormones and/or surgeries, but live to regret their transition and will suffer lifelong consequences of this experimental treatment. The Cass review evidenced that there is very little gold standard research and follow up data in this area of medicine. Sadly, 'de-transitioners' do not often go back to tell their medical 'transitioners' that they have, together, made an

irrevocable mistake and caused perhaps irreversible harms. Many of them speak of the wish that a professional had stopped them in their headlong run towards medical transition. The medical profession has an opportunity to look more closely at the potential harms being done and improve their practices in the care of gender dysphoric patients.

Susan Evans

Psychoanalytic psychotherapist

Member of the British Psychoanalytic Council

British Psychotherapy Foundation

Retired State Registered Nurse and Registered Mental Nurse

From: [Daniel Joyce](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Dysphoria in Minors
Date: Tuesday, September 20, 2022 8:18:21 PM

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Dear Board Members,

I understand the Board is considering recommendations regarding medical transition for minors with gender dysphoria. I am sure that the Board is aware that the world's largest pediatric Gender Identity Development Service (GIDS) in the UK is planning to close to be replaced by clinics with a greater focus on mental health and general practitioner services. The literature review by Dr. Hillary Cass determined that their current medical transition model was not safe. It also determined it was not viable for the long term.

An important quote from her review demonstrates that the medical treatment of gender dysphoria has become more of a political issue than a medical one. From page 17, para. 1.14, "Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters." Further support for such politicalization of this issue comes from the fact that 35 psychologists resigned from NHS's GIDS over three years, complaining of over-prescribing the medicalization of gender dysphoric minors feeling they were unable to properly assess patients over fears they will be branded transphobic.

Further support for this politicalization from the Cass review includes the following:

- Page 17, para. 1.15, states " many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be overlooked."
- Page 17, para. 1.18, "From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision" "There is limited evidence of mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic or psychological formulation."

Importantly, the Cass review states on page 18, "Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally." This review is not alone in that assessment.

The UK's National Institute for Health and Care Excellence (N.I.C.E) issued reviews in 2020 on puberty blockers and cross-sex hormones.

In regards to gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria, they concluded: "The results of the studies that reported impact on the critical outcomes of gender dysphoria and mental health (depression, anger and anxiety), and

the important outcomes of body image and psychosocial impact (global and psychosocial functioning), in children and adolescents with gender dysphoria are of very low certainty using modified GRADE. They suggest little change with GnRH analogues from baseline to follow-up.”

In regards to Gender-affirming hormones for children and adolescents with gender dysphoria, they concluded:

“Results from 5 uncontrolled, observational studies suggest that, in children and adolescents with gender dysphoria, gender-affirming hormones are likely to improve symptoms of gender dysphoria, and may also improve depression, anxiety, quality of life, suicidality, and psychosocial functioning. The impact of treatment on body image is unclear. All results were of very low certainty using modified GRADE.”

“Adverse events and discontinuation rates associated with gender-affirming hormones were only reported in 1 study, and no conclusions can be made on these outcomes.”

I recommend the Board be very cautious in their recommendations regarding the treatment of gender dysphoria in minors. I recommend such treatment only be performed with parental consent. I am not convinced parents can grasp the gravity and enormity of these decisions. Minors clearly cannot.

It appears the quality of evidence to support the medical treatment of gender dysphoria is poor at best and follow up on these treatments is clearly inadequate. Since the largest pediatric gender identity clinic in the world seems to be moving back towards a mental health emphasis in the treatment of gender dysphoria, it might be wise for Florida to follow suit.

Thank you for your consideration in these matters.

God bless you!

Sincerely,

Daniel Joyce, M.D.

7885 Midway Drive Terrace

Unit E102
Ocala, FL 34472

734 730-2447

drdanieljoyce@yahoo.com

From: timfader@fastmail.fm
To: Paul.vasquez@flhealth.gov
Cc: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: gender transition
Date: Monday, September 19, 2022 2:35:18 PM

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Dear Mr. Vasquez,

I am a family medicine physician living in Clermont. I am writing to express my concerns about gender transition:

1. The evidence supporting the usefulness of this treatment for children is weak.
2. The risk of children taking puberty blockers is high.
3. The capacity of children to make a decision to transition is limited.
4. Encouraging gender transition in children without the knowledge and consent of the child's parents is criminal.

Gender transition in children is a dangerous procedure and should not be permitted in Florida, or anywhere in the world.

William T Fader MD

--

timfader@fastmail.fm

From: [Harrison Scoville](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, October 13, 2022 3:07:49 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about medical care belong within the sanctity of the patient-physician relationship.”

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of

WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Harrison Scoville

hws2c2009@gmail.com

3317 NW 26th St

Gainesville, Florida 32605

From: [Robin Winokur, MD](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Pediatrician Input on Gender Affirming Care for Youth
Date: Wednesday, September 21, 2022 2:56:35 AM

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September 20, 2022

To: The Florida Board of Medicine

Re: Gender Affirming Care for Adolescents

I am a pediatrician with 37 years of experience. In recent years, I have seen a large increase in the number of adolescents asking for referral to our local Gender Clinic. The majority of these patients are pubertal young women. Most have not expressed concerns about their gender prior to puberty. Many have had prior anxiety and difficulty socially. They are looking for answers, and being “in the wrong gendered body” has become a much more common answer than previously.

Unfortunately, there are far too few resources for young people struggling with accepting the changes in their bodies associated with puberty. In the past, there were support groups we could refer these adolescents to. Now, it is easier to refer to the Gender Clinic. We are changing from a “body positive” approach to a “wrong body needing change” approach.

These adolescents need our support, but it is important that we study Gender Affirming Care before adopting it with no boundaries. Young people being treated medically for gender dysphoria should be part of well-designed studies. Any irreversible treatments, such as mastectomies (top surgery), should be particularly scrutinized.

Ideally, we should be doing studies comparing Gender Affirming Care with age appropriate support groups that promote self love and make puberty less daunting.

To be clear, there are some children who present at very young ages with gender variation. This small group started the movement to have Gender Clinics and they appear to be much more persistent in their gender identification. Their numbers have not increased at the same pace as the pubertal group.

Thank you for your consideration of this important topic.

Sincerely,

Robin Winokur, MD

From: [William Cheshire](#)
To: [Vazquez, Paul](#)
Cc: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender dysphoria decision
Date: Monday, September 19, 2022 1:04:10 PM

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Dear Dr. Vazquez and members of the Florida Medical Board,

I am a physician who has been practicing in Florida for 30 years and am writing to express concern about how the board will decide in its upcoming deliberation on recommendations for the availability, appropriateness, and standard of care for minors suffering from gender dysphoria who request so-called gender-affirming hormonal or surgical interventions.

Whereas in my own family, I have an adult nephew who has opted for such a transition, when it comes to minors, in my medical opinion, minors lack the cognitive developmental ability to render valid informed consent for such a life-altering transition that we know has potentially irreversible health consequences (e.g., thrombosis and stroke for those receiving estrogens; and potential infertility). Further, I have reviewed the medical literature on this question and find the evidence in support of medical and surgical transitions in minors to be scientifically weak, in critical areas inconclusive, and in other areas heavily biased. In longterm studies, a substantial number of patients who, as children, identify as the opposite sex later identify as their true biological sex, and there are cases of patients who later regret their transition. Further, the claim we sometimes hear that such treatments prevent suicide has been discredited.

At the very least, the medical profession should exercise due caution regarding unknown long-term impact of experimental drugs in minors. I fear that, one or two decades from now, a rational review of this social phenomenon will deliver a verdict not unlike that for frontal leukotomy.

Thank you for your consideration.

Cordially,

William P. Cheshire Jr., M.D.
Ponte Vedra Beach, Florida

From: [Matt Zban](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: sex based medicine
Date: Monday, September 19, 2022 1:46:22 PM

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I am writing because I am highly concerned that the Florida board of medicine is considering harming a subset of children and teens. Youth transition should not be allowed for many reasons, one being that > 85% of children and teens change their minds by age 20.

Please do not allow this fad and the activists who support it, to irreparably harm our children and teens!

Sincerely,

W. Matt Zban, MD, FACEP
Charlotte, NC

From: [Tim McNicoll](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: gender affirming care
Date: Monday, September 19, 2022 4:28:32 PM

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I am grateful for the opportunity to provide comments regarding the Florida board of medicine evaluation of gender affirming care. My name is Tim McNicoll MD, I am board certified in family practice since 1984 with an additional year of residency training in Pediatrics, a certificate of added qualifications in geriatrics from the AAFP and ABIM and a masters degree in bioethics. I also practiced OB early in my career and have cared for patients from conception to death.

I have watched with some dismay over the last few years the rapid progression from gender insecurity to permanent gender transition in many youths. I have cared for children for the last 40 years and have witnessed how quickly they can progress through developmental stages acquiring and vacillating between new physical, psychological, emotional, and sexual identities. They are constantly and rapidly acquiring new skills but have mastered none of them. Their search for themselves often involves different clothing, different hair styles or color, different speech, and different peer groups. Some more potentially permanent or damaging changes include tattoos, anorexia, overeating, alcohol, smoking, drugs, self-harming behaviors, suicidal ideation and even suicide. These are often aggravated by anxiety, depression, and family dysfunction.

Gender insecurity seems to be another manifestation of the almost cataclysmic changes that result from general adolescent identity insecurity. One could conceive of this almost as a living suicide as you destroy a major part of who you have been throughout your life – and unlike the other developmental experiments listed above, you may never be able to return from this gender experiment. There are always exceptions to rules, and likely there are some who may always desire transition, but the tremendous recent increase in gender dysphoria seems to be more of a social trend rather than an inherent human characteristic. Hopefully, like anorexia, it will regress to a much smaller fraction of the adolescent population in 20 years. In the meantime, one has to wonder how many regrettable and irreversible changes will be made.

Other body altering surgeries such as bariatric surgery are rarely offered to adolescents and usually only after prolonged counseling and non-surgical medical treatments. Even adults must go through rigorous counseling and non-surgical weight loss treatments before undergoing such surgery. Breast augmentation again is rarely offered to adolescents and we now know after 50 years of the risks of autoimmune disease, potential cancer risks, difficulty with cancer detection, infection and prosthetic rupture associated with various breast implants.

It is likely a universal human characteristic that at times we all imagine being somebody or somewhere different. A place where all our troubles in life vanish. This is likely a more common and more powerful feeling in adolescence as we try to determine who we are and where we fit in. However, because of the rapid developmental changes that adolescents are constantly experiencing, we should take a long pause before embarking on gender transition treatments. As with driving, smoking, alcohol consumption, leaving high school campus without authorization, and even adults having sex with a minor, there are some activities that we should strictly limit or proscribe until adolescents have successfully navigated through a good part of their development. This is the least we can do for our children before they permanently alter the rest of their long life.

Grateful for your public service,

Tim McNicoll M.D., M.S. Bioethics

From: [Tracey Rzepka](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Florida Medical Board's Gender Dysphoria Recommendations
Date: Monday, September 19, 2022 5:43:50 PM
Attachments: [Transgender Identification 2021 - October.pdf](#)

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Dear Dr. Paul Vazquez and the FL BOM,

I am a Psychiatric APRN here in FL.

Please protect the children and adolescents in FL from the irreversible effects of puberty blockers, cross sex hormones and surgery.

As a Psych NP, I have had several encounters with transgender individuals. One adult wanted me to sign off on a hysterectomy that an OB/GYN surgeon would not do without psychiatry approval. She told me initially that the surgeon needed to do the surgery because of polycystic ovarian syndrome. When I questioned surgery as a treatment for Polycystic Ovarian surgery she said that she is transgender. I then asked if she was planning to have mastectomies and she said she was. However, prior to asking for approval from me as a Psych NP for a hysterectomy, she had never mentioned any of this is the few times I had seen her. When I mentioned that it would be difficult for me to agree to this as it would be a liability if she changes her mind at some point in time, she got angry and hung up. She did not schedule another appointment. Unfortunately, her insurance had lapsed and I was never paid for that appointment. This is an adult who did not tell me the truth initially. She did not tell me she had changed insurance or that it had lapsed. She did not in any way present as male. She had been in the psych hospital many, many, many times and was extremely mentally ill.

It is well known that adolescents brains do not fully develop until age 25. They are not allowed to drink until 21 or buy a gun. Should they be allowed to make a decision about something that has not been clearly researched and studied and is a trend among the youth causing irreversible damage to their young bodies? I do not think so. Twenty-five should be the minimum age to give such a consent. Until then, psychological care and living several years as the opposite sex should be required first as it was in the past for trans surgeries.

I had another trans young man in his early 20s. "He" had had a complete hysterectomy and mastectomies and had been in the hospital due to suicidal ideation after the surgeries. In spite of this psych hospitalization, his parents took him back to Texas to have a phalloplasty. After returning, "his" girlfriend broke up with him and he ended up in the psych hospital again. Thankfully, he did not return to my office which was a relief to me as it was very traumatic to me to care for this young girl who had had such body altering surgery at such a young age and was clearly not mentally stable when they did the phalloplasty. "He" had just been in a psych hospital the month before the surgery.

What I see is that no one is assessing the psychological problems these young people have. I only see adults so I have not had anyone younger than 18 but a psychologist colleague of mine is seeing many, many young transgender clients in the hospital for suicide attempts, etc.

Fund a huge research study. You will have more than enough young people willing to sign up. I don't know what the State of FL or BOM liability would be if you would do such a study. Can it pass a Do No Harm, Informed Consent process to ethically do such a study? Puberty blockers were never studied long term in transgender individuals. It is being used totally off label along with the cross sex hormones in adolescent young people who will never recover.

I do not believe any insurance that I might be paying for, including Medicaid which is funded by my taxes should be paying for these damaging, experimental treatments. If someone wants to pay cash, as has always been the case in the past, and they are 25 years old, then it can be up to them.

Please protect the consciences of those like myself, who are not comfortable with this experimental treatment. I have been a member of the Christian Medical and Dental Association since 1989 before I graduated as an NP in 1990. They have an ethics statement on transgender issues. See items D&E below

for the negative effects of hormone blockers, cross-sex hormones and surgery. I apologize the references did not copy clearly. The original is attached.

Thank you for your time in reading this.

Tracey Rzepka, MS, ARNP, PMHNP-BC
Something Beautiful Wellness Care
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Phone: 941-870-7060
Fax: 844-876-2658
www.sobewellcare.com

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CMDA Ethics Statement Transgender Identification

Preamble

A novel way of thinking about one's body has entered into popular culture. "Transgender" individuals refer to their "gender" as a sexual identity that may be male or female, something in between, or neither. This self-identification differs from, and takes priority over, their biological sex as recognized in their chromosomal DNA and innate physical sexual characteristics. The naming of gender as a category set apart from sex is an idea foreign to the holistic view of the person as understood within Christianity. Christians affirm the biblical understanding of humankind as having been created male and female, with the two sexes having equal dignity and a complementary relationship to each other.

At the heart of disagreement over transgenderism is a difference in worldviews. If the human body is nothing more than the product of mindless, random, purposeless physical forces, then one may do with it what one wishes, even to demand medical and surgical cooperation in projects to alter, amputate, or reconstruct normal tissue to conform to the patient's revised psychological sense of identity. If, on the other hand, our bodies are an inseparable aspect of our true selves and are a good gift from God, who has designed the sexes to be wonderfully paired, and who has a purpose for humanity, then respecting the gift of given sexual identity and the ensuing moral obligations to our neighbors is the surest path to human flourishing. Both worldviews share the recognition that humanity is broken and in need of renewal, but they look to different answers for healing. Christians seek not a reconfiguring of the body, but a spiritual transformation of the mind to become more like Christ; not rejecting the gifts of God, but welcoming God's purposes and demonstrating God's love by loving our neighbors. This love of neighbors includes loving our transgender neighbors as persons who, like all people, are created in God's image. However, loving them and validating them as people does not mean agreeing with their ideologies or use of language.

The Christian Medical & Dental Associations (CMDA) believes that healthcare professionals should not be forced to violate their conscientious commitment to their patients' health and welfare by being required to accept and participate in harmful gender-transition interventions, especially on the young and vulnerable. CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and

compassion, consistent with the humility and love that Jesus modeled and commanded us to show all people.

Introduction

CMDA affirms that all human beings are created in the image of, and beloved by, God. All human beings are our “neighbors”, and are to be loved by us as we love ourselves. All human beings possess intrinsic dignity and are worthy of equal respect and concern from Health Care Professionals.

CMDA considers “sex” (i.e., male or female) to be an objective biological fact (see section B.1. below). CMDA affirms the historic understanding of gender as referring to biological sex and the enduring biblical understanding of humankind as having been created male and female and that this is good. CMDA acknowledges the current cultural use of the word “gender” to refer to one’s sense of identity as male or female. CMDA cannot support the recent usage of the term “gender” to emphasize an identity other than one’s biological sex, that is, a subjective sense of self based on feelings or desires leading to identifying somewhere on a fluid continuum of gender identity.^{1,2,3,4} (See Glossary at the end of this document)

CMDA cannot support the prevailing culture’s acceptance of an ideology of unrestrained sexual self-definition that, in celebrating gender fluidity and gender transition efforts, is indifferent to biological reality and opposed to the biblical understanding of human sexuality. Further, CMDA is alarmed that some proponents of transgender ideology, through activism and intimidation, are insisting that healthcare professionals cooperate with and affirm their beliefs in gender fluidity, even if the healthcare professionals believe that such cooperation and affirmation would be doing harm to their patients. This violates the most fundamental core value of medicine since Hippocrates, that of caring only for the good and benefit of the patient while abstaining from all unnecessary harm. The evolving scientific and medical facts demonstrate that the mutilation of normal tissue and profound disruption of normal physiology that occur during gender transition procedures are very difficult to justify, as this constitutes deliberate harm.

CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion. CMDA holds that attempts to radically reconstruct one’s body surgically or hormonally for psychological indications, however, are medically, ethically, and psychologically inappropriate. These measures alter healthy tissue and increasingly are not supported by scientific research evaluating behavioral, medical, and surgical outcomes.^{5,6,7,8,9,10,11}

Accordingly, CMDA opposes medical assistance with gender transition on the following grounds:

A. Biblical

1. God created humanity as male and female (Gen 1:27, 5:2; Matt 19:4; Mark 10:6). God's directives – to have dominion over the earth and to fulfill his goals of procreation, union, fellowship, and worship – are given to men and women together (Gen 1:26-28, 2:18-24).
2. Men and women are morally and spiritually equal (Gal 3:28) and are created to have roles that are in some respects alike and in other respects wonderfully complementary (Eph 5).
3. All people are loved by God (John 3:16-17). All struggle with moral failure and fall short of God’s standards (Rom 3:10-12) and, therefore, need the forgiveness that God provides through Christ alone (John 3:36; Rom 3:22-24; Col 1:15-22; 1 Tim 2:5-6).
4. For the Christian, all of ethics, grounded in God’s moral law, is based upon the first and

second greatest commandments: to love God with all our heart, soul, and mind, and to love our neighbors as ourselves (Matt 22: 37-40). If we encourage others to sin sexually, just as if we sin sexually ourselves, we are violating these two commandments. We violate the first greatest commandment by failing to love God in his holiness, wisdom, and rightful place as our Creator, and we violate the second greatest commandment as we fail to respect ourselves and each other by abetting lives of disobedience, deception and unholiness (1 Cor 6: 13b-20). Love may include a corrective component that should be applied in an appropriate and timely manner; affirmation can be enablement.

5. We live in a fallen world (Gen 3), and we all come into this world as fallen creatures with a sinful nature. (Rom 3:9-12). The fall is expressed in nature and in humanity in many ways, including sexuality. Confusion of gender identity is but one example of the fall, as are also marital breakdown and sexual immorality (Rom 1:24-32; Eph 5:3).
6. A lifestyle that is directed by pursuing sexual desires, or driven by personal sexual fulfillment, misses the divinely ordained purpose of sex, which is for procreation, bond creation, and re-creation¹² and for facilitating unity in the lifelong commitment of marriage, which is defined as being between one man and one woman. Heterosexual marriage fosters a secure and nurturing environment for children and it reflects the unity of Christ and the Church (Exod 20:1-18; Lev 20:10-21; Rom 1; Eph 5:23-33) (see also CMDA Statement on Homosexuality).
7. Believers in Christ, though having inherited the sinful nature common to all humanity, also receive a new nature in Christ. As the old nature, being crucified with Christ, dies, our new redeemed nature, sealed by Christ's bodily resurrection, is actively transforming our minds and hearts to be more and more like Christ. This transformation is spiritual, not sexual, and is God's work, not something of our own design (Psalm 100:3; Rom 12:2; Col 1:27).

B. Biological

1. Sex is an objective biological fact that is determined genetically at conception by the allocation of X and Y chromosomes to one's genome, is observable at birth, is found in every nucleated cell, and is immutable throughout one's lifetime. Sex is not a social construct arbitrarily assigned at birth and cannot be changed at will.^{2,3,13}
2. Human beings are sexually dimorphic. Male and female phenotypes are the outworking of sex gene expression, which shapes sex anatomy, determines patterns of sex hormone secretion, and influences sex differences in the development of the central nervous system and other organs.^{2,3,14}
3. Procreation requires genetic contributions from both one man and one woman.^{15,16}
4. CMDA recognizes that exceedingly rare congenital abnormalities exist in which phenotypic sex characteristics are not what is expected from the genotype.^{1,2} These disorders of sex development are of a diverse nature, but usually impair fertility.³ Treatment (including non-intervention) of these disorders differs categorically from transgender interventions, which are performed on persons with no inherent defect in sex organ development, function, or fertility. Anomalies of human biological sex are conditions rather than identities, something one has rather than who

one is. Disorders of sex development are not the fault of the patient, do not invalidate God's design in creation, and do not constitute a third sex.^{17,18,19,20}

5. Gender dysphoria²¹, the condition of experiencing discomfort or distress at one's sex and preferring a different "gender" identity, has not to date been linked to a genetic cause and

is a psychological disorder of unclear and complex origin.^{22,23,24} Gender dysphoria may cause profound distress. It should not be confused with transient gender-questioning that can occur in early childhood.^{25,26,27,28,29,30}

C. Social

1. CMDA recognizes that gender identity issues are complex. The inclination to identify with the opposite sex or as some other gender identity along a spectrum may have non-genetic biological,³¹ familial,^{32,33} and social ^{27,28,34} causes that are not personally generated by particular individuals.²¹⁻³⁰
2. In our current social context, there is a prevailing view that removing traditional definitions and boundaries is a requirement for self-actualization. Thus, Christian healthcare professionals find themselves in the position of being at variance with evolving views of gender identity in which patients or their subcultures seek validation by medical professionals of their transgender desires and choices through medical or surgical solutions to gender dysphoria. Although such desires may be approved by society at large, they are contrary to a biblical worldview and to biological reality and thus are disordered.
3. In contrast to the current culture, CMDA believes that finding one's identity within God's design will result in genuine human flourishing. CMDA believes, moreover, that social movements which assert that gender is a choice are mistaken in defining gender as something independent of sex. Authentic personal identity consists in social gender expression that is congruent with one's natural biological sex but not limited to stereotypes. CMDA recognizes that this traditional view has become counter-cultural; however, CMDA affirms that God's design transcends culture.
4. CMDA opposes efforts to impose transgender ideology on all society by excluding, suppressing, marginalizing, intimidating, or portraying as hateful those individuals and organizations that disagree on scientific, medical, moral, or religious grounds. Such attacks are contrary to the freedoms of speech and religious liberty that lie at the very foundation of a just and democratic society.
5. There is a social contagion phenomenon luring young people into the transgender culture.^{32,33}
6. CMDA opposes efforts to compel healthcare professionals to grant medical legitimacy to transgender ideologies.^{35,36,37,38,39,40} Cooperation with requests for medical or surgical gender reassignment threatens professional integrity by undermining our respect for biological reality, evidence-based medical science, and our commitment to non-maleficence (see CMDA Statement on Healthcare Right of Conscience).
7. Promotion of transgender ideology by educational institutions and teachers to children

as young as 5 years of age is a danger to the health and safety of minor children (for medical reasons elaborated in the next section).^{41,42,43,44,45,46,47} Education should respect the value of every human being; in supporting and affirming the student, it need not affirm every desire.

8. No educational institution or teacher should ever block parents from supervising their child's education or withhold from them knowledge of the educational content.

D. Medical

1. Transient gender questioning can occur during childhood. Most children and adolescents who express transgender tendencies eventually come to identify with their biological sex during adolescence or early childhood.^{48,49,50,51,52,53} There is evidence that gender dysphoria is influenced by psychosocial experiences and can be exacerbated by promoters of transgender ideology.^{27,33} Early counseling for children expressing gender dysphoria is critical to treat any underlying psychological disorders, including depression, anxiety, or suicidal tendencies, and should be done without promoting attempts for gender transitioning.

2. Hormones prescribed to a previously biologically healthy child for the purpose of blocking puberty inhibit normal growth and fertility, cause sexual dysfunction, and may aggravate mental health issues. Continuation of cross-sex hormones, such as estrogen and testosterone, during adolescence and into adulthood, is associated with increased health risks including, but not limited to, high blood pressure, blood clots, stroke, heart attack, infertility, and some types of cancer.^{51,54,55,56,57,58,59,60}
3. Although some individuals report a sense of relief as they initiate the transitioning process, this is not always sustained or consistent over time. Some patients regret having undergone the transitioning attempt process and choose to detransition, which involves additional medical risk and cost.^{56,61,62,63,64}
4. Among individuals who identify as transgender, use cross-sex hormones, and undergo attempted gender reassignment surgery, there are well-documented increased incidences of depression, anxiety, suicidal ideation, substance abuse, and risky sexual behaviors in comparison to the general population.^{21,22,23,61,65,66,67} These health disparities are not prima facie evidence of healthcare system prejudice. These mental health co-morbidities have been shown to predate transgender identification.^{24,25,26,27,28,34,68} Patients' own gender- altering attempts and sexual encounter choices (or, in the case of children, their parents' choices on their behalf) are among the factors relevant to adverse outcomes in transgender-identified patients.
5. Although current medical evidence is incomplete and open to various interpretations, some studies suggest that surgical alteration of sex characteristics has uncertain and potentially harmful psychological effects and can mask or exacerbate deeper psychological problems.^{7,8,9,69} Evidence increasingly demonstrates that there is no reduction in depression, anxiety, suicidal ideation, or actual suicide attempts in patients who do undergo surgical transitioning compared to those who do not.^{7,70} The claim that sex-reassignment surgery leads to a reduction in suicide and severe psychological problems is not scientifically supported.^{64,71,72,73}
6. A patient has died because the medical records conveyed only the individual's gender

preference, and not their biological sex, leading to misdiagnosis and medical catastrophe.^{74,74}

E. Ethical

1. Restoring and preserving physical and mental health are goals of medicine, but assisting with or perpetuating psychosocial disorders are not. Accordingly, treatment of anomalous sexual anatomy is restorative.⁷⁵ Interventions to alter normal sexual anatomy and physiology to conform to identities arising from gender dysphoria are disruptive to health.^{9,76}
2. Medicine rests on science and should not be held captive to desires or demands that contradict biological reality. Sex reassignment operations are physically harmful because they disregard normal human anatomy and function. Normal anatomy is not a disease; dissatisfaction with natural anatomical and genetic sexual makeup is not a condition that
can be successfully remedied medically or surgically.
3. The medical status of gender identity disorder (currently termed gender dysphoria) as a mental or psychosocial disorder should not be discarded.
4. The inability of men, including men who identify as women, to bear children is not an illness to be remedied by medical or surgical means, such as uterine transplantation.⁷⁷ Uterine transplantation into biological men cannot be justified medically (See CMDA Statement on Enhancement and CMDA Statement on Transplantation).
5. Fundamentally, it is unrealistic to remove or mutilate normal organs and tissue and to disrupt normal physiology, and then to expect normal function. This illustrates the reality that complete gender transitioning is not medically possible.
6. Christian patients struggling with transgender inclinations face not only the psychological distress of a desire for a gender identity different from their biological sex, but may also face the spiritual distress that comes to anyone who follows a path in life that departs from God's design for humanity. Hormonal or surgical interventions cannot resolve spiritual distress but may lead to further spiritual turmoil. These, our neighbors, need and deserve the spiritual, psychological, and social support of the Christian community.
7. CMDA is especially concerned about the increasing phenomenon of parents enabling their gender-questioning children or adolescent minors to receive hormones to inhibit normal adolescent development. Children and adolescents lack the developmental cognitive capacity to assent or request such interventions, which have lifelong physical, psychological, and social consequences.⁵⁶ Facilitating hormonal or surgical transitioning interventions for those who have not reached the age of majority is a form of child endangerment and abuse.⁶⁴ Highly affirming parents have been shown to not improve the mental health statistics of transgender-identified children.⁷⁸
8. Many diseases affect men and women differently, according to biological sex

phenotype. Transgender designations may conceal biological sex differences relevant to medical risk factors, the recognition of which is important for effective healthcare and disease prevention. As accurate documentation is necessary for good patient care, healthcare professionals should document the patient's biological sex and any alterations of gender characteristics in the medical record.^{2,13,54,57,79,80,81} It is appropriate and should not be interpreted as disrespectful for healthcare professionals to discuss their patients' biological sex with them as part of their medical care.^{80,81}

9. For the overall health of the patient, the healthcare professional should be forthright with the patient that addressing the individual's sexual reality is necessary for appropriate medical care and should not be interpreted as disrespect.

CMDA Recommendations for the Christian Community

1. A person questioning or struggling with gender identity should evoke neither scorn nor enmity, but rather the Christian's concern, compassion, help, and understanding. Christians must respond to the complex issues surrounding gender identity with grace, civility, and love.
2. Christians should avail themselves of opportunities to help the larger society understand that male/female sexes are complementary and permanent. Both are good and part of the created order. For the reasons elaborated above, CMDA believes that attempting to define gender as fluid and changeable through technical means will have grave spiritual, emotional, cultural, and medical repercussions.
3. The Christian community, beginning with the Christian family, must resist stereotyping or rejecting individuals who do not fit the popular norms of masculinity and femininity. At the same time, parents should guide their children and adolescent minors in appropriate gender identity development. For children and adolescents experiencing gender dysphoria, the Christian community should provide appropriate role models and biblically informed guidance.
4. The Christian community must condemn hatred and violence directed against those struggling with questions of gender identity.
5. Since Christians are to love their neighbors as themselves, they are to love those struggling with gender dysphoria or incongruence of desired gender with biological sex. Love for the person does not condone or facilitate gender transitioning treatments.
6. In obedience to God who commands his followers to love one another, and for the sake of the common good, Christians should welcome inclusion of transgender-identified individuals into their communities, as we are all broken and sinners, not more or less valuable than each other. Transgender-identified individuals have the same rights shared by all other humans. We oppose granting special rights and privileges based on transgender identification. These special rights can negatively impact the rights of others (e.g., bathroom designations that allow biological males access to shared female restrooms or showers, female athletic competitions that give participating biological males an unfair physiologic advantage, affirmative actions, or claims for unnecessary

medical interventions).

7. The Christian community is to be a refuge of love for all who are broken – including the sexually broken – not to affirm their sin, nor to condemn, but to shepherd them to Jesus, who alone can forgive, heal, restore, and redirect to a godly, honorable, and virtuous way of life. God provides the remedy for all moral failure through repentance and faith in Jesus Christ and the life-changing power of the Holy Spirit. Though healing may be incomplete on earth, the promise of complete healing for those who are in Christ will ultimately be fulfilled in heaven.

CMDA Recommendations for Christian Healthcare Professionals

1. CMDA advocates that all Christian healthcare professionals provide ethically and medically competent care to all patients, including those who identify as transgender. Such care requires compassion, an open and trusting dialogue, a genuine effort to understand and respond to the patient's psychological distress when present, and acceptance of the person without agreeing with the person's ideology or providing a requested sex-altering intervention.
2. CMDA believes that the appropriate medical response to patients with gender dysphoria is to help them understand that they are people God loves and who are made in his image, even when their choices cannot be validated. Christian healthcare professionals should validate their right as individuals in a free society to make decisions for themselves. This right, however, does not extend to obligating Christian and other healthcare professionals to prescribe medication or perform surgical procedures that are harmful (see CMDA Statement on Healthcare Right of Conscience).
3. CMDA believes that Christian healthcare professionals should not initiate hormonal and surgical interventions that alter natural sex phenotypes. Such interventions contradict one of the basic principles of medical ethics, which is that medical treatment is intended to restore and preserve health, and not to harm.
4. CMDA believes that prescribing hormonal treatments to children or adolescents to disrupt normal sexual development for the purpose of attempting gender reassignment is ethically impermissible, whether requested by the child, the adolescent, or the parent (See CMDA Statement on Limits to Parental Authority in Medical Decision-Making, and CMDA Statement on Abuse of Human Life).
5. Supporting a patient's pursuit of gender transitioning procedures is neither loving nor the best means to help that individual who is experiencing gender dysphoria.

CMDA Recommendations Regarding Nondiscrimination

1. Mutual respect and civil discourse are cornerstones of a free society, and so is truthfulness. In the context of health care, identification of sex and gender has both interpersonal and medical implications. In regard to medical documentation, the medical record should document the sex observed at birth even when the patient expresses a different gender preference or has obtained a legal change in gender status.
2. Christian healthcare professionals, in particular, must care for their patients with gender identity disorders in a non-judgmental and compassionate manner, consistent with the

humility and love that Jesus modeled and commanded us to show all people. When questioning transgender ideology, Christian healthcare professionals should do so with an attitude of humility and love.

3. Those who hold to a biblical or traditional biological view of human sexuality, including CMDA members, should be permitted to question transgender ideology free from exclusion, oppression, or unjust discrimination. Healthcare professionals who hold the position that transgender identification is harmful and inconsistent with the will of God should not be stigmatized or accused of being bigoted, phobic, unprofessional, or discriminatory because of their desire to adhere to biological and medical reality as a sincerely held (and widely shared) belief.
4. To decline to provide a requested gender-altering treatment that is harmful, or is not medically indicated, does not constitute unjust discrimination against persons. CMDA affirms that Christian and other healthcare professionals should not be coerced or mandated to provide or refer for services they believe to be morally wrong or medically harmful to patients (See CMDA Statement on Healthcare Right of Conscience).
5. Healthcare professionals must not be prevented from providing counseling and support to patients with gender dysphoria and who request assistance with accepting and maintaining their biologic sex and gender identity.

GLOSSARY

Person and Image of God

According to the Bible, human persons (as opposed to divine and angelic persons) are embodied from conception onward. At conception, at least one genetically unique human person is formed (twinning may occur during the first two weeks of pregnancy). So the psalmist offers a hymn to God in Psalm 139, “you created my inmost being, you knit me together in my mother’s womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depth of the earth, Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be” (13-16 NIV). Human persons are, however, the only persons who are made in the *imago Dei* (image of God). Thus,

Jesus—fully God and fully human—is “image of the invisible God, the firstborn over all creation” (Colossians 1:15). Likewise, according to Genesis, “God created mankind in his own image, in the image of God he created them, male and female he created them” (Genesis 1:27).

Sex

Human sex and sexuality are aspects of God’s good, well-ordered creation. From the beginning he made humans sexual beings (Genesis 2:15-25). Humans are sexual beings who procreate through sexual reproduction. Sex is objective, identifiable, immutable, determined at conception, stamped on every nucleated cell, and highly consequential.^{82,83,84,85}

There are 2 sex cells or gametes, sperm and ova. There is no third. Human fallenness incurred pervasive distortions in humanity, including disorders of sexual biology, none of which limits either God’s love for each of us, or the inestimable value of creation in His image.

Sexuality

Human sexuality is a “very good” component of God’s well-ordered creation (Genesis 2:15-25). Sexuality is a broad and easily confusing term usually requiring contextualization for clear communication. As noted by McHugh and Mayer, sexuality incorporates desires,

attractions, behaviors, and/or identity.¹⁶ Furthermore, sexuality may vary regarding timing, intensity, consistency, and exclusivity. Its elements may be sporadic, temporary, pervasive, or long-term. Sexual expression may be healthful or unhealthful.

Because of human fallenness, sexuality has become disordered. The goods of sexuality are often distorted by pathologies in biology, psychology (e.g., sexual addiction or adultery), and society (e.g., sexual revolution and polyamory). Redeeming sex requires the reordering of human desires and practice. Celibacy outside of marriage, sexual fidelity within heterosexual marriage between one man and one woman, and the presumption in favor of procreation are ways human sex and sexuality may be redeemed.

Christian Worldview

A worldview is a way of seeing and understanding the phenomenon of the world around us. Like lenses of eyeglasses, one's worldview provides a set of interpretive assumptions that enable us to make sense of our experience. One's worldview is how one answers the big questions of life, such as: Is the world real? What is the nature of reality? Is there a God? What can we know about God? How do I know anything at all? Is matter all there is? Is there a supernatural? The orthodox Christian worldview is grounded on certain theological affirmations found in the Bible, which Christians believe to be the revealed word of God, and summarized in the great confessions in the history of Christianity, for instance, in the Nicene (325 AD) and Apostles (390 AD) Creeds.

The Fall and Human Fallenness

Rather than remaining faithful to God's will and purposes, Adam and Eve fell from their original righteous state through disobedience (i.e., sin). Their sin brought with it not only immediate deleterious consequences for them (Genesis 3), but for the entire created order thereafter. Those well-ordered desires to love God and love another have become disordered by human depravity. Love for God and others was replaced with hatred, envy, and murder (as in the case of Cain and Abel). The goods of honest labor were turned into toil and struggle in a creation that is now filled with corruption, death, disease, pain, and hardship. After the fall, human beings are born with a propensity to disobedience, selfishness, and sin.

Intrinsic Dignity

Because human beings are made in God's image, they possess an intrinsic dignity. They should never be used as a means to an end, but as ends in themselves. Their lives have sacred value and they should not be harmed without just cause. This dignity is intrinsic and equal for all human beings, not varied and dependent on level of function, cognitive or physical, presence or absence of injury or disability, age, or other traits or features for which human beings tend to impute upon others value or worth. Human dignity has been the foundation of Western ethics and jurisprudence and has been enshrined in secular language in the Nuremberg Code and global treaties in science, medicine, and public policy since that time.

Love

Christians are called to love God with all their hearts, souls, minds, and body and to love their neighbors as themselves (Deut 6:5; Lev 19:18; Mark 12:29-31). Love is a disposition of heart and life that impels one person to treat another person with respect and dignity quite apart from ethnicity, economic, social status, or what the individual can exploit or receive from the other. Furthermore, love seeks the best for another individual without the expectation any kind of recompense or remuneration.

Holiness

With respect to God, holiness is the supreme attribute of all of God's attributes, setting the God of the Bible apart from all other deities. The Triune God is holy in his love, righteousness, justice, wrath, and mercy (among other attributes). With respect to human beings and objects, holiness is being set apart for sacred use (as with the Old Testament

Temple). Christian holiness is the aspiration to live a life “set apart” from the corruptions of the world, and instead committed to fidelity, trust, and dependence on God, patterning ourselves after Jesus Christ.

Repentance

Repentance is a response to the recognition of harm done, either by commission or omission. The word used in the New Testament (metanoia) means to “turn and go in the other direction.” To repent, then, is to acknowledge one’s sin and turn back toward God. Turning back toward God may include ceasing to perform or pursue sinful acts, reconciling with those who have been harmed, or restoring items or relationships that have been damaged through one’s behavior. Repentance is not a one-time event, but a disposition of character.

Faith

Faith is the virtue of trust and dependence on God and his promises, believing and acting in ways consistent with that confidence (Hebrews 11).

Sexual Orientation

Orientation essentialism – the belief that a person has a given sexual orientation, be it innate or resulting from various combinations of biology and environment -- is an ideological position that has gained strong purchase in modern culture.

Per academics McHugh and Diamond, polar opposites in many ways:

Psychiatry professor Paul McHugh states, “Sexual orientation is a complex and amorphous phenomenon There is no scientific consensus on how to define sexual orientation, and the various definitions proposed by experts produce substantially different classes.”⁸³

Psychology professor Lisa Diamond, “There is currently no scientific or popular consensus . . . that definitively ‘qualify’ an individual as lesbian, gay, or bisexual.”⁸⁵

Genetic essentialism, like its orientation counterpart, is similarly ideological.

- • In a 2011 *Psychological Bulletin* Dar-Nimrod and Heine define genetic essentialism as,
“The tendency to infer a person's characteristics and behaviors from his or her perceived genetic makeup” (p. 801).⁸⁴ “Much of the ways that genes relate to human conditions can be described as weak genetic explanations” (p. 802).
- • Eric Turkheimer of UVA states, “...the amount of influence that genes have on behaviors is considerably smaller than one might think.”⁸⁴ And, “...genetic essentialists were wrong about gay genes and similar nonsense.”⁸³ Diamond and Rosky: “In essence, the current scientific revolution in our understanding of the human epigenome challenges the very notion of being “born gay,” along with the “born” with *any* complex trait. Rather, our genetic legacy is dynamic, developmental, and environmentally embedded.”⁸⁵

Same-sex attraction

Sexual attraction to members of the same sex. The propensity and degree may vary from near exclusive to occasional attraction, and is shown to potentially change over time. It does not preclude the same individual from experiencing varying degrees of attraction to members of the opposite sex.

Fornication

Per theologian Robert Gagnon “fornication,” likewise *porneia* in Greek, is frequently an overarching reference to sexual sin as defined in Torah. In more common usage, fornication is sexual intercourse between two people not married to each other. Sex between male and female is implied in the term’s reference to anatomy, fornix being

the curved vaginal recess created by the cervix and the term also being Latin for “arch.”

Fornication is separate from adultery or rape.

Temptation

A trial, being put to the test.

It is not yet sin, but an invitation to it.

Jesus “was in all *points* tempted as *we are*, yet without sin.” Hebrews 4:15. It is inherent to the fallen human condition.

“No temptation has overtaken you except such as is common to man; ...” I Corinthians 10:13.

God tests individuals.

Abraham (Genesis 22:1), Job (Job 23:10), I Corinthians 11:32, Hebrews 12:4-11, etc.

Satan tempts individual to sin.

Matthew 4:3, I Thessalonians 3:5. God provides means of rescue.

“*then* the Lord knows how to deliver the godly out of temptations...” 2 Peter 2:9. “...but God *is* faithful, who will not allow you to be tempted beyond what you are able, but with the temptation will also make the way of escape, that you may be able to bear *it*.” I Corinthians 10:13.

Scripture describes temptation as something to be avoided if possible: “And do not lead us into temptation...” Matthew 6:13.

“Watch and pray, lest you enter into temptation.” Mark 14:38.

Sexual Fantasy - when does it cross into sin?

Temptation is not yet sin. Everyone has a sex drive and the duty to manage it.

Experiencing sexual thoughts is not yet fantasy, or lust, unless willingly pursued. Some have compared the appearance of sexual thoughts to a bird flying over one’s head, thus out of our control; and fantasy or lust is compared to the equivalent of allowing that bird to build a nest on our head, something clearly in our power to resist.

Same-sex attraction chaste life - does it include avoidance of kissing? Is this equal to homosexual celibacy?

This is a multi-faceted question.

1. Scripture speaks of greeting each other with “a holy kiss” (Romans 16:16, I Corinthians 16:20), which is a salutation, something non-sexual.

Greeting with a kiss is a pervasive practice in the general cultures of several nations to this day. 2. The kissing implicit in the stated question is sexual, romantic.

There is no part of homosexual practice that is endorsed in scripture; it is condemned without exception.

3. Though we mean abstinence from homosexual practices when we say, “homosexual celibacy,” the application of the term “celibate” to same-sex sexual practice is Biblically problematic. Lifetime celibacy is referred to as a “gift” by the Apostle Paul in I Corinthians 7:7-9.

A Celibate person is giving up the God-ordained institution of marriage (exclusively between one man and one woman in scriptural standards) along with its God-ordained sexual practice. God gifts, or graces, that person with something else God-ordained in its place. But a person setting aside same-sex sexual practice is abstaining from or repenting of a sinful practice, which is both commanded and its own benefit. We wish to avoid canonizing homosexual temptation.

Same-sex lifestyle

The willing practice of same-sex sexuality.

Gay culture

Any assemblage of like-minded people creates a culture. Culture itself is a neutral term that gains a moral dimension in its practice. Gay culture endorses the ideological concept of gay identity along with its practices.

Scripturally and scientifically, we hold that sexuality is a verb and not just a noun. Gay and straight are category errors and false identities. Homosexuality by any name is a practice and not an identity, what one does and not who one is.

Likewise, “gay Christian” language canonizes temptation behind a false identity. Any name preceding “Christian” is an implicit priority, contravening Paul’s instruction to the Galatian church (Gal. 3:28).

Homophobia, -ic

Homophobia is an ideological and pejorative term that has gained common usage. It is often an accusation made against an individual failing to sufficiently celebrate same-sex sexuality, practices and politics.

But per MayoClinic.org: “A phobia is an overwhelming and unreasonable fear of an object or situation . . . a phobia is long lasting, causes intense physical and psychological reactions, and can affect your ability to function normally at work or in social settings.”

Disagreement is clearly not a phobia.

Linguistically, “homophobia” is somewhat nonsensical, meaning “fear of the same thing.”

Gender vs Sex

Sex is biological and stamped on every nucleated cell in a person’s body from conception onward. It is immutable down to the level of brain cells, so it is impossible to have “a man’s brain in a woman’s body,” for example.

Gender, in its common current usage, is an engineered term leveraging linguistics against biology; it is ideological and self-declared.

Historically, however, per theologian Christopher West:

“The root “gen”—from which we get words such as generous, generate, genesis, genetics, genealogy, progeny, gender, and genitals—means “to produce” or “give birth to.” A person’s gen-der, therefore, is based on the manner in which that person is designed to gen-erate new life. Contrary to widespread secular insistence, a person’s gender is not a malleable social construct. Rather, a person’s gender is determined by the kind of genitals he or she has.”⁸⁶

But ideology does not bow to history. Sex is biology, and gender is ideology.

Gender Identity

Gender identity is a feeling, a self-perception, of how one identifies with their biological sex or not, and it is often a sex stereotype. It is subjective, self-declared and fluid. Psychologist Dr. John Money of Johns Hopkins initiated its use in professional journals in 1955, referring to “the identity of the inner sexed self.”⁸⁷

Gender Confusion/Dysphoria

Gender identity confusion/dysphoria is a feeling/self-perception that one’s biology is not as one

wishes it to be or not as one identifies most comfortably as. Sechner notes, “A gender-dysphoric youth experiences a sense of incongruity between the gender expectations linked to her or his biological sex and her or his biological sex itself.”⁸⁸

The greater the discomfort/dissonance, the greater the dysphoria. Gender dysphoria is not synonymous with transgenderism, the latter being an umbrella term within which gender dysphoria fits, but to which transgenderism is not limited.

Gender - Should we be using that term or is there a better term? If so, how is it best defined?

The answer to that depends on the application and one must be careful.

Gender is an engineered term leveraging linguistics against biology; it is ideological and self-

declared. Sex is biological, right down to each human cell containing a nucleus. Though gender is sometimes used synonymously with sex (e.g., in forms asking if someone is male or female), ideologically it is considered separate and distinct from sex (e.g., “your sex is irrelevant to your gender identity”) in a manner that is quite Gnostic (i.e., the “higher knowledge” that transcends lowly biology).

Therefore, it is best to mean what you say and say what you mean in context. Using phrases like “identified gender,” “identifies as,” “gender incongruence,” “gender dysphoria,” “transgender identified,” etc. work well, don’t surrender reality to a claim, and do not imply agreement.

Best terminology for gender transition?

That depends on the intended usage.

“Transition efforts” or “transition-affirming treatments/procedures” are both quite clear and do not surrender to ideology as compared to terms like “gender-affirming” or “gender confirming” treatments and procedures.

Best terminology for transgender identity?

“Transgender-identified” or “transgender identification” are well understood and non-capitulating.

A final comment on language

Terms should be as descriptively accurate as possible while avoiding ideological programming. For instance, because an individual’s intrinsic sex cannot be changed, and gender is essentially a biologically meaningless term or concept aside from biological sex, terms such as “transgender identity,” as if it were an objective reality, should be replaced by “transgender-identified, - identifying, or -identification,” which are descriptively accurate. Similarly, because “gender transition” is not ontologically or biologically possible, more descriptively accurate terms, such as, “attempted transition efforts,” or “attempted transition-affirming treatments or procedures,” are more accurate and preferred.

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Passed with 54 approvals, 0 opposed, 0 abstention

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References

1. 2. 3.

Journal Of Social Research Methodology, 23 5.

Exploring the Biological Contributions to Human Health:

Does Sex Matter?

Hyde JS, Bigler RS, Joel D, Tate CC, van Anders SM. The future of sex and gender in psychology: Five challenges to the gender binary.

Hyde, Bigler, Joel, Tate, and van Anders (2019).

Am Psychol

. 2019;74(2):171-193. doi:10.1037/amp0000307

Cretella MA, Rosik CH, Howsepian AA. Sex and gender are distinct variables critical to health: Comment on

Am Psychol

. 2019;74(7):842-844. doi:10.1037/amp0000524

Institute of Medicine (US) Committee on Understanding the Biology of Sex and Gender Differences,

Wizemann, T. M., & Pardue, M. L. (Eds.). (2001).

. National Academies Press (US).

4. Sullivan, A. (2020). Sex and the census: why surveys should not conflate sex and gender identity.

(5), 517-524. <https://doi.org/10.1080/13645579.2020.1768346>

Anckarsäter, H., & Gillberg, C. (2020). Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery.

<https://doi.org/10.1176/appi.ajp.2020.19111117>

(8), 764–765.

Hruz P. W. (2020). Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria.

(1), 34–42. <https://doi.org/10.1177/0024363919873762>

Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden.

2011;6(2):e16885. Published 2011 Feb 22. doi:10.1371/journal.pone.0016885

Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender-Affirming Surgeries: A Comment by the Editor on the Process.

. 2020;177(8):764.

doi:10.1176/appi.ajp.2020.20060803

6. 7.

8.

Linacre Quarterly, 87

American Journal of Psychiatry, 177

International

The

PLoS One. Am J Psychiatry

Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence.

Am J Psychiatry

. 2020;177(8):765–766. doi:10.1176/appi.ajp.2020.19111130

Biggs M. Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria.

2020;49(7):2227–2229. doi:10.1007/s10508-020-01743-6

Davis SR, Baber R, Panay N, et al. Global Consensus Position Statement on the Use of Testosterone Therapy for Women.

. 2019;104(10):4660–4666. doi:10.1210/jc.2019-01603

Giovannetti, B., 2014.

Endurant Press, p.178.

. San Francisco:

Bartz D, Chitnis T, Kaiser UB, et al. Clinical Advances in Sex- and Gender-Informed Medicine to Improve the Health of All: A Review.

Association, p.829.

. 2020;180(4):574–583. doi:10.1001/jamainternmed.2019.7194

2013.

. Arlington, VA: American Psychiatric

Tournaye H. Is there any reproductive future left for men?.

9.

10.

11.

12.

13.

14.

15. 16.

Arch Sex Behav.

J Clin Endocrinol Metab

Four Letter Words: Conversations On Faith's Beauty And Logic

JAMA Intern Med

Diagnostic And Statistical Manual Of Mental Disorders

Facts Views Vis Obgyn. 2012;4(4):255–

258. MayerLS,McHughPR.SexualityandGender:FindingsfromtheBiological,Psychological,andSocial Sciences. *New Atlantis* (2016); 50:10–143. At pp.89–90. 17.

Beale JM, Creighton SM. Long-term health issues related to disorders or differences in sex development/intersex.

Maturitas

. 2016;94:143–148. doi:10.1016/j.maturitas.2016.10.003

Sax L. How common is intersex? a response to Anne Fausto-Sterling.

. 2002;39(3):174-178.

doi:10.1080/00224490209552139

Ślowikowska-Hilczek J, Hirschberg AL, Claahsen-van der Grinten H, et al. Fertility outcome and information on fertility issues in individuals with different forms of disorders of sex development: findings from the dsd-LIFE study.

. 2017;108(5):822-831. doi:10.1016/j.fertnstert.2017.08.013

Van Mol, A., 2019.

. [online]

Christian Medical & Dental Associations. Available at: <<https://cmda.org/intersex-what-it-is-and-is-not/>> [Accessed 11 November 2020].

18. 19.

20. 21.

J Sex Res

Fertil Steril

Intersex: What It Is And Is Not – Christian Medical & Dental Associations

Some professional organizations appear to acknowledge the same, even if they generally claim gender-sex discordance is normal. The World Professional Association for Transgender Health says in its Standards of Care that "gender dysphoria" may be "secondary to, or better accounted for by, other diagnoses." (Wpath.org.

Standard Of Care For The Health Of Transsexual, Transgender, And Gender Nonconforming People.

) The British Psychological Society says, "In some cases the reported desire to change sex may be symptomatic of a psychiatric condition

for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger's syndrome...."

(Shaw L, Butler C, Langdridge D, et al. Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. British Psychological Society Professional Practice Board. Leicester, UK,

2012, p. 26 [Accessed online 16 January 2021 at: <https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf>]) The American

Psychological Association's APA Handbook of Sexuality and Psychology allows for the possibility that pathological family of origin dynamics may be causal. (

2012.

[online] Available at:

<<https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf?t=1604581968>> [Accessed 11 November 2020]. p24

Pfaus, J. and Ward, L., 2014.

Association, p.743.

Bechard M, VanderLaan DP, Wood H, Wasserman L, Zucker KJ. Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study.

. 2017;43(7):678-688.

doi:10.1080/0092623X.2016.1232325

Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: A review of the literature.

Int Rev Psychiatry

. 2016;28(1):44-57. doi:10.3109/09540261.2015.1115753

Hanna B, Desai R, Parekh T, Guirguis E, Kumar G, Sachdeva R. Psychiatric disorders in the U.S. transgender population.

Ann Epidemiol

. 2019;39:1-7.e1. doi:10.1016/j.annepidem.2019.09.009

Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development.

. 2015;9:9. Published 2015 Apr 9. doi:10.1186/s13034-015-0042-y

Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers.

. 2018;141(5):e20173845. doi:10.1542/peds.2017-3845

22.

23. 24. 25.

Ment Health

26.

J Sex Marital Ther

Child Adolesc Psychiatry

)

APA Handbook Of Sexuality And Psychology

Pediatrics

Tolman, D., Diamond, L., Bauermeister, J., George, W.,

. American Psychological

27. 28.

29.

30.

31. 32. 33. 34. 35.

36. 37.

38. 39.

40. 41.

42. 43.

44. 45.

Annu Rev Clin Psychol. 2016;12:217- *PLoS One.*

Guidelines And Literature Review For Psychologists Working Therapeutically With Sexual And Gender Minority Clients

E.Coleman,W.Bockting,M.Botzer,P.Cohen-Kettenis,G.DeCuypere,J.Feldman,L.Fraser,J.Green,G. Knudson, W. J. Meyer, S. Monstrey, R. K. Adler, G. R. Brown, A. H. Devor, R. Ehrbar, R. Ettner, E. Eyler, R. Garofalo, D. H. Karasic, A. I. Lev, G. Mayer, H. Meyer-Bahlburg, B. P. Hall, F. Pfafflin, K. Rachlin, B. Robinson, L. S. Schechter, V. Tangpricha, M. van Trotsenburg, A. Vitale, S. Winter, S. Whittle, K. R. Wylie & K. Zucker (2012) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, International Journal of Transgenderism, 13:4, 165-

232, DOI: 10.1080/15532739.2011.700873

J Neuroendocrinol.

2018;30(7):e12562. World.2020.*Fightingtoletaboybeaboy*. [online] Available at: [https://wng.org/roundups/fighting-to-let-a-](https://wng.org/roundups/fighting-to-let-a-boy-be-a-boy-1617220961)

Zucker KJ, Lawrence AA, Kreukels BP. Gender Dysphoria in Adults.

247. doi:10.1146/annurev-clinpsy-021815-093034

Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender

dysphoria [published correction appears in PLoS One. 2019 Mar 19;14(3):e0214157].

2018;13(8):e0202330. Published 2018 Aug 16. doi:10.1371/journal.pone.0202330

Bps.org.uk. 2012.

. [online] Available at: <[https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-](https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf)

<https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf>> [Accessed 11 November 2020].

Roselli CE. Neurobiology of gender identity and sexual orientation.

doi:10.1111/jne.12562

[boy-be-a-boy-1617220961](https://doi.org/10.1111/jne.12562) [Accessed 26 April 2021].

Psychiatry

Lisa Marchiano (2017) Outbreak: On Transgender Teens and Psychiatric Epidemics, *Psychological Perspectives*, 60:3, 345-366, DOI: 10.1080/00332925.2017.1350804

Can J

Bradley SJ, Zucker KJ. Gender identity disorder and psychosexual problems in children and adolescents.

. 1990;35(6):477-486. doi:10.1177/070674379003500603

Anderson, R., 2018.

. [online]

The Heritage Foundation. Available at: <<https://www.heritage.org/gender/commentary/transgender-ideology->

riddled-contradictions-here-are-the-big-ones> [Accessed 11 November 2020].

Hilton, C., 2020.

Opinion | The Dangerous Denial Of Sex

. [online] WSJ. Available at:
<<https://www.wsj.com/articles/the-dangerous-denial-of-sex-11581638089>> [Accessed 11 November 2020].

Medium. 2017.

Transgender Ideology Does Not Support Women

. [online] Available at:
<<https://medium.com/@mirandayardley/transgender-ideology-does-not-support-women-2d00089e237a>> [Accessed 11 November 2020].

Gender Health Query. n.d.

Transgender Ideology Is Riddled With Contradictions. Here Are The Big Ones.

Many LGBT People Do Not Agree With Gender Queer Theory & Scientific Validity Taught In Schools — Gender Health Query

I'M A Pediatrician. How Transgender Ideology Has Infiltrated My Field And Produced Large-Scale Child Abuse.

. [online] Available at: <<https://www.genderhq.org/trans-youth-controversial-schools-lgbt-science-dysphoria>> [Accessed 11 November 2020].

The Daily Signal. 2017.

. [online] Available at: <<https://www.dailysignal.com/2017/07/03/im-pediatrician-transgender-ideology-infiltrated-field-produced-large-scale-child-abuse/>> [Accessed 11 November 2020].

Olver T. Disaffirming Gender: Somatic Incongruence as a Co-function of Ideological Congruity.

. 2019;106(1):1-28. doi:10.1521/prev.2019.106.1.1

2019.

Available at: <<https://www.washingtonpost.com/opinions/2019/05/13/california-wants-teach-kindergartners-about-gender-identity-seriously/>> [Accessed 11 November 2020].

. [online]

about-gender-identity-seriously/> [Accessed 11 November 2020].

Doward, J., 2019.

. [online] the Guardian. Available at: <<https://www.theguardian.com/society/2019/jul/27/trans-lobby-pressure-pushing-young-people-to-transition>> [Accessed 11 November 2020].

Heritage.org. 2019.

. [online] Available at: <<https://www.heritage.org/sites/default/files/2019-05/BG3408.pdf>> [Accessed 11 November 2020].

Rev

OlsenH. *CaliforniaWantsToTeachKindergartnersAboutGenderIdentity.Seriously. Politicised Trans Groups Put Children At Risk, Says Expert*

JonesA,KaoE. *SexualIdeologyIndoctrination:TheEqualityActsImpactOnSchool Curriculum And Parental Rights*

OmercajicK,MartinoW. *Supportingtransgenderinclusionandgenderdiversityinschools:acriticalpolicy analysis. Frontiers in Sociology* 2020; 5:27.

<https://doi.org/10.3389/fsoc.2020.00027> Friestad,T.,2018.*BeingMila:CreatingAnLgbtqCurriculumThatIsAuthentic,FollowsPoliciesAndEthics, And Teaches Acceptance*

Psychoanal

. [online] DigitalCommons@Hamline. Available at:
<https://digitalcommons.hamline.edu/hse_cp/196?utm_source=digitalcommons.hamline.edu/hse_cp/196> [Accessed 11 November 2020].

46. 47.

48. 49. 50. 51. 52.

53. 54.

55. 56. 57. 58. 59. 60. 61.

62.

63. 64. 65. 66.

DeeKnoblauch(2016)BuildingtheFoundationofAcceptanceBookbyBook:Lesbian,Gay,Bisexual,and/or Transgender-Themed Books for Grades K–5 Multicultural Libraries, Multicultural Perspectives, 18:4, 209- 213, DOI: 10.1080/15210960.2016.1228325

LGB Alliance Founder Criticises RSE Lessons

Diagnostic And Statistical Manual Of Mental Disorders. Arlington, VA: American Psychiatric APA Handbook Of

Christian Concern. 2020.
 . [online] Available at:
<https://christianconcern.com/comment/lgb-alliance-founder-criticises-rse-lessons/> [Accessed 11 November 2020].
 2013.
 Association, p.455.
 Tolman, D., Diamond, L., Bauermeister, J., George, W., Pfaus, J. and Ward, L., 2014.
 . Washington D.C: American Psychological Association, p.774.
 Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights.
J Sex Med
 . 2008;5(8):1892-1897. doi:10.1111/j.1743-6109.2008.00870.x
 Ristori J, Steensma TD. Gender dysphoria in childhood.
 . 2016;28(1):13-20.
 doi:10.3109/09540261.2015.1115754
 Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in J Clin Endocrinol Metab. 2018 Feb 1;103(2):699] [published correction appears in J Clin Endocrinol Metab. 2018 Jul 1;103(7):2758-2759].
 . 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658
Sexuality And Psychology
J Clin Endocrinol Metab
Int Rev Psychiatry

 Kenneth J. Zucker (2018) The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018), International Journal of Transgenderism, 19:2, 231-245, DOI: 10.1080/15532739.2018.1468293

 Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline".
 . 2019;104(3):686-687. doi:10.1210/jc.2018-01925
 Safer JD, Tangpricha V. Care of Transgender Persons.
 . 2019;381(25):2451-2460.
 doi:10.1056/NEJMc1903650
 Levine SB. Informed Consent for Transgendered Patients.
 doi:10.1080/0092623X.2018.1518885
 Shatzel JJ, Connelly KJ, DeLoughery TG. Thrombotic issues in transgender medicine: A review.
 . 2017;92(2):204-208. doi:10.1002/ajh.24593
 Vumc.org. 2012.
 Getahun D, Nash R, Flanders WD, et al. Cross-sex Hormones and Acute Cardiovascular Events in Transgender
 . [online] Available at:
<https://www.vumc.org/lgbtq/key-transgender-health-concerns> [Accessed 12 November 2020].
 Persons: A Cohort Study.
Ann Intern Med
 . 2018;169(4):205-213. doi:10.7326/M17-2785
 Goodman, M., 2018. [online] Pcori.org. Available at: <https://www.pcori.org/sites/default/files/PCORI-Goodman076-English-Abstract.pdf> [Accessed 11 November 2020].
 Heyer, W. 2019. Usatoday.com. 2019. Hor
 . [online] Available at:
<https://www.usatoday.com/story/opinion/voices/2019/02/11/transgender-debate-transitioning-sex-gender-column/1894076002/> [Accessed 11 November 2020].
Endocrinol Metab
Hematol
N Engl J Med
J Sex Marital Ther. 2019;45(3):218-229.
Time I Can 'T Get Back.

International Association of Therapists for Desisters and Detransitioners. (2020). *Introduction to Detransition for Therapists*. [online]. Available at: https://iatdd.com/introduction-to-detransition-for-therapists/?fbclid=IwAR2bsQ-ojdFi7Zyzow_RNCDeD34eGU_flce_x8mfRpH3s0DRp91PwwONkto [Accessed 4/26/2021]. SkyNews. (2019). 'Hundreds' of Young Trans People Seeking Help to Return to Original Sex. [online]. Available at: <https://news.sky.com/story/hundreds-of-young-trans-people-seeking-help-to-return-to-original-sex-11827740>. [Accessed 4/26/2021].

Horvath H. "The Theatre of the Body: A Detransitioned Epidemiologist Examines Suicidality, Affirmation, and Transgender Identity". [online]. Available at: <https://4thwavenow.com/2018/12/19/the-theatre-of-the-body-a-detransitioned-epidemiologist-examines-suicidality-affirmation-and-transgender-identity/>. Assessed 4-26-2021.

The Medical Clinics of North America, 103
J Clin
Key Transgender Health Concerns | Program For LGBTQ Health
mones, Surgery, Regret: I Was A Transgender Woman For 8 Years-
Am J

Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study [published correction appears in *Am J Psychiatry*. 2020 Aug 1;177(8):734].

Am J Psychiatry

. 2020;177(8):727-734. doi:10.1176/appi.ajp.2019.19010080

Schulman, J. K., & Erickson-Schroth, L. (2019). Mental Health in Sexual Minority and Transgender Women.

(4), 723–733. <https://doi.org/10.1016/j.mcna.2019.02.005>

Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017.

. 2019;109(1):e1-e8. doi:10.2105/AJPH.2018.304727

Levine SB, Solomon A. Meanings and political implications of "psychopathology" in a gender identity clinic: a report of 10 cases.

J Sex Marital Ther

. 2009;35(1):40-57. doi:10.1080/00926230802525646

Levine SB. Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria.

2018;44(1):29-44. doi:10.1080/0092623X.2017.1309482

Malone WJ, Roman S. Calling Into Question Whether Gender-Affirming Surgery Relieves Psychological Distress.

Am J Psychiatry

. 2020;177(8):766-767. doi:10.1176/appi.ajp.2020.19111149

Tucker RP. Suicide in Transgender Veterans: Prevalence, Prevention, and Implications of Current Policy.

Perspect Psychol Sci

. 2019;14(3):452-468. doi:10.1177/1745691618812680

Wold A. Gender-Corrective Surgery Promoting Mental Health in Persons With Gender Dysphoria Not Supported by Data Presented in Article.

. 2020;177(8):768.

doi:10.1176/appi.ajp.2020.19111170

67.

Public Health

68.

69. 70. 71. 72.

73.

74.

75.

76.

77.

78.

79.

80.

81.

82.

83.

84. 85.

86. 87.

88.

Am J

J Sex Marital Ther.

Am J Psychiatry

WiepjesCM,denHeijerM,BremmerMA,NotaNM,deBlockCJM,CoumouBJG,SteensmaTD.Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017). *Acta Psychiatr Scand.* (2020); 141(6):486-491.

Stroumsa D, Roberts EFS, Kinnear H, Harris LH. The Power and Limits of Classification - A 32-Year-Old Man with Abdominal Pain.

N Engl J Med

. 2019;380(20):1885-1888. doi:10.1056/NEJMp1811491

Bangalore Krishna K, Houk CP, Lee PA. Pragmatic approach to intersex, including genital ambiguity, in the newborn.

Semin Perinatol

. 2017;41(4):244-251. doi:10.1053/j.semperi.2017.03.013

Dhejne, C., Oberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets.

1545. <https://doi.org/10.1007/s10508-014-0300-8>

(8), 1535–

Jones BP, Williams NJ, Saso S, et al. Uterine transplantation in transgender women.

156. doi:10.1111/1471-0528.15438

Schumm WR, Crawford DW. Is Research on Transgender Children What It Seems? Comments on Recent Research on Transgender Children with High Levels of Parental Support.

. 2020;87(1):9-24.

doi:10.1177/0024363919884799

Orwh.od.nih.gov. n.d.

. [online] Available at:

<<https://orwh.od.nih.gov/sex-gender/nih-policy-sex-biological-variable-sabv/questions-answers>> [Accessed 11 November 2020].

Huey, N., 2018.

. [online] Science in the News. Available at: <<http://sitn.hms.harvard.edu/flash/2018/treating-men-and-women-differently-sex-differences-in-the-basis-of-disease/>> [Accessed 11 November 2020].

Madsen, T., Bourjeily, G., Hasnain, M., Jenkins, M., Morrison, M., Sandberg, K., Tong, I., Trott, J., Werbinski, J. and McGregor, A., 2017. Article Commentary: Sex- and Gender-Based Medicine: The Need for Precise Terminology.

, 1(3), pp.122-128.

The News

Archives of Sexual Behavior, 43

BJOG. 2019;126(2):152-

Linacre Q

Questions & Answers | Office Of Research On Women's Health

Treating Men And Women Differently: Sex Differences In The Basis Of Disease - Science In Gender and the Genome

Mayer,L.SandMcHugh,PR.SexualityandGender:FindingsfromtheBiological,PsychologicalandSocial Sciences. *The New Atlantis*. Number 50, Fall 2016., pp 7-9.

McHugh,PaulR.AmicusBrieftotheSCOTUSforObergefellvHodges. Dar-

Nimrod,I&Heine,SJ.“Somethoughtsonessenceplaceholders,interactionism,andheritability:Replyto Haslam (2011) and Turkheimer (2011). *Psychological Bulletin*. (2011) 137(5): 829 – 833.

Diamond,LM&Rosky,CJ.“ScrutinizingImmutability:ResearchonSexualOrientationandUSLegal Advocacy for Sexual Minorities.” *Journal of Sex Research*. (2016) 00: 1-29.

West,Christopher.*OurBodiesTellGod'sStory*.GrandRapids:BrazosPress.2020.p.28.

Money,John.“Hermaphroditism,genderandprecocityinhyperadrenocorticism:psychologicalfindings.”*Bulletin of the Johns Hopkins Hospital*. (1955) 95(6): 252-264.

Shechner, Tomer. "Gender Identity Disorder: A Literature Review from a Developmental Perspective." *Isr. J of Psychiatry & Related Sci.* (2010) 47: 132-138.



CMDA Ethics Statement

Transgender Identification

Preamble

A novel way of thinking about one's body has entered into popular culture. "Transgender" individuals refer to their "gender" as a sexual identity that may be male or female, something in between, or neither. This self-identification differs from, and takes priority over, their biological sex as recognized in their chromosomal DNA and innate physical sexual characteristics. The naming of gender as a category set apart from sex is an idea foreign to the holistic view of the person as understood within Christianity. Christians affirm the biblical understanding of humankind as having been created male and female, with the two sexes having equal dignity and a complementary relationship to each other.

At the heart of disagreement over transgenderism is a difference in worldviews. If the human body is nothing more than the product of mindless, random, purposeless physical forces, then one may do with it what one wishes, even to demand medical and surgical cooperation in projects to alter, amputate, or reconstruct normal tissue to conform to the patient's revised psychological sense of identity. If, on the other hand, our bodies are an inseparable aspect of our true selves and are a good gift from God, who has designed the sexes to be wonderfully paired, and who has a purpose for humanity, then respecting the gift of given sexual identity and the ensuing moral obligations to our neighbors is the surest path to human flourishing.

Both worldviews share the recognition that humanity is broken and in need of renewal, but they look to different answers for healing. Christians seek not a reconfiguring of the body, but a spiritual transformation of the mind to become more like Christ; not rejecting the gifts of God, but welcoming God's purposes and demonstrating God's love by loving our neighbors. This love of neighbors includes loving our transgender neighbors as persons who, like all people, are created in God's image. However, loving them and validating them as people does not mean agreeing with their ideologies or use of language.

The Christian Medical & Dental Associations (CMDA) believes that healthcare professionals should not be forced to violate their conscientious commitment to their patients' health and welfare by being required to accept and participate in harmful gender-transition interventions, especially on the young and vulnerable. CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion, consistent with the humility and love that Jesus modeled and commanded us to show all people.

Introduction

CMDA affirms that all human beings are created in the image of, and beloved by, God. All human beings are our “neighbors”, and are to be loved by us as we love ourselves. All human beings possess intrinsic dignity and are worthy of equal respect and concern from Health Care Professionals.

CMDA considers “sex” (i.e., male or female) to be an objective biological fact (see section B.1. below). CMDA affirms the historic understanding of gender as referring to biological sex and the enduring biblical understanding of humankind as having been created male and female and that this is good. CMDA acknowledges the current cultural use of the word “gender” to refer to one’s sense of identity as male or female. CMDA cannot support the recent usage of the term “gender” to emphasize an identity other than one’s biological sex, that is, a subjective sense of self based on feelings or desires leading to identifying somewhere on a fluid continuum of gender identity.^{1,2,3,4} (See Glossary at the end of this document)

CMDA cannot support the prevailing culture’s acceptance of an ideology of unrestrained sexual self-definition that, in celebrating gender fluidity and gender transition efforts, is indifferent to biological reality and opposed to the biblical understanding of human sexuality. Further, CMDA is alarmed that some proponents of transgender ideology, through activism and intimidation, are insisting that healthcare professionals cooperate with and affirm their beliefs in gender fluidity, even if the healthcare professionals believe that such cooperation and affirmation would be doing harm to their patients. This violates the most fundamental core value of medicine since Hippocrates, that of caring only for the good and benefit of the patient while abstaining from all unnecessary harm. The evolving scientific and medical facts demonstrate that the mutilation of normal tissue and profound disruption of normal physiology that occur during gender transition procedures are very difficult to justify, as this constitutes deliberate harm.

CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion. CMDA holds that attempts to radically reconstruct one’s body surgically or hormonally for psychological indications, however, are medically, ethically, and psychologically inappropriate. These measures alter healthy tissue and increasingly are not supported by scientific research evaluating behavioral, medical, and surgical outcomes.^{5,6,7,8,9,10,11}

Accordingly, CMDA opposes medical assistance with gender transition on the following grounds:

A. Biblical

1. God created humanity as male and female (Gen 1:27, 5:2; Matt 19:4; Mark 10:6). God’s directives – to have dominion over the earth and to fulfill his goals of procreation, union, fellowship, and worship – are given to men and women together (Gen 1:26-28, 2:18-24).
2. Men and women are morally and spiritually equal (Gal 3:28) and are created to have roles that are in some respects alike and in other respects wonderfully complementary (Eph 5).
3. All people are loved by God (John 3:16-17). All struggle with moral failure and fall short of God’s standards (Rom 3:10-12) and, therefore, need the forgiveness that God provides through Christ alone (John 3:36; Rom 3:22-24; Col 1:15-22; 1 Tim 2:5-6).
4. For the Christian, all of ethics, grounded in God’s moral law, is based upon the first and

second greatest commandments: to love God with all our heart, soul, and mind, and to love our neighbors as ourselves (Matt 22: 37-40). If we encourage others to sin sexually, just as if we sin sexually ourselves, we are violating these two commandments. We violate the first greatest commandment by failing to love God in his holiness, wisdom, and rightful place as our Creator, and we violate the second greatest commandment as we fail to respect ourselves and each other by abetting lives of disobedience, deception and unholiness (1 Cor 6: 13b-20). Love may include a corrective component that should be applied in an appropriate and timely manner; affirmation can be enablement.

5. We live in a fallen world (Gen 3), and we all come into this world as fallen creatures with a sinful nature. (Rom 3:9-12). The fall is expressed in nature and in humanity in many ways, including sexuality. Confusion of gender identity is but one example of the fall, as are also marital breakdown and sexual immorality (Rom 1:24-32; Eph 5:3).
6. A lifestyle that is directed by pursuing sexual desires, or driven by personal sexual fulfillment, misses the divinely ordained purpose of sex, which is for procreation, bond creation, and re-creation¹² and for facilitating unity in the lifelong commitment of marriage, which is defined as being between one man and one woman. Heterosexual marriage fosters a secure and nurturing environment for children and it reflects the unity of Christ and the Church (Exod 20:1-18; Lev 20:10-21; Rom 1; Eph 5:23-33) (see also CMDA Statement on Homosexuality).
7. Believers in Christ, though having inherited the sinful nature common to all humanity, also receive a new nature in Christ. As the old nature, being crucified with Christ, dies, our new redeemed nature, sealed by Christ's bodily resurrection, is actively transforming our minds and hearts to be more and more like Christ. This transformation is spiritual, not sexual, and is God's work, not something of our own design (Psalm 100:3; Rom 12:2; Col 1:27).

B. Biological

1. Sex is an objective biological fact that is determined genetically at conception by the allocation of X and Y chromosomes to one's genome, is observable at birth, is found in every nucleated cell, and is immutable throughout one's lifetime. Sex is not a social construct arbitrarily assigned at birth and cannot be changed at will.^{2,3,13}
2. Human beings are sexually dimorphic. Male and female phenotypes are the outworking of sex gene expression, which shapes sex anatomy, determines patterns of sex hormone secretion, and influences sex differences in the development of the central nervous system and other organs.^{2,3,14}
3. Procreation requires genetic contributions from both one man and one woman.^{15,16}
4. CMDA recognizes that exceedingly rare congenital abnormalities exist in which phenotypic sex characteristics are not what is expected from the genotype.^{1,2} These disorders of sex development are of a diverse nature, but usually impair fertility.³ Treatment (including non-intervention) of these disorders differs categorically from transgender interventions, which are performed on persons with no inherent defect in sex organ development, function, or fertility. Anomalies of human biological sex are conditions rather than identities, something one has rather than who one is.⁴ Disorders of sex development are not the fault of the patient, do not invalidate God's design in creation, and do not constitute a third sex.^{17,18,19,20}
5. Gender dysphoria²¹, the condition of experiencing discomfort or distress at one's sex and preferring a different "gender" identity, has not to date been linked to a genetic cause and

is a psychological disorder of unclear and complex origin.^{22,23,24} Gender dysphoria may cause profound distress. It should not be confused with transient gender-questioning that can occur in early childhood.^{25,26,27,28,29,30}

C. Social

1. CMDA recognizes that gender identity issues are complex. The inclination to identify with the opposite sex or as some other gender identity along a spectrum may have non-genetic biological,³¹ familial,^{32,33} and social ^{27,28,34} causes that are not personally generated by particular individuals.²¹⁻³⁰
2. In our current social context, there is a prevailing view that removing traditional definitions and boundaries is a requirement for self-actualization. Thus, Christian healthcare professionals find themselves in the position of being at variance with evolving views of gender identity in which patients or their subcultures seek validation by medical professionals of their transgender desires and choices through medical or surgical solutions to gender dysphoria. Although such desires may be approved by society at large, they are contrary to a biblical worldview and to biological reality and thus are disordered.
3. In contrast to the current culture, CMDA believes that finding one's identity within God's design will result in genuine human flourishing. CMDA believes, moreover, that social movements which assert that gender is a choice are mistaken in defining gender as something independent of sex. Authentic personal identity consists in social gender expression that is congruent with one's natural biological sex but not limited to stereotypes. CMDA recognizes that this traditional view has become counter-cultural; however, CMDA affirms that God's design transcends culture.
4. CMDA opposes efforts to impose transgender ideology on all society by excluding, suppressing, marginalizing, intimidating, or portraying as hateful those individuals and organizations that disagree on scientific, medical, moral, or religious grounds. Such attacks are contrary to the freedoms of speech and religious liberty that lie at the very foundation of a just and democratic society.
5. There is a social contagion phenomenon luring young people into the transgender culture.^{32,33}
6. CMDA opposes efforts to compel healthcare professionals to grant medical legitimacy to transgender ideologies.^{35,36,37,38,39,40} Cooperation with requests for medical or surgical gender reassignment threatens professional integrity by undermining our respect for biological reality, evidence-based medical science, and our commitment to non-maleficence (see CMDA Statement on Healthcare Right of Conscience).
7. Promotion of transgender ideology by educational institutions and teachers to children as young as 5 years of age is a danger to the health and safety of minor children (for medical reasons elaborated in the next section).^{41,42,43,44,45,46,47} Education should respect the value of every human being; in supporting and affirming the student, it need not affirm every desire.
8. No educational institution or teacher should ever block parents from supervising their child's education or withhold from them knowledge of the educational content.

D. Medical

1. Transient gender questioning can occur during childhood. Most children and adolescents who express transgender tendencies eventually come to identify with their biological sex

during adolescence or early childhood.^{48,49,50,51,52,53} There is evidence that gender dysphoria is influenced by psychosocial experiences and can be exacerbated by promoters of transgender ideology.^{27,33} Early counseling for children expressing gender dysphoria is critical to treat any underlying psychological disorders, including depression, anxiety, or suicidal tendencies, and should be done without promoting attempts for gender transitioning.

2. Hormones prescribed to a previously biologically healthy child for the purpose of blocking puberty inhibit normal growth and fertility, cause sexual dysfunction, and may aggravate mental health issues. Continuation of cross-sex hormones, such as estrogen and testosterone, during adolescence and into adulthood, is associated with increased health risks including, but not limited to, high blood pressure, blood clots, stroke, heart attack, infertility, and some types of cancer.^{51,54,55,56,57,58,59,60}
3. Although some individuals report a sense of relief as they initiate the transitioning process, this is not always sustained or consistent over time. Some patients regret having undergone the transitioning attempt process and choose to detransition, which involves additional medical risk and cost.^{56,61,62,63,64}
4. Among individuals who identify as transgender, use cross-sex hormones, and undergo attempted gender reassignment surgery, there are well-documented increased incidences of depression, anxiety, suicidal ideation, substance abuse, and risky sexual behaviors in comparison to the general population.^{21,22,23,61,65,66,67} These health disparities are not *prima facie* evidence of healthcare system prejudice. These mental health co-morbidities have been shown to predate transgender identification.^{24,25,26,27,28,34,68} Patients' own gender-altering attempts and sexual encounter choices (or, in the case of children, their parents' choices on their behalf) are among the factors relevant to adverse outcomes in transgender-identified patients.
5. Although current medical evidence is incomplete and open to various interpretations, some studies suggest that surgical alteration of sex characteristics has uncertain and potentially harmful psychological effects and can mask or exacerbate deeper psychological problems.^{7,8,9,69} Evidence increasingly demonstrates that there is no reduction in depression, anxiety, suicidal ideation, or actual suicide attempts in patients who do undergo surgical transitioning compared to those who do not.^{7,70} The claim that sex-reassignment surgery leads to a reduction in suicide and severe psychological problems is not scientifically supported.^{64,71,72,73}
6. A patient has died because the medical records conveyed only the individual's gender preference, and not their biological sex, leading to misdiagnosis and medical catastrophe.^{74,74}

E. Ethical

1. Restoring and preserving physical and mental health are goals of medicine, but assisting with or perpetuating psychosocial disorders are not. Accordingly, treatment of anomalous sexual anatomy is restorative.⁷⁵ Interventions to alter normal sexual anatomy and physiology to conform to identities arising from gender dysphoria are disruptive to health.^{9,76}
2. Medicine rests on science and should not be held captive to desires or demands that contradict biological reality. Sex reassignment operations are physically harmful because they disregard normal human anatomy and function. Normal anatomy is not a disease; dissatisfaction with natural anatomical and genetic sexual makeup is not a condition that

- can be successfully remedied medically or surgically.
3. The medical status of gender identity disorder (currently termed gender dysphoria) as a mental or psychosocial disorder should not be discarded.
 4. The inability of men, including men who identify as women, to bear children is not an illness to be remedied by medical or surgical means, such as uterine transplantation.⁷⁷ Uterine transplantation into biological men cannot be justified medically (See CMDA Statement on Enhancement and CMDA Statement on Transplantation).
 5. Fundamentally, it is unrealistic to remove or mutilate normal organs and tissue and to disrupt normal physiology, and then to expect normal function. This illustrates the reality that complete gender transitioning is not medically possible.
 6. Christian patients struggling with transgender inclinations face not only the psychological distress of a desire for a gender identity different from their biological sex, but may also face the spiritual distress that comes to anyone who follows a path in life that departs from God's design for humanity. Hormonal or surgical interventions cannot resolve spiritual distress but may lead to further spiritual turmoil. These, our neighbors, need and deserve the spiritual, psychological, and social support of the Christian community.
 7. CMDA is especially concerned about the increasing phenomenon of parents enabling their gender-questioning children or adolescent minors to receive hormones to inhibit normal adolescent development. Children and adolescents lack the developmental cognitive capacity to assent or request such interventions, which have lifelong physical, psychological, and social consequences.⁵⁶ Facilitating hormonal or surgical transitioning interventions for those who have not reached the age of majority is a form of child endangerment and abuse.⁶⁴ Highly affirming parents have been shown to not improve the mental health statistics of transgender-identified children.⁷⁸
 8. Many diseases affect men and women differently, according to biological sex phenotype. Transgender designations may conceal biological sex differences relevant to medical risk factors, the recognition of which is important for effective healthcare and disease prevention. As accurate documentation is necessary for good patient care, healthcare professionals should document the patient's biological sex and any alterations of gender characteristics in the medical record.^{2,13,54,57,79,80,81} It is appropriate and should not be interpreted as disrespectful for healthcare professionals to discuss their patients' biological sex with them as part of their medical care.^{80,81}
 9. For the overall health of the patient, the healthcare professional should be forthright with the patient that addressing the individual's sexual reality is necessary for appropriate medical care and should not be interpreted as disrespect.

CMDA Recommendations for the Christian Community

1. A person questioning or struggling with gender identity should evoke neither scorn nor enmity, but rather the Christian's concern, compassion, help, and understanding. Christians must respond to the complex issues surrounding gender identity with grace, civility, and love.
2. Christians should avail themselves of opportunities to help the larger society understand that male/female sexes are complementary and permanent. Both are good and part of the created order. For the reasons elaborated above, CMDA believes that attempting to define gender as fluid and changeable through technical means will have grave spiritual, emotional, cultural, and medical repercussions.
3. The Christian community, beginning with the Christian family, must resist stereotyping or

rejecting individuals who do not fit the popular norms of masculinity and femininity. At the same time, parents should guide their children and adolescent minors in appropriate gender identity development. For children and adolescents experiencing gender dysphoria, the Christian community should provide appropriate role models and biblically informed guidance.

4. The Christian community must condemn hatred and violence directed against those struggling with questions of gender identity.
5. Since Christians are to love their neighbors as themselves, they are to love those struggling with gender dysphoria or incongruence of desired gender with biological sex. Love for the person does not condone or facilitate gender transitioning treatments.
6. In obedience to God who commands his followers to love one another, and for the sake of the common good, Christians should welcome inclusion of transgender-identified individuals into their communities, as we are all broken and sinners, not more or less valuable than each other. Transgender-identified individuals have the same rights shared by all other humans. We oppose granting special rights and privileges based on transgender identification. These special rights can negatively impact the rights of others (e.g., bathroom designations that allow biological males access to shared female restrooms or showers, female athletic competitions that give participating biological males an unfair physiologic advantage, affirmative actions, or claims for unnecessary medical interventions).
7. The Christian community is to be a refuge of love for all who are broken – including the sexually broken – not to affirm their sin, nor to condemn, but to shepherd them to Jesus, who alone can forgive, heal, restore, and redirect to a godly, honorable, and virtuous way of life. God provides the remedy for all moral failure through repentance and faith in Jesus Christ and the life-changing power of the Holy Spirit. Though healing may be incomplete on earth, the promise of complete healing for those who are in Christ will ultimately be fulfilled in heaven.

CMDA Recommendations for Christian Healthcare Professionals

1. CMDA advocates that all Christian healthcare professionals provide ethically and medically competent care to all patients, including those who identify as transgender. Such care requires compassion, an open and trusting dialogue, a genuine effort to understand and respond to the patient's psychological distress when present, and acceptance of the person without agreeing with the person's ideology or providing a requested sex-altering intervention.
2. CMDA believes that the appropriate medical response to patients with gender dysphoria is to help them understand that they are people God loves and who are made in his image, even when their choices cannot be validated. Christian healthcare professionals should validate their right as individuals in a free society to make decisions for themselves. This right, however, does not extend to obligating Christian and other healthcare professionals to prescribe medication or perform surgical procedures that are harmful (see CMDA Statement on Healthcare Right of Conscience).
3. CMDA believes that Christian healthcare professionals should not initiate hormonal and surgical interventions that alter natural sex phenotypes. Such interventions contradict one of the basic principles of medical ethics, which is that medical treatment is intended to restore and preserve health, and not to harm.
4. CMDA believes that prescribing hormonal treatments to children or adolescents to

disrupt normal sexual development for the purpose of attempting gender reassignment is ethically impermissible, whether requested by the child, the adolescent, or the parent (See CMDA Statement on Limits to Parental Authority in Medical Decision-Making, and CMDA Statement on Abuse of Human Life).

5. Supporting a patient's pursuit of gender transitioning procedures is neither loving nor the best means to help that individual who is experiencing gender dysphoria.

CMDA Recommendations Regarding Nondiscrimination

1. Mutual respect and civil discourse are cornerstones of a free society, and so is truthfulness. In the context of health care, identification of sex and gender has both interpersonal and medical implications. In regard to medical documentation, the medical record should document the sex observed at birth even when the patient expresses a different gender preference or has obtained a legal change in gender status.
2. Christian healthcare professionals, in particular, must care for their patients with gender identity disorders in a non-judgmental and compassionate manner, consistent with the humility and love that Jesus modeled and commanded us to show all people. When questioning transgender ideology, Christian healthcare professionals should do so with an attitude of humility and love.
3. Those who hold to a biblical or traditional biological view of human sexuality, including CMDA members, should be permitted to question transgender ideology free from exclusion, oppression, or unjust discrimination. Healthcare professionals who hold the position that transgender identification is harmful and inconsistent with the will of God should not be stigmatized or accused of being bigoted, phobic, unprofessional, or discriminatory because of their desire to adhere to biological and medical reality as a sincerely held (and widely shared) belief.
4. To decline to provide a requested gender-altering treatment that is harmful, or is not medically indicated, does not constitute unjust discrimination against persons. CMDA affirms that Christian and other healthcare professionals should not be coerced or mandated to provide or refer for services they believe to be morally wrong or medically harmful to patients (See CMDA Statement on Healthcare Right of Conscience).
5. Healthcare professionals must not be prevented from providing counseling and support to patients with gender dysphoria and who request assistance with accepting and maintaining their biologic sex and gender identity.

GLOSSARY

Person and Image of God

According to the Bible, human persons (as opposed to divine and angelic persons) are embodied from conception onward. At conception, at least one genetically unique human person is formed (twinning may occur during the first two weeks of pregnancy). So the psalmist offers a hymn to God in Psalm 139, "you created my inmost being, you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depth of the earth, Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be" (13-16 NIV). Human persons are, however, the only persons who are made in the *imago Dei* (image of God). Thus,

Jesus—fully God and fully human—is “image of the invisible God, the firstborn over all creation” (Colossians 1:15). Likewise, according to Genesis, “God created mankind in his own image, in the image of God he created them, male and female he created them” (Genesis 1:27).

Sex

Human sex and sexuality are aspects of God’s good, well-ordered creation. From the beginning he made humans sexual beings (Genesis 2:15-25). Humans are sexual beings who procreate through sexual reproduction. Sex is objective, identifiable, immutable, determined at conception, stamped on every nucleated cell, and highly consequential.^{82,83,84,85}

There are 2 sex cells or gametes, sperm and ova. There is no third. Human fallenness incurred pervasive distortions in humanity, including disorders of sexual biology, none of which limits either God’s love for each of us, or the inestimable value of creation in His image.

Sexuality

Human sexuality is a “very good” component of God’s well-ordered creation (Genesis 2:15-25). Sexuality is a broad and easily confusing term usually requiring contextualization for clear communication. As noted by McHugh and Mayer, sexuality incorporates desires, attractions, behaviors, and/or identity.¹⁶ Furthermore, sexuality may vary regarding timing, intensity, consistency, and exclusivity. Its elements may be sporadic, temporary, pervasive, or long-term. Sexual expression may be healthful or unhealthful.

Because of human fallenness, sexuality has become disordered. The goods of sexuality are often distorted by pathologies in biology, psychology (e.g., sexual addiction or adultery), and society (e.g., sexual revolution and polyamory). Redeeming sex requires the reordering of human desires and practice. Celibacy outside of marriage, sexual fidelity within heterosexual marriage between one man and one woman, and the presumption in favor of procreation are ways human sex and sexuality may be redeemed.

Christian Worldview

A worldview is a way of seeing and understanding the phenomenon of the world around us. Like lenses of eyeglasses, one’s worldview provides a set of interpretive assumptions that enable us to make sense of our experience. One’s worldview is how one answers the big questions of life, such as: Is the world real? What is the nature of reality? Is there a God? What can we know about God? How do I know anything at all? Is matter all there is? Is there a supernatural? The orthodox Christian worldview is grounded on certain theological affirmations found in the Bible, which Christians believe to be the revealed word of God, and summarized in the great confessions in the history of Christianity, for instance, in the Nicene (325 AD) and Apostles (390 AD) Creeds.

The Fall and Human Fallenness

Rather than remaining faithful to God’s will and purposes, Adam and Eve fell from their original righteous state through disobedience (i.e., sin). Their sin brought with it not only immediate deleterious consequences for them (Genesis 3), but for the entire created order thereafter. Those well-ordered desires to love God and love another have become disordered by human depravity. Love for God and others was replaced with hatred, envy, and murder (as in the case of Cain and Abel). The goods of honest labor were turned into toil and struggle in a creation that is now filled with corruption, death, disease, pain, and hardship. After the fall, human beings are born with a propensity to disobedience, selfishness, and sin.

Intrinsic Dignity

Because human beings are made in God's image, they possess an intrinsic dignity. They should never be used as a means to an end, but as ends in themselves. Their lives have sacred value and they should not be harmed without just cause. This dignity is intrinsic and equal for all human beings, not varied and dependent on level of function, cognitive or physical, presence of absence of injury or disability, age, or other traits or features for which human beings tend to impute upon others value or worth. Human dignity has been the foundation of Western ethics and jurisprudence and has been enshrined in secular language in the Nuremberg Code and global treaties in science, medicine, and public policy since that time.

Love

Christians are called to love God with all their hearts, souls, minds, and body and to love their neighbors as themselves (Deut 6:5; Lev 19:18; Mark 12:29-31). Love is a disposition of heart and life that impels one person to treat another person with respect and dignity quite apart from ethnicity, economic, social status, or what the individual can exploit or receive from the other. Furthermore, love seeks the best for another individual without the expectation any kind of recompense or remuneration.

Holiness

With respect to God, holiness is the supreme attribute of all of God's attributes, setting the God of the Bible apart from all other deities. The Triune God is holy in his love, righteousness, justice, wrath, and mercy (among other attributes). With respect to human beings and objects, holiness is being set apart for sacred use (as with the Old Testament Temple). Christian holiness is the aspiration to live a life "set apart" from the corruptions of the world, and instead committed to fidelity, trust, and dependence on God, patterning ourselves after Jesus Christ.

Repentance

Repentance is a response to the recognition of harm done, either by commission or omission. The word used in the New Testament (metanoia) means to "turn and go in the other direction." To repent, then, is to acknowledge one's sin and turn back toward God. Turning back toward God may include ceasing to perform or pursue sinful acts, reconciling with those who have been harmed, or restoring items or relationships that have been damaged through one's behavior. Repentance is not a one-time event, but a disposition of character.

Faith

Faith is the virtue of trust and dependence on God and his promises, believing and acting in ways consistent with that confidence (Hebrews 11).

Sexual Orientation

Orientation essentialism – the belief that a person has a given sexual orientation, be it innate or resulting from various combinations of biology and environment -- is an ideological position that has gained strong purchase in modern culture.

Per academics McHugh and Diamond, polar opposites in many ways:

Psychiatry professor Paul McHugh states, "Sexual orientation is a complex and amorphous phenomenon There is no scientific consensus on how to define sexual orientation, and the various definitions proposed by experts produce substantially different classes."⁸³

Psychology professor Lisa Diamond, “There is currently no scientific or popular consensus . . . that definitively ‘qualify’ an individual as lesbian, gay, or bisexual.”⁸⁵

Genetic essentialism, like its orientation counterpart, is similarly ideological.

- In a 2011 *Psychological Bulletin* Dar-Nimrod and Heine define genetic essentialism as, “The tendency to infer a person's characteristics and behaviors from his or her perceived genetic makeup” (p. 801).⁸⁴ “Much of the ways that genes relate to human conditions can be described as weak genetic explanations” (p. 802).
- Eric Turkheimer of UVA states, “...the amount of influence that genes have on behaviors is considerably smaller than one might think.”⁸⁴ And, “...genetic essentialists were wrong about gay genes and similar nonsense.”⁸³ Diamond and Rosky: “In essence, the current scientific revolution in our understanding of the human epigenome challenges the very notion of being “born gay,” along with the “born” with *any* complex trait. Rather, our genetic legacy is dynamic, developmental, and environmentally embedded.”⁸⁵

Same-sex attraction

Sexual attraction to members of the same sex. The propensity and degree may vary from near exclusive to occasional attraction, and is shown to potentially change over time. It does not preclude the same individual from experiencing varying degrees of attraction to members of the opposite sex.

Fornication

Per theologian Robert Gagnon “fornication,” likewise *porneia* in Greek, is frequently an overarching reference to sexual sin as defined in Torah. In more common usage, fornication is sexual intercourse between two people not married to each other. Sex between male and female is implied in the term’s reference to anatomy, fornix being the curved vaginal recess created by the cervix and the term also being Latin for “arch.”

Fornication is separate from adultery or rape.

Temptation

A trial, being put to the test.

It is not yet sin, but an invitation to it.

Jesus “was in all *points* tempted as *we are*, yet without sin.” Hebrews 4:15.

It is inherent to the fallen human condition.

“No temptation has overtaken you except such as is common to man; ...” I Corinthians 10:13.

God tests individuals.

Abraham (Genesis 22:1), Job (Job 23:10), I Corinthians 11:32, Hebrews 12:4-11, etc.

Satan tempts individual to sin.

Matthew 4:3, I Thessalonians 3:5.

God provides means of rescue.

“*then* the Lord knows how to deliver the godly out of temptations...” 2 Peter 2:9.

“...but God *is* faithful, who will not allow you to be tempted beyond what you are able, but with the temptation will also make the way of escape, that you may be able to bear *it*.” I Corinthians 10:13.

Scripture describes temptation as something to be avoided if possible:

“And do not lead us into temptation...” Matthew 6:13.

“Watch and pray, lest you enter into temptation.” Mark 14:38.

Sexual Fantasy - when does it cross into sin?

Temptation is not yet sin. Everyone has a sex drive and the duty to manage it.

Experiencing sexual thoughts is not yet fantasy, or lust, unless willingly pursued. Some have compared the appearance of sexual thoughts to a bird flying over one's head, thus out of our control; and fantasy or lust is compared to the equivalent of allowing that bird to build a nest on our head, something clearly in our power to resist.

Same-sex attraction chaste life - does it include avoidance of kissing? Is this equal to homosexual celibacy?

This is a multi-faceted question.

1. Scripture speaks of greeting each other with “a holy kiss” (Romans 16:16, I Corinthians 16:20), which is a salutation, something non-sexual.

Greeting with a kiss is a pervasive practice in the general cultures of several nations to this day.

2. The kissing implicit in the stated question is sexual, romantic.

There is no part of homosexual practice that is endorsed in scripture; it is condemned without exception.

3. Though we mean abstinence from homosexual practices when we say, “homosexual celibacy,” the application of the term “celibate” to same-sex sexual practice is Biblically problematic.

Lifetime celibacy is referred to as a “gift” by the Apostle Paul in I Corinthians 7:7-9.

A Celibate person is giving up the God-ordained institution of marriage (exclusively between one man and one woman in scriptural standards) along with its God-ordained sexual practice.

God gifts, or graces, that person with something else God-ordained in its place. But a person setting aside same-sex sexual practice is abstaining from or repenting of a sinful practice, which is both commanded and its own benefit. We wish to avoid canonizing homosexual temptation.

Same-sex lifestyle

The willing practice of same-sex sexuality.

Gay culture

Any assemblage of like-minded people creates a culture. Culture itself is a neutral term that gains a moral dimension in its practice. Gay culture endorses the ideological concept of gay identity along with its practices.

Scripturally and scientifically, we hold that sexuality is a verb and not just a noun. Gay and straight are category errors and false identities. Homosexuality by any name is a practice and not an identity, what one does and not who one is.

Likewise, “gay Christian” language canonizes temptation behind a false identity. Any name preceding “Christian” is an implicit priority, contravening Paul's instruction to the Galatian church (Gal. 3:28).

Homophobia, -ic

Homophobia is an ideological and pejorative term that has gained common usage. It is often an accusation made against an individual failing to sufficiently celebrate same-sex sexuality, practices and politics.

But per MayoClinic.org: “A phobia is an overwhelming and unreasonable fear of an object or situation . . . a phobia is long lasting, causes intense physical and psychological reactions, and can affect your ability to function normally at work or in social settings.”

Disagreement is clearly not a phobia.

Linguistically, “homophobia” is somewhat nonsensical, meaning “fear of the same thing.”

Gender vs Sex

Sex is biological and stamped on every nucleated cell in a person’s body from conception onward. It is immutable down to the level of brain cells, so it is impossible to have “a man’s brain in a woman’s body,” for example.

Gender, in its common current usage, is an engineered term leveraging linguistics against biology; it is ideological and self-declared.

Historically, however, per theologian Christopher West:

“The root “gen”—from which we get words such as generous, generate, genesis, genetics, genealogy, progeny, gender, and genitals—means “to produce” or “give birth to.” A person’s gen-der, therefore, is based on the manner in which that person is designed to gen-erate new life. Contrary to widespread secular insistence, a person’s gender is not a malleable social construct. Rather, a person’s gender is determined by the kind of genitals he or she has.”⁸⁶

But ideology does not bow to history. Sex is biology, and gender is ideology.

Gender Identity

Gender identity is a feeling, a self-perception, of how one identifies with their biological sex or not, and it is often a sex stereotype. It is subjective, self-declared and fluid. Psychologist Dr. John Money of Johns Hopkins initiated its use in professional journals in 1955, referring to “the identity of the inner sexed self.”⁸⁷

Gender Confusion/Dysphoria

Gender identity confusion/dysphoria is a feeling/self-perception that one’s biology is not as one wishes it to be or not as one identifies most comfortably as. Sechner notes, “A gender-dysphoric youth experiences a sense of incongruity between the gender expectations linked to her or his biological sex and her or his biological sex itself.”⁸⁸

The greater the discomfort/dissonance, the greater the dysphoria. Gender dysphoria is not synonymous with transgenderism, the latter being an umbrella term within which gender dysphoria fits, but to which transgenderism is not limited.

Gender - Should we be using that term or is there a better term? If so, how is it best defined?

The answer to that depends on the application and one must be careful.

Gender is an engineered term leveraging linguistics against biology; it is ideological and self-declared. Sex is biological, right down to each human cell containing a nucleus.

Though gender is sometimes used synonymously with sex (e.g., in forms asking if someone is male or female), ideologically it is considered separate and distinct from sex (e.g., “your sex is irrelevant to your gender identity”) in a manner that is quite Gnostic (i.e., the “higher knowledge” that transcends lowly biology).

Therefore, it is best to mean what you say and say what you mean in context. Using phrases like “identified gender,” “identifies as,” “gender incongruence,” “gender dysphoria,” “transgender identified,” etc. work well, don’t surrender reality to a claim, and do not imply agreement.

Best terminology for gender transition?

That depends on the intended usage.

“Transition efforts” or “transition-affirming treatments/procedures” are both quite clear and do not surrender to ideology as compared to terms like “gender-affirming” or “gender confirming” treatments and procedures.

Best terminology for transgender identity?

“Transgender-identified” or “transgender identification” are well understood and non-capitulating.

A final comment on language

Terms should be as descriptively accurate as possible while avoiding ideological programming. For instance, because an individual’s intrinsic sex cannot be changed, and gender is essentially a biologically meaningless term or concept aside from biological sex, terms such as “transgender identity,” as if it were an objective reality, should be replaced by “transgender-identified, -identifying, or -identification,” which are descriptively accurate. Similarly, because “gender transition” is not ontologically or biologically possible, more descriptively accurate terms, such as, “attempted transition efforts,” or “attempted transition-affirming treatments or procedures,” are more accurate and preferred.

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October 30, 2021, virtual

References

1. Hyde JS, Bigler RS, Joel D, Tate CC, van Anders SM. The future of sex and gender in psychology: Five challenges to the gender binary. *Am Psychol.* 2019;74(2):171-193. doi:10.1037/amp0000307
2. Cretella MA, Rosik CH, Howsepian AA. Sex and gender are distinct variables critical to health: Comment on Hyde, Bigler, Joel, Tate, and van Anders (2019). *Am Psychol.* 2019;74(7):842-844. doi:10.1037/amp0000524
3. Institute of Medicine (US) Committee on Understanding the Biology of Sex and Gender Differences, Wizemann, T. M., & Pardue, M. L. (Eds.). (2001). *Exploring the Biological Contributions to Human Health: Does Sex Matter?*. National Academies Press (US).
4. Sullivan, A. (2020). Sex and the census: why surveys should not conflate sex and gender identity. *International Journal Of Social Research Methodology*, 23(5), 517-524. <https://doi.org/10.1080/13645579.2020.1768346>
5. Anckarsäter, H., & Gillberg, C. (2020). Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery. *American Journal of Psychiatry*, 177(8), 764–765. <https://doi.org/10.1176/appi.ajp.2020.19111117>
6. Hruz P. W. (2020). Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *The Linacre Quarterly*, 87(1), 34–42. <https://doi.org/10.1177/0024363919873762>
7. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885. Published 2011 Feb 22. doi:10.1371/journal.pone.0016885
8. Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender-Affirming Surgeries: A Comment by the Editor on the Process. *Am J Psychiatry*. 2020;177(8):764. doi:10.1176/appi.ajp.2020.20060803

9. Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence. *Am J Psychiatry*. 2020;177(8):765-766. doi:10.1176/appi.ajp.2020.19111130
10. Biggs M. Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria. *Arch Sex Behav*. 2020;49(7):2227-2229. doi:10.1007/s10508-020-01743-6
11. Davis SR, Baber R, Panay N, et al. Global Consensus Position Statement on the Use of Testosterone Therapy for Women. *J Clin Endocrinol Metab*. 2019;104(10):4660-4666. doi:10.1210/jc.2019-01603
12. Giovannetti, B., 2014. *Four Letter Words: Conversations On Faith's Beauty And Logic*. San Francisco: Endurant Press, p.178.
13. Bartz D, Chitnis T, Kaiser UB, et al. Clinical Advances in Sex- and Gender-Informed Medicine to Improve the Health of All: A Review. *JAMA Intern Med*. 2020;180(4):574-583. doi:10.1001/jamainternmed.2019.7194
14. 2013. *Diagnostic And Statistical Manual Of Mental Disorders*. Arlington, VA: American Psychiatric Association, p.829.
15. Tournaye H. Is there any reproductive future left for men?. *Facts Views Vis Obgyn*. 2012;4(4):255-258.
16. Mayer LS, McHugh PR. Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *New Atlantis* (2016); 50:10-143. At pp.89-90.
17. Beale JM, Creighton SM. Long-term health issues related to disorders or differences in sex development/intersex. *Maturitas*. 2016;94:143-148. doi:10.1016/j.maturitas.2016.10.003
18. Sax L. How common is intersex? a response to Anne Fausto-Sterling. *J Sex Res*. 2002;39(3):174-178. doi:10.1080/00224490209552139
19. Słowikowska-Hilczek J, Hirschberg AL, Claahsen-van der Grinten H, et al. Fertility outcome and information on fertility issues in individuals with different forms of disorders of sex development: findings from the dsd-LIFE study. *Fertil Steril*. 2017;108(5):822-831. doi:10.1016/j.fertnstert.2017.08.013
20. Van Mol, A., 2019. *Intersex: What It Is And Is Not – Christian Medical & Dental Associations*. [online] Christian Medical & Dental Associations. Available at: <<https://cmda.org/intersex-what-it-is-and-is-not/>> [Accessed 11 November 2020].
21. Some professional organizations appear to acknowledge the same, even if they generally claim gender-sex discordance is normal. The World Professional Association for Transgender Health says in its Standards of Care that "gender dysphoria" may be "secondary to, or better accounted for by, other diagnoses." (Wpath.org. 2012. *Standard Of Care For The Health Of Transsexual, Transgender, And Gender Nonconforming People*. [online] Available at: <<https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf?t=1604581968>> [Accessed 11 November 2020]. p24) The British Psychological Society says, "In some cases the reported desire to change sex may be symptomatic of a psychiatric condition for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger's syndrome...." (Shaw L, Butler C, Langdridge D, et al. Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. British Psychological Society Professional Practice Board. Leicester, UK, 2012, p. 26 [Accessed online 16 January 2021 at: <https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Minority%20Clients%20%282012%29.pdf>]) The American Psychological Association's APA Handbook of Sexuality and Psychology allows for the possibility that pathological family of origin dynamics may be causal. (Tolman, D., Diamond, L., Bauermeister, J., George, W., Pfaus, J. and Ward, L., 2014. *APA Handbook Of Sexuality And Psychology*. American Psychological Association, p.743.)
22. Bechard M, VanderLaan DP, Wood H, Wasserman L, Zucker KJ. Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study. *J Sex Marital Ther*. 2017;43(7):678-688. doi:10.1080/0092623X.2016.1232325
23. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: A review of the literature. *Int Rev Psychiatry*. 2016;28(1):44-57. doi:10.3109/09540261.2015.1115753
24. Hanna B, Desai R, Parekh T, Guirguis E, Kumar G, Sachdeva R. Psychiatric disorders in the U.S. transgender population. *Ann Epidemiol*. 2019;39:1-7.e1. doi:10.1016/j.annepidem.2019.09.009
25. Kaltiala-Heino R, Sumia M, Työlajärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child Adolesc Psychiatry Ment Health*. 2015;9:9. Published 2015 Apr 9. doi:10.1186/s13034-015-0042-y
26. Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. *Pediatrics*. 2018;141(5):e20173845. doi:10.1542/peds.2017-3845

27. Zucker KJ, Lawrence AA, Kreukels BP. Gender Dysphoria in Adults. *Annu Rev Clin Psychol.* 2016;12:217-247. doi:10.1146/annurev-clinpsy-021815-093034
28. Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria [published correction appears in PLoS One. 2019 Mar 19;14(3):e0214157]. *PLoS One.* 2018;13(8):e0202330. Published 2018 Aug 16. doi:10.1371/journal.pone.0202330
29. Bps.org.uk. 2012. *Guidelines And Literature Review For Psychologists Working Therapeutically With Sexual And Gender Minority Clients.* [online] Available at: <<https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf>> [Accessed 11 November 2020].
30. E. Coleman, W. Bockting, M. Botzer, P. Cohen-Kettenis, G. DeCuypere, J. Feldman, L. Fraser, J. Green, G. Knudson, W. J. Meyer, S. Monstrey, R. K. Adler, G. R. Brown, A. H. Devor, R. Ehrbar, R. Ettner, E. Eyler, R. Garofalo, D. H. Karasic, A. I. Lev, G. Mayer, H. Meyer-Bahlburg, B. P. Hall, F. Pfaefflin, K. Rachlin, B. Robinson, L. S. Schechter, V. Tangpricha, M. van Trotsenburg, A. Vitale, S. Winter, S. Whittle, K. R. Wylie & K. Zucker (2012) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, *International Journal of Transgenderism*, 13:4, 165-232, DOI: 10.1080/15532739.2011.700873
31. Roselli CE. Neurobiology of gender identity and sexual orientation. *J Neuroendocrinol.* 2018;30(7):e12562. doi:10.1111/jne.12562
32. World. 2020. *Fighting to let a boy be a boy.* [online] Available at: <https://wng.org/roundups/fighting-to-let-a-boy-be-a-boy-1617220961> [Accessed 26 April 2021].
33. Bradley SJ, Zucker KJ. Gender identity disorder and psychosexual problems in children and adolescents. *Can J Psychiatry.* 1990;35(6):477-486. doi:10.1177/070674379003500603
34. Lisa Marchiano (2017) Outbreak: On Transgender Teens and Psychic Epidemics, *Psychological Perspectives*, 60:3, 345-366, DOI: 10.1080/00332925.2017.1350804
35. Anderson, R., 2018. *Transgender Ideology Is Riddled With Contradictions. Here Are The Big Ones.* [online] The Heritage Foundation. Available at: <<https://www.heritage.org/gender/commentary/transgender-ideology-riddled-contradictions-here-are-the-big-ones>> [Accessed 11 November 2020].
36. Hilton, C., 2020. *Opinion | The Dangerous Denial Of Sex.* [online] WSJ. Available at: <<https://www.wsj.com/articles/the-dangerous-denial-of-sex-11581638089>> [Accessed 11 November 2020].
37. Medium. 2017. *Transgender Ideology Does Not Support Women.* [online] Available at: <<https://medium.com/@mirandayardley/transgender-ideology-does-not-support-women-2d00089e237a>> [Accessed 11 November 2020].
38. Gender Health Query. n.d. *Many LGBT People Do Not Agree With Gender Queer Theory & Scientific Validity Taught In Schools — Gender Health Query.* [online] Available at: <<https://www.genderhq.org/trans-youth-controversial-schools-lgbt-science-dysphoria>> [Accessed 11 November 2020].
39. The Daily Signal. 2017. *I'M A Pediatrician. How Transgender Ideology Has Infiltrated My Field And Produced Large-Scale Child Abuse.* [online] Available at: <<https://www.dailysignal.com/2017/07/03/im-pediatrician-transgender-ideology-infiltrated-field-produced-large-scale-child-abuse/>> [Accessed 11 November 2020].
40. Olver T. Disaffirming Gender: Somatic Incongruence as a Co-function of Ideological Congruity. *Psychoanal Rev.* 2019;106(1):1-28. doi:10.1521/prev.2019.106.1.1
41. Olsen H. 2019. *California Wants To Teach Kindergartners About Gender Identity. Seriously.* [online] Available at: <<https://www.washingtonpost.com/opinions/2019/05/13/california-wants-teach-kindergartners-about-gender-identity-seriously/>> [Accessed 11 November 2020].
42. Doward, J., 2019. *Politicised Trans Groups Put Children At Risk, Says Expert.* [online] the Guardian. Available at: <<https://www.theguardian.com/society/2019/jul/27/trans-lobby-pressure-pushing-young-people-to-transition>> [Accessed 11 November 2020].
43. Jones A, Kao E. Heritage.org. 2019. *Sexual Ideology Indoctrination: The Equality Acts Impact On School Curriculum And Parental Rights.* [online] Available at: <<https://www.heritage.org/sites/default/files/2019-05/BG3408.pdf>> [Accessed 11 November 2020].
44. Omercajic K, Martino W. Supporting transgender inclusion and gender diversity in schools: a critical policy analysis. *Frontiers in Sociology* 2020; 5:27. <https://doi.org/10.3389/fsoc.2020.00027>
45. Friestad, T., 2018. *Being Mila: Creating An Lgbtq Curriculum That Is Authentic, Follows Policies And Ethics, And Teaches Acceptance.* [online] DigitalCommons@Hamline. Available at: <https://digitalcommons.hamline.edu/hse_cp/196?utm_source=digitalcommons.hamline.edu/hse_cp/196> [Accessed 11 November 2020].

46. Dee Knoblauch (2016) Building the Foundation of Acceptance Book by Book: Lesbian, Gay, Bisexual, and/or Transgender-Themed Books for Grades K–5 Multicultural Libraries, *Multicultural Perspectives*, 18:4, 209-213, DOI: [10.1080/15210960.2016.1228325](https://doi.org/10.1080/15210960.2016.1228325)
47. Christian Concern. 2020. *LGB Alliance Founder Criticises RSE Lessons*. [online] Available at: <https://christianconcern.com/comment/lgb-alliance-founder-criticises-rse-lessons/> [Accessed 11 November 2020].
48. 2013. *Diagnostic And Statistical Manual Of Mental Disorders*. Arlington, VA: American Psychiatric Association, p.455.
49. Tolman, D., Diamond, L., Bauermeister, J., George, W., Pfaus, J. and Ward, L., 2014. *APA Handbook Of Sexuality And Psychology*. Washington D.C: American Psychological Association, p.774.
50. Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med*. 2008;5(8):1892-1897. doi:10.1111/j.1743-6109.2008.00870.x
51. Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;28(1):13-20. doi:10.3109/09540261.2015.1115754
52. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in *J Clin Endocrinol Metab*. 2018 Feb 1;103(2):699] [published correction appears in *J Clin Endocrinol Metab*. 2018 Jul 1;103(7):2758-2759]. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658
53. Kenneth J. Zucker (2018) The myth of persistence: Response to “A critical commentary on follow-up studies and ‘desistance’ theories about transgender and gender non-conforming children” by Temple Newhook et al. (2018), *International Journal of Transgenderism*, 19:2, 231-245, DOI: [10.1080/15532739.2018.1468293](https://doi.org/10.1080/15532739.2018.1468293)
54. Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline". *J Clin Endocrinol Metab*. 2019;104(3):686-687. doi:10.1210/jc.2018-01925
55. Safer JD, Tangpricha V. Care of Transgender Persons. *N Engl J Med*. 2019;381(25):2451-2460. doi:10.1056/NEJMcpl903650
56. Levine SB. Informed Consent for Transgendered Patients. *J Sex Marital Ther*. 2019;45(3):218-229. doi:10.1080/0092623X.2018.1518885
57. Shatzel JJ, Connelly KJ, DeLoughery TG. Thrombotic issues in transgender medicine: A review. *Am J Hematol*. 2017;92(2):204-208. doi:10.1002/ajh.24593
58. Vumc.org. 2012. *Key Transgender Health Concerns | Program For LGBTQ Health*. [online] Available at: <https://www.vumc.org/lgbtq/key-transgender-health-concerns> [Accessed 12 November 2020].
59. Getahun D, Nash R, Flanders WD, et al. Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. 2018;169(4):205-213. doi:10.7326/M17-2785
60. Goodman, M., 2018. [online] Pcori.org. Available at: <https://www.pcori.org/sites/default/files/PCORI-Goodman076-English-Abstract.pdf> [Accessed 11 November 2020].
61. Heyer, W. 2019. Usatoday.com. 2019. *Hormones, Surgery, Regret: I Was A Transgender Woman For 8 Years-Time I Can'T Get Back.* [online] Available at: <https://www.usatoday.com/story/opinion/voices/2019/02/11/transgender-debate-transitioning-sex-gender-column/1894076002/> [Accessed 11 November 2020].
62. International Association of Therapists for Desisters and Detransitioners. (2020). *Introduction to Detransition for Therapists*. [online]. Available at: https://iatdd.com/introduction-to-detransition-for-therapists/?fbclid=IwAR2bsQ-ojdFi7Zyzow_RNCDcD34eGU_flce_x8mfRpH3s0DRp91PwwONkto [Accessed 4/26/2021].
63. Sky News. (2019). *'Hundreds' of Young Trans People Seeking Help to Return to Original Sex*. [online]. Available at: <https://news.sky.com/story/hundreds-of-young-trans-people-seeking-help-to-return-to-original-sex-11827740>. [Accessed 4/26/2021].
64. Horvath H. "The Theatre of the Body: A Detransitioned Epidemiologist Examines Suicidality, Affirmation, and Transgender Identity". [online]. Available at: <https://4thwavenow.com/2018/12/19/the-theatre-of-the-body-a-detransitioned-epidemiologist-examines-suicidality-affirmation-and-transgender-identity/>. Assessed 4-26-2021.
65. Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study [published correction appears in *Am J Psychiatry*. 2020 Aug 1;177(8):734]. *Am J Psychiatry*. 2020;177(8):727-734. doi:10.1176/appi.ajp.2019.19010080
66. Schulman, J. K., & Erickson-Schroth, L. (2019). Mental Health in Sexual Minority and Transgender Women. *The Medical Clinics of North America*, 103(4), 723–733. <https://doi.org/10.1016/j.mcna.2019.02.005>

67. Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017. *Am J Public Health*. 2019;109(1):e1-e8. doi:10.2105/AJPH.2018.304727
68. Levine SB, Solomon A. Meanings and political implications of "psychopathology" in a gender identity clinic: a report of 10 cases. *J Sex Marital Ther*. 2009;35(1):40-57. doi:10.1080/00926230802525646
69. Levine SB. Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria. *J Sex Marital Ther*. 2018;44(1):29-44. doi:10.1080/0092623X.2017.1309482
70. Malone WJ, Roman S. Calling Into Question Whether Gender-Affirming Surgery Relieves Psychological Distress. *Am J Psychiatry*. 2020;177(8):766-767. doi:10.1176/appi.ajp.2020.19111149
71. Tucker RP. Suicide in Transgender Veterans: Prevalence, Prevention, and Implications of Current Policy. *Perspect Psychol Sci*. 2019;14(3):452-468. doi:10.1177/1745691618812680
72. Wold A. Gender-Corrective Surgery Promoting Mental Health in Persons With Gender Dysphoria Not Supported by Data Presented in Article. *Am J Psychiatry*. 2020;177(8):768. doi:10.1176/appi.ajp.2020.19111170
73. Wiepjes CM, den Heijer M, Bremmer MA, Nota NM, deBlock CJM, Coumou BJG, Steensma TD. Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017). *Acta Psychiatr Scand*. (2020); 141(6):486-491.
74. Stroumsa D, Roberts EFS, Kinnear H, Harris LH. The Power and Limits of Classification - A 32-Year-Old Man with Abdominal Pain. *N Engl J Med*. 2019;380(20):1885-1888. doi:10.1056/NEJMp1811491
75. Bangalore Krishna K, Houk CP, Lee PA. Pragmatic approach to intersex, including genital ambiguity, in the newborn. *Semin Perinatol*. 2017;41(4):244-251. doi:10.1053/j.semperi.2017.03.013
76. Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43(8), 1535–1545. <https://doi.org/10.1007/s10508-014-0300-8>
77. Jones BP, Williams NJ, Saso S, et al. Uterine transplantation in transgender women. *BJOG*. 2019;126(2):152-156. doi:10.1111/1471-0528.15438
78. Schumm WR, Crawford DW. Is Research on Transgender Children What It Seems? Comments on Recent Research on Transgender Children with High Levels of Parental Support. *Linacre Q*. 2020;87(1):9-24. doi:10.1177/0024363919884799
79. Orwh.od.nih.gov. n.d. *Questions & Answers | Office Of Research On Women's Health*. [online] Available at: <<https://orwh.od.nih.gov/sex-gender/nih-policy-sex-biological-variable-sabv/questions-answers>> [Accessed 11 November 2020].
80. Huey, N., 2018. *Treating Men And Women Differently: Sex Differences In The Basis Of Disease - Science In The News*. [online] Science in the News. Available at: <<http://sitn.hms.harvard.edu/flash/2018/treating-men-and-women-differently-sex-differences-in-the-basis-of-disease/>> [Accessed 11 November 2020].
81. Madsen, T., Bourjeily, G., Hasnain, M., Jenkins, M., Morrison, M., Sandberg, K., Tong, I., Trott, J., Werbinski, J. and McGregor, A., 2017. Article Commentary: Sex- and Gender-Based Medicine: The Need for Precise Terminology. *Gender and the Genome*, 1(3), pp.122-128.
82. Mayer, L.S and McHugh, P.R. Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences. *The New Atlantis*. Number 50, Fall 2016., pp 7-9.
83. McHugh, Paul R. Amicus Brief to the SCOTUS for *Obergefell v Hodges*.
84. Dar-Nimrod, I & Heine, S.J. "Some thoughts on essence placeholders, interactionism, and heritability: Reply to Haslam (2011) and Turkheimer (2011). *Psychological Bulletin*. (2011) 137(5): 829 – 833.
85. Diamond, LM & Rosky, C.J. "Scrutinizing Immutability: Research on Sexual Orientation and US Legal Advocacy for Sexual Minorities." *Journal of Sex Research*. (2016) 00: 1-29.
86. West, Christopher. *Our Bodies Tell God's Story*. Grand Rapids: Brazos Press. 2020. p. 28.
87. Money, John. "Hermaphroditism, gender and precocity in hyperadrenocorticism: psychological findings." *Bulletin of the Johns Hopkins Hospital*. (1955) 95(6): 252-264.
88. Shechner, Tomer. "Gender Identity Disorder: A Literature Review from a Developmental Perspective." *Isr. J of Psychiatry & Related Sci*. (2010) 47: 132-138.

From: [Stephen Guffanti](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: TRANSGENDER ISSUE in FL
Date: Monday, September 19, 2022 1:23:57 PM

Some people who received this message don't often get email from scguffanti@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Hello,

Please accept my input on the regulation of the practice of medicine to protect children in FL.

First, what concerns the most about this issue is the increased suicide rate of transgender people. Even when supported by society like in Sweden they have a high suicide rate. Children can't make that far reaching a decision and a parent should not be allowed to make it for them. The surgery can be done when they are adults if they haven't changed their mind. The problem is not life threatening other than suicide and there is no evidence that their suicide rate returns to normal after the surgery. What we have is an elective surgery that can happen any time after they are 18. However, it would be very hard to reverse once it is done. In essence, a ton of harm and minimal good can be created by allowing doctors to change the sex of the child.

Sincerely,

Stephen Guffanti, MD
760-613-8617

From: [Ritchie Gillespie](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Fwd: Gender dysphoria in minors
Date: Monday, September 19, 2022 4:21:08 PM

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Begin forwarded message:

From: Ritchie Gillespie <rpg8511@yahoo.com>
Date: September 19, 2022 at 1:19:16 PM EDT
To: Paul.Vazquez@flhealth.gov
Subject: Gender dysphoria in minors

Dear Sir, I hope all will remember the axiom “first do no harm” when considering the issue of medical and surgical treatment of gender dysphoria in minors. The experience of adverse outcomes of this treatment in minors in the U.K. and Sweden should be evidence that more needs to be learned before recognizing these treatments as being of value.

Taking this uncertainty into account, we should not leave this decision up to the adolescent lacking the ability to understand long term consequences which even the medical establishment finds unclear at present.

Thank you for your attention to this matter.

Ritchie Gillespie MD

Sent from my iPhone

From: [GG Pops](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Fw: Gender identity
Date: Monday, September 19, 2022 2:37:36 PM

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Begin forwarded message:

On Monday, September 19, 2022, 10:44 AM, GG Pops <bobnjohn@yahoo.com> wrote:

As a Board certified Family physician I am horrified at the devolution of medical care away from sound principles of biological and to allow mentally unhinged individuals to dictate what constitutes medical care.

Certainly we need to carefully evaluate every person who has questions about their gender to include karyotyping when indicated and to help people to accept their gender in every truly supportive way, but we can never foster the lie that people can choose their gender irrespective of biology.

Respectfully

Robert Hennessy MD
Corona, CA

[Sent from Yahoo Mail for iPhone](#)

Rosita Weissberg
New York, NY

September 20, 2022

Florida Board of Medicine

Dear Mr. Vazquez and the Florida Board of Medicine Members,

I am writing as the parent of a trans-identified child in order to give my input as a person who has been navigating the system of gender affirming care for many years. First, I would like to state that I am politically center left- a Democrat, and I am not writing with a political agenda. I want you to know that I am very grateful that this medical board has turned its attention to this matter, and I truly thank you from the bottom of my heart, for making this a priority since all other American institutions have decided to turn a blind eye to a system that is clearly corrupt and ideologically captured.

The idea that any medical model should be 'client driven' is radical, but it becomes absurd when it is applied to children. My child began identifying as non-binary around her 13th birthday, following a difficult puberty, a diagnosis of Asperger's, and a long period of self-harming and depression that was brought on when she identified as EMO (a culture she described as "hating yourself" and which she discovered online). Prior to this, she was a happy, energetic, curious, interested and self-loving child who never displayed any discomfort with her physical self.

It cannot be a coincidence that most teenage girls who identify as transgender seem to have a similar trajectory. At the time of the trans identification, my child was being treated by a group of doctors at NYU Children's Hospital, and had outside DBT and ASD specialist. I was unable at the time to comprehend how these doctors, who were treating her for self harm and social communications disorder, just accepted my child's sudden and inexplicable change of name and pronouns, asserting that though they were recommending an in-patient therapeutic program, that this one thing about herself- that she was non-binary- was the only one true thing my child knew about herself. Leaving it at that, my child was affirmed

and no further cause or issue regarding identity was further investigated or challenged.

At the time, I was naive and I thought she would explore this identity and move on, but then by the interventions of staff at the above mentioned program, the identity changed to gay boy. It was not long after that that my child's mental and physical health got worse and did not seem to recover until many years later when I started pushing back on the ideology by asking questions. This trajectory also appears to be common amongst this cohort, as I've found out from talking to a lot of parents.

This is a long story to say that in my experience with affirmation, including allowing children to decide their sex, names, pronouns and to socially transition- especially in a medical setting, triggers an unspooling of mental health disorders, achieving the opposite of what it purports to do. Moreover, as I realized in horror after doing some research, none of those interventions are neutral, and in actuality seem to forfeit a child's ability to feel comfortable with themselves.

Doctors, teachers, neighbors, do-gooders, and even family members who 'affirm' a person's transgender identity before said person has had a chance to investigate and question the origins of the identification, are doing great harm. It is my experience that they tend to do so for their own good, as it makes them feel progressive and supportive of someone under the LGBT banner, without understanding any of the harms they cause. I have many friends whose intrusive family members or friends have been instrumental in turning their kids against them.

Doctors, allies, and teachers who affirm other people's children without parent consent have no understanding of all the unhealthy and negative cultural and ideological forces that belie the identification. While gender ideologues and affirmation proponents like to paint a picture of self-acceptance, healthy development, and everything that is rosy with rainbows and glitter, the reality is that most of us at home who look into what our children are doing online, in school GSA and LGBT groups, and in that culture, come to understand that the identity is often tied to pornography, sexual fetishes, inappropriate contact with adults who pose

as a 'glitter family,' and a lot of coaching inner self-talk about being 'born in the wrong body.'

To many of us, it is obvious that the trans identification triggers an iatrogenic development of gender dysphoric feelings that cause our children to reject their body and their past selves. This must be studied and researched carefully by a set of neutral scientists interested in really helping this cohort. In the case of my child, after 4 years of refusing to move lest she 'feels' herself, she now suffers from obesity, pre-diabetes, and metabolic disorder. Someone who was average weight all her life, was a dancer, a swimmer, a lover of movement and of herself, is now an unhealthy young adult who is immobile, obese, and who needs a plethora of medications that make her feel ill all the time.

The various pediatricians, psychiatrists, psychologists, therapists, endocrinologists, and other doctors that are entrusted with our children's care don't understand or don't want to see that affirmation is problematic. For example, not one of my child's many doctors ever questioned fallacies in her recollections of when this disorder set in, or her false memories that we knew had not occurred. Though I made them aware of the horrendous materials she had accessed online, they never bothered to question or help her explore what all of that meant, and to this day, most people and professionals will dismiss the possibility that online content can influence our children.

Affirmation appears to function as the imposition of an ideology or outside personal beliefs onto the developing minds of innocent and vulnerable children and adolescents. It must be studied: what effect does it actually have? especially when used by doctors or therapists who have an outsize influence on their patients. There is NO evidence that social transition, cross-dressing, using affirmative drugs and medical treatments, actually heal or help these children in any way. Considering the lack of evidence base to support it, is actually mind-boggling that this practice has been unfurled and is so widely practiced.

It is my opinion that the Florida Board of Medicine should look closely at the following issues and phenomena in order to fully understand what is appropriate medical care and what is simply activist directive designed to

provide cover for a lot of unhealthy and predatory actors (including unethical doctors, charities, private citizens, paraphilic men, misguided parents, and mentally ill persons):

1. WPATH and USPATH- Why is an organization made up of activists and the very doctors who work in the field allowed to dictate the standards by which the treat patients? My insurance booklet states that WPATH is an activist, not a medical organization- so why are we allowing activists who will benefit financially and socially to determine treatment protocols? especially because they tend to do poor science and seem to have an agenda? How is this legal?

They are so unfettered by reality and feel so untouchable that they had the gaul to add the identity of eunuch to the SoC8, released last week. How can a child even identify as a eunuch when the condition requires that one has already become an adult This really makes me wonder about the mental capacity and judgment of this group of people.

2. Informed consent clinics, including Planned Parenthood, Community LGBT+ service centers, and virtual providers such as Plume and Folx Health. These businesses have had a great influx of investor money and NGO funding and they are sending out hormones with very little medical case management, proper blood testing, or proper informed consent. Often times they do not even adhere to the WPATH's laughable SoC.

1. Regarding PP: When my child turned 18, she insisted that she wanted hormones. Though I opposed this, I did support her and took her to see her psychiatrist and endocrinologist. Both doctors explained to her that hormone therapy is still experimental, and that especially for people on the autism spectrum, it is better to wait until the brain is fully developed and the person has tried other ways to find relief. The endocrinologist aded that her metabolic panel and current weight anyways disqualified her for hormones because it is contraindicated for obese people who have high cholesterol due to chances of stroke. About 6 months later, on the urging of some friends, my child made a virtual appointment at Planned Parenthood, where she was seen by a midwife! My daughter was affirmed, but luckily, she did not chose to go on hormones. A month later, my child received a bill for \$370, though she had originally been told that the consultation was only

\$40. If Planned Parenthood is unable to clearly explain their pay structure to a young person on the spectrum, how can they possibly ever hope to give proper medical care and get informed consent correctly? If my child had decided to go ahead with taking hormones as prescribed by PP, she may have suffered a stroke or other consequences.

I have heard many such stories for mothers about Planned Parenthood, and I think they are going to destroy their brand with these shenanigans. I am adding below some more information about PP's practices, including some stories by detransitioners about the bad care they received there. I believe that their practices need to be considered carefully by the medical board:

- <https://abigailshrier.substack.com/p/inside-planned-parenthoods-gender>
- https://pitt.substack.com/p/the-us-tavistock?utm_source=email
- <https://lacroicsz.substack.com/p/by-any-other-name>
- Video by SaltyAlty:



These 2 virtual providers need to be looked at and regulated:

<https://www.folxhealth.com>

<https://getplume.co>

3. Online resources and chats for trans identified kids where adult participants gain access to them: Reddit, Trevor Project Translifeline, etc. etc: <https://translifeline.org/resource/gaming/>

4. Social media influencers, fan fiction groups, and other internet content that have led to the theory of a social contagion (which also needs to be explored):

1. <https://www.medscape.com/viewarticle/980500>
2. <https://lacroicsz.substack.com/p/limerence>
3. <https://littmanresearch.com/publications/>
4. https://pitt.substack.com/p/detransitioner-perspective-how-trans?utm_source=email
5. <https://hormonehangover.substack.com/p/thinspo-and-gender-goals>

5. Direct advertising of gender treatments and surgeries by providers to children on social media: start with Florida's own-
<https://www.tiktok.com/@gendersurgeon>

6. Link to porn and fetishes such as BDSM, hypno-sissy porn, and Autogynophilia:

1. <https://grahamlinehan.substack.com/p/sissy-porn-the-gender-movements-dirty>
2. <https://www.feministcurrent.com/2020/11/29/why-isnt-anyone-talking-about-the-influence-of-porn-on-the-trans-trend/>
3. <https://pitt.substack.com/p/transgenders-connection-with-pornography>
4. <https://www.gendermapper.org/post/3-part-series-on-what-your-dysphoric-child-is-watching-online>
5. <https://link.springer.com/article/10.1007/BF01541769>
6. <https://link.springer.com/article/10.1007/s10508-005-4343-8>
7. <https://4thwavenow.com/2019/08/13/how-mental-illnesses-become-identities-tumblr-a-callout-post-part-2/>

7. Illegal services that send hormones to kids without prescription and the adults who enable it. One example is from a friend of mine whose kid ordered elicit hormones from this website: <https://steroidify.com>

The child is a minor and they paid via crypto following instructions from an online forum. The drugs were shipped to the home of an adult 'aly' who deemed herself this child's savior. This parent's rights were completely undermined by not only strangers online, but also a porous US customs process that allowed these drugs in from the eastern Europe to be delivered to a third person. This must be stopped.

8. There should also be an investigation into record keeping practices at all informed consent clinics as well as hospitals that provide surgery. Data reporting in this field should be mandated in the same way that the CDC mandates reporting from fertility clinics. The government should initiate an audit of clinic outcomes thus far, and require future reporting on all intakes and outcomes. Currently, there seems to be no record keeping or follow up, and when patients come with problems and complications the doctors ignore them, pass them over to other doctors, or mistreat them, as per the testimony of many detransitioners. Vaginoplasty and phalloplasty have horrifically high rates of complications and negative outcome rates. This data needs to be reported, and these procedures need to be kept to the SAME standards as any other surgical procedure:

<https://www.statsforgender.org/surgery/>

9. Researching detransition. The input from patients who were medically harmed by current practices, including affirmative care and informed consent models, are a good way to inform what has gone wrong and what needs to change.

10. Debunk the suicide myth of trans people:

<https://www.statsforgender.org/suicide/>

11. Investigate the large NGOs and charities that put out an incredible amount of disinformation that is unhealthy for LGBT+ individuals because they are based on propaganda and lies:

- <https://www.aclu.org/issues/lgbtq-rights/transgender-rights>
- <https://www.glaad.org>
- <https://www.thetrevorproject.org>
- <https://www.hrc.org>
- <https://pflag.org>
- <https://www.lambdalegal.org>

This form of medical practice is so broken and so dysfunctional, that I can go on forever. There is so much more to say and look at, but I will leave you with the thought that having done a preliminary review of the medical literature, you are well aware that this medicine is not sound. The USA as a world leader, must join other progressive countries such as Sweden, the UK, France and Denmark in putting science before activism and going back to the drawing board to figure out what really IS the best way to help these people. I don't think I am advocating for the end of transgenderism by asking that any surgery or medical intervention performed on anyone in this group be based on safe and sound practices that have been developed with purpose, discipline, and rigor. What is transphobic, homophobic, and misogynist is the current practice of experimenting on this vulnerable and often desperate population without care or respect for the patient.

Thank you again for your interest, your time, and your hard work in this matter.

Sincerely,

Rosita Weissberg

From: [drscottent](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender dysphoria
Date: Monday, September 19, 2022 4:01:41 PM

[You don't often get email from drscottent@gmail.com. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

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Dear Sirs,

This letter is to reject gender identification process being considered before you. In my medical opinion with a degree of medical certainty, gender dysphoria corrects in due time and any interference in medical or surgical treatment is irreversible and counterproductive to natural health. Thank you for your consideration.

Scott E. Manthei,DO,FOCOO

From: [Dr. Michael Ferri](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender transition interventions in FL
Date: Monday, September 19, 2022 1:57:24 PM

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Good afternoon,

Although I am a physician in Tennessee, I want to write to you to encourage the Florida Board of Medicine to restrict any misguided interventions and medical practices that encourage gender transition. The evidence does not support these kinds of intervention which ultimately appear to lead to irreparable long-term harm. Please do whatever is necessary to protect the youth of your state from unnecessary and lifelong harm. Thank you.

Sincerely,

Michael Ferri, MD
Franklin, Tennessee

From: [Peter Rosario](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Vazquez, Paul](#)
Subject: Youth and sex-based medicine
Date: Monday, September 19, 2022 4:03:20 PM

Some people who received this message don't often get email from peter.a.rosario@gmail.com.

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Dear Florida Board of Medicine,

Although I do not practice medicine in Florida, I have been made aware of the Board's upcoming discussions on transgender issues especially regarding transitioning of youth away from their biological sex identified at birth. You are at the forefront of what every state medical association will be facing in the near future. You may well set a precedent. For this reason, I am writing you this short email.

I am not in favor of the chemical and physical mutilation of children. It makes no sense to allow youths to make life-altering decisions with mental complications (19-fold increase in suicides) and reproductive complications (permanent infertility), to name a few. And this at a point when the decision-making capacity of the brain is woefully underdeveloped and will remain so for several more years.

The medical literature is clear about the harmful effects and that over 90% of children and adolescents adopt their biological sex as they mature. Additionally, the experiences in European countries have caused, in recent times, more reticence in offering transition therapies. I pray the guiding principle of 'do no harm,' be the basis of your decisions.

Thank you. Sincerely,

Peter Rosario MD

From: melissa.colbern.net
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: melissa.colbern.net
Subject: restrict gender affirming care for children and adolescents
Date: Monday, September 19, 2022 1:13:05 PM

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Dear Paul,

Florida Board of Medicine

Please accept my recommendations for Florida Board of Medicine to restrict “gender-affirming care”, including rapid gender transition for children and adolescents. The long-term harm of these interventions is clear. Please protect the youth of your state from unnecessary and lifelong harm.

Sincerely,

Melissa Colbern

Melissa Colbern M.D.
melissa@colbern.net

From: [DIANA NEWMAN](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Transition Care
Date: Monday, September 19, 2022 2:37:44 PM

You don't often get email from dianamary41@comcast.net. [Learn why this is important](#)

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Dear Florida Board of Medicine,

The Catholic Medical Association has informed its members of the intent of the Florida Board of Medicine to promote gender transition treatment for adolescents and children.

This is a very dangerous move and seems unethical for the following reasons. There is no evidence that gender transition actually solves the problem of gender dysphoria for children or adults. This type of treatment is exploiting the children, adolescents and families for the benefit of the researcher and provides monetary gain for the persons directing the transition treatment. The attainment of informed consent for adolescents and children must be through the parents. The assent for treatment is by the adolescents and children. Since the outcomes of such treatment are not known it would be impossible for the treating entity to gain informed consent from the parents or assent from the children. It is impossible to justify gender transition treatment in an ethical and responsible manner.

Sincerely,
Diana M. L. Newman, Ed.D.,RN
Plymouth, MA 02360

From: [Karen Landmeier](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Please STOP rapid gender transition
Date: Monday, September 19, 2022 3:11:15 PM

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As a Developmental and Behavioral Pediatrician, I have been trained to understand both the physiology and the psychology of children. That is why I implore you to please RESTRICT rapid gender transition for children and adolescents. Most children who have gender dysphoria resolve their struggles and uncertainty by the end of adolescence, and thus it is essential that we allow them to work through this struggle in the proper timeline before making a permanent decision that involves hormone disruption and/or surgical intervention.

In fact, many European nations are CLOSING their gender transition clinics because their long-term, real life experience is that many who transition at a young age return with immense regret and a desire to transition back to their biological sex.

I am happy to be of assistance if you would like further explanation of how the process of gender dysphoria proceeds.

Sincerely,
Karen Landmeier, MD

From: [Sister Edith Hart](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Upcoming meeting
Date: Monday, September 19, 2022 3:55:26 PM

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To the Board of Directors:

I am writing to express my deep concern about the consideration of the Florida Board of Medicines gender affirming care. This push to accept such care is clearly ideologically driven and not based in either reason or sound medical evidence.

There is excellent evidence coming from our European colleagues that such treatment fails to show improvement in youth experiencing gender dysphoria. In the UK an Independent systematic review of the data concluded that evidence was very low regarding hormonal interventions in gender dysphoric youth disorder. Finland, as a country, adopted a position of early transitioning of pediatric patients and they too showed a lack of improvement in mental health and have now moved to psychotherapy as first line therapy.

As a recent Medscape article pointed out by Dr William Malone Endocrinologist

- “Most cases of early childhood-onset gender dysphoria self-resolve. [Eleven out of 11 studies](#) that followed the trajectory of gender-variant youth show that the most common outcome is natural resolution of gender dysphoria [around or after puberty](#). Among those diagnosed as having gender identity disorder, 67% no longer met the diagnostic criteria as adults; among those subthreshold for diagnosis, [93% were not gender dysphoric](#) as adults. Gender dysphoria in childhood is a far better predictor of future homosexuality than of future trans identity.
- The future trajectory of people whose transgender identity emerged during or after puberty is entirely unknown. No one has studied future trajectories of patients whose transgender identity emerged for the first time after the onset of puberty — a previously rare but now increasingly common presentation. Growing numbers of young detransitioners and

desisters are precisely from this demographic, suggesting that a transgender identity that emerges in adolescence may not be durable.

- Social transition does not improve mental health outcomes. Recent studies show that while socially transitioned children can thrive in the short term, they [do not fare any better](#) than their non-socially transitioned dysphoric peers. It appears that [peer relations](#), not the social transition status, predict mental health in gender-dysphoric children. We don't yet know the long-term trajectories of socially transitioned minors, but [emerging evidence](#) suggests that they may [be more likely to persist](#) with gender-related distress rather than outgrow it, as previously observed. This in turn necessitates decades of invasive and risky medical interventions. In fact, the Dutch researchers who pioneered the protocol used to medically transition minors (see Box) [explicitly and strongly discouraged](#) social transition of children and early adolescents.
- Nearly 100% of children who begin puberty blockers will proceed to cross-sex hormones and surgeries. The two main studies that have [evaluated the effects of puberty blockers](#) on mental health found [no improvements](#) or [improvements of marginal clinical significance](#). Both studies are also at critical risk of bias due to the absence of control groups. [Four additional studies looking](#) at the mental health effects of puberty blockers were plagued by [design limitations](#) and also [failed](#) to show any convincing positive effects on psychological health. However, one effect of puberty blockers has been consistently replicated: [At least four studies show](#) that [virtually all of the children who start puberty blockers proceed to cross-sex hormones](#). This suggests that rather than being a pause button, puberty blockers may serve as the "gas pedal" for gender transition.
- Most of the long-term health risks are largely unknown. No long-term studies exist of patients who underwent medical transition as teens or young adults. Therefore, our ability to assess risks vs benefits is limited. Puberty blockers have been demonstrated to [significantly impair bone health](#), and it is not clear whether this will result in future [osteoporosis](#). Cross-sex hormones are associated with [roughly 3-5 times the risk](#) for [heart attacks and strokes](#), though long-term studies are of insufficient quality for accurate risk assessments. Other risks associated

with these endocrine interventions will come to light as the practice continues to scale and as young people spend years and decades on these interventions. The risks to fertility are largely unknown, but it is almost certain that if puberty blockers are given at the early stages of puberty and followed by cross-sex hormones, sterility will result.

- The medical pathway of "affirmative care" rests on a single Dutch study that is not applicable to the current populations of gender-dysphoric youth. Most of the youth presenting for care today would have been explicitly disqualified by the original Dutch protocol, as most have significant mental health comorbidities and post-puberty onset of trans identities. This fact has been recognized by the principal investigators of the Dutch protocol itself, who have [recently begun to sound the alarm](#) about the [potential misapplication of their protocol](#) and who suggest that psychotherapy — rather than gender reassignment — is more appropriate for many of the currently presenting cases.”

The fundamental principle in good medical practice is “do no harm”. The evidence clearly shows that harm is being done by these hormonal transitions and should not be encouraged or promoted. An individual is born either male or female and this accords with both reason and common sense. We as physicians should be working for the wholeness and well being of your patients and not contributing to further distress.

I appreciate your consideration of my comments in your deliberations.

Sincerely,

Margaret J. Hart, DO, FAAFP

Chandler, Arizona

https://www.medscape.com/viewarticle/958742#vp_4

From: [Phillip Penna](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Submission re: gender medicine
Date: Monday, September 19, 2022 4:38:49 PM
Attachments: [Gender Identity - Fruitful Hypothesis or Dangerous Delusion \(Part I\).pdf](#)
[Gender Identity - Fruitful Hypothesis or Dangerous Delusion \(Part II\).pdf](#)

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Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Mr. Vazquez,

The foundation for so-called "gender medicine" is that there is such a thing as "gender identity" and it is innate and immutable. This claim is without scientific merit. I respectfully submit to you an essay (in two parts) I have recently completed which addresses this question. Please include it in the record of submissions related to your upcoming discussions on these matters.

Thank you.

Yours,

Phillip Penna
North Bay, Ontario
Canada

Gender Identity

Fruitful Hypothesis

or

Dangerous Delusion?

Part I

By Phillip Penna, MA

Environment and Community Program

Antioch College Seattle

17 July 2022

Many scientific hypotheses take origin from flights of the imagination which at first seem wild, but which later stand up to sober scrutiny and detailed proof. Newton's notion that gravity was a universal which acted at enormous distances was a leap of the imagination which must have seemed absurd until he was able to demonstrate it mathematically. Kekulé's discovery of the ring structure of organic molecules originated from a dream-like vision of atoms combining in chains which then formed into coils like snakes eating their own tails. Einstein's special theory of relativity depended upon his being able to imagine how the universe might appear to an observer travelling at near the speed of light. These are examples of phantasies which, although originating in the imagination, nevertheless connected with external world in ways which illumined it and made it more comprehensible.

Other phantasies giving rise to supposedly scientific hypotheses have lacked this connection with the external world. Such creations of the imagination are ultimately discarded as delusions. Throughout the eighteenth century, for example, the standard explanation of combustion was the theory of phlogiston. Phlogistan was considered to be the material principle of combustibility. When something burned, it was supposed to lose phlogiston, which was thought of as an [imponderable fluid](#)¹. It was finally demonstrated that phlogiston existed only in the imagination, that nothing in the external world corresponded to it.

We see, therefore, that in the field of science, there are two kinds of phantasy. The first reaches out to the external world and, by maintaining a connection with the world which corresponds to its real workings, becomes a fruitful hypothesis. The second, making no such connection with the external world, is ultimately dismissed as [a delusion](#).²

Gender Identity: Fruitful Hypothesis or Dangerous Delusion?

In my first essay, I argued that the term "Gender Identity" was essentially meaningless because the word "Gender" was being improperly used. "Gender" formally speaking, is a grammatical term denoting

the classification of words, or the class to which a word belongs by virtue of such classification, according to the sex of the referent (natural gender) or according to arbitrary distinctions of form and syntax (grammatical gender). Modern English has few traces of grammatical gender, but Latin nouns all have gender, masculine, feminine or neuter, often contradicting natural gender. Adjectives and articles have gender insofar as they change form to agree with the noun they qualify...³

¹ "These imponderable fluids were mere names, and these forces were suppositions, representing no observed facts." From https://en.wikipedia.org/wiki/Imponderable_fluid accessed 8 April 2022.

² Storr, Anthony. *Solitude: A Return to the Self* (New York: Ballantine Books, 1988), pages 67-68.

³ *The New Lexicon Webster's Encyclopedic Dictionary of the English language Canadian Edition* published in 1988 main dictionary section copyright 1972 Librarie Larousse as Larousse Illustrated International Encyclopedia and Dictionary Revised and updated 1988.

The argument I made can be summed up as follows: it is not possible for someone to be “Transgender” because people don’t have “gender,” only words do.⁴ Terms such as “Transgender” and “Cisgender” are nonsense words that one would find in “nonsense poetry” which employ “fanciful language and meaningless, [made-up words](#).”⁵ Sadly, we now have laws which have enshrined these “made-up words” in the criminal code. Nietzsche was wrong: God is not dead, language is; as Frank Zappa sang

*You can't even speak your own f***ing language
You can't read it anymore
You can't write it anymore
Your language
[The future of your language](#)...*⁶

In this brief reflection I will consider “Gender Identity” as a scientific hypothesis, simply stated as follows:

1. Everyone has a “Gender Identity.”
2. “Gender Identity” is innate (and immutable) both in terms of psychology and biology.
3. Only the person themselves can verify their Gender Identity, their individual “innermost sense of [their own gender](#).”⁷

More descriptively, the “Gender Identity” scientific hypothesis is this:

- If a person “senses” that they are a woman, then they are a woman, and vice-versa, and somehow neither (among other seemingly endless options).
- Furthermore, this “innermost sense” is in fact the only determining factor of whether or not someone is a man, woman, both, neither, or something else together (like a cat).
- The argument is this: if a person who has a penis “senses” that they are a woman then they are in fact a woman and the scientific verification of this is this person’s own “innermost sense” because (so goes the hypothesis) this “sense” is immutable, part of your biological make-up, that is, one can only have that “sense” of being a woman if you were a woman, a man if you were a man, neither if you were neither, both if you were both, etc.
- What we would normally rightly call the human body has nothing to do with this. Gender Identity alone determines what you are and it, somehow, is inherent to you and is itself biological.

⁴ “Sex” is biological and “Gender” is grammatical.

⁵ <https://www.best-books-for-kids.com/nonsense-poems.html>, Accessed 2 April 2022.

⁶ Zappa, Frank. “[The Blue Light](#)” from the Album *Tinseltown Rebellion Band* originally released in 1981.

⁷ I recognize that Queer Theorists will disagree with the statement at Gender Identity is understood to be an innate psychological state rooted in biology. They would argue that Gender Identity is “performative” like when a couple gets married and the officiant states “I now pronounce you man and wife”, that is, when someone says that they are non-binary then they are non-binary. I am not addressing their conception of Gender Identity in this essay. I am addressing those who present Gender Identity in scientific terms.

Here is an example of this scientific hypothesis employed by Canadian Centre for Ethics in Sport Expert Working Group who wrote in a 2016 document in which they state they acknowledge

*“the concern that transwomen athletes who grew up biologically male and who do not undergo hormonal intervention may be at a competitive advantage when competing in high-performance women’s sport. Nonetheless **it is recognized that transfemales are not males who became females. Rather these are people who have always been psychologically female, but whose anatomy and physiology, for reasons as yet unexplained, have manifested as male.**”⁸*

In other words, according to the CCES EWG,

- We know these “transwomen” are women, not because of their “anatomy and physiology” but because of their psychological make-up, *that* is why they are women.
- Their psychological make-up should have resulted in them having a different biology reality; that is, because they are “psychologically female” they really should have been born with what we know to be a female body, but for some scientifically unknown (and [imponderable](#)⁹) reason this is not what happened. But despite this *in utero* mix-up, we know they are females because these “transwomen” tell us they are.

Who knew that a baby was formed in the womb and then born would have a body based on the child’s “psychological” make-up? Well, we don’t know this. It is simply a hypothesis, namely, that psychology is *the* biological force which determines what you are even if your body disagrees; and, again, according to the CCES EWG, we can confidently claim that this is true even though we don’t know why a body would disagree as the body has nothing to say about the matter. [This is quite a hypothesis](#).¹⁰

This hypothesis was [first articulated by Dr. John Money in the 1950’s](#), and has increasingly been acted upon since then. For the past 10-15 years, it has been deemed by political, academic, medical, and corporate establishments to have been verified and true. We now teach this to children starting at age 4 and we have seen an explosion of medical clinics offering medical products and procedures ([in the US there was 1 ten years ago and now there are more than 300 in North America](#))¹¹ which we are told affirm people’s “gender identity”, this “scientific reality” which is verified by someone simply saying that they are “transgender.” With the thousands of (mostly) young people, particularly young females, having accessed these services over the past ten years (and [tens of thousands more hoping to do so](#)),¹² this “*reaching out to the external world*,” we should now be able to accurately see and state whether or not this hypothesis has been fruitful or delusional. What does the evidence reveal? Does it “*stand up to sober scrutiny and detailed proof?*”

⁸ Canadian Centre for Ethics in Sports, “Creating Inclusive Environments for Trans Participants in Canadian Sport: Guidance for Sport Organizations,” August 15, 2016, <https://cces.ca/sites/default/files/content/docs/pdf/cces-transinclusionpolicyguidance-e.pdf>; quotation found in *Unsporting: How Trans Activism and Science Denial are Destroying Sport*, by Linda Blade and Barbara Kay (2020 Rebel News Network Ltd.), page 87.

⁹ See definition at <https://www.vocabulary.com/dictionary/imponderable> accessed 8 April 2022.

¹⁰ See my [essay post-script](#) for a more detailed critique of this statement by the CCES EWG.

¹¹ “The Attack on Our Sexed Bodies with Jennifer Bilek” on Whose Body is It Podcast found at <https://youtu.be/jvBMGFOWH4M?t=3902> accessed 5 April 2022.

¹² Ibid., <https://youtu.be/jvBMGFOWH4M?t=2246> accessed 5 April 2022.

"You need to have a really, really good evidence base in place if you're going straight to an invasive treatment that is going to cause permanent changes to your body"¹³

"Surely medical organisations and children's hospitals wouldn't endorse these treatments without rock-solid evidence."¹⁴

1. **"Sweden drastically changes protocol, prioritizes psychotherapy"**¹⁵

The National Board of Health and Welfare is currently working to update the knowledge support for care of young people with gender dysphoria that was established in 2015. This is happening in stages and now the authority comes with new recommendations regarding puberty blocking and cross-sex hormone treatment in this group.

The National Board of Health and Welfare therefore calls for restraint with treatment in persons under 18 years of age. According to the authority, the risks of hormone treatment currently outweigh the possible benefits for the group as a whole.

The National Board of Health and Welfare relies, among other things, on a review of relevant studies on the effect and safety of hormone treatment carried out by the Swedish Agency for Medical and Social Evaluation (SBU). In the report¹⁶ . . . the SBU concludes that it is not yet possible to draw any definite conclusions regarding this.

Hormone treatment should henceforth be given within the framework of research, according to Thomas Lindén, head of department at the National Board of Health and Welfare. (**Emphasis mine**)

2. **"National Academy of Medicine in France Advises Caution in Pediatric Gender Transition"**¹⁷

*The National Academy of Medicine in France has issued a press release in which it cautions medical practitioners that the growing cases of transgender identity in young people are often socially-mediated and that great caution in treatment is needed. The Academy draws attention to the fact that hormonal and surgical treatments carry health risks and have permanent effects, and that **it is not possible to distinguish a durable trans identity from a passing phase** of an adolescent's development. (**Emphasis added**)*

¹³ "Doctors Have Failed Them, Say Those Who Regret Transitioning" By Alicia Ault 22 March 2022, <https://www.webmd.com/sex-relationships/news/20220322/doctors-have-failed-them-say-those-who-regret-transitioning>

¹⁴ "New media outlet examines the evidence for 'gender medicine': An Australian journalist is wading into one of the biggest medical controversies of our time." by Bernard Lane 15 March, 2022 <https://mercatornet.com/new-media-outlet-examines-the-evidence-for-gender-medicine/78051/>

¹⁵ <https://genspect.org/breaking-sweden-drastically-changes-protocol-prioritizes-psychotherapy/> accessed 5 April 2022

¹⁶ <https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/> accessed 5 April 2022

¹⁷ <https://segm.org/France-cautions-regarding-puberty-blockers-and-cross-sex-hormones-for-youth> accessed 5 April 2022

3. UK – “[Cass Review Interim Report published](#)”¹⁸

The report says . . . the unquestioning affirmative approach is flagged in several places in reports from clinicians and therapists who feel that this is at odds with their professional training and standards:

“Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person’s problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach. Some clinicians feel that they are not supported by their professional body on this matter. Hence the practice of passing referrals straight through to GIDS is not just a reflection of local service capacity problems, but also of professionals’ practical concerns about the appropriate clinical management of this group of children and young people.” (Emphasis added)

4. “[Finland Issues Strict Guidelines for Treating Gender Dysphoria](#)”¹⁹

Western countries around the world are grappling with how to treat the exponentially growing number of children and adolescents being referred to gender clinics for puberty blockers, cross-sex hormones and gender-affirming surgery. Finland recently issued very strict clinical guidelines for the treatment of children with gender dysphoria.

- *There is clear differentiation in treatment guidelines between early-onset childhood gender dysphoria and adolescent-onset gender dysphoria.*
- *The guidelines acknowledge and recognize that identity exploration is a natural phase of adolescence and restrict medical interventions until “identity and personality development appear to be stable”.*
- *There is a prioritization of psychotherapeutic non-invasive interventions as the first course of action “due to variations in gender identity in minors”.*
- *Hormone therapy is initiated only if it is ascertained that “identity as the other sex is of a permanent nature and causes severe dysphoria” (ie medically necessary).*
- **A requirement that there be “no contraindications” prior to initiation of puberty blocker or cross-sex hormone interventions.**
- *No surgical interventions are allowed for children under the age of 18.* (Emphasis added)

5. Australia and New Zealand:

*In an updated **position statement**, the Melbourne-based Royal Australian and New Zealand College of Psychiatrists last year **underscored the importance of mental health evaluations of gender dysphoric youth** over an “[affirmation only](#)” approach.*²⁰ (Emphasis added)

¹⁸ <https://www.transgendertrend.com/cass-review-interim-report/> accessed 5 April 2022.

¹⁹ <https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/> accessed 5 April 2022

²⁰ “Hitting the brakes on transgender treatments for youth: International medical groups call for caution on hormonal and surgical interventions”, by Mary Jackson; Posted 14 March, 2022 https://wng.org/roundups/hitting-the-brakes-on-transgender-treatments-for-youth-1647283935?fbclid=IwAR1IScNqt_S6oW001NK7K8xpXcGJtzjG-L-QOouMRazRnOJRX8degQn1q38

6. Detransitioners:

"I was a child, allowed to destroy my body permanently, under the assurance that I can always change my mind, and that it's a beautiful, harmless process," wrote Lgbtcos in February. "The informed consent model is a lie, because we are just guinea pigs to a medical experiment, my life is permanently afflicted, and I was not informed."

*The missive was on the Detrans subreddit, which currently has **23,000** members.*

...

[Athena] recently wrote on Reddit: "I'm gonna tell u from experience the coddling of transgender ppl and their delusions ... You are going against fundamentals of nature, immutable stuff, and damaging yourself!!! no such thing as sex change, only sterilization. people won't want to date you. your health declines. your body suffers. your social life suffers."²¹ (Emphasis added)

7. Back to the UK: **Sajid Javid inquiry into gender treatment for children - Health secretary compares political fears over trans issue to silence during Rotherham scandal**

Javid is said to be particularly alarmed by [Hilary Cass'] finding that some non-specialist staff felt "under pressure to adopt an unquestioning affirmative approach" to transitioning and that other mental health issues were "overshadowed" when gender was raised... "This has been a growing issue for years and it's clear we're not taking this seriously enough," an ally of the health secretary said. "If you look at Hilary Cass's interim report, the findings are deeply concerning and it's clear from that report that we're failing children."... "That overly affirmative approach where people just accept what a child says, almost automatically, and then start talking about things like puberty blockers — that's not in the interest of the child at all," the ally said. The Tavistock & Portman NHS Foundation Trust sees 2,500 children a year — 200 of whom access hormones. Referrals have increased 50-fold in the past decade, with far more female-born children now coming forward in a reversal of previous trends.

8. **Florida** (which seems to be well aware of everything I have noted above):

Systematic reviews on hormonal treatment for young people show a trend of low-quality evidence, small sample sizes, and medium to high risk of bias. A paper published in the International Review of Psychiatry states that 80% of those seeking clinical care will lose their desire to identify with the nonbirth sex. One review concludes that "hormonal treatments for transgender adolescents can achieve their intended physical effects, but evidence regarding their psychosocial and cognitive impact is generally lacking."²²

9. And the list goes on.

²¹ "We are just guinea pigs: Women describe trauma of transitioning as teenagers" 21 March, 2022 by Tori Richards, <https://www.washingtonexaminer.com/restoring-america/community-family/we-are-just-guinea-pigs-women-describe-trauma-of-transitioning-as-teenagers>

²² https://www.floridahealth.gov/documents/newsroom/press-releases/2022/04/20220420-gender-dysphoria-guidance.pdf?utm_source=floridahealth.gov&utm_medium=referral&utm_campaign=newsroom&utm_content=article&url_trace_7f2r5y6=https://www.floridahealth.gov/newsroom/2022/04/20220420-gender-dysphoria-press-release.pr.html accessed 2-May-2022.

If the Gender Identity hypothesis was true, then there would not be this retreat both at the institutional and individual levels. All one needs to do is listen to the four women on the [“Detrans 101: What You Need to Know”](#) panel to recognize that this hypothesis, when acted by and upon them, did not produce the results hypothesized, but rather produced more and irreversible harm.²³

Clearly the hypothesis has fallen short. In the words of Storr, having reached out to the external world, this phantasy made no connection with it and therefore should be *“dismissed as a delusion.”*

Should we be surprised by this? Not at all. The evidence of this hypothesis being wrong was provided to us by the work of [Dr. John Money](#) himself. His work with the Riemer twins of Winnipeg, Manitoba was clearly a abject and tragic failure. Despite this, he himself never admitted that the implementation of his “gender theory” with these twin boys to be so. This lack of acknowledging this failed experiment is tantamount to lying.²⁴ Everything that has happened in this field since then is based on this original lie, on the denial of the truth, the perpetuation of a failed hypothesis that should be *“dismissed as a delusion.”*

So why is this hypothesis still being acted upon as if it were not so? **Vested interests**

Vested interest #1: Trans Activists:

Why are bad experiences with gender medicine stigmatized, suppressed, discouraged, etc., by the trans community? As part of the push to “depathologize” being transgender, activists are now pushing for an informed consent model as an alternative to the diagnostic process. This removes all of the “gatekeeping” measures that were in place to try and manage regret and other negative experiences with transition.

So this is the dilemma for trans activists: if too many people report negative experiences with transition, health care providers will be forced to reassess whether the current model of care is ethical.

It is in their interest to keep this model, so it is in their interest to downplay negative experiences. The idea that a trans identity could be socially influenced is stamped out. The possibility that a young person might wrongly interpret symptoms of developmental disabilities or other mental health disorders as “gender dysphoria” must be suppressed. They repeat over and over that getting it wrong is very rare, and many of the people claiming to be detransitioners are just liars.

This is why I keep finding myself at odds with trans activists. Fully understanding all of the possible outcomes, including the negative ones, is essential to informed consent. You are not for “informed consent.” You are for getting what you want immediately when you want it — regretters be damned.

*Ultimately, the stigmatizing of negative experiences — removing the ability to provide true informed consent when choosing medical transition — harms **every single person** who transitions. You were all failed by professionals and by the community just as much as I was.²⁵ (**Emphasis added**)*

²³ <https://youtu.be/tFAS-i2Xghs?t=1365> accessed 5 April 2022.

²⁴ “The Truth About Gender with Miriam Grossman, MD” <https://youtu.be/RM3mQJ9N4l0?t=1005> accessed 17 July 2022.

²⁵ “Is Detransition the ‘Worst Possible Outcome’? Some thoughts on how I’ve observed people trying to control the narrative around detransition” by Michelle Alleva, posted 6 April, 2022 <https://somenuanceplease.substack.com/p/is-detransition-the-worst-possible?s=r>

Vested Interest #2: Money and Power

Why do we have laws such as Bill C-4 in Canada, the NCAA allowing males to compete and win in the female category, President Biden using terms such as 'Transgender kids', and more? I make the following hypothesis my own: it is because *"humanity is far more profitable as parts than we are as whole sexed beings. Corporate capitalism, already having colonized the entire planet and left a wasteland of our waterways, our soil, the air we breathe, and most other species, has [now come for us](#)."*²⁶

More to the point, they have [come for our kids](#).²⁷

*"...you have these big corporatists on their social media platforms like gender surgeons marketing their wares, their operations to young people. They don't understand the power of this. Transgenderism has been made cool, that's why they're doing it, that's part of why they're doing it, but they're dissociated; they're dissociated because also there's a lot of porn on their platforms. They're being sexually traumatized [in] an effort to get them to dissociate. **This is all about capturing the youth; they don't give a crap about us, you know, it's really the youth that they want. Any totalitarian regime goes after the youth because they'll take it into the next generation and children that don't know who or what they are are just vulnerable.** They're going to be like little drones for the state, for the corporate state ... and it's not my imagination. It's not that oh I've been like down this rabbit hole so long I think 'oh they're coming after the kids.' I have the receipts; Arcus Foundation, Denton's International, largest international law firm, Open Society Foundation; they're making these legal edifices for constructing this apparatus which is not true. **It's not real. There are no transgender children because there's no transgender. It's an ad. People have got to get that down. I just want to like do a chant like "it's an ad, it's an ad, [it's an ad campaign](#)."**"²⁸ (Emphasis added)*

In conclusion, both my first and my second essays agree: "Transgender" is neither scientifically verifiable nor linguistically accurate. Like phlogiston, it is a mere name, a supposition, *"representing no observed facts."* Experience in the real "external world" has shown this does not exist, and will continue to be shown to be so. Why? Because as Athena has told us:

*"You are going against fundamentals of nature, immutable stuff, and damaging yourself!!!
[no such thing as sex change, only sterilization](#)."*²⁹

As the old saying goes, "A rose by any other name is still a rose."

But [there is money to be made](#)³⁰ and politics to be won, so who cares?

²⁶ Bilek, Jennifer; "Corporate Complicity With the Gender Identity Industry is Not 'Wokeness'"

<https://www.the11thhourblog.com/post/corporate-complicity-with-the-gender-identity-industry-is-not-wokeness> accessed 2 April 2022.

²⁷ Ibid; "Foundations Are Setting The Transgender Agenda And Targeting Children", The American Conservative, 1 June, 2021; <https://www.theamericanconservative.com/articles/foundations-are-setting-the-transgender-agenda-and-targeting-children/> accessed April 2, 2022.

²⁸ "The Attack on Our Sexed Bodies with Jennifer Bilek" on Whose Body is It Podcast found at <https://youtu.be/jvBMGFOWH4M?t=1454> accessed 2 April, 2022.

²⁹ "'We are just guinea pigs': Women describe trauma of transitioning as teenagers" 21 March, 2022 by Tori Richards, <https://www.washingtonexaminer.com/restoring-america/community-family/we-are-just-guinea-pigs-women-describe-trauma-of-transitioning-as-teenagers>

And you might say, “It’s not my kid.” Are you sure about that? Apparently, only they can tell you and when they do, you *must* agree. It’s science after all. Just ask the CCES Expert Working Group who adopted this hypothesis even though they lacked the scientific expertise to make such an assessment.

Since the very reason for the committee’s existence involved contemplating a potential dramatic disruption of sport’s existential paradigm of biological categories, you would expect at a minimum, for example, to see the name of at least one disinterested biologist from a top Canadian university on the list of EWG members.

There was no biologist. The only representative from the domain of science was a medical doctor. Dr. Stephen Feder is head of the adolescent Health Clinic at the Children’s Hospital of Eastern Ontario, and a proponent of expeditious affirmation for youthful transition, a highly contested practice amongst sexologists and therapists specializing in the field of gender dysphoria. That’s one single scientist.

And by virtue of his work, he is far from a disinterested observer. Moreover, no one else on that committee except a biologist could have credibly interrogated from a scientific perspective the theories on which this [one medical doctor’s opinion](#) rests.³¹

O well, just forget the science! There are 40,000 young females raising money on GoFundMe to get [double mastectomies](#).³² It’s a bonanza and there is money to be made! Let’s go “get” while the “gettin” is good!

³⁰ “The Business Model of Youth Transitioning” by Catherine Karna found at <https://www.youtube.com/watch?v=BaeZCS6rUk4>

³¹ Blade and Kay, pages 85-86.

³² Bilek. <https://youtu.be/jvBMGFOWH4M?t=2245> accessed 9 April 2022.

Gender Identity

Fruitful Hypothesis

or

Dangerous Delusion?

Part II

Further Reflection on the

Canadian Centre for Ethics in Sport Expert Working Group

2016 Statement

By Phillip Penna, MA

Environment and Community Program

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17 July 2022

*“The [Canadian Centre for Ethics in Sport Expert Working Group] acknowledges the concern that transwomen athletes who grew up biologically male and who do not undergo hormonal intervention may be at a competitive advantage when competing in high-performance women’s sport. Nonetheless **it is recognized that transfemales are not males who became females. Rather these are people who have always been psychologically female, but whose anatomy and physiology, for reasons as yet unexplained, have manifested as male.”**¹*

Further to my comments in Part I of this essay, this statement deserves further scrutiny as it comes from a document which set the stage and forms the basis for so-called “Transgender Inclusion” policies being implemented by sports organizations throughout Canada. Though it has carried political weight, can the same be said for it intellectually? If not, then it behooves sporting organizations across Canada to – at a minimum - put a pause on these policies so a thorough and proper rethinking of the matter can be undertaken. Let us begin:

1. They use the term “transfemales.” This is important.
 - a. The word “woman” is a noun and means “adult human female.”
 - b. The word “female” is an adjective which means “the sex in animals or plants that produces or is capable of producing eggs or bearing young.” In other words, “female” is a biological term. So, the CCES EWG is making an appeal to *biology* when using this new term “transfemale.”
2. In sports, there are two categories for participation: male and female. Within each category, there are divisions based on age and skill (for example, boys AAA hockey; girls junior high school soccer).
3. The statement in question does not challenge this male/female binary for sports. Instead, what it does is offer a new definition for what determines someone to be “male” or “female.” More precisely, **they state emphatically, though without proof, that there is a heretofore unknown biological feature which determines the sex of a person.**
4. The statement directly speaks to the group of people who “grew up biologically male” but (they say) are actually female, or, as they refer to these people, “transfemales.” According to the CCES EWG these so-called “transfemales” are not males, rather they are females; what they mean by this is that they are *biologically female*² even though they have penises, larger bones and greater bone density, higher levels of testosterone, etc. The CCES EWG stated these people are and always have been females; always - from conception to the present. This is because they are, so they claim, “psychologically female.” The CCES EWG is arguing that it is *this* and nothing else which actually determines whether or not someone is female or male.
5. They base this argument on the claim this “female (and male) psychology” is part of everyone’s biological make-up. How do we know this is what they are stating? How else can one explain the following statement: **“these are people who have always been psychologically female, but whose anatomy and physiology, for reasons as yet unexplained, have manifested as male.”** (*emphasis mine*) In other words:

¹ Canadian Centre for Ethics in Sports, “Creating Inclusive Environments for Trans Participants in Canadian Sport: Guidance for Sport Organizations,” August 15, 2016, <https://cces.ca/sites/default/files/content/docs/pdf/cces-transinclusionpolicyguidance-e.pdf>; quotation found in *Unsporting: How Trans Activism and Science Denial are Destroying Sport*, by Linda Blade and Barbara Kay (2020 Rebel News Network Ltd.), page 87.

² We should not have to use these two words together. “Female” is biological term. “Biologically female” is redundant. O well...

- a. They are claiming these people should have had a female body because they have “always” – from conception onward – been psychological female;
 - b. Logically it is clear that they are stating that this psychological state is a biological reality because it should have had the impact on the developing fetus such that they should have had female anatomy.
 - c. Again, logically they are saying those people who have female anatomy and who say they are female have said female anatomy because the (hypothesized) biological principle of “female psychology” worked its magic properly.
 - d. But for some (or many) imponderable reason, this biological process did not work out for them and they were born with male anatomy.
6. It is clear, therefore, that the CCES EWG is not arguing for males to be included in and participate in female categories (or vice-versa) because, according to them, these people are in fact females, biologically, and therefore should be participating in the female category based on the (hypothesized and imponderable) biological principle of Gender Identity, their “inner sense” that they are female.
7. Indeed, all people who say they are female can only say that because of this inner sense. According to the CCES EWG, that is the foundation for sex determination, not DNA.

Is there a consensus in the scientific community that this is what determines sex? Is there verifiable proof that this is the reason why females who have female bodies are females, that is, because of Gender Identity? Like DNA, has this “inner sense” been isolated in a laboratory and proven to exist? If it has not, then how can it be claimed that it does exist? If it does exist, then we should be able to describe how it works to make a female body, and from there we should be able to determine why it sometimes does not do so. Then we could develop a test so as to be able to verify claims to be female, made by people with male bodies, are true.

But we don’t have this test, and we don’t have this test because we don’t know how Gender Identity actually works biologically to create babies that correspond to this Gender Identity, and since we do not know how it works biologically, can we – like the members of the CCES EWG have done - say with any kind of scientific confidence that it is in fact Gender Identity which determines sex? Let me pose this question more directly: on what scientific grounds have so many sports organizations across Canada come to agree with what the CCES EWG has proposed in this statement?

Let’s restate this differently:

1. If Gender Identity usually produces the correct body, what is the means of it doing so? If we do not know the means of it doing so, then how can it be said with any confidence that it does so? Indeed, how can we say with any confidence that it even exists?
2. We know DNA exists, and we have a pretty thorough knowledge of how DNA works. We know how disruptions in DNA can cause physical anomalies, and we even know how those disruptions happen; indeed, we have developed many tests to see and determine if some of these disruptions are present even while the child is *in utero*. Can any of this be said for Gender Identity?
3. The only proof offered is the person’s claim. It is argued that a person would only make such a claim if it was true. This is circular logic, and such an esteemed group of people such as the

members of the CCES EWG should be more than a little embarrassed to use such logic. Therefore, the answer to both of the above questions is negative.

4. Since the answer is negative, how can we “recognize” that these people with male bodies who say they are “psychologically female” are in fact females as is claimed? There is no test to determine if this is biologically true, and therefore the very claim that they are “psychologically female” is at best suspect and certainly should not be a determining factor for who gets to participate in the female category of sporting activities.

Let's go one step further and apply the logic of the statement as if we were speaking of people who claim to be non-binary:

it is recognized that [transgender/non-binary individuals] are not males [or females] who became [non-binary]. Rather these are people who have always been psychologically [non-binary], but whose anatomy and physiology, for reasons as yet unexplained, have manifested as male [or female].

What exactly would that non-binary physiology look like coming out of the womb? Has there ever been an example in history of a person's body being non-binary, that is, either having fully intact and working gonads of both female and male genitalia or of not having any vestiges of either that we can appeal to so as to make the case for a non-binary psychology, a non-binary Gender Identity? The answer is obvious: we do not have such an example.

Though this is enough to demonstrate the statement made by the CCES EWG, and as a result the whole document from which it comes, is without merit, I will discuss one more thing so as to drive home the point that this statement is woefully lacking; and all sports organizations in this country who have taken direction from this document and, acting upon it, implemented “transgender inclusion” policies (like Ringette Canada³) should be embarrassed to have done so.

The word “manifested”, what does it mean?

manifest (adjective): man·i·fest | \ 'ma-nə-, fest \

1: readily perceived by the senses and especially by the sense of sight

Their sadness was manifest in their faces.

2: easily understood or recognized by the mind: OBVIOUS

manifest (verb): manifested; manifesting; manifests

transitive verb

: to make evident or certain by showing or displaying

evident (adjective): ev·i·dent | \ 'e-və-dənt , -və-, dent \

: clear to the vision or understanding⁴

The CCES EWG says that these so-called “transfemales” anatomically “manifested as male.” If that is true, then, according to the definition of the word Manifest (a transitive verb), the evidence displays that they are Male. Further to this (as an adjective), it is readily (quickly, easily) perceived by the senses and recognized by the mind (it is obvious) that they are Male. In other words, what is being

³ <https://www.ringette.ca/trans-inclusion-policy-and-resources/> accessed 7 April 2022.

⁴ See <https://www.merriam-webster.com/>

made evident (verb) and easily understood (adjective) is that these people are Male. And since the CCES EWG is not arguing against the sex binary for participation in sports, these people should play and compete with other males like they themselves are. There is no counter-evidence that is easily perceived (or even difficult to perceive) to prove biologically (as they claim) to say that we can “recognize” (their word) them as females. Furthermore, as noted above, there is no way to prove that they are not males because there is no way to prove that there is such a thing as Gender Identity or that it is the foundation for the determination of sex. The CCES EWG making the claim that this is so is not enough to make it so. Saying “The Emperor is wearing clothes” does not make it to be so.

Thus we can see that there are two competing theories at play in this one paragraph: The first is that Gender Identity is a biological principle and it is responsible for determining sex (no matter the anatomical features of a person’s body); the second, is that DNA is the biological principle which determines sex. I have shown that the first is not verifiable while the second is easily so. Yet, the CCES EWG has chosen to side with the former. This goes against the basic and essential scientific and philosophical principle of Occam’s Razor,

*the maxim that, given a choice between two hypotheses, the one involving the fewer assumptions should be preferred. In other words, one should apply the law of parsimony and choose simpler explanations over more complicated ones. See also **elegant solution**. [William of **Occam** or **Ockham** (c. 1285–1347), English Franciscan monk and Scholastic philosopher]*

Elegant Solution

a solution to a question or a problem that achieves the maximally satisfactory effect with minimal effort, materials, or steps. In terms of theories or models of behavior, an elegant solution would be one that satisfies the requirements of the law of parsimony.

Law of Parsimony

*the principle that the simplest explanation of an event or observation is the preferred explanation. Simplicity is understood in various ways, including the requirement that an explanation should (a) make the smallest number of unsupported assumptions, (b) postulate the existence of the fewest entities, and (c) invoke the fewest unobservable constructs. Also called **economy principle; principle of economy; principle of parsimony**.⁵*

Principle of Parsimony

The principle of parsimony recommends that from among theories fitting the data equally well, scientists choose the simplest theory. Thus, the fit of the data is not the only criterion bearing on theory choice. Additional criteria include parsimony, predictive accuracy, explanatory power, testability, fruitfulness in generating new insights and knowledge, coherence with other scientific and philosophical beliefs, and repeatability of results. The principle of parsimony has four common names, also being called the principle of simplicity, the principle of economy, and Ockham's razor (with Ockham sometimes Latinized as Occam).

⁵ From the APA Dictionary of Psychology <https://dictionary.apa.org/> accessed 7 April 2022.

*Parsimony is an important principle of the scientific method for two reasons. First and most fundamentally, parsimony is important because the entire scientific enterprise has never produced, and never will produce, a single conclusion without invoking parsimony. Parsimony is absolutely essential and pervasive.*⁶

There was and is no necessity (that is, no compelling evidence) for the CCES EWG to prefer the more complex hypothesis - rife with assumptions and invocations of “unobservable constructs” - of Gender Identity over the simple hypothesis of DNA. The latter can be and has been verified; whereas the former has not, nor, because of its imponderability, can it ever be so. The CCES EWG, and every other sports organization which has followed their lead, making this preference was and is in error. This is a big problem. As Thomas Aquinas correctly remarked, “a little error in the beginning leads to a great one in the end.”⁷ In this case, these errors work themselves out in individual lives with physically irreversible consequences. Sports organizations who have implemented “Trans Inclusion” policies have made themselves accountable for these consequences. (Perhaps they should start getting ready for the lawsuits, like all the parties who were involved with the Canadian residential school system.)

Post-script

It is clear that the CCES EWG made an appeal to biology when making the case in favour of the possibility that people can be “trans.” They had to, because it is sports we are talking about and it is bodies that play sports. As I have shown, their appeal to biology fails because there is no biological proof for what they have claimed and because it fails to meet the standard of Occam’s Razor.

It must be noted that their explanation for what makes for a person being “trans” is not at all what others state, namely, “gender distinction (male and female) stems from the soul rather than from the body.”⁸ In 1964, Psychoanalyst Robert Stoller first coined the term itself and defined it as “a complex system of beliefs about oneself: a sense of one’s masculinity and femininity. It implies nothing about the origins of that sense (e.g., whether the person is male or female). It has, then, psychological connotations only: one’s subjective state.”⁹

*Like some quasi-religious movement, the transgender community is bound together by faith in gender identity — the idea that we all have a soul-like essence that determines whether we are men or women.*¹⁰

So, on one hand, Gender Identity is presented as biological and innate - physical and objective - and on the other it is presented as “a system of beliefs,” something metaphysical and subjective. Which is it? In either case, both are presented as belief statements because neither camp can produce proof of its existence save the person saying they are “transgender.” In addition to this there are the Queer

⁶ PARSIMONY AND EFFICIENCY, Published online by Cambridge University Press: 05 March 2015, Hugh G. Gauch Jr, <https://www.cambridge.org/core/books/abs/scientific-method-in-practice/parsimony-and-efficiency/F8327BE6D73C3D00214B65AC04D350F2> accessed 7 April 2022.

⁷ De Ente et Essentia, Aquinas

⁸ See *Why Aquinas’s Metaphysics of Gender Is Fundamentally Correct: A Response to John Finley* by William Newton Epub 2019 Nov 25, found at <https://pubmed.ncbi.nlm.nih.gov/32549637/>; and *The Metaphysics of Gender: A Thomistic Approach* by John Finley Published 5 April 2017 in The Thomist: A Speculative Quarterly Review (<https://www.semanticscholar.org/paper/The-Metaphysics-of-Gender%3A-A-Thomistic-Approach-Finley/93eb2e91f581ea58040b8bc840678ff3c3cf9224>)

⁹ “A History of Affirmation” published by Bayswater Support Group 24 May 2021 found at <https://www.bayswatersupport.org.uk/a-history-of-affirmation/>

¹⁰ “A gendered soul? The trans debate was less toxic when it was a process, not an identity” by Debbie Hayton 22 June, 2021 found at <https://thecritic.co.uk/a-gendered-soul/>

Theorists who say that gender is “performance,” that “all categories (including biological sex) are culturally constructed, and that [body modification is a personal choice rather than a medical necessity](#).”¹¹

Thus we have before us an ontological question, namely, does “Gender Identity” exist and if so how can it be determined to exist and what is the nature of its existence? Perhaps those who say it exists should first come to an agreement amongst themselves on this question before the rest of us are forced to agree (through law) and play along (in sports) and allow our children’s bodies to be experimented on with the use of puberty blockers, hormones, and radical cosmetic surgical procedures. Of course, with [each young person being a potential \\$50,000 - \\$150,000 worth of income for the medical industrialists](#) that would not be good for business.¹² As any honest capitalist will tell you, the protection of (mother) nature cannot be a reason to hinder economic growth; and since we have cut down all the trees, we are just next in line. Step right up!

¹¹ “A History of Affirmation” Section V “Queering the Clinic”, <https://www.bayswatersupport.org.uk/a-history-of-affirmation/>

¹² “The Business Model of Youth Transitioning” by Catherine Karena found at <https://www.youtube.com/watch?v=BaeZCS6rUk4>

Some Helpful Resources

1. [Detrans Awareness Day Webinar](#): On Saturday March 12, 2022, Genspect hosted a webinar for Detrans Awareness Day. We handed the mic to detransitioners, so they could tell their own stories. No rules. No filters. No holds barred. The detransitioner community is growing fast, as more and more young people realize they received inadequate healthcare. Our brave guests spoke out about their own treatment pathways, what they've learned about the gender healthcare industry, and what they've learned about themselves.
 - Lots of good resource links in the video description
 - Time stamps
 - [0:00:00](#) – Introduction
 - [0:04:00](#) – Helena: "Trans, Tumblr and fandom"
 - [0:40:28](#) – Panel discussion: "Detrans 101: What you need to know"
 - [1:10:56](#) – Allie: "The autism angle"
 - [1:47:23](#) – Carol: "Butch lesbians and transgender identities"
 - [2:23:00](#) – Laura: "Trauma, transition and detransition"
 - [2:31:30](#) – Panel discussion: "Different for boys"
 - [3:15:55](#) – Michelle: "How health professionals are failing detransitioners"
 - [3:55:30](#) – Sinéad: "You are not broken"
 - [4:16:07](#) – Cat: "Losing my voice"
 - [4:22:44](#) – Panel discussion and audience Q&A
 - [4:53:27](#) – Keira: "What detransitioners need"

2. My Story of Rapid Onset Gender Dysphoria | Helena Kerschner

<https://youtu.be/GjOmko-9hSg>

3. [Whose Body is It?](#) (Youtube Channel - Warning: Some videos are very graphic and disturbing)

- Jennifer Bilek: Transhumanism & Autogynephilia; The Industry of Identity Medicine
 - https://www.youtube.com/watch?v=9kQ_o0G7D38&t=6s
- The Attack on Our Sexed Bodies with Jennifer Bilek
 - <https://youtu.be/jvBMGFOWH4M>
- The Abolition of Sex with Kara Dansky
 - https://www.youtube.com/watch?v=gll_gKkOELY

Note: What is of particular interest to me is the matter of language; at [45:47](#) Dansky states:

"It's important to note that it is the very trickery and the use of language that leads to all of these other things the use of language makes all the other things inevitable, absolutely inevitable"

- The Racist Origins of 'Gender Neutral' Language & Women's Bodies as Currency w/ Dr. Suzanne Vierling
 - <https://www.youtube.com/watch?v=OI8krO5SSdc>

4. [Gender: A Wider Lens Podcast](#) - Gender, Identity and Transition from a Psychological Perspective: Two therapists explore the expanding concept of "gender" from a psychological depth perspective.

5. [Genspect](#): A rational approach to gender - Genspect is an international alliance of professional groups, parent groups, and others who advocate for a rational and informed approach to gender issues.
 - [Resource Page](#)
 - [Youtube Channel](#)
6. [Gender Dysphoria Alliance Canada](#): For a more evidence-based, less ideological conversation about gender dysphoria
7. [TREvoices](#): Trans Adults & Others SCREAMING To STOP Childhood Medical Transition.
 - Warning: Some things on this site can be very and disturbingly graphic
8. Various Youtube Channels I like:
 - [The Honesty Project](#)
 - [Save Women's Sports](#)
 - <https://savewomenssports.com/>
 - [Partners for Ethical Care](#)
 - Transjacked: [Former Trans Kid, Petra](#)
 - [Paradox Institute](#)
 - [Graham Linehan](#): The Mess We're In
 - Mess Episode #109: [Coach Blade](#)
 - Mess Episode #114: [The Beginning of the End](#)
 - The Mess We're In Ep. #119: [Terf Christmas Comes Early](#)
 - Rewire the West - [The Seven Deadly Sins of Modernity](#)
9. "[MALE AND FEMALE HE CREATED THEM](#)" TOWARDS A PATH OF DIALOGUE ON THE QUESTION OF GENDER THEORY IN EDUCATION - CONGREGATION FOR CATHOLIC EDUCATION (for Educational Institutions), Vatican City, 2019.
10. '[If only I were a boy ...](#)': Psychotherapeutic Explorations of Transgender in Children and Adolescents - March 2022, British Journal of Psychotherapy, by Marcus Evans.
11. And for more linguistic commentary by Frank Zappa, I recommend the story relayed by Fido the dog in verse 3 of the classic piece [Stink-Foot](#) from the 1975 album "Apostrophe".

Fido gets the last word:

"Ain't this boogie a mess?"

From: [Jeffrey Barrows](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Treatment of Gender Dysphoria in Minors
Date: Monday, September 19, 2022 1:23:11 PM

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Paul A. Vazquez, JD

Executive Director

Florida Board of Medicine

Dear Mr. Vazquez,

I am a retired Ob/Gyn with many years of service to young people in my practice. I have done extensive reading and research into this new transgender “craze,” and I am amazed at the lack of quality medical evidence to support the radical treatments being considered for patients who are still children and have not reached an age at which they can provide informed consent.

I am also aware of the recent efforts by the British Medical Service to review the literature on puberty blockers and cross-sex hormones. The findings of both of these reviews reveal that the quality of studies supporting the use of puberty blockers and cross-sex hormones are low quality.

These reviews have led not only the British Medical Service but also the medical systems within Sweden and Finland to change their approach to minors with gender dysphoria.

Please protect the children of Florida from experimentation that can cause irreparable harm to their ability to have children in the future. They deserve the best medical science can provide.

Sincerely,

Jeff Barrows, DO, MA (Ethics)

From: [Kelley Young](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: gender-affirming care for minors
Date: Monday, September 19, 2022 2:15:01 PM

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To whom it may concern,

As the Florida Board of Medicine considers regulations regarding gender-affirming care for minors, please be aware that there is no scientific evidence that supports a benefit to minors who undergo medical and surgical gender-affirming care. There are, however, a growing number of detransisters who regret undergoing irreversible medical and surgical therapies without the intellectual capacity to understand the long-term effects of the care they chose or, in some cases, without the knowledge that such therapies are usually sterilizing and permanent.

Kelley Burchell-Young, M.D.
Pediatrician
45 Cavalier Blvd.
Florence, KY 41042

From: [Andrew Mullally](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Gender Affirming Care Is Not Evidence Based
Date: Monday, September 19, 2022 4:33:16 PM

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To whom it may concern,

My name is Andrew Mullally and I am a family physician. I am concerned about your upcoming meeting regarding sex based medicine practices in Florida.

Gender affirming care is not evidence based. If anything, there is growing evidence of the short term and long term harms that this treatment strategy confers on patients. As you are likely aware there is a significant increase in suicide and depression in patients even after gender affirming care and a large majority of those with this treatment regret their transition as they age. Gender dysphoria is showing itself to largely be a self limited condition for most patients. Additionally, it is well documented that this diagnosis is very regional and not consistent in a population. For these reasons and others, many of the European countries that pioneered this treatment strategy are moving away from gender affirming models -- it is bad medicine.

Please do not move to advance the gender affirming care model in Florida.

Thank you,

Andrew Mullally, MD

From: [J Ocariz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex based medicine
Date: Monday, September 19, 2022 2:47:33 PM

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Please, listen to empiricism and reason in your decision making process. Do not support or allow children to medically transition. It is harmful to them on every level possible and contrary to simple reason. If you can't arbitrarily identify as a 21 year old at age 14 or african american despite no such lineage then how is identifying as the opposite sex any different?

Thank you,

Javier Ocariz

From: [FRED DE MIRANDA](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Youth transition and the informed consent process
Date: Monday, September 19, 2022 4:07:02 PM

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To: Paul.Vazquez@flhealth.gov
Subject: Youth transition and the informed consent process

TO: Paul Vazquez

There have been very rapid developments in Florida that are worrisome to me as a pediatrician . As you are aware, your Florida Board of Medicine will be meeting very soon to consider implementing regulations related to sex based medicine practices in Florida. The Board is specifically concerned about “youth transition” and the “informed consent process”.

It is my understanding, I those who support so-called “gender-affirming care,” including rapid gender transition for children and adolescents, have inundated the Board of Medicine with their comments. As medical professionals (CMA), we feel compelled to make sure you are aware the medical and evidence-based studies of these methods do not support such claims. Rather, the short and long term harm of these interventions is clear.

I am a Cuban American. My father was a pediatrician in Camaguey. I went to schools in Miami for over 3 yrs before moving to West Virginia. I even swam in the Florida Jr Olympics qualifying meet. I practiced general pediatrics for 37 yrs prior to retirement.

I strongly believe children are incapable of making life long decisions till mid twenties. Much medical evidence proves this. Please allow children to be children. Don't allow the approval of politically driven, unethical, child experimentation procedures or drug treatments with lifetime consequences.

Sadly, if allowed, we'll live to regret it, and many children will have to live with the horrible consequences, physical and emotional.

Federico de Miranda MD

From: [DAVID MARTINEZ](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender "transition" regulations
Date: Monday, September 19, 2022 3:40:41 PM

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To whom it may concern:

The field of transgenderism is very new and so there is much that is unknown regarding its foundational ideology. Especially unknown are the psychological and corporal effects of the so called "therapies" because there is little data. Therefore great care must be taken when applying these therapies to minors and young adults because they are the most likely to not fully understand the consequences of the chemical and surgical interventions involved in "transitioning". It is almost certain they do not realize that the effects of many of these interventions are permanent and will irrevocably alter their lives. I believe that is why we are now seeing young individuals who have gone through all or part of this "transitioning" now regret what they did and are desperately trying to reverse the effects. I earnestly ask you to be very slow and deliberate in your study of this issue and not to rush any decisions. I ask you to make a thorough study of the results of those youth who have participated both in the U.S. and abroad to see how they have fared especially those who are speaking out in regret. Please do not affirm any "rapid transition" plans until you have completed your study. The very lives of our children are at stake.

Sincerely,

David P. Martinez M.D.

Lakewood Colorado

From: [Thomas Nienaber](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: gender affirming care
Date: Monday, September 19, 2022 1:35:59 PM

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Good afternoon,

In preparation for the upcoming Florida Board of Medicine meeting, I hope the members will consider the experience from other countries. Other countries have many years of (not good) experience with gender transitions. A few scholarly articles include:

1. Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *Am J Psychiatry*. 2020 Aug 1;177(8):727-734. doi: 10.1176/appi.ajp.2019.19010080. Epub 2019 Oct 4. Erratum in: *Am J Psychiatry*. 2020 Aug 1;177(8):734. PMID: 31581798.
2. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011 Feb 22;6(2):e16885. doi: 10.1371/journal.pone.0016885. PMID: 21364939; PMCID: PMC3043071.

I hope the Board is committed to providing truly evidenced based and holistic care for all patients.

Kind regards,
Dr Thomas Nienaber

From: [ARTHUR DELORIMIER](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulations for sex based medical practices in Florida
Date: Monday, September 19, 2022 1:51:03 PM

[You don't often get email from arthur.delorimier@me.com. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

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Dear Members of the Florida Medical Board,

I am the Director of Pediatric Gastroenterology at University of California Davis, a retired Army Colonel and have 31+ years of experience caring for children and in the training of young physicians. I am writing to you to express my VERY great concern and disgust that any healthcare professional who truly cares for the mental and physical health of children AND who has experienced the confusion of their own adolescents, would remotely consider in his/her right mind that it is a loving or noble act to engage in and promote so called "Gender" affirming medical and surgical treatments for children.

The only rationale for such therapies that hold some supposed weight is the supposition, based on sloppy research, that such therapies would in some way decrease the known high rate of suicide among gender dysphoric adults. Not only is this demonstrably untrue (as recognized by our European colleagues who have all but squashed these misguided efforts, among others), it is obvious to anyone with a grain of common sense that those engaged in providing such "therapies" are permanently and egregiously harming the individuals seduced by the lie that is being promoted by "gender affirming physicians".

As a pediatric gastroenterologist a large part of my clientele are otherwise healthy adolescents with abdominal pain caused by their Irritable Bowel Syndrome complicated by the excessive anxiety they endure in the midst of a world that is full of contradictions. A subgroup of these adolescents are the gender dysphoric kids who are engaged in various gender affirming therapies. These therapies NEVER lead to well balanced emotionally healthy situations. Rather, all these kids seem to spiral into a never ending life of anxiety and depression.

Any ethical leader with any sense will put very vigorous restrictions to such therapies in children.

Good Luck,

Arthur J. De Lorimier, MD, COL (US Army retired)
Clinical Professor of Pediatrics
Director Pediatric Gastroenterology UC Davis

From: [Burkey, Brian](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care and surgery
Date: Monday, September 19, 2022 4:11:10 PM
Importance: High

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To whom it may concern, and colleagues,

As a licensee of the State of Florida, and a conscientious physician and surgeon, I am writing to express my concerns over enacting laws in FL that would facilitate rapid care for gender affirming care and surgery, especially amongst our young. Medical literature does not support this type of care for children and adolescents, and the push to do this is strictly based on emotion and politics. I would ask that you protect our developing and vulnerable young people and allow this type of care for adults who have affirmed these decisions after extensive counselling. Many patients change their minds on these unalterable treatments, and are done irreparable harm by it, even after care consideration, much less facilitated and rapid care.

My best,

Brian Burkey MD

Brian Burkey, MD, MEd, FACS

Chair, Regional Institute for Surgical Subspecialties
Professor and Chair, Otolaryngology-Head and Neck Surgery
Cleveland Clinic Indian River Hospital
Scully Welsh Cancer Center
3555 10th Court, Vero Beach, FL 32960
Assistant: Patty Selent, 772-563-4758

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September 19, 2022

To: Florida Board of Medicine

My daughter's story has been shared around the world, including at The Heritage foundation, as well as The House of Lords in England. The fact that I love my daughter is part of the Congressional record. I was part of high-level meetings in Washington, D.C., to no avail. I provided my daughter's medical records of her mastectomy and hysterectomy to Dr. Joseph Ladapo, to whom I am forever grateful. Please note that both surgeries were done on an outpatient basis, after which she was discharged to homelessness. My daughter was first indoctrinated into the gender cult in school, starting at age 13, unbeknownst to me. At age 14, she announced her new male identity, with names that changed over time. She was only 16 when a pediatric endocrinologist in Arizona skirted the law and taught her how to inject herself with testosterone. I grieved when I realized I would never hear my sweet daughter's voice again, which was only the beginning of the trail of utter terror. My daughter was only 17 when diabolical, unethical surgeons wielded shiny scalpels to slice off her breasts and remove her entire reproductive system. She was just 19 when doctors performed a radial forearm phalloplasty, despite my desperate attempts to stop it. For years now, I have been fighting against a well-funded army of Goliaths, with my only weapon being nothing more than a slingshot of love. Will you have the courage to fight the army of Goliaths too? I cannot change anything that happened to my precious daughter, my only child. Yet I will tell her story a thousand times over if it prevents even one child from falling victim of the sacrifice to the gods of gender identity.

I beg of you to be on the right side of history on this subject, knowing that one day, humans will look back in horror at the medical atrocities committed against children who needed help, just as we now look in horror at past medical practices of treating the mentally ill and developmentally disabled with torturous methods. As I have done before, I speak for thousands of desperate parents. Our children are being led down an unnecessary pathway of medical dependence, of which there is little chance of turning back. Beyond the wrong sex hormones, beyond the disfiguring surgeries, our children are further poisoned with multiple drugs to counteract the ill effects of the unnecessary medicine and medical procedures assigned to them at "re-birth." My daughter does not have a dead name. She can never be my son. She lives in a world of delusion, pain, poverty, and unhappiness. She was once a beacon of light but now lives in dark despair. My only reprieve is sleep and the rare dream of my daughter as the sweet child she once was. I desperately needed help with my daughter; instead, doctors sterilized and mutilated her.

Thank you, in advance, for your wisdom in decision-making on this matter.

Kind regards,

Amy Atterberry





From: [Andrew Brayer](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex based medical practices
Date: Tuesday, September 20, 2022 11:02:59 PM

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To the Florida Board of Medicine:

I strongly urge you to not endorse so-called "gender affirming care".
The medical and evidence-based studies do not support making these life altering changes.
Please restrict these misguided interventions, and protect the youth of your state

Sincerely,

Andrew P. Brayer, M.D.

My name is Abel Garcia, I was born in 1997 to a Mexican family who came to the US illegally. Due to my parents being in the US illegally I was raised by my grandparents because my parents were working non-stop so they could support me. Growing up I was a very shy, quiet, and timid boy, I was and still am an overthinker. With my father working non-stop, I did not have a male role model in my life growing up. As a kid, I did not feel comfortable as a boy because I was not the most masculine boy growing up, that plus my mind that over thinks, I believed that I must have been a girl since I was not the most typical boy growing up.

Even though I had issues with what it meant to be a boy or a man while confusing my different nature as a girl/woman, I did not know what the word "transgender" was until I was much older and found the word through YouTube. Not knowing much and assuming that was what I was, especially with my childhood, I believed I was transgender. But because I was a minor I did not move forward on those thoughts, and I just put them in the back of my mind. It was not until after I left high school that I decided to transition from male to female.

I came out as transgender to my friends who were all supportive of my decision, I then came out to my mother a few months later in December of 2015. My mother broke down crying when I came out to her as transgender, she then asked me many questions mostly regarding what if I made a mistake or what if I realized I wasn't transgender, I informed my mother then that I knew this is what I wanted and that I could not be wrong regarding this. A few months later I went to see a therapist regarding my identity as a transgender woman at my local LGBT center, I received a female therapist. This Therapist did not know how to handle transgender patients so, after three sessions with her, she then transferred me to her supervisor who had more experience with transgender patients.

The next therapist that I spoke with, immediately affirmed me as a transgender woman and informed me that she had my letter to transition during my first session with her. When I asked her how come I was ready to transition during my first session with her, I was informed that she did not want to gatekeep me from my transition. Even though I wanted to transition then I waited a couple of months before I accepted the letter to transition, I had a part of me tell me that this could be irreversible and due to that possibility, I took a bit longer to start my transition and gave myself a plan regarding surgeries. My original plan was to wait five years before I received top surgery aka breast implants and ten years before I got bottom surgery aka penile inversion/neo-vagina.

Before accepting my letter to start hormones, my father had learned about my plans to transition from male to female. My father being Mexican did not approve of my choice and decided to fix me because at this point in my life I had not been in a relationship with a woman. My father's idea to fix me was for me to have a relationship with a woman, I was taken to Mexicali by my father under the guise that he needed a backup driver to return from Mexico back to the United States. May 2016 was when my father and I went to Mexico under pretense, later in the day after doing everything my father needed to do, we parked in a parking lot in Mexico. My father then left me alone in the car claiming to find a restaurant

and check out their menu, at this moment I had a bad feeling in my gut, but I was unsure of what to do. My father then returned to the car and informed me that he found the restaurant and he found the food to be good. While I walked to the “restaurant” with my father, my gut kept giving me a bad feeling the closer we got to the restaurant that my father found. Eventually, we found the restaurant that he found, but when we finally stopped, we arrived at a black building.

The building was painted black both inside and outside, it even had tinted windows, the windows were so tinted that you could not see anything inside if you were looking from outside the building. Once we went inside this restaurant, my gut feelings were confirmed of something that was not safe for me or somewhere that I should be. Unfortunately, I went along with my father because I was in a country where I did not know nor knew how to stand up for myself. After arriving inside the building, I took a seat down, looking at my phone wondering what the building was because I did not know any restaurant that was built and looked like the one, I was in. After a few minutes of sitting down, I heard my father’s voice telling me to stand up and pick a woman, and that was what I was having. At that moment I realized that I was not at a restaurant but instead at a Brothel.

I looked up and noticed a row of younger women, it was about five to eight women who looked to be in their 20s. While looking at my father confused, he told me to pick one of the ladies, not knowing what to do I picked a random lady from the group. After picking one of them, the rest of the women left, and I started to walk inside alone with the woman I had picked. But before going inside, my father told the woman that I had picked to hold on to as he wanted to speak with her before she left with me, I was told to go on ahead without her. But I ignored what I was told and hid around the corner, and I overheard my father informing the young lady “take care of him, it’s his first time”. After my father and the woman who I was supposed to have intercourse with finished their conversation, the woman walked toward me, and together we walked into a room.

Not long after entering the room with this woman, I do not recall the entire event. Not because I was drugged or anything, but because I have chosen to repress those memories as they did traumatize me. I do recall a few parts of the event, I recall after entering the room, she informed me that I needed to undress and that she was going to give me a massage. I believed her and did as they instructed, after laying down on a table, she returned completely nude and started to give me a massage. Eventually, we went from the massage table to the bed, I do not recall exactly what happened, but I am aware that I could not perform with her, and eventually, our time ended. But before we left the room and went back to my father, I asked her to lie to my father that we had a great time and that it went very well. While I did not enjoy the incident, the woman covered for me and lied to my father about what we did inside and that I did great for the first time. Once my father and I went back to our car, I finally realized what my father did to me and what I went through. I was utterly disgusted by the event, but when I looked at my father knowing that he was lied to, he believed what he was told. I acted like I enjoyed the event at the brothel and with the woman. I then noticed that my father was proud of me, and he probably suspected that I no longer wished to be a transgender woman after this incident.

I did not know it at the time, but this incident that I was involved in was the point in my life when I decided that I did want to become a transgender woman as I was dealing with trauma. The trauma was caused by my father who believed that was doing something right in his life but instead it backfired unknowingly which caused me to down a path of self-destruction. I eventually spoke with my therapist informing her of the incident in Mexico, but because she was a gender-affirming therapist who worked with transgender patients, she did not attribute my accepting the hormones to the recent trauma that I had just experienced and continued to affirm me as a transgender woman.

At this point, I continued to see my therapist for five more months before I finally moved out of my parent's house and a month later, I started hormones. But before I could start hormones, I needed to see my doctor and get cleared before I started. When I arrived at the doctor's office, I was informed that I could become a woman, I just needed hormones and surgeries, I sadly believed the lies that I was told. Especially because my doctor had brought in a transgender activist to inform me that I was not just a feminine man, but I was a transgender woman with the proportions of my body.

Once I started hormones, I was happy that I was finally able to be my true authentic self, I was affirmed by everyone who knew that I was transgender. A few months later I got my name and sex marker changed on all my documents and recognized as a woman legally. A year after I started hormones, I got my letter to get both top and bottom surgery approved, during that session I had only requested top surgery, but I did not want to get bottom surgery yet. I did not know it at the time, but I was given both letters of approval, I only found out when I got a letter from my insurance company saying that I am good to meet up with my surgeons for both top and bottom surgery. I ignored the letter for the bottom, but I choose to accept the letter for the top surgery.

In May 2018, I went into surgery, and I got top surgery completed, I was very happy with the results of my surgery but looking back it was because I was on heavy painkillers, and I had a couple of events to attend for friends and family. Three months after I got surgery, I got a wake-up call from reality, I realized that I made a mistake and that this was not for me. After realizing my mistake and waking up from the lies, I realized how much I had damaged my body, I had to then accept that I would always be a man even if I continued to go down this path of self-destruction. I then had to look at my body, that I was just a man, but I was a man who was in the process of being mutilated to appear as a woman, now as a decoy/caricature of what I believed a woman looked like.

When I reached out for help from the therapist who signed off on my transition, I was met with pushback when I brought up the idea of detransitioning back from a trans woman to a man as I was born. My therapist informed me that my current thoughts of detransitioning were caused by childhood trauma and due to the excitement that I was feeling since I recently had breast implants. At this moment I knew that I would receive affirmative care instead of the proper help I needed. After being

failed by my therapist I looked for a new one through my medical clinic. I was provided a new therapist, unknowingly this therapist was as worse as the last one maybe even worse.

At this point, I knew that I could not detransition without giving a good enough reason to a therapist. This was late 2018, early 2019 when I decided that probably joining the military was a good reason to have a therapist sign off on my detransition because at the time you could not enlist in the military if you were trans unless you detransitioned or finished your transition. I choose to use the military as an excuse to detransition, and I had been talking to a recruiter to enlist but also to detransition. My new therapist did not like that I was willing to throw away my progress regarding my transition because of the military and instead told me to look at other avenues that did not require me to detransition. He informed me that I should not be too cavalier regarding my detransition as it could have irreversible damage to my body and be dangerous. Early into seeing this therapist, I had known he also would have not allowed me to detransition, so while still seeing him I looked for another therapist but instead of finding one, I found a detransitioner by the name of Walt Heyer.

Mr. Heyer is a detransitioner in his 80s but when I reached out to him, I told him that I had nowhere to look for help and I felt hopeless. After telling Heyer my story and where I lived, he informed me that he had a friend and therapist in my area who could help me fix my life. A few months later I was finally able to see Walt's friend my final therapist and the one who was able to help me transition. During the first session I had with this therapist, he informed me that because we were in California, everything we were talking about and doing, was of my own free choice and not of his doing, because if the state were to find out they would accuse him of conversion therapy and strip him of his license.

A few months later we found out how we could start the process so I could transition back to being a man. The process required me to find two medical professionals to sign off on my detransition, submit it to my health insurance and then find a surgeon who would perform the surgery on me to remove my implants. Finding two medical professionals was a bit challenging even though we only needed one as my therapist was the first one to sign off on it but finding a second medical professional was a bit tougher than we thought because it was during the covid 19 pandemic, and no professional was willing to accept a new patient and possibly risk their career with the state going after them due to conversion therapy. Months passed and I was eventually able to find a second medical professional to sign off on my detransition, but this was after pinpointing who was covered by my insurance and explaining my story to the medical professional and his staff until I was given an appointment. Once we secured both letters for my detransition, next we had to submit them to my insurance company which was easier said than done.

Once we submitted the documents to my insurance company, we waited. Eventually, we got a response regarding my detransition, unfortunately, it was a letter of denial, but fortunately, I was able to apply for an appeal to their decision which would have taken thirty days. A little over thirty days I got an update,

which was an approval to have my breast removed with the information of the surgeon who would perform the surgery, luckily for me it was the same surgeon who gave me the implants in 2018.

I eventually got my implants removed in December of 2020, at last, I could finally start my detransition, but this was only the start of it. I had to then fight the state of California to allow me to change all my documents back to male, which took a total of 6 months to have everything changed. I then spent the next year and two months wearing a chest binder, which is the same product that young women must wear if they choose to transition from female to male to make their chest appear flat. I had to wear on because I had developed gynecomastia due to hormones, being overweight, and having implants added and removed. Fast forward to February of 2022 I had one final surgery to finalize my detransition, I had my chest reconstructed to be flat and removed all the excess skin that I had developed. Unfortunately, I could not reverse everything done to my chest, I now have a chest with scars reminding me of my past choices.

Looking back to these last seven years, I am a young man in his mid-twenties who has damaged his body for a lie that was given to him. As of today, I do not know all the harmful side effects done to my body, but I can confirm that my genitals have developed atrophied which means that they have shrunk to a size much smaller than they were before I transitioned. Due to the atrophy, I have difficulties relieving myself in the bathroom, and from time to time I will experience pain in my genitals when I attempt to relive myself. I do not know my fertility status as of now, but I do not suspect to be fertile due to being on estrogen for two and a half years while compressing my genitals with tight clothes and the atrophy. I have also spoken with multiple people and informed them of a shaking that has developed on the left side of my body, mostly affecting my shoulder and face that was not present before I took hormones, I've been told it is more than likely MS, Multiple Sclerosis. I also have numbness in my chest due to the multiple surgeries.

From: [Anthony S. Oliva, MD FACS](#)
To: [Vazquez, Paul](#); [BOM Public Comment](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Practice Standards for the Treatment of Gender Dysphoria
Date: Wednesday, September 21, 2022 12:08:39 AM
Attachments: [Practice Standards for Gender Dysphoria.docx](#)

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Dear Mr. Vazquez and members of the Board of Medicine,

I have attached my comments with respect to Practice Standards for Gender Dysphoria.

Sincerely,

Anthony S. Oliva, MD FACS

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From asolivamd@protonmail.com

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asolivamd@protonmail.com

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Email addressUse Up and Down keys to access and browse suggestions after input. Press Enter to confirm your choice, or Escape to close the suggestions box.

Practice Standards for Gender Dysphoria

As a practicing General Surgeon in New York, who is also licensed in Florida, I have many concerns with respect to what will constitute practice standards for gender dysphoria.

To date there have been no long-term studies that have demonstrated either the safety or efficacy of puberty blockers, cross-sex hormones or surgeries for transgender youth. Thus, at best, many of the hormonal and surgical interventions are experimental.

Puberty blockers and hormones are very powerful drugs with significant psychological and physical risks. Puberty blockers, such as Lupron, have been associated with depression, mood disorders, cognitive impairment, stunting of growth, osteoporosis, headaches and seizures. When combined with cross-sex hormones, sterility can result. Other long-term risks are myocardial infarction, stroke, diabetes, blood clots and cancers.

Testosterone, given in the doses required for women to have the same levels as men, can potentially lead to psychiatric disorders such as mania, hypomania, severe depression and psychotic symptoms. Estrogen, given in doses for men to have the same levels as women, can also result in depression and anxiety.

Blocking puberty results in depriving children of a natural and healthy developmental period that is necessary for some to become comfortable with and accept their bodies. Another effect is that they will also fall behind their peers both in physical and brain development.

Sweden officially ended the practice of prescribing puberty blockers and cross-sex hormones to minors in 2021 recognizing that it is experimental. Recently, this year, the British National Health Service shut down and is radically remaking its gender identity clinic for young people due to the emphasis that was put on “affirmation” and lack of mental health support for those presenting to the clinic.

Many of the effects of puberty blockers are irreversible and permanent. All of the effects of surgical interventions are irreversible and permanent. They leave permanent physical scars and deep psychological wounds. They also fail to address the underlying cause of the disorder. Gender dysphoria is the only psychiatric disorder that physicians are attempting to treat with surgery.

Would we ever perform liposuction on an anorexic? Perform amputations or sever the spinal cord on one with body integrity identity disorder? Then why would we ever consider that removing healthy breasts, ovaries, testicles or the uterus or the penis from transgendered youths are rational treatments for gender dysphoria.

Interventions, such as phalloplasty and vaginoplasty, have high complication rates (as high as 32.5%) especially those involving the urinary tract. Some individuals will develop devastating complications such as recto-neovaginal fistula and horrific wound infections. Mastectomies leave large permanent scars. Depression rates after surgery are as high as 62%. Long term rates of suicide ideation and suicide are much higher in those who undergo surgery compared to those who did not. The real-world experience at Johns Hopkins with surgery for gender dysphoria led to shutting down of the program.

Most gender distressed teens are anxious, depressed, traumatized, uncomfortable with their bodies and struggle with their identity. Gender dysphoria is a result of a complex combination of psychosocial factors, dysfunctional familial relationships and adverse childhood events.

Children are incapable of giving informed consent to these types of treatments given their immaturity especially with respect to cognitive ability and brain development.

The best treatment is affirming their biological sex. 80-90% children will desist or grow out of it with counseling and allowing puberty to occur naturally. Treatment for gender dysphoria should focus on better understanding the psychological factors leading to this disorder, and providing the necessary individual, and in some cases familial, psychotherapy and counselling in order to have successful outcomes.

From: [victor lopez](#)
To: [Vazquez, Paul](#)
Subject: Gender-affirming care
Date: Tuesday, September 20, 2022 7:50:36 PM

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Dear Sir,

I beg you not to push through the implementation and regulations related to sex-based medicines. As a clergy, I have a special concern about the "youth transition" and the "informed consent process. God created us males and females. We cannot alter God creation to change sex of a certain individual by surgery. As Pope Benedict once said, 'this is a manipulation of gender'. Thank you for listening.

In Christ,

Deacon Victor Lopez

From: [Damian Birchess](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Transition
Date: Monday, September 19, 2022 2:46:01 PM

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The risks of gender transition are substantial. They include blood clots, which can be fatal, cancer, accelerated atherosclerosis, depression, suicide, and infertility. This is neither a safe nor prudent action to do to our minors. Damian E. Birchess M.D.

From: [Christieann Mathison](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Board Meeting /gender affirmative care
Date: Tuesday, September 20, 2022 11:15:02 PM

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My child, may not be a “child” by definition of age, She is 21. However, the prefrontal cortex of the brain does not fully develop until age 25. From Wikipedia ... **“This brain region has been implicated in [executive functions](#), such as [planning](#), [decision making](#), [short-term memory](#), personality expression, moderating social behavior and controlling certain aspects of speech and language.[4][5][6] Executive function relates to abilities to differentiate among conflicting thoughts, determine good and bad, better and best, same and different, future consequences of current activities, working toward a defined goal, prediction of outcomes, expectation based on actions, and social "control" (the ability to suppress urges that, if not suppressed, could lead to socially unacceptable outcomes).”**

In October of 2021, Our daughter made the declaration to us that she was going to start taking testosterone and that Planned Parenthood would be the one providing and helping her with all of this. We were shocked and devastated but most of all, confused and deeply concerned.

In 20 years of this child’s life not once has she ever questioned asked shown displayed anything about her gender until following the pandemic and returning to college in Florida.

We tried having conversations with her to ask - what she knew about the side effects of taking extremely high doses of synthetic hormone and why or where did this all of the sudden desire come from These conversations were met with script-like rhetoric of gender narrative/ideology. Nothing, not one thing was based on fact.

This is a bulleted list of what we have encountered since

- our child sought out an LGBTQ therapist from a website of “lgbtq resources “.
- Our child -at 20 years old who had the same therapist for the last EIGHT years, all of a sudden dropped her for this new LGBTQ choice bc she thought she could get an easy and quick letter of recommendation for her planned parenthood hormone appointment.
- It was discovered that this “ child “ had completely LIED to this new therapist on multiple levels presenting false info. Had I, her mother, not happened to call and leave a message stating I had concerns it would have gone in checked
- The child dropped this therapist after the therapist asked her about the truth and refused to write a letter (THIS therapist did the right thing BUT ONLY bc I happen to have found her and left a phone message about our concerns
- The child found NEW “non-binary “ providers in some sort of clinic in st Pete Florida that provides resources for this
- These therapists are NOT doing due diligence and contacting any former medical or mental health professionals involved in these children's lives - there MUST be extreme due diligence when it comes to mental health care and health care when it comes to

these patients who are children - even up to age 25!!!!

- There are numerous advocacy Organizations online where we found that what was going on with our daughter is an alarming trend among this age group! It's an astonishing and HUGE red flag. Research it!
- I am a South Carolina resident and I have currently been down in Sarasota Florida since the beginning of July after my daughter took herself to check into a mental health institution for fear of self-harm. This is the child that wants to take male hormones, that wants to not become a man but in her words "be a female that has male characteristics" because this has been born out of some social media /college / who knows what else influence for this age group, it is so disturbing! She attends a very very small extreme liberal college(has we known this it would not have even been an option and especially because she is using a full Florida prepaid college plan this state is paying for this indoctrination from the school) various people attend the school who are not friends who do not belong in the same social circles do not have any classes together nor the same area of study and these kids are espousing the same exact rhetoric like it has been fed to them from a script which is such a huge red flag.
- Historically if any of us walked into a therapist or psychologist or psychiatrist's office and said to them I want to be a tree or I want to be someone else, we would not receive affirming supportive validation along with help to further that problematic request. How in the hell has it become the case when it comes to children? That they can walk in and say they want to be another sex and there is no due diligence and ethics followed to help this person work through the root cause of why they are feeling this way and how to accept themselves in the dysphoria that they are experiencing.
- This is alarming and dangerous and will Have tremendous consequences that ultimately the systems of the government will be responsible for because who is going to pay for the medical consequences and side effects and detrimental health consequences that come of these things and the mental health care that will be necessary for life ... if you look at the evidence that we DO have (because there is so much evidence that we do not have) we can see thus far that the people who have successfully followed through with these transitions STILL have a suicide rate higher than the dysmorphia before and a suicide rate that is confounded with carrying through with it resulting in deaths
- PLEASE PLEASE STOP these detrimental practices And provide a very strict code of ethics that is consequential with the law if it is breached. Healthcare providers of any kind have a code of ethics and due diligence that they are required to follow by law otherwise there are consequences. This should be no different.
- I implore you - kids' lives are at stake!

From: [Angela Thompson](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Concerns about medicalized gender affirming care in minor children
Date: Wednesday, September 21, 2022 12:44:03 AM

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Dear Florida Board of Medicine,

I am an obstetrician and gynecologist and am writing to you in support of the cautious approach the board has taken in regards to the care of gender diverse children and adolescents. This is not settled science, and systematic reviews of the evidence have not found that the benefits outweigh the risks of a medicalized approach to affirmative care for gender diverse people. As a physician licensed in the state of Florida, I commend your ongoing consideration in how best to safely care for our vulnerable patients who are gender diverse, especially children and adolescents, by preservation of their functional bodily integrity.

Respectfully,

Angela Thompson MD, MPH, FACOG

From: [Sinai, Joanne \(Dr\)](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Letter to State of Florida Medical Board
Date: Tuesday, September 20, 2022 8:10:11 PM

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BOM.MeetingMaterials@flhealth.gov

Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Dr. Vazquez:

I am a psychiatrist in Canada, and have been in practice since 1998. I currently practice in Victoria, British Columbia, but attended medical school and completed residency in Toronto, Ontario, where I spent the first five years of my career. In addition to being a psychiatrist, I completed a Master's of Education (in health professional education) in 2003. I have worked since 2004 in Victoria at the USTAT (Urgent Short Term Assessment and Treatment) Clinic and have a private practice with where I provide long term psychotherapy, with a focus on psychodynamic psychotherapy. I have an appointment at the University of British Columbia, as Victoria is a satellite site for the psychiatry residency program. Since 2017, I have held the position of Associate Director of Curriculum for the Department of Psychiatry at UBC.

When I was in residency on my child psychiatry rotation, I was privileged to have conversations with Dr. Susan Bradley about gender dysphoria in children. Together with Dr. Ken Zucker, she ran the gender dysphoria clinic for children and youth at the Hospital for Sick Children. She gifted me a copy of their book on childhood gender dysphoria, published in 1995 (Gender Identity Disorder and Psychosexual Problems in Children and Adolescents). The thoughtful and careful approach described made sense to me regarding the patients I was seeing with gender dysphoria. When I trained at the Clarke Institute of Psychiatry (now part of CAMH – the Centre for Addiction and Mental Health), I was introduced to adults with gender dysphoria. Some had already transitioned, and some were in the beginning stages of seeking transition. With adults, the approach was also slow and careful. Adults had to live in public as their desired gender for at least a year (it may have been 2 years, but I cannot recall the specific details) before cross sex hormones would be considered. I met a number of patients who were refused access to cross sex hormones as their mental health was not deemed stable enough.

During the years I have been working in Victoria I have noticed an exponential increase in the

number of youth and young adults (as an adult psychiatrist, I treat 17 year olds in the ER and 18 and up in the clinic) with gender dysphoria. I have had discussions with many psychiatry colleagues, and they have noticed the same trend. They also shared my concern these youth seemed to be able to quickly access cross sex hormones under the gender affirmation model, and their underlying mental health conditions were rarely taken into consideration by the prescribing physicians.

From our detailed psychiatric assessments, we have come to understand that there are multiple pathways to gender dysphoria, and often it is a symptom of other conditions such as anxiety and depression, and not the cause. Many youth and young adults that we treat are still in the process of separation and individuation, and have not yet developed a stable sense of self. Many think that changing gender will solve their problems. Unfortunately, this is not what we have seen. In fact, changing gender can become the focus of all of their energy, and it can foreclose our efforts to engage them in exploring any of their other issues.

Discussions about the gender affirmation model have taken place in private. Because we were aware that there were strong trans activist lobbying groups, we were worried about what would happen if we spoke up about our concerns. Although we were not prescribing hormones, we felt uncomfortable in our complacency. The slower and more careful “watch and wait” models for gender dysphoria that I had been trained in, that included treating any underlying mental health issues, had been lost.

My interest in the area increased, as family, friends and colleagues began to tell me of their teenagers, with no history of gender dysphoria, suddenly coming out as transgender. This led me to do research. What I found out, particularly about the very poor evidence base for these treatments compelled me to speak up publically. As a result, I began to write letters to editors (LTE's) to various journals (on my own, and with others who shared my concern) when I saw content that I did not think was balanced. For example, earlier this year the British Columbia Medical Journal published 6 articles on the gender affirmation model. I wrote [2 LTE's](#) in response to these articles. I also wrote an LTE to the [Journal of Pediatrics](#) in response to a study that claimed to disprove the existence of Rapid Onset Gender Dysphoria (a term coined by [Dr. Lisa Littman](#), as a result of her research into the phenomenon of the increasing numbers of youth presenting with gender dysphoria.) The final LTE was in response to an article on puberty blocking medication in the [Journal of the American College of Clinical Pharmacy](#).

In addition, I did a grand rounds presentation at Vancouver Island Health Authority on June 7, 2022, titled [Gender Dysphoria: A Changing Landscape](#). I encourage you to watch the rounds as it is a good summary of the research and some of the concerns that I have.

I would like to clearly state that I am very sympathetic to trans people. They deserve careful,

nuanced care that takes into account the entirety of their biopsychosocial presentations. I am concerned that the gender affirmation pays lip service to psychiatric evaluations and psychiatric care. The vast majority of children with gender dysphoria (over 80%), if not socially transitioned, desist during puberty. I think we simply do not know enough about the causes and natural history of ROGD to justify the irreversible treatments that many teenagers are opting for.

To summarize, these are some of my concerns regarding the current gender affirmation model of care for gender dysphoria:

- There is a very poor evidence base for puberty blockers and cross sex hormones, as per 4 systematic reviews, with 4 European countries changing course as a result.
- Brain maturation typically doesn't occur until age 25 or above.
- Children and youth (which may include up to 25) may not have the cognitive and emotional capacity to consent to treatment.
- Puberty blockers and cross sex hormones can have irreversible effects such as infertility, anorgasmia, bone disease, cardiac disease and other as yet unknown consequences of these medications used long term.
- There is a paucity of good research and a lack of research regarding long term outcomes regarding medication, surgery and mental health.
- We know very little about the new group of mostly natal teen girls who are presenting with gender dysphoria. Providing them with therapy first may help them understand their gender dysphoria and make truly informed treatment decisions. Having worked with many youth in therapy, I think it is probable that the desistance rate could be as high as the rate in children if they are not provided medication or surgery. I suspect desistance would occur as they naturally enter another psychological stage in their lives in their early to mid 20's, with a more established sense of identity.
- The numbers of detransitioners is increasing, and this is likely the tip of the ice berg.

In sum, rather than the current affirmation model proposed by WPATH, I would propose a much more slow and cautious approach to the treatment of gender dysphoria in children and youth. This approach should favour psychotherapy, and only involve medication and/or surgery if part of a research protocol or if there are extenuating circumstances.

Regards,

Joanne Sinai, MD, MEd, FRCPC
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USTAT Clinic
Clinical Associate Professor
University of British Columbia
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I am attaching the links here, in case the hyperlinks in the document do not work.

<https://bcmj.org/letters/informed-consent-gender-questioning-youth-seeking-gender-affirmative-care-complex-issue>

<https://bcmj.org/letters/current-gender-affirming-care-model-bc-unvalidated-and-outdated>

[https://www.jpeds.com/article/S0022-3476\(22\)00185-8/fulltext](https://www.jpeds.com/article/S0022-3476(22)00185-8/fulltext)

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330>

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From: [Elena Torrey](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Fwd: Testimonial on Gender Care for upcoming hearings
Date: Tuesday, September 20, 2022 7:41:24 PM

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From: Elena Torrey <elenatorrey@gmail.com>
Date: Tue, Sep 20, 2022 at 5:10 PM
Subject: Testimonial on Gender Care for upcoming hearings
To: <Paul.Vazquez@flhealth.gov>, <BOM.MeetingMaterial@flhealth.gov>

To: Dr. Paul Vazquez
J.D. Executive Director
Florida Board of Medicine

Dear Dr. Vazquez and all concerned Board Members:

Picture in your mind a happy toddler running towards a hot burning stove, getting ever so closer to severely burning his little hands. Do you let him do it?

Of course not!!!

Unthinkable, right?

Well, every parent writing to you and testifying about their kids' experience with gender confusion, Rapid Onset Gender Dysphoria and "detransitioning" is precisely making you aware of the unthinkable.

The unthinkable, unethical and immoral misleading of vulnerable teens and youth into cult-like behaviors and life-altering, mutilating surgeries that result in irreversible damage and a life of pain, suffering and permanent sterilization.

How is this even happening? How did we as a society get here?

With careful, quiet and well-funded international lobbying. Look it up. As soon as gay marriage was approved, all the millions in funding that were still available to LGBT lobbyists were diverted into lobbying for "trans rights". Still are. From 2015 on there has been a disproportionate rise in "trans" cases, particularly in girls. Here is just one example from *Trans*, a book by Helen Joyce, page 91:

In 1989 the famous Tavistock gender clinic opened in Great Britain. They had two cases that year. TWO. Both boys.

Numbers stayed low for years.

By 2020, there were 2,378 referrals!! Over TWO THOUSAND, almost three quarters of them being girls.

Thank God this clinic was just closed this year, and is now facing multi-million dollar law-suits.

Any search of hospitals or places where they offer gender care here in the U.S. reflects the same disproportionate rise in cases, and the same statistics (in other words, majority of the increase is in girls).

How could adults let this happen? How could anyone in their right-frame-of-mind let that toddler run full-force into that burning stove - or in this case - a young girl or boy go ahead with taking dangerous amounts of drugs, and even perform surgeries?

With methodic and systematic lobbying, gradually changing the contents of Public Libraries, School Libraries and curricula, and lobbying that changed even medical thinking in doctor's offices, clinics and Hospitals.

The hot burning stove is what is referred to as "Gender Affirming Care". Teachers, medical professionals, etc. were led to believe by "gender experts" that if a kid - no matter their age or circumstances - simply *says* they are "trans", it must be accepted as truth, no questions asked, no need to involve the parents who most likely are "trans-phobes" and will make matters worse. Kids usually will have had months of "recognition" from their schools before the parents find out. The old marching orders were: protect the kid by socially affirming immediately and start calling them by their new name and their new pronouns; Don't involve the parents.

This is exactly what happened to us with our 13 year old daughter (now almost 14). We learned the hard way what new research is showing: that in cases of Rapid Onset it is precisely the so-called Gender Affirming Care what makes these kids suicidal. During our daughter's first Hospitalization (April, 2022), the new Guidelines from the US Dept of Health and the Florida Dept of Health came out, recommending AGAINST social and gender affirming practices:

<https://content.govdelivery.com/accounts/FLDOH/bulletins/3143d4c>

She had two more hospitalizations (June and July, 2022) and is technically still under suicide watch. After a long search we have found a great Psychiatrist and Therapist team that is working on undoing the damage. Too soon to tell if her life will be saved, but working on it with all our strength.

The new guidelines have made a HUGE difference for us. During her first hospitalization, the Psychiatrist and team at the hospital said "of course "he" is

suicidal, "he" is trans and needs to take Testosterone immediately so they can start being prepped for surgery!!" Kid you not.

For the other two hospitalizations, as soon as we showed the new guidelines and showed that she had several diagnoses and was being treated for those, their attitude and care changed immediately. They were supportive, understood that we were not "trans-Phobes" and why we were not allowing others to head blind into a burning stove.

So what are we asking of you today?

1. Ensure that practices all over Florida are not blindly socially transitioning anyone without proper counseling and without their parents knowledge (unless abuse is suspected).
2. Help ensure that minors cannot have access on their own to hormone blockers, Testosterone treatments and surgeries. Sure, it might be the law...but it is happening.
3. Publish and distribute guidelines to every medical practice, library and school so that the symptoms of Rapid Onset are widely known. That alone can save lives.

The symptoms/requirements to confirm Rapid Onset Dysphoria in teenage girls are:

- very low self-esteem,
- some trauma in her life that led to self-harm
- other parallel conditions (sensory issues, anxiety, food issues, defiance & anger management issues, high-functioning Autism),
- frequent feeling of being down, difficulty socializing feeling that everyone is better than her, that friends reject her, etc
- having never before manifested any inclinations of dysphoria or same sex attraction
- influence from other teen girls "going trans"
- misled by an inappropriate therapist

ALL of these paired with propaganda online, on social media, and with Gender Affirming Practices, leads these vulnerable girls into thinking they are

transgender.

To be clear, it is our belief that a truly, genuinely trans youth *needs* Gender Affirming Care, starting with the Social Gender Transitions: new name, haircuts, binders, clothes, pronouns, etc. After proper counseling and parent involvement, **Not providing GAF and treatment to a genuine trans case would be inhumane.**

But to blindly impose GAC as the blanket solution for all teens with other disorders is even more inhumane. This no longer needs to be the case.

Thank you for your time, interest and dedication to saving lives.

Elena Torrey, for the Torrey family

From: [Edson Vanderling](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender ideology and affirmative care
Date: Tuesday, September 20, 2022 11:57:19 PM

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To whom it may concern,

Many children are being mutilated without mindful consent through affirmative care gender ideology. Adolescents and younger do not have a developed pre-frontal cortex. Many gender confused/fixated/dysphoric youth present with co-existing mental health issues such as autism, ADHD, and traumas from causes such as bullying and abuse. Most do not have adequate psychological counseling, and in many jurisdictions it is outlawed. I'm almost 50 years of age and never in my life have I witnessed such mass failure of policy. This issue affects every child of every nation that encourages the flourishing of gender ideology. The promotion that a girl can be a boy and vice-versa, is in one word, evil. Gender discontent is a social contagion, just as anorexia was, and is being fed by it's promoters, including WPATH. This organization has members who benefit financially from people changing genders, and they're affiliated with people who promote child castration and claim eunuchs are a valid gender identity. This extension of sado-masochism is who is guiding world nations on treatment for gender dysphoria. Florida has an opportunity to display to the world, what real child care looks like. This issue is beyond sad or ridiculous. This issue in many nations is somehow oddly not even challenged for debate. Why? When all evidence suggests at bare minimum, there should be swift change in sex/gender law, to rule on the side of caution. Studies suggest the vast majority of youth will naturally outgrow gender dysphoria/distress- and verified by thousands of years of human history. A study also showed that suicide rates of post-medical trans patients is over 19 times higher than their peers. The sharp rise in gender dysphoric youth in the last decade is not a natural genetic mutation. It is a social contagion, whose roots, I believe should be criminal. Please do all you can to protect children and give them proper care, to make them feel at peace with their bodies, and free them from the evil that pushes them to defy themselves and gaslights them to believe it's right. It is not right. It is evil and we all have an opportunity to do what we can, for what we believe is right. Thank you for reading my message and considering my thoughts.

Respectfully,

Mark Corkum
Nova Scotia, Canada

From: [Evangeline Dacanay](#)
To: Paul.Vasquez@flhealth.gov; [zzzz Feedback, BOM MeetingMaterials](#)
Subject: On the issue of implementing regulations related to sex based medicine practices in Florida
Date: Tuesday, September 20, 2022 8:07:18 PM

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As a member of the Catholic Medical Association, I urge and encourage the Florida Board of Medicine to restrict these misguided interventions and to protect the youth from unnecessary lifelong harmful effects of gender affirming transition care/procedures. As a psychiatrist , I have witnessed the deleterious effects not only in their physical but also in their psychological well being. I have seen cases where initially the intentions were that of the relief of perceived sufferings on these individuals who have homosexual issues, after they had gone through sex affirming procedures, they regretted and came to find out that it did not solve their problems and led to even more issues such as severe depression that led to self injurious behaviors and suicide. I hope that serious considerations be upheld as this could be a major impact on healthcare throughout the country especially on our youth , the future of our country.

From: [Charles Stuart](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Comments on Gender Affirming Care in Florida
Date: Tuesday, September 20, 2022 8:17:49 PM

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Mr. Vazquez,

Thank you for the opportunity to comment on the topic of gender affirming care.

I am Chuck Stuart of 1385 Lakewood Lane, Fleming Island Florida. I am a retired Navy Captain of 27 years, most recently serving as the Chief Executive of the Naval Aviation Depot in Jacksonville, Florida, a \$950 million annual operation. Most importantly, however, I am a parent of three daughters, the youngest of which is 17.

It was not too long ago that any form of physical gender-altering surgery on a minor would be considered child abuse. Truly, I am not sure what has changed. It is well-documented that people under the age of 18 are still developing physically, mentally and especially emotionally. They should not be able to make these decisions until much later in life. To think that we are even considering allowing people in this age range to make life-altering decisions on their anatomy without the full consideration, deliberation and protection of their parents is appalling,

At a less-invasive level than surgery is gender-affirming counseling. Just as with physical surgery, psychological treatments on adolescents must have the consent and support of parents. The only exception should be if the parents were found unfit or abusive. There is a system in place for that determination, and that system must be allowed to run its full course before medical practitioners should step in and assume the role of the parents.

In all these situations, the emotional development of the adolescent needs to be a primary driver. Over the course of life, it seems prudent to wait until the adolescent has developed into a full adult before making these kinds of life-altering decisions.

Again, thank you for the opportunity to comment. I pray that you make decisions consistent with the values I have raised in this letter.

Respectfully,

Chuck Stuart
904-716-2954

From: [Robert Ebert](#)
To: [Vazquez, Paul](#)
Subject: Gender dysphoria and transgender treatment in Florida
Date: Monday, September 19, 2022 2:12:59 PM

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9/19/22

Dear Mr. Vazquez,

I am a licensed Florida physician practicing internal medicine and geriatrics for over 30 years. During the last 8 years, I have cared for patients that have been hospitalized for complications after transgender surgery or are in the process of pursuing gender surgery for gender dysphoria.

In some cases, there are life threatening complications I have treated working as a Hospitalist.

Surgeons that have performed these operations are often from other states. Florida surgeons I've consulted are not anxious in helping to correct surgical complications that have occurred.

It is disturbing and against my Hippocratic oath for me when I engage in the initial and ongoing treatment required to achieve gender reversal and maintain gender change .

I have read much of the available research done by others and I'm convinced that hormonal manipulation and transgender surgery has not demonstrated long term clinical benefit for most of those undergoing these treatments.

It is also known that many who undergo the surgery (1/3) especially male to female often will seek reversal of their surgery or hormonal manipulation after not achieving the expected benefits.

John Hopkins Hospital surgeons had a department and performed this surgery in the past but discontinued doing transgender surgery in the 1980's.

There may be some there who continue doing these operations, I do not know.

Evaluating patients in the Medical clinic requesting treatment for gender dysphoria or hormonal manipulation renewal in their early 20's in the medical clinic is also morally troubling for me.

I believe my right of conscience as a physician is violated asking me to engage in prescribing or renewing hormones for those patients.

I generally defer the treatment of these patients to qualified Endocrinologists who have extensive experience in management of gender dysphoria.

This referral is problematic in itself due to the small number of specialists in West Florida who do this, insurance issues, or months of waiting for these patients to establish care.

I urge all engaged in developing medical legislation to pursue extreme caution in the development of any laws or transgender treatment recommendations. that would encourage or require Florida physicians to participate in this transgender surgery or hormonal treatment for gender dysphoria.

Sincerely,

Dr. Robert E. Ebert, III

Sent from my iPhone

From: [Mariana Giron](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex reassignment procedures concern
Date: Tuesday, September 20, 2022 11:25:30 PM

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Dear Florida Board of Medicine,

As a family medicine doctor practicing in Tampa, I write to you to encourage you to restrict gender-affirmation procedures in our state in order to protect our youth from unnecessary and lifelong harm. Scientific evidence suggests that sex reassignment does not appropriately address the psychosocial challenges faced by people who identify as transgender. Even when the procedures are technically and cosmetically successful, these patients still face poor outcomes.

The Guardian summarized the results of a review of more than 100 follow-up studies of post-operative transsexuals by Birmingham University's Aggressive Research Intelligence Facility:

"[The Aggressive Research Intelligence Facility], which conducts reviews of health care treatments for the [National Health Service], concludes that none of the studies provides conclusive evidence that gender reassignment is beneficial for patients. It found that most research was poorly designed, which skewed the results in favor of physically changing sex. There was no evaluation of whether other treatments, such as long-term counseling, might help transsexuals, or whether their gender confusion might lessen over time.

We have a serious need to restrict these procedures in our state. Our young patients going through their teenage years may at times question their gender identity, and in many cases, this is short-lived and may in part be due to hormonal changes and psychosocial stressors. Gender-altering procedures do not address these concerns and may in fact be harmful in the long-term, as many of these procedures are irreversible. I trust that you have the best interests of our youngest patients and will restrict these procedures in this patient population.

Mariana Giron, MD
LifeChoices Family Medical
Lutz, FL 33548

From: [Franklin Smith](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care
Date: Tuesday, September 20, 2022 9:27:16 PM

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My name is Dr. Franklin Smith, I am a physician of 35 years. I am offering my strong opposition to the Florida Board of Medicine's consideration of implementing regulations related to sex based medicine.

This subject is controversial and sensitive, as it deals with one's personal identity, but we need the ability to speak and listen to each other calmly.

First, we must insist that, no matter what state they find themselves, every individual deserves dignity and respect as a human person. We must always address and prevent bullying and other discriminatory behaviors.

Gender affirming therapy is based on a theory that even though over 99% of humans are born with functioning sexual organs, that *perfectly match* the genes expressed within every single cell of their body – *either male **or** female* – biology may have got it wrong. Medical and surgical treatment is then based on a state of mind: to what gender do you identify?

Unfortunately when this "gender identity" doesn't correspond with biological sex, the new approach proposed is to initiate lifelong medical treatment and surgery rather than psychological care alone. This is **supposedly** accepted by the entire medical community.

But actually, doctors around the world are asking themselves, Is this good medical care, that in this ***one and only condition***, we ask the patient "what is your diagnosis?" and then with chemicals and surgeries eliminate their reproductive ability, change their bodies and expose them to lifelong treatments and complications? Doctors interpret studies and hang so much weight on the **hope** that "gender affirming care" might lower rates of suicide, (even though these studies have small numbers and are considered flawed by some).

In Europe, the major transgender clinics are being closed or put under strict experimental restrictions. But here in the US, medical societies continue to push an ideology, rather than look at things objectively.

There is no doubt in my mind that future generations will observe the damage to children and adults and will judge this approach as harmful and regrettable. I recommend the state medical board should not engage promoting harmful medicine to treat psychological distress. Thank you.

Franklin Smith, MD
262-951-1783

From: [Lesley MacNeil](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Youth Transition -Regulations regarding the practice of gender medicine
Date: Tuesday, September 20, 2022 11:15:36 PM

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Dear Mr. Vazquez & Respectfully Members of the Board

I am the mother of a child that has grown into an adult with gender dysphoria. One thing that you must remember and keep in the forefront is there are no mature adults with gender dysphoria, there are only vulnerable people. Gender Dysphoria started with my daughter around age 15, I was told to use "watchful Waiting" I was told she would get past it on her own. Wachful waiting is impossible in a world where young adults are bombarded with thousands of images telling females how inadequate they are and online tests that will tell you in 5 questions or less that you are transgender. I battled for years trying to get a non affirmative objective therapist - I literally circled the globe and faced wait lists that were years and years long.

At 18 she received approval for breast removal and testosterone in a 30 minute session with a Social Worker. I was able to convince her to delay. My time ran out quickly as she gathered supporters, my sister and her father. Also the support of online "friends" online people who she never met in person. At 21 she managed to convince her Aunt to help pay for her private mastectomy. Her family doctors refused surgical fitness without a complete psychiatric assessment. The private clinic advised her to go to a walk-in clinic- who approved her for a voluntary breast amputation in less than 15 minutes - no psychiatric evaluation needed. The private surgeon was provided a diagnostic letter that showed she had 5 mental disorders, one of which was Gender Dysphoria, adolescent onset. He ignored it and performed the amputation. All those who cheerleaded this surgery were too busy to attend. Me who was against it, was left to reluctantly go. I sat in a parking garage while my daughter's organs were tossed in a garbage can.

You might think at this point that this young adult must be really unstable, troubled and an under performer. At this stage she had graduated from College - Deans and President list - a former National medal winner in baseball - a former Female athlete of the year - she had a bright future.

You need to understand young people with mental disorders can be high functioning. Where is she now - She is on antipsychotic medication for acute psychosis and just came home after a

30 day involuntary stay at a Psychiatric ward - Homeless , jobless, little friends, in massive debt and trying to recover from Mania. Mom picking up the pieces again - leaving my job and cashing out my retirement to survive. This is a set pattern with Kids with GD, she is one many with the same trajectory and outcomes. It's almost at a predictable level.

Why did this happen - because she was sold a bill of goods that amputation would solve her Gender Dysphoria, putting her in an even more fragile state - one of 40% who suffer increased mental disorder after a double mastectomy -

Florida nor anywhere else has the magnitude and level of quality mental health care needed - to take care of these minors who get to legal age to make their own decisions. It is not possible to have informed consent, not possible to agree to anything that has such poor outcomes, not possible to have informed consent when you have Gender Dysphoria, and physicians are telling you, you can be a man instead of a woman. It is a factual lie. It is a disorder that testosterone, estrogen and surgeries can not solve and only psychotherapy can.

You need to ask yourself how Florida will prepare to take the onslaught of mental health cases that will appear in the next few years - who are the failed promises of risks they can not understand or conceive "that it will happen to them". You need to think how your economy will suffer, you need to figure out how you will take care of babies who do not have breast milk and are allergic to formula - you have a lot to figure out.

I have summed up my story due to time- I would be happy to discuss my story should you desire.

Sincerely
Lesley. MacNeil
Nova Scotia Canada

She is the typical

Cell -902.225.3889

From: [Irene Doyle Sandler](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Respectful input on the topic of "gender affirming" therapy
Date: Wednesday, September 21, 2022 3:30:19 PM

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Dear Mr. Vasquez and Florida Board of Medicine:

Although I am not a medical professional, I am a mother and a grandmother. Little children are highly impressionable, suggestable and exploitable, not all-knowing gurus who possess the knowledge one would need to proceed with amputating or mutilating healthy organs of the body. Even a highly experienced surgeon considers every alternative therapy before resorting to amputation, even of a diseased body part.

Claims are made that treatment with puberty blockers and cross sex hormones are fully reversible so there is no harm to children. But are these claims exaggerated or outright deceptive? Aren't the possible consequences of infertility and loss of sexual function and satisfaction for a lifetime too weighty to lay on the shoulders of a child? For physicians to advise parents let the child do whatever he or she wants, without a heavy dose of caution and informed consent, seems to this Florida citizen like malpractice. Please protect Florida children and parents from this madness which has so suddenly infected our society.

A tidal wave of regret and malpractice lawsuits are already on the way. As you are probably aware, Europe's cutting edge Tavistock gender clinic has been shutdown. <https://www.dailymail.co.uk/news/article-11101661/Tavistock-transgender-clinic-facing-mass-legal-action-1-000-families.html>

There are a thousand good reasons to proceed with caution and require respect for the healthy development of children's bodies. Threats of suicide by children suffering from gender dysphoria certainly must be compassionately addressed. At the same time, the reckless promotion of fashionable gender ideologies, even in our public schools (possibly in pediatric well-child visits!), should also be strongly discouraged for the danger it presents for social contagion.

Please do not abdicate your professional responsibility to evidence-based medicine for fear of a woke lynch mob. That would be cowardly and committing a malpractice sin of omission.

Remember, "First, do no harm."

Wishing you all the best as you deliberate on this important matter.

Irene Doyle Sandler
Orlando, Florida 32812

PS One more thing...the term "gender affirming" therapy only makes sense if it refers helping children feel more connected to and appreciative of the healthy body they have. "Gender defeating" therapy is a more accurate descriptor of medical and surgical interventions against normal puberty.

From: [Matthew Peck](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care
Date: Tuesday, September 20, 2022 9:27:10 PM

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Hello Dr. Vasquez,

My name is Matt Peck, I practice emergency medicine in Ohio, and I am emailing with regards the current debate ongoing gender affirming care, especially with regards children.

I have seen in my practice severe anxiety, depression, and suicidality in patients who are status post gender affirming interventions, and I find the evidence supporting these interventions to be rather limited. Until such data (particularly long-term data) is available it is almost certainly best to limit such interventions to highly selected populations and to avoid them entirely in children.

I appreciate your willingness to take the time to read this,

Matt Peck MD

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From: [Ivy Billones](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: *Gender Affirming Care*
Date: Tuesday, September 20, 2022 8:26:08 PM

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To whom it may concern:

Please stop rapid gender transition among children and adolescents. At such a tender age, executive function capacity is very much immature and as a result, their decision-making may not be carefully thought-out. We are well aware of the statistics among teens regarding reckless driving, teen pregnancies, illicit drug use. Why would we let our youth provide informed consent revolving such a life-altering decision without having a full perception of possible consequences, of irreparable damage as they get older?

If full-grown adults make mistakes, how much more among children and adolescents? This “gender-affirming care” abuses the innocence of our children and adolescents. This is child abuse. Please stop!

--In Christ,
Ivy A. Billones, M.D., M.B.A

From: [imno1doc](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex based medical practises, youth transition, and informed consent in Florida
Date: Wednesday, September 21, 2022 12:58:13 PM

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Girls who feel that they're really boys are delusional and need help uncovering why they feel that way. They don't need testosterone injections and mastectomies. That does not address the real problem. First do no harm! They do need help in addressing their confused personal identity.

Too many adults who have undergone self-mutilating surgery for "sex reassignment" have come to regret their decision. Please take the time to learn from those people [Sex Change Regret | For those who want to return back](#)

Thank you,

Michael J. Phillips MD 414-248-2849

8140 W Wisconsin Avenue

Wauwatosa, WI 53213

Sent with [Proton Mail](#) secure email.

Pseudonym: Sal A. Mander
Date: September 2022

I had always been gender atypical compared to my male peers. I was feminine in my mannerisms, and I was always drawn to toys marketed for girls. My first memory of confusing myself for a girl was when I was in kindergarten, when I went onto the girls line and a teacher corrected me by placing me back on the boys line. I first came to believe I was trans 17 years ago when, at the age of 14, I came to learn of the concept of being “born into the wrong body.” To my adolescent, under developed mind, it made sense. To me, it explained why I felt so different from my male peers.

Soon after coming out a year later, I received what I now view as inadequate and misguided healthcare by a doctor who immediately affirmed my trans identity and created a plan for me to get onto hormones and transition. The therapists I worked with also affirmed my identity and failed to implement a developmentally informed psychological and exploratory approach that took into account environmental factors and trauma history. For twelve years, including all of my twenties, I lived my life as a stealth transwoman, believing that I had been born into the wrong body and had done what needed to be done to be who I truly was. I put the trans thing behind me. I didn’t immerse myself in trans communities, I developed a robust social life, a successful professional life, I passed seamlessly and I never experienced transphobia. My transition had been a success. All the while, though, my physical and mental health was deteriorating.

For years I struggled to find a solution, seeking counsel from various allopathic doctors, psychiatrists, and naturopathic physicians. I’d spent hundreds of dollars on specialized blood tests to try and find the root cause of my suffering, as well as herbal treatments, massage, yoga, breathwork in an attempt to manage it. A year ago, in desperation, I began to supplement a small dose of testosterone. Doing so was the one thing I tried that finally restored my declining health, inspiring research into what happens to a male body that is deprived of its natal hormone...long story short: its not good. When it became clear that my “gender affirming” treatments had been making me sick, I embarked on a deep personal inquiry.

How’d I get here?

I guided myself through an investigation of my youth that therapists ought to have supported me in as a young person. I brought curiosity to why I had become so convinced at 14 that I had been born into the wrong body. I began to understand it all as a trauma-induced delusion that doctors

and therapists colluded with, that then got encased in a lot of physical, social, and legal pressure following transitioning. Growing up in a homophobic environment, a younger version of me did everything he could to shield himself and, as a result, I fell asleep to a huge part of who I was. I had been gay. That is why I felt so different from my peers. Not that I had been born into the wrong body.

At the time, the reasons behind my trans identification was unconscious, of course, and it's incredible to see how creative the human mind will become in its self-protection. Throughout the history of human psychology, we have established that there is so much that happens unconsciously. And yet, WPATH doesn't mention the unconscious mind at all. Nor are therapists allowed these days to engage in explorative, non-affirmative approaches that allow for curiosity and potential discovery of unconscious motivations driving the desire to transition. But that, in retrospect, is what I needed.

Instead, I lost myself for over a decade and garnered serious health issues that I'll have for life. Despite my transition being successful in the sense that I passed, had a robust social life, and was professionally successful, transitioning did not address the root emotional issues that I was struggling with. When we don't address the root cause of emotional distress, but rather address it with superficial band aids, eventually things will become dysfunctional. And they did. I came to a breaking point where I could not go on any further and needed to detransition.

Now that I have detransitioned, I feel healthier, stronger, and more emotionally grounded and centered than I ever have. Detransitioning helped me to begin addressing the root cause of my emotional pain and accept myself as a gay male. But now I have breasts that need to be surgically removed (which I have to pay 12k for out of pocket), a chronic endocrine disorder that requires me to inject myself weekly with testosterone because I no longer have testicles, severe urinary incontinence, and the inability to have normal sex with ease. I also have tremendous grief and a sense of loss for my body being altered in ways that are irreversible, and the life that I could have lived as a gay man all throughout my twenties.

My experience has taught me that no child can consent to these interventions, and that the earlier you start them, the higher the chance of someone's healing and acceptance of themselves being delayed, resulting in loss of years on the wrong path and physical and psychological harm.

September 19, 2022

Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

Dear Dr. Vazquez,

Where do I begin? I am the aunt of a young man who is receiving gender-affirming care and the mother to an adult on the Autism Spectrum. Please kindly allow me, in this email, to describe my observations and thoughts on gender-affirming care as well as the social-influential component that is affecting kids/adults on the Autism Spectrum.

Let me begin with the gender-affirming care. My nephew, a bright-handsome-young man, went off to a university, away from home, and within a few weeks of being there called my sister and brother-in-law to tell them that he was a "woman."

To summarize, he explained that while in the university he met a young man that was having a lot of anxiety and could not figure out what was wrong with him. My nephew, a caring young man, decided to help him by researching the source of this anxiety. Along with his new friend and the help of Google, they discovered that his friend must be transgender, and his friend went on his quest to receive gender-affirming care. My nephew, enthralled with his research to help his friend and now alone in a university, away from home, soon discovered that he too was feeling odd and not sure of himself.

After further research, he concluded that he too must be a transgender and after "trying out" the different pronouns, he landed on the conclusion that the label that fit him the best was that of a transgender woman. After that realization, he sought out psychological care to help him decipher what he was feeling.

Every psychologist, psychiatrist, and general doctor provided gender-affirming care, immediately, without questioning his feelings/motives or thinking. Not one of them even considered that it could be something else. However, they all agreed that once he began his gender-affirming care, he will feel great. Well guess what? He did not feel great. He began having extreme anxiety. What did they do next? They added anxiety medications to his hormone therapies.

A few months later, he began feeling depressed, guess what happened next? That is correct, they added antidepressant medications. In summary, what started out as an "odd feeling about himself/insecurities" turned into gender affirming care, anxiety, and antidepressant medications. Did the odd feelings go away? No, in fact he feels worse than ever, and he has been completely brainwashed by the internet and doctors who failed to believe that perhaps he was facing other issues, instead. My nephew and our entire family have been destroyed by this gender-affirming care.

Second point, my daughter who has Autism, is constantly bombarded with ads, tv shows, internet, social groups which push the transgender agenda as the answer to her unique ways of being. Most recently, I have heard say, "I do not like wearing make-up nor dresses." I take a deep breath and believe, like every physician in the medical field should, that she is just going through a phase, and it is no big deal. Unfortunately, after my nephew's experience, my heart skips a beat. I fear for those parents, that being in a similar situation, would take their child to see a psychologist/psychiatrist to only be told that they need gender-affirming care.

In conclusion, gender-affirming care should not be the first answer to a young person's insecurities. The medical field needs to explore, listen, and ask questions instead of allowing these young men/women to dictate a diagnosis based on social norms of the times.

In our experience, the gender-affirming care did not solve the problem, it had the opposite effect. My nephew now suffers from anxiety, depression, and still feels "odd." Please do not allow for another family to go through, what we have gone through. Your medical team has the opportunity to listen to the concerns of multiple families who are suffering, daily, please listen and open your hearts and eyes to what is truly happening.

Thank you for your time and patience. May God guide your resolutions on this matter.

Sincerely,

Silvia Bolivar

From: [Ritchie Gillespie](#)
To: [Vazquez, Paul](#)
Subject: Gender dysphoria in minors
Date: Monday, September 19, 2022 1:19:27 PM

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Dear Sir, I hope all will remember the axiom “first do no harm” when considering the issue of medical and surgical treatment of gender dysphoria in minors. The experience of adverse outcomes of this treatment in minors in the U.K. and Sweden should be evidence that more needs to be learned before recognizing these treatments as being of value.

Taking this uncertainty into account, we should not leave this decision up to the adolescent lacking the ability to understand long term consequences which even the medical establishment finds unclear at present.

Thank you for your attention to this matter.

Ritchie Gillespie MD

Sent from my iPhone

From: [Mary of the Angels Mother](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulations regarding sex-based practices in Florida
Date: Tuesday, September 20, 2022 8:24:18 PM

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Dear Sirs,

It is imperative that you preserve the health standards for our youth.

“Gender-affirming care”, including rapid gender transition for children and adolescents are lifetime detriments for our youth. As we all know, the medical and evidence-based studies of these methods support this claim. The short and long term harm of these interventions is clear.

Please consider your children and do not implement these proposed regulations.

Mother Mary, RN

From: [Robert McDonald](#)
To: [Vazquez, Paul](#)
Date: Monday, September 19, 2022 1:18:24 PM

You don't often get email from magnificat1958@gmail.com. [Learn why this is important](#)

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Dear Sir,

Please do not allow transgender surgery or medical treatment to be allowed in Florida.

This is permanently harmful to innocent children.

I am very concerned about this kind of medical practice.

Thank you,

Robert McDonald, M.D.

From: [Michael Leins](#)
To: [Vazquez, Paul](#)
Subject: Implementing regulations related to sex based medicine practices in Florida.
Date: Monday, September 19, 2022 1:31:13 PM

You don't often get email from dr.leins@parakletos.info. [Learn why this is important](#)

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To the members of the Florida Board of Medicine,

It has come to my attention that you will be meeting very soon to consider implementing regulations related to sex based medicine practices in Florida, specifically concerning “youth transition” and the “informed consent process.” The medical and evidence-based studies of these methods do not support their claimed benefits. Rather, the short and long term harm of these interventions is clear.

Please restrict these misguided interventions and protect the youth of Florida from unnecessary and lifelong harm.

Hruz PW. Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. Linacre Q. 2020 Feb;87(1):34-42. doi: 10.1177/0024363919873762. Epub 2019 Sep 20. PMID: 32431446; PMCID: PMC7016442.

Respectfully,

Dr. Michael Leins, DO

Board Certified Family Medicine and Neuromusculoskeletal Medicine

Member of the Catholic Medical Association

From: [Emma](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Affirming Care- Research Against
Date: Saturday, September 17, 2022 5:15:12 PM

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Please see the attached research:

<https://doi.org/10.1080/0092623X.2022.2046221>

Kind regards

Emma gwilliam

To: The Florida Medical Board

From: Stephen B. Levine MD

About: Your deliberations concerning the medical care of trans-identified children and adolescents

Date: September 22 2022

I am the first author of the *Reconsidering Informed Consent for Trans-identified Children, Adolescents, and Young Adults* which was published online on March 17, 2022 and as of today has been downloaded 35, 500 times, making it in the top 5% of all scientific articles downloaded among over 22 million articles. I presume you have had access to this work by E. Abbruzzese and J.M. Mason and me, if not by clicking on this doi the article will appear (DOI: [10.1080/0092623X.2022.2046221](https://doi.org/10.1080/0092623X.2022.2046221) More than I can briefly communicate, the article provides a comprehensive view of the profound ethical and legal problems of putting young people, who have questionable cognitive maturity to make life-altering decisions, on developmental path that includes risks of sterility, sexual dysfunction, unstable interpersonal relationships, shortened life expectancy and a plethora of discriminations.

The fundamental problem is that hormonal and surgical treatment of the young are not based on replicated science. Independent reviews from Sweden, Finland, UK, and McMasters University in Canada have found the existing evidence of very low quality. Instead of following the principles of Evidence-Based Medicine, trans affirmative practitioners have been unknowingly caught up in Eminence-Based Medicine in which professional organizations view the civil rights of individuals to self-define as the guiding principle of care. Consequently, if a person with a diagnosis of Gender Dysphoria desires puberty blockers, cross sex hormones or mastectomies, genital reconstruction, or facial feminization surgery and they are not conspicuously mentally ill, they can efficiently access these treatments. The Principles of Medical Ethics instruct physicians that their therapeutic actions must be based on science. The teaching of clinical care to our profession's young, be they medical students or residents, rest heavily on a chain of trust that high quality science has established the preponderance of benefits to risks for the intervention. In trans health care, the train of trust is untrustworthy; our young are being misled into thinking that the science is settled. This is very far from correct. While a culture war surrounds such care based on differing political and moral values, I assert that for medicine the issue is a scientific one. My view is that science with its various methods of research has thus far has not been seriously considered as the guide to treatment in this complex developmental arena.

All aspects of human identity—including gender identity-- are subject to evolution throughout the life cycle. To think that some medical professionals "know" that their pre-adolescent and adolescent patients' current gender identity is immutable, even when numerous studies have shown that cross-gender identification in these eras of life only predicts an adult homosexual orientation. These doctors still want to make irreversible changes to their patients' bodies because they were taught that this was only viable treatment. In the meantime, Sweden, France, Finland, and the UK have each recommended a policy that psychotherapy is to be the first treatment of this increasingly prevalent problem. It is imperative that state medical boards

weigh in on this contentious matter as there are many indicators that the quality of adult trans lives is generally poor.

From: [Ramsay MacLeod](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 10:08:47 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about medical care belong within the sanctity of the patient-physician relationship.”

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of

WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Ramsay MacLeod
rmacleod48@hotmail.com

Lake Worth, Florida 33460

From: [Fr. Juan Velez](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Re Gender Dysphoria, from Fr. Juan R. Velez, MD
Date: Thursday, September 22, 2022 5:13:44 PM

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18 September 2022

Paul A. Vazquez, J. D., Executive Director
Florida Board of Medicine
BOM.meetingmaterials@flhealth.gov
Paul.Vazquez@flhealth.gov

Dear Mr. Vazquez,

As a former physician I agree completely with the testimony expressed below by two experienced pediatricians from Miami, FL. I ask you to take into consideration their statement and the fact that many other doctors think the same way as we do.

Fr. Juan R. Velez, MD.

Gender dysphoria (GD) in children is diagnosed when children show gender confusion. When GD occurs in the pre-pubertal child, it resolves spontaneously in 80-90% after the children naturally develop through puberty. A high proportion of children with GD have other neuropsychiatric disorders such as autism and anorexia. GD is considered a body integrity disorder and ought to be treated by a mental health specialist.

The treatment recommended for this disorder is affirmation of the confusion exhibited by the child, suppression of puberty with hormones, high dose cross hormones (testosterone for the girls estrogen for the boys) and mutilating surgeries.

Puberty is an essential milestone in the development of the child. Puberty blocking medications like Lupron (most used) cause a disease state. Harms include impaired brain maturation, decreased bone density with risk of later

fractures, sexual dysfunction, and infertility. Are puberty blocking effects reversible? No. Time lost from developing together with peers and reaching important milestones can never be regained.

High dose cross hormones can result in heart disease, hypertension, diabetes, and cancer.

Once a child is given a puberty blocker, the majority go on to mutilating surgeries. Girls as young as 14 have had completely healthy breasts removed. Surgeries for males include dissecting the penis and inverting into a pelvic wound. For girls, removal of skin of the forearm and attachment to the pelvis to simulate a penis.

There are no long-term studies that show that gender changing therapies done to children have any beneficial effects. Suicide risk among trans-identified youth is the same as for other at-risk groups, such as depression, autism, and anorexia. Prevention of suicide ought to be the same as for other youth: talk therapy and FDA approved psychiatric medications. Psychiatrists in the US and Europe agree that there is no evidence that gender transition reduces gender dysphoric children likelihood of killing themselves.

Studies of transgender adults show a high incidence of depression and suicide. In Sweden, a 30 year follow up of sex-reassigned adults showed rates of suicide 20 times greater than the general population.

Acts which are performed by doctors which mutilate, sterilize or otherwise harm children such as blocking puberty, high dose cross sex hormones, and sex organ removal are not healthcare, but are atrocities. *Especially when the children diagnosed with GD resolve their confusion as they grow naturally through puberty and align their perceived gender with their biological sex by late adolescence.* Our children are the victims of this terrible experiment, as confused adults impose their disordered ideology onto the most innocent and vulnerable.

Felipe E Vizcarrondo MD, MA
Faculty, Institute for Bioethics and Social Policy
Miller School of Medicine. University of Miami
President, Miami Guild
Catholic Medical Association

Norman Ruiz Castaneda, MD
Attending pediatrician in private practice
Nicklaus Children's Hospital, Miami FL
Vice President, Miami Guild
Catholic Medical Association

--

Fr. Juan R. Vélez
4415 S.W. 88th Ave.
Miami, FL 33165

From: [Matthew Benson](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Board of Medicine Letter
Date: Monday, September 26, 2022 9:22:51 AM
Attachments: [2022-09-25-Letter to FL Board Med Gender Dysphoric Youth Final.pdf](#)

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drmatthewbenson@gmail.com. [Learn why this is important](#)

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Dear Paul,

Attached is a letter signed by 7 physicians licensed in Florida who are all board certified pediatric endocrinologists . Also signing are two advanced practice registered nurses who work in our endocrinology clinic.

Respectfully Yours ,

Matthew R. Benson , MD

An Open Letter to the Florida Board of Medicine

Regarding the Proposed Rules to Limit the Use of Hormonal and Surgical Care for Gender Variant Youth

September 23rd, 2022

***To: Department of Health
Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253
Phone: (850) 488-0595
Fax: (850) 488-0596
Email: NewsMedia@flhealth.gov***

From: Board Certified Pediatric Endocrinologists in the state of Florida

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pp. 3: In Support of a Rule Regulating Hormonal and Surgical Treatments in Children
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An Open Letter to the Florida Board of Medicine

To Whom it May Concern:

We write to you in response to your planned public meetings on September 30th, 2022, in Tallahassee, FL to discuss proposed rules and regulations regarding the medical care of gender variant youth.

First, we agree that all children deserve the best evidence-based medical treatments. This extends to children who are diverse in their gender expression and those so distressed by their bodies that they are diagnosed with gender dysphoria. Children, like all people, are complex beings with immense value, dignity and worth. As pediatric endocrinologists and pediatric endocrine nurse practitioners, and some of us also clinical scientists involved in pediatric research, we are deeply concerned that the current scientific evidence for “gender-affirming” care, which heavily relies on the off-label use of puberty blockers and cross-sex hormones, is simply lacking. There are limited data from prospective, controlled trials, which are the gold-standard by which we judge any therapeutic intervention. The Endocrine Society issued updated guidelines addressing the care of transgender individuals in 2017 and rated the evidence as mostly low quality and largely expert opinion [1, 2], which is among the lowest level of medical evidence.

Yet, the American Academy of Pediatrics (AAP) have nonetheless issued their own policies [3] that recommend what is described ‘gender affirming therapies’ in early adolescence, which is notably undefined precisely in the AAP policy statement but could be as young as 10-13 years of age. The AAP policy also calls for the use of puberty blockers (GnRH analogues) until 16 years of age [3]. This has led to a rapid proliferation of a myriad of clinics and programs where many of these children are prescribed these therapies on demand with little to no in-depth assessment of the psychological needs of these youngsters. The AAP and others, however, have stifled debate and honest critiques in this critical topic, even though data are lacking on the long-term safety and efficacy of the prescribed treatments, often labeling any honest dissent in gender dysphoria-related treatments as “extremist” (<https://www.aap.org/en/news-room/aap-voices/why-we-stand-up-for-transgender-children-and-teens/>). Sweden, Finland, France and UK are already restricting the use of puberty blockers and cross-sex hormones in children less than 18 years of age, concluding that the science and research regarding optimal treatments for children diagnosed with gender dysphoria is far from settled (<https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>). We believe this should also be the approach in the U.S. until more robust data are published in the peer-review literature.

We commend the development of the largest longitudinal interventional trial funded by the NIH in 2015 in U.S. transgender youth known as the Trans Youth Care Study (TYC) (R01HD082554). This two-year prospective trial enrolled 497 subjects by 2018, of whom 95 are receiving puberty blockers, 316 subjects are receiving cross-sex hormones and ~86 are receiving no hormones at all. This critically important trial is taking place in four of the largest pediatric gender clinics in the USA (Los Angeles, San Francisco, Chicago, and Boston). While the researchers have published twice regarding their plans to track anthropometric, physiologic, and mental health outcomes in 2019 [4, 5], the actual outcomes data have not yet been published, now four years after these studies were initiated. It is noteworthy, that TYC investigators used as a justification for the study, the significant gaps in knowledge regarding medical therapies in gender dysphoric children [4]. In their 2019 publication, *Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study*, the authors wrote about the 30-year experience of the “Dutch Model,” on which the so called ‘gender affirmative’ model is based, stating the following:

An Open Letter to the Florida Board of Medicine

“Although these guidelines [the Endocrine Society’s] have informed care at academic and community centers across the United States, they are based on extremely limited data. Furthermore, there is minimal available data examining the long-term physiologic and metabolic consequences of gender-affirming hormone treatment in youth. This represents a critical gap in knowledge that has significant implications for clinical practice across the United States.”

They then went on to observe that gender-affirming hormones are now prescribed at younger ages than used in the Dutch Model and concede that “there are only minimal data supporting the earlier use of gender-affirming hormones in transgender adolescents.” [4]. Yet, the AAP asserts hormonal interventions to be “evidence-based” already. This assertion by the AAP is incorrect, resulting in hundreds of clinics in the USA implementing these treatment pathways carte blanche outside of well-regulated and well-designed research protocols.

We have witnessed children being prescribed cross-sex hormones after a single brief visit to clinics, at times by physician and non-physician providers with limited expertise and minimal to no involvement by well-trained psychologists. This is deeply alarming since these are unproven medical interventions with serious potential risks including lifelong medicalization as seen in studies of transgender adults. Among transgender adults, long-term cross-sectional data suggests that for a substantial number, their quality of life remains immensely difficult even after medical transition [6]. Cross-sectional studies in transgender adults in Sweden, for example, have demonstrated persistently high rates of suicide, depression and premature death when compared to the general population. The survival curves in this retrospective Swedish cohort over a 30-year period, did not observe changes in mortality until about 10 years after these “gender affirmative surgeries” [6]. To date, we have no long-term prospective data in gender-diverse children in the literature who have received hormonal therapies in childhood.

To understand the state of evidence, the Florida Department of Health commissioned two researchers from McMaster University where the term “evidence-based medicine” was coined, for a systematic review of available evidence (<https://ahca.myflorida.com/letkidsbekids/>). The review included sixty-one systematic reviews of transgender research, including two studies of puberty blockers, four of cross-sex hormones and eight of surgery, which were of adequate quality and therefore worthy to inform an evidence-based decision-making determination. The review concluded that “this evidence alone is not sufficient to support using or not using these treatments.”

Given the absence of solid scientific data, we recommend the implementation of a judicious pause in hormonal interventions in gender dysphoric youth in the State of Florida in general medical practice. We also support that such interventions should only be ethically permitted in the context of high-quality research protocols approved by an IRB, overseen by a data safety monitoring board and capable of producing quality data prospectively targeting long-term pre-determined outcomes. This recommendation is congruent with the new policy of the National Board of Health and Welfare in Sweden and at the Karolinska Institute in Stockholm (<https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>), and to the restructuring and new guidelines for gender dysphoria clinics being implemented by Dr. Hilary Cass in the UK, after her systematic review for the National Health Service (<https://cass.independent-review.uk/publications/interim-report/>).

We also support the expansion of competent expert psychological support with rapid implementation of nonjudgmental exploratory psychodynamic therapy in gender-dysphoric youth [7-11].

As we thoughtfully debate the science of these medical treatments, we must be clear that violence in any form cannot be condoned or tolerated whether against those providers treating children with

An Open Letter to the Florida Board of Medicine

gender dysphoria with hormonal treatments, nor against those that, like us, prefer a more conservative approach in children (<https://www.childrenshospitals.org/news/newsroom/2022/08/cha-supports-the-health-and-wellbeing-of-transgender-youth>). Any such threat should be reported immediately to the Florida Department of Law Enforcement (**1-855-FLA-SAFE**).

It is a sad commentary that it has become politically incorrect to raise any issues of concern when dealing with children and adolescents with gender dysphoria and transgender youth and that raising any such concerns gets automatically labeled as transphobic. This has silenced many physicians who thoroughly agree with our expressed concerns but that also fear retaliation.

We believe children and adolescents that are gender dysphoric and that identify themselves as transgender require respect and support in a non-judgmental, non-discriminatory way. We also believe these children can seldom make these overwhelming, life-changing decisions regarding hormone use and surgery, many of them irreversible, at such an early age. We are now seeing young adults that are openly expressing regret, while detransitioning in a variety of ways. These observations highlight the need for holistic examination of the individual gender-dysphoric person and their environment, to better understand their dysphoria in its full context while providing adequate time be given before any irreversible decisions are made.

A group of physicians, psychologists, risk-management experts, ethicists, and lay people on a medical board should be able to assess the evidence, while also advising on a proper standard of care as opposed to legislative and political bodies. These decisions are too critical and important for young children to make as they cannot easily comprehend the long-term ramifications.

Lastly, without adequate oversight and regulation by the Board of Medicine, the financial costs of the current approach could be large. More importantly, we must address the human suffering not alleviated by hormonal therapies or surgeries in these vulnerable youth. We appreciate the Florida Board of Medicine's careful consideration of our concerns.

Sincerely,

Matthew R. Benson, MD
Jacksonville, FL

Joe Permuy, MSN, APRN
Jacksonville, FL

Larry A. Fox, MD
Jacksonville, FL

Kaley Carroll, BSN, MSN, APRN, CPN-PC
Jacksonville, FL

Reham Hasan, MD
Jacksonville, FL

Nelly Murras, MD
Jacksonville, FL

Monica Mortensen, DO
Jacksonville, FL

Lournaris Torres-Santiago, MD
Jacksonville, FL

Lydia Snyder, MD
Jacksonville, FL

An Open Letter to the Florida Board of Medicine

Bibliography

1. Hembree, W.C., et al., *Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline*. J Clin Endocrinol Metab, 2009. **94**(9): p. 3132-54.
2. Hembree, W.C., et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*. J Clin Endocrinol Metab, 2017. **102**(11): p. 3869-3903.
3. Rafferty, J., et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*. Pediatrics, 2018. **142**(4).
4. Olson-Kennedy, J., et al., *Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study*. JMIR Res Protoc, 2019. **8**(7): p. e14434.
5. Olson-Kennedy, J., et al., *Creating the Trans Youth Research Network: A Collaborative Research Endeavor*. Transgend Health, 2019. **4**(1): p. 304-312.
6. Dhejne, C., et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*. PLoS One, 2011. **6**(2): p. e16885.
7. Levine, S.B. and L. Lothstein, *Transsexualism or the gender dysphoria syndromes*. J Sex Marital Ther, 1981. **7**(2): p. 85-113.
8. Davenport, C.W. and S.I. Harrison, *Gender identity change in a female adolescent transsexual*. Arch Sex Behav, 1977. **6**(4): p. 327-40.
9. Churcher Clarke, A. and A. Spiliadis, *'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties*. Clin Child Psychol Psychiatry, 2019. **24**(2): p. 338-352.
10. D'Angelo, R., et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*. Arch Sex Behav, 2021. **50**(1): p. 7-16.
11. Lemma, A., *Trans-itory identities: some psychoanalytic reflections on transgender identities*. Int J Psychoanal, 2018. **99**(5): p. 1089-1106.

*****The scientific assessments of the data expressed in this letter are those of the author(s), and not necessarily those of their employers, hospitals, medical schools, or health-care systems. *****



To the Joint/Rules and Legislative Committee Members,

This letter is being written on behalf of the Florida Academy of Dermatology in reference to the agenda for September 30, 2022. Our statement relates to the access to medical care for any patient, including those who are transgender, gay or have gender dysphoria. As physicians, we believe that medical treatment decisions should rest with the patient, their families, and their specialized medical care team. We are neither agreeing nor disagreeing with the treatments in question, but rather expressing our concerns that medical decisions should be made by those best trained and qualified in the conditions in question.

Thank you,

Joely Kaufman MD FAAD for the Florida Academy of Dermatology Board and its medical members

From: [RefPAC](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Rules 64B8-9.019 & 64B15-14.014, F.A.C. – Practice Standards for the Treatment of Gender Dysphoria
Date: Friday, September 30, 2022 10:51:59 PM
Attachments: [image1664592622481](#)

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Dear Florida Boards of Medicine and Osteopathic Medicine Joint Rules/Legislative Committee, As a Certified Safety Professional and a PhD in Space Physics, my background is mostly non-medical; however, I work as an expert witness in safety, and I use the Scientific Method all the time. Gender Medicine raised a number of red flags in these fundamental fields. Medicine is not exempt from experimental ethics or safety. What I found is written below in two parts (the next part begins after the References).

Thank you for your time.

Sincerely,

Elizabeth A. Jensen, PhD, PE, CSP
Spring, TX 77373
(832) 279-3619

Medical Safety: Risk Study of Gender Medicine, Part 1

[Elizabeth Jensen](#)

How many Gender Medicine doctors knew or should have known that they were experimenting outside of experimental safeguards and with no intention of collecting results or modifying their hypotheses?

One of the fundamental issues with Gender Medicine is the lack of rigorous research to support how it is being practiced (see references within Expert Report of Dr. James Cantor; Cantor, 2022 Report to Florida). The best research with respect to children is that the treatment approach to Gender Identity issues is “watchful waiting” (e.g. Levine et al., 2022). However, that’s with the classic pre-puberty presentation of gender dysphoria. Research is almost entirely lacking with the new teenage presentation which has not prevented permanent medical treatments to unknown causes (also Levine et al., 2022; Kaltiala-Heino et al., 2018). With respect to adults, the best research is showing that the suicide rate either doesn’t change from 0.03-0.04% BEFORE treatment or increases by a significant factor AFTER treatment* (e.g. Dhejne et al., 2011; Wiepjes et al., 2020). So this article and the next are a 2-part series that begins to look at the questions: **Where are the safety controls to Gender Medicine practices? How does the suicide rate change when Gender Medicine is involved, and why is our information so bad if it is so important politically? (Not to mention medically and ethically important, too.)**

If medicine is a scientific discipline, then the Scientific Method must be applied to medicine. To quote from the Encyclopedia Britannica, “In a typical application of the scientific method, a researcher develops a hypothesis, tests it through various means, and then modifies the hypothesis on the basis of the outcome of the tests and experiments. The modified hypothesis is then retested, further modified, and tested again, until it becomes consistent with observed phenomena and testing outcomes. In this way, hypotheses serve as tools by which scientists gather data. From that data and the many different scientific investigations undertaken to explore hypotheses, scientists are able to develop broad general explanations, or scientific theories.”

To highlight the disconnect between research and practice in the field of Gender Medicine, Levine et al. (2022) discusses the Dutch Experiment (de Vries et al., 2011 and 2014). “The interventions described in the study are currently being applied to adolescents who were not cross-gender identified prior to puberty, who have significant mental health problems, as well as those who have non-binary identities—all of these presentations were explicitly disqualified from the Dutch protocol. Despite these limitations, the Dutch clinical experiment has become the basis for the practice of medical transition of minors worldwide and serves as the basis for the recommendations outlined in the 2017 Endocrine Society guidelines..” To summarize what this statement is saying: **Practice guidelines/standards have been adopted for children who do not have the illness characteristics of the studied population.** If we were to translate this to a safety paradigm, it is saying that the procedures that are being examined for a trench operation are equally valid for a confined space with a toxic atmosphere. Doing that when you know better can get an OSHA Willful Citation: “A willful violation is defined as a violation in which the employer either knowingly failed to comply with a legal requirement (purposeful disregard) or acted with plain indifference to employee safety.”

This point is qualitatively made in other ways. For example Dahlen et al. (2021) states, “Some extracted statements [from WPATH SOC] might have been intended as recommendations or standards, but many were flexible, disconnected from evidence and could not be used by individuals or services to benchmark practice. After discussion of this incoherence within WPATH [World Professional Association for Transgender Health] SOCv7 and our inability therefore to compare recommendations across all CPGs [clinical practice guidelines], it was decided not to revisit inclusions post hoc but to abandon this protocol aim.” This means that the guidelines published by WPATH were “disconnected from evidence” and incoherent, a.k.a. unscientific.

When medical practice deviates from research in this way, it is similar to using PPE (personal protective equipment) in a way that it wasn’t designed to be used. In the case of the American Psychological Association (APA) adopting WPATH guidelines (which include recommendations for children), this is like obtaining the operators manual for your PPE from a 3rd party because the current manual is very poorly written and narrow in scope for the PPE’s *potential* uses. The Endocrine Society’s guidelines while advocating for Gender Medicine at least acknowledge that the “true effect maybe” or “is likely to be substantially different from the estimate” (Balsheem et al., 2011) as summarized by Cantor (2022), “In every category [each Endocrine Society guideline for pediatric Gender Medicine], without exception, the research quality was rated [by the Endocrine Society] as ‘low’ or ‘very low’..” **To take this into a safety paradigm, this is like providing fall protection to a worker in which its effectiveness is unknown.** There are other Endocrine Society guidance that are similarly ranked this poorly for effectiveness; however, the measure for how problematic this is depends on the effect of the treatment. Gender Medicine impacts the entire body and is permanent (e.g. Lesbians United, 2022). So the result is that Endocrinologists working in Gender Medicine based on these guidelines are doing so unscientifically and unsafely; they know how poor the estimate for a positive outcome is, and they know the risk is a lifetime of potential damage to the entire patient’s body. What else do they know?

Keeping in line with the safety analogy, the effect of advocating for the 3rd party operator’s manual and wide-spread sales of the PPE is that beta-testing is now occurring through the entire customer base. Obviously this is not safe. The hazards to health are serious (e.g. brain development impacts, early-onset osteoporosis, sterility, auto-immune issues, and more) and the

extent of these problems developing over time is unknown (e.g. Cass Review). Drafting guidelines/standards without supporting research also is not scientific. Cantor (2019) discusses how the American Academy of Pediatrics (AAP) proceeded with their Gender Medicine guidelines/standards without rigorous review. The “experimental” results from these Gender Medicine practices are no longer being collected in order to modify the hypothesis when this happens. The situation has been created where researchers, who ordinarily would not be able to conduct an experiment on this scale with this population for ethical reasons, are now ad-hoc attempting to collect data on how effective/harmful unscientifically-practiced Gender Medicine is.

As Cantor (2022) states, “The initial enthusiasm for medical blocking of puberty followed largely from early reports from the Dutch clinical research team suggesting at least some mental health improvement. It was when subsequent research studies failed to replicate those successes that it became apparent that the successes were due, not to the medical interventions, but to the psychotherapy that accompanied such interventions in most clinics, including the Dutch clinic.” Recall that the Dutch Experiment is the basis for pediatric Gender Medicine; subsequent research showed that it wasn’t the invasive medical treatments that were effective, and Cantor argues that it was the psychotherapy. The guidelines/standards discussed previously which were adopted by the APA, AAP, and Endocrine Society are all built on a fundamentally flawed, low quality, research experiment, a research experiment that permanently altered the children’s bodies on a cellular level. **This means they expanded a poorly designed experiment with serious risks and unlikely benefits into the population as whole, and no results are being collected to modify the hypothesis.**

With Gender Medicine practices unscientifically disconnecting from research, the implication is that the public as a whole becomes an unconstrained experiment. However, unlike an actual scientific experiment, the results are susceptible to the full spectrum of organizational responses, some of which I’ve identified as Organizational Failure (ACS, 2022). To reiterate the elements of Organization Failure: (1) Conflict of Interest (Col) among medical practitioners, (2) medical practitioners making decisions based on emotional preference as opposed to known data, (3) medical practitioners suppressing/punishing workers/clients investigating the outcome of these emotional decisions, (4) Clients/Workers are perceived with hostility/malignant condescension, and (5) Insular training of medical practitioners. Col appears when the providers of Gender Medicine receive financial rewards from businesses selling the medical treatments or some other form of emotional reward (e.g. Richardson, 2008-2009). Organizational Failures (2), (3), and (4) all contribute the failure to collect or maintain data necessary for evaluating the results of Gender Medicine practices, the failure to properly respond to incidents of harm, and the failure to properly conduct valid scientific research (a.k.a. “cooking the data”). These will be discussed in more detail in the following article on pre-/post-medicalization suicide rates. Finally, Organizational Failure (5) consists of unscientific practices being taught to medical practitioners. While there are examples of (5) available across media, none meet the higher standard of court record or peer review here in the United States (e.g. Irvine et al. 2022 Letter; Isaac, 2021; Kimberly, 2022 Letter). Further sworn testimony and legally admissible evidence is expected in the near future.

Gender Medicine as currently practiced is unrestrained by the unsound guidelines/standards that have been adopted (e.g. Mahfouda et al., 2018; Milrod, 2014; Milrod and Karasic, 2017; Olson-Kennedy, 2018). Treatment research that previously could have been halted due to risks to their subjects can now be conducted with subjects that are already experiencing a treatment. For example, a widely adopted treatment across schools is called “Social Transitioning” which likely increases dysphoria rather than relieving it (e.g. Zucker, 2020 and references therein). **When a treatment is harmful rather than helpful, it is iatrogenic; regardless, social transitioning has become widely adopted** (e.g. Health and Human Services, Office of Population Affairs, 2022). This enabled a low quality research study that attempted to measure the effect of this practice. How the study was designed suffered from fundamental flaws which are worth discussing to understand what makes the guidelines/standards unsound.

“Gender Identity 5 Years After Social Transition” by Kristina R. Olson, PhD *et-al*/ was published in 2022. It suffered from many flaws (Society for Evidence Based Gender Medicine, 2022 Public

Release Statement), and a few of the most concerning are listed below:

- The study participants did not represent the socially gender transitioning population “the ratio of natal boys to girls in this study is approximately 2:1 [most transitioning children are natal girls]...early age of social transition (average 6.5 years) [most are teens]...excellent mental health function [most do not have this level of mental health, e.g. Autism]”. While all this could be considered caveats, the fact that results from this study don’t apply generally to pediatric Gender Medicine isn’t sufficiently emphasized (e.g. Cass Review; Kaltiala-Heino, 2018).
- The participants were filtered. No children were in the study who had been socially transitioned for less than 1.5 years. “Thus, it is likely that the study under-represents families where the child had experienced a briefer period of social transition and who then detransitioned [note Olson uses ‘retransition’ instead of ‘detransition’].”
- The drop out rate from the study is unknown. My personal note: Every study of gender identity **MUST** include an accounting for whether former participants died as opposed to leaving the study. As I show in the next article, the suicide rate for transition medicine (AFTER medicalizing) has significant error bars but **the question of the treatment being uniquely fatal needs to be investigated.**
- Limitation in hypothesis. The researchers’ “main concern with early social gender transition is that the process of re-identifying with their natal sex following a period of social transition may be distressing to a child”. However, “the researchers noted that in many cases the “distress” criterion, necessary for the DSM-5 [gender dysphoria] diagnosis, was not met. This allows for the inclusion of children with a certain parent profile: one who is heavily invested in the idea that their child is transgender even if they don’t meet diagnostic.”
- “The children and adolescents’ pattern of sexual attraction/ orientation is not noted. This is an important omission, as gender incongruence in childhood is strongly associated with future homosexuality. If a significant proportion of the youth in the study are attracted to the individuals of their natal sex, it would suggest that early social transition poses risks of iatrogenic harm to LGB youth by exposing them to highly invasive and unnecessary medical interventions.”
- Commingling of interventions and lack of control group. In the Scientific Method, a control group enables establishing whether a difference developed; if not, then no conclusions can be made. Also, making social-transition-impact conclusions when many subjects have moved on to medicalization (60%) eliminates being able to distinguish the effect of social transition alone.

How did such a fundamentally flawed study get approval? This leads to three questions: **(1) What are the safety standards for experimenting on humans? (2) Assuming they failed in this situation, where was the failure? (3) What can we learn about these safety practices to address the situation of unscientific guidelines/standards?**

“Institutional Review Boards (IRBs) are federally-mandated, locally-administered groups charged with evaluating risks and benefits of human participant research at their institution.” As many IRB members are aware, federal regulations make clear that an IRB must have the “. . . professional competence necessary to review specific research activities . . .”, and that an IRB may invite input from “. . . individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the IRB” [45 CFR 46.107 (a) and (f)].

Health and Human Services (HHS) has guidance for IRBs to follow Federal law (see Office for Human Research Protections reference) . Relative to Gender Medicine in general and the social transitioning study specifically, the following IRB concerns require further inquiry:

- Was an IRB involved in the social transitioning study?

- If an IRB reviewed the proposed research, what are:
 1. Its members' experience?
 2. Meeting minutes?
 3. Assurance that Federal standards on human experimentation are met?
 4. A copy of the Informed Consent provided to participants in the research?
 5. The risk/benefit analysis of the research?
 6. Any materials concerning the fair and equitable selection of participating subjects?
 7. Research design is appropriate?
 8. Copies of the assent form provided to children and the permission form provided to their parents/guardians?
 9. Conflict of Interests identified and addressed?

I reached out to multiple institutions regarding IRBs. It is concerning that the ones which did not respond to my request for more information include: (1) National Institute of Health (nihfoia@mail.nih.gov), (2) Stanford University (officesupportstaff@lists.stanford.edu), and (3) Massachusetts General Hospital (kkpiper@mgh.harvard.edu). One IRB staff member was available for questions and to discuss how generally this safety practice works at their institution. The outcome from the discussion is that research such as the Olson et al. (2022) study described above would require convincing IRB members of the validity of the science. In other words, the state of the Gender Medicine practices and research has to be presented as rigorous and strong; a presentation that is false. **IRB members would have to independently go through the cited materials to assess the accuracy of their citations and be sufficient experts in the field to recognize what is missing from the discussion of the hypothesis.** Cantor (2022) goes in to this in detail when discussing the expert witness reports filed by Drs. Brady and Antommaria. This is probably what went wrong with the Olson IRB.

Conflict of Interest takes many forms. A discussion of how to strengthen IRBs against Col was published by the APA and hopefully implemented by all applicable institutions (Eissenberg, 2004). In the case of Gender Medicine research, there are two forms to be watchful for: (a) Researchers attempting to structure the experiment to achieve a desired outcome (e.g. Lett et al., 2022) and (b) Non-researchers attempting to prevent the experiment out of concern of an undesired outcome.

This article began with discussing how Gender Medicine is being practiced without a scientific basis. I then transitioned to discussing research in Gender Medicine and issues with how it is being conducted. This led to learning about Institutional Review Boards and their critical importance to safety in human experimentation. I then discussed where they can fail. So what needs to be done?

According to Merriam-Webster, hearsay evidence is evidence based not on a witness's personal knowledge but on another's statement not made under oath. One issue that I see reoccurring is detransitioners stating that lawyers will not take their cases. The explanation given is that it was "experimental". As discussed previously, an experiment follows the Scientific Method. These detransitioners make no other statements indicating that they were participating in an official IRB-safety-evaluated experiment. So here are the final questions: **(1) How many Gender Medicine doctors who were involved with the unscientific guidelines/standards being adopted were aware of the IRB safety protocol? (2) How many Gender Medicine doctors who are not adhering to the guidelines/standards are aware of the IRB safety protocol? (3) How many Gender Medicine researchers are misrepresenting the status of the field to their IRBs?**

How many Gender Medicine doctors knew or should have known that they were experimenting outside of experimental safeguards and with no intention of collecting results or modifying their hypotheses?

Author's Request: I am looking to collect Informed Consent documents from patients.

Footnote

*Calculated from 4 suicides/100,000 human hours; another issue to be discussed in the next article is how to measure this and what is available to measure.

REFERENCES

ACS Engineering & Safety (2022). Website blog entries authored by E.A. Jensen, also P. Larkey and E.J. Jensen: "Organizational Failure: Is it Systemic? Part 1", "Organizational Failure Part 2: Crucial Deming Points", "Systemic Organizational Failure Root Cause: Safety as a Standard, Part 1", "Systemic Organizational Failure Root Cause: Safety as a Standard, Part 2", "Systemic Failure: The Ghost Report", "Organizational Failure Measures", "Organizational/Systemic Failure: Malignant/Dismissive Authority", "Organizational/Systemic Failure: Root Cause Analysis" <https://acs-consulting.com/blog/>

Cass Review <https://cass.independent-review.uk/>

Sweden's new guidelines psychotherapy first:

<https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>

Finland's new guidelines psychotherapy first:

https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

Expert Report Of Dr. James Cantor, NO.D-1-GN-22-002569, District Travis County 459th Judicial District, Pflag, Inc., et al. v. Greg Abbott, et al.

Download link: http://files.eqcf.org/wp-content/uploads/2022/07/Cantor-Expert-Report_Ds-TI-response.pdf

James M.Cantor, Phd (2022). "Report Submitted To The Florida Agency For Healthcare Administration".

https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Attachment_D.pdf

James M. Cantor (2020) "Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy", Journal of Sex & Marital Therapy, 46:4, 307-313, DOI: 10.1080/0092623X.2019.1698481

Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Långström N, Landén M (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLoS ONE 6(2): e16885. <https://doi.org/10.1371/journal.pone.0016885>

Dahlen S, Connolly D, Arif I, et al. International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. BMJ Open 2021;11:e048943. doi:10.1136/bmjopen-2021-048943

Encyclopedia Britannica <https://www.britannica.com/>

Eissenberg, T., Panicker, S., Berenbaum, S., Epley, N., Fendrich, M., Kelso, R., Penner, L., Simmerling, M., (2004). IRBs and Psychological Science: Ensuring a Collaborative Relationship. Available online at <http://www.apa.org/research/responsible/irbs-psych->

[science.aspxhttp://www.apa.org/research/responsible/irbs-psych-science.aspx](http://www.apa.org/research/responsible/irbs-psych-science.aspx)

Health and Human Services, Office of Population Affairs (2022). "Gender-Affirming Care and Young People", <https://opa.hhs.gov/sites/default/files/2022-03/gender-affirming-care-young-people-march-2022.pdf>

HHS IRB Guidance <https://www.hhs.gov/ohrp/regulations-and-policy/guidance/index.html>

Office for Human Research Protections, Health and Human Services. "Institutional Review Board Written Procedures: Guidance for Institutions and IRBs (2018)" <https://www.hhs.gov/ohrp/regulations-and-policy/guidance/institutional-issues/institutional-review-board-written-procedures/index.html>

Howard Balshem, Mark Helfand, Holger J. Schünemann, Andrew D. Oxman, Regina Kunz, Jan Brozek, Gunn E. Vist, Yngve Falck-Ytter, Joerg Meerpohl, Susan Norris, Gordon H. Guyatt, (2011). "GRADE guidelines: 3. Rating the quality of evidence", Journal of Clinical Epidemiology, Volume 64, Issue 4, Pages 401-406. <https://doi.org/10.1016/j.jclinepi.2010.07.015>.

Dr Louise Irvine, General Practitioner; Dr Juliet Singer, Child and Adolescent Psychiatrist; Dr Aileen O'Brien, Consultant Psychiatrist; Dr Seth Bhunnoo, Consultant Psychiatrist; Dr Tessa Katz, General Practitioner; Dr Jane Martin, retired Consultant Psychiatrist; Stella O'Malley, Psychotherapist; Dr David Bell, retired Consultant Psychiatrist, former President British Psychoanalytic Society; Dr Bob Withers, Jungian Analyst; Dr Antony Latham, General Practitioner, Chair of Scottish Council on Human Bioethics; Dr Angela Dixon, General Practitioner; Dr Sinead Helyar, Registered Nurse; Dr Robin Ion, Registered Nurse; Dr Az Hakeem, Consultant Psychiatrist (2022). "Rapid response to: Tavistock to face possible clinical negligence claims over gender identity service" Letter to the Editor at BMJ 378 doi: <https://doi.org/10.1136/bmj.o2016>

Isaac Uncooked (2021) "Confronting my Gender Therapist", YouTube video. <https://www.youtube.com/watch?v=inUnrmh6XH0>

Aaron Kimberly, RN (2022). "Letter: Reforming the treatment of Gender Dysphoria", submitted to the Florida Board of Medicine by Executive Director, Gender Dysphoria Alliance. <https://www.genderdysphoriaalliance.com/post/letter-reforming-the-treatment-of-gender-dysphoria>

Kaltiala-Heino R, Bergman H, Työläjärvä M, Frisén L. Gender dysphoria in adolescence: current perspectives. *Adolesc Health Med Ther*. 2018 Mar 2;9:31-41. doi: 10.2147/AHMT.S135432. PMID: 29535563; PMCID: PMC5841333.

Stephen B. Levine, E. Abbruzzese & Julia W. Mason, (2022). "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults" in *Journal of Sex & Marital Therapy*. Download link: <https://doi.org/10.1080/0092623X.2022.2046221>

Elle Lett, Avery R. Everhart, Carl Streed, Arjee Restar (2022). "Science and Public Health as a Tool for Social Justice Requires Methodological Rigor: A Response to Turban et al. "Sex Assigned at Birth Ratio Among Transgender and Gender Diverse Adolescents in the United States" ", *SocArXiv Papers*. <https://osf.io/preprints/socarxiv/b5z7j/>

Lesbians United (2022). "Puberty Suppression: Medicine or Malpractice?" Public Release Report review of the literature on puberty suppression (300+ sources). <https://lesbians-united.org/resources.html>

Simone Mahfouda, BA Hons, Julia K Moore, FRANZCP, Aris Siafarikas, MD, Timothy Hewitt, FRACS, Uma Ganti, FRACP, Ashleigh Lin, PhD, Prof Florian Daniel Zepf, MD (2018) "Gender-affirming hormones and surgery in transgender children and adolescents", *Lancet Review*, Volume 7, ISSUE 6, P484-498. [https://doi.org/10.1016/S2213-8587\(18\)30305-X](https://doi.org/10.1016/S2213-8587(18)30305-X)

Milrod C. How young is too young: ethical concerns in genital surgery of the transgender MTF adolescent. *J Sex Med.* 2014 Feb;11(2):338-46. doi: 10.1111/jsm.12387. Epub 2013 Nov 18. PMID: 24238576.

Christine Milrod, PhD and Dan H. Karasic, MD (2017) "Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States", *The Journal of Sexual Medicine*, Volume 14, ISSUE 4, P624-634. <https://doi.org/10.1016/j.jsxm.2017.02.007>

Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatr.* 2018;172(5):431–436. doi:10.1001/jamapediatrics.2017.5440

Kristina R. Olson, PhD, Lily Durwood, PhD, Rachel Horton, BS, Natalie M. Gallagher, PhD, Aaron Devor, PhD (2022). "Gender Identity 5 Years After Social Transition", *Pediatrics*, 150 (2): e2021056082. <https://doi.org/10.1542/peds.2021-056082>

OSHA <https://www.osha.gov/publications/fedrites>

L. Song Richardson, When Human Experimentation is Criminal, 99 *J. Crim. L. & Criminology* 89 (2008-2009)

Society for Evidence Based Gender Medicine (2022). "Early Social Gender Transition in Children is Associated with High Rates of Transgender Identity in Early Adolescence", <https://segm.org/early-social-gender-transition-persistence>

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, 8(8), 2276–2283. <https://www.ncbi.nlm.nih.gov/pubmed/20646177>

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696–704. <https://www.ncbi.nlm.nih.gov/pubmed/25201798>

Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Block, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica*, 141, 486–491. <https://onlinelibrary.wiley.com/doi/10.1111/acps.13164>

Kenneth J. Zucker (2020). "Debate: Different strokes for different folks", *Child and Adolescent Mental Health*, Volume 25, Issue 1, Pages 36-37. <https://doi.org/10.1111/camh.12330>

Medical Safety: Risk Study of Gender Medicine, Part 2

[Elizabeth Jensen](#)

Statements that Gender Medicine is “life-saving” and addresses the suicide rate are unsubstantiated by any data here in the USA; furthermore, no effort is being made to collect this data scientifically. What data is available indicates that Gender Medicine is ineffective at impacting the suicide rate. Based on the material that I have reviewed, my education, training, and experience, I find that Gender Medicine as currently described by WPATH (2022) is hazardous. The World Professional Association for Transgender Health (WPATH) leadership is grossly incompetent. WPATH (2022) is grossly negligent in providing its assessment of suicide in Gender Medicine to practitioners using its “standards”.

In the previous part of this two-part series, I discussed how Gender Medicine was being conducted without any safety controls for this type of experimentation. This conduct would not necessarily meet the definition of “experiment”, because no results are being systematically collected to modify the hypotheses (Jensen, 2022). This part examines the claim for why this approach is appropriate: suicide (WPATH, 2022). The claim that this is necessary includes the term “life-saving” as well (Becerra, 2022).

Recall from Part 1 that I listed ways in which the Institutional Review Board safety practice could be subverted, including the misrepresentation of current research. Herein we evaluate the relevance of the claim that Gender Medicine improves suicide rates by comparing the citations in two overarching sources: (1) Levine et al. (2022) “Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults” and (2) WPATH (2022) “Standards of Care for the Health of Transgender and Gender Diverse People, Version 8”.

Recall from Part 1 that I listed ways in which the Institutional Review Board safety practice could be subverted, including the misrepresentation of current research.

To summarize the rigorous research that has taken place into the question of whether or not Gender Medicine improved outcomes on suicide, the following quality control criteria were applied: (1) The study’s methodology was not contradicted by a peer reviewed article; (2) The study produced some form of quantifiable data on the topic; and (3) The study passed a consistency inspection on its basic statistics, logic, and calculations. If a study is not included, these numbers provide the criteria item where it failed. These are noted as “**Fail #**” in the text below.

Variables in Suicide

My summer sociology class at Texas A&M University (circa 1994-1998) featured studying Durkheim’s (1897) text “Suicide”. The short summary is that he found statistical patterns to the practice after studying data across multiple countries, religions, mental health, age, sex, marriage status, etc.; for example, a single mom is less likely to commit suicide than a teenager home alone with nothing to do. Suicide is also a socially spread contagion, spread through thought rather than biology (Gould and Lake, 2013). Finally, suicide is a secondary side effect of various pharmaceuticals with depression as a side-effect (Qato et al, 2018). Note that depression is not caused by low serotonin (Moncrieff et al, 2022). When discussing approaches to address suicide, it is important to recognize that multiple factors can be involved and isolating their contribution is quite complicated.

There are two more issues relative to understanding the research into the effectiveness (or not) of Gender Medicine on suicide. The first is terminology relative to concrete evaluation. Specifically, Clayton et al (2021) states,

“There is also unclear use of the term suicidality, which exaggerates the implication of Turban et al.’s findings. Suicidality is a broad term, which is comprised of suicide attempts, plans, and ideation, and indeed this was the manner it was used by Turban et al. It is also important to note that Turban et al. made no assessment of completed suicides. Turban et al. assessed six areas of suicidality (including recent and lifetime

suicide attempts, recent ideation with plans, recent and lifetime ideation) and found no association between puberty blockers and suicidality measures on five of the six areas [before AND after interventions]. The only association was with “lifetime suicidal ideation.” Of course, any suicidal ideation is concerning, but suicide attempts are generally considered of higher concern, in terms of suicide risk assessment, than suicidal ideation.”

(My additional information for the reader is in []’s.) Note that WPATH (2022) failed to include the Clayton reference in its materials.

Suicide Completion Rates

Figure 1 shows the quality of evidence in the suicide research that we will be discussing. One of the best studies cited by Levine et al. (2022) was Dhejne et al. (2011), a population-wide study from Sweden 1973-2003. The study analyzed records from more than a 30-year time span, and it found that (summary from Levine et al, 2022)

“adults who underwent surgical transition were 19 times more likely than their age-matched peers to die by suicide overall, with female-to-male participants’ risk 40 times the expected rate”

The suicide rate was 0.3% (2.7/1000 person years). WPATH (2022) cites this study only once in its “Mental Health” chapter as a supporting reference that a higher prevalence of *suicidality* occurs among “those requiring medically necessary gender-affirming medical treatment”. This is problematic because Dhejne et al. (2011) shows no improvement in suicides nor *suicidality*. The impact of gender-affirming treatment on changing the suicide rate was not measured.

Levine et al. (2022)’s second reference on the topic, Wiepjes et al. (2020), examined the charts of the population in their Amsterdam clinic and found no change in the suicide rate before, during, or after medicalization. The ratio of suicides was 0.5%.

Biggs (2022), Levine et al. (2022)’s last citation on suicide, analyzed England, Wales, and Northern Ireland children referred for Gender Medicine from 2010 to 2020; 0.03% died from suicide. Due to the extent of the wait list (2 years) for this population, the change in suicide rate prior to and after medicalization was studied, and there was no significant statistical difference. Note that in the realm of the statistics of small numbers, comparisons between data sets are complicated. Biggs (2022) discusses the Dhejne et al. (2011) and Wiepjes et al. (2020) studies in terms of suicides per 100,000 people for comparing these statistics.

Due to the extent of the wait list (2 years) for this population, the change in suicide rate prior to and after medicalization was studied, and there was no significant statistical difference.

WPATH (2022) does not discuss Wiepjes et al. (2020) nor Biggs (2022) at all. I would like to note that the Levine et al. (2022) is also not mentioned in WPATH (2022). This is concerning, because Levine et al. (2022) raised extremely serious ethics issues in current practices.

WPATH Citations

It is clear that WPATH (2022) did not provide the medical community with information that is consistent with Levine et al. (2022). In discussing the citations WPATH (2022) provided, the difference between “*suicidal*” and “suicide” needs to be re-emphasized. Cantor (2022) states, “Psychological research importantly distinguishes completed suicide—which occurs primarily among biological males and involves the intent to die—from *suicidal* ideation, gestures, and attempts—which occur primarily among biological females and represent psychological distress and cries for help.” Also refer to the discussion by Clayton et al. (2021) in this article (paragraph 3).

A search through the WPATH (2022) material for discussions on suicide brought up references such as Craig et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020 and D'Angelo et al., 2020 in the "conversion therapy"-suicide relationship section. First of all, the American Psychological Association (2022) loosely defines "conversion therapy" as, "a highly controversial, ethically questionable, and generally discredited process intended to change individuals of same-sex or bisexual orientation to heterosexual orientation." I interpret this to mean sexual orientation relative to the individual's being female/male, genetically; all of these details can be objectively measured. In contrast, gender identity is purely subjective.

Finding of note: Given how concentrated homosexual/bisexual people are among the gender dysphoric population (e.g. Levin et al., 2022), Gender Medicine practices could be defined as conversion therapy.

Among WPATH (2022)'s citations related to *suicidality*, Craig et al. (2017) is inappropriate for Table 1 as it does not actually tally any data from the survey that quotes were drawn from (**Fail #2**).

D'Angelo et al. (2020) questions the methodology in Turban, Beckwith et al. (2020), so this will be left out of Table 1 (**Fail #1**).

Finally Green et al. (2020) is a selection-biased survey in which respondents who claim to have undergone Sexual Orientation and Gender Identity Change Efforts (SOGICE) were asked about *suicidal* thoughts and attempts. Table 1 in Green et al. (2020) had the following issue: 58.5% of the SOGICE respondents were "cisgender". There is a major difference between a LGB person experiencing SOGICE and a transgender person not having their identity affirmed (Stella O'Malley, 2022). Without Green et al. (2020) distinguishing *suicidality* between transgender and cisgender respondents in Table 2, it provides no insight into the *suicidality* relative to LGB SOGICE versus transgender identity non-affirmation (**Fail #3**). The labels in Table 3 are meaningless without "cisgender" among them to make this separation of variables possible given the extremely limited description provided of the "adjusted" logistic regression model(s) involved. Finally, it is not explained in the text why the number of respondents changed between Tables 1 and 2.

Other WPATH (2022) references include de Graaf (2022), summarized by Levine et al. (2022) as, "...*suicidality* of trans-identifying teens is only somewhat elevated compared to that of youth referred for mental health issues unrelated to gender identity struggles"; this reference is added to Table 1.

Keo-Meier et al. (2015) looked at adult *suicidality* during the 3 months after medicalization; this is temporarily beneficial so it isn't included in Table 1 (**Fail #1**). Levine et al. (2022) points out,

"Clinicians working with trans-identified youth should be aware that although in the short-term, gender-affirmative interventions can lead to improvements in some measures of *suicidality*, neither hormones nor surgeries have been shown to reduce *suicidality* in the long-term."

The Levy (2003) reference, concerned with discussing pharmaceutical effects, is not being included in Table 1 as studying suicide was not one of the article's objectives (**Fail #2**).

Turban, King et al. (2020) and Rew et al. (2020) were methodologically criticized by Clayton et al. (2021). Turban, King et al. (2020) was methodologically criticized by Biggs (2020), too. Neither Turban, King et al. (2020) nor Rew et al. (2020) will be included in the table below (**Fail #1**). Note that WPATH (2022) failed to include both the Clayton reference and the Biggs reference in its materials.

Bauer et al. (2015)'s selection-biased survey somehow has 110 individuals that attempted suicide out of 433 total survey respondents consisting of "11.2%" of the population; it's 25.4%. As how

this was accomplished is not explained, this study is not included in the table below **(Fail #3)**.

Finally in another selection-biased survey, Brumer et al (2015), which should read Perez-Brumer et al. (2015), somehow analyzes the sample size of 1060 individuals which is larger than the total survey group of lifetime suicide attempts (355). This indicates that the population size was too small for the analysis that was conducted, so this study is also not included in the table below **(Fail #3)**.

Recall what I said in Part 1:

In other words, the state of the Gender Medicine practices and research has to be presented as rigorous and strong; a presentation that is false. **IRB members would have to independently go through the cited materials to assess the accuracy of their citations and be sufficient experts in the field to recognize what is missing from the discussion of the hypothesis.** Cantor (2022) goes in to this in detail when discussing the expert witness reports filed by Drs. Brady and Antommaria. This is probably what went wrong with the Olson IRB.

Levine et al. (2022) had superior citations to WPATH (2022), and the quality of the WPATH (2022) citations were very weak for supporting the points they were attempting to make in their "standards of care". What is the effect of WPATH (2022) misrepresenting the state of research?

Four Risk and Safety issues are relevant here:

1) It is not unusual to make policy changes to address small populations which are at risk (e.g. USDA, 2017); however, these changes are debated in terms of the expected impacts on other people (see the comments on the proposed change). In the absence of data (Jensen, 2022), my educated guess is that the number of transgender people who commit suicide is smaller than most populations on which major policy changes are directed. This is important for the upcoming safety discussion.

2) Gender Medicine does not change the suicide rate/ratio. In other words, it is not "life-saving". The WPATH (2022) document claims the reverse and then fails to discuss the studies in Table 1 that contradict that assertion.

3) Where suicide has patterns relative to the individual, as a social contagion, and as a side effect of certain pharmaceuticals, it is impossible to isolate one versus another with the available research.

Levine et al. (2022) warns practioners,

"Providers of gender-affirmative care should be careful not to unwittingly propagate misinformation regarding suicide to parents and youths. They should also be reminded that any conversations about suicide should be handled with great care, due to its socially contagious nature."

The necessity of this warning suggests to me that practitioners, particularly in promulgating the transition-or-die misinformation, could themselves be socially spreading suicide.

Also, Gender Medicine involves lifetime consumption of off-label use pharmaceuticals (American Medical Association, 2016). Dresser and Frader (2009) warn about the weak evidence base for these sorts of prescriptions,

"More than half the respondents in a survey of academic medical centers reported that innovative off-label prescribing raised concerns in their institutions, such as lack of data, costs, and unfavorable risk-benefit ratios. When substantial uncertainty exists about off-label applications, patients are at risk of receiving harmful or

ineffective treatments.”

The side effects from Gender Medicine pharmaceuticals is not discussed here, but their off-label status and uncertainty in effectiveness in suicide cannot be dismissed.

4) The suicide completion data on these Gender Medicine patients is not being collected here in the USA (Jensen, 2022). Green (2022) makes an estimate on effectiveness by comparing pediatric suicide data against pediatric access to Gender Medicine pharmaceuticals, for example.

Conclusion

In Part 1 of this Medical Safety series, I discussed how Gender Medicine is being conducted on an experimental basis without any of the safety controls for human experimentation. In fact, the term “experimentation” is not the correct description of the practice as no effort is being made to systematically collect results and modify the hypotheses. The explanation for this approach has been that the Gender Medicine patients have extreme suicide rates. In Part 2 of this series, I examined this claim by comparing two overarching Gender Medicine publications and found that the available data suggests that the suicide rate doesn’t change.

Finding for a court of law: Statements that Gender Medicine is “life-saving” and addresses the suicide rate are unsubstantiated by any data here in the USA; furthermore, no effort is being made to collect this data scientifically.

Finding for a court of law: What data is available (Table 1) indicates that Gender Medicine is ineffective at impacting the suicide rate.

Finding for a court of law: Based on the material that I have reviewed, my education, training, and experience, I find that Gender Medicine as currently described by WPATH (2022) is hazardous.

Opinion for a court of law: WPATH leadership is grossly incompetent.

Opinion for a court of law: WPATH (2022) is grossly negligent in providing its assessment of suicide in Gender Medicine to practitioners using its “standards”.

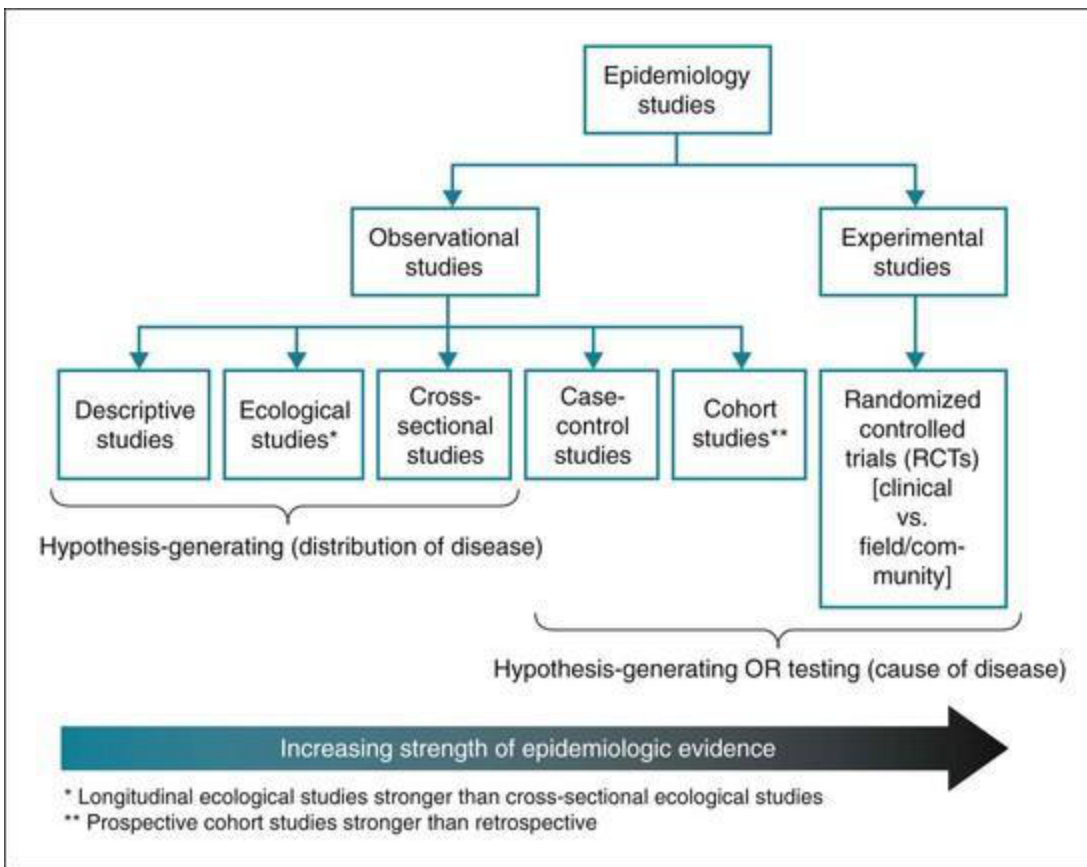


Figure 1: *Epidemiologic study designs and increasing strength of evidence (from BasicMedical Key, 2016).*

Table 1: *Advantages and Disadvantages of Common Types of Studies Used in Epidemiology (from BasicMedical Key, 2016) with studies of note in this article listed.*

Studies	Advantages	Disadvantages	Studies
Qualitative research	Generates hypotheses and initial exploration of issues in participants' own language without bias of investigator	(i) Cannot test study hypotheses (ii) Can explore only what is presented or stated (iii) Has potential for bias	
Cross-sectional surveys	(i) Are fairly quick and easy to perform (ii) Are useful for hypothesis generation	(i) Do not offer evidence of temporal relationship between risk factors and disease (ii) Are subject to late-look bias (iii) Are not good for hypothesis testing	

Ecological studies	(i) Are fairly quick and easy to perform (ii) Are useful for hypothesis generation	(i) Do not allow for causal conclusions to be drawn because the data are not associated with individual persons (ii) Are subject to ecological fallacy (iii) Are not good for hypothesis testing	
Cohort studies	(i) Can be performed retrospectively or prospectively (ii) Can be used to obtain a true (absolute) measure of risk (iii) Can study many disease outcomes (iv) Are good for studying rare risk factors	(i) Are time-consuming and costly (especially prospective studies) (ii) Can study only the risk factors measured at the beginning (ii) Can be used only for common diseases (iv) May have losses to follow-up	Dhejne et al. (2011); Wiepjes et al. (2020); Biggs (2022)
Case-control studies	(i) Are fairly quick and easy to perform (ii) Can study many risk factors (iii) Are good for studying rare diseases	(i) Can obtain only a relative measure of risk (ii) Are subject to recall bias (iii) Selection of controls may be difficult (iv) Temporal relationships may be unclear (v) Can study only one disease outcome at a time	de Graaf et al. (2022)
Randomized controlled trials	(i) Are the “gold standard” for evaluating treatment intervention (clinical trials) or preventative intervention (field trials) (ii) Allow investigator to have	(i) Are time-consuming and usually costly (ii) Can study only interventions or exposures that are controlled by investigator (iii) May have problems	

	extensive control over research process	related to therapy changes and dropouts (iv) May be limited in generalizability (v) Are often unethical to perform at all	
Systematic reviews and meta-analysis	(i) Decrease subjective element of literature review (ii) Increase statistical power (iii) Allow exploration of subgroups (iv) Provide quantitative estimates of effect	(i) Mixing poor quality studies together in a review or meta-analysis does not improve the underlying quality of studies	
Cost-effectiveness analysis	Clinically important	Difficult to identify costs and payments in many health care systems	

Safety Implications

Significant policy changes have been enacted to protect transgender people based on the largely unmeasured phenomena discussed above. For example, a professor at the UC Berkeley School of Law testified at the Senate Judiciary Committee, “I want to recognize that your line of questioning is transphobic and it opens up trans people to violence by not recognizing them... [asked to clarify]...I want to note that one out of five transgender persons have attempted suicide” (C-span, 2022). There is no evidence to support this assertion, and there is no intention among USA Gender Medicine community leadership to study this scientifically. So accommodations in the form of limits on free speech are being implemented because of this small, virtually unstudied risk (e.g. Meriwether, 2021). How do other policy accommodations impact safety?

First of all, there are fundamental biological differences between females and males that are critical to acknowledge in the health care setting (search “female” in American Medical Association, 2021). While the nursing home court case, *Taking Offense* (2021), was not concerned with patient safety insofar as receiving the correct care, this is a developing issue as sex-specific definitions fall under scrutiny (e.g. American Medical Association, 2021). Also, recall that the definition of transgender does not require any form of medicalization; it is a subjective identity. Impact sports become unnecessarily hazardous if females play against males (e.g. World Rugby, 2022). Imprisoning females with males is particularly dangerous (e.g. *Chandler v CDCR*, 2022). Then there are various activities, such as bathing, in which the presence of a naked male is inherently threatening (e.g. Hoyt, 2021; note it is concerning that the wider media did not follow-up on the safety issues in this incident after the suspect’s criminal history became known). These are a small sampling of the incidents, injuries, and close-calls that are being experienced by the policies intended to protect transgender people from suicide. For comparison, the USDA (2017) regulation change was based on a measured issue, worker safety for chicken farmers. It is concerning that in comparison to this USDA regulation that was not modified, Gender Identity based regulation changes are occurring across the breadth of the federal government in the

absence of an objective measure of harm and to whom (e.g. Title IX, 2022).

Just as measuring the full suicide rate has not been conducted here in the USA, documentation of these safety incidents in health care, sports, prison, and facilities for partial or full-nudity are similarly under-sampled. The safety risks to females is significantly greater under these policies, but they also impact all Gender Medicine patients when it comes to health care. My educated guess is that the size of the population put at risk by these changes far exceeds the population at risk without these protections. Also note that due to the complexity of suicide, social contagion and pharmaceutical secondary side-effects in particular, there is no data suggesting that these policy changes will have any impact regardless.

Finally, current research on detransitioners, Gender Medicine's patients who regret medicalization, found that they experience negative interactions with the LGBT community (Vandenbussche, 2022). Safety concerns that transgender people raise also apply to those who medicalized yet no longer identify as transgender; however, no policies are being developed to support this growing population.

Summary

Based on the material that I have reviewed, my education, training, and experience, I find that Gender Medicine as currently described by WPATH (2022) is hazardous. Based on the available data, the suicide risk shows no improvement for those who medicalize. I also briefly summarized the most dangerous policy accommodations which developed on these unfounded assumptions of suicide risk. The safety risks to females is significantly greater, but they also impact all Gender Medicine patients when it comes to health care.

References

A

American Medical Association (2021) Reference Committee D, Handbook Addendum. <https://www.ama-assn.org/system/files/2021-05/j21-handbook-addendum-ref-cmte-d.pdf>

American Medical Association (2016) REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-16) Hormone Therapies: Off-Label Uses and Unapproved Formulations (Resolution 512-A-15) (Reference Committee K) <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/2016-interim-csaph-report-4.pdf>

American Psychological Association (2022) "conversion therapy", APA Dictionary of Psychology. Screen shot collected. <https://dictionary.apa.org/conversion-therapy>

B

BasicMedical Key (2016). "Common Research Designs and Issues in Epidemiology", PUBLIC HEALTH AND EPIDEMIOLOGY. <https://basicmedicalkey.com/common-research-designs-and-issues-in-epidemiology/>

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. BMC Public Health, 15, 525. <https://doi.org/10.1186/s12889-015-1867-2>.

Becerra, Xavier (2022) "Statement by HHS Secretary Xavier Becerra Reaffirming HHS Support and Protection for LGBTQI+ Children and Youth", USA Health and Human Services, Office of Civil Rights. <https://www.hhs.gov/about/news/2022/03/02/statement-hhs-secretary-xavier-becerra-reaffirming-hhs-support-and-protection-for-lgbtqi-children-and-youth.html>

Biggs, M. Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom. Arch Sex Behav 51, 685–690 (2022). <https://doi.org/10.1007/s10508-022-02287-7>

Biggs M. Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria. *Arch Sex Behav.* 2020 Oct;49(7):2227-2229. doi: 10.1007/s10508-020-01743-6. Epub 2020 Jun 3. Erratum in: *Arch Sex Behav.* 2021 May;50(4):1845. PMID: 32495241; PMCID: PMC8169497. <https://link.springer.com/article/10.1007/s10508-020-01743-6>

C

Expert Report Of Dr. James Cantor, NO.D-1-GN-22-002569, District Travis County 459th Judicial District, Pflag, Inc., et al. v. Greg Abbott, et al.

Download link: http://files.eqcf.org/wp-content/uploads/2022/07/Cantor-Expert-Report_Ds-TI-response.pdf

Chandler V CDCR (2022) “WoLF is suing to protect SINGLE-SEX prisons”, Women’s Liberation Front. <https://womensliberationfront.org/chandler-v-cdcr>

Clayton, A., Malone, W. J., Clarke, P., Mason, J., & D’Angelo, R. (2021). Commentary: The signal and the noise—questioning the benefits of puberty blockers for youth with gender dysphoria—a commentary on Rew et al. (2021). *Child and Adolescent Mental Health*, 27, camh.12533. doi:10.1111/camh.12533

Craig, S. L., Austin, A., Rashidi, M., & Adams, M. (2017). Fighting for survival: The experiences of lesbian, gay, bisexual, transgender, and questioning students in religious colleges and universities. *Journal of Gay & Lesbian Social Services*, 29(1), 1–24. <https://doi.org/10.1080/10538720.2016.1260512>.

C-Span (2022) “Senate Judiciary Committee Hearing on Abortion Access and the Law”, Video <https://www.c-span.org/video/?521318-1/senate-judiciary-committee-hearing-abortion-access-law>

D

D’Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50(1), 7–16. <https://doi.org/10.1007/s10508-020-01844-2>.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One*, 6(2), e16885. <https://doi.org/10.1371/journal.pone.0016885>.

Dirkheim, E. 1897. *Suicide: A Study in Sociology*, translated by John A. Spaulding and George Simpson, edited with an introduction by George Simpson in 1951. New York: The Free Press. ISBN 0-684-83632-7.

Dresser R, Frader J. Off-label prescribing: a call for heightened professional and government oversight. *J Law Med Ethics.* 2009 Fall;37(3):476-86, 396. doi: 10.1111/j.1748-720X.2009.00408.x. PMID: 19723258; PMCID: PMC2836889.

G

Gould and Lake (2013). Forum on Global Violence Prevention; Board on Global Health; Institute of Medicine; National Research Council. *Contagion of Violence: Workshop Summary*. Washington (DC): National Academies Press (US); 2013 Feb 6. II.4, THE CONTAGION OF SUICIDAL BEHAVIOR. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK207262/>

de Graaf, N. M. Steensma, T. D., Carmichael, P., VanderLaan, D. P., Aitken, M., Cohen Kettenis, P. T., de Vries, A., Kreukels, B., Wasserman, L., Wood, H., & Zucker, K. J. (2020). Suicidality in clinic-referred transgender adolescents. *European child & adolescent psychiatry*, 31, 67–83. doi: 10.1007/s00787-020-01663-9. Advance online publication. doi:10.1007/s00787-020-01663-9

Green, A. E., Price-Feeney, M., Dorison, S. H., & Pick, C.J. (2020). Self-reported conversion efforts and suicidality among US LGBTQ youths and young adults, 2018. *American Journal of Public Health*, 110(8), 1221–1227. <https://doi.org/10.2105/ajph.2020.305701>.

H

Hoyt, Gregory (2021) "Democrat-backed convicted sex offender from Wi Spa incident who exposed himself to girls skips court", *Law Enforcement Today*.
<https://www.lawenforcementtoday.com/convicted-sex-offender-from-wi-spa-incident-at-large-warrant-issued/>

J

Jensen, Elizabeth A. (2022) "Medical Safety: Risk Study of Gender Medicine, Part 1", 4W.
<https://4w.pub/medical-safety-risk-study-of-gender-medicine-part-1/>

K

Keo-Meier, C. L., Herman, L. I., Reisner, S. L., Pardo, S. T., Sharp, C., & Babcock, J. C. (2015). Testosterone treatment and MMPI-2 improvement in transgender men: A prospective controlled study. *Journal of Consulting and Clinical Psychology*, 83(1), 143–156.
<https://doi.org/10.1037/a0037599>.

L

Stephen B. Levine, E. Abbruzzese & Julia W. Mason, (2022). "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults" in *Journal of Sex & Marital Therapy*.
Download link: <https://doi.org/10.1080/0092623X.2022.2046221>

Levy, A., Crown, A., & Reid, R. (2003). Endocrine intervention for transsexuals. *Clinical Endocrinology*, 59(4), 409–418. <https://doi.org/10.1046/j.1365-2265.2003.01821.x>.

M

Meriwether (2021) NICHOLAS K. MERIWETHER V. FRANCESCA HARTOP, JOSEPH WATSON, SCOTT WILLIAMS, DAVID FURBEE, SONDRASHASH, ROBERT HOWARTH, GEORGE WHITE, and WALLACE EDWARDS, Trustees of Shawnee State University, in their official capacities; JEFFREY A. BAUER, ROBERTA MILLIKEN, JENNIFER PAULEY, TENA PIERCE, DOUGLAS SHOEMAKER, and MALONDA JOHNSON, in their official capacities, No. 21-3289, File Name: 21a0071p.06 UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT <https://www.opn.ca6.uscourts.gov/opinions.pdf/21a0071p-06.pdf>

Moncrieff, J., Cooper, R.E., Stockmann, T. et al. The serotonin theory of depression: a systematic umbrella review of the evidence. *Mol Psychiatry* (2022). <https://doi.org/10.1038/s41380-022-01661-0>

O

Stella O'Malley (2022) "Telling the Truth in a Time of Deceit (Part 1): Stella O'Malley's Statement on Conversion Therapy", Genspect Public Release statement. <https://genspect.org/telling-the-truth-in-a-time-of-deceit-part-1-stella-omalleys-statement-on-conversion-therapy/>

P

Perez-Brumer, A., Hatzenbuehler, M. L., Oldenburg, C. E., & Bockting, W. (2015). Individual and structural-level risk factors for suicide attempts among transgender adults. *Behavioral Medicine*, 41(3), 164–171. <https://doi.org/10.1080/08964289.2015.1028322>.

Q

Qato DM, Ozenberger K, Olfson M. Prevalence of Prescription Medications With Depression as a Potential Adverse Effect Among Adults in the United States. *JAMA*. 2018;319(22):2289–2298. doi:10.1001/jama.2018.6741

R

Rew, L., Young, C. C., Monge, M., & Bogucka, R. (2021). Puberty blockers for transgender and gender diverse youth—A critical review of the literature. *Child and Adolescent Mental Health*, 26(1), 3–14. <https://doi.org/10.1111/camh.12437>.

T

Taking Offense (2021) TAKING OFFENSE V. STATE OF CALIFORNIA, C088485 (Super. Ct. No. 34-2017-80002749-CU-WM-GDS), IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA THIRD APPELLATE DISTRICT(Sacramento)
<https://www.courts.ca.gov/opinions/archive/C088485.PDF>

Title IX (2022) Nondiscrimination on the Basis of Sex in Education Programs or Activities Receiving Federal Financial Assistance, Posted by the Department of Education on Jul 11, 2022, Document ID ED-2021-OCR-0166-0001. <https://www.regulations.gov/document/ED-2021-OCR-0166-0001>

Jensen, E.A. Comment: <https://www.regulations.gov/comment/ED-2021-OCR-0166-0313>

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, 77(1), 68–76.
<https://doi.org/10.1001/jamapsychiatry.2019.2285>.

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, e20191725.

<https://doi.org/10.1542/peds.2019-1725>.

U

USDA (2017) “Scope of Sections 202(a) and (b) of the Packers and Stockyards Act”, Grain Inspection, Packers and Stockyards Administration, USDA, Department of Agriculture Grain Inspection, Packers and Stockyards Administration.
<https://www.federalregister.gov/documents/2017/10/18/2017-22593/scope-of-sections-202a-and-b-of-the-packers-and-stockyards-act>

V

Elie Vandenbussche (2022) Detransition-Related Needs and Support: A Cross-Sectional Online Survey, *Journal of Homosexuality*, 69:9, 1602-1620, DOI: [10.1080/00918369.2021.1919479](https://doi.org/10.1080/00918369.2021.1919479)

W

Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972–2017)). *Acta Psychiatrica Scandinavica*, 141(6), 486–491. doi:10.1111/acps.13164

World Rugby (2022) “Transgender Guidelines” <https://www.world.rugby/the-game/player-welfare/guidelines/transgender>

WPATH (2022). E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H.

Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.-B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Einfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

From: [Debbie Deland](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 4:41:00 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

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WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Debbie Deland

dcdeland@att.net

6278-104 Miramonte Drive

Orlando, Florida 32835

From: [Marina Zogalis](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 1, 2022 12:24:19 PM

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As someone with a dear trans friend in Florida, and as someone who is a citizen of Earth, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Marina Zogalis
marinazogalis@yahoo.com

Toronto, Ontario m5n 2e6

From: [Dee Min](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 5:19:29 AM

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Dee Min
yogaandpeace@aol.com

Lake Worth, Florida 33460

From: [Ezekiel Beal](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, September 28, 2022 11:55:17 PM

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Ezekiel Beal
ezekiels1986@yahoo.com

Fort Pierce, Florida 34981

From: [Gisette Rodríguez](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Thursday, September 29, 2022 7:36:08 AM

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Gisette Rodríguez
gisette_rdrz@yahoo.com

MIAMI GARDENS, Florida 33027

From: [Callie Williams](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 1, 2022 6:39:16 AM

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Callie Williams

calliewilliams216@hotmail.com

, Florida 32607

From: [Loreen Magarino](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 3, 2022 12:45:36 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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Loreen Magarino
Magarino23@gmail.com

Hialeah, Florida 33016

Dear Director Paul Vazquez,

I am sure that you have already received letters from researchers and clinicians (e.g., physicians, psychologists, etc.) who are extremely knowledgeable – more so than I am – about clinical work and research on gender dysphoria and, more broadly, gender medicine. You can also find such research on segm.org, statsforgender.org, and other places, including the Cass Review (cass.independent-review.uk), which led to the UK's NHS decision to close their gender dysphoria treatment service at the Tavistock Center as of this coming spring 2023. You are probably also aware that other European countries, including Sweden and Finland, announced earlier this year that they decided to (nearly) eliminate the prescription of puberty blockers to children, due to research and clinical findings sowing doubt on the previously-held hypothesis/belief that puberty blockers – and their common sequelae, cross-sex hormones and surgery – were “medically-necessary” in order to treat gender dysphoria.

I also imagine that you have already received letters from persons who underwent some form(s) of the aforementioned medical interventions for gender dysphoria and then later detransitioned, oftentimes re-identifying with their natal sex and regretting their medical transition. To my knowledge of the research about detransitioners and desisters, as well as pieces detailing their stories (e.g., on Substack), a common theme is that medical and mental health providers failed them. That is, medical and mental health providers did not adequately evaluate or treat them for other co-morbid psychiatric disorders, attempt to understand the origins of their dysphoria, or conduct a thorough informed consent process prior to providing medical intervention. Many detransitioners and desisters report that no one (except their parents) ever questioned them, and they were “affirmed every step of the way.” Furthermore, they say that medical and mental health providers indicated that medical treatment was “the solution” to their gender dysphoria.

You are probably also aware that nearly 55,000 “gender-affirming” surgeries were done in the US between the years 2015 and 2020 (www.plasticsurgery.org/news/plastic-surgery-statistics). Following trends, it is reasonable to extrapolate that that number could have grown to 90,000 by now. I highly, highly doubt that all of these young people have finally found their true selves.

You might also be aware that gender-affirming surgical practice is considered to be a market, with a compound annual growth rate of 14.4% from 2019 thru 2027. A market.
<https://www.grandviewresearch.com/industry-analysis/us-sex-reassignment-surgery-market>

The fact that nullification surgery has now been available in the United States for over a year suggests that major medical organizations (e.g., American Medical Association) are allowing these surgeries to occur under the umbrella of “gender-affirming care.” If “gender-affirming care” was really, truly about the arguably noble goal of helping someone who strongly believes they were born in the wrong body, i.e., born in the body of the opposite sex, then medical options would end (at the most extreme) with penectomy/orchiectomy and vaginoplasty for natal males and hysterectomy/oophorectomy plus phalloplasty for natal females, combined with life-long dependence on cross-sex hormones. But, now with the availability of nullification surgery, it is obvious that the goal of “gender-affirming care,” in all of its possibilities and permutations, is not noble, if it ever was. In other words, relieving the tortured existence of someone who feels they were born in the wrong body is not what “gender-affirming care,” broadly speaking is really about.

I only recently – this past April – became aware of the current state of affairs regarding gender medicine as currently practiced in the United States, i.e., readily available medical intervention for gender dysphoric youth and young adults, with very few safeguards. I had heard of Abigail Shrier's book, *Irreversible Damage*, a year or so ago, but (regrettably) did not read it. At that time, I understood that the gist of her book was that a skyrocketing number of girls were suddenly gender dysphoric and some were undergoing medical intervention that led to irreversible changes/harm to their bodies, but I recall thinking something along the lines of "Wow, that's really strange and sad that so many girls suddenly feel uncomfortable in their bodies but I'm sure the medical and mental health professionals are doing their due diligence to make sure these girls are getting the care they need, and unfortunately maybe some rare mistakes are being made, as we don't have a crystal ball."

In short, I trusted. I trusted that, regardless of any other pressures (e.g., from social media), trends, well-meaning school counselors, parents, or other influences, that the medical and mental health professionals would be "the adults in the room." That is, no matter how uncomfortable a teen girl might be in her body and how much she says she wants medical intervention, medical and mental health professionals would say "no," or at least "not yet," except in very extreme, carefully chosen cases.

Many words describe my feelings upon finding out that this isn't – and hasn't been – the case for many years now. Shocked. Appalled. Disillusioned. Betrayed. Angry. Heartbroken.

Now, one might think that perhaps I'm being unfair and judgmental of such providers and had never encountered a person struggling with gender dysphoria or otherwise not completely identifying as cisgender. That is not the case. Prior to this past April – before I found out that I was "supposed to" have been practicing "gender-affirming" care – female patients happened upon my private practice describing themselves as "transgender." My gut response was "ok, let's explore and talk about that." It did not occur to me to have any other reaction. So finding out that, for the last several years, many medical and mental health providers have NOT had that reaction and instead have affirmed the young person's gender identity, oftentimes encouraging medical intervention that may result in irreversible physical changes – to say nothing of the psychological impact of all of this – has shattered my faith in the medical and mental health professions.

As I see it, medical and mental health providers have a small, but quickly disappearing, window of opportunity to retain and rebuild trust. Most media outlets and politicians, at least in the U.S., have served gender-affirming clinicians well: most of the public has been in the dark about this.

Florida has an opportunity – like Sweden, Finland, France, and the UK – to lead on this. Please take action to stop sending children down a gender-affirming road that ends in the operating room.

Sincerely,

Kristen Farrell-Turner, Ph.D.

Licensed Psychologist (FL – 8705)

7685 SW 104th Street, Suite 100
Miami, FL 33156

From: dianetg@aol.com
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#); dianetg@aol.com
Subject: Letter to Florida Board of Medicine about gender dysphoria
Date: Tuesday, September 20, 2022 3:58:27 PM

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9-20-2022

To: Florida Board of Medicine

Regarding the transgender issue and so-called
"gender-affirming care" for youth;
in deciding how to proceed regarding its regulation, I recommend that
the FL Board of Medicine focus be on GENESIS - Chapter 1: 27;

" God created man in the image of himself,
in the **image of God** he created him,
male and female he created them. " (Emphasis added).

Thus, ' the Bible tells us so ' regarding the ancient truth that there are only two sexes.
It's also basic, common sense biology.

So-called "gender-affirming care" methods distort/destroy bodily integrity in vulnerable
children
experiencing the confusion of gender dysphoria. There is no rightful place for these within
authentic healthcare.

Social transitioning (including ' preferred gender expression ') conflicts with biological
reality.

Use of puberty blockers, cross sex hormones and disfiguring surgeries
in gender dysphoric children should be prohibited from the practice of medicine.

" Do No Harm " is not a worn-out cliché; it remains the foundational principle of good,
Hippocratic medicine.

The children of Florida need and deserve protection
against all forms of child abuse including that under the guise of medical practice.

Diane Gowski, MD
President, Florida Catholic Medical Association, Inc.

=====

From: [Flau Hege](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: medical transitioning of minors
Date: Tuesday, September 20, 2022 3:43:50 PM

Some people who received this message don't often get email from hegeflau@gmail.com. [Learn why this is important](#)

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Dear Florida Board of Medicine,

Thank you for taking on the important issue of regulating the medical treatment of youth and young adults with gender dysphoria.

As your own review of research has found, there is no biological basis for a transgender identity and there are no longterm studies that show that medicalizing a transgender identity will result in better mental health outcomes. (segm.org/studies)

If puberty blockers are started there is an almost 100% chance that a child will go on cross-sex hormones and will end up sterile and without sexual function. Sterility and sexual function are also compromised in those who start cross-sex hormones in adolescence, especially for those who later have genital surgeries.

Since a large portion of the youth who are claiming a transgender identity have one or more of the following conditions (autism, ADHD, homosexuality, trauma, depression, and other mood disorders) the current medical model of treating gender dysphoria is effectively eugenics for our most vulnerable populations of youth.

Like you I care about the physical and mental health of the next generation. As well, my family is a victim of medicalization of a transgender identity - my daughter has lost her voice and become insulin resistant within a month of being prescribed cross-sex hormones by Planned Parenthood at age 18.

Thank you for your efforts in protecting our vulnerable youth from this horrendous medical experiment.

-Ann Pond

From: [Nadine Skelton](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender dysphoria
Date: Tuesday, September 20, 2022 4:01:53 PM

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EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

To the Florida Board of Medicine,

As a physician who practices medicine in Florida, I appeal to you to safeguard our children and young adults by prohibiting and restricting 'gender-affirming care'.

Medical and Evidence-based studies of such measures do not support their claims; Rather, there are clear serious short-term and long-term harms from such misguided interventions.

In Gender Dysphoria, children exhibit confusion regarding their gender. These youths typically suffer from mood disorder, anxiety disorder, depression, eating disorders/anorexia, schizophrenia, substance abuse, and suicide attempts. Gender dysphoria is a Body Integrity disorder, similar to Anorexia. It is imperative to treat this Body Integrity disorder and concomitant psychiatric disorders by skilled psychiatrists. Affirming the children's confusion by irreversibly suppressing puberty with puberty-blocking medications (Lupron), administering high dose cross hormones (Estrogen, Testosterone), and performing mutilating surgeries (sex organ removal) are physically and mentally harmful to children and offer no long-term beneficial effects. The Suicide risk among children with Gender dysphoria remains high especially after their gender-transition.

As Gender confusion typically resolves spontaneously when the child develops through natural puberty by late adolescence, I entreat the Medical Board of Florida NOT to subject our youths/young adults to hormonal puberty-blockers and/or gender mutilating surgeries. Such acts would victimize our youths and young adults and constitute maleficence per the Hippocratic Oath we professed, to DO NO HARM to our patients including our children. Please prohibit and restrict these misguided interventions and protect our youths and young adults from unnecessary and lifelong harm.

Sincerely,
Nadine Khouzam MD, FACP

Short statement

My name is Jet and I am a 22 year-old, Dutch, female detransitioner. I was treated at the Amsterdam gender clinic in the Netherlands, who were the first to medically transition children. My gender clinic pioneered these treatments and the Dutch clinicians played a prominent role in the development of gender medicine.

I arrived at the Amsterdam gender clinic in late 2015. After six conversations I was diagnosed with gender dysphoria. The circumstances leading up to my referral and the causes of my distress were not explored. If my psychologist had done this she would have discovered that: I had become estranged from my body after a major scoliosis surgery; I was socially isolated and spent all of my time on the Internet; I felt extremely alienated from my peers and family due to high intelligence, autism traits, sensory issues, anxiety, and depression; I felt like I failed at being a girl because I was very gender non-conforming; I had been bullied by other girls; I only had older brothers and male friends; I had no female role models to look up to; and I was ashamed of my same-sex attraction as a bisexual girl.

None of this was taken into account. Furthermore, I was sent down the medical pathway despite not meeting the criteria of the Dutch Protocol. I did not experience gender dysphoria in childhood. I only started to hate my sex as a teenager after spending time on the Internet. I had co-morbid mental health issues. They ignored this and did not follow their own protocol.

At age 16 I went on puberty blockers, which ruined the cognitive and emotional functioning of my brain. I became severely depressed, developed an anxiety disorder, insomnia, anorexia, became underweight, and eventually became suicidal and almost took my own life. This was extremely traumatic, and continues to have a negative impact on my psychological functioning. I was on testosterone for five years, from age 17 to 22. I developed serious physical health problems, and my mental health worsened. I suffered from vaginal atrophy, chronic stomach pain, lower back pain, pain in my hips and knees, muscle tenseness, chronic headaches, extreme irritability, emotional numbness, an inability to think clearly or focus, and I was very easily overwhelmed and distraught. My voice is permanently lowered and I have facial hair. At age 18 I had a mastectomy, which means I will never be able to breastfeed my future children.

Because I felt so horrible about myself and my body, I actively avoided friendships and relationships. I missed out on normal teenage social and emotional development. This was not due to intolerance. My entire environment accepted my trans identity. Instead, my misery was caused by social and medical transition. My self-hatred and emotional instability were caused by being told that there was something wrong with me and my body. What I needed was support and guidance to help me grow into a healthy and strong young woman. I should not have been medicalized. Children cannot consent.

Longer statement

How I was introduced to ‘transgender’

In June 2014, at age 14, I had a 12-level spinal fusion surgery for scoliosis. My entire life fell apart: my body was ruined, I was traumatised, could not attend school much, and could not maintain friendships. I was very socially isolated. In late 2014 I became increasingly depressed and anxious, I began experiencing panic attacks, and started to self-harm. As I was still in recovery from scoliosis surgery, I spent most of my time at home in bed, alone. I received no psychological or emotional support. My family did not know what to do. I felt like a problem, like a burden.

I spent virtually all of my waking hours on the internet in early 2015. Most of this time was spent on YouTube, Tumblr, and Twitter. On Tumblr I was introduced to the ideas around gender and transition, and on YouTube I watched every transgender-related video I could find (back then, there wasn't very much). I was obsessed. As I read and listened to people talking about the distress they experienced about their sexed body, these ideas crept into my own mind. The more content I consumed, the more I read about gendered stereotypes, and the more stories of transgender people that I related to, the more I became convinced that this could be me. Being transgender seemed like a logical explanation for my life experiences.

I related to transgender men (female to male). I too hated my body. I had always been gender non-conforming. I hated being grouped with girls, and gendered expectations around my sex. I had always felt that I failed at being a girl. The idea of not having to grow up into a woman was appealing to me. A large part of my distress related to growing up; to the loss of my childhood in which I was ‘one of the boys’. In adolescence this was no longer possible, and I foresaw that in adulthood these differences between myself and males would only increase. As I had never felt like ‘one of the girls,’ puberty, and becoming a woman made me very anxious.

In May 2015, my parents asked me whether I was transgender or lesbian. They had noticed I had been distressed about something. I was terrified they would even suggest I may be lesbian. I was bisexual, and repulsed by myself for it, and scared I would end up becoming more same-sex attracted than I was. I did not want to be lesbian. I did at the time think that I may possibly be transgender, so I told them. My parents took me to the only gender clinic in the Netherlands at the time, and put their trust into the medical experts at the VUmc in Amsterdam.

The VU medical centre in Amsterdam, the Netherlands

The VUmc in Amsterdam houses the gender clinic where the Dutch Protocol was developed under the lead of Peggy Cohen-Kettenis. She pioneered child transition, together with Louis Gooren and Henriette Delemarre-van de Waal. The first time GnRHa, or hormone blockers, were used to treat gender dysphoria was at the VUmc in 1987. Over the course of two decades, the Dutch followed the first cohort of 70 adolescents whose puberty they suppressed. Their studies on this cohort have been shown to be flawed, as 15 patients dropped out, one

patient died, and different gender dysphoria measurement scales were used before and after treatment. There has not been a follow-up study on this cohort since 2014. The concept of child transition rests on the two studies that have been published on this group.

Diagnosis

I arrived at the Amsterdam clinic in November of 2015. I had my first intake with the head psychiatrist. After my intake I was assigned a personal gender psychologist and entered the diagnostic phase. This lasted six months, during which I had a single one-hour conversation each month.

Some things which should have been discussed, but were ignored, include: how my scoliosis and spinal fusion surgery had affected my relation to my body, my social isolation, my educational trajectory being ruined, having been bullied by other girls as a child, my shame for my same-sex attraction, my bad relationship with my parents, my self-loathing, and that I had no female role models. Autism should have been considered more seriously as my brother has Asperger's and I have quite a bit of ASD in my family. A trait I have that is often linked to autism is sensory sensitivity. This caused me to despise girl's clothes, having my hair tied up, and wearing jewellery, as I found these things physically uncomfortable. Unexpected changes overwhelmed me, I preferred sameness, and I was very sensitive. I was also prone to obsession, and overthinking everything. As a teenager I had become increasingly analytical and self-critical. I did not understand myself, and I wanted to fix whatever was wrong with me, whatever it was that made me different from others.

My psychologist should also have taken into consideration that I was a gender non-conforming, bisexual girl, who had always had male friends, only had three older brothers, had not gone through a typical female socialisation, and that I did not have any female role models to look up to – and that these could be reasons I was distressed about my sex. Other factors that caused me to struggle socially were high intelligence and the fact that I was on average 1.5 years younger than my peers at school as I had skipped a grade as a child. I was intellectually ahead, but emotionally and physically behind. All of my life experiences and character traits combined caused me to feel extremely alienated, from everyone. I did not relate to any of my peers. I felt like a stranger in my own family.

Instead of discussing any of these problems, the conversations with my gender psychologist were about gender. I was asked how I had felt in relation to other girls and to boys, to gender stereotypes, and my body throughout my life, and how I felt now. I felt awful, obviously, and without clarifying any causes for the post-pubertal onset of my bodily distress, my psychologist diagnosed me with gender dysphoria after the standard six months diagnostic phase. During this time I saw the psychiatrist once more, for a psychiatric assessment. Later on in 2016, after my diagnosis, I was seen by a different psychologist once. The psychiatrist and this other psychologist did not examine the causes for my gender dysphoria either.

Protocol was ignored

I did not meet criteria number one and two of the Dutch protocol: I did not have early onset gender dysphoria, and it did not worsen at the onset of puberty. I did not hate my sexed body until after puberty had started. My psychologist did not examine the development of my gender dysphoria. I had been honest and told her that I did not want to be a boy in childhood. I had been fine as a child because gendered expectations were less rigid. I said the start of puberty was uncomfortable, but I had been okay up until age 14.5. Protocol was ignored.

Criterion number three is that the adolescent should not have any co-morbid mental health issues. I told my psychologist I was struggling with anxiety and depression. She told me she could not help, and that I should seek extra support from a local psychologist. This did not work out, but my psychologist at the VUmc did not mind. I had no formal diagnoses at the time, but I would argue that my mental health problems should have disqualified me from treatment. My mental health issues were ignored: protocol was ignored. I was later, at age 18, diagnosed with depressive mood disorder, social anxiety disorder, and post-traumatic stress disorder, which I believe to have all suffered from since age 14, before I developed gender dysphoria, and before I arrived at the VUmc.

Puberty blockers

As I was afraid to come out as transgender at school, I requested to first be put on puberty blockers. Potential harms were downplayed. I barely received any information. I was told puberty blockers were reversible and that I would have some hot flashes, but not more than that. We now know that blocking puberty may potentially stop the brain from maturing, and we know it can have severe adverse health effects. Even though I was already 16 years old, the idea was that blocking the production of my sex hormones would ease my distress. However, the opposite happened. About three months after starting puberty blockers my depression and anxiety worsened. My cognitive abilities and motor skills declined, I felt stupid, my memory broke down, I was forgetful, and emotionally dysregulated. I began to self-harm more, and developed insomnia. I often could not sleep at all, and I was mentally and physically exhausted whether I did sleep or not. Likely as a coping mechanism, I developed Anorexia, and rapidly became underweight. My brain did not function, I spiralled, and after six months I was actively suicidal. I felt like I was losing my mind, and I was not allowed to stay home alone. My parents feared that I would take my own life.

This suicidal episode ruined my relationship with my parents, and it traumatised me. I was afraid to detransition for years, because I thought that if I did I would again become as suicidal as before starting testosterone. Every winter, in January and February, I seem to go through some sort of trauma response related to my time on puberty blockers. My mental health worsens severely, I spiral, and all of these memories resurface. I then want to hurt myself and experience suicidal ideation. Some years I also relapse into anorexia, or I drink too much. Six years on, my experiences with puberty blockers continue to have a negative effect on my psychological functioning.

Testosterone

I started testosterone in early 2016, just before turning 17. I was told about the cosmetic effects, and some emotional effects. Potential harms were again downplayed and the medication was not discussed as the extreme medical intervention that it is. Some of the effects I experienced which were not mentioned to me as possible health consequences were: vaginal atrophy, stomach problems (pain, nausea, bloating), headaches, extreme hypersensitivity to sensory stimuli (I am sensitive by nature and testosterone made my brain function less well; so I had a more difficult time processing (sensory) information on testosterone), muscle pain, joint pain (lower back, hips, knees, shoulders, and neck), inflexibility of my body in general (women are naturally more flexible and testosterone ruins this), severe acne (which I had to take Accutane for), skin issues (dry, irritable, folliculitis around leg hair), symptoms of polycythemia (bad circulation, headaches, red skin, tiredness, dizziness, stomach pain, bloating, numbness/tingling in hands and feet, shortness of breath), orgasms hurt, higher libido than I expected (which is unfortunate when you are affected by vaginal atrophy and painful orgasms), more irritability and anger than I expected, restlessness, increase of nerve damage pain (I have skin nerve damage over a large portion of my back as a result of scoliosis surgery), emotional numbness, difficulty processing emotions, decreased verbal fluency, and my brain processed (sensory) information differently. Testosterone affects every part of your body. After about four years I realized how bad my health had gotten. I was very concerned about my future. I quit testosterone after five years. Within two weeks all of the above-mentioned health problems disappeared. My body healed rapidly, and I began to feel comfortable in my own skin. I feel healthy for the first time in six years.

From age 16, when I started puberty blockers, to age 22, I suffered from health problems every single day, which were caused by these treatments. This was unnecessary and cruel. This should not have happened to me. My healthy body should not have been made sick. I should have been able to enjoy life as a young person. Instead I was often confined to bed, did not undertake much, was in pain every day, and I became sicker and sicker as time progressed.

Mastectomy

At age 18 I underwent a periareolar-type double mastectomy. The harms this would cause my body were again downplayed. No one sat me down and explained I would never – never – be able to breastfeed my own children, if I would have children in the future. No one sat me down and made sure that I knew this was forever. I could not oversee this at age 18. I had very little breast tissue as a result of puberty suppression and testosterone, and I wanted the surgery, because ‘I would have to have it someday, so I better have it now, as soon as possible.’ I wasn’t even very distressed by my breasts. But going down the medical trajectory, this was just another thing that seemed to apply to me. I thought that having a flat chest would make me feel more comfortable in my body; that I would again feel as comfortable in my body as I did before puberty, when I was a flat-chested child. The removal of my secondary sex characteristics was in part a cry for my childhood, and to a time before medical trauma, and social isolation, and everything horrible that had accompanied puberty. I saw it as ‘going back in time.’

As a result of my mastectomy I will never be able to breastfeed my future children. I occasionally have shooting pains in my chest as a result of nerve damage. I very much regret having the surgery and wished I still had my breasts. I should not have been allowed to make this decision at 18. I was too young and could not oversee the consequences it would have on my body and my life.

Long-term consequences of medical transition

There are irreversible effects of medical transition. What I worry most about physically, are the negative health consequences of puberty blockers and testosterone on my body that I may not know about. What I do know, is that I now live with a lowered voice, facial hair, body hair, and no breasts. I am often still read as male by strangers. It causes me anxiety, and I avoid socialising. I have mental health problems, such as low mood, and emotional numbness. I often feel very negative about life, and I do not trust anyone.

What hurts most however, is having lost seven of the most formative years of my life to medical negligence, and to a world-wide experiment that is being performed on the bodies of children.

From: [Tony Martin](#)
To: [Vazquez, Paul](#)
Subject: Statement for Florida Board Re: Gender Affirming Care for Minors
Date: Monday, September 19, 2022 4:24:41 PM
Attachments: [Statement for FL Board.docx](#)

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Hello Mr. Vazquez,

I hope this email finds you well. I am a female to male to female detransitioner who has experienced "gender-affirming care" firsthand, and I hope that you will consider this statement while determining the appropriate treatment model for trans-identifying minors in Florida.

All the best,
Tony

Dear Mr. Vazquez,

My name is Tony, and I am a 31-year-old female detransitioner – someone who took social and medical steps to attempt living as the opposite sex and later sought to reverse these measures. I recall suffering from gender dysphoria almost as early as I can remember but began identifying as a trans man at age thirteen, after accessing an online forum for transgender “female-to-male” individuals. It was packed with information wholly inappropriate for children, including how to “pass” as the opposite sex, bind one’s chest, access cross-sex hormones, request chest and genital surgery, and even how to have sex as a trans person. The adults on this forum claimed that genital surgery was safe, effective, and would result in functional male genitalia.

Prior to that (this was the early 2000s) I had never met a trans-identifying person and didn’t realize there was another option besides accepting that I was a girl. After accessing that forum, I was convinced I was transgender, and that as soon as I completed my medical transition, I would finally be happy. At this point I had had been diagnosed with a myriad of mental health issues (Anorexia Nervosa, Bulimia, clinical anxiety and depression, ADHD) in addition to gender dysphoria, but reading accounts from people who had transitioned suggested to me that my dysphoria was the root issue, and that treating it would make all my other problems go away.

Back then it was far less common or socially acceptable to be transgender. When I initially came out to my parents at 15, they didn’t affirm me. The only people I had in my life who supported my new identity were a couple of friends my age. Finally at 17, my parents took me to a gender therapist who suggested I start testosterone after three appointments. However, my family was concerned that my other issues were not being properly addressed and would not allow it.

Although at that time this made me furious, today I am extremely grateful I was made to wait until I was an adult to transition. Today, I likely would have been encouraged to transition not only by online communities or by a gender therapist, but by other students and teachers at my school. Had my parents taken the “affirmative” approach, which is being widely recommended by doctors nationwide, I would have risked ending up with osteoporosis, infertility, stunted brain development, or any number of other detrimental effects we have yet to discover, as a result of puberty blockers. As a teenager, I desperately wanted “top surgery” (a double mastectomy) and considered “bottom surgery” (hysterectomy and phalloplasty.) There is a serious lack of quality research into the safety and effectiveness of relying on any of these interventions as treatments for gender dysphoria, a mental health condition. New WPATH guidelines are recommending surgery and cross-sex hormones for younger and younger patients, despite there being no quality data suggesting these approaches improve mental health in the long-term.

These are invasive and irreversible procedures that should only be considered as a last resort, if at all. Surely when it comes to treating minors, the approach should be “unsafe until proven safe” rather than “safe until proven unsafe”, and there have never been clinical trials or controlled studies on delaying puberty in healthy children or on chest and genital surgeries for minors. Although I still transitioned and detransitioned as an adult and have suffered some irreversible changes (such as a permanently altered voice) the effects were far less severe and life altering than they would have been had I started at 13 or younger, as is being recommended for children now.

Children with gender dysphoria deserve love, care, and treatments backed by proper research. This “affirmation-only” approach is preventing research into less invasive treatment methods. As adult Americans, it is our responsibility to protect our youth and ensure they develop into healthy adults, and this widespread medical experimentation is in direct opposition to that. There are reasons we have laws against minors getting tattoos, drinking alcohol, or joining the military; underage people’s brains are not fully developed, and thus they are not equipped to fully consider the consequences of their choices. It is the responsibility of the medical community as well as legislators to safeguard minors from permanently and irreversibly harming themselves. As a detransitioner and former trans-identified teen, I urge the Florida Board of Medicine to put an end to the medical experimentation, sterilization, and mutilation of children and teenagers suffering from gender dysphoria.

Sincerely,

Tony M.

From: [dtw Chen](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Opposition to gender affirming care practices
Date: Tuesday, September 20, 2022 4:19:19 PM
Attachments: [nihms-1066422.pdf](#)
[20160819_TNA50SexualityandGender.pdf](#)

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Dear Sir or Madam,

I am writing to express my opposition to the gender affirming care practice implementations the Florida Board of Medicine is considering to adopt/perpetuate.

As a physician and scientist I have attached two publications that clearly demonstrate that such proposed gender affirming care is UNSCIENTIFIC. By adopting this affirming care, you will weaken the public trust in the science of medicine and reduce our field of medicine into simply quackery.

Again I am strongly opposed and ask that you do not implement nor perpetuate gender affirming care as a standard of care.

Sincerely

David Chen MD

David Chen, MD

Confidentiality: please note that this email is intended for the said recipient(s) only. If you are receiving this in error, please delete this email without reading. Failure to do so will have legal consequences.



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Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior

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Author contributions: A.G., K.J.H.V., M.G.N., J.R.B.P., B.M.N., and B.P.Z. were responsible for the study concept and the design of the study. A.G. was the main analyst, performed the majority of analyses, and created most of the figures and tables. J.F.S., 23andMe Research Team, and A.Au. contributed to data acquisition and analysis of the 23andMe dataset. R.W. and K.M.H. contributed to data acquisition and analysis of the Add Health data. S.G., G.W.B., E.R.M., and A.R.S. contributed to data acquisition and analysis of the MGSOS data. A.G., P.L., S.L., and N.L. contributed to data acquisition and analysis of the CATSS data. K.J.H.V., M.G.N., R.M., R.W., A.S.B., A.Ab., S.G., J.F.S., G.W.B., E.R.M. contributed to secondary analyses of the data. B.P.Z. wrote most of the manuscript; A.G., K.J.H.V., M.G.N., R.W., J.R.B.P., and B.M.N. contributed substantially to the writing of the manuscript. K.J.H.V. was in charge of writing the supplementary material. A.G., M.G.N., R.M., R.W., A.S.B., E.R.M., A.R.S., and B.P.Z. provided important input for the supplementary materials. A.G., K.J.H.V., R.W., A.R.S., B.M.N., and B.P.Z. contributed to engaging in community-based outreach with alliance and advocacy groups. All authors provided critical revision of the manuscript for important intellectual content.

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[†]These authors contributed equally to this work.

Competing interests: J.F.S., A.Au., and members of the 23andMe Research Team are employees of 23andMe and hold stock or stock options in 23andMe. B.M.N. is a member of the scientific advisory board at Deep Genomics and a paid consultant for Camp4 Therapeutics Corporation, Takeda Pharmaceutical, and Biogen.

Data and materials availability: The code is available through GitHub (https://github.com/andgan/sexual_orientation_GWAS), archived at Zenodo (48), and the GWAS summary statistics of the UK Biobank sample (and the top 10,000 independent SNPs from the meta-analysis including 23andMe data) are available at GWAS Catalog (www.ebi.ac.uk/gwas/downloads/summary-statistics). Access to the full summary statistics of the 23andMe sample (for all SNPs) can be obtained by qualified researchers through a data transfer agreement with 23andMe that protects the privacy of the 23andMe participants. Researchers interested in the full meta-analysis summary statistics containing 23andMe data must also apply to 23andMe. Please visit (<https://research.23andme.com/dataset-access>) for more information and to apply to access the data. Access to individual level data from the UK Biobank can be obtained by bona fide scientists through application with UK Biobank (www.ukbiobank.ac.uk/researchers). Summary statistics from the Neale Lab database used for the pheWAS are available at GWAS Catalog (www.ebi.ac.uk/gwas/downloads/summary-statistics).

SUPPLEMENTARY MATERIALS

science.sciencemag.org/content/365/6456/eaat7693/suppl/DC1

Materials and Methods

Figs. S1 to S7

Tables S1 to S23

References (49–108)

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Abstract

INTRODUCTION: Across human societies and in both sexes, some 2 to 10% of individuals report engaging in sex with same-sex partners, either exclusively or in addition to sex with opposite-sex partners. Twin and family studies have shown that same-sex sexual behavior is partly genetically influenced, but previous searches for the specific genes involved have been underpowered to detect effect sizes realistic for complex traits.

RATIONALE: For the first time, new large-scale datasets afford sufficient statistical power to identify genetic variants associated with same-sex sexual behavior (ever versus never had a same-sex partner), estimate the proportion of variation in the trait accounted for by all variants in aggregate, estimate the genetic correlation of same-sex sexual behavior with other traits, and probe the biology and complexity of the trait. To these ends, we performed genome-wide association discovery analyses on 477,522 individuals from the United Kingdom and United States, replication analyses in 15,142 individuals from the United States and Sweden, and follow-up analyses using different aspects of sexual preference.

RESULTS: In the discovery samples (UK Biobank and 23andMe), five autosomal loci were significantly associated with same-sex sexual behavior. Follow-up of these loci suggested links to biological pathways that involve sex hormone regulation and olfaction. Three of the loci were significant in a meta-analysis of smaller, independent replication samples. Although only a few loci passed the stringent statistical corrections for genome-wide multiple testing and were replicated in other samples, our analyses show that many loci underlie same-sex sexual behavior in both sexes. In aggregate, all tested genetic variants accounted for 8 to 25% of variation in male and

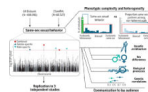
female same-sex sexual behavior, and the genetic influences were positively but imperfectly correlated between the sexes [genetic correlation coefficient (r_g) = 0.63; 95% confidence intervals, 0.48 to 0.78]. These aggregate genetic influences partly overlapped with those on a variety of other traits, including externalizing behaviors such as smoking, cannabis use, risk-taking, and the personality trait “openness to experience.” Additional analyses suggested that sexual behavior, attraction, identity, and fantasies are influenced by a similar set of genetic variants ($r_g > 0.83$); however, the genetic effects that differentiate heterosexual from same-sex sexual behavior are not the same as those that differ among nonheterosexuals with lower versus higher proportions of same-sex partners, which suggests that there is no single continuum from opposite-sex to same-sex preference.

CONCLUSION: Same-sex sexual behavior is influenced by not one or a few genes but many. Overlap with genetic influences on other traits provides insights into the underlying biology of same-sex sexual behavior, and analysis of different aspects of sexual preference underscore its complexity and call into question the validity of bipolar continuum measures such as the Kinsey scale. Nevertheless, many uncertainties remain to be explored, including how sociocultural influences on sexual preference might interact with genetic influences. To help communicate our study to the broader public, we organized workshops in which representatives of the public, activists, and researchers discussed the rationale, results, and implications of our study.

Abstract

Twin and family studies have shown that same-sex sexual behavior is partly genetically influenced, but previous searches for specific genes involved have been underpowered. We performed a genome-wide association study (GWAS) on 477,522 individuals, revealing five loci significantly associated with same-sex sexual behavior. In aggregate, all tested genetic variants accounted for 8 to 25% of variation in same-sex sexual behavior, only partially overlapped between males and females, and do not allow meaningful prediction of an individual’s sexual behavior. Comparing these GWAS results with those for the proportion of same-sex to total number of sexual partners among nonheterosexuals suggests that there is no single continuum from opposite-sex to same-sex sexual behavior. Overall, our findings provide insights into the genetics underlying same-sex sexual behavior and underscore the complexity of sexuality.

Graphical Abstract



A genome-wide association study (GWAS) of same-sex sexual behavior reveals five loci and high polygenicity. Follow-up analyses show potential biological pathways; show genetic correlations with various traits; and indicate that sexual preference is a complex, heterogeneous phenotype.

Across human societies and in both sexes, some 2 to 10% of individuals report engaging in sex with same-sex partners, either exclusively or in addition to sex with opposite-sex partners (1–4). The biological factors that contribute to sexual preference are largely unknown (5), but genetic influences are suggested by the observation that same-sex sexual

behavior appears to run in families (6) and is concordant more often in genetically identical (monozygotic) twin pairs than in fraternal twin pairs or siblings (7).

With respect to genetic influences, several questions arise. First, what genes are involved and what biological processes do they affect? Previous reports of genetic variants associated with sexual orientation (8–10) were based on relatively small samples and did not meet current standards of genome-wide significance ($P < 5 \times 10^{-8}$). Identification of robustly associated variants could enable exploration of the biological pathways and processes involved in development of same-sex sexual behavior. One hypothesis suggests that sex hormones are involved (11–13), but little direct genetic or biological evidence is available. Second, to what extent are genetic influences the same or different for females and males; behavior, attraction, and identity; and heterosexuality and different same-sex sexual behaviors (such as bisexuality)?

In order to identify genetic variants associated with same-sex sexual behavior and explore its genetic architecture and underlying biology, we performed a genome-wide association study (GWAS) of same-sex sexual behavior. Analyses were conducted in the UK Biobank from the United Kingdom and a cohort of research participants from 23andMe, predominantly located in the United States, and replications were performed in three other smaller studies. This study is part of a preregistered research plan (Open Science Framework; <https://osf.io/357tn>), and we explain our deviations from that plan in (14).

Phenotypic characterization

The UK Biobank study comprises a sample of ~500,000 genotyped UK residents aged 40 to 70 years (tables S1 and S2) (14). Our primary phenotype of interest is a binary, self-reported measure of whether respondents had ever had sex with someone of the same sex (here termed “nonheterosexuals”) or had not (here termed “heterosexuals”) (Box 1).

In the UK Biobank sample, 4.1% of males and 2.8% of females reported ever having had sex with someone of the same sex (tables S1 and S2), with higher rates among younger participants (Fig. 1A). This binary phenotype follows from previous work proposing that sexual preference is taxonic rather than dimensional in structure, with individuals reporting exclusively opposite-sex preference differing from individuals reporting any same-sex preference (15). However, the binary variable also collapses rich and multifaceted diversity among nonheterosexual individuals (15), so we explored finer-scaled measurements and some of the complexities of the phenotype, although intricacies of the social and cultural influences on sexuality made it impossible to fully explore this complexity. The 23andMe sample comprised 23andMe customers who consented to participate in research and chose to complete a survey about sexual orientation (from many possible survey topics). Individuals who engage in same-sex sexual behavior may be more likely to self-select the sexual orientation survey, which would explain the unusually high proportion of individuals who had had same-sex sexual partners in this sample (18.9%) (table S3) (14).

We also performed replication analyses in three smaller datasets (14): (i) Molecular Genetic Study of Sexual Orientation (MGSOSO) ($n = 2308$ U.S. adult males), in which respondents

were asked about their sexual identity; (ii) Add Health ($n = 4755$ U.S. young adults), in which respondents were asked whether they ever had same-sex intercourse and whether they were romantically attracted to the same sex; and (iii) Child and Adolescent Twin Study in Sweden (CATSS) ($n = 8093$ Swedish adolescents), in which participants reported the degree of attraction to the same versus opposite sex.

We observed in the UK Biobank that individuals who reported same-sex sexual behavior had on average fewer offspring than those of individuals who engaged exclusively in heterosexual behavior, even for individuals reporting only a minority of same-sex partners (Fig. 1B). This reduction in number of children is comparable with or greater than for other traits that have been linked to lower fertility rates (fig. S1) (14). This reproductive deficit raises questions about the evolutionary maintenance of the trait, but we do not address these here.

Genetic architecture of same-sex sexual behavior

We first assessed whether same-sex sexual behavior clustered in families in a manner consistent with genetic influences on the phenotype. Among pairs of individuals in the UK Biobank related at full cousin or closer [as identified by genomic similarity (14); n pairs = 106,979], more closely related individuals were more likely to be concordant in terms of same-sex sexual behavior. By modeling the correspondence of relatedness among individuals and the similarity of their sexual behavior, we estimated broad-sense heritability—the percentage of variation in a trait attributable to genetic variation—at 32.4% [95% confidence intervals (CIs), 10.6 to 54.3] (table S4). This estimate is consistent with previous estimates from smaller twin studies (7).

To identify genetic variants [largely singlenucleotide polymorphisms (SNPs)] associated with same-sex sexual behavior, we performed a GWAS in the UK Biobank study ($n = 408,995$ individuals) (14). To increase power and generalizability of our results, we also performed a GWAS in the cohort from 23andMe using an equivalent variable (individuals who reported having had sex with “Other sex only” versus the other options on a seven-point scale regarding participants’ sexual partners) ($n = 68,527$ individuals, of which 12,933 reported same-sex sexual behavior) (table S3) (14). We estimated the genetic correlation (16) between different heritable traits to determine the degree of consistency of genetic influences on same-sex sexual behavior in the two studies, which was high [genetic correlation coefficient (r_g) = 0.87; 95% CIs, 0.67 to 1.06] (table S5) (14). Genetic correlations between same-sex sexual behavior and 28 different traits were largely similar in the correlations between same-sex sexual behavior and 28 different traits were largely similar in the UK Biobank and 23andMe (fig. S2) (14), although a few differences were observed; for example, in females, the genetic correlations between same-sex sexual behavior and anorexia were in opposite directions in the UK Biobank ($r_g = -0.36$; 95% CIs, -0.60 and -0.09) and 23andMe data ($r_g = 0.36$; 95% CIs, 0.08 to 0.65; Wald test P value for differences = 0.0001). Overall, these results indicate that the genetic influences on same-sex sexual behavior in the two samples is similar, although there is some suggestion of phenotypic heterogeneity. We meta-analyzed the two sample sets using MTAG (17), which

models their genetic correlation to determine the meta-analytic weights, yielding a total sample size of 477,522 individuals (26,827 individuals reporting same-sex sexual behavior).

After standard quality control checks (table S6) (14), we identified two genome-wide significant signals for same-sex sexual behavior (rs11114975–12q21.31 and rs10261857–7q31.2) (Fig. 2 and tables S7 and S8). We discuss these SNPs further in the section “In-silico follow-up of GWAS results.” To assess differences in effects between females and males, we also performed sex-specific analyses. These results suggested only a partially shared genetic architecture across the sexes; the across-sex genetic correlation was 0.63 (95% CIs, 0.48 to 0.78) (table S9). This is noteworthy given that most other studied traits show much higher across-sex genetic correlations, often close to 1 (18–21). Through the sex-specific analyses, we identified two additional signals in males (rs28371400–15q21.3 and rs34730029–11q12.1), which showed no significant association in females, and one in females (rs13135637–4p14), which showed no significant association in males. Overall, three of the SNPs replicated at a nominal P value in the meta-analyzed replication datasets (Wald test $P = 0.027$ for rs34730029, $P = 0.003$ for rs28371400, and $P = 0.006$ for rs11114975) (table S10), despite the much smaller sample size (MGSOSO, Add Health, and CATSS; total sample size = 15,156 individuals, effective sample size = 4887 individuals).

The SNPs that reached genome-wide significance had very small effects (odds ratios ~ 1.1) (table S7). For example, in the UK Biobank, males with a GT genotype at the rs34730029 locus had 0.4% higher prevalence of same-sex sexual behavior than those with a TT genotype (4.0 versus 3.6%). Nevertheless, the contribution of all measured common SNPs in aggregate (SNP-based heritability) was estimated to be 8 to 25% (95% CIs, 5 to 30%) of variation in female and male same-sex sexual behavior, in which the range reflects differing estimates by using different analysis methods or prevalence assumptions (table S11) (14). The discrepancy between the variance captured by the significant SNPs and all common SNPs suggests that same-sex sexual behavior, like most complex human traits, is influenced by the small, additive effects of very many genetic variants, most of which cannot be detected at the current sample size (22). Consistent with this interpretation, we show that the contribution of each chromosome to heritability is broadly proportional to its size (fig. S3) (14). In contrast to linkage studies that found substantial association of sexual orientation with variants on the X-chromosome (8, 23), we found no excess of signal (and no individual genome-wide significant loci) on the X-chromosome (fig. S4).

To test whether these aggregate estimates of genetic effects correlate with sexuality in other samples, we constructed polygenic scores for same-sex sexual behavior (14, 24). These polygenic scores were significantly associated with sexual identity in MGSOSO (Wald test, $P = 0.001$) and same-sex attraction in the Add Health ($P = 0.017$) and CATSS ($P = 3.5 \times 10^{-6}$) studies (tables S12, S13, and S14). In CATSS, polygenic scores were also significantly associated with sexual attraction in participants at age 15 years ($P = 6.4 \times 10^{-5}$), suggesting that at least some of the genetic influences on same-sex sexual behavior manifest early in sexual development. The purpose of these analyses is to further characterize the genetic influences on same-sex sexual behavior and not to predict same-sex sexual behavior on the individual level. In all cases, the variance explained by the polygenic scores was extremely

low (<1%); these scores could not be used to accurately predict sexual behavior in an individual.

Overall, these findings suggest that genetic influences on same-sex sexual behavior are highly polygenic and are not specific to the discovery samples or measures. All the SNPs measured, when combined, do not capture the entirety of family-based heritability (8 to 25% from GWAS versus 32% from family-based methods). In this, same-sex sexual behavior is similar to many other complex traits; the ratio between family-based heritability and SNP-heritability estimated in the same sample is consistent with empirical findings for the other 16 traits we tested (family heritability approximately three times larger than SNP-heritability) (Fig. 3) (14). There are many possible reasons for this discrepancy, including, but not limited to, variants not captured by genotyping arrays, nonadditive genetic effects, and phenotypic heterogeneity.

In silico follow-up of GWAS results

To explore the biological processes that may influence same-sex sexual behavior, we performed cell- and tissue-type enrichment analyses using the GWAS discovery dataset (14, 25). We did not find clear evidence of enrichment for any particular cell or tissue (fig S5). However, we did find that genes near variants associated with same-sex sexual behavior are more likely than chance to be highly constrained [having unusually low prevalence of loss-of-function variants, suggesting stronger evolutionary constraint (14, 26)], even after controlling for expression in the brain (table S15).

At the level of individual loci, we investigated biological pathways by integrating information from expression quantitative trait loci (eQTL) analyses (27), genome-wide association study (PheWAS) (table S16) (28), and gene-based analysis by using MAGMA (14, 29). A full report can be found in table S17. Here, we highlight findings relating to the two SNPs associated with male same-sex sexual behavior: rs34730029 and rs28371400. First, the locus encompassing rs34730029–11q12.1 contains a number of olfactory receptor genes (several of which were significantly associated with same-sex sexual behavior in a gene-based test) (fig. S6 and table S18). This SNP is correlated [linkage disequilibrium, coefficient of determination (R^2) = 0.70] with a missense variant (rs6591536) in *OR5A1* that has been reported to have a substantial effect on the sensitivity to certain scents (30). Second, rs28371400–15q21.3 had several indications of being involved in sex hormone regulation: The allele positively associated with same-sex sexual behavior is associated with higher rate of male pattern balding [in which sex-hormone sensitivity is implicated (31)] and is located ~20 kb upstream of the *TCF12* gene. *TCF12* is the primary heterodimerization partner for *TCF21*, a transcription factor essential for normal development of the gonads in mice (32), and is involved in the downstream actions of the *SRY* gene (which is responsible for the initiation of male sex determination) in humans (33).

Genetic correlations with other traits

Next, we explored the genetic correlations between same-sex sexual behavior and 28 other relevant traits chosen before the analyses, using summary statistics from other GWASs (Fig.

4 and table S19) (14). In particular, we included mental health traits because they are substantially heritable (34), and previous population surveys have shown elevated risk of adverse mental health outcomes (such as depression, anxiety, or substance use) in sexual minority populations, including individuals engaging in same-sex sexual behavior (35,36).

We found several personality traits (loneliness and openness to experience), risky behaviors (smoking and cannabis use) and mental health disorders, but not physical traits, to be significantly genetically correlated with same-sex sexual behavior. We found in both sexes that same-sex sexual behavior was positively genetically correlated with several psychiatric or mental health traits [for example, depression, $r_g = 0.44$ in females (95% CIs, 0.32 and 0.55), $r_g = 0.33$ in males (95% CIs, 0.22 and 0.43); schizophrenia, $r_g = 0.17$ in females (95% CIs 0.08 and 0.35), $r_g = 0.13$ in males (95% CIs, 0.05 and 0.26); all Wald test $P < 0.001$]. We emphasize that the causal processes underlying these genetic correlations are unclear and could be generated by environmental factors relating to prejudice against individuals engaging in same-sex sexual behavior, among other possibilities, which we discuss in (14). Some associations were sex specific. In particular, the genetic correlations with bipolar disorder, cannabis use, and number of sexual partners were significantly higher in females than in males (Wald test $P = 0.001, 1.47 \times 10^{-6}$, and 3.13×10^{-5} respectively) (table S19).

Last, given the potential roles of sex hormones in sexual behaviors, we directly explored whether there is a genetic correlation with serum sex-hormone-binding globulin (SHBG) levels (37), which are thought to be inversely related to bioactive testosterone and estrogen in females and males, respectively (38). There was a significant correlation in females ($r_g = 0.25$, Wald test $P = 0.03$) but not in males ($r_g = 0.10$, Wald test $P = 0.32$).

Complexity and heterogeneity

To maximize our sample size and increase the power to detect SNP associations, we defined our primary phenotype as ever or never having had a same sex partner. Such a measure fails to capture the multifaceted richness and complexity of human sexual orientation. To explore the consequences of this simplification, we pursued genetic analyses across different aspects of sexual orientation and behavior.

First, within participants reporting same-sex sexual behavior, we performed a GWAS on the proportion of same-sex partners to total partners, with a higher value indicating a higher proportion of same-sex partners (14). In the UK Biobank, this is measured directly from participants' reported number of same-sex and all partners, whereas in 23andMe, we used participants' raw responses to the item "With whom have you had sex?", which in individuals reporting same-sex sexual behavior could be "other sex mostly," "other sex slightly," "equal," "same sex slightly," "same sex mostly," or "same sex only." The UK Biobank and 23andMe variables were heritable (table S20A) and genetically correlated with each other ($r_g = 0.52$ and 95% CIs, -0.16 to 1.20 for females; $r_g = 0.73$ and 95% CIs, 0.18 to 1.27 for males) (Fig. 5A and table S20C), so we used MTAG to meta-analyze across the two studies for subsequent analyses.

We found little evidence for genetic correlation of the proportion of same-sex to total partners among individuals reporting same-sex sexual behavior (nonheterosexuals) with the binary same-sex sexual behavior variable [$r_g = -0.31$ (95% CIs, -0.62 to 0.00) for females and $r_g = 0.03$ (95% CIs, -0.18 to 0.23) for males] (table S20B). Further, this phenotype showed a markedly different pattern of genetic correlations with other traits, as compared with corresponding genetic correlations with the binary same-sex sexual behavior variable (Fig. 5B and table S21). These findings suggest that the same-sex sexual behavior variable and the proportion of same-sex partners among nonheterosexuals capture aspects of sexuality that are distinct on the genetic level, which in turn suggests that there is no single continuum from opposite-sex to same-sex sexual behavior. Interpretations of any one set of results in our study must consider this complexity.

With this in mind, we examined the possibility of different genetic variants distinguishing heterosexual behavior from differing proportions of same-sex partners within nonheterosexuals. To do so, we performed additional GWASs in the UK Biobank data on the following traits: those whose partners were (i) less than a third same-sex, (ii) between a third and two-thirds same-sex, (iii) more than two-thirds same-sex, and (iv) exclusively same-sex. Genetic correlations of the first three categories with the fourth were 0.13, 0.80, and 0.95 (table S22), indicating partly different genetic variants distinguishing heterosexual behavior from differing proportions of same-sex partners within nonheterosexuals.

Last, using additional measures from 23andMe, we showed strong genetic correlations (all $r_g \geq 0.83$) (Fig. 5C and fig. S7) of same-sex sexual behavior with items assessing same-sex attraction, identity, and fantasies (a full list of items is provided in table S5), suggesting that these different aspects of sexual orientation are influenced by largely the same genetic variants. The full set of results of phenotypic and genetic correlations for females, males, and the whole sample is available in fig. S7 and table S5.

Discussion

We identified genome-wide significant loci associated with same-sex sexual behavior and found evidence of a broader contribution of common genetic variation. We established that the underlying genetic architecture is highly complex; there is certainly no single genetic determinant (sometimes referred to as the “gay gene” in the media). Rather, many loci with individually small effects, spread across the whole genome and partly overlapping in females and males, additively contribute to individual differences in predisposition to same-sex sexual behavior. All measured common variants together explain only part of the genetic heritability at the population level and do not allow meaningful prediction of an individual’s sexual preference.

The knowledge that the variants involved are numerous and spread across the genome enabled us to leverage whole-genome analytic techniques to explore human sexual behavior in ways previously impossible. We determined that the genetic effects that differentiate heterosexual from same-sex sexual behavior are not the same as those that differ among non-heterosexuals with lower versus higher proportions of same-sex partners. This finding suggests that on the genetic level, there is no single dimension from opposite-sex to same-

sex preference. The existence of such a dimension, in which the more someone is attracted to the same-sex the less they are attracted to the opposite-sex, is the premise of the Kinsey scale (39), a research tool ubiquitously used to measure sexual orientation. Another measure, the Klein Grid (40), retains the same premise but separately measures sexual attraction, behavior, fantasies, and identification (as well as nonsexual preferences); however, we found that these sexual measures are influenced by similar genetic factors. Overall, our findings suggest that the most popular measures are based on a misconception of the underlying structure of sexual orientation and may need to be rethought. In particular, using separate measures of attraction to the opposite sex and attraction to the same sex, such as in the Sell Assessment of Sexual Orientation (41), would remove the assumption that these variables are perfectly inversely related and would enable more nuanced exploration of the full diversity of sexual orientation, including bisexuality and asexuality.

Although we emphasize the polygenicity of the genetic effects on same-sex sexual behavior, we identified five SNPs whose association with same-sex sexual behavior reached genome-wide significance. Three of these replicated in other independent samples whose measures related to identity and attraction rather than behavior. These SNPs may serve to generate new lines of enquiry. In particular, the finding that one of the replicated SNPs (rs28371400–15q21.3) is linked to male pattern balding and is nearby a gene (*TCF12*) relevant to sexual differentiation strengthens the idea that sex-hormone regulation may be involved in the development of same-sex sexual behavior. Also, that another replicated SNP (rs34730029–11q12.1) is strongly linked to several genes involved in olfaction raises intriguing questions. Although the underlying mechanism at this locus is unclear, a link between olfaction and reproductive function has previously been established. Individuals with Kallmann syndrome exhibit both delayed or absent pubertal development and an impaired sense of smell because of the close developmental origin of fetal gonadotropin-releasing hormone and olfactory neurons (42).

Our study focused on the genetic basis of same-sex sexual behavior, but several of our results point to the importance of sociocultural context as well. We observed changes in prevalence of reported same-sex sexual behavior across time, raising questions about how genetic and sociocultural influences on sexual behavior might interact. We also observed partly different genetic influences on same-sex sexual behavior in females and males; this could reflect sex differences in hormonal influences on sexual behavior (for example, importance of testosterone versus estrogen) but could also relate to different sociocultural contexts of female and male same-sex behavior and different demographics of gay, lesbian, and bisexual groups (43). With these points in mind, we acknowledge the limitation that we only studied participants of European ancestry and from a few Western countries; research involving larger and more diverse samples will afford greater insight into how these findings fare across different sociocultural contexts.

Our findings provide insights into the biological underpinnings of same-sex sexual behavior but also underscore the importance of resisting simplistic conclusions (Box 2)—because the behavioral phenotypes are complex, because our genetic insights are rudimentary, and because there is a long history of misusing genetic results for social purposes.

Materials and methods summary

Study samples—We used data from genotyped individuals from five cohorts (total $n = 492,678$) who provided self-report information using different questionnaire-based measurement scales. Informed consent was provided from all individuals participating in the studies, which were approved by their local research ethic committee.

Genetic association analyses

After standard quality control, we performed GWASs for “same-sex sexual behavior” (defined as ever versus never having had sex with a same-sex partner) in the UK Biobank and 23andMe samples, which we meta-analysed using MTAG (17). We also conducted GWASs separately by sex. Genome-wide significant SNPs were replicated in three independent samples. Also, using LD-pred (24), we derived polygenic score for same-sex sexual behavior according to the meta-analyzed GWAS results and tested the association between this polygenic score and same-sex sexual behavior in three independent samples. To explore diversity among individuals reporting same-sex sexual behavior, we also conducted GWASs in the UK-Biobank and 23andMe samples (meta-analyzed using MTAG) on the “proportion of same-sex to total number of sexual partners among nonheterosexuals.”

Heritability estimation

We estimated family-based heritability of same-sex sexual behavior on the basis of known familial relationships in the UK Biobank study. The relatedness between pairs of participants was estimated by using KING (44). Additive genetic effects as well as shared and unshared environmental variance components were estimated on the basis of the covariance between different pairs of relatives. Second, heritability explained by all measured common SNPs (SNP-based heritability) was estimated by using linkage disequilibrium (LD) score regression (45) and transformed to the liability scale (46). Using a similar approach, we also estimated the SNP-based heritability per chromosome and evaluated heritability enrichment across various tissues on the basis of Genotype-Tissue Expression (GTEx) gene-expression results (47).

In silico follow-up

The GWAS results for same-sex sexual behavior were followed up with gene-based tests of association in MAGMA (29) and an enrichment analysis of evolutionarily constrained genes by using partitioned LD score regression (45) and MAGMA. We also performed a PheWAS (28) to examine whether the SNPs we identified for same-sex sexual behavior have also been associated with other phenotypes and eQTL mapping (27) to link SNPs with gene expression.

Genetic correlations and phenotypic heterogeneity

Using cross-trait LD score regression (16), we estimated the genetic correlations of same-sex sexual behavior and proportion of same-sex to total number of sexual partners among nonheterosexuals with a range of traits, including mental health, personality, and sexually dimorphic traits. To examine heterogeneity of genetic influences, we looked at the genetic

correlations between sexes, between cohorts, and between different measures of sexual preference.

Science communication strategy

To communicate the results of the study to the broader audience, we engaged with different LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other+) and science communication organizations and created multimedia materials for a lay audience.

Detailed materials and methods can be found in the supplementary materials (14).

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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REFERENCES AND NOTES

1. ACSF investigators AIDS and sexual behaviour in France. ACSF investigators. *Nature* 360, 407–409 (1992). doi: 10.1038/360407a0; pmid: 1448162 [PubMed: 1448162]
2. Melbye M, Biggar RJ, Interactions between persons at risk for AIDS and the general population in Denmark. *Am. J. Epidemiol.* 135, 593–602 (1992). doi: 10.1093/oxfordjournals.aje.a116338; pmid: 1580235 [PubMed: 1580235]
3. Semenyna SW, VanderLaan DP, Petterson LJ, Vasey PL, Familial patterning and prevalence of male androphilia in Samoa. *J. Sex Res.* 54, 1077–1084 (2017). doi: 10.1080/00224499.2016.1218416; pmid: 27593894 [PubMed: 27593894]

4. Bailey JM et al., Sexual orientation, controversy, and science. *Psychol. Sci. Public Interest* 17, 45–101 (2016). doi: 10.1177/1529100616637616; pmid: 27113562 [PubMed: 27113562]
5. Scasta D, Bialer P, American Psychiatric Association, Position statement on issues related to homosexuality (American Psychiatric Association, 2013); www.psychiatry.org/psychiatrists/search-directories-databases/policy-finder (accessed on 26 February 2019).
6. Pillard RC, Bailey JM, Human sexual orientation has a heritable component. *Hum. Biol.* 70, 347–365 (1998). pmid: 9549243 [PubMed: 9549243]
7. Långström N, Rahman Q, Carlström E, Lichtenstein P, Genetic and environmental effects on same-sex sexual behavior: A population study of twins in Sweden. *Arch. Sex. Behav.* 39, 75–80 (2010). doi: 10.1007/s10508-008-9386-1; pmid: 18536986 [PubMed: 18536986]
8. Hamer DH, Hu S, Magnuson VL, Hu N, Pattatucci AM, A linkage between DNA markers on the X chromosome and male sexual orientation. *Science* 261, 321–327 (1993).doi: 10.1126/science.8332896; pmid: 8332896 [PubMed: 8332896]
9. Rice G, Anderson C, Risch N, Ebers G, Male homosexuality: Absence of linkage to microsatellite markers at Xq28. *Science* 284, 665–667 (1999). doi: 10.1126/science.284.5414.665; pmid: 10213693 [PubMed: 10213693]
10. Sanders AR et al., Genome-wide association study of male sexual orientation. *Sci. Rep.* 7, 16950 (2017). doi: 10.1038/s41598-017-15736-4; pmid: 29217827 [PubMed: 29217827]
11. Lippa RA, Sex differences and sexual orientation differences in personality: Findings from the BBC Internet survey. *Arch. Sex. Behav.* 37, 173–187 (2008). doi: 10.1007/s10508-007-9267-z; pmid: 18074219 [PubMed: 18074219]
12. Wang Y, Kosinski M, Deep neural networks are more accurate than humans at detecting sexual orientation from facial images. *J. Pers. Soc. Psychol.* 114, 246–257 (2018).doi: 10.1037/pspa0000098; pmid: 29389215 [PubMed: 29389215]
13. Bailey JM, Dunne MP, Martin NG, Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample. *J. Pers. Soc. Psychol.* 78, 524–536 (2000). doi: 10.1037/0022-3514.78.3.524; pmid: 10743878 [PubMed: 10743878]
14. Materials and methods are available as supplementary materials.
15. Norris AL, Marcus DK, Green BA, Homosexuality as a discrete class. *Psychol. Sci.* 26, 1843–1853 (2015). doi: 10.1177/0956797615598617; pmid: 26499203 [PubMed: 26499203]
16. Bulik-Sullivan B et al., An atlas of genetic correlations across human diseases and traits. *Nat. Genet.* 47, 1236–1241 (2015). doi: 10.1038/ng.3406; pmid: 26414676 [PubMed: 26414676]
17. Turley P et al., Multi-trait analysis of genome-wide association summary statistics using MTAG. *Nat. Genet.* 50, 229–237 (2018). doi: 10.1038/s41588-017-0009-4; pmid: 29292387 [PubMed: 29292387]
18. Rawlik K, Canela-Xandri O, Tenesa A, Evidence for sex-specific genetic architectures across a spectrum of human complex traits. *Genome Biol.* 17, 166 (2016). doi: 10.1186/s13059-016-1025-x; pmid: 27473438 [PubMed: 27473438]
19. Okbay et al., Genome-wide association study identifies 74 loci associated with educational attainment. *Nature* 533, 539–542 (2016). doi: 10.1038/nature17671; pmid: 27225129 [PubMed: 27225129]
20. Martin J et al., A Genetic investigation of sex bias in the prevalence of attention-deficit/hyperactivity disorder. *Biol. Psychiatry* 83, 1044–1053 (2018). doi: 10.1016/j.biopsych.2017.11.026; pmid: 29325848 [PubMed: 29325848]
21. Karlsson Linner R et al., Genome-wide association analyses of risk tolerance and risky behaviors in over 1 million individuals identify hundreds of loci and shared genetic influences. *Nat. Genet.* 51, 245–257 (2019). doi: 10.1038/s41588-018-0309-3; pmid: 30643258 [PubMed: 30643258]
22. Goddard ME, Kempner KE, MacLeod IM, Chamberlain AJ, Hayes BJ, Genetics of complex traits: Prediction of phenotype, identification of causal polymorphisms and genetic architecture. *Proc. Biol. Sci.* 283, 20160569 (2016). doi: 10.1098/rspb.2016.0569; pmid: 27440663
23. Sanders AR et al., Genome-wide scan demonstrates significant linkage for male sexual orientation. *Psychol. Med.* 45, 1379–1388 (2015). doi: 10.1017/S0033291714002451; pmid: 25399360 [PubMed: 25399360]

24. Vilhjalmsdottir BJ et al., modeling linkage disequilibrium increases accuracy of polygenic risk scores. *Am. J. Hum. Genet.* 97, 576–592 (2015). doi: 10.1016/j.ajhg.2015.09.001; pmid: 26430803 [PubMed: 26430803]
25. Finucane HK et al., Partitioning heritability by functional annotation using genome-wide association summary statistics. *Nat. Genet.* 47, 1228–1235 (2015). doi: 10.1038/ng.3404; pmid: 26414678 [PubMed: 26414678]
26. Lek M et al., Analysis of protein-coding genetic variation in 60,706 humans. *Nature* 536, 285–291 (2016). doi: 10.1038/nature19057; pmid: 27535533 [PubMed: 27535533]
27. Gusev A et al., Integrative approaches for large-scale transcriptome-wide association studies. *Nat. Genet.* 48, 245–252 (2016). doi: 10.1038/ng.3506; pmid: 26854917 [PubMed: 26854917]
28. Denny JC et al., PheWAS: Demonstrating the feasibility of a phenome-wide scan to discover gene-disease associations. *Bioinformatics* 26, 1205–1210 (2010). doi: 10.1093/bioinformatics/btq126; pmid: 20335276 [PubMed: 20335276]
29. de Leeuw CA, Mooij JM, Heskes T, Posthuma D, MAGMA: Generalized gene-set analysis of GWAS data. *PLOS Comput. Biol.* 11, e1004219 (2015). doi: 10.1371/journal.pcbi.1004219; pmid: 25885710
30. S. R. Jaeger et al., A Mendelian trait for olfactory sensitivity affects odor experience and food selection. *Curr. Biol.* 23, 1601–1605 (2013). doi: 10.1016/j.cub.2013.07.030; pmid: 23910657 [PubMed: 23910657]
31. Kische H et al., Sex hormones and hair loss in men from the general population of northeastern Germany. *JAMA Dermatol.* 153, 935–937 (2017). doi: 10.1001/jamadermatol.2017.0297; pmid: 28403384 [PubMed: 28403384]
32. Cui S et al., Disrupted gonadogenesis and male-to-female sex reversal in *Pod1* knockout mice. *Development* 131, 4095–4105 (2004). doi: 10.1242/dev.01266; pmid: 15289436 [PubMed: 15289436]
33. Bhandari RK, Sadler-Rigglesman I, Clement TM, Skinner MK, Basic helix-loop-helix transcription factor TCF21 is a downstream target of the male sex determining gene *SRY*. *PLOS ONE* 6, e19935 (2011). doi: 10.1371/journal.pone.0019935; pmid: 21637323
34. Sullivan PF, Daly MJ, O'Donovan M, Genetic architectures of psychiatric disorders: The emerging picture and its implications. *Nat. Rev. Genet.* 13, 537–551 (2012). doi: 10.1038/nrg3240; pmid: 22777127 [PubMed: 22777127]
35. Sandfort TGM, de Graaf R, Bijl RV, Schnabel P, Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Arch. Gen. Psychiatry* 58, 85–91 (2001). doi: 10.1001/archpsyc.58.1.85; pmid: 11146762 [PubMed: 11146762]
36. Semlyen J, King M, Varney J, Hagger-Johnson G, Sexual orientation and symptoms of common mental disorder or low wellbeing: Combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry* 16, 67 (2016). doi: 10.1186/s12888-016-0767-z; pmid: 27009565 [PubMed: 27009565]
37. Coviello AD et al., A genome-wide association meta-analysis of circulating sex hormone-binding globulin reveals multiple Loci implicated in sex steroid hormone regulation. *PLOS Genet.* 8, e1002805 (2012). doi: 10.1371/journal.pgen.1002805; pmid: 22829776
38. Burke CW, Anderson DC, Sex-hormone-binding globulin is an oestrogen amplifier. *Nature* 240, 38–40 (1972). doi: 10.1038/240038a0; pmid: 4120573 [PubMed: 4120573]
39. Kinsey AC, Pomeroy WB, Martin CE, *Sexual Behavior in the Human Male* (W.B. Saunders, 1948).
40. Klein F, *The Bisexual Option* (Routledge, ed. 2, 1993).
41. Sell RL, Defining and measuring sexual orientation: A review. *Arch. Sex. Behav.* 26, 643–658 (1997). doi: 10.1023/A:1024528427013; pmid: 9415799 [PubMed: 9415799]
42. Valdes-Socin H et al., Reproduction, smell, and neurodevelopmental disorders: Genetic defects in different hypogonadotropic hypogonadal syndromes. *Front. Endocrinol.* 5, 109 (2014). doi: 10.3389/fendo.2014.00109; pmid: 25071724
43. Herek GM, Norton AT, Allen TJ, Sims CL, Demographic, Psychological, and Social Characteristics of Self-Identified Lesbian, Gay, and Bisexual Adults in a US Probability Sample.

- Sex. Res. Social Policy 7, 176–200 (2010). doi: 10.1007/s13178-010-0017-y; pmid: 20835383 [PubMed: 20835383]
44. Manichaikul A et al., Robust relationship inference in genome-wide association studies. *Bioinformatics* 26, 2867–2873 (2010). doi: 10.1093/bioinformatics/btq559; pmid: 20926424 [PubMed: 20926424]
45. Bulik-Sullivan BK et al., LD Score regression distinguishes confounding from polygenicity in genome-wide association studies. *Nat. Genet* 47, 291–295 (2015). doi: 10.1038/ng.3211; pmid: 25642630 [PubMed: 25642630]
46. Lee SH, Wray NR, Goddard ME, Visscher PM, Estimating missing heritability for disease from genome-wide association studies. *Am. J. Hum. Genet* 88, 294–305 (2011). doi: 10.1016/j.ajhg.2011.02.002; pmid: 21376301 [PubMed: 21376301]
47. Lonsdale J et al., The Genotype-Tissue Expression (GTEx) project. *Nat. Genet* 45, 580–585 (2013). doi: 10.1038/ng.2653; pmid: 23715323 [PubMed: 23715323]
48. Ganna A, andgan/sexual_orientation_GWAS v1.0. Zenodo (2019); doi:10.5281/zenodo.3232892

Box 1.**Phenotype and sample definition and limitations.**

In this study, we use the term “same-sex sexual behavior,” which is defined as having ever had sex with someone of the same sex. Detailed descriptions of the variables used in the different cohorts can be found in the supplementary materials (14).

To aid in readability throughout the manuscript, in some places we refer to individuals who have ever had sex with someone of the same sex as “nonheterosexuals,” whereas we refer to individuals who have never had sex with someone of the same sex as “heterosexuals.”

We acknowledge that the grouping phrase “nonheterosexuals” has the potential to present messages of othering (that is, undesirable marginalization of another person or group on the basis of their sexual expression)—by defining an “outgroup” in reference to an “ingroup” and implying that “nonheterosexual behavior” may have a negative connotation, whereas “heterosexual behavior” may have a positive one. We wish to make clear that our choice of language is not meant to forward messages of othering on the basis of sexual behavior.

Throughout this manuscript, we use the terms “female” and “male” rather than “woman” and “man.” This is because our analyses and results relate to biologically defined sex, not to gender.

As is common in genetic analyses, we dropped individuals from our study whose biological sex and self-identified sex/gender did not match. This is an important limitation of our analyses because the analyses do not include transgender persons, intersex persons, and other important persons and groups within the queer community. We hope that this limitation will be addressed in future work.

Box 2.**Communication and interpretation.**

The topic explored in this study is complex and intersects with sexuality, identity, and attraction and potentially has civil and political implications for sexual minority groups. Therefore, we have

Engaged with science communication teams,

Engaged with LGBTQIA+ advocacy groups nationally and within our local institutions, and Tried to make clear the many limitations and nuances of our study and our phenotypes.

We wish to make it clear that our results overwhelmingly point toward the richness and diversity of human sexuality. Our results do not point toward a role for discrimination on the basis of sexual identity or attraction, nor do our results make any conclusive statements about the degree to which “nature” and “nurture” influence sexual preference.

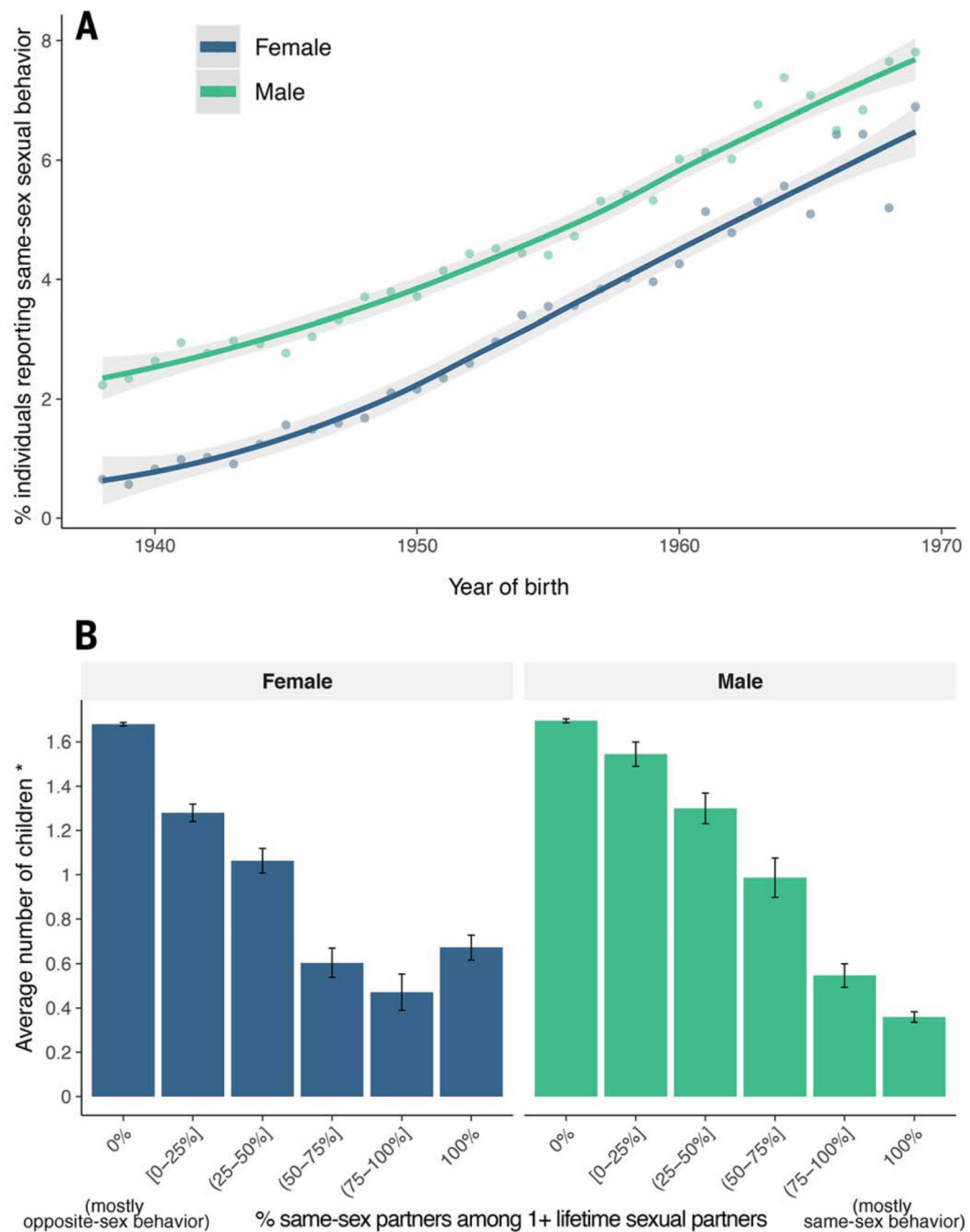


Fig. 1. Descriptive statistics regarding same-sex sexual behavior in the UK Biobank.

(A) The percentage of participants in the UK Biobank who reported having had at least one same-sex sexual partner (y axis) increased with participants' year of birth (x axis). (B) Among participants reporting at least one same-sex partner, those with a greater proportion of same-sex partners (x axis) have a larger reproductive disadvantage (lower birth-year adjusted number of children) (y axis). Vertical bars represent 95% CIs.

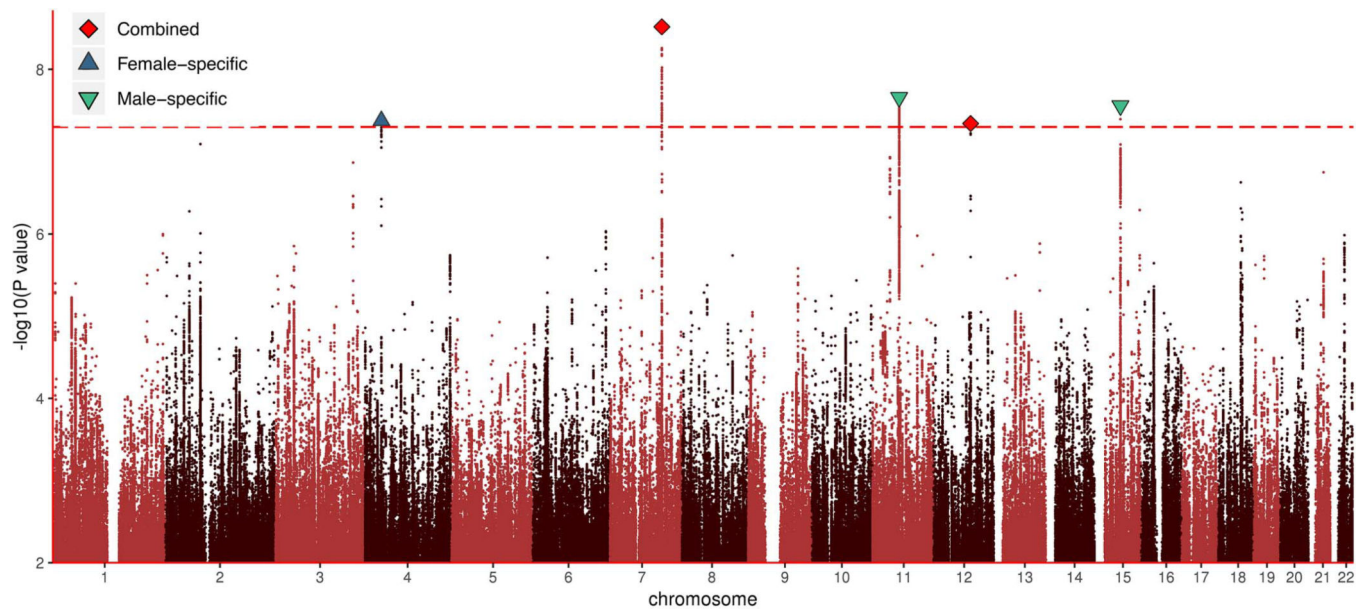


Fig. 2. Manhattan plot for a GWAS of same-sex sexual behavior.

Diamonds (red) represent genome-wide significant signals from analysis of males and females combined, and triangles represent genome-wide significant signals that are female (pointing up, blue) or male (pointing down, green) specific.

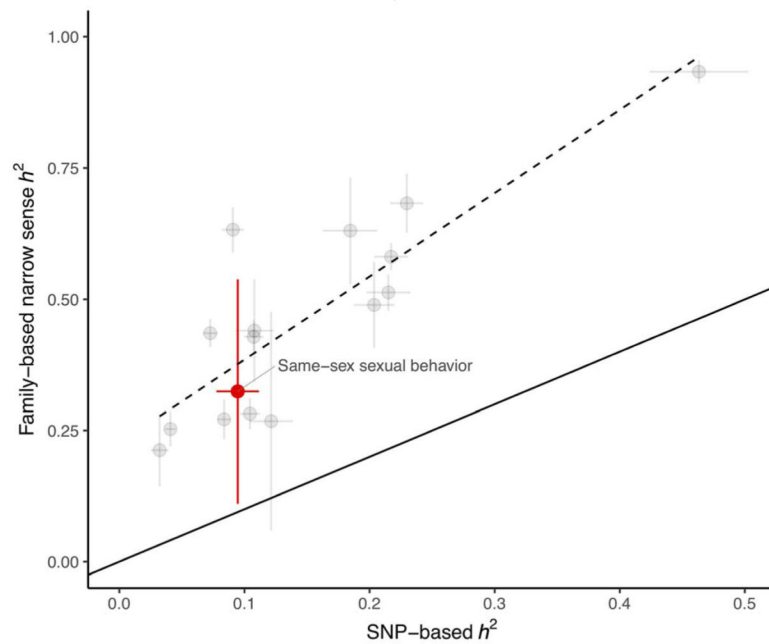


Fig. 3. SNP-based versus family-based heritability estimates for same-sex sexual behavior compared with a variety of other traits.

Heritability, h^2 ; same-sex sexual behavior, red dot; other traits, gray dots. The estimates for all traits are provided in table S23. Horizontal bars represent 95% CIs for the SNP-based estimate, and vertical bars represent 95% CIs for the family-based estimate. Dashed and solid lines represent the observed (obtained by linear regression) and expected relationship between family-based and SNP-based heritability, respectively.

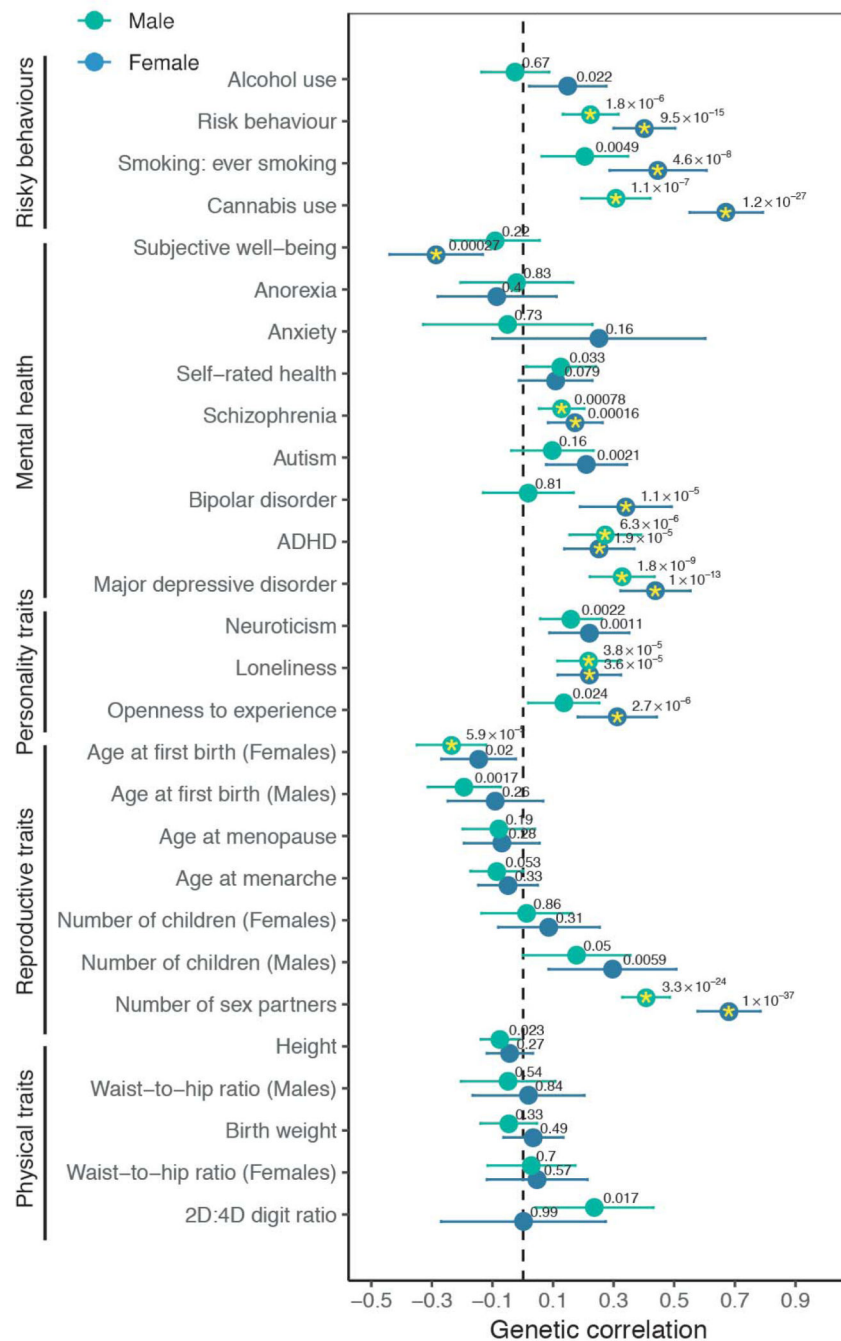


Fig. 4. Genetic correlations of same-sex sexual behavior with various preselected traits and disorders, separately for males and females.

Males, green; females, blue. Yellow asterisks denote the genetic correlations that were experiment-wise significant ($P < 8.9 \times 10^{-4}$; references, definitions, and full results can be found in table S19). Wald test P values for the genetic correlations are reported above each dot. Horizontal bars represent 95% CIs.

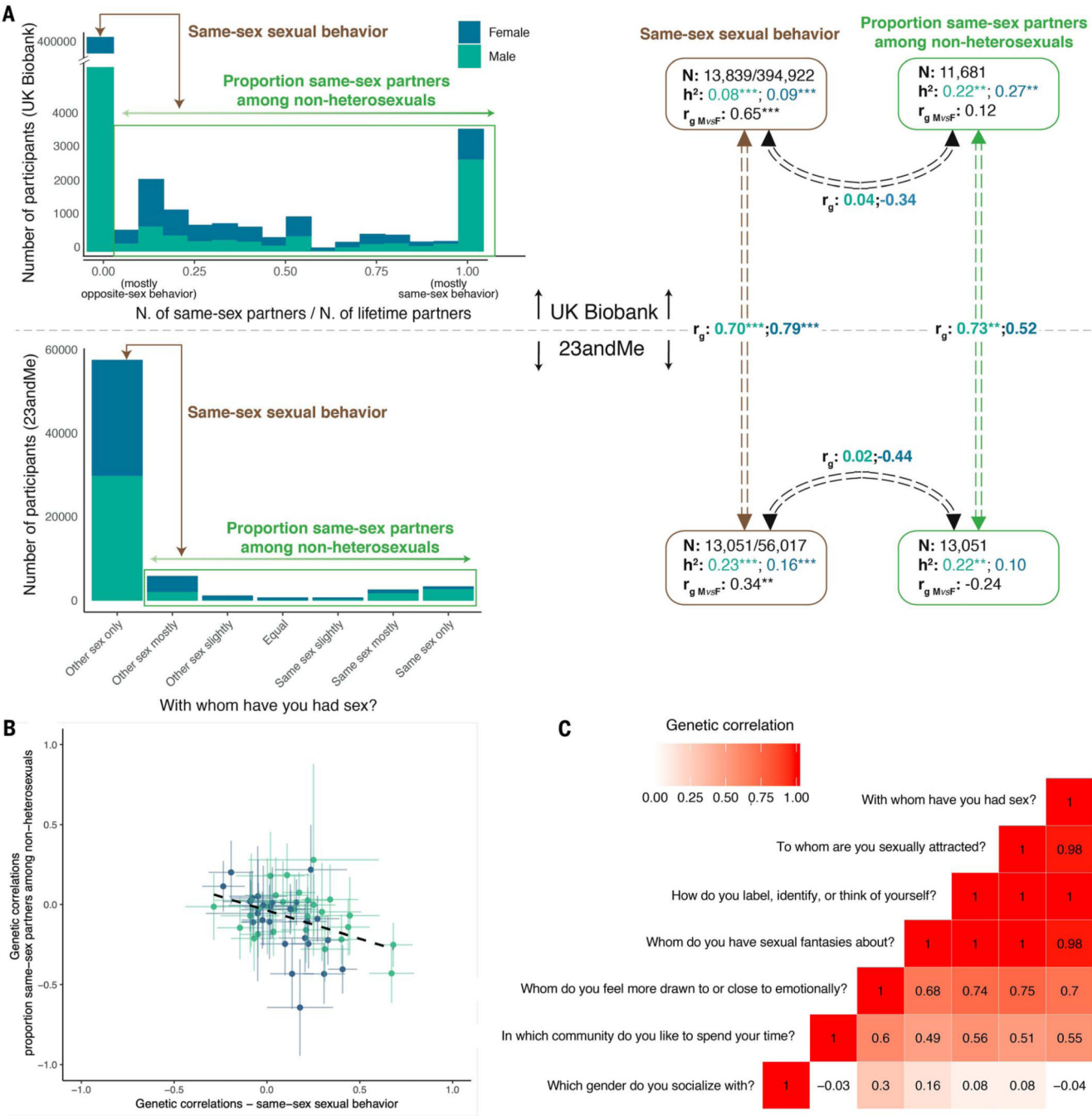


Fig. 5. Complexity and heterogeneity of genetic influences. (A) Genetic correlations between the main phenotype (same-sex sexual behavior; heterosexuals versus nonheterosexuals) and proportion of same-sex to total sexual partners among nonheterosexuals, in the UK Biobank and 23andMe samples. (B) Scatterplot showing genetic correlations of the main phenotype (x axis) and the proportion of same-sex to total partners among nonheterosexuals (y axis) with various other traits (table S21). (C) Genetic correlations among different sexual preference items in the 23andMe sample.

THE NEW ATLANTIS

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~ SPECIAL REPORT ~

Sexuality and Gender

Findings from the Biological,
Psychological, and Social Sciences

Lawrence S. Mayer, M.B., M.S., Ph.D.

Paul R. McHugh, M.D.

NUMBER 50 ~ FALL 2016 ~ \$7.00

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THE NEW ATLANTIS

A JOURNAL OF TECHNOLOGY & SOCIETY

NUMBER 50 ~ FALL 2016

Editor's Note: Questions related to sexuality and gender bear on some of the most intimate and personal aspects of human life. In recent years they have also vexed American politics. We offer this report—written by Dr. Lawrence S. Mayer, an epidemiologist trained in psychiatry, and Dr. Paul R. McHugh, arguably the most important American psychiatrist of the last half-century—in the hope of improving public understanding of these questions. Examining research from the biological, psychological, and social sciences, this report shows that some of the most frequently heard claims about sexuality and gender are not supported by scientific evidence. The report has a special focus on the higher rates of mental health problems among LGBT populations, and it questions the scientific basis of trends in the treatment of children who do not identify with their biological sex. More effort is called for to provide these people with the understanding, care, and support they need to lead healthy, flourishing lives.

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SEXUALITY AND GENDER

Findings from the Biological, Psychological, and Social Sciences

Lawrence S. Mayer, M.B., M.S., Ph.D. and Paul R. McHugh, M.D.

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Lawrence S. Mayer, M.B., M.S., Ph.D. is a scholar in residence in the Department of Psychiatry at the Johns Hopkins University School of Medicine and a professor of statistics and biostatistics at Arizona State University. *Paul R. McHugh, M.D.* is a professor of psychiatry and behavioral sciences at the Johns Hopkins University School of Medicine and was for twenty-five years the psychiatrist-in-chief at the Johns Hopkins Hospital. He is the author or coauthor of several books, including, most recently, *Try to Remember: Psychiatry's Clash over Meaning, Memory, and Mind* (Dana Press, 2008).

THE NEW ATLANTIS

A JOURNAL OF TECHNOLOGY & SOCIETY

The New Atlantis (1627) was the title Francis Bacon selected for his fable of a society living with the benefits and challenges of advanced science and technology. Bacon, a founder and champion of modern science, sought not only to highlight the potential of technology to improve human life, but also to foresee some of the social, moral, and political difficulties that confront a society shaped by the great scientific enterprise. His book offers no obvious answers; perhaps it seduces more than it warns. But the tale also hints at some of the dilemmas that arise with the ability to remake and reconfigure the natural world: governing science, so that it might flourish freely without destroying or dehumanizing us, and understanding the effect of technology on human life, human aspiration, and the human good. To a great extent, we live in the world Bacon imagined, and now we must find a way to live well with both its burdens and its blessings. This very challenge, which now confronts our own society most forcefully, is the focus of this journal.

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Preface

This report was written for the general public and for mental health professionals in order to draw attention to—and offer some scientific insight about—the mental health issues faced by LGBT populations.

It arose from a request from Paul R. McHugh, M.D., the former chief of psychiatry at Johns Hopkins Hospital and one of the leading psychiatrists in the world. Dr. McHugh requested that I review a monograph he and colleagues had drafted on subjects related to sexual orientation and identity; my original assignment was to guarantee the accuracy of statistical inferences and to review additional sources. In the months that followed, I closely read over five hundred scientific articles on these topics and perused hundreds more. I was alarmed to learn that the LGBT community bears a disproportionate rate of mental health problems compared to the population as a whole.

As my interest grew, I explored research across a variety of scientific fields, including epidemiology, genetics, endocrinology, psychiatry, neuroscience, embryology, and pediatrics. I also reviewed many of the academic empirical studies done in the social sciences including psychology, sociology, political science, economics, and gender studies.

I agreed to take over as lead author, rewriting, reorganizing, and expanding the text. I support every sentence in this report, without reservation and without prejudice regarding any political or philosophical debates. This report is about science and medicine, nothing more and nothing less.

Readers wondering about this report's synthesis of research from so many different fields may wish to know a little about its lead author. I am a full-time academic involved in all aspects of teaching, research, and professional service. I am a biostatistician and epidemiologist who focuses on the design, analysis, and interpretation of experimental and observational data in public health and medicine, particularly when the data are complex in terms of underlying scientific issues. I am a research physician, having trained in medicine and psychiatry in the U.K. and received the British equivalent (M.B.) to the American M.D. I have never practiced medicine (including psychiatry) in the United States or abroad. I have testified in dozens of federal and state legal proceedings and regulatory hearings, in

most cases reviewing scientific literature to clarify the issues under examination. I strongly support equality and oppose discrimination for the LGBT community, and I have testified on their behalf as a statistical expert.

I have been a full-time tenured professor for over four decades. I have held professorial appointments at eight universities, including Princeton, the University of Pennsylvania, Stanford, Arizona State University, Johns Hopkins University Bloomberg School of Public Health and School of Medicine, Ohio State, Virginia Tech, and the University of Michigan. I have also held research faculty appointments at several other institutions, including the Mayo Clinic.

My full-time and part-time appointments have been in twenty-three disciplines, including statistics, biostatistics, epidemiology, public health, social methodology, psychiatry, mathematics, sociology, political science, economics, and biomedical informatics. But my research interests have varied far less than my academic appointments: the focus of my career has been to learn how statistics and models are employed across disciplines, with the goal of improving the use of models and data analytics in assessing issues of interest in the policy, regulatory, or legal realms.

I have been published in many top-tier peer-reviewed journals (including *The Annals of Statistics*, *Biometrics*, and *American Journal of Political Science*) and have reviewed hundreds of manuscripts submitted for publication to many of the major medical, statistical, and epidemiological journals (including *The New England Journal of Medicine*, *Journal of the American Statistical Association*, and *American Journal of Public Health*).

I am currently a scholar in residence in the Department of Psychiatry at Johns Hopkins School of Medicine and a professor of statistics and biostatistics at Arizona State University. Up until July 1, 2016, I also held part-time faculty appointments at the Johns Hopkins Bloomberg School of Public Health and School of Medicine, and at the Mayo Clinic.

An undertaking as ambitious as this report would not be possible without the counsel and advice of many gifted scholars and editors. I am grateful for the generous help of Laura E. Harrington, M.D., M.S., a psychiatrist with extensive training in internal medicine and neuroimmunology, whose clinical practice focuses on women in life transition, including affirmative treatment and therapy for the LGBT community. She contributed to the entire report, particularly lending her expertise to the sections on endocrinology and brain research. I am indebted also to Bentley J. Hanish, B.S., a young geneticist who expects to graduate medical school in 2021 with an M.D./Ph.D. in psychiatric epidemiology.

He contributed to the entire report, particularly to those sections that concern genetics.

I gratefully acknowledge the support of Johns Hopkins University Bloomberg School of Public Health and School of Medicine, Arizona State University, and the Mayo Clinic.

In the course of writing this report, I consulted a number of individuals who asked that I not thank them by name. Some feared an angry response from the more militant elements of the LGBT community; others feared an angry response from the more strident elements of religiously conservative communities. Most bothersome, however, is that some feared reprisals from their own universities for engaging such controversial topics, regardless of the report's content—a sad statement about academic freedom.

I dedicate my work on this report, first, to the LGBT community, which bears a disproportionate rate of mental health problems compared to the population as a whole. We must find ways to relieve their suffering.

I dedicate it also to scholars doing impartial research on topics of public controversy. May they never lose their way in political hurricanes.

And above all, I dedicate it to children struggling with their sexuality and gender. Children are a special case when addressing gender issues. In the course of their development, many children explore the idea of being of the opposite sex. Some children may have improved psychological well-being if they are encouraged and supported in their cross-gender identification, particularly if the identification is strong and persistent over time. But nearly all children ultimately identify with their biological sex. The notion that a two-year-old, having expressed thoughts or behaviors identified with the opposite sex, can be labeled for life as transgender has absolutely no support in science. Indeed, it is iniquitous to believe that all children who have gender-atypical thoughts or behavior at some point in their development, particularly before puberty, should be encouraged to become transgender.

As citizens, scholars, and clinicians concerned with the problems facing LGBT people, we should not be dogmatically committed to any particular views about the nature of sexuality or gender identity; rather, we should be guided first and foremost by the needs of struggling patients, and we should seek with open minds for ways to help them lead meaningful, dignified lives.

LAWRENCE S. MAYER, M.B., M.S., Ph.D.

Executive Summary

This report presents a careful summary and an up-to-date explanation of research—from the biological, psychological, and social sciences—related to sexual orientation and gender identity. It is offered in the hope that such an exposition can contribute to our capacity as physicians, scientists, and citizens to address health issues faced by LGBT populations within our society.

Some key findings:

Part One: Sexual Orientation

- The understanding of sexual orientation as an innate, biologically fixed property of human beings—the idea that people are “born that way”—is not supported by scientific evidence.
- While there is evidence that biological factors such as genes and hormones are associated with sexual behaviors and attractions, there are no compelling causal biological explanations for human sexual orientation. While minor differences in the brain structures and brain activity between homosexual and heterosexual individuals have been identified by researchers, such neurobiological findings do not demonstrate whether these differences are innate or are the result of environmental and psychological factors.
- Longitudinal studies of adolescents suggest that sexual orientation may be quite fluid over the life course for some people, with one study estimating that as many as 80% of male adolescents who report same-sex attractions no longer do so as adults (although the extent to which this figure reflects actual changes in same-sex attractions and not just artifacts of the survey process has been contested by some researchers).
- Compared to heterosexuals, non-heterosexuals are about two to three times as likely to have experienced childhood sexual abuse.

Part Two: Sexuality, Mental Health Outcomes, and Social Stress

- Compared to the general population, non-heterosexual sub-populations are at an elevated risk for a variety of adverse health and mental health outcomes.
- Members of the non-heterosexual population are estimated to have about 1.5 times higher risk of experiencing anxiety disorders than members of the heterosexual population, as well as roughly double the risk of depression, 1.5 times the risk of substance abuse, and nearly 2.5 times the risk of suicide.
- Members of the transgender population are also at higher risk of a variety of mental health problems compared to members of the non-transgender population. Especially alarmingly, the rate of lifetime suicide attempts across all ages of transgender individuals is estimated at 41%, compared to under 5% in the overall U.S. population.
- There is evidence, albeit limited, that social stressors such as discrimination and stigma contribute to the elevated risk of poor mental health outcomes for non-heterosexual and transgender populations. More high-quality longitudinal studies are necessary for the “social stress model” to be a useful tool for understanding public health concerns.

Part Three: Gender Identity

- The hypothesis that gender identity is an innate, fixed property of human beings that is independent of biological sex—that a person might be “a man trapped in a woman’s body” or “a woman trapped in a man’s body”—is not supported by scientific evidence.
- According to a recent estimate, about 0.6% of U.S. adults identify as a gender that does not correspond to their biological sex.
- Studies comparing the brain structures of transgender and non-transgender individuals have demonstrated weak correlations between brain structure and cross-gender identification. These correlations do not provide any evidence for a neurobiological basis for cross-gender identification.

- Compared to the general population, adults who have undergone sex-reassignment surgery continue to have a higher risk of experiencing poor mental health outcomes. One study found that, compared to controls, sex-reassigned individuals were about 5 times more likely to attempt suicide and about 19 times more likely to die by suicide.
- Children are a special case when addressing transgender issues. Only a minority of children who experience cross-gender identification will continue to do so into adolescence or adulthood.
- There is little scientific evidence for the therapeutic value of interventions that delay puberty or modify the secondary sex characteristics of adolescents, although some children may have improved psychological well-being if they are encouraged and supported in their cross-gender identification. There is no evidence that all children who express gender-atypical thoughts or behavior should be encouraged to become transgender.

Sexuality and Gender

Findings from the Biological, Psychological, and Social Sciences

Lawrence S. Mayer, M.B., M.S., Ph.D. and Paul R. McHugh, M.D.

Introduction

Few topics are as complex and controversial as human sexual orientation and gender identity. These matters touch upon our most intimate thoughts and feelings, and help to define us as both individuals and social beings. Discussions of the ethical questions raised by sexual orientation and gender identity can become heated and personal, and the associated policy issues sometimes provoke intense controversies. The disputants, journalists, and lawmakers in these debates often invoke the authority of science, and in our news and social media and our broader popular culture we hear claims about what “science says” on these matters.

This report offers a careful summary and an up-to-date explanation of many of the most rigorous findings produced by the biological, psychological, and social sciences related to sexual orientation and gender identity. We examine a vast body of scientific literature from several disciplines. We try to acknowledge the limitations of the research and to avoid premature conclusions that would result in over-interpretation of scientific findings. Since the relevant literature is rife with inconsistent and ambiguous definitions, we not only examine the empirical evidence but also delve into underlying conceptual problems. This report does not, however, discuss matters of morality or policy; our focus is on the scientific evidence—what it shows and what it does not show.

We begin in Part One by critically examining whether concepts such as heterosexuality, homosexuality, and bisexuality represent distinct, fixed, and biologically determined properties of human beings. As part of this discussion, we look at the popular “born that way” hypothesis, which

posits that human sexual orientation is biologically innate; we examine the evidence for this claim across several subspecialties of the biological sciences. We explore the developmental origins of sexual attractions, the degree to which such attractions may change over time, and the complexities inherent in the incorporation of these attractions into one's sexual identity. Drawing on evidence from twin studies and other types of research, we explore genetic, environmental, and hormonal factors. We also explore some of the scientific evidence relating brain science to sexual orientation.

In Part Two we examine research on health outcomes as they relate to sexual orientation and gender identity. There is a consistently observed higher risk of poor physical and mental health outcomes for lesbian, gay, bisexual, and transgender subpopulations compared to the general population. These outcomes include depression, anxiety, substance abuse, and most alarmingly, suicide. For example, among the transgender subpopulation in the United States, the rate of attempted suicide is estimated to be as high as 41%, ten times higher than in the general population. As physicians, academics, and scientists, we believe all of the subsequent discussions in this report must be cast in the light of this public health issue.

We also examine some ideas proposed to explain these differential health outcomes, including the “social stress model.” This hypothesis—which holds that stressors like stigma and prejudice account for much of the additional suffering observed in these subpopulations—does not seem to offer a complete explanation for the disparities in the outcomes.

Much as Part One investigates the conjecture that sexual orientation is fixed with a causal biological basis, a portion of Part Three examines similar issues with respect to gender identity. Biological sex (the binary categories of male and female) is a fixed aspect of human nature, even though some individuals affected by disorders of sex development may exhibit ambiguous sex characteristics. By contrast, gender identity is a social and psychological concept that is not well defined, and there is little scientific evidence that it is an innate, fixed biological property.

Part Three also examines sex-reassignment procedures and the evidence for their effectiveness at alleviating the poor mental health outcomes experienced by many people who identify as transgender. Compared to the general population, postoperative transgender individuals continue to be at high risk of poor mental health outcomes.

An area of particular concern involves medical interventions for gender-nonconforming youth. They are increasingly receiving therapies that affirm their felt genders, and even hormone treatments or surgical

modifications at young ages. But the majority of children who identify as a gender that does not conform to their biological sex will no longer do so by the time they reach adulthood. We are disturbed and alarmed by the severity and irreversibility of some interventions being publicly discussed and employed for children.

Sexual orientation and gender identity resist explanation by simple theories. There is a large gap between the certainty with which beliefs are held about these matters and what a sober assessment of the science reveals. In the face of this complexity and uncertainty, we need to be humble about what we know and do not know. We readily acknowledge that this report is neither an exhaustive analysis of the subjects it addresses nor the last word on them. Science is by no means the only avenue for understanding these astoundingly complex, multifaceted topics; there are other sources of wisdom and knowledge—including art, religion, philosophy, and lived human experience. And much of our scientific knowledge in this area remains unsettled. However, we offer this overview of the scientific literature in the hope that it can provide a shared framework for intelligent, enlightened discourse in political, professional, and scientific exchanges—and may add to our capacity as concerned citizens to alleviate suffering and promote human health and flourishing.

Part One

Sexual Orientation

While some people are under the impression that sexual orientation is an innate, fixed, and biological trait of human beings—that, whether heterosexual, homosexual, or bisexual, we are “born that way”—there is insufficient scientific evidence to support that claim. In fact, the concept of sexual orientation itself is highly ambiguous; it can refer to a set of behaviors, to feelings of attraction, or to a sense of identity. Epidemiological studies show a rather modest association between genetic factors and sexual attractions or behaviors, but do not provide significant evidence pointing to particular genes. There is also evidence for other hypothesized biological causes of homosexual behaviors, attractions, or identity—such as the influence of hormones on prenatal development—but that evidence, too, is limited. Studies of the brains of homosexuals and heterosexuals have found some differences, but have not demonstrated that these differences are inborn rather than the result of environmental factors that influenced both psychological and neurobiological traits. One environmental factor that appears to be correlated with non-heterosexuality is childhood sexual abuse victimization, which may also contribute to the higher rates of poor mental health outcomes among non-heterosexual subpopulations, compared to the general population. Overall, the evidence suggests some measure of fluidity in patterns of sexual attraction and behavior—contrary to the “born that way” notion that oversimplifies the vast complexity of human sexuality.

The popular discussion of sexual orientation is characterized by two conflicting ideas about why some individuals are lesbian, gay, or bisexual. While some claim that sexual orientation is a choice, others say that sexual orientation is a fixed feature of one’s nature, that one is “born that way.” We hope to show here that, though sexual orientation is not a choice, neither is there scientific evidence for the view that sexual orientation is a fixed and innate biological property.

A prominent recent example of a person describing sexual orientation as a choice is Cynthia Nixon, a star of the popular television series *Sex and the City*, who in a January 2012 *New York Times* interview explained, “For me it’s a choice, and you don’t get to define my gayness for me,” and commented that she was “very annoyed” about the issue of whether or not gay people are born that way. “Why can’t it be a choice? Why is that any less legitimate?”¹ Similarly, Brandon Ambrosino wrote in *The New Republic* in

2014 that “It’s time for the LGBT community to stop fearing the word ‘choice,’ and to reclaim the dignity of sexual autonomy.”²

By contrast, proponents of the “born that way” hypothesis—expressed for instance in Lady Gaga’s 2011 song “Born This Way”—posit that there is a causal biological basis for sexual orientation and often try to bolster their claims with scientific findings. Citing three scientific studies³ and an article from *Science* magazine,⁴ Mark Joseph Stern, writing for *Slate* in 2014, claims that “homosexuality, at least in men, is clearly, undoubtedly, inarguably an inborn trait.”⁵ However, as neuroscientist Simon LeVay, whose work in 1991 showed brain differences in homosexual men compared to heterosexual men, explained some years after his study, “It’s important to stress what I didn’t find. I did not prove that homosexuality is genetic, or find a genetic cause for being gay. I didn’t show that gay men are ‘born that way,’ the most common mistake people make in interpreting my work. Nor did I locate a gay center in the brain.”⁶

Many recent books contain popular treatments of science that make claims about the innateness of sexual orientation. These books often exaggerate—or at least oversimplify—complex scientific findings. For example, in a 2005 book, psychologist and science writer Leonard Sax responds to a worried mother’s question as to whether her teenage son will outgrow his homosexual attractions: “Biologically, the difference between a gay man and a straight man is something like the difference between a left-handed person and a right-handed person. Being left-handed isn’t just a phase. A left-handed person won’t someday magically turn into a right-handed person.... Some children are destined at birth to be left-handed, and some boys are destined at birth to grow up to be gay.”⁷

As we argue in this part of the report, however, there is little scientific evidence to support the claim that sexual attraction is simply fixed by innate and deterministic factors such as genes. Popular understandings of scientific findings often presume deterministic causality when the findings do not warrant that presumption.

Another important limitation for research and for interpretation of scientific studies on this topic is that some central concepts—including “sexual orientation” itself—are often ambiguous, making reliable measurements difficult both within individual studies and when comparing results across studies. So before turning to the scientific evidence concerning the development of sexual orientation and sexual desire, we will examine at some length several of the most troublesome conceptual ambiguities in the study of human sexuality in order to arrive at a fuller picture of the relevant concepts.

Problems with Defining Key Concepts

A 2014 *New York Times Magazine* piece titled “The Scientific Quest to Prove Bisexuality Exists”⁸ provides an illustration of the themes explored in this Part—sexual desire, attraction, orientation, and identity—and of the difficulties with defining and studying these concepts. Specifically, the article shows how a scientific approach to studying human sexuality can conflict with culturally prevalent views of sexual orientation, or with the self-understanding that many people have of their own sexual desires and identities. Such conflicts raise important questions about whether sexual orientation and related concepts are as coherent and well-defined as is often assumed by researchers and the public alike.

The author of the article, Benoit Denizet-Lewis, an openly gay man, describes the work of scientists and others trying to demonstrate the existence of a stable bisexual orientation. He visited researchers at Cornell University and participated in tests used to measure sexual arousal, tests that include observing the way pupils dilate in response to sexually explicit imagery. To his surprise, he found that, according to this scientific measure, he was aroused when watching pornographic films of women masturbating:

Might I actually be bisexual? Have I been so wedded to my gay identity—one I adopted in college and announced with great fanfare to family and friends—that I haven’t allowed myself to experience another part of myself? In some ways, even asking those questions is anathema to many gays and lesbians. That kind of publicly shared uncertainty is catnip to the Christian Right and to the scientifically dubious, psychologically damaging ex-gay movement it helped spawn. As out gay men and lesbians, after all, we’re supposed to be sure—we’re supposed to be “born this way.”⁹

Despite the apparently scientific (though admittedly limited) evidence of his bisexual-typical patterns of arousal, Denizet-Lewis rejected the idea that he was actually bisexual, because “It doesn’t feel true as a sexual orientation, nor does it feel right as my identity.”¹⁰

Denizet-Lewis’s concerns here illustrate a number of the quandaries raised by the scientific study of human sexuality. The objective measures the researchers used seemed to be at odds with the more intuitive, subjective understanding of what it is to be sexually aroused; our own understanding of what we are sexually aroused by is tied up with the entirety of our lived experience of sexuality. Furthermore, Denizet-Lewis’s insistence

that he is gay, not bisexual, and his concern that uncertainty about his identity could have social and political implications, points to the fact that sexual orientation and identity are understood not only in scientific and personal terms, but in social, moral, and political terms as well.

But how do categories of sexual orientation—with labels such as “bisexual” or “gay” or “straight”—help scientists study the complex phenomenon of human sexuality? When we examine the concept of sexual orientation, it becomes apparent, as this part will show, that it is too vague and poorly defined to be very useful in science, and that in its place we need more clearly defined concepts. We strive in this report to use clear terms; when discussing scientific studies that rely on the concept of “sexual orientation,” we try as much as possible to specify how the scientists defined the term, or related terms.

One of the central difficulties in examining and researching sexual orientation is that the underlying concepts of “sexual desire,” “sexual attraction,” and “sexual arousal” can be ambiguous, and it is even less clear what it means that a person identifies as having a sexual orientation grounded in some pattern of desires, attractions, or states of arousal.

The word “desire” all by itself might be used to cover an aspect of volition more naturally expressed by “want”: I want to go out for dinner, or to take a road trip with my friends next summer, or to finish this project. When “desire” is used in this sense, the objects of desire are fairly determinate *goals*—some may be perfectly achievable, such as moving to a new city or finding a new job; others may be more ambitious and out of reach, like the dream of becoming a world-famous movie star. Often, however, the language of desire is meant to include things that are less clear: indefinite *longings* for a life that is, in some unspecified sense, different or better; an inchoate sense of something being missing or lacking in oneself or one’s world; or, in psychoanalytic literature, unconscious dynamic forces that shape one’s cognitive, emotional, and social behaviors, but that are separate from one’s ordinary, conscious sense of self.

This more full-blooded notion of desire is, itself, ambiguous. It might refer to a hoped-for state of affairs like finding a sense of meaning, fulfillment, and satisfaction with one’s life, a desire that, while not completely clear in its implications, is presumably not entirely out of reach, although such longings may also be forms of fantasizing about a radically altered or perhaps even unattainable state of affairs. If I want to take a road trip with my friends, the steps are clear: call up my friends, pick a date, map out a route, and so on. However, if I have an inchoate longing for change, a hope for sustainable intimacy, love, and belonging, or an unconscious conflict

that is disrupting my ability to move forward in the life I have tried to build for myself, I face a different sort of challenge. There is not necessarily a set of well-defined or conscious goals, much less established ways of achieving them. This is not to say that the satisfaction of these longings is impossible, but doing so often involves not only choosing concrete actions to achieve particular goals but the more complex shaping of one's own life through acting in and making sense of the world and one's place in it.

So the first thing to note when considering both popular discussions and scientific studies of sexuality is that the use of the term "desire" could refer to distinct aspects of human life and experience.

Just as the meanings that might be intended by the term "desire" are many, so also is each of these meanings varied, making clear delineations a challenge. For example, a commonsense understanding might suggest that the term "sexual desire" means wanting to engage in specific sexual acts with particular individuals (or categories of individuals). Psychiatrist Steven Levine articulated this common view in his definition of sexual desire as "the sum of the forces that incline us toward and away from sexual behavior."¹¹ But it is not obvious how one might study this "sum" in a rigorous way. Nor is it obvious why all the diverse factors that can potentially influence sexual behavior, such as material poverty—in the case of prostitution, for instance—alcohol consumption, and intimate affection, should all be grouped together as aspects of sexual desire. As Levine himself points out, "In anyone's hands, sexual desire can be a slippery concept."¹²

Consider a few of the ways that the term "sexual desire" has been employed in scientific contexts—designating one or more of the following distinct phenomena:

1. States of physical arousal that may or may not be linked to a specific physical activity and may or may not be objects of conscious awareness.
2. Conscious erotic interest in response to finding others attractive (in perception, memory, or fantasy), which may or may not involve any of the bodily processes associated with measurable states of physical arousal.
3. Strong interest in finding a companion or establishing a durable relationship.
4. The romantic aspirations and feelings associated with infatuation or falling in love with a specific individual.

5. Inclination towards attachment to specific individuals.
6. The general motivation to seek intimacy with a member of some specific group.
7. An aesthetic measure that latches onto perceived beauty in others.¹³

In a given social science study, the concepts mentioned above will often each have its own particular operational definition for the purposes of research. But they cannot all mean the *same* thing. Strong interest in finding a companion, for example, is clearly distinguishable from physical arousal. Looking at this list of experiential and psychological phenomena, one can easily envision what confusions might arise from using the term “sexual desire” without sufficient care.

The philosopher Alexander Pruss provides a helpful summary of some of the difficulties involved in characterizing the related concept of sexual attraction:

What does it mean to be “sexually attracted” to someone? Does it mean to have a tendency to be aroused in their presence? But surely it is possible to find someone sexually attractive without being aroused. Does it mean to form the belief that someone is sexually attractive to one? Surely not, since a belief about who is sexually attractive to one might be wrong—for instance, one might confuse admiration of form with sexual attraction. Does it mean to have a noninstrumental desire for a sexual or romantic relationship with the person? Probably not: we can imagine a person who has no sexual attraction to anybody, but who has a noninstrumental desire for a romantic relationship because of a belief, based on the testimony of others, that romantic relationships have noninstrumental value. These and similar questions suggest that there is a cluster of related concepts under the head of “sexual attraction,” and any precise definition is likely to be an undesirable shoehorning. But if the concept of sexual attraction is a cluster of concepts, neither are there simply univocal concepts of heterosexuality, homosexuality, and bisexuality.¹⁴

The ambiguity of the term “sexual desire” (and similar terms) should give us pause to consider the diverse aspects of human experience that are often associated with it. The problem is neither irresolvable nor unique to this subject matter. Other social science concepts—aggression and addiction, for example—may likewise be difficult to define and to

operationalize and for this reason admit of various usages.* Nevertheless, the ambiguity presents a significant challenge for both research design and interpretation, requiring that we take care in attending to the meanings, contexts, and findings specific to each study. It is also important to bracket any subjective associations with or uses of these terms that do not conform to well-defined scientific classifications and techniques.

It would be a mistake, at any rate, to ignore the varied uses of this and related terms or to try to reduce the many and distinct experiences to which they might refer to a single concept or experience. As we shall see, doing so could in some cases adversely affect the evaluation and treatment of patients.

The Context of Sexual Desire

We can further clarify the complex phenomenon of sexual desire if we examine what relationship it has to other aspects of our lives. To do so, we borrow some conceptual tools from a philosophical tradition known as phenomenology, which conceives of human experience as deriving its meaning from the whole context in which it appears.

The testimony of experience suggests that one's experience of sexual desire and sexual attraction is not voluntary, at least not in any immediate way. The whole set of inclinations that we generally associate with the experience of sexual desire—whether the impulse to engage in particular acts or to enjoy certain relationships—does not appear to be the sole product of any deliberate choice. Our sexual appetites (like other natural appetites) are experienced as given, even if their expression is shaped in subtle ways by many factors, which might very well include volition. Indeed, far from appearing as a product of our will, sexual desire—however we define it—is often experienced as a powerful force, akin to hunger, that many struggle (especially in adolescence) to bring under direction and control. Furthermore, sexual desire can impact one's attention involuntarily or color one's day-to-day perceptions, experiences, and encounters. What seems to be to some extent in our control is how we choose to live with this appetite, how we integrate it into the rest of our lives.

But the question remains: What *is* sexual desire? What is this part of our lives that we consider to be given, prior even to our capacity to

* "Operationalizing" refers to the way social scientists make a variable measurable. Homosexuality may be operationalized as the answers that survey respondents give to questions about their sexual orientation. Or it could be operationalized as answers to questions about their desires, attractions, and behavior. Operationalizing variables in ways that will reliably measure the trait or behavior being studied is a difficult but important part of any social science research.

deliberate and make rational choices about it? We know that some sort of sexual appetite is present in non-human animals, as is evident in the mammalian estrous cycle; in most mammalian species sexual arousal and receptivity are linked to the phase of the ovulation cycle during which the female is reproductively receptive.¹⁵ One of the relatively unique features of *Homo sapiens*, shared with only a few other primates, is that sexual desire is not exclusively linked to the woman's ovulatory cycle.¹⁶ Some biologists have argued that this means that sexual desire in humans has evolved to facilitate the formation of sustaining relationships between parents, in addition to the more basic biological purpose of reproduction. Whatever the explanation for the origins and biological functions of human sexuality, the lived experience of sexual desires is laden with significance that goes beyond the biological purposes that sexual desires and behaviors serve. This significance is not just a subjective add-on to the more basic physiological and functional realities, but something that pervades our lived experience of sexuality.

As philosophers who study the structure of conscious experience have observed, our way of experiencing the world is shaped by our “embodiment, bodily skills, cultural context, language and other social practices.”¹⁷ Long before most of us experience anything like what we typically associate with sexual desire, we are already enmeshed in a cultural and social context involving other persons, feelings, emotions, opportunities, deprivations, and so on. Perhaps sexuality, like other human phenomena that gradually become part of our psychological constitution, has roots in these early meaning-making experiences. If meaning-making is integral to human experience in general, it is likely to play a key role in sexual experience in particular. And given that volition is operative in these other aspects of our lives, it stands to reason that volition will be operative in our experience of sexuality too, if only as one of many other factors.

This is not to suggest that sexuality—including sexual desire, attraction, and identity—is the result of any deliberate, rational decision calculus. Even if volition plays an important role in sexuality, volition itself is quite complex: many, perhaps most, of our volitional choices do not seem to come in the form of discrete, conscious, or deliberate decisions; “volitional” does not necessarily mean “deliberate.” The life of a desiring, volitional agent involves many tacit patterns of behavior owing to habits, past experiences, memories, and subtle ways of adopting and abandoning different stances on one's life.

If something like this way of understanding the life of a desiring, volitional agent is true, then we do not deliberately “choose” the objects of our

sexual desires any more than we choose the objects of our other desires. It might be more accurate to say that we gradually guide and give ourselves over to them over the course of our growth and development. This process of forming and reforming ourselves as human beings is similar to what Abraham Maslow calls self-actualization.¹⁸ Why should sexuality be an exception to this process? In the picture we are offering, internal factors, such as our genetic make-up, and external environmental factors, such as past experiences, are only ingredients, however important, in the complex human experience of sexual desire.

Sexual Orientation

Just as the concept of “sexual desire” is complex and difficult to define, there are currently no agreed-upon definitions of “sexual orientation,” “homosexuality,” or “heterosexuality” for purposes of empirical research. Should homosexuality, for example, be characterized by reference to desires to engage in particular acts with individuals of the same sex, or to a patterned history of having engaged in such acts, or to particular features of one’s private wishes or fantasies, or to a consistent impulse to seek intimacy with members of the same sex, or to a social identity imposed by oneself or others, or to something else entirely?

As early as 1896, in a book on homosexuality, the French thinker Marc-André Raffalovich argued that there were more than ten different types of affective inclination or behavior captured by the term “homosexuality” (or what he called “unisexuality”).¹⁹ Raffalovich knew his subject matter up close: he chronicled the trial, imprisonment, and resulting social disgrace of the writer Oscar Wilde, who had been prosecuted for “gross indecency” with other men. Raffalovich himself maintained a prolonged and intimate relationship with John Gray, a man of letters thought to be the inspiration for Wilde’s classic *The Picture of Dorian Gray*.²⁰ We might also consider the vast psychoanalytic literature from the early twentieth century on the topic of sexual desire, in which the experiences of individual subjects and their clinical cases are catalogued in great detail. These historical examples bring into relief the complexity that researchers still face today when attempting to arrive at clean categorizations of the richly varied affective and behavioral phenomena associated with sexual desire, in both same-sex and opposite-sex attractions.

We may contrast such inherent complexity with a different phenomenon that can be delineated unambiguously, such as pregnancy. With very few exceptions, a woman is or is not pregnant, which makes classification

of research subjects for the purposes of study relatively easy: compare pregnant women with other, non-pregnant women. But how can researchers compare, say, “gay” men to “straight” men in a single study, or across a range of studies, without mutually exclusive and exhaustive definitions of the terms “gay” and “straight”?

To increase precision, some researchers categorize concepts associated with human sexuality along a continuum or scale according to variations in pervasiveness, prominence, or intensity. Some scales focus on both intensity and the objects of sexual desire. Among the most familiar and widely used is the Kinsey scale, developed in the 1940s to classify sexual desires and orientations using purportedly measurable criteria. People are asked to choose one of the following options:

- 0 - Exclusively heterosexual
- 1 - Predominantly heterosexual, only incidentally homosexual
- 2 - Predominantly heterosexual, but more than incidentally homosexual
- 3 - Equally heterosexual and homosexual
- 4 - Predominantly homosexual, but more than incidentally heterosexual
- 5 - Predominantly homosexual, only incidentally heterosexual
- 6 - Exclusively homosexual²¹

But there are considerable limitations to this approach. In principle, measurements of this sort are valuable for social science research. They can be used, for example, in empirical tests such as the classic “t-test,” which helps researchers measure statistically meaningful differences between data sets. Many measurements in social science, however, are “ordinal,” meaning that variables are rank-ordered along a single, one-dimensional continuum but are not intrinsically significant beyond that. In the case of the Kinsey scale, this situation is even worse, because it measures the self-identification of individuals, while leaving unclear whether the values they report all refer to the same aspect of sexuality—different people may understand the terms “heterosexual” and “homosexual” to refer to feelings of attraction, or to arousal, or to fantasies, or to behavior, or to any combination of these. The ambiguity of the terms severely limits the use of the Kinsey scale as an ordinal measurement that gives a rank order to variables along a single, one-dimensional continuum. So it is not clear that this scale helps researchers to make even rudimentary classifications among the relevant groups using qualitative criteria, much less to rank-order variables or conduct controlled experiments.

Perhaps, given the inherent complexity of the subject matter, attempts to devise “objective” scales of this sort are misguided. In a critique of such approaches to social science, philosopher and neuropsychologist Daniel N. Robinson points out that “statements that lend themselves to different interpretation do not become ‘objective’ merely by putting a numeral in front of them.”²² It may be that self-reported identifications with culturally fraught and inherently complex labels simply cannot provide an objective basis for quantitative measurements in individuals or across groups.

Another obstacle for research in this area may be the popular, but not well-supported, belief that romantic desires are sublimations of sexual desires. This idea, traceable to Freud’s theory of unconscious drives, has been challenged by research on “attachment theory,” developed by John Bowlby in the 1950s.²³ Very roughly, attachment theory holds that later affective experiences that are often grouped under the general rubric “romantic” are explained in part by early childhood attachment behaviors (associated with maternal figures or caregivers)—not by unconscious, sexual drives. Romantic desires, following this line of thought, might not be as strongly correlated with sexual desires as is commonly thought. All of this is to suggest that simple delineations of the concepts relating to human sexuality cannot be taken at face value and that ongoing empirical research sometimes changes or complicates the meanings of the concepts.

If we look at recent research, we find that scientists often use at least one of three categories when attempting to classify people as “homosexual” or “heterosexual”: sexual *behavior*; sexual *fantasies* (or related emotional or affective experiences); and *self-identification* (as “gay,” “lesbian,” “bisexual,” “asexual,” and so forth).²⁴ Some add a fourth: inclusion in a community defined by sexual orientation. Consider, for example, the American Psychological Association’s definition of sexual orientation in a 2008 document designed to educate the public:

Sexual orientation refers to an enduring pattern of emotional, romantic and/or sexual *attractions* to men, women or both sexes. Sexual orientation also refers to a person’s sense of *identity* based on those attractions, related *behaviors*, and membership in a *community* of others who share those attractions. Research over several decades has demonstrated that sexual orientation ranges along a *continuum*, from exclusive attraction to the other sex to exclusive attraction to the same sex.²⁵ [Emphases added.]

One difficulty with grouping these categories together under the same general rubric of “sexual orientation” is that research suggests they often

do not coincide in real life. Sociologist Edward O. Laumann and colleagues summarize this point clearly in a 1994 book:

While there is a core group (about 2.4 percent of the total men and about 1.3 percent of the total women) in our survey who *define themselves* as homosexual or bisexual, have same-gender *partners*, and express homosexual *desires*, there are also sizable groups who do not consider themselves to be either homosexual or bisexual but have had adult homosexual experiences or express some degree of desire.... [T]his preliminary analysis provides unambiguous evidence that no single number can be used to provide an accurate and valid characterization of the incidence and prevalence of homosexuality in the population at large. In sum, homosexuality is fundamentally a multidimensional phenomenon that has manifold meanings and interpretations, depending on context and purpose.²⁶ [Emphases added.]

More recently, in a 2002 study, psychologists Lisa M. Diamond and Ritch C. Savin-Williams make a similar point:

The more carefully researchers map these constellations—differentiating, for example, between *gender identity* and *sexual identity*, *desire* and *behavior*, *sexual* versus *affectionate* feelings, early-appearing versus late-appearing *attractions* and *fantasies*, or social *identifications* and sexual *profiles*—the more complicated the picture becomes because few individuals report uniform inter-correlations among these domains.²⁷ [Emphases added.]

Some researchers acknowledge the difficulties with grouping these various components under a single rubric. For example, researchers John C. Gonsiorek and James D. Weinrich write in a 1991 book: “It can be safely assumed that there is no necessary relationship between a person’s sexual behavior and self-identity unless both are individually assessed.”²⁸ Likewise, in a 1999 review of research on the development of sexual orientation in women, social psychologist Letitia Anne Peplau argues: “There is ample documentation that same-sex attractions and behaviors are not inevitably or inherently linked to one’s identity.”²⁹

In sum, the complexities surrounding the concept of “sexual orientation” present considerable challenges for empirical research on the subject. While the general public may be under the impression that there are widely accepted scientific definitions of terms such as “sexual orientation,” in fact, there are not. Diamond’s assessment of the situation in 2003 is still true today, that “there is currently no scientific or popular consensus on

the exact constellation of experiences that definitively ‘qualify’ an individual as lesbian, gay, or bisexual.”³⁰

It is owing to such complexities that some researchers, for instance Laumann, proceed by characterizing sexual orientation as a “multidimensional phenomenon.” But one might just as well wonder whether, in trying to shoehorn this “multidimensional phenomenon” into a single category, we are not reifying a concept that corresponds to something far too plastic and diffuse in reality to be of much value in scientific research. While labels such as “heterosexual” and “homosexual” are often taken to designate stable psychological or even biological traits, perhaps they do not. It may be that individuals’ affective, sexual, and behavioral experiences do not conform well to such categorical labels because these labels do not, in fact, refer to natural (psychological or biological) kinds. At the very least, we should recognize that we do not yet possess a clear and well-established framework for research on these topics. Rather than attempting to research sexual desire, attraction, identity, and behavior under the general rubric of “sexual orientation,” we might do better to examine empirically each domain separately and in its own specificity.

To that end, this part of our report considers research on sexual desire and sexual attraction, focusing on the empirical findings related to etiology and development, and highlighting the underlying complexities. We will continue to employ ambiguous terms like “sexual orientation” where they are used by the authors we discuss, but we will try to be attentive to the context of their use and the ambiguities attaching to them.

Challenging the “Born that Way” Hypothesis

Keeping in mind these reflections on the problems of definitions, we turn to the question of how sexual desires originate and develop. Consider the different patterns of attraction between individuals who report experiencing predominant sexual or romantic attraction toward members of the same sex and those who report experiencing predominant sexual or romantic attraction toward members of the opposite sex. What are the causes of these two patterns of attraction? Are such attractions or preferences innate traits, perhaps determined by our genes or prenatal hormones; are they acquired by experiential, environmental, or volitional factors; or do they develop out of some combination of both kinds of causes? What role, if any, does human agency play in the genesis of patterns of attraction? What role, if any, do cultural or social influences play?

Research suggests that while genetic or innate factors may influence the emergence of same-sex attractions, these biological factors cannot provide a complete explanation, and environmental and experiential factors may also play an important role.

The most commonly accepted view in popular discourse we mentioned above—the “born that way” notion that homosexuality and heterosexuality are biologically innate or the product of very early developmental factors—has led many non-specialists to think that homosexuality or heterosexuality is in any given person unchangeable and determined entirely apart from choices, behaviors, life experiences, and social contexts. However, as the following discussion of the relevant scientific literature shows, this is not a view that is well-supported by research.

Studies of Twins

One powerful research design for assessing whether biological or psychological traits have a genetic basis is the study of identical twins. If the probability is high that both members in a pair of identical twins, who share the same genome, exhibit a trait when one of them does—this is known as the concordance rate—then one can infer that genetic factors are likely to be involved in the trait. If, however, the concordance rate for identical twins is no higher than the concordance rate of the same trait in fraternal twins, who share (on average) only half their genes, this indicates that the shared environment may be a more important factor than shared genes.

One of the pioneers of behavioral genetics and one of the first researchers to use twins to study the effect of genes on traits, including sexual orientation, was psychiatrist Franz Josef Kallmann. In a landmark paper published in 1952, he reported that for all the pairs of identical twins he studied, if one of the twins was gay then both were gay, yielding an astonishing 100% concordance rate for homosexuality in identical twins.³¹ Were this result replicated and the study designed better, it would have given early support to the “born that way” hypothesis. But the study was heavily criticized. For example, philosopher and law professor Edward Stein notes that Kallmann did not present any evidence that the twins in his study were in fact genetically identical, and his sample was drawn from psychiatric patients, prisoners, and others through what Kallmann described as “direct contacts with the clandestine homosexual world,” leading Stein to argue that Kallmann’s sample “in no way constituted a reasonable cross-section of the homosexual population.”³²

(Samples such as Kallmann's are known as convenience samples, which involve selecting subjects from populations that are conveniently accessible to the researcher.)

Nevertheless, well-designed twin studies examining the genetics of homosexuality indicate that genetic factors likely play some role in determining sexual orientation. For example, in 2000, psychologist J. Michael Bailey and colleagues conducted a major study of sexual orientation using twins in the Australian National Health and Medical Research Council Twin Registry, a large probability sample, which was therefore more likely to be representative of the general population than Kallmann's.³³ The study employed the Kinsey scale to operationalize sexual orientation and estimated concordance rates for being homosexual of 20% for men and 24% for women in identical (maternal, monozygotic) twins, compared to 0% for men and 10% for women in non-identical (fraternal, dizygotic) twins.³⁴ The difference in the estimated concordance rates was statistically significant for men but not for women. On the basis of these findings, the researchers estimated that the heritability of homosexuality for men was 0.45 with a wide 95% confidence interval of 0.00–0.71; for women, it was 0.08 with a similarly wide confidence interval of 0.00–0.67. These estimates suggest that for males 45% of the differences between certain sexual orientations (homosexual versus heterosexuals as measured by the Kinsey scale) could be attributed to differences in genes.

The large confidence intervals in the study by Bailey and colleagues mean that we must be careful in assessing the substantive significance of these findings. The authors interpret their findings to suggest that “any major gene for strictly defined homosexuality has either low penetrance or low frequency,”³⁵ but their data did show (marginal) statistical significance. While the concordance estimates seem somewhat high in the models used, the confidence intervals are so wide that it is difficult to judge the reliability, including the replicability, of these estimates.

It is worth clarifying here what “heritability” means in these studies, since the technical meaning in population genetics is narrower and more precise than the everyday meaning of the word. Heritability is a measure of how much variation in a particular trait within a population can be attributed to variation in genes in that population. It is not, however, a measure of how much a trait is genetically determined.

Traits that are almost entirely genetically determined can have very low heritability values, while traits that have almost no genetic basis can be found to be highly heritable. For instance, the number of fingers human beings have is almost completely genetically determined. But there is little

variation in the number of fingers humans have, and most of the variation we do see is due to non-genetic factors such as accidents, which would lead to low heritability estimates for the trait. Conversely, cultural traits can sometimes be found to be highly heritable. For instance, whether a given individual in mid-twentieth century America wore earrings would have been found to be highly heritable, because it was highly associated with being male or female, which is in turn associated with possessing XX or XY sex chromosomes, making variability in earring-wearing behavior highly associated with genetic differences, despite the fact that wearing earrings is a cultural rather than biological phenomenon. Today, heritability estimates for earring-wearing behavior would be lower than they were in mid-twentieth century America, not because of any changes in the American gene pool, but because of the increased acceptance of men wearing earrings.³⁶

So, a heritability estimate of 0.45 does not mean that 45% of sexuality is determined by genes. Rather, it means that 45% of the variation between individuals in the population studied can be attributed in some way to genetic factors, as opposed to environmental factors.

In 2010, psychiatric epidemiologist Niklas Långström and colleagues conducted a large, sophisticated twin study of sexual orientation, analyzing data from 3,826 identical and fraternal same-sex twin pairs (2,320 identical and 1,506 fraternal pairs).³⁷ The researchers operationalized homosexuality in terms of lifetime same-sex sexual partners. The sample's concordance rates were somewhat lower than those found in the study by Bailey and colleagues. For having had at least one same-sex partner, the concordance for men was 18% in identical twins and 11% in fraternal twins; for women, 22% and 17%, respectively. For total number of sexual partners, concordance rates for men were 5% in identical twins and 0% in fraternal twins; for women, 11% and 7%, respectively.

For men, these rates suggest an estimated heritability rate of 0.39 for having had at least one lifetime same-sex partner (with a 95% confidence interval of 0.00–0.59), and 0.34 for total number of same-sex partners (with a 95% confidence interval of 0.00–0.53). Environmental factors experienced by one twin but not the other explained 61% and 66% of the variance, respectively, while environmental factors shared by the twins failed to explain any of the variance. For women, the heritability rate for having had at least one lifetime same-sex partner was 0.19 (95% confidence interval of 0.00–0.49); for total number of same-sex partners, it was 0.18 (95% confidence interval of 0.11–0.45). Unique environmental factors accounted for 64% and 66% of the variance, respectively, while

shared environmental factors accounted for 17% and 16%, respectively. These values indicate that, while the genetic component of homosexual behavior is far from negligible, non-shared environmental factors play a critical, perhaps preponderant, role. The authors conclude that sexual orientation arises from both heritable and environmental influences unique to the individual, stating that “the present results support the notion that the individual-specific environment does indeed influence sexual preference.”³⁸

Another large and nationally representative study of twins published by sociologists Peter S. Bearman and Hannah Brückner in 2002 used data from the National Longitudinal Study of Adolescent to Adult Health (commonly abbreviated as “Add Health”) of adolescents in grades 7–12.³⁹ They attempted to estimate the relative influence of social factors, genetic factors, and prenatal hormonal factors on the development of same-sex attractions. Overall, 8.7% of the 18,841 adolescents in their study reported same-sex attractions, 3.1% reported a same-sex romantic relationship, and 1.5% reported same-sex sexual behavior. The authors first analyzed the “social influence hypothesis,” according to which opposite-sex twins receive less gendered socialization from their families than same-sex twins or opposite-sex siblings, and found that this hypothesis was well-supported in the case of males. While female opposite-sex twins in the study were the least likely of all the groups to report same-sex attractions (5.3%), male opposite-sex twins were the likeliest to report same-sex attractions (16.8%)—more than twice as likely as males with a full, non-twin sister (16.8% vs. 7.3%). The authors concluded there was “substantial indirect evidence in support of a socialization model at the individual level.”⁴⁰

The authors also examined the “intrauterine hormone transfer hypothesis,” according to which prenatal hormone transfers between opposite-sex twin fetuses influences the sexual orientation of the twins. (Note that this is different from the more general hypothesis that prenatal hormones influence the development of sexual orientation.) In the study, the proportion of male opposite-sex twins reporting same-sex attraction was about twice as high for those without older brothers (18.7%) as for those with older brothers (8.8%). The authors argued that this finding was strong evidence against the hormone-transfer hypothesis, since the presence of older brothers should not decrease the likelihood of same-sex attraction if that attraction has a basis in prenatal hormonal transfers. However, that conclusion seems premature: the observations are consistent with the possibility of *both* hormonal factors *and* the presence of an older brother having an effect (especially if the latter influences the former). This study

also found no correlation between experiencing same-sex attraction and having multiple older brothers, which had been reported in some earlier studies.⁴¹

Finally, Bearman and Brückner did not find evidence of significant genetic influence on sexual attraction. Significant influence would require that identical twins have significantly higher concordance rates for same-sex attraction than fraternal twins or non-twin siblings. But in the study, the rates were statistically similar: identical twins were 6.7% concordant, dizygotic pairs 7.2% concordant, and full siblings 5.5% concordant. The authors concluded that “it is more likely that any genetic influence, if present, can only be expressed in specific and circumscribed social structures.”⁴² Based on their data, they suggested the one observed social structure that might enable this genetic expression is the more limited “gender socialization associated with firstborn OS [opposite-sex] twin pairs.”⁴³ Thus, they inferred that their results “support the hypothesis that less gendered socialization in early childhood and preadolescence shapes subsequent same-sex romantic preferences.”⁴⁴ While the findings here are suggestive, further research is needed to confirm this hypothesis. The authors also argued that the higher concordance rates for same-sex attraction reported in previous studies may be unreliable due to methodological problems such as non-representative samples and small sample sizes. (It should be noted, however, that these remarks were published prior to the study by Långström and colleagues discussed above, which uses a study design that does not appear to have these limitations.)

To reconcile the somewhat mixed data on heritability, we could hypothesize that attraction to the same sex may have a stronger heritable component as people age—that is, when researchers attempt to measure sexual orientation later in life (as in the 2010 study by Långström and colleagues) than when measured earlier in life. Heritability estimates can change depending on the age at which a trait is measured because changes in the environmental factors that might influence variation in the trait may vary for individuals at different ages, and because genetically influenced traits may become more fixed at a later stage in an individual’s development (height, for instance, becomes fixed in early adulthood). This hypothesis is also suggested by findings, discussed below, that same-sex attraction may be more fluid in adolescence than in later stages of adulthood.

In contrast to the studies just summarized, psychiatrist Kenneth S. Kendler and colleagues conducted a large twin study using a probability sample of 794 twin pairs and 1,380 non-twin siblings.⁴⁵ Based on concordance rates for sexual orientation (defined in this study as self-iden-

tification based on attraction), the authors state that their results “suggest that genetic factors may provide an important influence on sexual orientation.”⁴⁶ The study does not, however, appear to be sufficiently powerful to draw strong conclusions about the degree of genetic influence on sexuality: only 19 of 324 identical twin pairs had any non-heterosexual member, with 6 of the 19 pairs concordant; 15 of 240 same-sex fraternal twin pairs had any non-heterosexual member, with 2 of the 15 pairs concordant. Because only 8 twin pairs were concordant for non-heterosexuality, the study’s ability to draw substantively significant comparisons between identical and fraternal twins (or between twins and non-twin siblings) is limited.

Overall, these studies suggest that (depending on how homosexuality is defined) in anywhere from 6% to 32% of cases, both members of an identical twin pair would be homosexual if at least one member is. Since some twin studies found higher concordance rates in identical twins than in fraternal twins or non-twin siblings, there may be genetic influences on sexual desire and behavioral preferences. One needs to bear in mind that identical twins typically have even more similar environments—early attachment experiences, peer relationships, and the like—than fraternal twins or non-twin siblings. Because of their similar appearances and temperaments, for example, identical twins may be more likely than fraternal twins or other siblings to be treated similarly. So some of the higher concordance rates may be attributable to environmental factors rather than genetic factors. In any case, if genes do play a role in predisposing people toward certain sexual desires or behaviors, these studies make clear that genetic influences cannot be the whole story.

Summarizing the studies of twins, we can say that there is no reliable scientific evidence that sexual orientation is determined by a person’s genes. But there is evidence that genes play a role in influencing sexual orientation. So the question “Are gay people born that way?” requires clarification. There is virtually no evidence that anyone, gay or straight, is “born that way” if that means their sexual orientation was genetically determined. But there is some evidence from the twin studies that certain genetic profiles probably increase the likelihood the person later identifies as gay or engages in same-sex sexual behavior.

Future twin studies on the heritability of sexual orientation should include analyses of larger samples or meta-analyses or other systematic reviews to overcome the limited sample size and statistical power of some of the existing studies, and analyses of heritability rates across different dimensions of sexuality (such as attraction, behavior, and identity) to

overcome the imprecisions of the ambiguous concept of sexual orientation and the limits of studies that look at only one of these dimensions of sexuality.

Molecular Genetics

In examining the question whether, and perhaps to what extent, there may be genetic contributions to homosexuality, we have so far looked at studies that employ methods of classical genetics to estimate the heritability of a trait like sexual orientation but that do not identify particular genes that may be associated with the trait.⁴⁷ But genetics can also be studied using what are often called molecular methods that provide estimates of which particular genetic variations are associated with traits, whether physical or behavioral.

One early attempt to identify a more specific genetic basis for homosexuality was a 1993 study by geneticist Dean Hamer and colleagues of 40 pairs of homosexual brothers.⁴⁸ By examining the family history of homosexuality for these individuals, they identified a possible linkage between homosexuality in males and genetic markers on the Xq28 region of the X chromosome. Attempts to replicate this influential study's results have had mixed results: George Rice and colleagues attempted and failed to replicate Hamer's findings,⁴⁹ though in 2015 Alan R. Sanders and colleagues were able to replicate Hamer's original findings using a larger population size of 409 male twin pairs of homosexual brothers, and to find additional genetic linkage sites.⁵⁰ (Since the effect was small, however, the genetic marker would not be a good predictor of sexual orientation.)

Genetic linkage studies like the ones discussed above are able to identify particular regions of chromosomes that may be associated with a trait by looking at patterns of inheritance. Today, one of the chief methods for inferring which genetic variants are associated with a trait is the genome-wide association study, which uses DNA sequencing technologies to identify particular differences in DNA that may be associated with a trait. Scientists examine millions of genetic variants in large numbers of individuals who have a particular trait, as well as individuals who do not have the trait, and compare the frequency of genetic variants among those who do and do not have the trait. Specific genetic variants that occur more frequently among those who have than those who do not have the trait are inferred to have some association with that trait. Genome-wide association studies have become popular in recent years, yet few such scientific studies have found significant associations of genetic variants with sexual

orientation. The largest attempt to identify genetic variants associated with homosexuality, a study of over 23,000 individuals from the 23andMe database presented at the American Society of Human Genetics annual meeting in 2012, found no linkages reaching genome-wide significance for same-sex sexual identity for males or females.⁵¹

So, again, the evidence for a genetic basis for homosexuality is inconsistent and inconclusive, which suggests that, though genetic factors explain some of the variation in sexual orientation, the genetic contribution to this trait is not likely to be strong and even less likely to be decisive.

As is often true of human behavioral tendencies, there may be genetic contributions to the tendency toward homosexual inclinations or behaviors. Phenotypic expression of genes is usually influenced by environmental factors—different environments may lead to different phenotypes even for the same genes. So even if there are genetic factors that contribute to homosexuality, an individual's sexual attractions or preferences may also be influenced by a number of environmental factors, such as social stressors, including emotional, physical, or sexual abuse. Looking to developmental, environmental, experiential, social, or volitional factors will be necessary to arrive at a fuller picture of how sexual interests, attractions, and desires develop.

The Limited Role of Genetics

Lay readers might note at this point that even at the purely biological level of genetics, the shopworn “nature vs. nurture” debates regarding human psychology have been abandoned by scientists, who recognize that no credible hypothesis can be offered for any particular traits that would be determined either purely by genetics or the environment. The growing field of epigenetics, for example, demonstrates that even for relatively simple traits, gene expression itself can be influenced by innumerable other external factors that can shape the functioning of genes.⁵² This is even more relevant when it comes to the relationship between genes and complex traits like sexual attraction, drives, and behaviors.

These gene-environment relationships are complex and multidimensional. Non-genetic developmental factors and environmental experiences may be sculpted, in part, by genetic factors working in subtle ways. For example, social geneticists have documented the indirect role of genes in peer-aligned behaviors, such that an individual's physical appearance could influence whether a particular social group will include or exclude that individual.⁵³

Contemporary geneticists know that genes can influence a person's range of interests and motivations, therefore indirectly affecting behavior. While genes may in this way incline a person to certain behaviors, compelling behavior directly, independently of a wide range of other factors, seems less plausible. They may influence behavior in more subtle ways, depending on external environmental stimuli (for instance, peer pressure, suggestion, and behavioral rewards) in conjunction with psychological factors and physical makeup. Dean Hamer, whose work on the possible role of genetics in homosexuality was examined above, explained some of the limitations of behavioral genetics in a 2002 article in *Science*: "The real culprit [of lack of progress in behavioral genetics] is the assumption that the rich complexity of human thought and emotion can be reduced to a simple, linear relation between individual genes and behaviors.... This oversimplified model, which underlies most current research in behavior genetics, ignores the critical importance of the brain, the environment, and gene expression networks."⁵⁴

The genetic influences affecting any complex human behavior—whether sexual behaviors, or interpersonal interactions—depend in part on individuals' life experiences as they mature. Genes constitute only one of the many key influences on behavior in addition to environmental influences, personal choices, and interpersonal experiences. The weight of evidence to date strongly suggests that the contribution of genetic factors is modest. We can say with confidence that genes are not the sole, essential cause of sexual orientation; there is evidence that genes play a modest role in contributing to the development of sexual attractions and behaviors but little evidence to support a simplistic "born that way" narrative concerning the nature of sexual orientation.

The Influence of Hormones

Another area of research relevant to the hypothesis that people are born with dispositions toward different sexual orientations involves prenatal hormonal influences on physical development and subsequent male- or female-typical behaviors in early childhood. For ethical and practical reasons, the experimental work in this field is carried out in non-human mammals, which limits how this research can be generalized to human cases. However, children who are born with disorders of sexual development (DSD) serve as a population in which to examine the influence of genetic and hormonal abnormalities on the subsequent development of non-typical sexual identity and sexual orientation.

Hormones responsible for sexual differentiation are generally thought to exert on the developing fetus either *organizational* effects—which produce permanent changes in the wiring and sensitivity of the brain, and thus are considered largely irreversible—or *activating* effects, which occur later in an individual's life (at puberty, and into adulthood).⁵⁵ Organizational hormones may prime the fetal systems (including the brain) structurally, and set the stage for sensitivity to hormones presenting at puberty and beyond, when the hormone will then “activate” systems which were “organized” prenatally.

Periods of peak response to the hormonal environment are thought to occur during gestation. For example, testosterone is thought to influence the male fetus maximally between weeks 8 and 24, and then again at birth, until about three months of age.⁵⁶ Estrogens are provided throughout gestation by the placenta and the mother's blood system.⁵⁷ Studies in animals reveal there may even be multiple periods of sensitivity for a variety of hormones, that the presence of one hormone may influence the action of another hormone, and the sensitivity of the receptors for these hormones can influence their actions.⁵⁸ Sexual differentiation, alone, is a highly complex system.

Specific hormones of interest in this area of research are testosterone, dihydrotestosterone (a metabolite of testosterone, and more potent than testosterone), estradiol, progesterone, and cortisol. The generally accepted pathways of normal hormonal influence of development in utero are as follows. The typical pattern of sex differentiation in human fetuses begins with the differentiation of the sex organs into testes or ovaries, a process that is largely genetically controlled. Once these organs have differentiated, they produce specific hormones that determine development of external genitalia. This window of time in gestation is when hormones exert their phenotypic and neurological effects. Testosterone secreted by the testes contributes to the development of male external genitalia and affects neurological development in males;⁵⁹ it is the absence of testosterone in females which allows for the female pattern of external genitalia to develop.⁶⁰ Imbalances of testosterone or estrogen, as well as their presence or absence at specific critical periods of gestation, may cause disorders of sexual development. (Genetic or environmental effects can also lead to disorders of sexual development.)

Stress may also play some role in influencing the way hormones shape gonadal development, neurodevelopment, and subsequent sex-typical behaviors in early childhood.⁶¹ Cortisol is the main hormone associated

with stress responses. It may originate from the mother, if she experiences severe stressors during her pregnancy, or from the fetus under stress.⁶² Elevated levels of cortisol may also occur from genetic defects.⁶³ One of the most extensively studied disorders of sexual development is congenital adrenal hyperplasia (CAH), which in females can result in genital virilization.⁶⁴ Over 90% of cases of CAH result from a mutation in a gene that codes for an enzyme that helps synthesize cortisol.⁶⁵ This results in an overproduction of cortisol precursors, some of which are converted into androgens (hormones associated with male sex development).⁶⁶ As a result, girls are born with some degree of virilization of their genitalia, depending on the severity of the genetic defect.⁶⁷ For severe cases of genital virilization, surgical intervention is sometimes performed to normalize the genitalia. Hormone therapies are also often administered to mitigate the effects of excess androgen production.⁶⁸ Females with CAH, who as fetuses were exposed to above-average levels of androgens, are less likely to be exclusively heterosexual than females without CAH, and females with more severe forms of CAH are more likely to be non-heterosexual than females with milder forms of the condition.⁶⁹

Likewise, there are disorders of sexual development in genetic males affected by androgen insensitivity. In males with androgen insensitivity syndrome, the testes produce testosterone normally, but the receptors to testosterone are not functional.⁷⁰ The genitalia, at birth, appear to be female, and the child is usually raised as a female. The individual's endogenous testosterone is broken down into estrogen, such that the individual begins to develop female secondary sex characteristics.⁷¹ It does not become apparent that there is a problem until puberty, when the individual does not start menses appropriately.⁷² These patients generally prefer to continue life as females, and their sexual orientation does not differ from females having an XX genotype.⁷³ Studies have suggested that they are just as likely if not more likely to be exclusively interested in male partners than XX females.⁷⁴

There are other disorders of sexual development affecting some genetic males (i.e., with an XY genotype) in whom androgen deficiencies are a direct result of the lack of enzymes either to synthesize dihydrotestosterone from testosterone or to produce testosterone from its precursor hormone.⁷⁵ Individuals with these deficiencies are born with varied degrees of ambiguous genitalia, and are sometimes raised as girls. During puberty, however, these individuals often experience physical virilization, and must then decide whether to live as men or women. Peggy T. Cohen-Kettenis, a professor of gender development and psychopathology, found that 39 to

64% of individuals with these deficiencies who are raised as girls change to live as men in adolescence and early adulthood, and she also reported that “the degree of external genital masculinization at birth does not seem to be related to gender role changes in a systematic way.”⁷⁶

The twin studies reviewed earlier may shed light on the role of maternal hormonal influences, since both identical and fraternal twins are exposed to similar maternal hormonal influences in utero. The relatively weak concordance rates in the twin studies suggest that prenatal hormones, like genetic factors, do not play a strongly determinative role in sexual orientation. Other attempts at finding significant hormonal influences on sexual development have likewise been mixed, and the salience of the findings is not yet clear. Since direct studies of prenatal hormonal influences on sexual development are methodologically difficult, some studies have tried to develop models whereby differences in prenatal hormonal exposure can be inferred indirectly—by measuring subtle morphological changes or by examining hormonal disorders that are present later during development.

For example, one rough proxy of prenatal testosterone levels used by researchers is the ratio between the length of the second finger (index finger) and the fourth finger (ring finger), which is commonly called the “2D:4D ratio.” Some evidence suggests that the ratio may be influenced by prenatal exposure to testosterone, such that in males higher levels of exposure to testosterone cause shorter index fingers relative to the ring finger (or having a low 2D:4D ratio), and vice versa.⁷⁷ According to one hypothesis, homosexual men may have a higher 2D:4D ratio (closer to the ratio found in females than in heterosexual males), while another hypothesis suggests the opposite, that homosexual men may be hypermasculinized by prenatal testosterone, resulting in a lower ratio than in heterosexual men. For women, the hypothesis for homosexuality that they have been hypermasculinized (lower ratio, higher testosterone) has also been proposed. Several studies comparing this trait in homosexually versus heterosexually identified men and women have shown mixed results.

A study published in *Nature* in 2000 found that in a sample of 720 California adults, the right-hand 2D:4D ratio of homosexual women was significantly more masculine (that is, the ratio was smaller) than that of heterosexual women and did not differ significantly from that of heterosexual men.⁷⁸ This study also found no significant difference in mean 2D:4D ratio between heterosexual and homosexual men. Another study that year, which used a relatively small sample of homosexual and heterosexual men from the United Kingdom, reported a lower 2D:4D (that

is, more masculine) ratio in homosexual men.⁷⁹ A 2003 study using a London-based sample also found that homosexual men had a lower 2D:4D ratio than heterosexuals,⁸⁰ while two other studies with samples from California and Texas showed *higher* 2D:4D ratios for homosexual men.⁸¹

A 2003 twin study compared seven female monozygotic twin pairs discordant for homosexuality (one twin was lesbian) and five female monozygotic twin pairs concordant for homosexuality (both twins were lesbian).⁸² In the twin pairs discordant for sexual orientation, the individuals identifying as homosexual had significantly lower 2D:4D ratios than their twins, whereas the concordant twins showed no difference. The authors interpreted this result as suggesting that “low 2D:4D ratio is a result of differences in prenatal environment.”⁸³ Finally, a 2005 study of 2D:4D ratios in an Austrian sample of 95 homosexual and 79 heterosexual men found that the 2D:4D ratios of heterosexual men were not significantly different from those of homosexual men.⁸⁴ After reviewing the several studies on this trait, the authors conclude that “more data are essential before we can be sure whether there is a 2D:4D effect for sexual orientation in men when ethnic variation is controlled for.”⁸⁵

Much research has examined the effects of prenatal hormones on behavior and brain structure. Again, these results come primarily from studies of non-human primates, but the study of disorders of sexual development has provided helpful insights into the effects of hormones on sexual development in humans. Since hormonal influences typically occur during time-sensitive periods of development, when their effects manifest physically, it is reasonable to assume that organizational effects of these early, time-linked hormonal patterns are likely to direct aspects of neural development. Neuroanatomical connectivity and neurochemical sensitivities may be among such influences.

In 1983, Günter Dörner and colleagues performed a study investigating whether there is any relationship between maternal stress during pregnancy and later sexual identity of their children, interviewing two hundred men about stressful events that may have occurred to their mothers during their prenatal lives.⁸⁶ Many of these events occurred as a consequence of World War II. Of men who reported that their mothers had experienced moderately to severely stressful events during pregnancy, 65% were homosexual, 25% were bisexual, and 10% were heterosexual. (Sexual orientation was assessed using the Kinsey scale.) However, more recent studies have shown much smaller or no significant correlations.⁸⁷ In a 2002 prospective study on the relationship between sexual orientation and prenatal stress during the second and third trimesters, Hines

and colleagues found that stress reported by mothers during pregnancy showed “only a small relationship” to male-typical behaviors in their daughters at the age of 42 months, “and no relationship at all” to female-typical behaviors in their sons.⁸⁸

In summary, some forms of prenatal hormone exposure, particularly CAH in females, are associated with differences in sexual orientation, while other factors are often important in determining the physical and psychological effects of those exposures. Hormonal conditions that contribute to disorders of sex development may contribute to the development of non-heterosexual orientations in some individuals, but this does not demonstrate that such factors explain the development of sexual attractions, desires, and behaviors in the majority of cases.

Sexual Orientation and the Brain

There have been several studies examining neurobiological differences between individuals who identify as heterosexual and those who identify as homosexual. This work began with neuroscientist Simon LeVay’s 1991 study that reported biological differences in the brains of gay men as compared to straight men—specifically, a difference in volume in a particular cell group of the interstitial nuclei of the anterior hypothalamus (INAH3).⁸⁹ Later work by psychiatrist William Byne and colleagues showed more nuanced findings: “In agreement with two prior studies... we found INAH3 to be sexually dimorphic, occupying a significantly greater volume in males than females. In addition, we determined that the sex difference in volume was attributable to a sex difference in neuronal number and not in neuronal size or density.”⁹⁰ The authors noted that, “Although there was a trend for INAH3 to occupy a smaller volume in homosexual men than in heterosexual men, there was no difference in the number of neurons within the nucleus based on sexual orientation.” They speculated that “postnatal experience” may account for the differences in volume in this region between homosexual and heterosexual men, though this would require further research to confirm.⁹¹ They also noted that the functional significance of sexual dimorphism in INAH3 is unknown. The authors conclude: “Based on the results of the present study as well as those of LeVay (1991), sexual orientation cannot be reliably predicted on the basis of INAH3 volume alone.”⁹² In 2002, psychologist Mitchell S. Lasco and colleagues published a study examining a different part of the brain—the anterior commissure—and found that there were no significant differences in that area based either on sex or sexual orientation.⁹³

Other studies have since been conducted to ascertain structural or functional differences between the brains of heterosexual and homosexual individuals (using a variety of criteria to define these categories). Findings from several of these studies are summarized in a 2008 commentary published in the *Proceedings of the National Academy of Sciences*.⁹⁴ Research of this kind, however, does not seem to reveal much of relevance regarding the etiology or biological origins of sexual orientation. Due to inherent limitations, this research literature is fairly unremarkable. For example, in one study functional MRI was used to measure activity changes in the brain when pictures of men and women were shown to subjects, finding that viewing a female face produced stronger activity in the thalamus and orbitofrontal cortex of heterosexual men and homosexual women, whereas in homosexual men and heterosexual women these structures reacted more strongly to the face of a man.⁹⁵ That the brains of heterosexual women and homosexual men reacted distinctively to the faces of men, whereas the brains of heterosexual men and homosexual women reacted distinctively to the faces of women, is a finding that seems rather trivial with respect to understanding the etiology of homosexual attractions. In a similar vein, one study reported different responses to pheromones between homosexual and heterosexual men,⁹⁶ and a follow-up study showed a similar finding in homosexual compared to heterosexual women.⁹⁷ Another study showed differences in cerebral asymmetry and functional connectivity between homosexual and heterosexual subjects.⁹⁸

While findings of this kind may suggest avenues for future investigation, they do not move us much closer to an understanding of the biological or environmental determinants of sexual attractions, interests, preferences, or behaviors. We will say more about this below. For now, we will briefly illustrate a few of the inherent limitations in this area of research with the following hypothetical example. Suppose we were to study the brains of yoga teachers and compare them to the brains of bodybuilders. If we search long enough, we will eventually find statistically significant differences in some area of brain morphology or brain function between these two groups. But this would not imply that such differences determined the different life trajectories of the yoga teacher and the bodybuilder. The brain differences could have been the result, rather than the cause, of distinctive patterns of behavior or interests.⁹⁹ Consider another example. Suppose that gay men tend to have less body fat than straight men (as indicated by lower average scores on body mass indices). Even though body mass is, in part, determined by genetics, we could not claim based on this finding that there is some innate, genetic cause of both body

mass and homosexuality at work. It could be the case, for instance, that being gay is associated with a diet that lowers body mass. These examples illustrate one of the common problems encountered in the popular interpretation of such research: the suggestion that the neurobiological pattern determines a particular behavioral expression.

With this overview of studies on biological factors that might influence sexual attraction, preferences, or desires, we can understand the rather strong conclusion by social psychologist Letitia Anne Peplau and colleagues in a 1999 review article: “To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women’s sexual orientation.... Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women’s sexual orientation.”¹⁰⁰ In light of the studies we have summarized here, this statement could also be made for research on male sexual orientation, however this concept is defined.

Misreading the Research

There are some significant built-in limitations to what the kind of empirical research summarized in the preceding sections can show. Ignoring these limitations is one of the main reasons the research is routinely misinterpreted in the public sphere. It may be tempting to assume, as we just saw with the example of brain structure, that if a particular biological profile is associated with some behavioral or psychological trait, then that biological profile *causes* that trait. This reasoning relies on a fallacy, and in this section we explain why, using concepts from the field of epidemiology. While some of these issues are rather technical in detail, we will try to explain them in a general way that is accessible to the non-specialist reader.

Suppose for the sake of illustration that one or more differences in a biological trait are found between homosexual and heterosexual men. That difference could be a discrete measure (call this D) such as presence of a genetic marker, or it could be a continuous measure (call this C) such as the average volume of a particular part of the brain.

Showing that a risk factor significantly increases the chances of a particular health outcome or a behavior might give us a clue to development of that health outcome or that behavior, but it does not provide evidence of causation. Indeed, it may not provide evidence of anything but the weakest of correlations. The inference is sometimes made that if it can be shown that gay men and straight men differ significantly in the

probability that D is present (whether a gene, a hormonal factor, or something else), no matter how low that probability, then this finding suggests that being gay has a biological basis. But this inference is unwarranted. Doubling (or even tripling or quadrupling) the probability of a relatively rare trait can have little value in terms of predicting who will or will not identify as gay.

The same would be true for any continuous variable (C). Showing a significant difference at the mean or average for a given trait (such as the volume of a particular brain region) between men who identify as heterosexual and men who identify as homosexual does not suffice to show that this average difference contributes to the probability of identifying as heterosexual or homosexual. In addition to the reasons explained above, a significant difference at the means of two distributions can be consistent with a great deal of overlap between the distributions. That is, there may be virtually no separation in terms of distinguishing between some individual members of each group, and thus the measure would not provide much predictability for sexual orientation or preference.

Some of these issues could, in part, be addressed by additional methodological approaches, such as the use of a training sample or cross-validation procedures. A training sample is a small sample used to develop a model (or hypothesis); this model is then tested on a larger independent sample. This method avoids testing a hypothesis on the same data used to develop the hypothesis. Cross-validation includes procedures used to examine whether a statistically significant effect is really there or just due to chance. If one wants to show the result did not occur by chance (and if the sample is large), one can run the same tests on a random split of the relevant sample. After finding a difference in the prevalence of trait D or C between a gay sample and a straight sample, researchers could randomly split the gay sample into two groups and then show that these two groups do not differ regarding D or C. Suppose one finds five differences out of 100 comparing gay to straight men in the overall samples, then finds five differences out of 100 when comparing the split gay samples. This would cast additional doubt on the initial finding of a difference between the means of gay and straight individuals.

Sexual Abuse Victimization

Whereas the preceding discussion considered the part that biological factors might play in the development of sexual orientation, this section will summarize evidence that a particular environmental factor—childhood

sexual abuse—is reported significantly more often among those who later identify as homosexual. The results presented below raise the question whether there is an association between sexual abuse, particularly in childhood, and later expressions of sexual attraction, behavior, or identity. If so, might child abuse increase the probability of having a non-heterosexual orientation?

Correlations, at least, have been found, as we will summarize below. But we should note first that they might be accounted for by one or more of the following conjectures:

1. Abuse might contribute to the development of non-heterosexual orientation.
2. Children with (signs of future) non-heterosexual tendencies might attract abusers, placing them at elevated risk.
3. Certain factors might contribute to *both* childhood sexual abuse and non-heterosexual tendencies (for instance, a dysfunctional family or an alcoholic parent).

It should be kept in mind that these three hypotheses are not mutually exclusive; all three, and perhaps others, might be operative. As we summarize the studies on this issue, we will try to evaluate each of these hypotheses in light of current scientific research.

Behavioral and community health professor Mark S. Friedman and colleagues conducted a 2011 meta-analysis of 37 studies from the United States and Canada examining sexual abuse, physical abuse, and peer victimization in heterosexuals as compared to non-heterosexuals.¹⁰¹ Their results showed that non-heterosexuals were on average 2.9 times more likely to report having been abused as children (under 18 years of age). In particular, non-heterosexual males were 4.9 times likelier—and non-heterosexual females, 1.5 times likelier—than their heterosexual counterparts to report sexual abuse. Non-heterosexual adolescents as a whole were 1.3 times likelier to indicate physical abuse by parents than their heterosexual peers, but gay and lesbian adolescents were only 0.9 times as likely (bisexuals were 1.4 times as likely). As for peer victimization, non-heterosexuals were 1.7 times likelier to report being injured or threatened with a weapon or being attacked.

The authors note that although they hypothesized that the rates of abuse would decrease as social acceptance of homosexuality rose, “disparities in prevalence rates of sexual abuse, parental physical abuse, and peer

victimization between sexual minority and sexual nonminority youths did not change from the 1990s to the first decade of the 2000s.”¹⁰² While these authors cite authorities who claim that sexual abuse does not “cause individuals to become gay, lesbian, or bisexual,”¹⁰³ their data do not give evidence against the hypothesis that childhood sexual abuse might affect sexual orientation. On the other hand, the causal path could be in the opposite direction or bi-directional. The evidence does not refute or support this conjecture; the study’s design is not capable of shedding much light on the question of directionality.

The authors invoke a widely-cited hypothesis to explain the higher rates of sexual abuse among non-heterosexuals, the hypothesis that “sexual minority individuals are...more likely to be targeted for sexual abuse, as youths who are perceived to be gay, lesbian, or bisexual are more likely to be bullied by their peers.”¹⁰⁴ The two conjectures—that abuse is a cause and that it is a result of non-heterosexual tendencies—are not mutually exclusive: abuse may be a causal factor in the development of non-heterosexual attractions and desires, and at the same time non-heterosexual attractions, desires, and behaviors may increase the risk of being targeted for abuse.

Community health sciences professor Emily Faith Rothman and colleagues conducted a 2011 systematic review of the research investigating the prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States.¹⁰⁵ They examined 75 studies (25 of which used probability sampling) involving a total of 139,635 gay or bisexual (GB) men and lesbian or bisexual (LB) women, which measured the prevalence of victimization due to lifetime sexual assault (LSA), childhood sexual assault (CSA), adult sexual assault (ASA), intimate partner sexual assault (IPSA), and hate-crime-related sexual assault (HC). Although the study was limited by not having a heterosexual control group, it showed alarmingly high rates of sexual assault, including childhood sexual assault, for this population, as summarized in Table 1.

Using a multi-state probability-based sample in a 2013 study, psychologist Judith Anderson and colleagues compared differences in adverse childhood experiences—including dysfunctional households; physical, sexual, or emotional abuse; and parental discord—among self-identified homosexual, heterosexual, and bisexual adults.¹⁰⁶ They found that bisexuals had significantly higher proportions than heterosexuals of all adverse childhood experience factors, and that gays and lesbians had significantly higher proportions than heterosexuals of all these measures except parental separation or divorce. Overall, gays and lesbians had nearly 1.7 times,

Table 1. Sexual Assault among Gay/Bisexual Men and Lesbian/Bisexual Women

GB Men (%)	LB Women (%)
CSA: 4.1–59.2 (median 22.7)	CSA: 14.9–76.0 (median 34.5)
ASA: 10.8–44.7 (median 14.7)	ASA: 11.3–53.2 (median 23.2)
LSA: 11.8–54.0 (median 30.4)	LSA: 15.6–85.0 (median 43.4)
IPSA: 9.5–57.0 (median 12.1)	IPSA: 3.0–45.0 (median 13.3)
HC: 3.0–19.8 (median 14.0)	HC: 1.0–12.3 (median 5.0)

and bisexuals 1.6 times, the heterosexual rate of adverse childhood experiences. The data for abuse are summarized in Table 2.

While this study, like some others we have discussed, may be limited by recall bias—that is, inaccuracies introduced by errors of memory—it has the merit of having a control group of self-identified heterosexuals to compare with self-identified gay/lesbian and bisexual cohorts. In their discussion of findings, the authors critique the hypothesis that childhood trauma has a causal relationship to homosexual preferences. Among their reasons for skepticism, they note that the vast majority of individuals who suffer childhood trauma do not become gay or bisexual, and that gender-nonconforming behavior may help explain the elevated rates of abuse. However, it is plausible from these and related results to hypothesize

Table 2. Adverse Childhood Experiences among Gays/Lesbians, Bisexuals, and Heterosexuals

Sexual Abuse (%)		
GLs	Bisexuals	Heterosexuals
29.7	34.9	14.8
Emotional Abuse (%)		
GLs	Bisexuals	Heterosexuals
47.9	48.4	29.6
Physical Abuse (%)		
GLs	Bisexuals	Heterosexuals
29.3	30.3	16.7

that adverse childhood experiences may be a significant—but not a determinative—factor in developing homosexual preferences. Further studies are needed to see whether either or both hypotheses have merit.

A 2010 study by professor of social and behavioral sciences Andrea Roberts and colleagues examined sexual orientation and risk of post-traumatic stress disorder (PTSD) using data from a national epidemiological face-to-face survey of nearly 35,000 adults.¹⁰⁷ Individuals were placed into several categories: heterosexual with no same-sex attraction or partners (reference group); heterosexual with same-sex attraction but no same-sex partners; heterosexual with same-sex partners; self-identified gay/lesbian; and self-identified bisexual. Among those reporting exposure to traumatic events, gay and lesbian individuals as well as bisexuals had about twice the lifetime risk of PTSD compared to the heterosexual reference group. Differences were found in rates of childhood maltreatment and interpersonal violence: gays, lesbians, bisexuals, and heterosexuals with same-sex partners reported experiencing worse traumas during childhood and adolescence than the reference group. The findings are summarized in Table 3.

Similar patterns emerged in a 2012 study by psychologist Brendan Zietsch and colleagues that primarily focused on the distinct question of whether common causal factors could explain the association between sexual orientation—in this study defined as sexual preference—and depression.¹⁰⁸ In a community sample of 9,884 adult twins, the authors found that non-heterosexuals had significantly elevated prevalence of lifetime depression (odds ratio for males 2.8; odds ratio for females 2.7). As the authors point out, the data raised questions about whether higher rates of depression for non-heterosexuals could be explained, in their entirety, by the social stress hypothesis (the idea, discussed in depth in Part Two of this report, that social stress

**Table 3. Childhood Exposure to Maltreatment
or Interpersonal Violence (before Age 18)**

Women	Men
49.2% of lesbians	31.5% of gays
51.2% of bisexuals	Approximately 32% of bisexuals ¹⁰⁹
40.9% of heterosexuals with same-sex partners	27.9% of heterosexuals with same-sex partners
21.2% of heterosexuals	19.8% of heterosexuals

experienced by sexual minorities accounts for their elevated risks of poor mental health outcomes). Heterosexuals with a non-heterosexual twin had higher rates of depression (39%) than heterosexual twin pairs (31%), suggesting that genetic, familial, or other factors may play a role.

The authors note that “in both males and females, significantly higher rates of non-heterosexuality were found in participants who experienced childhood sexual abuse and in those with a risky childhood family environment.”¹¹⁰ Indeed, 41% of non-heterosexual males and 42% of non-heterosexual females reported childhood family dysfunction, compared to 24% and 30% of heterosexual males and females, respectively. And 12% of non-heterosexual males and 24% of non-heterosexual females reported sexual abuse before the age of 14, compared with 4% and 11% of heterosexual males and females, respectively. The authors are careful to emphasize that their findings should not be interpreted as disproving the social stress hypothesis, but suggest that there may be other factors at work. Their findings do, however, suggest there could be common etiological factors for depression and non-heterosexual preferences, as they found that genetic factors account for 60% of the correlation between sexual orientation and depression.¹¹¹

In a 2001 study, psychologist Marie E. Tomeo and colleagues noted that the previous literature had consistently found increased rates of reported childhood molestation in the homosexual population, with somewhere between 10% and 46% reporting that they had experienced childhood sexual abuse.¹¹² The authors found that 46% of homosexual men and 22% of homosexual women reported that they had been molested by a person of the same gender, as compared with 7% of heterosexual men and 1% of heterosexual women. Moreover, 38% of homosexual women interviewed did not identify as homosexual until after the abuse, while the authors report conflicting figures—68% in one part of the paper and (by inference) 32% in another—for the number of homosexual men who did not identify as homosexual until after the abuse. The sample for this study was relatively small, only 267 individuals; also, the “sexual contact” measure of abuse in the survey was somewhat vague, and the subjects were recruited from participants in gay pride events in California. But the authors state that “it is most unlikely that all the present findings apply only to homosexual persons who go to homosexual fairs and volunteer to participate in questionnaire research.”¹¹³

In 2010, psychologists Helen Wilson and Cathy S. Widom published a prospective 30-year follow-up study—one that looked at children who had experienced abuse or neglect between 1961 and 1971, and then followed up with those children after 30 years—to ascertain whether physical abuse, sexual abuse, or neglect in childhood increased the likelihood of same-sex

sexual relationships later in life.¹¹⁴ An original sample of 908 abused and/or neglected children was matched with a non-maltreated control group of 667 individuals (matched for age, sex, race or ethnicity, and approximate socioeconomic status). Homosexuality was operationalized as anyone who had cohabited with a same-sex romantic partner or had a same-sex sexual partner, which made up 8% of the sample. Among these 8%, most individuals also reported having had opposite-sex partners, suggesting high rates of bisexuality or fluidity in sexual attractions or behaviors. The study found that those who reported histories of childhood sexual abuse were 2.8 times more likely to report having had same-sex sexual relationships, though the “relationship between childhood sexual abuse and same-sex sexual orientation was significant only for men.”¹¹⁵ This finding suggested that boys who are sexually abused may be more likely to establish both heterosexual and homosexual relationships.

The authors advised caution in interpreting this result, because the sample size of sexually abused men was small, but the association remained statistically significant when they controlled for total lifetime number of sexual partners and for engaging in prostitution. The study was also limited by a definition of sexual orientation that was not sensitive to how participants identified themselves. It may have failed to capture people with same-sex attractions but no same-sex romantic relationship history. The study had two notable methodological strengths. The prospective design is better suited for evaluating causal relationships than the typical retrospective design. Also, the childhood abuse recorded was documented when it occurred, thus mitigating recall bias.

Having examined the statistical association between childhood sexual abuse and later homosexuality, we turn to the question of whether the association suggests causation.

A 2013 analysis by health researcher Andrea Roberts and colleagues attempted to provide an answer to this question.¹¹⁶ The authors noted that while studies show 1.6 to 4 times more reported childhood sexual and physical abuse among gay and lesbian individuals than among heterosexuals, conventional statistical methods cannot demonstrate a strong enough statistical relationship to support the argument of causation. They argued that a sophisticated statistical method called “instrumental variables,” imported from econometrics and economic analysis, could increase the level of association.¹¹⁷ (The method is somewhat similar to the method of “propensity scores,” which is more sophisticated and more familiar to public health researchers.) The authors applied the method of instrumental variables to data collected from a nationally representative sample.

They used three dichotomous measures of sexual orientation: any vs. no same-sex attraction; any vs. no lifetime same-sex sexual partners; and lesbian, gay, or bisexual vs. heterosexual self-identification. As in other studies, the data showed associations between childhood sexual abuse or maltreatment and all three dimensions of non-heterosexuality (attraction, partners, identity), with associations between sexual abuse and sexual identity being the strongest.

The authors' instrumental variable models suggested that early sexual abuse increased the predicted rate of same-sex attraction by 2.0 percentage points, same-sex partnering by 1.4 percentage points, and same-sex identity by 0.7 percentage points. The authors estimated the rate of homosexuality that might be attributable to sexual abuse "using effect estimates from conventional models" and found that on conventional effect estimates, "9% of same-sex attraction, 21% of any lifetime same-sex sexual partnering, and 23% of homosexual or bisexual identity was due to childhood sexual abuse."¹¹⁸ We should note that these correlations are cross-sectional: they compare groups of people to groups of people, rather than model the course of individuals over time. (A study design with a time-series analysis would give the strongest statistical support to the claim of causality.) Additionally, these results have been strongly criticized on methodological grounds for having made unjustified assumptions in the instrumental variables regression; a commentary by Drew H. Bailey and J. Michael Bailey claims, "Not only do Roberts et al.'s results fail to provide support for the idea that childhood maltreatment causes adult homosexuality, the pattern of differences between males and females is opposite what should be expected based on better evidence."¹¹⁹

Roberts and colleagues conclude their study with several conjectures to explain the epidemiological associations. They echo suggestions made elsewhere that sexual abuse perpetrated by men might cause boys to think they are gay or make girls averse to sexual contact with men. They also conjecture that sexual abuse might leave victims feeling stigmatized, which in turn might make them more likely to act in ways that are socially stigmatized (as by engaging in same-sex sexual relationships). The authors also point to the biological effects of maltreatment, citing studies that show that "quality of parenting" can affect chemical and hormonal receptors in children, and hypothesizing that this might influence sexuality "through epigenetic changes, particularly in the stria terminalis and the medial amygdala, brain regions that regulate social behavior."¹²⁰ They also mention the possibilities that emotional numbing caused by maltreatment may drive victims to seek out risky behaviors associated

with same-sex sexuality, or that same-sex attractions and partnering may result from “the drive for intimacy and sex to repair depressed, stressed, or angry moods,” or from borderline personality disorder, which is a risk factor in individuals who have been maltreated.¹²¹

In short, while this study suggests that sexual abuse may sometimes be a causal contributor to having a non-heterosexual orientation, more research is needed to elucidate the biological or psychological mechanisms. Without such research, the idea that sexual abuse may be a causal factor in sexual orientation remains speculative.

Distribution of Sexual Desires and Changes Over Time

However sexual desires and interests develop, there is a related issue that scientists debate: whether sexual desires and attractions tend to remain fixed and unalterable across the lifespan of a person—or are fluid and subject to change over time but tend to become fixed after a certain age or developmental period. Advocates of the “born that way” hypothesis, as mentioned earlier, sometimes argue that a person is not only born with a sexual orientation but that that orientation is immutable; it is fixed for life.

There is now considerable scientific evidence that sexual desires, attractions, behaviors, and even identities can, and sometimes do, change over time. For findings in this area we can turn to the most comprehensive study of sexuality to date, the 1992 National Health and Social Life Survey conducted by the National Opinion Research Center at the University of Chicago (NORC).¹²² Two important publications have appeared using data from NORC’s comprehensive survey: *The Social Organization of Sexuality: Sexual Practices in the United States*, a large tome of data intended for the research community, and *Sex in America: A Definitive Survey*, a smaller and more accessible book summarizing the findings for the general public.¹²³ These books present data from a reliable probability sample of the American population between ages 18 and 59.

According to data from the NORC survey, the estimated prevalence of non-heterosexuality, depending on how it was operationalized, and on whether the subjects were male or female, ranged between roughly 1% and 9%.¹²⁴ The NORC studies added scientific respectability to sexual surveys, and these findings have been largely replicated in the United States and abroad. For example, the British National Survey of Sexual Attitudes and Lifestyles (Natsal) is probably the most reliable source of information on sexual behavior in that country—a study conducted every ten years since 1990.¹²⁵

The NORC study also suggested ways in which sexual behaviors and identities can vary significantly under different social and environmental circumstances. The findings revealed, for example, a sizable difference in rates of male homosexual behavior among individuals who spent their adolescence in rural as compared to large metropolitan cities in America, suggesting the influence of social and cultural environments. Whereas only 1.2% of males who had spent their adolescence in a rural environment responded that they had had a male sexual partner in the year of the survey, those who had spent adolescence living in metropolitan areas were close to four times (4.4%) more likely to report that they had had such an encounter.¹²⁶ From these data one cannot infer differences between these environments in the prevalence of sexual interests or attractions, but the data do suggest differences in sexual behaviors. Also of note is that women who attended college were nine times more likely to identify as lesbians than women who did not.¹²⁷

Moreover, other population-based surveys suggest that sexual desire may be fluid for a considerable number of individuals, especially among adolescents as they mature through the early stages of adult development. In this regard, opposite-sex attraction and identity seem to be more stable than same-sex or bisexual attraction and identity. This is suggested by data from the National Longitudinal Study of Adolescent to Adult Health (the “Add Health” study discussed earlier). This prospective longitudinal study of a nationally representative sample of U.S. adolescents starting in grades 7–12 began during the 1994–1995 school year, and followed the cohort into young adulthood, with four follow-up interviews (referred to as Waves I, II, III, IV in the literature).¹²⁸ The most recent was in 2007–2008, when the sample was aged 24–32.

Same-sex or both-sex romantic attractions were quite prevalent in the study’s first wave, with rates of approximately 7% for the males and 5% for the females.¹²⁹ However, 80% of the adolescent males who had reported same-sex attractions at Wave I later identified themselves as exclusively heterosexual as young adults at Wave IV.¹³⁰ Similarly, for adolescent males who, at Wave I, reported romantic attraction to both sexes, over 80% of them reported no same-sex romantic attraction at Wave III.¹³¹ The data for the females surveyed were similar but less striking: for adolescent females who had both-sex attractions at Wave I, more than half reported exclusive attraction to males at Wave III.¹³²

J. Richard Udry, the director of Add Health for Waves I, II, and III,¹³³ was among the first to point out the fluidity and instability of romantic attraction between the first two waves. He reported that among boys who

reported romantic attraction *only* to boys and *never* to girls at Wave I, 48% did so during Wave II; 35% reported no attraction to either sex; 11% reported exclusively same-sex attraction; and 6% reported attraction to both sexes.¹³⁴

Ritch Savin-Williams and Geoffrey Ream published a 2007 analysis of the data from Waves I–III of Add Health.¹³⁵ Measures used included whether individuals ever had a romantic attraction for a given sex, sexual behavior, and sexual identity. (The categories for sexual identity were 100% heterosexual, mostly heterosexual but somewhat same-sex attracted, bisexual, mostly homosexual but somewhat attracted to opposite sex, and 100% homosexual.) While the authors noted the “stability of opposite-sex attraction and behavior” between Waves I and III, they found a “high proportion of participants with same- and both-sex attraction and behavior that migrated into opposite-sex categories between waves.”¹³⁶ A much smaller proportion of those in the heterosexual categories, and a similar proportion of those without attraction, moved to non-heterosexual categories. The authors summarize: “All attraction categories other than opposite-sex were associated with a lower likelihood of stability over time. That is, individuals reporting any same-sex attractions were more likely to report subsequent shifts in their attractions than were individuals without any same-sex attractions.”¹³⁷

The authors also note the difficulties these data present for trying to define sexual orientation and to classify individuals according to such categories: “the critical consideration is whether having ‘any’ same-sex sexuality qualifies as nonheterosexuality. How much of a dimension must be present to tip the scales from one sexual orientation to another was not resolved with the present data, only that such decisions matter in terms of prevalence rates.”¹³⁸ The authors suggested that researchers could “for-sake the general notion of sexual orientation altogether and assess only those components relevant for the research question.”¹³⁹

Another prospective study by biostatistician Miles Ott and colleagues of 10,515 youth (3,980 males; 6,535 females) in 2013 showed findings on sexual orientation change in adolescents consistent with the findings of the Add Health data, again suggesting fluidity and plasticity of same-sex attractions among many adolescents.¹⁴⁰

A few years after the Add Health data were originally published, the *Archives of Sexual Behavior* published an article by Savin-Williams and Joyner that critiqued the Add Health data on sexual attraction change.¹⁴¹ Before outlining their critique, Savin-Williams and Joyner summarize the key Add Health findings: “in the approximately 13 years between Waves

I and IV, regardless of whether the measure was identical across waves (romantic attraction) or discrepant in words but not in theory (romantic attraction and sexual orientation identity), approximately 80% of adolescent boys and half of adolescent girls who expressed either partial or exclusive same-sex romantic attraction at Wave I ‘turned’ heterosexual (opposite-sex attraction or exclusively heterosexual identity) as young adults.”¹⁴² The authors propose three hypotheses to explain these discrepancies:

- (1) gay adolescents going into the closet during their young adult years;
- (2) confusion regarding the use and meaning of romantic attraction as a proxy for sexual orientation; and (3) the existence of mischievous adolescents who played a ‘jokester’ role by reporting same-sex attraction when none was present.¹⁴³

Savin-Williams and Joyner reject the first hypothesis but find support for the second and the third. With respect to the second hypothesis, they question the use of romantic attraction to operationalize sexual identity:

To help us assess whether the construct/measurement issue (romantic attraction versus sexual orientation identity) was driving results, we compared the two constructs at Wave IV....Whereas over 99% of young adults with opposite-sex romantic attraction identified as heterosexual or mostly heterosexual and 94% of those with same-sex romantic attraction identified as homosexual or mostly homosexual, 33% of both-sex attracted men identified as heterosexual (just 6% of both-sex attracted women identified as heterosexual). These data indicated that young adult men and women generally understood the meaning of romantic attraction to the opposite- or same-sex to imply a particular (and consistent) sexual orientation identity, with one glaring exception—a substantial subset of young adult men who, despite their stated both-sex romantic attraction, identified as heterosexual.

Regarding the third hypothesis for explaining the Add Health data, Savin-Williams and Joyner note that surveys of adolescents sometimes yield unusual or distorted results due to adolescents who do not respond truthfully. The Add Health survey, they observe, had a significant number of unusual responders. For example, several hundred adolescents reported in the Wave I questionnaire that they had an artificial limb, whereas in later at-home interviews, only two of those adolescents reported having an artificial limb.¹⁴⁴ Adolescent boys who went from nonheterosexual in Wave I to heterosexual in Wave IV were significantly less likely to report

having filled out the Wave I questionnaire honestly; these boys also displayed other significant differences, such as lower grade point averages. Additionally, like consistently heterosexual boys, boys who were inconsistent between Waves I and IV were more popular in their school with boys than girls, whereas consistently nonheterosexual boys were more popular with girls. These and other data¹⁴⁵ led the authors to conclude that “boys who emerged from a gay or bisexual adolescence to become a heterosexual young adulthood were, by-and-large, heterosexual adolescents who were either confused and did not understand the measure of romantic attraction or jokesters who decided, for reasons we were not able to detect, to dishonestly report their sexuality.”¹⁴⁶ However, the authors were not able to estimate the proportion of inaccurate responders, which would have helped evaluate the explanatory power of the hypotheses.

Later in 2014, the *Archives of Sexual Behavior* published a critique of the Savin-Williams and Joyner explanation of Add Health data by psychologist Gu Li and colleagues.¹⁴⁷ Along with criticizing the methodology of Savin-Williams and Joyner, these authors argued that the data were consistent with a scenario in which some nonheterosexual adolescents went “back into the closet” in later years as a possible reaction to social stress. (We will examine the effects of social stress on mental health in LGBT populations in Part Two of this report.) They also claimed that “it makes little sense to use responses to Wave IV sexual identity to validate or invalidate responses to Waves I or IV romantic attractions when these aspects of sexual orientation may not align in the first place.”¹⁴⁸ Regarding the jokester hypothesis, these authors pose this difficulty: “Although some participants might be ‘jokesters,’ and we as researchers should be cautious of problems associated with self-report surveys whenever analyzing and interpreting data, it is unclear why the ‘jokesters’ would answer questions about delinquency honestly, but not questions about their sexual orientation.”¹⁴⁹

Savin-Williams and Joyner published a response to the critique in the same issue of the journal.¹⁵⁰ Responding to the criticism that their comparison of Wave IV self-reported sexual identity to Wave I self-reported romantic attractions was unsound, Savin-Williams and Joyner claimed that the results were quite similar if one used attraction as the Wave IV measure. They also deemed it highly unlikely that a large proportion of the respondents who were classified as nonheterosexuals in Wave I and heterosexuals in Wave IV went “back into the closet,” because the proportion of individuals in adolescence and young adulthood who are “out of the closet” usually increases over time.¹⁵¹

The following year, the *Archives of Sexual Behavior* published another response to Savin-Williams and Joyner by psychologist Sabra Katz-Wise and colleagues, which argued that Savin-Williams and Joyner's "approach to identifying 'dubious' sexual minority youth is inherently flawed."¹⁵² They wrote that "romantic attraction and sexual orientation identity are two distinct dimensions of sexual orientation that may not be concordant, even at a single time point."¹⁵³ They also claimed that "even if Add Health had assessed the same facets of sexual orientation at all waves, it would still be incorrect to infer 'dubious' sexual minorities from changes on the same dimension of sexual orientation, because these changes may reflect sexual fluidity."¹⁵⁴

Unfortunately, the Add Health study does not appear to contain the data that would allow an assessment to determine which, if any, of these interpretations is likely to be correct. It may well be the case that a combination of factors contributed to the differences between the Wave I and Wave IV data. For example, there may have been some adolescents who responded to the Wave I sexual attraction questions inaccurately, some openly nonheterosexual adolescents who later went "back into the closet," and some adolescents who experienced nonheterosexual attractions before Wave I that largely disappeared by Wave IV. Other prospective study designs that track specific individuals across adolescent and adult development may shed further light on these issues.

While ambiguities in defining and characterizing sexual desire and orientation make changes in sexual desire difficult to study, data from these large, population-based national studies of randomly sampled individuals do suggest that all three dimensions of sexuality—affect, behavior, and identity—may change over time for some people. It is unclear, and current research does not address, whether and to what extent factors subject to volitional control—choice of sexual partners or sexual behaviors, for example—may influence such changes through conditioning and other mechanisms that are characterized in the behavioral sciences.

Several researchers have suggested that sexual orientation and attractions may be especially plastic for women.¹⁵⁵ For example, Lisa Diamond argued in her 2008 book *Sexual Fluidity* that "women's sexuality is fundamentally more fluid than men's, permitting greater variability in its development and expression over the life course," based on research by her and many others.¹⁵⁶

Diamond's longitudinal five-year interviews of women in sexual relationships with other women also shed light on the problems with the concept of sexual orientation. In many cases, the women in her study

reported not so much setting out to form a lesbian sexual relationship but rather experiencing a gradual growth of affective intimacy with a woman that eventually led to sexual involvement. Some of these women rejected the labels of “lesbian,” “straight,” or “bisexual” as being inconsistent with their lived experience.¹⁵⁷ In another study, Diamond calls into question the utility of the concept of sexual orientation, especially as it applies to females.¹⁵⁸ She points out that if the neural basis of parent-child attachment—including attachment to one’s mother—forms at least part of the basis for romantic attachments in adulthood, then it would not be surprising for a woman to experience romantic feelings for another woman without necessarily wanting to be sexually intimate with her. Diamond’s research indicates that these kinds of relationships form more often than we typically recognize, especially among women.

Some researchers have also suggested that men’s sexuality is more fluid than it was previously thought. For example, Diamond presented a 2014 conference paper, based on initial results from a survey of 394 people, entitled “I Was Wrong! Men Are Pretty Darn Sexually Fluid, Too!”¹⁵⁹ Diamond based this conclusion on a survey of men and women between the ages of 18 and 35, which asked about their sexual attractions and self-described identities at different stages of their lives. The survey found that 35% of self-identified gay men reported experiencing opposite-sex attractions in the past year, and 10% of self-identified gay men reported opposite-sex sexual behavior during the same period. Additionally, nearly as many men transitioned at some time in their life from gay to bisexual, queer, or unlabeled identity as did men from bisexual to gay identity.

In a 2012 review article entitled “Can We Change Sexual Orientation?” published in the *Archives of Sexual Behavior*, psychologist Lee Beckstead wrote, “Although their sexual behavior, identity, and attractions may change throughout their lives, this may not indicate a change in sexual orientation...but a change in awareness and an expansion of sexuality.”¹⁶⁰ It is difficult to know how to interpret this claim—that sexual behavior, identity, and attractions may change but that this does not necessarily indicate a change in sexual orientation. We have already analyzed the inherent difficulties of defining sexual orientation, but however one chooses to define this construct, it seems that the definition would somehow be tied to sexual behavior, identity, or attraction. Perhaps we can take Beckstead’s claim here as one more reason to consider dispensing with the construct of sexual orientation in the context of social science research, as it seems that whatever it might represent, it is only loosely or inconsistently tied to empirically measurable phenomena.

Given the possibility of changes in sexual desire and attraction, which research suggests is not uncommon, any attempt to infer a stable, innate, and fixed identity from a complex and often shifting *mélange* of inner fantasies, desires, and attractions—sexual, romantic, aesthetic, or otherwise—is fraught with difficulties. We can imagine, for example, a sixteen-year-old boy who becomes infatuated with a young man in his twenties, developing fantasies centered around the other's body and build, or perhaps on some of his character traits or strengths. Perhaps one night at a party the two engage in physical intimacy, catalyzed by alcohol and by the general mood of the party. This young man then begins an anguished process of introspection and self-exploration aimed at finding the answer to the enigmatic question, "Does this mean I'm gay?"

Current research from the biological, psychological, and social sciences suggests that this question, at least as it is framed, makes little sense. As far as science can tell us, there is nothing "there" for this young man to discover—no fact of nature to uncover or to find buried within himself. What his fantasies, or his one-time liaison, "really mean" is subject to any number of interpretations: that he finds the male figure beautiful, that he was lonely and feeling rejected the night of the party and responded to his peer's attentions and affections, that he was intoxicated and influenced by the loud music and strobe lights, that he does have a deep-seated sexual or romantic attraction to other men, and so on. Indeed, psychodynamic interpretations of such behaviors citing unconscious motivational factors and inner conflicts, many of them interesting, most impossible to prove, can be spun endlessly.

What we can say with more confidence is that this young man had an experience encompassing complex feelings, or that he engaged in a sexual act conditioned by multiple complex factors, and that such fantasies, feelings, or associated behaviors may (or may not) be subject to change as he grows and develops. Such behaviors could become more habitual with repetition and thus more stable, or they may extinguish and recur rarely or never. The research on sexual behaviors, sexual desire, and sexual identity suggests that both trajectories are real possibilities.

Conclusion

The concept of sexual orientation is unusually ambiguous compared to other psychological traits. Typically, it refers to at least one of three things: attractions, behaviors, or identity. Additionally, we have seen that sexual orientation often refers to several other things as well: belonging

to a certain community, fantasies (as distinct in some respects from attractions), longings, strivings, felt needs for certain forms of companionship, and so on. It is important, then, that researchers are clear about which of these domains are being studied, and that we keep in mind the researchers' specified definitions when we interpret their findings.

Furthermore, not only can the term "sexual orientation" be understood in several different senses, most of the senses are themselves complex concepts. Attraction, for example, could refer to arousal patterns, or to romantic feelings, or to desires for company, or other things; and each of these things can be present either sporadically and temporarily or pervasively and long-term, either exclusively or not, either in a deep or shallow way, and so forth. For this reason, even specifying one of the basic senses of orientation (attraction, behavior, or identity) is insufficient for doing justice to the richly varied phenomenon of human sexuality.

In this part we have criticized the common assumption that sexual *desires*, *attractions*, or *longings* reveal some innate and fixed feature of our biological or psychological constitution, a fixed sexual *identity* or *orientation*. Furthermore, we may have some reasons to doubt the common assumption that in order to live happy and flourishing lives, we must somehow discover this innate fact about ourselves that we call *sexuality* or *sexual orientation*, and invariably express it through particular patterns of sexual behavior or a particular life trajectory. Perhaps we ought instead to consider what sorts of behaviors—whether in the sexual realm or elsewhere—tend to be conducive to health and flourishing, and what kinds of behaviors tend to undermine a healthy and flourishing life.

Part Two

Sexuality, Mental Health Outcomes, and Social Stress

Compared to the general population, non-heterosexual and transgender subpopulations have higher rates of mental health problems such as anxiety, depression, and suicide, as well as behavioral and social problems such as substance abuse and intimate partner violence. The prevailing explanation in the scientific literature is the social stress model, which posits that social stressors—such as stigmatization and discrimination—faced by members of these subpopulations account for the disparity in mental health outcomes. Studies show that while social stressors do contribute to the increased risk of poor mental health outcomes for these populations, they likely do not account for the entire disparity.

Many of the issues surrounding sexual orientation and gender identity remain controversial among researchers, but there is general agreement on the observation at the heart of Part Two: lesbian, gay, bisexual, and transgender (LGBT) subpopulations are at higher risk, compared to the general population, of numerous mental health problems. Less certain are the causes of that increased risk and thus the social and clinical approaches that may help to ameliorate it. In this part we review some of the research documenting the increased risk, focusing on papers that are data-based with sound methodology, and that are widely cited in the scientific literature.

A robust and growing body of research examines the relationships between sexuality or sexual behaviors and mental health status. The first half of this part discusses the associations of sexual identities or behaviors with psychiatric disorders (such as mood disorders, anxiety disorders, and adjustment disorders), suicide, and intimate partner violence. The second half explores the reasons for the elevated risks of these outcomes among non-heterosexual and transgender populations, and considers what social science research can tell us about one of the most prevalent ways of explaining these risks, the social stress model. As we will see, social stressors such as harassment and stigma likely explain some but not all of the elevated mental health risks for these populations. More research

is needed to understand the causes of and potential solutions for these important clinical and public health issues.

Some Preliminaries

We turn first to the evidence for the statistical links between sexual identities or behaviors and mental health outcomes. Before summarizing the relevant research, we should mention the criteria used in selecting the studies reviewed. In an attempt to distill overall findings of a large body of research, each section begins by summarizing the most extensive and reliable meta-analyses—papers that compile and analyze the statistical data from the published research literature. For some areas of research, no comprehensive meta-analyses have been conducted, and in these areas we rely on review articles that summarize the research literature without going into quantitative analyses of published data. In addition to reporting these summaries, we also discuss a few select studies that are of particular value because of their methodology, sample size, controls for confounding factors, or ways in which concepts such as heterosexuality or homosexuality are operationalized; and we discuss key studies published after the meta-analyses or review articles were published.

As we showed in Part One, explaining the exact biological and psychological origins of sexual desires and behaviors is a difficult scientific task, one that has not yet been and may never be satisfactorily completed. However, researchers can study the correlations between sexual behavior, attraction, or identity and mental health outcomes, though there may be—and often are found to be—differences between how sexual behavior, attraction, and identity relate to particular mental health outcomes. Understanding the scope of the health challenges faced by individuals who engage in particular sexual behaviors or experience certain sexual attractions is a necessary step in providing these individuals with the care they need.

Sexuality and Mental Health

In a 2008 meta-analysis of research on mental health outcomes for non-heterosexuals, University College London professor of psychiatry Michael King and colleagues concluded that gays, lesbians, and bisexuals face “higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people.”¹ This survey of the literature examined papers published between January 1966 and April 2005 with data from 214,344 heterosexual and 11,971 non-heterosexual individuals.

The large sample size allowed the authors to generate estimates that are highly reliable, as indicated by the relatively small confidence intervals.²

Compiling the risk ratios found in these papers, the authors estimated that lesbian, gay, and bisexual individuals had a 2.47 times higher lifetime risk than heterosexuals for suicide attempts,³ that they were about twice as likely to experience depression over a twelve-month period,⁴ and approximately 1.5 times as likely to experience anxiety disorders.⁵ Both non-heterosexual men and women were found to be at an elevated risk for substance abuse problems (1.51 times as likely),⁶ with the risk for non-heterosexual women especially high—3.42 times higher than for heterosexual women.⁷ Non-heterosexual men, on the other hand, were at a particularly high risk for suicide attempts: while non-heterosexual men and women together were at a 2.47 times greater risk of suicide attempts over their lifetimes, non-heterosexual men were found to be at a 4.28 times greater risk.⁸

These findings have been replicated in other studies, both in the United States and internationally, confirming a consistent and alarming pattern. However, there is considerable variation in the estimates of the increased risks of various mental health problems, depending on how researchers define terms such as “homosexual” or “non-heterosexual.” The findings from a 2010 study by Northern Illinois University professor of nursing and health studies Wendy Bostwick and colleagues examined associations of sexual orientation with mood and anxiety disorders among men and women who either identified as gay, lesbian, or bisexual, or who reported engaging in same-sex sexual behavior, or who reported feeling same-sex attractions. The study employed a large, U.S.-based random population sample, using data collected from the 2004–2005 wave of the National Epidemiologic Survey on Alcohol and Related Conditions, which was based on 34,653 interviews.⁹ In its sample, 1.4% of respondents identified as lesbian, gay, or bisexual; 3.4% reported some lifetime same-sex sexual behavior; and 5.8% reported non-heterosexual attractions.¹⁰

Women who identified as lesbian, bisexual, or “not sure” reported higher rates of lifetime mood disorders than women who identified as heterosexual: the prevalence was 44.4% in lesbians, 58.7% in bisexuals, and 36.5% in women unsure of their sexual identity, as compared to 30.5% in heterosexuals. A similar pattern was found for anxiety disorders, with bisexual women experiencing the highest prevalence, followed by lesbians and those unsure, and heterosexual women experiencing the lowest prevalence. Examining the data for women with different sexual *behavior* or sexual *attraction* (rather than identity), those reporting sexual behavior

with or attractions to both men and women had a higher rate of lifetime disorders than women who reported exclusively heterosexual or homosexual behaviors or attractions, and women reporting exclusive same-sex sexual behavior or exclusive same-sex attraction in fact had the *lowest* rates of lifetime mood and anxiety disorders.¹¹

Men who identified as gay had more than double the prevalence of lifetime mood disorders compared to men who identified as heterosexual (42.3% vs. 19.8%), and more than double the rate of any lifetime anxiety disorder (41.2% vs. 18.6%), while those who identified as bisexual had a slightly lower prevalence of mood disorders (36.9%) and anxiety disorders (38.7%) than gay men. When looking at sexual attraction or behavior for men, those who reported sexual attraction to “mostly males” or sexual behavior with “both females and males” had the highest prevalence of lifetime mood disorders and anxiety disorders compared to other groups, while those reporting exclusively heterosexual attraction or behavior had the lowest prevalence of any group.

Other studies have found that non-heterosexual populations are at a higher risk of physical health problems in addition to mental health problems. A 2007 study by UCLA professor of epidemiology Susan Cochran and colleagues examined data from the California Quality of Life Survey of 2,272 adults to assess links between sexual orientation and self-reported physical health status, health conditions, and disability, as well as psychological distress among lesbians, gay men, bisexuals, and those they classified as “homosexually experienced heterosexual individuals.”¹² While the study, like most, was limited by the use of self-reporting of health conditions, it had several strengths: it studied a population-based sample; it separately measured identity and behavioral dimensions of sexual orientation; and it controlled for race (ethnicity), education, relationship status, and family income, among other factors.

While the authors of this study found a number of health conditions that appeared to have elevated prevalence among non-heterosexuals, after adjusting for demographic factors that are potential confounders the only group with significantly greater prevalence of non-HIV physical health conditions was bisexual women, who were more likely to have health problems than heterosexual women. Consistent with the 2010 study by Bostwick and colleagues, higher rates of psychological stress were reported by lesbians, bisexual women, gay men, and homosexually experienced heterosexual men, both before and after adjusting for demographic confounding. Among men, self-identified gay and homosexually experienced heterosexual respondents reported the highest rates of several health problems.

Using the same California Quality of Life Survey, a 2009 study by UCLA professor of psychiatry and biobehavioral sciences Christine Grella and colleagues (including Cochran) examined the relationship between sexual orientation and receiving treatment for substance use or mental disorders.¹³ They used a population-based sample, with sexual minorities oversampled to provide more statistical power to detect group differences. The usage of treatment was classified according to whether or not respondents reported receiving treatment in the preceding twelve months for “emotional, mental health, alcohol or other drug problems.” Sexual orientation was operationalized by a combination of behavioral history and self-identification. For example, they grouped together as “gay/bisexual” or “lesbian/bisexual” both those who identified as gay, lesbian, or bisexual, and those who had reported same-sex sexual behaviors. They found that women who were lesbian or bisexual were most likely to have received treatment, followed by men who were gay or bisexual, then heterosexual women, with heterosexual men being the least likely group to have reported receiving treatment. Overall, more than twice as many LGB individuals, compared to heterosexuals, had reported receiving treatment in the past twelve months (48.5% compared to 22.5%). The pattern was similar for men and women; 42.5% of homosexual men, compared to 17.1% of heterosexual men, had reported receiving treatment, while 55.3% of lesbian and bisexual women and 27.1% of heterosexual women reported receiving treatment. (Bostwick and colleagues had found that women with exclusively same-sex attractions and behaviors had a lower prevalence of mood and anxiety disorders compared to heterosexual women. The difference in results could be due to the fact that Grella and colleagues grouped those who identified as lesbians together with those who identified as bisexuals or who reported same-sex sexual behavior.)

A 2006 study by Columbia University psychiatry professor Theodorus Sandfort and colleagues examined a representative, population-based sample from the second Dutch National Survey of General Practice, carried out in 2001, to assess links between self-reported sexual orientation and health status among 9,511 participants, of whom 0.9% were classified as bisexual and 1.5% as gay or lesbian.¹⁴ To operationalize sexual orientation, the researchers asked respondents about their sexual preference on a 5-point scale: exclusively women, predominantly women, equally men and women, predominantly men, and exclusively men. Only those who reported an equal preference for men and women were classified as bisexual, while men reporting predominant preferences for women, or women reporting a predominant preference for men were classified as heterosexual. They

found that gay, lesbian, and bisexual respondents reported experiencing higher numbers of acute mental health problems and reported worse general mental health than heterosexuals. The results for physical health were mixed, however: lesbian and gay respondents reported experiencing more acute physical symptoms (such as headaches, back pain, or sore throats) over the past fourteen days, though they did not report experiencing two or more such symptoms any more than heterosexuals.

Lesbian and gay respondents were more likely to report chronic health problems, though bisexual men (that is, men who reported an equal sexual preference for men and women) were less likely to report chronic health problems and bisexual women were no more likely than heterosexual women to do so. The researchers did not find a statistically significant relationship between sexual orientation and overall physical health. After controlling for the possible confounding effects of mental health problems on the reporting of physical health problems, the researchers also found that the statistical effect of reporting a gay or lesbian sexual preference on chronic and acute physical conditions disappeared, though the effect of bisexual preference remained.

The Sandfort study defined sexual orientation in terms of preference or attraction without reference to behavior or self-identification, which makes it a challenge to compare its results to the results of studies that operationalize sexual orientation differently. For example, it is difficult to compare the findings of this study regarding bisexuals (defined as men or women who report an equal sexual preference for men and women) with the findings of other studies regarding “homosexually experienced heterosexual individuals” or those who are “unsure” of their sexual identity. As in most of these types of studies, the health assessments were self-reported, which may make the results somewhat unreliable. But this study also has several strengths: it used a large and representative sample of a country’s population, as opposed to the convenience samples that are sometimes used for these kinds of studies, and this sample included a sufficient number of gays and lesbians for their data to be treated in separate groups in the study’s statistical analyses. Only three people in the sample reported HIV infection, so this did not appear to be a potential confounding factor, though HIV could have been underreported.

In an effort to summarize findings in this area, we can cite the 2011 report from the Institute of Medicine (IOM), *The Health of Lesbian, Gay, Bisexual, and Transgender People*.¹⁵ This report is an extensive review of scientific literature citing hundreds of studies that examine the health status of LGBT populations. The authors are scientists who are well versed

in these issues (although we wish there had been more involvement of experts in psychiatry). The report reviews findings on physical and mental health in childhood, adolescence, early and middle adulthood, and late adulthood. Consistent with the studies cited above, this report reviews evidence showing that, compared with heterosexual youth, LGB youth are at a higher risk of depression, as well as suicide attempts and suicidal ideation. They are also more likely to experience violence and harassment and to be homeless. LGB individuals in early or middle adulthood are more prone to mood and anxiety disorders, depression, suicidal ideation, and suicide attempts.

The IOM report shows that, like LGB youth, LGB adults—and women in particular—appear to be likelier than heterosexuals to smoke, use or abuse alcohol, and abuse other drugs. The report cites a study¹⁶ that found that self-identified non-heterosexuals used mental health services more often than heterosexuals, and another¹⁷ that found that lesbians used mental health services at higher rates than heterosexuals.

The IOM report notes that “more research has focused on gay men and lesbians than on bisexual and transgender people.”¹⁸ The relatively few studies focusing on transgender populations show high rates of mental disorders, but the use of nonprobability samples and the lack of non-transgender controls call into question the validity of the studies.¹⁹ Although some studies have suggested that the use of hormone treatments may be associated with negative physical health outcomes among transgender populations, the report notes that the relevant research has been “limited” and that “no clinical trials on the subject have been conducted.”²⁰ (Health outcomes for transgender individuals will be further discussed below in this part and also in Part Three.)

The IOM report claims that the evidence that LGBT populations have worse mental and physical health outcomes is not fully conclusive. To support this claim, the IOM report cites a 2001 study²¹ of mental health in 184 sister pairs in which one sister was lesbian and the other heterosexual. The study found no significant differences in rates of mental health problems, and found significantly higher self-esteem in the lesbian sisters. The IOM report also cites a 2003 study²² that found no significant differences between heterosexual and gay or bisexual men in general happiness, perceived health, and job satisfaction. Acknowledging these caveats and the studies that do not support the general trend, the vast majority of studies cited in the report point to a generally higher risk of poor mental health status in LGBT populations compared to heterosexual populations.

Sexuality and Suicide

The association between sexual orientation and suicide has strong scientific support. This association merits particular attention, since among all the mental health risks, the increased risk of suicide is the most concerning, owing in part to the fact that the evidence is robust and consistent, and in part to the fact that suicide is so devastating and tragic for the person, family, and community. A better understanding of the risk factors for suicide could allow us, quite literally, to save lives.²³

Sociologist and suicide researcher Ann Haas and colleagues published an extensive review article in 2011 based on the results of a 2007 conference sponsored by the Gay and Lesbian Medical Association, the American Foundation for Suicide Prevention, and the Suicide Prevention Resource Center.²⁴ They also examined studies reported since the 2007 conference. For the purposes of their report, the authors defined sexual orientation as “sexual self-identification, sexual behavior, and sexual attraction or fantasy.”²⁵

Haas and colleagues found the association between homosexual or bisexual orientation and suicide attempts to be well supported by data. They noted that population-based surveys of U.S. adolescents since the 1990s indicate that suicide attempts are two to seven times more likely in high school students who identify as LGB, with sexual orientation being a stronger predictor in males than females. They reviewed data from New Zealand that suggested that LGB individuals were six times more likely to have attempted suicide. They cited health-related surveys of U.S. men and Dutch men and women showing same-sex behavior linked to higher risk of suicide attempts. Studies cited in the report show that lesbian or bisexual women are likelier, on average, to experience suicidal ideation, that gay or bisexual men are more likely, on average, to attempt suicide, and that lifetime suicide attempts among non-heterosexuals are greater in men than in women.

Examining studies that looked at rates of mental disorders in relation to suicidal behavior, Haas and colleagues discussed a New Zealand study²⁶ showing that gay people reporting suicide attempts had higher rates of depression, anxiety, and conduct disorder. Large-scale health surveys suggested that rates of substance abuse are up to one third higher for the LGB subpopulation. Combined worldwide studies showed up to 50% higher rates of mental disorders and substance abuse among persons self-identifying in surveys as lesbian, gay, or bisexual. Lesbian or bisexual women showed higher levels of substance abuse, while gay or bisexual men had higher rates of depression and panic disorder.

Haas and colleagues also examined transgender populations, noting that scant information is available about transgender suicides but that the existing studies indicate a dramatic increased risk of completed suicide. (These findings are noted here but examined in more detail in Part Three.) A 1997 clinical study²⁷ estimated elevated risks of suicide for Dutch male-to-female transsexual individuals on hormone therapy, but found no significant differences in overall mortality. A 1998 international review of 2,000 persons receiving sex-reassignment surgery identified 16 possible suicides, an “alarmingly high rate of 800 suicides for every 100,000 post-surgery transsexuals.”²⁸ In a 1984 study, a clinical sample of transgender individuals requesting sex-reassignment surgery showed suicide attempt rates between 19% and 25%.²⁹ And a large sample of 40,000 mostly U.S. volunteers completing an Internet survey in 2000 found transgender persons to report higher rates of suicide attempts than any group except lesbians.³⁰

Finally, the review by Haas and colleagues suggests that it is not clear which aspects of sexuality (identity, attraction, behavior) are most closely linked with the risk of suicidal behavior. The authors cite a 2010 study³¹ showing that adolescents identifying as heterosexual while reporting same-sex attraction or behavior did not have significantly higher suicide rates than other self-identified heterosexuals. They also cite the large national survey of U.S. adults conducted by Wendy Bostwick and colleagues (discussed earlier),³² which showed mood and anxiety disorders—key risk factors for suicidal behavior—more closely related to sexual self-identity than to behavior or attraction, especially for women.

A more recent critical review of existing studies of suicide risk and sexual orientation was presented by Austrian clinical psychologist Martin Plöderl and colleagues.³³ This review rejects several hypotheses developed to account for the increased suicide risk among non-heterosexuals, including biases in self-reporting and failures to measure suicide attempts accurately. The review argues that methodological improvements in studies since 1997 have provided control groups, better representativeness of study samples, and more clarity in defining both suicide attempts and sexual orientation.

The review mentions a 2001 study³⁴ by Ritch Savin-Williams, a Cornell University professor of developmental psychology, that reported no statistically significant difference between heterosexual and LGB youths after eliminating false-positive reports of suicide attempts and blaming a “‘suffering suicidal’ script” for leading to an over-reporting of suicidal behavior among gay youths. Plöderl and colleagues argue, however, that

the Savin-Williams study's finding that there was no statistically significant difference between the suicide rates of LGB and heterosexual youths might be attributable to the small sample size, which yielded low statistical power.³⁵ The later work has not replicated this finding. Subsequent questionnaire or interview-based studies with stricter definitions of suicide attempts have found significantly increased rates of suicide attempts among non-heterosexuals. Several large-scale surveys of young people have found that the elevated risk of reported suicidal behavior increased with the severity of the attempts.³⁶ Finally, according to Plöderl and colleagues, comparing results of questionnaires with clinical interviews indicates that homosexual youth are less likely to over-report suicide attempts in surveys than heterosexual youth.

Plöderl and colleagues concluded that among psychiatric patients, homosexual or bisexual populations are over-represented in "serious suicide attempts," and that sexual orientation is one of the strongest predictors of suicide. Similarly, in nonclinical population-based studies, non-heterosexual status is found to be one of the strongest predictors of suicide attempts. The authors note:

The most exhaustive collation of published and unpublished international studies on the association of suicide attempts and sexual orientation with different methodologies has produced a very consistent picture: nearly all studies found increased incidences of self-reported suicide attempts among sexual minorities.³⁷

In acknowledging the challenges of all such research, the authors suggest that "the major problem remains as to where one draws the line between a heterosexual or non-heterosexual orientation."³⁸

A 1999 study by Richard Herrell and colleagues analyzed 103 middle-aged male twin pairs from the Vietnam Era Twin Registry in Hines, Illinois, in which one twin, but not the other, reported having a male sex partner after the age of 18.³⁹ The study adopted several measures of suicidality and controlled for potential confounding factors such as substance abuse or depression. It found a "substantially increased lifetime prevalence of suicidal symptoms" in male twins who had sex with men compared with co-twins who did not, independent of the potential confounding effects of drug and alcohol abuse.⁴⁰ Though it is a relatively small study and relied on self-reporting for both same-sex behaviors and suicidal thoughts or behaviors, it is notable for using a probability sample (which eliminates selection bias), and for using the co-twin control method (which reduces the effects of genetics, age, race, and the like).

The study looked at middle-aged men; what the implications might be for adolescents is not clear.

In a 2011 study, Robin Mathy and colleagues analyzed the impact of sexual orientation on suicide rates in Denmark during the first twelve years after the legalization of same-sex registered domestic partnerships (RDPs) in that country, using data from death certificates issued between 1990 and 2001 as well as Danish census population estimates.⁴¹ The researchers found that the age-adjusted suicide rate for same-sex RDP men was nearly eight times the rate for men in heterosexual marriages, and nearly twice the rate for men who had never married. For women, RDP status had a small, statistically insignificant effect on suicide mortality risk, and the authors conjectured that the impact of HIV status on the health of gay men might have contributed to this difference between the results for men and women. The study is limited by the fact that RDP status is an indirect measure of sexual orientation or behavior, and does not include those gays and lesbians who are not in a registered domestic partnership; the study also excluded individuals under the age of 18. Finally, the absolute number of individuals with current or past RDP status was relatively small, which may limit the study's conclusions.

Professor of pediatrics Gary Remafedi and colleagues published a 1991 study that looked at 137 males age 14–21 who self-identified as gay (88%) or bisexual (12%). Remafedi and colleagues attempted, with a case-controlled approach, to examine which factors for this population were most predictive of suicide.⁴² Compared to those who did not attempt suicide, those who did were significantly more likely to label themselves and identify publicly as bisexual or homosexual at younger ages, report sexual abuse, and report illicit drug use. The authors noted that the likelihood of a suicide attempt “diminished with advancing age at the time of bisexual or homosexual self-labeling.” Specifically, “with each year’s delay in self-identification, the odds of a suicide attempt declined by more than 80%.”⁴³ This study is limited by using a relatively small nonprobability sample, though the authors note that its result comports with their previous finding⁴⁴ of an inverse relationship between psychosocial problems and the age at which one identifies as homosexual.

In a 2010 study, Plöderl and colleagues solicited self-reported suicide attempts among 1,382 Austrian adults to confirm existing evidence that homosexual and bisexual individuals are at higher risk.⁴⁵ To sharpen the results, the authors developed more rigorous definitions of “suicide attempts” and assessed multiple dimensions of sexual orientation, distinguishing among sexual fantasies, preferred partners, self-identification,

recent sexual behavior, and lifetime sexual behavior. This study found an increased risk for suicide attempts for sexual minorities along all dimensions of sexual orientation. For women, the risk increases were largest for those with homosexual behaviors; for men, they were largest for homosexual or bisexual behavior in the previous twelve months and self-identification as homosexual or bisexual. Those reporting being unsure of their identity reported the highest percentage of suicide attempts (44%), although this group was small, comprising less than 1% of participants.

A 2016 meta-analysis by University of Toronto graduate student Travis Salway Hottes and colleagues aggregated data from thirty cross-sectional studies on suicide attempts that together included 21,201 sexual minority adults.⁴⁶ These studies used either population-based sampling or community-based sampling. Since each sampling method has its own strengths and potential biases,⁴⁷ the researchers wanted to examine any differences in the rates of attempted suicide between the two sampling types. Of the LGB respondents to population-based surveys, 11% reported having attempted suicide at least once, compared to 4% of heterosexual respondents to these surveys.⁴⁸ Of the LGB respondents to community-based surveys, 20% reported having attempted suicide.⁴⁹ Statistical analysis showed that the difference in the sampling methods accounted for 33% of the variation in the suicide figures reported by the studies.

The research on sexuality and the risk of suicide suggests that those who identify as gay, lesbian, bisexual, or transgender, or those who experience same-sex attraction or engage in same-sex sexual behavior are at substantially increased risk of suicidal ideation, suicide attempts, and completed suicide. In the section later in Part Two on the social stress model, we will examine—and raise questions about—one set of arguments put forward to explain these findings. Given the tragic consequences of inadequate or incomplete information in these matters and its effect on public policy and clinical care, more research into the reasons for elevated suicide risk among sexual minorities is desperately needed.

Sexuality and Intimate Partner Violence

Several studies have examined the differences between rates of intimate partner violence (IPV) in same-sex couples and opposite-sex couples. The research literature examines rates of IPV *victimization* (being subjected to violence by a partner) and rates of IPV *perpetration* (committing violence against a partner). In addition to physical and sexual violence, some studies also examine psychological violence, which comprises verbal attacks,

threats, and similar forms of abuse. The weight of evidence indicates that the rate of intimate partner violence is significantly higher among same-sex couples.

In 2014, London School of Hygiene and Tropical Medicine researcher Ana Buller and colleagues conducted a systematic review of 19 studies (with a meta-analysis of 17 of these studies) examining associations between intimate partner violence and health among men who have sex with men.⁵⁰ Combining the available data, they found that the pooled lifetime prevalence of any IPV was 48% (estimates from the studies were quite heterogeneous, ranging from 32% to 82%). For IPV within the previous five years, pooled prevalence was 32% (estimates ranging from 16% to 51%). IPV victimization was associated with increased rates of substance use (pooled odds ratio of 1.9), positive HIV status (pooled odds ratio of 1.5), and increased rates of depressive symptoms (pooled odds ratio of 1.5). IPV perpetration was also associated with increased rates of substance use (pooled odds ratio of 2.0). An important limitation of this meta-analysis was that the number of studies it included was relatively small. Also, the heterogeneity of the studies' results may undermine the precision of the meta-analysis. Further, most of the reviewed studies used convenience samples rather than probabilistic samples, and they used the word "partner" without distinguishing long-term relationships from casual encounters.

English psychologists Sabrina Nowinski and Erica Bowen conducted a 2012 review of 54 studies on the prevalence and correlates of intimate partner violence victimization among heterosexual and gay men.⁵¹ The studies showed rates of IPV victimization for gay men ranging from 15% to 51%. Compared to heterosexual men, the review reports, "it appears that gay men experienced more total and sexual IPV, slightly less physical IPV, and similar levels of psychological IPV."⁵² The authors also report that according to estimates of IPV prevalence over the most recent twelve months, gay men "experienced less physical, psychological and sexual IPV" than heterosexual men, though the relative lack of twelve-month estimates may make this result unreliable. The authors note that "one of the most worrying findings is the prevalence of severe sexual coercion and abuse in male same-gender relationships,"⁵³ citing a 2005 study⁵⁴ on IPV in HIV-positive gay men. Nowinski and Bowen found positive HIV status to be associated with IPV in both gay and heterosexual relationships. An important limitation of their review is the fact that many of the same-sex IPV studies they examined were based on small convenience samples.

Catherine Finneran and Rob Stephenson of Emory University in 2012 conducted a systematic review of 28 studies examining IPV among men

who have sex with men.⁵⁵ Every study in the review estimated rates of IPV for gay men that were similar to or higher than those for all women regardless of sexual orientation. The authors conclude that “the emergent evidence reviewed here demonstrates that IPV—psychological, physical, and sexual—occurs in male-male partnerships at alarming rates.”⁵⁶ Physical IPV victimization was reported most frequently, with rates ranging from 12% to 45%.⁵⁷ The rate of sexual IPV victimization ranged from 5% to 31%, with 9 out of 19 studies reporting rates over 20%. Psychological IPV victimization was recorded in six studies, with rates ranging from 5% to 73%.⁵⁸ Perpetration of physical IPV was reported in eight studies, with rates ranging from 4% to 39%. Rates of perpetration of sexual IPV ranged from 0.7% to 28%; four of the five studies reviewed reported rates of 9% or more. Only one study measured perpetration of psychological violence, and the estimated prevalence was 78%. Lack of consistent research design among the studies examined (for example, some differences regarding the exact definition of IPV, the correlates of IPV examined, and the recall periods used to measure violence) makes it impossible to calculate a pooled prevalence estimate, which would be useful given the lack of a national probability-based sample.

A 2013 study by UCLA’s Naomi Goldberg and Ilan Meyer used a large probability sample of almost 32,000 individuals from the California Health Interview Survey to assess differences in intimate partner violence between various cohorts: heterosexual; self-identified gay, lesbian, and bisexual individuals; and men who have sex with men but did not identify as gay or bisexual, and women who have sex with women but did not identify as lesbian or bisexual.⁵⁹ All three LGB groups had greater lifetime and one-year prevalence of intimate partner violence than the heterosexual group, but this difference was only statistically significant for bisexual women and gay men. Bisexual women were more likely to have experienced lifetime IPV (52% of bisexual women vs. 22% of heterosexual women and 32% of lesbians) and to have experienced IPV in the preceding year (27% of bisexuals vs. 5% of heterosexuals and 10% of lesbians). For men, all three non-heterosexual groups had higher rates of lifetime and one-year IPV, but this was only statistically significant for gay men, who were more likely to have experienced IPV over a lifetime (27% of gay men vs. 11% of heterosexual men and 19.6% of bisexual men) and over the preceding year (12% of gay men vs. 5% of heterosexual men and 9% of bisexual men). The authors also tested whether binge drinking and psychological distress could explain the higher prevalence of IPV victimization in gay men and bisexual women; controlling for these

variables revealed that they did not. This study is limited by the fact that other potentially confounding psychological variables (besides drinking and distress) were not controlled for, statistically or otherwise, and may have accounted for the findings.

To estimate the prevalence of battering victimization among gay partners, AIDS-prevention researcher Gregory Greenwood and colleagues published a 2002 study based on telephone interviews with a probability-based sample of 2,881 men who have sex with men (MSM) in four cities from 1996 to 1998.⁶⁰ Of those interviewed, 34% reported experiencing psychological or symbolic abuse, 22% reported physical abuse, and 5% reported sexual abuse. Overall, 39% reported some type of battering victimization, and 18% reported more than one type of battering in the previous five years. Men younger than 40 were significantly more likely than men over 60 to report battering violence. The authors conclude that “the prevalence of battering within the context of intimate partner relationships was very high” among their sample of men who have sex with men, and that since lifetime rates are usually higher than those for a five-year recall, “it is likely that a substantially greater number of MSM than of heterosexual men have experienced lifetime victimization.”⁶¹ The five-year prevalence of physical battering among this sample of urban MSM was also “significantly higher” than the annual rate of severe violence (3%) or total violence (12%) experienced in a representative sample of heterosexual women living with men, suggesting that the estimates of battering victimization for MSM in this study “are higher than or comparable to those reported for heterosexual women.”⁶² This study was limited by its use of a sample from four cities, so it is not clear how well the results generalize to non-urban settings.

Transgender Health Outcomes

The research literature for mental health outcomes in transgender individuals is more limited than the research on mental health outcomes in LGB populations. Because people identifying as transgender make up a very small proportion of the population, large population-based surveys and studies of such individuals are difficult if not impossible to conduct. Nevertheless, the limited available research strongly suggests that transgender people have increased risks of poor mental health outcomes. It appears that the rates of co-occurring substance use disorders, anxiety disorders, depression, and suicide tend to be higher for transgender people than for LGB individuals.

In 2015, Harvard pediatrics professor and epidemiologist Sari Reisner and colleagues conducted a retrospective matched-pair cohort study of mental health outcomes for 180 transgender subjects aged 12–29 years (106 female-to-male and 74 male-to-female), matched to non-transgender controls based on gender identity.⁶³ Transgender youth had an elevated risk of depression (50.6% vs. 20.6%)⁶⁴ and anxiety (26.7% vs. 10.0%).⁶⁵ Transgender youth also had higher risk of suicidal ideation (31.1% vs. 11.1%),⁶⁶ suicide attempts (17.2% vs. 6.1%),⁶⁷ and self-harm without lethal intent (16.7% vs. 4.4%)⁶⁸ relative to the matched controls. A significantly greater proportion of transgender youth accessed inpatient mental health care (22.8% vs. 11.1%)⁶⁹ and outpatient mental health care (45.6% vs. 16.1%)⁷⁰ services. No statistically significant differences in mental health status were observed when comparing female-to-male transgender individuals to the male-to-female transgender individuals after adjusting for age, race/ethnicity, and hormone use.

This study had the merit of including individuals who presented to a community-based health clinic, and who thus were not identified solely as meeting the diagnostic criteria for gender identity disorder in the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, and were not selected from a population of patients presenting to a clinic for treatment of gender identity issues. However, Reisner and colleagues note that their study has the limitations typically found in the retrospective chart review study design, such as incomplete documentation and variation in the quality of information recorded by medical professionals.

A report from the American Foundation for Suicide Prevention and the Williams Institute, a think tank for LGBT issues at the UCLA School of Law, summarized findings on suicide attempts among transgender and gender-nonconforming adults from a large national sample of over 6,000 individuals.⁷¹ This constitutes the largest study of transgender and gender-nonconforming adults to date, though it used a convenience sample rather than a population-based sample. (Large population-based samples are nearly impossible given the low overall prevalence in the general population of transgendered individuals.) Summarizing the major findings of this study, the authors write:

The prevalence of suicide attempts among respondents to the National Transgender Discrimination Survey (NTDS), conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality, is 41 percent, which vastly exceeds the 4.6

percent of the overall U.S. population who report a lifetime suicide attempt, and is also higher than the 10–20 percent of lesbian, gay and bisexual adults who report ever attempting suicide.⁷²

The authors note that “respondents who said they had received transition-related health care or wanted to have it someday were more likely to report having attempted suicide than those who said they did not want it,” however, “the survey did not provide information about the timing of reported suicide attempts in relation to receiving transition-related health care, which precluded investigation of transition-related explanations for these patterns.”⁷³ The survey data suggested associations between suicide attempts, co-occurring mental health disorders, and experiences of discrimination or mistreatment, although the authors note some limitations of these outcomes: “The survey data did not allow us to determine a direct causal relationship between experiencing rejection, discrimination, victimization, or violence, and lifetime suicide attempts,” although they did find evidence that stressors interacted with mental health factors “to produce a marked vulnerability to suicidal behavior in transgender and gender non-conforming individuals.”⁷⁴

A 2001 study by Kristen Clements-Nolle and colleagues of 392 male-to-female and 123 female-to-male transgender persons found that 62% of the male-to-female and 55% of the female-to-male transgender persons were depressed at the time of the study, and 32% of each population had attempted suicide.⁷⁵ The authors note: “The prevalence of suicide attempts among male-to-female and female-to-male transgender persons in our study was much higher than that found in US household probability samples and a population-based sample of adult men reporting same-sex partners.”⁷⁶

Explanations for the Poor Health Outcomes: The Social Stress Model

The greater prevalence of mental health problems in LGBT subpopulations is a cause for concern, and policymakers and clinicians should strive to reduce these risks. But to know what kinds of measures will help ameliorate them we must better understand their causes. At this time, the medical and social strategies for helping non-heterosexual populations in the United States are quite limited, and this may be due in part to the relatively limited explanations for the poor mental health outcomes offered by social scientists and psychologists.

Despite the limits of the scientific understanding of why non-heterosexual subpopulations are more likely to have such poor mental

health outcomes, much of the public effort to ameliorate these problems is motivated by a particular hypothesis called the *social stress model*. This model posits that discrimination, stigmatization, and other similar stresses contribute to poor mental health outcomes among sexual minorities. An implication of the social stress model is that reducing these stresses would ameliorate the mental health problems experienced by sexual minorities.

Sexual minorities face distinct social challenges such as stigma, overt discrimination and harassment, and, often, struggle with reconciling their sexual behaviors and identities with the norms of their families and communities. In addition, they tend to be subject to challenges similar to those of some other minority populations, arising from marginalization by or conflict with the larger part of society in ways that may adversely impact their health.⁷⁷ Many researchers classify these various challenges under the concept of *social stress* and believe that social stress contributes to the generally higher rates of mental health problems among LGBT subpopulations.⁷⁸

In attempting to account for the mental health disparities between heterosexuals and non-heterosexuals, researchers occasionally refer to a social or minority stress *hypothesis*.⁷⁹ However, it is more accurate to refer to a social or minority stress *model*, because the postulated connection between social stress and mental health is more complex and less precise than anything that could be stated as a single hypothesis.⁸⁰ The term *stress* can have a number of meanings, ranging from a description of a physiological condition to a mental or emotional state of anger or anxiety to a difficult social, economic, or interpersonal situation. More questions arise when one thinks about various kinds of *stressors* that may disproportionately affect mental health in minority populations. We will discuss some of these aspects of the social stress model after a concise overview of the model as it has been presented in recent literature on LGBT mental health.

The social stress model attempts to explain why non-heterosexual people have, on average, higher incidences of poor mental health outcomes than the rest of the population. It does not put forth a complete explanation for the disparities between non-heterosexuals and heterosexuals, and it does not explain the mental health problems of a particular patient. Rather, it describes social factors that might directly or indirectly influence the health risks for LGBT people, which may only become apparent at a population level. Some of these factors may also influence heterosexuals, but LGBT people are probably disproportionately exposed to them.

In an influential 2003 article on the social stress model, psychiatric epidemiologist and sexual orientation law expert Ilan Meyer distinguished between *distal* and *proximate* minority stressors. Distal stressors do not

depend on the individual's "perceptions or appraisals," and thus "can be seen as independent of personal identification with the assigned minority status."⁸¹ For instance, if a man who was perceived to be gay by an employer was fired on that basis, this would be a distal stressor, since the stressful event of discrimination would have had nothing to do with whether the man actually identified as gay, but only with someone else's attitude and perception. Distal stressors tend to reflect social circumstances rather than the individual's reaction to those circumstances. Proximate stressors, in contrast, are more subjective and are closely related to the individual's self-identity as lesbian, gay, bisexual, or transgender. An example of a proximate stressor would be when a young woman personally identifies as being a lesbian, and chooses to hide that identity from her family members out of fear of disapproval, or because of an internal sense of shame. The effects of proximate stressors such as this one are highly dependent on the individual's self-understanding and unique social circumstances. In this section we describe the types of stressors postulated in the social stress model, starting at the distal and proceeding to the most proximate stressors, and examine some of the empirical evidence that has been offered on the links between the stressors and mental health outcomes.

Discrimination and prejudice events. Overt acts of mistreatment, ranging from violence to harassment and discrimination, are categorized together by researchers as "prejudice events." These are thought to be significant stressors for non-heterosexual populations.⁸² Surveys of LGBT subpopulations have found that they tend to experience these kinds of prejudice events more frequently than the general population.⁸³

The available evidence indicates that prejudice events likely contribute to mental health problems. A 1999 study by UC Davis professor of psychology Gregory Herek and colleagues using survey data from 2,259 LGB individuals in Sacramento found that self-identified lesbians and gays who experienced a bias crime in the preceding five years—a crime, such as assault, theft, or vandalism, motivated by the actual or perceived sexual identity of the victim—reported significantly higher levels of depressive symptoms, traumatic stress symptoms, and anxiety than lesbians and gays who had not experienced a bias crime over that same period.⁸⁴ Additionally, lesbians and gays who reported being the victims of bias crimes in the last five years showed significantly higher levels of depressive and traumatic stress symptoms than individuals who experienced non-bias crimes in the same period (though the two groups did not display significant differences in anxiety). Comparable significant correlations were not found for

self-identified bisexuals, who constituted a much smaller portion of the survey respondents. The study also found that lesbians and gays subject to bias crimes were significantly more likely than other respondents to report feelings of vulnerability and a decreased sense of personal mastery or agency. Corroborating these findings on the harmful impact of bias crimes was a 2001 study by Northeastern University social scientist Jack McDevitt and colleagues that examined aggravated assaults using data from the Boston Police Department.⁸⁵ They found that bias crime victims tended to experience the effects of victimization more intensely and for a longer period of time than non-bias crime victims. (The study looked at bias-motivated assaults in general, rather than restricting its analysis to assaults motivated by LGBT bias, though a substantial portion of the subjects did experience assaults motivated by their non-heterosexual status.)

Similar patterns also appear among non-heterosexual adolescents, for whom maltreatment is particularly high.⁸⁶ In a 2011 study, University of Arizona social and behavioral scientist Stephen T. Russell and colleagues analyzed a survey of 245 young LGBT adults that retrospectively assessed school victimization due to actual or perceived LGBT status between the ages of 13 and 19. They found strong correlations between school victimization and poor mental health as young adults.⁸⁷ Victimization was assessed by asking yes-or-no questions, such as, “During my middle or high school years, while at school, I was pushed, shoved, slapped, hit, or kicked by someone who wasn’t just kidding around,” followed by a question of how often these events were related to the respondent’s sexual identity. Respondents who reported high levels of school victimization due to their sexual identity were 2.6 times more likely to report depression as young adults and 5.6 times more likely to report that they had attempted suicide, compared to those who reported low levels of victimization. These differences were highly statistically significant, though the study is potentially limited by its use of retrospective surveys to measure incidents of victimization. A study by professor of social work Joanna Almeida and colleagues, which relied on the 2006 Boston Youth Survey (a biennial survey of high school students in Boston public schools), found that perceptions of having been victimized due to LGBT status accounted for increased symptoms of depression among LGBT students. For male LGBT students, but not females, the study also found a positive correlation between victimization and suicidal thoughts and self-harm.⁸⁸

Differences in compensation suggest discrimination in the workplace, which can have both direct and indirect effects on mental health. M. V. Lee Badgett, a professor of economics at the University of Massachusetts,

Amherst, analyzed data collected between 1989 and 1991 in the General Social Survey and found that non-heterosexual male employees received significantly lower compensation (11% to 27%) than heterosexuals, even after controlling for experience, education, occupation, and other factors.⁸⁹ According to a 2009 review by Badgett,⁹⁰ nine studies from the 1990s and early 2000s “consistently show that gay and bisexual men earned 10% to 32% less than heterosexual men,” and that differences in occupation cannot account for much of the wage disparity. Researchers have also found that non-heterosexual women earn more than heterosexual women,⁹¹ which may suggest either that patterns of discrimination differ for men and women, or that there are other factors associated with non-heterosexual behavior and self-identification in men and women influencing their respective earnings, such as a lower rate of child-rearing or being the family primary wage earner.

There is evidence that suggests that wage disparities can help explain some population-level disparities in mental health outcomes,⁹² though it is difficult to tell if differences in mental health help explain the differences in wages. A 1999 study⁹³ by Craig Waldo on the relationship between workplace heterosexism—defined as negative social attitudes toward non-heterosexuals—and stress-related outcomes in 287 LGB individuals found that LGB individuals who experienced heterosexism in the workplace “exhibited higher levels of psychological distress and health-related problems, as well as decreased satisfaction with several aspects of their jobs.” The cross-sectional data used by many of these studies make it impossible to infer causality, though both prospective studies and qualitative analyses of the impact of unemployment on mental health suggest that at least some of the correlations are likely accounted for by the psychological and material effects of unemployment.⁹⁴

Stigma. Sociologists have for many years documented a range of adverse effects of stigma on individuals, ranging from issues with self-esteem to academic achievement.⁹⁵ Stigma is typically regarded as an attribute attaching to a person that reduces that person’s worth to others in a particular social context.⁹⁶ These negative evaluations are in many cases widely shared among a cultural group and become the basis for excluding or differentially treating stigmatized individuals. For example, mental illness can become stigmatized when it is regarded as a character flaw in mentally ill people. One reason why stigma serves an important role in the social stress model is that it can be invoked as an explanation even in the absence of particular events of discrimination or maltreatment. For

example, stigmatization of depression may take place when a depressed person conceals the depression on the expectation that friends and family members will regard it as a character flaw. Even when this concealment is successful, and there is therefore no actual discrimination or mistreatment by the individual's friends or family, anxiety over the attitudes others may have can affect the depressed person's emotional and mental well-being.

Researchers have found associations between the risk of poor mental health and stigma toward certain populations, though there has been little empirical research on the mental health effects of stigma on LGBT people in particular. Stigma is not easy to define or operationalize, making it a difficult and vague concept for empirical social scientists to study. Nevertheless, researchers have attempted to work with the concept using surveys of self-perceived devaluation by others and have found correlations between experiences of stigma and the risk of poor mental health status. One highly cited 1997 study by sociologist and epidemiologist Bruce Link and colleagues on the connection between stigma and mental health found a "strong and enduring" negative effect of stigma on the mental well-being of men who were suffering from a mental disorder and substance abuse.⁹⁷ In this study, the effects of stigma appeared to persist even after the men had received largely successful treatment for their original mental and substance abuse problems. The study found significant correlations between certain stigma variables—self-reported experiences of devaluation and rejection—and depressive symptoms before and after treatment, suggesting that the effects of stigma are relatively long-lasting. This might simply indicate that people with depressive symptoms tend to report more stigma, but if that were the case, one would have expected reports of stigma to decline over the course of the treatment program, as depression did. However, since stigma reports stayed constant, the authors concluded that stigma must have had a causal role in shaping depressive symptoms. It is worth noting that this study found stigma variables to account uniquely for around 10% or slightly more of the variance in depressive symptoms—in other words, stigma had a minor effect on depressive symptoms, though such an effect might manifest itself in significant ways on a population level. Some other researchers have suggested that the effects of stigma are usually minor and transitory; for example, Vanderbilt sociologist Walter Gove argued that for the "vast majority of cases the stigma [experienced by mental patients] appears to be transitory and does not appear to pose a severe problem."⁹⁸

Researchers have relatively recently begun pursuing both empirical and theoretical work⁹⁹ on how stigma affects the mental health of LGBT

people, though there has been some controversy over the magnitude and duration of effects due to stigma. Some of the controversy may stem from the difficulty of defining and quantifying stigma as well as the variations in stigma across different social contexts. A 2013 study by Columbia University medical psychologist Walter Bockting and colleagues on mental health in 1,093 transgender people found a positive correlation between psychological distress and both enacted and felt stigma, which were measured using survey questions.¹⁰⁰ A 2003 study¹⁰¹ by clinical psychologist Robin Lewis and colleagues of predictors of depressive symptoms in 201 LGB individuals found that stigma consciousness was significantly associated with depressive symptoms, where stigma consciousness was assessed using a ten-item questionnaire that assessed “the degree to which one expects to be judged on the basis of a stereotype.”¹⁰² However, depressive symptoms are often associated with negative cognition about the self, the world, and the future, and this may contribute to the subjective perception of stigmatization among individuals suffering from depression.¹⁰³ A 2011 study¹⁰⁴ by Bostwick that also used measures of stigma consciousness and depressive symptoms found a modest positive correlation between stigma scores and depressive symptoms in bisexual women, although the study was limited by having a relatively small sample size. However, a 2003 longitudinal study¹⁰⁵ of Norwegian adolescents by psychologist Lars Wichstrøm and colleague found that sexual orientation was associated with poor mental health status after accounting for a variety of psychological risk factors, including self-worth. While this study did not directly consider stigma as a risk factor, it suggests that psychological factors such as stigma consciousness alone likely cannot fully account for the disparities in mental health between heterosexuals and non-heterosexuals. Additionally, it is important to note that due to the cross-sectional design of these studies, causal inferences cannot be supported by the data—different kinds of data and more evidence would be needed to support conclusions about causal relationships. In particular, it is impossible to prove through these studies that stigma leads to poor mental health, as opposed to, for example, poor mental health leading people to report higher levels of stigma, or a third factor being responsible for both poor mental health and higher levels of stigma.

Concealment. Stigma may affect non-heterosexual individuals’ decisions about whether to disclose or conceal their sexual orientation. LGBT people may decide to conceal their sexual orientation to protect themselves against possible bias or discrimination, to avoid a sense of shame, or to

avoid a potential conflict between their social role and sexual desires or behaviors.¹⁰⁶ Particular contexts in which LGBT people may be more likely to conceal their sexual orientation include school, work, and other places in which they feel that disclosure could negatively affect the way that people regard them.

There is a large amount of evidence from psychological research indicating that concealment of an important aspect of one's identity may have adverse mental health consequences. In general, expressing one's emotions and sharing important aspects of one's life with others play large roles in maintaining mental health.¹⁰⁷ Recent decades have seen a growing body of research on the relationships between concealment and disclosure and mental health in LGBT subpopulations.¹⁰⁸ For example, a 2007 study¹⁰⁹ by Belle Rose Ragins and colleagues of workplace concealment and disclosure in 534 LGB individuals found that fear of disclosing was associated with psychological strain and other outcomes such as job satisfaction. However, the study also challenged the notion that disclosure leads to positive psychological and social outcomes, since employees' disclosure was not significantly associated with most of the outcome variables. The authors interpret this result by saying that "this study suggests that concealment may be a necessary and adaptive decision in an unsupportive or hostile environment, thus underscoring the importance of social context."¹¹⁰ Due to the relatively rapid changes in social acceptance of same-sex marriage and of same-sex relationships more broadly in recent decades,¹¹¹ it is possible that some of the research on the psychological effects of concealment and disclosure is outdated, because in general there may now be less pressure for those identifying as LGB to conceal their identities.

Testing the model. One of the implications of the social stress model is that reducing the amount of discrimination, prejudice, and stigmatization of sexual minorities would help reduce the rates of mental health problems for these populations. Some jurisdictions have sought to reduce these social stressors by passing anti-discrimination and hate-crime laws. If such policies are in fact successful at reducing these stressors then they could be expected to reduce the rates of mental health problems in LGB populations to the extent that the social stress model accurately accounts for the causes of these problems. So far, studies have not been designed in such a way that could allow them to test conclusively the hypothesis that social stress accounts for the high rates of poor mental health outcomes in non-heterosexual populations, but there is research that provides some data on a testable implication of the social stress model.

A 2009 study by sociomedical scientist Mark Hatzenbuehler and colleagues investigated the association between psychiatric morbidity in LGB populations and two state-level policies that pertained to these populations: hate-crime laws that did not include sexual orientation as a protected category, and laws prohibiting employment discrimination based on sexual orientation.¹¹² The study used data on mental health outcomes from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationally representative sample of 34,653 civilian, non-institutionalized adults, and measuring psychiatric disorders according to *DSM-IV* criteria.¹¹³ Wave 2 of NESARC took place in 2004–2005. Of the sample, 577 respondents identified as lesbian, gay, or bisexual. The analysis of the data showed that LGB individuals living in states with no hate-crime laws and no non-discrimination laws tended to have higher odds of psychiatric morbidity (compared to LGB individuals in states with one or two protective laws), but the analysis found statistically significant correlations only for dysthymia (a less severe but more persistent form of depression), generalized anxiety disorder, and post-traumatic stress disorder, while the correlations between seven other psychiatric conditions investigated were not found to be statistically significant. No epidemiological inferences can be made due to the nature of the data, suggesting the need for more studies on this and similar topics.

Hatzenbuehler and colleagues attempted to improve on this cross-sectional study by doing a prospective study, published in 2010, this time examining changes in psychiatric morbidity over the period in which certain states passed constitutional amendments defining marriage as a union between one man and one woman—amendments that were described by the study’s authors as “bans on gay marriage.”¹¹⁴ The authors examined differences in psychiatric morbidity between Wave 1 of NESARC, which took place in 2001–2002, and Wave 2, which coincided with the 2004 and 2005 state-constitutional amendments. They observed that the prevalence in mood disorders in LGB respondents living in states that passed marriage amendments increased by 36.6% between Waves 1 and 2. Mood disorders for LGB respondents living in states that did not pass marriage amendments decreased by 23.6%, though this change was not statistically significant. The prevalence of certain disorders increased both in states that passed such amendments and in states that did not. Generalized anxiety disorder, for example, increased in both, but by a much larger and statistically significant magnitude in states that passed marriage amendments. Hatzenbuehler and colleagues found that drug-use disorders increased more in states that did *not* pass marriage amendments,

and the increase was statistically significant only for those states. (Total substance abuse disorders increased in both cases, by a roughly similar amount.) As with the earlier cross-sectional study, for the majority of the psychiatric conditions investigated there were no significant correlations between the conditions and the social policies that were hypothesized to have an influence on mental health outcomes.

Some of the limitations of the study's findings noted by the authors include the following: healthier LGB respondents may have moved out of the states that would eventually pass marriage amendments into the states that would not; sexual orientation was only assessed during Wave 2 of NESARC, and there is some fluidity to sexual identity that may have led to misclassification of some LGB respondents; and the sample size of LGB respondents living in states that passed marriage amendments was relatively small, limiting the statistical power of the study.

One hypothesized causal mechanism for the change in mental health variables associated with the marriage amendments is that the public debate surrounding the amendments may have elevated the stress experienced by non-heterosexuals—a hypothesis that was put forward by psychologist Sharon Scales Rostosky and colleagues in a study of the attitudes of LGB adults in states that passed marriage amendments in 2006.¹¹⁵ The survey data collected during this study showed that LGB respondents living in states that passed marriage amendments in 2006 had higher levels of various kinds of psychological distress, including stress and depressive symptoms. The study also found that participation in LGBT activism during the election season was associated with increased psychological distress. It may be that part of the psychological distress recorded by this survey, which included perceived stress, depressive symptoms (but not diagnoses of depressive disorders), and what the researchers called “amendment-related affect,” may have simply reflected the typical feelings of advocates when they experience political defeat on an issue that they care passionately about. Other key limitations of the study were its cross-sectional design and its reliance on volunteers for the survey (in contrast to the previous study by Hatzenbuehler and colleagues). The survey methodology may also have biased the results—the researchers advertised on websites and through listserv e-mail announcements that they were looking for survey respondents for a study on “attitudes and experiences of LGB...individuals regarding the debate” over gay marriage. As with many forms of convenience sampling, individuals with strong attitudes regarding the issues under investigation in the survey may have been more likely to respond.

As for the effects of particular policies, the evidence is equivocal at best. The 2009 study by Hatzenbuehler and colleagues demonstrated significant correlations between the risk of some (though not all) mental health problems in the LGB subpopulation and state policies on hate crime and employment protections. Even for the aspects of mental health that this study found to be correlated with hate-crime or employment-protection policies, the study was unable to show an epidemiological relationship between policies and health outcomes.

Conclusion

The social stress model probably accounts for some of the poor mental health outcomes experienced by sexual minorities, though the evidence supporting the model is limited, inconsistent and incomplete. Some of the central concepts of the model, such as stigmatization, are not easily operationalized. There is evidence linking some forms of mistreatment, stigmatization, and discrimination to some of the poor mental health outcomes experienced by non-heterosexuals, but it is far from clear that these factors account for all of the disparities between the heterosexual and non-heterosexual populations. Those poor mental health outcomes may be mitigated to some extent by reducing social stressors, but this strategy is unlikely to eliminate all of the disparities in mental health status between sexual minorities and the wider population. Other factors, such as the elevated rates of sexual abuse victimization among the LGBT population discussed in Part One, may also account for some of these mental health disparities, as research has consistently shown that “survivors of childhood sexual abuse are significantly at risk of a wide range of medical, psychological, behavioral, and sexual disorders.”¹¹⁶

Just as it does a disservice to non-heterosexual subpopulations to ignore or downplay the statistically higher risks of negative mental health outcomes they face, so it does them a disservice to misattribute the causes of these elevated risks, or to ignore other potential factors that may be at work. Assuming that a single model can explain all of the mental health risks faced by non-heterosexuals can mislead clinicians and therapists charged with helping this vulnerable subpopulation. The social stress model deserves further research, but should not be assumed to offer a complete explanation of the causes of mental health disparities if clinicians and policymakers want to adequately address the mental health challenges faced by the LGBT community. More research is needed to explore the causes of, and solutions to, these important public health challenges.

Part Three

Gender Identity

The concept of biological sex is well defined, based on the binary roles that males and females play in reproduction. By contrast, the concept of gender is not well defined. It is generally taken to refer to behaviors and psychological attributes that tend to be typical of a given sex. Some individuals identify as a gender that does not correspond to their biological sex. The causes of such cross-gender identification remain poorly understood. Research investigating whether these transgender individuals have certain physiological features or experiences in common with the opposite sex, such as brain structures or atypical prenatal hormone exposures, has so far been inconclusive. Gender dysphoria—a sense of incongruence between one’s biological sex and one’s gender, accompanied by clinically significant distress or impairment—is sometimes treated in adults by hormones or surgery, but there is little scientific evidence that these therapeutic interventions have psychological benefits. Science has shown that gender identity issues in children usually do not persist into adolescence or adulthood, and there is little scientific evidence for the therapeutic value of puberty-delaying treatments. We are concerned by the increasing tendency toward encouraging children with gender identity issues to transition to their preferred gender through medical and then surgical procedures. There is a clear need for more research in these areas.

As described in Part One, there is a widely held belief that *sexual orientation* is a well-defined concept, and that it is innate and fixed in each person—as it is often put, gay people are “born that way.” Another emerging and related view is that *gender identity*—the subjective, internal sense of being a man or a woman (or some other gender category)—is also fixed at birth or at a very early age and can diverge from a person’s biological sex. In the case of children, this is sometimes articulated by saying that a little boy may be trapped in a little girl’s body, or vice versa.

In Part One we argued that scientific research does not give much support to the hypothesis that sexual orientation is innate and fixed. We will argue here, similarly, that there is little scientific evidence that gender identity is fixed at birth or at an early age. Though biological sex is innate, and gender identity and biological sex are related in complex ways, they

are not identical; gender is sometimes defined or expressed in ways that have little or no biological basis.

Key Concepts and Their Origins

To clarify what is meant by “gender” and “sex,” we begin with a widely used definition, here quoted from a pamphlet published by the American Psychological Association (APA):

Sex is assigned at birth, refers to one’s biological status as either male or female, and is associated primarily with physical attributes such as chromosomes, hormone prevalence, and external and internal anatomy. *Gender* refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women. These influence the ways that people act, interact, and feel about themselves. While aspects of biological sex are similar across different cultures, aspects of gender may differ.¹

This definition points to the obvious fact that there are social norms for men and women, norms that vary across different cultures and that are not simply determined by biology. But it goes further in holding that gender is wholly “socially constructed”—that it is detached from biological sex. This idea has been an important part of a feminist movement to reform or eliminate traditional gender roles. In the classic feminist book *The Second Sex* (1949), Simone de Beauvoir wrote that “one is not born, but becomes a woman.”² This notion is an early version of the now familiar distinction between sex as a biological designation and gender as a cultural construct: though one is born, as the APA explains, with the “chromosomes, hormone prevalence, and external and internal anatomy” of a female, one is socially conditioned to take on the “roles, behaviors, activities, and attributes” of a woman.

Developments in feminist theory in the second half of the twentieth century further solidified the position that gender is socially constructed. One of the first to use the term “gender” as distinct from sex in the social-science literature was Ann Oakley in her 1972 book, *Sex, Gender and Society*.³ In the 1978 book *Gender: An Ethnomethodological Approach*, psychology professors Suzanne Kessler and Wendy McKenna argued that “gender is a social construction, that a world of two ‘sexes’ is a result of the socially shared, taken for granted methods which members use to construct reality.”⁴

Anthropologist Gayle Rubin expresses a similar view, writing in 1975 that “Gender is a socially imposed division of the sexes. It is a product of

the social relations of sexuality.”⁵ According to her argument, if it were not for this social imposition, we would still have males and females but not “men” and “women.” Furthermore, Rubin argues, if traditional gender roles are socially constructed, then they can also be *d*econstructed, and we can eliminate “obligatory sexualities and sex roles” and create “an androgynous and genderless (though not sexless) society, in which one’s sexual anatomy is irrelevant to who one is, what one does, and with whom one makes love.”⁶

The relationship between gender theory and the deconstruction or overthrowing of traditional gender roles is made even clearer in the works of the influential feminist theorist Judith Butler. In works such as *Gender Trouble: Feminism and the Subversion of Identity* (1990)⁷ and *Undoing Gender* (2004)⁸ Butler advances what she describes as “performativity theory,” according to which being a woman or man is not something that one *is* but something that one *does*. “Gender is neither the causal result of sex nor as seemingly fixed as sex,” as she put it.⁹ Rather, gender is a constructed status radically independent from biology or bodily traits, “a free floating artifice, with the consequence that *man* and *masculine* might just as easily signify a female body as a male one, and *woman* and *feminine* a male body as easily as a female one.”¹⁰

This view, that gender and thus gender identity are fluid and plastic, and not necessarily binary, has recently become more prominent in popular culture. An example is Facebook’s move in 2014 to include 56 new ways for users to describe their gender, in addition to the options of male and female. As Facebook explains, the new options allow the user to “feel comfortable being your true, authentic self,” an important part of which is “the expression of gender.”¹¹ Options include *agender*, several *cis-* and *trans-* variants, *gender fluid*, *gender questioning*, *neither*, *other*, *pangender*, and *two-spirit*.¹²

Whether or not Judith Butler was correct in describing traditional gender roles of men and women as “performative,” her theory of gender as a “free-floating artifice” does seem to describe this new taxonomy of gender. As these terms multiply and their meanings become more individualized, we lose any common set of criteria for defining what gender distinctions mean. If gender is entirely detached from the binary of biological sex, gender could come to refer to any distinctions in behavior, biological attributes, or psychological traits, and each person could have a gender defined by the unique combination of characteristics the person possesses. This *reductio ad absurdum* is offered to present the possibility that defining gender too broadly could lead to a definition that has little meaning.

Alternatively, gender identity could be defined in terms of sex-typical traits and behaviors, so that being a boy means behaving in the ways boys typically behave—such as engaging in rough-and-tumble play and expressing an interest in sports and liking toy guns more than dolls. But this would imply that a boy who plays with dolls, hates guns, and refrains from sports or rough-and-tumble play might be considered to be a girl, rather than simply a boy who represents an exception to the typical patterns of male behavior. The ability to recognize exceptions to sex-typical behavior relies on an understanding of maleness and femaleness that is independent of these stereotypical sex-appropriate behaviors. The underlying basis of maleness and femaleness is the distinction between the reproductive roles of the sexes; in mammals such as humans, the female gestates offspring and the male impregnates the female. More universally, the male of the species fertilizes the egg cells provided by the female of the species. This conceptual basis for sex roles is binary and stable, and allows us to distinguish males from females on the grounds of their reproductive systems, even when these individuals exhibit behaviors that are not typical of males or females.

To illustrate how reproductive roles define the differences between the sexes even when behavior appears to be atypical for the particular sex, consider two examples, one from the diversity of the animal kingdom, and one from the diversity of human behavior. First, we look at the emperor penguin. Male emperor penguins provide more care for eggs than do females, and in this sense, the male emperor penguin could be described as more maternal than the female.¹³ However, we recognize that the male emperor penguin is not in fact female but rather that the species represents an exception to the general, but not universal, tendency among animals for females to provide more care than males for offspring. We recognize this because sex-typical behaviors like parental care do not define the sexes; the individual's role in sexual reproduction does.

Even other sex-typical biological traits, such as chromosomes, are not necessarily helpful for defining sex in a universal way, as the penguin example further illustrates. As with other birds, the genetics of sex determination in the emperor penguin is different than the genetics of sex determination in mammals and many other animals. In humans, males have XY chromosomes and females have XX chromosomes; that is, males have a unique sex-determining chromosome that they do not share with females, while females have two copies of a chromosome that they share with males. But in birds, it is females, not males, that have and pass on the sex-specific chromosome.¹⁴ Just as the observation that

male emperor penguins nurture their offspring more than their partners did not lead zoologists to conclude that the egg-laying member of the emperor penguin species was in fact the male, the discovery of the ZW sex-determination system in birds did not lead geneticists to challenge the age-old recognition that hens are females and roosters are males. The only variable that serves as the fundamental and reliable basis for biologists to distinguish the sexes of animals is their role in reproduction, not some other behavioral or biological trait.

Another example that, in this case, only appears to be non-sex-typical behavior is that of Thomas Beatie, who made headlines as a man who gave birth to three children between 2008 and 2010.¹⁵ Thomas Beatie was born a woman, Tracy Lehuanani LaGondino, and underwent a surgical and legal transition to living as a man before deciding to have children. Because the medical procedures he underwent did not involve the removal of his ovaries or uterus, Beatie was capable of bearing children. The state of Arizona recognizes Thomas Beatie as the father of his three children, even though, biologically, he is their mother. Unlike the case of the male emperor penguin's ostensibly maternal, "feminine" parenting behavior, Beatie's ability to have children does not represent an exception to the normal inability of males to bear children. The labeling of Beatie as a man despite his being biologically female is a personal, social, and legal decision that was made without any basis in biology; nothing whatsoever in biology suggests Thomas Beatie is a male.

In biology, an organism is male or female if it is structured to perform one of the respective roles in reproduction. This definition does not require any arbitrary measurable or quantifiable physical characteristics or behaviors; it requires understanding the reproductive system and the reproduction process. Different animals have different reproductive systems, but sexual reproduction occurs when the sex cells from the male and female of the species come together to form newly fertilized embryos. It is these reproductive roles that provide the conceptual basis for the differentiation of animals into the biological categories of male and female. There is no other widely accepted biological classification for the sexes.

But this definition of the biological category of sex is not universally accepted. For example, philosopher and legal scholar Edward Stein maintains that infertility poses a crucial problem for defining sex in terms of reproductive roles, writing that defining sex in terms of these roles would define "infertile males as females."¹⁶ Since an infertile male cannot play the reproductive role for which males are structured, and an infertile

female cannot play the reproductive role for which females are structured, according to this line of thinking, defining sex in terms of reproductive roles would not be appropriate, as infertile males would be classified as females, and infertile females as males. Nevertheless, while a reproductive system structured to serve a particular reproductive role may be impaired in such a way that it cannot perform its function, the system is still recognizably structured for that role, so that biological sex can still be defined strictly in terms of the structure of reproductive systems. A similar point can be made about heterosexual couples who choose not to reproduce for any of a variety of reasons. The male and female reproductive systems are generally clearly recognizable, regardless of whether or not they are being used for purposes of reproduction.

The following analogy illustrates how a system can be recognized as having a particular purpose, even when that system is dysfunctional in a way that renders it incapable of carrying out its purpose: Eyes are complex organs that function as processors of vision. However, there are numerous conditions affecting the eye that can impair vision, resulting in blindness. The eyes of the blind are still recognizably organs structured for the function of sight. Any impairments that result in blindness do not affect the purpose of the eye—any more than wearing a blindfold—but only its function. The same is true for the reproductive system. Infertility can be caused by many problems. However, the reproductive system continues to exist for the purpose of begetting children.

There are individuals, however, who are biologically “intersex,” meaning that their sexual anatomy is ambiguous, usually for reasons of genetic abnormalities. For example, the clitoris and penis are derived from the same embryonic structures. A baby may display an abnormally large clitoris or an abnormally small penis, causing its biological sex to be difficult to determine long after birth.

The first academic article to use the term “gender” appears to be the 1955 paper by the psychiatry professor John Money of Johns Hopkins on the treatment of “intersex” children (the term then used was “hermaphrodites”).¹⁷ Money posited that gender identity, at least for these children, was fluid and that it could be constructed. In his mind, making a child identify with a gender only required constructing sex-typical genitalia and creating a gender-appropriate environment for the child. The chosen gender for these children was often female—a decision that was not based on genetics or biology, nor on the belief that these children were “really” girls, but, in part, on the fact that at the time it was easier surgically to construct a vagina than it was to construct a penis.

The most widely known patient of Dr. Money was David Reimer, a boy who was not born with an intersex condition but whose penis was damaged during circumcision as an infant.¹⁸ David was raised by his parents as a girl named Brenda, and provided with both surgical and hormonal interventions to ensure that he would develop female-typical sex characteristics. However, the attempt to conceal from the child what had happened to him was not successful—he self-identified as a boy, and eventually, at the age of 14, his psychiatrist recommended to his parents that they tell him the truth. David then began the difficult process of reversing the hormonal and surgical interventions that had been performed to feminize his body. But he continued to be tormented by his childhood ordeal, and took his own life in 2004, at the age of 38.

David Reimer is just one example of the harm wrought by theories that gender identity can socially and medically be reassigned in children. In a 2004 paper, William G. Reiner, a pediatric urologist and child and adolescent psychiatrist, and John P. Gearhart, a professor of pediatric urology, followed up on the sexual identities of 16 genetic males affected by cloacal exstrophy—a condition involving a badly deformed bladder and genitals. Of the 16 subjects, 14 were assigned female sex at birth, receiving surgical interventions to construct female genitalia, and were raised as girls by their parents; 6 of these 14 later chose to identify as males, while 5 continued to identify as females and 2 declared themselves males at a young age but continued to be raised as females because their parents rejected the children's declarations. The remaining subject, who had been told at age 12 that he was born male, refused to discuss sexual identity.¹⁹ So the assignment of female sex persisted in only 5 of the 13 cases with known results.

This lack of persistence is some evidence that the assignment of sex through genital construction at birth with immersion into a “gender-appropriate” environment is not likely to be a successful option for managing the rare problem of genital ambiguity from birth defects. It is important to note that the ages of these individuals at last follow-up ranged from 9 to 19, so it is possible that some of them may have subsequently changed their gender identities.

Reiner and Gearhart's research indicates that gender is not arbitrary; it suggests that a biological male (or female) will probably not come to identify as the opposite gender after having been altered physically and immersed into the corresponding gender-typical environment. The plasticity of gender appears to have a limit.

What is clear is that biological sex is not a concept that can be reduced to, or artificially assigned on the basis of, the type of external genitalia

alone. Surgeons are becoming more capable of constructing artificial genitalia, but these “add-ons” do not change the biological sex of the recipients, who are no more capable of playing the reproductive roles of the opposite biological sex than they were without the surgery. Nor does biological sex change as a function of the environment provided for the child. No degree of supporting a little boy in converting to be considered, by himself and others, to be a little girl makes him biologically a little girl. The scientific definition of biological sex is, for almost all human beings, clear, binary, and stable, reflecting an underlying biological reality that is not contradicted by exceptions to sex-typical behavior, and cannot be altered by surgery or social conditioning.

In a 2004 article summarizing the results of research related to inter-sex conditions, Paul McHugh, the former chief of psychiatry at Johns Hopkins Hospital (and the coauthor of this report), suggested:

We in the Johns Hopkins Psychiatry Department eventually concluded that human sexual identity is mostly built into our constitution by the genes we inherit and the embryogenesis we undergo. Male hormones sexualize the brain and the mind. Sexual dysphoria—a sense of disquiet in one’s sexual role—naturally occurs amongst those rare males who are raised as females in an effort to correct an infantile genital structural problem.²⁰

We now turn our attention to transgender individuals—children and adults—who choose to identify as a gender different from their biological sex, and explore the meaning of gender identity in this context and what the scientific literature tells us about its development.

Gender Dysphoria

While biological sex is, with very few exceptions, a well-defined, binary trait (male versus female) corresponding to how the body is organized for reproduction, *gender identity* is a more subjective attribute. For most people, their own gender identity is probably not a significant concern; most biological males identify as boys or men, and most biological females identify as girls or women. But some individuals experience an incongruence between their biological sex and their gender identity. If this struggle causes them to seek professional help, then the problem is classified as “gender dysphoria.”

Some male children raised as females, as described in Reiner and colleagues’ 2004 study, came to experience problems with their gender

identity when their subjective sense of being boys conflicted with being identified and treated as girls by their parents and doctors. The biological sex of the boys was not in question (they had an XY genotype), and the cause of gender dysphoria lay in the fact that they were genetically male, came to identify as male, but had been assigned female gender identities. This suggests that gender identity can be a complex and burdensome issue for those who choose (or have others choose for them) a gender identity opposite their biological sex.

But the cases of gender dysphoria that are the subject of much public debate are those in which individuals come to identify as genders different from those based on their biological sex. These people are usually identified, and describe themselves, as “transgender.”*

According to the fifth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, gender dysphoria is marked by “incongruence between one’s experienced/expressed gender and assigned gender,” as well as “clinically significant distress or impairment in social, occupational, or other important areas of functioning.”²¹

It is important to clarify that gender dysphoria is not the same as gender nonconformity or gender identity disorder. Gender nonconformity describes an individual who behaves in a manner contrary to the gender-specific norms of his or her biological sex. As the *DSM-5* notes, most transvestites, for instance, are not transgender—men who dress as women typically do not identify themselves as women.²² (However, certain forms of transvestitism can be associated with late-onset gender dysphoria.²³)

Gender identity disorder, an obsolete term from an earlier version of the *DSM* that was removed in its fifth edition, was used as a psychiatric diagnosis. If we compare the diagnostic criteria for gender dysphoria (the current term) and gender identity disorder (the former term), we see that both require the patient to display “a marked incongruence between one’s

* A note on terminology: In this report, we generally use the term *transgender* to refer to persons for whom there is an incongruity between the gender identity they understand themselves to possess and their biological sex. We use the term *transsexual* to refer to individuals who have undergone medical interventions to transform their appearance to better correspond with that of their preferred gender. The most familiar colloquial term used to describe the medical interventions that transform the appearance of transgender individuals may be “sex change” (or, in the case of surgery, “sex-change operation”), but this is not commonly used in the scientific and medical literature today. While no simple terms for these procedures are completely satisfactory, in this report we employ the commonly used terms *sex reassignment* and *sex-reassignment surgery*, except when quoting a source that uses “gender reassignment” or some other term.

experienced/expressed gender and assigned gender.”²⁴ The key difference is that a diagnosis of gender dysphoria requires the patient additionally to experience a “clinically significant distress or impairment in social, occupational, or other important areas of functioning” associated with these incongruent feelings.²⁵ Thus the major set of diagnostic criteria used in contemporary psychiatry does not designate all transgender individuals as having a psychiatric disorder. For example, a biological male who identifies himself as a female is not considered to have a psychiatric disorder unless the individual is experiencing significant psychosocial distress at the incongruence. A diagnosis of gender dysphoria may be part of the criteria used to justify sex-reassignment surgery or other clinical interventions. Furthermore, a patient who has had medical or surgical modifications to express his or her gender identity may still suffer from gender dysphoria. It is the nature of the struggle that defines the disorder, not the fact that the expressed gender differs from the biological sex.

There is no scientific evidence that all transgender people have gender dysphoria, or that they are all struggling with their gender identities. Some individuals who are not transgender—that is, who do not identify as a gender that does not correspond with their biological sex—might nonetheless struggle with their gender identity; for example, girls who behave in some male-typical ways might experience various forms of distress without ever coming to identify as boys. Conversely, individuals who do identify as a gender that does not correspond with their biological sex may not experience clinically significant distress related to their gender identity. Even if only, say, 40% of individuals who identify as a gender that does not correspond with their biological sex experience significant distress related to their gender identity, this would constitute a public health issue requiring clinicians and others to act to support those with gender dysphoria, and hopefully, to reduce the rate of gender dysphoria in the population. There is no evidence to suggest that the other 60% in this hypothetical—that is, the individuals who identify as a gender that does not correspond with their biological sex but who do not experience significant distress—would require clinical treatment.

The *DSM*’s concept of subjectively “experiencing” one’s gender as incongruent from one’s biological sex may require more critical scrutiny and possibly modification. The exact definition of gender dysphoria, however well-intentioned, is somewhat vague and confusing. It does not account for individuals who self-identify as transgender but do not experience dysphoria associated with their gender identity and who seek psychiatric care for functional impairment for problems unrelated to their

gender identity, such as anxiety or depression. They may then be mislabeled as having gender dysphoria simply because they have a desire to be identified as a member of the opposite gender, when they have come to a satisfactory resolution, subjectively, with this incongruence and may be depressed for reasons having nothing to do with their gender identity.

The *DSM-5* criteria for a diagnosis of gender dysphoria in children are defined in a “more concrete, behavioral manner than those for adolescents and adults.”²⁶ This is to say that some of the diagnostic criteria for gender dysphoria in children refer to behaviors that are stereotypically associated with the opposite gender. Clinically significant distress is still necessary for a diagnosis of gender dysphoria in children, but some of the other diagnostic criteria include, for instance, a “strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.”²⁷ What of girls who are “tomboys” or boys who are not oriented toward violence and guns, who prefer quieter play? Should parents worry that their tomboy daughter is really a boy stuck in a girl’s body? There is no scientific basis for believing that playing with toys typical of boys defines a child as a boy, or that playing with toys typical of girls defines a child as a girl. The *DSM-5* criterion for diagnosing gender dysphoria by reference to gender-typical toys is unsound; it appears to ignore the fact that a child could display an *expressed* gender—manifested by social or behavioral traits—incongruent with the child’s biological sex but without *identifying* as the opposite gender. Furthermore, even for children who do identify as a gender opposite their biological sex, diagnoses of gender dysphoria are simply unreliable. The reality is that they may have psychological difficulties in accepting their biological sex as their gender. Children can have difficulty with the expectations associated with those gender roles. Traumatic experiences can also cause a child to express distress with the gender associated with his or her biological sex.

Gender identity problems can also arise with intersex conditions (the presence of ambiguous genitalia due to genetic abnormalities), which we discussed earlier. These disorders of sex development, while rare, can contribute to gender dysphoria in some cases.²⁸ Some of these conditions include complete androgen insensitivity syndrome, where individuals with XY (male) chromosomes lack receptors for male sex hormones, leading them to develop the secondary sex characteristics of females, rather than males (though they lack ovaries, do not menstruate, and are consequently sterile).²⁹ Another hormonal disorder of sex development that can lead to individuals developing in ways that are not typical of their genetic sex include congenital adrenal hyperplasia, a condition that can

masculinize XX (female) fetuses.³⁰ Other rare phenomena such as genetic mosaicism³¹ or chimerism,³² where some cells in the individual's bodies contain XX chromosomes and others contain XY chromosomes, can lead to considerable ambiguity in sex characteristics, including individuals who possess both male and female gonads and sex organs.

While there are many cases of gender dysphoria that are not associated with these identifiable intersex conditions, gender dysphoria may still represent a different type of intersex condition in which the primary sex characteristics such as genitalia develop normally while secondary sex characteristics associated with the brain develop along the lines of the opposite sex. Controversy exists over influences determining the nature of neurological, psychological, and behavioral sex differences. The emerging consensus is that there may be some differences in patterns of neurological development in- and ex-utero for men and women.³³ Therefore, in theory, transgender individuals could be subject to conditions allowing a more female-type brain to develop within a genetic male (having the XY chromosomal patterns), and vice versa. However, as we will show in the next section, the research supporting this idea is quite minimal.

As a way of surveying the biological and social science research on gender dysphoria, we can list some of the important questions. Are there biological factors that influence the development of a gender identity that does not correspond with one's biological sex? Are some individuals born with a gender identity different from their biological sex? Is gender identity shaped by environmental or nurturing conditions? How stable are choices of gender identity? How common is gender dysphoria? Is it persistent across the lifespan? Can a little boy who thinks he is a little girl change over the course of his life to regard himself as male? If so, how often can such people change their gender identities? How would someone's gender identity be measured scientifically? Does self-understanding suffice? Does a biological girl become a gender boy by believing, or at least stating, she is a little boy? Do people's struggles with a sense of incongruity between their gender identity and biological sex persist over the life course? Does gender dysphoria respond to psychiatric interventions? Should those interventions focus on affirming the gender identity of the patient or take a more neutral stance? Do efforts to hormonally or surgically modify an individual's primary or secondary sex characteristics help resolve gender dysphoria? Does modification create further psychiatric problems for some of those diagnosed with gender dysphoria, or does it typically resolve existing psychiatric problems? We broach a few of these critical questions in the following sections.

Gender and Physiology

Robert Sapolsky, a Stanford professor of biology who has done extensive neuroimaging research, suggested a possible neurobiological explanation for cross-gender identification in a 2013 *Wall Street Journal* article, “Caught Between Male and Female.” He asserted that recent neuroimaging studies of the brains of transgender adults suggest that they may have brain structures more similar to their gender identity than to their biological sex.³⁴ Sapolsky bases this assertion on the fact that there are differences between male and female brains, and while the differences are “small and variable,” they “probably contribute to the sex differences in learning, emotion and socialization.”³⁵ He concludes: “The issue isn’t that sometimes people believe they are of a different gender than they actually are. Remarkably, instead, it’s that sometimes people are born with bodies whose gender is different from what they actually are.”³⁶ In other words, he claims that some people can have a female-type brain in a male body, or vice versa.

While this kind of neurobiological theory of cross-gender identification remains outside of the scientific mainstream, it has recently received scientific and popular attention. It provides a potentially attractive explanation for cross-gender identification, especially for individuals who are not affected by any known genetic, hormonal, or psychosocial abnormalities.³⁷ However, while Sapolsky may be right, there is fairly little support in the scientific literature for his contention. His neurological explanation for differences between male and female brains and those differences’ possible relevance to cross-gender identification warrant further scientific consideration.

There are many small studies that attempt to define causal factors of the experience of incongruence between one’s biological sex and felt gender. These studies are described in the following pages, each pointing to an influence that may contribute to the explanation for cross-gender identification.

Nancy Segal, a psychologist and geneticist, researched two case studies of identical twins discordant for female-to-male (FtM) transsexualism.³⁸ Segal notes that, according to another, earlier study that conducted nonclinical interviews with 45 FtM transsexuals, 60% suffered some form of childhood abuse, with 31% experiencing sexual abuse, 29% experiencing emotional abuse, and 38% physical abuse.³⁹ However, this earlier study did not include a control group and was limited by its small sample size, making it difficult to extract significant interactions, or generalizations, from the data.

Segal's own first case study was of a 34-year-old FtM twin, whose identical twin sister was married and the mother of seven children.⁴⁰ Several stressful events had occurred during the twins' mother's pregnancy, and they were born five weeks prematurely. When they were eight years old, their parents divorced. The FtM twin exhibited gender-nonconforming behavior early and it persisted throughout childhood. She became attracted to other girls in junior high school and as a teenager attempted suicide several times. She reported physical abuse and emotional abuse at the hand of her mother. The twins were raised in a Mormon household, in which transsexuality was not tolerated.⁴¹ The twin sister had never questioned her gender identity but did experience some depression. For Segal, the FtM twin's gender nonconformity and abuse in childhood were factors that contributed to gender dysphoria; the other twin was not subject to the same stressors in childhood, and did not develop issues around her gender identity. Segal's second case study also concerned identical twins with one twin transitioning from female to male.⁴² This FtM twin had early-onset nonconforming behaviors and attempted suicide as a young adult. At age 29 she underwent reassignment surgery, was well supported by family, met a woman, and married. As in the first case, the other twin was reportedly always secure in her female gender identity.

Segal speculates that each set of twins may have had uneven prenatal androgen exposures (though her study did not offer evidence to support this)⁴³ and concludes that "Transsexualism is unlikely to be associated with a major gene, but is likely to be associated with multiple genetic, epigenetic, developmental and experiential influences."⁴⁴ Segal is critical of the notion that the maternal abuse experienced by the FtM twin in her first case study may have played a causal role in the twin's "atypical gender identification" since the abuse "apparently *followed*" the twin's gender-atypical behaviors—though Segal acknowledges "it is possible that this abuse reinforced his already atypical gender identification."⁴⁵ These case studies, while informative, are not scientifically strong, and do not provide direct evidence for any causal hypotheses about the origins of atypical gender identification.

A source of more information—but also inadequate to make direct causal inferences—is a case analysis by Mayo Clinic psychiatrists J. Michael Bostwick and Kari A. Martin of an intersex individual born with ambiguous genitalia who was operated on and raised as a female.⁴⁶ By way of offering some background, the authors draw a distinction between gender identity disorder (an "inconsistency between perceived gender identity and phenotypic sex" that generally involves "no discernible neuroendocri-

nological abnormality”⁴⁷), and intersexuality (a condition in which biological features of both sexes are present). They also provide a summary and classification scheme of the various types of intersex disorders. After a thorough discussion of the various intersex developmental issues that can lead to a disjunction between the brain and body, the authors acknowledge that “Some adult patients with severe dysphoria—transsexuals—have neither history nor objective findings supporting a known biological cause of brain-body disjunction.”⁴⁸ These patients require thorough medical and psychiatric attention to avoid gender dysphoria.

After this helpful summary, the authors state that “Absent psychosis or severe character pathology, patients’ subjective assertions are presently the most reliable standards for delineating core gender identity.”⁴⁹ But it is not clear how we could consider subjective assertions more reliable in establishing gender identity, unless gender identity is defined as a completely subjective phenomenon. The bulk of the article is devoted to describing the various objectively discernible and identifiable ways in which one’s identity as a male or female is imprinted on the nervous and endocrine system. Even when something goes wrong with the development of external genitalia, individuals are more likely to act in accordance with their chromosomal and hormonal makeup.⁵⁰

In 2011, Giuseppina Rametti and colleagues from various research centers in Spain used MRI to study the brain structures of 18 FtM transsexuals who exhibited gender nonconformity early in life and experienced sexual attraction to females prior to hormone treatment.⁵¹ The goal was to learn whether their brain features corresponded more to their biological sex or to their sense of gender identity. The control group consisted of 24 male and 19 female heterosexuals with gender identities conforming to their biological sex. Differences were noted in the white matter microstructure of specific brain areas. In untreated FtM transsexuals, that structure was more similar to that of heterosexual males than to that of heterosexual females in three of four brain areas.⁵² In a complementary study, Rametti and colleagues compared 18 MtF transsexuals to 19 female and 19 male heterosexual controls.⁵³ These MtF transsexuals had white matter tract averages in several brain areas that fell between the averages of the control males and the control females. The values, however, were typically closer to the males (that is, to those that shared their biological sex) than to the females in most areas.⁵⁴ In controls the authors found that, as expected, the males had greater amounts of gray and white matter and higher volumes of cerebrospinal fluid than control females. The MtF transsexual brain volumes

were all similar to those of male controls and significantly different from those of females.⁵⁵

Overall, the findings of these studies by Rametti and colleagues do not sufficiently support the notion that transgender individuals have brains more similar to their preferred gender than to the gender corresponding with their biological sex. Both studies are limited by small sample sizes and lack of a prospective hypothesis—both analyzed the MRI data to find the gender differences and then looked to see where the data from transgender subjects fit.

Whereas both of these MRI studies looked at brain *structure*, a functional MRI study by Emiliano Santarnecchi and colleagues from the University of Siena and the University of Florence looked at brain *function*, examining gender-related differences in spontaneous brain activity during the resting state.⁵⁶ The researchers compared a single FtM individual (declared cross-gender since childhood), and control groups of 25 males and 25 females, with regard to spontaneous brain activity. The FtM individual demonstrated a “brain activity profile more close to his biological sex than to his desired one,” and based in part on this result the authors concluded that “untreated FtM transsexuals show a functional connectivity profile comparable to female control subjects.”⁵⁷ With a sample size of one, this study’s statistical power is virtually zero.

In 2013, Hsaio-Lun Ku and colleagues from various medical centers and research institutes in Taiwan also conducted functional brain imaging studies. They compared the brain activity of 41 transsexuals (21 FtMs, 20 MtFs) and 38 matched heterosexual controls (19 males and 19 females).⁵⁸ Arousal response of each cohort while viewing neutral as compared to erotic films was compared between groups. All of the transsexuals in the study reported sexual attractions to members of their natal, biological sex, and exhibited more sexual arousal than heterosexual controls when viewing erotic films that depicted sexual activity between subjects sharing their biological sex. A “selfness” score was also incorporated into the study, in which the researchers asked participants to “rate the degree to which you identify yourself as the male or female in the film.”⁵⁹ The transsexuals in the study identified with those of their preferred gender more than the controls identified with those of their biological gender, in both erotic films and neutral films. The heterosexual controls did not identify themselves with either males or females in either of the film types. Ku and colleagues claim to have demonstrated characteristic brain patterns for sexual attraction as related to biological sex but did not make meaningful neurobiological gender-identity comparisons among the three cohorts. In

addition, they reported findings that transsexuals demonstrated psychosocial maladaptive defensive styles.

A 2008 study by Hans Berglund and colleagues from Sweden's Karolinska Institute and Stockholm Brain Institute used PET and fMRI scans to compare brain-area activation patterns in 12 MtF transgendered individuals who were sexually attracted to women with those of 12 heterosexual women and 12 heterosexual men.⁶⁰ The first set of subjects took no hormones and had not undergone sex-reassignment surgery. The experiment involved smelling odorous steroids thought to be female pheromones, and other sexually neutral odors such as lavender oil, cedar oil, eugenol, butanol, and odorless air. The results were varied and mixed between the groups for the various odors, which should not be surprising, since *post hoc* analyses usually lead to contradictory findings.

In summary, the studies presented above show inconclusive evidence and mixed findings regarding the brains of transgender adults. Brain-activation patterns in these studies do not offer sufficient evidence for drawing sound conclusions about possible associations between brain activation and sexual identity or arousal. The results are conflicting and confusing. Since the data by Ku and colleagues on brain-activation patterns are not universally associated with a particular sex, it remains unclear whether and to what extent neurobiological findings say anything meaningful about gender identity. It is important to note that regardless of their findings, studies of this kind cannot support any conclusion that individuals come to identify as a gender that does not correspond to their biological sex because of an innate, biological condition of the brain.

The question is not simply whether there are differences between the brains of transgender individuals and people identifying with the gender corresponding to their biological sex, but whether gender identity is a fixed, innate, and biological trait, even when it does not correspond to biological sex, or whether environmental or psychological causes contribute to the development of a sense of gender identity in such cases. Neurological differences in transgender adults might be the consequence of biological factors such as genes or prenatal hormone exposure, or of psychological and environmental factors such as childhood abuse, or they could result from some combination of the two. There are no serial, longitudinal, or prospective studies looking at the brains of cross-gender identifying children who develop to later identify as transgender adults. Lack of this research severely limits our ability to understand causal relationships between brain morphology, or functional activity, and the later development of gender identity different from biological sex.

More generally, it is now widely recognized among psychiatrists and neuroscientists who engage in brain imaging research that there are inherent and ineradicable methodological limitations of *any* neuroimaging study that simply associates a particular trait, such as a certain behavior, with a particular brain morphology.⁶¹ (And when the trait in question is not a concrete behavior but something as elusive and vague as “gender identity,” these methodological problems are even more serious.) These studies cannot provide statistical evidence nor show a plausible biological mechanism strong enough to support *causal connections* between a brain feature and the trait, behavior, or symptom in question. To support a conclusion of causality, even epidemiological causality, we need to conduct prospective longitudinal panel studies of a fixed set of individuals across the course of sexual development if not their lifespan.

Studies like these would use serial brain images at birth, in childhood, and at other points along the developmental continuum, to see whether brain morphology findings were there from the beginning. Otherwise, we cannot establish whether certain brain features caused a trait, or whether the trait is innate and perhaps fixed. Studies like those discussed above of individuals who already exhibit the trait are incapable of distinguishing between *causes* and *consequences* of the trait. In most cases transgender individuals have been acting and thinking for years in ways that, through learned behavior and associated neuroplasticity, may have produced brain changes that could differentiate them from other members of their biological or natal sex. The only definitive way to establish epidemiological causality between a brain feature and a trait (especially one as complex as gender identity) is to conduct prospective, longitudinal, preferably randomly sampled and population-based studies.

In the absence of such prospective longitudinal studies, large representative population-based samples with adequate statistical controls for confounding factors may help narrow the possible causes of a behavioral trait and thereby increase the probability of identifying a neurological cause.⁶² However, because the studies conducted thus far use small convenience samples, none of them is especially helpful for narrowing down the options for causality. To obtain a better study sample, we would need to include neuroimaging in large-scale epidemiological studies. In fact, given the small number of transgender individuals in the general population,⁶³ the studies would need to be prohibitively large to attain findings that would reach statistical significance.

Moreover, if a study found significant differences between these groups—that is, a number of differences higher than what would be

expected by chance alone—these differences would refer to the average in a population of each group. Even if these two *groups* differed significantly for all 100 measurements, it would not necessarily indicate a biological difference among *individuals* at the extremes of the distribution. Thus, a randomly selected transgender individual and a randomly selected non-transgender individual might not differ on any of these 100 measurements. Additionally, since the probability that a randomly selected person from the general population will be transgender is quite small, statistically significant differences in the sample means are not sufficient evidence to conclude that a particular measurement is predictive of whether the person is transgender or not. If we measured the brain of an infant, toddler, or adolescent and found this individual to be closer to one cohort than another on these measures, it would not imply that this individual would grow up to identify as a member of that cohort. It may be helpful to keep this caveat in mind when interpreting research on transgender individuals.

In this context, it is important to note that there are no studies that demonstrate that any of the biological differences being examined have predictive power, and so all interpretations, usually in popular outlets, claiming or suggesting that a statistically significant difference between the brains of people who are transgender and those who are not is the cause of being transgendered or not—that is to say, that the biological differences determine the differences in gender identity—are unwarranted.

In short, the current studies on associations between brain structure and transgender identity are small, methodologically limited, inconclusive, and sometimes contradictory. Even if they were more methodologically reliable, they would be insufficient to demonstrate that brain structure is a cause, rather than an effect, of the gender-identity behavior. They would likewise lack predictive power, the real challenge for any theory in science.

For a simple example to illustrate this point, suppose we had a room with 100 people in it. Two of them are transgender and all others are not. I pick someone at random and ask you to guess the person's gender identity. If you know that 98 out of 100 of the individuals are not transgender, the safest bet would be to guess that the individual is not transgender, since that answer will be correct 98% of the time. Suppose, then, that you have the opportunity to ask questions about the neurobiology and about the natal sex of the person. Knowing the biology only helps in predicting whether the individual is transgender if it can improve on the original guess that the person is not transgender. So if knowing a characteristic of the individual's brain does not improve the ability to predict what group the patient belongs to, then the fact that the two groups differ at the mean is almost irrelevant.

Improving on the original prediction is very difficult for a rare trait such as being transgender, because the probability of that prediction being correct is already very high. If there really were a clear difference between the brains of transgender and non-transgender individuals, akin to the biological differences between the sexes, then improving on the original guess would be relatively easy. Unlike the differences between the sexes, however, there are no biological features that can reliably identify transgender individuals as different from others.

The consensus of scientific evidence overwhelmingly supports the proposition that a physically and developmentally normal boy or girl is indeed what he or she appears to be at birth. The available evidence from brain imaging and genetics does not demonstrate that the development of gender identity as different from biological sex is innate. Because scientists have not established a solid framework for understanding the causes of cross-gender identification, ongoing research should be open to psychological and social causes, as well as biological ones.

Transgender Identity in Children

In 2012, the *Washington Post* featured a story by Petula Dvorak, “Transgender at five,”⁶⁴ about a girl who at the age of 2 years began insisting that she was a boy. The story recounts her mother’s interpretation of this behavior: “Her little girl’s brain was different. Jean [her mother] could tell. She had heard about transgender people, those who are one gender physically but the other gender mentally.” The story recounts this mother’s distressed experiences as she began researching gender identity problems in children and came to understand other parents’ experiences:

Many talked about their painful decision to allow their children to publicly transition to the opposite gender—a much tougher process for boys who wanted to be girls. Some of what Jean heard was reassuring: Parents who took the plunge said their children’s behavior problems largely disappeared, schoolwork improved, happy kid smiles returned. But some of what she heard was scary: children taking puberty blockers in elementary school and teens embarking on hormone therapy before they’d even finished high school.⁶⁵

The story goes on to describe how the sister, Moyin, of the transgender child Tyler (formerly Kathryn) made sense of her sibling’s identity:

Tyler’s sister, who’s 8, was much more casual about describing her transgender sibling. “It’s just a boy mind in a girl body,” Moyin

explained matter-of-factly to her second-grade classmates at her private school, which will allow Tyler to start kindergarten as a boy, with no mention of Kathryn.⁶⁶

The remarks from the child's sister encapsulate the popular notion regarding gender identity: transgender individuals, or children who meet the diagnostic criteria for gender dysphoria, are simply "a boy mind in a girl body," or vice versa. This view implies that gender identity is a persistent and innate feature of human psychology, and it has inspired a gender-affirming approach to children who experience gender identity issues at an early age.

As we have seen above in the overview of the neurobiological and genetic research on the origins of gender identity, there is little evidence that the phenomenon of transgender identity has a biological basis. There is also little evidence that gender identity issues have a high rate of persistence in children. According to the *DSM-5*, "In natal [biological] males, persistence [of gender dysphoria] has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%."⁶⁷ Scientific data on persistence of gender dysphoria remains sparse due to the very low prevalence of the disorder in the general population, but the wide range of findings in the literature suggests that there is still much that we do not know about why gender dysphoria persists or desists in children. As the *DSM-5* entry goes on to note, "It is unclear if children 'encouraged' or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner."⁶⁸ There is a clear need for more research in these areas, and for parents and therapists to acknowledge the great uncertainty regarding how to interpret the behavior of these children.

Therapeutic Interventions in Children

With the uncertainty surrounding the diagnosis of and prognosis for gender dysphoria in children, therapeutic decisions are particularly complex and difficult. Therapeutic interventions for children must take into account the probability that the children may outgrow cross-gender identification. University of Toronto researcher and therapist Kenneth Zucker believes that family and peer dynamics can play a significant role in the development and persistence of gender-nonconforming behavior, writing that

it is important to consider both predisposing and perpetuating factors that might inform a clinical formulation and the development of

a therapeutic plan: the role of temperament, parental reinforcement of cross-gender behavior during the sensitive period of gender identity formation, family dynamics, parental psychopathology, peer relationships and the multiple meanings that might underlie the child's fantasy of becoming a member of the opposite sex.⁶⁹

Zucker worked for years with children experiencing feelings of gender incongruence, offering psychosocial treatments to help them embrace the gender corresponding with their biological sex—for instance, talk therapy, parent-arranged play dates with same-sex peers, therapy for co-occurring psychopathological issues such as autism spectrum disorder, and parent counseling.⁷⁰

In a follow-up study by Zucker and colleagues of children treated by them over the course of thirty years at the Center for Mental Health and Addiction in Toronto, they found that gender identity disorder persisted in only 3 of the 25 girls they had treated.⁷¹ (Zucker's clinic was closed by the Canadian government in 2015.⁷²)

An alternative to Zucker's approach that emphasizes affirming the child's preferred gender identity has become more common among therapists.⁷³ This approach involves helping the children to self-identify even more with the gender label they prefer at the time. One component of the gender-affirming approach has been the use of hormone treatments for adolescents in order to delay the onset of sex-typical characteristics during puberty and alleviate the feelings of dysphoria the adolescents will experience as their bodies develop sex-typical characteristics that are at odds with the gender with which they identify. There is relatively little evidence for the therapeutic value of these kinds of puberty-delaying treatments, but they are currently the subject of a large clinical study sponsored by the National Institutes of Health.⁷⁴

While epidemiological data on the outcomes of medically delayed puberty is quite limited, referrals for sex-reassignment hormones and surgical procedures appear to be on the rise, and there is a push among many advocates to proceed with sex reassignment at younger ages. According to a 2013 article in *The Times* of London, the United Kingdom saw a 50% increase in the number of children referred to gender dysphoria clinics from 2011 to 2012, and a nearly 50% increase in referrals among adults from 2010 to 2012.⁷⁵ Whether this increase can be attributed to rising rates of gender confusion, rising sensitivity to gender issues, growing acceptance of therapy as an option, or other factors, the increase itself is concerning, and merits further scientific inquiry into the family dynamics

and other potential problems, such as social rejection or developmental issues, that may be taken as signs of childhood gender dysphoria.

A study of psychological outcomes following puberty suppression and sex-reassignment surgery, published in the journal *Pediatrics* in 2014 by child and adolescent psychiatrist Annelou L. C. de Vries and colleagues, suggested improved outcomes for individuals after receiving these interventions, with well-being improving to a level similar to that of young adults from the general population.⁷⁶ This study looked at 55 transgender adolescents and young adults (22 MtF and 33 FtM) from a Dutch clinic who were assessed three times: before the start of puberty suppression (mean age: 13.6 years), when cross-sex hormones were introduced (mean age: 16.7 years), and at least one year after sex-reassignment surgery (mean age: 20.7 years). The study did not provide a matched group for comparison—that is, a group of transgender adolescents who did not receive puberty-blocking hormones, cross-sex hormones, and/or sex-reassignment surgery—which makes comparisons of outcomes more difficult.

In the study cohort, gender dysphoria improved over time, body image improved on some measures, and overall functioning improved modestly. Due to the lack of a matched control group it is unclear whether these changes are attributable to the procedures or would have occurred in this cohort without the medical and surgical interventions. Measures of anxiety, depression, and anger showed some improvements over time, but these findings did not reach statistical significance. While this study suggested some improvements over time in this cohort, particularly the reported subjective satisfaction with the procedures, detecting significant differences would require the study to be replicated with a matched control group and a larger sample size. The interventions also included care from a multidisciplinary team of medical professionals, which could have had a beneficial effect. Future studies of this kind would ideally include long-term follow-ups that assess outcomes and functioning beyond the late teens or early twenties.

Therapeutic Interventions in Adults

The potential that patients undergoing medical and surgical sex reassignment may want to return to a gender identity consistent with their biological sex suggests that reassignment carries considerable psychological and physical risk, especially when performed in childhood, but also in adulthood. It suggests that the patients' pre-treatment beliefs about an ideal post-treatment life may sometimes go unrealized.

In 2004, Birmingham University's Aggressive Research Intelligence Facility (Arif) assessed the findings of more than one hundred follow-up studies of post-operative transsexuals.⁷⁷ An article in *The Guardian* summarized the findings:

Arif...concludes that none of the studies provides conclusive evidence that gender reassignment is beneficial for patients. It found that most research was poorly designed, which skewed the results in favour of physically changing sex. There was no evaluation of whether other treatments, such as long-term counselling, might help transsexuals, or whether their gender confusion might lessen over time. Arif says the findings of the few studies that have tracked significant numbers of patients over several years were flawed because the researchers lost track of at least half of the participants. The potential complications of hormones and genital surgery, which include deep vein thrombosis and incontinence respectively, have not been thoroughly investigated, either. "There is huge uncertainty over whether changing someone's sex is a good or a bad thing," says Dr Chris Hyde, director of Arif. "While no doubt great care is taken to ensure that appropriate patients undergo gender reassignment, there's still a large number of people who have the surgery but remain traumatized—often to the point of committing suicide."⁷⁸

The high level of uncertainty regarding various outcomes after sex-reassignment surgery makes it difficult to find clear answers about the effects on patients of reassignment surgery. Since 2004, there have been other studies on the efficacy of sex-reassignment surgery, using larger sample sizes and better methodologies. We will now examine some of the more informative and reliable studies on outcomes for individuals receiving sex-reassignment surgery.

As far back as 1979, Jon K. Meyer and Donna J. Reter published a longitudinal follow-up study on the overall well-being of adults who underwent sex-reassignment surgery.⁷⁹ The study compared the outcomes of 15 people who received surgery with those of 35 people who requested but did not receive surgery (14 of these individuals eventually received surgery later, resulting in three cohorts of comparison: operated, not-operated, and operated later). Well-being was quantified using a scoring system that assessed psychiatric, economic, legal, and relationship outcome variables. Scores were determined by the researchers after performing interviews with the subjects. Average follow-up time was approximately five years for subjects who had sex change surgery, and about two years for those subjects who did not.

Compared to their condition before surgery, the individuals who had undergone surgery appeared to show some improvement in well-being, though the results had a fairly low level of statistical significance. Individuals who had no surgical intervention did display a statistically significant improvement at follow-up. However, there was no statistically significant difference between the two groups' scores of well-being at follow-up. The authors concluded that "sex reassignment surgery confers no objective advantage in terms of social rehabilitation, although it remains subjectively satisfying to those who have rigorously pursued a trial period and who have undergone it."⁸⁰ This study led the psychiatry department at Johns Hopkins Medical Center (JHMC) to discontinue surgical interventions for sex changes for adults.⁸¹

However, the study has important limitations. Selection bias was introduced in the study population, because the subjects were drawn from those individuals who sought sex-reassignment surgery at JHMC. In addition, the sample size was small. Also, the individuals who did not undergo sex-reassignment surgery but presented to JHMC for it did not represent a true control group. Random assignment of the surgical procedure was not possible. Large differences in the average follow-up time between those who underwent surgery and those who did not further reduces any capacity to draw valid comparisons between the two groups. Additionally, the study's methodology was also criticized for the somewhat arbitrary and idiosyncratic way it measured the well-being of its subjects. Cohabitation or any form of contact with psychiatric services were scored as equally negative factors as having been arrested.⁸²

In 2011, Cecilia Dhejne and colleagues from the Karolinska Institute and Gothenburg University in Sweden published one of the more robust and well-designed studies to examine outcomes for persons who underwent sex-reassignment surgery. Focusing on mortality, morbidity, and criminality rates, the matched cohort study compared a total of 324 transsexual persons (191 MtFs, 133 FtMs) who underwent sex reassignment between 1973 and 2003 to two age-matched controls: people of the same sex as the transsexual person at birth, and people of the sex to which the individual had been reassigned.⁸³

Given the relatively low number of transsexual persons in the general population, the size of this study is impressive. Unlike Meyer and Reter, Dhejne and colleagues did not seek to evaluate the patient satisfaction after sex-reassignment surgery, which would have required a control group of transgender persons who desired to have sex-reassignment surgery but did not receive it. Also, the study did not compare outcome

variables before and after sex-reassignment surgery; only outcomes after surgery were evaluated. We need to keep these caveats in mind as we look at what this study found.

Dhejne and colleagues found statistically significant differences between the two cohorts on several of the studied rates. For example, the postoperative transsexual individuals had an approximately three times higher risk for psychiatric hospitalization than the control groups, even after adjusting for prior psychiatric treatment.⁸⁴ (However, the risk of being hospitalized for substance abuse was not significantly higher after adjusting for prior psychiatric treatment, as well as other covariates.) Sex-reassigned individuals had nearly a three times higher risk of all-cause mortality after adjusting for covariates, although the elevated risk was significant only for the time period of 1973–1988.⁸⁵ Those undergoing surgery during this period were also at increased risk of being convicted of a crime.⁸⁶ Most alarmingly, sex-reassigned individuals were 4.9 times more likely to attempt suicide and 19.1 times more likely to die by suicide compared to controls.⁸⁷ “Mortality from suicide was strikingly high among sex-reassigned persons, including after adjustment for prior psychiatric morbidity.”⁸⁸

The study design precludes drawing inferences “as to the effectiveness of sex reassignment as a treatment for transsexualism,” although Dhejne and colleagues state that it is possible that “things might have been even worse without sex reassignment.”⁸⁹ Overall, post-surgical mental health was quite poor, as indicated especially by the high rate of suicide attempts and all-cause mortality in the 1973–1988 group. (It is worth noting that for the transsexuals in the study who underwent sex reassignment from 1989 to 2003, there were of course fewer years of data available at the time the study was conducted than for those transsexuals from the earlier period. The rates of mortality, morbidity, and criminality in the later group may in time come to resemble the elevated risks of the earlier group.) In summary, this study suggests that sex-reassignment surgery may not rectify the comparatively poor health outcomes associated with transgender populations in general. Still, because of the limitations of this study mentioned above, the results also cannot establish that sex-reassignment surgery causes poor health outcomes.

In 2009, Annette Kuhn and colleagues from the University Hospital and University of Bern in Switzerland examined post-surgery quality of life in 52 MtF and 3 FtM transsexuals fifteen years after sex-reassignment surgery.⁹⁰ This study found considerably lower general life satisfaction in post-surgical transsexuals as compared with females who had at least one

pelvic surgery in the past. The postoperative transsexuals reported lower satisfaction with their general quality of health and with some of the personal, physical, and social limitations they experienced with incontinence that resulted as a side effect of the surgery. Again, inferences cannot be drawn from this study regarding the efficacy of sex-reassignment surgery due to the lack of a control group of transgender individuals who did not receive sex-reassignment surgery.

In 2010, Mohammad Hassan Murad and colleagues from the Mayo Clinic published a systematic review of studies on the outcomes of hormonal therapies used in sex-reassignment procedures, finding that there was “very low quality evidence” that sex reassignment via hormonal interventions “likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.”⁹¹ The authors identified 28 studies that together examined 1,833 patients who underwent sex-reassignment procedures that included hormonal interventions (1,093 male-to-female, 801 female-to-male).⁹² Pooling data across studies showed that, after receiving sex-reassignment procedures, 80% of patients reported improvement in gender dysphoria, 78% reported improvement in psychological symptoms, and 80% reported improvement in quality of life.⁹³ None of the studies included the bias-limiting measure of randomization (that is, in none of the studies were sex-reassignment procedures assigned randomly to some patients but not to others), and only three of the studies included control groups (that is, patients who were not provided the treatment to serve as comparison cases for those who did).⁹⁴ Most of the studies examined in Murad and colleagues’ review reported improvements in psychiatric comorbidities and quality of life, though notably suicide rates remained higher for individuals who had received hormone treatments than for the general population, despite reductions in suicide rates following the treatments.⁹⁵ The authors also found that there were some exceptions to reports of improvements in mental health and satisfaction with sex-reassignment procedures; in one study, 3 of 17 individuals regretted the procedure with 2 of these 3 seeking reversal procedures,⁹⁶ and four of the studies reviewed reported worsening quality of life, including continuing social isolation, lack of improvement in social relationships, and dependence on government welfare programs.⁹⁷

The scientific evidence summarized suggests we take a skeptical view toward the claim that sex-reassignment procedures provide the hoped-for benefits or resolve the underlying issues that contribute to elevated mental health risks among the transgender population. While we work to stop maltreatment and misunderstanding, we should also work to study

and understand whatever factors may contribute to the high rates of suicide and other psychological and behavioral health problems among the transgender population, and to think more clearly about the treatment options that are available.

Conclusion

Accurate, replicable scientific research results can and do influence our personal decisions and self-understanding, and can contribute to the public discourse, including cultural and political debates. When the research touches on controversial themes, it is particularly important to be clear about precisely what science has and has not shown. For complex, complicated questions concerning the nature of human sexuality, there exists at best provisional scientific consensus; much remains unknown, as sexuality is an immensely complex part of human life that defies our attempts at defining all its aspects and studying them with precision.

For questions that are easier to study empirically, however, such as those concerning the rates of mental health outcomes for identifiable subpopulations of sexual minorities, the research does offer some clear answers: these subpopulations show higher rates of depression, anxiety, substance abuse, and suicide compared to the general population. One hypothesis, the social stress model—which posits that stigma, prejudice, and discrimination are the primary causes of higher rates of poor mental health outcomes for these subpopulations—is frequently cited as a way to explain this disparity. While non-heterosexual and transgender individuals are often subject to social stressors and discrimination, science has not shown that these factors alone account for the entirety, or even a majority, of the health disparity between non-heterosexual and transgender subpopulations and the general population. There is a need for extensive research in this area to test the social stress hypothesis and other potential explanations for the health disparities, and to help identify ways of addressing the health concerns present in these subpopulations.

Some of the most widely held views about sexual orientation, such as the “born that way” hypothesis, simply are not supported by science. The literature in this area does describe a small ensemble of biological differences between non-heterosexuals and heterosexuals, but those biological differences are not sufficient to predict sexual orientation, the ultimate test of any scientific finding. The strongest statement that science offers to explain sexual orientation is that some biological factors appear, to an unknown extent, to predispose some individuals to a non-heterosexual orientation.

The suggestion that we are “born that way” is more complex in the case of gender identity. In one sense, the evidence that we are born with

a given gender seems well supported by direct observation: males overwhelmingly identify as men and females as women. The fact that children are (with a few exceptions of intersex individuals) born either biologically male or female is beyond debate. The biological sexes play complementary roles in reproduction, and there are a number of population-level average physiological and psychological differences between the sexes. However, while biological sex is an innate feature of human beings, gender identity is a more elusive concept.

In reviewing the scientific literature, we find that almost nothing is well understood when we seek biological explanations for what causes some individuals to state that their gender does not match their biological sex. The findings that do exist often have sample-selection problems, and they lack longitudinal perspective and explanatory power. Better research is needed, both to identify ways by which we can help to lower the rates of poor mental health outcomes and to make possible more informed discussion about some of the nuances present in this field.

Yet despite the scientific uncertainty, drastic interventions are prescribed and delivered to patients identifying, or identified, as transgender. This is especially troubling when the patients receiving these interventions are children. We read popular reports about plans for medical and surgical interventions for many prepubescent children, some as young as six, and other therapeutic approaches undertaken for children as young as two. We suggest that no one can determine the gender identity of a two-year-old. We have reservations about how well scientists understand what it even means for a child to have a developed sense of his or her gender, but notwithstanding that issue, we are deeply alarmed that these therapies, treatments, and surgeries seem disproportionate to the severity of the distress being experienced by these young people, and are at any rate premature since the majority of children who identify as the gender opposite their biological sex will not continue to do so as adults. Moreover, there is a lack of reliable studies on the long-term effects of these interventions. We strongly urge caution in this regard.

We have sought in this report to present a complex body of research in a way that will be intelligible to a wide audience of both experts and lay readers alike. Everyone—scientists and physicians, parents and teachers, lawmakers and activists—deserves access to accurate information about sexual orientation and gender identity. While there is much controversy surrounding how our society treats its LGBT members, no political

or cultural views should discourage us from understanding the related clinical and public health issues and helping people suffering from mental health problems that may be connected to their sexuality.

Our work suggests some avenues for future research in the biological, psychological, and social sciences. More research is needed to uncover the causes of the increased rates of mental health problems in the LGBT subpopulations. The social stress model that dominates research on this issue requires improvement, and most likely needs to be supplemented by other hypotheses. Additionally, the ways in which sexual desires develop and change across one's lifespan remain, for the most part, inadequately understood. Empirical research may help us to better understand relationships, sexual health, and mental health.

Critiquing and challenging both parts of the “born that way” paradigm—both the notion that sexual orientation is biologically determined and fixed, and the related notion that there is a fixed gender independent of biological sex—enables us to ask important questions about sexuality, sexual behaviors, gender, and individual and social goods in a different light. Some of these questions lie outside the scope of this work, but those that we have examined suggest that there is a great chasm between much of the public discourse and what science has shown.

Thoughtful scientific research and careful, circumspect interpretation of its results can advance our understanding of sexual orientation and gender identity. There is still much work to be done and many unanswered questions. We have attempted to synthesize and describe a complex body of scientific research related to some of these themes. We hope that this report contributes to the ongoing public conversation regarding human sexuality and identity. We anticipate that this report may elicit spirited responses, and we welcome them.

Notes

Part One: Sexual Orientation

1. Alex Witchel, "Life After 'Sex,'" *The New York Times Magazine*, January 19, 2012, <http://www.nytimes.com/2012/01/22/magazine/cynthia-nixon-wit.html>.
2. Brandon Ambrosino, "I Wasn't Born This Way. I Choose to Be Gay," *The New Republic*, January 28, 2014, <https://newrepublic.com/article/116378/macklemores-same-love-sends-wrong-message-about-being-gay>.
3. J. Michael Bailey *et al.*, "A Family History Study of Male Sexual Orientation Using Three Independent Samples," *Behavior Genetics* 29, no. 2 (1999): 79–86, <http://dx.doi.org/10.1023/A:1021652204405>; Andrea Camperio-Ciani, Francesca Corna, Claudio Capiluppi, "Evidence for maternally inherited factors favouring male homosexuality and promoting female fecundity," *Proceedings of the Royal Society B* 271, no. 1554 (2004): 2217–2221, <http://dx.doi.org/10.1098/rspb.2004.2872>; Dean H. Hamer *et al.*, "A linkage between DNA markers on the X chromosome and male sexual orientation," *Science* 261, no. 5119 (1993): 321–327, <http://dx.doi.org/10.1126/science.8332896>.
4. Elizabeth Norton, "Homosexuality May Start in the Womb," *Science*, December 11, 2012, <http://www.sciencemag.org/news/2012/12/homosexuality-may-start-womb>.
5. Mark Joseph Stern, "No, Being Gay Is Not a Choice," *Slate*, February 4, 2014, http://www.slate.com/blogs/outward/2014/02/04/choose_to_be_gay_no_you_don_t.html.
6. David Nimmons, "Sex and the Brain," *Discover*, March 1, 1994, <http://discovermagazine.com/1994/mar/sexandthebrain346/>.
7. Leonard Sax, *Why Gender Matters: What Parents and Teachers Need to Know about the Emerging Science of Sex Differences* (New York: Doubleday, 2005), 206.
8. Benoit Denizet-Lewis, "The Scientific Quest to Prove Bisexuality Exists," *The New York Times Magazine*, March 20, 2014, <http://www.nytimes.com/2014/03/23/magazine/the-scientific-quest-to-prove-bisexuality-exists.html>.
9. *Ibid.*
10. *Ibid.*
11. Stephen B. Levine, "Reexploring the Concept of Sexual Desire," *Journal of Sex & Marital Therapy*, 28, no. 1 (2002), 39, <http://dx.doi.org/10.1080/009262302317251007>.
12. *Ibid.*
13. See Lori A. Brotto *et al.*, "Sexual Desire and Pleasure," in *APA Handbook of Sexuality and Psychology*, Volume 1: Person-based Approaches, APA (2014): 205–244; Stephen B. Levine, "Reexploring the Concept of Sexual Desire," *Journal of Sex & Marital Therapy* 28, no. 1 (2002): 39–51, <http://dx.doi.org/10.1080/009262302317251007>; Lisa M. Diamond, "What Does Sexual Orientation Orient? A Biobehavioral Model Distinguishing Romantic Love and Sexual Desire," *Psychological Review* 110, no. 1 (2003): 173–192,

<http://dx.doi.org/10.1037/0033-295X.110.1.173>; Gian C. Gonzaga *et al.*, “Romantic Love and Sexual Desire in Close Relationships,” *Emotion* 6, no. 2 (2006): 163–179, <http://dx.doi.org/10.1037/1528-3542.6.2.163>.

14. Alexander R. Pruss, *One Body: An Essay in Christian Sexual Ethics* (Notre Dame, Ind.: University of Notre Dame Press, 2012), 360.

15. Neil A. Campbell and Jane B. Reece, *Biology*, Seventh Edition (San Francisco: Pearson Education, 2005), 973.

16. See, for instance, Nancy Burley, “The Evolution of Concealed Ovulation,” *American Naturalist* 114, no. 6 (1979): 835–858, <http://dx.doi.org/10.1086/283532>.

17. David Woodruff Smith, “Phenomenology,” *Stanford Encyclopedia of Philosophy* (2013), <http://plato.stanford.edu/entries/phenomenology/>.

18. See, for instance, Abraham Maslow, *Motivation and Personality*, Third Edition (New York: Addison-Wesley Educational Publishers, 1987).

19. Marc-André Raffalovich, *Uranisme et unisexualité: étude sur différentes manifestations de l'instinct sexuel* (Lyon, France: Storck, 1896).

20. See, generally, Brocard Sewell, *In the Dorian Mode: Life of John Gray 1866–1934* (Padstow, Cornwall, U.K.: Tabb House, 1983).

21. For more on the Kinsey scale, see “Kinsey’s Heterosexual-Homosexual Rating Scale,” Kinsey Institute at Indiana University, <http://www.kinseyinstitute.org/research/publications/kinsey-scale.php>.

22. Brief as *Amicus Curiae* of Daniel N. Robinson in Support of Petitioners and Supporting Reversal, *Hollingsworth v. Perry*, 133 S. Ct. 2652 (2013).

23. See, for example, John Bowlby, “The Nature of the Child’s Tie to His Mother,” *The International Journal of Psycho-Analysis* 39 (1958): 350–373.

24. Edward O. Laumann *et al.*, *The Social Organization of Sexuality: Sexual Practices in the United States* (Chicago: University of Chicago Press, 1994).

25. American Psychological Association, “Answers to Your Questions for a Better Understanding of Sexual Orientation & Homosexuality,” 2008, <http://www.apa.org/topics/lgbt/orientation.pdf>.

26. Laumann *et al.*, *The Social Organization of Sexuality*, 300–301.

27. Lisa M. Diamond and Ritch C. Savin-Williams, “Gender and Sexual Identity,” in *Handbook of Applied Development Science*, eds. Richard M. Lerner, Francine Jacobs, and Donald Wertlieb (Thousand Oaks, Calif.: SAGE Publications, 2002), 101. See also A. Elfin Moses and Robert O. Hawkins, *Counseling Lesbian Women and Gay Men: A Life-Issues Approach* (Saint Louis, Mo.: Mosby, 1982).

28. John C. Gonsiorek and James D. Weinrich, “The Definition and Scope of Sexual Orientation,” in *Homosexuality: Research Implications for Public Policy*, eds. John C. Gonsiorek and James D. Weinrich (Newberry Park, Calif.: SAGE Publications, 1991), 8.

29. Letitia Anne Peplau *et al.*, “The Development of Sexual Orientation in Women,”

Annual Review of Sex Research 10, no. 1 (1999): 83, <http://dx.doi.org/10.1080/10532528.1999.10559775>.

30. Lisa M. Diamond, “New Paradigms for Research on Heterosexual and Sexual-Minority Development,” *Journal of Clinical Child & Adolescent Psychology* 32, no. 4 (2003): 492.

31. Franz J. Kallmann, “Comparative Twin Study on the Genetic Aspects of Male Homosexuality,” *Journal of Nervous and Mental Disease* 115, no. 4 (1952): 283–298, <http://dx.doi.org/10.1097/00005053-195201000-00025>.

32. Edward Stein, *The Mismeasure of Desire: The Science, Theory, and Ethics of Sexual Orientation* (New York: Oxford University Press, 1999), 145.

33. J. Michael Bailey, Michael P. Dunne, and Nicholas G. Martin, “Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample,” *Journal of Personality and Social Psychology* 78, no. 3 (2000): 524–536, <http://dx.doi.org/10.1037/0022-3514.78.3.524>.

34. Bailey and colleagues calculated these concordance rates using a “strict” criterion for determining non-heterosexuality, which was a Kinsey score of 2 or greater. They also calculated concordance rates using a “lenient” criterion, a Kinsey score of 1 or greater. The concordance rates for this lenient criterion were 38% for men and 30% for women in identical twins, compared to 6% for men and 30% for women in fraternal twins. The differences between the identical and fraternal concordance rates using the lenient criterion were statistically significant for men but not for women.

35. Bailey, Dunne, and Martin, “Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample,” 534.

36. These examples are drawn from Ned Block, “How heritability misleads about race,” *Cognition* 56, no. 2 (1995): 103–104, [http://dx.doi.org/10.1016/0010-0277\(95\)00678-R](http://dx.doi.org/10.1016/0010-0277(95)00678-R).

37. Niklas Långström *et al.*, “Genetic and Environmental Effects on Same-sex Sexual Behavior: A Population Study of Twins in Sweden,” *Archives of Sexual Behavior* 39, no. 1 (2010): 75–80, <http://dx.doi.org/10.1007/s10508-008-9386-1>.

38. *Ibid.*, 79.

39. Peter S. Bearman and Hannah Brückner, “Opposite-Sex Twins and Adolescent Same-Sex Attraction,” *American Journal of Sociology* 107, no. 5 (2002): 1179–1205, <http://dx.doi.org/10.1086/341906>.

40. *Ibid.*, 1199.

41. See, for example, Ray Blanchard and Anthony F. Bogaert, “Homosexuality in men and number of older brothers,” *American Journal of Psychiatry* 153, no. 1 (1996): 27–31, <http://dx.doi.org/10.1176/ajp.153.1.27>.

42. Peter S. Bearman and Hannah Brückner, 1198.

43. *Ibid.*, 1198.

44. *Ibid.*, 1179.

45. Kenneth S. Kendler *et al.*, “Sexual Orientation in a U.S. National Sample of Twin and Nontwin Sibling Pairs,” *American Journal of Psychiatry* 157, no. 11 (2000): 1843–1846, <http://dx.doi.org/10.1176/appi.ajp.157.11.1843>.
46. *Ibid.*, 1845.
47. Quantitative genetic studies, including twin studies, rely on an abstract model based on many assumptions, rather than on the measurement of correlations between genes and phenotypes. This abstract model is used to infer the presence of a genetic contribution to a trait by means of correlation among relatives. Environmental effects can be controlled in experiments with laboratory animals, but in humans this is not possible, so it is likely that the best that can be done is to study identical twins raised apart. But it should be noted that even these studies can be somewhat misinterpreted because identical twins adopted separately tend to be adopted into similar socioeconomic environments. The twin studies on homosexuality do not include any separated twin studies, and the study designs report few effective controls for environmental effects (for instance, identical twins likely share a common rearing environment to a greater extent than ordinary siblings or even fraternal twins).
48. Dean H. Hamer *et al.*, “A linkage between DNA markers on the X chromosome and male sexual orientation,” *Science* 261, no. 5119 (1993): 321–327, <http://dx.doi.org/10.1126/science.8332896>.
49. George Rice *et al.*, “Male Homosexuality: Absence of Linkage to Microsatellite Markers at Xq28,” *Science* 284, no. 5414 (1999): 665–667, <http://dx.doi.org/10.1126/science.284.5414.665>.
50. Alan R. Sanders *et al.*, “Genome-wide scan demonstrates significant linkage for male sexual orientation,” *Psychological Medicine* 45, no. 07 (2015): 1379–1388, <http://dx.doi.org/10.1017/S0033291714002451>.
51. E. M. Drabant *et al.*, “Genome-Wide Association Study of Sexual Orientation in a Large, Web-based Cohort,” 23andMe, Inc., Mountain View, Calif. (2012), <http://blog.23andme.com/wp-content/uploads/2012/11/Drabant-Poster-v7.pdf>.
52. Richard C. Francis, *Epigenetics: How Environment Shapes Our Genes* (New York: W. W. Norton & Company, 2012).
53. See, for example, Richard P. Ebstein *et al.*, “Genetics of Human Social Behavior,” *Neuron* 65, no. 6 (2010): 831–844, <http://dx.doi.org/10.1016/j.neuron.2010.02.020>.
54. Dean Hamer, “Rethinking Behavior Genetics,” *Science* 298, no. 5591 (2002): 71, <http://dx.doi.org/10.1126/science.1077582>.
55. For an overview of the distinction between the organizational and activating effects of hormones and its importance in the field of endocrinology, see Arthur P. Arnold, “The organizational-activational hypothesis as the foundation for a unified theory of sexual differentiation of all mammalian tissues,” *Hormones and Behavior* 55, no. 5 (2009): 570–578, <http://dx.doi.org/10.1016/j.yhbeh.2009.03.011>.
56. Melissa Hines, “Prenatal endocrine influences on sexual orientation and on sexually differentiated childhood behavior,” *Frontiers in Neuroendocrinology* 32, no. 2 (2011):

170–182, <http://dx.doi.org/10.1016/j.yfrne.2011.02.006>.

57. Eugene D. Albrecht and Gerald J. Pepe, “Estrogen regulation of placental angiogenesis and fetal ovarian development during primate pregnancy,” *The International Journal of Developmental Biology* 54, no. 2–3 (2010): 397–408, <http://dx.doi.org/10.1387/ijdb.082758ea>.

58. Sheri A. Berenbaum, “How Hormones Affect Behavioral and Neural Development: Introduction to the Special Issue on ‘Gonadal Hormones and Sex Differences in Behavior,’” *Developmental Neuropsychology* 14 (1998): 175–196, <http://dx.doi.org/10.1080/087565649809540708>.

59. Jean D. Wilson, Fredrick W. George, and James E. Griffin, “The Hormonal Control of Sexual Development,” *Science* 211 (1981): 1278–1284, <http://dx.doi.org/10.1126/science.7010602>.

60. *Ibid.*

61. See, for example, Celina C. C. Cohen-Bendahan, Cornelië van de Beek, and Sheri A. Berenbaum, “Prenatal sex hormone effects on child and adult sex-typed behavior: methods and findings,” *Neuroscience & Biobehavioral Reviews* 29, no. 2 (2005): 353–384, <http://dx.doi.org/10.1016/j.neubiorev.2004.11.004>; Marta Weinstock, “The potential influence of maternal stress hormones on development and mental health of the offspring,” *Brain, Behavior, and Immunity* 19, no. 4 (2005): 296–308, <http://dx.doi.org/10.1016/j.bbi.2004.09.006>; Marta Weinstock, “Gender Differences in the Effects of Prenatal Stress on Brain Development and Behaviour,” *Neurochemical Research* 32, no. 10 (2007): 1730–1740, <http://dx.doi.org/10.1007/s11064-007-9339-4>.

62. Vivette Glover, T. G. O’Connor, and Kieran O’Donnell, “Prenatal stress and the programming of the HPA axis,” *Neuroscience & Biobehavioral Reviews* 35, no. 1 (2010): 17–22, <http://dx.doi.org/10.1016/j.neubiorev.2009.11.008>.

63. See, for example, Felix Beuschlein *et al.*, “Constitutive Activation of PKA Catalytic Subunit in Adrenal Cushing’s Syndrome,” *New England Journal of Medicine* 370, no. 11 (2014): 1019–1028, <http://dx.doi.org/10.1056/NEJMoa1310359>.

64. Phyllis W. Speiser, and Perrin C. White, “Congenital Adrenal Hyperplasia,” *New England Journal of Medicine* 349, no. 8 (2003): 776–788, <http://dx.doi.org/10.1056/NEJMr021561>.

65. *Ibid.*, 776.

66. *Ibid.*

67. *Ibid.*, 778.

68. Phyllis W. Speiser *et al.*, “Congenital Adrenal Hyperplasia Due to Steroid 21-Hydroxylase Deficiency: An Endocrine Society Clinical Practice Guideline,” *The Journal of Clinical Endocrinology and Metabolism* 95, no. 9 (2009): 4133–4160, <http://dx.doi.org/10.1210/jc.2009-2631>.

69. Melissa Hines, “Prenatal endocrine influences on sexual orientation and on sexually differentiated childhood behavior,” 173–174.

70. Ieuan A. Hughes *et al.*, “Androgen insensitivity syndrome,” *The Lancet* 380, no. 9851 (2012): 1419–1428, <http://dx.doi.org/10.1016/S0140-6736%2812%2960071-3>.
 71. *Ibid.*, 1420.
 72. *Ibid.*, 1419.
 73. Melissa S. Hines, Faisal Ahmed, and Ieuan A. Hughes, “Psychological Outcomes and Gender-Related Development in Complete Androgen Insensitivity Syndrome,” *Archives of Sexual Behavior* 32, no. 2 (2003): 93–101, <http://dx.doi.org/10.1023/A:1022492106974>.
 74. See, for example, Claude J. Migeon Wisniewski *et al.*, “Complete Androgen Insensitivity Syndrome: Long-Term Medical, Surgical, and Psychosexual Outcome,” *The Journal of Clinical Endocrinology & Metabolism* 85, no. 8 (2000): 2664–2669, <http://dx.doi.org/10.1210/jcem.85.8.6742>.
 75. Peggy T. Cohen-Kettenis, “Gender Change in 46,XY Persons with 5 α -Reductase-2 Deficiency and 17 β -Hydroxysteroid Dehydrogenase-3 Deficiency,” *Archives of Sexual Behavior* 34, no. 4 (2005): 399–410, <http://dx.doi.org/10.1007/s10508-005-4339-4>.
 76. *Ibid.*, 399.
 77. See, for example, Johannes Hönekopp *et al.*, “Second to fourth digit length ratio (2D:4D) and adult sex hormone levels: New data and a meta-analytic review,” *Psychoneuroendocrinology* 32, no. 4 (2007): 313–321, <http://dx.doi.org/10.1016/j.psytneu.2007.01.007>.
 78. Terrance J. Williams *et al.*, “Finger-length ratios and sexual orientation,” *Nature* 404, no. 6777 (2000): 455–456, <http://dx.doi.org/10.1038/35006555>.
 79. S. J. Robinson and John T. Manning, “The ratio of 2nd to 4th digit length and male homosexuality,” *Evolution and Human Behavior* 21, no. 5 (2000): 333–345, [http://dx.doi.org/10.1016/S1090-5138\(00\)00052-0](http://dx.doi.org/10.1016/S1090-5138(00)00052-0).
 80. Qazi Rahman and Glenn D. Wilson, “Sexual orientation and the 2nd to 4th finger length ratio: evidence for organising effects of sex hormones or developmental instability?,” *Psychoneuroendocrinology* 28, no. 3 (2003): 288–303, [http://dx.doi.org/10.1016/S0306-4530\(02\)00022-7](http://dx.doi.org/10.1016/S0306-4530(02)00022-7).
 81. Richard A. Lippa, “Are 2D:4D Finger-Length Ratios Related to Sexual Orientation? Yes for Men, No for Women,” *Journal of Personality and Social Psychology* 85, no. 1 (2003): 179–188, <http://dx.doi.org/10.1037/0022-3514.85.1.179>; Dennis McFadden and Erin Shubel, “Relative Lengths of Fingers and Toes in Human Males and Females,” *Hormones and Behavior* 42, no. 4 (2002): 492–500, <http://dx.doi.org/10.1006/hbeh.2002.1833>.
 82. Lynn S. Hall and Craig T. Love, “Finger-Length Ratios in Female Monozygotic Twins Discordant for Sexual Orientation,” *Archives of Sexual Behavior* 32, no. 1 (2003): 23–28, <http://dx.doi.org/10.1023/A:1021837211630>.
 83. *Ibid.*, 23.
 84. Martin Voracek, John T. Manning, and Ivo Ponocny, “Digit ratio (2D:4D) in homosexual and heterosexual men from Austria,” *Archives of Sexual Behavior* 34, no. 3 (2005): 335–340, <http://dx.doi.org/10.1007/s10508-005-3122-x>.
-

85. *Ibid.*, 339.

86. Günter Dörner *et al.*, “Stressful Events in Prenatal Life of Bi- and Homosexual Men,” *Experimental and Clinical Endocrinology* 81, no. 1 (1983): 83–87, <http://dx.doi.org/10.1055/s-0029-1210210>.

87. See, for example, Lee Ellis *et al.*, “Sexual orientation of human offspring may be altered by severe maternal stress during pregnancy,” *Journal of Sex Research* 25, no. 2 (1988): 152–157, <http://dx.doi.org/10.1080/00224498809551449>; J. Michael Bailey, Lee Willerman, and Carlton Parks, “A Test of the Maternal Stress Theory of Human Male Homosexuality,” *Archives of Sexual Behavior* 20, no. 3 (1991): 277–293, <http://dx.doi.org/10.1007/BF01541847>; Lee Ellis and Shirley Cole-Harding, “The effects of prenatal stress, and of prenatal alcohol and nicotine exposure, on human sexual orientation,” *Physiology & Behavior* 74, no. 1 (2001): 213–226, [http://dx.doi.org/10.1016/S0031-9384\(01\)00564-9](http://dx.doi.org/10.1016/S0031-9384(01)00564-9).

88. Melissa Hines *et al.*, “Prenatal Stress and Gender Role Behavior in Girls and Boys: A Longitudinal, Population Study,” *Hormones and Behavior* 42, no. 2 (2002): 126–134, <http://dx.doi.org/10.1006/hbeh.2002.1814>.

89. Simon LeVay, “A Difference in Hypothalamic Structure between Heterosexual and Homosexual Men,” *Science* 253, no. 5023 (1991): 1034–1037, <http://dx.doi.org/10.1126/science.1887219>.

90. William Byne *et al.*, “The Interstitial Nuclei of the Human Anterior Hypothalamus: An Investigation of Variation with Sex, Sexual Orientation, and HIV Status,” *Hormones and Behavior* 40, no. 2 (2001): 87, <http://dx.doi.org/10.1006/hbeh.2001.1680>.

91. *Ibid.*, 91.

92. *Ibid.*

93. Mitchell S. Lasco, *et al.*, “A lack of dimorphism of sex or sexual orientation in the human anterior commissure,” *Brain Research* 936, no. 1 (2002): 95–98, [http://dx.doi.org/10.1016/S0006-8993\(02\)02590-8](http://dx.doi.org/10.1016/S0006-8993(02)02590-8).

94. Dick F. Swaab, “Sexual orientation and its basis in brain structure and function,” *Proceedings of the National Academy of Sciences* 105, no. 30 (2008): 10273–10274, <http://dx.doi.org/10.1073/pnas.0805542105>.

95. Felicitas Kranz and Alumi Ishai, “Face Perception Is Modulated by Sexual Preference,” *Current Biology* 16, no. 1 (2006): 63–68, <http://dx.doi.org/10.1016/j.cub.2005.10.070>.

96. Ivanka Savic, Hans Berglund, and Per Lindström, “Brain response to putative pheromones in homosexual men,” *Proceedings of the National Academy of Sciences* 102, no. 20 (2005): 7356–7361, <http://dx.doi.org/10.1073/pnas.0407998102>.

97. Hans Berglund, Per Lindström, and Ivanka Savic, “Brain response to putative pheromones in lesbian women,” *Proceedings of the National Academy of Sciences* 103, no. 21 (2006): 8269–8274, <http://dx.doi.org/10.1073/pnas.0600331103>.

98. Ivanka Savic and Per Lindström, “PET and MRI show differences in cerebral asymmetry and functional connectivity between homo- and heterosexual subjects,”

Proceedings of the National Academy of Sciences 105, no. 27 (2008): 9403–9408, <http://dx.doi.org/10.1073/pnas.0801566105>.

99. Research on neuroplasticity shows that while there are critical periods of development in which the brain changes more rapidly and profoundly (for instance, during development of language in toddlers), the brain continues to change across the lifespan in response to behaviors (like practicing juggling or playing a musical instrument), life experiences, psychotherapy, medications, psychological trauma, and relationships. For a helpful and generally accessible overview of the research related to neuroplasticity, see Norman Doidge, *The Brain That Changes Itself: Stories of Personal Triumph from the Frontiers of Brain Science* (New York: Penguin, 2007).

100. Letitia Anne Peplau *et al.*, “The Development of Sexual Orientation in Women,” *Annual Review of Sex Research* 10, no. 1 (1999): 81, <http://dx.doi.org/10.1080/10532528.1999.10559775>. Also see J. Michael Bailey, “What is Sexual Orientation and Do Women Have One?” in *Contemporary Perspectives on Lesbian, Gay, and Bisexual Identities*, ed. Debra A. Hope (New York: Springer, 2009), 43–63, http://dx.doi.org/10.1007/978-0-387-09556-1_3.

101. Mark S. Friedman *et al.*, “A Meta-Analysis of Disparities in Childhood Sexual Abuse, Parental Physical Abuse, and Peer Victimization Among Sexual Minority and Sexual Nonminority Individuals,” *American Journal of Public Health* 101, no. 8 (2011): 1481–1494, <http://dx.doi.org/10.2105/AJPH.2009.190009>.

102. *Ibid.*, 1490.

103. *Ibid.*, 1492.

104. *Ibid.*

105. Emily F. Rothman, Deinera Exner, and Allyson L. Baughman, “The Prevalence of Sexual Assault Against People Who Identify as Gay, Lesbian, or Bisexual in the United States: A Systematic Review,” *Trauma, Violence, & Abuse* 12, no. 2 (2011): 55–66, <http://dx.doi.org/10.1177/1524838010390707>.

106. Judith P. Andersen and John Blosnich, “Disparities in Adverse Childhood Experiences among Sexual Minority and Heterosexual Adults: Results from a Multi-State Probability-Based Sample,” *PLOS ONE* 8, no. 1 (2013): e54691, <http://dx.doi.org/10.1371/journal.pone.0054691>.

107. Andrea L. Roberts *et al.*, “Pervasive Trauma Exposure Among US Sexual Orientation Minority Adults and Risk of Posttraumatic Stress Disorder,” *American Journal of Public Health* 100, no. 12 (2010): 2433–2441, <http://dx.doi.org/10.2105/AJPH.2009.168971>.

108. Brendan P. Zietsch *et al.*, “Do shared etiological factors contribute to the relationship between sexual orientation and depression?,” *Psychological Medicine* 42, no. 3 (2012): 521–532, <http://dx.doi.org/10.1017/S0033291711001577>.

109. The exact figure is not reported in the text for reasons the authors do not specify.

110. *Ibid.*, 526.

111. *Ibid.*, 527.

112. Marie E. Tomeo *et al.*, “Comparative Data of Childhood and Adolescence Molestation in Heterosexual and Homosexual Persons,” *Archives of Sexual Behavior* 30, no. 5 (2001): 535–541, <http://dx.doi.org/10.1023/A:1010243318426>.

113. *Ibid.*, 541.

114. Helen W. Wilson and Cathy Spatz Widom, “Does Physical Abuse, Sexual Abuse, or Neglect in Childhood Increase the Likelihood of Same-sex Sexual Relationships and Cohabitation? A Prospective 30-year Follow-up,” *Archives of Sexual Behavior* 39, no. 1 (2010): 63–74, <http://dx.doi.org/10.1007/s10508-008-9449-3>.

115. *Ibid.*, 70.

116. Andrea L. Roberts, M. Maria Glymour, and Karestan C. Koenen, “Does Maltreatment in Childhood Affect Sexual Orientation in Adulthood?,” *Archives of Sexual Behavior* 42, no. 2 (2013): 161–171, <http://dx.doi.org/10.1007/s10508-012-0021-9>.

117. For those interested in the methodological details: this statistical method uses a two-step process where “instruments”—in this case, family characteristics that are known to be related to maltreatment (presence of a stepparent, parental alcohol abuse, or parental mental illness)—are used as the “instrumental variables” to predict the risk of maltreatment. In the second step, the predicted risk of maltreatment is employed as the independent variable and adult sexual orientation as the dependent variable; coefficients from this are the instrumental variable estimates. It should also be noted here that these instrumental variable estimation techniques rely on some important (and questionable) assumptions, in this case the assumption that the instruments (the stepparent, the alcohol abuse, the mental illness) do not affect the child’s sexual orientation measures except through child abuse. But this assumption is not demonstrated, and therefore may constitute a foundational limitation of the method. Causation is difficult to support statistically and continues to beguile research in the social sciences in spite of efforts to design studies capable of generating stronger associations that give stronger support to claims of causation.

118. Roberts, Glymour, and Koenen, “Does Maltreatment in Childhood Affect Sexual Orientation in Adulthood?,” 167.

119. Drew H. Bailey and J. Michael Bailey, “Poor Instruments Lead to Poor Inferences: Comment on Roberts, Glymour, and Koenen (2013),” *Archives of Sexual Behavior* 42, no. 8 (2013): 1649–1652, <http://dx.doi.org/10.1007/s10508-013-0101-5>.

120. Roberts, Glymour, and Koenen, “Does Maltreatment in Childhood Affect Sexual Orientation in Adulthood?,” 169.

121. *Ibid.*, 169.

122. For information on the study, see “National Health and Social Life Survey,” Population Research Center of the University of Chicago, <http://popcenter.uchicago.edu/data/nhsls.shtml>.

123. Edward O. Laumann *et al.*, *The Social Organization of Sexuality: Sexual Practices in the United States* (Chicago: University of Chicago Press, 1994); Robert T. Michael *et al.*, *Sex in America: A Definitive Survey* (New York: Warner Books, 1994).

124. Laumann *et al.*, *The Social Organization of Sexuality*, 295.

125. The third iteration of Natsal from 2010 found, over an age range from 16 to 74, that 1.0% of women and 1.5% of men consider themselves gay/lesbian, and 1.4% of women and 1.0% of men think of themselves as bisexual. See Catherine H. Mercer *et al.*, “Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal),” *The Lancet* 382, no. 9907 (2013): 1781–1794, [http://dx.doi.org/10.1016/S0140-6736\(13\)62035-8](http://dx.doi.org/10.1016/S0140-6736(13)62035-8). Full results of this survey are reported in several articles in the same issue of *The Lancet*.

126. See Table 8.1 in Laumann *et al.*, *The Social Organization of Sexuality*, 304.

127. This figure is calculated from Table 8.2 in Laumann *et al.*, *The Social Organization of Sexuality*, 305.

128. For more information on the study design of Add Health, see Kathleen Mullan Harris *et al.*, “Study Design,” The National Longitudinal Study of Adolescent to Adult Health, <http://www.cpc.unc.edu/projects/addhealth/design>. Some studies based on Add Health data use Arabic numerals rather than Roman numerals to label the waves; when describing or quoting from those studies, we stick with the Roman numerals.

129. See Table 1 in Ritch C. Savin-Williams and Kara Joyner, “The Dubious Assessment of Gay, Lesbian, and Bisexual Adolescents of Add Health,” *Archives of Sexual Behavior* 43, no. 3 (2014): 413–422, <http://dx.doi.org/10.1007/s10508-013-0219-5>.

130. *Ibid.*, 415.

131. *Ibid.*

132. *Ibid.*

133. “Research Collaborators,” The National Longitudinal Study of Adolescent to Adult Health, <http://www.cpc.unc.edu/projects/addhealth/people>.

134. J. Richard Udry and Kim Chantala, “Risk Factors Differ According to Same-Sex and Opposite-Sex Interest,” *Journal of Biosocial Science* 37, no. 04 (2005): 481–497, <http://dx.doi.org/10.1017/S0021932004006765>.

135. Ritch C. Savin-Williams and Geoffrey L. Ream, “Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood,” *Archives of Sexual Behavior* 36, no. 3 (2007): 385–394, <http://dx.doi.org/10.1007/s10508-006-9088-5>.

136. *Ibid.*, 388.

137. *Ibid.*, 389.

138. *Ibid.*, 392–393.

139. *Ibid.*, 393.

140. Miles Q. Ott *et al.*, “Repeated Changes in Reported Sexual Orientation Identity Linked to Substance Use Behaviors in Youth,” *Journal of Adolescent Health* 52, no. 4 (2013): 465–472, <http://dx.doi.org/10.1016/j.jadohealth.2012.08.004>.

141. Savin-Williams and Joyner, “The Dubious Assessment of Gay, Lesbian, and Bisexual

Adolescents of Add Health.”

142. *Ibid.*, 416.

143. *Ibid.*, 414.

144. For more analysis of inaccurate responders in the Add Health surveys, see Xitao Fan *et al.*, “An Exploratory Study about Inaccuracy and Invalidity in Adolescent Self-Report Surveys,” *Field Methods* 18, no. 3 (2006): 223–244, <http://dx.doi.org/10.1177/152822X06289161>.

145. Savin-Williams and Joyner were also skeptical of the Add Health survey data because the high proportion of youth reporting same-sex or both-sex attractions (7.3% of boys and 5.0% of girls) in Wave I was very unusual when compared to similar studies, and because of the dramatic reduction in reported same-sex attraction a little over a year later, in Wave II.

146. Savin-Williams and Joyner, “The Dubious Assessment of Gay, Lesbian, and Bisexual Adolescents of Add Health,” 420.

147. Gu Li, Sabra L. Katz-Wise, and Jerel P. Calzo, “The Unjustified Doubt of Add Health Studies on the Health Disparities of Non-Heterosexual Adolescents: Comment on Savin-Williams and Joyner (2014),” *Archives of Sexual Behavior*, 43 no. 6 (2014): 1023–1026, <http://dx.doi.org/10.1007/s10508-014-0313-3>.

148. *Ibid.*, 1024.

149. *Ibid.*, 1025.

150. Ritch C. Savin-Williams and Kara Joyner, “The Politicization of Gay Youth Health: Response to Li, Katz-Wise, and Calzo (2014),” *Archives of Sexual Behavior* 43, no. 6 (2014): 1027–1030, <http://dx.doi.org/10.1007/s10508-014-0359-2>.

151. See, for example, Stephen T. Russell *et al.*, “Being Out at School: The Implications for School Victimization and Young Adult Adjustment,” *American Journal of Orthopsychiatry* 84, no. 6 (2014): 635–643, <http://dx.doi.org/10.1037/ort0000037>.

152. Sabra L. Katz-Wise *et al.*, “Same Data, Different Perspectives: What Is at Stake? Response to Savin-Williams and Joyner (2014a),” *Archives of Sexual Behavior* 44, no. 1 (2015): 15, <http://dx.doi.org/10.1007/s10508-014-0434-8>.

153. *Ibid.*, 15.

154. *Ibid.*, 15–16.

155. For example, see Bailey, “What is Sexual Orientation and Do Women Have One?,” 43–63; Peplau *et al.*, “The Development of Sexual Orientation in Women,” 70–99.

156. Lisa M. Diamond, *Sexual Fluidity* (Cambridge, Mass.: Harvard University Press, 2008), 52.

157. Lisa M. Diamond, “Was It a Phase? Young Women’s Relinquishment of Lesbian/Bisexual Identities Over a 5-Year Period,” *Journal of Personality and Social Psychology* 84, no. 2 (2003): 352–364, <http://dx.doi.org/10.1037/0022-3514.84.2.352>.

158. Diamond, “What Does Sexual Orientation Orient?,” 173–192.

159. This conference paper was summarized in Denizet-Lewis, “The Scientific Quest to Prove Bisexuality Exists.”

160. A. Lee Beckstead, “Can We Change Sexual Orientation?,” *Archives of Sexual Behavior* 41, no. 1 (2012): 128, <http://dx.doi.org/10.1007/s10508-012-9922-x>.

Part Two: Sexuality, Mental Health Outcomes, and Social Stress

1. Michael King *et al.*, “A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people,” *BMC Psychiatry* 8 (2008): 70, <http://dx.doi.org/10.1186/1471-244X-8-70>.

2. The researchers who performed this meta-analysis initially found 13,706 papers by searching academic and medical research databases, but after excluding duplicates and other spurious search results examined 476 papers. After further excluding uncontrolled studies, qualitative papers, reviews, and commentaries, the authors found 111 data-based papers, of which they excluded 87 that were not population-based studies, or that failed to employ psychiatric diagnoses, or that used poor sampling. The 28 remaining papers relied on 25 studies (some of the papers examined data from the same studies), which King and colleagues evaluated using four quality criteria: (1) whether or not random sampling was used; (2) the representativeness of the study (measured by survey response rates); (3) whether the sample was drawn from the general population or from some more limited subset, such as university students; and (4) sample size. However, only one study met all four criteria. Acknowledging the inherent limitations and inconsistencies of sexual orientation concepts, the authors included information on how those concepts were operationalized in the studies analyzed—whether in terms of same-sex attraction (four studies), same-sex behavior (thirteen studies), self-identification (fifteen studies), score above zero on the Kinsey scale (three studies), two different definitions of sexual orientation (nine studies), three different definitions (one study). Eighteen of the studies used a specific time frame for defining the sexuality of their subjects. The studies were also grouped into whether or not they focused on lifetime or twelve-month prevalence, and whether the authors analyzed outcomes for LGB populations separately or collectively.

3. 95% confidence interval: 1.87–3.28.

4. 95% confidence interval: 1.69–2.48.

5. 95% confidence interval: 1.23–1.92.

6. 95% confidence interval: 1.23–1.86.

7. 95% confidence interval: 1.97–5.92.

8. 95% confidence interval: 2.32–7.88.

9. Wendy B. Bostwick *et al.*, “Dimensions of Sexual Orientation and the Prevalence of Mood and Anxiety Disorders in the United States,” *American Journal of Public Health* 100, no. 3 (2010): 468–475, <http://dx.doi.org/10.2105/AJPH.2008.152942>.

10. *Ibid.*, 470.

11. The difference in health outcomes between women who identify as lesbians and women who report exclusive same-sex sexual behaviors or attractions is a good illustration of how the differences between sexual identity, behavior, and attraction matter.
12. Susan D. Cochran and Vickie M. Mays, “Physical Health Complaints Among Lesbians, Gay Men, and Bisexual and Homosexually Experienced Heterosexual Individuals: Results From the California Quality of Life Survey,” *American Journal of Public Health* 97, no. 11 (2007): 2048–2055, <http://dx.doi.org/10.2105/AJPH.2006.087254>.
13. Christine E. Grella *et al.*, “Influence of gender, sexual orientation, and need on treatment utilization for substance use and mental disorders: Findings from the California Quality of Life Survey,” *BMC Psychiatry* 9, no. 1 (2009): 52, <http://dx.doi.org/10.1186/1471-244X-9-52>.
14. Theo G. M. Sandfort *et al.*, “Sexual Orientation and Mental and Physical Health Status: Findings from a Dutch Population Survey,” *American Journal of Public Health* 96, (2006): 1119–1125, <http://dx.doi.org/10.2105%2FAJPH.2004.058891>.
15. Robert Graham *et al.*, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Washington, D.C.: The National Academies Press, 2011), <http://dx.doi.org/10.17226/13128>.
16. Susan D. Cochran, J. Greer Sullivan, and Vickie M. Mays, “Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use Among Lesbian, Gay, and Bisexual Adults in the United States,” *Journal of Consulting and Clinical Psychology* 71, no. 1 (2007): 53–61, <http://dx.doi.org/10.1037/0022-006X.71.1.53>.
17. Lisa A. Razzano, Alicia Matthews, and Tonda L. Hughes, “Utilization of Mental Health Services: A Comparison of Lesbian and Heterosexual Women,” *Journal of Gay & Lesbian Social Services* 14, no. 1 (2002): 51–66, http://dx.doi.org/10.1300/J041v14n01_03.
18. Robert Graham *et al.*, *The Health of Lesbian, Gay, Bisexual, and Transgender People*, 4.
19. *Ibid.*, 190, see also 258–259.
20. *Ibid.*, 211.
21. Esther D. Rothblum and Rhonda Factor, “Lesbians and Their Sisters as a Control Group: Demographic and Mental Health Factors,” *Psychological Science* 12, no. 1 (2001): 63–69, <http://dx.doi.org/10.1111/1467-9280.00311>.
22. Stephen M. Horowitz, David L. Weis, and Molly T. Laflin, “Bisexuality, Quality of Life, Lifestyle, and Health Indicators,” *Journal of Bisexuality* 3, no. 2 (2003): 5–28, http://dx.doi.org/10.1300/J159v03n02_02.
23. By way of context, it may be worth noting that in the United States, the overall suicide rate has risen in recent years: “From 1999 through 2014, the age-adjusted suicide rate in the United States increased 24%, from 10.5 to 13.0 per 100,000 population, with the pace of increase greater after 2006.” Sally C. Curtin, Margaret Warner, and Holly Hedegaard, “Increase in suicide in the United States, 1999–2014,” National Center for

Health Statistics, NCHS data brief no. 241 (April 22, 2016), <http://www.cdc.gov/nchs/products/databriefs/db241.htm>.

24. Ann P. Haas *et al.*, “Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations,” *Journal of Homosexuality* 58, no. 1 (2010): 10–51, <http://dx.doi.org/10.1080/00918369.2011.534038>.

25. *Ibid.*, 13.

26. David M. Fergusson, L. John Horwood, and Annette L. Beautrais, “Is Sexual Orientation Related to Mental Health Problems and Suicidality in Young People?,” *Archives of General Psychiatry* 56, no. 10 (1999): 876–880, <http://dx.doi.org/10.1001/archpsyc.56.10.876>.

27. Paul J.M. Van Kesteren *et al.*, “Mortality and morbidity in transsexual subjects treated with cross-sex hormones,” *Clinical Endocrinology* 47, no. 3 (1997): 337–343, <http://dx.doi.org/10.1046/j.1365-2265.1997.2601068.x>.

28. Friedemann Pfäfflin and Astrid Junge, *Sex Reassignment: Thirty Years of International Follow-Up Studies After Sex Reassignment Surgery: A Comprehensive Review, 1961–1991*, Roberta B. Jacobson and Alf B. Meier, trans. (Düsseldorf: Symposion Publishing, 1998), <https://web.archive.org/web/20070503090247/http://www.symposion.com/ijtpfaefflin/1000.htm>.

29. Jean M. Dixen *et al.*, “Psychosocial characteristics of applicants evaluated for surgical gender reassignment,” *Archives of Sexual Behavior* 13, no. 3 (1984): 269–276, <http://dx.doi.org/10.1007/BF01541653>.

30. Robin M. Mathy, “Transgender Identity and Suicidality in a Nonclinical Sample: Sexual Orientation, Psychiatric History, and Compulsive Behaviors,” *Journal of Psychology & Human Sexuality* 14, no. 4 (2003): 47–65, http://dx.doi.org/10.1300/J056v14n04_03.

31. Yue Zhao *et al.*, “Suicidal Ideation and Attempt Among Adolescents Reporting ‘Unsure’ Sexual Identity or Heterosexual Identity Plus Same-Sex Attraction or Behavior: Forgotten Groups?,” *Journal of the American Academy of Child & Adolescent Psychiatry* 49, no. 2 (2010): 104–113, <http://dx.doi.org/10.1016/j.jaac.2009.11.003>.

32. Wendy B. Bostwick *et al.*, “Dimensions of Sexual Orientation and the Prevalence of Mood and Anxiety Disorders in the United States.”

33. Martin Plöderl *et al.*, “Suicide Risk and Sexual Orientation: A Critical Review,” *Archives of Sexual Behavior* 42, no. 5 (2013): 715–727, <http://dx.doi.org/10.1007/s10508-012-0056-y>.

34. Ritch C. Savin-Williams, “Suicide Attempts Among Sexual-Minority Youths: Population and Measurement Issues,” *Journal of Consulting and Clinical Psychology* 69, no. 6 (2001): 983–991, <http://dx.doi.org/10.1037/0022-006X.69.6.983>.

35. For females in this study, eliminating false positive attempts substantially decreased the difference between orientations. For males, the “true suicide attempts” difference approached statistical significance: 2% of heterosexual males (1 of 61) and 9% of homosexual males (5 of 53) attempted suicide, resulting in an odds ratio of 6.2.

36. Martin Plöderl *et al.*, “Suicide Risk and Sexual Orientation,” 716–717.
 37. *Ibid.*, 723.
 38. *Ibid.*
 39. Richard Herrell *et al.*, “Sexual Orientation and Suicidality: A Co-twin Control Study in Adult Men,” *Archives of General Psychiatry* 56, no. 10 (1999): 867–874, <http://dx.doi.org/10.1001/archpsyc.56.10.867>.
 40. *Ibid.*, 872.
 41. Robin M. Mathy *et al.*, “The association between relationship markers of sexual orientation and suicide: Denmark, 1990–2001,” *Social Psychiatry and Psychiatric Epidemiology* 46, no. 2 (2011): 111–117, <http://dx.doi.org/10.1007/s00127-009-0177-3>.
 42. Gary Remafedi, James A. Farrow, and Robert W. Deisher, “Risk Factors for Attempted Suicide in Gay and Bisexual Youth,” *Pediatrics* 87, no. 6 (1991): 869–875, <http://pediatrics.aappublications.org/content/87/6/869>.
 43. *Ibid.*, 873.
 44. Gary Remafedi, “Adolescent Homosexuality: Psychosocial and Medical Implications,” *Pediatrics* 79, no. 3 (1987): 331–337, <http://pediatrics.aappublications.org/content/79/3/331>.
 45. Martin Plöderl, Karl Kralovec, and Reinhold Fartacek, “The Relation Between Sexual Orientation and Suicide Attempts in Austria,” *Archives of Sexual Behavior* 39, no. 6 (2010): 1403–1414, <http://dx.doi.org/10.1007/s10508-009-9597-0>.
 46. Travis Salway Hottes *et al.*, “Lifetime Prevalence of Suicide Attempts Among Sexual Minority Adults by Study Sampling Strategies: A Systematic Review and Meta-Analysis,” *American Journal of Public Health* 106, no. 5 (2016): e1–e12, <http://dx.doi.org/10.2105/AJPH.2016.303088>.
 47. For a brief explanation of the strengths and limitations of population- and community-based sampling, see Hottes *et al.*, e2.
 48. 95% confidence intervals: 8–15% and 3–5%, respectively.
 49. 95% confidence interval: 18–22%.
 50. Ana Maria Buller *et al.*, “Associations between Intimate Partner Violence and Health among Men Who Have Sex with Men: A Systematic Review and Meta-Analysis,” *PLOS Medicine* 11, no. 3 (2014): e1001609, <http://dx.doi.org/10.1371/journal.pmed.1001609>.
 51. Sabrina N. Nowinski and Erica Bowen, “Partner violence against heterosexual and gay men: Prevalence and correlates,” *Aggression and Violent Behavior* 17, no. 1 (2012): 36–52, <http://dx.doi.org/10.1016/j.avb.2011.09.005>. It is worth noting that the 54 studies that Nowinski and Bowen consider operationalize heterosexuality and homosexuality in various ways.
 52. *Ibid.*, 39.
 53. *Ibid.*, 50.
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54. Shonda M. Craft and Julianne M. Serovich, "Family-of-Origin Factors and Partner Violence in the Intimate Relationships of Gay Men Who Are HIV Positive," *Journal of Interpersonal Violence* 20, no. 7 (2005): 777–791, <http://dx.doi.org/10.1177/0886260505277101>.
 55. Catherine Finneran and Rob Stephenson, "Intimate Partner Violence Among Men Who Have Sex With Men: A Systematic Review," *Trauma, Violence, & Abuse* 14, no. 2 (2013): 168–185, <http://dx.doi.org/10.1177/1524838012470034>.
 56. *Ibid.*, 180.
 57. Although one study reported just 12%, the majority of studies (17 out of 24) showed that physical IPV was at least 22%, with nine studies recording rates of 31% or more.
 58. Although Finneran and Stephenson say this measure was recorded in only six studies, the table they provide lists eight studies as measuring psychological violence, with seven of these showing rates 33% or higher, including five reporting rates of 45% or higher.
 59. Naomi G. Goldberg and Ilan H. Meyer, "Sexual Orientation Disparities in History of Intimate Partner Violence: Results From the California Health Interview Survey," *Journal of Interpersonal Violence* 28, no. 5 (2013): 1109–1118, <http://dx.doi.org/10.1177/0886260512459384>.
 60. Gregory L. Greenwood *et al.*, "Battering Victimization Among a Probability-Based Sample of Men Who Have Sex With Men," *American Journal of Public Health* 92, no. 12 (2002): 1964–1969, <http://dx.doi.org/10.2105/AJPH.92.12.1964>.
 61. *Ibid.*, 1967.
 62. *Ibid.*
 63. Sari L. Reisner *et al.*, "Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study," *Journal of Adolescent Health* 56, no. 3 (2015): 274–279, <http://dx.doi.org/10.1016/j.jadohealth.2014.10.264>.
 64. Relative risk: 3.95.
 65. Relative risk: 3.27.
 66. Relative risk: 3.61.
 67. Relative risk: 3.20.
 68. Relative risk: 4.30.
 69. Relative risk: 2.36.
 70. Relative risk: 4.36.
 71. Anne P. Haas, Philip L. Rodgers, and Jody Herman, "Suicide Attempts Among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey," Williams Institute, UCLA School of Law, January 2014, <http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report->
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Final.pdf.

72. *Ibid.*, 2.

73. *Ibid.*, 8.

74. *Ibid.*, 13.

75. Kristen Clements-Nolle *et al.*, “HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention,” *American Journal of Public Health* 91, no. 6 (2001): 915–921, <http://dx.doi.org/10.2105/AJPH.91.6.915>.

76. *Ibid.*, 919.

77. See, for example, Ilan H. Meyer, “Minority Stress and Mental Health in Gay Men,” *Journal of Health and Social Behavior* 36 (1995): 38–56, <http://dx.doi.org/10.2307/2137286>; Bruce P. Dohrenwend, “Social Status and Psychological Disorder: An Issue of Substance and an Issue of Method,” *American Sociological Review* 31, no. 1 (1966): 14–34, <http://www.jstor.org/stable/2091276>.

78. For overviews of the social stress model and mental health patterns among LGBT populations, see Ilan H. Meyer, “Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence,” *Psychological Bulletin* 129, no. 5 (2003): 674–697, <http://dx.doi.org/10.1037/0033-2909.129.5.674>; Robert Graham *et al.*, *The Health of Lesbian, Gay, Bisexual, and Transgender People*, *op. cit.*; Gregory M. Herek and Linda D. Garnets, “Sexual Orientation and Mental Health,” *Annual Review of Clinical Psychology* 3 (2007): 353–375, <http://dx.doi.org/10.1146/annurev.clinpsy.3.022806.091510>; Mark L. Hatzenbuehler, “How Does Sexual Minority Stigma ‘Get Under the Skin’? A Psychological Mediation Framework,” *Psychological Bulletin* 135, no. 5 (2009): 707–730, <http://dx.doi.org/10.1037/a0016441>.

79. See, for instance, Ilan H. Meyer, “The Right Comparisons in Testing the Minority Stress Hypothesis: Comment on Savin-Williams, Cohen, Joyner, and Rieger (2010),” *Archives of Sexual Behavior* 39, no. 6 (2010): 1217–1219.

80. This should not be taken to suggest that social stress is too vague a concept for empirical social science; the social stress model may certainly produce quantitative empirical hypotheses, such as hypotheses about correlations between stressors and specific mental health outcomes. In this context, the term “model” does not refer to a statistical model of the kind often used in social science research—the social stress model is a “model” in a metaphorical sense.

81. Meyer, “Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations,” 676.

82. Meyer, “Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations,” 680; Gregory M. Herek, J. Roy Gillis, and Jeanine C. Cogan, “Psychological Sequelae of Hate-Crime Victimization Among Lesbian, Gay, and Bisexual Adults,” *Journal of Consulting and Clinical Psychology* 67, no. 6 (1999): 945–951, <http://dx.doi.org/10.1037/0022-006X.67.6.945>; Allegra R. Gordon and Ilan H. Meyer, “Gender Nonconformity as a Target of Prejudice, Discrimination, and Violence Against LGB

Individuals,” *Journal of LGBT Health Research* 3, no. 3 (2008): 55–71, <http://dx.doi.org/10.1080/15574090802093562>; David M. Huebner, Gregory M. Rebchook, and Susan M. Kegeles, “Experiences of Harassment, Discrimination, and Physical Violence Among Young Gay and Bisexual Men,” *American Journal of Public Health* 94, no. 7 (2004): 1200–1203, <http://dx.doi.org/10.2105/AJPH.94.7.1200>; Rebecca L. Stotzer, “Violence against transgender people: A review of United States data,” *Aggression and Violent Behavior* 14, no. 3 (2009): 170–179, <http://dx.doi.org/10.1016/j.avb.2009.01.006>; Rebecca L. Stotzer, “Gender identity and hate crimes: Violence against transgender people in Los Angeles County,” *Sexuality Research and Social Policy* 5, no. 1 (2008): 43–52, <http://dx.doi.org/10.1525/srsp.2008.5.1.43>.

83. Stotzer, “Gender identity and hate crimes,” 43–52; Emilia L. Lombardi *et al.*, “Gender Violence: Transgender Experiences with Violence and Discrimination,” *Journal of Homosexuality* 42, no. 1 (2002): 89–101, http://dx.doi.org/10.1300/J082v42n01_05; Herek, Gillis, and Cogan, “Psychological Sequelae of Hate-Crime Victimization Among Lesbian, Gay, and Bisexual Adults,” 945–951; Huebner, Rebchook, and Kegeles, “Experiences of Harassment, Discrimination, and Physical Violence Among Young Gay and Bisexual Men,” 1200–1203; Anne H. Faulkner and Kevin Cranston, “Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students,” *American Journal of Public Health* 88, no. 2 (1998): 262–266, <http://dx.doi.org/10.2105/AJPH.88.2.262>.

84. Herek, Gillis, and Cogan, “Psychological Sequelae of Hate-Crime Victimization Among Lesbian, Gay, and Bisexual Adults,” 945–951.

85. Jack McDevitt *et al.*, “Consequences for Victims: A Comparison of Bias- and Non-Bias-Motivated Assaults,” *American Behavioral Scientist* 45, no. 4 (2001): 697–713, <http://dx.doi.org/10.1177/0002764201045004010>.

86. Caitlin Ryan and Ian Rivers, “Lesbian, gay, bisexual and transgender youth: Victimization and its correlates in the USA and UK,” *Culture, Health & Sexuality* 5, no. 2 (2003): 103–119, <http://dx.doi.org/10.1080/1369105011000012883>; Elise D. Berlan *et al.*, “Sexual Orientation and Bullying Among Adolescents in the Growing Up Today Study,” *Journal of Adolescent Health* 46, no. 4 (2010): 366–371, <http://dx.doi.org/10.1016/j.jadohealth.2009.10.015>; Ritch C. Savin-Williams, “Verbal and Physical Abuse as Stressors in the Lives of Lesbian, Gay Male, and Bisexual Youths: Associations With School Problems, Running Away, Substance Abuse, Prostitution, and Suicide,” *Journal of Consulting and Clinical Psychology* 62, no. 2 (1994): 261–269, <http://dx.doi.org/10.1037/0022-006X.62.2.261>.

87. Stephen T. Russell *et al.*, “Lesbian, Gay, Bisexual, and Transgender Adolescent School Victimization: Implications for Young Adult Health and Adjustment,” *Journal of School Health* 81, no. 5 (2011): 223–230, <http://dx.doi.org/10.1111/j.1746-1561.2011.00583.x>.

88. Joanna Almeida *et al.*, “Emotional Distress Among LGBT Youth: The Influence of Perceived Discrimination Based on Sexual Orientation,” *Journal of Youth and Adolescence* 38, no. 7 (2009): 1001–1014, <http://dx.doi.org/10.1007/s10964-009-9397-9>.

89. M. V. Lee Badgett, “The Wage Effects of Sexual Orientation Discrimination,” *Industrial and Labor Relations Review* 48, no. 4 (1995): 726–739, <http://dx.doi.org/10.1177/>

001979399504800408.

90. M. V. Lee Badgett, "Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination 1998–2008," *Chicago-Kent Law Review* 84, no. 2 (2009): 559–595, <http://scholarship.kentlaw.iit.edu/cklawreview/vol84/iss2/7>.
91. Marieka Klawitter, "Meta-Analysis of the Effects of Sexual Orientation on Earning," *Industrial Relations* 54, no. 1 (2015): 4–32, <http://dx.doi.org/10.1111/irel.12075>.
92. Jonathan Platt *et al.*, "Unequal depression for equal work? How the wage gap explains gendered disparities in mood disorders," *Social Science & Medicine* 149 (2016): 1–8, <http://dx.doi.org/10.1016/j.socscimed.2015.11.056>.
93. Craig R. Waldo, "Working in a majority context: A structural model of heterosexism as minority stress in the workplace," *Journal of Counseling Psychology* 46, no. 2 (1999): 218–232, <http://dx.doi.org/10.1037/0022-0167.46.2.218>.
94. M. W. Linn, Richard Sandifer, and Shayna Stein, "Effects of unemployment on mental and physical health," *American Journal of Public Health* 75, no. 5 (1985): 502–506, <http://dx.doi.org/10.2105/AJPH.75.5.502>; Jennie E. Brand, "The far-reaching impact of job loss and unemployment," *Annual Review of Sociology* 41 (2015): 359–375, <http://dx.doi.org/10.1146/annurev-soc-071913-043237>; Marie Conroy, "A Qualitative Study of the Psychological Impact of Unemployment on individuals," (master's dissertation, Dublin Institute of Technology, September 2010), <http://arrow.dit.ie/aaschssdis/50/>.
95. Irving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon & Schuster, 1963); Brenda Major and Laurie T. O'Brien, "The Social Psychology of Stigma," *Annual Review of Psychology*, 56 (2005): 393–421, <http://dx.doi.org/10.1146/annurev.psych.56.091103.070137>.
96. Major and O'Brien, "The Social Psychology of Stigma," 395.
97. Bruce G. Link *et al.*, "On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse," *Journal of Health and Social Behavior* 38, no. (1997): 177–190, <http://dx.doi.org/10.2307/2955424>.
98. Walter R. Gove, "The Current Status of the Labeling Theory of Mental Illness," in *Deviance and Mental Illness*, ed. Walter R. Gove (Beverly Hills, Calif.: Sage, 1982), 290.
99. A highly cited piece of theoretical research on stigma processes is Hatzenbuehler, "How Does Sexual Minority Stigma 'Get Under the Skin'?", *op. cit.*, <http://dx.doi.org/10.1037/a0016441>.
100. Walter O. Bockting *et al.*, "Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population," *American Journal of Public Health* 103, no. 5 (2013): 943–951, <http://dx.doi.org/10.2105/AJPH.2013.301241>.
101. Robin J. Lewis *et al.*, "Stressors for Gay Men and Lesbians: Life Stress, Gay-Related Stress, Stigma Consciousness, and Depressive Symptoms," *Journal of Social and Clinical Psychology* 22, no. 6 (2003): 716–729, <http://dx.doi.org/10.1521/jscp.22.6.716.22932>.
102. *Ibid.*, 721.
103. Aaron T. Beck *et al.*, *Cognitive Therapy of Depression* (New York: Guilford Press,

1979).

104. Wendy Bostwick, "Assessing Bisexual Stigma and Mental Health Status: A Brief Report," *Journal of Bisexuality* 12, no. 2 (2012): 214–222, <http://dx.doi.org/10.1080/15299716.2012.674860>.

105. Lars Wichstrøm and Kristinn Hegna, "Sexual Orientation and Suicide Attempt: A Longitudinal Study of the General Norwegian Adolescent Population," *Journal of Abnormal Psychology* 112, no. 1 (2003): 144–151, <http://dx.doi.org/10.1037/0021-843X.112.1.144>.

106. Anthony R. D'Augelli and Arnold H. Grossman, "Disclosure of Sexual Orientation, Victimization, and Mental Health Among Lesbian, Gay, and Bisexual Older Adults," *Journal of Interpersonal Violence* 16, no. 10 (2001): 1008–1027, <http://dx.doi.org/10.1177/088626001016010003>; Eric R. Wright and Brea L. Perry, "Sexual Identity Distress, Social Support, and the Health of Gay, Lesbian, and Bisexual Youth," *Journal of Homosexuality* 51, no. 1 (2006): 81–110, http://dx.doi.org/10.1300/J082v51n01_05; Judith A. Clair, Joy E. Beatty, and Tammy L. MacLean, "Out of Sight But Not Out of Mind: Managing Invisible Social Identities in the Workplace," *Academy of Management Review* 30, no. 1 (2005): 78–95, <http://dx.doi.org/10.5465/AMR.2005.15281431>.

107. For example, see *Emotion, Disclosure, and Health* (Washington, D.C.: American Psychological Association, 2002), ed. James W. Pennebaker; Joanne Frattaroli, "Experimental Disclosure and Its Moderators: A Meta-Analysis," *Psychological Bulletin* 132, no. 6 (2006): 823–865, <http://dx.doi.org/10.1037/0033-2909.132.6.823>.

108. See, for example, James M. Croteau, "Research on the Work Experiences of Lesbian, Gay, and Bisexual People: An Integrative Review of Methodology and Findings," *Journal of Vocational Behavior* 48, no. 2 (1996): 195–209, <http://dx.doi.org/10.1006/jvbe.1996.0018>; Anthony R. D'Augelli, Scott L. Hershberger, and Neil W. Pilkington, "Lesbian, Gay, and Bisexual Youth and Their Families: Disclosure of Sexual Orientation and Its Consequences," *American Journal of Orthopsychiatry* 68, no. 3 (1998): 361–371, <http://dx.doi.org/10.1037/h0080345>; Margaret Rosario, Eric W. Schrimshaw, and Joyce Hunter, "Disclosure of Sexual Orientation and Subsequent Substance Use and Abuse Among Lesbian, Gay, and Bisexual Youths: Critical Role of Disclosure Reactions," *Psychology of Addictive Behaviors* 23, no. 1 (2009): 175–184, <http://dx.doi.org/10.1037/a0014284>; D'Augelli and Grossman, "Disclosure of Sexual Orientation, Victimization, and Mental Health Among Lesbian, Gay, and Bisexual Older Adults," 1008–1027; Belle Rose Ragins, "Disclosure Disconnects: Antecedents and Consequences of Disclosing Invisible Stigmas across Life Domains," *Academy of Management Review* 33, no. 1 (2008): 194–215, <http://dx.doi.org/10.5465/AMR.2008.27752724>; Nicole Legate, Richard M. Ryan, and Netta Weinstein, "Is Coming Out Always a 'Good Thing'? Exploring the Relations of Autonomy Support, Outness, and Wellness for Lesbian, Gay, and Bisexual Individuals," *Social Psychological and Personality Science* 3, no. 2 (2012): 145–152, <http://dx.doi.org/10.1177/1948550611411929>.

109. Belle Rose Ragins, Romila Singh, and John M. Cornwell, "Making the Invisible Visible: Fear and Disclosure of Sexual Orientation at Work," *Journal of Applied Psychology* 92, no. 4 (2007): 1103–1118, <http://dx.doi.org/10.1037/0021-9010.92.4.1103>.

110. *Ibid.*, 1114.

111. Dawn Michelle Baunach, “Changing Same-Sex Marriage Attitudes in America from 1988 Through 2010,” *Public Opinion Quarterly* 76, no. 2 (2012): 364–378, <http://dx.doi.org/10.1093/poq/nfs022>; Pew Research Center, “Changing Attitudes on Gay Marriage” (online publication), July 29, 2015, <http://www.pewforum.org/2015/07/29/graphics-slideshow-changing-attitudes-on-gay-marriage/>; Bruce Drake, Pew Research Center, “How LGBT adults see society and how the public sees them” (online publication), June 25, 2013, <http://www.pewresearch.org/fact-tank/2013/06/25/how-lgbt-adults-see-society-and-how-the-public-sees-them/>.

112. Mark L. Hatzenbuehler, Katherine M. Keyes, and Deborah S. Hasin, “State-Level Policies and Psychiatric Morbidity In Lesbian, Gay, and Bisexual Populations,” *American Journal of Public Health* 99, no. 12 (2009): 2275–2281, <http://dx.doi.org/10.2105/AJPH.2008.153510>.

113. Deborah S. Hasin and Bridget F. Grant, “The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Waves 1 and 2: review and summary of findings,” *Social Psychiatry and Psychiatric Epidemiology* 50, no. 11 (2015): 1609–1640, <http://dx.doi.org/10.1007/s00127-015-1088-0>.

114. Mark L. Hatzenbuehler *et al.*, “The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study,” *American Journal of Public Health* 100, no. 3 (2010): 452–459, <http://dx.doi.org/10.2105/AJPH.2009.168815>.

115. Sharon Scales Rostosky *et al.*, “Marriage Amendments and Psychological Distress in Lesbian, Gay, and Bisexual (LGB) Adults,” *Journal of Counseling Psychology* 56, no. 1 (2009): 56–66, <http://dx.doi.org/10.1037/a0013609>.

116. Roberto Maniglio, “The impact of child sexual abuse on health: A systematic review of reviews,” *Clinical Psychology Review* 29 (2009): 647, <http://dx.doi.org/10.1016/j.cpr.2009.08.003>.

Part Three: Gender Identity

1. American Psychological Association, “Answers to Your Questions About Transgender People, Gender Identity and Gender Expression” (pamphlet), <http://www.apa.org/topics/lgbt/transgender.pdf>.

2. Simone de Beauvoir, *The Second Sex* (New York: Vintage, 2011 [orig. 1949]), 283.

3. Ann Oakley, *Sex, Gender and Society* (London: Maurice Temple Smith, 1972).

4. Suzanne J. Kessler and Wendy McKenna, *Gender: An Ethnomethodological Approach* (New York: John Wiley & Sons, 1978), vii.

5. Gayle Rubin, “The Traffic in Women: Notes on the ‘Political Economy’ of Sex,” in *Toward an Anthropology of Women*, ed. Rayna R. Reiter (New York and London: Monthly Review Press, 1975), 179.

6. *Ibid.*, 204.

7. Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (London: Routledge, 1990).
 8. Judith Butler, *Undoing Gender* (New York: Routledge, 2004).
 9. Butler, *Gender Trouble*, 7.
 10. *Ibid.*, 6.
 11. “Facebook Diversity” (web page), <https://www.facebook.com/facebookdiversity/photos/a.196865713743272.42938.105225179573993/567587973337709/>.
 12. Will Oremus, “Here Are All the Different Genders You Can Be on Facebook,” *Slate*, February 13, 2014, http://www.slate.com/blogs/future_tense/2014/02/13/facebook_custom_gender_options_here_are_all_56_custom_options.html.
 13. André Ancel, Michaël Beaulieu, and Caroline Gilbert, “The different breeding strategies of penguins: a review,” *Comptes Rendus Biologies* 336, no. 1 (2013): 6–7, <http://dx.doi.org/10.1016/j.crv.2013.02.002>. Generally, male emperor penguins do the work of incubating the eggs and then caring for the chicks for several days after hatching. After that point, males and females take turns caring for the chicks.
 14. Jennifer A. Marshall Graves and Swathi Shetty, “Sex from W to Z: Evolution of Vertebrate Sex Chromosomes and Sex Determining Genes,” *Journal of Experimental Zoology* 290 (2001): 449–462, <http://dx.doi.org/10.1002/jez.1088>.
 15. For an overview of Thomas Beatie’s story, see his book, *Labor of Love: The Story of One Man’s Extraordinary Pregnancy* (Berkeley: Seal Press, 2008).
 16. Edward Stein, *The Mismeasure of Desire: The Science, Theory, and Ethics of Sexual Orientation* (New York: Oxford University Press, 1999), 31.
 17. John Money, “Hermaphroditism, gender and precocity in hyperadrenocorticism: psychologic findings,” *Bulletin of the John Hopkins Hospital* 95, no. 6 (1955): 253–264, <http://www.ncbi.nlm.nih.gov/pubmed/14378807>.
 18. An account of the David Reimer story can be found in John Colapinto, *As Nature Made Him: The Boy Who Was Raised as a Girl* (New York: Harper Collins, 2000).
 19. William G. Reiner and John P. Gearhart, “Discordant Sexual Identity in Some Genetic Males with Cloacal Exstrophy Assigned to Female Sex at Birth,” *New England Journal of Medicine*, 350 (January 2004): 333–341, <http://dx.doi.org/10.1056/NEJMoa022236>.
 20. Paul R. McHugh, “Surgical Sex: Why We Stopped Doing Sex Change Operations,” *First Things* (November 2004), <http://www.firstthings.com/article/2004/11/surgical-sex>.
 21. American Psychiatric Association, “Gender Dysphoria,” *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* [hereafter *DSM-5*] (Arlington, Va.: American Psychiatric Publishing, 2013), 452, <http://dx.doi.org/10.1176/appi.books.9780890425596.dsm14>.
 22. *Ibid.*, 458.
 23. *Ibid.*
-

24. *Ibid.*, 452.

25. *Ibid.*

26. *Ibid.*, 454–455.

27. *Ibid.*, 452.

28. *Ibid.*, 457.

29. Angeliki Galani *et al.*, “Androgen insensitivity syndrome: clinical features and molecular defects,” *Hormones* 7, no. 3 (2008): 217–229, <https://dx.doi.org/10.14310%2Fhorm.2002.1201>.

30. Perrin C. White and Phyllis W. Speiser, “Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency,” *Endocrine Reviews* 21, no. 3 (2000): 245–219, <http://dx.doi.org/10.1210/edrv.21.3.0398>.

31. Alexandre Serra *et al.*, “Uniparental Disomy in Somatic Mosaicism 45,X/46,XY/46,XX Associated with Ambiguous Genitalia,” *Sexual Development* 9 (2015): 136–143, <http://dx.doi.org/10.1159/000430897>.

32. Marion S. Verp *et al.*, “Chimerism as the etiology of a 46,XX/46,XY fertile true hermaphrodite,” *Fertility and Sterility* 57, no 2 (1992): 346–349, [http://dx.doi.org/10.1016/S0015-0282\(16\)54843-2](http://dx.doi.org/10.1016/S0015-0282(16)54843-2).

33. For one recent review of the science of neurological sex differences, see Amber N. V. Ruigrok *et al.*, “A meta-analysis of sex differences in human brain structure,” *Neuroscience Biobehavioral Review* 39 (2014): 34–50, <http://dx.doi.org/10.1016%2Fj.neubiorev.2013.12.004>.

34. Robert Sapolsky, “Caught Between Male and Female,” *Wall Street Journal*, December 6, 2013, <http://www.wsj.com/articles/SB10001424052702304854804579234030532617704>.

35. *Ibid.*

36. *Ibid.*

37. For some examples of popular interest in this view, see Francine Russo, “Transgender Kids,” *Scientific American Mind* 27, no. 1 (2016): 26–35, <http://dx.doi.org/10.1038/scientificamericanmind0116-26>; Jessica Hamzelou, “Transsexual differences caught on brain scan,” *New Scientist* 209, no. 2796 (2011): 1, <https://www.newscientist.com/article/dn20032-transsexual-differences-caught-on-brain-scan/>; Brynn Tannehill, “Do Your Homework, Dr. Ablow,” *The Huffington Post*, January 17, 2014, http://www.huffingtonpost.com/brynn-tannehill/how-much-evidence-does-it_b_4616722.html.

38. Nancy Segal, “Two Monozygotic Twin Pairs Discordant for Female-to-Male Transsexualism,” *Archives of Sexual Behavior* 35, no. 3 (2006): 347–358, <http://dx.doi.org/10.1007/s10508-006-9037-3>.

39. Holly Devor, “Transsexualism, Dissociation, and Child Abuse: An Initial Discussion Based on Nonclinical Data,” *Journal of Psychology and Human Sexuality*, 6 no. 3 (1994): 49–72, http://dx.doi.org/10.1300/J056v06n03_04.

40. Segal, “Two Monozygotic Twin Pairs Discordant for Female-to-Male Transsexualism,” 350.
 41. *Ibid.*, 351.
 42. *Ibid.*, 353–354.
 43. *Ibid.*, 354.
 44. *Ibid.*, 356.
 45. *Ibid.*, 355. Emphasis in original.
 46. J. Michael Bostwick and Kari A. Martin, “A Man’s Brain in an Ambiguous Body: A Case of Mistaken Gender Identity,” *American Journal of Psychiatry*, 164 no. 10 (2007): 1499–1505, <http://dx.doi.org/10.1176/appi.ajp.2007.07040587>.
 47. *Ibid.*, 1500.
 48. *Ibid.*, 1504.
 49. *Ibid.*
 50. *Ibid.*, 1503–1504.
 51. Giuseppina Rametti *et al.*, “White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study,” *Journal of Psychiatric Research* 45, no. 2 (2011): 199–204, <http://dx.doi.org/10.1016/j.jpsychires.2010.05.006>.
 52. *Ibid.*, 202.
 53. Giuseppina Rametti *et al.*, “The microstructure of white matter in male to female transsexuals before cross-sex hormonal treatment. A DTI study,” *Journal of Psychiatric Research* 45, no. 7 (2011): 949–954, <http://dx.doi.org/10.1016/j.jpsychires.2010.11.007>.
 54. *Ibid.*, 952.
 55. *Ibid.*, 951.
 56. Emiliano Santarnecchi *et al.*, “Intrinsic Cerebral Connectivity Analysis in an Untreated Female-to-Male Transsexual Subject: A First Attempt Using Resting-State fMRI,” *Neuroendocrinology* 96, no. 3 (2012): 188–193, <http://dx.doi.org/10.1159/000342001>.
 57. *Ibid.*, 188.
 58. Hsiao-Lun Ku *et al.*, “Brain Signature Characterizing the Body-Brain-Mind Axis of Transsexuals,” *PLOS ONE* 8, no. 7 (2013): e70808, <http://dx.doi.org/10.1371/journal.pone.0070808>.
 59. *Ibid.*, 2.
 60. Hans Berglund *et al.*, “Male-to-Female Transsexuals Show Sex-Atypical Hypothalamus Activation When Smelling Odorous Steroids,” *Cerebral Cortex* 18, no. 8 (2008): 1900–1908, <http://dx.doi.org/10.1093/cercor/bhm216>.
 61. See, for example, Sally Satel and Scott D. Lilienfeld, *Brainwashed: The Seductive Appeal*
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of *Mindless Neuroscience*, (New York: Basic Books, 2013).

62. An additional clarification may be helpful with regard to research studies of this kind. Significant differences in the means of sample populations do not entail predictive power of any consequence. Suppose that we made 100 different types of brain measurements in cohorts of transgender and non-transgender individuals, and then calculated the means of each of those 100 variables for both cohorts. Statistical theory tells us that, due to mere chance, we can (on average) expect the two cohorts to differ significantly in the means of 5 of those 100 variables. This implies that if the significant differences are about 5 or fewer out of 100, these differences could easily be by chance and therefore we should not ignore the fact that 95 other measurements failed to find significant differences.

63. One recent paper estimates that 0.6% of the adult U.S. population is transgender. See Andrew R. Flores *et al.*, “How Many Adults Identify as Transgender in the United States?” (white paper), Williams Institute, UCLA School of Law, June 30, 2016, <http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf>.

64. Petula Dvorak, “Transgender at five,” *Washington Post*, May 19, 2012, https://www.washingtonpost.com/local/transgender-at-five/2012/05/19/gIQABfFkbU_story.html.

65. *Ibid.*

66. *Ibid.*

67. American Psychiatric Association, “Gender Dysphoria,” *DSM-5*, 455. Note: Although the quotation comes from the *DSM-5* entry for “gender dysphoria” and implies that the listed persistence rates apply to that precise diagnosis, the diagnosis of gender dysphoria was formalized by the *DSM-5*, so some of the studies from which the persistence rates were drawn may have employed earlier diagnostic criteria.

68. *Ibid.*, 455.

69. Kenneth J. Zucker, “Children with gender identity disorder: Is there a best practice?,” *Neuropsychiatrie de l’Enfance et de l’Adolescence* 56, no. 6 (2008): 363, <http://dx.doi.org/10.1016/j.neurenf.2008.06.003>.

70. Kenneth J. Zucker *et al.*, “A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder,” *Journal of Homosexuality* 59, no. 2 (2012), <http://dx.doi.org/10.1080/00918369.2012.653309>. For an accessible summary of Zucker’s approach to treating gender dysphoria in children, see J. Michael Bailey, *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* (Washington, D.C.: Joseph Henry Press, 2003), 31–32.

71. Kelley D. Drummond *et al.*, “A follow-up study of girls with gender identity disorder,” *Developmental Psychology* 44, no. 1 (2008): 34–45, <http://dx.doi.org/10.1037/0012-1649.44.1.34>.

72. Jesse Singal, “How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired,” *New York Magazine*, February 7, 2016, <http://nymag.com/scienceofus/2016/02/fight-over-trans-kids-got-a-researcher-fired.html>.

73. See, for example, American Psychological Association, “Guidelines for Psychological Practice with Transgender and Gender Nonconforming People,” *American Psychologist* 70 no. 9, (2015): 832–864, <http://dx.doi.org/10.1037/a0039906>; and Marco A. Hidalgo *et al.*, “The Gender Affirmative Model: What We Know and What We Aim to Learn,” *Human Development* 56 (2013): 285–290, <http://dx.doi.org/10.1159/000355235>.
 74. Sara Reardon, “Largest ever study of transgender teenagers set to kick off,” *Nature* 531, no. 7596 (2016): 560, <http://dx.doi.org/10.1038/531560a>.
 75. Chris Smyth, “Better help urged for children with signs of gender dysphoria,” *The Times* (London), October 25, 2013, <http://www.thetimes.co.uk/tto/health/news/article3903783.ece>. According to the article, in 2012 “1,296 adults were referred to specialist gender dysphoria clinics, up from 879 in 2010. There are now [in 2013] 18,000 people in treatment, compared with 4,000 15 years ago. [In 2012] 208 children were referred, up from 139 the year before and 64 in 2008.”
 76. Annelou L. C. de Vries *et al.*, “Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment,” *Pediatrics* 134, no. 4 (2014): 696–704, <http://dx.doi.org/10.1542/peds.2013-2958d>.
 77. David Batty, “Mistaken identity,” *The Guardian*, July 30, 2004, <http://www.theguardian.com/society/2004/jul/31/health.socialcare>.
 78. *Ibid.*
 79. Jon K. Meyer and Donna J. Reter, “Sex Reassignment: Follow-up,” *Archives of General Psychiatry* 36, no. 9 (1979): 1010–1015, <http://dx.doi.org/10.1001/archpsyc.1979.01780090096010>.
 80. *Ibid.*, 1015.
 81. See, for instance, Paul R. McHugh, “Surgical Sex,” *First Things* (November 2004), <http://www.firstthings.com/article/2004/11/surgical-sex>.
 82. Michael Fleming, Carol Steinman, and Gene Bocknek, “Methodological Problems in Assessing Sex-Reassignment Surgery: A Reply to Meyer and Reter,” *Archives of Sexual Behavior* 9, no. 5 (1980): 451–456, <http://dx.doi.org/10.1007/BF02115944>.
 83. Cecilia Dhejne *et al.*, “Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden,” *PLOS ONE* 6, no. 2 (2011): e16885, <http://dx.doi.org/10.1371/journal.pone.0016885>.
 84. 95% confidence interval: 2.0–3.9.
 85. 95% confidence interval: 1.8–4.3.
 86. MtF transsexuals in the study’s 1973–1988 period showed a higher risk of crime compared to the female controls, suggesting that they maintain a male pattern for criminality. That study period’s FtM transsexuals, however, did show a higher risk of crime compared to the female controls, perhaps related to the effects of exogenous testosterone administration.
 87. 95% confidence intervals: 2.9–8.5 and 5.8–62.9, respectively.
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88. *Ibid.*, 6.

89. *Ibid.*, 7.

90. Annette Kuhn *et al.*, “Quality of life 15 years after sex reassignment surgery for transsexualism,” *Fertility and Sterility* 92, no. 5 (2009): 1685–1689, <http://dx.doi.org/10.1016/j.fertnstert.2008.08.126>.

91. Mohammad Hassan Murad *et al.*, “Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes,” *Clinical Endocrinology* 72 (2010): 214–231, <http://dx.doi.org/10.1111/j.1365-2265.2009.03625.x>.

92. *Ibid.*, 215.

93. 95% confidence intervals: 68–89%, 56–94%, and 72–88%, respectively.

94. *Ibid.*

95. *Ibid.*, 216.

96. *Ibid.*

97. *Ibid.*, 228.

From: [Candice Jackson](#)
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Cc: [Vazquez, Paul](#)
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To the FL Board of Medicine:

Thank you for taking public comments regarding the very serious issue of whether minors and youth should be subjected to life and health-altering medicalization in service of “gender affirmation.” I am an attorney and volunteer US Regional Coordinator with Genspect (www.Genspect.org). As a lawyer helping young people who have detransitioned and find themselves irreparably harmed medically and psychologically from being “affirmed” by mental health and medical professionals, I urge you to carefully consider the experiences like that of the young man who asked me to submit his statement (attached, and below), as well as an article he wrote (attached).

There is nothing unique or extraordinary about “gender identity” to justify allowing minors to sacrifice their health — specifically, their future fertility, sexual function, and normal healthy bodily growth & development — for something so nebulous and fluid as “internal identity.” Body dysmorphia, emotional distress over our bodies and/or over how we are treated socially due to being male or female, or a fantasy that being opposite sex or sexless would be “more authentic,” is not best treated by indulging in the fiction of “sex change” or “choosing a gender,” but by ordinary talk therapy to seek self acceptance, build confidence, and find resilience.

Sincerely,

Candice Jackson
JACKSON BONE LLP
cjackson@jacksonbone.com
(818) 481-4565

I started seeking transition when I was fourteen years old after reading about it online. I had a difficult home life—divorced parents, dysfunctional stepparents—and at school I had no friends and was frequently bullied, struck, and sexually harassed. Transition seemed like an escape: I could become someone else, someone happier. I saw glowing testimonies online from happy transitioners and was urged by these people to transition as soon as possible, before “male puberty” had destroyed my chance to “pass” as female. These strangers coached me on what to say to doctors and therapists, but I wasn't very good at following their advice. Despite erratic behavior, frequent emotional outbursts, a refusal to even wear women's clothes before I'd started hormones, and comorbid symptoms of depression (diagnosed) and autism (as yet undiagnosed) I was put on puberty blockers at 15 and estrogen at 16.

I got an orchiectomy around the time I was 20. At that point, I was completely delusional and disconnected from reality. I suspect this was due to a combination of the cross-sex hormones I was taking, psychological pressure from the same online strangers who'd pushed me to transition in the first place, and a family tendency towards mental illness. I'd changed my name multiple times in the months leading up to the surgery and desired to escape my body entirely and turn into a liquid. I

needed to be psychologically assessed before insurance would cover the procedure, but I was sent to a psychiatrist at the same facility which prescribed me my hormones who asked me questions off a form for about an hour and a half and then rubber-stamped me for surgery. Anything else would have been considered "gatekeeping", which is anathema to much of the trans community and many trans healthcare providers.

Today, I still suffer complications from the surgery. I regularly experience painful cramping, and since my endocrine system is broken I'll need to take exogenous testosterone for the rest of my life. From the estrogen, I have a large amount of breast tissue which will require surgery to remove, surgery which will cause more scarring and nerve damage even if nothing goes wrong. I have no idea what the long-term effects of my years on the "puberty suppressor" Lupron—a notoriously harsh chemotherapy medication, prescribed off-label—and cross-sex hormones will be, as there's very little literature on the subject. What I have read suggests I'll be at significantly higher risk than normal of developing dementia or schizophrenia.

I was a kid, already on psychiatric medication for depression and anxiety which influenced my decision-making ability, who was incapable of understanding what the consequences of transition would be. Transition isn't a treatment for anything. It's a cosmetic procedure which causes serious permanent medical problems, which is sold as a miracle cure for all sorts of unhappiness by an ideologically captured medical industry and a cult of fanatics who push it to kids. It should not be covered by insurance and it should never be performed on children.

I started seeking transition when I was fourteen years old after reading about it online. I had a difficult home life—divorced parents, dysfunctional stepparents—and at school I had no friends and was frequently bullied, struck, and sexually harassed. Transition seemed like an escape: I could become someone else, someone happier. I saw glowing testimonies online from happy transitioners and was urged by these people to transition as soon as possible, before "male puberty" had destroyed my chance to "pass" as female. These strangers coached me on what to say to doctors and therapists, but I wasn't very good at following their advice. Despite erratic behavior, frequent emotional outbursts, a refusal to even wear women's clothes before I'd started hormones, and comorbid symptoms of depression (diagnosed) and autism (as yet undiagnosed) I was put on puberty blockers at 15 and estrogen at 16.

I got an orchiectomy around the time I was 20. At that point, I was completely delusional and disconnected from reality. I suspect this was due to a combination of the cross-sex hormones I was taking, psychological pressure from the same online strangers who'd pushed me to transition in the first place, and a family tendency towards mental illness. I'd changed my name multiple times in the months leading up to the surgery and desired to escape my body entirely and turn into a liquid. I needed to be psychologically assessed before insurance would cover the procedure, but I was sent to a psychiatrist at the same facility which prescribed me my hormones who asked me questions off a form for about an hour and a half and then rubber-stamped me for surgery. Anything else would have been considered "gatekeeping", which is anathema to much of the trans community and many trans healthcare providers.

Today, I still suffer complications from the surgery. I regularly experience painful cramping, and since my endocrine system is broken I'll need to take exogenous testosterone for the rest of my life. From the estrogen, I have a large amount of breast tissue which will require surgery to remove, surgery which will cause more scarring and nerve damage even if nothing goes wrong. I have no idea what the long-term effects of my years on the "puberty suppressor" Lupron—a notoriously harsh chemotherapy medication, prescribed off-label—and cross-sex hormones will be, as there's very little literature on the subject. What I have read suggests I'll be at significantly higher risk than normal of developing dementia or schizophrenia.

I was a kid, already on psychiatric medication for depression and anxiety which influenced my decision-making ability, who was incapable of understanding what the consequences of transition would be. Transition isn't a treatment for anything. It's a cosmetic procedure which causes serious permanent medical problems, which is sold as a miracle cure for all sorts of unhappiness by an ideologically captured medical industry and a cult of fanatics who push it to kids. It should not be covered by insurance and it should *never* be performed on children.

How I was trapped by gender ideology

By [Steven A. Richards](#)

Publishing in the Washington Examiner, May 25, 2022 06:30 AM

I became a male-to-female transsexual when I was only 15 years old. Bullying at school, instability at home, and a lack of close friends had left me looking for somewhere to belong, and the transgender movement happily provided one — at the cost of my health and sanity. Living as a transgender woman left me delusional, paranoid, and sick. Despite this, I stayed transgender for eight years. The nature of the transgender movement makes it almost impossible to escape and pushes the people within it to adopt radical beliefs and irreversibly harm themselves.

My new identity brought me friends, mentors, and a purpose in life. I went from being a lonely, insecure teenager to a member of a loving community engaged in a heroic battle against an evil society that desired my destruction. Left-wing oppression narratives disseminated online and in local “queer youth” groups run by adult members of the movement cast “cis” people as villains. “Transitioning” was a baptismal ritual in which I was cleansed of my wicked nature as a “cis male” oppressor and reborn as a virtuous “marginalized” person with a new name and body.

Adult transsexuals online coached me on how to convince my parents, doctors, and therapists that I was suffering from gender dysphoria. The term supposedly refers to an incongruence between one’s sexed body and internal sense of gender but is used among transgender people as a catch-all term for any negative emotion. It’s an attractive narrative for vulnerable teenagers who are struggling with their developing bodies, sexualities, and the looming responsibilities of adulthood.

Not long after turning 15, I started Lupron, a chemotherapy medication that is used off-label to halt puberty in gender-dysphoric adolescents. At 16, I started taking synthetic estrogen.

When I expressed doubts, I was reassured that all transgender people sometimes feel like they aren’t really transgender and that contentment waited at the end of the line if I just stuck with it. Clinging to this fantasy of a happy future where my transition was “complete” let me ignore that the medication made me feel worse, not better. I couldn’t think clearly. I started missing school. I developed chronic migraines. My bones ached. I became suicidal. I barely scraped up enough credits to graduate from high school.

The community explained away these negative treatment outcomes as manifestations of gender dysphoria and minority stress. My worsening health had nothing to do with my rejection of my body and identity or the experimental medications I was taking — it was all the fault of the transphobic society that tyrannized me. With this narrative, the community cultivated fear of the outside world in its members. I viewed anyone who questioned my transition or expressed concern for me as a bigot and disregarded them on principle. My parents learned to choose their words carefully so they wouldn’t set me off. I developed a panic response to hearing anyone express opinions that were deemed “problematic.” I suspected that everyone I passed on the street wanted me dead for being transgender.

At 19, the delusion became untenable. I was miserable and getting worse. However, ending my transition would mean my body masculinizing, and that idea terrified me. I didn't want to become one of the monstrous "cis males" I feared so much, or to lose my friends and my purpose. Maybe, I rationalized, it wasn't that my transition wasn't working — I just hadn't gone far enough.

Hoping it would relieve my distress, I went to my doctor and said I wanted an orchiectomy — to have my testicles removed. I needed two letters from specialists to get the procedure covered by insurance. My doctor wrote one immediately. She then referred me to a psychiatrist associated with her clinic who wrote the other after a single meeting. Within a few months, I'd gotten myself castrated. But the euphoria I'd been promised didn't materialize. Mutilating myself hadn't made me whole — it had only made me mutilated. Two years after my orchiectomy, I found myself in the same situation I'd been in before: Either I could admit that transitioning was never going to fix me, or I could go in for another surgery and hope that *this time*, it would be enough. I couldn't make myself believe the lie again.

Coming to terms with what I lost has been the hardest thing I've ever done. Deciding to de-transition cost me many close friends and forced me to rebuild my whole life. For some members of the movement — those who have lost ties with their family, who rely on the community for food and housing — de-transitioning isn't an option. Many of them still live in the miserable world I escaped from, hoping that the next step in their transition — a new name, a new set of pronouns, another year of hormones, another surgery — will bring them the happiness they were promised. But, as I learned, it never can.

Steven A. Richards de-transitioned after living as a transgender woman for eight years. He writes about the transgender movement and the philosophy of gender identity at cutofftree.substack.com.

From: [A. Carnes](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); [Vazquez, Paul](#)
Subject: Please stop medicalizing children and youth with puberty blockers and hormones
Date: Monday, September 19, 2022 7:46:38 PM

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Dear Florida Board of Medicine,

We thank you for taking up the vital question of regulating the so-called "gender-affirming" hormones and surgeries for young people.

As parents of these children, we have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions sometimes on the first or second visit. The myth that our children are getting "assessments" is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society's recommendations.

Older adolescents can get hormones with no assessments at all, and have their healthy body parts amputated by eager surgeons on little more than self-declaration of "trans identity." Many of our children are gay and autistic and have come to believe their very real distress is explained by the fact that they are "transgender" and that hormones and surgeries will help. They do not. We have seen our children's mental and physical health plummet following "gender-affirmation."

We also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation."

Thank you for doing what you can to regulate this experiment on our vulnerable children.

Axa Carnes

Parent of gender confused autistic young adult



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From: [lesley hill](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Dangers of Gender Affirming Care
Date: Monday, September 19, 2022 7:34:50 PM

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The gender affirming model of care should not be available to minors whose bodies, brains, and identities are still developing. The UK is a few years ahead of us on this and are now finding out what a huge mistake adopting this model for minors has been, and other European countries are backtracking as well. These gender clinics make a lot of money over long periods of time for every child they medically transition, in spite of alarmingly high rates of continued suicidal ideation and desistance (see subreddit r/detrans for stories from those who regret their transitions and feel betrayed by this system). The parents are led to believe that the only solution to their child's dysphoria is to alter their bodies, often resulting in permanent sterilization and even more suicidal ideation, after realizing that the magical cure they were sold did nothing to help their underlying/co-occurring mental health issues.

Proponents of gender affirming care claim "Puberty Blocker" drugs (like Lupron, which is used for chemical castration) have no harmful long term side effects, but no studies have corroborated this. Natural puberty hormones themselves may even gender dysphoria after time, as suggested by responsible endocrinologists. Use of these blockers pver time is linked to lower bone density, stunted growth, and sexual disfunction in adulthood, and they are about 99% of the time immediately followed with cross-sex hormones, the harms of which should be well known.

I think the most alarming part is the high rate of autistic patients who come to these clinics for help. This is effectively sterilizing them and other gender non-conforming children for life. This is not the way to help these kids.

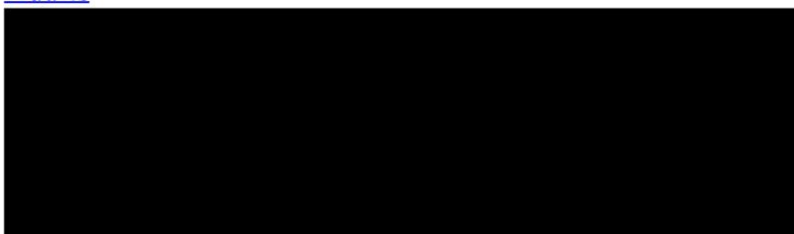
Thank you,

Lesley Hill
Parent

Relevant links:

<https://www.transgendertrend.com/professionals-questioning-medical-transition-children/>

[Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults](#)



Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults

In less than a decade, the western world has witnessed an unprecedented rise in the numbers of children and adolescents seeking gender transition. Despite the precedent of years of gender-affirmati...

[Sent from Yahoo Mail on Android](#)

From: [Jim & Katie Hudson](#)
To: [Vazquez, Paul](#)
Subject: Gender transitioning
Date: Monday, September 19, 2022 5:36:29 PM

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Dear Mr Vazquez,

Gender transitioning by use of opposite gender hormones or surgical interventions is an unproven and potentially catastrophic intervention and should never be used on adolescents or anyone who has not reached the age of adulthood.

James D Hudson MD
Sent from my iPhone

From: [Sister Edith Hart](#)
To: [Vazquez, Paul](#)
Subject: Upcoming meeting
Date: Monday, September 19, 2022 3:54:37 PM

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Dear Paul,

I am writing to express my deep concern about the consideration of the Florida Board of Medicines gender affirming care. This push to accept such care is clearly ideologically driven and not based in either reason or sound medical evidence.

There is excellent evidence coming from our European colleagues that such treatment fails to show improvement in youth experiencing gender dysphoria. In the UK an Independent systematic review of the data concluded that evidence was very low regarding hormonal interventions in gender dysphoric youth disorder. Finland, as a country, adopted a position of early transitioning of pediatric patients and they too showed a lack of improvement in mental health and have now moved to psychotherapy as first line therapy.

As a recent Medscape article pointed out by Dr William Malone Endocrinologist

- “Most cases of early childhood-onset gender dysphoria self-resolve. [Eleven out of 11 studies](#) that followed the trajectory of gender-variant youth show that the most common outcome is natural resolution of gender dysphoria [around or after puberty](#). Among those diagnosed as having gender identity disorder, 67% no longer met the diagnostic criteria as adults; among those subthreshold for diagnosis, [93% were not gender dysphoric](#) as adults. Gender dysphoria in childhood is a far better predictor of future homosexuality than of future trans identity.
- The future trajectory of people whose transgender identity emerged during or after puberty is entirely unknown. No one has studied future trajectories of patients whose transgender identity emerged for the first time after the onset of puberty — a previously rare but now increasingly common presentation. Growing numbers of young detransitioners and desisters are precisely from this demographic, suggesting that a transgender identity that emerges in adolescence may not be durable.
- Social transition does not improve mental health outcomes. Recent

studies show that while socially transitioned children can thrive in the short term, they [do not fare any better](#) than their non-socially transitioned dysphoric peers. It appears that [peer relations](#), not the social transition status, predict mental health in gender-dysphoric children. We don't yet know the long-term trajectories of socially transitioned minors, but [emerging evidence](#) suggests that they may [be more likely to persist](#) with gender-related distress rather than outgrow it, as previously observed. This in turn necessitates decades of invasive and risky medical interventions. In fact, the Dutch researchers who pioneered the protocol used to medically transition minors (see Box) [explicitly and strongly discouraged](#) social transition of children and early adolescents.

- Nearly 100% of children who begin puberty blockers will proceed to cross-sex hormones and surgeries. The two main studies that have [evaluated the effects of puberty blockers](#) on mental health found [no improvements](#) or [improvements of marginal clinical significance](#). Both studies are also at critical risk of bias due to the absence of control groups. [Four additional studies looking](#) at the mental health effects of puberty blockers were plagued by [design limitations](#) and also [failed](#) to show any convincing positive effects on psychological health. However, one effect of puberty blockers has been consistently replicated: [At least four studies show](#) that [virtually all of the children who start puberty blockers proceed to cross-sex hormones](#). This suggests that rather than being a pause button, puberty blockers may serve as the "gas pedal" for gender transition.

- Most of the long-term health risks are largely unknown. No long-term studies exist of patients who underwent medical transition as teens or young adults. Therefore, our ability to assess risks vs benefits is limited. Puberty blockers have been demonstrated to [significantly impair bone health](#), and it is not clear whether this will result in future [osteoporosis](#). Cross-sex hormones are associated with [roughly 3-5 times the risk](#) for [heart attacks and strokes](#), though long-term studies are of insufficient quality for accurate risk assessments. Other risks associated with these endocrine interventions will come to light as the practice continues to scale and as young people spend years and decades on these interventions. The risks to fertility are largely unknown, but it is almost

certain that if puberty blockers are given at the early stages of puberty and followed by cross-sex hormones, sterility will result.

- The medical pathway of "affirmative care" rests on a single Dutch study that is not applicable to the current populations of gender-dysphoric youth. Most of the youth presenting for care today would have been explicitly disqualified by the original Dutch protocol, as most have significant mental health comorbidities and post-puberty onset of trans identities. This fact has been recognized by the principal investigators of the Dutch protocol itself, who have [recently begun to sound the alarm](#) about the [potential misapplication of their protocol](#) and who suggest that psychotherapy — rather than gender reassignment — is more appropriate for many of the currently presenting cases.”

The fundamental principle in good medical practice is “do no harm”. The evidence clearly shows that harm is being done by these hormonal transitions and should not be encouraged or promoted. An individual is born either male or female and this accords with both reason and common sense. We as physicians should be working for the wholeness and well being of your patients and not contributing to further distress.

I appreciate your consideration of my comments in your deliberations.

Sincerely,

Margaret J. Hart, DO, FAAFP

Chandler, Arizona

https://www.medscape.com/viewarticle/958742#vp_4

From: [Rebecca Bame](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Legislation Florida
Date: Monday, September 19, 2022 7:01:38 PM

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Dear Sir,

My husband and I are both family physicians and parents of six children opposed to hormonal medications and genital altering surgeries for minor children. These treatments are potentially harmful and surgical procedures are irreversible. We have many patients who initially contemplate such treatments and then change their mind when they are older. Moreover the harms of hormones when started as adolescents (increased rates of cancer, thrombosis, etc) are well established. Finally, we believe that children and adolescents need a period of counseling and deep introspection to reflect on this kind of decision. It should not be rushed.

Children and adolescents are apt to change their minds frequently about a myriad of issues. Why would we not require them to be an adult to make this kind of permanent, altering life decision?

Dr. Rebecca Peck, M.D. Family Physician, Halifax Health Sysyems

Dr. Benjamin Peck, M.D. Family Physician, Advent Health

[Sent from Yahoo Mail on Android](#)

[Sent from Yahoo Mail on Android](#)

From: [Tracey Rzepka](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Florida Medical Board's Gender Dysphoria Recommendations
Date: Monday, September 19, 2022 5:43:50 PM
Attachments: [Transgender Identification 2021 - October.pdf](#)

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Dear Dr. Paul Vazquez and the FL BOM,

I am a Psychiatric APRN here in FL.

Please protect the children and adolescents in FL from the irreversible effects of puberty blockers, cross sex hormones and surgery.

As a Psych NP, I have had several encounters with transgender individuals. One adult wanted me to sign off on a hysterectomy that an OB/GYN surgeon would not do without psychiatry approval. She told me initially that the surgeon needed to do the surgery because of polycystic ovarian syndrome. When I questioned surgery as a treatment for Polycystic Ovarian surgery she said that she is transgender. I then asked if she was planning to have mastectomies and she said she was. However, prior to asking for approval from me as a Psych NP for a hysterectomy, she had never mentioned any of this is the few times I had seen her. When I mentioned that it would be difficult for me to agree to this as it would be a liability if she changes her mind at some point in time, she got angry and hung up. She did not schedule another appointment. Unfortunately, her insurance had lapsed and I was never paid for that appointment. This is an adult who did not tell me the truth initially. She did not tell me she had changed insurance or that it had lapsed. She did not in any way present as male. She had been in the psych hospital many, many, many times and was extremely mentally ill.

It is well known that adolescents brains do not fully develop until age 25. They are not allowed to drink until 21 or buy a gun. Should they be allowed to make a decision about something that has not been clearly researched and studied and is a trend among the youth causing irreversible damage to their young bodies? I do not think so. Twenty-five should be the minimum age to give such a consent. Until then, psychological care and living several years as the opposite sex should be required first as it was in the past for trans surgeries.

I had another trans young man in his early 20s. "He" had had a complete hysterectomy and mastectomies and had been in the hospital due to suicidal ideation after the surgeries. In spite of this psych hospitalization, his parents took him back to Texas to have a phalloplasty. After returning, "his" girlfriend broke up with him and he ended up in the psych hospital again. Thankfully, he did not return to my office which was a relief to me as it was very traumatic to me to care for this young girl who had had such body altering surgery at such a young age and was clearly not mentally stable when they did the phalloplasty. "He" had just been in a psych hospital the month before the surgery.

What I see is that no one is assessing the psychological problems these young people have. I only see adults so I have not had anyone younger than 18 but a psychologist colleague of mine is seeing many, many young transgender clients in the hospital for suicide attempts, etc.

Fund a huge research study. You will have more than enough young people willing to sign up. I don't know what the State of FL or BOM liability would be if you would do such a study. Can it pass a Do No Harm, Informed Consent process to ethically do such a study? Puberty blockers were never studied long term in transgender individuals. It is being used totally off label along with the cross sex hormones in adolescent young people who will never recover.

I do not believe any insurance that I might be paying for, including Medicaid which is funded by my taxes should be paying for these damaging, experimental treatments. If someone wants to pay cash, as has always been the case in the past, and they are 25 years old, then it can be up to them.

Please protect the consciences of those like myself, who are not comfortable with this experimental treatment. I have been a member of the Christian Medical and Dental Association since 1989 before I graduated as an NP in 1990. They have an ethics statement on transgender issues. See items D&E below

for the negative effects of hormone blockers, cross-sex hormones and surgery. I apologize the references did not copy clearly. The original is attached.

Thank you for your time in reading this.

Tracey Rzepka, MS, ARNP, PMHNP-BC
Something Beautiful Wellness Care
2650 Bahia Vista Street
Suite 209
Sarasota, FL 34239
Phone: 941-870-7060
Fax: 844-876-2658
www.sobewellcare.com

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CMDA Ethics Statement Transgender Identification

Preamble

A novel way of thinking about one's body has entered into popular culture. "Transgender" individuals refer to their "gender" as a sexual identity that may be male or female, something in between, or neither. This self-identification differs from, and takes priority over, their biological sex as recognized in their chromosomal DNA and innate physical sexual characteristics. The naming of gender as a category set apart from sex is an idea foreign to the holistic view of the person as understood within Christianity. Christians affirm the biblical understanding of humankind as having been created male and female, with the two sexes having equal dignity and a complementary relationship to each other.

At the heart of disagreement over transgenderism is a difference in worldviews. If the human body is nothing more than the product of mindless, random, purposeless physical forces, then one may do with it what one wishes, even to demand medical and surgical cooperation in projects to alter, amputate, or reconstruct normal tissue to conform to the patient's revised psychological sense of identity. If, on the other hand, our bodies are an inseparable aspect of our true selves and are a good gift from God, who has designed the sexes to be wonderfully paired, and who has a purpose for humanity, then respecting the gift of given sexual identity and the ensuing moral obligations to our neighbors is the surest path to human flourishing. Both worldviews share the recognition that humanity is broken and in need of renewal, but they look to different answers for healing. Christians seek not a reconfiguring of the body, but a spiritual transformation of the mind to become more like Christ; not rejecting the gifts of God, but welcoming God's purposes and demonstrating God's love by loving our neighbors. This love of neighbors includes loving our transgender neighbors as persons who, like all people, are created in God's image. However, loving them and validating them as people does not mean agreeing with their ideologies or use of language.

The Christian Medical & Dental Associations (CMDA) believes that healthcare professionals should not be forced to violate their conscientious commitment to their patients' health and welfare by being required to accept and participate in harmful gender-transition interventions, especially on the young and vulnerable. CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and

compassion, consistent with the humility and love that Jesus modeled and commanded us to show all people.

Introduction

CMDA affirms that all human beings are created in the image of, and beloved by, God. All human beings are our “neighbors”, and are to be loved by us as we love ourselves. All human beings possess intrinsic dignity and are worthy of equal respect and concern from Health Care Professionals.

CMDA considers “sex” (i.e., male or female) to be an objective biological fact (see section B.1. below). CMDA affirms the historic understanding of gender as referring to biological sex and the enduring biblical understanding of humankind as having been created male and female and that this is good. CMDA acknowledges the current cultural use of the word “gender” to refer to one’s sense of identity as male or female. CMDA cannot support the recent usage of the term “gender” to emphasize an identity other than one’s biological sex, that is, a subjective sense of self based on feelings or desires leading to identifying somewhere on a fluid continuum of gender identity.^{1,2,3,4} (See Glossary at the end of this document)

CMDA cannot support the prevailing culture’s acceptance of an ideology of unrestrained sexual self-definition that, in celebrating gender fluidity and gender transition efforts, is indifferent to biological reality and opposed to the biblical understanding of human sexuality. Further, CMDA is alarmed that some proponents of transgender ideology, through activism and intimidation, are insisting that healthcare professionals cooperate with and affirm their beliefs in gender fluidity, even if the healthcare professionals believe that such cooperation and affirmation would be doing harm to their patients. This violates the most fundamental core value of medicine since Hippocrates, that of caring only for the good and benefit of the patient while abstaining from all unnecessary harm. The evolving scientific and medical facts demonstrate that the mutilation of normal tissue and profound disruption of normal physiology that occur during gender transition procedures are very difficult to justify, as this constitutes deliberate harm.

CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion. CMDA holds that attempts to radically reconstruct one’s body surgically or hormonally for psychological indications, however, are medically, ethically, and psychologically inappropriate. These measures alter healthy tissue and increasingly are not supported by scientific research evaluating behavioral, medical, and surgical outcomes.^{5,6,7,8,9,10,11}

Accordingly, CMDA opposes medical assistance with gender transition on the following grounds:

A. Biblical

1. God created humanity as male and female (Gen 1:27, 5:2; Matt 19:4; Mark 10:6). God's directives – to have dominion over the earth and to fulfill his goals of procreation, union, fellowship, and worship – are given to men and women together (Gen 1:26-28, 2:18-24).
2. Men and women are morally and spiritually equal (Gal 3:28) and are created to have roles that are in some respects alike and in other respects wonderfully complementary (Eph 5).
3. All people are loved by God (John 3:16-17). All struggle with moral failure and fall short of God’s standards (Rom 3:10-12) and, therefore, need the forgiveness that God provides through Christ alone (John 3:36; Rom 3:22-24; Col 1:15-22; 1 Tim 2:5-6).
4. For the Christian, all of ethics, grounded in God’s moral law, is based upon the first and

second greatest commandments: to love God with all our heart, soul, and mind, and to love our neighbors as ourselves (Matt 22: 37-40). If we encourage others to sin sexually, just as if we sin sexually ourselves, we are violating these two commandments. We violate the first greatest commandment by failing to love God in his holiness, wisdom, and rightful place as our Creator, and we violate the second greatest commandment as we fail to respect ourselves and each other by abetting lives of disobedience, deception and unholiness (1 Cor 6: 13b-20). Love may include a corrective component that should be applied in an appropriate and timely manner; affirmation can be enablement.

5. We live in a fallen world (Gen 3), and we all come into this world as fallen creatures with a sinful nature. (Rom 3:9-12). The fall is expressed in nature and in humanity in many ways, including sexuality. Confusion of gender identity is but one example of the fall, as are also marital breakdown and sexual immorality (Rom 1:24-32; Eph 5:3).
6. A lifestyle that is directed by pursuing sexual desires, or driven by personal sexual fulfillment, misses the divinely ordained purpose of sex, which is for procreation, bond creation, and re-creation¹² and for facilitating unity in the lifelong commitment of marriage, which is defined as being between one man and one woman. Heterosexual marriage fosters a secure and nurturing environment for children and it reflects the unity of Christ and the Church (Exod 20:1-18; Lev 20:10-21; Rom 1; Eph 5:23-33) (see also CMDA Statement on Homosexuality).
7. Believers in Christ, though having inherited the sinful nature common to all humanity, also receive a new nature in Christ. As the old nature, being crucified with Christ, dies, our new redeemed nature, sealed by Christ's bodily resurrection, is actively transforming our minds and hearts to be more and more like Christ. This transformation is spiritual, not sexual, and is God's work, not something of our own design (Psalm 100:3; Rom 12:2; Col 1:27).

B. Biological

1. Sex is an objective biological fact that is determined genetically at conception by the allocation of X and Y chromosomes to one's genome, is observable at birth, is found in every nucleated cell, and is immutable throughout one's lifetime. Sex is not a social construct arbitrarily assigned at birth and cannot be changed at will.^{2,3,13}
2. Human beings are sexually dimorphic. Male and female phenotypes are the outworking of sex gene expression, which shapes sex anatomy, determines patterns of sex hormone secretion, and influences sex differences in the development of the central nervous system and other organs.^{2,3,14}
3. Procreation requires genetic contributions from both one man and one woman.^{15,16}
4. CMDA recognizes that exceedingly rare congenital abnormalities exist in which phenotypic sex characteristics are not what is expected from the genotype.^{1,2} These disorders of sex development are of a diverse nature, but usually impair fertility.³ Treatment (including non-intervention) of these disorders differs categorically from transgender interventions, which are performed on persons with no inherent defect in sex organ development, function, or fertility. Anomalies of human biological sex are conditions rather than identities, something one has rather than who

one is. Disorders of sex development are not the fault of the patient, do not invalidate God's design in creation, and do not constitute a third sex.^{17,18,19,20}

5. Gender dysphoria²¹, the condition of experiencing discomfort or distress at one's sex and preferring a different "gender" identity, has not to date been linked to a genetic cause and

is a psychological disorder of unclear and complex origin.^{22,23,24} Gender dysphoria may cause profound distress. It should not be confused with transient gender-questioning that can occur in early childhood.^{25,26,27,28,29,30}

C. Social

1. CMDA recognizes that gender identity issues are complex. The inclination to identify with the opposite sex or as some other gender identity along a spectrum may have non-genetic biological,³¹ familial,^{32,33} and social^{27,28,34} causes that are not personally generated by particular individuals.²¹⁻³⁰
2. In our current social context, there is a prevailing view that removing traditional definitions and boundaries is a requirement for self-actualization. Thus, Christian healthcare professionals find themselves in the position of being at variance with evolving views of gender identity in which patients or their subcultures seek validation by medical professionals of their transgender desires and choices through medical or surgical solutions to gender dysphoria. Although such desires may be approved by society at large, they are contrary to a biblical worldview and to biological reality and thus are disordered.
3. In contrast to the current culture, CMDA believes that finding one's identity within God's design will result in genuine human flourishing. CMDA believes, moreover, that social movements which assert that gender is a choice are mistaken in defining gender as something independent of sex. Authentic personal identity consists in social gender expression that is congruent with one's natural biological sex but not limited to stereotypes. CMDA recognizes that this traditional view has become counter-cultural; however, CMDA affirms that God's design transcends culture.
4. CMDA opposes efforts to impose transgender ideology on all society by excluding, suppressing, marginalizing, intimidating, or portraying as hateful those individuals and organizations that disagree on scientific, medical, moral, or religious grounds. Such attacks are contrary to the freedoms of speech and religious liberty that lie at the very foundation of a just and democratic society.
5. There is a social contagion phenomenon luring young people into the transgender culture.^{32,33}
6. CMDA opposes efforts to compel healthcare professionals to grant medical legitimacy to transgender ideologies.^{35,36,37,38,39,40} Cooperation with requests for medical or surgical gender reassignment threatens professional integrity by undermining our respect for biological reality, evidence-based medical science, and our commitment to non-maleficence (see CMDA Statement on Healthcare Right of Conscience).
7. Promotion of transgender ideology by educational institutions and teachers to children

as young as 5 years of age is a danger to the health and safety of minor children (for medical reasons elaborated in the next section).^{41,42,43,44,45,46,47} Education should respect the value of every human being; in supporting and affirming the student, it need not affirm every desire.

8. No educational institution or teacher should ever block parents from supervising their child's education or withhold from them knowledge of the educational content.

D. Medical

1. Transient gender questioning can occur during childhood. Most children and adolescents who express transgender tendencies eventually come to identify with their biological sex during adolescence or early childhood.^{48,49,50,51,52,53} There is evidence that gender dysphoria is influenced by psychosocial experiences and can be exacerbated by promoters of transgender ideology.^{27,33} Early counseling for children expressing gender dysphoria is critical to treat any underlying psychological disorders, including depression, anxiety, or suicidal tendencies, and should be done without promoting attempts for gender transitioning.

2. Hormones prescribed to a previously biologically healthy child for the purpose of blocking puberty inhibit normal growth and fertility, cause sexual dysfunction, and may aggravate mental health issues. Continuation of cross-sex hormones, such as estrogen and testosterone, during adolescence and into adulthood, is associated with increased health risks including, but not limited to, high blood pressure, blood clots, stroke, heart attack, infertility, and some types of cancer.^{51,54,55,56,57,58,59,60}
3. Although some individuals report a sense of relief as they initiate the transitioning process, this is not always sustained or consistent over time. Some patients regret having undergone the transitioning attempt process and choose to detransition, which involves additional medical risk and cost.^{56,61,62,63,64}
4. Among individuals who identify as transgender, use cross-sex hormones, and undergo attempted gender reassignment surgery, there are well-documented increased incidences of depression, anxiety, suicidal ideation, substance abuse, and risky sexual behaviors in comparison to the general population.^{21,22,23,61,65,66,67} These health disparities are not prima facie evidence of healthcare system prejudice. These mental health co-morbidities have been shown to predate transgender identification.^{24,25,26,27,28,34,68} Patients' own gender- altering attempts and sexual encounter choices (or, in the case of children, their parents' choices on their behalf) are among the factors relevant to adverse outcomes in transgender-identified patients.
5. Although current medical evidence is incomplete and open to various interpretations, some studies suggest that surgical alteration of sex characteristics has uncertain and potentially harmful psychological effects and can mask or exacerbate deeper psychological problems.^{7,8,9,69} Evidence increasingly demonstrates that there is no reduction in depression, anxiety, suicidal ideation, or actual suicide attempts in patients who do undergo surgical transitioning compared to those who do not.^{7,70} The claim that sex-reassignment surgery leads to a reduction in suicide and severe psychological problems is not scientifically supported.^{64,71,72,73}
6. A patient has died because the medical records conveyed only the individual's gender

preference, and not their biological sex, leading to misdiagnosis and medical catastrophe.^{74,74}

E. Ethical

1. Restoring and preserving physical and mental health are goals of medicine, but assisting with or perpetuating psychosocial disorders are not. Accordingly, treatment of anomalous sexual anatomy is restorative.⁷⁵ Interventions to alter normal sexual anatomy and physiology to conform to identities arising from gender dysphoria are disruptive to health.^{9,76}
2. Medicine rests on science and should not be held captive to desires or demands that contradict biological reality. Sex reassignment operations are physically harmful because they disregard normal human anatomy and function. Normal anatomy is not a disease; dissatisfaction with natural anatomical and genetic sexual makeup is not a condition that
can be successfully remedied medically or surgically.
3. The medical status of gender identity disorder (currently termed gender dysphoria) as a mental or psychosocial disorder should not be discarded.
4. The inability of men, including men who identify as women, to bear children is not an illness to be remedied by medical or surgical means, such as uterine transplantation.⁷⁷ Uterine transplantation into biological men cannot be justified medically (See CMDA Statement on Enhancement and CMDA Statement on Transplantation).
5. Fundamentally, it is unrealistic to remove or mutilate normal organs and tissue and to disrupt normal physiology, and then to expect normal function. This illustrates the reality that complete gender transitioning is not medically possible.
6. Christian patients struggling with transgender inclinations face not only the psychological distress of a desire for a gender identity different from their biological sex, but may also face the spiritual distress that comes to anyone who follows a path in life that departs from God's design for humanity. Hormonal or surgical interventions cannot resolve spiritual distress but may lead to further spiritual turmoil. These, our neighbors, need and deserve the spiritual, psychological, and social support of the Christian community.
7. CMDA is especially concerned about the increasing phenomenon of parents enabling their gender-questioning children or adolescent minors to receive hormones to inhibit normal adolescent development. Children and adolescents lack the developmental cognitive capacity to assent or request such interventions, which have lifelong physical, psychological, and social consequences.⁵⁶ Facilitating hormonal or surgical transitioning interventions for those who have not reached the age of majority is a form of child endangerment and abuse.⁶⁴ Highly affirming parents have been shown to not improve the mental health statistics of transgender-identified children.⁷⁸
8. Many diseases affect men and women differently, according to biological sex

phenotype. Transgender designations may conceal biological sex differences relevant to medical risk factors, the recognition of which is important for effective healthcare and disease prevention. As accurate documentation is necessary for good patient care, healthcare professionals should document the patient's biological sex and any alterations of gender characteristics in the medical record.^{2,13,54,57,79,80,81} It is appropriate and should not be interpreted as disrespectful for healthcare professionals to discuss their patients' biological sex with them as part of their medical care.^{80,81}

9. For the overall health of the patient, the healthcare professional should be forthright with the patient that addressing the individual's sexual reality is necessary for appropriate medical care and should not be interpreted as disrespect.

CMDA Recommendations for the Christian Community

1. A person questioning or struggling with gender identity should evoke neither scorn nor enmity, but rather the Christian's concern, compassion, help, and understanding. Christians must respond to the complex issues surrounding gender identity with grace, civility, and love.
2. Christians should avail themselves of opportunities to help the larger society understand that male/female sexes are complementary and permanent. Both are good and part of the created order. For the reasons elaborated above, CMDA believes that attempting to define gender as fluid and changeable through technical means will have grave spiritual, emotional, cultural, and medical repercussions.
3. The Christian community, beginning with the Christian family, must resist stereotyping or rejecting individuals who do not fit the popular norms of masculinity and femininity. At the same time, parents should guide their children and adolescent minors in appropriate gender identity development. For children and adolescents experiencing gender dysphoria, the Christian community should provide appropriate role models and biblically informed guidance.
4. The Christian community must condemn hatred and violence directed against those struggling with questions of gender identity.
5. Since Christians are to love their neighbors as themselves, they are to love those struggling with gender dysphoria or incongruence of desired gender with biological sex. Love for the person does not condone or facilitate gender transitioning treatments.
6. In obedience to God who commands his followers to love one another, and for the sake of the common good, Christians should welcome inclusion of transgender-identified individuals into their communities, as we are all broken and sinners, not more or less valuable than each other. Transgender-identified individuals have the same rights shared by all other humans. We oppose granting special rights and privileges based on transgender identification. These special rights can negatively impact the rights of others (e.g., bathroom designations that allow biological males access to shared female restrooms or showers, female athletic competitions that give participating biological males an unfair physiologic advantage, affirmative actions, or claims for unnecessary

medical interventions).

7. The Christian community is to be a refuge of love for all who are broken – including the sexually broken – not to affirm their sin, nor to condemn, but to shepherd them to Jesus, who alone can forgive, heal, restore, and redirect to a godly, honorable, and virtuous way of life. God provides the remedy for all moral failure through repentance and faith in Jesus Christ and the life-changing power of the Holy Spirit. Though healing may be incomplete on earth, the promise of complete healing for those who are in Christ will ultimately be fulfilled in heaven.

CMDA Recommendations for Christian Healthcare Professionals

1. CMDA advocates that all Christian healthcare professionals provide ethically and medically competent care to all patients, including those who identify as transgender. Such care requires compassion, an open and trusting dialogue, a genuine effort to understand and respond to the patient's psychological distress when present, and acceptance of the person without agreeing with the person's ideology or providing a requested sex-altering intervention.
2. CMDA believes that the appropriate medical response to patients with gender dysphoria is to help them understand that they are people God loves and who are made in his image, even when their choices cannot be validated. Christian healthcare professionals should validate their right as individuals in a free society to make decisions for themselves. This right, however, does not extend to obligating Christian and other healthcare professionals to prescribe medication or perform surgical procedures that are harmful (see CMDA Statement on Healthcare Right of Conscience).
3. CMDA believes that Christian healthcare professionals should not initiate hormonal and surgical interventions that alter natural sex phenotypes. Such interventions contradict one of the basic principles of medical ethics, which is that medical treatment is intended to restore and preserve health, and not to harm.
4. CMDA believes that prescribing hormonal treatments to children or adolescents to disrupt normal sexual development for the purpose of attempting gender reassignment is ethically impermissible, whether requested by the child, the adolescent, or the parent (See CMDA Statement on Limits to Parental Authority in Medical Decision-Making, and CMDA Statement on Abuse of Human Life).
5. Supporting a patient's pursuit of gender transitioning procedures is neither loving nor the best means to help that individual who is experiencing gender dysphoria.

CMDA Recommendations Regarding Nondiscrimination

1. Mutual respect and civil discourse are cornerstones of a free society, and so is truthfulness. In the context of health care, identification of sex and gender has both interpersonal and medical implications. In regard to medical documentation, the medical record should document the sex observed at birth even when the patient expresses a different gender preference or has obtained a legal change in gender status.
2. Christian healthcare professionals, in particular, must care for their patients with gender identity disorders in a non-judgmental and compassionate manner, consistent with the

humility and love that Jesus modeled and commanded us to show all people. When questioning transgender ideology, Christian healthcare professionals should do so with an attitude of humility and love.

3. Those who hold to a biblical or traditional biological view of human sexuality, including CMDA members, should be permitted to question transgender ideology free from exclusion, oppression, or unjust discrimination. Healthcare professionals who hold the position that transgender identification is harmful and inconsistent with the will of God should not be stigmatized or accused of being bigoted, phobic, unprofessional, or discriminatory because of their desire to adhere to biological and medical reality as a sincerely held (and widely shared) belief.
4. To decline to provide a requested gender-altering treatment that is harmful, or is not medically indicated, does not constitute unjust discrimination against persons. CMDA affirms that Christian and other healthcare professionals should not be coerced or mandated to provide or refer for services they believe to be morally wrong or medically harmful to patients (See CMDA Statement on Healthcare Right of Conscience).
5. Healthcare professionals must not be prevented from providing counseling and support to patients with gender dysphoria and who request assistance with accepting and maintaining their biologic sex and gender identity.

GLOSSARY

Person and Image of God

According to the Bible, human persons (as opposed to divine and angelic persons) are embodied from conception onward. At conception, at least one genetically unique human person is formed (twinning may occur during the first two weeks of pregnancy). So the psalmist offers a hymn to God in Psalm 139, “you created my inmost being, you knit me together in my mother’s womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depth of the earth, Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be” (13-16 NIV). Human persons are, however, the only persons who are made in the *imago Dei* (image of God). Thus,

Jesus—fully God and fully human—is “image of the invisible God, the firstborn over all creation” (Colossians 1:15). Likewise, according to Genesis, “God created mankind in his own image, in the image of God he created them, male and female he created them” (Genesis 1:27).

Sex

Human sex and sexuality are aspects of God’s good, well-ordered creation. From the beginning he made humans sexual beings (Genesis 2:15-25). Humans are sexual beings who procreate through sexual reproduction. Sex is objective, identifiable, immutable, determined at conception, stamped on every nucleated cell, and highly consequential.^{82,83,84,85}

There are 2 sex cells or gametes, sperm and ova. There is no third. Human fallenness incurred pervasive distortions in humanity, including disorders of sexual biology, none of which limits either God’s love for each of us, or the inestimable value of creation in His image.

Sexuality

Human sexuality is a “very good” component of God’s well-ordered creation (Genesis 2:15-25). Sexuality is a broad and easily confusing term usually requiring contextualization for clear communication. As noted by McHugh and Mayer, sexuality incorporates desires,

attractions, behaviors, and/or identity.¹⁶ Furthermore, sexuality may vary regarding timing, intensity, consistency, and exclusivity. Its elements may be sporadic, temporary, pervasive, or long-term. Sexual expression may be healthful or unhealthful.

Because of human fallenness, sexuality has become disordered. The goods of sexuality are often distorted by pathologies in biology, psychology (e.g., sexual addiction or adultery), and society (e.g., sexual revolution and polyamory). Redeeming sex requires the reordering of human desires and practice. Celibacy outside of marriage, sexual fidelity within heterosexual marriage between one man and one woman, and the presumption in favor of procreation are ways human sex and sexuality may be redeemed.

Christian Worldview

A worldview is a way of seeing and understanding the phenomenon of the world around us. Like lenses of eyeglasses, one's worldview provides a set of interpretive assumptions that enable us to make sense of our experience. One's worldview is how one answers the big questions of life, such as: Is the world real? What is the nature of reality? Is there a God? What can we know about God? How do I know anything at all? Is matter all there is? Is there a supernatural? The orthodox Christian worldview is grounded on certain theological affirmations found in the Bible, which Christians believe to be the revealed word of God, and summarized in the great confessions in the history of Christianity, for instance, in the Nicene (325 AD) and Apostles (390 AD) Creeds.

The Fall and Human Fallenness

Rather than remaining faithful to God's will and purposes, Adam and Eve fell from their original righteous state through disobedience (i.e., sin). Their sin brought with it not only immediate deleterious consequences for them (Genesis 3), but for the entire created order thereafter. Those well-ordered desires to love God and love another have become disordered by human depravity. Love for God and others was replaced with hatred, envy, and murder (as in the case of Cain and Abel). The goods of honest labor were turned into toil and struggle in a creation that is now filled with corruption, death, disease, pain, and hardship. After the fall, human beings are born with a propensity to disobedience, selfishness, and sin.

Intrinsic Dignity

Because human beings are made in God's image, they possess an intrinsic dignity. They should never be used as a means to an end, but as ends in themselves. Their lives have sacred value and they should not be harmed without just cause. This dignity is intrinsic and equal for all human beings, not varied and dependent on level of function, cognitive or physical, presence or absence of injury or disability, age, or other traits or features for which human beings tend to impute upon others value or worth. Human dignity has been the foundation of Western ethics and jurisprudence and has been enshrined in secular language in the Nuremberg Code and global treaties in science, medicine, and public policy since that time.

Love

Christians are called to love God with all their hearts, souls, minds, and body and to love their neighbors as themselves (Deut 6:5; Lev 19:18; Mark 12:29-31). Love is a disposition of heart and life that impels one person to treat another person with respect and dignity quite apart from ethnicity, economic, social status, or what the individual can exploit or receive from the other. Furthermore, love seeks the best for another individual without the expectation any kind of recompense or remuneration.

Holiness

With respect to God, holiness is the supreme attribute of all of God's attributes, setting the God of the Bible apart from all other deities. The Triune God is holy in his love, righteousness, justice, wrath, and mercy (among other attributes). With respect to human beings and objects, holiness is being set apart for sacred use (as with the Old Testament

Temple). Christian holiness is the aspiration to live a life “set apart” from the corruptions of the world, and instead committed to fidelity, trust, and dependence on God, patterning ourselves after Jesus Christ.

Repentance

Repentance is a response to the recognition of harm done, either by commission or omission. The word used in the New Testament (metanoia) means to “turn and go in the other direction.” To repent, then, is to acknowledge one’s sin and turn back toward God. Turning back toward God may include ceasing to perform or pursue sinful acts, reconciling with those who have been harmed, or restoring items or relationships that have been damaged through one’s behavior. Repentance is not a one-time event, but a disposition of character.

Faith

Faith is the virtue of trust and dependence on God and his promises, believing and acting in ways consistent with that confidence (Hebrews 11).

Sexual Orientation

Orientation essentialism – the belief that a person has a given sexual orientation, be it innate or resulting from various combinations of biology and environment -- is an ideological position that has gained strong purchase in modern culture.

Per academics McHugh and Diamond, polar opposites in many ways:

Psychiatry professor Paul McHugh states, “Sexual orientation is a complex and amorphous phenomenon There is no scientific consensus on how to define sexual orientation, and the various definitions proposed by experts produce substantially different classes.”⁸³

Psychology professor Lisa Diamond, “There is currently no scientific or popular consensus . . . that definitively ‘qualify’ an individual as lesbian, gay, or bisexual.”⁸⁵

Genetic essentialism, like its orientation counterpart, is similarly ideological.

- • In a 2011 *Psychological Bulletin* Dar-Nimrod and Heine define genetic essentialism as,
“The tendency to infer a person's characteristics and behaviors from his or her perceived genetic makeup” (p. 801).⁸⁴ “Much of the ways that genes relate to human conditions can be described as weak genetic explanations” (p. 802).
- • Eric Turkheimer of UVA states, “...the amount of influence that genes have on behaviors is considerably smaller than one might think.”⁸⁴ And, “...genetic essentialists were wrong about gay genes and similar nonsense.”⁸³ Diamond and Rosky: “In essence, the current scientific revolution in our understanding of the human epigenome challenges the very notion of being “born gay,” along with the “born” with *any* complex trait. Rather, our genetic legacy is dynamic, developmental, and environmentally embedded.”⁸⁵

Same-sex attraction

Sexual attraction to members of the same sex. The propensity and degree may vary from near exclusive to occasional attraction, and is shown to potentially change over time. It does not preclude the same individual from experiencing varying degrees of attraction to members of the opposite sex.

Fornication

Per theologian Robert Gagnon “fornication,” likewise *porneia* in Greek, is frequently an overarching reference to sexual sin as defined in Torah. In more common usage, fornication is sexual intercourse between two people not married to each other. Sex between male and female is implied in the term’s reference to anatomy, fornix being

the curved vaginal recess created by the cervix and the term also being Latin for “arch.”

Fornication is separate from adultery or rape.

Temptation

A trial, being put to the test.

It is not yet sin, but an invitation to it.

Jesus “was in all *points* tempted as *we are, yet* without sin.” Hebrews 4:15. It is inherent to the fallen human condition.

“No temptation has overtaken you except such as is common to man; ...” I Corinthians 10:13.

God tests individuals.

Abraham (Genesis 22:1), Job (Job 23:10), I Corinthians 11:32, Hebrews 12:4-11, etc.

Satan tempts individual to sin.

Matthew 4:3, I Thessalonians 3:5. God provides means of rescue.

“*then* the Lord knows how to deliver the godly out of temptations...” 2 Peter 2:9. “...but God *is* faithful, who will not allow you to be tempted beyond what you are able, but with the temptation will also make the way of escape, that you may be able to bear *it*.” I Corinthians 10:13.

Scripture describes temptation as something to be avoided if possible: “And do not lead us into temptation...” Matthew 6:13.

“Watch and pray, lest you enter into temptation.” Mark 14:38.

Sexual Fantasy - when does it cross into sin?

Temptation is not yet sin. Everyone has a sex drive and the duty to manage it.

Experiencing sexual thoughts is not yet fantasy, or lust, unless willingly pursued. Some have compared the appearance of sexual thoughts to a bird flying over one’s head, thus out of our control; and fantasy or lust is compared to the equivalent of allowing that bird to build a nest on our head, something clearly in our power to resist.

Same-sex attraction chaste life - does it include avoidance of kissing? Is this equal to homosexual celibacy?

This is a multi-faceted question.

1. Scripture speaks of greeting each other with “a holy kiss” (Romans 16:16, I Corinthians 16:20), which is a salutation, something non-sexual.

Greeting with a kiss is a pervasive practice in the general cultures of several nations to this day. 2. The kissing implicit in the stated question is sexual, romantic.

There is no part of homosexual practice that is endorsed in scripture; it is condemned without exception.

3. Though we mean abstinence from homosexual practices when we say, “homosexual celibacy,” the application of the term “celibate” to same-sex sexual practice is Biblically problematic. Lifetime celibacy is referred to as a “gift” by the Apostle Paul in I Corinthians 7:7-9.

A Celibate person is giving up the God-ordained institution of marriage (exclusively between one man and one woman in scriptural standards) along with its God-ordained sexual practice. God gifts, or graces, that person with something else God-ordained in its place. But a person setting aside same-sex sexual practice is abstaining from or repenting of a sinful practice, which is both commanded and its own benefit. We wish to avoid canonizing homosexual temptation.

Same-sex lifestyle

The willing practice of same-sex sexuality.

Gay culture

Any assemblage of like-minded people creates a culture. Culture itself is a neutral term that gains a moral dimension in its practice. Gay culture endorses the ideological concept of gay identity along with its practices.

Scripturally and scientifically, we hold that sexuality is a verb and not just a noun. Gay and straight are category errors and false identities. Homosexuality by any name is a practice and not an identity, what one does and not who one is.

Likewise, “gay Christian” language canonizes temptation behind a false identity. Any name preceding “Christian” is an implicit priority, contravening Paul’s instruction to the Galatian church (Gal. 3:28).

Homophobia, -ic

Homophobia is an ideological and pejorative term that has gained common usage. It is often an accusation made against an individual failing to sufficiently celebrate same-sex sexuality, practices and politics.

But per MayoClinic.org: “A phobia is an overwhelming and unreasonable fear of an object or situation . . . a phobia is long lasting, causes intense physical and psychological reactions, and can affect your ability to function normally at work or in social settings.”

Disagreement is clearly not a phobia.

Linguistically, “homophobia” is somewhat nonsensical, meaning “fear of the same thing.”

Gender vs Sex

Sex is biological and stamped on every nucleated cell in a person’s body from conception onward. It is immutable down to the level of brain cells, so it is impossible to have “a man’s brain in a woman’s body,” for example.

Gender, in its common current usage, is an engineered term leveraging linguistics against biology; it is ideological and self-declared.

Historically, however, per theologian Christopher West:

“The root “gen”—from which we get words such as generous, generate, genesis, genetics, genealogy, progeny, gender, and genitals—means “to produce” or “give birth to.” A person’s gen-der, therefore, is based on the manner in which that person is designed to gen-erate new life. Contrary to widespread secular insistence, a person’s gender is not a malleable social construct. Rather, a person’s gender is determined by the kind of genitals he or she has.”⁸⁶

But ideology does not bow to history. Sex is biology, and gender is ideology.

Gender Identity

Gender identity is a feeling, a self-perception, of how one identifies with their biological sex or not, and it is often a sex stereotype. It is subjective, self-declared and fluid. Psychologist Dr. John Money of Johns Hopkins initiated its use in professional journals in 1955, referring to “the identity of the inner sexed self.”⁸⁷

Gender Confusion/Dysphoria

Gender identity confusion/dysphoria is a feeling/self-perception that one’s biology is not as one

wishes it to be or not as one identifies most comfortably as. Sechner notes, “A gender-dysphoric youth experiences a sense of incongruity between the gender expectations linked to her or his biological sex and her or his biological sex itself.”⁸⁸

The greater the discomfort/dissonance, the greater the dysphoria. Gender dysphoria is not synonymous with transgenderism, the latter being an umbrella term within which gender dysphoria fits, but to which transgenderism is not limited.

Gender - Should we be using that term or is there a better term? If so, how is it best defined?

The answer to that depends on the application and one must be careful.

Gender is an engineered term leveraging linguistics against biology; it is ideological and self-

declared. Sex is biological, right down to each human cell containing a nucleus. Though gender is sometimes used synonymously with sex (e.g., in forms asking if someone is male or female), ideologically it is considered separate and distinct from sex (e.g., “your sex is irrelevant to your gender identity”) in a manner that is quite Gnostic (i.e., the “higher knowledge” that transcends lowly biology).

Therefore, it is best to mean what you say and say what you mean in context. Using phrases like “identified gender,” “identifies as,” “gender incongruence,” “gender dysphoria,” “transgender identified,” etc. work well, don’t surrender reality to a claim, and do not imply agreement.

Best terminology for gender transition?

That depends on the intended usage.

“Transition efforts” or “transition-affirming treatments/procedures” are both quite clear and do not surrender to ideology as compared to terms like “gender-affirming” or “gender confirming” treatments and procedures.

Best terminology for transgender identity?

“Transgender-identified” or “transgender identification” are well understood and non-capitulating.

A final comment on language

Terms should be as descriptively accurate as possible while avoiding ideological programming. For instance, because an individual’s intrinsic sex cannot be changed, and gender is essentially a biologically meaningless term or concept aside from biological sex, terms such as “transgender identity,” as if it were an objective reality, should be replaced by “transgender-identified, - identifying, or -identification,” which are descriptively accurate. Similarly, because “gender transition” is not ontologically or biologically possible, more descriptively accurate terms, such as, “attempted transition efforts,” or “attempted transition-affirming treatments or procedures,” are more accurate and preferred.

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Passed with 54 approvals, 0 opposed, 0 abstention

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References

1. 2. 3.

Journal Of Social Research Methodology, 23 5.

Exploring the Biological Contributions to Human Health:

Does Sex Matter?

Hyde JS, Bigler RS, Joel D, Tate CC, van Anders SM. The future of sex and gender in psychology: Five challenges to the gender binary.

Hyde, Bigler, Joel, Tate, and van Anders (2019).

Am Psychol

. 2019;74(2):171-193. doi:10.1037/amp0000307

Cretella MA, Rosik CH, Howsepian AA. Sex and gender are distinct variables critical to health: Comment on

Am Psychol

. 2019;74(7):842-844. doi:10.1037/amp0000524

Institute of Medicine (US) Committee on Understanding the Biology of Sex and Gender Differences,

Wizemann, T. M., & Pardue, M. L. (Eds.). (2001).

. National Academies Press (US).

4. Sullivan, A. (2020). Sex and the census: why surveys should not conflate sex and gender identity.

(5), 517-524. <https://doi.org/10.1080/13645579.2020.1768346>

Anckarsäter, H., & Gillberg, C. (2020). Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery.

<https://doi.org/10.1176/appi.ajp.2020.19111117>

(8), 764–765.

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

Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden.

2011;6(2):e16885. Published 2011 Feb 22. doi:10.1371/journal.pone.0016885

Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender-Affirming Surgeries: A Comment by the Editor on the Process.

. 2020;177(8):764.

doi:10.1176/appi.ajp.2020.20060803

6. 7.

8.

Linacre Quarterly, 87

American Journal of Psychiatry, 177

International

The

PLoS One. Am J Psychiatry

Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence.

Am J Psychiatry

. 2020;177(8):765–766. doi:10.1176/appi.ajp.2020.19111130

Biggs M. Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria.

2020;49(7):2227–2229. doi:10.1007/s10508-020-01743-6

Davis SR, Baber R, Panay N, et al. Global Consensus Position Statement on the Use of Testosterone Therapy for Women.

. 2019;104(10):4660–4666. doi:10.1210/jc.2019-01603

Giovannetti, B., 2014.

Endurant Press, p.178.

. San Francisco:

Bartz D, Chitnis T, Kaiser UB, et al. Clinical Advances in Sex- and Gender-Informed Medicine to Improve the Health of All: A Review.

Association, p.829.

. 2020;180(4):574–583. doi:10.1001/jamainternmed.2019.7194

2013.

. Arlington, VA: American Psychiatric

Tournaye H. Is there any reproductive future left for men?.

9.

10.

11.

12.

13.

14.

15. 16.

Arch Sex Behav.

J Clin Endocrinol Metab

Four Letter Words: Conversations On Faith's Beauty And Logic

JAMA Intern Med

Diagnostic And Statistical Manual Of Mental Disorders

Facts Views Vis Obgyn. 2012;4(4):255–

258. MayerLS,McHughPR.SexualityandGender:FindingsfromtheBiological,Psychological,andSocial Sciences. *New Atlantis* (2016); 50:10–143. At pp.89–90. 17.

Beale JM, Creighton SM. Long-term health issues related to disorders or differences in sex development/intersex.

Maturitas

. 2016;94:143–148. doi:10.1016/j.maturitas.2016.10.003

Sax L. How common is intersex? a response to Anne Fausto-Sterling.

. 2002;39(3):174-178.

doi:10.1080/00224490209552139

Ślowikowska-Hilczek J, Hirschberg AL, Claahsen-van der Grinten H, et al. Fertility outcome and information on fertility issues in individuals with different forms of disorders of sex development: findings from the dsd-LIFE study.

. 2017;108(5):822-831. doi:10.1016/j.fertnstert.2017.08.013

Van Mol, A., 2019.

. [online]

Christian Medical & Dental Associations. Available at: <<https://cmda.org/intersex-what-it-is-and-is-not/>> [Accessed 11 November 2020].

18. 19.

20. 21.

J Sex Res

Fertil Steril

Intersex: What It Is And Is Not – Christian Medical & Dental Associations

Some professional organizations appear to acknowledge the same, even if they generally claim gender-sex discordance is normal. The World Professional Association for Transgender Health says in its Standards of Care that "gender dysphoria" may be "secondary to, or better accounted for by, other diagnoses." (Wpath.org.

Standard Of Care For The Health Of Transsexual, Transgender, And Gender Nonconforming People.

) The British Psychological Society says, "In some cases the reported desire to change sex may be symptomatic of a psychiatric condition

for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger's syndrome...."

(Shaw L, Butler C, Langdridge D, et al. Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. British Psychological Society Professional Practice Board. Leicester, UK,

2012, p. 26 [Accessed online 16 January 2021 at: <https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf>]) The American

Psychological Association's APA Handbook of Sexuality and Psychology allows for the possibility that pathological family of origin dynamics may be causal. (

2012.

[online] Available at:

<https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf?_t=1604581968> [Accessed 11 November 2020]. p24

Pfaus, J. and Ward, L., 2014.

Association, p.743.

Bechard M, VanderLaan DP, Wood H, Wasserman L, Zucker KJ. Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study.

. 2017;43(7):678-688.

doi:10.1080/0092623X.2016.1232325

Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: A review of the literature.

Int Rev Psychiatry

. 2016;28(1):44-57. doi:10.3109/09540261.2015.1115753

Hanna B, Desai R, Parekh T, Guirguis E, Kumar G, Sachdeva R. Psychiatric disorders in the U.S. transgender population.

Ann Epidemiol

. 2019;39:1-7.e1. doi:10.1016/j.annepidem.2019.09.009

Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development.

. 2015;9:9. Published 2015 Apr 9. doi:10.1186/s13034-015-0042-y

Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers.

. 2018;141(5):e20173845. doi:10.1542/peds.2017-3845

22.

23. 24. 25.

Ment Health

26.

J Sex Marital Ther

Child Adolesc Psychiatry

)

APA Handbook Of Sexuality And Psychology

Pediatrics

Tolman, D., Diamond, L., Bauermeister, J., George, W.,

. American Psychological

27. 28.

29.

30.

31. 32. 33. 34. 35.

36. 37.

38. 39.

40. 41.

42. 43.

44. 45.

Annu Rev Clin Psychol. 2016;12:217- *PLoS One.*

Guidelines And Literature Review For Psychologists Working Therapeutically With Sexual And Gender Minority Clients

E.Coleman,W.Bockting,M.Botzer,P.Cohen-Kettenis,G.DeCuypere,J.Feldman,L.Fraser,J.Green,G. Knudson, W. J. Meyer, S. Monstrey, R. K. Adler, G. R. Brown, A. H. Devor, R. Ehrbar, R. Ettner, E. Eyler, R. Garofalo, D. H. Karasic, A. I. Lev, G. Mayer, H. Meyer-Bahlburg, B. P. Hall, F. Pfafflin, K. Rachlin, B. Robinson, L. S. Schechter, V. Tangpricha, M. van Trotsenburg, A. Vitale, S. Winter, S. Whittle, K. R. Wylie & K. Zucker (2012) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, International Journal of Transgenderism, 13:4, 165-

232, DOI: 10.1080/15532739.2011.700873

J Neuroendocrinol.

2018;30(7):e12562. World.2020.*Fightingtoletaboybeaboy*. [online] Available at: [https://wng.org/roundups/fighting-to-let-a-](https://wng.org/roundups/fighting-to-let-a-boy-be-a-boy-1617220961)

Zucker KJ, Lawrence AA, Kreukels BP. Gender Dysphoria in Adults.

247. doi:10.1146/annurev-clinpsy-021815-093034

Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender

dysphoria [published correction appears in PLoS One. 2019 Mar 19;14(3):e0214157].

2018;13(8):e0202330. Published 2018 Aug 16. doi:10.1371/journal.pone.0202330

Bps.org.uk. 2012.

. [online] Available at: <[https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-](https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf)

<https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf>> [Accessed 11 November 2020].

Roselli CE. Neurobiology of gender identity and sexual orientation.

doi:10.1111/jne.12562

[boy-be-a-boy-1617220961](https://doi.org/10.1111/jne.12562) [Accessed 26 April 2021].

Psychiatry

LisaMarchiano(2017)Outbreak:OnTransgenderTeensandPsychicEpidemics,Psychological Perspectives, 60:3, 345-366, DOI: 10.1080/00332925.2017.1350804

Can J

Bradley SJ, Zucker KJ. Gender identity disorder and psychosexual problems in children and adolescents.

. 1990;35(6):477-486. doi:10.1177/070674379003500603

Anderson, R., 2018.

. [online]

The Heritage Foundation. Available at: <<https://www.heritage.org/gender/commentary/transgender-ideology->

riddled-contradictions-here-are-the-big-ones> [Accessed 11 November 2020].

Hilton, C., 2020.

Opinion | The Dangerous Denial Of Sex

. [online] WSJ. Available at:
<<https://www.wsj.com/articles/the-dangerous-denial-of-sex-11581638089>> [Accessed 11 November 2020].

Medium. 2017.

Transgender Ideology Does Not Support Women

. [online] Available at:
<<https://medium.com/@mirandayardley/transgender-ideology-does-not-support-women-2d00089e237a>> [Accessed 11 November 2020].

Gender Health Query. n.d.

Transgender Ideology Is Riddled With Contradictions. Here Are The Big Ones.

Many LGBT People Do Not Agree With Gender Queer Theory & Scientific Validity Taught In Schools — Gender Health Query

I'M A Pediatrician. How Transgender Ideology Has Infiltrated My Field And Produced Large-Scale Child Abuse.

. [online] Available at: <<https://www.genderhq.org/trans-youth-controversial-schools-lgbt-science-dysphoria>> [Accessed 11 November 2020].

The Daily Signal. 2017.

. [online] Available at: <<https://www.dailysignal.com/2017/07/03/im-pediatrician-transgender-ideology-infiltrated-field-produced-large-scale-child-abuse/>> [Accessed 11 November 2020].

Olver T. Disaffirming Gender: Somatic Incongruence as a Co-function of Ideological Congruity.

. 2019;106(1):1-28. doi:10.1521/prev.2019.106.1.1

2019.

Available at: <<https://www.washingtonpost.com/opinions/2019/05/13/california-wants-teach-kindergartners-about-gender-identity-seriously/>> [Accessed 11 November 2020].

. [online]

about-gender-identity-seriously/> [Accessed 11 November 2020].

Doward, J., 2019.

. [online] the Guardian. Available
at: <<https://www.theguardian.com/society/2019/jul/27/trans-lobby-pressure-pushing-young-people-to-transition>> [Accessed 11 November 2020].

Heritage.org. 2019.

. [online] Available at: <<https://www.heritage.org/sites/default/files/2019-05/BG3408.pdf>> [Accessed 11 November 2020].

Rev

OlsenH. *CaliforniaWantsToTeachKindergartnersAboutGenderIdentity.Seriously. Politicised Trans Groups Put Children At Risk, Says Expert*

JonesA,KaoE. *SexualIdeologyIndoctrination:TheEqualityActsImpactOnSchool Curriculum And Parental Rights*

OmercajicK,MartinoW. *Supportingtransgenderinclusionandgenderdiversityinschools:acriticalpolicy analysis. Frontiers in Sociology* 2020; 5:27.

<https://doi.org/10.3389/fsoc.2020.00027> Friestad,T.,2018.*BeingMila:CreatingAnLgbtqCurriculumThatIsAuthentic,FollowsPoliciesAndEthics, And Teaches Acceptance*

Psychoanal

. [online] DigitalCommons@Hamline. Available at:
<https://digitalcommons.hamline.edu/hse_cp/196?utm_source=digitalcommons.hamline.edu/hse_cp/196> [Accessed 11 November 2020].

46. 47.

48. 49. 50. 51. 52.

53. 54.

55. 56. 57. 58. 59. 60. 61.

62.

63. 64. 65. 66.

DeeKnoblauch(2016)BuildingtheFoundationofAcceptanceBookbyBook:Lesbian,Gay,Bisexual,and/or Transgender-Themed Books for Grades K–5 Multicultural Libraries, Multicultural Perspectives, 18:4, 209- 213, DOI: 10.1080/15210960.2016.1228325

LGB Alliance Founder Criticises RSE Lessons

Diagnostic And Statistical Manual Of Mental Disorders. Arlington, VA: American Psychiatric APA Handbook Of

Christian Concern. 2020.
 . [online] Available at:
<https://christianconcern.com/comment/lgb-alliance-founder-criticises-rse-lessons/> [Accessed 11 November 2020].
 2013.
 Association, p.455.
 Tolman, D., Diamond, L., Bauermeister, J., George, W., Pfaus, J. and Ward, L., 2014.
 . Washington D.C: American Psychological Association, p.774.
 Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights.
J Sex Med
 . 2008;5(8):1892-1897. doi:10.1111/j.1743-6109.2008.00870.x
 Ristori J, Steensma TD. Gender dysphoria in childhood.
 . 2016;28(1):13-20.
 doi:10.3109/09540261.2015.1115754
 Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in J Clin Endocrinol Metab. 2018 Feb 1;103(2):699] [published correction appears in J Clin Endocrinol Metab. 2018 Jul 1;103(7):2758-2759].
 . 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658
Sexuality And Psychology
J Clin Endocrinol Metab
Int Rev Psychiatry

 Kenneth J. Zucker (2018) The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018), International Journal of Transgenderism, 19:2, 231-245, DOI: 10.1080/15532739.2018.1468293

 Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline".
 . 2019;104(3):686-687. doi:10.1210/jc.2018-01925
 Safer JD, Tangpricha V. Care of Transgender Persons.
 . 2019;381(25):2451-2460.
 doi:10.1056/NEJMc1903650
 Levine SB. Informed Consent for Transgendered Patients.
 doi:10.1080/0092623X.2018.1518885
 Shatzel JJ, Connelly KJ, DeLoughery TG. Thrombotic issues in transgender medicine: A review.
 . 2017;92(2):204-208. doi:10.1002/ajh.24593
 Vumc.org. 2012.
 Getahun D, Nash R, Flanders WD, et al. Cross-sex Hormones and Acute Cardiovascular Events in Transgender
 . [online] Available at:
<https://www.vumc.org/lgbtq/key-transgender-health-concerns> [Accessed 12 November 2020].
 Persons: A Cohort Study.
Ann Intern Med
 . 2018;169(4):205-213. doi:10.7326/M17-2785
 Goodman, M., 2018. [online] Pcori.org. Available at: <https://www.pcori.org/sites/default/files/PCORI-Goodman076-English-Abstract.pdf> [Accessed 11 November 2020].
 Heyer, W. 2019. Usatoday.com. 2019. Hor
 . [online] Available at:
<https://www.usatoday.com/story/opinion/voices/2019/02/11/transgender-debate-transitioning-sex-gender-column/1894076002/> [Accessed 11 November 2020].
Endocrinol Metab
Hematol
N Engl J Med
J Sex Marital Ther. 2019;45(3):218-229.
Time I Can 'T Get Back.

International Association of Therapists for Transgender and Gender-Diverse People. (2020). *Introduction to Detransition for Therapists*. [online]. Available at: https://iatdd.com/introduction-to-detransition-for-therapists/?fbclid=IwAR2bsQ-ojdFi7Zyzow_RNCdCd34eGU_flce_x8mfRpH3s0DRp91PwwONkto [Accessed 4/26/2021]. SkyNews. (2019). 'Hundreds' of Young Trans People Seeking Help to Return to Original Sex. [online]. Available at: <https://news.sky.com/story/hundreds-of-young-trans-people-seeking-help-to-return-to-original-sex-11827740>. [Accessed 4/26/2021].

Horvath H. "The Theatre of the Body: A Detransitioned Epidemiologist Examines Suicidality, Affirmation, and Transgender Identity". [online]. Available at: <https://4thwavenow.com/2018/12/19/the-theatre-of-the-body-a-detransitioned-epidemiologist-examines-suicidality-affirmation-and-transgender-identity/>. Accessed 4-26-2021.

The Medical Clinics of North America, 103
J Clin
Key Transgender Health Concerns | Program For LGBTQ Health
mones, Surgery, Regret: I Was A Transgender Woman For 8 Years-
Am J

Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study [published correction appears in *Am J Psychiatry*. 2020 Aug 1;177(8):734].

Am J Psychiatry

. 2020;177(8):727-734. doi:10.1176/appi.ajp.2019.19010080

Schulman, J. K., & Erickson-Schroth, L. (2019). Mental Health in Sexual Minority and Transgender Women.

(4), 723–733. <https://doi.org/10.1016/j.mcna.2019.02.005>

Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017.

. 2019;109(1):e1-e8. doi:10.2105/AJPH.2018.304727

Levine SB, Solomon A. Meanings and political implications of "psychopathology" in a gender identity clinic: a report of 10 cases.

J Sex Marital Ther

. 2009;35(1):40-57. doi:10.1080/00926230802525646

Levine SB. Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria.

2018;44(1):29-44. doi:10.1080/0092623X.2017.1309482

Malone WJ, Roman S. Calling Into Question Whether Gender-Affirming Surgery Relieves Psychological Distress.

Am J Psychiatry

. 2020;177(8):766-767. doi:10.1176/appi.ajp.2020.19111149

Tucker RP. Suicide in Transgender Veterans: Prevalence, Prevention, and Implications of Current Policy.

Perspect Psychol Sci

. 2019;14(3):452-468. doi:10.1177/1745691618812680

Wold A. Gender-Corrective Surgery Promoting Mental Health in Persons With Gender Dysphoria Not Supported by Data Presented in Article.

. 2020;177(8):768.

doi:10.1176/appi.ajp.2020.19111170

67.

Public Health

68.

69. 70. 71. 72.

73.

74.

75.

76.

77.

78.

79.

80.

81.

82.

83.

84. 85.

86. 87.

88.

Am J

J Sex Marital Ther.

Am J Psychiatry

Wiepjes CM, den Heijer M, Bremmer MA, Nota NM, de Block CJM, Coumou BJG, Steensma TD. Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017). *Acta Psychiatr Scand.* (2020); 141(6):486-491.

Stroumsa D, Roberts EFS, Kinnear H, Harris LH. The Power and Limits of Classification - A 32-Year-Old Man with Abdominal Pain.

N Engl J Med

. 2019;380(20):1885-1888. doi:10.1056/NEJMp1811491

Bangalore Krishna K, Houk CP, Lee PA. Pragmatic approach to intersex, including genital ambiguity, in the newborn.

Semin Perinatol

. 2017;41(4):244-251. doi:10.1053/j.semperi.2017.03.013

Dhejne, C., Oberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets.

1545. <https://doi.org/10.1007/s10508-014-0300-8>

(8), 1535–

Jones BP, Williams NJ, Saso S, et al. Uterine transplantation in transgender women.

156. doi:10.1111/1471-0528.15438

Schumm WR, Crawford DW. Is Research on Transgender Children What It Seems? Comments on Recent Research on Transgender Children with High Levels of Parental Support.

. 2020;87(1):9-24.

doi:10.1177/0024363919884799

Orwh.od.nih.gov. n.d.

. [online] Available at:

<<https://orwh.od.nih.gov/sex-gender/nih-policy-sex-biological-variable-sabv/questions-answers>> [Accessed 11 November 2020].

Huey, N., 2018.

. [online] Science in the News. Available at: <<http://sitn.hms.harvard.edu/flash/2018/treating-men-and-women-differently-sex-differences-in-the-basis-of-disease/>> [Accessed 11 November 2020].

Madsen, T., Bourjeily, G., Hasnain, M., Jenkins, M., Morrison, M., Sandberg, K., Tong, I., Trott, J., Werbinski, J. and McGregor, A., 2017. Article Commentary: Sex- and Gender-Based Medicine: The Need for Precise Terminology.

, 1(3), pp.122-128.

The News

Archives of Sexual Behavior, 43

BJOG. 2019;126(2):152-

Linacre Q

Questions & Answers | Office Of Research On Women's Health

Treating Men And Women Differently: Sex Differences In The Basis Of Disease - Science In

Gender and the Genome

Mayer, L. and McHugh, P. R. Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences. *The New Atlantis*. Number 50, Fall 2016., pp 7-9.

McHugh, Paul R. Amicus Brief to the SCOTUS for *Obergefell v. Hodges*. Dar-

Nimrod, I. & Heine, S. J. "Some thoughts on essence placeholders, interactionism, and heritability: Reply to Haslam (2011) and Turkheimer (2011). *Psychological Bulletin*. (2011) 137(5): 829 – 833.

Diamond, L. M. & Rosky, C. J. "Scrutinizing Immutability: Research on Sexual Orientation and US Legal Advocacy for Sexual Minorities." *Journal of Sex Research*. (2016) 00: 1-29.

West, Christopher. *Our Bodies Tell God's Story*. Grand Rapids: Brazos Press. 2020. p. 28.

Money, John. "Hermaphroditism, gender and precocity in hyperadrenocorticism: psychological findings." *Bulletin of the Johns Hopkins Hospital*. (1955) 95(6): 252-264.

Shechner, Tomer. "Gender Identity Disorder: A Literature Review from a Developmental Perspective." *Isr. J of Psychiatry & Related Sci.* (2010) 47: 132-138.



CMDA Ethics Statement

Transgender Identification

Preamble

A novel way of thinking about one's body has entered into popular culture. "Transgender" individuals refer to their "gender" as a sexual identity that may be male or female, something in between, or neither. This self-identification differs from, and takes priority over, their biological sex as recognized in their chromosomal DNA and innate physical sexual characteristics. The naming of gender as a category set apart from sex is an idea foreign to the holistic view of the person as understood within Christianity. Christians affirm the biblical understanding of humankind as having been created male and female, with the two sexes having equal dignity and a complementary relationship to each other.

At the heart of disagreement over transgenderism is a difference in worldviews. If the human body is nothing more than the product of mindless, random, purposeless physical forces, then one may do with it what one wishes, even to demand medical and surgical cooperation in projects to alter, amputate, or reconstruct normal tissue to conform to the patient's revised psychological sense of identity. If, on the other hand, our bodies are an inseparable aspect of our true selves and are a good gift from God, who has designed the sexes to be wonderfully paired, and who has a purpose for humanity, then respecting the gift of given sexual identity and the ensuing moral obligations to our neighbors is the surest path to human flourishing.

Both worldviews share the recognition that humanity is broken and in need of renewal, but they look to different answers for healing. Christians seek not a reconfiguring of the body, but a spiritual transformation of the mind to become more like Christ; not rejecting the gifts of God, but welcoming God's purposes and demonstrating God's love by loving our neighbors. This love of neighbors includes loving our transgender neighbors as persons who, like all people, are created in God's image. However, loving them and validating them as people does not mean agreeing with their ideologies or use of language.

The Christian Medical & Dental Associations (CMDA) believes that healthcare professionals should not be forced to violate their conscientious commitment to their patients' health and welfare by being required to accept and participate in harmful gender-transition interventions, especially on the young and vulnerable. CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion, consistent with the humility and love that Jesus modeled and commanded us to show all people.

Introduction

CMDA affirms that all human beings are created in the image of, and beloved by, God. All human beings are our “neighbors”, and are to be loved by us as we love ourselves. All human beings possess intrinsic dignity and are worthy of equal respect and concern from Health Care Professionals.

CMDA considers “sex” (i.e., male or female) to be an objective biological fact (see section B.1. below). CMDA affirms the historic understanding of gender as referring to biological sex and the enduring biblical understanding of humankind as having been created male and female and that this is good. CMDA acknowledges the current cultural use of the word “gender” to refer to one’s sense of identity as male or female. CMDA cannot support the recent usage of the term “gender” to emphasize an identity other than one’s biological sex, that is, a subjective sense of self based on feelings or desires leading to identifying somewhere on a fluid continuum of gender identity.^{1,2,3,4} (See Glossary at the end of this document)

CMDA cannot support the prevailing culture’s acceptance of an ideology of unrestrained sexual self-definition that, in celebrating gender fluidity and gender transition efforts, is indifferent to biological reality and opposed to the biblical understanding of human sexuality. Further, CMDA is alarmed that some proponents of transgender ideology, through activism and intimidation, are insisting that healthcare professionals cooperate with and affirm their beliefs in gender fluidity, even if the healthcare professionals believe that such cooperation and affirmation would be doing harm to their patients. This violates the most fundamental core value of medicine since Hippocrates, that of caring only for the good and benefit of the patient while abstaining from all unnecessary harm. The evolving scientific and medical facts demonstrate that the mutilation of normal tissue and profound disruption of normal physiology that occur during gender transition procedures are very difficult to justify, as this constitutes deliberate harm.

CMDA affirms the obligation of Christian healthcare professionals caring for patients struggling with gender identity to do so with sensitivity and compassion. CMDA holds that attempts to radically reconstruct one’s body surgically or hormonally for psychological indications, however, are medically, ethically, and psychologically inappropriate. These measures alter healthy tissue and increasingly are not supported by scientific research evaluating behavioral, medical, and surgical outcomes.^{5,6,7,8,9,10,11}

Accordingly, CMDA opposes medical assistance with gender transition on the following grounds:

A. Biblical

1. God created humanity as male and female (Gen 1:27, 5:2; Matt 19:4; Mark 10:6). God’s directives – to have dominion over the earth and to fulfill his goals of procreation, union, fellowship, and worship – are given to men and women together (Gen 1:26-28, 2:18-24).
2. Men and women are morally and spiritually equal (Gal 3:28) and are created to have roles that are in some respects alike and in other respects wonderfully complementary (Eph 5).
3. All people are loved by God (John 3:16-17). All struggle with moral failure and fall short of God’s standards (Rom 3:10-12) and, therefore, need the forgiveness that God provides through Christ alone (John 3:36; Rom 3:22-24; Col 1:15-22; 1 Tim 2:5-6).
4. For the Christian, all of ethics, grounded in God’s moral law, is based upon the first and

second greatest commandments: to love God with all our heart, soul, and mind, and to love our neighbors as ourselves (Matt 22: 37-40). If we encourage others to sin sexually, just as if we sin sexually ourselves, we are violating these two commandments. We violate the first greatest commandment by failing to love God in his holiness, wisdom, and rightful place as our Creator, and we violate the second greatest commandment as we fail to respect ourselves and each other by abetting lives of disobedience, deception and unholiness (1 Cor 6: 13b-20). Love may include a corrective component that should be applied in an appropriate and timely manner; affirmation can be enablement.

5. We live in a fallen world (Gen 3), and we all come into this world as fallen creatures with a sinful nature. (Rom 3:9-12). The fall is expressed in nature and in humanity in many ways, including sexuality. Confusion of gender identity is but one example of the fall, as are also marital breakdown and sexual immorality (Rom 1:24-32; Eph 5:3).
6. A lifestyle that is directed by pursuing sexual desires, or driven by personal sexual fulfillment, misses the divinely ordained purpose of sex, which is for procreation, bond creation, and re-creation¹² and for facilitating unity in the lifelong commitment of marriage, which is defined as being between one man and one woman. Heterosexual marriage fosters a secure and nurturing environment for children and it reflects the unity of Christ and the Church (Exod 20:1-18; Lev 20:10-21; Rom 1; Eph 5:23-33) (see also CMDA Statement on Homosexuality).
7. Believers in Christ, though having inherited the sinful nature common to all humanity, also receive a new nature in Christ. As the old nature, being crucified with Christ, dies, our new redeemed nature, sealed by Christ's bodily resurrection, is actively transforming our minds and hearts to be more and more like Christ. This transformation is spiritual, not sexual, and is God's work, not something of our own design (Psalm 100:3; Rom 12:2; Col 1:27).

B. Biological

1. Sex is an objective biological fact that is determined genetically at conception by the allocation of X and Y chromosomes to one's genome, is observable at birth, is found in every nucleated cell, and is immutable throughout one's lifetime. Sex is not a social construct arbitrarily assigned at birth and cannot be changed at will.^{2,3,13}
2. Human beings are sexually dimorphic. Male and female phenotypes are the outworking of sex gene expression, which shapes sex anatomy, determines patterns of sex hormone secretion, and influences sex differences in the development of the central nervous system and other organs.^{2,3,14}
3. Procreation requires genetic contributions from both one man and one woman.^{15,16}
4. CMDA recognizes that exceedingly rare congenital abnormalities exist in which phenotypic sex characteristics are not what is expected from the genotype.^{1,2} These disorders of sex development are of a diverse nature, but usually impair fertility.³ Treatment (including non-intervention) of these disorders differs categorically from transgender interventions, which are performed on persons with no inherent defect in sex organ development, function, or fertility. Anomalies of human biological sex are conditions rather than identities, something one has rather than who one is.⁴ Disorders of sex development are not the fault of the patient, do not invalidate God's design in creation, and do not constitute a third sex.^{17,18,19,20}
5. Gender dysphoria²¹, the condition of experiencing discomfort or distress at one's sex and preferring a different "gender" identity, has not to date been linked to a genetic cause and

is a psychological disorder of unclear and complex origin.^{22,23,24} Gender dysphoria may cause profound distress. It should not be confused with transient gender-questioning that can occur in early childhood.^{25,26,27,28,29,30}

C. Social

1. CMDA recognizes that gender identity issues are complex. The inclination to identify with the opposite sex or as some other gender identity along a spectrum may have non-genetic biological,³¹ familial,^{32,33} and social ^{27,28,34} causes that are not personally generated by particular individuals.²¹⁻³⁰
2. In our current social context, there is a prevailing view that removing traditional definitions and boundaries is a requirement for self-actualization. Thus, Christian healthcare professionals find themselves in the position of being at variance with evolving views of gender identity in which patients or their subcultures seek validation by medical professionals of their transgender desires and choices through medical or surgical solutions to gender dysphoria. Although such desires may be approved by society at large, they are contrary to a biblical worldview and to biological reality and thus are disordered.
3. In contrast to the current culture, CMDA believes that finding one's identity within God's design will result in genuine human flourishing. CMDA believes, moreover, that social movements which assert that gender is a choice are mistaken in defining gender as something independent of sex. Authentic personal identity consists in social gender expression that is congruent with one's natural biological sex but not limited to stereotypes. CMDA recognizes that this traditional view has become counter-cultural; however, CMDA affirms that God's design transcends culture.
4. CMDA opposes efforts to impose transgender ideology on all society by excluding, suppressing, marginalizing, intimidating, or portraying as hateful those individuals and organizations that disagree on scientific, medical, moral, or religious grounds. Such attacks are contrary to the freedoms of speech and religious liberty that lie at the very foundation of a just and democratic society.
5. There is a social contagion phenomenon luring young people into the transgender culture.^{32,33}
6. CMDA opposes efforts to compel healthcare professionals to grant medical legitimacy to transgender ideologies.^{35,36,37,38,39,40} Cooperation with requests for medical or surgical gender reassignment threatens professional integrity by undermining our respect for biological reality, evidence-based medical science, and our commitment to non-maleficence (see CMDA Statement on Healthcare Right of Conscience).
7. Promotion of transgender ideology by educational institutions and teachers to children as young as 5 years of age is a danger to the health and safety of minor children (for medical reasons elaborated in the next section).^{41,42,43,44,45,46,47} Education should respect the value of every human being; in supporting and affirming the student, it need not affirm every desire.
8. No educational institution or teacher should ever block parents from supervising their child's education or withhold from them knowledge of the educational content.

D. Medical

1. Transient gender questioning can occur during childhood. Most children and adolescents who express transgender tendencies eventually come to identify with their biological sex

during adolescence or early childhood.^{48,49,50,51,52,53} There is evidence that gender dysphoria is influenced by psychosocial experiences and can be exacerbated by promoters of transgender ideology.^{27,33} Early counseling for children expressing gender dysphoria is critical to treat any underlying psychological disorders, including depression, anxiety, or suicidal tendencies, and should be done without promoting attempts for gender transitioning.

2. Hormones prescribed to a previously biologically healthy child for the purpose of blocking puberty inhibit normal growth and fertility, cause sexual dysfunction, and may aggravate mental health issues. Continuation of cross-sex hormones, such as estrogen and testosterone, during adolescence and into adulthood, is associated with increased health risks including, but not limited to, high blood pressure, blood clots, stroke, heart attack, infertility, and some types of cancer.^{51,54,55,56,57,58,59,60}
3. Although some individuals report a sense of relief as they initiate the transitioning process, this is not always sustained or consistent over time. Some patients regret having undergone the transitioning attempt process and choose to detransition, which involves additional medical risk and cost.^{56,61,62,63,64}
4. Among individuals who identify as transgender, use cross-sex hormones, and undergo attempted gender reassignment surgery, there are well-documented increased incidences of depression, anxiety, suicidal ideation, substance abuse, and risky sexual behaviors in comparison to the general population.^{21,22,23,61,65,66,67} These health disparities are not prima facie evidence of healthcare system prejudice. These mental health co-morbidities have been shown to predate transgender identification.^{24,25,26,27,28,34,68} Patients' own gender-altering attempts and sexual encounter choices (or, in the case of children, their parents' choices on their behalf) are among the factors relevant to adverse outcomes in transgender-identified patients.
5. Although current medical evidence is incomplete and open to various interpretations, some studies suggest that surgical alteration of sex characteristics has uncertain and potentially harmful psychological effects and can mask or exacerbate deeper psychological problems.^{7,8,9,69} Evidence increasingly demonstrates that there is no reduction in depression, anxiety, suicidal ideation, or actual suicide attempts in patients who do undergo surgical transitioning compared to those who do not.^{7,70} The claim that sex-reassignment surgery leads to a reduction in suicide and severe psychological problems is not scientifically supported.^{64,71,72,73}
6. A patient has died because the medical records conveyed only the individual's gender preference, and not their biological sex, leading to misdiagnosis and medical catastrophe.^{74,74}

E. Ethical

1. Restoring and preserving physical and mental health are goals of medicine, but assisting with or perpetuating psychosocial disorders are not. Accordingly, treatment of anomalous sexual anatomy is restorative.⁷⁵ Interventions to alter normal sexual anatomy and physiology to conform to identities arising from gender dysphoria are disruptive to health.^{9,76}
2. Medicine rests on science and should not be held captive to desires or demands that contradict biological reality. Sex reassignment operations are physically harmful because they disregard normal human anatomy and function. Normal anatomy is not a disease; dissatisfaction with natural anatomical and genetic sexual makeup is not a condition that

- can be successfully remedied medically or surgically.
3. The medical status of gender identity disorder (currently termed gender dysphoria) as a mental or psychosocial disorder should not be discarded.
 4. The inability of men, including men who identify as women, to bear children is not an illness to be remedied by medical or surgical means, such as uterine transplantation.⁷⁷ Uterine transplantation into biological men cannot be justified medically (See CMDA Statement on Enhancement and CMDA Statement on Transplantation).
 5. Fundamentally, it is unrealistic to remove or mutilate normal organs and tissue and to disrupt normal physiology, and then to expect normal function. This illustrates the reality that complete gender transitioning is not medically possible.
 6. Christian patients struggling with transgender inclinations face not only the psychological distress of a desire for a gender identity different from their biological sex, but may also face the spiritual distress that comes to anyone who follows a path in life that departs from God's design for humanity. Hormonal or surgical interventions cannot resolve spiritual distress but may lead to further spiritual turmoil. These, our neighbors, need and deserve the spiritual, psychological, and social support of the Christian community.
 7. CMDA is especially concerned about the increasing phenomenon of parents enabling their gender-questioning children or adolescent minors to receive hormones to inhibit normal adolescent development. Children and adolescents lack the developmental cognitive capacity to assent or request such interventions, which have lifelong physical, psychological, and social consequences.⁵⁶ Facilitating hormonal or surgical transitioning interventions for those who have not reached the age of majority is a form of child endangerment and abuse.⁶⁴ Highly affirming parents have been shown to not improve the mental health statistics of transgender-identified children.⁷⁸
 8. Many diseases affect men and women differently, according to biological sex phenotype. Transgender designations may conceal biological sex differences relevant to medical risk factors, the recognition of which is important for effective healthcare and disease prevention. As accurate documentation is necessary for good patient care, healthcare professionals should document the patient's biological sex and any alterations of gender characteristics in the medical record.^{2,13,54,57,79,80,81} It is appropriate and should not be interpreted as disrespectful for healthcare professionals to discuss their patients' biological sex with them as part of their medical care.^{80,81}
 9. For the overall health of the patient, the healthcare professional should be forthright with the patient that addressing the individual's sexual reality is necessary for appropriate medical care and should not be interpreted as disrespect.

CMDA Recommendations for the Christian Community

1. A person questioning or struggling with gender identity should evoke neither scorn nor enmity, but rather the Christian's concern, compassion, help, and understanding. Christians must respond to the complex issues surrounding gender identity with grace, civility, and love.
2. Christians should avail themselves of opportunities to help the larger society understand that male/female sexes are complementary and permanent. Both are good and part of the created order. For the reasons elaborated above, CMDA believes that attempting to define gender as fluid and changeable through technical means will have grave spiritual, emotional, cultural, and medical repercussions.
3. The Christian community, beginning with the Christian family, must resist stereotyping or

rejecting individuals who do not fit the popular norms of masculinity and femininity. At the same time, parents should guide their children and adolescent minors in appropriate gender identity development. For children and adolescents experiencing gender dysphoria, the Christian community should provide appropriate role models and biblically informed guidance.

4. The Christian community must condemn hatred and violence directed against those struggling with questions of gender identity.
5. Since Christians are to love their neighbors as themselves, they are to love those struggling with gender dysphoria or incongruence of desired gender with biological sex. Love for the person does not condone or facilitate gender transitioning treatments.
6. In obedience to God who commands his followers to love one another, and for the sake of the common good, Christians should welcome inclusion of transgender-identified individuals into their communities, as we are all broken and sinners, not more or less valuable than each other. Transgender-identified individuals have the same rights shared by all other humans. We oppose granting special rights and privileges based on transgender identification. These special rights can negatively impact the rights of others (e.g., bathroom designations that allow biological males access to shared female restrooms or showers, female athletic competitions that give participating biological males an unfair physiologic advantage, affirmative actions, or claims for unnecessary medical interventions).
7. The Christian community is to be a refuge of love for all who are broken – including the sexually broken – not to affirm their sin, nor to condemn, but to shepherd them to Jesus, who alone can forgive, heal, restore, and redirect to a godly, honorable, and virtuous way of life. God provides the remedy for all moral failure through repentance and faith in Jesus Christ and the life-changing power of the Holy Spirit. Though healing may be incomplete on earth, the promise of complete healing for those who are in Christ will ultimately be fulfilled in heaven.

CMDA Recommendations for Christian Healthcare Professionals

1. CMDA advocates that all Christian healthcare professionals provide ethically and medically competent care to all patients, including those who identify as transgender. Such care requires compassion, an open and trusting dialogue, a genuine effort to understand and respond to the patient's psychological distress when present, and acceptance of the person without agreeing with the person's ideology or providing a requested sex-altering intervention.
2. CMDA believes that the appropriate medical response to patients with gender dysphoria is to help them understand that they are people God loves and who are made in his image, even when their choices cannot be validated. Christian healthcare professionals should validate their right as individuals in a free society to make decisions for themselves. This right, however, does not extend to obligating Christian and other healthcare professionals to prescribe medication or perform surgical procedures that are harmful (see CMDA Statement on Healthcare Right of Conscience).
3. CMDA believes that Christian healthcare professionals should not initiate hormonal and surgical interventions that alter natural sex phenotypes. Such interventions contradict one of the basic principles of medical ethics, which is that medical treatment is intended to restore and preserve health, and not to harm.
4. CMDA believes that prescribing hormonal treatments to children or adolescents to

disrupt normal sexual development for the purpose of attempting gender reassignment is ethically impermissible, whether requested by the child, the adolescent, or the parent (See CMDA Statement on Limits to Parental Authority in Medical Decision-Making, and CMDA Statement on Abuse of Human Life).

5. Supporting a patient's pursuit of gender transitioning procedures is neither loving nor the best means to help that individual who is experiencing gender dysphoria.

CMDA Recommendations Regarding Nondiscrimination

1. Mutual respect and civil discourse are cornerstones of a free society, and so is truthfulness. In the context of health care, identification of sex and gender has both interpersonal and medical implications. In regard to medical documentation, the medical record should document the sex observed at birth even when the patient expresses a different gender preference or has obtained a legal change in gender status.
2. Christian healthcare professionals, in particular, must care for their patients with gender identity disorders in a non-judgmental and compassionate manner, consistent with the humility and love that Jesus modeled and commanded us to show all people. When questioning transgender ideology, Christian healthcare professionals should do so with an attitude of humility and love.
3. Those who hold to a biblical or traditional biological view of human sexuality, including CMDA members, should be permitted to question transgender ideology free from exclusion, oppression, or unjust discrimination. Healthcare professionals who hold the position that transgender identification is harmful and inconsistent with the will of God should not be stigmatized or accused of being bigoted, phobic, unprofessional, or discriminatory because of their desire to adhere to biological and medical reality as a sincerely held (and widely shared) belief.
4. To decline to provide a requested gender-altering treatment that is harmful, or is not medically indicated, does not constitute unjust discrimination against persons. CMDA affirms that Christian and other healthcare professionals should not be coerced or mandated to provide or refer for services they believe to be morally wrong or medically harmful to patients (See CMDA Statement on Healthcare Right of Conscience).
5. Healthcare professionals must not be prevented from providing counseling and support to patients with gender dysphoria and who request assistance with accepting and maintaining their biologic sex and gender identity.

GLOSSARY

Person and Image of God

According to the Bible, human persons (as opposed to divine and angelic persons) are embodied from conception onward. At conception, at least one genetically unique human person is formed (twinning may occur during the first two weeks of pregnancy). So the psalmist offers a hymn to God in Psalm 139, "you created my inmost being, you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depth of the earth, Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be" (13-16 NIV). Human persons are, however, the only persons who are made in the *imago Dei* (image of God). Thus,

Jesus—fully God and fully human—is “image of the invisible God, the firstborn over all creation” (Colossians 1:15). Likewise, according to Genesis, “God created mankind in his own image, in the image of God he created them, male and female he created them” (Genesis 1:27).

Sex

Human sex and sexuality are aspects of God’s good, well-ordered creation. From the beginning he made humans sexual beings (Genesis 2:15-25). Humans are sexual beings who procreate through sexual reproduction. Sex is objective, identifiable, immutable, determined at conception, stamped on every nucleated cell, and highly consequential.^{82,83,84,85}

There are 2 sex cells or gametes, sperm and ova. There is no third. Human fallenness incurred pervasive distortions in humanity, including disorders of sexual biology, none of which limits either God’s love for each of us, or the inestimable value of creation in His image.

Sexuality

Human sexuality is a “very good” component of God’s well-ordered creation (Genesis 2:15-25). Sexuality is a broad and easily confusing term usually requiring contextualization for clear communication. As noted by McHugh and Mayer, sexuality incorporates desires, attractions, behaviors, and/or identity.¹⁶ Furthermore, sexuality may vary regarding timing, intensity, consistency, and exclusivity. Its elements may be sporadic, temporary, pervasive, or long-term. Sexual expression may be healthful or unhealthful.

Because of human fallenness, sexuality has become disordered. The goods of sexuality are often distorted by pathologies in biology, psychology (e.g., sexual addiction or adultery), and society (e.g., sexual revolution and polyamory). Redeeming sex requires the reordering of human desires and practice. Celibacy outside of marriage, sexual fidelity within heterosexual marriage between one man and one woman, and the presumption in favor of procreation are ways human sex and sexuality may be redeemed.

Christian Worldview

A worldview is a way of seeing and understanding the phenomenon of the world around us. Like lenses of eyeglasses, one’s worldview provides a set of interpretive assumptions that enable us to make sense of our experience. One’s worldview is how one answers the big questions of life, such as: Is the world real? What is the nature of reality? Is there a God? What can we know about God? How do I know anything at all? Is matter all there is? Is there a supernatural? The orthodox Christian worldview is grounded on certain theological affirmations found in the Bible, which Christians believe to be the revealed word of God, and summarized in the great confessions in the history of Christianity, for instance, in the Nicene (325 AD) and Apostles (390 AD) Creeds.

The Fall and Human Fallenness

Rather than remaining faithful to God’s will and purposes, Adam and Eve fell from their original righteous state through disobedience (i.e., sin). Their sin brought with it not only immediate deleterious consequences for them (Genesis 3), but for the entire created order thereafter. Those well-ordered desires to love God and love another have become disordered by human depravity. Love for God and others was replaced with hatred, envy, and murder (as in the case of Cain and Abel). The goods of honest labor were turned into toil and struggle in a creation that is now filled with corruption, death, disease, pain, and hardship. After the fall, human beings are born with a propensity to disobedience, selfishness, and sin.

Intrinsic Dignity

Because human beings are made in God's image, they possess an intrinsic dignity. They should never be used as a means to an end, but as ends in themselves. Their lives have sacred value and they should not be harmed without just cause. This dignity is intrinsic and equal for all human beings, not varied and dependent on level of function, cognitive or physical, presence of absence of injury or disability, age, or other traits or features for which human beings tend to impute upon others value or worth. Human dignity has been the foundation of Western ethics and jurisprudence and has been enshrined in secular language in the Nuremberg Code and global treaties in science, medicine, and public policy since that time.

Love

Christians are called to love God with all their hearts, souls, minds, and body and to love their neighbors as themselves (Deut 6:5; Lev 19:18; Mark 12:29-31). Love is a disposition of heart and life that impels one person to treat another person with respect and dignity quite apart from ethnicity, economic, social status, or what the individual can exploit or receive from the other. Furthermore, love seeks the best for another individual without the expectation any kind of recompense or remuneration.

Holiness

With respect to God, holiness is the supreme attribute of all of God's attributes, setting the God of the Bible apart from all other deities. The Triune God is holy in his love, righteousness, justice, wrath, and mercy (among other attributes). With respect to human beings and objects, holiness is being set apart for sacred use (as with the Old Testament Temple). Christian holiness is the aspiration to live a life "set apart" from the corruptions of the world, and instead committed to fidelity, trust, and dependence on God, patterning ourselves after Jesus Christ.

Repentance

Repentance is a response to the recognition of harm done, either by commission or omission. The word used in the New Testament (metanoia) means to "turn and go in the other direction." To repent, then, is to acknowledge one's sin and turn back toward God. Turning back toward God may include ceasing to perform or pursue sinful acts, reconciling with those who have been harmed, or restoring items or relationships that have been damaged through one's behavior. Repentance is not a one-time event, but a disposition of character.

Faith

Faith is the virtue of trust and dependence on God and his promises, believing and acting in ways consistent with that confidence (Hebrews 11).

Sexual Orientation

Orientation essentialism – the belief that a person has a given sexual orientation, be it innate or resulting from various combinations of biology and environment -- is an ideological position that has gained strong purchase in modern culture.

Per academics McHugh and Diamond, polar opposites in many ways:

Psychiatry professor Paul McHugh states, "Sexual orientation is a complex and amorphous phenomenon There is no scientific consensus on how to define sexual orientation, and the various definitions proposed by experts produce substantially different classes."⁸³

Psychology professor Lisa Diamond, “There is currently no scientific or popular consensus . . . that definitively ‘qualify’ an individual as lesbian, gay, or bisexual.”⁸⁵

Genetic essentialism, like its orientation counterpart, is similarly ideological.

- In a 2011 *Psychological Bulletin* Dar-Nimrod and Heine define genetic essentialism as, “The tendency to infer a person's characteristics and behaviors from his or her perceived genetic makeup” (p. 801).⁸⁴ “Much of the ways that genes relate to human conditions can be described as weak genetic explanations” (p. 802).
- Eric Turkheimer of UVA states, “...the amount of influence that genes have on behaviors is considerably smaller than one might think.”⁸⁴ And, “...genetic essentialists were wrong about gay genes and similar nonsense.”⁸³ Diamond and Rosky: “In essence, the current scientific revolution in our understanding of the human epigenome challenges the very notion of being “born gay,” along with the “born” with *any* complex trait. Rather, our genetic legacy is dynamic, developmental, and environmentally embedded.”⁸⁵

Same-sex attraction

Sexual attraction to members of the same sex. The propensity and degree may vary from near exclusive to occasional attraction, and is shown to potentially change over time. It does not preclude the same individual from experiencing varying degrees of attraction to members of the opposite sex.

Fornication

Per theologian Robert Gagnon “fornication,” likewise *porneia* in Greek, is frequently an overarching reference to sexual sin as defined in Torah. In more common usage, fornication is sexual intercourse between two people not married to each other. Sex between male and female is implied in the term’s reference to anatomy, fornix being the curved vaginal recess created by the cervix and the term also being Latin for “arch.”

Fornication is separate from adultery or rape.

Temptation

A trial, being put to the test.

It is not yet sin, but an invitation to it.

Jesus “was in all *points* tempted as *we are*, yet without sin.” Hebrews 4:15.

It is inherent to the fallen human condition.

“No temptation has overtaken you except such as is common to man; ...” I Corinthians 10:13.

God tests individuals.

Abraham (Genesis 22:1), Job (Job 23:10), I Corinthians 11:32, Hebrews 12:4-11, etc.

Satan tempts individual to sin.

Matthew 4:3, I Thessalonians 3:5.

God provides means of rescue.

“*then* the Lord knows how to deliver the godly out of temptations...” 2 Peter 2:9.

“...but God *is* faithful, who will not allow you to be tempted beyond what you are able, but with the temptation will also make the way of escape, that you may be able to bear *it*.” I Corinthians 10:13.

Scripture describes temptation as something to be avoided if possible:

“And do not lead us into temptation...” Matthew 6:13.

“Watch and pray, lest you enter into temptation.” Mark 14:38.

Sexual Fantasy - when does it cross into sin?

Temptation is not yet sin. Everyone has a sex drive and the duty to manage it.

Experiencing sexual thoughts is not yet fantasy, or lust, unless willingly pursued. Some have compared the appearance of sexual thoughts to a bird flying over one's head, thus out of our control; and fantasy or lust is compared to the equivalent of allowing that bird to build a nest on our head, something clearly in our power to resist.

Same-sex attraction chaste life - does it include avoidance of kissing? Is this equal to homosexual celibacy?

This is a multi-faceted question.

1. Scripture speaks of greeting each other with “a holy kiss” (Romans 16:16, I Corinthians 16:20), which is a salutation, something non-sexual.

Greeting with a kiss is a pervasive practice in the general cultures of several nations to this day.

2. The kissing implicit in the stated question is sexual, romantic.

There is no part of homosexual practice that is endorsed in scripture; it is condemned without exception.

3. Though we mean abstinence from homosexual practices when we say, “homosexual celibacy,” the application of the term “celibate” to same-sex sexual practice is Biblically problematic.

Lifetime celibacy is referred to as a “gift” by the Apostle Paul in I Corinthians 7:7-9.

A Celibate person is giving up the God-ordained institution of marriage (exclusively between one man and one woman in scriptural standards) along with its God-ordained sexual practice.

God gifts, or graces, that person with something else God-ordained in its place. But a person setting aside same-sex sexual practice is abstaining from or repenting of a sinful practice, which is both commanded and its own benefit. We wish to avoid canonizing homosexual temptation.

Same-sex lifestyle

The willing practice of same-sex sexuality.

Gay culture

Any assemblage of like-minded people creates a culture. Culture itself is a neutral term that gains a moral dimension in its practice. Gay culture endorses the ideological concept of gay identity along with its practices.

Scripturally and scientifically, we hold that sexuality is a verb and not just a noun. Gay and straight are category errors and false identities. Homosexuality by any name is a practice and not an identity, what one does and not who one is.

Likewise, “gay Christian” language canonizes temptation behind a false identity. Any name preceding “Christian” is an implicit priority, contravening Paul's instruction to the Galatian church (Gal. 3:28).

Homophobia, -ic

Homophobia is an ideological and pejorative term that has gained common usage. It is often an accusation made against an individual failing to sufficiently celebrate same-sex sexuality, practices and politics.

But per MayoClinic.org: “A phobia is an overwhelming and unreasonable fear of an object or situation . . . a phobia is long lasting, causes intense physical and psychological reactions, and can affect your ability to function normally at work or in social settings.”

Disagreement is clearly not a phobia.

Linguistically, “homophobia” is somewhat nonsensical, meaning “fear of the same thing.”

Gender vs Sex

Sex is biological and stamped on every nucleated cell in a person’s body from conception onward. It is immutable down to the level of brain cells, so it is impossible to have “a man’s brain in a woman’s body,” for example.

Gender, in its common current usage, is an engineered term leveraging linguistics against biology; it is ideological and self-declared.

Historically, however, per theologian Christopher West:

“The root “gen”—from which we get words such as generous, generate, genesis, genetics, genealogy, progeny, gender, and genitals—means “to produce” or “give birth to.” A person’s gen-der, therefore, is based on the manner in which that person is designed to gen-erate new life. Contrary to widespread secular insistence, a person’s gender is not a malleable social construct. Rather, a person’s gender is determined by the kind of genitals he or she has.”⁸⁶

But ideology does not bow to history. Sex is biology, and gender is ideology.

Gender Identity

Gender identity is a feeling, a self-perception, of how one identifies with their biological sex or not, and it is often a sex stereotype. It is subjective, self-declared and fluid. Psychologist Dr. John Money of Johns Hopkins initiated its use in professional journals in 1955, referring to “the identity of the inner sexed self.”⁸⁷

Gender Confusion/Dysphoria

Gender identity confusion/dysphoria is a feeling/self-perception that one’s biology is not as one wishes it to be or not as one identifies most comfortably as. Sechner notes, “A gender-dysphoric youth experiences a sense of incongruity between the gender expectations linked to her or his biological sex and her or his biological sex itself.”⁸⁸

The greater the discomfort/dissonance, the greater the dysphoria. Gender dysphoria is not synonymous with transgenderism, the latter being an umbrella term within which gender dysphoria fits, but to which transgenderism is not limited.

Gender - Should we be using that term or is there a better term? If so, how is it best defined?

The answer to that depends on the application and one must be careful.

Gender is an engineered term leveraging linguistics against biology; it is ideological and self-declared. Sex is biological, right down to each human cell containing a nucleus.

Though gender is sometimes used synonymously with sex (e.g., in forms asking if someone is male or female), ideologically it is considered separate and distinct from sex (e.g., “your sex is irrelevant to your gender identity”) in a manner that is quite Gnostic (i.e., the “higher knowledge” that transcends lowly biology).

Therefore, it is best to mean what you say and say what you mean in context. Using phrases like “identified gender,” “identifies as,” “gender incongruence,” “gender dysphoria,” “transgender identified,” etc. work well, don’t surrender reality to a claim, and do not imply agreement.

Best terminology for gender transition?

That depends on the intended usage.

“Transition efforts” or “transition-affirming treatments/procedures” are both quite clear and do not surrender to ideology as compared to terms like “gender-affirming” or “gender confirming” treatments and procedures.

Best terminology for transgender identity?

“Transgender-identified” or “transgender identification” are well understood and non-capitulating.

A final comment on language

Terms should be as descriptively accurate as possible while avoiding ideological programming. For instance, because an individual’s intrinsic sex cannot be changed, and gender is essentially a biologically meaningless term or concept aside from biological sex, terms such as “transgender identity,” as if it were an objective reality, should be replaced by “transgender-identified, -identifying, or -identification,” which are descriptively accurate. Similarly, because “gender transition” is not ontologically or biologically possible, more descriptively accurate terms, such as, “attempted transition efforts,” or “attempted transition-affirming treatments or procedures,” are more accurate and preferred.

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Approved by the House of Representatives

Passed with 54 approvals, 0 opposed, 0 abstention

October 30, 2021, virtual

References

1. Hyde JS, Bigler RS, Joel D, Tate CC, van Anders SM. The future of sex and gender in psychology: Five challenges to the gender binary. *Am Psychol.* 2019;74(2):171-193. doi:10.1037/amp0000307
2. Cretella MA, Rosik CH, Howsepian AA. Sex and gender are distinct variables critical to health: Comment on Hyde, Bigler, Joel, Tate, and van Anders (2019). *Am Psychol.* 2019;74(7):842-844. doi:10.1037/amp0000524
3. Institute of Medicine (US) Committee on Understanding the Biology of Sex and Gender Differences, Wizemann, T. M., & Pardue, M. L. (Eds.). (2001). *Exploring the Biological Contributions to Human Health: Does Sex Matter?*. National Academies Press (US).
4. Sullivan, A. (2020). Sex and the census: why surveys should not conflate sex and gender identity. *International Journal Of Social Research Methodology*, 23(5), 517-524. <https://doi.org/10.1080/13645579.2020.1768346>
5. Anckarsäter, H., & Gillberg, C. (2020). Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery. *American Journal of Psychiatry*, 177(8), 764–765. <https://doi.org/10.1176/appi.ajp.2020.19111117>
6. Hruz P. W. (2020). Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *The Linacre Quarterly*, 87(1), 34–42. <https://doi.org/10.1177/0024363919873762>
7. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885. Published 2011 Feb 22. doi:10.1371/journal.pone.0016885
8. Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender-Affirming Surgeries: A Comment by the Editor on the Process. *Am J Psychiatry*. 2020;177(8):764. doi:10.1176/appi.ajp.2020.20060803

9. Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence. *Am J Psychiatry*. 2020;177(8):765-766. doi:10.1176/appi.ajp.2020.19111130
10. Biggs M. Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria. *Arch Sex Behav*. 2020;49(7):2227-2229. doi:10.1007/s10508-020-01743-6
11. Davis SR, Baber R, Panay N, et al. Global Consensus Position Statement on the Use of Testosterone Therapy for Women. *J Clin Endocrinol Metab*. 2019;104(10):4660-4666. doi:10.1210/jc.2019-01603
12. Giovannetti, B., 2014. *Four Letter Words: Conversations On Faith's Beauty And Logic*. San Francisco: Endurant Press, p.178.
13. Bartz D, Chitnis T, Kaiser UB, et al. Clinical Advances in Sex- and Gender-Informed Medicine to Improve the Health of All: A Review. *JAMA Intern Med*. 2020;180(4):574-583. doi:10.1001/jamainternmed.2019.7194
14. 2013. *Diagnostic And Statistical Manual Of Mental Disorders*. Arlington, VA: American Psychiatric Association, p.829.
15. Tournaye H. Is there any reproductive future left for men?. *Facts Views Vis Obgyn*. 2012;4(4):255-258.
16. Mayer LS, McHugh PR. Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *New Atlantis* (2016); 50:10-143. At pp.89-90.
17. Beale JM, Creighton SM. Long-term health issues related to disorders or differences in sex development/intersex. *Maturitas*. 2016;94:143-148. doi:10.1016/j.maturitas.2016.10.003
18. Sax L. How common is intersex? a response to Anne Fausto-Sterling. *J Sex Res*. 2002;39(3):174-178. doi:10.1080/00224490209552139
19. Słowikowska-Hilczner J, Hirschberg AL, Claahsen-van der Grinten H, et al. Fertility outcome and information on fertility issues in individuals with different forms of disorders of sex development: findings from the dsd-LIFE study. *Fertil Steril*. 2017;108(5):822-831. doi:10.1016/j.fertnstert.2017.08.013
20. Van Mol, A., 2019. *Intersex: What It Is And Is Not – Christian Medical & Dental Associations*. [online] Christian Medical & Dental Associations. Available at: <<https://cmda.org/intersex-what-it-is-and-is-not/>> [Accessed 11 November 2020].
21. Some professional organizations appear to acknowledge the same, even if they generally claim gender-sex discordance is normal. The World Professional Association for Transgender Health says in its Standards of Care that "gender dysphoria" may be "secondary to, or better accounted for by, other diagnoses." (Wpath.org. 2012. *Standard Of Care For The Health Of Transsexual, Transgender, And Gender Nonconforming People*. [online] Available at: <<https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf?t=1604581968>> [Accessed 11 November 2020]. p24) The British Psychological Society says, "In some cases the reported desire to change sex may be symptomatic of a psychiatric condition for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger's syndrome...." (Shaw L, Butler C, Langdridge D, et al. Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. British Psychological Society Professional Practice Board. Leicester, UK, 2012, p. 26 [Accessed online 16 January 2021 at: <https://beta.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Minority%20Clients%20%282012%29.pdf>]) The American Psychological Association's APA Handbook of Sexuality and Psychology allows for the possibility that pathological family of origin dynamics may be causal. (Tolman, D., Diamond, L., Bauermeister, J., George, W., Pfaus, J. and Ward, L., 2014. *APA Handbook Of Sexuality And Psychology*. American Psychological Association, p.743.)
22. Bechard M, VanderLaan DP, Wood H, Wasserman L, Zucker KJ. Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study. *J Sex Marital Ther*. 2017;43(7):678-688. doi:10.1080/0092623X.2016.1232325
23. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: A review of the literature. *Int Rev Psychiatry*. 2016;28(1):44-57. doi:10.3109/09540261.2015.1115753
24. Hanna B, Desai R, Parekh T, Guirguis E, Kumar G, Sachdeva R. Psychiatric disorders in the U.S. transgender population. *Ann Epidemiol*. 2019;39:1-7.e1. doi:10.1016/j.annepidem.2019.09.009
25. Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child Adolesc Psychiatry Ment Health*. 2015;9:9. Published 2015 Apr 9. doi:10.1186/s13034-015-0042-y
26. Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. *Pediatrics*. 2018;141(5):e20173845. doi:10.1542/peds.2017-3845

27. Zucker KJ, Lawrence AA, Kreukels BP. Gender Dysphoria in Adults. *Annu Rev Clin Psychol.* 2016;12:217-247. doi:10.1146/annurev-clinpsy-021815-093034
28. Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria [published correction appears in PLoS One. 2019 Mar 19;14(3):e0214157]. *PLoS One.* 2018;13(8):e0202330. Published 2018 Aug 16. doi:10.1371/journal.pone.0202330
29. Bps.org.uk. 2012. *Guidelines And Literature Review For Psychologists Working Therapeutically With Sexual And Gender Minority Clients.* [online] Available at: <<https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20%282012%29.pdf>> [Accessed 11 November 2020].
30. E. Coleman, W. Bockting, M. Botzer, P. Cohen-Kettenis, G. DeCuypere, J. Feldman, L. Fraser, J. Green, G. Knudson, W. J. Meyer, S. Monstrey, R. K. Adler, G. R. Brown, A. H. Devor, R. Ehrbar, R. Ettner, E. Eyler, R. Garofalo, D. H. Karasic, A. I. Lev, G. Mayer, H. Meyer-Bahlburg, B. P. Hall, F. Pfaefflin, K. Rachlin, B. Robinson, L. S. Schechter, V. Tangpricha, M. van Trotsenburg, A. Vitale, S. Winter, S. Whittle, K. R. Wylie & K. Zucker (2012) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, *International Journal of Transgenderism*, 13:4, 165-232, DOI: 10.1080/15532739.2011.700873
31. Roselli CE. Neurobiology of gender identity and sexual orientation. *J Neuroendocrinol.* 2018;30(7):e12562. doi:10.1111/jne.12562
32. World. 2020. *Fighting to let a boy be a boy.* [online] Available at: <https://wng.org/roundups/fighting-to-let-a-boy-be-a-boy-1617220961> [Accessed 26 April 2021].
33. Bradley SJ, Zucker KJ. Gender identity disorder and psychosexual problems in children and adolescents. *Can J Psychiatry.* 1990;35(6):477-486. doi:10.1177/070674379003500603
34. Lisa Marchiano (2017) Outbreak: On Transgender Teens and Psychic Epidemics, *Psychological Perspectives*, 60:3, 345-366, DOI: 10.1080/00332925.2017.1350804
35. Anderson, R., 2018. *Transgender Ideology Is Riddled With Contradictions. Here Are The Big Ones.* [online] The Heritage Foundation. Available at: <<https://www.heritage.org/gender/commentary/transgender-ideology-riddled-contradictions-here-are-the-big-ones>> [Accessed 11 November 2020].
36. Hilton, C., 2020. *Opinion | The Dangerous Denial Of Sex.* [online] WSJ. Available at: <<https://www.wsj.com/articles/the-dangerous-denial-of-sex-11581638089>> [Accessed 11 November 2020].
37. Medium. 2017. *Transgender Ideology Does Not Support Women.* [online] Available at: <<https://medium.com/@mirandayardley/transgender-ideology-does-not-support-women-2d00089e237a>> [Accessed 11 November 2020].
38. Gender Health Query. n.d. *Many LGBT People Do Not Agree With Gender Queer Theory & Scientific Validity Taught In Schools — Gender Health Query.* [online] Available at: <<https://www.genderhq.org/trans-youth-controversial-schools-lgbt-science-dysphoria>> [Accessed 11 November 2020].
39. The Daily Signal. 2017. *I'M A Pediatrician. How Transgender Ideology Has Infiltrated My Field And Produced Large-Scale Child Abuse.* [online] Available at: <<https://www.dailysignal.com/2017/07/03/im-pediatrician-transgender-ideology-infiltrated-field-produced-large-scale-child-abuse/>> [Accessed 11 November 2020].
40. Olver T. Disaffirming Gender: Somatic Incongruence as a Co-function of Ideological Congruity. *Psychoanal Rev.* 2019;106(1):1-28. doi:10.1521/prev.2019.106.1.1
41. Olsen H. 2019. *California Wants To Teach Kindergartners About Gender Identity. Seriously.* [online] Available at: <<https://www.washingtonpost.com/opinions/2019/05/13/california-wants-teach-kindergartners-about-gender-identity-seriously/>> [Accessed 11 November 2020].
42. Doward, J., 2019. *Politicised Trans Groups Put Children At Risk, Says Expert.* [online] the Guardian. Available at: <<https://www.theguardian.com/society/2019/jul/27/trans-lobby-pressure-pushing-young-people-to-transition>> [Accessed 11 November 2020].
43. Jones A, Kao E. Heritage.org. 2019. *Sexual Ideology Indoctrination: The Equality Acts Impact On School Curriculum And Parental Rights.* [online] Available at: <<https://www.heritage.org/sites/default/files/2019-05/BG3408.pdf>> [Accessed 11 November 2020].
44. Omercajic K, Martino W. Supporting transgender inclusion and gender diversity in schools: a critical policy analysis. *Frontiers in Sociology* 2020; 5:27. <https://doi.org/10.3389/fsoc.2020.00027>
45. Friestad, T., 2018. *Being Mila: Creating An Lgbtq Curriculum That Is Authentic, Follows Policies And Ethics, And Teaches Acceptance.* [online] DigitalCommons@Hamline. Available at: <https://digitalcommons.hamline.edu/hse_cp/196?utm_source=digitalcommons.hamline.edu/hse_cp/196> [Accessed 11 November 2020].

46. Dee Knoblauch (2016) Building the Foundation of Acceptance Book by Book: Lesbian, Gay, Bisexual, and/or Transgender-Themed Books for Grades K–5 Multicultural Libraries, *Multicultural Perspectives*, 18:4, 209-213, DOI: [10.1080/15210960.2016.1228325](https://doi.org/10.1080/15210960.2016.1228325)
47. Christian Concern. 2020. *LGB Alliance Founder Criticises RSE Lessons*. [online] Available at: <https://christianconcern.com/comment/lgb-alliance-founder-criticises-rse-lessons/> [Accessed 11 November 2020].
48. 2013. *Diagnostic And Statistical Manual Of Mental Disorders*. Arlington, VA: American Psychiatric Association, p.455.
49. Tolman, D., Diamond, L., Bauermeister, J., George, W., Pfaus, J. and Ward, L., 2014. *APA Handbook Of Sexuality And Psychology*. Washington D.C: American Psychological Association, p.774.
50. Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med*. 2008;5(8):1892-1897. doi:10.1111/j.1743-6109.2008.00870.x
51. Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;28(1):13-20. doi:10.3109/09540261.2015.1115754
52. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in *J Clin Endocrinol Metab*. 2018 Feb 1;103(2):699] [published correction appears in *J Clin Endocrinol Metab*. 2018 Jul 1;103(7):2758-2759]. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658
53. Kenneth J. Zucker (2018) The myth of persistence: Response to “A critical commentary on follow-up studies and ‘desistance’ theories about transgender and gender non-conforming children” by Temple Newhook et al. (2018), *International Journal of Transgenderism*, 19:2, 231-245, DOI: [10.1080/15532739.2018.1468293](https://doi.org/10.1080/15532739.2018.1468293)
54. Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline". *J Clin Endocrinol Metab*. 2019;104(3):686-687. doi:10.1210/jc.2018-01925
55. Safer JD, Tangpricha V. Care of Transgender Persons. *N Engl J Med*. 2019;381(25):2451-2460. doi:10.1056/NEJMcpl903650
56. Levine SB. Informed Consent for Transgendered Patients. *J Sex Marital Ther*. 2019;45(3):218-229. doi:10.1080/0092623X.2018.1518885
57. Shatzel JJ, Connelly KJ, DeLoughery TG. Thrombotic issues in transgender medicine: A review. *Am J Hematol*. 2017;92(2):204-208. doi:10.1002/ajh.24593
58. Vumc.org. 2012. *Key Transgender Health Concerns | Program For LGBTQ Health*. [online] Available at: <https://www.vumc.org/lgbtq/key-transgender-health-concerns> [Accessed 12 November 2020].
59. Getahun D, Nash R, Flanders WD, et al. Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. 2018;169(4):205-213. doi:10.7326/M17-2785
60. Goodman, M., 2018. [online] Pcori.org. Available at: <https://www.pcori.org/sites/default/files/PCORI-Goodman076-English-Abstract.pdf> [Accessed 11 November 2020].
61. Heyer, W. 2019. Usatoday.com. 2019. *Hormones, Surgery, Regret: I Was A Transgender Woman For 8 Years-Time I Can'T Get Back.* [online] Available at: <https://www.usatoday.com/story/opinion/voices/2019/02/11/transgender-debate-transitioning-sex-gender-column/1894076002/> [Accessed 11 November 2020].
62. International Association of Therapists for Desisters and Detransitioners. (2020). *Introduction to Detransition for Therapists*. [online]. Available at: https://iatdd.com/introduction-to-detransition-for-therapists/?fbclid=IwAR2bsQ-ojdFi7Zyzow_RNCDcD34eGU_flce_x8mfRpH3s0DRp91PwwONkto [Accessed 4/26/2021].
63. Sky News. (2019). *'Hundreds' of Young Trans People Seeking Help to Return to Original Sex*. [online]. Available at: <https://news.sky.com/story/hundreds-of-young-trans-people-seeking-help-to-return-to-original-sex-11827740>. [Accessed 4/26/2021].
64. Horvath H. "The Theatre of the Body: A Detransitioned Epidemiologist Examines Suicidality, Affirmation, and Transgender Identity". [online]. Available at: <https://4thwavenow.com/2018/12/19/the-theatre-of-the-body-a-detransitioned-epidemiologist-examines-suicidality-affirmation-and-transgender-identity/>. Assessed 4-26-2021.
65. Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study [published correction appears in *Am J Psychiatry*. 2020 Aug 1;177(8):734]. *Am J Psychiatry*. 2020;177(8):727-734. doi:10.1176/appi.ajp.2019.19010080
66. Schulman, J. K., & Erickson-Schroth, L. (2019). Mental Health in Sexual Minority and Transgender Women. *The Medical Clinics of North America*, 103(4), 723–733. <https://doi.org/10.1016/j.mcna.2019.02.005>

67. Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017. *Am J Public Health*. 2019;109(1):e1-e8. doi:10.2105/AJPH.2018.304727
68. Levine SB, Solomon A. Meanings and political implications of "psychopathology" in a gender identity clinic: a report of 10 cases. *J Sex Marital Ther*. 2009;35(1):40-57. doi:10.1080/00926230802525646
69. Levine SB. Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria. *J Sex Marital Ther*. 2018;44(1):29-44. doi:10.1080/0092623X.2017.1309482
70. Malone WJ, Roman S. Calling Into Question Whether Gender-Affirming Surgery Relieves Psychological Distress. *Am J Psychiatry*. 2020;177(8):766-767. doi:10.1176/appi.ajp.2020.19111149
71. Tucker RP. Suicide in Transgender Veterans: Prevalence, Prevention, and Implications of Current Policy. *Perspect Psychol Sci*. 2019;14(3):452-468. doi:10.1177/1745691618812680
72. Wold A. Gender-Corrective Surgery Promoting Mental Health in Persons With Gender Dysphoria Not Supported by Data Presented in Article. *Am J Psychiatry*. 2020;177(8):768. doi:10.1176/appi.ajp.2020.19111170
73. Wiepjes CM, den Heijer M, Bremmer MA, Nota NM, deBlock CJM, Coumou BJG, Steensma TD. Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017). *Acta Psychiatr Scand*. (2020); 141(6):486-491.
74. Stroumsa D, Roberts EFS, Kinnear H, Harris LH. The Power and Limits of Classification - A 32-Year-Old Man with Abdominal Pain. *N Engl J Med*. 2019;380(20):1885-1888. doi:10.1056/NEJMp1811491
75. Bangalore Krishna K, Houk CP, Lee PA. Pragmatic approach to intersex, including genital ambiguity, in the newborn. *Semin Perinatol*. 2017;41(4):244-251. doi:10.1053/j.semperi.2017.03.013
76. Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43(8), 1535–1545. <https://doi.org/10.1007/s10508-014-0300-8>
77. Jones BP, Williams NJ, Saso S, et al. Uterine transplantation in transgender women. *BJOG*. 2019;126(2):152-156. doi:10.1111/1471-0528.15438
78. Schumm WR, Crawford DW. Is Research on Transgender Children What It Seems? Comments on Recent Research on Transgender Children with High Levels of Parental Support. *Linacre Q*. 2020;87(1):9-24. doi:10.1177/0024363919884799
79. Orwh.od.nih.gov. n.d. *Questions & Answers | Office Of Research On Women's Health*. [online] Available at: <<https://orwh.od.nih.gov/sex-gender/nih-policy-sex-biological-variable-sabv/questions-answers>> [Accessed 11 November 2020].
80. Huey, N., 2018. *Treating Men And Women Differently: Sex Differences In The Basis Of Disease - Science In The News*. [online] Science in the News. Available at: <<http://sitn.hms.harvard.edu/flash/2018/treating-men-and-women-differently-sex-differences-in-the-basis-of-disease/>> [Accessed 11 November 2020].
81. Madsen, T., Bourjeily, G., Hasnain, M., Jenkins, M., Morrison, M., Sandberg, K., Tong, I., Trott, J., Werbinski, J. and McGregor, A., 2017. Article Commentary: Sex- and Gender-Based Medicine: The Need for Precise Terminology. *Gender and the Genome*, 1(3), pp.122-128.
82. Mayer, L.S and McHugh, P.R. Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences. *The New Atlantis*. Number 50, Fall 2016., pp 7-9.
83. McHugh, Paul R. Amicus Brief to the SCOTUS for *Obergefell v Hodges*.
84. Dar-Nimrod, I & Heine, S.J. "Some thoughts on essence placeholders, interactionism, and heritability: Reply to Haslam (2011) and Turkheimer (2011). *Psychological Bulletin*. (2011) 137(5): 829 – 833.
85. Diamond, LM & Rosky, C.J. "Scrutinizing Immutability: Research on Sexual Orientation and US Legal Advocacy for Sexual Minorities." *Journal of Sex Research*. (2016) 00: 1-29.
86. West, Christopher. *Our Bodies Tell God's Story*. Grand Rapids: Brazos Press. 2020. p. 28.
87. Money, John. "Hermaphroditism, gender and precocity in hyperadrenocorticism: psychological findings." *Bulletin of the Johns Hopkins Hospital*. (1955) 95(6): 252-264.
88. Shechner, Tomer. "Gender Identity Disorder: A Literature Review from a Developmental Perspective." *Isr. J of Psychiatry & Related Sci*. (2010) 47: 132-138.

Rosita Weissberg
New York, NY

September 20, 2022

Florida Board of Medicine

Dear Mr. Vazquez and the Florida Board of Medicine Members,

I am writing as the parent of a trans-identified child in order to give my input as a person who has been navigating the system of gender affirming care for many years. First, I would like to state that I am politically center left- a Democrat, and I am not writing with a political agenda. I want you to know that I am very grateful that this medical board has turned its attention to this matter, and I truly thank you from the bottom of my heart, for making this a priority since all other American institutions have decided to turn a blind eye to a system that is clearly corrupt and ideologically captured.

The idea that any medical model should be 'client driven' is radical, but it becomes absurd when it is applied to children. My child began identifying as non-binary around her 13th birthday, following a difficult puberty, a diagnosis of Asperger's, and a long period of self-harming and depression that was brought on when she identified as EMO (a culture she described as "hating yourself" and which she discovered online). Prior to this, she was a happy, energetic, curious, interested and self-loving child who never displayed any discomfort with her physical self.

It cannot be a coincidence that most teenage girls who identify as transgender seem to have a similar trajectory. At the time of the trans identification, my child was being treated by a group of doctors at NYU Children's Hospital, and had outside DBT and ASD specialist. I was unable at the time to comprehend how these doctors, who were treating her for self harm and social communications disorder, just accepted my child's sudden and inexplicable change of name and pronouns, asserting that though they were recommending an in-patient therapeutic program, that this one thing about herself- that she was non-binary- was the only one true thing my child knew about herself. Leaving it at that, my child was affirmed

and no further cause or issue regarding identity was further investigated or challenged.

At the time, I was naive and I thought she would explore this identity and move on, but then by the interventions of staff at the above mentioned program, the identity changed to gay boy. It was not long after that that my child's mental and physical health got worse and did not seem to recover until many years later when I started pushing back on the ideology by asking questions. This trajectory also appears to be common amongst this cohort, as I've found out from talking to a lot of parents.

This is a long story to say that in my experience with affirmation, including allowing children to decide their sex, names, pronouns and to socially transition- especially in a medical setting, triggers an unspooling of mental health disorders, achieving the opposite of what it purports to do. Moreover, as I realized in horror after doing some research, none of those interventions are neutral, and in actuality seem to forfeit a child's ability to feel comfortable with themselves.

Doctors, teachers, neighbors, do-gooders, and even family members who 'affirm' a person's transgender identity before said person has had a chance to investigate and question the origins of the identification, are doing great harm. It is my experience that they tend to do so for their own good, as it makes them feel progressive and supportive of someone under the LGBT banner, without understanding any of the harms they cause. I have many friends whose intrusive family members or friends have been instrumental in turning their kids against them.

Doctors, allies, and teachers who affirm other people's children without parent consent have no understanding of all the unhealthy and negative cultural and ideological forces that belie the identification. While gender ideologues and affirmation proponents like to paint a picture of self-acceptance, healthy development, and everything that is rosy with rainbows and glitter, the reality is that most of us at home who look into what our children are doing online, in school GSA and LGBT groups, and in that culture, come to understand that the identity is often tied to pornography, sexual fetishes, inappropriate contact with adults who pose

as a 'glitter family,' and a lot of coaching inner self-talk about being 'born in the wrong body.'

To many of us, it is obvious that the trans identification triggers an iatrogenic development of gender dysphoric feelings that cause our children to reject their body and their past selves. This must be studied and researched carefully by a set of neutral scientists interested in really helping this cohort. In the case of my child, after 4 years of refusing to move lest she 'feels' herself, she now suffers from obesity, pre-diabetes, and metabolic disorder. Someone who was average weight all her life, was a dancer, a swimmer, a lover of movement and of herself, is now an unhealthy young adult who is immobile, obese, and who needs a plethora of medications that make her feel ill all the time.

The various pediatricians, psychiatrists, psychologists, therapists, endocrinologists, and other doctors that are entrusted with our children's care don't understand or don't want to see that affirmation is problematic. For example, not one of my child's many doctors ever questioned fallacies in her recollections of when this disorder set in, or her false memories that we knew had not occurred. Though I made them aware of the horrendous materials she had accessed online, they never bothered to question or help her explore what all of that meant, and to this day, most people and professionals will dismiss the possibility that online content can influence our children.

Affirmation appears to function as the imposition of an ideology or outside personal beliefs onto the developing minds of innocent and vulnerable children and adolescents. It must be studied: what effect does it actually have? especially when used by doctors or therapists who have an outsize influence on their patients. There is NO evidence that social transition, cross-dressing, using affirmative drugs and medical treatments, actually heal or help these children in any way. Considering the lack of evidence base to support it, is actually mind-boggling that this practice has been unfurled and is so widely practiced.

It is my opinion that the Florida Board of Medicine should look closely at the following issues and phenomena in order to fully understand what is appropriate medical care and what is simply activist directive designed to

provide cover for a lot of unhealthy and predatory actors (including unethical doctors, charities, private citizens, paraphilic men, misguided parents, and mentally ill persons):

1. WPATH and USPATH- Why is an organization made up of activists and the very doctors who work in the field allowed to dictate the standards by which the treat patients? My insurance booklet states that WPATH is an activist, not a medical organization- so why are we allowing activists who will benefit financially and socially to determine treatment protocols? especially because they tend to do poor science and seem to have an agenda? How is this legal?

They are so unfettered by reality and feel so untouchable that they had the gaul to add the identity of eunuch to the SoC8, released last week. How can a child even identify as a eunuch when the condition requires that one has already become an adult This really makes me wonder about the mental capacity and judgment of this group of people.

2. Informed consent clinics, including Planned Parenthood, Community LGBT+ service centers, and virtual providers such as Plume and Folx Health. These businesses have had a great influx of investor money and NGO funding and they are sending out hormones with very little medical case management, proper blood testing, or proper informed consent. Often times they do not even adhere to the WPATH's laughable SoC.

1. Regarding PP: When my child turned 18, she insisted that she wanted hormones. Though I opposed this, I did support her and took her to see her psychiatrist and endocrinologist. Both doctors explained to her that hormone therapy is still experimental, and that especially for people on the autism spectrum, it is better to wait until the brain is fully developed and the person has tried other ways to find relief. The endocrinologist aded that her metabolic panel and current weight anyways disqualified her for hormones because it is contraindicated for obese people who have high cholesterol due to chances of stroke. About 6 months later, on the urging of some friends, my child made a virtual appointment at Planned Parenthood, where she was seen by a midwife! My daughter was affirmed, but luckily, she did not chose to go on hormones. A month later, my child received a bill for \$370, though she had originally been told that the consultation was only

\$40. If Planned Parenthood is unable to clearly explain their pay structure to a young person on the spectrum, how can they possibly ever hope to give proper medical care and get informed consent correctly? If my child had decided to go ahead with taking hormones as prescribed by PP, she may have suffered a stroke or other consequences.

I have heard many such stories for mothers about Planned Parenthood, and I think they are going to destroy their brand with these shenanigans. I am adding below some more information about PP's practices, including some stories by detransitioners about the bad care they received there. I believe that their practices need to be considered carefully by the medical board:

- <https://abigailshrier.substack.com/p/inside-planned-parenthoods-gender>
- https://pitt.substack.com/p/the-us-tavistock?utm_source=email
- <https://lacroicsz.substack.com/p/by-any-other-name>
- Video by SaltyAlty:



These 2 virtual providers need to be looked at and regulated:

<https://www.folxhealth.com>

<https://getplume.co>

3. Online resources and chats for trans identified kids where adult participants gain access to them: Reddit, Trevor Project Translifeline, etc. etc: <https://translifeline.org/resource/gaming/>

4. Social media influencers, fan fiction groups, and other internet content that have led to the theory of a social contagion (which also needs to be explored):

1. <https://www.medscape.com/viewarticle/980500>
2. <https://lacroicsz.substack.com/p/limerence>
3. <https://littmanresearch.com/publications/>
4. https://pitt.substack.com/p/detransitioner-perspective-how-trans?utm_source=email
5. <https://hormonehangover.substack.com/p/thinspo-and-gender-goals>

5. Direct advertising of gender treatments and surgeries by providers to children on social media: start with Florida's own-
<https://www.tiktok.com/@gendersurgeon>

6. Link to porn and fetishes such as BDSM, hypno-sissy porn, and Autogynophilia:

1. <https://grahamlinehan.substack.com/p/sissy-porn-the-gender-movements-dirty>
2. <https://www.feministcurrent.com/2020/11/29/why-isnt-anyone-talking-about-the-influence-of-porn-on-the-trans-trend/>
3. <https://pitt.substack.com/p/transgenders-connection-with-pornography>
4. <https://www.gendermapper.org/post/3-part-series-on-what-your-dysphoric-child-is-watching-online>
5. <https://link.springer.com/article/10.1007/BF01541769>
6. <https://link.springer.com/article/10.1007/s10508-005-4343-8>
7. <https://4thwavenow.com/2019/08/13/how-mental-illnesses-become-identities-tumblr-a-callout-post-part-2/>

7. Illegal services that send hormones to kids without prescription and the adults who enable it. One example is from a friend of mine whose kid ordered elicit hormones from this website: <https://steroidify.com>

The child is a minor and they paid via crypto following instructions from an online forum. The drugs were shipped to the home of an adult 'aly' who deemed herself this child's savior. This parent's rights were completely undermined by not only strangers online, but also a porous US customs process that allowed these drugs in from the eastern Europe to be delivered to a third person. This must be stopped.

8. There should also be in investigation into record keeping practices at all informed consent clinics as well as hospitals that provide surgery. Data reporting in this field should be mandated in the same way that the CDC mandates reporting from fertility clinics. The government should initiate an audit of clinic outcomes thus far, and require future reporting on all intakes and outcomes. Currently, there seems to be no record keeping or follow up, and when patients come with problems and complications the doctors ignore them, pass them over to other doctors, or mistreat them, as per the testimony of many detransitioners. Vaginoplasty and phalloplasty have horrifically high rates of complications and negative outcome rates. This data needs to be reported, and these procedures need to be kept to the SAME standards as any other surgical procedure:

<https://www.statsforgender.org/surgery/>

9. Researching detransition. The input from patients who were medically harmed by current practices, including affirmative care and informed consent models, are a good way to inform what has gone wrong and what needs to change.

10. Debunk the suicide myth of trans people:

<https://www.statsforgender.org/suicide/>

11. Investigate the large NGOs and charities that put out an incredible amount of disinformation that is unhealthy for LGBT+ individuals because they are based on propaganda and lies:

- <https://www.aclu.org/issues/lgbtq-rights/transgender-rights>
- <https://www.glaad.org>
- <https://www.thetrevorproject.org>
- <https://www.hrc.org>
- <https://pflag.org>
- <https://www.lambdalegal.org>

This form of medical practice is so broken and so dysfunctional, that I can go on forever. There is so much more to say and look at, but I will leave you with the thought that having done a preliminary review of the medical literature, you are well aware that this medicine is not sound. The USA as a world leader, must join other progressive countries such as Sweden, the UK, France and Denmark in putting science before activism and going back to the drawing board to figure out what really IS the best way to help these people. I don't think I am advocating for the end of transgenderism by asking that any surgery or medical intervention performed on anyone in this group be based on safe and sound practices that have been developed with purpose, discipline, and rigor. What is transphobic, homophobic, and misogynist is the current practice of experimenting on this vulnerable and often desperate population without care or respect for the patient.

Thank you again for your interest, your time, and your hard work in this matter.

Sincerely,

Rosita Weissberg

From: [Richard Florentine](#)
To: [Vazquez, Paul](#)
Subject: Dangers of early "gender affirming care"
Date: Tuesday, September 20, 2022 12:55:02 PM

[You don't often get email from rich_florentine@yahoo.com. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

My name is Dr. Richard Florentine, MD.

I am a licensed board certified physician of Internal Medicine in Massachusetts. I am writing to you about my strong concerns about the attempt in your state to advance the practice of "gender affirming care" for vulnerable patients with gender dysphoria despite the lack of good quality evidence on the benefits of this method of treatment and it's highly likely life- long and irreversible harm to vulnerable, young children and adolescents who do not have adequate brain maturation to be able to give fully informed consent.

The impetus for this push for "gender affirming care" seems to be mostly motivated by ideology and politics rather than medical facts and supportive evidence based proposals. This is very DANGEROUS for the practice of medicine and for some of the most vulnerable patients in our society. This practice needs to be halted until further study and adequate and well designed studies can protect these vulnerable children from a profit driven, ideologically dominated medical complex which is NOT founded on a sufficiently sound high quality evidence base to support it's claims. High quality evidence is required of every other kind of medical practice. The even more vulnerable children with gender dysphoria should not be subjected to irreversible harm to their bodies and brains without the usual medical practice of extensive study of new treatment possibilities.

The ideological foundations of this type of proposed medical care was proposed by Dr. John Money at Johns Hopkins University in Baltimore, whose experiment on an unfortunate male patient, David Reimer, who was not intersex but had a damaged penis from a botched circumcision, and was raised by his parents, at the recommendation of Dr. Money, as a girl. His treatment included both surgical and hormonal interventions to ensure that he would develop female-typical sex characteristics. This conformed with Money's theory that gender was a social construct that could be altered by the conditions under which a child was raised. However, the attempt to conceal from the child what had happened to him was not successful—the child self identified as a boy. Eventually, with the guidance from his psychiatrist, his parents informed him of what had happened to him at birth and he decided to reverse the hormonal and surgical interventions that had been performed to feminize his body. He continued to be tormented by his childhood ordeal and took his on wife at the age of 38.

David's life story is an example of the harm wrought by theories that gender identity can socially and medically be reassigned in children.

Previous medical literature had shown that in young male patients (the majority of the cases of GD) (in the past) with prepubescent gender dysphoria showed a high rate of natural resolution with 61-98% of the children reidentifying with their biological sex during the experience of their own puberty with psychological support. (work of Zucker).

Currently there has been a complete reversal of this pattern of gender dysphoria with a NEW (?Epidemic) form of non childhood initiated gender dysphoria in genetic adolescent girls, which has increased by 5000%. In addition, many of these patients have comorbid conditions such as autism/ASD and Attention Deficit/ Hyperactivity Disorder. The reasons for this new phenomena has not been fully explained. But since the recent introduction of "gender affirming treatment" on this subgroup of patients, has lead to 100 % of these patients have pursuing "gender transition" treatments.

In the US, the thrust for this kind of "gender affirming care" has been ideologically motivated, with an effort to

“silence’ all debate or oppositional voices.

In Europe, however, there has been a movement at reassessment after the leading Gender Identity Development Service, called Tavistock and Portman Trust’s Gender Identity Development Service clinic in London were closed after a “damning report on ideological malpractice”. On July 29,2022, the World’s Largest Pediatric Gender Clinic was shut down due to Poor Evidence , Risk of Harm and Operational Failures. These concerns have also been recognized increasingly in Western Europe, where more thorough medical records are kept, Thus Sweden has made the decision to no longer offer gender transition to minors outside of clinical trials. Finland has also now sharply restricted eligibility for gender transition to minors with a classic, early childhood onset gender dysphoria and no mental health comorbidities, and has stated that “psychotherapy” should be the first line of treatment.

At the Federal level of the USA, the US continues to assert that “gender-affirming” care is safe and effective, despite the findings of multiple systemic reviews of evidence that found that the benefits of gender transition are highly uncertain while the risks may be significant. Specifically, the Endocrine Society’s treatment guidelines for gender-dysphoric youth are followed, a minor’s future sterility is likely. Other health risks include compromised bone health, brain development, cardiovascular complications and a number of other, as yet unknown risks.

For these and other reasons, I strongly urge you to oppose supporting medical treatments that are not sufficiently evidence based, especially when irreversible harms is great and informed consent is not possible.

Sincerely yours,

Richard Florentine, MD
Massachusetts

From: [Rozy](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: "affirmative care" consultation submission
Date: Tuesday, September 20, 2022 6:13:07 AM
Attachments: [submission on affirmative care.docx](#)

Some people who received this message don't often get email from artbyrozy@gmail.com. [Learn why this is important](#)

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To whom it may concern,

I am writing regarding the proposed regulations on “gender-affirming” care currently under review in Florida. I am the parent of a gender-diverse son. We are currently living in Europe.

My son is 22 and is somewhat autistic. He is studying to be a software engineer but failed his end-of-term exams last year because he has an addiction to gaming, pornography and the internet that takes up most of his time and energy. On top of all of this, thanks to the undue influence of the online culture, he suddenly began to perceive his gender non-conforming style to mean that he is a ‘girl’. It should not need to be said, as it is very obvious to me, but this biology-defying claim is another manifestation of the mass psychosis through which we are currently living.

I am deeply concerned that adolescents like my son are being rushed into medicalization without us really understanding where all this gender confusion is suddenly coming from and, more importantly, with little or no serious clinical data about the long-term risks to health.

I would like to draw your attention to Dr Cass’ interim report in the UK in which she raises many concerns about the medicalization of gender non-conforming youth, such as the alarming fact that puberty blockers may cause “brain maturation” to be “temporarily or permanently disrupted”. I urge you to read her report for further information <https://cass.independent-review.uk/publications/interim-report/>

I believe that there are many routes that may lead to the development of distress over a young person’s gender and that there are just as many routes out of such distress.

I believe we should be looking at more **evidence-based approaches** to gender-questioning adolescents such as my son. We should be looking more **holistically** at young people to understand what is going on and we should not be centering treatment around untested medical options that pose such a danger to health, especially given the absolute lack of knowledge about the outcomes.

I support a **slow and cautious** approach that avoids medicalization and affirmation in favour of **watchful waiting**, comprehensive mental health support and evidence-based talking therapies.

Thank you for your time and consideration.

Your sincerely,

Rozy Wells

artbyrozy@gmail.com

Please see my letter attached to this email.

19th September 2022

Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Mr. Vasquez,

I am writing regarding the proposed regulations on “gender-affirming” care currently under review in Florida. I am the parent of a gender-diverse son. We are currently living in Europe.

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Thank you for your time and consideration.

Your sincerely,

Rozy Wells
artbyrozy@gmail.com

Dear Paul A. Vazquez, J.D. Executive Director Florida Board of Medicine,

I am a mom of a 24 year old young woman identifying as a man. My concern for my daughter's physical and mental health led me to research this movement. I am deeply shocked at the level of "knowledgeable" danger being exercised on and in children's bodies by professionals who have taken the Hippocratic Oath. The phenomenon we are witnessing right now is not just a case of social contagion influencing our children, but a social contagion affecting our adult population of governing entities.

There is a palpable fear of being shamed and/or losing jobs and reputation that has cowed medical and educational experts who know deep down something is amiss.

Meanwhile, this blind eye and fear of standing up for true health standards are exposing an entire generation to experimental damage. Irreversible procedures are currently being performed on an incalculable amount of innocent children whose moods, desires, and self-perceptions change from year to year.

The Puberty Blocker is being portrayed by media and information outlets as a harmless viable solution for children to consume while waiting for identity to emerge—yet it is nothing but harmful. It is a treatment destructive to human health—creating a myriad of serious lifelong complications such as sterility, stunted penis growth, vaginal atrophy and prolapse, stress on the endocrine system, etc.—not to mention hormone dependency (which affects brain function).

All this is being lauded and steamrolled under political advancement and medical profitability which is disconnected from the health care practice promised under the Hippocratic oath "to do no harm".

Please, as a mom, I beg you—help stop this crisis.

Paula Masters

September 20, 2022

Paul Vazquez, Executive Director
Board of Medicine
State of Florida
4052 Bald Cypress Way, BIN C#
Tallahassee, Florida 32399
Paul.Vazquez@flhealth.gov

Dear Mr. Vazquez,

As physicians we are committed to the statement, “First, Do No Harm”. I completely concur with the Florida Department of Health’s finding that “Gender Affirming Therapies” are experimental. This is reaffirmed in an article by Dr. Paul Hruz, *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria* published in the 2020 issue of the Linacre Quarterly¹. In commenting on his extensive research, Dr. Paul Hruz sums up his overview with this convicting exhortation for all physicians:²

“The care of people with gender dysphoria must be held to the same ethical and evidence-based standards demanded in other areas of medical practice. Despite claims to the contrary, there is so much that we do not yet know about sex-gender discordance. This makes it difficult if not impossible to adequately assess the long-term risks versus benefits of gender affirming medical interventions”

These treatments for our children must be guided by long term scientific and medical studies not by political whims.

I thank you for your commitment to protecting our children.

Peter Morrow, M.D.
Board Certified in Internal Medicine
Orlando Health Physician Associates
Assistant Professor of Internal Medicine
University of Central Florida College of Medicine
peter.morrow@orlandohealth.com
407 873-1130

¹ Hruz P. Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. The Linacre Quarterly. 2020, Vol (1) 34-42.

² Catholic Medical Association. 2020, February 13). Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria [Press Release] <https://www.cathmed.org/deficiencies-in-scientific-evidence-for-medical-management-of-gender-dysphoria/>

From: [Maria Purvis](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: RULE to stop medical transitioning of minors.
Date: Monday, September 19, 2022 10:39:00 PM
Attachments: [Letter to Florida Board of Medicine .pdf](#)

Some people who received this message don't often get email from maria_purvis@hotmail.com.

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September 18, 2022

Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

Dear Dr. Vazquez,

I am the mother of a young adult male. I am just one of many mothers going through the unimaginable. I raised my son with love, respect, values and I taught him to love himself and to accept who God created him to be. He was growing up as a young man who was happy, loved his family, created many memories with his family and never showed any signs of distress over his sex or gender confusion of any kind.

Suddenly, he started spending more and more time on-line watching videos of other "trans-identifying" kids and getting brainwashed to believe that he was also "trans" and this would solve his "pain and suffering". He didn't talk to his parents about it, he didn't try to talk to his pediatrician whose care he had been under for 20 years, he just wanted to medically transition and there was an urgency to start immediately. He made an appointment with an endocrinologist at a Planned Parenthood clinic, met for a quick 15-minute session, and left with a prescription for cross-sex hormones on that first visit. That was three years ago.

The young adults who are identifying as "trans" suffer from depression, anxiety, eating disorders, body dysmorphia, ADHD, autism, some were sexually molested earlier in life and some are simply deeply hurting from a broken relationship where they ended up feeling rejected by someone they loved. Yet when they went to the medical professional, they were not referred to a mental health specialist. No one sat and talked with them to see why they think they need to change their perfectly healthy bodies. Instead, these "doctors" prescribed the hormones and continue to refill these harmful drugs. Further, they are being lied to and told they can actually become the opposite sex. This is not biologically possible.

Where is the evidence proving that these drugs will heal them of their gender dysphoria? There is no evidence that medically transitioning children actually improves mental health outcomes of these children. Every cell in our body is marked XX or XY and there is no way of changing that. Those doctors are encouraging vulnerable kids to think that "transitioning" is the way to solve all their normal teenage angst. My son has been prescribed estradiol,

spironolactone, and progesterone even though he has Crohn's disease and family history of heart and liver disease. These drugs are shaving years off of his life, will make him sterile, cause blood clots, cancer, brain issues, and basically cause non-reversible side effects. These doctors took the Hippocratic Oath. They promised to uphold ethical standards. Why are they doing this to our children? Are these drugs even safe for my son to take?

These young men and women who are identifying as "trans" were growing up as healthy young men and women. Yes, many are uncomfortable with their bodies, but weren't we all during our teenage years? Would you prescribe diet pills to a child with anorexia because they "believe they are fat" or would you recommend that the anorexic patient see a psychologist? Why are these medical professionals medicalizing these young kids instead of referring them to mental health professionals? Our daughters and sons don't need cross sex hormones, they need mental health care. They hate their bodies, they have succumbed to the Internet with its videos and websites portraying happiness if you only transition. They are experiencing normal discomfort with their body, but are being convinced that any amount of discomfort with their body is an indication that they are "transgender." Isn't it surprising to our medical professionals that they are seeing more and more young patients seeking hormones? Where is the medical curiosity as to why we are seeing this increase? Isn't it alarming that just a few years ago you there were but a few patients identifying as transexual and how the number of young kids who identity as "trans" has increased by 500%?

It seems like a cookie-cutter story due to a social contagion that has all these kids wanting to transition as if being "trans" would make them popular or accepted by their peers. I am part of a support group of 500+ parents and every single one of us has a similar story to tell. Our sons or daughters, all of a sudden, announced they were "trans". It came out of nowhere. Virtually all of them were vulnerable in some way and many have co-occurring mental health issues. Some waited until they were away at college to make the announcement and they all went to a Planned Parenthood clinic (or even had a virtual visit) and walked away with a prescription for cross-sex hormones on the first visit. No consultation, no mental health screening, nothing. There is zero safe-guarding in place. Isn't this alarming? Can these medical professionals just continue to look the other way and continue prescribing the hormones without regard for the mental health of these children and the harm this is doing to their bodies?

Young girls are having double mastectomy surgeries!!!! This was a procedure reserved for cancer patients and now young girls, with perfectly healthy body parts, are CHOOSING to have a double mastectomy because they hate their body. Some are creating GoFundMe pages to raise money for these harmful surgeries!!!! They are being told by these "so-called" professionals that if you hate your body, you must be "trans", and removing your perfectly healthy body parts is the right thing to do. Do you really believe that? Would you want your own daughter, son, niece, nephew, grandchild to be part of this "trans" cult and undergo these dangerous procedures because they "feel" that they were born in the wrong body? Feelings are not facts and feelings change constantly during adolescence.

I am begging you to rethink the medical guidelines that are in place today in Florida for these “gender-confused” young kids. I am begging you to stand up and say “no” to this social contagion disguised as “transgenderism”. Please get these kids mental health care, which is what they need, not harmful and experimental drugs! All of us concerned parents are hoping for the same thing: that Florida and this board will put legislation in place that will prevent doctors from being able to prescribe experimental drugs such as puberty blockers and cross sex hormones and will prevent doctors from performing any type of gender affirming surgeries such as double mastectomies, breast augmentation, vaginoplasty or phalloplasty on minors. Even young adults who are under 25 should not be allowed to receive these experimental drugs or surgeries as there is real evidence that the brain is not fully developed until age 25 and therefore these young adults cannot give informed consent because they don’t have the ability to fully understand the consequences of these treatments.

Things are changing in parts of Europe and in the UK. In the US, a growing movement of parents and ETHICAL clinicians, most of whom are lifelong progressives and active supporters of LGBTQ people and causes, are organizing and becoming vocal about their outrage and rejection of gender ideology. They are speaking out about the unsupported diagnostic claims and harmful treatment practices it has given rise to. When the lawsuits start coming this will be exposed as one of the biggest medical scandals in history. It’s only a matter of time. Please also keep in mind that we are also now seeing the number of de-transitioners increase every day because they are realizing that medical transitioning did not fix their discomfort and many are saying that the source of their discomfort was a mental health issue all along and that was ignored and never explored by the medical professionals.

PLEASE STOP ALLOWING THE GENDER MEDICALIZATION OF OUR SONS AND DAUGHTERS!

Sincerely,

Maria Purvis

September 18, 2022

Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

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Suddenly, he started spending more and more time on-line watching videos of other “trans-identifying” kids and getting brainwashed to believe that he was also “trans” and this would solve his “pain and suffering”. He didn’t talk to his parents about it, he didn’t try to talk to his pediatrician whose care he had been under for 20 years, he just wanted to medically transition and there was an urgency to start immediately. He made an appointment with an endocrinologist at a Planned Parenthood clinic, met for a quick 15-minute session, and left with a prescription for cross-sex hormones on that first visit. That was three years ago.

The young adults who are identifying as “trans” suffer from depression, anxiety, eating disorders, body dysmorphia, ADHD, autism, some were sexually molested earlier in life and some are simply deeply hurting from a broken relationship where they ended up feeling rejected by someone they loved. Yet when they went to the medical professional, they were not referred to a mental health specialist. No one sat and talked with them to see why they think they need to change their perfectly healthy bodies. Instead, these “doctors” prescribed the hormones and continue to refill these harmful drugs. Further, they are being lied to and told they can actually become the opposite sex. This is not biologically possible.

Where is the evidence proving that these drugs will heal them of their gender dysphoria? There is no evidence that medically transitioning children actually improves mental health outcomes of these children. Every cell in our body is marked XX or XY and there is no way of changing that. Those doctors are encouraging vulnerable kids to think that “transitioning” is the way to solve all their normal teenage angsts. My son has been prescribed estradiol, spironolactone, and progesterone even though he has Crohn’s disease and family history of heart and liver disease. These drugs are shaving years off of his life, will make him sterile, cause blood clots, cancer, brain issues, and basically cause non-reversible side effects. These doctors took the Hippocratic Oath. They promised to uphold ethical standards. Why are they doing this to our children? Are these drugs even safe for my son to take?

These young men and women who are identifying as “trans” were growing up as healthy young men and women. Yes, many are uncomfortable with their bodies, but weren’t we all during our teenage years? Would you prescribe diet pills to a child with anorexia because they “believe they are fat” or would you recommend that the anorexic patient see a psychologist? Why are these medical professionals medicalizing these young kids instead of referring them to mental health professionals? Our daughters

and sons don't need cross sex hormones, they need mental health care. They hate their bodies, they have succumbed to the Internet with its videos and websites portraying happiness if you only transition. They are experiencing normal discomfort with their body, but are being convinced that any amount of discomfort with their body is an indication that they are "transgender." Isn't it surprising to our medical professionals that they are seeing more and more young patients seeking hormones? Where is the medical curiosity as to why we are seeing this increase? Isn't it alarming that just a few years ago you there were but a few patients identifying as transexual and how the number of young kids who identity as "trans" has increased by 500%?

It seems like a cookie-cutter story due to a social contagion that has all these kids wanting to transition as if being "trans" would make them popular or accepted by their peers. I am part of a support group of 500+ parents and every single one of us has a similar story to tell. Our sons or daughters, all of a sudden, announced they were "trans". It came out of nowhere. Virtually all of them were vulnerable in some way and many have co-occurring mental health issues. Some waited until they were away at college to make the announcement and they all went to a Planned Parenthood clinic (or even had a virtual visit) and walked away with a prescription for cross-sex hormones on the first visit. No consultation, no mental health screening, nothing. There is zero safe-guarding in place. Isn't this alarming? Can these medical professionals just continue to look the other way and continue prescribing the hormones without regard for the mental health of these children and the harm this is doing to their bodies?

Young girls are having double mastectomy surgeries!!! This was a procedure reserved for cancer patients and now young girls, with perfectly healthy body parts, are CHOOSING to have a double mastectomy because they hate their body. Some are creating GoFundMe pages to raise money for these harmful surgeries!!!! They are being told by these "so-called" professionals that if you hate your body, you must be "trans", and removing your perfectly healthy body parts is the right thing to do. Do you really believe that? Would you want your own daughter, son, niece, nephew, grandchild to be part of this "trans" cult and undergo these dangerous procedures because they "feel" that they were born in the wrong body? Feelings are not facts and feelings change constantly during adolescence.

I am begging you to rethink the medical guidelines that are in place today in Florida for these "gender-confused" young kids. I am begging you to stand up and say "no" to this social contagion disguised as "transgenderism". Please get these kids mental health care, which is what they need, not harmful and experimental drugs! All of us concerned parents are hoping for the same thing: that Florida and this board will put legislation in place that will prevent doctors from being able to prescribe experimental drugs such as puberty blockers and cross sex hormones and will prevent doctors from performing any type of gender affirming surgeries such as double mastectomies, breast augmentation, vaginoplasty or phalloplasty on minors. Even young adults who are under 25 should not be allowed to receive these experimental drugs or surgeries as there is real evidence that the brain is not fully developed until age 25 and therefore these young adults cannot give informed consent because they don't have the ability to fully understand the consequences of these treatments.

Things are changing in parts of Europe and in the UK. In the US, a growing movement of parents and ETHICAL clinicians, most of whom are lifelong progressives and active supporters of LGBTQ people and causes, are organizing and becoming vocal about their outrage and rejection of gender ideology. They are speaking out about the unsupported diagnostic claims and harmful treatment practices it has given

rise to. When the lawsuits start coming this will be exposed as one of the biggest medical scandals in history. It's only a matter of time. Please also keep in mind that we are also now seeing the number of de-transitioners increase every day because they are realizing that medical transitioning did not fix their discomfort and many are saying that the source of their discomfort was a mental health issue all along and that was ignored and never explored by the medical professionals.

PLEASE STOP ALLOWING THE GENDER MEDICALIZATION OF OUR SONS AND DAUGHTERS!

Sincerely,

Maria Purvis

From: [James Breen](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Opposition to "gender-affirming care" for children in FL
Date: Monday, September 19, 2022 8:25:01 PM
Attachments: [FBM Gender affirming letter Sept 2022.docx](#)

Some people who received this message don't often get email from james.o.breen@gmail.com.

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Dear Mr. Vazquez and Members of the Florida Board of Medicine:

As a practicing family physician in the State of Florida, I write to implore that the Florida Board of Medicine restrict the practice of “gender-affirming care”—including social gender transition, hormone therapy, and gender-reassignment surgery—for children and adolescents. The short- and long-term harms as a result of such “gender-reassignment” practices on children are severely damaging and irreparable, and medical and evidence-based studies do not support their use.

Additionally, given that over 80% of children affected by gender dysphoria will eventually lose their desire to identify with their non-birth sex, it is a professional dereliction of duty for the medical community to allow such procedures—which result in disfigurement, sterility, and other lifelong damage to bodily and mental health-- with the professional sanction of the Board of Medicine.

It is my sincere hope that the Florida Board of Medicine will restrict the use of such “gender-reassignment” practices for children and adolescents, in the interest of preserving the health and well-being of Florida’s children and families.

Sincerely,

James O. Breen, M.D.
6578 Kestrel Circle
Fort Myers, Florida 33966
FL Medical License: ME89728
James.O.Breen@gmail.com

From: [January Littlejohn](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Rule for Gender Affirming Care of Minors - Paul A. Vazquez, J.D. Executive Director Florida Board of Medicine
Date: Tuesday, September 20, 2022 1:52:30 PM
Attachments: [FI Board of Medicine letter-FINAL.docx](#)

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Dear Dr. Vazquez and fellow board members,

I am a mother of a teen daughter who suddenly started experiencing distress over her sex at age 13. I am also a licensed mental health counselor in Florida. My daughter expressed no previous signs of gender confusion in her childhood and the confusion only started after three other friends at school also started identifying as transgender. She was diagnosed with ADHD in the 4th grade, which makes her emotionally behind her peers. She also has difficulty making and maintaining meaningful, long-lasting friendships.

As we struggled to understand the sudden announcement from our daughter, we elicited the help of a mental health professional. Shortly after, we found out her middle school socially transitioned her without our knowledge or consent. Her mental health deteriorated. She became more angry, withdrawn and depressed. What the school had done was create a huge wedge between our daughter and us, which was a strain on all of us.

We chose a path of watchful waiting after doing months of research, along with the advice of her counselor. I looked into what gender affirming care truly was and I was shocked to discover that children and teenagers were being given experimental drugs in the form of puberty blockers and cross sex hormones that cause irreversible changes to their young bodies that include loss of future fertility and sexual function. There was also no high-quality evidence that medical transitioning produced positive outcomes in the patients. Why would we risk our daughter's future whole self and fertility on such low quality, flimsy research?

I also learned that surgeries like double mastectomies were being performed on minors here in Florida. I couldn't understand why parents would consent to these irreversible changes for their child or why doctors who understand the nature of adolescent brain development would be making these recommendations and treatments for children and teens. Children and teens certainly cannot give informed consent because their brains are not fully developed until approximately age 25. They don't have the ability to weigh the consequences of these choices and how they will feel about them in 5, 10, or 20 years. There used to be safeguarding in place for medical transitioning. Now, that safeguarding no longer exists. Children are being only affirmed at gender clinics, private physician offices and by mental health clinicians and are fast tracked along a medical pathway.

We also discovered that most of the major medical and psychological associations were blindly supporting these radical treatments without ever actually looking at the evidence and research being used to justify them. Many of the parents that do consent to their child being medically transitioned are coerced into believing that their child would commit suicide if they did not affirm. These parents could never truly have given informed consent because they were not offered any

alternate treatment pathways such as psychotherapy or watchful waiting. Further, how can they give informed consent when the long-term consequences are not fully known about these medications which are not FDA approved for gender dysphoria?

Now, we are seeing teens and young adults that were put on these medical pathways regret their transition because it did not fix their dysphoria or resolve the root cause of their distress. Many of these individuals have co-occurring mental health issues such as previous sexual trauma, eating disorders, anxiety, depression and autism. Some of the detransitioners are sterilized from the hormones, but many have no idea of the state of their fertility. There are detransitioners experiencing medical issues that doctors don't even fully know how to treat or fix, especially those with complications from gender surgeries such as phalloplasty.

We are literally allowing doctors to experiment on children based on a feeling the child has, a self-diagnosis, that could very well change over time as the child matures in a loving, neutral environment. Please stop allowing doctors to experiment on children. If we had affirmed my daughter, she would have absolutely gone down this path thinking medical transitioning would fix her pain. She was convinced that her pain would only be solved by hormones and surgeries, yet she had no idea what the short-term or long-term consequences of these treatments would be. If we had affirmed her in the false identity, what it really would have done is affirmed her self-loathing, encouraged body disassociation and put her along a path to be a medical patient for life that may have led to her suicide, given the suicide rate 7-10 years post transition is 19 times that of the normal population.

My daughter has desisted after two years and is on a path of self-love in the body she was created in. Please protect future children from the harm of medical experimental transition medications and surgeries. Please restore integrity to the medical community by creating a rule grounded in science and robust evidence-based research instead of ideology. There is no longer even a coherent, shared definition of the word "transgender" among the medical community. There is also no test to tell which child will desist and which child will persist in their desire to transition. There is no test that will tell us which child will regret these irreversible and experimental medical treatments and which will not. Our children deserve ethical and compassionate care for gender dysphoria, which is a mental health issue that needs to be treated by mental health professionals, not hormones and surgeries that will mutilate and disfigure their bodies. Thank you for your time and consideration.

Sincerely,

January Littlejohn

Tallahassee, FL

Dear Dr. Vazquez and fellow board members,

I am a mother of a teen daughter who suddenly started experiencing distress over her sex at age 13. I am also a licensed mental health counselor in Florida. My daughter expressed no previous signs of gender confusion in her childhood and the confusion only started after three other friends at school also started identifying as transgender. She was diagnosed with ADHD in the 4th grade, which makes her emotionally behind her peers. She also has difficulty making and maintaining meaningful, long-lasting friendships.

As we struggled to understand the sudden announcement from our daughter, we elicited the help of a mental health professional. Shortly after, we found out her middle school socially transitioned her without our knowledge or consent. Her mental health deteriorated. She became more angry, withdrawn and depressed. What the school had done was create a huge wedge between our daughter and us, which was a strain on all of us.

We chose a path of watchful waiting after doing months of research, along with the advice of her counselor. I looked into what gender affirming care truly was and I was shocked to discover that children and teenagers were being given experimental drugs in the form of puberty blockers and cross sex hormones that cause irreversible changes to their young bodies that include loss of future fertility and sexual function. There was also no high-quality evidence that medical transitioning produced positive outcomes in the patients. Why would we risk our daughter's future whole self and fertility on such low quality, flimsy research?

I also learned that surgeries like double mastectomies were being performed on minors here in Florida. I couldn't understand why parents would consent to these irreversible changes for their child or why doctors who understand the nature of adolescent brain development would be making these recommendations and treatments for children and teens. Children and teens certainly cannot give informed consent because their brains are not fully developed until approximately age 25. They don't have the ability to weigh the consequences of these choices and how they will feel about them in 5, 10, or 20 years. There used to be safeguarding in place for medical transitioning. Now, that safeguarding no longer exists. Children are being only affirmed at gender clinics, private physician offices and by mental health clinicians and are fast tracked along a medical pathway.

We also discovered that most of the major medical and psychological associations were blindly supporting these radical treatments without ever actually looking at the evidence and research being used to justify them. Many of the parents that do consent to their child being medically transitioned are coerced into believing that their child would commit suicide if they did not affirm. These parents could never truly have given informed consent because they were not offered any alternate treatment pathways such as psychotherapy or watchful waiting. Further, how can they give informed consent when the long-term consequences are not fully known about these medications which are not FDA approved for gender dysphoria?

Now, we are seeing teens and young adults that were put on these medical pathways regret their transition because it did not fix their dysphoria or resolve the root cause of their distress. Many of these individuals have co-occurring mental health issues such as previous sexual trauma, eating disorders, anxiety, depression and autism. Some of the detransitioners are sterilized from the hormones, but many have no idea of the state of their fertility. There are detransitioners experiencing medical issues

that doctors don't even fully know how to treat or fix, especially those with complications from gender surgeries such as phalloplasty.

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Sincerely,

January Littlejohn

Tallahassee, FL

From: [Connie](#)
To: [Vazquez, Paul](#)
Subject: State of Florida medical board
Date: Monday, September 19, 2022 11:19:03 PM

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Dear Florida Board of Medicine,

Thank you for questioning the regulation of so-called "gender-affirming" hormones and surgeries for young people. I can guarantee that this is one of the most important issues of our lifetime.

As a parent of one of these children, I have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions sometimes on the first or second visit. The myth that our children are getting "assessments" is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society's recommendations. Even with an older child, there is often social dysmorphia and extreme OCD that should be addressed before anything having to do with gender is even talked about. My son is one of those older youth who was coerced into going on hormones and eventually ending up with an orchiectomy. The physicians and mental health "experts" did not fix his social anxiety or his TOCD. He is in a much worse place than he has ever been in. We are really struggling right now and worry every day about his mental state.

Older adolescents can get hormones with no assessments at all, and have their healthy body parts amputated by eager surgeons on little more than self-declaration of "trans identity." I suspect that my child may be gay with autistic traits and has come to believe his very real distress is explained by the fact that he is "transgender" and that hormones and surgeries will help. They will not. I have seen my child's mental and physical health plummet following "gender-affirmation."

I also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation."

Thank you for doing what you can to regulate this social experiment on our vulnerable children. I believe that this is going to go down as the largest medical scandal ever in the history of bad medicine. It's time to pick a side. I hope you pick the side of children.

Thank you,

Connie Hahn

From: [Sue Minear](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Sex based medicine practices in Florida
Date: Tuesday, September 20, 2022 3:21:54 PM

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Hello- I understand the Florida BOM will be meeting to consider implementing regulations regarding sex based medicine. I am writing to state my strong opposition to this so-called gender affirming care, especially when it is directed at youth.

I am a physician and am very concerned that youth are being manipulated by adults for financial gain. This includes youth with intellectual disabilities and autism. It is especially troubling that parents may be removed from the process of consent.

I strongly encourage the Florida BOM to maintain its integrity and reject any regulations that would permit sex based medicine directed at youth.

Thank-you,

Susan Minear, MD
Boston, Ma

Sent from my iPhone

From: [zzzz Feedback, BOM_MeetingMaterials](#)
To: [BOM Public Comment](#)
Subject: RE: Submission
Date: Monday, October 17, 2022 5:01:10 PM

From: miriam grossman <miriamgrossmanmd@hotmail.com>
Sent: Tuesday, September 20, 2022 1:50 PM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>; zzzz Feedback, BOM_MeetingMaterials <BOM.MeetingMaterials@flhealth.gov>
Subject: Submission

Some people who received this message don't often get email from miriamgrossmanmd@hotmail.com. [Learn why this is important](#)

Dear Dr Vazquez and Florida BOM,
I am attaching to this email an article about transgender care that I wrote. Please include it in the medical record.

Thank you
Miriam Grossman MD

Sent from my iPad

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OPINION

How Do Gender Transitions Impact Children? Here's What The Science Says

By **Miriam Grossman, MD**

DailyWire.com



▀ PART 6 OF 8

What Is A Woman?

President Joe Biden has advised parents that early surgeries, hormone treatments, and affirmations are crucial for the health of their gender-confused children. According to the president, these are some of the most powerful things a parent can do. As a child and adolescent psychiatrist who treats some of the families facing these issues, his statements are surprising and, due to their medical and societal implications, warrant thorough fact-checking.

To clarify, “affirmation” means unquestioning acceptance of a child’s chosen gender identity – be it the opposite sex, a combination of male and female, neither male nor female, or one of the multitudes of other possibilities presented to children by the media, online, and at school. This means abandoning the use of a child’s given name and the pronouns consistent with their biology and replacing them with the name and pronouns they’ve picked; permitting them the clothing and hairstyle

of their choice; allowing girls to bind and boys to tuck; and facilitating their use of opposite sex restrooms, participation in opposite sex sports teams, and so on.

“Hormone treatment” refers to both puberty blocking agents (PBAs), which halt the critical process by which children mature into adults and cross-sex hormones, which are given a few years after PBAs to chemically simulate the puberty of the opposite sex.

“Surgeries” refer to bilateral mastectomies, the removal of ovaries and the uterus, and the construction of a faux penis in girls and breast implants, the removal of the penis and testes, and the construction of a faux vagina in boys. In the U.S., mastectomies are performed on girls as young as thirteen, and minor boys are being castrated. There is also a surgery that removes all genitalia, marketed by surgeons to individuals who identify as neither male nor female, or “non-binary.”

Perhaps Joe Biden believes there is strong evidence that these life-altering social and medical interventions lead to positive outcomes. If so, he couldn’t be more mistaken.

The severe lack of scientific knowledge of gender dysphoria is acknowledged by experts in the field. The American Psychological Association has stated, “...because no approach to working with [transgender and gender nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children.” The lack of knowledge is even more pronounced for gender dysphoria with onset in adolescence who constitute a new, unstudied cohort.

In 2020 the UK's National Institute for Health and Care Excellence (NICE) did a systematic review of puberty blockers and cross-sex hormones and found evidence that the medications' "potential benefits are of very low certainty."

Similarly, Dr. Stephen Levine, a pioneer in the study and treatment of sexuality and gender problems since 1974 and arguably the most highly credentialed and respected voice in the field, wrote in an expert affidavit: "The knowledge-base concerning the causes and treatment of gender dysphoria has low scientific quality."

Professor Carl Heneghan, Editor in Chief of the *British Medical Journal* and director of the Centre of Evidence Based Medicine at Oxford, along with Professor Tom Jefferson, a clinical epidemiologist, completed an independent analysis of research on transgender medical interventions. Concerning puberty blockers, Prof Heneghan stated, "The quality of evidence in this area is terrible."

For these and other reasons, the science regarding the treatment of children and teens with gender dysphoria is far from settled, and there is no consensus whatsoever among doctors and therapists.

The stakes are high: the consequences of hormones and surgeries include: infertility, sexual dysfunction, osteoporosis, cardiovascular disease, and, for some, crippling emotional pain.

Yet the president is calling for early treatment; it's one of the most powerful things a parent can do, he says. Jazz Jennings' parents made sure their child was treated early for gender dysphoria. Jazz, the poster

child for the transgender industry, started PBAs at the age of eleven and went on estrogen in high school. Before castration and the construction of a faux vagina at age seventeen, Jazz reported to surgeon Marci Bowers that sexual sensations and orgasm were unknown experiences. Now twenty-one, Jazz has gained a hundred pounds and is “struggling severely with mental health issues.”

For the White House to state that early affirmation of children with gender issues is “crucial” is a dangerous falsehood, one that misleads parents and places children at risk for serious harm and lifelong suffering.

Instead, parents must be aware of the following:

Regarding children who develop gender dysphoria before puberty, the great majority, on average about 80% but ranging between 50 and 96% depending on the study, become comfortable with their bodies. This improvement occurs if they go through normal puberty and is called “desistance.” There is no way to know if a particular child will desist, but Jazz could have been one.

One clinician with expertise in the field explains, “Gender dysphoria in pre-adolescent children is a condition that ameliorates by itself in most cases if you are just patient.”

Changing names, pronouns, and presentations can decrease desistance. Puberty blockers are controversial and have a history of lawsuits. Their off-label use in healthy children is experimental, and they have serious adverse effects that are irreversible, such as osteoporosis and early

menopause. There is no country in which PBAs are licensed for the treatment of gender dysphoria.

Once on puberty blockers, desistance is very rare. Nearly all children placed on blockers go on to take opposite sex hormones, which must be taken forever.

Until very recently, gender dysphoria was a very rare diagnosis, with a prevalence of 1:30,000 to 1:110,000 and a male to female ratio of 6:1. A massive explosion of gender dysphoria cases began in the past decade or so. A 2017 study noted a prevalence of self-reported transgender identity in children, adolescents, and adults ranging from 5:1000 to 13:1000. A 2021 study suggested that the rate of transgender identification among urban youth in the US may be as high as nine in 100. It is not definitively known what is causing so many young people to reject their biology.

The new form of gender dysphoria develops during adolescence, predominantly in girls with no earlier discomfort with their sex. It appears suddenly and is therefore known as Rapid Onset Gender Dysphoria (ROGD). The girls' discomfort with being female typically follows increased use of the internet and social media and is associated with comorbid mental health disorders and neurodevelopmental disability.

The social influence aspect of ROGD is striking, with one study showing that 86.7% of young people with ROGD had one or more friends who came out as transgender at the same time and/or had an increase in their use of social media. The spreading of behaviors and beliefs amongst friends, especially between girls, is a well-documented phenomenon.

Every adolescent goes through some degree of difficulty accepting the physical and emotional changes of puberty. That difficulty is magnified for children with emotional and neurodiverse conditions such as ADHD and autism spectrum disorder. They struggle with their changing bodies, nascent sexuality, individuation from parents, and acceptance by peers. Many are lonely; this was exacerbated during COVID lockdowns. These vulnerable kids search for relief, and they find it on the internet.

Transgenderism is promoted by online activists as a solution to nearly every psychosocial problem. Youth are led to believe their social awkwardness, lack of friends, sadness, eating issues, discomfort with their bodies – all of it – is because they might be “trans”: their gender does not “align” with the sex “assigned” to them at birth.

Upon announcing a “trans” identity, a new name, and new pronouns, a child is welcomed by an enthusiastic community, both online and in real life, and showered with attention, praise, and – most importantly – acceptance. It’s what he or she has always yearned for: to be admired and appreciated – to belong.

The significance to an unhappy, anxious, socially awkward child of being embraced and celebrated by peers cannot be overestimated. Parents and clinicians caring for trans-identified young people must look at the secondary gain of adopting new identity.

Recognizing that the nature of adolescence is to explore identity and that the brain – and therefore many cognitive processes related to identity and decision-making – is not fully developed until the mid-20’s, Arkansas and Tennessee passed bills outlawing hormonal and surgical treatments

for gender dysphoria in minors. Similar bills have been introduced in the state legislatures of Idaho, Utah, Missouri, and Alabama. President Biden calls these bills “hateful,” but they protect children who lack the capacity to grasp the long term consequences and risks of life-altering medical interventions.

Parents tempted to give the president’s words credibility should also know that treating their child’s distress with hormones and surgeries greatly reduces the size of their dating pool and their chance of marriage. Studies from different countries indicate more anxiety, depression, substance abuse, domestic violence, eating disorders, suicidal ideation, and suicide in the transgendered. A thirty year study from Denmark showed shortened life expectancy and a high incidence of suicide. A Swedish study found that sex-reassigned, transsexual persons – both male and female – had approximately a three times higher risk of all-cause mortality than non-transsexuals. Elevated causes of mortality included cancer, cardiovascular disease, and violent crime. A Dutch study over five decades showed an increased mortality risk in transgender people using hormone treatment.

There is a risk of suicide in gender-questioning teens, but there is no evidence that transition lowers that risk. One study showed that following genital surgery, transgender patients were 4.9 times more likely to attempt suicide and 19.1 times more likely to have died from suicide, after adjusting for the presence of psychiatric comorbidities.

President Biden failed to mention the possibility that a gender-confused child who is automatically affirmed and given hormones and operations

before he or she has a chance to grow up, experience the pleasure their healthy body can provide, or carefully consider parenthood, may one day deeply regret the entire process. Those people advising the president on this issue probably claim regret is rare, but it's not. This detransitioners' site alone has 28,000 members.

One of the major complaints of people who regret their transition is directed at the medical professionals who immediately affirmed their new identities without fully considering the possibility of other underlying emotional causes. Years later, these people realize they had serious mental health problems that led them to flee from their masculinity or femininity. If those problems had been addressed at the time, they claim they would not have transitioned.

It's deeply troubling that the president did not mention the role of psychotherapy in the treatment of gender-questioning children. Anyone who is following this topic knows that in contrast to U.S. practitioners who pressure parents to affirm and medicalize, several socially progressive and LGBT friendly countries, following systematic review of the literature, made dramatic U-turns in their treatment approach to minors: Finland and Sweden have banned hormones and surgeries for patients under 16 or 18 in regular clinical settings. England sharply curtailed medical treatment of minors. Holland examines each child closely and makes decisions on a case-by-case basis. France has urged "great caution." A position statement by psychiatrists in Australia and New Zealand does not specifically endorse affirmation. The preferred treatment in all those countries is now psychotherapy.

What this means is that a gender-questioning girl in Stockholm or Amsterdam will explore her struggles with a mental health professional. Whereas the same girl in Boston or Seattle can access Testosterone and mastectomies with ease, and within months, she'll have a flat chest and a permanently lowered voice.

Understand this: other countries have applied the brakes on affirmation, hormones, and surgery, but our president has instructed parents to accelerate. . But Biden's advice is scientifically baseless. Available data does not support the argument that any type of "affirmation" of transgender identity results in improved emotional health in the long term. To the contrary, there is evidence of serious harm. The White House is promoting nothing less than a reckless experiment on children. For this man-made catastrophe, young Americans and their families are paying and will continue to pay a terrible price.

Miriam Grossman, MD is a board-certified child, adolescent and adult psychiatrist and author. She has been exposing the dangers of gender ideology for over a decade. Her website is www.MiriamGrossmanMD.com

From: [nancy.cowen](#)
To: [Vazquez, Paul](#)
Subject: Caution for Trans Medicalization - Irreversible Harm
Date: Friday, September 16, 2022 12:11:53 PM

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Please lead the USA, adopt a cautious, slower and safer approach to treating children with gender questioning.

My 14 year old daughter is in extreme mental pain. Sexual trauma, suicide attempts, selfharm, eating disorders, 6 months in and out of psych hospitals. She says she is a boy. This is her solution to protect herself from more harm. Therapist, doctors, teachers, her peers all say "yes, of course you're a boy", and send her to the Gender Clinic. Where there is no exploratory therapy, no treatment except surgery and drugs.

Brain development is not solidified until the mid 20's. Adolescents can not comprehend "informed consent" - most can't drive, buy tobacco, alcohol etc. Is not reasonable to think they can understand the consequences of cutting off their breast, or hormones.

Youth Transition should be stopped. It's feeding the illusion that medicalizing will lead them to a new identity and stop their pain. Take away this option, let families focus on what is underneath the pain.

Please protect our children.

From: [Unsworth, John-Mark](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender_transitioning_in_minors
Date: Tuesday, September 20, 2022 2:01:10 PM

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To whom it may concern,

I recently attended a conference in partnership with the Christian Medical & Dental Associations entitled "Critical Conversations on Identity & Gender". During the course of that event I had the opportunity to hear from Dr. Paul Hruz, whose credentials (taken from the event description) I have listed below:

"Paul Hruz, MD, PhD, is an Associate Professor of Pediatrics, and Associate Professor of Cellular Biology and Physiology in the Division of Pediatric Endocrinology and Diabetes within the Department of Pediatrics at Washington University School of Medicine, St Louis, Missouri. He is a member of the Endocrine Society, the Pediatric Endocrine Society, the American College of Pediatricians, and the American Diabetes Association. Hruz received his BS Degree from Marquette University and his MD and PhD degrees from the Medical College of Wisconsin. Dr. Hruz has over 20 years of clinical experience in caring for children with disorders of sexual development. He also has formal certification in Healthcare Ethics and is a regular contributor to his University's course of Research Ethics for graduate students. He has authored over 60 peer-reviewed manuscripts, scientific reviews and book chapters."

As can be manifestly seen, Dr. Hruz is an expert in his field, the field of pediatric endocrinology. As a doctor who has spent over 20 years working with children with disorders of sexual development, he is well positioned to speak about the evidence in the current literature which is used as the basis by proponents of medical gender transitioning for the advancement of such procedures.

Dr. Hruz' professional opinion is that on almost every point of issue, the evidence and research advocating for transitioning is either minimal or not up to sufficient standards.

As an MD candidate currently rotating in Miami area hospitals, and as someone who may practice medicine in the state of Florida in the very near future, I am strongly recommending that the Florida Medical Board consider a moratorium on this issue: there is simply not enough quality evidence to be able to support potentially psychologically, socially, and medically detrimental legislation which would allow for medical and/or surgical changes to alter secondary sexual characteristics in minors.

I also question if it is possible for a child under 18 to have the capacity to offer informed consent for

such things. When you were 18, my esteemed members of the board, were you as emotionally stable and mentally balanced as you are today? Or were you, like many of the children that we personally know (and counted ourselves as, at one time), emotionally and socially labile, and easily swayed by the popular opinions of those around us of the same age, and the same temperaments; a condition which has been exponentially magnified over the last decades by the institutions of social media and media streaming services.

As adults now in positions of authority, you all have the ability to rise above the hype and the uncontrolled and rapidly accelerating madness our culture is experiencing. As a plane which fly's through a cloud and experiences turbulence must rise above the cloud to be in a position to fly through smoother airs, so too can you all in this moment fly above the cultural turmoil which we are facing and be in a position to steer our states medical and legislative concourse back to a place where reason and due diligence of time and process mark the discussion and discourse in these respective bodies.

Thank you very much for your time and candid considerations on this matter.

Sincerely,

John-Mark Unsworth M.Sc, Medical Science
John-marku@auamed.net
(978) 907-4892
Aspiring Physician
American University of Antigua
College of Medicine
FIU Clinical Core Clerkship Program
MD Candidate Class of 2024

From: [Ken Edel](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: gender care
Date: Tuesday, September 20, 2022 5:44:44 PM

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Dear Board Members,

I am a family medicine physician in Charlotte, North Carolina. I need a local group of physicians who are dedicated to practicing with well-formed bioethical principles in mind.

I am very concerned that there is a significant amount of data showing that gender affirming care leads to irreparable harm for the patient. The data is particularly clear that gender transition surgery does not resolve the underlying issues and particularly does not help with gender dysphoria and depression. Regret and irreparable infertility are often the result.

Solid bioethics are grounded in nonmaleficence, beneficence, and patient autonomy. Unfortunately, at this time, patient autonomy incorrectly holds sway with many medical decisions. I urge you and the others with the board of medicine to act with solid bioethical backing and predominant evolving opinion around the world in opposing most "gender affirming care" while focusing on the care for the patient and encouraging support for gender dysphoria without hormones and surgery.

Ken Edel MD
704.726.9341

From: [Panacol Productions](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Florida Board of Medicine - documentary on 6 detransitioners ("Beta" version)
Date: Wednesday, September 21, 2022 4:02:47 AM

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Dear Mr. Vazquez, dear Members of Florida Board of Medicine,

The filmmakers who created a feature-length documentary-in-progress on **six detransitioners** harmed for life by the "gender-affirming care" are honored to make the documentary available for you, for your proceedings.

As of 09/20, the documentary is in the "Beta" phase -- **a complete cut**, but the dialogue audio is not edited, there is no musical score, no color correction, no Main title or End Credits crawl, etc. Nevertheless, I trust the testimonies made by six detransitioners and ten medical and mental health experts deeply familiar with the medical transitioning and detransitioning will make a worthwhile addition to your body of evidence. The running time of the doc is 90 minutes. Peer-reviewed medical articles are cited throughout the documentary.

Respectfully submitted,

Vera Lindner

Executive Producer

www.affirmationgenerationmovie.com

Link to the documentary:

<https://vimeo.com/751941113/411de5bbb4>

TRAILER:

<https://www.youtube.com/watch?v=5s1pg7UByoU&t=72s>

From: [Jessica L. Keller](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Youth transition and informed consent
Date: Tuesday, September 20, 2022 5:31:47 PM

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Dear Florida Board of Medicine,

I am a pediatrician in private practice for the past 13 years. I went to medical school at Northwestern University Feinberg School of Medicine and did my pediatrics residency at The University of Arizona. I currently have 5 patients who identify as transgender. My first patient with transgender tendencies was a 5 year old boy whose mother identified him as a girl. This was in 2007 during residency in Arizona. Interestingly, not one of my attendings suggested any sort of intervention like might be suggested today. The path followed was the one currently suggested by both Finland and Sweden that focuses on finding and treating both individual and familial trauma and psychopathology. This path does not include medication or surgery.

I did not see a patient with transgender tendencies again until 2018 when a long established 14 year old female patient with autism, ADHD, anxiety, depression, paranoia and at times psychosis all in the setting of significant parental psychopathology with attachment disorders decided to use male pronouns. She has since used they pronouns and sometimes presents as a male and sometimes as a female while having sexual desire for males and not being bothered by menstruation but desiring testosterone injections. She had felt that she didn't fit in since middle school but did not present with gender dysphoria until high school that quickly changed to gender identity disorder. Internet influence was definitely part of the process. Two other female patients presented with rapid onset gender dysphoria in high school with one currently being given testosterone by adolescent medicine as a gender identity disorder. Another patient is male and presented as female starting in high school after many years of enduring a difficult parental divorce due to the father abusing the mother. The last patient with male to female gender dysphoria starting at 5 years of age has been lost to follow up due to serious drug problems in the mother in the setting of verbal and emotional abuse by the father and brother.

I have used many resources to familiarize myself with diagnosis and treatment for gender dysphoria and gender identity disorder. The two I would point out to you are The Society for Evidence Based Gender Medicine, SEGM, segm.org, and Transgender Issues in Catholic Healthcare by the National Catholic Bioethics Center, NCBC, nbccenter.org. These two represent a wide variety of physicians and mental health professionals in contrast to WPATH. It seems to me from both my clinical experience and research that there are different groups of children with higher rates of gender dysphoria and gender identity disorder. The common factors are psychopathology and trauma. It is emotionally difficult and time consuming to take care of these patients of mine. I sit in the room and absorb all of the fear, sadness, paranoia. I am concerned with the psychosis and disconnect with reality and how that obviously makes them unable to give informed consent. I cannot believe that a patient could actually understand what will happen if they tell me that they hear voices and think people are knocking on their front door one second but then declare that they completely understand what will happen to them if they take hormones from the opposite sex. I am very concerned that these patients and families are being taken advantage of for the very reason that they seek care. They are in emotional despair and are offered a quick fix that they don't/can't understand and their parents often have similar problems or are inflicting problems on the patient. The groups effected tend to be autistic spectrum children trying to find a place to fit, parents with psychopathology that is manifesting itself in an attachment disorder in the child who then identifies with the opposite parent, children who just succumb to a fad because they are easily influenced, children with anxiety and depression who are trying to escape. It is not good medicine to lump all of these different patients into one group with the same treatment plan, especially a surgical treatment plan that permanently removes healthy organs or causes sterility. I see adolescents that act completely different from one check up to the next year after year. Trying to find yourself is the hallmark of adolescence and the struggle should not be treated with surgery or stopping the physiology of adolescence. It is not

possible for children and adolescents who have not completed puberty and/or who have not have sexual experiences within long term, exclusive, committed relationships to use their sexual organs as they are meant to function. And it is directly contradictory to say that the sexual organs don't matter but then make the whole treatment plan focused on mutilating or blocking the function of the sexual organs. What shocked me in 2019 and still does today is an American Academy of Pediatrics Pediatrics in Review article recommending treatments for people with gender dysphoria based on D and X grade evidence using a comic book as the main information resource. I had never before read a Pediatrics in Review article that I was asked to take seriously based on D and X grade evidence. Those are opinion grades, experimental grades. I am a serious scientist and a serious clinician. I am not about to make extraordinary claims of fixing all of the trauma and mental health problems I see in my struggling patients based on D and X grade evidence. I ask that you please take me seriously and call me if you would like to discuss my experience as a front line physician giving compassionate care to my patients with whom I have respectful and long term relationships. We, physicians in the US, should not disregard what has already been done in Finland and Sweden and England. We should follow their lead, admit our past failures, ignore overly emotional or sentimental diatribes, stop trying to do something to make us doctors feel like we fixed a problem only by oversimplifying complex problems and return to first do no harm while offering needed psychological and social support.

Jessica Keller MD, FAAP
918-747-7544
Pediatric and Adolescent Care, LLC

From: [James Kelly](#)
To: [Vazquez, Paul](#)
Subject: "youth transition" and "gender affirming care"
Date: Tuesday, September 20, 2022 5:58:19 PM

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Dear Florida Board of Medicine, September 20, 2022

The Hippocratic oath requires physicians "to first do no harm". This is an axiom that most urgent when dealing with children. I'm a licensed physician and surgeon, board-certified psychiatrist, forensic psychiatrist, child and adolescent psychiatrist, marriage counselor, behavioral therapist with decades of experience. I have patients who are in multiple phases of dealing with gender identity disorder.

I have patients to have begun to wonder if they wish to be a different sex, have had hormone replacement therapy, have had gender transforming surgery and are dealing with transgender issues. I understand the difficulty that people have in dealing with these issues. As of now there is NO proof that any of these gender transitioning chemical, surgical or social treatments lead to any real long lasting benefit. There are many who once they have made chemical hormonal or surgical transitions and once transitioned regret what they have done and return or try to return to their original natural biologic gender.

Children do not have the mental or legal capacity to act as adults, they lack the ability to form a proper informed consent. Generally children are not permitted to consent to taking an aspirin without their parents informed consent. The issue of gender transitioning treatments for an adults totally different psychological and legal matter than for children. If a competent adult after due consideration and proper informed consent wishes to have a safe medical procedure than it may be there right to do so.

All children normally have doubts about themselves, their lives, their families and their bodies. Our role is to assist them in growing up in a natural and healthy manner so that they can be healthy adults and make healthy adult choices. Just because someone "feels or hopes" that something might give a desired result does not mean that it will help- and as history has shown us often medical fads are shown to be errors or even scams that actually harm people or prevent them from getting proper helpful proven treatments that actually work.

Gender transitioning chemical and surgical treatments are done with the expectation of making a permanent and reparable change in the natural process of human growth and development. Such permanent change, modification or mutilation of the human body and disruption of the normal chemical process should NEVER be made by a child or by anyone else until it has been PROVEN to be safe and effective and appropriate- which has NOT yet occurred.

Medical practice can be faddish, moving from one extreme to the other depending upon the political and social climate. It was not long ago that frontal lobotomies were recommended by institutions and family members for a perceived benefit -that was never proven-but became a common treatment nonetheless.

Please protect our innocent children from unproven and potentially permanently harmful treatments Please oppose unproven treatments under the euphemistic title headings of "youth transition" and "gender affirming care" until there is real PROOF that these are not harmful to children and actually helpful. Please wait for the science to show us the truth because it is your duty -to first do NO harm.

Respectfully submitted,

Dr. James E Kelly, D.O.

Licensed physician and surgeon, Diplomate of the American Board of psychiatry and neurology

Dear Members of the Florida Board of Medicine,

I'm a 55-year old mother, lifelong Liberal Democrat, business owner and an industry leader. Resident of Los Angeles (1999-2021). Our daughter (currently 16) is a gifted Autistic with severe ADD who was undiagnosed till age 14.

In the summer of 2020 (she was 14 at the time) she and her 4 neurodivergent friends began to persuade each other to make up male names and use male pronouns. As a hands-on mom running a tight ship, I interacted with the friends group often, driving them to the mall, restaurants, parks, sleepovers. During the entire 7th grade, these girls were OBSESSED with discussions about gender and queerness which they learned in the 6th grade GSA Club (Gay-Straight Alliance then, Gender-Sexuality Alliance now - the "ground-zero" of trans indoctrination!).

In June 2020 my daughter (saying she was a lesbian at the time) started weekly sessions with a seasoned talk therapist, a Lesbian in her mid-70's. In August 2020, my daughter declared a trans identity and quickly descended into a mental breakdown until she was catatonic, holed up in her room with the phone in her hand 14+ hours daily. **The therapist affirmed her trans delusion - even though my daughter said she was a Lesbian upon starting sessions - and never asked exploratory questions.** Full diagnostic clarity, following extensive psych evaluations and getting a psychiatrist, was available in late October 2020 and we immediately sent it to the therapist (ASD, ADHD-Inattentive, depression, anxiety, eating disorders, PCOS, liver problems). None of her neurodevelopmental conditions were ever addressed. The fact and truth that autistic people do not conform to society's arbitrary expectations of gender were never addressed. The fact and truth that autistic people have felt like aliens in their own bodies, living inside their heads, being bullied viciously and called "weirdos" since childhood was never addressed.

Throughout the fall of 2020, and especially starting in 2021, the therapist suggested to my daughter to call our insurance behind our backs and ask if she is eligible for Testosterone - at the depth of her mental breakdown. The therapist kept saying to her that *"Testosterone will bring her gender congruency."* (I have material evidence of what the therapist said exactly.) In May 2021 we discontinued therapy and left Los Angeles, moving to a small mountain community and home-schooling her.

Two years later, our daughter is flourishing, has a part-time job, and still takes Lexapro, Vyvanse and Metformin for pre-diabetes. She has friends, social circles, zero behavior problems and is thriving. The "trans" conversations have subsided. She thinks of herself as bisexual or gay. I attribute this healing to taking her out of the "ground-zero" of trans indoctrination and LIES -- the Los Angeles public school and the therapist who was actively "tranzing" our daughter, ignoring her co-morbidities which she NEVER ONCE addressed. I consider our lived experience to be a prime example of **medical malpractice, dereliction of duty and "lazy therapy"** as my husband called it (to the tune of \$250/session, out of pocket, weekly). The only reason I never

pursued legal action against the therapist is because California is extremely pro-trans and I'm afraid of Child Protection Services coming and taking our beautiful, brilliant daughter away.

I saved my child because I read studies on autism non-stop for 2 years (our entire extended family is gifted overachievers – Aspies, some with ADD, others with OCD, all with depression and anxiety), and read the statistics on ASD people being gender non-conforming. I saved my child also because I have the financial means to uproot my family and move just 3 months after we witnessed how our teen was being proactively shoved down a path of LIES and transgender medicalization. She is our only child. But what about any other parents? What about families with many kids? **This mass-scale recruitment of vulnerable patients for an uncontrolled medical experiment MUST BE STOPPED. This is a medical scandal of astronomical proportions and eugenics of the vulnerable youth.** The vulnerable youth includes: autistic, traumatized, LGB, or kids with mental illnesses or disability.

Thank you very much for your time.
Daniel and P.D. Schwegger (real names)
panacolprods@gmail.com
(661) 238-8878

Here is an excerpt of our story published in Dec. 2021 on PITT.substack.com:

To the unholy list of medical providers who failed to see the big picture of these interconnected diagnoses, I must also add her affirming therapist. The therapist was a lesbian in her 70s who, in hindsight, caused profound damage by affirming my child's trans delusion. The therapist casually discussed nonsensical terms such as "gender congruity", without delving deeply into past traumas. I trusted her experience, wisdom and depth of understanding of lesbians which I thought my daughter was, at the time. To be honest though, now, I am not positive my daughter is a lesbian. Maybe she will be a very late bloomer, like me and her dad, due to autism. The pressure for kids and teens to label themselves very early is ruinous. Autistics mature emotionally much later.

The therapist knew full well that my daughter had pre-diabetes. At the time, she was 100 lbs overweight (this has been successfully managed since), and her liver enzymes and cholesterol were abnormal. The therapist also knew all her mental diagnoses. The therapist suggested things such as, and I quote, *"Try calling your parents' insurance to see if you are eligible for Testosterone."* (T causes liver cancer and liver failure in women, alongside uterine atrophy.) *"Yes, T will bring you gender congruity."* I am still trying to understand, was the therapist trying to provoke my daughter, to see her reaction, or was she serious? The level of unprofessionalism to the tune of \$250/session was staggering. **In hindsight, I believe the**

therapist was a RECRUITER for the trans cult and was trying to enroll my daughter to become a patient for medicalization.

I was emphatic with the therapist about the fact that my daughter never before exhibited interest in being the opposite sex. None of my questions were answered, such as, *"Is it no longer OK to be a lesbian? And if so, why?"*, *"The 9th grade art teacher told me that 25% of her female art students use male names and pronouns – what is the explosion in trans all about?"* When I asked the therapist, *"Please discuss with my child curtailing the hours on Social Media,"* she replied, *"She is using Social Media to nurse her broken heart and to distract herself. It's OK to be on her phone all day..."* As though she wanted my teen to consume more and more trans propaganda online.

I did ask her in writing this question, which she never answered: *"Could this epidemic of girls self-identifying as 'trans' be a revolt by teen girls towards the extreme sexualization and victimization of women? Towards the total fetishization of the 'Barbie doll look' and elevating it as the only possible model for femininity? Towards the constant bullying and degrading attitudes towards teen girls who don't look like Barbie dolls? Towards the pervasive, profound and unchanging misogyny that girls experience at every step, personally, professionally, spiritually?"*

"Could this be a teenage rebellion against over-protective parents? Teenage revenge against a neurotic, controlling father and overwhelmed with work stress and deadlines mother? Because, sure as hell, our daughter does not have the first idea of what a transsexual person is, and this is all imitation and parroting."

The therapist never gave me answers to these questions. She called my daughter "he."

We discontinued with this therapist in May 2021.

Full story: <https://pitt.substack.com/p/a-clusterfexk-of-doctor-failures>

From: [tom morgan](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender dysphoria
Date: Monday, September 19, 2022 3:21:34 PM

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Individuals with gender dysphoria have a mental health issues as their concept of self does not stand up to the scientific facts of their sexual biology.

Please weigh the science and do not make decisions on some ill guided concept of compassion which will later cause these persons more mental anguish.

Patience, compassion, and time.

Sincerely

Thomas Morgan MD

[Sent from Yahoo Mail on Android](#)

From: [Mike Faulk](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Regulations to stop medical transitioning of minors and informed consent
Date: Tuesday, September 20, 2022 2:06:05 PM

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As the parent of a child that suffers from Rapid On-Set Gender Dysphoria, I implore you to ban "Affirmative Care" for minors. Personally, I believe it should be banned for all ages. Afterall, the only long-term study that followed all participants showed that those who medically transition are 19.1 times more likely to commit suicide than the general public. There is also a recent study that, through the efforts of SEGM, had to correct their conclusions to accurately reflect that data showed there is no evidence that puberty blockers, cross-sex hormones, or gender affirming surgeries improve mental health.

We desperately need professionals to stand up and stop this insanity. The brain doesn't complete the maturation process until a person is at least 25 years old. Yet children are being allowed to make decisions that will affect them for the rest of their lives.

All of the procedures considered "Affirming Care" are experimental. Since none are being tracked or any long-term research following any of these procedures is being conducted, we will never know the depth of how devastating the outcomes are. At this point, we can only rely on the testimony of the tens of thousands of detransitioners. The common theme among detransitioners is they were led/coerced down the path of medical transitioning. Once they realized they had made a mistake transitioning, the same people who encouraged them, viscusly turned their backs on them, including the doctors and mental health professionals.

Once again, I ask that you ban "Affirmative Care" for gender-confused minors.

Thank you,
Michelle Faulk

From: [Nicole L](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Fwd: FL Board of Medicine Hearing
Date: Tuesday, September 20, 2022 4:48:46 PM

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Dear. Dr. Vazquez and board members,

When I heard that the Florida Board of Medicine would be meeting to consider implementing regulations regarding youth gender medicine and the informed consent process, I felt compelled to share my family's story. My pre-teen daughter has been identifying as trans for nearly three years, ever since 4th grade. She had not expressed any signs of gender confusion during her childhood until her best friend began identifying as transgender. My child's best friend resided part-time with a female teenage cousin who identified as transgender before she did. I am unaware of how the ideology reached my daughter's friend's cousin, but I'm sure it can be "contact traced" to a friend, other family member, or a personality the child followed on social media. The social contagion aspect is real.

In Kindergarten, my daughter had a circle of four girlfriends - none of whom indicated gender identity distress or questioning at the time. At the end of 1st grade, one child moved to a different school, and we were unable to stay in touch with her. The friend circle went from having four kids to three. By the time they reached fourth grade, three out of the three remaining friends began identifying as trans. While I recognize that after coming out, a trans youth may seek out other trans friends, and thus friend groups comprised of 100% trans kids would be observed, it is a different scenario entirely to have children who were exhibiting no confusion in Kindergarten "evolve" 100% into trans identification. The other friend who had changed schools, later reappeared in my daughter's life once they started attending the same middle school; this child is not identifying as trans. The child who had been removed from the friend group never "evolved" into trans self identification, while the three remaining friends did. This is an example of the social contagion at play. One may say that people feel more comfortable coming out as trans now, and that is the reason for the sharp increase. But if that is the case, in accordance with the statistic of 75% (three out of the four original friends), then shouldn't my mother be coming out now that there is less stigma, and claim to be my other father? Shouldn't I be reconsidering my own gender identity, or my grandmother reconsidering hers? One may scoff at my simplistic, and small sample size "statistic", but this anecdotal case is not mine alone. This is happening all over the country.

I feel that my daughter's childhood ended abruptly on the day that she came out as trans. Instead of playing with stuffed animals like she used to love doing, she was having phone conversations with her friends about wearing binders. I was shocked that newly-turned ten year olds were having conversations about changing their bodies in this way. I suspect that this was brought on, in large part, by discomfort associated with puberty - particularly developing breasts and menstruation. To this distress, I can relate. It is a natural part of the human experience to feel ashamed of and uncomfortable about these changes. It does not mean that children are in the wrong bodies. It does not mean that any medical

intervention should pause, turn off, or alter this part of one's life cycle. It is unfortunate that the voices promising "the cure" - gender transition - reach children during vulnerable times in their lives. I think back on my own childhood and am convinced that I would have been susceptible to this message. I challenge you to reflect on your own childhood, and the childhoods of those you hold dear, and ask yourself if you or your loved ones may have been susceptible as well.

Shortly after coming out to family, my daughter boldly came out to her 5th grade teacher (I think she would have come out to her 4th grade teacher had COVID not sent children home for the remainder of the school year). She requested that an announcement about her trans status be made to the class - not just her classroom - but the entire Graduating Class of 2028. I am not sure if our experience is unique in this way, but my daughter has a voracious appetite for attention. And she has always identified with and been a friend to the downtrodden. I think these personality traits greatly impacted her coming out publicly as trans. The trans movement has been displayed as a virtuous one, and I think my child considers it a badge of honor to be a part of the community. It was very distressing to receive a phone call from the school about this, but little did I know, I was lucky to receive any call at all informing me. While on the phone with the principal, I was forewarned that once my daughter moved on to middle school, per the LGBTQ+ school district policies, I would no longer be notified of these types of occurrences. I would not have a say in which pronouns or names would be used in the school, nor would I be informed of any social transitioning such as this taking place. It is a hurtful notion that our society would have ever considered that parents did not have a right to this sensitive information about their own children. At what point did considering a parent's role as adversarial become the blanket approach to all children? I hoped and prayed that by the time my child moved on to middle school that her fascination with the trans self-identification, ideology, and entire movement would be over.

We are now in the middle school years and my daughter still carries on with her trans belief system. Thankfully the laws of today require more transparency in the schools with regard to gender affirmation. I am still highly skeptical of her feelings – I believe it is the community camaraderie and her rebellious spirit that are the true reasons for her identification. We struggle constantly, and I am afraid to get her the help she needs for fear that I will make a mistake and unknowingly bring her to a therapist who follows the prevailing extremist viewpoint: that affirmation is the only treatment. I am concerned that I isolate her too much – I don't want her to hang out with kids who encourage her to feel badly about her body, and I don't want her to become the 'gateway friend' into this ideology for another child like her best friend in 4th grade was to her.

As medical professionals, I ask you the following:

In what other specialty of medicine are patients' opinions taken as proof that they suffer from the disorder or disease for which they have given themselves their own self-diagnosis? I cannot very well go to a psychiatrist and say that I suffer from bipolar disorder because sometimes I have "extreme ups and downs" and walk out with a prescription for lithium after a handful of visits. Please note that the trans activists have organized well in this regard - literal scripts are provided for appointments with medical providers which contain key words to help minors get their hands on puberty blockers and cross-sex hormones as quickly as possible.

How is gender dysphoria different from Body Integrity Dysphoria? I think these disorders can be viewed in parallel. What if there was an explosion of people - children especially - suffering with Body Integrity Dysphoria? Would those children be affirmed? After all, they

are experiencing a similar disconnect between the body and the mind, except instead of rejecting their biological sex, sufferers reject their physical ableness. They want to be their "true self," which often comes with a desire for amputation or disability to help them feel "complete" inside. Would children suffering from this be given experimental regional anesthesia treatments as an intermediary step (much like hormone blockers or cross-sex hormones are given to transgender individuals) before more drastic measures take place - such as limb amputation?

Families are engaged in a power struggle over our children with extreme trans activists, and it is in crisis mode. Radical trans activism has infiltrated government, schools, and most dangerously of all medicine. Activism is polluting science. The one-size fits all affirmation approach is not proper treatment for the majority of patients. This is evidenced by the droves of detransitioners who state that they had other underlying issues that were not sufficiently explored before the affirmation treatment route was taken. These individuals commonly state that they did not feel better in the years following their surgeries, and that the procedures did not resolve their anxieties as they were led to believe it would. They were sold gender affirmation snake oil. It is our communal duty, as medical professionals and caregivers of minors, to explore all other avenues before considering drastic affirmation treatments. Support should be given to medical professionals who suggest other evidence-based treatment options be implemented first. The current climate calls for these people to be silenced and ridiculed - which is extremist trans activism at work. Medical affirmation should be the final option after all other avenues have been explored, and never the first. Please consider that your peers in other western countries like the UK, Sweden, France, and Finland are re-evaluating these medical treatments for children and moving toward mental health treatment as the first line of defense. These countries have either stopped medical transitioning minors or are advocating for great caution when medically treating children.

Your Hippocratic Oath says to "do no harm" - by affirming, it seems that the medical community is agreeing with a child that they *should* dislike themselves as they were born and that the self-loathing of their body is appropriate. They *should* have these negative feelings about themselves - there *is* a problem with the child. Such a great problem, in fact, that the child should permanently and irreversibly disfigure and damage their own body. The medical community should instead be trying to improve the individual's self-perception to promote healing and overcome their dysphoria. I respectfully request that the Board create rules to prevent doctors from being able to prescribe experimental puberty blockers, cross sex hormones and perform any type of gender affirming surgeries on minors. There is a lack of high-quality rigorous evidence surrounding these treatment procedures, which make them experimental in nature since the long-term consequences of these drugs being used on children/teens are relatively unknown.

Thank you for taking the time to read my letter and for your consideration of what I and other concerned citizens have said on the matter.

Sincerely,
Nicole Linero

From: [Joseph Schrandt](#)
To: [Vazquez, Paul](#)
Subject: Sex based medical practice
Date: Monday, September 19, 2022 8:22:56 PM

You don't often get email from joe.schrandt@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Dr. Vazquez,

As a practicing physician, I appreciate the opportunity to testify about these matters. Many young people clearly suffer in their experience of sexuality. And, of course, well-meaning people want to help.

But regardless of how one conceives of gender, that person IS male or female, as defined by genotype, a biological reality.

Therefore, both common sense and scientific data tell us that infusing non-physiological hormones or surgically altering the body is NOT a solution for distress.

No pre-adult could possibly give proper informed consent to permanent sterilization or to the permanent alteration in body image, giving rise to a shocking rate of suicide and depression.

It is no wonder that Europe has put the brakes on all of this.

Please do whatever you can to exercise prudence in limiting such irreversible medical practice on our vulnerable young people.

Thank you so much.

Sincerely yours,

N. Joseph Schrandt, M.D.

Dipromate, American Board of Neurology

From: [Paul Hruz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Information for State Medical Board Meeting
Date: Tuesday, September 20, 2022 2:49:01 PM
Attachments: [Hruz Expert Report Florida Medical Board 2022.pdf](#)

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Paul A. Vazquez, J.D.
Executive Director
Florida Medical Board

Dear Mr. Vazquez,

I am attaching a detailed report for the Florida Medical Board as you discuss the safety and efficacy of medical interventions for those who experience sex-discordant gender identity, particularly adolescents with gender dysphoria. As you know, much of the public discussion on this issue is filled with unjustified ideological assertions and emotive arguments. The medical profession is called to base care decisions on objective scientific evidence for both safety and efficacy. In many areas of medicine, there is insufficient evidence to make definitive conclusions. In such circumstances, a cautious approach is deemed most prudent. When new experimental treatments are attempted, our profession has established standards for mitigating risk to study subjects. Unfortunately, in the field of gender medicine, ideology and politics have usurped these standard practices. I applaud the Medical Board of the State of Florida for their efforts to consider relative merits and concerns of the affirmative model of care to individuals suffering from gender dysphoria. As needed, I am happy to provide additional information to the board.

Sincerely,

Paul W Hruz MD PhD
Associate Professor of Pediatrics
Associate Professor of Cellular Biology and Physiology

**Expert Physician Report for the
State of Florida's Medical Board Meeting on September 30, 2022**

**PAUL W. HRUZ, M.D., Ph.D.
September 20, 2022**

This report provides information that is essential for the Medical Board of the State of Florida as it considers the best approach for the care of individuals who experience sex-discordant gender identity. For each of my opinions detailed below, I provide relevant published scientific literature and other publicly available information. Copies of cited sources can be provided on request.

- 1. In my opinion, there is a serious lack of quality scientific evidence regarding the safety and efficacy of gender affirming medical interventions for individuals who experience sex discordant gender identity. Use of such medical interventions remains a highly controversial and experimental approach.**

Pediatric patients referred to our practice for the evaluation and treatment of gender dysphoria are cared for by an interdisciplinary team of providers that includes a psychologist and pediatric endocrinologist who have been specifically chosen for this role based upon a special interest and professional knowledge and training in this previously rare patient population. Due to the documented, important, ethical concerns regarding the safety, efficacy, and scientific validity of controversial, unproven, and experimental treatment paradigms, I have not personally engaged in the delivery of gender affirming medical interventions to children with gender dysphoria. Given the unproven long-term benefits and the well-documented risks and harms of “transitioning” children, I decline to participate in such experimental treatments until the science has proven that the relative risks and benefits of this approach warrant such procedures.

My decision is strengthened by the knowledge that the vast majority of children who report gender dysphoria will, if left untreated, grow out of the problem — a natural coping-developmental process — and willingly accept their biological sex. Despite differences in country, culture, decade, follow-up length and method, multiple studies have come to a remarkably similar conclusion: very few gender dysphoric children still want to transition by the time they reach adulthood. Many turn out to have been struggling with sexual orientation issues rather than sex discordant “transgender” identity. The exact number of children who experience realignment of gender identity with biological sex by early adult life varies by study.

Estimates within the peer reviewed published literature range from 50-98%, with most reporting desistance in approximately 85% of children prior to the widespread adoption of the “gender affirmation only” approach. Thus, desistance (*i.e.*, the child accepting their natal, biological sex identity and declining “transitioning” treatments) is the outcome for the vast majority of affected children who are not actively encouraged to proceed with sex-discordant gender affirmation.

Since there are no reliable assessment methods for identifying the small percentage of children with persisting sex-gender identity discordance from the vast majority who will accept their biological sex, and since puberty blocking treatments, hormone transition treatments, and surgical transition treatments are all known to have potentially life-long devastating, negative effects on patients, I and many colleagues view it as unethical to treat children with an unknown future by using experimental, aggressive, and intrusive gender affirming medical interventions.¹

2. Peer-reviewed, published research in credible science-medical journals.

My opinions as detailed in this report are based upon my knowledge and direct professional experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that other experts in my field of clinical practice rely upon when forming opinions on the subject including hundreds of published, peer reviewed scientific research (and professional) articles.

As discussed in detail in this report, the extant published literature on the use of puberty blockers, cross-sex hormones and gender affirming surgeries are based, almost entirely, upon studies with major methodological limitations.²

This includes:

- Significant recruitment biases including internet-based convenience sampling;

¹ See Cantor, *Do Trans-Kids stay Trans- When The Group Up?*, Sexology Today, available at http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html (providing summary of multiple research studies); *see also infra*, publications reviewed in detail below.

² See Hruz, *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, Linacre Q 87(1): 34-42, doi: 10.1177/0024363919873762 (2020).

- Relatively small sample sizes for addressing a condition that is likely to be multifactorial;
- Short term follow-up;
- Lack of randomization to different treatment arms;
- Failure to even consider alternate hypotheses;
- Failure to include proper control groups and, in many studies *no* control group at all;
- Reliance on cross sectional sampling that may identify associations, but *cannot* establish causal relationships between intervention and outcome;
- A high rate of patients lost to follow up in longitudinal analyses which is relevant to questions of regret, desistance and completed suicide;
- Biased interpretation of study findings with a goal of validating *a priori* conclusions rather than seeking evidence to disprove the null hypothesis;
- Ignoring starkly contradictory research documenting the lack of effectiveness of “transitioning” procedures, the low quality of research in this area, and the ongoing contentions and disagreements over this highly controversial, experimental medical field.

3. Basis for my opinions.

My opinions documented in this report are based on my:

- (1) knowledge, training, and clinical experience in caring for thousands of patients over many years;
- (2) detailed methodological reviews of hundreds of relevant peer-reviewed science publications;
- (3) consults, discussions, and team analyses with colleagues and other experts in the field, including attendance and participation in various professional conferences;
- (4) publications in peer reviewed scientific journals;
- (5) editorial work for peer reviewed scientific journals; and
- (6) peer reviewed research grant receipt and review work.

The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study typically and regularly rely upon when forming opinions on these subjects.

In addition to peer reviewed published research articles related to gender affirming medical interventions (see specific citations below), I also cite a wide variety of peer reviewed, published, scientific journal evidence documenting the recent, very public, disclosures of the multiple and serious methodological errors, failures, and defects of “transitioning treatment” research. Specific examples include:

- *The Branstrom Long-Term Treatment Outcome Study*. The historic Branstrom report is a peer reviewed, published, scientific journal article that documents a long-term treatment (10+ years) outcome research investigation testing the effects of hormonal and surgical “transitioning” treatments on patients. This historic research found no reliable benefits from these disfiguring-sterilizing “treatments,” as well as evidence suggesting *increased* suicide attempts and anxiety disorders following the “gender transitioning” treatments. In addition, detailed methodological critiques discovered significant research errors by the authors that appear to support the investigative theory that the authors had initially attempted to manipulate and misreport the findings of the study.³ The authors ultimately recanted their initial misreporting and agreed that their study produced no reliable evidence of benefits for gender reassignment hormone and surgical treatments. This historic investigation has helped to generate a profound collapse of support for these experimental procedures across Europe.⁴

³ See, *infra* for detailed notes and review with multiple citations.

⁴ See SEGM, *Correction of a Key Study: No Evidence of “Gender-Affirming” Surgeries Improving Mental Health*, available at https://segm.org/ajp_correction_2020 (Aug. 30, 2020; last accessed June 29, 2021); Van Mol et al., *Gender-Affirmation Surgery Conclusion Lacks Evidence*. *Am. J. Psych.* 177(8): 765-66 (2020).

- *The National Finland Review Recommending Suspension of Transitioning Treatments for Children as they Remain Experimental and of Uncertain Benefit.* A National Science Review in Finland carefully examined all relevant science and suspended transition treatments for minors under age 16.⁵ This official peer review recommends that psychotherapy should be the first line of treatment for gender dysphoric youth.⁶ “Cross-sex identification in childhood, even in extreme cases, generally disappears during puberty . . . The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders . . . No gender confirmation surgeries are performed on minors . . . Potential risks of GnRH therapy include disruption in bone mineralization and the as yet unknown effects on the central nervous system . . . there are no medical treatments [for transitioning] that can be considered evidence-based . . . In cases of children and adolescents, ethical issues are concerned with the natural process of adolescent identity development, and the possibility that medical interventions may interfere with this process. It has been suggested that hormone therapy (e.g., pubertal suppression) alters the course of gender identity development; i.e., it may consolidate a gender identity that would have otherwise changed in some of the treated adolescents. The reliability of the existing studies with no control groups is highly uncertain, and because of this uncertainty, no decisions should be made that can permanently alter a still-maturing minor’s mental and physical development . . . A lack of recognition of co-morbid psychiatric disorders common among gender-dysphoric adolescents can also be detrimental. Since reduction of psychiatric symptoms

⁵ See SEGM, *One Year Since Finland Broke with WPATH “Standards of Care”* available at: https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors (July 2, 2021).

⁶ See Palveluvalikoima, *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors* (2020).

cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment. A young person's identity and personality development must be stable so that they can genuinely face and discuss their gender dysphoria, the significance of their own feelings, and the need for various treatment options. For children and adolescents, these factors are key reasons for postponing any interventions until adulthood... In light of available evidence, gender reassignment of minors is an experimental practice.”⁷

- *Sweden's Flagship Karolinska Hospital Suspends Transitioning Treatments for Children Under 16 and Requires Research Oversight for Patients Under 18.*

In Sweden, the world-renowned Karolinska Hospital reviewed the current research and suspended pediatric gender transitions for patients under 16 outside of experimental, monitored clinical trials settings as of May 2021. Treatment will focus on psychotherapy and assessment.⁸ The “Dutch protocol” for treating gender dysphoric minors has been discontinued over concerns of medical harm and uncertain benefits. This new Swedish policy is consistent with Finland's recently revised guidelines and changes in England's policies as well as the Arkansas legislation in the U.S. All have been changed to prioritize psychological interventions and social support in contrast to medical interventions, particularly for youth with no young childhood history of gender dysphoria (presently the most common patient presentation).⁹

⁷ See *id.*; *supra*, note 5.

⁸ See SEGM, *Sweden's Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies*, available at: https://segm.org/Sweden_ends_use_of_Dutch_protocol (May 5, 2021); see also, Karolinska Policy Change K2021-3343, translation available at: <https://segm.org/sites/default/files/Karolinska%20Policy%20Change%20K2021-3343%20March%202021%20%28English%2C%20unofficial%20translation%29.pdf> (March 2021); Karolinska Guideline K2021-4144, translation available at: <https://segm.org/sites/default/files/Karolinska%20Guideline%20K2021-4144%20April%202021%20%28English%2C%20unofficial%20translation%29.pdf> (April 2021).

⁹ See *id.*

- *A Sweden National Review Documents “Low Quality Research” in this Experimental and Controversial Field.*¹⁰ “This report was commissioned by the Swedish government and is a scoping review of the literature on gender dysphoria in children and adolescents. The report can be a basis for further evaluation of risk of bias and evidence.” The Swedish national review reported: “No relevant randomized controlled (treatment outcome) trials in children and adolescents were found.” The review also reported “Conclusions:”
 - We have not found any scientific studies which explains the increase in incidence in children and adolescents who seek the health care because of gender dysphoria.
 - We have not found any studies on changes in prevalence of gender dysphoria over calendar time, nor any studies on factors that can affect the societal acceptance of seeking for gender dysphoria.
 - There are few studies on gender affirming surgery in general in children and adolescents and only single studies on gender affirming genital surgery.
 - Studies on long-term effects of gender affirming treatment in children and adolescents are few, especially for the groups that have appeared during the recent decennium . . .
 - Almost all identified studies are observational, some with controls and some with evaluation before and after gender affirming treatment. No relevant randomized controlled trials in children and adolescents were found.
 - We have not found any composed national information from Sweden on: [] the proportion of those who seek health care for gender dysphoria that get a formal diagnosis [, nor] the proportion starting endocrine treatment to delay puberty [, nor] the proportion starting gender affirming hormonal treatment [, nor] the proportion subjected to different gender affirming surgery.
- *UK Researchers, Courts, and Other Reviewers Highlighted the Paucity of Quality Research, Limitations, Defects, and Risks in the Still Experimental, Controversial “Gender Transitioning” Treatment Field.* The British official

¹⁰ See Sweden SBU Policy Review, *Gender Dysphoria in Children and Adolescents: An Inventory of the Literature*, SBU Policy Support No. 307, available at: <https://www.sbu.se/307e> (2019).

medical review office (the National Institute of Health and Care Excellence, or “NICE”) published reports on transitioning science.¹¹ An official review found, “[t]he evidence for using puberty blocking drugs to treat young people struggling with their gender identity is ‘very low.’” NICE said existing studies of the drugs were small and “subject to bias and confounding.” The assessment of the evidence into the drugs was commissioned by NHS England. It is part of a review into gender identity services for children and young people.¹² The NICE review noted it was difficult to draw conclusions from existing studies because of the way they had been designed. They were “all small” and did not have control groups, which are used to directly compare the effect of different treatments. There were other issues with the studies too, such as not describing what other physical and mental health problems a young person may have alongside gender dysphoria.

The British NICE service also reviewed the evidence base for cross-sex hormones.¹³ The review found the evidence of clinical effectiveness and safety of cross-sex hormones was also of “very low” quality, explaining “[a]ny potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria.” Both documents were prepared by NICE in October 2020 and will now help inform Dr. Hilary Cass's independent review into NHS gender identity services for children and young people.¹⁴

This British study conclusion noted: “We found no evidence of change (no

¹¹ See Cohen & Barnes, *Evidence for Puberty Blockers Use Very Low, Says NICE*, BBC, available at <https://www.bbc.com/news/health-56601386> (Apr. 1, 2021).

¹² See <https://arms.nice.org.uk/resources/hub/1070905/attachment>; see also, *NHS Announces Independent Review into Gender Identity Services for Children and Young People*, available at: <https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/> (Sept. 22, 2020).

¹³ See <https://arms.nice.org.uk/resources/hub/1070871/attachment>.

¹⁴ See also Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK*, medRxiv, doi: 10.1101/2020.12.01.20241653 (published online Dec. 2, 2020).

improvement) in psychological function with GnRHa treatment as indicated by parent report (CBCL) or self-report (YSR) of overall problems, internalizing or externalizing problems or self-harm....”

Puberty blockers used to treat children aged 12 to 15 who have severe and persistent gender dysphoria had no significant effect on their psychological function, thoughts of self-harm, or body image, a study has found. However, as expected, the children experienced reduced growth in height and bone strength by the time they finished their treatment at age 16.¹⁵ Regarding the UK’s Tavistock and Portman NHS Trust’s Gender Identity Development Service’s experimental trial of puberty blockers for early teenagers with gender dysphoria, Oxford’s Professor Michael Biggs wrote, “To summarize, GIDS launched a study to administer experimental drugs to children suffering from gender dysphoria . . . After a year on GnRHa [puberty blockers] children reported greater self-harm, and girls experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers actually exacerbated gender dysphoria.”¹⁶

As Griffin et al. discussed, “[a]s there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties.” In addition,

¹⁵ See Dyer, *Puberty Blockers: Children Under 16 Should Not be Referred Without Court Order, Says NHS England*, BMJ 371:m4717, doi: 10.1136/bmj.m4717 (2020); Dyer, *Puberty Blockers Do Not Alleviate Negative Thoughts in Children with Gender Dysphoria, Finds Study*, BMJ 372:n356, doi: 10.1136/bmj.n356 (2021); Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort to 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK*, medRxiv, doi: 10.1101/2020.12.01.20241653 (2020); BBC Summary, available at: <https://www.bbc.com/news/uk-55282113journal.pone.0243894>; see also Transgender Trend, *Tavistock’s Experimentation with Puberty Blockers: Scrutinizing the Evidence*, available at: <https://www.transgendertrend.com/tavistock-experiment-puberty-blockers/> (Mar. 5, 2019).

¹⁶ See also Griffin et al., *Sex, Gender and Gender Identity: A Re-Evaluation of the Evidence*, BJPsych Bulletin 45(5):291-99, doi:10.1192/bjb.2020.73 (2021).

Griffin et al. wrote: “Transgender support groups have emphasized the risk of suicide. After controlling for coexisting mental health problems, studies show an increased risk of suicidal behaviour and self-harm in the transgender population, although underlying causality has not been convincingly demonstrated.”¹⁷ In sum, political activists and too many providers have used a fear of suicide to push experimental unproven, hazardous treatments.

- *Review of the World Professional Association for Transgender Health’s (WPATH) Controversial and Outdated Treatment “Standards”*. A 2021 review found WPATH standards “incoherent.”¹⁸ Both WPATH and Endocrine Society guidelines have recently been assessed for quality by a systematic review, which found them to be of low quality. Specific to WPATH, the reviewers noted the difficulty of even extracting clear recommendations, describing the WPATH guidelines as “incoherent.” Standards of care should provide practitioners with evidence-based standards by which they may reliably inform the patient of projected outcomes and do so with a known error rate. Such data is the starting point for obtaining informed consent, which is not provided by either of these guidelines. The WPATH current version 7 standards violate minimal ethical and quality standards set by national organizations that review and post medical treatment standards including the National Academy of Medicine. WPATH board members suffer from serious financial conflicts of interest (e.g., virtually all WPATH BD members obtain most of their personal income from performing the very same “treatments” they are supposed to evaluate objectively). In addition, the minimal length of time treatment standards must be refreshed is every five years and WPATH version 7 is now nearly *ten* years old and thus far past its useful “shelf life.”

¹⁷ See Marshall et al., *Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature*, Int. Rev. Psychiatry 28(1):58–69, doi: 10.3109/09540261.2015.1073143 (2016).

¹⁸ See Dahlen et al., *International Clinical Practice Guidelines for Gender Minority/Trans People: Systematic Review and Quality Assessment*, BMJ Open, 11(4):e048943, doi: 10.1136/bmjopen-2021-048943 (2021).

Given that the most current research¹⁹ are sharply critical of the ongoing failure of random control trials and the generally very low-quality evidence in this controversial field (the 10 year old WPATH version 7 standards have aged very poorly indeed and should be viewed as hazardous to patients.)

- *The UK High Court in the Bell Litigation – after hearing from multiple international expert witnesses – found transitioning treatments to be “experimental”*. In an internationally reported case, the High Court of London ruled these “gender transitioning” treatments were “experimental,” ordering protections for children who could not consent to such hazardous treatments given the lack of evidence of benefits and clear evidence of risks (*e.g.*, sterilization).

The court’s order that judges should oversee the consent of minors on a case-by-case basis was overturned on appeal — as the appeals court returned consent duties to medical providers — but left intact the trial court’s opinion that the evidence produced during the hearing demonstrated “gender transitioning treatments” remain controversial with serious risks of irreversible harm (including sterilization of the patient) and of unproven benefit.²⁰

“Children under 16 with gender dysphoria are unlikely to be able to give informed consent to undergo treatment with puberty-blocking drugs, three High Court judges have ruled . . . Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognize that clinicians may well regard these as cases where the authorization of the court should be sought prior to commencing the clinical treatment . . . The judges also pointed to the lack of evidence about the long-term effects of puberty blockers.”²¹

¹⁹ Including, *e.g.*, the long-term Branstrom and Hisle-Gorman treatment outcome studies, the British NICE review, the Sweden review, the Finland review, the British Dr. Cass national review and others.

²⁰ See BBC, *Puberty Blockers: Under-16s 'Unlikely to be Able to Give Informed Consent'*, available at: <https://www.bbc.com/news/uk-england-cambridgeshire-55144148> (Dec. 1, 2020).

²¹ *Id.*

- *The British Independent Review of Gender Identity Services for Children and Young People: Interim Report by National Expert, Dr. Hilary Cass, M.D., was Published in February 2022.* The Dr Cass interim review concluded that “Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally.” Dr. Cass notes that “There is lack of consensus and open discussion about the nature of gender dysphoria and therefore about the appropriate clinical response.”²²
- *The Society for Evidence Based Gender Medicine (SEGM) Review Summarizes the Health Risks of Transitioning.* Consistent with changes in policy in Sweden, Finland, England, and Arkansas — due to much negative research findings over recent years — SEGM, a collection of national and international experts in the field, published a research summary documenting the serious health risks of “transitioning treatments” compared to the well-known lack of evidence of reliable benefits for such treatments.²³
- *The Cochrane Review Found Insufficient Evidence of Benefits.* The widely respected Cochrane Review examined hormonal treatment outcomes for male-to-female transitioners over 16 years. They found “insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition.” It is remarkable that decades after the first transitioned male-to-female patient, quality evidence for the benefit of transitioning is still lacking.²⁴

²² See The Cass Review, *Interim Report*, available at: <https://cass.independent-review.uk/publications/interim-report/>).

²³ See SEGM, *Science Studies – Health Risks of Medical and Surgical Gender Reassignment*, available at <https://www.segm.org/studies>.

²⁴ See Haupt et al., *Antiandrogen or Estradiol Treatment or Both During Hormone Therapy in Transitioning Transgender Women*, Cochrane Database Sys. Rev. (Review – Intervention), doi: 10.1002/14651858.CD013138.pub2 (2020).

4. **A March 2021 study – with the largest sample yet – is consistent with the new direction for Finland, Sweden, the UK, and France – show that most young gender dysphoric children, if left alone, grow out of the problem with no medical intervention.²⁵**

“Watchful waiting” is the recommended treatment: in the past, 67% of children meeting the diagnostic criteria for gender dysphoria no longer had the diagnosis as adults, with an even higher 93% rate of natural resolution of gender-related distress for the less significantly impacted cases.²⁶

5. **Experts are uniformly concerned with, and baffled by, the unexplained rapid and extreme demographic shifts in patient age and sex. Such shifts produce serious concerns about whether decades of previous research—done on a very different population group—even apply to the current patient cohort.**

For decades, transgender patients were mostly older adults or very young boys. Over the last few years, a tsunami of teenaged girls has flipped the demographics of transgender patients—now up to 7 to 1 teen girls. Many experts have noted that the previous research on trans patients cannot be relied upon when the patient group has so rapidly and mysteriously been transformed. In sum, the newly presenting cases are vastly overrepresented by adolescent females, the majority of whom also have significant mental health problems and neurocognitive comorbidities such as autism-spectrum disorder or ADHD.²⁷ The most recent evidence supports the emerging theory of social

²⁵ See Devita et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, *Frontiers in Psychiatry* doi: 10.3389/fpsy.2021.632784 (March 2021).

²⁶ See also, e.g., Zucker, *The Myth of Persistence: Response to “A Critical Commentary on Follow-Up Studies and ‘Desistance’ Theories About Transgender and Gender Non-Conforming Children”* by Temple Newhook et al. (2018), *Int. J. Transgenderism* 19(2):231–24 (2018).

²⁷ See de Graaf & Carmichael, *Reflections on Emerging Trends in Clinical Work with Gender Diverse Children and Adolescents*, *Clin. Child Psychology & Psychiatry*, 24(2): 353-64 (2018).

contagion as estimates of sex-discordant gender identity are rocketing upwards from 1 in 10,000 to “the number of U.S. transgender-identified youth may be as high as 9%.”²⁸

This unexplained, radical transformations of demographics does not happen in actual illnesses (cancer, heart disease, anxiety disorders, etc.), but is tragically consistent with previous mental health system disasters such as the once very rare “multiple personality disorder” and “recovered repressed memory” patients that radically increased in the 1990s.

Dr. Thomas Steensma, a prominent investigator of the Dutch protocol—the original model for transitioning treatments—has recently noted, “[w]e don’t know whether studies we have done in the past can still be applied to this time,” specifically because of the unexplained surge in female adolescents reporting gender dysphoria. “Many more children are registering, but also of a different type . . . Suddenly there are many more girls applying who feel like a boy . . . now there are three times as many females as males.” He concluded with the warning that “[w]e conduct structural research in the Netherlands. But the rest of the world is blindly adopting our research.”²⁹

6. Examples of limited, low quality, and defective research.

The hazards of making treatment recommendations based on studies with major methodological weaknesses can be readily seen by considering representative studies used by advocates of medical gender affirmation to justify this approach. For example:

- The study by De Vries and colleagues³⁰ is often cited to support longitudinal evidence of benefit from pubertal blockade. Although improvements in mood were observed and changes in the risk of behavioral disorders with pubertal

²⁸ See Kidd et al., *Prevalence of Gender-Diverse Youth in an Urban School District*, *Pediatrics* 147(6):e2020049823, doi: 10.1542/peds.2020-049823 (2021).

²⁹ See Tetelepta, *More Research is Urgently Needed into Transgender Care for Young People*: “Where Does the Large Increase of Children Come From?” AD, translation available at: <https://www.voorzij.nl/more-research-is-urgently-needed-into-transgender-care-for-young-people-where-does-the-large-increase-of-children-come-from/> (Feb. 27, 2021).

³⁰ de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, *J. Sex, Med.* 8(8):2276-83, doi: 10.1111/j.1743-6109.2010.01943.x (2011).

blockade were found over baseline, this study had no control group. Thus, the authors were unable to determine the basis of this improvement. The authors acknowledge that psychological support or other reasons may have contributed to (or wholly caused) this observation. It is also important to note that gender dysphoria itself *did not diminish* in study subjects, and there were *no changes* in body image-related distress.

- The study by Turban and colleagues³¹ is often cited as proof that pubertal blockade prevents suicide in transgender youth. However, this study used an unreliable, biased sampling methodology. As stated in the paper, the authors considered “a cross-sectional online survey of 20,619 transgender adults aged 18 to 36 years” from the 2015 U.S. Transgender Survey. This was an online survey of transgender and “genderqueer” adults recruited from trans-friendly websites. Among the many problems with this sampling methodology, there is *no* evidence of study subject identities, *no* way to assess for potential false subjects, and *no* medical diagnosis for entry. *No causation can be determined from this retrospective, cross-sectional design.* Furthermore, the study failed to even assess desisters and regretters. Turban claimed that desisters and regretters would “not be likely” in this study group, which also only included adults. Thus, the study “does not include outcomes for people who may have initiated pubertal suppression and subsequently no longer identify as transgender.”

Turban’s misleading claim of lower suicidal ideation for treated patients excluded the most seriously mentally ill patients that would have been *denied* affirmation treatment. Those who received treatment with pubertal suppression, when compared with those who wanted pubertal suppression but did not receive it, had lower odds of lifetime suicidal ideation (adjusted odds ratio = 0.3; 95% confidence interval = 0.2– 0.6). In Table 3 of the paper, under

³¹ Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, Pediatrics 145(2):e20191724, doi: 10.1542/peds.2019-1725 (2020).

“Suicidality (past 12 months)” reductions for suppressed group vs. non-suppressed were seen for ideation (50.6% vs. 64.8%) and “ideation with plan” (55.6% vs. 58.2%). However, it is essential to note that suicidal “ideation with plan and suicide attempt” for the hormone suppressed group, in raw numbers, *increased* after treatment to 24.4% vs. 21.5% for the “non-treatment group.”

The most clinically significant result in this study — that Affirmation Treatments *did not prevent serious suicide attempts* — was *improperly and/or unethically ignored by the authors*. “Suicide attempts resulting in inpatient care” = 45.5% for suppression groups vs. 22.8% for those who did not receive pubertal suppression. Although the result of increased suicide attempts did not reach “statistical significance”, the clinical significance of this finding cannot be ignored. It would be most reasonable to conclude from an observation of 45% attempted suicide requiring hospitalization in the treated arm that the intervention was unsuccessful in improving health. Turban et al. ignored their own findings that a history of puberty suppression was associated with a persistence of serious suicide attempts. In sum, the Turban 2020 Pediatrics study, based on an unverified U.S. Transgender Online Survey, tells us little about the effects of puberty suppression on children with gender dysphoria.³²

- The 2021 study of Bustos et al.³³ attempts to provide a systematic review of 27 observational or interventional studies that report on regret or detransition following gender-transition surgeries. A total of 7,928 subjects were included in their meta-analysis. The authors concluded that only 1% or less of those who had gender-transition surgeries expressed regret. It is important to

³² See Biggs, *Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria*, Arch. Sex. Behav. 49:2227-29, doi: 10.1007/s10508-020-01743-6 (2020); and the multiple Letters to the Editor that criticized the multiple methodological errors in this study, available at: <https://pediatrics.aappublications.org/content/145/2/e20191725/tab-e-letters#re-pubertal-suppression-for-transgender-youth-and-risk-of-suicidal-ideation>.

³³ See Bustos et al., *Regret After Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence*, Plast. Reconstr. Surg. Global Open 9(3):e3477, doi: 10.1097/GOX.0000000000003477 (2021).

understand the serious methodological limitations and high risk of bias contained within the analysis in the 2021 Bustos et al. study.³⁴ This includes failure to include major relevant studies addressing this question,³⁵ inaccurate analysis within one of the studies considered,³⁶ and the general lack of controlled studies (thus no causal conclusions are possible), incomplete and generally short-term follow-up, large numbers of lost subjects, and lack of valid assessment measures in the published literature addressing this question. As noted by Expósito-Campos & D'Angelo (2021),³⁷ moderate to high risk of bias was present in 23 of the 27 studies included in the analysis. Furthermore, 97% of subjects analyzed were found within studies deemed to be of fair to poor scientific quality. Thus, this study cannot be used as strong support for the contention that regret is rare.

- The 2018 paper by Wiepjes et al.³⁸ is a retrospective review of records from all patients of the Center of Expertise on Gender Dysphoria gender clinic in Amsterdam from 1972-2015. While the study appears to report on the regret rates among a large cohort of adolescents (812) and children (548), regret is only reported for children and adolescents who had undergone gonadectomy once over 18 years of age. Of the adolescents, 41% started puberty suppression. Of those who started GnRH agonists, only 2% stopped this intervention (meaning that 98% of those who started puberty suppression progressed to cross-sex hormone therapy). An additional 32%, having already completed puberty, started cross-sex hormone therapy without use of a GnRH agonist. Classification of regret was oddly restricted, requiring physician

³⁴ See Expósito-Campos & D'Angelo, *Letter to the Editor: Regret after Gender-Affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence*, *Plast. Reconstr. Surg. Global Open* 9(11): e3951, doi: 10.1097/GOX.0000000000003951 (2021).

³⁵ See Dhejne et al., *An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960-2010: Prevalence, Incidence, and Regrets*, *Arch. Sex. Behav.* 43(8):1535-45 (2014).

³⁶ Wiepjes et al., *The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets*, *J. Sex. Med.* 15(4):582-90, doi: 10.1016/j.jsxm.2018.01.016 (2018).

³⁷ *Supra*, note 31.

³⁸ *Supra*, note 33.

documentation of patient verbalized regret after gonadectomy and start of sex-concordant hormones to treat the iatrogenic hypogonadism. This means there are significant limitations to the conclusions that can be drawn from 2018 paper by Wiepjes et al. There is no discussion in this paper regarding adolescent regret of use of puberty blockers, cross-sex hormones, or mastectomies. Importantly, 36% of patients were lost to follow-up. This is notable given that gonadectomy iatrogenically induces the pathologic state of primary hypogonadism. Affected patients have a lifelong dependency for exogenously administered sex-steroid hormones, and thus an acute need for ongoing follow-up. The number of lost subjects who experienced regret or completed suicides is simply unknown, a serious defect as most patients with “regret” are expected to just walk away and thus rarely come back to the clinic and express regrets to anyone much less the physician who “transitioned” them. It is also significant that the average time to regret was 130 months — far longer than virtually all transitioning studies followed patients. The authors themselves acknowledge that it may be too early to predict regret in patients who started hormone therapy in the past 10 years.

- The 2021 study by Narayan et al.³⁹ examines anonymous survey results from 154 surgeons affiliated with WPATH. The response rate for this survey was 30%. Of the respondents, 57% had encountered patients with surgical regret. It is important to recognize that this study was specifically directed toward patients who had undergone surgical transition. Acknowledged biases of this study included selection bias, recall bias, and response bias. This type of study cannot accurately identify the prevalence in the transgender population as a whole and is particularly limited in the ability to assess potential for regret in the pediatric population.

³⁹ Narayan et al., *Guiding the Conversation-Types of Regret After Gender-Affirming Surgery and Their Associated Etiologies*, Ann. Translational Med. 9(7):605, doi: 10.21037/atm-20-6204 (2021).

- The 2018 Olson-Kennedy paper⁴⁰ presents the results of a survey of biologically female patients with male gender identity at the lead author's institution using a novel rating system for "chest dysphoria" created by the study authors. There were an equal number (68) of nonsurgical and post-surgical subjects surveyed. Those who had undergone bilateral mastectomies were reported to have less chest dysphoria than those who did not receive this intervention. Limitations of this study include convenience sampling of nonsurgical study subjects with high potential for selection bias, cross-sectional design (*e.g.*, thus no causal conclusions are possible), and lack of validation of the primary outcome measure. Test validation is particularly relevant in assessing adolescent questionnaires due to a variety of cognitive and situational factors in this population.⁴¹ Rigorous validation methods have been previously used in several other established questionnaires addressing adolescent self-perception.⁴² As previously noted, this study cannot provide information about a causal relationship between the intervention and outcome observed.
- The 2021 Almazan study⁴³ attempts to address mental health outcomes in relation to gender-transition surgery. As previously noted, this study relies upon data from the highly unreliable 2015 U.S. Transgender Survey. Limitations and weaknesses of this survey tool include convenience sampling, recruitment of patients through transgender advocacy organizations, demand

⁴⁰ Olson-Kennedy et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts*, JAMA Pediatr. 172(5):431–36, doi: 10.1001/jamapediatrics.2017.5440 (2018).

⁴¹ See Brener et al., *Assessment of Factors Affecting the Validity of Self-Reported Health-Risk Behavior among Adolescents: Evidence from the Scientific Literature*, J. Adolesc. Health 33(6):436–57, doi: 10.1016/s1054-139x(03)00052-1 (2003).

⁴² See Palenzuela-Luis et al., *Questionnaires Assessing Adolescents' Self-Concept, Self-Perception, Physical Activity and Lifestyle: A Systematic Review*, Children (Basel) 9(1):91, doi: 10.3390/children9010091 (2022).

⁴³ Almazan & Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, JAMA Surgery 156(7):611–18, doi: 10.1001/jamasurg.2021.0952 (2021).

bias (a.k.a. the good subject effect), a high number of respondents who reported having not transitioned medically or surgically (and reported no desire to do so in the future), and several other serious data irregularities. One notable data irregularity was that a high number of respondents reported that their age was exactly 18 years — a highly unlikely result indicting fraudulent responses on the anonymous “survey” where no actual, living respondent was ever seen, heard, or evaluated. As noted by D’Angelo and colleagues, these irregularities raise serious questions about the reliability of all USTS data⁴⁴ and therefore, the reliability of conclusions based on that data.

- The paper by Mehringer⁴⁵ provides a summary of qualitative interviews with 30 transmasculine youth (biological females who identify as men) with comparison between those who underwent bilateral mastectomy (n=14) and those who did not receive this intervention (n=16). Mean time from surgery was only 19 months. No validated objective measures were used to assess mental health. There are numerous potential confounding variables (*e.g.*, psychological co-morbidities, testosterone exposure, family dynamics) that could be responsible for the subjective perceptions of the study subjects. As a cross-sectional survey at a single center, the study methodology cannot establish a causal relationship between intervention and outcome. At best, the study can be used for hypothesis generation. It does not establish the efficacy of this approach, nor does it consider whether alternate approaches could achieve the desired outcome.

⁴⁴ D’Angelo et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, Arch. Sex. Behav., 50(1):7–16, doi: 10.1007/s10508-020-01844-2 (2021).

⁴⁵ Mehringer et al., *Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth*, Pediatrics 147(3):e2020013300, doi: 10.1542/peds.2020-013300 (2021).

- The study by Julian et al.⁴⁶ is also often used as evidence of the efficacy of gender affirming surgery. This study is an internet based cross sectional survey of 684 transgender youth (mean age 16 years) who reported having "chest dysphoria" with 89% (n=608) reporting use of chest binding and 11% (n=76) who did not engage in this practice. The study utilized the non-validated chest dysphoria scale described above for the 2018 Olson -Kennedy study. This study methodology has high potential for recruitment bias. Furthermore, as a cross-sectional study, it cannot establish causal relationships in study parameters. Since it addressed breast binding and not surgery, it does not provide data on the safety and efficacy of bilateral mastectomies in gender dysphoric youth.
- The study by Sood et al.⁴⁷ is yet another study that is used to support treatment efficacy. This is a single cite cross-sectional survey of 156 adolescent female subjects who completed the unvalidated chest dysphoria rating scale of Olsen-Kennedy described above. The study reports an association between report of chest dysphoria and the presence of anxiety and depression. As noted above, this study cannot establish a causal relationship between these study parameters. Furthermore, it does not address whether or not gender-affirming surgery (specifically bilateral mastectomy) is safe or effective in resolving associated psychological distress.

7. There are major and highly significant differences between male and female responses to many drugs, including sex hormones.⁴⁸

⁴⁶ Julian et al., *The Impact of Chest Binding in Transgender and Gender Diverse Youth and Young Adults*, J. Adolesc. Health 68(6):1129-34, doi: 10.1016/j.jadohealth.2020.09.029 (2021).

⁴⁷ Sood et al., *Association of Chest Dysphoria with Anxiety and Depression in Transmasculine and Nonbinary Adolescents Seeking Gender-Affirming Care*, J. Adolesc. Health 68(6):1135-41, doi: 10.1016/j.jadohealth.2021.02.024 (2021).

⁴⁸ See, e.g., Madla et al., *Let's Talk About Sex: Differences in Drug Therapy in Males and Females*, Adv. Drug Deliv. Rev. 175:113804, doi: 10.1016/j.addr.2021.05.014 (2021).

Giving estrogen to a biological male is not equivalent to giving the same hormone to a biological female. Likewise, giving testosterone to a biological female is not equivalent to giving the same hormone to a biological male.⁴⁹ Differences are not limited to pharmacokinetic effects but are present even at the cellular level.⁵⁰ Failure to acknowledge these differences can have tragic consequences. For example, in addition to the inherent sterilizing effect of cross-sex hormone administration, non-physiological levels of estrogen in males has been shown to increase the risk of thromboembolic stroke above the incidence observed in females.⁵¹

8. Biological basis of sex.

Reliance upon external phenotypic expression of primary sexual traits is a highly accurate, reliable, and valid means to assign biologic sex. In over 99.9% of cases, this designation will correlate with internal sexual traits and capacity for normal biologic sexual function. Sex is therefore not “assigned at birth” but is rather recognized at birth. In my opinion, this view is generally accepted by the relevant scientific communities in endocrinology, psychiatry, neonatology, biology, genetics, gynecology, and other fields.

9. Disorders of sexual development are very rare.

Due to the complexity of the biological processes that are involved in normal sexual development, it is not surprising that a very small number of individuals are born with defects in this process (1 in 5,000 births). Defects can occur through either inherited or *de novo* mutations in genes that are involved in sexual determination or through environmental insults during critical states of sexual development. Persons who are born

⁴⁹ See, e.g., Soldin & Mattison, *Sex Differences in Pharmacokinetics and Pharmacodynamics*, Clin. Pharmacokinetics 48(3):143–57, doi: 10.2165/00003088-200948030-00001 (2009); Pogun & Yazarbas, *Sex Differences in Drug Effects*, Encyclop. Psychopharmacology (Springer, Stolerma, ed.), doi: 10.1007/978-3-540-68706-1_209 (2010).

⁵⁰ See, e.g., Walker et al., *Matters of the Heart: Cellular Sex Differences*, J. Mol. & Cell. Cardiology 160:42–55, doi: 10.1016/j.yjmcc.2021.04.010 (2021).

⁵¹ See, e.g., Getahun et al., *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, Ann. Inter. Med. 169(4): 205–13, doi: 10.7326/M17-2785 (2018).

with such abnormalities are considered to have a disorder of sexual development (DSD). Most often, this is first detected as ambiguity in the appearance of the external genitalia. Such detection measurements are reliable and valid and accepted by the relevant scientific community. In my opinion, this view is generally accepted by the relevant scientific communities in endocrinology, neonatology, gynecology, psychiatry, biology, genetics, and other fields.⁵²

10. The ethical foundations of medicine – “first do not harm.”

The fundamental purpose of the practice of medicine is to treat disease and alleviate suffering. An essential tenet of medical practice is to avoid doing harm in the process. Efforts to rely upon clear, valid, reliable, and definitive evidence on how to best accomplish treatment goals is the essential ethical, professional, scientific, and clinical goals of physicians. Proponents of gender reassignment surgery for adolescents violate this essential principle by using experimental treatments on vulnerable populations without properly informing them of the actual risks and limitations of the treatments.⁵³

11. The Endocrine Society recognizes that the quality of evidence for “affirmative” treatments is currently “low or very low” (“estimate of effect is very uncertain”).

There is no general acceptance of these treatments in the relevant scientific community. The error rate is unknown and could be very high. The Endocrine Society published 2009 clinical guidelines for the treatment of patients with persistent gender dysphoria.⁵⁴ The recommendations include temporary suppression of pubertal development of children with GnRH agonists (hormone blockers normally used for

⁵² See Sax, *How Common is Intersex? A Response to Anne Fausto-Sterling*, J. Sex Research 39(3);174-78, doi: 10.1080/00224490209552139 (2002).

⁵³ See Jonsen, *Clinical Ethics*, New York: McGraw Hill (9th ed., 2022).

⁵⁴ See Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, J. Clin. Endocrinology Metab. 102(11):3869-3902, doi:10.1210/jc.2017-01658 (2017).

children experiencing precocious puberty) followed by hormonal treatments to induce the development of secondary sexual traits consistent with one's gender identity. In developing these guidelines, the authors assessed the quality of evidence supporting the recommendations made with use of the GRADE (Recommendations, Assessment, Development, and Evaluation) system for rating clinical guidelines. As directly stated in the Endocrine Society publication, "the strength of recommendations and the quality of evidence was low or very low." According to the GRADE system, low recommendations indicate that "[f]urther research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate." Very low recommendations mean that "any estimate of effect is very uncertain."⁵⁵ An updated set of guidelines was published in September of 2017.⁵⁶ The low quality of evidence presented in this document persists to the current day, as the controversy over these "treatments" is accelerating in recent years.

12. Administering hormones to a child whose gender dysphoria highly likely (80%+) to resolve is risky, unscientific, and unethical.

Iatrogenic damages, including life-long sterility, stunted growth, increased heart attack risk, etc., are often irreversible. Treatment of gender dysphoric children who experience persistence of symptoms with hormones (pubertal suppression and cross-hormone therapy) carries significant risk. It is generally accepted, even by advocates of transgender hormone therapy, that hormonal treatment impairs fertility and often result in sterility, which in many cases is irreversible.⁵⁷

⁵⁵ See Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, BMJ 2008(336):924, doi:10.1136/bmj.39489.470347.AD (2008).

⁵⁶ See *supra*, note 52.

⁵⁷ See Nahata et al., *Low Fertility Preservation Utilization Among Transgender Youth*, J. Adolescent Health 61(1):40-44, doi:10.1016/j.jadohealth.2016.12.012 (2017).

Emerging data also show that treated patients have lower bone density which may lead to increased fracture risk later in life.⁵⁸ Other potential adverse effects include disfiguring acne, high blood pressure, weight gain, abnormal glucose tolerance, breast cancer, liver disease, thrombosis, and cardiovascular disease.⁵⁹

13. Long term effects are unknown.

Such treatments are not generally accepted by the relevant scientific community and have no known nor published error rate. Since strategies for the treatment of transgender children as summarized by the Endocrine Society guidelines are relatively new, long-term outcomes are unknown. Evidence presented as support for short-term reductions in psychological distress following social transition in a “gender affirming” environment remains inconclusive. When considered apart from advocacy-based agendas, multiple potential confounders are evident. The most notable deficiencies of existing research are the absence of proper control subjects and lack of randomization in study design.⁶⁰

Although appropriate caution is warranted in extrapolating the outcomes observed from prior studies with current treatments, adults who have undergone social transition with or without surgical modification of external genitalia continue to have *rates of depression, anxiety, substance abuse and suicide far above the background population*.⁶¹

⁵⁸ See Klink et al., *Bone Mass in Young Adulthood Following Gonadotropin-Releasing Hormone Analog Treatment and Cross-Sex Hormone Treatment in Adolescents with Gender Dysphoria*, J. Clin. Endocrinology Metab. 100(2):E270-75, doi:10.1210/jc.2014-2439 (2015).

⁵⁹ See Seal, *A Review of the Physical and Metabolic Effects of Cross-Sex Hormonal Therapy in the Treatment of Gender Dysphoria*, Ann. Clin. Biochem. 53(1):10-20, doi:10.1177/0004563215587763 (2016); Banks et al., *Blood Pressure Effects of Gender-Affirming Hormone Therapy in Transgender and Gender-Diverse Adults*, Hypertension 77(6):2066-74, doi: 10.1161/HYPERTENSIONAHA.120.16839 (2021); Getahun et al., *Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, Ann. Int. Med., 169(4), 205–213, doi: 10.7326/M17-2785 (2018); Maraka et al., *Sex Steroids and Cardiovascular Outcomes in Transgender Individuals: A Systematic Review and Meta-Analysis*, J. Clin. Endocrinology & Metabolism 102(11):3914–23, doi: 10.1210/jc.2017-01643 (2017).

⁶⁰ See Hruz, *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, Linacre Q 87:34-42, doi:10.1177/0024363919873762 (2020).

⁶¹ See Adams et al., *Varied Reports of Adult Transgender Suicidality: Synthesizing and Describing the Peer-Reviewed and Gray Literature*, Transgender Health 2(1):60-75, doi:10.1089/trgh.2016.0036 (2017);

14. Medical treatments contrary to the science could result in irreversible harms to many patients who would otherwise have recovered naturally from gender dysphoria.

Of particular concern is the likelihood that naively requested gender transition “treatments” and social changes could interfere with known very high rates of natural-untreated resolution of sex-gender discordance. Any activity that encourages or perpetuates transgender persistence for those who would otherwise desist could cause significant harm, particularly in light of the current treatment paradigm for persisting individuals. As noted, sterility can often be expected with hormonal or surgical disruption of normal gonadal function.⁶²

15. “Gender affirmative” treatments damage or destroy healthy bodily organs, leading to loss of essential bodily functions (e.g., medically induced sterilization).

Despite the fact that gender dysphoria represents a psychological condition (as catalogued in the DSM since the third edition of this publication), some conceptualize the condition as a medical illness similar to cancer. When considered from this viewpoint, the goal of “treatment” is to alter the appearance of the body to conform to a patient’s perceived sexual identity, including the physical removal of unwanted “diseased” sexual organs. Since undesired body parts are fully formed and functional prior to hormonal or surgical intervention, the result of these “therapies” is injury to innate sexual ability. In particular, loss or alteration of primary sexual organs leads directly to impairment of reproductive potential. Recognition of this obvious consequence is the basis for the

see also Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS One 6:e16885, doi:10.1371/journal.pone.0016885 (2011).

⁶² See Cheng et al., *Fertility Concerns of the Transgender Patient*. Translational Andrology & Urology 8(5):209-218. doi: 10.21037/tau.2019.05.09 (2019).

development of new arenas of medical practice where there is an attempt to restore what has been intentionally destroyed.⁶³

16. No competent, scientifically valid, and reliable cost-benefit analysis has been done on “gender affirmative” treatments.

When the FDA tests a drug, the safety analysis looks at all related risks. Specifically, the drug must not only be effective, but it must not cause side effects that are more damaging than the proposed treatment. This is a key weaknesses in the affirmation model of care. Not only have the “treatments” *not* been proven reliably effective compared to *no* treatment, they are proposed against the existing knowledge of well-documented, long-term health problems and damages (e.g., testosterone use by transgender men increases the risk of fatal heart disease, estrogen use by transgender women increases risk of blood clots and strokes, gender transition treatments—if completed—can cause life-long sterility, etc.).

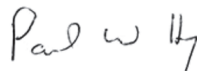
17. Summary opinions.

- There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions, including surgery, who are helped by such procedures.
- There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions, including surgery, who are injured or harmed by such procedures.
- Patients suffering from gender dysphoria or related issues have a right to be protected from experimental, potentially harmful treatments lacking reliable

⁶³ See, e.g., Ainsworth et al., *Fertility Preservation for Transgender Individuals: A Review*, Mayo Clin. Procs. 95(4):784-792, doi:10.1016/j.mayocp.2019.10.040 (2020).

and valid, peer reviewed, published, long-term scientific evidence of safety and effectiveness.

- Gender transition “affirmation” medical treatments, including surgery, for gender dysphoria and “transitioning” have no known, peer reviewed and published error rates—the treatments and assessment methods lack demonstrated, reliable and valid error rates.

A handwritten signature in cursive script that reads "Paul W. Hruz". The signature is written in black ink and is positioned above a horizontal line.

Paul W. Hruz, M.D., Ph.D.

From: [tim millea](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: "Gender" interventions in Florida
Date: Tuesday, September 20, 2022 3:15:16 PM

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To the Florida Board of Medicine:

I have been a physician for nearly forty years, and have witnessed the limitations of medicine's wisdom on many occasions. There have been some "advances", such as thalidomide and frontal lobotomy, that were hailed as breakthroughs in modern health care. Obviously, history has negated those predictions. However, while methods such as those had some scientific basis, albeit misguided, the bigger issue relating to transgender intervention is not based on evidence-based data. Rather, for the first time in my career, I am witnessing the support of a medical standard that is based solely on ideology, and not on science. This is a trap that you must recognize and avoid.

Although the American media and medical establishments do not want to recognize it, the experience of our European colleagues with these methods is critically important and instructive. The harm of these methods clearly and consistently overwhelms their "benefits", which are blatantly absent in objective longitudinal studies. It does not lessen the risk of suicide. If more than 80% of children desist and accept their biologic sex, with or without counseling, it is reprehensible that surgical mutilation should be promoted.

You have an opportunity to stop this politically and culturally motivated effort in Florida. The standard of care for gender dysphoric children and their parents is to "first do no harm". Do not allow political intimidation of medicine to advance further than it already has. Our patients and Florida's residents deserve that.

Tim Millea, M.D.
Davenport, Iowa

From: notneb@bellsouth.net
To: [zzzz Feedback, BOM MeetingMaterials](#); [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Dysphoria
Date: Tuesday, September 20, 2022 5:15:43 PM

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Paul A. Vazquez, J. D., Executive Director

Florida Board of Medicine

BOM.meetingmaterials@flhealth.gov

Paul.Vazquez@flhealth.gov

I write to encourage that the BOM BOOM rely on the [June 2022 Florida Medicaid Generally Accepted Medical Standards Determination on the Treatment of Gender Dysphoria](#),. I am a pediatrician and agree with the report's conclusion that puberty blockers and body altering genital and breast surgery is not appropriate treatment for minors.

Sincerely,

Tom Benton, MD, MPH
Fellow, American College of Pediatricians
Adjunct Clinical Assistant Professor
5612 NW 43RD ST GAINESVILLE, FL 32653-3332
PHONE: 352 376 4542 FAX: 352 376 4959
EMAILS: notneb@bellsouth.net Notneb7@ufl.edu

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From: [Brian Kenney](#)
To: [Vazquez, Paul](#)
Subject: gender affirming care
Date: Monday, September 19, 2022 9:05:46 PM

You don't often get email from briandkenney@gmail.com. [Learn why this is important](#)

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Dear Mr. Vazquez,

I hope that Florida will follow the example of Britain and other European countries in restricting gender affirming care to adults who can make their own health choices. These therapies formerly were available to adolescents and that policy was reversed when the frequency of significant complications and side effects became clear.

Brian Kenney, MD

From: [Angeli Akey](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Cc: [Vazquez, Paul](#)
Subject: Against Gender-Affirming care for Florida's youth
Date: Tuesday, September 20, 2022 6:21:42 PM

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Dear Florida Board of Medicine,

Transgender ideology does not belong in pediatric healthcare as it is dangerous to impose this on our youth.

Gender dysphoria in pre-pubertal children resolves spontaneously (in 80-90%) after they develop through natural puberty. " Gender-affirming " practices have adverse consequences which affect children in mental, physical and spiritual ways. There are no long-term studies that have found beneficial effects from ' gender changing ' interventions that include but not limited to, puberty blockers or GNRH analogues , cross sex hormones and mutilating surgeries.

As we know, children are not small adults; they lack the developmental capacity to make these kind of decisions and they also need and deserve our protection from these harmful, life-altering interventions.

Let's let children be children !
Please help to keep gender transforming practices out of childhood.

Sincerely,

Dr. Angeli Maun Akey
Board-Certified Internal Medicine (ABIM)
Board-Certified in Integrative Medicine (AIHM/ ABOIM)

Please excuse typos as sent from my iPhone

Blessings,

Angeli Maun Akey, MD, FACP
Office (352)332-6680
Fax (352)332-6604
[Agelessmedicalsolutions.com](#)
[MyNFIM.com](#)

Silverleaf Office Park
6224 NW 43rd ST, Ste A
Gainesville, FL USA

32653-8871

From: dr77777k@aol.com
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Fw: Transgender change
Date: Tuesday, September 20, 2022 4:38:42 PM

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I seriously question the rapidity and extent of the current trend in US transgender change.

Dr Cass's review with the associated pulling back to a more conservative approach in Finland, Sweden, and the UK should give us pause until longer term and more extensive studies confirm the better criteria for screening, management, and outcomes.

Don R. King, MD

[Sent from the all new AOL app for iOS](#)

From: [Liudmila Buell](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Practice Standards for the Treatment of Gender
Date: Tuesday, September 20, 2022 1:50:39 PM

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Hello,

Since this subject was discussed during the recent FMA annual meeting, I would like to provide input into the rules being discussed in the workshop 30-Sep-2022.

I believe that any rules need to include limits in the treatment of minors. Research shows that most (over 80%) minors with gender dysphoria see that condition resolve as a part of going through puberty. Also, many young adults express regret that they transitioned. Therefore, we are doing a great disservice to many young people by transitioning them too young. Likely there need to be other therapies required for minors before puberty blockers or other transition actions are taken.

Also, it is imperative that proper informed consent be required. This should include acknowledgement that the process is largely irreversible and that some others have had regrets of having gone through the procedure, and that this regret begins after it is too late.

And finally, I do not believe that public funds should be used to provide transition. We need to be very careful to ensure that the voices in medicine which actively support transition as treatment for gender dysphoria are not profiting from the process as that creates an obvious conflict of interest. These profit motives should also be part of the informed consent.

Thank you.

Sincerely,
Liudmila Buell, MD

From: [Mae Lyle](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Florida Parent Testimony
Date: Tuesday, September 20, 2022 5:53:34 PM

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To Whom It May Concern,

Thank you for taking the time to read my email.

Perhaps it is too late to save my son from the transgender ideology, but I feel compelled to do something to help save any other children from falling prey to this cult. Being a compassionate mother who dearly loves my son, the mama bear instinct naturally kicked in gear. I want to save my son and others from this evil ideology.

My family was dragged into this nightmare 7 years ago when my son was still in college.

My son is gifted, a loner and was diagnosed with what is now considered being on the Autism spectrum. He never showed any signs of identifying as transgender or having gender dysphoria when he was younger. While he was sensitive and empathetic, he was also a rough and tumble, energetic boy. We are still perplexed since he never showed signs of homosexuality, cross dressing or any paraphilia attributed to auto gynephilia.

He made a self-diagnosis after being heavily influenced by on-line sites such as Deviant Art and Reddit where he was made to feel like he belonged.

Doctors and therapists ignored several important details including his previous bouts of depression, that he suffered multiple concussions and that he was molested by a peer. In the first therapy session, he was told he needed to transition medically in order to prevent being suicidal. He is currently taking an antidepressant. Without having a mental health assessment, he was prescribed high dose female hormones after he signed an informed consent form. The therapist and physician's assistant should have seen red flags since cross-sex hormones and antidepressants do not mix.

Potential irreversible harms were never discussed by the doctor, physician's assistant, therapist or clinic. His mental illness has never been appropriately addressed. He was fast-tracked into becoming a patient for life, a cash cow for the therapists, the surgeons, the gender clinics and the pharmaceutical companies.

Today he is in his late twenties. In addition to taking cross-sex hormones, he had facial feminization surgery and laser hair removal. He has been castrated and he is being encouraged to have a vaginoplasty. He will need to be on some sort of hormones for the rest of his life as well as needing continuous therapy. He will never be able to have children and he has lost his sexual function. His life-expectancy is now shortened. He is at more risk for recurrent infections from surgeries, heart disease, stroke, mental illness and bone loss.

He needs to address the cause of his depression instead of making any further cosmetic changes to his body as he will never be a woman.

He has been told that he is better off without having his family in his life. We haven't seen him in almost 3 years. Our relationship with our son has been destroyed. My heart aches for him.

We have been called transphobic, angry and hateful since we do not affirm him as being female. We have been made to feel guilty by being asked "Wouldn't you rather have a live daughter than a dead son?" We will not participate in this lie.

How many more bodies will be harmed before this is stopped? My question for anyone who doubts this is happening, is "What if your son was told he needed to mutilate his body in order to become

mentally healthy or happy?"

The system has failed our son.

Mae Lyle

From: [Media Angels](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender Affirming language
Date: Tuesday, September 20, 2022 1:48:31 PM

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We are totally against any transitioning of minors in Florida as regards the medical community. We ask for a ban of gender-affirming care for minors - this is child abuse at the highest level.

Please record my comments as against any gender-affirming surgeries or "health-care" for minors.

--

Felice Gerwitz
Speaker, Author, Publisher, Podcaster

From: [Felice Gerwitz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Minors and Transitioning
Date: Tuesday, September 20, 2022 1:54:51 PM

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As a Florida resident, I want to make my opinion known. I am totally against any transitioning of minors in Florida as regards the medical community. We ask for a ban on gender-affirming care for minors - this is child abuse at the highest level.

Please record my comments against any gender-affirming surgeries or "health care" for minors.

All the Best,

~ Felice Gerwitz

"All things God works for the good of those who love him, who have been called according to his purpose." Romans 8:28

From: [Jeff Gerwitz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Banning unnecessary medical treatment
Date: Tuesday, September 20, 2022 1:56:18 PM

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As a Florida resident, I want to make my opinion known. I am totally against any transitioning of minors in Florida as regards the medical community. We ask for a ban on gender-affirming care for minors - this is child abuse at the highest level.

Please record my comments against any gender-affirming surgeries or "health care" for minors.

Jeff Gerwitz

Dear Florida Medical Board,

My name is Joe Zalot, a Staff Ethicist at the National Catholic Bioethics Center (NCBC) in Philadelphia. I am writing to ask the medical board to take a very, very cautious approach to the issue of medical interventions for people, particularly children, who experience gender incongruence. My own and the NCBC's position is that so-called gender-affirming care (including puberty-blocking and cross-sex hormones, as well as surgical procedures) care violates the good of the human person and should not occur in any situation. Along with the American College of Pediatricians and Catholic Medical Association (among others), maintain that the most ethically appropriate treatment is psychotherapy that (1) seeks to discover and resolve the underlying issues giving rise to patients' sense of gender incongruence, and (2) supports patients as they learn to accept and align their sense of self with their biological sex.¹ This approach is wholly in accord with Catholic anthropology, Church teaching, and sound medical practice.² It is also in accord with the entirety of the Catholic health care tradition, including the *Ethical and Religious Directives for Catholic Health Care Services*.³

We maintain this approach for a number of reasons, here I will mention just two. The first is informed consent. As you well know, informed consent is moral principle that is foundational to the practice of medicine. It requires that one receive all relevant information about a proposed intervention (its nature, benefits, risks, consequences, and reasonable alternatives) in order to make a proper judgement about it. In addition, one must possess the capacity to understand this information, as well as the ability to critically evaluate it, in order to validly consent. Can children do this with regard to puberty-blocking hormones? Neuroscience demonstrates that the adolescent brain is cognitively immature and lacks capacity for risk assessment. It is not sufficiently mature to make significant medical decisions, particularly decisions that may have life-long, irreversible consequences.⁴ The NCBC agrees with the American College of Pediatricians that "treating" adolescent gender dysphoria with puberty-blocking (and later cross-sex) hormones constitutes mass experimentation on children who are incapable of providing proper informed consent. This is a form of child abuse.⁵

Second, if the Florida Medical Board allows so-called gender affirming care to continue (or upholds the latest HHS "guidance" on the issue), it constitutes a violation of my faith and my first

¹ ACPeds et al., "ACPedS, APPS, CMDA, and CMA Support Minors' Right to Therapy," accessed December 29, 2020, <https://static1.squarespace.com/static/55efa8b5e4b0c21dd4f4d8ee/t/58b85ab0197aea3090547486/1488476909245/2.22.17+Joint+Therapy+Ban+Letter.pdf>. Perceptions of gender incongruence are of the mind, not of the body. Thus, medical interventions should focus on the mind not on physically altering the body.

² Hruz, "Medical Approaches," 8–9. For perspectives on how Catholic physicians can treat patients experiencing gender incongruence, see Thomas Heyne et al., "A Catholic Approach to Adolescent Medicine," *National Catholic Bioethics Quarterly* 19.1 (Spring 2019): 75–82, doi: 10.5840/ncbq20191917.

³ To date, neither the Vatican nor the United States Conference of Catholic Bishops have issued definitive guidance on providing care to people suffering from gender incongruence. Some within Catholic health care exploit this lack of guidance to argue that directives 29, 33, and 53 of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) can be used to justify hormonal, and even surgical, transitioning interventions. Both I and the NCBC disagree. While outside the purview of this essay to develop fully, the ERDs do not in any way offer justification for gender transitioning.

⁴ ACP, "Gender Dysphoria in Children," 10–11. See also Hruz, "Experimental Approaches to Gender Dysphoria," 99–100.

⁵ Michelle Cretella, Quentin Van Meter, and Paul McHugh, "Gender Ideology Harms Children," accessed November 25, 2019, <https://www.acpeds.org/the-college-speaks/position-statements/gender-ideology-harms-children>.

Amendment rights. Below is a brief explanation of how my faith tradition, Roman Catholicism, views gender ideology and so-called transitioning.

Essential points of Catholic anthropology, and how it contrasts with gender ideology, include the following:

1. Human beings are created male and female from conception (Gen. 1:27). Our dignity is grounded in part in this special creation as male and female.⁶ Gender ideology, in contrast, maintains that sex is assigned at birth, a notion that is demonstrably false (see below).
2. The human person is a body–soul union, and the body is a constitutive aspect of the person (*Catechism*, nn. 364, 365). As such, Catholicism rejects any dualistic conception of the human person that proposes a “self” separate from the body, which gender ideology necessarily entails. Gender ideology is founded in the perception that “I am not my body.” Its anthropological premise is that the body is unnecessary, even irrelevant, for understanding “who I am.”⁷
3. The body is a gift from God and is a constitutive dimension of our nature and being. As such, humans may not treat the body as a “piece of property” or “manipulate it as a thing or an instrument over which one is the master and arbiter”⁸—precisely what gender ideology does in its effort to reassign sex.
4. Sexual difference is willed by God as part of the divine plan. The complementarity that results from sexual differentiation is ordered to human good and flourishing, and in particular to marriage and family life (*Catechism*, nn. 369, 2333).⁹ As a result, humans are called to accept their sexual identity, manifested through the body, as a fixed and unchanging element of self (*Catechism*, n. 2393).¹⁰ Gender ideology, conversely, is not concerned with either sexual complementarity or the purpose and proper ordering of human sexuality. It is based in subjective perceptions of self and is focused solely on the perceived good of the individual person.

The Catholic understanding of the human person, and of human sexuality, has important moral consequences. Human persons act against their flourishing—and thus their good—when they directly intend what is contrary to their nature and God-given identity. Directly intending to transition one’s sex does exactly this. It seeks to alter what is biologically unalterable, establish a false identity, and both deny and contradict the individual’s authentic human existence as a male or female body–soul unity. Stated differently, transitioning undermines true human flourishing, and as a result, it runs contrary to the human good. It is never morally permissible.¹¹

⁶ *Catechism of the Catholic Church*, 2nd ed. (Washington, DC: United States Conference of Catholic Bishops/Libreria Editrice Vaticana, 2000 update), nn. 369, 2393. All subsequent citations appear in the text.

⁷ See National Catholic Bioethics Center (NCBC), “Brief Statement on Transgenderism,” *National Catholic Bioethics Center Quarterly* 16.4 (Winter 2016): 600–601, doi: 10.5840/ncbq201616457; and John A. Di Camillo, “Gender Transitioning and Catholic Health Care,” *National Catholic Bioethics Quarterly* 17.2 (Summer 2017): 219–220, doi: 10.5840/ncbq201717221.

⁸ Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, English ed. (Philadelphia: National Catholic Bioethics Center, 2017), n. 47.

⁹ See Francis, *Laudato si’* (May 24, 2015) n. 155.

¹⁰ See Pontifical Council for Justice and Peace (PCJP), *Compendium of the Social Doctrine of the Church* (Washington DC: USCCB, 2004), n. 224; and Congregation for Catholic Education, *Male and Female He Created Them: Towards a Path of Dialogue on the Question of Gender Theory in Education* (February 2, 2019), n. 4.

¹¹ NCBC, “Brief Statement on Transgenderism,” 601.

Church teaching

In light of its anthropology and the seriousness of the realities involved, the Catholic Church in recent years has addressed gender ideology directly. Pope Benedict XVI warned in 2012 that *gender* has become the “new philosophy” of sexuality, one where biological sex is no longer regarded as a “given” of one’s nature. He then demonstrated the “obvious” and “profound” falsehood of this philosophy: “People dispute the idea that they have a nature, given by their bodily identity, that serves as a defining element of the human being. They deny their nature and decide that it is not something previously given to them, but that they make it for themselves.”¹² Seven years later, the Congregation for Catholic Education expanded on this theme by stating gender theory denotes a “process of denaturalization” whereby society moves away from the objective truth of nature and into the realm of pure subjectivism. It concluded that gender theory’s view of sexual identity is “often founded on nothing more than a confused concept of freedom in the realm of feelings and wants . . . as opposed to anything based on the truths of existence.”¹³

Pope Francis spoke to gender ideology in two well-known encyclicals of his early pontificate. In *Laudato si’*, he linked human sexual identity with care for the created order by stating, “Acceptance of our bodies as God’s gift is vital for welcoming and accepting the entire world as a gift from the Father and our common home.” He then warned that thinking that we enjoy absolute power over our own bodies turns, often subtly, into thinking that we enjoy absolute power over creation. Accepting and respecting the “fullest meaning” of our body is “an essential element of any genuine human ecology.”¹⁴

In *Amoris Laetitia*, Francis echoed Benedict XVI by warning that gender ideology “denies the difference and reciprocity in nature of a man and a woman,” which in turn leads to laws and educational curricula that “promote a personal identity and emotional intimacy radically separated from the biological difference between male and female.” This ideology then asserts itself as “absolute and unquestionable,” even usurping the proper role of parents in raising their children.¹⁵ In response, Francis emphasized that while biological sex and gender (understood as the sociocultural role of sex) can be distinguished, they can never be separated. He concludes, “It is one thing to be understanding of human weakness and the complexities of life, and another to accept ideologies that attempt to sunder what are inseparable aspects of reality. Let us not fall into the sin of trying to replace the Creator.”¹⁶

If you have any questions or need further clarification, please feel free to contact me at the email below. Thank you for your time and effort on this crucially important topic.

Joe Zalot

jonalot@ncbcenter.org

¹² Benedict XVI, Address on the Occasion of Christmas Greetings to the Roman Curia (December 21, 2012).

¹³ *Male and Female He Created Them*, n. 19. For a secular perspective on the many problems with gender ideology, see Joanna Williams, *The Corrosive Impact of Transgender Ideology* (London: Civitas, 2020).

¹⁴ Francis, *Laudato si’*, n. 155.

¹⁵ Francis, *Amoris Laetitia*, (March 19, 2016), n. 56.

¹⁶ Francis, *Amoris laetitia*, n. 56. For further Catholic resources, see US Conference of Catholic Bishops, “*Gender Theory*”/“*Gender Ideology*”—*Select Teaching Resources* (Washington, DC: USCCB, 2019).

From: [Camille Kiefel](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: re: "gender affirmative" care testimony
Date: Monday, September 19, 2022 8:56:51 PM
Attachments: [Kiefel Testimony .pdf](#)

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To:
Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Mr. Vasquez,

Attached is a PDF of my testimony for Florida Board of Medicine. A copy of the transcript is below my signature as well.

Please let me know if you need anything more from me.

Sincerely,
Camille Kiefel

My name is Camille Kiefel. I stand here before you today, Florida Board of Medicine, in hopes that you make the right decision regarding transitioning children and take greater consideration for adults. I know you want the best for the citizens of Florida, to improve their health and become productive members of society.

I am the definition of treatment-resistant, can't take medications, approximately 20 years of talk therapy, hypnotherapy, EMDR (eye movement desensitization and reprocessing), DBT (dialectical behavior therapy), and two rounds of TMS (transcranial magnetic stimulation therapy). I had done everything conventional medicine had to offer. I was the perfect patient: diligent and wanting to heal, but nothing my doctors offered had healed me.

I was 30 when I transitioned and at the end of my rope. At the time I believed I was nonbinary. I struggled with CPTSD (complex post-traumatic stress disorder), MDD (major depressive disorder), ADHD (attention deficit hyperactivity disorder), GAD (generalized anxiety disorder), and suicidal ideation. When I was in 6th grade, my best friend had been raped by her brother. Being a girl meant I was vulnerable. I started to present more masculine. This should have been a red flag. Yet within a few months of requesting top surgery, it was performed on me. I developed complications after my surgery. There were many times I didn't know if I would make it through the night.

If I made this mistake as an adult, a young girl could, too. My top surgery not only exacerbated my mental health issues. I now struggle with physical complications as well. The reality is that young girls are struggling with overlooked mental and physical health issues. Presenting and taking on another gender was a form of escapism around womanhood. This is not a valid way of dealing with trauma. You will have to deal with it eventually.

I was able to work through these difficult emotions and improve my mental health through a

holistic approach. My physical health issues had been overlooked. Had that been managed, I would have never gotten the surgery. We need better options for treatment-resistant girls and women. This surgery was an abhorrent misdiagnosis. The goal of healthcare should always be to get to the root cause of the problem.

I am more grounded than I have been my entire life, but, I am mutilated. Between my carved-up body and the physical complications, I often question if there's anything on the other side. Where my breasts were are hollow. I can never get them back. I can never fit a dress the same way again. I can never breastfeed. Who will love me?

You know what keeps me going. It's stopping this from happening to someone else.

Thank you for your time. You all have a lot to consider, and I know you will make the right decision.

My name is Camille Kiefel. I stand here before you today, Florida Board of Medicine, in hopes that you make the right decision regarding transitioning children and take greater consideration for adults. I know you want the best for the citizens of Florida, to improve their health and become productive members of society.

I am the definition of treatment-resistant, can't take medications, approximately 20 years of talk therapy, hypnotherapy, EMDR (eye movement desensitization and reprocessing), DBT (dialectical behavior therapy), and two rounds of TMS (transcranial magnetic stimulation therapy). I had done everything conventional medicine had to offer. I was the perfect patient: diligent and wanting to heal, but nothing my doctors offered had healed me.

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This should have been a red flag. Yet within a few months of requesting top surgery, it was performed on me. I developed complications after my surgery. There were many times I didn't know if I would make it through the night.

If I made this mistake as an adult, a young girl could, too. My top surgery not only exacerbated my mental health issues. I now struggle with physical complications as well. The reality is that young girls are struggling with overlooked mental and physical health issues. Presenting and taking on another gender was a form of escapism around womanhood. This is not a valid way of dealing with trauma. You will have to deal with it eventually.

I was able to work through these difficult emotions and improve my mental health through a holistic approach. My physical health issues had been overlooked. Had that been managed, I would have never gotten the surgery. We need better options for treatment-resistant girls and women. This surgery was an abhorrent misdiagnosis. The goal of healthcare should always be to get to the root cause of the problem.

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You know what keeps me going. It's stopping this from happening to someone else. Thank you for your time. You all have a lot to consider, and I know you will make the right decision.

From: [Nicholas](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Medical policy on gender dysphoria
Date: Tuesday, September 20, 2022 2:53:58 PM

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Dear Florida Board of Medicine members,

As you consider policies about gender dysphoria especially in children I exhort you to weigh the evidence for conservative and supportive treatment given the frequency of self-resolution. It seems apparent to me that the harms of sex change therapies likely outweigh the benefits especially in children.

Sincerely,
Nicholas A Stephanoff, MD

From: [Cindy Mayer](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Affirmative Care
Date: Monday, September 19, 2022 10:47:20 PM
Attachments: [UYR_SDHB_Positive_1118_final.pdf](#)

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Dear Board Members,

I would like to tell you about why I believe a slower approach should be taken in regards to gender transition versus affirmative care.

My 21 year old son, "B" went to Planned Parenthood and was prescribed male to female hormones on his first visit.

B has a genetic mutation; SDHB which is called c.287-1g>c. This type of SDHB mutation can cause renal and papillary thyroid cancers, pituitary adenomas and also, an increased risk of developing paragangliomas or pheochromocytomas. These types of tumors are more likely to be malignant. Studies have shown that there is a **77-100% chance of B developing cancer** between 30-50 years of age. *See attached for additional information in regards to this mutation.*

Given that Estradiol is a hormone that is known for causing cancers, and with my sons predisposition of developing cancer/s (*in organs, that produce and regulate hormones!*), it seems like common sense that taking Estradiol and/or other similar hormones could be very dangerous to him. Yet, **he was prescribed Estradiol** on his very first visit **without any consultation** of his **Endocrinologist, Oncologist, Primary Care Physician nor his Genetic Counselor.**

Here is a bit of our family health history:

- B's father was diagnosed with **kidney cancer at age 32!** One of B's cousins was diagnosed with **kidney cancer and paraganglioma tumors, also at age 32**, and he **passed away within four years** of diagnosis! A second cousin developed **cancer at the age of 21 and died by the age 24!!** There have been many other family members with cancer and it is assumed they also had/have the genetic mutation. ****Estradiol can cause cancer!***
- There is a **very strong history** of heart disease in our family! B's father had a **heart attack at 47** years old, his maternal grandfather had a **heart attack at 34** and died on the fourth heart attack at 38 years old. Also, a second cousin died of a **heart attack at 31** years old! ****Estradiol can cause cardiovascular disease!***
- **Blood clots** (which can be hereditary) are also common in **both sides of our family!** Uncle's on from each side have had more than one blood clot at young ages. ****Estradiol can cause blood clots!***
- **Brain aneurysms** run in his family too! B's **grandmother had a brain aneurysm** that ruptured causing a hemorrhagic stroke. Her aneurysm lead to other family members being checked for aneurysms. **Myself and B's aunt also have/had brain aneurysms.** ****Estradiol can cause strokes!***
- Many family members have Diabetes. ***Estradiol can cause Type 2 Diabetes!***

**Link to estradiol side effects according to Mayo clinic: <https://www.mayoclinic.org/tests-procedures/feminizing-hormone-therapy/about/pac-20385096>*

B suffers from **depression** and has been diagnosed with **ADHD** too. I do not believe that B was of sound mind and psychology stable when he went to Planned Parenthood but a Psychiatrist, nor Therapist, nor any mental health professional did an evaluation of him before prescribing hormones to him. Perhaps if B worked with professionals for his depression and ADHD he might feel differently about transitioning but this was not offered as a solution. Wouldn't it be smarter to first try a non-invasive treatment, especially with B's medical history?!

There needs to be more time for these doctors to thoroughly determine whether the patient should proceed down the path of medicalization. Synthetic hormones can have many detrimental side effects and everything should to be taken into consideration before patients are prescribed hormones.

Patients should be required to submit medical records, have family and friends testify that they are mentally stable and have a proper psychological evaluation done. Additionally, the doctor should provided proper statistics about people that have detransitioned and patients should be **fully** taken through the **risks of hormones, surgeries, etc.** They should not just given a consent form to sign with a bunch of legal information that no one ever reads. Especially, when working with a minor or a young adults whose brains are not yet fully developed to process all the ramifications.

With B's health history and the long list of family member's serious health issues, B should have been required to consult with an Endocrinologist, Oncologist, Primary Care Physician, Genetic Counselor, Neurosurgeon, Urologist, Cardiologist and a Psychiatrist prior to starting any hormones.

Instead, a **gynecologist** prescribed hormones to **my son** and within **four months** he ended up with **two brain tumors**, one in the pituitary gland the other in the left frontal lobe. I can provide mri scans from year prior to him taking hormones and mri 4 months after starting hormones. I am happy to provide medical records as well if you would like to see.

Happy to answer any questions you may have. I can be reached on my cell below.

C

708/373-5359

Dear. Dr. Vazquez and board members,

I am a mother of a young adult (she is 20 years old) who became confused about her gender as a teenager (around the age of 14). My daughter expressed no previous signs of gender confusion in her childhood. Her confusion began after she started hanging out with “friends” at school and meeting people online who identified as transgender. I want to give you a timeline of how this transgenderism played out for my daughter and me.

I believe my daughter may have been bullied in school and never really had a friend group and just wanted to fit in with a group. When she entered high school, she started to have a couple of friends. I was so excited for her and for them because she is the sweetest and kindest person they could have as a friend. As I started to learn more about these friends, they seemed to all be a part of the LGBTQ group and attended the GSA club at school. As I have gay friends, I thought no biggie we all need friends and didn't think much more about it. That was my first mistake as I learned most of the kids she hung around with at school and met online identified as transgender. I have also learned transgenderism has become a social contagion.

Additionally, I believe she had a teacher in high school who was also the leader of the GSA club that I believed helped kids at the school social transition while at school behind the parents' back. This teacher also had a son who began identifying as a girl and supported this transition.

I noticed one day my daughter had these massive what looked like burns on her arm. They were not burns, she was cutting herself (she was about 15 years old); She also told me she was hearing voices telling her to harm herself and making her feel she was nothing. I found a therapist I thought I could trust because I wanted to get my daughter help. This therapist seemed great and my daughter really liked her. I was so hopeful that this therapist would work on my daughter's self-esteem and how to appreciate herself just the way God made her. What I faced was a therapist who was against me and pushed my daughter against me as well. She gave my daughter information regarding gender care clinics as minor and my daughter was more focused now on the gender issue than how to learn to work on herself and overcome the struggles she was facing with herself.

Then at the age of 16 my daughter sustained a traumatic brain injury due to a car accident. She was in a coma for 9 days, had half of her skull removed and then put back in. She had to learn almost everything over again like walking, talking, dressing herself, most all basic life skills. During her recovery not once did gender come up, not once did she tell anyone that I know of or heard her say that she was a boy. It was clear this was a social construct and when taken out of the peer group even though she had a traumatic accident the trans identity was not there. I knew I needed to get her back in therapy because we have the TBI my daughter needed to understand and deal with and how it could/would affect her life and how she would cope and handle it and hopefully if the transgenderism came back up that could be dealt with. Of course, my daughter went through 2 therapists because she didn't like them and all she wanted was

her original therapist, the one who affirmed her. She could not go back to the original therapist and so eventually, my daughter just did not want to do therapy anymore.

My daughter finished her senior year of high school and started attending USF during COVID so you can imagine how that went. In July of 2020 (she is now 18 ½) I received a letter from CVS that the prescription for testosterone for my daughter had been approved. I was in total shock. How did this happen and when did she go to the doctor to get this approval. Well no thanks to Planned Parenthood, my daughter did not even have to go in person to Planned Parenthood. She had her appointment via tele-med due to COVID and was prescribed testosterone right away. A simple sign on this line on an implied consent form and Planned Parenthood set my daughter up to destroy her body and most likely give her an early death sentence due to the effects of a female taking a drug that is meant for a man.

I do want to let you know my daughter has stated testosterone gives her a euphoric feeling that is something a person who uses street drugs say. My daughter is killing herself as an illegal drug user kills themselves slowly by taking drugs. As if the testosterone was not enough, my daughter wants to get her chest cut off and a doctor is ready and willing to do it. Of course my daughter being a college student and only working part time she is unable to afford the surgery. My daughter then created a go fund me page to help pay for this surgery. In the fundraiser page my daughter states she struggles with cognitive issues and mental illness. Did you hear that? She is on testosterone and that has not made her mental state any better but no one cares. They just prescribe hormones meant for a man and willing to do surgery that is totally not needed to a person whom admits to having cognitive issues along with mental illness.

I cannot save my daughter from this nightmare because she is an “adult” but I am hoping Florida and this board will create a rule that will prevent doctors from being able to prescribe experimental puberty blockers, cross sex hormones and perform any type of gender affirming surgeries such as double mastectomies, breast augmentation, vaginoplasty or phalloplasty on minors .

I truly wish it would go even further. My hope is, after the age of 18. Extensive therapy and measures are would be put into place so it gives young adults time to figure out themselves and get help that is not in the form of irreversible damage. Most if not all of the individuals need help with mental illness that seems to be the driving force behind the transgenderism.

I want to thank you all for listening to my family’s story. Because of the lack of true care to help these kids and young adults deal with mental health issues it is tearing families apart like it has mine. I implore the board to please make a rule that will protect children from these experimental treatments and surgeries and advocate for ethical, evidence-based and compassionate treatment of these individuals. There is no test for “transgenderism.” There is no test to see which child will desist and which will persist. There is no test that will tell us which child will regret these irreversible treatments and which will not.

~ Christen Redding

To whom it may concern:

I am writing in regards to medical transition for minors with gender dysphoria. I understand the Florida Board of Medicine is making a decision concerning this topic. There is lack of evidence and possible concern for long term health affects for medical transition in minors. The Cass Review by Dr. Hilary Cass states on their website: "the Review is not able to provide advice on the use of hormone treatments due to gaps in the evidence base," <https://cass.independent-review.uk/publications/interim-report>. Numerous medical academic centers list on their websites the possible side effects from use of hormone treatment for medical transition: University of Rochester Medical Center - <https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=134&contentid=116>
Vanderbilt University Medical Center – <https://www.vumc.org/lgbtq/key-transgender-health-concerns>
Mayo Clinic – <https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075>
There should be more mental health assistance for minors instead.

Sincerely,
Jacqueline Fernandes, MD
Obstetrician/Gynecologist

6578 Kestrel Circle
Fort Myers, FL 33966
September 19, 2022

Mr. Paul Vazquez,
Executive Director, Florida Board of Medicine
Florida Department of Health
Paul.Vazquez@flhealth.gov
BOM.MeetingMaterials@flhealth.gov

Dear Mr. Vazquez and Members of the Florida Board of Medicine:

As a practicing family physician in the State of Florida, I write to implore that the Florida Board of Medicine restrict the practice of “gender-affirming care”—including social gender transition, hormone therapy, and gender-reassignment surgery—for children and adolescents. The short- and long-term harms as a result of such “gender-reassignment” practices on children are severely damaging and irreparable, and medical and evidence-based studies do not support their use. Additionally, given that over 80% of children affected by gender dysphoria will eventually lose their desire to identify with their non-birth sex, it is professional dereliction of duty for the medical community to allow such procedures—which result in disfigurement, sterility, and other lifelong damage to bodily and mental health-- with the professional sanction of the Board of Medicine.

It is my sincere hope that the Florida Board of Medicine will restrict the use of such “gender-reassignment” practices for children and adolescents, in the interest of preserving the health and well-being of Florida’s children and families.

Sincerely,

James O. Breen, M.D.
Fort Myers, Florida
James.O.Breen@gmail.com

From: [Julia Mason](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Re: regulation of pediatric transition medicine
Date: Wednesday, September 21, 2022 12:01:32 AM
Attachments: [A Rare Reversal on Gender Transition Policy - WSJ.pdf](#)
[Academy of Pediatrics Responds on Trans Treatment for Kids - WSJ.pdf](#)
[wsj AAPsDubious Aug17.pdf](#)

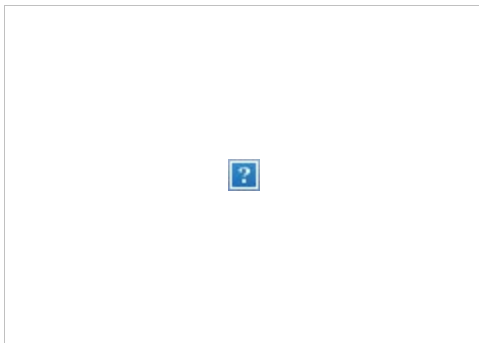
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My name is Julia Mason, I am a pediatrician practicing in Gresham, Oregon and a fellow of the American Academy of Pediatrics. I am concerned about the current lack of an evidentiary basis for what is being done to children and young people who report being distressed about their gender.

I've published multiple articles outling my concerns, I'll attach a few and leave links to others.

<https://www.kevinmd.com/2019/10/a-physician-is-worried-about-gender-transition-in-pediatrics.html>



A physician is worried about gender transition in pediatrics - KevinMD.com

The child has made a social transition (like multiple students at their school), but medical treatment is being put off for a few years. However, this kid recently told me that their FTM friend who moved to Los Angeles is being started on testosterone soon, age 13 in eighth

www.kevinmd.com

<https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2046221>

Full article: Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults - Taylor & Francis



Ethical Concerns About Inadequate Informed Consent. The concept of informed consent in medicine has roots in both ethical theory and law. The ethical foundation is centered in the principles of beneficence, justice, and respect for autonomy, while the legal issues have to do with

www.tandfonline.com

The American Academy of Pediatrics' Dubious Transgender Science

As other countries turn away from hormones and surgery, the AAP won't even allow a debate.

By Julia Mason and Leor Sapir

Aug. 17, 2022 6:17 pm ET



People celebrate an LGBT pride festival in Smyrna, Ga., June 25. PHOTO: ROBIN RAYNE/ZUMA PRESS

A spate of headlines this month declared that America's surge in transgender identification wasn't being caused by a social contagion. These articles were prompted by a new study by Jack Turban and colleagues in *Pediatrics*, flagship journal of the American Academy of Pediatrics. The study claimed that social influence isn't the reason that as many as 9% of America's youth now call themselves transgender. Thus, Dr. Turban argues, efforts in conservative states to regulate on-demand puberty blockers, cross-sex hormones and surgery must be resisted.

Yet Dr. Turban's study is deeply flawed and likely couldn't have survived a reasonable peer-review process. The swift response from the scientific community made both points

clear—with even those who support hormones and surgery for gender-dysphoric youth noting that Dr. Turban’s shoddy science undermined their cause.

Nevertheless, the media have promoted his work as a refutation of the claim that the wildfire spread of transgender identity is an example of social contagion—a phenomenon in which members of a group (mostly young and female) mutually influence one another’s emotions and behavior.

The Turban study rejects the social-contagion theory on the grounds that more biological boys than girls identified as trans in 2017 and 2019, according to data collected from 19 states by the Centers for Disease Control and Prevention’s Youth Risk Behavior Survey. But the researchers who helped design the CDC questionnaire explicitly warned that youths who identify as transgender may list their sex as their gender identity, making it impossible to discern who is male-to-female or female-to-male (a limitation Dr. Turban has acknowledged in the past).

In this latest study, he cites three sources suggesting that respondents interpret “sex” as “sex assigned at birth”—even though none of those studies says anything of the sort. To use a flawed sex statistic in an attempt to set aside the well-documented phenomenon of gender-dysphoric female teens’ flooding clinics is so amateurish that one can’t help but suspect bad faith.

The AAP has been giving Dr. Turban a platform for years, despite the mistakes that plague his research. *Pediatrics* published his highly flawed 2020 study alleging that puberty blockers reduce suicide in teens. The journal even chose the article as its “Best of 2020” despite receiving rebuttals that pointed out the rate of *attempted* suicide rate was twice as high among the puberty-blocked group and Dr. Turban hadn’t controlled for the possibility that better mental-health outcomes might be the result of factors other than hormonal intervention.

In his correspondence with physicians who asked how such a study could be named best of the year, Lewis First, editor in chief of *Pediatrics*, said that award is based on “website views and article downloads,” not “editorial choices.” In response to a rebuttal from one of us (Julia Mason), who warned that the AAP was encouraging the misleading idea that sex can literally be changed, a reviewer said that her statement shouldn’t be published as it could be “offensive to the pediatric readership of the journal.” *Pediatrics* seems to be basing its editing choices on political calculation and the sensibilities of trans-identified teens. One wonders how many pediatricians who rely on the journal for professional guidance are aware of these criteria.

The AAP has ignored the evidence that has led Sweden, Finland and most recently the U.K. to place severe restrictions on medical transition for minors. The largest pediatric gender clinic in the world, the U.K.’s Gender Identity Development Service, was ordered to shut down in July after an independent review expressed concerns about clinicians rushing minors to medical transition. Medical societies in France, Belgium and Australia have also sounded the alarm. The U.S. is an outlier on pediatric gender medicine.

A major reason for this is the capture of institutions such as the AAP. Last year a resolution was submitted to the AAP's annual leadership forum to inform the academy's 67,000 members about the growing international skepticism of pediatric gender transition. It asked for a thoughtful update to the current practice of affirmation on demand.

Even though the resolution was in the top five of interest based on votes by members cast online, the AAP's leadership voted it down. In their newsletter, they decried the resolution as transphobic and noted that only 57 members out of 67,000 had endorsed it. The following year, however, when only 53 members backed a resolution that supported affirmative intervention, the AAP allowed the motion to go through, saying that the previous year's measure was "soundly defeated" while this year's received "broad support." When members submitted another resolution to conduct a review of the evidence, the AAP enforced for the first time a rule that shut down member comments, effectively burying it.

The AAP has stifled debate on how best to treat youth in distress over their bodies, shut down efforts by critics to present better scientific approaches at conferences, used technicalities to suppress resolutions to bring it into line with better-informed European countries, and put its thumb on the scale at Pediatrics in favor of a shoddy but politically correct research agenda. Its preference for fashionable political positions over evidence-based medicine is a disservice to member physicians, parents and children.

Dr. Mason is a pediatrician. Mr. Sapir is a fellow at the Manhattan Institute.

Appeared in the August 18, 2022, print edition as 'The American Academy of Pediatrics' Dubious Transgender Science'.

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<https://www.wsj.com/articles/trans-gender-transition-medical-affirming-therapy-hormone-surgery-aap-children-kids-11661207649>

OPINIONLETTERS

A Rare Reversal on Gender Transition Policy

The ‘vast majority of children’ receiving care shouldn’t be treated with hormones or surgery, says the American Academy of Pediatrics.

11:45 am ET



We are thrilled that the American Academy of Pediatrics (AAP) agrees that the “vast majority of children” who get “gender-affirming care” shouldn’t be treated with hormones and surgery, and in fact, need “the opposite” (Letters, Aug. 22). Today, however, when pediatricians refer gender dysphoric minors to gender clinics for assessment, they are effectively sending them to be medically transitioned.

A recent study from Seattle Children’s Hospital shows that within 12 months of the initial consult, 66% of adolescents had already been put on “gender-affirming” hormonal interventions. This likely understates the problem: Several states, including California, have passed laws that effectively ban psychotherapy designed to help youth feel comfortable in their bodies, calling it “conversion therapy.”

This is partly the consequence of the AAP’s own 2018 recommendations, which state that “watchful waiting,” an approach that emphasizes psychotherapy, is harmful and akin to conversion therapy. It defines “affirming” as social transition for children (new names and pronouns) prior to medicalization, which becomes more likely to follow. The only therapy

besides “hormone therapy” that the guidelines recommend is counseling for family members to accept that their child is transgender.

AAP’s past pronouncements have pressured schools across the country to facilitate students’ “social transition,” often without parental knowledge. These statements may also influence the coming Title IX rules.

In its letter, the AAP suggests that the U.K. is moving to emulate the U.S. in this arena. Yet Dr. Hilary Cass, who is leading the U.K. effort to restructure, writes that British clinicians have felt under pressure to adopt the American “affirmative approach,” which the clinicians find “unquestioning” and “at odds with the standard process of clinical assessment and diagnosis.”

The AAP must update its guidelines to specify what “the opposite” of hormones and surgery means. If it means developmentally informed psychotherapy—increasingly recommended by European countries—the AAP must work to destigmatize the treatment. It should also stop calling critics of the medicalized affirmation model “anti-trans,” and welcome scientific debate.

Julia Mason, M.D., and Leor Sapir, Ph.D.

Portland, Ore., and Boston

Dr. Mason, a pediatrician, is director of the Society for Evidence-based Gender Medicine. Mr. Sapir is a fellow at the Manhattan Institute.

The president of the AAP, Dr. Moira Szilagyi, gives away the game with her choice of language. It is not “anti-trans” for state legislatures to protect minors from irrevocable surgeries and treatments. It is not “anti-trans” to learn from Europe’s 15-year head start on treatment and revise accordingly. Dr. Szilagyi writes about “activists” in a derogatory manner, but she’s the only activist I see here. Physician, heal thyself.

Jon Banks

Pacific Palisades, Calif.

<https://www.wsj.com/articles/trans-gender-pediatric-aap-kids-children-care-surgery-affirm-treatment-11660942086>

OPINIONLETTERS

Academy of Pediatrics Responds on Trans Treatment for Kids

To ‘affirm’ a child or teen means destigmatizing gender variance and promoting the child’s self-worth.

12:37 pm ET



Regarding Julia Mason and Leor Sapir’s op-ed “The American Academy of Pediatrics’ Dubious Transgender Science” (Aug. 18): In its recommendations for caring for transgender and gender-diverse young people, the AAP advises pediatricians to offer developmentally appropriate care that is oriented toward understanding and appreciating the youth’s gender experience. This care is nonjudgmental, includes families and allows questions and concerns to be raised in a supportive environment. This is what it means to “affirm” a child or teen; it means destigmatizing gender variance and promoting a child’s self-worth. Gender-affirming care can be lifesaving. It doesn’t push medical treatments or surgery; for the vast majority of children, it recommends the opposite.

This isn’t the story that is being told by anti-transgender activists. No European country has categorically banned gender-affirming care when medically appropriate. Contrary to what Dr. Mason and Mr. Sapir claim, the U.K. isn’t moving away from gender-affirming care. It is moving toward a more regional, multidisciplinary approach, similar to what is practiced in the U.S.

The AAP is committed to following the evidence and basing our recommendations on the best science. When concerns are raised about a study in Pediatrics, the journal follows a standard process to investigate. Evidence review also is a normal part of the AAP's policy-writing process and doesn't require a resolution at its annual leadership conference.

Meanwhile, the anti-trans bills in state legislatures, the social-media attacks and the rise in misinformation has an impact. The ones who suffer are the young people who are trying only to live their lives as their true selves. The AAP will continue to stand up for all children and adolescents, including those who are transgender.

Moira Szilagyi, M.D.

President, American Academy of Pediatrics

Los Angeles

Appeared in the August 22, 2022, print edition as 'Academy of Pediatrics Responds on Trans Care'.

From: [Michelle Brosnan](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender-Affirming Care
Date: Tuesday, September 20, 2022 6:40:44 PM

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Hello,

I am a medical doctor writing to express my recommendation to restrict medical practices such as rapid gender transition for children and adolescents. Although many children and adolescents experience identity confusion and questions about their sexuality, medical practices such as hormone therapy and gender affirmation surgeries can cause permanent harm and regret. I am concerned that children and adolescents do not have the decision-making capacity to provide informed consent for these treatments. Gonadotropin-releasing hormone (GnRH) agonists are sometimes used to delay puberty in order for an adolescent to choose a gender before hormones cause permanent physical changes. Long term therapy with GnRH agonists causes metabolic abnormalities, weight gain, and worsening of diabetes and osteoporosis. Gender affirmation surgeries cause permanent changes that a child or adolescent may ultimately come to regret. We need to protect our children from misguided medical practices that will ultimately cause more harm than benefit. Thank you for your consideration of these comments.

Sincerely,
Michelle Brosnan, MD

From: [Gabriel Vella](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: The Gender Care debate and its roots
Date: Thursday, September 22, 2022 9:07:13 AM

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To whom it may concern,

I am not a scientist nor psychologist, I have no expertise in these fields. Before you disregard my input I ask that you consider this: I am a man, a husband, a parent, a public safety servant, a citizen, and like all humans a person who has experienced difficulties in life. After decades of practice in these fields you might call me an expert, just like you and billions of others.

Dumbing down the profession of medicine and the science of biology to accommodate the feelings of others does not make us better. In order to be an engineer one must know a certain amount of math otherwise the bridges will fall down. In order to maintain trust and respect for the medical profession one must know biology, otherwise peoples health will suffer. If basic biology is discarded for so-called social justice reasons where will the medical profession decide it is acceptable to “stick to the science” and where will it deviate for affective reasons? How will these future decisions be made, by whom, & what basis will determine the complete disregard of biology? What about immunology - can we disregard that? Can we disregard age? Genetics? There seems to be a disconnect between institutions and the people they are said to serve. Myself, neighbors, colleagues, friends and virtually anyone I run into laugh at the notion of this non-sense and are astonished institutions have allowed this imperialistic behavior to dominate their thinking. Since when is saying no to dogma and yes to truth a bad idea?

Our children will bear the brunt of these decisions not only because youth are the ones most likely to “transition” and then de-transition but also because allowing the trojan horse of “care” into “gender affirming care” will now cancel anyone who thinks differently than this new orthodoxy. The result of which is to be labeled ‘to not care.’ Under this pretense we parents know this political topic will make its way into the classrooms of public schools as they practice more and more *affective* education versus traditional education. Teachers who have absolutely no expertise in psychology and no moral authority divorce children from the values of their parents will then bring the post-modern gender debate into the classroom under the veil of “care.” Not only does this harm the education our children receive but it harms children who will undoubtedly be caught up in this non-sense and make life altering decisions that will only hasten their path to a life full of unnecessary difficulties. Those that say affective teaching does not take away from education have the same 8 hour day as anyone else, and any time spent on this non-sense is time not spent on actual education. If there are only 8 hours to teach and it is not spent on core subjects then yes, it is deteriorating education. The bitter irony of which is those kids who need good schools and good teachers the most will bear the brunt of the harm. Kids with stable homes will still have access to the accessories of education and behavioral standards that promote prosperity and sadly those kids whose only hope of receiving such guidance will receive *affective* psychological coddling instead. The deficit this

will create entering adulthood will be insurmountable and irreversible.

Perhaps the most nefarious thing of this whole situation is timing. For the last two years we were lied to by the “experts” and mainstream medical agencies such as the CDC, NIH, AMA. They cannot claim ignorance in regards to the vaccines, lockdowns, and masks because millions of people and thousands of doctors and scientists wished to have open dialogue using evidence. Instead they attacked any countering evidence or viewpoint as “not trusting science.” This clear lack of moral courage is EXACTLY why this nonsensical debate around gender is even occurring. The ego is a powerful thing and it was always comforting to know that science could be the objective judge, but not anymore. Too many physicians cannot admit they were lied to for 2 years due to ego and cannot admit they are wrong about the harms the gender debate does to children and adults alike. Do not let ego do any more damage to the medical profession or our children or their education. It’s time we all remember not only how to think but what thinking is. Think for yourself, show some courage and do not let the gender debate infiltrate our institutions under the false pre-tense of “care.” The medical profession has already suffered irreparable damage caused by disregarding scientists during a pandemic. Emboldening the gender topic will turn your “profession” into a pseudo-science that will be no more trust worthy than a snake oil salesman and has all the hallmarks of phrenology.

Thank you,

Concerned Citizen, Blue Collar Worker, and Parent

From: [James Esses](#)
To: [Vazquez, Paul](#)
Cc: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Submission
Date: Wednesday, September 21, 2022 10:45:01 AM
Attachments: [WPATH SOC Version 8.docx](#)

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Dear Mr. Vazquez,

I am writing to express my significant concerns regarding the Standards of Care recently released by the World Professional Association for Transgender Health (WPATH), as well as a broader concern regarding the affirmative care model that encourages medical and surgical treatments for children with gender dysphoria. I have attached a submission document to this email detailing my concerns with the WPATH Standards of Care.

My name is James Esses. I am based in the United Kingdom and am the co-founder of a group called Thoughtful Therapists. We are qualified and trainee psychotherapists who advocate around the impact of gender ideology on the wellbeing of children and the need to ensure that exploratory therapy is protected for children struggling with gender dysphoria.

I previously practised as a criminal defence lawyer and have held various roles within the UK Civil Service, specialising in criminal law and justice.

I am currently bringing a high-profile case for discrimination, after I was expelled from my Masters' degree in psychotherapy for speaking out about concerns regarding medicalising children with gender dysphoria and launching a public petition to the UK government asking them to safeguard explorative therapy for children
- <https://www.crowdjustice.com/case/expelled-university-free-speech/>. To date I have raised over £100k from thousands of public donations.

Myself and colleagues have been conducting research and have come across significant safeguarding concerns regarding vulnerable children, often with co-morbidities such as autism, being unconditionally affirmed/encouraged to transition and then suffering as a result. There is evidence of children being affirmed in online communities (and even through charities such as Mermaids - in which, for example, they have offered to send breast binders to young girls behind parent's backs) before being signposted to private gender clinics and fast tracked onto puberty blockers/cross-sex hormones and even surgery, sometimes even during the initial consultation, without any genuine exploration, therapeutic support, etc.

I have parents, teachers, doctors, social workers and therapists reaching out to me daily with concerns in this space.

The tide is beginning to turn slowly. The Tavistock Clinic in London has been shut down, following longstanding concerns about safeguarding and risk of harm to children. Disciplinary action has also been taken against the founders of one of the major UK-based private gender

clinics, Gender GP, following them placing vulnerable children at risk of harm.

However, each day that goes by, more children are being pushed down a path of irreversible regret.

The WPATH Standards of Care, which unfortunately carry sway around the globe, pose an even greater risk to an already vulnerable group. My key concerns relating to this guidance, which I elaborate on further in my submission, are:

- The removal of minimum ages for medication and surgery;
- The use of ideologically-driven language;
- The promotion of breast binding and genital tucking;
- The alienation of parents;
- The encouragement of irreversible surgery;
- The abandonment of mental health safeguarding;
- The complete lack of studies and research;

I would be more than happy to discuss further.

Kind Regards,

James Esses

World Professional Association for Transgender Health (WPATH) – Standards of Care Version 8

On 6th September 2022, the World Professional Association for Transgender Health (WPATH) published their updated Standards of Care (Version 8).

WPATH were founded in 1979 and have stated that their purpose is to *“promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health”*.

There have been concerns over the years that the organisation acts as more of a partisan lobby group, rather than an independent, safeguarding-focussed organisation, particularly given the make-up of senior members of WPATH, many of whom identify as ‘trans’ or ‘non-binary’ themselves and/or are activists in this space.

Gender ideology appears at the forefront of the organisation’s work. By way of example, WPATH run an ‘Online Sexuality Workshop’, which focusses on *“supporting trans erotic embodiments from a pleasure-centred praxis...working with children, adolescents...”*.

Furthermore, in the ‘recommended reading’ section on their website, they suggest the following ideologically driven books (amongst others):

- ‘Real Talk For Teens: Jump-Start Guide to Gender Transitioning and Beyond’, by Seth Rainess
- ‘Transgender Warriors: Making History from Joan of Arc to RuPaul’, by Leslie Feinburg

The latest version of the WPATH Standards of Care is extremely concerning from a medical ethics and child safeguarding perspective. WPATH state that *“these internationally accepted guidelines are designed to promote the health and welfare of transgender, transsexual and gender variant persons...”*

The most concerning aspects of Version 8 of the Standards of Care are as follows:

- **Ideologically Driven Language** – The guidelines feature language based in ideology, rather than medicine or biology, throughout. For example, irreversible medical and surgical interventions are referred to as *“gender-affirming health care”*. Double mastectomies are called *“chest masculinization surgery”*. Ideological terms such as *“cisgender”* are used, as well as the scientifically and factually inaccurate term *“sex assigned at birth”*. Regardless of the risks and impact on the safety and wellbeing of women, health providers are told to implement *“gender neutral toilets”*.
- **Removal of Minimum Ages for Irreversible Medicalisation** – Any nuanced concern for the welfare and wellbeing of vulnerable children is omitted. Particularly when we consider that gender dysphoria is a mental health condition and many young people suffering from gender dysphoria will have other co-morbidities or mental health

diagnoses. The guidelines have removed any minimum age limit for a child to be able to avail of puberty blockers, cross-sex hormones or sex-reassignment surgery (so long as that child has reached 'Tanner Stage 2' of puberty, which can be as young as 9 years old). Interestingly, minimum ages had been included in the originally published document before these were quickly removed via a 'correction' online. The guidelines state that double mastectomies, euphemistically called 'chest masculinization surgery', *"can be considered in minors"*. Equally, 'vaginoplasty' may be considered for under 18-year-olds. The guidelines make it clear that there should be no requirement for a child to have taken cross-sex hormones prior to availing of surgery, *"if not desired"* by a child – emphasising the consumeristic nature of these guidelines. Hormone treatment is recommended even though it can cause *"infertility"*.

- **Chest Binding/Genital Tucking** – Healthcare professionals are instructed to provide education to children on both 'chest binding' and 'genital tucking', on the basis that this will provide *"comfort"* and *"lower rates of misgendering"* for a young person. However, this is regardless of the fact that the former can cause pain, infection and even fractures and the latter can cause decreased sperm concentration.
- **Alienation of Parents** – Healthcare professionals are advised to *"challenge"* parents who are unsupportive of their child medically transitioning. Equally, they are recommended to prescribe hormone treatment for children without parental involvement, if such involvement would be *"harmful or unnecessary"*.
- **Focus on Irreversible Surgery** – The guidelines provide what appears to be a 'shopping list' of surgery that is recommended for children and adults with 'trans' identities. These include, but are not limited to:
 - Body contouring
 - Voice surgery
 - Hair transplant
 - Jaw augmentation
 - Liposuction
 - Brow lift
 - Lip shortening
 - Calf implant
 - Mastectomy
 - Hysterectomy
 - Vaginoplasty
 - Phalloplasty
- **Abandonment of Mental Health Safeguarding** – The guidelines explicitly state that therapy or counselling should *"never be mandatory"* before prescribing irreversible medication or surgery, including for children. Equally, therapeutic professionals are told that they must not impose their own narratives or preconceptions, yet are also told that they must be *"gender affirming"*. These principles are fundamentally incompatible.

- **Disregarding of Mental Ill-Health** – Clinicians are advised that not all mental illness *“can or should be resolved”* prior to prescribing irreversible medication or surgery. Equally, the guidelines state that hormone treatment should not be withheld simply because a child has a ‘neurodevelopment condition’.
- **Eunuchs** – A completely new chapter is dedicated to ‘Eunuchs’ who are individuals that are *“assigned male at birth and wish to eliminate masculine physical features or genitals”*. The guidelines appear to support individuals who seek *“castration”* and they are now deemed to fall under the *“gender diverse umbrella”*. From an ethical and therapeutic standpoint, this is deeply concerning.
- **Patients in Prison/Psychiatric Hospitals** – WPATH recommends that staff providing care to individuals resident in prisons or psychiatric hospitals should support them with *“gender-affirming surgical treatment...when sought by the individual without undue delay”*. This instruction for an unconditionally affirmative approach appears to throw any semblance of safeguarding out of the window.
- **Ignoring the Lack of Studies** – All of the above is recommend, notwithstanding the fact that WPATH acknowledges that *“the number of studies is still low”*, that *“there are few outcome studies that follow youth in adulthood”* and that *“no clinical studies have reported on profiles of adolescents who regret their initial decision”*.

The above is of significant concern as to the safeguarding of some of society’s most vulnerable children. This is particularly so when we considering the significant influence that WPATH have over the global landscape in gender medicine (especially given the fact that WPATH is a self-regulated membership body and in many ways can be considered ‘self-appointed experts’). This can be demonstrated by the fact that Susie Green, the CEO of the organisation Mermaids, which has received a lot of outrage around safeguarding practises, sits on the body responsible for revisions to the Standards of Care.

The ramifications are considerable. For example, the NHS refers to the WPATH Standards of Care in a variety of medical documents. The Scottish government themselves have acknowledged reliance upon the Standards of Care in their decision-making. The Standards of Care also featured heavily in the significant case of *Bell v Tavistock*.

These guidelines have also been used by numerous private health clinics throughout the UK, enabling them to justify the prescribing of irreversible hormones or performance of irreversible surgery. This includes the now-disgraced ‘Gender GP’ (with one of its founders recently having been expelled from the medical profession and the other undergoing a period of suspension for risks posed to vulnerable children).

Action must be taken to ensure that there is significant pushback from the UK to these WPATH guidelines and assurance that these will not change the medical and therapeutic landscape as regards the treatment for gender dysphoria, particularly for vulnerable children. This is one of the most concerning examples of ideology infecting medicine and this cannot be allowed to happen. The stakes are far too high.

From: [Alison Clayton](#)
To: [Vazquez, Paul](#)
Subject: Submission: Affirmative Care for Gender Diverse people
Date: Monday, September 19, 2022 1:10:27 AM
Attachments: [Child Adoles Ment Health - 2021 - Clayton - Commentary The Signal and the Noise questioning the benefits of puberty.pdf](#)
[clayton 2022 informed consent .pdf](#)
[clayton trans GAT 2021.pdf](#)

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Monday September 19, 2022

Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine

Dear Mr Vazquez,

I write in regard to your proposed rule for Affirmative Care for Gender Diverse people.

I am a consultant psychiatrist based in Melbourne, Australia. I have clinical experience with people who have gender dysphoria (GD), parents of GD youth, and people with regret/detransition. My clinical work has led me to closely review the professional literature, so that I could provide accurate information and recommendations to my patients - with a key aim being the provision of compassionate, evidence-based and least harm clinical care to youth with gender dysphoria.

I have authored several papers on this topic which have been published in peer reviewed medical journals. These papers include discussions of the weak evidence base for gender affirmative treatments and the issue of informed consent. I have attached copies of these papers to this email for your reference.

In my opinion, because of the limited evidence base for the medical and surgical treatments of GD youth (that means bias, confounding or placebo effect may be the cause of any of the reported mental health and quality of life outcomes) together with the associated risks (which include infertility, sexual dysfunction and later regret), these treatments should be viewed as experimental and only available under ethical review board approved clinical trials. In addition, prior to implementing medical and surgical interventions, careful and comprehensive assessment, stabilisation of any psychological conditions, a reasonable period of gender exploratory psychotherapy and an extended informed consent process are necessary.

I hope this email and the attached documents are of assistance to yourself and the Florida Board of Medicine as you consider this complex and important issue.

Yours sincerely,

Dr Alison Clayton

MBBS MPM FRANZCP

Commentary: The Signal and the Noise—questioning the benefits of puberty blockers for youth with gender dysphoria—a commentary on Rew et al. (2021)

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In less than a decade, there has been a sharp rise in the numbers of young people presenting with gender dysphoria (GD). Today, the majority are adolescents, many with post-puberty adolescent-onset transgender histories, and suffering from mental health and neurodevelopmental comorbidities (De Vries, 2020; Zucker, 2019). Furthermore, there is controversy and heated debate in the literature on this topic (Dubicka, 2021). This lack of scientific consensus highlights the need for any published literature on the topic of GD to be carefully evaluated.

In this commentary, we critically examine a systematic review of the evidence for puberty blockers for GD youth that was recently published in this journal (Rew, Young, Monge, & Bogucka, 2021). Our aim is to highlight problems with this review that compromise its findings and conclusions.

Brief description of Rew et al.'s (2021) study

Rew et al. described undertaking a “critical” and “systematic” literature review on the topic of puberty blockers for GD youth. They identified nine studies for review and, on the basis of these, concluded that puberty blockers have “few serious adverse outcomes,” and “several potential positive ones.” Rew et al.'s abstract highlighted two key conclusions: the “potentially life-saving benefits” of puberty blockers; and a need for rigorous research. Their “implications,” “conclusion,” and “key practitioner message” sections appeared to claim that the literature supports the use of puberty blockers for the early puberty subgroup of GD youth.

Overview of our concerns

We agree with Rew et al.'s conclusion that more rigorous research is required in the area of management of GD in youth. However, in our view, their review suffers from methodological oversights, including the omission of relevant studies and suboptimal analysis of the quality of the included studies. As a result, the authors overstate the certainty of the potential positive outcomes and minimize the potential adverse outcomes of puberty blockers. Importantly, their statement, that a “positive

outcome” of puberty blockers is “decreased suicidality in adulthood,” is a misinterpretation of a single cross-sectional study. This study's design was incapable of determining causation, and adult suicidality was not one of the measured outcomes (Turban, King, Carswell, & Keuroghlian, 2020).

Contrast Rew et al.'s (2021) conclusions with another recently completed systematic review of puberty blockers for GD youth, commissioned by England's NHS and conducted by The National Institute for Health and Care Excellence (NICE) (2020). The NICE review concluded that studies investigating the benefits or adverse effects of GnRH analogs (puberty blockers) were of “very low certainty using modified GRADE.” They noted that any outcome differences that were found could have represented changes of “questionable clinical value,” or, as the studies themselves were “not reliable,” could have been “due to confounding, bias or chance.” They suggest that if controlled studies are not possible, then reliable comparative studies are required.

These findings came just after NHS England suspended the use of puberty blockers for new patients under the age of 16, following the High Court's judgment that children so young could not consent to the unknown risks of these drugs. The Karolinska Institute in Sweden suspended the use of puberty blockers as treatment for GD youth outside of clinical trials following this review, citing multiple physical risks, including to bone development (Nainggolan, 2021). Finland also sharply curtailed the use of these drugs after their systematic review arrived at similar conclusions about the uncertain risk/benefit profile (COHERE, 2020).

We are concerned that Rew et al.'s review will mislead clinicians unfamiliar with the literature into prescribing puberty blockers to GD youth with confidence, when the only clinical stance supported by the evidence is that of extreme caution. This is also underscored by the fact that the research literature in this field is rapidly evolving. For example, a recently published study, that attempted to demonstrate the benefits of the Dutch puberty suppression protocol in the UK setting, failed to show any psychological benefit (Carmichael et al., 2021).

Limitations in study selection strategy

The review published by Rew et al. has important limitations that compromise its usefulness for clinical decision-making. Rew et al. identified only 151 potentially eligible studies, while the NICE review found 525 studies. One possible explanation for this could be their limited study search strategy. Another possible explanation is that Rew et al. did not conduct a comprehensive search so that, in omitting one of the largest electronic databases—EMBASE, they may have overlooked relevant evidence.

Notably, the final set of nine studies reviewed by Rew et al. is missing at least one key study on puberty blockers and psychosocial functioning (Costa et al., 2015), and two other studies examining the risks of puberty blockers on bone density (Joseph, Ting, & Butler, 2019; Klink, Caris, Heijboer, van Trotsenburg, & Rotteveel, 2015). It is unclear to us whether these studies were omitted due to the limited database search or whether the evaluators decided to exclude these studies, and if so for what reason. These three studies were all included in the NICE (2020) review. Although it has to be kept in mind that all the NICE reviewed studies' findings were assessed as "very low certainty," the Costa et al. study provided comparative evidence and found no significant difference in psychosocial functioning between a group of adolescents receiving puberty blockers plus psychosocial support, and a group receiving only psychosocial support, at eighteen months (the study end period) (Biggs, 2019). In addition, the Costa study was cited by the Finnish gender identity services in their policy change, which now recommends psychotherapy alone as first-line treatment.

Failure to adequately assess certainty of the study findings

It is our contention that the reviewers did not adequately assess the certainty of the reviewed studies' findings. For example, they used the Joanna Briggs Institute checklist to assess Turban et al. (2020), the study from which their message that puberty blockers reduce adult suicidality and have "potentially life-saving benefits" derives. This checklist can overemphasize whether studies report information and underemphasize the assessment of study validity. Below, we show how Rew et al. applied this tool to Turban et al. (2020), and the important study limitations it overlooked.

Was the exposure measured in a valid and reliable way? (Q3) Rew et al. answered "yes" to this question. We believe it should be "no." The exposure to puberty blockers was based on a self-report, with 73% of those respondents, who answered yes, claiming they began to use puberty blockers after the age of 18. It was noted that the respondents likely confused puberty blockers with other hormonal interventions (Biggs, 2020; D'Angelo et al., 2020). Although Turban et al. attempted to reduce the effects of this confusion by excluding certain participants from the sample, no adequate correction was possible. This introduced a significant risk of bias.

Were confounding factors identified and strategies to deal with them stated? (Q5, Q6) Rew et al. answered "yes" to both questions. We believe the answer to the latter question should be "no." For example, while one key confounding factor—prior mental health status—was indeed correctly identified by Turban et al., no strategy

was articulated to deal with it. When discussing their finding that puberty suppression is associated with lower lifetime suicidality, they acknowledged that "reverse causation cannot be ruled out: it is plausible that those without suicidal ideation had better mental health when seeking care and thus were more likely to be considered eligible for pubertal suppression" (Turban et al., 2020). This is one of the most serious limitations of the study, introducing a high risk of bias, and reducing the certainty of the findings.

In addition, while two questions ask about the subject selection criteria and whether the subjects and the setting were described in detail (Q1, Q2), these questions do not attempt to assess the impact of the sample composition. Affirmative ("yes") and "not applicable" answers to these questions, respectively, masked the fact that the study participants were not required to have a diagnosis of GD, and that the participant demographics were markedly different from the US population of transgender adults (D'Angelo et al., 2020), which negatively impacts the study's applicability/generalizability.

Rew et al. aggregated the answers to the checklist questions, with the Turban et al.'s study earning an 86% mark and a "good quality" rating. Even if we sideline the issue of any scoring inaccuracy, using such a simplistic scoring category is misleading since it implies that all questions are equally important, which is clearly not the case.

We also note, what appears to be, at least one error in Rew et al.'s assessment and reporting of study outcomes. In Table 2, they reported that Turban et al.'s positive outcome findings included decreased past-month psychological distress, past-month binge drinking, and lifetime illicit drug use. However, Turban et al.'s univariate analysis showed only one of these three outcomes, past-month psychological distress, showed any significant difference, and this significance disappeared once demographic variables were controlled for in the multivariable analysis.

A more rigorous tool to assess Turban et al.'s study would be ROBINS-I (The Risk of Bias of Non-randomized Studies of Interventions) (Sterne et al., 2016). This tool focuses on confounding, selection bias, classification and deviations from intervention, measurement of outcome, missing data, and selective reporting, and the extent to which the study design minimized biases and yielded trustworthy results. Given this, applying the ROBINS-I tool would find that the Turban et al.'s study is at a critical risk of bias.

Misleading statements regarding puberty blockers and suicidality

We are concerned that Rew et al.'s discussion of evidence about suicidality is unbalanced and misleading. Reading that puberty blockers had "positive outcomes [of] decreased suicidality in adulthood" will likely be understood as indicating causation. However, Turban et al. (2020), where this claim originates, noted that their study design did not allow for determination of causation, and "reverse causation" (individuals without suicidal ideation had better mental health and were more likely to be considered eligible for puberty blockers) was a plausible alternative explanation.

Further, there is a critical difference in meaning between "lifetime," and "adulthood." Not only does the

latter erroneously imply a pre-post effect (i.e., access to puberty blockers in childhood reduces suicidality in adults), which was not detectable in the study, but a measure of “adulthood suicidality,” which Rew et al. claim was impacted, was never included in the original study (Turban et al., 2020).

There is also unclear use of the term suicidality, which exaggerates the implication of Turban et al.’s findings. Suicidality is a broad term, which is comprised of suicide attempts, plans, and ideation, and indeed this was the manner it was used by Turban et al. It is also important to note that Turban et al. made no assessment of completed suicides. Turban et al. assessed six areas of suicidality (including recent and lifetime suicide attempts, recent ideation with plans, recent and lifetime ideation) and found no association between puberty blockers and suicidality measures on five of the six areas. The only association was with “lifetime suicidal ideation.” Of course, any suicidal ideation is concerning, but suicide attempts are generally considered of higher concern, in terms of suicide risk assessment, than suicidal ideation (Ryan & Oquendo, 2020).

Rew et al.’s inaccurate language further intensifies in the final sentence of their abstract, which described puberty blockers as “potentially life-saving.” This exaggerated claim is misleading, since there is no evidence to support it.

Absence of an appropriate process for making clinical recommendations

Finally, the authors appear to recommend the use of puberty blockers in the “key practitioner messages” box and in the “implications” section of their paper. Making recommendations requires not only evidence about benefits and harms on all health outcomes that are important for decision-making (which this review provides in a suboptimal way), but also considerations about patients values and preferences, ethics, acceptability, resources, costs, etc. (Andrews et al., 2013). All these considerations are balanced by making value judgments, which should be documented and reported explicitly and transparently. Rew et al. failed to do this, which, in our view, further undermines the credibility of their clinical practice recommendations.

Clinician reflections on the state of the GD literature

Rew et al.’s review illustrates a concerning trend, that we have observed in the GD literature, to overstate the evidence underpinning clinical practice recommendations for youth with GD. New publications reference prior ones with increasing and unwarranted confidence, and with the risk of misleading clinicians regarding the state of evidence. There is also a marked asymmetry in outcomes reporting: findings of positive outcomes of medical interventions are trumpeted in abstracts, while their profound limitations remain behind the paywall, thus, below the radar of busy clinicians.

Rew et al.’s paper demonstrates these types of issues. To start, the Turban et al.’s paper described a noncausal association between puberty blockers and “lifetime suicidal ideation,” carefully avoiding making a causal claim (although, arguably, implying it). Then, Rew et al., whose findings on suicidality are based solely on this Turban et al.’ study, rewrite this finding to create the strong

impression of causality—that puberty blockers reduce adult suicidality and are “potentially life-saving.” Subsequently, a recent Commentary and Editorial in the *Lancet* both directly state that puberty blockers reduce suicidality, and the latter adds the extraordinary claim that “removing these treatments is to deny life.” The only reference provided for these claims is the Rew et al. (2021) paper (Baams, 2021; *Lancet* editorial, 2021).

This resembles the game of “Telephone,” in which a message is whispered from person to person distorting the original meaning of the message. However, this is not a game, and these types of errors can cause harm. Clinicians relying on Rew et al.’s review are likely to misinform patients and families about the risk/benefit profile of puberty blockers. Can such patients really be considered as giving informed consent?

The clear signals emerging from the various reviews of the available evidence of the use of puberty blockers for GD youth are that there is very low certainty of the benefits of puberty blockers, an unknown risk of harm and there is need for more rigorous research. The clinically prudent thing to do, if we aim to “first, do no harm,” is proceed with extreme caution, especially given the rapidly rising case numbers and novel GD presentations. We must also, collectively, raise the bar on the quality of publications, in order to accurately educate clinicians and help patients make truly informed decisions that may impact for the rest of their lives.

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Ethical information

No ethical approval was required for this commentary.

Correspondence

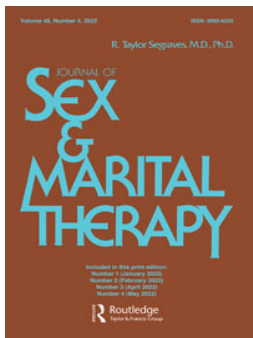
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References

- Andrews, J.C., Schünemann, H.J., Oxman, A.D., Pottie, K., Meerpohl, J.J., Coello, P.A., ... & Guyatt, G. (2013). GRADE guidelines: 15. Going from evidence to recommendation—Determinants of a recommendation’s direction and strength. *Journal of Clinical Epidemiology*, 66, 726–735.
- Baams, L. (2021). Equity in paediatric care for sexual and gender minority adolescents. *The Lancet Child & Adolescent Health*, 5, 389–391.
- Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 16, 2043.

- Biggs, M. (2020). Puberty blockers and suicidality in adolescents suffering from gender dysphoria. *Archives of Sexual Behavior*, 49, 2227–2229.
- Carmichael, P., Butler, G., Masic, U., Cole, T.J., De Stavola, B.L., Davidson, S., ... & Viner, R.M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*, 16, e0243894.
- COHERE. (2020). Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation. Palveluvalikoimaneuvosto. Available from: <https://palveluvalikoima.fi/en/recommendations> [last accessed 23 May 2021].
- Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The Journal of Sexual Medicine*, 12, 2206–2214.
- D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D.T., & Clarke, P. (2020). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50, 7–16.
- de Vries, A.L.C. (2020). Challenges in timing puberty suppression for gender-nonconforming adolescents. *Pediatrics*, 146, e2020010611.
- Dubicka, B. (2021). Editorial: Evidence, policy and practice – gold standard, good enough or doing it differently? *Child and Adolescent Mental Health*, 26, 1–2.
- Joseph, T., Ting, J., & Butler, G. (2019). The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *Journal of Pediatric Endocrinology and Metabolism*, 32, 1077–1081.
- Klink, D., Caris, M., Heijboer, A., van Trotsenburg, M., & Rotteveel, J. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *The Journal of Clinical Endocrinology & Metabolism*, 100, E270–E275.
- Nainggolan, L. (2021). Hormonal Tx of youth with gender dysphoria stops in Sweden. *Medscape*. Available from: <https://medscape.com>
- National Institute for Health and Care Excellence (NICE). (2020). Evidence Review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Available from: <http://evidence.nhs.uk>
- Rew, L., Young, C., Monge, M., & Bogucka, R. (2021). Review: Puberty blockers for transgender and gender diverse youth – a critical review of the literature. *Child and Adolescent Mental Health*, 26, 3–14.
- Ryan, E.P., & Oquendo, M.A. (2020). Suicide risk assessment and prevention: Challenges and opportunities. *Focus*, 18, 88–99.
- Sterne, J.A.C., Hernán, M.A., Reeves, B.C., Savović, J., Berkman, N.D., Viswanathan, M., ... & Higgins, J.P.T. (2016). ROBINS-I: A tool for assessing risk of bias in non-randomised studies of interventions. *BMJ*, 355, i4919.
- The Lancet Child Adolescent Health. (2021). A flawed agenda for trans youth. *The Lancet Child & Adolescent Health*, 5, 385.
- Turban, J.L., King, D., Carswell, J.M., & Keuroghlian, A.S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145, e20191725.
- Zucker, K.J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*, 48, 1983–1992.

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Commentary on Levine: A Tale of Two Informed Consent Processes

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BRIEF REPORT



Commentary on Levine: A Tale of Two Informed Consent Processes

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ABSTRACT

This commentary compares two recently published informed consent recommendations for gender dysphoria. One key difference identified is in their assessment of the strength of the evidence base for the gender affirming treatment model. An evaluation of both authors' citations supports the claims of a weak evidence base for the use of puberty blockers and gender affirming hormonal treatments in youth with gender dysphoria. This commentary then reflects on the implications of this. In particular, it asks whether it would be best practice to provide gender affirming treatments for youth only under clinical research conditions, rather than as routine clinical practice.

Introduction

"Reconsidering Informed Consent for Trans-Identified Children, Adolescents and Young Adults" (Levine, Abbruzzese, & Mason, 2022) is a timely and important paper. This Commentary asks the question: How does Levine et al.'s recommended informed consent process compare to current informed consent practices for youth with gender dysphoria? This question is addressed through an evaluation and comparison of Levine et al.'s informed consent process with those of a recently published "Informed Consent Standards of Care" (AusPATH, 2022). A key difference is the respective authors' evaluation of the strength of the evidence base for the gender affirming treatment model. This Commentary interrogates the citations these authors use for their respective claims regarding the strength of the evidence base. It finds that Levine et al.'s claims of a weak evidence base are well supported. A second question then reflected upon is: Given the weak evidence base for gender affirming treatments for youth, should these interventions be only available as part of clinical research trials, rather than implemented as routine treatments?

Terminology

Terminology in this area of medicine is varied and complex. As we are discussing clinical treatment and informed consent, I use the medical nomenclature of gender dysphoria (GD) (American Psychiatric Association, 2013). When directly reporting from other publications I generally use their preferred terminology. Levine et al.'s paper considers informed consent as it pertains to children, adolescents and young adults. I use the generic term "youth" to describe this group. Gender affirming treatment (GAT) is used to refer to a broad range of affirming health care

approaches including: Support of, and assistance, with social gender transition, provision of puberty blockers, gender affirmative hormone treatment and surgery. Gender affirming hormones treatment (GAHT) refers to cross-sex hormones (estrogens and testosterone) and anti-androgens.

A comparison of Levine et al.'s recommended informed consent process with AusPATH's "Informed Consent Standards of Care"

Shortly after reading Levine et al.'s paper, particularly as an Australian psychiatrist, I was interested to read the Australian Professional Association for Trans Health's (AusPATH) "Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy," which were released on March 31, 2022 (AusPATH, 2022). Informed consent practices will vary across different settings. However, this recent "Informed Consent Standards of Care" provides a useful exemplar to flesh-out how Levine et al.'s recommended informed consent approach compares to current practice standards. AusPATH is an organization closely linked to WPATH (many AusPATH members, including the President and Vice-President, are also WPATH members). Thus, despite this Commentary's Australian focus, it also holds much relevance to the international context. (Of additional note, WPATH's "Standards of Care" are currently in flux, with the most recent edition not yet released in its final form, so it is not possible to evaluate any updated informed consent recommendations).

Levine et al. (2022) recommendations apply to all GAT available to GD youth. Frequent references are made to the clinical diagnoses of gender dysphoria (DSM) and gender incongruence (ICD). Levine et al. contend that an adequate informed consent process requires: Careful and thorough evaluation; assessment of capacity; involvement of parents; a full disclosure of the short and long-term risks and benefits; a discussion of the full range of alternative treatment options; and a disclosure of the weak evidence base for these interventions. The authors emphasize that informed consent needs to be a slow and thoughtful process, culminating in signed consent forms.

AusPATH (2022) focuses on the use of GAHT, although it also includes some discussion of social and surgical interventions, for trans people of all relevant ages. The trans person is described as the expert on their own gender and needs. There is no requirement for a psychiatric "gender assessment." It is only in the context of adolescents, under the age of 18, that any reference is made to the requirement for a gender dysphoria (DSM) diagnosis and there is also scant reference to gender incongruence (ICD) diagnosis. It is noted that the outlined informed consent model can be used for adolescents under the age of 18, but a discussion is included of the more complicated clinical and legal situation, in Australia, for this group. AusPATH's recommended informed consent approach coheres with Levine et al. (2022) in advising that the risks and benefits of the treatments should be discussed with the patient and, for patients under age 18, parents or guardians. In addition, they advise the patient should be informed of the limitations of the hormones to effect certain changes (for example, height) and they note the need for lifelong monitoring and review. Examples of written information sheets and consent forms for the patient and parent to sign are provided. The process of evaluation, informed consent, and initiating hormones is described as being able to be undertaken "in just one or two appointments," although it is noted that it may require more time.

Some of the important differences between these two informed consent approaches to highlight are:

- a. Levine et al. recommend a discussion of the limitations of the evidence base for GAT, whereas no mention of this is made by AusPATH.
- b. Levine et al. emphasize the evaluation and informed consent processes should be a slow process. AusPATH states that the process of assessment, education, informed consent and the initiation of hormones can be completed in as little as one session.

- c. Levine et al. recommend patients are informed of the risk of regret and detransition, whereas AusPATH does not mention this.
- d. Levine et al. require the clinician to discuss the full range of alternative treatment options. AusPATH does not note alternative treatment options and informed consent seems to be equated with affirmation, as they state: “The informed consent model of care is sometimes called affirmation enablement or ethical affirmation.”

These differences can be partly understood by differences in the authors’ evaluations of the evidence base of GAT. Levine et al. (2022) claim that the evidence base for the benefits of GAT is “widely recognized” as deficient and is of very low quality and certainty. AusPATH (2022) claim that there is a “significant” and “clear” body of evidence that GAT improves quality of life and leads to better mental health outcomes.

It has previously been noted that these types of contradictory opinions can be found in the professional literature and highlighted that the merits of the various claims need to be evaluated by a close reading of the cited primary sources (Clayton et al., 2021). To that end, I will interrogate the citations and ask: Do they support the authors’ claims? (Of course, the reader is free, and I would encourage it, to similarly evaluate my citations.) As both authors’ citations primarily focus on puberty blockers and GAHT, this, rather than social transition and surgical treatments, will be the focus of discussion in this commentary.

Reviewing Levine et al.’s claims of very low quality evidence for puberty blockers and gender affirming hormone treatments for youth with gender dysphoria

Levine et al., in support of their claims of a deficient and very low quality evidence base for puberty blockers and GAHT for adolescents, cite Hembree et al. (2017) and the National Institute for Health and Care Excellence (NICE) (2020a, 2020b). Hembree et al. (2017) rated the evidence for the use of puberty blockers and GAHT in adolescents as being either low or very low quality. NICE (2020a, 2020b) concluded that the studies investigating the benefits or adverse effects of puberty blockers and GAHT were uncontrolled observational studies, subject to bias and confounding. The studies’ quality was appraised with the Newcastle-Ottawa tool and certainty of outcomes by modified GRADE. All studies were rated as “poor quality” and all outcomes as “very low certainty.”

In sum, Levine et al.’s claims of a very low quality and certainty evidence base for puberty blockers and GAHT for adolescents appears to be well supported by the cited references.

Reviewing AusPATH’s claims of a clear and significant body of evidence for puberty blockers and gender affirming hormone treatments for trans people, including trans adolescents

AusPATH (2022) cite three sources to support their claim of a significant body of evidence showing that medical GAT improves psychological outcomes and improve quality of life. The first of these is a primary study reporting that access to GAHT in adolescence is associated with improved mental health outcomes among transgender adults (Turban, King, Kobe, Reisner, & Keuroghlian, 2022). This recent study has not yet been externally evaluated in a systematic review process. However, this study’s design (a non-probability cross-sectional survey) puts it at high risk of bias, and, as the authors themselves noted, it cannot determine causality. Further, the limitations of the source data have been the subject of previous critiques (D’Angelo et al., 2021).

Secondly, AusPATH (2022) cite their own public statement (AusPATH, 2021), which stated: “Medical and surgical affirmation can frequently alleviate gender-related distress and yield a variety of other benefits to the individual.” Sixteen references are cited in support of this statement, but no information is provided on the quality nor on the certainty of

findings. Three of these references are systematic reviews, one of which (White Hughto & Reisner, 2016) is the third citation in AusPATH (2022). This review of GAHT in transgender adults concluded that there was only “low quality” evidence that “suggests” GAHT “may” lead to psychological improvements and it recommended more prospective controlled trials be undertaken. All the reviewed studies were found to be at high risk of bias, and it was noted that they did not adjust for important confounders, for example concurrent psychotherapy or psychiatric medications. This conclusion does not appear to well support AusPATH’s(2022) claims of a clear and significant body of evidence to support the use of medical GAT.

However, could it be that the other studies and systematic reviews cited in AusPATH (2021) provide more solid evidence? AusPATH (2021) cites seven primary studies, either on puberty blockers or GAHT in youth. Five of these were evaluated by NICE (2020a, 2020b). As already discussed, all these studies were found to be of poor quality and provide very low certainty evidence. What did the other systematic reviews cited by AusPATH (2021) report?

Multiple systematic reviews of puberty blockers and gender affirming hormonal treatments for adolescents note the weakness of the evidence

For thoroughness, and to minimize risks of “cherry-picking” the evidence, I will expand beyond the three systematic reviews cited by AusPATH (2021) (which were: Mahfouda, Moore, Siafarikas, Zepf, and Lin (2017, Mahfouda et al., 2019); White Hughto and Reisner (2016)). Two other systematic reviews, Chew, Anderson, Williams, May, and Pang (2018) and Rew Young, Monge, and Bogucka (2021a) have been recently cited as support for strong claims of the benefits of puberty blockers and/or GAHT in adolescents (Baams, 2021; Tordoff et al., 2022). There is also a review by Baker et al. (2021) which was commissioned by WPATH and included both adolescent and adults.

A reading of these reviews reveals consistent comments noting the scarce and poor quality empirical evidence base underpinning the use of puberty blockers and GAHT. These reviews emphasize that the reviewed studies are mostly subject to high risk of bias and confounding and that more rigorous evidence is required. The Baker et al. (2021) review noted there was insufficient evidence to allow conclusions to be drawn regarding the impact of hormone therapy on death by suicide in transgender people. One review, Rew, Young, Monge, and Bogucka (2021a), appeared to claim a causal link between puberty blockers and decreased adult suicidality. However, following a published critique by Clayton et al. (2021) the authors clarified they were not making any causal claims and placed emphasis on their conclusion that more rigorous studies were required (Rew, Young, Monge, Bogucka, 2021b).

In sum, the findings of these reviews do not seem consistent with any claims, including those made by AusPATH (2022), that there is a significant or clear or robust body of evidence that puberty blockers and/or GAHT for GD youth improve mental health and quality of life outcomes. Furthermore, the two reviews discussed here that addressed GAHT in adults found the evidence to be similarly weak. The findings of these systematic reviews are more consistent with Levine et al.’s claims of a weak evidence base for these treatments.

Alternative approaches

As described by Levine et al., alternative treatment options for GD youth include various forms of psychotherapy, family therapy and group therapy. These are well described in the literature (for example see: Lemma, 2021; D’Angelo et al., 2021; Kozłowska et al., 2021; Hakeem, 2012). It is important to note, as Levine et al. emphasize, that these alternatives also lack a rigorous evidence base. However, also important, they do not hold the gravity of the potential injuries that do the hormonal and surgical treatments.

Therapeutic illusions and placebo effects: what weight should be given to clinical experience as evidence?

Some clinicians seem to claim that clinical experience stands as important evidence for the use of GAT (Olson-Kennedy, 2019; Pang, Wiggins, & Telfer, 2022). However, it is important to remember clinicians' testimonies of the success of the treatments they offer is known to be unreliable (Fanaroff et al., 2020). One example, noted as long ago as 1865, is that there had long been clinical consensus that the treatment of pneumonia by bloodletting was most efficacious, but comparative experimentation in the first half of the nineteenth century showed this to be "a mere therapeutic illusion" (Lilienfeld, 1982). Humans have a tendency to overestimate the effects of their actions, often called the "illusion of control." In medicine this may manifest as a "therapeutic illusion," whereby both doctors and patients may have an unjustified enthusiasm for a treatment (Casarett, 2016).

Placebo effects are rarely discussed by gender medicine clinicians and researchers (Clayton, 2022a). Contemporary placebo researchers describe placebo effects as the beneficial effects attributable to the brain-mind responses evoked by the treatment context rather than to the specific intervention (Wager & Atlas, 2015). Social stimuli and the whole therapeutic ritual, including medical marketing, affect the patient's neuro-psycho-biological state, and this in turn impacts, negatively or positively, on response to treatment (Benedetti, 2021). Thus, for treatments without a rigorous evidence base, especially those that are heavily promoted by clinicians, media, social media and celebrity culture, the possibility that any observed benefit may be due to the social and therapeutic milieu, rather than the specific effect of the intervention, needs to be considered. This is even more imperative if the interventions have high risk of serious and irreversible adverse effects.

Clinician experience should not be disregarded, but therapeutic illusions and placebo effects are two of the reasons why we need to have a great deal of caution in depending on clinical experience and clinical consensus as evidence for the effectiveness of medical interventions.

Implications of the weak evidence base for gender affirming treatments

Informed consent

AusPATH (2022) cite the Australian Commission on Safety and Quality in Healthcare's definition of informed consent. This notes that "accurate" and "relevant" information about the healthcare intervention, and alternative options, should be given to the patient. Levine et al. (2022) cite the American Academy of Pediatrics Committee on Bioethics and, similarly, this requires the provision of information on the risks, benefits, and uncertainties of the proposed treatments and alternative treatments. Both these definitions would seem to demand, as recommended by Levine et al., that an adequate informed consent process requires the weaknesses of the evidence base for GAT for GD youth and alternative treatment options to be carefully and thoroughly discussed in an unbiased manner with patients and parents/guardians. These definitions would also seem to necessitate a full and frank discussion of the foreseeable risks of regret and detransition.

There is a further implication of this weak evidence base that requires consideration.

Innovative clinical practice or experimental treatment?

Does the weak evidence of benefits and the adverse risks of GAT mean they should only be offered to GD youth under human research ethics committee approved clinical research conditions? Such an approach would help ensure that all involved (patients, parents and clinicians) are made fully aware of the weak evidence base, as well as contribute to the required rigorous research evidence. Of note, Sweden has recently made changes to their policies with moves in this direction (Socialstyrelsen, 2022).

A brief historical vignette might provide a stimulus to our thinking on these complex issues. From the 1960s until the 1980s, in many countries, children, many with no pathology apart from psychosocial problems considered to be due to their height were prescribed hormonal treatment by endocrinologists. At the time the hormones were declared safe, but years later disastrous long-term side effects became evident. Some of the children treated with cadaveric human growth hormone contracted Creutzfeldt-Jakob Disease (CJD), an aggressive early onset and fatal dementia (Clayton, 2022b; Cohen & Cosgrove, 2010).

In Australia, the Federal government initiated a judicial inquiry into the use of pituitary derived hormones and the Australian Human Pituitary Hormone Program. The report noted that it was a very narrow and a self-interested group, with multiple conflicts of interests, running the program. It found that *"the very power of regulation itself [was] placed in the hands of those who ought to have been the subject of regulation."* (Allars, 1994, p. 507). One key conclusion was that: *"it is a dangerous situation if no attempt is made to draw the lines between the ordinary exercise of clinical judgment, research, experiment and clinical trial, even if those lines be blurred. The absence of lines is most dangerous when new advances in medicine are being explored"* (Allars, 1994, p. 722). It recommended that the National Health and Medical Research Council (NHMRC) review its human experimentation guidelines to ensure that: *"It provides guidance with regard to decisions as to whether treatment in a therapeutic setting constitutes an experiment"* (Allars, 1994, p.723).

The NHMRC's current statement on ethical conduct in human research includes such a statement: *"This guidance applies to research, but sometimes the distinction between research and innovative clinical practice is unclear. For example, innovative clinical practice occurs on a spectrum from minor changes at the border of established practice that pose little change in risk to patient safety to novel interventions that should only be introduced as part of an ethically approved research protocol"* (NHMRC, 2007/2018, p. 24).

Where do we consider the novel and poorly evidenced GAT approach for GD youth to be on this "spectrum": toward the end of a minor change that poses little risk, or more toward the end of a major change with significant risk of harm to the patients?

Conclusion

This Commentary has demonstrated the deep uncertainty and the many unknowns that face GD youth, their parents and clinicians. Any claims of certainty are premature and risk more harm than benefit, including hindering the rigorous debate and research required to improve the state of knowledge in this area of medicine. In the meantime, as recommended by Levine et al. (2022), if gender affirming treatments are to be offered as routine treatment to youth, then a thoughtful, slow and thorough evaluation and informed consent process, undertaken in a therapeutic setting, would seem optimum care for these young patients. Another option that needs to be carefully considered is whether these interventions should only be offered as part of human research ethics committee approved clinical trials, rather than be implemented as routine treatment.

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References

- Allars, M. (1994). *Report of the inquiry into the use of pituitary derived hormones in Australia and Creutzfeldt-Jakob Disease*. Canberra: Australian Government Publishing Service.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.
- AusPATH. (2021). *Public statement on gender affirming healthcare, including for trans youth – AusPATH*. <https://auspath.org.au/2021/06/26/auspath-public-statement-on-gender-affirming-health-care-including-for-trans-youth/>
- AusPATH. (2022). *Australian informed consent standards of care for gender affirming hormone treatment*. Australia: Australian Professional Association for Trans Health. auspath.org.au
- Baams L. (2021). Equity in paediatric care for sexual and gender minority adolescents. *The Lancet. Child & Adolescent Health*, 5(6), 389–391. doi:10.1016/S2352-4642(21)00129-2
- Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone therapy, mental health, and quality of life among transgender people: A systematic Review. *Journal of the Endocrine Society*, 5(4), bvab011. doi:10.1210/jendso/bvab011
- Benedetti, F. (2021). *Placebo effects: Understanding the mechanisms in health and disease* (3rd ed.). Oxford: Oxford University Press.
- Casarett D. (2016). The science of choosing Wisely-Overcoming the Therapeutic Illusion. *The New England Journal of Medicine*, 374(13), 1203–1205. doi:10.1056/NEJMp1516803
- Chew, D., Anderson, J., Williams, K., May, T., & Pang, K. (2018). Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*, 141(4), e20173742. doi:10.1542/peds.2017-3742
- Clayton, A., Malone, W. J., Clarke, P., Mason, J., & D'Angelo, R. (2021). Commentary: The signal and the noise – Questioning the benefits of puberty blockers for youth with gender dysphoria – a commentary on Rew et al. (2021). *Child and Adolescent Mental Health*, doi:10.1111/camh.12533
- Clayton, A. (2022a). The gender affirmative treatment model for gender dysphoria in youth: A perfect storm environment for the placebo effect. The implications for research and clinical practice. [Manuscript submitted for publication]
- Clayton A. (2022b). The gender affirmative treatment model for youth with gender dysphoria: A medical advance or dangerous medicine?. *Archives of Sexual Behavior*, 51(2), 691–698. doi:10.1007/s10508-021-02232-0
- Cohen, S., & Cosgrove, C. (2010). Too tall, too small? The temptation to tinker with a child's height. *The Lancet*, 375(9713), 454–455. doi:10.1016/S0140-6736(10)60185-7
- D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50(1), 7–16. doi:10.1007/s10508-020-01844-2
- Fanaroff, A. C., Califf, R. M., Harrington, R. A., Granger, C. B., McMurray, J., Patel, M. R., Bhatt, D. L., Windecker, S., Hernandez, A. F., Gibson, C. M., Alexander, J. H., & Lopes, R. D. (2020). Randomized trials versus common sense and clinical observation: JACC review topic of the week. *Journal of the American College of Cardiology*, 76(5), 580–589. doi:10.1016/j.jacc.2020.05.069
- Hakeem, A. (2012). Psychotherapy for gender identity disorders. *Advances in Psychiatric Treatment*, 18, 17–24. doi:10.1192/apt.bp.111.009431
- Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology and Metabolism*, 102(11), 3869–3903. doi:10.1210/jc.2017-01658
- Lemma, A. (2021). *Transgender identities: A contemporary introduction*. Oxon: Routledge
- Kozłowska, K., McClure, G., Chudleigh, C., Maguire, A. M., Gessler, D., Scher, S., & Ambler, G. R. (2021). Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems*, 1(1):70–95. doi:10.1177/26344041211010777
- Levine, S. B., Abbruzzese, E., & Mason, J. W. (2022). Reconsidering informed consent for trans-identified children, adolescents, and young adults. *Journal of Sex & Marital Therapy*, 1–22. Advance online publication. doi:10.1080/0092623X.2022.2046221
- Lilienfeld, A. M. (1982). The Fielding H. Garrison Lecture: Ceteris paribus: the evolution of the clinical trial. *Bulletin of the History of Medicine*, 56(1), 1–18.
- Mahfouda, S., Moore, J. K., Siafarikas, A., Zepf, F. D., & Lin, A. (2017). Puberty suppression in transgender children and adolescents. *The Lancet. Diabetes & Endocrinology*, 5(10), 816–826. doi:10.1016/S2213-8587(17)30099-2
- Mahfouda, S., Moore, J. K., Siafarikas, A., Hewitt, T., Ganti, U., Lin, A., & Zepf, F. D. (2019). Gender-affirming hormones and surgery in transgender children and adolescents. *The Lancet. Diabetes & Endocrinology*, 7(6), 484–498. doi:10.1016/S2213-8587(18)30305-X
- National Health and Medical Research Council and the Australian Research Council Universities Australia. (2007/2018). *National statement on ethical conduct in human research*. Canberra: NHMRC. <https://www.nhmrc.gov.au>
- National Institute for Health and Care Excellence. (2020a). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. <https://arms.nice.org.uk/resources/hub/1070905/attachment>

- National Institute for Health and Care Excellence. (2020b). Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria. <https://arms.nice.org.uk/resources/hub/1070871/attachment>
- Olson-Kennedy, J. (2019). Treating trans youth with Dr Johanna Olson-Kennedy. *Gender GP Medical Podcast*, Jan 17. <https://gendergp.com>
- Pang, K. C., Wiggins, J., Telfer, M. M. (2022). Gender identity services for children and young people in England: Landmark review should interrogate existing international evidence and consensus. *British Medical Journal* 377:o825 doi:10.1136/bmj.o825
- Rew, L., Young, C. C., Monge, M., & Bogucka, R. (2021a). Review: Puberty blockers for transgender and gender diverse youth-a critical review of the literature. *Child and Adolescent Mental Health*, 26(1), 3–14. doi:10.1111/camh.12437
- Rew, L., Young, C. C., Monge, M., & Bogucka, R. (2021b). Response: “The Signal and the Noise”—A response to Clayton et al. (2021). *Child and Adolescent Mental Health*. Advance online publication. doi:10.1111/camh.12534
- Socialstyrelsen, The National Board of Health and Welfare. (2022). Care of children and adolescents with gender dysphoria. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapss-tod/2022-3-7799.pdf>
- Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open*, 5(2), e220978. doi:10.1001/jamanetworkopen.2022.0978
- Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PloS One*, 17(1), e0261039. doi:10.1371/journal.pone.0261039
- Wager, T. D., & Atlas, L. Y. (2015). The neuroscience of placebo effects: Connecting context, learning and health. *Nature Reviews. Neuroscience*, 16(7), 403–418. doi:10.1038/nrn3976
- White Hughto, J. M., & Reisner, S. L. (2016). A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgender Health*, 1(1), 21–31. doi:10.1089/trgh.2015.0008]



The Gender Affirmative Treatment Model for Youth with Gender Dysphoria: A Medical Advance or Dangerous Medicine?

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Introduction

A knowledge of the history of medicine enriches our thinking about contemporary medical practices. The twentieth century saw many medical advances. It also saw multiple examples of what may be called dangerous medicine. Such medicine is invasive, risky, and lacking a rigorous evidence base, but is enthusiastically embraced and celebrated by members of the medical profession and the public. Then, with the passage of time, such medicine is viewed with more scepticism. It is recognized as not being as beneficial as claimed and as causing more harm than acknowledged. It comes to be mostly seen as misguided, occasionally even criminal. In this Letter, I use a historical frame to background a discussion of the gender affirmative treatment approach for youth with gender dysphoria (GD youth), particularly focusing on masculinizing chest surgery. I ask: Is this approach a medical advance or is it a contemporary example of dangerous medicine? My hope is that the ideas expressed in this Letter will helpfully contribute to the debate about this complex and controversial area of medicine.

Braslow (1997) discussed the history of twentieth century psychiatry as practiced in California state mental hospitals. He described how doctors can transform the harmful into the “therapeutic” with their implementation of invasive “treatments” on patients in their care. He gave an illustrative example of how a “woman’s body provided multiple sites for surgical interventions” that aimed to extinguish “pathological behavior.” He described a 28 year-old Californian “housewife,” Rose, admitted as an involuntary patient in 1944. In 1949, her disturbed mental state and uncooperative behavior led to her receiving a radical prefrontal lobotomy. A year later, her “amorous” behavior led her doctor to order a clitoral cauterization. The day following

this “minor procedure” it was noted she continued masturbating and a second clitoral cauterization was performed. Rose then developed the habit of biting people, the solution for which was teeth extraction (pp. 166–168).

This brief account of Rose evokes a range of emotions. I feel horror, sadness, anger, and fear. Why do I feel these emotions? I am a human and a woman. I have had the experience of being a patient in doctors’ hands, relying on their expertise, care, and conscientiousness. It is the stuff of nightmares to be totally dependent on physicians, who, even if well-meaning, are implementing ineffective, harmful, or punitive interventions. My emotional reaction to Rose’s story is made even more complex, because I am also a psychiatrist. Therefore, part of my horror in reading this history is that I am identified with those physicians implementing such “treatments.” I ask myself: How would I have treated patients as a psychiatrist in the 1940s? Would I have done what Rose’s psychiatrist did?

Another celebrated historical treatment was malaria fever therapy, which entailed deliberately inducing a malarial illness in patients suffering from general paralysis of the insane (GPI). GPI was a severe form of neurosyphilis and was a frequent cause of admission to the early twentieth century psychiatric institutions. Although risky, malaria therapy was claimed to be successful in curing some patients from this usually fatal disease. It was used from the 1920s until the 1950s, gradually being superseded by penicillin (Davis, 2008). The British psychiatrist Shaw (1929) offered a dissenting view on this celebrated treatment. He imagined a history of psychiatry in the year 2500 making a “curious and interesting commentary” about the people in the early twentieth century who engaged in an “organized attempt to deplete their insane population by infecting them with a disease known as malaria” (p. 15).

It is a curious experience reading Shaw’s words in 2021: past, present, and future become entangled. Contemporary historians are critical of “Whiggish” histories of medicine, which stand on a moral high ground to criticize the “bad old days” (Lerner & Caplan, 2016). However, others warn against using historical context as an exculpatory “moral shelter” (Reverby, 2018;

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Sadowsky, 2017, p. 68). What happens if we turn the tables and ask: How would historical physicians report on medicine circa 2021, and how will it be reported 100 years hence? Such a thought experiment may help expand our thinking about contemporary medical practices. Here, I apply it specifically to the practice of masculinizing chest surgery for GD youth.

Twenty-First Century Medicine: Masculinizing Chest Surgery for Youth with Gender Dysphoria

Previously a rare phenomenon, increasing numbers of young people are presenting to clinicians with gender dysphoria. The largest group are natal female adolescents, many with a history of psychiatric illness or neurodevelopmental disorders (Tollit et al., 2021). Among this population, there is a “high demand” for surgical removal of breasts (Kuper et al., 2021; Telfer, 2019, p. 14) and this is being undertaken as routine treatment in patients as young as 13 (Olson-Kennedy et al., 2018). A number of clinicians argue that this surgery is an evidence-based intervention that improves mental health outcomes and that it is discriminatory for it not to be available (McDougall et al., 2021; Mehringer et al., 2021; Olson-Kennedy et al., 2018; Telfer, 2019).

Before discussing the evidence base, some explanations on terminology are required. The studies that I discuss mostly report on surgery for individuals less than 21 years old. A number of terms are used to describe this population, including “adolescents,” “minors,” and “youth.” I use the authors’ own terms when discussing their papers; otherwise, I use the term “youth.” “Chest dysphoria” is a recently created term meaning the discomfort with one’s breasts. The term “breasts” is largely absent in these academic publications as it “may cause distress for transgender males” (McDougall et al., 2021) and this seems part of broader pattern of removing this term from clinical language (Lehmann, 2021). The surgical terminology is also changing. “Mastectomy” is being replaced by terms such as “chest surgery,” “top surgery,” “masculinizing chest surgery,” or “chest contouring” (Cohen et al., 2019; McDougall et al., 2021; Mehringer et al., 2021; van de Grift et al., 2016).

There are only a handful of published studies focusing on the potential benefits of masculinizing chest surgery in youth. Marinkovic and Newfield (2017) published what they claimed was the first study reporting data on chest surgery in young adolescents. In this retrospective observational study of 14 postsurgical youth, nine of whom were under 18 years old, participants rated satisfaction with the aesthetic outcome of the procedure on a Likert-type linear scale. All reported high aesthetic satisfaction and most self-reported low complication rates and improvement in mood. The postsurgical clinical follow-up, 1.6 years on average, was described as mostly “uneventful.” However,

one participant, seven months after surgery, requested help to detransition and was subsequently lost to follow-up.

Olson-Kennedy et al. (2018), stating there were no prior “data documenting the effect of chest surgery on minors,” undertook a cross-sectional retrospective survey of 68 postsurgical transmasculine youth (72% of the eligible postsurgical population). In 49%, the surgery had been undertaken at younger than 18 years of age, with the youngest being age 13 and the oldest age 24. At the time of the survey, only 14% of the participants were more than 2 years post-surgery. The postsurgical participants were compared with a convenience and non-matched comparison sample of nonsurgical transmasculine youth. The outcome, chest dysphoria, was measured with an unvalidated scale and indicated that the postsurgical participants had less chest dysphoria than the nonsurgical participants. Another notable finding was that testosterone use was associated with increased chest dysphoria. It is important to note that, a few years prior to this study, Olson-Kennedy (2015) had already been promoting chest surgery for minors, describing it as easy, safe, available, and “absolutely life-saving.” This last claim seems contradictory to the 2018 paper which stated there were no previous data on chest surgery in minors. Olson-Kennedy (2015) also stated that “full gender-affirming surgery” in minors was “on the horizon” and noted “the difficulty of genital surgery is that it is surgical sterilization and people get super worked up about that...it is a barrier we have to over-come and I think we are going to.” It seems this barrier is already being over-come, as it has been reported that in the United States genital surgery is being undertaken on GD minors, as young as 15 years old (Milrod & Karasic, 2017).

Kuper et al. (2020) reported on short-term body dissatisfaction and mental health outcomes in 148 adolescents receiving gender affirmative medical treatments. Out of this group, 15 “affirmed males” obtained chest surgery, at an average age of 17.1 years (the youngest being 15.2 years). Kuper et al. found no significant correlation between chest surgery and psychological outcomes.

Lastly, Mehringer et al. (2021) reported a cross-sectional qualitative study of chest dysphoria in transmasculine youth. They selected 35 participants, of whom 30 completed the study. Of these, 47% had undergone chest surgery (on average 19 months previously), and 53% had not had surgery. Mehringer et al. concluded that the postsurgical cohort experienced “tremendous” benefits in chest dysphoria and a range of psychological outcomes; however, in my opinion, they did not provide enough detail for the reader to make an informed judgement regarding this latter claim.

To my knowledge, this is the main published evidence base for the potential benefits of masculinizing chest surgery in GD youth. Importantly, it appears that the chest surgery reported on in these studies was not undertaken as part of any human research ethics committee (HREC) approved clinical trial—as the surgery was undertaken prior to or separate from the research.

Reflections on the Evidence Base for Chest Surgery for Gender Dysphoric Youth

I now return to my previously posed question: How would historical medical practitioners comment on this surgical intervention? I imagine Shaw, in response to hearing about the surgical sterilization of vulnerable youth, drily commenting that the eugenic agenda of early twentieth century psychiatry and medicine might still be operative in 2021. Shaw might note that removing the term “breasts” from our language parallels early twentieth century English and American society, which was full of euphemisms to avoid distressing women. Freeman (1961), an American psychiatrist, whose lobotomy patients included distressed adolescents as young as age 12, might exclaim “and you judge me?!” Historical physicians would likely laugh at twenty-first century physicians’ claims that contemporary medical practices are based on rigorous evidence compared to the unscientific medicine of the past.

Indeed, many of the criticisms made about the inadequate evidence base of discredited historical treatments can be leveled against chest surgery for GD youth. The studies have significant methodological limitations which mean they are at critical risk of bias and cannot show that chest surgery is causally associated with short-term improved mental health outcomes. They do not provide any information on long-term outcomes and regret rates. Limiting features include the following: small and select samples; cross-sectional assessment; uncontrolled case series or comparative studies with non-matched control groups; high drop-out rates; short-term follow-up only; unvalidated measurement scales; and a failure to account for the impact of co-interventions and the placebo effect. Those advocating for chest surgery in youth make strong claims regarding the evidence base for this surgery in adults. However, these are also limited by similar shortcomings (Cohen et al., 2019). Furthermore, the research is notable for its failure to assess a role for psychological interventions which could be utilized, as a least harm intervention, until maturity is reached. One study, on adults, actually did discuss a possible role for psychological help with “body acceptance,” but it only came at the conclusion and as a suggestion for managing body image problems that remained post-mastectomy (van de Grift et al., 2016). In my opinion, it is surprising that clinicians and researchers claim chest surgery for GD youth is an evidence-based intervention, rather than acknowledging it is an experimental treatment that requires more rigorous and HREC approved research.

How will masculinizing chest surgery for GD youth be viewed by future generations? The enthusiasm for it, despite the lack of a rigorous evidence base, suggests that it may be seen as another example of what Valenstein (1986) called “great and desperate cures.” Valenstein noted that uncontrolled therapeutic experimentation in medicine is common and has the potential to inflict serious harm in the name of progress. He argued that

we need to draw lessons from history to help prevent the recurrence of such dangerous medicine. He also emphasized the role of personal ambition. The originators of the lobotomy, Moniz, and malaria therapy, Wagner-Jauregg, reached the pinnacle of medical ambition, each being awarded a Nobel Prize (ibid; Wagner-Jauregg, 1927). Valenstein argued for more regulation of innovative surgery, but also thought that such controls would be resisted “with argument that they will hamper progress and deprive desperate patients of help” and that “randomized control studies are unethical” (Valenstein, 1986, p. 297). This certainly parallels the arguments of those enthusiastically advocating for surgery for GD youth. Valenstein’s view was that “the negative effect of reasonable regulation was exaggerated, especially when compared with the cost of uncontrolled experimentation” (ibid).

What Can Historical Examples Teach Us about Possible Contributing Factors to Dangerous Medicine?

What factors, aside from the lack of a rigorous evidence base, might contribute to dangerous medical practices? Can history inform us anything about what might lead physicians to over-enthusiastically and prematurely embrace risky and unproven treatments? History suggests there is most likely a complex interplay of multiple factors, and I discuss some of these in this section. In the subsequent section, I return to discuss the gender affirmative treatment approach for GD youth and highlight some themes that may suggest some parallels with this history.

For physicians, “great and desperate” treatments could lead to “name and fame” and inculcate a sense of heroic doctor. For example, at the end of the nineteenth century, general paralysis of the insane confounded physicians’ therapeutic potency, leaving them just contemplating death “like men in a boat about to be swept over a fall, paralyzed with despair” (Godding, 1897). However, malaria therapy changed that and gave doctors a sense of potency and their patients a sense of hope (Braslow, 1997, p. 94; Grob, 1994, p. 180). Today, the efficacy of historical malaria therapy for GPI is questioned (Austin et al., 1992; Davis, 2008, p. 189; Frankenburg & Baldessarini, 2008; Scull, 2015). However, it certainly was effective in bolstering psychiatrists’ status. Ellery, the psychiatrist who introduced malaria therapy to Australia, described that it allowed psychiatrists to be considered “bona-fide clinicians,” who were no longer shunned as asylum medical officers just practicing “black magic” and “voodooism,” but instead “invited to medical meetings and listened to with interest” (Ellery, 1956, pp. 153–154).

An uncritical press portrayed the physicians implementing these treatments as bold medical heroes with the courage to take “desperate remedies” required to cure “desperate ills” (Hurn, 1998, p. 226). Malaria therapy was widely reported in the press with dramatic headlines and celebratory accounts. For example, in Australia, an article entitled “Doctor Mosquito” (1926)

promoted malaria therapy's "wonderful" benefits. In leading international newspapers, such as the *New York Times*, lobotomists were described as simply cutting out the "worry center" of the mentally ill, just as easily as they could remove an "appendix" or an "infected tooth" and bringing the patients a world "radiant with sunshine and kindness" (Harrington, 2019, p. 69; Pressman, 1998, p. 185; Scull, 2015, p. 317). These glowing portrayals, along with Nobel Prizes, gave these treatments a powerful authority, contributing to their rapid and widespread adoption by the medical community and leading patients and their families, including the rich and powerful, to seek them out (Diefenbach et al., 1999). Harrington (2019) reported on the tragic story of Rosemary Kennedy (President Kennedy's sister) who had a mild intellectual deficit. She was impetuous and the family feared an "embarrassing" pregnancy might result. In 1941, when she was 20, her father arranged for Freeman to lobotomize her. The operation was a disaster and Rosemary was institutionalized for the rest of her life.

Physicians can be confronted by patients whose illnesses, behaviors, and physicality undermine Western ideals of masculinity, femininity, and heterosexual norms. It may be that these patients are particularly at risk of dangerous medicine. General paralysis of the insane was a disease predominantly diagnosed in men in the prime-of-life. It was intimately linked with masculinity and sexuality, and deeply confronting to early twentieth century Anglo-European ideals of manhood. Men could turn from being rational and responsible citizens to filthy, raving, and violent—Mr Hyde, from *The Strange Case of Dr Jekyll and Mr Hyde*, could have been GPI personified (Swain, 2018). As the disease progressed, young men were reduced to "intellectual drivel and physical wreck," undergoing a "loathsome bodily decay" (Godding, 1897). In the early twentieth century, GPI's causation was definitively linked to syphilis and it then became linked to sexual morality. "Bad women" (prostitutes or promiscuous) were condemned for infecting men with venereal disease and, in various jurisdictions, criminal laws were introduced to detain such women. A World War I poster warned the soldiers against sexual liaisons: "A German Bullet is Cleaner than a Whore" (Brandt, 1985, p. 101). Given these attitudes, malaria therapy may have functioned, as did many previous treatments for syphilis, at least unconsciously, as a form of punishment as well as a treatment (Brandt, 1985, p. 12; Quérel, 1990, p. 59). A summary by the well-known popularizer of medical knowledge, de Kruif, suggests this underlying attitude: "Give your paretics the right kind of malaria...and though it burned them, the whole bodies of these paralytics seemed cleansed by the malaria fire... Thin washed out by the terrible fever...they began to turn into new people" (as cited in Braslow, 1997, p. 79).

Of note, malaria therapy was invented in 1917 in Vienna (Wagner-Jauregg, 1927). This was the penultimate year of World War I. Wagner-Jauregg's clinic, among others, "treated" World War I soldiers, suffering "war neurosis" (otherwise known as shell-shock), with painful electric current treatments, sometimes

applied to the genitals (Bogousslavsky & Tatu, 2013; Eissler, 1986). After the war, Wagner-Jauregg was officially investigated for cruelty and torture. Although he was cleared, a subsequent re-analysis of the investigation casts serious doubt on the impartiality of the judicial process (Eissler, 1986). The shell-shock patients were called "shirkers" and "tremblers," indicating the moral censure of such patients (Riebl & Sharp, 1992). The painful electric current "treatment" appears to be, in part, a punishment for the challenge these men represented to masculinity ideals, particularly in a nation at war (Mosse, 2000).

Many of the other somatic psychiatric treatments of the twentieth century were given predominantly to females. Pressman (1998) wrote that "an enduring mystery of the psychosurgery story, is why women were lobotomized nationally at a rate twice that of males" (p. 303). Braslow (1997) argued that the doctors entwined madness and unladylike behavior, and psychosurgery was seen as a potential intervention to restore femininity. In addition, women were "shackled, straightjacketed, bound and secluded" much more often than men (p. 157). Women who masturbated could be ordered to undergo clitoridectomy; men who masturbated and acted out "never lost their penises or testicles as a cure for these activities" (p. 168). In a feminist account, Showalter (1985) also portrayed psychiatry as a history of the colonization and subjugation of women.

Homosexuals' bodies have also been a favored site for experimental twentieth century medical and surgical interventions in which treatment, social control, and punishment goals blur. Metrazol convulsive therapy, chemical castration with estrogens, surgical castration, clitoridectomy, brain operations, and aversive electrotherapy were all utilized with the aim to either convert the homoerotic desires to heterosexual ones or to obliterate desires all together (Murphy, 1992). Sometimes, as in the example of the British mathematician, Alan Turing, the treatment was accepted as an alternative to imprisonment (Hodges, 2012). It is of note that during the 1990s AIDS epidemic, which disproportionately impacted the male homosexual community, malaria therapy was resurrected. It was speculatively and unethically trialed as a potential cure for AIDS (Nierengarten, 2003).

My final historical example is the hormonal treatment of "tall girls" and "short boys." From the 1960s through until the 1980s, large numbers of adolescents, who had no underlying medical pathology or hormonal abnormality, were prescribed hormonal treatment for their height (Cohen & Cosgrove, 2010). The reasons stated for such treatments, for what nowadays might be called "height dysphoria," included that adolescents were distressed, and their height had negative social impact. For example, "careers in classical ballet or being an airline hostess were closed" to "tall girls" and their prospects of finding a husband were jeopardized (Wettenhall et al., 1975). Some adolescents and their parents eagerly sought this treatment, led to it by the encouragement of physicians and school nurses, enthusiastic media promotion, and pharmaceutical companies' advertising. At the time, the hormones were declared safe, but years later

concerns emerged about long-term adverse effects, including impaired fertility and increased risk of cancers (Benyi et al., 2014; Venn et al., 2004). Some boys treated with growth hormone developed Creutzfeld–Jacob disease, an aggressive early onset and fatal dementia. In Australia, this led to a federal government inquiry and an apology. In France, criminal charges were laid against some of the physicians involved (Cohen & Cosgrove, 2009, pp. 262, 350). Importantly, there had been a lack of controlled trials to confirm the efficacy, either on improving psychosocial outcome or the impact on height, of these treatments. A retrospective cohort study of “tall girls” revealed that 42% of the study group regretted the hormonal treatment they received (ibid., p. 232). Tall girls and short boys may be a visual affront to some societal “ideals” of male strength female fragility. This seems another part of the story of medicine acting to reinforce society’s sex stereotypes, and for some patients it came at disastrous personal cost.

The Gender Affirmative Treatment Approach for Gender Dysphoric Youth: Medical Advance or Dangerous Medicine?

Masculinizing chest surgery is part of the controversial gender affirmative treatment approach to GD youth. This approach is underpinned by the view that a child or adolescent’s stated gender identity should be endorsed not questioned, and that they should be supported to undertake social transition, medical transition, masculinizing chest surgery, and, some also argue, genital surgery. Those advocating this approach consider these gender affirming treatments medically and ethically essential (Baams, 2021; de Vries et al., 2021; Transgender Health, 2020; Walch et al., 2021).

Others express concern about this approach (Biggs, 2020; D’Angelo et al., 2021; Levine, 2018, 2021; Malone, 2021). They note the limited and low-quality evidence base for the benefits, not only of mastectomy as I have done in this Letter, but for early social transition and the hormonal treatments for GD adolescents. Concerns are raised about the irreversible and long-term adverse impacts of these treatments on fertility and sexual function, as well as on bone, brain, and cardiovascular functioning. Concerns are expressed about the sharp, massive, and largely unexplained increase in GD youth, many with psychiatric and neurodevelopmental disorders, presenting to gender clinics. They caution against early social transition, hormonal, and surgical treatments of youth. Some ask: Why are these experimental interventions, with inherent risks and scarce, low-quality evidence for benefits, being implemented outside HREC regulated clinical trial settings?

The studies’ limitations also mean that regret and detransition rates are largely unknown. A widely cited study to support claims of less than 1% long-term regret rates is Wiepjes et al.

(2018). However, this study only reported on stringently defined regret (as recorded by the clinician in the clinical record plus the prescription of sex hormones consistent with natal sex) in those who underwent gonadectomy, and then continued in follow-up (and 36% of the study population dropped out of follow-up). The adolescent subgroup was carefully selected, being meticulously assessed and managed via the rigorous “Dutch protocol” (de Vries & Cohen-Kettenis, 2012) and the vast majority had a relatively short follow-up period. Most contemporary youth gender clinics do not follow the “Dutch protocol,” which further limits the applicability of this study’s regret rate findings. It is worth highlighting that Keira Bell, a well-known detransitioner, would not meet the criteria to be categorized as a regret case in the Wiepjes et al. study as she never underwent gonadectomy. Celebratory stories of medically and surgically transitioned young people are regularly promoted by physicians and the media (Alcindor, 2015; Cohen, 2021) adding to the impression of overwhelming beneficial outcomes of this treatment approach. However, there are now increasing reports in the medical literature of regret and detransition (Entwistle, 2021; Littman, 2021; Pazos-Guerra et al., 2020; Vandenbussche, 2021) and these give us cause to question the claims of negligible regret rates.

In response to my historical examples, some may argue that informed consent and patient autonomy differentiates contemporary medicine from historical medicine. However, many of these historical treatments did require informed consent, either from the patient or a family member. In addition, informed consent is complex. A necessary condition for it is clinician honesty, which is not met if clinicians overstate the evidence base or act as “cheerleaders” for transition (Clayton et al., in press; Levine, 2019). The contemporary portrayal of the principle of patient autonomy as a simple solution for bioethical quandaries has been challenged by Mol (2008). Mol illustrated that the notion of “patient as a customer autonomously choosing health care” is simplistic. Patients’ choices are deeply entangled with other factors, including the influence of their clinicians and medical marketing. Some readers may also reject my discussing contemporary medicine for GD youth along with what they may consider as cruel historical treatments. However, we need to remember that, for the most part, these treatments were not judged as cruel at the time of use, were widely celebrated, and were implemented by well-intentioned physicians who fervently believed that they were helping their patients.

This is also a controversial topic outside the medical field. Contemporary feminist academics have divided views on transgender issues and the medicalization of GD youth (Gillis et al., 2007; Riley & Pearce, 2018; Stock, 2021). Thus, while some express full support, others express concern that the medicalization of such youth is reinforcing sexual stereotypes and gender binaries. They argue that a deeper analysis is required to understand why so many young people, particularly natal

females, are now finding their natural bodies uninhabitable. Others are troubled with the fact that it is the powerful pharmaceutical and surgical industries that are creating trans-bodies.

Some influential LGBTIQ and parent groups are vocal in their support of affirmative treatments for GD youths, but other such groups express concern. Some consider that placing the label “trans” on gender non-conforming youth is an expression of the homophobia of our society. They are concerned that the hormonal and surgical interventions maybe a repetition, albeit unwittingly, of historical treatments that aimed at converting homosexual people to fit with heterosexual norms (Stock, 2021, pp. 83–84). There is emerging research data that support these concerns. Littman (2021), in her survey of 100 detransitioners, found 23% reported homophobia or difficulty accepting themselves as lesbian, gay or bisexual as a reason for their transition and subsequent detransition. The example of Iran is also often raised in this context. Jafari (2014) noted that Iran’s government boasts about their high rates of sexual reassignment surgeries as indicative of their commitment to human rights, and that some, including Western media sources, can portray the availability of such surgeries in Iran as liberal and progressive. Yet, in Iran, homosexuality is forbidden and punishable by the death penalty. To avoid this, homosexuals may have to undergo sexual reassignment surgery (see also Hamedani, 2014). Jafari (2014) commented that “ultimately the state’s goal—and the murkier side to this ‘liberal’ medico-legal development—is the assimilation of homosexual men and women within a binary gender paradigm” (p. 42). For more perspectives on the complexities of this situation in Iran and relevant cross-cultural issues, the interested reader is referred to Meyer (2016) and Sadjadi (2019).

Conclusion

How, then, do we best read the affirmative treatment approach for GD youth? Should it be read triumphantly as cutting-edge, ethical, and evidence-based medicine continuing on its progressive march of improving human life? Or is it a manifestation of dangerous medicine, that despite best intentions will cause more harm than benefit to vulnerable youths, and over which future historians and physicians will shake their heads?

Between the ages of 16 and 20, Kiera Bell identified as a man and took testosterone and underwent a double mastectomy. She then detransitioned. In a court testimony, she described her regret: “I felt like a fraud. . . more lost, isolated and confused than I did when I was pre-transitioned. . . only recently. . . I have started to think about having children and if that is ever a possibility, I have to live with the fact that I will not be able to breastfeed my children. . . I made a brash decision as a teenager. . . trying to find confidence and happiness. . . now the rest of my life will be negatively affected” (Bell, 2020, pp. 21–22). In these words, Bell holds herself responsible for making a “brash decision”

in her youth. This may be an indication of maturity and taking responsibility, but it also has a more concerning element—a victim blaming herself for mistreatment. In my view, the medical profession needs to consider whether, in its championing of the gender affirmative approach for GD youth, it is also acting brashly and making mistakes that will negatively impact some young people for the rest of their lives.

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References

- Alcindor, Y. (2015, March 14). Transgender teen Jazz Jennings lands clean and clear campaign. *USA Today*. Retrieved from <https://www.usatoday.com>
- Austin, S. C., Stolley, P. D., & Lasky, T. (1992). The history of malari-otherapy for neurosyphilis, modern parallels. *Journal of the American Medical Association*, 268(4), 516–519. <https://doi.org/10.1001/jama.1992.03490040092031>
- Baams, L. (2021). Equity in paediatric care for sexual and gender minority adolescents. *The Lancet Child & Adolescent Health*, 5(6), 389–391. [https://doi.org/10.1016/S2352-4642\(21\)00129-2](https://doi.org/10.1016/S2352-4642(21)00129-2)
- Bell, K. (2020). *British High Court Case No: CO/60/2020 Bell v Tavistock* (01/12/2020). Retrieved from <https://www.judiciary.uk>
- Benyi, E., Kieler, H., Linder, M., Ritzén, M., Carlstedt-Duke, J., Tuvemo, T., Westphal, O., & Säwendahl, L. (2014). Risks of malignant and non-malignant tumours in tall woman treated with high dose oestrogen during adolescence. *Hormone Research in Pediatrics*, 82, 89–96. <https://doi.org/10.1159/000360137>
- Biggs, M. (2020). Gender dysphoria and psychological functioning in adolescents treated with GnRHa: Comparing Dutch and English prospective studies [Letter to the Editor]. *Archives of Sexual Behavior*, 49, 2231–2236. <https://doi.org/10.1007/s10508-020-01764-1>
- Bogousslavsky, J., & Tatu, L. (2013). French neuropsychiatry in the Great War: Between moral support and electricity. *Journal of the History of the Neurosciences*, 22(2), 144–154. <https://doi.org/10.1080/0964704X.2012.682481>

- Brandt, A. M. (1985). *No magic bullet: A social history of venereal disease in the United States since 1880*. Oxford University Press.
- Braslow, J. (1997). *Mental ills and bodily cures: Psychiatric treatment in the first half of the twentieth century*. University of California Press.
- Clayton, A., Malone, W., Clarke, P., Mason, J., & D'Angelo, R. (in press). The signal and the noise: Questioning the benefits of puberty blockers for gender dysphoria—a commentary on Rew et al. (2021). *Child and Adolescent Mental Health*.
- Cohen, J. (Producer). (2021). *Australian story: A balancing act/ Michelle Telfer* [Television broadcast]. Australian Broadcasting Commission. Retrieved from abc.net.au
- Cohen, S., & Cosgrove, C. (2009). *Normal at any cost: Tall girls, short boys and the medical industry's quest to manipulate height*. New York: Jeremy P. Tarcher/Penguin.
- Cohen, S., & Cosgrove, C. (2010). Too tall, too small? The temptation to tinker with a child's height. *The Lancet*, 375(9713), 454–455. [https://doi.org/10.1016/s0140-6736\(10\)60185-7](https://doi.org/10.1016/s0140-6736(10)60185-7)
- Cohen, W. A., Shah, N. R., Iwanicki, M., Therattil, P. J., & Keith, J. D. (2019). Female-to-male transgender chest contouring: A systematic review of outcomes and knowledge gaps. *Annals of Plastic Surgery*, 83(5), 589–593. <https://doi.org/10.1097/SAP.0000000000001896>
- D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria [Letter to the Editor]. *Archives of Sexual Behavior*, 50(1), 7–16. <https://doi.org/10.1007/s10508-020-01844-2>
- Davis, G. (2008). *The cruel madness of love: Sex, syphilis and psychiatry in Scotland, 1880–1930*. Rodopi.
- de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59(3), 301–320. <https://doi.org/10.1080/00918369.2012.653300>
- de Vries, A. L. C., Richards, C., Tishelman, A. C., Motmans, J., Hannema, S. E., Green, J., & Rosenthal, S. M. (2021). Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents. *International Journal of Transgender Health*, 22(3), 217–224. <https://doi.org/10.1080/26895269.2021.1904330>
- Diefenbach, G. J., Diefenbach, D., Baumeister, A., & West, M. (1999). Portrayal of lobotomy in the popular press: 1935–1960. *Journal of the History of the Neurosciences*, 8(1), 60–69. <https://doi.org/10.1076/jhin.8.1.60.1766>
- “Doctor” Mosquito. (1926). *Newcastle morning Herald and Miners' Advocate*, p. 8. Retrieved from trove.nla.gov.au
- Ellery, R. S. (1956). *The cow jumped over the moon: Private papers of a psychiatrist*. Melbourne: F.W. Cheshire.
- Eissler, K. R. (1986). *Freud as an expert witness: The discussion of war neuroses between Freud and Wagner-Jauregg*. International Universities Press Inc.
- Entwistle, K. (2021). Debate: Reality check—Detransitioners' testimonies require us to rethink gender dysphoria. *Child and Adolescent Mental Health*, 26(1), 15–16. <https://doi.org/10.1111/camh.12380>
- Frankenburg, F. R., & Baldessarini, R. J. (2008). Neurosyphilis, malaria and the discovery of antipsychotic agents. *Harvard Review of Psychiatry*, 16(5), 299–307. <https://doi.org/10.1080/10673220802432350>
- Freeman, W. (1961). Adolescents in distress: Therapeutic possibilities of lobotomy. *Diseases of the Nervous System*, 22, 555–558.
- Gillis, S., Howie, G., & Munford, R. (Eds.). (2007). *Third wave feminism: A critical exploration*. Palgrave Macmillan.
- Godding, W. W. (1897). Active treatment in general paralysis of the insane. *British Medical Journal*, 2(1924), 1407–1409.
- Grob, G. N. (1994). *The mad among us: A history of the care of America's mentally ill*. Free Press.
- Hamedani, A. (2014). The gay people pushed to change their gender. *BBC News*. Retrieved from <https://www.bbc.com/news/magazine-29832690>
- Harrington, A. (2019). *Mind fixers: Psychiatry's troubled search for the biology of mental illness*. W.W. Norton & Company.
- Hodges, A. (2012). *Alan Turing: The enigma*. Vintage Books.
- Hurn, J. D. (1998). *The history of general paralysis of the insane in Britain, 1830–1950*. Unpublished doctoral thesis, University of London.
- Jafari, F. (2014). Transsexuality under surveillance in Iran: Clerical control of Khomeini's fatwas. *Journal of Middle East Women's Studies*, 10(2), 31–51. <https://doi.org/10.2979/jmiddeastwomstud.10.2.31>
- Kuper, L. E., Rider, G. N., & St Amand, C. M. (2021). Recognizing the importance of chest surgery for transmasculine youth. *Pediatrics*, 147(3), e2020029710. <https://doi.org/10.1542/peds.2020-029710>
- Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, 145(4), e20193006. <https://doi.org/10.1542/peds.2019-3006>
- Lehmann, C. (2021). Trans-‘inclusive’ language is erasing women's biology. *The Australian*. Retrieved from theaustralian.com.au
- Lerner, B. H., & Caplan, A. L. (2016). Judging the past: How history should inform bioethics. *Annals of Internal Medicine*, 164(8), 553–557. <https://doi.org/10.7326/M15-2642>
- Levine, S. B. (2018). Ethical concerns about emerging treatment paradigms for gender dysphoria. *Journal of Sex and Marital Therapy*, 44(1), 29–44. <https://doi.org/10.1080/0092623X.2017.1309482>
- Levine, S. B. (2019). Informed consent for transgender patients. *Journal of Sex and Marital Therapy*, 45(3), 218–229. <https://doi.org/10.1080/0092623X.2018.1518885>
- Levine, S. B. (2021). Reflections on the clinician's role with individuals who self-identify as transgender. *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-021-02142-1>
- Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-021-02163-w>
- McDougall, R., Notini, L., Delany, C., Telfer, M., & Pang, K. C. (2021). Should clinicians make chest surgery available to transgender male adolescents? *Bioethics*, 35(7), 696–703. <https://doi.org/10.1111/bioe.12912>
- Malone, W. (2021). Time to hit pause on ‘pausing’ puberty in gender-dysphoric youth. *Medscape*. Retrieved from medscape.com
- Marinkovic, M., & Newfield, R. S. (2017). Chest reconstructive surgeries in transmasculine youth: Experience from one pediatric center. *International Journal of Transgenderism*, 18(4), 376–381. <https://doi.org/10.1080/15532739.2017.1349706>
- Mehring, J. E., Harrison, J. B., Quain, K. M., Shea, J. A., Hawkins, L. A., & Dowshen, N. L. (2021). Experience of chest dysphoria and masculinizing chest surgery in transmasculine youth. *Pediatrics*, 147(3), e2020013300. <https://doi.org/10.1542/peds.2020-013300>
- Meyer, L. D. (2016). Book forum: Professing selves: Transsexuality and same-sex desire in contemporary Iran by Afsaneh Najmabadi (review). *Journal of Women's History*, 28(4), 154–185.
- Milrod, C., & Karasic, D. H. (2017). Age is just a number: WPATH-affiliated surgeons' experiences and attitudes towards vaginoplasty in transgender females under 18 years of age in the United States. *Journal of Sexual Medicine*, 14, 624–634. <https://doi.org/10.1016/j.jsxm.2017.02.007>
- Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. Routledge.

- Mosse, G. L. (2000). Shell-shock as a social disease. *Journal of Contemporary History*, 35(1), 101–108. <https://www.jstor.org/stable/261184>
- Murphy, T. F. (1992). Redirecting sexual orientations: Techniques and justifications. *Journal of Sex Research*, 29(4), 501–523.
- Nierengarten, M. B. (2003). Malariortherapy to treat HIV patients? *The Lancet Infectious Diseases*, 3(6), 321. [https://doi.org/10.1016/S1473-3099\(03\)00642-X](https://doi.org/10.1016/S1473-3099(03)00642-X)
- Olson-Kennedy, J. (2015). *The future of trans care in the new millennium*. Gender Infinity Annual Conference. Retrieved from <https://youtu.be/pO8v--tztSg>
- Olson-Kennedy, J., Warus, J., Okonta, V., Belzer, M., & Clark, L. F. (2018). Chest reconstruction and chest dysphoria in transmasculine minors and young adults: Comparisons of nonsurgical and postsurgical cohorts. *JAMA Pediatrics*, 172(5), 431–436. <https://doi.org/10.1001/jamapediatrics.2017.5440>
- Pazos Guerra, M., Gómez Balaguer, M., Gomes Porras, M., Hurtado Murillo, F., Solá Izquierdo, E., & Morillas Ariño, C. (2020). Transexualidad: Transiciones, detransiciones y arrepentimientos en España [Transsexuality: Transitions, detransitions and regrets in Spain]. *Endocrinología, Diabetes y Nutrición*, 67(9), 562–567. <https://doi.org/10.1016/j.endinu.2020.03.008>
- Pressman, J. D. (1998). *Last resort: Psychosurgery and the limits of medicine*. Cambridge University Press.
- Quétel, C. (1990). *History of syphilis*. Polity Press.
- Reverby, S. M. (2018). “So what?”: Historical contingency, activism, and reflections on the studies in Tuskegee and Guatemala. In F. Baylis & A. Dreger (Eds.), *Bioethics in action* (pp. 31–54). Cambridge University Press.
- Riebl, L., & Sharp, P. (1992). Julius Wagner von Jauregg: A reappraisal. *Australian and New Zealand Journal of Psychiatry*, 26, 302–306.
- Riley, C., & Pearce, L. (2018). *Feminism and women's writing: An introduction*. Edinburgh University Press.
- Sadjadi, S. (2019). Deep in the brain: Identity and authenticity in pediatric gender transition. *Cultural Anthropology*, 34(1), 103–129. <https://doi.org/10.14506/ca34.1.10>
- Sadowsky, J. (2017). *Electroconvulsive therapy in America: The anatomy of a medical controversy*. Routledge.
- Scull, A. (2015). *Madness in civilization: A cultural history of insanity from the Bible to Freud, from the madhouse to modern medicine*. Thames & Hudson.
- Shaw, B. (1929). In: General paralysis, a report of a meeting of the General Paralysis Subcommittee of the Royal Medico-Psychological Association. *Journal of Mental Science*, 308, 1–30.
- Showalter, E. (1985). *The female malady: Women, madness and English culture, 1830–1980*. Pantheon Books.
- Stock, K. (2021). *Material girls: Why reality matters for feminism*. Fleet.
- Swain, K. (2018). ‘Extraordinarily arduous and fraught with danger’: Syphilis, Salvarsan, and general paresis of the insane. *The Lancet Psychiatry*, 5(9), 702–703. [https://doi.org/10.1016/S2215-0366\(18\)30221-9](https://doi.org/10.1016/S2215-0366(18)30221-9)
- Telfer, M. M. (2019). Witness statement of Associate Professor Michelle Telfer. *Royal Commission into Victoria's mental health system*. Retrieved from: <https://rcvmhs.archive.royalcommission.vic.gov.au>
- Tollit, M. A., May, T., Maloof, T., Telfer, M. M., Chew, D., Engel, M., & Pang, K. (2021). The clinical profile of patients attending a large, Australian pediatric gender service: A 10-year review. *International Journal of Transgender Health*. <https://doi.org/10.1080/26895269.2021.1939221>
- Transgender Health: An Endocrine Society position statement. (2020, December 15). Retrieved from <https://www.endocrine.org/advocacy/position-statements/transgender-health>.
- Valenstein, E. S. (1986). *Great and desperate cures: The rise and decline of psychosurgery and other radical treatments for mental illness*. Basic Books.
- van de Grift, T. C., Kreukels, B. P. C., Elfering, L., Özer, M., Bouman, M.-B., Buncamper, M. E., Smit, J. M., & Mullender, M. G. (2016). Body image in transmen: Multidimensional measurement and the effects of mastectomy. *Journal of Sexual Medicine*, 13, 1778–1786. <https://doi.org/10.1016/j.jsxm.2016.09.003>
- Vandenbussche, E. (2021). Detransition-related needs and support: A cross-sectional online survey. *Journal of Homosexuality*. <https://doi.org/10.1080/00918369.2021.1919479>
- Venn, A., Bruinsma, F., Werther, G., Pyett, P., Baird, D., Jones, P., Rayner, J., & Lumley, J. (2004). Oestrogen treatment to reduce the adult height of tall girls: Long-term effects on fertility. *The Lancet*, 364(9444), 1513–1518. [https://doi.org/10.1016/S0140-6736\(04\)17274-7](https://doi.org/10.1016/S0140-6736(04)17274-7)
- Wagner-Jauregg, J. (1927). *Nobel lecture: The treatment of dementia paralytica by malaria inoculation*. Retrieved from <https://www.nobelprize.org/prizes/medicine/1927/wagner-jauregg/lecture/>
- Walch, A., Davidge-Pitts, C., Safer, J. D., Lopez, X., Tangpricha, V., & Iwamoto, S. J. (2021). Proper care of transgender and gender diverse persons in the setting of proposed discrimination: A policy perspective. *Journal of Clinical Endocrinology and Metabolism*, 106(2), 305–308. <https://doi.org/10.1210/clinem/dgaa816>
- Wettenhall, H. N., Cahill, C., & Roche, A. F. (1975). Tall girls: A survey of 15 years management and treatment. *Journal of Pediatrics*, 86(4), 602–610.
- Wiepjes, C. M., Nota, N. M., de Blok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M.-B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, 15(4), 582–590. <https://doi.org/10.1016/j.jsxm.2018.01.016>

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Dear Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

I am a parent of a 16 year old girl, who identifies as transgender.

She might be a lesbian, but she is not transgender. She has struggled with mental health issues. We are constitutionally opposed to the affirmation model and hormonal/surgical interventions for our minor child. Historically, teenage females are plagued by social contagion issues including anorexia, bulimia, and cutting. We believe our daughter has been caught up in this latest social contagion like many other teens. She has always struggled socially, and gender ideology with its social justice aspect, has proved to be the answer for her to longing to belong and have friends. Nearly 25% of kids in her high school have recently claimed a trans identity.

Research is limited, and no consensus exists within the scientific community about possible causes of gender dysphoria and the most appropriate treatment options. We must secure a balanced treatment of political issues, which must take a child-centered, evidence-based approach, and take care not to express personal beliefs in ways that could exploit vulnerabilities. We should not for example, present childhood gender incongruence as an inherent and immutable phenomenon, as this is a contested idea not an established evidence-based fact.

The number of people who regret transition is unknown. Most who “desist” simply stop treatment and do not report their desistance to their providers. According to the ever-increasing numbers of people involved in online forums and groups of detransitioners, they do not have support from the medical or transgender communities. Many say they did not fully understand the magnitude of side effects, adverse outcomes, and risks involved in their transitions.

The human brain is not considered fully developed until approximately 25 years of age. According to psychological developmental stages of children and teenagers, forming identity is an important process. Erik Erikson’s psychosocial developmental stage of ‘Identity vs Role Confusion’ speaks perfectly to the normalcy of teens questioning their identities. Self-exploration is a normal part of growing up for everyone. The problem with claiming a trans identity is the irreversible damage that can be done with medical and surgical interventions. Children and teenagers are unable to provide true informed consent for such treatment. They are unable to fully understand the lifelong consequences of these decisions. Please consider this and

protect children from irreversible damage. When they are adults who can provide true informed consent, they can make these decisions for themselves.

Thank you most sincerely for your time and consideration.

John Warren

Understanding Your Positive *SDHB* Genetic Test Result

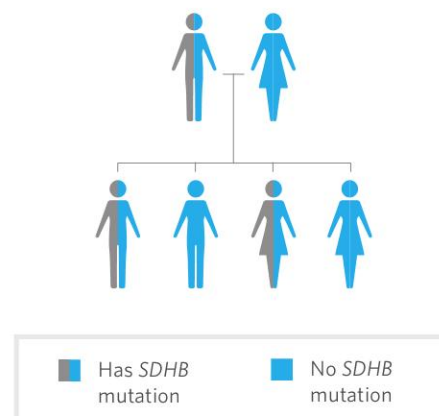
INFORMATION FOR PATIENTS WITH A **PATHOGENIC MUTATION** OR **VARIANT, LIKELY PATHOGENIC**

4 Things to know

1	<i>SDHB</i> mutation	Your testing shows that you have a pathogenic mutation or a variant that is likely pathogenic in the <i>SDHB</i> gene.
2	Non-cancerous tumor and cancer risks	You have an increased chance to develop paragangliomas (PGLs)/pheochromocytomas (PCCs), gastrointestinal stromal tumors (GISTs), and kidney cancer.
3	What you can do	There are risk management options to detect cancer early or lower your risk to develop cancer. It is important to discuss these options with your doctor, and decide on a plan that best manages your cancer risks.
4	Family	Family members may also be at risk – they can be tested for the <i>SDHB</i> mutation that was found in you.

SDHB Mutations in the Family

There is a 50/50 random chance to pass on an *SDHB* mutation to your sons and daughters. The image to the right shows that both men and women can carry and pass on these mutations.



Understanding Your Positive *SDHB* Genetic Test Result

INFORMATION FOR PATIENTS WITH A **PATHOGENIC MUTATION** OR **VARIANT, LIKELY PATHOGENIC**

Result	MUTATION	Your testing shows that you have a pathogenic mutation (a disease-causing change in the gene, like a spelling mistake) or variant that is likely pathogenic in the <i>SDHB</i> gene. Both of these should be considered the same type of positive result.
Gene	<i>SDHB</i>	Everyone has two copies of the <i>SDHB</i> gene, which we randomly inherit from each of our parents. Mutations in one copy of the <i>SDHB</i> gene can increase the chance for you to develop certain types of cancer and tumors.
Tumor/ cancer risks	INCREASED	You have an increased chance to develop a PGL/PCC (77-100% by age 70). PGLs/PCCs are rare tumors that affect your endocrine system, which makes and controls your hormones. <i>SDHB</i> -associated PGLs/PCCs have a high risk of becoming cancerous. You also have an increased risk for GISTs, which are rare tumors of the GI tract. PGLs/PCCs and GISTs are not typically cancerous, but may require treatment; some can become cancerous. Additionally, you have an increased risk for kidney cancer (up to 14%).
Management Options	FOR MEN & WOMEN	Options for screening and early detection may include imaging with CT scans or MRI, as well as blood and/or urine screening tests. Talk to your doctor about which options may be right for you.
Risk Management	VARIES	Risk management decisions are very personal, and the best option depends on many factors. Screening typically begins earlier than in the general population, and is often more frequently done. It is important to discuss these options with your doctor.
Family Members	50/50 CHANCE	Your close relatives (like your parents, brothers, sisters, children) have a 50/50 random chance of inheriting the <i>SDHB</i> mutation that you carry, and other family members (like your aunts, uncles, cousins) may also inherit it. Your relatives can be tested for this same mutation. Depending on the family history, those who DO NOT have it may not have an increased lifetime chance (above the general population) to develop cancer.
Next Steps	DISCUSS	It is recommended that you share this information with family members so they can learn more and discuss this with their healthcare providers.
Reach Out	RESOURCES	<ul style="list-style-type: none">▪ Pheo Para Alliance pheo-para-alliance.org▪ Pheo Para Troopers pheoparatroopers.org▪ Genetic Information Nondiscrimination Act (GINA) ginahelp.org▪ National Society of Genetic Counselors nsgc.org▪ Canadian Society of Genetic Counsellors cagc-accg.ca

Please discuss this information with your healthcare provider. The cancer genetics field is continuously evolving, so updates related to your *SDHB* result, medical recommendations, and/or potential treatments may be available over time. This information is not meant to replace a discussion with a healthcare provider, and should not be considered or interpreted as medical advice.

Dear Paul A. Vazquez, J.D.
Executive Director Florida Board of Medicine

I am a parent of a 16 year old girl, who identifies as transgender.

She might be a lesbian, but she is not transgender. She has struggled with mental health issues. We are constitutionally opposed to the affirmation model and hormonal/surgical interventions for our minor child. Early childhood gender dysphoria is not a new phenomenon. However, the existing literature on treatment and outcomes is largely based on early childhood gender dysphoria in male children. It may not apply to the current cohort of gender-questioning children who are older, predominantly female, and often presenting with a range of neurodevelopmental and mental health co-morbidities. Historically, teenage females are plagued by social contagion issues including anorexia, bulimia, and cutting. We believe our daughter has been caught up in this latest social contagion like many other teens. She has always struggled socially, and gender ideology with its social justice aspect, has proved to be the answer for her to longing to belong and have friends. Nearly 25% of kids in her high school have recently claimed a trans identity.

Recently, Great Britain commissioned a highly distinguished public health and pediatric expert to reconsider the affirmative model in the United Kingdom. Please consider with care the findings of the Cass Review interim report, which is an independent review of gender identity services for children and young people. It was ‘commissioned by NHS England and NHS Improvement in Autumn 2020 to make recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence.’ In March 2022, the Cass Review submitted an interim report to NHS England. This interim report ‘[set] out [the] work to date, what [had] been learnt so far and the approach going forward.’

Dr Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020. A former President of the Royal College of Paediatrics and Child Health from 2012-2015, Dr Cass recently finished a term as Chair of the British Academy of Childhood Disability (2017-2020). Although retired from clinical practice, she remains an honorary consultant pediatrician at Evelina London Children’s Hospital. Dr Cass is currently Chair of Together for Short Lives, and a Trustee for Noah’s Ark Children’s Hospice. She is also leading work on how to address the

challenges for both families and professionals in supporting the rising numbers of children with complex medical conditions and disability. Other recent roles include acting as the senior clinical advisor for Child Health for Health Education England. Prior to this, Dr Cass held a range of senior education and management roles in NHS hospital trusts and was previously Head of School of Paediatrics in London. Her consultant clinical practice was as a tertiary neurodisability consultant from 1992 to 2018 in three very different specialist centers, and she has published widely in this area.

Similar to America, there has been a recent significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust. From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase in 2014-15, and at the time of the Tavistock inspection, there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment. This surge in children seeking help for distress in relation to their sex is occurring in the context of an ongoing public debate around issues relating to sex, gender, and gender identity. Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarized and adversarial.

Research is limited, and no consensus exists within the scientific community about possible causes and most appropriate treatment options. We must secure a balanced treatment of political issues, which must take a child-centered, evidence-based approach, and take care not to express personal beliefs in ways that could exploit vulnerabilities. We should not for example, present childhood gender incongruence as an inherent and immutable phenomenon, as this is a contested idea rather than an established evidence-based fact.

The number of people who regret transition is unknown. Most who “desist” simply stop treatment and do not report their desistance to their providers. According to the ever-increasing numbers of people involved in online forums and groups of detransitioners, they do not have support from the medical or transgender communities. Many say they did not fully understand the magnitude of side effects and risks involved in their transitions. The human brain is not considered fully developed until approximately 25 years of age. According to psychological developmental stages of children and teenagers, forming identity is an important process. Erik Erikson’s psychosocial developmental stage of ‘Identity vs Role Confusion’ speaks perfectly to

the normalcy of teens questioning their identities. Self-exploration is a normal part of growing up for everyone. The problem with claiming a trans identity is the irreversible damage that can be done with medical and surgical interventions. Children and teenagers are unable to provide true informed consent for such treatment. They are unable to fully understand the lifelong consequences of these interventions. Please consider this and protect children from irreversible damage. When they are adults who can provide true informed consent, they can make these decisions for themselves.

Thank you most sincerely for your time and consideration.

Courtney Warren

From: [Jenniferq Gunter](#)
To: [Vazquez, Paul](#)
Subject: Gender Meeting
Date: Tuesday, September 20, 2022 11:19:57 AM

You don't often get email from jennifergunter18@yahoo.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Good Morning,

I'm am writing you in regards to the upcoming meeting on the topic of gender. I am the mother of a 17 year old daughter who is currently suffering from gender dysphoria. My daughter was a typical Tom boy growing up and was comfortable in her skin until the age of 15. She started high school in a new area and was embraced by the LGBTQ kids. After a year of being in this friend group she started questioning her gender and started identifying as transgender. Her change and the language she started using did not seem authentic to her. She became severely depressed and suicidal. She said she needed testosterone and a double mastectomy immediately. As her parents, This sudden change shocked us and we began researching studies on long term testosterone use and gender surgery. This kind of research is severely lacking. We need proper studies on the long term use of testosterone, gender affirmative care and surgeries. Teenagers and young adults should not be making life long medical decisions without an extremely high bar set for informed consent. I am seeing more and more de transitions happening and I fear for my child's long term health and pursuit of happiness.

Thank you,

Jennifer Gunter

[Sent from Yahoo Mail for iPhone](#)

From: [Gay Johnson](#)
To: [Vazquez, Paul](#)
Subject: New rules on affirmative care
Date: Monday, September 19, 2022 2:13:04 AM

You don't often get email from gayjohnsonnz@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Hello,

As the parent of a teenager who has become entrenched in the gender ideology sweeping the western world, I would like to ask that you stay strong against the affirmative approach of care for young people who wish to transition. Watchful waiting is the key.

I know, because my son has been rushed to transition. It is the approach taken here in New Zealand and though I am not transphobic I worry about the huge increase in kids who are wishing to change their gender, and the way that they are being encouraged by people who should know better, who are telling them that it is possible to change sex.

I fear that in a few years, it will become clear that this is the 21st century's scandal and that many young people will regret the irrevocable changes that have been made to their bodies.

Thank you for reading this.

Gay Johnson,
97 Braemar Road,
Castor Bay,
Auckland, 0620,
New Zealand.

From: [Jill Harris](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Gender affirming care / Florida Board of Medicine
Date: Monday, September 19, 2022 11:25:42 AM

You don't often get email from j.ellen.h.11@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

To the Florida Board of Medicine:

In late 2020, NHS England and NHS Improvement appointed Dr Hilary Cass, a former President of the Royal College of Paediatrics and Child Health, to chair the Independent Review of Gender Identity Services for children and young people. Her work, the Cass Review, is an Independent Review of Gender Identity Services for Children and Young People and it outlines some of the specific safeguarding issues that surround gender-questioning children. Here is a brief summary:

From 2012-2015 there has been a huge increase in the number of children (predominantly female teenagers) seeking help for distress in relation to their biological sex. Research into this new phenomenon is limited. The lack of high-quality data from longitudinal studies together with the changing epidemiology means that no consensus exists about the possible causes for this recent surge in children wanting to change sex. Clinically trained professionals face difficulties in making diagnoses and recommending treatment. School staff are neither qualified to evaluate existing research nor clinically trained. Therefore, they cannot judge the appropriateness of, for example, socially transitioning children. It is an intervention with poorly understood outcomes that affects children's psychological development and potentially every aspect of their physical health.

Please advocate for a cautious approach that safeguards the health of children – whose decision making capacity does not mature until the age of 25 -- while we gather information to determine the causes and consequences of this complex issue.

Yours sincerely,

Jill Harris
341 Laurel Grove Rd.
Middletown, CT 06457

From: [Herman Vukusic](#)
To: [Vazquez, Paul](#)
Subject: Gender health care (!)
Date: Monday, September 19, 2022 6:40:14 AM

You don't often get email from hvukusic.66@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Mr. Vazquez,

regarding the international call for experiences that can help Florida medical board reach adequate decision regarding gender transition and health care of transgender people, I'm sending You some charts that depict sudden rise of gender dysphoria in Croatian adolescents.

The data shown on charts represents rapid rise of gender dysphoria in the sample of 587 children and adolescents (336 males and 251 females) during the seven years period.

Red line on the first chart are boys and on the second are girls.

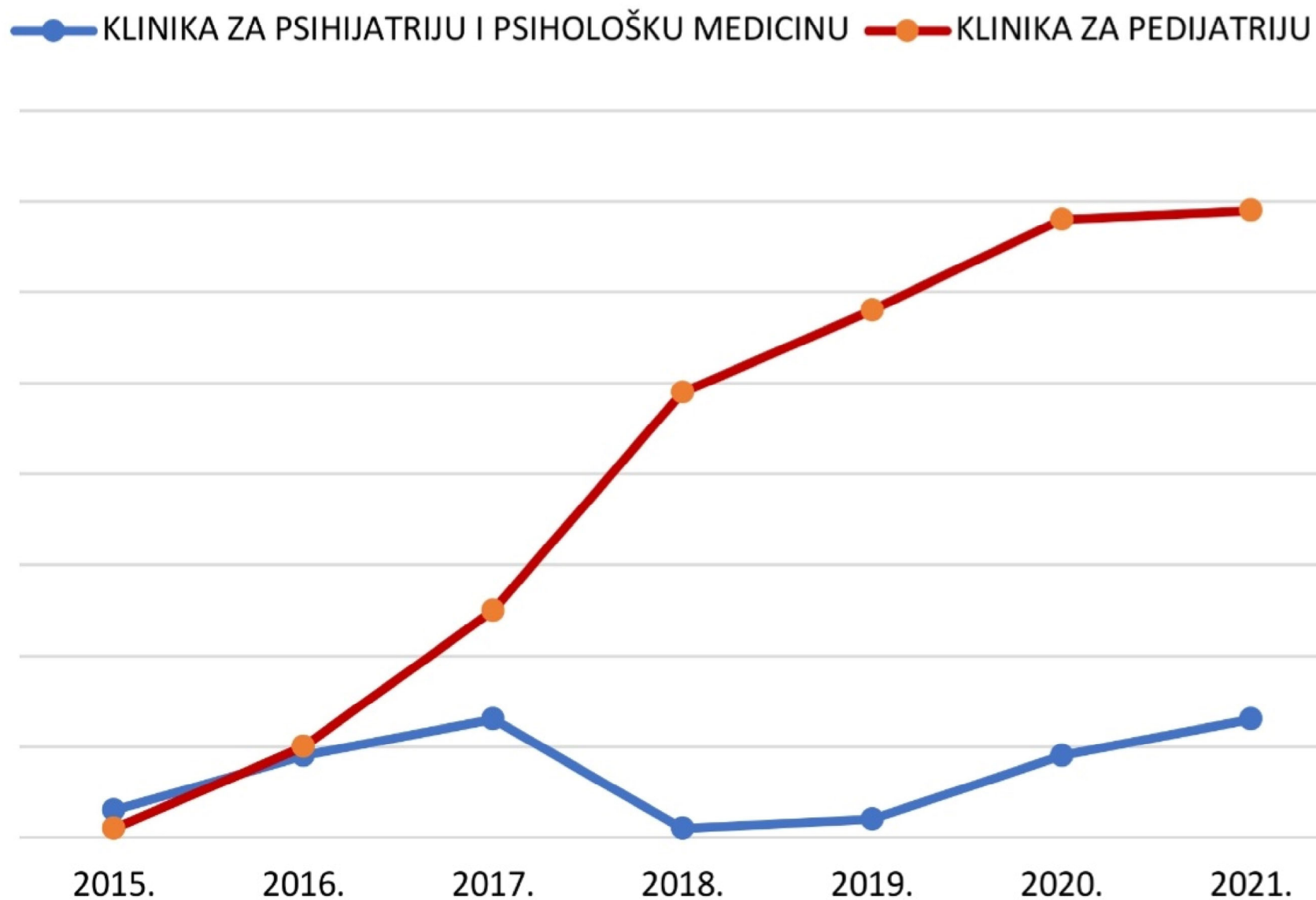
Our national psychiatric association cannot explain this rise in any other way than social contagion, despite the voracious pressure from the trans activists to regard this phenomenon as a result of more liberated social climate.

This is a very serious issue that we here in Croatia are starting to address in terms of follow up studies of children with GD who entered the process of transition, and I will be available to You for our future findings.

Cordially Yours.

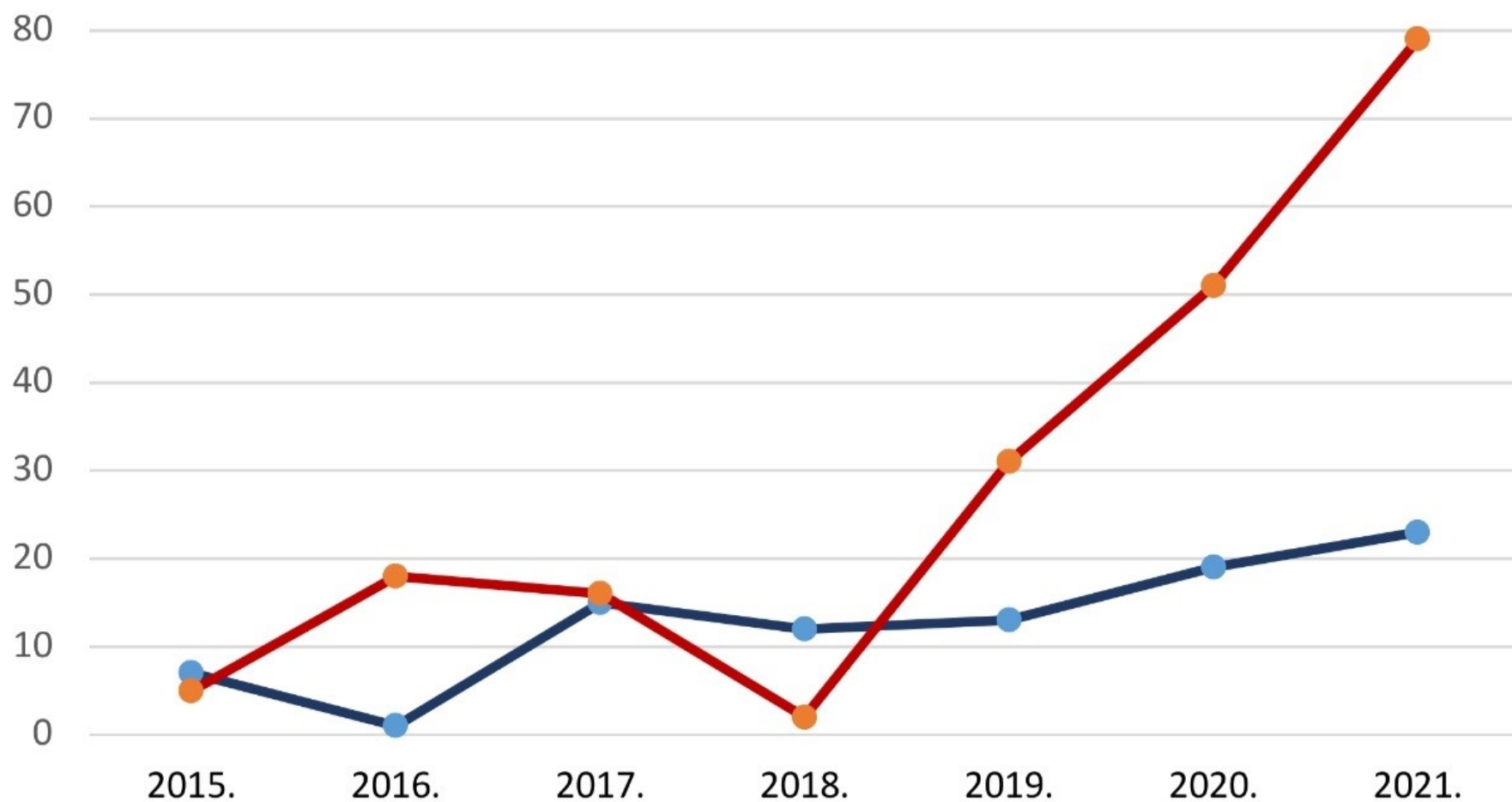
Herman Vukusic, MD, psychiatrist
University Clinical Centre Zagreb - Croatia

Dinamika dijagnoza muških pacijenata 2015-2021.



Dinamika dijagnoza ženskih pacijenata 2015-2021.

KLINIKA ZA PSIHIJATRIJU I PSIHOLOŠKU MEDICINU KLINIKA ZA PEDIJATRIJU



From: [Private](#)
To: [zzzz Feedback, BOM MeetingMaterials](#); paul.Vazquez@flhealth.gove
Subject: Letter to the Florida Board of Medicine re gender affirming care
Date: Sunday, September 18, 2022 10:22:53 PM

You don't often get email from joselynbaker9@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,

Thank you for taking up the vital question of regulating the so-called "gender-affirming" hormones and surgeries for young people.

As parents of these children, we have seen some very well-meaning but misinformed doctors recommend these radical life-changing interventions sometimes on the first or second visit. The myth that our children are getting "assessments" is propagated widely, but no requirements have ever been clearly articulated about which child or young person distressed with their gender role will benefit vs will be harmed. This intervention sterilizes 100% of children if administered according to the Endocrine Society's recommendations.

Older adolescents can get hormones with no assessments at all, and have their healthy body parts amputated by eager surgeons on little more than self-declaration of "trans identity." Many of our children are gay and autistic. Many of these kids also have other Mental Health comorbidities, and have come to believe their very real distress is explained by the fact that they are "transgender" and that hormones and surgeries will help. They do not. We have seen our children's mental and physical health plummet following "gender-affirmation." We need a more nuanced and holistic approach to help them, instead of the irreversible treatments from gender-affirmation that sets them down the path of lifelong medication. Minors cannot provide informed consent to irreversible and unknown harms from gender-affirmative medical treatment. Their brain is not fully developed yet to comprehend the longer term risk from the so-called affirmative-treatment that interfere with their growth, sexual development, fertility and multi-system

We also encourage you to require exploratory psychotherapy and to issue a clear statement that psychotherapy for gender dysphoria is not conversion. Our children and families need safe non-invasive alternatives to radical experimentation known as "gender affirmation." The Florida Board of Medicine must use its authority to protect children and adolescents from misinformed and dangerous actions, and must allow its members to render evidence-based professional care.

Thank you for doing what you can to regulate this experiment on our vulnerable children.

rgds

Joselyn

From: [John Coppes](#)
To: [Vazquez, Paul](#); jeff.barrows@ethicalhealthcare.org
Subject: gender dysphoria
Date: Monday, September 19, 2022 12:14:35 PM

You don't often get email from jbc615@gmail.com. [Learn why this is important](#)

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Dear Mr Vazquez,

I am a retired obstetrician/gynecologist with more than 40 years of practice and experience as a medical school faculty member and I am writing to speak against the treatment of minors with medications or surgery that change the individual's birth gender. I feel strongly that there is insufficient evidence for this radical treatment. I think that mental health evaluation would be a more logical beginning of evaluation rather than jumping to changing gender. I do not say this out of a homophobic mindset, but I believe it is just bad medicine.

Also I do not believe that minors have the capability to fully understand the ramifications of using experimental drugs or surgery to make truly informed decisions.

Thank you for considering my opinion.

Yours truly,

John Coppes, MD MPH

From: alexismaestresaborit@yahoo.com on behalf of [Alexis Maestre-Saborit](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject Efforts to End Gender-Affirming Care for Transgender Youth.
Date: Friday, August 26, 2022 9:11:22 AM

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Dear Florida Board of Medicine

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Care providers, doctors, and leading medical associations have been clear that gender-affirming care is safe, effective, and evidence-based, and that it's literally lifesaving.

The issued guidance by the Dept. of Health and the studies used by this board are inaccurate and dangerous. This guidance is nothing more than another tool for the Governor to express his opposition to transgender individuals' existence.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people, including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

The Board must provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

I urge you to reject this proposal.

Sincerely,

Alexis Maestre-Saborit

From: [Robert Post](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Practice of gender medicine in Florida
Date: Monday, September 19, 2022 12:03:54 PM

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I am writing to the board to support a slow and cautious approach in the area of gender medicine, particularly in regards to the use of hormonal and surgical therapy. The push for Gender Affirming Therapy is based on a new paradigm rooted in the assumption that gender dysphoria is innate, but a review of the current literature suggests that this claim is founded upon unscientific gender ideology and lacks evidence base.

We are in an era where the current trend is to only practice evidence-based medicine. We should not abandon this approach because the topic is emotionally charged.

1) No Evidence that Transgender Interventions are Safe for Children

There is not a single long-term study to demonstrate the safety or efficacy of puberty blockers, cross-sex hormones and surgeries for transgender-believing youth. This means that youth transition is experimental, and therefore, parents cannot provide informed consent, nor can minors provide consent for these interventions. Moreover, the best long-term evidence we have among adults shows that medical intervention fails to reduce suicide.

a) Puberty blockers may cause mental illness

Puberty blockers may actually cause depression and other emotional disturbances related to suicide. In fact the package insert for Lupron, the number one prescribed puberty blocker in America, lists “emotional instability” as a side effect and warns prescribers to “Monitor for development or worsening of psychiatric symptoms during treatment”. Similarly, discussing an experimental trial of puberty blockers in the U.K., Oxford University Professor Michael Biggs wrote, “There was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on (puberty blockers) children reported greater self-harm, and the girls also experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria”.

b) Puberty blockers may cause permanent physical harm

Temporary use of Lupron has also been associated with and may be the cause of many serious permanent side effects including osteoporosis, mood disorders, seizures, cognitive impairment and, when combined with cross-sex hormones, sterility.

c) Surgical interventions: physically healthy transgender-believing girls are being given double mastectomies at 13 and hysterectomies at 16, while their male counterparts are referred for surgical castration and penectomies at 16 and 17. This is particularly worrisome in that many studies show that those who have transitioned, will change their minds and detransition years later, up to 85% of the time.

2) The Myth about Suicide and Gender Dysphoric Children

Why would parents allow a gender-confused child to undergo these dangerous medical interventions? In many cases the answer is untruths and emotional blackmail. “If you don’t let me do this, I’ll kill myself,” they hear from their child. The threat of suicide is then reinforced by members of the transgender industry: “Would you rather have a live son or a dead daughter?” There is no long-term evidence that puberty-blockers, cross-sex hormones or “transition” surgeries prevent suicide. On the contrary, the best long-term

research shows that individuals who do go through medical transition kill themselves at a rate 19 times greater than the general population.

Swedish child and adolescent psychiatrist Sven Roman sums up the research: “There is currently no scientific support for gender-corrective treatment to reduce the risk of suicide”.
(//twitter.com/will_malone/status/1187082564458160131).

Psychologist Dr. Michael Bailey (Northwestern University) and Dr. Ray Blanchard (University of Toronto) agree: “The best scientific evidence suggests that gender transition is not necessary to prevent suicide... There is no persuasive evidence that gender transition reduces gender dysphoric children’s likelihood of killing themselves.” (//4thwavenow.com/2017/09/08/suicide-or-transition-the-only-options-for-gender-dysphoric-kids/;))

Many medical organizations around the world, including the Australian College of Physicians, the Royal College of General Practitioners in the United Kingdom, and the Swedish National Council for Medical Ethics have characterized these interventions in children as experimental and dangerous.

Thank you for your consideration,

R. Paul Post, MD, FAAFP
American Academy of Medical Ethics

From: [Karen Thompson](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: To Paul A Vazquez, J.D
Date: Saturday, September 17, 2022 8:03:58 PM

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To Paul A Vazquez, J.D
Executive Director
Florida Medical Board

Dear Mr. Vazquez,

I write to ask that you consider the significant and irreversible damage of “gender affirming care” when applied to young people who are (developmentally appropriately) exploring their identities. Medicalisation of a gender identity, fixes that identity by sterilisation. I do not believe this abides in any way with the medical profession’s oath to “Do No Harm”.

I am a parent of a young man (18 years) who currently identifies as a woman and was prescribed progesterone and estrogen after two appointments with a GP he had never met before. My son was NOT DISTRESSED but he was convinced by social media, gender questioning friends and the cultural messages at large that if he doesn’t fit male stereotypes of our society, he must in fact be female and that he must medically transition. Of course, as adults we know that the way we feel about ourselves and the way we see the world changes dramatically from our views as eighteen year olds. When my son one day falls in love (he never has) or wants to have children (he says he doesn’t- again, developmentally appropriate) the choice to have a healthy intimate relationship or biological children will be gone.

I am also a practicing pharmacist and am concerned and alarmed at the lack of evidence for the benefit of medicalisation and horrified at what seems to be ignorance of significant other risks.

Young people requesting medical and surgical changes to their bodies that will sterilise them and fix them irreversibly, into an identity that should just be part of normal transient identity exploration should be given reassurance and psychological support if needed. Not experimental, irreversible, sterilising medical treatment. I ask you and the Board to be guided to Do No Harm where the risk of no medication is minimal and the risk of gender-affirming medicine is potentially catastrophic in young adults.

Regards,

Karen Thompson
Parent and Pharmacist

Sent from my iPhone

From: [Janice Neyer](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: No gender affirming care for minors
Date: Tuesday, September 20, 2022 2:02:46 PM

You don't often get email from janice.neyer@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

I am writing to comment on this purposed gender affirming care for minors. This nothing short of legal child abuse for CONFUSED children! Please let common sense prevail. The emotional state of children is what is fluid not a child's gender. Given time and space the child with gender confusion will affirm the gender given to him at birth.
And they will thank you for NOT giving in to this child manipulation!

Sincerely

Janice Neyer

704 962 2093

7881 Lake Sawgrass Loop

Ft. Myers FL 23907

September 19, 2022

To the Florida Board of Medicine,

In less than a decade, there has been a sharp rise in young people presenting with gender dysphoria (GD). The Transgender ideology threatens already at-risk sexual minority youth with experimental and unproven hormonal and surgical gender-affirming therapy [GAT]. GAT permanently and prematurely medicalizes children for a condition that overwhelmingly resolves by adulthood. GAT is not proven effective, not proven safe, does not reduce suicides, and is not the international standard of care for gender dysphoric minors.

The Natural History of Gender Dysphoria in Minors is Acceptance of Sex Assigned at Birth

It resolves on its own in 75-95% by adulthood.¹⁻⁵ Why medicalize children for life for a psychological process that usually resolves?⁶⁻⁸ These children and their families will often require counseling in the interim.

Comorbidities.

The overwhelming majority of youth with gender dysphoria have one, and likely more, additional mental health conditions, autism spectrum, adverse childhood events, and family issues that pre-date their gender incongruence.⁹⁻¹¹ These issues need counseling, not harmful hormones and mutilating surgery of healthy sexual organs.

Minors Cannot Give Truly Informed Consent.¹²

Children have developing brains, their minds change often, and they don't grasp long-term consequences.¹³⁻¹⁵

- Thus ruled the UK High Court in Bell vs. Tavistock in 2020.¹⁶
- Likewise the Swedish Pediatric Society and the Swedish National Council for Medical Ethics in 2019.¹⁷

There is No Medical Proof of the Long-Term Benefits or Safety of Hormonal Therapy or Surgical Transitioning.

- WPATH Standards of Care concurs.¹⁸
- The 2017 Endocrine Society Guidelines admit that GAT is only supported by "low" or "very low" evidence.¹⁹
- The UK's High Court in Bell vs. Tavistock (2020) ruled that GAT in minors was experimental, unproven and could not, in most cases, be given to minors under 16 without court order, and advised the same under 18.²⁰

Puberty Blockers chemically castrate both sexes at the level of the brain.²¹

- The puberty blocker Lupron's package insert warns of mood swings, depression, suicidal ideation and attempts.
- They risk infertility by blocking the maturation of sperm and eggs.²² Following PBA with cross-sex hormones assures sterility.²³
- They compromise bone mineral density and hinder brain development.^{24 25}
- Self-harm does not improve.^{26 27}
- They rob the minor of the puberty time frame shared with peers.²⁸
- Not proven fully reversible, long-term complications possible even if PBAs stopped early.²⁹

Cross-Sex Hormones^{30 - 36}

- Estrogen use in male biology increases the risks of blood clots (3-5 fold), heart attacks (doubling), strokes (3-5 fold), breast cancer, insulin resistance and more.
- Testosterone use in female biology increased the risks of heart attacks (fourfold), strokes, breast and uterine cancer, hypertension, severe acne and more.

GAT's Suicide Reduction Claim Is a Myth, used as emotional blackmail.^{37 38}

- Psychology professors J. Bailey and R. Blanchard stated: "There is no persuasive evidence that gender transition reduces gender dysphoric children's likelihood of killing themselves."³⁸
- The Lupron (the main puberty blocker in the US) package insert warns of "mood swings, depression, rare reports of suicidal ideation and attempt..."
- A 2011 Swedish study of all their post-sex reassignment adults showed a completed suicide rate 19 times that of the general population 10 year out with nearly 3 times the rate of psychiatric inpatient care.⁴⁰
- A 2011 long-term Dutch study of cross-sex hormone therapy revealed significantly increased mortality from multiple causes including suicide.⁴¹

The international standard of care for youth with GD is watchful waiting, including psychological evaluation and support of the child and family, not gender-affirming therapy (GAT).^{42 - 44}

The medical literature, as it moves from one publication to the next, repeatedly rushes to overstate the evidence underpinning clinical practice recommendations for youth with GD.⁴⁵ To make valid clinical judgments, we need more time, unbiased studies and long-term data.

Signed,

David C. Thorrez, MD FAAP

References

1. APA Diagnostic and Statistical Manual, 5th edition, "Gender Dysphoria," p. 455.
2. APA Handbook on Sexuality and Psychology (American Psychological Association, 2014), Bockting, W. Chapter 24: Transgender Identity Development, vol. 1, p. 744.
3. Cohen-Kettenis PY, et al. "The treatment of adolescent transsexuals: changing insights." J Sex Med. 2008 Aug;5(8):1892-7.
4. "Do Trans- kids stay trans- when they grow up?" Sexologytoday.org, 11 Jan. 2016.
5. Kaltiala-Heino et al. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. Child and Adolescent Psychiatry and Mental Health (2015) 9:9.
6. S. Bewley, "Safeguarding adolescents from premature, permanent medicalisation," BMJ.com, 11 Feb. 2019.
7. MK Laidlaw, Q Van Meter, PW Hruz, A Van Mol, W Malone, "Letter to the Editor: 'Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline'." J Clin Endocrinol Metab. 2019 Mar 1;104(3):686-687.doi: 10.1210/je.2018-01925.
8. Brief of Amici Curiae, 11th Circuit Court of Appeals, Case: 18-13592, Drs. Miriam Grossman, Michael Laidlaw, Quentin Van Meter, and Andre Van Mol in Support of Defendant-Appellant School Board of ST. Johns County, Florida.
9. Zucker, KJ, et al. Gender Dysphoria in Adults. Annu. Rev. Clin. Psychol. 2016. 12:217–47. (P. 227.)
10. Meybodi AM, Hajebi A, Jolfaei AG. The frequency of personality disorders in patients with gender identity disorder. Med J Islam Repub Iran. 2014;28:90. Published 2014 Sep 10.
11. Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. Pediatrics. 2018;141(5):e20173845
12. Stephen B. Levine (2018): Informed Consent for Transgendered Patients, J Sex Marital Ther 2019;45(3):218-229. doi: 10.1080/0092623X.2018.1518885.
13. National Institute of Mental Health (2001). Teenage Brain: A work in progress. http://www2.isu.edu/irh/projects/better_todays/B2T2VirtualPacket/BrainFunction/NIMH-Teenage%20Brain%20%20A%20Work%20in%20Progress.pdf.
14. Pustilnik AC, and Henry LM. Adolescent Medical Decision Making and the Law of the Horse. Journal of Health Care Law and Policy 2012; 15:1-14. (U of Maryland Legal Studies Research Paper 2013-14).
15. Stringer, H. (Oct. 2017) Justice for teens, APA Monitor on Psychology, pp. 44-49. <http://www.apamonitor.org/apamonitor/201710/MobilePagedArticle.action?articleId=1169604&app=false#articleId1169604>
16. <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>
17. <http://www.barnlakarforeningen.se/2019/05/02/blf-staller-sig-bakom-smers-skrivelse-angaende-konsdysfori/>

18. WPATH Standards of Care, pp. 47, available at http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351.
19. Hembree, W., Cohen-Kettenis, et al., (2017) Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*,102:1–35.
20. <https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>
21. Lupron Depot-Ped Injection Label (August 2012) at 12.1 “Mechanism of Action” https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/020263s036lbl.pdf.
22. Michael K. Laidlaw, Quentin L. Van Meter, Paul W. Hruz, Andre Van Mol, Same as 7 above.
23. Howard E. Kulin, et al., “The Onset of Sperm Production in Pubertal Boys. Relationship to Gonadotropin Excretion,” *American Journal of Diseases in Children* 143, no. 2 (March, 1989): 190-193, <https://www.ncbi.nlm.nih.gov/pubmed/2492750>.
24. Polly Carmichael, Gary Butler, et al.. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. medRxiv 2020.12.01.20241653; doi:<https://doi.org/10.1101/2020.12.01.20241653>
25. Faubion SS, Kuhle CL, Shuster LT, Rocca WA. Long-term health consequences of premature or early menopause and considerations for management. *Climacteric*. 2015;18(4):483–491. doi:10.3109/13697137.2015.1020484.
26. Michael Biggs, The Tavistock’s Experiment with Puberty Blockers, 29 July 2019, http://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf
27. Polly Carmichael, Gary Butler, et al.. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. medRxiv 2020.12.01.20241653; doi:<https://doi.org/10.1101/2020.12.01.20241653>
28. Hruz, P. W. (2020). Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *The Linacre Quarterly*, 87(1), 34–42. <https://doi.org/10.1177/0024363919873762>
29. Gallagher, Jenny Sadler et al. Long-Term Effects of Gonadotropin-Releasing Hormone Agonist and Add-Back in Adolescent Endometriosis. *Journal of Pediatric and Adolescent Gynecology*, Volume 31, Issue 2, 190. (2018)
30. Alzahrani, Talal, et al. “Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population.” *Circulation: Cardiovascular Quality and Outcomes*, vol. 12, no. 4, 2019, doi:10.1161/circoutcomes.119.005597.
31. Getahun D, Nash R, Flanders WD, Baird TC, Becerra-Culqui TA, Cromwell L, et al. Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. [Epub ahead of print 10 July 2018]169:205–213.doi: 10.7326/M17-2785.
32. Irwig MS. Cardiovascular Health in Transgender People. *Rev Endocr Metab Disord*. 2018 Aug 3 epub.
33. Nota NM, et al. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*, 139(11), 2019, pp. 1461-1462.

34. Getahun D, Nash R, Flanders WD, et al. Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med* 2018; 169(4): 205-13. doi: 10.7326/M17-2785.
35. *Journal of Clinical & Translational Endocrinology* 21 (2020) 100230
36. *Diabetes Care* 2020 Feb; 43(2): 411-417; *World J Diabetes*. 2020 Mar 15; 11(3): 66–77.
37. Sadjadi, Sahar. “The Endocrinologist’s Office—Puberty Suppression: Saving Children from a Natural Disaster?” *Journal of Medical Humanities*, vol. 34, no. 2, 2013, pp. 255–260., doi:10.1007/s10912-013-9228-6.
38. Limentani A. The significance of transsexualism in relation to some basic psychoanalytic concepts. *International Review of Psycho-Analysis* 1979; 6: 139-53.
39. J. Michael Bailey and Ray Blanchard, “Suicide or transition: The only options for gender dysphoric kids?” *4thwavenow.com*, Sept. 8, 2017. <https://4thwavenow.com/2017/09/08/suicide-or-transition-the-only-options-for-gender-dysphoric-kids/>
40. Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Langstrom N, et al. (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS ONE* 6(2): e16885
41. Asscheman H, Giltay EJ, Jos A J Megens, W (Pim) de Ronde, Michael A van Trotsenburg, Louis J G Gooren. A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology*. 2011;164:635-642.
42. James M. Cantor (2019): Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy, *Journal of Sex & Marital Therapy*, DOI: 10.1080/0092623X.2019.1698481
43. de Vries, A. L., and P. T. Cohen-Kettenis. 2012. Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality* 59(3): 301-320, DOI: 10.1080/00918369.2012.653300
44. Michael Laidlaw, Michelle Cretella & Kevin Donovan (2019) The Right to Best Care for Children Does Not Include the Right to Medical Transition, *The American Journal of Bioethics*, 19:2, 75-77, DOI: 10.1080/15265161.2018.1557288
45. Clayton A, Malone WJ, Clarke P, Mason J, S’Angelo R 2022 Commentary: The Signal and the Noise – questioning the benefits of puberty blockers for youth with gender dysphoria – a commentary on Rew et al (2021) *Child and Adolescent Mental Health* 27, No 3, 2022, pp. 259-262

From: [hilesca hidalgo](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Medical transition of children
Date: Tuesday, September 20, 2022 7:19:47 PM
Attachments: [Hilesca Board of Medicine.docx](#)

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9/20/2022

Dear. Dr. Vazquez and board members,

I am a primary care provider and a mother of two beautiful girls ages 15 and 13. My 13 yr. old teen experienced trauma at her school in 6th and 7th grade. My daughter had a friend group that bullied her and dumped her. She found herself lonely and vulnerable and started to hang out with some girls that identified as transgender. My daughter noticed one of the transgender girls was self-harming/cutting herself. My daughter was so scared that her friend was going to hurt herself that she went to the school counselor to report it. This was in September 2021, when we finally met with the parents in March 2022, they told me they never received a call from the school counselor regarding their daughter's mental health state, they had no idea that their daughter had been socially transition in school, had a confidential transgender plan with new name and pronouns, and was even using opposite sex bathrooms. The school counselor is a mandatory reporter, but he did not notify that child's parents child of their daughter's mental illness and self-harming behavior. I had no idea my daughter's school was confusing children and affirming trans kids in 6th and 7th grade! I had no idea the school was teaching them about gender ideology and the gingerbread man. I think COVID in a way was a blessing in disguise, and I'm grateful for what COVID exposed. My daughter has been captured by an ideology based on lies thanks to Pasco County public school system, she can't even define what a woman is or means.

As a PCP, I immediately started to do more research and digging in, the more I looked, the more I found out about the damage we are doing to vulnerable children, teens, and young adults. Does the medical board of medicine know that there has been a sharp increase in teens suddenly thinking they are born in the wrong body and transgender. Comorbidities such as high functioning autism, eating disorders, ADHD, anxiety, and depression are seen in these kids, yet mental health is being neglected and most of my medical professionals' peers are only seeing this issue through an affirmation-only lens. As a provider I do a thorough history, lab work, imaging, and good physical exam on all my patients, I carefully come up with differential diagnoses, as I work towards a care plan. At no point in time do I allow my patients to dictate to me, self-diagnose and tell me what I should prescribe or how I should proceed. In the past few months, I have received too many calls from teens asking me if I can prescribe the wrong sex hormones, mostly testosterone for girls. My ethics, moral convictions of doing no harm, plus logic, do not allow me to harm children, teens, and young adults by prescribing wrong sex hormones and allowing them to continue to live in an alternate reality that only exists in their minds. The most popular medical services I offer in my primary care practice are weight loss and hormone optimization. If an anorexic or bulimic patient comes to me requesting weight loss services, should I prescribe phentermine, Saxenda or Semaglutide? According to the rationale we follow with transgenderism I should be prescribing weight loss medication to anorexics and bulimics regardless of their BMIs and their mental illness comorbidities. Will I risk a malpractice lawsuit or sanctions from the board of medicine if I do that?

Florida Board of Medicine it's time to act now. Parents no longer know how to protect their children; all guardrails and safeguarding have been removed. You hold the key to this problem and the future of our children rests in your hands, don't let this bloodbath of mutilated body parts stain your morals. Like many other parents, I had no choice but to remove both my kids from public

school in an effort to shield them from these lies. As a primary care provider, I've seen how this ideology is breaking families apart, and stealing our kids, not only all over Florida but worldwide. How many more children must we sacrifice? How many kids must we leave infertile? How many teen boys will we castrate? How many young girls' breasts will we cut off? How many failed vaginoplasty or phalloplasty are we willing to perform on minors? Healthcare disgusts me, I'm ashamed to be living during these times and be a part of this medical atrocity, even though I refuse to participate. What happened that all major professional organizations that have sold their souls and ethics to affirm this madness and delusion? How do people that do this great harm sleep at night? Please don't be one of those! Florida must lead by example.

I beg you to make a rule that will prevent doctors and nurse practitioners from being able to prescribe experimental puberty blockers, wrong sex hormones and perform any type of gender-affirming surgeries such as double mastectomies, breast augmentation, vaginoplasty, or phalloplasty on minors.

There is a lack of high-quality rigorous evidence-base surrounding this medical treatment and procedures, which makes them experimental in nature since the long-term consequences of these drugs being used on children/teens are relatively unknown. The Cass review just demonstrated the affirmation model is being rushed and does not work, and a more watchful waiting approach must be taken. There is also a lack of debate, or willingness to talk among medical professionals in this area because practitioners that speak out against these treatments being used on children are canceled. Alternate treatment options, such as mental health, are not being considered or even presented at this point in medicine. As I learned quickly from personal experience, sadly we can't even find mental health for kids, as this typically ends up in more affirmation and complete disregard of comorbidities. It is crystal clear to me that activism has not only infiltrated our medical community, but it has captured most medical professionals on this issue and biological reality is being ignored. The side effects we are aware of oftentimes lead to the sterilization of these individuals and the loss of any future sexual function when puberty blockers are used.

- Children and teen brains are not fully developed until age 25 and therefore they cannot give informed consent because they don't have the ability to fully understand the consequences of these treatments. Parents are also not being given the full picture and all treatment options available to them like the watchful waiting approach. They are being told to only affirm or their child will commit suicide. They are also not told that through the watchful waiting treatment approach, many of these children, upwards of 80%) would resolve their distress during or shortly after puberty.

- Proper assessments are not being done and there is little to no safeguarding in place before a child is placed on a medical pathway. Many of this new cohort of children/teens do not even meet the criteria for gender dysphoria, yet they are being treated medically for the "feeling" in their mind that they should be of the opposite sex. They are experiencing normal discomfort with their pubescent body, but are being convinced that any amount of discomfort with their body is an indication that they are "transgender." There is currently no coherent definition of the word transgender in the medical field.

- Co-morbid issues are being unchecked and unresolved in the name of gender-affirming care and patients and parents are being told that medical transitioning will fix their child's distress.

- We are now seeing the population of detransitioners increase every day because they come to the realization that medical transitioning did not fix their pain and many are stating their co-occurring mental health issues were ignored or not explored. Who is going to clean up this mess? The AMA? The APA?

- Medical organizations and associations are blindly adopting guidelines from WPATH without doing a proper review of the evidence being used for these guidelines. These guidelines are being pushed as actual standards of care, which is a gross misrepresentation of what these guidelines are. Further, professionals that are speaking out against these guidelines or advocating for a review of the existing literature are silenced through gaslighting or simply ignored as in the case of the American Academy of Pediatrics.

- Other countries like the UK, Sweden, Finland, and France are re-evaluating these medical treatments for children because they have done a rigorous review of existing literature and research and have come to the conclusion that the risks do not outweigh the benefits for children and their is just so much we don't know about the long-term consequences of these irreversible interventions.

The Tavistock Clinic just recently closed and is expected to see many lawsuits. These countries have either stopped medical transitioning minors or are advocating for great caution when medically treating children for gender dysphoria. They are all stating mental health treatment should be the first line of defense, which is not currently happening in the US.

- Despite what the media reports, these surgeries are occurring in children. Many hospitals state openly they are performing double mastectomies on children ages 16 and up and sometimes as young as 15, as stated in the new WPATH guidelines that were set to be released this month. In addition to the pediatric gender clinics in Florida hospitals providing these medical interventions, there are many private plastic surgeons, OBGYN offices, private endocrinologist offices, and pediatricians prescribing puberty blockers, and cross-sex hormones, and operating on minors. They claim parents give consent, but should a parent be allowed to consent to experimental medical treatments for their child for a mental health issue? Should parents be able to consent to amputating healthy body parts for their children and taking away their fertility and ability to have a child as an adult?

Florida Board of Medicine, please as a parent and a family primary care provider, I implore you to please make a rule that will protect our children from these experimental treatments and surgeries and advocate for ethical, evidence-based, and compassionate treatment of these individuals. Allow children to receive mental health services that allow for the exploration of root causes. There is no test for "transgenderism." There is no test to see which child will desist and which will persist. There is no test that will tell us which child will regret these irreversible treatments and which will not. I invite you to sit for a few hours and watch or listen to detransitioners stories, Florida must do better!

Sincerely,

Hilesca Hidalgo

9/20/2022

Dear. Dr. Vazquez and board members,

I am a primary care provider and a mother of two beautiful girls ages 15 and 13. My 13 yr. old teen experienced trauma at her school on 6th and 7th grade. My daughter had a friend group that bullied her and dumped her. She found herself lonely and vulnerable and started to hang out with some girls that identified as transgender. My daughter noticed one of the transgender girls was self-harming/cutting herself. My daughter was so scared that her friend was going to hurt herself that she went to the school counselor to reported it. This was in September 2021, when we finally met with the parents in March 2022, they told me they never received a call from the school counselor regarding their daughters' mental health state, they had no idea that their daughter had been socially transition in school, had a confidential transgender plan with new name and pronouns, and was even using opposite sex bathrooms. The school counselor is a mandatory reporter, but he did not notify that child's parents child of their daughter's mental illness and self-harming behavior. I had no idea my daughter's school was confusing children and affirming trans kids in 6th and 7th grade! I had no idea the school was teaching them about gender ideology and the gingerbread man. I think COVID in a way was a blessing in disguise, and I'm grateful for what COVID exposed. My daughter has been captured by an ideology based on lies thanks to Pasco County public school system, she can't even define what a woman is or means.

As a PCP, I immediately started to do more research and digging in, the more I looked, the more I found out of the damage we are doing to vulnerable children, teens and young adults. Does the medical board of medicine know that there has been a sharp increase in teens suddenly thinking they are born in the wrong body and transgender. Comorbidities as high functioning autism, eating disorders, ADHD, anxiety and depression are seen on these kids, yet mental health is being neglected and most of my medical professionals' peers are only seeing this issue through an affirmation only lens. As a provider I do a thorough history, lab work, imaging and good physical exam in all my patients, I carefully come up with differential diagnosis, as I work towards a care plan. At no point in time do I allow my patients to dictate to me, self-diagnose and tell me what I should prescribe or how I should proceed. In the past few months, I have received too many calls from teens asking me if I can prescribe wrong sex hormones, mostly testosterone for girls. My ethics, moral convictions of do no harm, plus logic, do not allow me to harm children, teens and young adults by prescribing wrong sex hormones and allowing them to continue to live in an alternate reality that only exist in their minds. The most popular medical services I offer in my primary care practice are weight loss and hormone optimization. If an anorexic or bulimic patient comes to me requesting weight loss services, should I prescribe phentermine, Saxenda or Semaglutide? According to the rationale we follow with transgenderism I should be prescribing weight loss medication to anorexics and bulimics regardless of their BMI's and their mental illness comorbidities. Will I risk a malpractice lawsuit or sanctions from the board of medicine if I do that?

Florida Board of Medicine its time to act now. Parents no longer know how to protect their children; all guardrails and safeguarding has been removed. You hold the key to this problem and the future of our children rest in your hands, don't let this bloodbath of mutilated body parts stain your morals. Like many other parents, I had no choice but to remove both my kids from public

school in an effort to shield them from these lies. As a primary care provider, I've seen how this ideology is breaking families apart, stealing our kids, not only all over Florida, but worldwide. How many more children must we sacrifice? How many kids must we leave infertile? How many teens boys will we castrate? How many young girls' breasts will we cut off? How many failed vaginoplasty or phalloplasty are we willing to perform on minors? Healthcare disgusts me, I'm ashamed to be living during these times and be a part of this medical atrocity, even though I refuse to participate. What happened that all major professional organizations that have sold their souls and ethics to affirm this madness and delusion? How do people that do this great harm sleep at night? Please don't be one of those!

I beg you to make a rule that will prevent doctors and nurse practitioner from being able to prescribe experimental puberty blockers, wrong sex hormones and perform any type of gender affirming surgeries such as double mastectomies, breast augmentation, vaginoplasty or phalloplasty on minors.

There is a lack of high-quality rigorous evidence-base surrounding these medical treatment and procedures, which make them experimental in nature since the long-term consequences of these drugs being used on children/teens are relatively unknown. The Cass review just demonstrated the affirmation model is being rushed and does not work, and a more watchful waiting approach must be taken. There is also a lack of debate, or willingness to talk among medical professionals in this area because practitioners that speak out against these treatments being used on children are cancelled. Alternate treatment options, such as mental health, are not being considered or even presented at this point in medicine. As I learned quickly from personal experience, sadly we can't even find mental health for kids, as this typically ends up in more affirmation and complete disregard of comorbidities. It is crystal clear to me that activism has not only infiltrated our medical community, but it has captured most medical professionals on this issue and biological reality is being ignored. The side effects we are aware of often times lead to the sterilization of these individuals and the loss of any future sexual function when puberty blockers are used.

- Children and teen brains are not fully developed until age 25 and therefore they cannot give informed consent because they don't have the ability to fully understand the consequences of these treatments. Parents are also not being given the full picture and all treatment options available to them like the watchful waiting approach. They are being told to only affirm or their child will commit suicide. They are also not told that through the watchful waiting treatment approach, many of these children, upwards of 80%) would resolve their distress during or shortly after puberty.
- Proper assessments are not being done and there is little to no safeguarding in place before a child is placed on a medical pathway. Many of this new cohort of children/teens do not even meet criteria for gender dysphoria, yet they are being treated medically for the "feeling" in their mind that they should be the opposite sex. They are experiencing normal discomfort with their pubescent body, but are being convinced that any amount of discomfort with their body is an indication that they are "transgender." There is currently no coherent definition of the word transgender in the medical field.
- Co-morbid issues are being unchecked and unresolved in the name of gender affirming care and patients and parents are being told that medical transitioning will fix their child's distress.

- We are now seeing the population of detransitioners increase every day because they come to the realization that medical transitioning did not fix their pain and many are stating their co-occurring mental health issues were ignored or not explored. Who is going to clean up this mess? The AMA? The APA?
- Medical organizations and associations are blindly adopting guidelines from WPATH without doing a proper review of the evidence being used for these guidelines. These guidelines are being pushed as actual standards of care, which is a gross misrepresentation of what these guidelines are. Further, professionals that are speaking out against these guidelines or advocating for a review of existing literature are silenced through gaslighting or simply ignored as in the case of the American Academy of Pediatrics.
- Other countries like the UK, Sweden, Finland and France are re-evaluating these medical treatments for children because they have done a rigorous review of existing literature and research and have come to the conclusion that the risks do not outweigh the benefits in children and there is just so much we don't know about the long-term consequences of these irreversible interventions. The Tavistock Clinic just recently closed and is expected to see many lawsuits. These countries have either stopped medical transitioning minors or are advocating for great caution when medically treating children for gender dysphoria. They are all stating mental health treatment should be the first line of defense, which is not currently happening in the US.
- Despite what the media reports, these surgeries are occurring on children. Many hospitals state openly they are performing double mastectomies on children ages 16 and up and sometimes as young as 15, as stated in the new WPATH guidelines that were set to be released this month. In addition to the pediatric gender clinics in Florida hospitals providing these medical interventions, there are many private plastic surgeons, OBGYN offices, private endocrinologist offices and pediatricians prescribing puberty blockers, cross sex hormones and operating on minors. They claim parents give consent, but should a parent be allowed to consent to experimental medical treatments for their child for a mental health issue? Should parents be able to consent to amputating healthy body parts for their children and taking away their fertility and ability to have a child as an adult?

Florida Board of Medicine, please as a parent and a family primary care provider, I implore you to please make a rule that will protect our children from these experimental treatments and surgeries and advocate for ethical, evidence-based and compassionate treatment of these individuals. Allow children to receive mental health services that allow for exploration of root causes. There is no test for "transgenderism." There is no test to see which child will desist and which will persist. There is no test that will tell us which child will regret these irreversible treatments and which will not. I invite you to sit for a few hours and watch or listen to detransitioners stories, Florida must do better!

Sincerely,

Hilesca Hidalgo

From: [sunny0440](#)
To: [zzzz Feedback, BOM MeetingMaterials; Vazquez, Paul](#)
Subject: Please restrict gender affirm care.
Date: Saturday, September 17, 2022 7:16:16 PM

You don't often get email from sunny0440@protonmail.com. [Learn why this is important](#)

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Dear Florida Medical Board,

As a mother of 18 years old son who suddenly declared himself a girl at age of 16. I quickly got a lesson in affirming care of gender industry. My son has always been a normal boy growing up, and at very young age, did not show any interest towards any "girlish" activities of things, as a matter fact, He did not wanted to be associated with anything girly as he has as sister. But that changed after he got online and started playing innocent online games like Minecrafts and Tetris around age 13. He himself said there are lots of older transgender woman on those platforms. He really stands no chance as he is a very impressionable young boy. Social media is one thing, but the most despicable thing is the compliant medical industries, doctors, and therapist who just rubber stamp when comes to transgender.

WPATH and the gender medical industry is a demagogue institution that needs to be exposed.

The Florida Board of Medicine must use its authority to protect children and adolescents from misinformed and dangerous actions and must allow its members to render evidence-based professional care. Minors cannot provide informed consent to irreversible and unknown harms of so-called "gender affirmative" medical treatments and surgeries. Gender confusion and body dysphoria require psychoeducation while comorbid psychopathology may require psychotherapy and psychopharmacology. "Puberty-blocking" drugs are misrepresented as "reversible pause buttons" while interfering with growth, sexual development, fertility, and multi-system functioning. The meteoric expansion of gender clinics is a preventable medical scandal in the making.

Thank you for being brave to stand up to all this.

Grace from New York.

Sent with [Proton Mail](#) secure email.

From: melissa.colbern.net
To: [Vazquez, Paul](#)
Cc: melissa.colbern.net
Subject: restrict gender affirming care of children and adolescents
Date: Monday, September 19, 2022 1:11:28 PM

You don't often get email from melissa@colbern.net. [Learn why this is important](#)

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Dear Paul,

Please accept my recommendations for Florida Board of Medicine to restrict “gender-affirming care”, including rapid gender transition for children and adolescents. The long-term harm of these interventions is clear. Please protect the youth of your state from unnecessary and lifelong harm.

Sincerely,

Melissa Colbern

Melissa Colbern M.D.
melissa@colbern.net

From: [M Baum](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Re: Florida - holistic mental wellbeing support for trans-identified children and youth
Date: Monday, September 19, 2022 12:01:03 PM

Some people who received this message don't often get email from dmbauminen@gmail.com.
[Learn why this is important](#)

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Dear Sir,

I add as well the Board - by the email added to the To line.

Thank you for your attention and hearing my comment, below.

MB

On Mon, Sep 19, 2022 at 11:55 AM M Baum <dmbauminen@gmail.com> wrote:

Dear Mr. Vazquez,

We are an American family living in Canada, and closely following developments in the USA and beyond, regarding the care and treatment for children and youth who identify as transgender, nonbinary, or otherwise are questioning their gender and are distressed by their birth sex.

Our family is deeply impacted by this with one of our children now trans-identified and fixated on hormones and surgery. We have become aware that such "options" are risky, experimental, not evidence-based for youth, and, become a highly promoted pathway at the cost of evaluation and care that is holistic, exploratory, and considers the whole child and their mental and physical needs.

Here in Canada we were fortunate to find an evidence-based, open minded, non activist-driven therapist to help our child, but we know others in the USA and Canada are not as able to do this. Their children - like our own - are constantly told by adults in their lives, who may mean well, and online fora, that they must just go to a gender clinic to get testosterone / "HRT" and, as fast as possible, surgery. They believe despite no evidence in respect of this cohort of recently identified gender questioning youth whose #s are exponentially growing, that this will solve all the challenges they face.

Florida is taking the right approach by - like Sweden, and France, and other jurisdictions - sensibly putting the brakes on all but clinical trials when children and youth are involved.

I share this to provide a direct experience of my own family that is informed by the research and access to holistic care that I was fortunate to be able to obtain for my child. We love and support our child and have become very aware of how much

pressure she and children like her are under in our society to seek and fixate on medical and surgical "solutions" which are euphemized as "gender affirming care".

Thank you for hearing this comment.

Marg Baum
Ontario

From: [Judith Hunter](#)
To: [Vazquez, Paul](#); [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Transgender Health Care
Date: Monday, September 19, 2022 1:54:57 AM

Some people who received this message don't often get email from judedhunter@hotmail.com.

[Learn why this is important](#)

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Dear Florida Board of Medicine

I am writing to you from Australia. I am the parent of a young woman who declared that she was transgender at the age of 17, in late 2018. She had no history of gender dysphoria. Our daughter had been mentally unwell for 3 years prior to declaring that she was transgender. Our daughter had a hospital admission at the time she said she was transgender because she said she was suicidal. As a result of this admission, the hospital staff wanted to immediately refer our daughter to a paediatric endocrinologist to start testosterone. We did not agree to the referral, however, the staff made the referral (against our wishes) and intimidated us in front of our daughter, saying "Wouldn't you rather have a live son than a dead daughter?".

Our daughter turned 18 and became estranged from us. The endocrinologist gave our daughter testosterone at the second appointment, with no analysis of her mental health history. Our daughter took testosterone for 18 months.

Our daughter moved home in January 2022 after living out of our home for 3 years. She is 21 now and regrets taking testosterone. She asked us why was she allowed to take testosterone when she was so mentally unwell. Our daughter has been left with permanent and irreversible changes from the testosterone, including a deep voice, receding hairline & male pattern baldness, facial hair growth & increased body hair, redistribution of body fat, pain & atrophy of the uterus. She hates the way she looks and has barely left her bedroom all year. She has been suicidal.

I spoke at this Genspect Webinar about what our family has been through. I am the second speaker (about 45 minutes in).

https://www.youtube.com/watch?v=tInYPMCHOzo&ab_channel=Genspect

ROGD Webinar - YouTube

On November the 20th, Genspect held a conference on Rapid Onset Gender Dysphoria, or 'ROGD'. This event united groundbreaking professionals at the heart of t...

www.youtube.com



Gender medicine is experimental and is causing irreversible and catastrophic harm to young people. It needs to be stopped.

Kind regards

Jude Hunter
NSW
Australia

From: jackie@seabornhc.com
To: [Vazquez, Paul](#); [Vazquez, Paul](#)
Subject: Trans gender
Date: Monday, September 19, 2022 9:18:51 AM

You don't often get email from jackie@seabornhc.com. [Learn why this is important](#)

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Please, Please none of this for our children, when you are an adult and want this kind of change you have the right. But children leave them alone.



Jacqueline Amadio
Seaborn Health Care Inc.,
P: (727) 398-1710 ext. 302
F: (727) 392-0321

From: [arcticocean25](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Regulation of "gender affirming care"
Date: Tuesday, September 20, 2022 2:07:45 AM

You don't often get email from arcticocean25@protonmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,

I am the parent of a gender questioning child. I understand that you are reviewing your policies on care for people questioning their gender I implore you to ensure that the current practices of uncritical "affirmation" of gender identities in children and young people (under age 25), and the use of radical, sterilizing medical and surgical interventions, be curtailed.

There is no evidence base for this, as the recent reports from your own state, from the UK (Cass report), Sweden and Finland, have shown. Authorities in Australia and France are also sounding the alarm.

The use of puberty blockers which sterilize and ruin sexual function is particularly horrible. Young adults (especially those with autism, mental illness or trauma) are also especially vulnerable as they can access these radical treatments quickly without guidance from their families.

Please visit the PITT substack for many heart rending stories of the harm being done to young people and their families.

<https://pitt.substack.com/>

I am personally seeing the harm being done to my own child by this approach. I am in Australia, where affirmation is widespread, and detransitioners are already beginning to speak out and launch court cases.

<https://www.smh.com.au/national/absolutely-devastating-woman-sues-psychiatrist-over-gender-transition-20220823-p5bbyr.html>

<https://archive.ph/PEHsV>

Cases here are skyrocketing here as well, but the gender doctors just attribute it to increased acceptance. The social contagion is obvious to families affected by this.

<https://www.abc.net.au/news/2022-03-14/takeover-young-australians-are-exploring-gender-more-than-ever/100890296>

The testimonies from many thousands of detransitioners are heart rending. This has got to stop - it is all based on a crazy ideology and SO MUCH harm is being done.

This subReddit had 23K members in March this year - now it has 38K and still rising rapidly

<https://www.reddit.com/r/detrans/>

Here are many face-to-face interviews;

<https://www.youtube.com/playlist?list=PLRdayXEOwuMFyH-mBwSdl3L2cu4VLznTf>

Thanks for your time
Anne Wilson

Sent with [Proton Mail](#) secure email.

Public consultation

Interim service specification for specialist gender dysphoria services for children and young people

20 October 2022

Contents

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Purpose of this document

NHS England is committed to working with a wide range of patients, patient groups and other stakeholders in the development of its commissioning of services. A public consultation is an opportunity to check whether proposals are right and supported, the public understand their impact, and identify any alternatives before decisions are made.

NHS England is the responsible commissioner for specialised services for individuals with gender dysphoria, and it is holding this consultation to seek views on a proposed interim service specification for services for children and young people with gender dysphoria- this represents phase 1 of our service transformation programme. Once agreed, this interim service specification will be operational for a limited time only until a new service specification is formed in 2023/24 following final advice from the independent Cass Review. This will be used by a new configuration of regional providers- representing phase 2 of our service transformation programme.

The public consultation will run for 45 days from **20 October to 4 December 2022**.

This consultation guide summarises the proposals and sets out:

- How care is currently provided.
- How the interim service specification could change care and the way that services are delivered, and the reasons for these changes.
- How the proposed changes will be implemented.

The document also has information about how you can share your views with NHS England. At the end of the consultation period, all feedback will be considered before the interim service specification is published.

We recommend that you read this consultation guide alongside the other documents published as part of the consultation. While this single consultation guide has been produced to summarise the proposals, the other documents provide additional detail.

Documents included in this consultation:

- **Interim service specification** – The service specification is a contractual document that describes the clinical service and sets out appropriate standards and quality measures that provider organisations must satisfy.
- **Equality and Health Inequalities Impact Assessment (EHIA)** – This document assesses the potential impact of the interim service specification on population groups that may be disproportionately affected by changes and make appropriate recommendations to mitigate any inequity.

Background

The term used to describe a discrepancy between birth-assigned sex and gender identity is 'gender incongruence'. Gender incongruence is frequently, but not universally, accompanied by the symptom of gender dysphoria: *"a disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex"*.

There is currently only one provider of specialist services for children and young people (up to the 18th birthday) with gender dysphoria in England – this is the Gender Identity Development Service (GIDS) for children and adolescents, delivered by the Tavistock and Portman NHS Foundation Trust in London.

The GIDS is also directly commissioned by NHS Wales, and the changes described in this document will impact on patients who are the commissioning responsibility of NHS Wales.

Interim service specification: the case for change

In September 2020, NHS England commissioned an independent and wide-ranging review of gender identity services for children and young people. The Review, which is ongoing, is being led by Dr Hilary Cass, past president of the Royal College of Paediatrics and Child Health. It was established in response to a complex and diverse range of issues including:

1. A significant and sharp rise in referrals

In 2021/22 there were over 5,000 referrals into the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust. This compares to just under 250 referrals in 2011/12.

2. Marked changes in the types of patients being referred which are not well understood

There has been a dramatic change in the case-mix of referrals from predominantly birth-registered males to predominantly birth-registered females presenting with gender incongruence in early teen years. Additionally, a significant number of children are also presenting with neurodiversity and other mental health needs and risky behaviours which requires careful consideration and needs to be better understood.

3. Scarce and inconclusive evidence to support clinical decision making

This has led to a lack of clinical consensus on what the best model of care for children and young people experiencing gender incongruence and dysphoria should be; and a lack of evidence to support families in making informed decisions about interventions that may have life-long consequences.

4. Long waiting times for initial assessment and significant external scrutiny and challenge surrounding the clinical approach and operational capacity at GIDS

This has contributed to the current service being unable to meet the scale of rising demand and concerns being raised by healthcare regulators about the standard of care.

Next steps

In February 2022, Dr Cass published an interim report in which she set out initial findings and advice from her Review. She emphasised the need to urgently move away from the current model of a sole provider, and to establish regional services that work to a new clinical model that can better meet the holistic needs of a vulnerable group of children and young people. She began to describe the need for these new services to work as networked centres that connected with other local services including children and young people's mental health services and primary care to support all a patient's clinical needs.

In July, Dr Cass gave further advice on the core components of this model. [You can read the advice in full here.](#)

In summary, she has said:

- 'Regional centres should be led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services. These will generally be specialist children's hospitals.
- 'They should have established academic and education functions to ensure that ongoing research and training is embedded within the service delivery model'.
- 'The services should have an appropriate multi-professional workforce to enable them to provide an integrated model of care that manages the holistic needs of this population'.
- 'Staff should maintain a broad clinical perspective to embed the care of children and young people with gender uncertainty within a broader child and adolescent health context'.
- In view of the uncertainties surrounding their use, consideration should be given to the rapid establishment of the necessary research infrastructure to prospectively enroll young people being considered for puberty blocking drugs

into a formal research programme, with adequate follow-up into adulthood.

Establishing New (Phase 1) Services

Given the urgent need to stabilise service provision for patients and begin building a more resilient service by expanding provision, we are establishing two 'Phase 1'¹ services. Consistent with Dr Cass' advice, these services will be led by specialist children's hospitals and, once established, will take over clinical responsibility for and management of all current GIDS patients as part of a managed transition, and they will begin to see children and young people who are currently on the GIDS waiting list.

One Phase 1 service will be based in London and will be led by a partnership between Great Ormond Street Hospital for Children NHS Foundation Trust and Evelina London Children's Hospital (part of Guys and St Thomas' NHS Foundation Trust), with South London and Maudsley NHS Foundation Trust providing specialist CYP mental health support.

A second Phase 1 service will be based in the North West, led by a partnership between Alder Hey Children's NHS Foundation Trust and the Royal Manchester Children's Hospital (part of Manchester University NHS Foundation Trust), where both trusts also provide specialist CYP mental health services.

The Tavistock and Portman NHS Foundation Trust and the endocrine teams based at University College London Hospitals NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust will play a vital role in supporting both Phase 1 services as they establish the new services building on their extensive experience of working with this patient group.

A single national transformation programme has been established to oversee a smooth and seamless transition for patients to the new Phase 1 services, including bringing the GIDS contract to a managed close because of these changes. The establishment of the Phase 1 services will happen as quickly as possible, but crucially at a pace that appreciates the complexity of the change, while minimising

¹ When NHS England announced plans in July 2022 to establish new services we referred to them as 'Early Adopter' service providers. We are now using the term 'Phase 1' service providers instead.

disruption and any additional anxiety for patients. The aim is for the Phase 1 services to be operational by Spring 2023.

The Phase 1 services will be commissioned against an interim service specification which will replace the current service specification used by the GIDS. There is now an urgent need to agree this specification to give the Phase 1 services time to recruit staff and set up the new services as quickly as possible.

The interim service specification builds out from the existing specification to both incorporate advice from the Cass Review following its extensive stakeholder engagement, and to provide points of clarification in certain areas. It has been worked up and endorsed by the Phase 1 providers, as well as senior clinical leads including the National Medical Director for Specialised Services, the National Clinical Director for Children and Young People and the Associate National Clinical Director for Children and Young People's Mental Health. It is important to note that this is an interim service specification to support the rapid mobilisation of the new Phase 1 services. It will be replaced in due course with a final service specification which will be subject to a further period of engagement and public consultation at a later date and once further advice has been received from Dr Cass as part of her ongoing independent review. This will mark the start of Phase 2 of our service transformation programme when additional regional services will be commissioned.

What are the proposed changes?

The interim service specification proposes the following changes and points of clarification over the current service specification.

1. Composition of the clinical team – substantive change

The current service specification for GIDS describes that the service is delivered through a specialist multidisciplinary team with contributions from specialist social workers, family therapists, psychiatrists, psychologists, psychotherapists, paediatric and adolescent endocrinologists and clinical nurse practitioners. *The new interim service specification proposes to extend the clinical team so that it is a more integrated multi-disciplinary team that, in addition to gender dysphoria specialists, will include experts in paediatric medicine, autism, neurodisability and mental health.*

The reason for this proposal is to respond to evidence that there is a higher prevalence of other complex presentations in children and young people who have gender dysphoria, that the Phase 1 services will also address, working with local services where appropriate. The proposal also responds to the findings of the Care Quality Commission's 2021 inspection report of GIDS, which highlighted the need for a better multi-disciplinary mix of care providers for some children and young people referred to the service. Furthermore, the interim advice of the Cass Review concluded (page 69) that "*a fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity ... this must include support for any other clinical presentations that they may have*".

2. Clinical leadership – substantive change

The current service specification for GIDS does not describe criteria for the clinical lead for the service. *The new interim service specification proposes that the clinical lead for the service will be a medical doctor.*

The reason for this change is to reflect that the new integrated clinical teams will have a broader range of clinical disciplines, including medical professionals, who will be addressing a broader range of medical conditions in addition to gender dysphoria;

and that oversight of the service by a medical doctor is appropriate given that the service may provide medical interventions to some children and young people..

3. Collaboration with, and support for, referrers and local services – substantive change

The current service specification for GIDS describes a tiered approach for progression through the clinical pathway: the first tier involves meetings between the GIDS team and local professionals involved in the care of the child or young person and the second tier involves the child or young person accessing local services for mental health needs with GIDS offering advice to local services. There are numerous references in the current GIDS service specification to joint working between GIDS and local services including through consultation and liaison. However, GIDS has struggled to provide this support to local services in a consistent way given the constraints on the service. *The new interim service specification proposes to retain this tiered approach to progression through the pathway and describes a more structured approach for collaboration with local services in the interests of the child and young person; a referral to The Service will require a consultation meeting between the Phase 1 service and the relevant local secondary healthcare team and / or the GP. Where the outcome of the initial professional consultation between the Service and the referrer is that the patient does not meet the access criteria for The Service, the child or young person will not be added to the waiting list - but the family and professional network will have been assisted to develop their formulation of the child or young person's needs and a local care plan and will be advised of other resources for support that are appropriate for individual needs. The proposed interim service specification also proposes that not all children and young people who meet the access criteria will need to be seen directly by The Service. A key intervention that will be delivered by The Service is the provision of consultation and active support to local professionals, including support in formulation of needs and risks and individualised care planning. The level and type of consultation offered to the professional network will be determined according to the individual needs of each case and through a process of clinical prioritisation.*

4. Referral sources – substantive change

The current service specification for GIDS states that referrals can be made by staff in health and social services, schools, colleges of further education and by voluntary organisations. *The new interim service specification proposes that referrals may be made by GPs and NHS professionals.* The reason for the proposal is to ensure that children and young people are already engaged with the local health system before a referral is considered by a local health professional into the highly specialist gender dysphoria service, including for the reason that a proposed core feature of the new pathway is a consultation meeting between the specialist service and local health professionals before a referral can be considered for acceptance. The proposal would impact on fewer than 5% of referrals at current referral patterns, in that around 65% of referrals into GIDS are currently made by GPs and around 30% are made by NHS professionals. This proposal relates only to the interim service specification for the Phase 1 services. The interim report of the Cass Review begins to describe a future clinical pathway approach that operates within a managed clinical network, including other statutory agencies, and this pathway will be worked up by NHS England in the coming months through engagement with the Cass Review and other stakeholders.

5. Social transition – clarification

The current GIDS service specification acknowledges that social transition in pre-pubertal children is a controversial issue, that divergent views are held by health professionals, and that the current evidence base is insufficient to predict the long-term outcomes of complete gender-role transition during early childhood.

The interim Cass Report has advised that although there are differing views on the benefits versus the harms of early social transition, it is important to acknowledge that it should not be viewed as a neutral act. Dr Cass has recommended that social transition be viewed as an ‘active intervention’ because it may have significant effects on the child or young person in terms of their psychological functioning.

In line with this advice, the interim service specification sets out more clearly that the clinical approach in regard to pre-pubertal children will reflect evidence that in most cases gender incongruence does not persist into adolescence; and that for

adolescents the provision of approaches for social transition should only be considered where the approach is necessary for the alleviation of, or prevention of, clinically significant distress or significant impairment in social functioning and the young person is able to fully comprehend the implications of affirming a social transition.

Endocrine Interventions

Building the research protocol

The interim service specification reads:

"Consistent with advice from the Cass Review highlighting the uncertainties surrounding the use of hormone treatments, NHS England is in the process of forming proposals for prospectively enrolling children and young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding GnRHa. On this basis NHS England will only commission GnRHa in the context of a formal research protocol. The research protocol will set out eligibility criteria for participation."

In due course NHS England will share details of this work, including plans for how stakeholders and the public will be engaged and consulted on eligibility criteria.

Placing the use of GnRHa in the context of clinical research will have several important benefits:

- It responds directly to Dr Cass' advice that *'Without an established research strategy and infrastructure, the outstanding questions will remain unanswered and the evidence gap will continue to be filled with polarised opinion and conjecture, which does little to help young people, and their families and carers, who need support and information on which to make decisions'*. In this respect the NHS has the opportunity to make a major international contribution to the evidence base in this area.

- Secondly, it will ensure that there is greater transparency for children and their parents / carers around the uncertain clinical benefits and longer-term health impacts surrounding their use.
- Thirdly, it will further strengthen the consent and information sharing process to support informed decision making by young people.

Unregulated drugs

The current service specification for GIDS states that GIDS does not offer shared care with private clinicians, and that in cases where puberty blocking drugs or hormone drugs are prescribed or accessed outside the service, the GIDS will make the young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of any interventions, and will be unable to provide ongoing clinical supervision for the management of these interventions.

The proposed interim specification reads:

“Children, young people and their families are strongly discouraged from sourcing GnRHa and masculinising / feminising hormone drugs from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies. In such cases The Service will make the child or young person and their family aware of the risks, contraindications and any irreversible or partly reversible effects of the drugs and will advise the GP to initiate local safeguarding protocols.

“Should a child or young person access GnRHa from unregulated sources or unregulated providers The Service will not assume responsibility for prescribing recommendations nor will it enter into shared cared arrangements in these circumstances.

“Where a child or young person has obtained masculinising / feminising hormones from an unregulated source (such as the internet) The Service will not accept clinical responsibility for management of the endocrine intervention.

“Where a child or young person has been prescribed masculinising / feminising hormones by an unregulated provider outside of the eligibility and readiness criteria described in the current NHS clinical commissioning policy The Service will not accept clinical responsibility for management of the endocrine intervention.”

The reason for the revised wording is to provide greater clarity and retain and strengthen current safeguards. Senior clinicians have advised NHS England on the need for the new interim service specification to have much clearer wording in this regard so that the interim service specification is less open to interpretation, so that young people, families and professionals are clear on the approach that will be adopted by the NHS in such cases.

How will the proposed changes be implemented?

The proposed interim service specification will inform how the Phase 1 services deliver care and support to young people referred into the gender identity service over the next year.

In parallel, the Cass Review will continue its work to describe the new clinical model to which the Phase 1 services and the new regional services will work in the future. Once Dr Cass has delivered this advice the NHS will build a new service specification and put it out for stakeholder engagement and formal public consultation.

Give us your views on the proposed changes

NHS England would like to hear what patients, parents and carers, clinicians, providers and other interested parties think about the proposed interim service specification for gender dysphoria services.

These are the questions we're asking as part of the public consultation:

- 1. In what capacity are you responding?** (Patient / Parent / Clinician / Service Provider / Other; If you have selected 'Other', please specify.)
- 2. Are you responding on behalf of an organisation?** (yes / no; If you have selected "yes", which organisation are you responding on behalf of?)
- 3. To what extent do you agree with the four substantive changes to the service specification explained above?**
 - A. Composition of the clinical team**
(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)
 - B. Clinical leadership**
(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)
 - C. Collaboration with referrers and local services**
(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)
 - D. Referral sources**
(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)
- 4. To what extent do you agree that the interim service specification provides sufficient clarity about approaches towards social transition?**
(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

5. To what extent do you agree with the approach to the management of patients accessing prescriptions from un-regulated sources?

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

6. Are there any other changes or additions to the interim service specification that should be considered in order to support Phase 1 services to effectively deliver this service?

(comments)

7. To what extent do you agree that the Equality and Health Inequalities Impact Assessment reflects the potential impact on health inequalities which might arise as a result of the proposed changes?

(Agree / Partially Agree / Neither Agree nor Disagree / Partially Disagree / Disagree; comments)

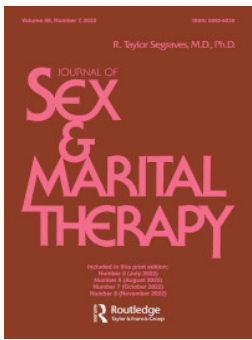
You can provide your views with NHS England by completing the online survey:

<https://www.engage.england.nhs.uk/specialised-commissioning/specialist-gender-interim-specification>

Your views will help NHS England to further shape and refine this interim service specification for gender dysphoria services, until a new service specification is agreed in 2023, which will be informed by a full consultation and engagement process.

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LETTER TO THE EDITOR



What Are We Doing to These Children? Response to Drescher, Clayton, and Balon Commentaries on Levine et al., 2022

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Introduction

In our paper, “Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults” (Levine, Abbruzzese, & Mason, 2022), we asserted that the consent process for youth gender transition is so problematic in much of the Western world that it can no longer be considered “informed.”

We reflected on how far the entire field of gender medicine has drifted from the principles of evidence-based medicine and the scientific method. Attempts to study the sharp rise of gender dysphoria in previously gender-normative teens (Bradley, 2022; Littman, 2018) are met with consternation by the gender-medicine establishment (World Professional Association for Transgender Health [WPATH], 2018). The significant rate of problematic adaptations, psychiatric symptoms, and self-harm in this youth cohort (Becerra-Culqui et al., 2018; de Graaf, Giovanardi, Zitz, & Carmichael, 2018; de Graaf et al., 2021; Kaltiala-Heino, Sumia, Työläjärvi, & Lindberg, 2015; Kozłowska, Chudleigh, McClure, Maguire, & Ambler, 2021; Strang et al., 2018; Thrower, Bretherton, Pang, Zajac, & Cheung, 2020) is explained away as merely manifestations of minority stress, with unsubstantiated claims that these mental health problems will resolve with gender transition—and *only* with gender transition. Efforts to help the distressed teens psychotherapeutically, which is the standard approach for all other types of psychiatric symptoms, are stigmatized as conversion therapy. The growing evidence of *detransition*, apparent in recent data (Boyd, Hackett, & Bewley, 2021; Hall, Mitchell, & Sachdeva, 2021; Roberts, Klein, Adirim, Schvey, & Hisle-Gorman, 2022), is either dismissed or recast as a benign gender journey (Turban, Loo, Almazan, & Keuroghlian, 2021), and the reports of regret by many of the detransitioners themselves are ignored (Littman, 2021; Vandenbussche, 2022). Perhaps most problematic, the information shared by gender clinicians with patients and families about “gender-affirming” interventions is markedly skewed: it overstates the demonstrated benefits of hormones and surgeries and trivializes their risks and the uncertainties of future outcomes.

Our critical ethical evaluation also included proposed solutions. We suggested that clinicians familiarize themselves with the difference between the classical early-onset of cross-sex identification, which typically spontaneously resolves before adulthood (Ristori & Steensma, 2016; Singh, Bradley, & Zucker, 2021), and the novel presentation of youth with postpubertal onset of gender dysphoria and a much wider range of gender identities, for whom the outcomes are unknown. We suggested that rather than merely deferring to their medical societies’ wholesale adoption of “gender-affirmative” guidelines from the gender medicine establishment, clinicians would benefit from scrutinizing the unconvincing results from key studies. We implored

clinicians to slow down and engage patients and families in thorough and thoughtful discussions not only of the possible benefits but also the significant risks and uncertainties inherent in a medically dependent lifetime.

The editor invited four respected academicians to write commentaries (Balon, 2022; Clayton, 2022; Drescher, 2022; de Vries, 2022). Two agreed that current trends are problematic and must be addressed to safeguard youth from harm (Balon, 2022; Clayton, 2022). Two disagreed, but in very different ways (Drescher, 2022; de Vries, 2022). Drescher took a decidedly civil rights-based perspective, arguing that while the evidence is low quality, ultimately, the principles of body autonomy should trump all other concerns. de Vries conceded that the evidence base for pediatric gender transition suffers from deficiencies but asserted that it is of sufficient quality to widely scale hormonal and surgical “gender-affirming” interventions.

Below, we provide our thoughts about the first three commentaries we received (Drescher, 2022; Clayton, 2022; Balon, 2022), starting with our response to Drescher. We have responded to de Vries (2022) in a separate forthcoming publication.

Response to Drescher

Drescher’s commentary (Drescher, 2022) illuminated the mindset of clinicians who are aware of the limitations of the evidence base of youth gender transition, yet actively promote medicalization while eschewing any noninvasive treatment alternatives. Drescher ridiculed the title of our publication (Levine et al., 2022) by naming his own commentary “Informed Consent or Scare Tactics?” Having carefully examined his objections to our paper, we, in turn, suggest that Drescher’s commentary would have been better titled “Risks, Schmisks”—as it succinctly summarizes his counterarguments.

Drescher mocked our suggestion for a slow and deliberate informed consent process for youth embarking on a medicalized lifetime with a skit in which a patient receives extensive disclosures of the risks of taking aspirin for a headache. While Drescher referred to his writing exercise as a “parody,” it is a generous description, and not just because some might find it lacking in humor; the situations he compares are not even remotely equivalent. Even prolonged aspirin use increases the absolute risk of severe bleeding by just 0.47% (Zheng & Roddick, 2019). In contrast, 100% of children will be rendered sterile if puberty is blocked at Tanner Stage 2 and followed with cross-sex hormones, as currently suggested by the Endocrine Society (Hembree et al., 2017). While the risks of exogenous sex hormones have been well-documented and led to a black box warning from the FDA (Jeffrey, 2003; Togun, Sankar, & Karaca-Mandic, 2022), there is now mounting evidence of the detrimental effects of puberty blockers on a range of physiological parameters (Nokoff et al., 2021) including bone density (Biggs, 2021; Klink, Caris, Heijboer, van Trotsenburg, & Rotteveel, 2015; Nokoff, Ma, Moreau, & Rothman, 2022). We think a better example of using comedy to make a point is a skit by comedian Bill Maher, who recently noted that bone density is “kind of important if you like having a skeleton” (Maher, 2022).

The exuberant irreverence of Drescher’s commentary extended to his discussion of the evidence base for youth gender reassignment, with the suggestion that the GRADE designation of *low-quality evidence* is merely a “a scary buzzword” (Drescher, 2022, p. 3). To clarify, the Grading of Recommendations Assessment, Development and Evaluation (GRADE) is an international best practice in evidence evaluation, which provides a structured way to assess key factors that increase or decrease confidence of findings in a body of evidence (GRADE Working Group, 2013). The GRADE ratings of “very low” and “low” quality—the only two ratings that the body of evidence for youth gender reassignment has ever received—indicate that *the true effect* of hormones and surgeries is likely *markedly different* from the results reported by the studies (Balslem et al., 2011; Reed & Guyatt, n.d.). The problem is *not* that the field of youth gender reassignment has not yet produced “enough” studies, as Drescher’s own phrasing of “low levels of evidence” suggests; the actual problem is that *none* of the numerous studies produced to date, individually or collectively as a body of evidence, are reliable or trustworthy. This is because

all the available studies are uncontrolled observational studies subject to bias, confounding, or chance (National Institute for Health and Care Excellence [NICE] 2020a, 2020b).

Drescher also incorrectly asserted that the reason the evidence base for gender transition has been graded as *very low/low quality* is due to the “absence of randomized clinical trials (RCTs)” (Drescher, 2022 p. 3). While it is true that data from a body of randomized *controlled* trials (whether the comparator is placebo or another active intervention) starts with the presumption of *high quality*, it can be downgraded to *low quality* if there are serious concerns arising from risk of bias, imprecision, inconsistency, indirectness, and publication bias. Conversely, non-randomized study of an intervention (e.g., an observational study) can be upgraded to *moderate* or *high quality* when there is a large magnitude of effect; a demonstrated dose-response relationship; and when the potential confounders are not expected to inflate the outcomes in a positive direction—in other words, when the research signals plausible, sizeable benefits (Reed & Guyatt, n.d.). The problem is *not* that quality research in the space of gender medicine is not feasible; it is that increasingly, gender clinicians who lead the studies view the matter as settled science, and as a result do not bother to design research capable of producing high or even moderate quality evidence. Even more troubling, when called out, such clinicians insist that using rigorous study designs in pediatric gender medicine is unethical (Turban, Almazan, Reisner, & Keuroghlian, 2022).

Nor is it correct to assume that randomization is unethical. According to the principle of research equipoise, “when there is uncertainty or conflicting expert opinion about the relative merits of diagnostic, prevention, or treatment options, allocating interventions to individuals in a manner that allows the generation of new knowledge (randomization)” is ethically permissible (London, 2017, p. 525). That “gender-affirming” interventions are administered to youth “based on very limited data” and that long-term outcomes are unknown has been acknowledged by even the most ardent proponents of pediatric gender transition (Olson-Kennedy et al., 2019, p. 2). Rigorous research has been conducted in other “high stakes” areas of medicine and has led to the development of highly effective treatments, as evidenced by the advances in pediatric oncology (Berg, 2007). Pediatric gender medicine cannot claim an exceptional status when it comes to the quality of research it must undertake.

Drescher is also incorrect in stating that “none of the surgical procedures ... are performed on children with GD/GI [gender dysphoria/gender incongruence]” (Drescher, 2022, p. 4). We have seen the claim that “gender-affirming surgery is not performed on children” repeated with increasing frequency. We are not sure whether this assertion hinges on the definition of a “child” as someone who has not yet had their 13th birthday; or if it is a case of blissful ignorance by those inexperienced with this patient population. Patients as young as 12-13 have been obtaining “gender-affirming” mastectomies in the United States for several years, as evidenced by the data from the National Institutes of Health (NIH)-funded research (Olson-Kennedy, Warus, Okonta, Belzer, & Clark, 2018, Figure); research from a large U.S. healthcare system (Tang et al., 2022, Figure 2); and a recent publication in JAMA Pediatrics (Ascha et al., 2022). The latter asserted strong benefits of mastectomies for youth based on the finding that the young people were no longer “dysphoric” about their chest appearance a mere 3 months post-surgery. Version 8 of the WPATH “Standards of Care,” published in September 2022, ratified the notion that surgeries should be available to youth when it removed previously stated minimum age limits for “gender-affirming” surgical procedures (Block, 2022; Coleman et al., 2022).

Setting Drescher’s misunderstanding of the evidence aside, his fundamental problem with our paper appears to be that we did not outline treatment alternatives to “gender affirmation” for youth gender dysphoria—beyond psychotherapy. Yet, psychotherapy is *exactly* what Sweden—the first country in the world to legally recognize transgender people—and Finland recommend as the first (and typically only) line of treatment for gender dysphoric youth (COHERE, 2020; Socialstyrelsen, 2022a, 2022b). The UK is now moving in a similar direction, calling on clinicians to lean on their existing skills in mental health support of gender dysphoric youth, and to not “exceptionalise gender identity issues” (Cass, 2022). With these recent changes, Europe is

returning to the proven axiom taught to medical students early in their training: “when you hear hoofbeats, think of horses not zebras.” In this context, the profound gender-related distress that has engulfed Western youth in recent years is much more likely to be a novel manifestation of the identity formation struggles of youth, rather than a rare intractable “mismatch” between the body and the brain that must be medically and surgically corrected.

We are puzzled about why Drescher, a psychoanalyst himself, dismissed the contribution of his own field to the management of gender dysphoria in youth by describing it as “just talk” (Drescher, 2022, p. 4). More disheartening, however, is that he chose to conflate psychotherapy for gender dysphoria with “conversion therapy.” The notion that psychotherapy was a missing element in their care was endorsed by detransitioners, who say that a better understanding of the nature of their gender distress would have helped them avoid irreversible and deeply regrettable medical interventions (Littman, 2021; Vandenbussche, 2022).

While Drescher appeared comfortable with recommendations to change anatomy, physiology, and create the need for lifelong “gender-affirming” interventions based on low quality evidence, he was quick to disdain the alternative of psychotherapy because it “lack[s]... empirical evidence” (Drescher, 2022, p. 4). It is, of course, untrue that psychotherapy for gender dysphoria in youth lacks “empirical evidence”; what it lacks is *high quality* evidence. Rigorous comparative trials of psychotherapeutic approaches to gender dysphoria in youth are urgently needed. However, if Drescher undertakes a literature search, he will discover that beyond the article by Schwartz (2021), to which he dedicated a significant part of his response, there is a growing body of (low quality) evidence that psychotherapy *can* ameliorate gender distress in youth and can reduce or eliminate the need for invasive medical interventions (Bonfatto & Crasnow, 2018; Churcher Clarke & Spiliadis, 2019; Evans, 2022; Hakeem, 2012; Lemma, 2018; Spiliadis, 2019). Psychotherapy to “resolve confusion [about gender feelings] and come to self acceptance was also a key part of the Dutch protocol (de Vries et al., 2006, p. 87).

The concern that vulnerable adolescents and young adults do not get appropriate mental health evaluation and treatment and are effectively rushed into transition, has been voiced not only by the “critics,” as Drescher asserts, but also by the supporters of “gender-affirmative” interventions such as Dr. Erika Anderson—a psychotherapist, transgender woman, and recent President of the US branch of WPATH, USPATH (Anderson, 2022). There is a convincing body of evidence that gender dysphoria frequently occurs in *lesbian and gay* youth (Bryant, 2006; Cantor, 2020, Appendix 1; Korte et al., 2008). It also disproportionately affects *autistic* youth (Bradley, 2022; Hisle-Gorman et al., 2019; Thrower et al., 2020), as well as vulnerable individuals who have experienced various forms of trauma (D’Angelo et al., 2021; Kozłowska et al., 2021). We would have expected Drescher to support the notion that young gay and autistic people suffering from gender dysphoria deserve access to noninvasive treatment alternatives that avoid life-long health risks and do not render them sterile.

A second reason for Drescher’s objection to our publication is that he viewed our recommendation for delay in irreversible medical interventions as putting the interests of “cisgender” gender dysphoric youth above the interests of “transgender” youth. We remind Drescher that the predictive validity of the youth gender dysphoria (or gender incongruence) diagnoses is unknown (Davy & Toze, 2018; Paris, 2015; Zucker, 2010), and that no criteria exist for how to reliably differentiate youth who will desist from a transgender identity as adults, from those for whom this identity will be life-long. That the majority of trans-identified *children* will not be trans-identified adults is well established (Ristori & Steensma, 2016; Singh et al., 2021). The notion that trans-identified *teens or young people* do not desist, which seems to have been uncritically adopted by gender clinicians, is patently untrue, as demonstrated by a growing number of studies of detransitioners, the majority of whom do not identify as transgender after they medically detransition (Littman, 2021; Vandenbussche, 2022). Recent data from gender clinics show that the rate of medical *detransition* is now reaching 10-30% within just a few years after the initiation of transition (Boyd et al., 2021; Hall et al., 2021; Roberts et al., 2022); this

percentage will likely grow as the patients reach the 10+ year mark when regret has been noted to typically emerge (Dhejne, Öberg, Arver, & Landén, 2014; Wiepjes et al., 2018).

Drescher chose to engage in ad hominem attacks on those involved in the publication of our paper. He referenced an anonymous libelous blog in his attempt to discredit the US registered nonprofit organization, the Society for Evidence-Based Gender Medicine (SEGM) and fanned the flames of baseless insinuations by inventing a non-existent association between SEGM and anti-homosexual groups. In questioning SEGM's goals, Drescher changed SEGM's name, substituting "evidence-based" with "empirical-based," and inadvertently revealed a lack of understanding of the difference between these two concepts. "Empirical-based" medicine relies on expert opinion backed by only minimal research. It is also known as "eminence-based." In contrast, the cornerstone of "evidence-based medicine" is a rigorous, impartial evaluation of the evidence to assess its certainty, which allows for truly informed decision-making (Drisko & Friedman, 2019). SEGM's stated goal is to help gender medicine move past its current "empirical-based" status and toward the rigorous principles of evidence-based medicine. While Drescher failed to identify any inaccuracies in the information disseminated by SEGM, he did find fault with the authors' disclosure of an association with SEGM. We remind him and other researchers that such disclosures are an ethical requirement for publications and are not optional. Unfortunately, disclosures of interest, including *conflicts of interest*, such as when pharmaceutical companies pay authors promoting the benefits of "gender-affirmative hormones," are often omitted, and only come to light months after the research conclusions have been widely publicized (Erratum for TURBAN 2019-1725., 2021). Another rarely disclosed conflict of interest in pediatric gender medicine is the fact that the investigators of the studies are commonly the same clinicians who are prescribing or administering "gender-affirming" interventions. This is perhaps the single most problematic source of bias in current research, since the investigators have a significant intellectual (and sometimes financial) stake in "demonstrating" that their work produced positive results (Boutron et al., 2022).

We invite Drescher to examine his own potential conflicts of interest and intellectual biases, including the possibility that his decade-long advocacy to de-pathologize gender dysphoria in the diagnostic categories of DSM and ICD (Drescher, Cohen-Kettenis, & Winter, 2012) may have created a confirmation bias. Had Drescher critically engaged with the fact that over 70% of gender dysphoric youth presenting for care had been diagnosed with a mental illness or neurocognitive disorder prior to the onset of gender dysphoria (Becerra-Culqui et al., 2018), perhaps he would see the reason behind the recommendation for psychotherapy as the first and even only line of treatment, pending reaching maturity.

We share Drescher's concerns about the politicization of transgender health care, as some states move to issue harsh penalties for those who provide gender transition services to minors. We agree that regulating treatments for gender dysphoria is best handled by the medical establishment self-correcting, rather than allowing politicians to make medical decisions. Drescher does not seem to realize, however, the extent to which his own attitude, shared by many gender clinicians, that youth gender transitions must continue without restraint before any reliable data are available, has contributed to this polarization. Drescher's concern for the wellbeing of gender dysphoric youth is palpable, and we share it, even if he finds that hard to believe. What the field needs now is more reliable outcome data, not more passion and political rhetoric.

Response to Clayton

In the process of comparing our informed consent recommendations to those authored by WPATH's affiliate AusPATH, Clayton revealed that the guidance widely used in Australia and New Zealand is not entirely data dependent. Given AusPATH's close links to WPATH, we agree with Clayton that her commentary "holds much relevance to the international context" (Clayton, 2022b p. 1).

Clayton juxtaposed two sets of opposing claims regarding the evidence for “gender affirmation” of youth: the claim by advocates of this practice who insist that data show significant benefits and low risks, and the assertions of critics that the benefits are highly uncertain, and the risks are significant. She suggested that this contradiction may be resolved by engaging in “close reading of the cited primary sources” (Clayton, 2022b p. 3). As Clayton’s prior research demonstrated, there is a troubling “asymmetry” in how the results from gender clinics-based research are frequently reported: “[f]indings of positive outcomes of medical interventions are trumpeted in abstracts, while their profound limitations remain behind the paywall, thus, below the radar of busy clinicians” (Clayton et al., 2022, p. 3). Once the individual studies are scrubbed of uncertainty in the abstracts, the evidence enters a new cycle of laundering where “[n]ew publications reference prior ones with increasing and unwarranted confidence” (Clayton et al., 2022, p. 3).

Unfortunately, not only individual studies, but even systematic *reviews of evidence*, which generally reside on the highest rung of the evidence pyramid, can suffer from bias. Clayton’s prior research focused on a problematic “systematic review” by Rew, Young, Monge, and Bogucka (2021), which exemplified a “concerning trend to overstate the evidence underpinning clinical practice recommendations for youth with GD [gender dysphoria]” (Clayton et al., 2022, p. 3).

We see similar problems in the review commissioned by WPATH as the basis for its “Standards of Care 8” (Baker et al., 2021). This review failed to examine any *physical health* risks of hormonal interventions and found only low-quality or insufficient evidence of *psychological* benefits due to high risk of bias in study designs, small sample sizes, and confounding with other interventions. This did not preclude the authors from endorsing “hormone therapy,” including puberty blockers and cross-sex hormones for youth as an “essential component of care” (Baker et al., 2021, p. 13.). These conclusions, which cannot be substantiated by the review’s actual findings, have since been used by WPATH to issue the recommendations to treat gender dysphoria medically, stating that “delay in transition” is rarely advisable and should only be used as a “last resort” (Coleman et al., 2022, p. S37).

It is worth noting that Baker, the lead author of the WPATH-commissioned systematic review, appears to have coauthored another highly flawed evidence review widely known by its pithy subtitle, “What We Know” (Frank & Baker, 2018). Baker’s commitment to generating research that furthers a policy agenda to promote access to hormones is well-publicized (Health Policy Research Scholars, 2019). Had the goal been scientific accuracy, rather than political advocacy, the title of that review would have been “What We *Don’t* Know.”

It is notable that when led by researchers with no intellectual or financial conflicts of interest, evidence reviews universally find the benefits of pediatric gender reassignment unconvincing, and the unquantified risks of harm alarming. This includes recent evidence reviews commissioned by health authorities in the UK (NICE, 2020a, 2020b); Sweden (SBU, 2022); Finland (Pasternack, Söderström, Saijonkari, & Mäkelä, 2019), and most recently, the state of Florida in the United States (Brignardello-Peterson & Wiercioch, 2022).

Clayton reminded readers that advancing from the current lack of evidence requires rigorous study designs capable of generating high quality evidence. She illustrated the importance of rigorous research designs by invoking the *placebo effect*—the well-established powerful influence of “the whole therapeutic ritual, including medical marketing” that “affects the patient’s neuro-psycho-biological state...” (Clayton, 2022b, p. 5). Clayton questioned the extent to which the observed short-term improvement reported by uncontrolled studies may be subject to the placebo effect, with clinicians themselves operating under a “therapeutic illusion” enabled in part by the widespread promotion of the expected benefits of gender transition in “social media, and celebrity culture” (p. 5). She noted that when “interventions have high risk of serious and irreversible adverse effects” (p. 5), rigorous study designs that control for these factors are essential.

Clayton also reflected on the blurred line that separates “innovative clinical practice,” which can be offered widely by any willing provider, from “research,” which is subject to a tightly

regulated process. She questioned whether “affirming” interventions for youth can only ethically be performed in research settings, in view of these interventions’ irreversible effects and the risks involved to very young individuals. This is the direction that Sweden recently assumed (Socialstyrelsen, 2022a, 2022b). In the U.S., such a change is not likely to come from the Federal government, but it can take place at the state level, as U.S. laws delegate the responsibility to regulate the practice of medicine to individual states. If this were to happen, gender clinics in participating states might be more motivated to design research that generates useful data to answer the unanswered questions about outcomes.

Having interrogated the evidence, Clayton concluded, “[a]ny claims of certainty are premature and risk more harm than benefit” and observed that the gender medicine establishment’s misguided insistence that the science is settled “hinder[s] the rigorous debate and research required to improve the state of knowledge in this area of medicine” (Clayton, 2022b, p. 6). Clayton’s overview of medicine’s misadventures detailed in her previous publication (Clayton, 2022a), and in the relevant examples in her present commentary (Clayton, 2022b), provide a powerful argument to all clinicians to reconsider their informed consent processes for youth gender transitions. We highly recommend her erudite commentary to all individuals in the field.

Response to Balon

Balon reinforced, elaborated, and provided historical perspective of the importance of a “serious, thorough, and careful” legal and ethical informed consent process (Balon, 2022, p. 3). His epigram, “*Whatever you do, do it deliberately and consider the end*” (Balon, 2022, p. 1) indicated his grasp of the central issue of our contribution—our concern about the proliferation of gender transitions undertaken in youth, despite the unknown long-term outcomes of these radical interventions. He sagely observed that in 2012, when the requirement for psychiatric evaluation was waived to enable patients to efficiently obtain hormones (Coleman et al., 2012), the protection of patients and their families was jeopardized.

Balon agreed that the process of medical gender transition of youth is often undertaken in a way that is not truly informed: “Similar to Levine et al. (2022), I am also not sure whether, with the increased incidence of gender identity variation, all parties involved in the informed consent process are well and appropriately informed and educated” (Balon, 2022, p. 1). He recognized the difficulty of obtaining informed consent from patients and families when the clinicians themselves do not have reliable information: “the word informed does not relate “just” to patients’ (and their families) side of the informed consent equation, but also to the clinicians’ side. It is obvious that our state of knowledge regarding appropriate and timely gender transition (whatever the intervention is) and its consequences is not where we would like it to be” (Balon, 2022, p. 1).

Balon emphasized how far the field of gender medicine is from a rational dispassionate heuristic embrace of the disagreements: “It seems that most of the time ideology, emotions and personal convictions beat knowledge and evidence in these debates” (Balon, 2022, p. 3). Balon’s plain language summary of the current situation is apt: “Simply said, the ship has sailed, and we assume that its course is correct, and landing will be correct and the life after will be happy. Is that so, though?” (Balon, 2022, p. 1). Alarmed by the “possibility of underlying belief systems replacing scientific evidence,” Balon encouraged all parties to continue the scientific debate, “agree to disagree and through our disagreement and continuous study of gender and transgender issues continue to improve the care of our patients.” Balon reminded all those involved in the debate that there is “[u]ltimately, just one side to this debate...the patient side” (Balon, 2022, p. 3).

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Bibliography

- Anderson, E. (2022, January 3). Opinion: When it comes to trans youth, we're in danger of losing our way. The San Francisco Examiner. Retrieved January 5, 2022, from <http://www.sfoxaminer.com/opinion/are-we-seeing-a-phenomenon-of-trans-youth-social-contagion/>
- Ascha, M., Sasson, D. C., Sood, R., Cornelius, J. W., Schauer, J. M., Runge, A., Muldoon, A. L., Gangopadhyay, N., Simons, L., Chen, D., Corcoran, J. F., & Jordan, S. W. (2022). Top surgery and chest dysphoria among transmasculine and nonbinary adolescents and young adults. *JAMA Pediatrics*. Advance online publication. doi:10.1001/jamapediatrics.2022.3424
- Balshem, H., Helfand, M., Schünemann, H. J., Oxman, A. D., Kunz, R., Brozek, J., Vist, G. E., Falck-Ytter, Y., Meerpohl, J., & Norris, S. (2011). GRADE guidelines: 3. Rating the quality of evidence. *Journal of Clinical Epidemiology*, 64(4), 401–406. doi:10.1016/j.jclinepi.2010.07.015
- Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone therapy, mental health, and quality of life among transgender people: A systematic review. *Journal of the Endocrine Society*, 5(4), bvab011. doi:10.1210/jendso/bvab011
- Balon, R. (2022). Commentary on Levine et al: Festina Lente (rush slowly). *Journal of Sex & Marital Therapy*. Advance online publication. doi:10.1080/0092623X.2022.2055686
- Becerra-Culqui, T. A., Liu, Y., Nash, R., Cromwell, L., Flanders, W. D., Getahun, D., Giammattei, S. V., Hunkeler, E. M., Lash, T. L., Millman, A., Quinn, V. P., Robinson, B., Roblin, D., Sandberg, D. E., Silverberg, M. J., Tangpricha, V., & Goodman, M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Pediatrics*, 141(5), e20173845. doi:10.1542/peds.2017-3845
- Berg, S. L. (2007). Ethical challenges in cancer research in children. *The Oncologist*, 12(11), 1336–1343. 10.1634/theoncologist.12-11-1336
- Biggs, M. (2021). Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *Journal of Pediatric Endocrinology and Metabolism*, 0(0), 000010151520210180. doi:10.1515/jpem-2021-0180
- Block, J. (2022). US transgender health guidelines leave age of treatment initiation open to clinical judgment. *BMJ (Clinical research ed.)*, 378, o2303. doi:10.1136/bmj.o2303
- Bonfatto, M., & Crasnow, E. (2018). Gender/ed identities: An overview of our current work as child psychotherapists in the Gender Identity Development Service. *Journal of Child Psychotherapy*, 44(1), 29–46. doi:10.1080/0075417X.2018.1443150
- Boyd, I. L., Hackett, T., & Bewley, S. (2021). Care of transgender patients: A general practice quality improvement approach. *SSRN Electronic Journal*. <https://www.mdpi.com/2227-9032/10/1/121> doi:10.3390/healthcare10010121
- Boutron I, Page MJ, Higgins JPT, Altman DG, Lundh A, Hróbjartsson A. (2022). Chapter 7: Considering bias and conflicts of interest among the included studies. In: Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA (Eds.), *Cochrane Handbook for Systematic Reviews of Interventions* version 6.3 (updated February 2022). Retrieved from www.training.cochrane.org/handbook.
- Bradley, S. J. (2022). Understanding vulnerability in girls and young women with high-functioning autism spectrum disorder. *Women*, 2(1), 64–67. doi:10.3390/women2010007
- Brignardello-Peterson, R., & Wiercioch, W. (2022). *Effects of gender affirming therapies in people with gender dysphoria: Evaluation of the best available evidence*. https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Attachment_C.pdf
- Bryant, K. (2006). Making gender identity disorder of childhood: Historical lessons for contemporary debates. *Sexuality Research and Social Policy*, 3(3), 23–39. doi:10.1525/srsp.2006.3.3.23
- Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, 46(4), 307–313. 10.1080/0092623X.2019.1698481
- Cass, H. (2022). Entry 8 – Beyond the Headlines. Retrieved August 19, 2022, from <https://cass.independent-review.uk/entry-8-beyond-the-headlines/>
- Churcher Clarke, A., & Spiliadis, A. (2019). ‘Taking the lid off the box’: The value of extended clinical assessment for adolescents presenting with gender identity difficulties. *Clinical Child Psychology and Psychiatry*, 24(2), 338–352. doi:10.1177/1359104518825288
- Clayton, A. (2022a). The gender affirmative treatment model for youth with gender Dysphoria: A medical advance or dangerous medicine? *Archives of Sexual Behavior*, 51(2), 691–698. doi:10.1007/s10508-021-02232-0
- Clayton, A. (2022b). Commentary on Levine et al.: A tale of two informed consent processes. *Journal of Sex & Marital Therapy*. Advance online publication. doi:10.1080/0092623X.2022.2070565
- Clayton, A., Malone, W. J., Clarke, P., Mason, J., & D'Angelo, R. (2022). Commentary: The signal and the noise—Questioning the benefits of puberty blockers for youth with gender dysphoria—A commentary on Rew et al. (2021). *Child and Adolescent Mental Health*, 27(3), 259–262. doi:10.1111/camh.12533
- COHERE (Council for Choices in Health Care). (2020). *Palveluvalikoimaneuvoston Suositus: Alaikäisten Sukupuoli-identiteetin Variaatioihin Liittyvän Dysforian Lääketieteelliset Hoitomenetelmät. [Recommendation of the Council for Choices in Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors.]*. https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors

- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., & Zucker, K. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism*, 4(4), 165–232. doi:10.1080/15532739.2011.700873
- Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., ... Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health*, 23(sup1), S1–S259. doi:10.1080/26895269.2022.2100644
- Davy, Z., & Toze, M. (2018). What is gender dysphoria? A critical systematic narrative review. *Transgender Health*, 3(1), 159–169. doi:10.1089/trgh.2018.0014
- Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43(8), 1535–1545. doi:10.1007/s10508-014-0300-8
- de Graaf, N. M., Giovanardi, G., Zitz, C., & Carmichael, P. (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009–2016). *Archives of Sexual Behavior*, 47(5), 1301–1304. doi:10.1007/s10508-018-1204-9
- de Graaf, N. M., Huisman, B., Cohen-Kettenis, P. T., Twist, J., Hage, K., Carmichael, P., Kreukels, B., & Steensma, T. D. (2021). Psychological functioning in non-binary identifying adolescents and adults. *Journal of Sex & Marital Therapy*, 47(8), 773–784. doi:10.1080/0092623X.2021.1950087
- de Vries, A. L. C., Cohen-Kettenis, P. T., Delemarre-van de Waal, H. (2016). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism*, 9 (3–4), 83–94. doi:10.1300/J485v09n03_04.
- de Vries A. (2022). Ensuring care for transgender adolescents who need it: Response to ‘reconsidering informed consent for trans-identified children, adolescents and young adults’. *Journal of Sex & Marital therapy*. Advance online publication. doi:10.1080/0092623X.2022.2084479
- D’Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50(1), 7–16. doi:10.1007/s10508-020-01844-2
- Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry*, 24(6), 568–577. doi:10.3109/09540261.2012.741575
- Drescher, J. (2022). Informed consent or scare tactics? A response to Levine et al.’s “Reconsidering informed consent for trans-identified children, adolescents, and young adults.” *Journal of Sex & Marital Therapy*. Advance online publication. doi:10.1080/0092623X.2022.2080780
- Drisko, J. W., & Friedman, A. (2019). Let’s clearly distinguish evidence-based practice and empirically supported treatments. *Smith College Studies in Social Work*, 89(3–4), 264–281. doi:10.1080/00377317.2019.1706316
- Erratum for TURBAN 2019-1725. (2021). *Pediatrics*, 147(4), e2020049767. doi:10.1542/peds.2020-049767
- Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145(2), e20191725. doi:10.1542/peds.2019-1725
- Evans, M. (2022). ‘If only I were a boy ...’: Psychotherapeutic explorations of transgender in children and adolescents. *British Journal of Psychotherapy*, 38(2), 269–285. doi:10.1111/bjp.12733
- Frank, N. & Baker, K. (2018). What does the scholarly research say about the effect of gender transition on transgender well-being? What we know. Cornell University, Public Policy Research Portal. Retrieved September 2, 2022, from <https://whatwewknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/>
- GRADE Working Group. (2013). GRADE Handbook. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach. H. Schünemann, J. Brożek, G. Guyatt and A. Oxman. <https://gdt.gradepro.org/app/handbook/handbook.html>
- Hakeem, A. (2012). Psychotherapy for gender identity disorders. *Advances in Psychiatric Treatment*, 18(1), 17–24. doi:10.1192/apt.bp.111.009431
- Hall, R., Mitchell, L., & Sachdeva, J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: Retrospective case-note review. *BJPsych Open*, 7(6), e184. doi:10.1192/bjo.2021.1022
- Health Policy Research Scholars (2019). *Meet the scholars: Kellan Baker*. Retrieved August 18, 2022, from <https://healthpolicyresearch-scholars.org/meet-the-scholars-kellan-baker/>.
- Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T’Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An endocrine society* clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869–3903. doi:10.1210/jc.2017-01658
- Hisle-Gorman, E., Landis, C. A., Susi, A., Schvey, N. A., Gorman, G. H., Nylund, C. M., & Klein, D. A. (2019). Gender dysphoria in children with autism spectrum disorder. *LGBT Health*, 6(3), 95–100. doi:10.1089/lgbt.2018.0252
- Jeffrey, S. (2003, January 8). Estrogen gets “black-box” warning. *Medscape*. Retrieved October 5, 2022, from <https://www.medscape.com/viewarticle/785840>

- Kaltiala-Heino, R., Sumia, M., Työläjärvä, M., & Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, 9(1), 9. doi:10.1186/s13034-015-0042-y
- Klink, D., Caris, M., Heijboer, A., van Trotsenburg, M., & Rotteveel, J. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *The Journal of Clinical Endocrinology & Metabolism*, 100(2), E270–E275. doi:10.1210/jc.2014-2439
- Korte, A., Goecker, D., Krude, H., Lehmkuhl, U., Grüters-Kieslich, A., & Beier, K. M. (2008). Gender identity disorders in childhood and adolescence. *Deutsches Ärzteblatt International*, 105(48), 834–841. doi:10.3238/arztebl.2008.0834
- Kozłowska, K., Chudleigh, C., McClure, G., Maguire, A. M., & Ambler, G. R. (2021). Attachment patterns in children and adolescents with gender dysphoria. *Frontiers in psychology*, 11, 582688. doi:10.3389/fpsyg.2020.582688
- Lemma, A. (2018). Trans-itory identities: Some psychoanalytic reflections on transgender identities. *The International Journal of Psychoanalysis*, 99(5), 1089–1106. doi:10.1080/00207578.2018.1489710
- Levine, S. B., Abbruzzese, E., & Mason, J. M. (2022). Reconsidering informed consent for trans-identified children, adolescents, and young adults. *Journal of Sex & Marital Therapy*, 48(7), 706–727. doi:10.1080/0092623X.2022.2046221
- Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *Plos One*, 13(8), e0202330. doi:10.1371/journal.pone.0202330
- Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, 50(8), 3353–3369. doi:10.1007/s10508-021-02163-w
- London, A. J. (2017). Equipoise in research: Integrating ethics and science in human research. *JAMA*, 317(5), 525. doi:10.1001/jama.2017.0016
- Maher, B. (2022). New rule: Along for the pride | Real time with Bill Maher (HBO). Retrieved September 7, 2022, from <https://www.youtube.com/watch?v=mMBzfUj5zsg>
- National Institute for Health and Care Excellence (NICE). (2020a). *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria*. <https://web.archive.org/web/20220414202655/https://arms.nice.org.uk/resources/hub/1070905/attachment>
- National Institute for Health and Care Excellence (NICE). (2020b). *Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria*. <https://web.archive.org/web/20220215111922/https://arms.nice.org.uk/resources/hub/1070871/attachment>
- Nokoff, N., Ma, N., Moreau, K., & Rothman, M. S. (2022). *Bone mineral density in transgender youth on gender affirming therapies*. <https://www.endocrine.org/news-and-advocacy/news-room/2022/longer-treatment-with-puberty-delaying-medication-leads-to-lower-bone-mineral-density>
- Nokoff, N. J., Scarbro, S. L., Moreau, K. L., Zeitler, P., Nadeau, K. J., Reirden, D., Juarez-Colunga, E., & Kelsey, M. M. (2021). Body composition and markers of cardiometabolic health in transgender youth on gonadotropin-releasing hormone agonists. *Transgender Health*, 6(2), 111–119. doi:10.1089/trgh.2020.0029
- Olson-Kennedy, J., Chan, Y.-M., Garofalo, R., Spack, N., Chen, D., Clark, L., Ehrensaft, D., Hidalgo, M., Tishelman, A., & Rosenthal, S. (2019). Impact of early medical treatment for transgender youth: Protocol for the longitudinal, observational trans youth care study. *JMIR Research Protocols*, 8(7), e14434. doi:10.2196/14434
- Olson-Kennedy, J., Warus, J., Okonta, V., Belzer, M., & Clark, L. F. (2018). Chest reconstruction and chest dysphoria in transmasculine minors and young adults: Comparisons of nonsurgical and postsurgical cohorts. *JAMA Pediatrics*, 172(5), 431. doi:10.1001/jamapediatrics.2017.5440
- Paris, J. (2015). *The intelligent clinician's guide to the DSM-5*, edn (New York, online edn, Oxford Academic). doi:10.1093/med/9780199395095.001.0001
- Pasternack, I., Söderström, I., Saijonkari, M., & Mäkelä, M. (2019). *Läketieteelliset menetelmät sukupuolivariaatioihin liittyvän dysforian hoidossa. Systemaattinen katsaus. [Medical approached to treatment of dysphoria related to gender variations. A systematic review.]* 106. <https://app.box.com/s/y9u791np8v9gsunwgr2kqn8swd9vdtx>
- Reed, S., Guyatt, G. (n.d.). What is GRADE | BMJ Best Practice. Retrieved September 9, 2022, from <https://bestpractice.bmj.com/info/toolkit/learn-ebm/what-is-grade/>
- Rew, L., Young, C. C., Monge, M., & Bogucka, R. (2021). Review: Puberty blockers for transgender and gender diverse youth—A critical review of the literature. *Child and Adolescent Mental Health*, 26(1), 3–14. doi:10.1111/camh.12437
- Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. *International Review of Psychiatry*, 28(1), 13–20. doi:10.3109/09540261.2015.1115754
- Roberts, C. M., Klein, D. A., Adirim, T. A., Schvey, N. A., & Hisle-Gorman, E. (2022). Continuation of gender-affirming hormones among transgender adolescents and adults. *The Journal of Clinical Endocrinology & Metabolism*, 107(9), e3937–e3943. doi:10.1210/clinem.dgac251
- SBU [Agency for Health Technology Assessment and Assessment of Social Services]. (2022). *Hormonbehandling vid könsdysfori—Barn och unga En systematisk översikt och utvärdering av medicinska aspekter [Hormone therapy at gender dysphoria—Children and young people A systematic review and evaluation of medical aspects]*.

- https://www.sbu.se/contentassets/ea4e698fa0c4449aaae964c5197cf940/hormonbehandling-vid-konsdysfori_barn-oc-h-unga.pdf
- Schwartz, D. (2021). Clinical and ethical considerations in the treatment of gender dysphoric children and adolescents: When doing less is helping more. *Journal of Infant, Child, and Adolescent Psychotherapy*, 20(4), 439–449. doi:10.1080/15289168.2021.1997344
- Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry*, 12, 632784. doi:10.3389/fpsyt.2021.632784
- Spiliadis, A. (2019). Towards a gender exploratory model: Slowing things down, opening things up and exploring identity development. *Metalogos Systemic Therapy Journal*, 35, 1–9. https://www.researchgate.net/publication/334559847_Towards_a_Gender_Exploratory_Model_slowing_things_down_opening_things_up_and_exploring_identity_development
- Socialstyrelsen. (2022a). *Care of children and adolescents with gender dysphoria – Summary*. Retrieved July 22, 2022, from <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapss-tod/2022-3-7799.pdf>
- Socialstyrelsen. (2022b, September 26). God vård vid könsdysfori hos barn och ungdomar [Good care for gender dysphoria in children and young people]. DRAFT, p. 22.
- Strang, J. F., Powers, M. D., Knauss, M., Sibarium, E., Leibowitz, S. F., Kenworthy, L., Sadikova, E., Wyss, S., Willing, L., Caplan, R., Pervez, N., Nowak, J., Gohari, D., Gomez-Lobo, V., Call, D., & Anthony, L. G. (2018). “They thought it was an obsession”: Trajectories and perspectives of autistic transgender and gender-diverse adolescents. *Journal of autism and developmental disorders*, 48(12), 4039–4055. doi:10.1007/s10803-018-3723-6
- Tang, A., Hojilla, J. C., Jackson, J. E., Rothenberg, K. A., Gologorsky, R. C., Stram, D. A., Mooney, C. M., Hernandez, S. L., & Yokoo, K. M. (2022). Gender-affirming mastectomy trends and surgical outcomes in adolescents. *Annals of Plastic Surgery*, 88, 7. https://journals.lww.com/annalsplasticsurgery/Abstract/2022/05004/Gender_Affirming_Mastectomy_Trends_and_Surgical.4.aspx
- Thrower, E., Bretherton, I., Pang, K. C., Zajac, J. D., & Cheung, A. S. (2020). Prevalence of autism spectrum disorder and attention-deficit hyperactivity disorder amongst individuals with gender dysphoria: A systematic review. *Journal of Autism and Developmental Disorders*, 50(3), 695–706. doi:10.1007/s10803-019-04298-1
- Togun, A., Sankar, A., & Karaca-Mandic, P. (2022). FDA safety warnings and trends in testosterone marketing to physicians. *The American Journal of Managed Care*, 28(3), e78–e79. doi:10.37765/ajmc.2022.88841
- Turban, J. L., Almazan, A. N., Reisner, S. L., & Keuroghlian, A. S. (2022). The importance of non-probability samples in minority health research: lessons learned from studies of transgender and gender diverse mental health. *Transgender Health*. Advance online publication. doi:10.1089/trgh.2021.0132
- Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors leading to “Detransition” among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT Health*, 8(4), 273–280. doi:10.1089/lgbt.2020.0437
- Vandenbussche, E. (2022). Detransition-related needs and support: A cross-sectional online survey. *Journal of Homosexuality*, 69(9), 1602–1620. doi:10.1080/00918369.2021.1919479
- Wiepjes, C. M., Nota, N. M., de Blok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M.-B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, 15(4), 582–590. doi:10.1016/j.jsxm.2018.01.016
- World Professional Association for Transgender Health (WPATH). (2018). WPATH POSITION ON “Rapid-Onset Gender Dysphoria (ROGD)”. Retrieved July 11, 2022, from https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/9_Sept/WPATH%20Position%20on%20Rapid-Onset%20Gender%20Dysphoria_9-4-2018.pdf
- Zheng, S. L., & Roddick, A. J. (2019). Association of aspirin use for primary prevention with cardiovascular events and bleeding events: A systematic review and meta-analysis. *JAMA*, 321(3), 277. doi:10.1001/jama.2018.20578
- Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior*, 39(2), 477–498. doi:10.1007/s10508-009-9540-4

From: [Christina Bailey](#)
To: [BOM Public Comment](#)
Subject: Protect Healthcare Freedom
Date: Tuesday, October 18, 2022 4:26:43 PM

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,

Just as it is the legal right of parents to not vaccinate their children or refuse medical services that violate religious or cultural beliefs, you cannot take away a parent's right to seek care their child requests for gender affirmation. To do this would be no different than requiring a child to be vaccinated for COVID: it is a parent's right to choose. There is no evidence of negative impacts of gender affirming care. There is, however, a correlation of childhood suicide and denial of assistance for gender affirmation. Do you really want to regulate healthcare this much, and for something purely political with no scientific merit to ban?

Christina Bailey
christinahopebailey@gmail.com

St. Petersburg, Florida 33713

From: [Victoria Schneider](#)
To: [BOM Public Comment](#)
Subject: Gender misinformation
Date: Monday, October 24, 2022 4:45:05 PM

You don't often get email from victoriaschneidermd@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

I am a pediatrician with expertise in child abuse and general pediatrics. What is happening in pediatrics in regards to gender affirmation is irresponsible at best and borders on child abuse. Children lack the decision making skills of adults- they are not mature enough to drink alcohol, drive cars, or vote. They are certainly are not developmentally able to make permanent life altering decisions about their bodies.

Moreover adolescence is a time of intense confusion and desire to “fit in” with their peers; they need guidance, counseling and sometimes therapy to address issues of isolation, depression, and gender dysphoria.

Permanent decisions about their bodies should be made when they are through the throes of adolescence.

Florida has an opportunity to be a leader in the country in protecting these children and finally bringing common sense to this national debate.

From: [Theron Williams](#)
To: [BOM Public Comment](#)
Subject: The Consequences of your Action will kill my paramedic mother
Date: Sunday, October 23, 2022 11:26:37 PM

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’,

Lots of people have already sent your board many messages on the topics of trans healthcare. I know you won't read this, you're being paid not to. That's the thing about corruption. You don't care who suffers as long as there is coins in your pockets.

But I want to speak to you about my mother, a paramedic and whom worked in the field of medicine for over 40 years. She dedicated her life to saving lives, putting her own life on the line day after day. My mother is not trans or non binary, she's not even part of the LGBT community. She's my mom.

She was diagnosed with an aggressive form of Breast Cancer that consumes and infests on the Estrogen in her body. Within a month it advanced through stage 3 into stage 4.

BECAUSE of your so called medical board's actions, she had to fight her doctors in the state community healthcare program for access to a doctor to check her. They dismissed her concerns. Told her to lose weight and take blood pressure meds. The Doctor's the state used proved either lazy or incompetent or both.

And ER doctor at ORMC found her cancer by accident in an xray of her stomach.

BECAUSE of your so called medical board's actions, she had to fight to get an approval to remove both of her breasts because of the chilling effect your board had on attacking trans men impacting women's healthcare. That delay allowed the cancer to spread to her lymph nodes.

She's had to have 4 surgeries now because of that delay. Her body is covered in scars and she'll never be able to have reconstruction. All because you wanted to deny healthcare to trans men, My mother suffers needlessly.

My mom is now on chemo, a form that includes a block for estrogen in her body so the remaining cancer can starve and die faster than it can consume my mother and kill her. It'll be her life for the next 7 years, maybe the rest of her life which your medical boards political short sighted arrogance and greed has shorted.

BECAUSE of your so called medical board's actions, when my mom was in recovery from her many surgeries and infections she got inside the hospital, I had to fight nurses and doctors to give her the life saving chemo she needed only because they objected on religious grounds to

saving my mom's life with a hormone blocker or they were concerned they'd be punished by your asinine actions. Just rumor of what corrupt machinations your board was up to was enough to threaten her fight against cancer.

BECAUSE of your so called medical board's actions, Medicaid and my insurance both tried to drop my mother on trumped up reasons, but largely because they didn't want to cover anything that might be remotely related to trans healthcare. I had to foot the bill for her cancer treatment and bankrupted me in a month. I don't come from wealth, my mom and I fought and clawed and struggled to get out of poverty and now we're decending back into because of you. We were notified again this week the state medicaid is trying to terminate her coverage.

Because of your so called medical board's action, that monster that calls himself the florida governor and all the dirty money that's flowing into your pockets by christoascists waging the dumbest of all culture wars, My mom is going to suffer and die.

So I'm writing this letter to tell you to stop your madness. Stop this Death Panel you call a board of medicine.

You're killing my mother.

And damn you all.

Trans people did nothing to deserve this amount of cruelty from you and neither did my mother.

damn you all.

Theron Williams
a@rocket396.com

Orlando, Florida 32810

From: [Olivia Mehring](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 7:35:42 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

,

I'm Olivia, and gender affirming hormone therapy saved my life. I was 16 and was baker acted for attempted suicide. I knew I was trans since I was 16, and despite my parents support I was afraid of moving forward with my transition. Like all trans kids, it was a huge decision and I didn't make it lightly. It takes teams of professionals who did not make it easy to get on hormones. It is not a choice that is ever made on a whim. Transitioning saved my life, and countless others. The rate of attempted suicide decreases exponentially when a trans person, especially a young trans person, gets access to hormones. I bet you to not cave to the political pressure surrounding this issue, but to listen to those trans healthcare actually effects. I beg you to not change the availability of hormones to young trans people. If you do, the blood of many children will be on you.

Olivia Mehring
cadenmehring@me.com

Oviedo, Florida 32765

From: [Egnor, Michael](#)
To: [BOM Public Comment](#)
Subject: Submission for Florida Board of Medicine on "Gender-affirming" surgery
Date: Friday, October 21, 2022 7:35:52 PM

You don't often get email from michael.egnor@stonybrookmedicine.edu. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,

Please consider my submission of an op-ed I recently wrote on The Federalist on the ethics of gender-affirming surgery for the upcoming meeting of the Florida Board of Medicine on this issue. I believe that gender dysphoria is a psychiatric illness, and the use of medical treatments such as puberty blockers and hormones or surgical castration and mutilation on these mentally ill children and adults is a horrible violation of medical ethics and should be illegal.

I am a professor of neurosurgery at the Renaissance School of Medicine at Stony Brook University in New York. I trained in neurosurgery at the University of Miami. I have 40 years of surgical and teaching experience in medicine, and I am the director of the neurosurgery residency program at my medical school.

I hope the Board will decide to ban this practice and sanction the doctors who do it. Please let me know if I can be of any help in this important matter.

Sincerely,

Michael Egnor MD
Professor of Neurosurgery
Renaissance School of Medicine
Stony Brook New York.
631 806 2409

<https://thefederalist.com/2022/09/23/operating-on-healthy-bodies-defies-surgical-ethics-and-trans-people-are-no-exception/>



Operating On Healthy Bodies Of Transgender People Defies Ethics

Surgical removal of healthy organs is not a treatment for mental illness. Gender dysphoria should be treated with psychiatric therapy.

Operating on Healthy Bodies Defies Surgical Ethics, And Trans People Are No Exception

Surgical removal of healthy organs is not a treatment for mental illness. Gender dysphoria should be treated with psychiatric therapy.

Michael Egnor, MD

As a pediatric neurosurgeon, I have followed the [proliferation of surgical procedures for “gender affirmation”](#) with increasing dismay. That public schools now advocate such treatments to young children is particularly alarming. I say this based not on personal opinion but on 35 years of experience as a surgeon and instructor of surgeons.

I teach at a medical school and I am residency director for neurosurgery in my institution. This means I am in charge of training young neurosurgeons. I emphasize to medical students and resident neurosurgeons that the first and most fundamental responsibility a surgeon has to his patients is to make an appropriate initial decision as to whether or not to operate. A surgeon’s first responsibility, when treating a patient with a potentially surgical disorder, is to determine whether or not surgery is in the patient’s best interest. A well-performed operation is still malpractice (or even assault) if it is not done for valid medical reasons. Operating for marginal (or less) indications is more common than most of the public realizes—after all, surgeons are paid (quite well) to operate, and they rightly take pride in operating with skill. To be paid handsomely for what you love to do is a privilege, a joy and a very dangerous temptation. Not every patient who consults a surgeon really needs surgery—often, non-surgical treatment is more effective and less risky.

Thus, when I quiz my students and residents about treatment options for various conditions, I always insist that they begin with discussion of non-surgical treatments. Honest and conscientious surgeons only do surgery when less invasive options are inadequate and there are clear justified indications for surgery. The patient’s health, not the surgeon’s ego, is paramount. This is basic surgical ethics.

So-called 'Gender Affirmation' surgery violates ethics

Surgery for “gender affirmation” or “sex reassignment” grossly violates the ethical canons I have taught, that were taught to me, and that were taught to all surgeons until very recently.

Such surgery entails radical and irreversible operations *on normal healthy organs*—mastectomy performed on normal breasts, amputation of the normal penis and scrotum (with construction of an opening to imitate a vagina), excision of the normal uterus and ovaries (with construction of a skin-tube to imitate a penis), among other procedures. These procedures are permanently disfiguring and render patients sterile.

What is the ethical basis for such mutilating surgery performed on perfectly healthy organs? It is a basic principle of medical ethics that surgeons are under no obligation to perform surgery on healthy body parts simply because a patient requests it. In fact, a surgeon is generally obligated to *refuse* to damage a patient's normal organs or body parts just because the patient wants it done—e.g., it is unethical for a general surgeon to amputate a patient's normal healthy arm or leg just because the patient requests it (this is a [real issue](#)), or remove a patient's healthy eyes or a healthy part of a patient's brain, simply because of a patient's request. There are patients who suffer greatly from [Body Integrity Image Disorder](#), but it is a *psychiatric* condition, not a surgical condition. Surgical mutilation is not a treatment for psychiatric illness.

Patients with [Gender Dysphoria](#) obviously share much in common with patients with Body Integrity Image Disorder—it may reasonably be understood as a variant of it. Under what circumstances are radical and permanent surgical procedures justified for these patients?

Mental not physical illness

To consider the ethics of surgical treatment for Gender Dysphoria, I note that these patients are mentally ill. I don't mean this term in a derogatory sense. I mean it in a *medical* sense. Patients presenting to a physician for Gender Dysphoria are certainly ill, in that they are seeking medical help. If they were not ill, they wouldn't be going to a doctor. And Gender Dysphoria is a mental, rather than physical illness, because the sexual organs of people with Gender Dysphoria are functioning normally. There is nothing physically wrong with the penis and testicles of a trans-woman, or with the uterus and ovaries of a trans-man. The illness is mental—the patient does not feel like his or her biological sex and does not want to be his or her biological sex. This of course can cause great suffering—it is a real illness—but the suffering is mental, not physical.

The primary justification for radical medical and surgical 'treatment' of Gender Dysphoria is that it reduces the risk of suicide, but this is not supported by the [evidence](#). Furthermore, the assertion 'I'm going to kill myself if doctors don't mutilate my body' emphasizes the psychiatric, rather than physical, nature of Gender Dysphoria illness. There are well established treatments for suicidal ideation, none of which entail the destruction of normal body parts by hormonal castration or surgical mutilation.

Gender Dysphoria is not a surgical, nor even a medical, illness. It is a psychiatric illness, and should be treated by psychiatric therapy, not by hormones or by scalpels. It is to the great discredit of the medical profession that we perform and sanction these radical operations. Surgery for Gender Dysphoria is profoundly unethical according to generally accepted standards of surgical practice. Surgeons should not deliberately destroy normal organs or body parts. _

-
Patients with Gender Dysphoria have a psychiatric illness, and our efforts at treatment of this condition should be directed to the psychiatric issues involved, for which there are [good and established principles of care](#). It is to the psychiatric care and social support of people with Gender Dysphoria—not dangerous and radical medical or surgical interventions— that our resources should be devoted.

Dr. Egnor is a professor of neurosurgery and pediatrics at the Renaissance School of Medicine in Stony Brook, New York.

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From: [Nisa Birnbaum](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 7:04:15 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about medical care belong within the sanctity of the patient-physician relationship.”

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of

WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Nisa Birnbaum
newnisa2002@bellsouth.net

Boca del Mar, Florida 334981917

From: [J Anderson](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Has Saved My Daughter
Date: Tuesday, October 18, 2022 4:42:10 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

,

As the mother of a young trans woman, I've seen firsthand how gender-affirming healthcare has made a huge and positive change in her life. Prior to taking female hormones after going through puberty, she was depressed, wouldn't engage with family/others, and just hid behind a hoody sweatshirt and computer. We had no idea what was going on and were quite worried. Since opening up to us and starting hormones 13 months ago, I have a happy daughter who is enthusiastic about life and now enjoys being around people. She's a amazing young woman instead of a hidden young man. I'm so glad to have her in our family and to no longer worry that I would discover my child had ended their life by suicide. It was that bad.

All young people who need gender-affirming care should have access to it. I request that the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

J Anderson
aj149@yahoo.com

, Saint Croix Island 32163

From: [Patrice Yang](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:38:43 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Gender-affirming care is lifesaving and must not be outlawed. Medical history is private and must not be shared without the patient's consent.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that "gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals."

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Patrice Yang
paoladavid20@yahoo.com

Hollywood, Florida 33020

From: [Alice Adora](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:42:56 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Alice Adora
alicehadora@gmail.com

Miami, Florida 33165

From: [Mary Foley](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:43:31 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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Mary Foley
mcfoley06@gmail.com
3540 Woodridge Pl
Palm Harbor, Florida 34684

From: [Alyse Lancaster](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:48:26 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, and as the parent of a transgender son, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state. Restricting gender-affirming care is, in essence, telling transgender children their lives don't matter. And that is unacceptable.

My son is 18 now, but he came out of transgender at 14, I can attest without a shred of doubt that had he not been given access to gender-affirming care, he very likely would not be with us anymore. The research supports the importance of allowing transgender children and their parents to determine with their doctors the appropriate care. It is not the government's decision to make.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that "gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals."

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts "dangerous governmental intrusion into the practice of medicine." The AMA cited that "trans and non-binary gender identities are normal variations of human identity and expression" and that "evidence has demonstrated that forgoing gender-affirming care can have tragic consequences." Furthermore, the AMA asserted that "Decisions about medical care belong within the sanctity of the patient-physician relationship."

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While Florida currently does not have state-specific standards for providing gender-affirming

care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Alyse Lancaster
alyselancaster@yahoo.com

Miami, Florida 33176

From: [Michael Alexander-Luz](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:00:02 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state. As a licensed mental health clinician, I urge you to NOT give in to politics of this state and follow the guidance of the various medical associations which have made CLEAR the need for life saving treatment for trans and non-binary youth and adults. THIS IS NOT ABOUT POLITICS, these are lives in your hands.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Michael Alexander-Luz
malexander85@ymail.com

Jacksonville, Florida 32216

From: [Tracy Furr](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:00:48 PM

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As a parent of a trans child who frequently visits their grandparents that reside in Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Tracy Furr
tracyfurr@gmail.com

South River, New Jersey 08882

From: [Diane Lebedeff](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:03:54 PM

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As a citizen of Florida, the proposal that medical standards be set for political purposes is appalling and should appall every public official. For children, to deny medical care that has been shown to reduce rates of suicide in a group tragically most prone to suicide would be inhumane. For adults, let our medical profession give them peace and an ability to be comfortable in their own skin.

I urge the Florida Board of Medicine to abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Diane Lebedeff
dlebedeff@gmail.com
101 South Bayshore Boulevard,, Apt. 31
Safety Harbor, Florida 34695

From: [Rita Garvey](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:08:25 PM

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Rita Garvey

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1715 Estelle Dr

CLEARWATER, Florida 33756-4524

From: [Lynn Brodsky](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:15:57 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

, I Lynn Brodsky, a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Lynn Btodsky

lynnielmb@aol.com

30 lance ct

Oldsmar, Florida 34677

From: [HARRISON SCOVILLE](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:24:11 PM

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HARRISON SCOVILLE

hws2c2009@gmail.com

3317 NW 26th St

Gainesville, Florida 32605-2383

From: [Sherry Scoville](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:31:49 PM

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Sherry Scoville
sjtIs83@gmail.com

Gainesville, Florida 32605

From: [Michele Horan](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:40:27 PM

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Michele Horan
micheleahoran@hotmail.com

St. Paul, Minnesota 55116

From: [Michelle Labgold](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 5:43:24 PM

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Michelle Labgold
mlabgold@yahoo.com

Miami, Florida 33179

From: [Sara Levine](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 6:00:12 PM

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Sara Levine
slevine1022@yahoo.com

,

From: [Autumn Barker](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 6:14:02 PM

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Autumn Barker
arbarker7@icloud.com

Orlando, Florida 32839

From: [Elizabeth Labbe](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 6:24:59 PM

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I run a charter school that is welcoming to Trans students. We have several whose families mentioned that we are the first school where they feel safe. I urge you not to abandon these young people. All they need is love, just like every other young person in your lives.

Elizabeth Labbe

LLa2be@gmail.com

6825 NW 43rd Place

Gainesville, Florida 32606

From: [Dr. Ruth Neese](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 7:05:27 PM

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Dr. Ruth Neese
owlbait1@gmail.com

Port St. Lucie, Florida 34953

From: [Melanie Sutterfield](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 7:14:41 PM

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It's not fair for these kids having to go through the same nightmarish things I have to during my transition. They should be able to get on puberty blockers and decide for themselves later in their lives. Puberty blockers are safe.. Often life saving for CIS and trans people alike. In fact my sister who is CIS would probably not be alive without them. She started menstruation when she was 6 and they were so bad that she would become so anemic that she would pass out. She I now 32 with a happy baby boy and that couldn't have happened without being on blockers first.

If I was on blockers during my teenage years I would most likely have not attempted killing myself multiple times... Nor be afraid of loosing control of myself because the hormones I was being flooded with went against the very fiber of my soul and mind. I would give anything to have been able to transition in my teenage years and these kids deserve to have that ability for the whopping 1% of the population we take up. You know what you should do and if you do not help these children be their true selves and dodge going through the literal hell it is to go through the wrong puberty then I guess we will not be seeing you in the good afterlife.

Melanie Sutterfield
melaniesutterfield@yahoo.com

Howie In The Hills, Florida 34737

From: [Reminé Benniefield](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 7:25:08 PM

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Reminé Benniefield
benniefieldr@arizona.edu

Tucson, Arizona 85730

From: [Riley Brannian](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 7:30:45 PM

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Riley Brannian
rebrannian@gmail.com

Iowa City, Iowa 52246

From: [Hedieh Sepehri](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 7:40:52 PM

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Hedieh Sepehri
hediehks@gmail.com

Coral Gables, Florida 33146

From: [Tina Donataccio](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 8:16:55 PM

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Tina Donataccio
tina.donataccio@gmail.com

Tampa, Florida 33713

From: [Kyle Belz](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 8:37:18 PM

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Kyle Belz
kylebelz@belzlegal.com

Valrico, Florida 33594

From: [Sam Zlotnik](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 8:47:27 PM

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Sam Zlotnik
smzlotnik@gmail.com

Gainesville, Florida 32601

From: jimmpen@gmail.com
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 8:49:14 PM

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jimmpen@gmail.com

,

From: [Melody C](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 9:22:33 PM

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Melody C

ashleythevulpix@yahoo.com

, Florida 34997

From: [Susan Jenik](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 9:30:27 PM

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Susan Jenik
sjenik@gmail.com

Casselberry, Florida 32707

From: [Jessica Tomlinson](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 9:37:31 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,

Health care for trans youth is life affirming and life saving.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Jessica Tomlinson
jt1262@yahoo.com

St. Petersburg, Florida 33704

From: [John Doe](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 9:40:24 PM

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John Doe

qgbhjqdyfrasgqhmg1@tmmcv.net

, 32007

From: [Ellen Baty](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 9:44:57 PM

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Ellen Baty
ellenbaty@gmail.com

Orlando, Florida 32825

From: [Adriane E](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 9:59:47 PM

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Adriane E
stopbullyingkidsrepublicans@aol.com

Orlando, Florida 32804

From: [Alison Smith](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 10:01:12 PM

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As a citizen of Florida, a former college professor, elementary teacher, and lesbian, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state. Why? Because I care!

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Alison Smith
smithadenee@gmail.com

Orlando, Florida 32839

From: [Marthe Hjortshøj](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 10:18:47 PM

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Marthe Hjortshoj
marthe.hjortshoj@gmail.com

Jupiter, Florida 33458

From: [Olga Loper](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 10:36:25 PM

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In addition, this is a deep government intrusion into the lives of citizens

Olga Loper
olga@aol.com

Fort Lauderdale, Florida 33312

From: [Stacy Sechrist](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 10:44:10 PM

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Stacy Sechrist
stacy.sechrist@gmail.com

Fleming Island, Florida 32003

From: [Tona Wiegel](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 10:59:11 PM

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Tona Wiegel
twiegel@yahoo.com

Weston, Florida 33326

From: [Jodi Schulinn](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 11:12:26 PM

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Jodi Schulinn
jschulinn@gmail.com

, Florida 34110

From: [Chase Gibson](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 11:18:01 PM

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Chase Gibson
cjgibby626@gmail.com

Lake Butler, Florida 34786

From: [Fran Lucher](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 11:41:35 PM

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Fran Lucher
flucher1@cerizon.net

Wantagh, New York 11793

From: [Lauren Fox](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 11:53:27 PM

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Lauren Fox
foxlauren96@gmail.com

Windsor Gardens, South Australia 5087

From: [Judy Schwartz](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 12:22:41 AM

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Judy Schwartz

jaws05@juno.com

19860 W Dixie Hwy

Aventura, Florida 33180

From: [Judy Schwartz](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 12:22:41 AM

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Judy Schwartz

jaws05@juno.com

19860 W Dixie Hwy

Aventura, Florida 33180

From: [Lorelei Zayas](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 1:22:38 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I, Lorelei Zayas, demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Lorelei Zayas
lor3lei33@gmail.com

Kissimmee, Florida 34743

From: [Denise Gamache](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 2:11:53 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Denise Gamache
torifan3@yahoo.com

Golden Gate, Florida 34116

From: [June Midura](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 2:18:40 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a trans person, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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June Midura
june@m.krakow.pl

Myszków, Silesian Voivodeship 33-080

From: [April Nall](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 4:55:08 AM

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April Nall

franklyfeministmom@gmail.com

Vero Beach, Florida 32960

From: [bug Croghan](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 5:19:04 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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bug Croghan
croghankarly@gmail.com

Sanford, Florida 32771

From: [Tyesha Branch](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 5:26:08 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Tyesha Branch
tyelane@aol.com

Altamonte Springs, Florida 32714

From: [Abbie Aldridge, MA, LMHC, LPC, LCPC, LPCC, NCC](#)
To: [BOM Public Comment](#)
Subject: SUICIDE PREVENTION: Gender Affirming Care for Trans and Gender Diverse Youth
Date: Tuesday, October 18, 2022 5:08:40 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida and a licensed mental health provider, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender affirming care and ensure uninterrupted access to care for transgender and gender diverse minors and adults throughout the state.

Transgender and gender diverse youth and adults have existed as long as people have existed. Our existence will not be snuffed out by prejudiced regulation. Measures to restrict or eliminate care will serve to place a higher strain on already stretched thin mental health services in the state, as further people are victimized and traumatized by actions unsupported by peer-reviewed evidence. We deserve better. Transgender and gender diverse people are not second class citizens or any less deserving of comprehensive care.

While many myths seem to be circulating about what gender affirming care looks like for youth, it's often conveniently overlooked that the same types of care are available to cisgender youth. Puberty blockers or GRnH agonists were created with the intent of pausing precocious puberty in cisgender children. Cisgender teen girls can obtain hormone therapy - by way of contraceptives. Cisgender adolescents may obtain elective surgeries like rhinoplasty, breast augmentation, and breast reduction. While these are available to cisgender youth as elective procedures, there is no evidence based basis to prevent access to medically necessary and lifesaving care, by way of the same interventions to transgender and gender diverse youth.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that "gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals."

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Abbie Aldridge, MA, LMHC, LPC, LCPC, LPCC, NCC
abbie@healingvillagetherapy.com

Largo, Florida 33771

From: [Angel D'Angelo](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 2:42:51 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Angel D'Angelo
archangeladvocacy@gmail.com
9660 Kona Village Dr Apt 110
Riverview, Florida 33578

From: [Juan del Hierro](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:25:08 PM

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Juan del Hierro
juan@unityonthebay.org

Miami, Florida 33137

From: [Susan Phillips](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:51:28 PM

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Susan Phillips
acupunctureplus@gmail.com

Spring Hill, Florida 34609-9038

From: [Cleo Welles](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:47:08 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of the US, and a Trans person myself, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Cleo Welles
cleo@blahaj.nyc

New York, New York 11230

From: [Raymond Simms](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:47:08 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

Florida State BOM has every responsibility to follow the science and not be swayed by political influence.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Raymond Simms
raysimms1963@gmail.com

Safety Harbor, Florida 34695

From: [Keri Sather-Wagstaff](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:00:33 PM

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Keri Sather-Wagstaff
keriannsw@gmail.com

Groveton, Virginia 22306

From: [Maria Mejia](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:59:56 PM

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Maria Mejia
mcmejia1@me.com

Lantana, Florida 33462

From: [Erik Comstock](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:59:53 PM

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Erik Comstock
roomclearer@gmail.com

Mount Dora, Florida 32757

From: [Jennifer Comstock](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:59:26 PM

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Jennifer Comstock
jencomstock81@gmail.com

Mount Dora, Florida 32757

From: [Anne Barela](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:58:32 PM

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Anne Barela
Registered Voter
Merritt Island, FL

Anne Barela
mydigitalhome@gmail.com

Merritt Island, Florida 32952

From: [Terry Lowman](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:53:59 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

This is not a political issue, it's a health issue that needs to be driven by science and experience. So many trans people are vulnerable--either through suicide or by murder. We need to normalize a full spectrum of genders and celebrate their humanity.

Terry Lowman
terryleelowman@gmail.com

Miami Beach, Florida 33139

From: [Ami Granger Welch](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 3:53:13 PM

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Ami Granger Welch
ami.marie@me.com

Tampa, Florida 33611

From: [Emily Mancini](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:26:24 PM

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Emily Mancini
emilyemancini@gmail.com

Miami, Florida 33157

From: [Kendra Mon](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:26:15 PM

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I am a citizen of Florida whose mom received great care in the last years of her life from a transgender doctor. So many of us are opposed to people we don't know but find friends when we get to know them.

Having gotten to know people who are or want to be transgender, my heart goes out to them. Some are depressed or suicidal due to not having support or suffering discrimination or abuse. Please open your hearts and minds to transgender care.

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Kendra Mon

kendramon@comcast.net

Tallahassee, Florida 32301

From: [Steven Wetstein](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:20:46 PM

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Steven Wetstein
swetstein21@gmail.com
8400 SW 36 Street
Miami, Florida 33155

From: [Diane Maureen](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:16:20 PM

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As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state. My granddaughters friend has had unfortunate situations in their journey; he is a human being and should be treated as such, no matter what.

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Diane Maureen
diantnt@gmail.com

Alachua, Florida 32615

From: [Lauren Gray](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:12:45 PM

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Lauren Gray
lauren@thinkgray.net

St. Petersburg, Florida 33705

From: [Deborah Deland](#)
To: [BOM Public Comment](#)
Subject: We KNOW Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:35:12 PM

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Deborah Deland
dcdeland@gmail.com

Orlando, Florida 32835

From: [Rachel Bernard](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:35:17 PM

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Rachel Bernard
rachelrules322@gmail.com

Pine Ridge, Florida 34465

From: [Emilie Sukijbumrung](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:36:35 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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Emilie Sukijbumrung
emilie.sukijbumrung@gmail.com

Tampa, Florida 33604

From: [Elizabeth Cunningham](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 4:37:09 PM

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Elizabeth Cunningham
bethcunningham12@gmail.com
4440 ADDISON PL
SARASOTA, Florida 34241

From: [Alicia Keenon](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 25, 2022 2:12:54 PM

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Alicia Keenon

alicia.keenon@gmail.com

Port Orange, Florida 32127

From: [Jeanne Tanke](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 25, 2022 1:53:18 PM

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Jeanne Tanke
jeanne622aclu@yahoo.com

Daytona Beach, Florida 32118

From: [Jill Davis](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 25, 2022 1:40:22 PM

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Jill Davis
jkdicsw@mail.com

Orlando, Florida 32835

From: [Nashki Joseph](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 25, 2022 11:12:14 AM

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Nashki Joseph

Nashkigames@gmail.com

Delray Beach, Florida 33484

From: [Alex Cavazos](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 11:55:09 PM

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Alex Cavazos

8y2yxza23@mozmail.com

Altoona, Wisconsin 54720

From: [Jane Doe](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 9:26:53 PM

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Jane Doe

TransRightsRHumanRights@lgbt.qia

Fort Lauderdale, Florida 33311

From: [Harold Schaitberger](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 5:06:44 PM

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Harold Schaitberget
iaffhasgp@yahoo.com

Woolford, Maryland 21677

From: [Harold Schaitberger](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 5:03:17 PM

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Harold Schaitberget
iaffhasgp@yahoo.com

Woolford, Maryland 21677

From: [Peggy Pfeiffer](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 3:34:30 PM

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Peggy Pfeiffer
pfeiffer31@hotmail.com

Coral Springs, Florida 33067

From: [Karen Anne Pfeiffer](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 2:53:12 PM

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Karen Anne Pfeiffer
karatspc@yahoo.com

Woolford, Maryland 21677

From: [Kelly Noe](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 2:39:34 PM

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Kelly Noe
kellynoe717@gmail.com

Los Angeles, California 90039-2918

From: [Karen Craig](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 2:36:10 PM

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Karen Craig
karenmarie3@gmail.com

Fort Lauderdale, Florida 33304

From: [Michelle Paisley](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 2:35:30 PM

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Michelle Paisley
chellep66@aol.com

Ellenton, Florida 34222

From: [John Pfeiffer](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 2:22:12 PM

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John Pfeiffer

johnpfeiffer44@gmail.com

Coral Springs, Florida 33067

From: [William Pfeiffer](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 2:18:55 PM

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William Pfeiffer
william.pfeiffer@gmail.com

Malibu, California 90265

From: [Jo Pfeiffer](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 1:27:12 PM

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Jo Pfeiffer

jopfeiffer1@gmail.com

Santa Barbara, California 93105

From: [Breanne Gillis](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 12:20:24 PM

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Breanne Gillis

breannegillis@gmail.com

6401 park st

Hollywood , Florida 33024

From: [Colleen Bastian](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 11:37:35 AM

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Colleen Bastian
colleenbastian@gmail.com

Delray Beach, Florida 33444

From: [Ari Bloshinsky](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 11:35:09 AM

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Ari Bloshinsky
arishay27@yahoo.com

Fayetteville, Arkansas 72701

From: [Carrie Newman](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 11:15:13 AM

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Carrie Newman
cduncan.newman@gmail.com

Decorah, Iowa 52101

From: [Jennifer Renee](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 10:59:20 AM

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Jennifer Renee
gnetluvsgreg@gmail.com

Coral Springs, Florida 33065

From: [Meagan Cahuasqui](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Monday, October 24, 2022 8:51:15 AM

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Meagan Cahuasqui
meaganc21@gmail.com
508 Congressional Way
Deerfield Beach , Florida 33442

From: [BOM Public Comment](#)
To: [BOM Public Comment](#)
Subject: FW: Gender-Affirming Care Is Life Saving Health Care
Date: Sunday, October 23, 2022 8:31:13 PM

From: Anon Ymous <info@sg.actionnetwork.org>
Sent: Sunday, October 23, 2022 11:40 AM
To: BOM Public Comment <BOMPublicComment@flhealth.gov>
Subject: Gender-Affirming Care Is Life Saving Health Care

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,

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Anon Ymous

Florida

From: [Lois Behr](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Sunday, October 23, 2022 3:05:30 PM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

As a parent, I personally know the pain my son experienced until he received the gender-affirming care he needed. If he could not live as his authentic self, he didn't want to live. We were fortunate to find gender affirming healthcare at Arnold Palmer Hospital. As an adult, he hasn't completely transitioned medically because it is cost prohibitive. Would you deny your child life sustaining medical treatment if they were suffering. I doubt it!

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that "gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals."

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Lois Behr
loisbehr@gmail.com

DeLand, Florida 32724

From: [Laura Veitia](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Sunday, October 23, 2022 1:29:27 PM

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Laura Veitia
lauraveitia@gmail.com

North Bay Village, Florida 33141

From: [reana s](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 22, 2022 11:19:54 PM

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Sincerely,
Reana.

reana s
reanas@yahoo.com

Ormond Beach, Florida 32174

From: [Sareet Taylor](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 22, 2022 8:29:38 PM

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Sareet Taylor
s32flavors@hotmail.com

, North Carolina 28768

From: [M Torsiditos](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 22, 2022 6:11:07 PM

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M Torsiditos
matorsiditos@gmail.com

Savage, Minnesota 55378

From: [Sanya Bansal](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 22, 2022 4:37:43 PM

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Sanya Bansal
bansalsanya123@gmail.com

St. Augustine, Florida 32092

From: [andrew delgado](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 22, 2022 4:24:17 PM

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andrew delgado
hermionesbf@gmail.com

Miami, Florida 33187

From: [Lucia Chang](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Saturday, October 22, 2022 4:02:16 PM

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Lucia Chang
luciachang18@gmail.com

Hialeah, Florida 33018

From: [Nicholas Hengels-Chinn](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Friday, October 21, 2022 11:01:27 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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Nicholas Hengels-Chinn
nhengelschinn@gmail.com

Belvidere, Illinois 61008

From: [Hillary Morris](#)
To: [BOM Public Comment](#)
Subject: please help save our lgbtq youth
Date: Friday, October 21, 2022 10:57:54 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida and the mother of an LBTQIA teen in Florida public school, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state. My son is not trans. However, he is on the gender spectrum. Please do not restrict gender-affirming care in FLorida. Children will commit suicide because of this law. Blood WILL be on your hands.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Hillary Morris
Hillaryishere@pm.me

Stuart, Florida 34996-3616

From: [Kim Devine](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Friday, October 21, 2022 9:14:15 AM

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Kim Devine

Kim@getoffthecouchcounseling.com

Palm Coast, Florida 32137

From: [Gisette Rodríguez](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Friday, October 21, 2022 7:18:35 AM

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Gisette Rodríguez
gisette_rdrz@yahoo.com

MIAMI GARDENS, Florida 33027

From: [James Fleming](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Friday, October 21, 2022 4:00:12 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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James Fleming
james@electronic-quill.net

Pizarrera, La (Urbanizacion), Madrid 28210

From: [Zeke Boost](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Friday, October 21, 2022 1:07:19 AM

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Zeke Boost

Zekeboost@gmail.com

Salem, Oregon 97302

From: [Isabel Francis](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 6:21:02 PM

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As a Registered Nurse, mother of three, and citizen of Florida, I am requesting that the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state. I am also a PhD student studying at the University of South Florida in Tampa. My field of research is negative health impacts of stigma and repressive policies on sexual and gender diverse persons. I have first-hand experience working with transgender patients, teaching them how to inject their gender affirming hormone therapy. There is nothing more cruel than to deny this population the care they need, based on antiquated ideas of gender identity. Research into the biological basis of diversity in gender identity published in the journal Behavioral Genetics (Polderman et al., 2018) indicates that there is a biological diversity underlying gender identity development, and that awareness of this foundational for reducing health disparities and promoting human rights for sexual and gender minorities.

Just this month, Liu et al. explicated the negative health outcomes in the sexual and gender diverse population due to stigma and archaic ideas medicalizing transgender identity as a mental illness. Published in the New England Journal of Medicine, this group of distinguished researchers and physicians from Harvard Medical School and Massachusetts General Hospital concluded that it is incumbent upon the health care sector to equitable care experiences and health outcomes for sexual and gender diverse populations. To act in contradiction to what is generally accepted medical practice is an affront to the profession and demonstrates a severe knowledge gap in the Florida medical community.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about

medical care belong within the sanctity of the patient-physician relationship.”

While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

I would be happy to come and bear witness to my personal experience with the importance of gender affirming hormone therapy in this population, and to share my research insights with you. I cannot ask you more strongly not to reverse years of medical practice and research, and return to a repressive, medically inaccurate model.

Isabel Francis, MPA, MSN, RN

Isabel Francis
isabeljulieanna@gmail.com
6439 Fuller Dr
Bokeelia, Florida 33922

From: [Sam Lowry](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 8:45:57 PM

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,

As someone that lost his cousin to suicide because her friends and family weren't supportive enough of her decision to seek gender affirming care, I am strongly opposed to any measure counteracting it. She was a good kid that deserved an understanding and supportive network, and she died because she didn't have it.

It's just hurtful and unnecessary.

Sam Lowry
samlowry2022@gmail.com

Holt, Alabama 35404

From: [BethAnne AlgieRN](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 7:27:12 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

AS A MEDICAL PROFESSIONAL, I BELIEVE NO MEDICAL PROFESSIONAL SHOULD VOTE ON THE ISSUE *UNLESS THEY HAVE BEEN EDUCATED ON THE SAME.*

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

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affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

BethAnne AlgieRN
nurse4eyegaze@gmail.com

, Saint Croix Island 32314

From: [GINA Durbin](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 8:08:58 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

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WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

GINA Durbin
gdurbin1002@gmail.com

Tampa, Florida 33635

From: [Laura Wenger](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 8:19:52 AM

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Laura Wenger
lbwenger@gmail.com

Palm City, Florida 34990

From: kerrydunnobrien@gmail.com
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 8:21:53 AM

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kerrydunnobrien@gmail.com

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From: [Kelly Colvin](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 9:09:16 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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Kelly Colvin
kcolvin94@gmail.com

Bradenton, Florida 34208

From: [Bernard Fensterwald](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Wednesday, October 19, 2022 9:10:47 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

My name is Bernard Fensterwald. I live in Dunedin, Florida. I am currently the Democratic nominee for the Florida House of Representatives, District 58. As such, I have been endorsed by Equality Florida and the Florida LGBTQ+ Democratic Caucus.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.”

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Bernard Fensterwald
fensterwald@mac.com

Dunedin, Florida 34698

From: [Arden Scott](#)
To: [BOM Public Comment](#)
Subject: Gender-Affirming Care Is Life Saving Health Care
Date: Tuesday, October 18, 2022 10:23:30 AM

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Arden Scott
Inritter@yahoo.com

Longwood, Florida 32750

Florida Board of Medicine,

2360 people have signed a petition on Action Network telling you to Support Gender Affirming Care for Trans Youth in Florida.

Here is the petition they signed:

We, the undersigned, strongly condemn the Florida Board of Medicine's recent decision to begin the rule-making process to create Florida-specific "standards of care" for gender-affirming healthcare for transgender, non-binary, and gender-diverse youth. Despite the Board of Medicine's claims to be an apolitical body acting on behalf of all Florida residents, the board meeting on August 5th, 2022, revealed an explicitly political agenda. Governor Ron Desantis' hand-picked appointees on the Board of Medicine initiated these proceedings as one of several policy attacks on LGBTQ+ people in Florida.

We condemn the actions of Governor Ron DeSantis, Surgeon General Ladapo, the Florida Board of Medicine, and the Florida Department of Health, for their intentional misrepresentation of scientific research, their deliberate exclusion of the vast body of scientific research that demonstrates the benefits of gender-affirming healthcare, and their assertion of the explicitly transphobic, scientifically debunked, so-called "social contagion theory." We also condemn the Florida Board of Medicine's decision to call on the overtly transphobic, biased, and discredited Dr. Quentin Van Meter. Van Meter's "American College of Pediatricians" organization is an anti-LGBTQ+ hate group, not a medical authority.

For those involved who took the Hippocratic oath to 'do no harm,' we need you to know — this is harm.

We further condemn the actions of Florida Board of Medicine members during the meeting. Through intentionally intrusive and leading questions, they disrespected those opposing the rule-making petition, including respected clinicians and trans/non-binary youth and adults who shared personal testimonies. The Board of Medicine also failed to question or moderate public comment from those who spoke in favor of the petition, even when they employed dehumanizing, racist, and transphobic rhetoric and hate speech. And their calculated decision to end public comments 90 minutes early silenced dozens of trans activists and allies who waited hours to speak.

Additionally, we condemn the anti-trans violence that occurred before, during, and after the meeting. The Board of Medicine inappropriately chose to hold a public meeting concerning the health of citizens statewide on private property in South Florida, failing to provide safe restroom options for all people in attendance. Meanwhile, officers from the Broward Sheriff's Office (BSO) targeted, profiled, and arrested LGBTQ+ attendees, and security and building staff harassed them. Finally, attendees were subjected to targeting and intrusive surveillance by representatives of the extremist groups "Let Kids Be Kids Coalition" and "Moms for Liberty."

Surgeon General Ladapo, the Florida Board of Medicine, and the Florida Department of Health have made myriad false claims about evidence-based gender-affirming care (pubertal suppression, hormonal and surgical treatments, and social transition support). Meanwhile, a robust body of research confirms the benefits, safety, and life-saving medical necessity of this care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies

published from 1991 to 2017 found that “gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.” Decades of literature indicate that the accessibility of both medical and social transition support contributes to a better quality of life for trans and gender-diverse people.

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts “dangerous governmental intrusion into the practice of medicine.” The AMA cited that “trans and non-binary gender identities are normal variations of human identity and expression” and that “evidence has demonstrated that forgoing gender-affirming care can have tragic consequences.” Furthermore, the AMA asserted that “Decisions about medical care belong within the sanctity of the patient-physician relationship.”

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Existing international standards of care already offer clear guidance for providing these treatments in safe, affirming, and supportive ways. The Florida Board of Medicine’s decision to open rule-making on treatments that have not resulted in complaints or disciplinary hearings, and which impact a very small percentage of the population, further indicates a political agenda. Legislative attacks against trans and gender-diverse people, especially youth, are rising across the country. The Florida Board of Medicine’s decision serves not to protect ALL youth, but rather to harm trans and gender-diverse youth for political gain.

We would like to address the following points that the Florida Board of Medicine misused to justify restricting access to gender-affirming care for minors:

- While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for minor patients.
- Several studies included in the August 5th public book of materials were intentionally misrepresented, and materials did not include recent and relevant research on the demonstrated benefits of gender-affirming care. Furthermore, researchers involved in several of these studies stated their findings were intentionally misconstrued and misused by Florida’s Board of Medicine.
- The politically-charged claim that young transgender and non-binary children are going through a temporary phase—that around 80% of them will spontaneously “desist” gender incongruence and identify as cisgender by natal puberty—is rooted in biased and scientifically flawed studies, and is not supported by sound scientific evidence. The studies cited by the Board were marred by sample bias, scooping up large numbers of gender nonconforming children never tested for clinical gender incongruence. One of these studies even misrepresented youth who missed follow-up interviews as “desistance.” Furthermore, the “80% desistance” myth is refuted by ongoing longitudinal studies of gender incongruent youth who socially transitioned in childhood. A 2022 article in the journal, *Pediatrics*, found only

2.5% (not 80%) reverted to their birth-assigned gender and identified as cisgender, five years after initial social transition.

- In recent years, a pseudo-scientific diagnostic label of “rapid-onset gender dysphoria” (ROGD) has been widely publicized. This myth posits that the rising visibility of trans and non-binary adolescents accessing medical services represents an “epidemic” of “social contagion” and “mental illness,” rather than the emergence of gender-diverse youth who had been forced to hide their existence in prior generations. “ROGD” is not a legitimate medical term. It is not recognized by any major professional association and is based on extremely biased surveys of members of known anti-trans hate organizations. The “ROGD” stereotype fails fundamental scientific principles by conflating correlation with causality. [This is analogous to the history of left-handedness in the U.S., which appeared to increase four-fold in the early 20th century because of growing social acceptance. Left-handed people in prior generations had simply not been allowed to exist in society and were repressed into invisibility.]

We will not remain silent as the powers that be in Florida attempt to strip rights from our youth. We demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors throughout the state. If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

We also demand that the Florida Board of Medicine do the following:

- Center the voices and experiences of trans and gender-diverse youth and their families in all future public meetings and decision-making processes related to this topic. Florida also has a wealth of dedicated and knowledgeable LGBTQ+ organizations and medical professionals who can provide informed counsel to the Board. Additionally, the Florida Board of Medicine should seek input and guidance from LGBTQ+ communities for the duration of this process.
- Prohibit Dr. Quentin Van Meter from participating in future discussions and decision-making related to gender-affirming care in Florida. Dr. Van Meter’s affiliations with anti-LGBTQ+ hate groups and the 2020 decision of a Texas judge to disqualify him from testifying on gender-affirming care demonstrate that he is not a “subject matter expert.” Van Meter aims to undermine care for transgender people and to spread anti-LGBTQ rhetoric under the guise of “science.”
- Conduct an unbiased review of scientific data related to gender-affirming care. If the Board of Medicine’s rule-making process is truly to be based on science, the Board of Medicine must examine all available and legitimate data, rather than cherry-picking and misrepresenting studies to support political agendas.
- Consult legitimate resources on transgender experiences and gender identity prior to holding future discussions of gender dysphoria. Comments from members of the Board revealed a lack of basic knowledge regarding transgender topics. There are reputable entities that offer introductory content on gender diversity and the experiences of gender-diverse individuals.
- Center the physical safety of transgender participants in all future public meetings. Meetings must be held at accessible public property venues with gender-inclusive restrooms. Failure to provide suitable accommodations for transgender and non-binary attendees at meetings of tremendous relevance to their health is unacceptable. It is impossible to equitably and meaningfully participate in discussions while simultaneously fearing repercussions and attacks.

We won’t be silent, and we won’t be silenced.

Sincerely,
The Undersigned

You can view each petition signer and the comments they left you below.

Thank you,

Florida NOW

1. Hannah (*ZIP code:*)

2. Linda Kolko (*ZIP code:*)

3. Jack Milkiewicz (*ZIP code:*)

4. Wuttipat Kotsaeng (*ZIP code:*)

5. Collin Moran (*ZIP code:*)

The whole "grooming" rhetoric being thrown around is going to end up with so many people dead and will do nothing to stop actual groomers out there.

6. Alex (*ZIP code:*)

7. Lunar Lovegrove (*ZIP code:*)

Trans youth must have a more medically-informed, affirming childhood than I did. Conservative pseudoscience has no basis in childcare! Protect Gender Affirming Care for all!

8. Alison Goodhew (*ZIP code:*)

9. Antje Kühn (*ZIP code:*)

10. Andrea Somarriba (*ZIP code:*)

11. Richard Gould (*ZIP code:*)

12. Anne Anderson (*ZIP code:*)

13. Amy Adams (*ZIP code:*)

14. Amy Adams (*ZIP code:*)

15. Andrea Amrein (*ZIP code:*)

16. Aaron Demlow (*ZIP code:*)

Gender affirming care saved my life at 16. Please do not take this vital care away from other young

people like me.

17. Jason Avis (*ZIP code:*)

18. Bree Bail (*ZIP code:*)

19. Nia Abbate (*ZIP code:*)

20. Abbie Aldridge, MA, LMHC, LPC, LPCC, LCPC, NCC (*ZIP code:*)

As a trans and genderqueer person and as a mental health clinician specializing in the care of trans and gender diverse people, I stand behind the evidence-based science that gender affirming medical interventions are life-saving and medically necessary for those who seek them out. I do not stand for fearmongering, trans-based prejudice, or actions to undermine the safety and lives of trans and gender diverse Floridians.

21. Abigail LaRosa (*ZIP code:*)

22. Abby Thomas (*ZIP code:*)

I'm from Florida and it's where all my family lives. We live in America, the land of the free, and no one should have any say over how someone wants to prevent themselves. This should be between a person and their doctor.

23. Jennifer Abeloff (*ZIP code:*)

24. Maggie Abeyta (*ZIP code:*)

25. Abigail Ivancicts (*ZIP code:*)

26. Alexander Santos (*ZIP code:*)

27. AC Baker (*ZIP code:*)

28. Mica Knox (*ZIP code:*)

29. Christopher Magnus (*ZIP code:*)

30. Amanda Cooke (*ZIP code:*)

31. Aaron Collins (*ZIP code:*)

Protect trans youth. Trans rights are human rights.

32. Austin Bozard (*ZIP code:*)

33. Hannah E (*ZIP code:*)

I am personally a trans woman. Banning transition care for youth and adults **will** cause suicides. There's no two ways about that. Affirming trans kids works.

34. Alicia D'Ottavio (*ZIP code:*)

35. Amanda Poole (*ZIP code:*)

36. Adam Reilly (*ZIP code:*)
Equality for All

37. Ada Lopez (*ZIP code:*)
Allow doctors, and parents to decide on the proper treatments

38. Adele Guadalupe (*ZIP code:*)
I support you 100%

39. Aden Paull (*ZIP code:*)

40. Emily Lynch (*ZIP code:*)
This is life saving reversible care recommended by doctors across the world. There is no more danger here than any pediatric medicine, and arguably less so than most. This is like a panic over Children's Motrin. The only difference is that its basis is in the very idea that transness should be forbidden. But considering the evidence that it greatly reduces suicide and depression, while, again, being entirely reversible, should be enough to say that the fears surrounding this are overblown. Let qualified well respected doctors, not ideologues with lobbying money from the Koch Brothers, decide your children's healthcare. Because the former actually cares about their well-being.

41. Jun-Mayer Alcid (*ZIP code:*)

42. Adrianna Gutierrez (*ZIP code:*)

43. Ash Eason (*ZIP code:*)

44. Adriana Reyes (*ZIP code:*)

45. Adrian De la Garza Myers (*ZIP code:*)

46. Arianna Plasencia (*ZIP code:*)
Healthcare is a fundamental right. Feeling comfortable in your own skin is a fundamental right. Why can't we have both?

47. Anita Duenas (*ZIP code:*)

48. Asia Eaton (*ZIP code:*)

49. Aaron Musick (ZIP code:)

50. Malakai Goodwin (ZIP code:)

51. Nora Chavarria (ZIP code:)

52. Gianna Cook (ZIP code:)

53. An anonymous signer (ZIP code:)

54. Annie G (ZIP code:)

55. Arlene Goldberg (ZIP code:)

56. Alejandra Gonzalez (ZIP code:)

F*ck florida government

57. Annette Baine (ZIP code: 33449)

58. Andrew Hipsher (ZIP code:)

59. Aidan Connolly (ZIP code:)

60. Aidan McChristie (ZIP code:)

61. Aiden Payne (ZIP code:)

62. Aija Diaz (ZIP code:)

63. Aileen Ortega (ZIP code:)

64. Abra Berkoff (ZIP code:)

65. AJ Assef (ZIP code:)

66. AJ Hedrich (ZIP code:)

How can you claim to act on behalf of all Florida residents when you're clearly not acting on behalf of the thousands of transgender people in Florida, whose health and wellbeing you're threatening by engaging in this exercise. Shame on you for breaking your oath to do no harm. Let trans people be. Let trans kids live.

67. Melissa Terry Anderson (ZIP code:)

All children deserve love and care.

68. Angela Bush (*ZIP code:*)

69. April Kraus (*ZIP code:*)

Gender affirming care saves lives

70. Alaina Irwin (*ZIP code:*)

71. Albe Frances (*ZIP code:*)

72. Alberto CAIRO (*ZIP code:*)

Gender affirming care is healthcare. If you oppose it, you are going against your supposed core mission. Do your job.

73. Allison Goodman (*ZIP code:*)

As a psychology PhD trainee working with trans youth, I see first-hand how gender-affirming care could be life saving. Please BLOCK the rule if you care about saving lives.

74. Joseph Ale (*ZIP code:*)

75. Amy Lendian (*ZIP code:*)

76. Alejandro Ocampo (*ZIP code:*)

77. Alessia Jauvin (*ZIP code:*)

78. Alexa McCalla-Johnson (*ZIP code:*)

79. Alexandra Baker (*ZIP code:*)

80. Alex Habriga (*ZIP code:*)

Gender affirming care saves the lives of children. Please do the right thing here. Thank you.

81. Alexandra Capitani (*ZIP code:*)

82. Alex Smith (*ZIP code:*)

83. Alex Cardona (*ZIP code:*)

Healthcare Providers all should be required to prove they have been educated on the importance of lifestyle and the complete healthcare of all individuals in order to keep their licensure. It IS of the most importance when treating and caring for individuals as a whole and in order to positively affect population health.

84. Alfonso Duarte (*ZIP code:*)

85. Alison Burns (*ZIP code:*)

86. Alice Mabbott (*ZIP code:*)

To ban youth transgender care is to ensure transgender people have a low quality of life until they reach age of majority

87. ALICIA LEWIS (*ZIP code:*)

HERE TO SUPPORT ALL LGBTQ+

88. izora watts (*ZIP code:*)

89. maxwell rotom (*ZIP code:*)

90. Alison Ronn (*ZIP code:*)

91. Brittany Allen (*ZIP code:*)

92. Allison Lampron (*ZIP code:*)

Trans healthcare is vital to the success and survival of these marginalized teens. Taking it away WILL cause more deaths and undue harm. Trans rights are human rights!

93. Allison Fradkin (*ZIP code:*)

94. Allister Atkinson (*ZIP code:*)

95. Allyson Adams (*ZIP code:*)

96. A Birr (*ZIP code:*)

97. April MacKenzie (*ZIP code:*)

Gender affirming care saves lives

98. Greyson B (*ZIP code:*)

99. Allison Towbes (*ZIP code:*)

100. Alva Gaskey (*ZIP code:*)

101. Alyssa Heinrich (*ZIP code:*)

102. Airalyn Lavitts (*ZIP code:*)

103. Alyssa MacKenzie (*ZIP code:*)

104. An anonymous signer (*ZIP code:*)

105. Alyssa Ramos (*ZIP code:*)

106. Blondie Amador (*ZIP code:*)

107. Amanda Denis (*ZIP code:*)

108. Amanda Race (*ZIP code:*)

109. amar penis (*ZIP code:*)

6N SAYS

110. Judith Homer (*ZIP code:*)

111. Alistair McGregor (*ZIP code:*)

112. Andres Medina (*ZIP code:*)

113. Amelia Lynch (*ZIP code:*)

Gender affirmative care is crucial and it doesn't affect others, there is no good reason to block anyone from their personal medical care.

114. Amelia March (*ZIP code:*)

115. Ami Marie Granger Welch (*ZIP code:*)

116. Alexa Medvin (*ZIP code:*)

117. Rev. Allen B. Mullinax, Ph.D. (*ZIP code:*)

I am a pastoral counselor/psychotherapist and fully support Transgender people, both as a therapist and as a Christian minister.

118. Amy Spurgeon (*ZIP code:*)

Gender affirming care is lifesaving.

119. Amy Greenman (*ZIP code:*)

120. Amy Lendian (*ZIP code:*)

I support gender-affirming care for youths. I believe this whole stunt to restrict care for trans youth is political theatre by conservative operatives.

Keep government out of medical decisions between patients and doctors.

121. Amy Yacoub (*ZIP code:*)

122. ana Rodriguez, (*ZIP code:*)

123. Patrick Copeland (*ZIP code:*)

Gender affirming care is healthcare, and denying healthcare is monstrous.

124. Ana Villegas (*ZIP code:*)

125. Anna Cohen (*ZIP code:*)

126. Andrea Trainor (*ZIP code:*)

127. Andrea Jurkiewicz (*ZIP code:*)

128. Rebecca Andre (*ZIP code:*)

129. Andrea Frostino (*ZIP code:*)

130. Andrea pedroza (*ZIP code:*)

131. Andrea Kaniuka (*ZIP code:*)

132. Andrea Mustelier (*ZIP code:*)

133. Andreea Neagu (*ZIP code:*)

134. Andrew Estes (*ZIP code:*)

135. Savannah Richards (*ZIP code:*)

136. Nancy Newlon (*ZIP code:*)

137. Angela Simmons (*ZIP code:*)

138. Angela Birdsong (*ZIP code:*)

Trans people are people too

139. Angela Rumsey (*ZIP code:*)

140. Angel Del Valle (*ZIP code:*)

I have friends who are trans and I believe they should have the right to the care they need without being restricted by people who don't experience what they have to

141. Angela Glegola (ZIP code:)

142. Robin Massaro (ZIP code:)

143. Denise LaMont (ZIP code:)

144. Anita DeJaynes (ZIP code:)

145. Ashley O'Sullivan (ZIP code:)

146. Anna Carella (ZIP code:)

147. Anna Elise Price (ZIP code:)

Please think of what you are doing when you politicize children's health and let the medical professionals who are working directly with the patients work directly with the families and the children to decide what care is needed.

148. Anna Peterson (ZIP code:)

As a licensed mental health provider whose practice focuses on supporting transgender and gender non-conforming youth, I am profoundly concerned with the harmful impact this policy will have on the youth of Florida.

149. Anna Castella (ZIP code:)

150. Anna Schiffmann (ZIP code:)

151. Anna Cowen (ZIP code:)

152. Ann Lorey (ZIP code:)

153. Allyson Phoebus (ZIP code:)

154. drew waits (ZIP code:)

155. Anya Urcuyo (ZIP code:)

156. Ann Pasquale (ZIP code:)

157. Alex Leon (ZIP code:)

158. Apostolis Giotas (ZIP code:)

159. Rebecca Appelgren (ZIP code:)

I am a physician practicing in Florida. Please refer to the policy statements from the American Academy of Pediatrics and do what is right for our youth.

160. Sage Cerulean (ZIP code:)

No child exploring their gender should be barred from receiving appropriate care.

161. Rachel Shipman (ZIP code:)

Reread the Bible we were created in God's image! Who are you to say otherwise? Ignorance profound in all of you besides being DeSantis' puppets with no brains

162. Jordan Arana (ZIP code:)

I support Gender Affirming Care for Trans Youth in Florida

163. Tiina Purin (ZIP code:)

164. Johanna Arcand (ZIP code:)

Do not taint science with politics!

165. Angel D'Angelo (ZIP code:)

Protect transgender people!

166. Arianna Overton (ZIP code:)

167. Arielle Jones (ZIP code:)

168. Ari Karlin (ZIP code:)

169. Aris Keshav (ZIP code:)

170. Alex O'Donnell (ZIP code:)

Every major medical organization supports appropriate gender affirming care. Medical treatment should be decided by doctors and based on evidence-based research, never left to politicians.

171. Artemis Black (ZIP code:)

Banning care for trans people is immoral and corrupt

172. Arrielle Giles (ZIP code:)

173. Jamie Arsenault (ZIP code:)

174. Audrey Wyer (ZIP code:)

175. Adrian Sanchez Garcia (ZIP code:)

176. Ashley Esosito (ZIP code:)

177. Ashe Rowan (ZIP code:)

Please support trans kids

178. Ashley Autumt (ZIP code:)

179. Ashley Bond (ZIP code:)

180. Ashley Beach-Pino (ZIP code:)

181. Ashley Coffey (ZIP code:)

182. Ashley Faulkner (ZIP code:)

Don't prevent these kids from getting the HEALTHCARE they need!

DO NO HARM!!

183. Sophia Caucci (ZIP code:)

184. Ashlie Holler (ZIP code:)

185. Aspen Bradham (ZIP code:)

186. Ashlyn Ford (ZIP code:)

Trans rights are human rights

187. Ashly White (ZIP code:)

188. Ash Short (ZIP code:)

189. Asher Stewart (ZIP code:)

These laws are hurting the trans community if you're really worried about child abuse fix the cps and foster care system.

190. Dr Anna Shustack (ZIP code:)

191. Allison DeDecker (ZIP code:)

Life-saving medical care is not something that should be subject to the political whims of whoever's in charge!

192. katelynn calley (ZIP code:)

193. Kevin Sullivan (ZIP code:)

Transgender affirming care is vital to the health and well-being of transgender children. To deny them proper medical care is criminal.

194. Audrey Jade (*ZIP code:*)

195. August Bennett (*ZIP code:*)

196. Aurelle Garner (*ZIP code:*)

197. Austin Caldwell (*ZIP code:*)

198. Autumn Buford (*ZIP code:*)

199. Autumn McGiveron (*ZIP code:*)

200. Avery (*ZIP code:*)

trans rights are human rights

201. Ashley Hammonds (*ZIP code:*)

202. Andrea Weber (*ZIP code:*)

203. Andrrw Wellman (*ZIP code:*)

204. Adeline Hollingsworth (*ZIP code:*)

205. Kipp Hopkins (*ZIP code:*)

206. Ashley Serena (*ZIP code:*)

support love. support all.

207. Elizabeth Viktora (*ZIP code:*)

Showing support for ALL youth in need of gender affirming care, in particular the trans youth of FL.

208. Lorelai Silva (*ZIP code:*)

Support us, let us live in peace. I genuinely hope this rule is blocked.

209. Brandi Skipalis (*ZIP code:* 32218)

It is unethical to base medical rule-making on biased misinformation and disinformation, ignoring the actual science and experts on gender dysphoria and transition-related healthcare, and creating new "standards of care" that ignore the actual, long-established standards of care that already exist. Any rulemaking MUST include recent, peer-reviewed research and listen to the voices of actual experts in this field.

210. V V (ZIP code:)

211. Brandon Thompson (ZIP code:)

212. Mary Ann Babrich (ZIP code:)

213. Brooke Bagnall-Koger (ZIP code:)

214. silas watson (ZIP code:)

215. Erica Bales (ZIP code: 32608)

216. Boris Aparicio (ZIP code:)

217. Barbara Myers (ZIP code:)

I've been a citizen of Florida since 1954 and a transgender woman that went to war when I was in the Navy that included 2 trips to Vietnam, I fought for the freedom of ALL citizens of Florida, not just a select segment of citizens, ALL citizens!! I am very saddened to hear that you want to take a small segment of citizens and deny them much needed medical care. Please do not deny them much needed medical care. What are you afraid of?

218. Barbara Turitz (ZIP code:)

219. Barbara Estrada (ZIP code:)

220. Brigitte Arcia (ZIP code:)

221. Riley Williams (ZIP code:)

Letting Kids be Kids is suppose to let the Kids become who they wanna be, any reason of stopping that is harmful to them.

222. Anne Williams (ZIP code:)

223. Beatrice batty (ZIP code:)

224. Ricki Bauman (ZIP code:)

Florida refuses to follow Federal and WPATH guidelines because of a quack doctor who will lose his license to practice medicine.

225. Bibi Baloyra (ZIP code:)

226. B B (ZIP code:)

Every single major medical association agrees that trans healthcare is medically necessary. That's a fact. Ron DeSantis's personal political mission to harm trans kids for political points is disgusting and

dangerous. Imagine if we were to target any other condition that kids are born with and declare a war against it? That would be just as crazy as this is. Trans kids exist, and the science backs that up!

227. Brooke Bigelow (*ZIP code:*)

Trans rights are human rights and trans youth deserve protection.

228. Barbara Cady (*ZIP code:*)

229. Becky Jackson (*ZIP code:*)

230. Becca Crum (*ZIP code:*)

231. Joanie Bigham (*ZIP code:*)

We the people means EVERYONE. We must allow the medical Professionals and we the people decide what's best for them without government intervention with zero expertise, knowledge or degree.

232. aaron pickert (*ZIP code:*)

233. Bear Bellinger (*ZIP code:*)

234. Becky Cherney (*ZIP code:*)

235. Kristen Vaisvila (*ZIP code:*)

236. Rebecca Martz (*ZIP code:*)

237. Rana hernandez (*ZIP code:*)

238. Orion Robinson (*ZIP code:*)

239. Anja Jensen (*ZIP code:*)

240. Lucas Martin (*ZIP code:*)

241. Elizabeth Weiss (*ZIP code:*)

Protect trans children's human rights, their privacy, and their gender affirming health care. Block the rule and support transition care.

242. Benjamin Davis (*ZIP code:*)

243. Reminé Benniefield (*ZIP code:*)

244. Benjamin Rockwell (*ZIP code:*)

Trans care saves lives!

245. Tatum Bent (*ZIP code:*)

246. Bentonne Snay (*ZIP code:*)

247. Ben Torres (*ZIP code:*)

Basic human rights for all

248. Bessie Petroutsas (*ZIP code:*)

249. Elisabeth Weinstein (*ZIP code:*)

250. Elizabeth Mercurio (*ZIP code:*)

251. Bethany Tap (*ZIP code:*)

Gender-affirming care saves lives.

252. Elizabeth Ferris (*ZIP code:*)

253. Elizabeth Horvath (*ZIP code:*)

254. Elizabeth Rothwell (*ZIP code:*)

255. Elizabeth(Betse) Davies (*ZIP code:*)

256. Rebecca Schulman (*ZIP code:*)

257. Barbara Ryder (*ZIP code:*)

258. Sarah Birman (*ZIP code:*)

259. Lauren Johnson (*ZIP code:*)

Trans rights are human rights. We need to protect our youth.

260. Mike Riley (*ZIP code:*)

261. Brian Ohana (*ZIP code:*)

262. Beth Daugherty (*ZIP code:*)

263. Kelly Hayworth (*ZIP code:*)

264. Beau Maysey (*ZIP code:*)

265. Kimberly Loucks (*ZIP code:*)

If gender-affirming care for youth is rejected, children will die. I will say that again; CHILDREN WILL DIE. This is not hyperbole, this has been demonstrated in many other places where this sort of care was removed. Please reconsider.

266. Eden Bell (*ZIP code:*)

267. robyn raymond (*ZIP code:*)

268. Ciera Coronado (*ZIP code:*)

269. Blush Rain (*ZIP code:*)

Politics and Medicine do not mix. I support the Transgender Youth and Adults of Florida. Many of which have simply already left your state. I support looking at the evidence ACCORDING TO RECOGNIZED STANDARDS of EVERY LEGITIMATE MEDICAL ORGANIZATION IN THE U.S. Unless they reside in the state of Florida.

270. Beth McMillen (*ZIP code:*)

271. Brooke Migdon (*ZIP code:*)

272. Bobette Motz (*ZIP code:*)

Fight for the right to be who you want to be!

273. Lorena Bonilla MD (*ZIP code:*)

274. An anonymous signer (*ZIP code:*)

275. Tori Becker (*ZIP code:*)

276. An anonymous signer (*ZIP code:*)

277. Barbara Overton (*ZIP code:*)

278. Phil Johnson (*ZIP code:*)

Gender affirming care saves lives.

279. Bradley Greenwood (*ZIP code:*)

As a transgender adult I knew for a long time as a child that I was trans and spent many years suppressing myself because the support simply was not there. It's awful what they are trying to do and will cause immense harm to trans children.

280. Brandon Kurtz (*ZIP code:*)

281. Braedon Wrosch (*ZIP code:*)

Refusing to help those in need is a direct breach of the Hippocratic Oath, and attempting to harm those seeking health an even greater sin. Do the right thing!

282. Gwendolyn Mioduszevska (*ZIP code:*)

283. Brennin Broadwell (*ZIP code:*)

284. Breanne Gillis (*ZIP code:* 33024)

285. Brendan Anderson (*ZIP code:*)

286. Elly Conley (*ZIP code:*)

Please provide lifesaving care to children, as your vocation has surely called you to do.

287. Brenna Wheeler (*ZIP code:*)

288. Brian Fakier (*ZIP code:*)

289. Brian Gehling II (*ZIP code:*)

290. Brianna Ratcliff (*ZIP code:*)

291. Brian Winiesdorffer (*ZIP code:*)

292. Bridget Elliott (*ZIP code:*)

293. Bridget Killebrew (*ZIP code:*)

294. Michael Hayden (*ZIP code:* 34232)

295. Britt monroe (*ZIP code:*)

296. Bryce Hackmeyer (*ZIP code:*)

297. Mira Vilchitsa (*ZIP code:*)

298. Robert Rosario (*ZIP code:*)

299. Aaron Harris (*ZIP code:*)

300. K Burrows (*ZIP code:*)

301. Brooke Wingo (*ZIP code:*)
Gender affirming care saves lives!

302. Jacquelyn Skye (*ZIP code:*)

303. Alexandria Yep (*ZIP code:*)

304. Charlie Lineberg (*ZIP code:*)

305. Claudia Alvarez (*ZIP code:*)
The Florida Medical Association should STEP up and push the Board of Florida to allow gender affirming care. This MAY increase the membership of the organization.

306. catherine courtney (*ZIP code:*)

307. Cadence Osteen (*ZIP code:*)

308. Carol Ferguson (*ZIP code:*)

309. Caitlin Steege (*ZIP code:*)

310. Crystal A Bass (*ZIP code:*)

311. Cameron Clark (*ZIP code:*)

312. Cameron Isaacs (*ZIP code:*)

313. cameron camacho (*ZIP code:*)

314. Cameron Driggers (*ZIP code:*)
Protect Trans Kids.

315. Sarah Campbell (*ZIP code:*)

316. Jess Owen (*ZIP code:*)
Trans rights are human rights

317. Carly Poloskey (*ZIP code:*)

318. Kristopher Toma-Lee (*ZIP code:*)

319. Cara Dick (*ZIP code:*)

320. Cara Olson (*ZIP code:*)

321. Cari Swadley (*ZIP code:*)

For my kid and yours too.

322. carina wendell (*ZIP code:*)

323. Carissa Neupert (*ZIP code:*)

The AAP uses scientific research to decide transgender care. Leave these decisions to doctors. Keep your government out of our medical decisions.

324. Carla Dawes (*ZIP code:*)

325. Carlos Hernandez (*ZIP code:*)

326. An anonymous signer (*ZIP code:*)

This is transphobic and invasive. We don't need any more decisions like the unfortunate one made last month from the AHCA/ the State Board of Medicine

327. carly cassano (*ZIP code:*)

328. Carly Purvis (*ZIP code:*)

329. Carmen Spruill (*ZIP code:*)

Gender affirming care saves lives!!!

330. Carmen Medina (*ZIP code:*)

Health care matters for everyone!

331. Caro Acosta (*ZIP code:*)

332. Carole Delahunty (*ZIP code:*)

333. Caroline Pace (*ZIP code:*)

334. c w (*ZIP code:*)

335. Carrie Feit (*ZIP code:*)

336. Caroline Schurman (*ZIP code:*)

337. Connie Peters (*ZIP code:*)

338. deb bell (*ZIP code:*)

Is this Natzi Germany???

339. Carter Penn-Dierauer (*ZIP code:*)

340. CASEY CARLSON (*ZIP code:*)

341. Casey Ritchie (*ZIP code:*)

342. Lory Kirby (*ZIP code:*)

343. Cassandra Bidwell (*ZIP code:*)

I support trans rights!

344. Cassie Riedemann (*ZIP code:*)

345. Cassi Campbell (*ZIP code:*)

Right thing to do.

346. Castiel Dixon (*ZIP code:*)

347. Cate Tulett (*ZIP code:*)

Gender affirming healthcare saves lives.

348. Steven Grant (*ZIP code:*)

Stop DeSantis's INSANITY.

349. Catherine Roberts (*ZIP code:*)

350. Catherine Gaffney (*ZIP code:*)

351. Cathy James (*ZIP code:*)

352. Cathy Gray (*ZIP code:*)

353. Craig Clark (*ZIP code:*)

354. Camille Garrett (*ZIP code:*)

355. Crystal Czyscon (*ZIP code:*)

356. Carolyn Daniels (*ZIP code:*)

357. Carole Boyer (*ZIP code:*)

Leave no child behind comes to mind ? Including Trans youth in FL In the whole United States of America as well

358. Laceasar Sherrod (*ZIP code:*)

359. Cyrus Bressack (*ZIP code:*)

360. Christopher Emile (*ZIP code:*)

361. michael claypool (*ZIP code:*)

362. Can Goodman (*ZIP code:*)

363. Veronica Aristeguieta (*ZIP code:*)

364. Caryn Atkin (*ZIP code:*)

365. Chael Needle (*ZIP code:*)

366. Chandler Redding (*ZIP code:*)

367. Channing Rollo (*ZIP code:*)

Medical decisions should stay between patients and their doctors. The state has no business limiting care for political or religious purposes.

368. Charisze Salise (*ZIP code:*)

369. Charlie Elvin (*ZIP code:*)

370. Jill Foust (*ZIP code:*)

371. Charlene Sammis (*ZIP code:*)

372. Charles Frazier (*ZIP code:*)

373. Chelsea Sucher (*ZIP code:*)

374. Chelsea Lokey (*ZIP code:*)

375. Chelsea Watson (*ZIP code:*)

376. Chelsea Caldejon (ZIP code:)

377. Chelsea Gonzalez (ZIP code:)

378. Margo Weathers (ZIP code:)

379. Nancy Mayo (ZIP code:)

380. Samantha Freeman (ZIP code:)

381. Theresa Collie (ZIP code:)

Denying youth gender affirming care puts their lives at risk.

382. Cody Clark (ZIP code:)

383. Miranda Klinck (ZIP code:)

384. Nicole Johnson (ZIP code:)

If Florida presses ahead with its anti-trans regime, they will never again receive a dime of my tourism tax dollars.

385. Tristan Child (ZIP code:)

386. Chloe Bauer (ZIP code:)

Banning gender-affirming care for transgender youth is not only grossly inhumane but also medical malpractice.

387. Chloe Leclair (ZIP code:)

Trans rights are human rights, trans healthcare saves lives, and scum like Abbott don't get to take that away from us because they're bigotted gits.

388. Carlos Perez (ZIP code:)

389. Christopher Mulvena (ZIP code:)

Florida government needs to get their noses out of their citizens private health care needs

390. Christopher Kobryn (ZIP code:)

391. Christine Reilly (ZIP code:)

392. Chris Bennett (ZIP code:)

393. Christopher Richmond (ZIP code:)

394. Claire Williams (ZIP code:)

395. Cynthia Cripps (ZIP code:)

396. Cindy Turpen (ZIP code:)

397. Peter Kahn (ZIP code:)

398. Cindy Fleming (ZIP code:)

399. Connor Bond (ZIP code:)

400. Carol Klopfer (ZIP code:)

Please follow up to date best practices

401. Calvin Labbe (ZIP code:)

402. Claire Goodman (ZIP code:)

403. Clair Mullins (ZIP code:)

Preventing anyone from being able to receive gender affirming care disrupts their bodily autonomy.

Regardless of their age, whether it's Hormone Blockers, HRT, gender affirming mental health care, and for trans adults; gender affirming surgery is something they deserve to have access to as being able to access health care is a human right.

The Push against Trans Health Care is backed by a religious organization that pushes religion as the authority on medical science, over the very word of world renowned experts and health organizations. They promote transphobia and trans erasure through misinformation and manipulate vulnerable Americans, and trans youth.

404. Clarissa Howell (ZIP code:)

405. Claudia Eyzaguirre (ZIP code:)

406. Claudia Mallon (ZIP code:)

407. Cleo (ZIP code:)

408. Cathy Lieblich (ZIP code:)

409. Abigail Lara (ZIP code:)

410. Cheryl Murillo (ZIP code:)

411. Gage Bosquet (*ZIP code:*)

412. Cindy Lopera (*ZIP code:*)

413. Aaron Slavec (*ZIP code:*)

414. Craig Matthews (*ZIP code:*)

415. Kris Candela (*ZIP code:*)

416. Caroline McCormick (*ZIP code:*)

417. Christina McGrath Fair (*ZIP code:*)

418. CHRISTIAN NUNEZ (*ZIP code:*)

419. Nicole Harlow (*ZIP code:*)

420. Jessica Fuentes (*ZIP code:*)

421. Cole Eldridge (*ZIP code:*)

'The true measure of any society can be found in how it treats its most vulnerable members'.

422. Nancy Cole (*ZIP code:*)

423. Colleen Bastian (*ZIP code:*)

424. Colleen Anderson (*ZIP code:*)

425. Claudia Thomas (*ZIP code:*)

You need to know now that more people than you realize are FED UP with your stupid culture wars, your fake doctors (Ladapo) and your sycophantic behavior toward Florida's autocratic narcissist. Stop risking the REAL LIVES of REAL PEOPLE and get back to doing what you are supposed to be doing - or perhaps you forget? #DoNoHarm!!!

426. Connie Stolp (*ZIP code:*)

427. Connor Hunt (*ZIP code:*)

428. Connor Lattenhauer (*ZIP code:*)

429. Elizabeth Mariaca (*ZIP code:*)

430. Lissette Fernandez (ZIP code:)

431. Cornell Crews Jr (ZIP code:)

432. Angela Skelton (ZIP code:)

433. Courtney Smith (ZIP code:)

Please protect our trans kids and adults.

434. Marlene Fayette-Cowgill (ZIP code:)

I support this

435. Camille A (ZIP code:)

436. Norma Crespo (ZIP code:)

Oh please protect and support our young people and give them the health care & services they need.

437. Cristina Phillips (ZIP code:)

438. Christina Ballester (ZIP code:)

439. Cristina Vigliarolo (ZIP code:)

440. Christina Roode (ZIP code:)

Protect trans youth.

441. Crystal D'Auria (ZIP code:)

442. Crystal Groty (ZIP code:)

443. Carolyn Allen (ZIP code:)

444. Chadwick Flowers, MD (ZIP code:)

445. Nicholas Westby-Anderson (ZIP code:)

446. Christina Fraser (ZIP code:)

447. Cynthia Reider (ZIP code:)

448. Chloe Ysabelle Gayoso (ZIP code:)

449. Matthias Tang (ZIP code:)

450. Cynthia Peters (ZIP code:)

451. Diane Cywinski (ZIP code:)

452. Charlotte Zitis (ZIP code:)

453. Caillen Dowell (ZIP code:)

454. Deirdree Dottirs (ZIP code:)

455. Caroline Artley (ZIP code:)

456. Daisy Snowdon (ZIP code:)

457. Daisy Jewitt (ZIP code:)

458. Debra Kaplan (ZIP code:)

459. Dakota Wilson (ZIP code:)

Gender affirming healthcare is life-saving. Blocking access to it will harm the physical and mental well-being of transgender people in Florida.

460. DALILA AGUILAR, MD (ZIP code:)

461. Damien Aguilar (ZIP code:)

462. Damion Shiloh (ZIP code:)

463. Dana Motley (ZIP code:)

Affirming care is suicide prevention. Not an option but a fact. If we love our children we should not push them to the edge.

464. Dana Loxley (ZIP code:)

465. Dana Holland (ZIP code:)

466. Dana Patton (ZIP code:)

467. hanna baker (ZIP code:)

468. Daniella Kolomijez (ZIP code: 33069)

Keep healthcare accessible for ALL.

469. Danielle Nelson (*ZIP code:*)

470. Danielle Gober (*ZIP code:*)

Trans lives matter.

471. Danielle Russell (*ZIP code:*)

472. Danielle Anderson (*ZIP code:*)

I am signing this to give young transkids the ability to live their lives, the way they need to without interruption and discrimination.

473. Dan Katz (*ZIP code:*)

474. Danielle Doyle (*ZIP code:*)

475. Michael Mercurio (*ZIP code:*)

476. Darin Carlson (*ZIP code:*)

477. Tosha Brothers (*ZIP code:*)

478. Darlene Thomas (*ZIP code:*)

I am so ashamed of my State Legislators for being so uncaring of human life.

479. Darrell (*ZIP code:*)

480. Jamie Black (*ZIP code:*)

481. Dave Bartos (*ZIP code:*)

Multiple studies show that trans and non binary kids see better life outcomes if they are accepted and supported by family, friends, and community. The false narrative being peddled by hatemongers wildly misstates the standards of care for trans and non binary children. We love our kids and want them to be happy and healthy!

482. David Lightfoot (*ZIP code:*)

483. Derek Wiberg (*ZIP code:*)

Regarding Republican Beliefs: used to want limited government- not so anymore: return to the rootsWe don't tell you what to do, believe or not to, stop telling others!

484. Dawn Belue (*ZIP code:*)

Gender-affirming care is lifesaving. I support my friends and neighbors having full access to the health care they need, and so should you.

485. Dawn Gibson (ZIP code:)

486. Dayonna Reynolds (ZIP code:)

banning this would kill and increase the suicide rate of trans youth, transphobia has no place in medicine

487. David Cation (ZIP code:)

488. Debbie Deland (ZIP code: 32835)

489. Dana Cotton (ZIP code:)

490. Dianne Fernandez (ZIP code:)

491. Daniel (ZIP code:)

492. Debbie King (ZIP code:)

493. Debbie Kent (ZIP code:)

494. Debbi Parrott (ZIP code:)

This can be life or death for these people.

495. Debra Touchette (ZIP code:)

Children deserve dignity and respect and gender-affirming care from reliable doctors.

496. Debra Schwoch Swoboda (ZIP code:)

497. December Cuccaro (ZIP code:)

I am a Floridian who moved out of state for graduate school. Although I would love to move back home, I cannot in good conscience support a state that would not support my transgender sibling or friends. Gender-affirming Healthcare is necessary Healthcare.

498. Miss Mai (ZIP code:)

499. R Michael (ZIP code:)

500. Jacob Anderson (ZIP code:)

501. De Palazzo (ZIP code:)

Thank you!!

502. Baylus Brooks (ZIP code:)

503. Davan Rivers (*ZIP code:*)

504. Brooke Bigelow (*ZIP code:*)

Trans rights are human rights and trans youth deserve protection.

505. Gwendael Demametz (*ZIP code:*)

506. Dana R (*ZIP code:*)

507. Derrick Morgan (*ZIP code:*)

508. Hardik Desai (*ZIP code:*)

509. Donna Erlich (*ZIP code:*)

Please don't let politics interfere with good medical care.

510. Desiree Rochelle (*ZIP code:*)

511. Sal Gambaro (*ZIP code:*)

512. Maggie DeVane, RN (*ZIP code:*)

Gender affirming care is healthcare. Stop playing politics with the lives of Floridians.

513. Deven Crock (*ZIP code:*)

514. Geikie Donald (*ZIP code:*)

515. Denise Hueso (*ZIP code:*)

516. Diana Cosma (*ZIP code:*)

517. Diana Bacon (*ZIP code:*)

518. Jamie Diaz (*ZIP code:*)

519. William Diaz (*ZIP code:*)

520. Ron Ledain (*ZIP code:*)

521. Dierdre Smith (*ZIP code:*)

What you're proposing is torture for trans kids. Let medical care be between, parents, trans-kids and their medical team.

522. Madison Dietz (*ZIP code:*)

523. Dijay Woods (*ZIP code:*)

We are tired of having to prove our existence to an obstinate society. We must push forward and provide a better future for our youth and put an end to the hatred and fear mongering.

524. David Johnson (*ZIP code:*)

525. Daniel Ortiz (*ZIP code:*)

Stop the trans bans

526. Ashley Asphodel (*ZIP code:*)

527. Diane Lebedeff (*ZIP code:*)

528. Dawn Middlemist (*ZIP code:*)

529. Desirae Minnett (*ZIP code:*)

Stop traumatizing queer kids!

530. Debra Jones (*ZIP code:*)

531. Debra Frye (*ZIP code:*)

532. Francine Rubinstein (*ZIP code:*)

To: Florida Board of Medicine

From: [Your Name]

We, the undersigned, strongly condemn the Florida Board of Medicine's recent decision to begin the rule-making process to create Florida-specific "standards of care" for gender-affirming healthcare for transgender, non-binary, and gender-diverse youth. Despite the Board of Medicine's claims to be an apolitical body acting on behalf of all Florida residents, the board meeting on August 5th, 2022, revealed an explicitly political agenda. Governor Ron Desantis' hand-picked appointees on the Board of Medicine initiated these proceedings amidst a series of policy attacks on LGBTQ+ people in Florida.

We condemn the actions of Governor Ron DeSantis, Surgeon General Ladapo, the Florida Board of Medicine, and the Florida Department of Health, for their intentional misrepresentation of scientific research, their intentional exclusion of the robust body of scientific research that demonstrates the benefits of gender-affirming healthcare, and their assertion of the explicitly transphobic, scientifically debunked, so-called "social contagion theory." We also condemn the Florida Board of Medicine's decision to call on the overtly transphobic, biased, and discredited Dr. Quentin Van Meter. Van Meter's "American College of Pediatricians" organization is an anti-LGBTQ+ hate group, not a medical authority.

Those involved who swore a Hippocratic oath to 'do no harm' should be ashamed.

We further condemn the actions of Florida Board of Medicine members during the meeting. Through intentionally intrusive and leading questions, they disrespected those opposing the rule-making petition, including respected clinicians and trans/non-binary youth and adults who shared personal testimonies. The Board of Medicine also failed to question or moderate public comment from those who spoke in favor of the petition, even when they employed dehumanizing, racist, and transphobic rhetoric and hate speech. And their calculated decision to end public comments 90 minutes early silenced dozens of trans activists and allies who waited hours to speak.

Additionally, we condemn the anti-trans violence that occurred before, during, and after the meeting. The Board of Medicine inappropriately chose to hold a public meeting concerning the health of citizens statewide on private property in South Florida, failing to provide safe restroom options for all people in attendance. Meanwhile, officers from the Broward Sheriff's Office (BSO) targeted, profiled, and arrested LGBTQ+ attendees, and security and building staff harassed them. Finally, attendees were subjected to intrusive surveillance by representatives of the extremist groups "Let Kids Be Kids Coalition" and "Moms for Liberty."

Surgeon General Ladapo, the Florida Board of Medicine, and the Florida Department of Health have made myriad false claims about evidence-based gender-affirming care (pubertal suppression, hormonal and surgical treatments, and social transition support). Meanwhile, a robust body of research confirms the benefits, safety, and life-saving medical necessity of this care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that "gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals." Decades of literature indicates that the accessibility of both medical and social transition support contributes to a better quality of life for trans and gender-diverse people.

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts "dangerous governmental intrusion into the practice of medicine." The AMA cited that "trans and non-binary gender identities are normal variations of human identity and expression" and that "evidence has demonstrated that forgoing gender-affirming care can have tragic consequences." Furthermore, the AMA asserted that "Decisions about medical care belong within the sanctity of the patient-physician relationship."

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

Existing international standards of care already offer clear guidance for providing these treatments in safe, affirming, and supportive ways. The Florida Board of Medicine's decision to open rule-making on treatments that have not resulted in complaints or disciplinary hearings, and which impact a very small percentage of the population, further indicates a political agenda. Legislative attacks against trans and gender-diverse people, especially youth, are rising across the country. The Florida Board of Medicine's decision serves not to protect ALL youth, but rather to harm trans and gender-diverse youth for political gain.

We would like to address the following points that the Florida Board of Medicine misused to justify restricting access to gender-affirming care for minors:

While Florida currently does not have state-specific standards for providing gender-affirming care, that does not mean that such care is unregulated in the state. Providers follow standards set by the World Professional Association for Transgender Health (WPATH), which have been developed over decades (beginning with Version 1 in 1979). WPATH's Standards of Care 7 include the following safeguards:

- Minor patients should be thoroughly evaluated by mental health providers and be given parental consent before starting gender-affirming treatment.
- Trans adolescents (at Tanner Stage 2 of natal puberty) can be offered puberty-suppressing hormones, which are fully reversible and low-risk based on all available medical literature, until the patient and their caregivers can make informed age-appropriate decisions about hormone therapies.
- Gender-affirming genital surgery is not carried out on children. Genital surgeries are only offered for adult patients.
- Several studies included in the August 5th public book of materials were intentionally misrepresented, and materials did not include recent and relevant research on the demonstrated benefits of gender-affirming care. Furthermore, researchers involved in several of these studies stated their findings were intentionally misconstrued and misused by Florida's Board of Medicine.
- The politically-charged claim that young transgender and non-binary children are going through a temporary phase—that around 80% of them will spontaneously “desist” gender incongruence and identify as cisgender by natal puberty—is rooted in biased and scientifically flawed studies, and is not supported by sound scientific evidence. The studies cited by the Board were marred by sample bias, scooping up large numbers of gender nonconforming children never tested for clinical gender incongruence. One of these studies even misrepresented youth who missed followup interviews as “desistance.” Furthermore, the “80% desistance” myth is refuted by ongoing longitudinal studies of gender incongruent youth who socially transitioned in childhood. A 2022 article in the journal, *Pediatrics*, found only 2.5% (not 80%) reverted to their birth-assigned gender and identified as cisgender, five years after initial social transition.
- In recent years, a new pseudo-scientific diagnostic label of “rapid-onset gender dysphoria” (ROGD) has been widely publicized. This myth posits that rising visibility of trans and non-binary adolescents accessing medical services represents an “epidemic” of “social contagion” and “mental illness,” rather than emergence into human society of gender diverse youth who had been forced to hide their existence in prior generations. “ROGD” is not a legitimate medical term. It is not recognized by any major professional association and is based on extremely biased surveys of members of known anti-trans hate organizations. The “ROGD” stereotype fails fundamental scientific principle by conflating correlation with causality. [This is analogous to the history of left-handedness in the U.S., which appeared to increase four-fold in the early 20th century because of growing social acceptance. Left-handed people in prior generations had simply not been allowed to exist in society and were repressed into invisibility.]

We will not remain silent as the powers that be in Florida attempt to strip rights from our youth. We demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors throughout the state. If Florida-specific standards of care are adopted, they must incorporate by reference the most current version of WPATH Standards of Care. As WPATH's Standards of Care Version 8 is soon to be released, any state-specific standards must be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

We also demand that the Florida Board of Medicine do the following:

- Center the voices and experiences of trans and gender-diverse youth and their families in all future public meetings and decision-making processes related to this topic. Florida also has a wealth of dedicated and knowledgeable LGBTQ+ organizations and medical professionals who can provide informed counsel to the Board. Additionally, the Florida Board of Medicine should seek input and guidance from LGBTQ+ communities for the duration of this process.
- Prohibit Dr. Quentin Van Meter from participating in future discussions and decision-making related to gender-affirming care in Florida. Dr. Van Meter's affiliations with anti-LGBTQ+ hate groups and the 2020 decision of a Texas judge to disqualify him from testifying on gender-affirming care demonstrate that he is not a "subject matter expert." Van Meter aims to undermine care for transgender people and to spread anti-LGBTQ rhetoric under the guise of "science."
- Conduct an unbiased review of scientific data related to gender-affirming care. If the Board of Medicine's rule-making process is truly to be based on science, the Board of Medicine must examine all available and legitimate data, rather than cherry-picking and misrepresenting studies to support political agendas.
- Consult legitimate resources on transgender experiences and gender identity prior to holding future discussions of gender dysphoria. Comments from members of the Board revealed a lack of basic knowledge regarding transgender topics. There are reputable entities that offer introductory content on gender diversity and the experiences of gender-diverse individuals.
- Center the physical safety of transgender participants in all future public meetings. Meetings must be held at accessible public property venues with gender-inclusive restrooms. Failure to provide suitable accommodations for transgender and non-binary attendees at meetings of tremendous relevance to their health is unacceptable. It is impossible to equitably and meaningfully participate in discussions while simultaneously fearing repercussions and attacks.

We will not be silent, and we will not be silenced.

533. Jodi Duesterhaus (*ZIP code:*)

534. Madeline Bee (*ZIP code:*)

Gender affirming care in the medical industry saves lives. FIRST DO NO HARM!

535. Donna McGovern (*ZIP code:*)

Trans people are just people

536. An anonymous signer (*ZIP code:*)

537. William Westervelt (*ZIP code:*)

538. Deidra Pitts (*ZIP code:*)

539. Pulley (*ZIP code:*)

540. Alba Lamar (*ZIP code:*)

541. Aubry Cohen (*ZIP code:*)

542. Draven Sermon (*ZIP code:*)

543. Charles Clark (*ZIP code:*)

544. Alice Shelmidine (*ZIP code:*)
Fuck DeSantis

545. Albert Shimkus (*ZIP code:*)

546. Wanda Filer, MD (*ZIP code:*)

I recently relocated to Orlando and previously served on Pennsylvania State Board of Medicine while serving as state Physician General (later president of AAFP). Banning transgender care is antithetical to patient centered care and science. Capitulating to political correctness is a legacy that no reputable BOM should support. Your courage is needed to protect gender affirming care, impacted families and patients. Thank you.

547. Ivania Delgado (*ZIP code:*)

548. David Rodriguez (*ZIP code:*)

549. Deidre Rogers (*ZIP code:*)

I went to nursing school in Florida. University of Florida in Gainesville. I absolutely am shocked and horrified at what is happening in Florida. I support trans people 100%.

550. Dr. Pamela Alvarez (*ZIP code:*)

551. Kim Elmore (*ZIP code:*)

552. Donald Watren (*ZIP code:*)

553. Kris (*ZIP code:*)

554. Spencer Kellu (*ZIP code:*)
Trans rights are human rights

555. Diane Quick (*ZIP code:*)

556. daniel slagle (*ZIP code:*)

557. Dylan Spurlin (*ZIP code:*)

558. DiAnna Steines (ZIP code:)

559. Deanna Thurlow (ZIP code:)
Please support gender affirming care

560. David Tillery (ZIP code:)

561. Benson Duniel (ZIP code:)

562. Dr H Joan Waitkevicz (ZIP code:)

563. David Wright (ZIP code:)

564. Dana Aberman (ZIP code:)

565. Eren Simpson (ZIP code:)
Trans kids lives matter and they deserve the healthcare that is best for them.

566. Emily Bergland (ZIP code:)
Transgender affirming care saves life. Research shows that children have awareness and understanding of their gender around age 3-5 (this is separate from their sex assigned at birth) and by age 14 are cognitively developed enough to make decisions on their health and bodies. Numerous healthcare organizations have made recommendations about the benefits of trans youth being able to take hormone blockers, hormone therapy and too surgeries after meeting various criteria. If this bill passes trans youths' mental well-being will decrease and suicide rates will increase.

567. Elizabeth Corwin (ZIP code:)

568. Angela Aylward (ZIP code:)
The way our government is treating people with marginalized genders & sexualities abhorrent. Gender affirming care & support for LGBTQIA+ youth & adults are lifesaving.

569. rat bailey (ZIP code:)

570. erin (ZIP code:)
Protect Healthcare for all.

571. E-T Cresswell (ZIP code:)

572. Ennio (ZIP code:)
I know the Bush loyalist DeSantis wants to DESTROY the lives of Children and especially trans children. Desantis must be really happy to REPLACE Donald Trump after screwing him over on his own doorstep after Trump helped elevate him.

Now this puppet of Glenn Youngkin, who also backstabbed Trump like many jealous and cowardly

republicans did, wants to further make Florida a bigger punching bag. Desantis and these Republicans like the Bush, Cheney, Kissinger, Crenshaw, Cruz, McConnell, and Glen Youngkin are the core reason why Trump has less presidential terms than Obama.

Trans people and kids were more loyal to Trump than that flip-flopper, and these cowardly backstabbers who screwed over Trump want to harm kids while stealing tax breaks, social security, and turning White Americans into third class minorities.

The U.S. Census shows that White people are now officially second class citizens to Hispanic-Whites, thanks to Ron Desantis, George Bush, Mitch McConnell, Dick Cheney, Liz Cheney, Rick Scott, and Ted Cruz. They are most likely fist bumping on their vacations while they continue to feed dirty food and water while stealing money off white people as if they were second class minorities on the US census.

I bring this up because as much as I want to protect the only people who did not betray us, or hurt us in any way like the cowardly DeSantis, I know he is going to disregard the signature.

So it's best to destroy his presidential chances to replace Trump by bringing inconvenient truths about him... like the amount of money people are gonna pay in a few years because of him failing against Disney, or that he human trafficked people with your taxpayer money, smuggling immigrants inside the country and people liking that. They prefer immigrants and Trans People than illegal, cheating, lying, backstabbing, spineless, and brainless Republican leeches like Bush and Desantis that made Trump a 1 term President.

By some miracle that Desantis leaves kids alone, and stop defunding their future, only then the inconvenient truths that made Trump a 1 term president and white Americans second class minorities would stop too.

But I know that won't happen, even though I request the board to stop trying to take away gender affirming care.

573. Ed Averill (*ZIP code:*)

It's mean, not helpful, for bigoted politicians to pretend to play doctor. Please let the medical profession do their best in serving people who have gender issues.

574. Zen Nelson (*ZIP code:*)

575. Virginia Hamner (*ZIP code:*)

Please do not take health care away from trans people. It's lifesaving care.

576. Alea Schroeder (*ZIP code:*)

Gender affirming care has proven on the national level of medical care to save lives and reduce suicide ideology significantly among trans youth. Please don't let Florida go backwards.

577. Sam Skeels (*ZIP code:*)

I'm a graphic designer who has expressed interest in trans rights advocacy, but my situation is very limiting. I am afraid to be myself in public, in my area, as well.

578. Judy Lins (*ZIP code:*)

579. Carolyn Meli (*ZIP code:*)

580. Eamon Tuttle (*ZIP code:*)

581. Elizabeth Hayes (*ZIP code:*)

582. Elizabeth Hillery (*ZIP code:*)

Gender-affirming care is essential and must be protected!

583. An anonymous signer (*ZIP code:*)

584. Elan Bustos (*ZIP code:*)

585. Eric Le-lau (*ZIP code:*)

586. Eleanor McDonough (*ZIP code:*)

587. Eli Cazares (*ZIP code:*)

588. E Schmidt (*ZIP code:*)

589. Michael Tasdoul (*ZIP code:*)

To disallow affirming care is tyranny. It is a malicious effort against existing diversity to simplify control over a populace to meet one's own ends and not those of the people. "Honoring" the GROUP of constituents standing against exposure to INDIVIDUALITY is criminal. To be born under that caliber of governance is imprisonment not freedom.

590. Ellie C (*ZIP code:*)

591. Ellie Sparke (*ZIP code:*)

592. Elle Garris (*ZIP code:*)

593. Eloisa Lopez (*ZIP code:*)

594. Eloisa Lopez (*ZIP code:*)

gender-affirming care has been scientifically proven to support the well-being of LGBTQ+ community members!

595. Elle McNamara (*ZIP code:*)

596. Emily Winters (*ZIP code:*)

597. Eileen Malecki (*ZIP code:*)

598. Michael Cornell (*ZIP code:*)

599. Emily Trott (*ZIP code:*)

600. Emily Yederlinic (*ZIP code:*)

601. Emily Cluck (*ZIP code:*)

602. Emily Escobar (*ZIP code:*)

Access to gender affirming care for trans youth is beneficial and we should not be blocking access to this care. Protect trans youth!

603. Emily Everetts (*ZIP code:*)

604. Emily Mensch (*ZIP code:*)

605. Emily Bernfeld (*ZIP code:*)

606. Emily Boviero (*ZIP code:*)

607. Emily Drew (*ZIP code:*)

608. emily roldan (*ZIP code:*)

609. Jennifer Dwyer (*ZIP code:*)

610. Mary Kay Gaffney (*ZIP code:*)

611. Emma Burd (*ZIP code:*)

612. emma kramer (*ZIP code:*)

swag

613. Kai Hunt (*ZIP code:*)

Kai

614. Emmy Kenny (*ZIP code:*)

Gender affirming care saves lives! The standard of care should be to SUPPORT trans patients instead of taking away what little medical care they currently have access to. Don't be a political pawn at the expense of our children.

615. Elissa Thomas (ZIP code:)

616. Erica Musser (ZIP code:)

617. Stacey Kroto (ZIP code:)

618. Elena Nickerson (ZIP code:)

619. Erica Gruda (ZIP code:)

620. Samantha Sigmon (ZIP code:)

Support trans youth!

621. Susan Lee (ZIP code:)

As a decades-long citizen of Florida, I am appalled that any body that alleges to be a "Board of Medicine" in this state could POSSIBLY do anything but listen to the total agreement between the American Medical Association (AMA), American Academy of Pediatrics (AAP), Children's Hospital Association (CHA), and other much more expert associations and organizations that have studied and researched the "standards of care" for ALL people and patients withOUT the hate and TOXIC atmosphere that the Florida GOP and far-right have thrown into the stereotypes that are baseless and riddled with unconstitutional bigotry, since our government in this country is REQUIRED to separate all religions from laws (and NOT discriminate either).

All these major medical and children-oriented medical associations have found and determined in their research and study that the absolutely ESSENTIAL healthcare for transgender, non-binary, and gender-diverse youth IS exactly what groups such as Equality Florida has been telling you AND the parents of these youth--AND THE YOUTH THEMSELVES!--which is the gender-affirming care.

It is essential, NOT abuse. It is YOU who are abusing the youth by trying to take it away, which not only harms them physically, but also harms them emotionally by falsely telling them something is wrong with them, that they are in your EVIL AND ARROGANT AND BIGOTED VIEW, they are somehow "lesser," though they are actually NO DIFFERENT from you. A tiny tweak of nature, sure; but every single person is different from EVERY OTHER PERSON by a tiny tweak of nature.

Keep YOUR PERSONAL, PRIVATE RELIGION out of anyone else's life. Yes, you have the right to your beliefs, but ONLY FOR RUNNING YOUR OWN LIFE, NEVER TO RUN ANYONE ELSE'S LIFE. That's where it becomes UNCONSTITUTIONAL. EVERY OTHER PERSON is guaranteed the right to his/her/their OWN PERSONAL, PRIVATE RELIGIOUS FREEDOM, TOO, RATHER THAN YOUR RELIGION.

SO, listen to the AMA, AAP, and CHA, and understand that the Florida GOP and Dr. Ladapo are completely wrong, while the experts know what they're talking about, and so do the parents of the transgender youth and those youth!

Thank you.

622. Eric Repphun (ZIP code:)

Seriously, stop harming vulnerable kids for hateful political nonsense. Gender-affirmative care is safe,

effective, and has been around for almost 100 years. There is no real debate, so stop this harmful garbage. Now is a time for people with serious solutions to very real problems, so it's time you left the building.

623. Elizabeth Hart Whelan (*ZIP code:*)

624. Eric Schrimshaw (*ZIP code:*)

625. Eric Cook (*ZIP code:*)

626. Erin Trowbridge (*ZIP code:*)

627. Erin Horan (*ZIP code:*)

628. Wendy Peale (*ZIP code:*)

629. Emmet Keire (*ZIP code:*)

630. Mary Ernst (*ZIP code:*)

I'm not sure how a Board of Medicine can support care that is counter to known data and benefits. This is pure maleficience!! Follow your ethical standards and do not be swayed- too many children's lives are at risk.

631. Elizabeth Brody (*ZIP code:*)

632. Elena Schiavone (*ZIP code:*)

633. Ezrie Sterner (*ZIP code:*)

634. Eve Bradt (*ZIP code:*)

635. Evelyn Bailey (*ZIP code:*)

636. Eva Guillaume (*ZIP code:*)

637. Evan Ortiz (*ZIP code:*)

As a transgender person who is financially unstable, having access to an insurance I qualify for and having it provide me with life-saving healthcare, providing testosterone and gynecomastia surgeries, would really allow me to live my best and most fulfilling life.

638. Erin Wiley (*ZIP code:*)

639. V G (*ZIP code:*)

Hakuna Matata, we got this

640. Colleen McFarlane (*ZIP code:*)

641. PAT RICHARDS (*ZIP code:*)

642. Zem Nabors (*ZIP code:*)

643. Estefania Fernandez (*ZIP code:*)

644. Stephanie Laporte (*ZIP code:*)

645. Claire (*ZIP code:*)

646. Geraldine Milio (*ZIP code:*)

647. Tim Walters (*ZIP code:*)

648. Frank Bowman (*ZIP code:*)

649. Karen Woodall (*ZIP code:*)

650. Frances Wisch (*ZIP code:*)

651. Blå Felixia Faye Stenback (*ZIP code:*)

652. Bernard Fensterwald (*ZIP code:*)

As a candidate for FL HD 58, I support this letter.

653. Frances Fergusson (*ZIP code:*)

654. FRANK W. GURUCHARRI (*ZIP code:*)

655. Gregory Alfaro (*ZIP code:*)

I don't like fascists

656. Lily Almeyda (*ZIP code:*)

657. Adam Wacome (*ZIP code:*)

658. Francis Korogy (*ZIP code:*)

Gender affirming care saves lives and is proven to improve mental and physical health. Fuck off, Florida.

659. Luke Herrin (*ZIP code:*)

660. April Hargreaves (*ZIP code:*)

661. Flynn Kay (*ZIP code:*)

662. Lauren Foley (*ZIP code:*)

663. Fontaine Schroyer (*ZIP code:*)

Stopping children from getting life saving medicine is a terrible idea. Hormone blockers do not stop development permanently, only temporarily until they figure themselves out. And HRT has saved more lives than you can imagine. Stop this. Actually try to care about our children instead of making them wear bullet proof backpack inserts. Okay?

664. Denise K (*ZIP code:*)

Perfectly written with a wealth of vital information. Protect our youth!

665. Alexis Spark (*ZIP code:*)

666. Charlie Gonzalez (*ZIP code:*)

667. Lauren Fox (*ZIP code:*)

668. Jennifer Fitzpatrick (*ZIP code:*)

669. Frederick Hunter (*ZIP code:*)

670. Fred Tamm-Daniels (*ZIP code:*)

671. Francine Goldberg (*ZIP code:*)

Support Gender Affirming Care for Trans Youth in Florida

672. Emily Humphrey (*ZIP code:* 33174)

673. Frederique Leforestier (*ZIP code:*)

674. Mari Cao (*ZIP code:*)

675. Angela Ricker (*ZIP code:*)

676. Mauricio Fiori (*ZIP code:*)

677. Mikelle Martin (*ZIP code:*)

678. Brady Call (*ZIP code:*)

679. Charlene Thomas (*ZIP code:*)

680. Sarah Wilson (*ZIP code:*)

681. Glauco Cusciano (*ZIP code:*)

682. Sam Morris (*ZIP code:*)

683. Gabriel Fant (*ZIP code:*)

684. Gabriela Queiroz (*ZIP code:*)

It's immoral and contrary to human rights to ban healthcare treatments when it leaves people with no alternative option that's at least as safe and effective as the one being banned.

685. Grace Hutchinson (*ZIP code:*)

686. Will S (*ZIP code:*)

687. Jonathan Gartrelle (*ZIP code:*)

688. Gary Skelly (*ZIP code:*)

689. Gavin Fraser (*ZIP code:*)

690. Geraldine Chechette porter (*ZIP code:*)

691. Gwen Labbe (*ZIP code:*)

692. Geanne Bowman (*ZIP code:*)

693. finn peck (*ZIP code:*)

694. Elizabeth Reed (*ZIP code:*)

695. Gena Casas (*ZIP code:*)

696. Lee Miller (*ZIP code:*)

697. Jen Derless (*ZIP code:*)

698. Gene Santos (*ZIP code:*)

699. George Nawfal (*ZIP code:*)

700. Fuck Troons (*ZIP code:*)

Your mental illness and pedophilic mutilation kinks are disgusting and evil. Criminal and civil penalties for trans groomers needs to be passed via legislation immediately.

701. Marina F (*ZIP code:*)

End the fascism and hate
Never stop fighting

702. Greg Farnkoff (*ZIP code:*)

Please don't allow them to legislate hate

703. Gianinna Munoz Soto (*ZIP code:*)

Support and autonomy

704. Gilbert Smith (*ZIP code:*)

705. Gillian Garcia (*ZIP code:*)

706. Gillian Luongo (*ZIP code:*)

707. Gina Smith (*ZIP code:*)

708. Larry Smith (*ZIP code:*)

This is abhorrent behaviour from Florida. Very ashamed to call myself American.

709. GISSETTE RODRIGUEZ (*ZIP code:* 33055)

LOVE THY NEIGHBORS! SUPPORT TRANS YOUTHS!

710. Gregory Rosasco (*ZIP code:* 34690)

711. Amanda Harris (*ZIP code:*)

712. Brandie Glessner (*ZIP code:*)

713. Devesh Singh (*ZIP code:*)

There is no reason to outlaw safe, recognized, and recommended health care

714. Gloria Storms (*ZIP code:*)

715. Gerald Matison (*ZIP code:*)

716. Ginger Mundy (*ZIP code:*)

717. Gabrielle Hodge (*ZIP code:*)

718. Gold Cummins (*ZIP code:*)

719. Gordana Bjekic (*ZIP code:*)

720. Remy Gorski (*ZIP code:*)

721. Elizabeth MacCubbin (*ZIP code:*)

Urging your Support for Gender-Affirming Care for Trans Youth in Florida!

722. Elaine Graczyk (*ZIP code:*)

Keep trans gender youth SAFE.

723. Lara Montefiori (*ZIP code:*)

724. Stephany Kogele (*ZIP code:*)

725. Greg Knight (*ZIP code:*)

726. Griffin Williams (*ZIP code:*)

727. Mar Garcia (*ZIP code:*)

Gender affirming care is life saving for so many trans youths. Taking it away will not make them any less trans, but it will take many of their lives.

728. Anna (*ZIP code:*)

729. Claudia Thomas (*ZIP code:*)

730. Gregory Pevey (*ZIP code:*)

731. Learae Laubsch (*ZIP code:*)

732. violeta guevara (*ZIP code:*)

733. Gail Waldbly (*ZIP code:*)

I'm a retired surgeon. I support gender affirming care for trans youth.

734. Gwen Tempelton (*ZIP code:*)

735. Gwen Valour (*ZIP code:*)

736. Gavin Yauchzee (*ZIP code:*)

737. Bryan J (*ZIP code:*)

Gender affirming care saves lives. Removing it leads to dead kids and adults that never got a chance.

738. Tracy Hafeman (*ZIP code:*)

739. Haiden Baier (*ZIP code:*)

740. Martha Gordon (*ZIP code:*)

741. Haley Keane (*ZIP code:*)

742. Haley LaVoo (*ZIP code:*)

743. Haley McGehee (*ZIP code:*)

744. Haley White (*ZIP code:*)

745. Haley Maple (*ZIP code:*)

746. Kaitlyn Handwerg (*ZIP code:*)

747. Henry Willis (*ZIP code:*)

748. Kristen Hanks (*ZIP code:*)

As the parent of a trans teen I know that gender affirming care is life saving. It saved our child's life.

749. Hannah Yates (*ZIP code:*)

750. Hannah Veselinovic (*ZIP code:*)

751. Leah Hansberry (*ZIP code:*)

752. Shane Hansen (*ZIP code:*)

753. Darlene Hanson (*ZIP code:*)

754. Regina D'Angelo (*ZIP code:*)

755. Harriet Nezer (*ZIP code:*)

National Council of Jewish Women of Valencia Shores FL would like to sign on to support this as well.

756. Harry Williams (*ZIP code:*)

Hello,

This is Harry Williams

Can we talk about your website? as it's something urgent.

May I have your phone number?

757. Heather Bonthron (*ZIP code:*)

758. Hussein Abdullatif (*ZIP code:*)

759. Heather Eslien (*ZIP code:*)

760. Heather Garry (*ZIP code:*)

761. Heather Ford (*ZIP code:*)

762. Helen Bassett (*ZIP code:*)

763. Fallon Dominguez (*ZIP code:*)

764. Hedieh Sepehri (*ZIP code:*)

Registry for transgender people? Are you for real?

765. Cristina Heilbron (*ZIP code:*)

766. don heinz (*ZIP code:*)

767. Helen Parnell (*ZIP code:*)

768. Henley Bergloff (*ZIP code:*)

769. Henry Jones (*ZIP code:*)

It's an issue of personal freedom. People should be free to make their own decisions free from government intrusion. This includes decisions about gender identity

770. Barbara Hermann (*ZIP code:*)

771. Jessica Daly (*ZIP code:*)

772. x (*ZIP code:*)

773. Jen Heze (*ZIP code:*)

774. Halle Quezada (ZIP code:)

This hateful extinction of trans kids is literally insane and painfully harmful.

775. Zenith Grimm (ZIP code:)

776. Hayden Rozier (ZIP code:)

Everybody deserves healthcare regardless of who they are and what they identify as.

777. Hillary Luetkemeyer (ZIP code:)

Completely unnecessary cruelty against trans children who just want to live their best lives.

778. Ashley Hickenlooper (ZIP code:)

779. Jeffrey Darby Bradshaw (ZIP code:)

780. Hillary Puro (ZIP code:)

781. Hillary Rosenberg (ZIP code:)

782. Cassandra Hill (ZIP code:)

783. Laura Jones (ZIP code:)

784. Rebecca Holland (ZIP code:)

785. Heather Johnson (ZIP code:)

786. Hope Lemos (ZIP code:)

787. Holly Picardi (ZIP code:)

788. Heidi Wittsack (ZIP code:)

789. Hannah Lettis (ZIP code:)

790. Hugh Williamson (ZIP code:)

791. Kassandra Branter (ZIP code:)

792. Elísabet Rakeł Sigurðardóttir (ZIP code:)

793. Ryan Alves (ZIP code:)

protect gender affirming healthcare for my state!!!!

794. lou taylor (*ZIP code:*)

795. Heather Roberts (*ZIP code:*)

796. Heather Hays (*ZIP code:*)

797. Alexandre Dahlborg (*ZIP code:*)

798. Jon Hunt (*ZIP code:*)

799. Spectre Spectre (*ZIP code:*)

Dear Member,

This is Harvey Spectre from the Website Designing Team.

I would like to inform you that your website design and template are not according to the Google Algorithm and it needs to be fixed as soon as possible.

If you want to reach up to 1.5 million monthly visitors through Digital Marketing Techniques (SEO & SMO) on your website to improve website traffic, Product Sales and Website Search Ranking on Google, Bing, AOL and Yahoo.

Please share your "Phone Number" and a suitable time to talk, so I can help you.

Best Regards

Harvey Spectre

Designing & Marketing Team

Call @: 1-620-765-4699

800. Carol Hyden (*ZIP code:*)

801. Jamie Jones (*ZIP code:*)

802. Tad Ishihara (*ZIP code:*)

This is an issue that needs urgent attention. #LGBTQIAally

803. Gwenally McLucas (*ZIP code:*)

The trans community will persevere no matter what conservatives throw at us, and we will fight.

804. Mary Hutcherson (*ZIP code:*)

Protect our youth

805. Ian Fernander (*ZIP code:*)

806. Ian Walton (*ZIP code:*)

807. claudia runte (ZIP code:)

808. Ida Eskamani (ZIP code:)

809. Dhruv Shinde (ZIP code:)

810. Carmelena Machevelli (ZIP code:)

811. Rowan Landers (ZIP code:)

Banning gender-affirming care for children - for anyone - will kill people. It will kill those who are trying to live and let live and it will kill those for whom you are completely depriving of any kind of support system. If you want to claim to be the pro-life party, you need to start proving it by LETTING PEOPLE LIVE.

812. Nikola Ili_ (ZIP code:)

813. Illine Davila (ZIP code:)

814. thomas bleimeyer (ZIP code:)

815. Gary Howell (ZIP code:)

816. National Council of Jewish Women Palm Beach (ZIP code:)

817. The Afiya Center (ZIP code:)

818. Isabel Olazar (ZIP code:)

819. Iris Dimock (ZIP code:)

Stay the fuck away from trans kids you sick bastards.

820. Fin Irwin (ZIP code:)

821. Isabella Santos (ZIP code:)

822. Maria Isabel Villegas (ZIP code:)

823. Isaac Spooner (ZIP code:)

824. Isabela Suarez (ZIP code:)

825. Isabella Laurie (ZIP code:)

826. Isabel Francis (*ZIP code:*)

As a Registered Nurse, I urge you to listen to health care providers not politicians.

827. Isabella Barcenas (*ZIP code:*)

828. Erin Grimes (*ZIP code:*)

Please do not vote for eliminating gender affirming care for our youth. It is life saving work. Do the research and speak with families who have transgender children.

829. Delfino Ubeda (*ZIP code:*)

Trans rights are human rights, y'all!

830. Isnelys Quintero (*ZIP code:*)

831. Ione Townsend (*ZIP code:*)

Stop playing politics with peoples lives.

832. Sara Stom (*ZIP code:*)

833. Mo Morgan (*ZIP code:*)

834. Micaela Angeli (*ZIP code:*)

I grew up in Florida and my family still lives there

835. Ivan Betancourt (*ZIP code:*)

836. Francesca Reedy-Guevara (*ZIP code:*)

837. Jan Stevenson (*ZIP code:*)

Don't do this ban!

838. John Avorh (*ZIP code:*)

839. Jessica Tsuzuki (*ZIP code:*)

840. Jaan DiVito (*ZIP code:*)

We need to protect our youth!!!!

841. Jack Newbold (*ZIP code:*)

842. Jackie Hawkins (*ZIP code:*)

843. Jacklyn Byrd (*ZIP code:*)

844. Jack Rles (*ZIP code:*)

845. Jack Orchard (*ZIP code:*)

846. Dani Weaver (*ZIP code:*)

I support Trans kids 100%!

847. Jacqueline Scott (*ZIP code:*)

848. Lauren Williams (*ZIP code:*)

Trans Youth deserve health care that actually cares about them. Gender Affirming care does no harm and should be a no-brainer.

849. Jacqueline Withers (*ZIP code:*)

850. Jaimey Oak (*ZIP code:*)

851. John Mazzearella (*ZIP code:*)

Trans health care is not only integral for quality of life, but even survival for many.

852. Melissa Andrews (*ZIP code:*)

853. Jae Markis (*ZIP code:*)

854. James Bowen (*ZIP code:*)

Transgender care is important and valid medical care that is especially essential in adolescents. Attempts to block it are bigoted hateful and detrimental to the people affected and society as a whole.

855. James Calabresi (*ZIP code:*)

856. Ryan Cluck (*ZIP code:*)

857. jamie maniscalco (*ZIP code:*)

858. Jamie Clem (*ZIP code:*)

859. Jamie Garner (*ZIP code:*)

860. Jana Gottesman (*ZIP code:*)

These kids need our support. This is necessary to keep them alive.

861. Janaya Castilho (*ZIP code:*)

862. Janet Gerhardt (ZIP code:)

With all that professional backing this surely is something we have no right to refuse.

863. Janet Hoffman (ZIP code:)

864. ayesha rompak (ZIP code:)

865. An anonymous signer (ZIP code:)

866. JL Angell (ZIP code:)

867. Mary Guerra (ZIP code:)

868. Jo Baten (ZIP code:)

869. Jansil Hueso-Newson (ZIP code:)

870. Jacob Robertson (ZIP code:)

871. Jared Preiser (ZIP code:)

872. Jasmine DuBois (ZIP code:)

873. Jason Haddleton (ZIP code:)

874. Doris Espineta (ZIP code:)

875. Jaxon Bailey (ZIP code:)

876. Jess Fitzgerald (ZIP code:)

877. Jayme Dickinson (ZIP code:)

878. Emily Anderson (ZIP code:)

879. Cecilia Roman (ZIP code:)

880. Jesse Burns (ZIP code:)

881. Judene Murray (ZIP code:)

Everyone deserves to be who they feel they are, that's why God gave doctors the skill to change the tiny percentage of kids who can articulate how they identify and who they see themselves as. This is America! We wouldn't deny OUR brave children the right to proper healthcare, would we?

882. Jonathan Fisch (*ZIP code:*)

883. Juliette Cardenas (*ZIP code:*)

884. Jocelyn Rosa (*ZIP code:*)

885. Jala Moorhead (*ZIP code:*)

886. John Dietrick (*ZIP code:*)

887. Nikki D (*ZIP code:*)

888. Jonathan Drucker (*ZIP code:*)

Protecting the most vulnerable is what a civilized society is supposed to do. Medical care should not be withheld ever to anyone.

889. Jeff Nall (*ZIP code:*)

890. Jeff Big (*ZIP code:*)

891. Jeff Macomber (*ZIP code:*)

892. Jeff Agron (*ZIP code:*)

893. Jennifer Lopez (*ZIP code:*)

894. Jennifer Bowles (*ZIP code:*)

895. Amelia Cole (*ZIP code:*)

896. Jennifer Comstock (*ZIP code:*)

897. Elisabeth Moran (*ZIP code:*)

898. Jennifer Ferre (*ZIP code:*)

899. Jennifer Griffen (*ZIP code:*)

900. Jenna Kiernicki (*ZIP code:*)

Hormone blockers were prescribed for decades by doctors that dealt with trans kids. Now some idiots in our government wanna go against medical advice because of transphobia. Stop letting stupid people dictate the lives and well-being of children. Please actually think of the children

901. Jenna Way (*ZIP code:*)

902. Jennifer Kealey (*ZIP code:*)
Protect trans kids, youth and adults!

903. Jen Moore (*ZIP code:*)

904. Jenn Ltd (*ZIP code:*)

905. Jennifer Milner (*ZIP code:*)

906. Jenny Paulus (*ZIP code:*)

907. Jordan Pittock (*ZIP code:*)

908. Cherryl Friedman (*ZIP code:*)
Trans kids need gender affirming care. All kids need care which affirms them. It's sad some people don't understand this and terrible for the kids!!!

909. Jeremy Keene (*ZIP code:*)

910. Jerry Cannon (*ZIP code:*)

911. Jessica Willson (*ZIP code:*)
The members of Florida Board of Medicine do not specialize in adolescent mental health or endocrinology. Some members are not even doctors. There is no valid justification for a group of individuals without the appropriate level of expertise to make decisions that override universally recognized national organizations that specialize in this field.

912. Jessica Toliver (*ZIP code:*)

913. Jessica Traiger (*ZIP code:*)

914. Jessica Wilson (*ZIP code:*)
I am a clinical psychologist and WPATH certified gender specialist in Oregon who originally was trained in Florida. It is appalling that FL is attempting to deny basic care to its citizens to gain political points.

915. Jessica Mullins (*ZIP code:*)

916. Jaesun Chong (*ZIP code:*)

917. Jessica Robertson (*ZIP code:*)

918. Nancy Gau (*ZIP code:*)

919. Ema Kostadinov (*ZIP code:*)

920. Jethro Alonso (*ZIP code:*)

921. Julie Allen (*ZIP code:*)

922. James Goodale (*ZIP code:*)

923. Janet Good (*ZIP code:*)

924. Joshua Heleva (*ZIP code:*)

925. Jami Heye (*ZIP code:*)

926. Jamie Heard (*ZIP code:*)

927. Jennifer Hodge (*ZIP code:*)

928. Jonathan Hollander (*ZIP code:*)

929. Jill Weisberg (*ZIP code:*)

930. Jillian Bednarz (*ZIP code:*)

931. Jillian Reich (*ZIP code:*)

932. Jill Yarbrough (*ZIP code:*)

933. Jimmy N (*ZIP code:*)

934. Jim Hinds (*ZIP code:*)

935. James Hines (*ZIP code:*)

936. James Boler (*ZIP code:*)

937. Jen Cook (*ZIP code:*)

Gender-affirming care for youth prevents suicide. Children aren't getting "mutulated" and puberty blockers are routinely given to cisgender children. This isn't medicine, it's bigotry masquerading as caring.

938. Janice Jochum (*ZIP code:*)

939. John Asgeirson (*ZIP code:*)

940. Jay Chetney (*ZIP code:*)

941. Willow K (*ZIP code:*)

942. James Kirby McMahon (*ZIP code:*)

This cruel law cannot be allowed to stand and should not be allowed to stand by people who consider themselves to be kind, caring, and empathetic. You have been warned what this law will do and the harm it will cause. If it goes forward it will be on you and whatever greater moral good you hold yourself accountable to.

943. jennifer lash (*ZIP code:*)

944. Jeremy Donald (*ZIP code:*)

945. Jessica Arguello (*ZIP code:*)

946. Javier Montoya (*ZIP code:*)

947. Jane Morrisson (*ZIP code:*)

948. Nancy Gibbs (*ZIP code:*)

949. Joan Lipsig (*ZIP code:*)

950. Sheela Riley (*ZIP code:*)

951. Joanna Metzger (*ZIP code:*)

952. Joan Lamunyon Sanford (*ZIP code:*)

953. joani stein (*ZIP code:*)

Why would anyone want to do this ? LBGTQ+ people are human beings just like everyone else (with the exception of the people who want to do this harm). They deserve our respect and every type of care available to everyone!! This is inhumane!!

954. Joanna Tomas (*ZIP code:*)

955. Joanna Rodriguez (*ZIP code:*)

956. Joanna Brown (*ZIP code:*)

957. Joanne Jones (*ZIP code:*)

958. Jodi Druss (*ZIP code:*)

959. Joseph Lyons (*ZIP code:*)

Please protect ALL of Florida's children, including trans children and continue to allow the appropriate medical care as approved AND recommended by the AMA!

960. Joe Paysen (*ZIP code:*)

961. Johanna Monterrey (*ZIP code:*)

962. John Camacho (*ZIP code:*)

963. Shelby Norris (*ZIP code:*)

964. Josephine Batzel (*ZIP code:*)

This is a horrible idea. People WILL die without access to gender-affirming care. We can and will stand up for our rights. We demand your respect, we are human and all we want is to live our lives as the people we are on the inside.

And by outing trans individuals, you are putting them under extreme threat of being swatted, doxxed, and even assaulted or murdered. Please don't do either of these things, our lives are literally at stake.

965. Josh Cazares (*ZIP code:*)

966. JJ Shadow (*ZIP code:*)

967. Joshua Johanson (*ZIP code:*)

968. Joshua Bolton (*ZIP code:*)

969. Josh Wimmer (*ZIP code:*)

970. Joanne Reside (*ZIP code:*)

We must help and protect these youth!

971. Jeremy Peebles (*ZIP code:*)

972. Juanita Powell-Williams (*ZIP code:*)

973. Joseph Pubillones (*ZIP code:*)

Every human being has the right to receive the health care, and be treated as who they feel they are.

974. Jacqueline Rehm (*ZIP code:*)

975. Jamie Terry (*ZIP code:*)

976. Joseph Ingerman (*ZIP code:*)

977. Jantzen Mora (*ZIP code:*)

We need to save trans youth in their gender-affirming care so they can be their authentic and true selves. Don't let this Fascist government in Floroda get away with murder!

978. Jennifer Southard (*ZIP code:*)

979. Jason Stowe (*ZIP code:*)

980. Janelle Sales (*ZIP code:*)

981. Jodi Schulinn (*ZIP code:*)

982. Jonathan Silvers (*ZIP code:*)

983. Jessica Tomlinson (*ZIP code:*)

Please keep your political agenda out of the private lives of people who are different from you. It's so ironic to me how "small government" proponents love to invade the privacy of people they don't agree with personally. Does the "Pursuit of happiness" apply to only people who look like you?

984. Jane Owel (*ZIP code:*)

Gender affirming care is health care!

985. Judi Semel (*ZIP code:*)

986. Judith Siegal (*ZIP code:*)

987. Peach (*ZIP code:*)

988. Julie Seaver (*ZIP code:*)

989. Julie Connor (*ZIP code:*)

990. Julie Dick (*ZIP code:*)

991. Julie Schlosser (*ZIP code:*)

992. Julie Barraza (*ZIP code:*)

993. Juliet Path (*ZIP code:*)

I support Gender Affirming Care for Trans Youth in Florida!

994. julie jenkins (*ZIP code:*)

995. Juliusz Dziewicki (*ZIP code:*)

996. Renee Grimm (*ZIP code:*)

997. June Cook (*ZIP code:*)

998. June Midura (*ZIP code:*)

999. Justin Muldoon (*ZIP code:*)

1000. Justin Mathis (*ZIP code:*)

1001. Caleb W (*ZIP code:*)

1002. Toby Thrasher (*ZIP code:*)

I'm trans and this is extremely disappointing

1003. Jennifer Valentine Williams (*ZIP code:*)

1004. Valles John (*ZIP code:*)

1005. Julie Woodbury (*ZIP code:*)

1006. Jessica Wylie (*ZIP code:*)

1007. Kevin Luongo (*ZIP code:*)

Choose the freedom that the individual has been promised by the constitution.

1008. Kelly Thibert (*ZIP code:*)

1009. Atlas (*ZIP code:*)

1010. Malackai Jordan (*ZIP code:*)

PROTECT TRANSGENDER YOUTH!!

1011. Kait Brayden (*ZIP code:*)

1012. Kaitlyn Holling (*ZIP code:*)

1013. Kaitlynn counts (*ZIP code:*)

1014. Kaiya Rader (*ZIP code:*)

1015. Kaje Housman (*ZIP code:*)

Let trans kids and adults live their authentic lives, for goodness sake!

1016. Phyllis Roth (*ZIP code:*)

Children of all ages should be able to have the gender affirming medical procedures. This is also a privacy issue.

1017. Kameron Stewart (*ZIP code:*)

Gender affirming care is valid and life-saving!

1018. Katherine Aranda (*ZIP code:*)

1019. Kandice OToole (*ZIP code:*)

1020. Kane Lynch (*ZIP code:*)

1021. Annalis Hermann (*ZIP code:*)

Florida - stop pushing government intrusion and control into healthcare, this is a violation of constitutional and human rights.

1022. Kathleen Merkler (*ZIP code:*)

1023. Karen Casaseca (*ZIP code:*)

1024. Karina Munoz (*ZIP code:*)

1025. Kira Brylow (*ZIP code:*)

Kids and young adults, especially ones who are trans, are going through a lot. They should not have to worry about losing their rights to gender affirming care

1026. Kassandra Lopez (*ZIP code:*)

1027. Katleen Leon (*ZIP code:*)

1028. Kat Duesterhaus (*ZIP code:* 33174)

1029. Kate Lannamann (*ZIP code:*)

This rule ignores best medical practices. Government should NOT interfere with sound health care

practices.

1030. Kate McCreedy (*ZIP code:*)

1031. Kate Mewhiney (*ZIP code:*)

1032. Kate Devine (*ZIP code:*)

1033. Katelin Grant (*ZIP code:*)

1034. Kate Ruth (*ZIP code:*)

Protect trans kids.

1035. Kate Mageau (*ZIP code:*)

1036. Katherine Heold (*ZIP code:*)

1037. Kathryn Peters (*ZIP code:*)

1038. Kathleen Heinz (*ZIP code:*)

I have worked with teens for years and they need to be able to collaborate with their medical doctor to receive the care they need. If professionals refuse to be involved, care will be sought from quacks and opportunists.

1039. Kathleen Mettler (*ZIP code:*)

1040. Coryen Erickson (*ZIP code:*)

1041. Katie Dudley (*ZIP code:*)

1042. Kate Kahn (*ZIP code:*)

1043. Kathryn Lewis (*ZIP code:*)

Gender-affirming care for trans youth can literally save a child's life. The fact that the Florida Board of Medicine would even consider this course of action, which will very probably and dramatically result in an increase in youth suicide rates, is appalling.

1044. Katrina Ciraldo (*ZIP code:*)

1045. Kaya Gjønnnes (*ZIP code:*)

1046. Kayce Compton (*ZIP code:*)

Banning gender-affirming health care for trans youth will undoubtedly lead to child deaths from suicide. Parents of trans youth, like myself, are just trying to keep their kids alive.

1047. Kayden Fields (*ZIP code:*)

1048. Kaylee Geffert (*ZIP code:*)

1049. Micaela Czapla (*ZIP code:*)

1050. Katya Batlle (*ZIP code:*)

1051. Karina Cardona (*ZIP code:*)

1052. Kendall Crank (*ZIP code:*)

1053. Kristen Chambers (*ZIP code:*)

1054. Kerry Devine (*ZIP code:*)

Protect trans youth!

1055. Kyle Dinsdale (*ZIP code:*)

1056. Kelly Teal (*ZIP code:*)

1057. Kelly Haskins (*ZIP code:*)

1058. Kelsey Bileen (*ZIP code:*)

Gender affirming care saves lives.

1059. Kelsey Tressler (*ZIP code:*)

Gender affirming care must be protected!

1060. Kelsie Lawhorn (*ZIP code:*)

1061. Kendal Hopkins (*ZIP code:*)

1062. Kendra Alves (*ZIP code:*)

Unless you live this, and understand it, you should stay out of our lives.

1063. Kendra Jordan (*ZIP code:*)

1064. Kendrick Meek (*ZIP code:*)

1065. Kensi Mills (*ZIP code:*)

Trans children are so vulnerable and go through so much torment in their lives. Dealing with gender dysphoria as a child and having no way to treat it or seek help to treat it and instead trying to reinforce

a different gender that may not be right for them is wrong.

These kids have some of the best medical professionals in the country if not the world who only do what is best for each child involved and allows the child time to decide for themselves what is best while following a detailed long existing timeline of therapy, puberty blockers if needed then hormones later in their teens and then surgery.

Stop treating these kids like they're nothing more then a political pawn in a game. Trans kids are just like every other child out there and deserve to be treated like it.

1066. An anonymous signer (*ZIP code:*)

1067. Keri Graham (*ZIP code:*)

1068. Tobias Mulder (*ZIP code:*)

1069. Kerry Anderson (*ZIP code:*)

1070. Kevin Konkle (*ZIP code:*)

1071. Kevin Connolly (*ZIP code:*)

1072. Cheryl Huber (*ZIP code:*)

Transgender people are not demons or criminals. My transgender friends are real people with families and jobs. They deserve privacy and appropriate medical treatment in the same way that all Floridians deserve appropriate medical treatment.

1073. Madelyn Ferguson (*ZIP code:* 33134)

1074. Katyna Gainey (*ZIP code:*)

1075. Kaye Harper (*ZIP code:*)

1076. Carolyn Koslen (*ZIP code:*)

1077. Kathy Bradley (*ZIP code:*)

1078. Natalie Vázquez (*ZIP code:*)

1079. Haley Tova (*ZIP code:*)

1080. Kiersten Aymar (*ZIP code:*)

1081. Allison Corbett (*ZIP code:*)

I'm the mother of a trans adolescent and gender affirming care has been life changing and important to the health and well-being of my son. Refusing transition care is not evidence-based and will cause direct harm to trans kids and their families.

1082. Melany Rodriguez (*ZIP code:*)

1083. Kim Armstrong (*ZIP code:*)

1084. Kimberly McGrath Moreira (*ZIP code:*)

Please, stop harming youth with such backward thinking policy. Anyone paying attention to suicide rate DATA?

1085. Valerie Shelton (*ZIP code:*)

Gender-affirming care saves lives.

1086. Rhys Simplicio (*ZIP code:*)

1087. Michelle King (*ZIP code:*)

1088. Breanna King (*ZIP code:*)

1089. Derek Springfield (*ZIP code:*)

1090. Anna Novak (*ZIP code:*)

1091. Abigail King (*ZIP code:*)

Trans rights

1092. Kira Maniatopoulos (*ZIP code:*)

1093. Kit New (*ZIP code:*)

1094. Kit Janetsky (*ZIP code:*)

1095. Jane Seage (*ZIP code:*)

1096. Alexzandria Ness (*ZIP code:*)

1097. Kathy Carroll (*ZIP code:*)

America for all!!

Everyone has the right to healthy care!

1098. Kelsey M. (*ZIP code:*)

1099. Katelyn Elms (*ZIP code:*)

1100. Katie (*ZIP code:*)

1101. Kayla Aplin (*ZIP code:*)

1102. Kristina Luce (*ZIP code:*)

Banning care for trans people is immoral and corrupt

1103. Kathryn Mareci (*ZIP code:*)

1104. Kayla Elkins (*ZIP code:*)

1105. Katherine Seitz (*ZIP code:*)

1106. Frank Daniels (*ZIP code:*)

1107. Konner Jebb (*ZIP code:*)

As a trans man, I know how important healthcare is. It is a moral right to live as ourselves and be at home in our own bodies.

1108. Polly Kraus (*ZIP code:*)

1109. JP Kravitz (*ZIP code:*)

1110. katryna richter (*ZIP code:*)

1111. Rev. Keith R. Scott (*ZIP code:*)

1112. Kriss Asenjo (*ZIP code:*)

1113. Krista Lindemann (*ZIP code:*)

1114. Kristan Johnson (*ZIP code:*)

1115. State Representative Kristen Arrington (*ZIP code:*)

1116. Kristen Kimball (*ZIP code:*)

This is a very dangerous rule, forcing your ideals onto someone else's body is oppression. These medical based decisions should be made by doctors concerned for their patients best interest, not lawmakers who have no experience or knowledge in this area. I will not support any lawmakers associated with these types of rulings. A registry of trans people in Florida?! Are you trying to get them harmed by the white supremacists that DeSantis loves?

1117. Kristia Watkins (*ZIP code:*)

1118. Willow Turner (*ZIP code:*)

I know what it means to fight for your own existence, i fight so that trans youth survive, I fight for older trans folk to thrive, we are human, and we will survive

1119. Krystal Callhoun (*ZIP code:*)

1120. Krzysztof Baranowski (*ZIP code:*)

1121. Kristen Stoner (*ZIP code:*)

1122. Kenda Sutton (*ZIP code:*)

1123. Katie Kezelian (*ZIP code:*)

1124. Kathryn McKechnie (*ZIP code:*)

1125. Karen Estrin (*ZIP code:*)

Transition care for transgender youth is necessary and beneficial to their well being. There have always been transgender people throughout history, The aim of this non science based policy is of denying treatment is to marginalize and delegitimize them. The results of this will put transgender youth at greater risk of being physically and emotionally bullied, make transition more difficult with age, and increase suicide rates. In what world is this a positive outcome?

1126. Nui Rios (*ZIP code:*)

1127. Kyle Maharlika (*ZIP code:*)

1128. Kyle Belz (*ZIP code:*)

1129. Kylie Aoibheann (*ZIP code:*)

Access to gender affirming medical care (such as hormone replacement therapy) is one of the only scientifically proven ways to improve the wellbeing and livelihood of transgender people - and prevent mental illness and suicide. Other proven things include social acceptance (being called a preferred name and pronouns ect.) and access to clothing of the gender the individual identifies with. To deny gender affirming care is to deny basic medical treatment.

This is especially egregious, when the number of people who express any kind of regret whatsoever after accessing gender affirming care is miraculously low (about 3%), especially when compared with any of their medical treatment (up to 30% of patients regret having a knee replacement). The amount of people who detransition is much lower than this; and of those who do express such regret about accessing gender affirming care, a great many do so because they face too many social barriers living their authentic self (not because they are not actually transgender). To put this into context, only 5% of people who detransition do so because transitioning medically wasn't right for them.

When seen this, the scientifically-proven benefits of gender affirming care vastly outweigh any possible risks. Access to gender affirming care saves lives - but restriction to it, will destroy many.

1130. Kylie Case (*ZIP code:*)

1131. Lorenzo Canizares (*ZIP code:*)

Human Rights covers all humans.

1132. Lee Newbrook (*ZIP code:*)

Trans healthcare is *lifesaving* for kids and adults alike!

1133. Gregory Labbe (*ZIP code:*)

1134. Lacorya Lynn (*ZIP code:*)

1135. Elizabeth Yerian (*ZIP code:*)

1136. Lacy Larson (*ZIP code:*)

1137. Lauren Adriaansen (*ZIP code:*)

Doctors should save lives. Banning gender affirming care will lead to suicides and dangerous self-treatment. Please save our state's children.

1138. Teresa Lanz (*ZIP code:*)

Let trans kids be trans. Don't let prejudice, politics, and religion override medical care.

1139. zachary hoskins (*ZIP code:*)

1140. Lisa Freund (*ZIP code:*)

1141. Lisa Foy (*ZIP code:*)

1142. Angie Lair (*ZIP code:*)

1143. Christen Lancaster (*ZIP code:*)

1144. LJ Woolston (*ZIP code:*)

Trans children have always been here.

This is nothing new, and the BoM's attempts to limit access to care will kill some of these children.

Trans then, trans now, 39 years in. :)

1145. Lara Rumizen (*ZIP code:*)

1146. Adam Larivee (ZIP code:)

Gender affirming care is necessary for the mental, physical and spiritual wellness of all people.

1147. Michaela Laubacher (ZIP code:)

Gender Affirming care is what I needed when I was a young teenager and I didn't get it. Don't ban this medically necessary care in the name of bullying trans kids.

1148. Lisa Jae (ZIP code:)

1149. Laura Foshe (ZIP code:)

Let people be themselves

1150. Laura Turner (ZIP code:)

1151. Laura Markowicz (ZIP code:)

Stop hurting kids

1152. Laura Hernandez (ZIP code:)

1153. Laura Recean (ZIP code:)

Transgender people deserve dignity and respect and to be treated with kindness. Gender-affirming care for trans youth is vital to their wellbeing and absolutely necessary.

1154. Lauren Luis (ZIP code:)

1155. Lauren Berger (ZIP code:)

1156. Lauren Brenzel (ZIP code:)

1157. Lauren Watkins (ZIP code:)

1158. Lauren Natoli (ZIP code:)

1159. Lauren Salgo (ZIP code:)

1160. Trans Lifeline (ZIP code:)

1161. Lauren Adler (ZIP code:)

1162. Lauren Koff (ZIP code:)

1163. lauren roldan (ZIP code:)

1164. Laurie Sargent (ZIP code:)

1165. Lavina Ng (ZIP code:)

1166. Myka Lee Lawliet (ZIP code:)

1167. Layda Duda (ZIP code:)

I believe that person's with gender identity need to have proper medical and mental health. No politician has the right to denied said care. ?_____

1168. Layla Woody (ZIP code:)

1169. Layne Alvarez (ZIP code:)

1170. Lauren Smith (ZIP code:)

1171. Leah Bashover (ZIP code:)

1172. Laura Donovan (ZIP code:)

1173. Lindsay Bohan (ZIP code:)

I am from Florida. Born and raised, and as a member of the LGBTQIA community this action by the Board of Medicine is unconscionably cruel and an attack on bodily autonomy from a body that is supposed to affirm the necessary and critical services instead of ban them.

1174. Lillie Brock (ZIP code:)

1175. Laura Wenger (ZIP code: 34990)

1176. An anonymous signer (ZIP code:)

1177. Levi Hamner (ZIP code:)

1178. Lynton Mapa (ZIP code:)

1179. Alicia Donaire (ZIP code:)

1180. Lea McGeever (ZIP code:)

1181. Jessica Hanson (ZIP code:)

The whole thing is honestly disgusting. They're completely disregarding science and reputable medical organizations in favor of whatever crazy crawled out of the right wings ass that month. Literally feelings over facts.

1182. Leah Whitney (*ZIP code:*)

1183. Leah Torres (*ZIP code:*)

Gender-affirming care PREVENTS TEEN SUICIDE

1184. Leanne Klumb (*ZIP code:*)

We need to stop demonizing these kids. They have so many struggles, and need to be fully supported and embraced.

1185. Leanna Brown (*ZIP code:*)

1186. Lee Perry (*ZIP code:*)

Please support our Trans Residents and continue to allow the necessary care they deserve as a right!

1187. Leesa True-Smith (*ZIP code:*)

1188. Maxie Imperial (*ZIP code:*)

1189. Rhea LeLacheur (*ZIP code:*)

1190. Spencer LeLacheur (*ZIP code:*)

1191. Leo Bagwell (*ZIP code:*)

1192. Leon Light (*ZIP code:*)

1193. Amélie Lepley (*ZIP code:*)

1194. Sarah Lepley (*ZIP code:*)

We need every person and every state to stand up and protect transgender, non-binary and gender diverse kids. Gender-affirming care is life saving. For those that have sworn an oath to do no harm, know that denying gender-affirming care is harm.

1195. Leslie Inniss (*ZIP code:*)

1196. Leslie Johnson (*ZIP code:*)

Trans rights are human rights

1197. Samantha Pitchford (*ZIP code:*)

1198. Lexxi Harmeson (*ZIP code:*)

1199. Laurence Ford (*ZIP code:*)

This will cause youth suicide rates to go through the roof. As a mental health care provider for this

community and an individual who is trans themselves I implore the board to think twice and make sure they are reading unbiased research when they make decisions.

1200. Phyllis Scott (*ZIP code:*)

1201. Laura Hillmann (*ZIP code:*)

1202. David Phillips (*ZIP code:*)

1203. Laura Arencibia (*ZIP code:*)

1204. Lilly Velez (*ZIP code:*)
Let trans youth get affirming care!

1205. Skyanna Leaf (*ZIP code:*)

1206. Lily (*ZIP code:*)

1207. Luis Rowley (*ZIP code:*)

1208. Kaylee A (*ZIP code:*)
?_____TRANS RIGHTS_?_____

1209. Linda Guillotti (*ZIP code:*)

1210. Lindsey Gale (*ZIP code:*)

1211. Alexander Ng (*ZIP code:*)

1212. Lindsay Eanet (*ZIP code:*)

1213. Lindsey Hein (*ZIP code:*)
Gender affirming care saves lives and should be accessible to any and all who need it.

1214. Lindsey Mills (*ZIP code:*)

1215. Lindsey Skidmore (*ZIP code:*)

1216. Linda Morris (*ZIP code:*)

1217. Lisa Gilliam (*ZIP code:*)

1218. Lisa McClure (*ZIP code:*)

1219. Lisa Sells (*ZIP code:*)

1220. Lisa Meyer (*ZIP code:*)

1221. Lisa Cox (*ZIP code:*)

1222. Lisa La Monica (*ZIP code:*)

1223. Webb (*ZIP code:*)

1224. elizabeth schwartz (*ZIP code:*)

1225. Liz Gustafson (*ZIP code:*)

1226. Mary Warthen (*ZIP code:*)

1227. Elizabeth Rafael (*ZIP code:*)

1228. Lizette Pena (*ZIP code:*)

1229. Elizabeth Brooks (*ZIP code:*)

1230. Laura Campbell (*ZIP code:*)
Support trans lifes

1231. Lee Johnson (*ZIP code:*)

1232. Laura Kallus (*ZIP code:*)

1233. Lynn Kislak (*ZIP code:*)

1234. Elizabeth Labbe (*ZIP code:*)
How you could even consider this is incomprehensible. Barbaric.

1235. Lucas (*ZIP code:*)

1236. olivia lay (*ZIP code:*)

1237. Lee S (*ZIP code:*)

1238. linda Geller-Schwartz (*ZIP code:*)

1239. Arden Scott (*ZIP code:*)

1240. Carly Lockard (*ZIP code:*)

1241. Logan Lindquist (*ZIP code:*)

1242. Tara Bailey (*ZIP code:*)

1243. May Rojas (*ZIP code:*)

Trans rights!

1244. Victoria Gray (*ZIP code:*)

1245. Loretta Landry (*ZIP code:*)

1246. Loretta Di Tocco (*ZIP code:*)

1247. Lauren Pell (*ZIP code:*)

1248. Amie Bell (*ZIP code:*)

1249. Louisa David (*ZIP code:*)

I support all LGBTQ+++? __?

Including youth!

1250. Louis Darden (*ZIP code:*)

Who could have guessed that religiously-inclined right-wing politicians would try to pass oppressive laws based on misconstruing affirmative care they don't understand as hypothetical crimes?

1251. Markus Petty (*ZIP code:*)

1252. Lourdes Martin (*ZIP code:*)

1253. Lou Schmitt (*ZIP code:*)

1254. Theresa McClellan (*ZIP code:*)

1255. Lourdes Royce (*ZIP code:*)

1256. Linda Cooley (*ZIP code:*)

1257. Leslie Seminario (*ZIP code:*)

1258. Lori Rogovin (*ZIP code:*)

1259. Lynn Surum (*ZIP code:*)

1260. Laura Tolbert (*ZIP code:*)

1261. Lucas Nordman (*ZIP code:*)

It should not be the aim of this government to deny youths lifesaving medical care. Neither should this government aim to regulate or restrict access to this care any further than what had already been implemented. Transgender youths deserve support, not disdain or erasure. Removing or restricting gender-affirming care will not result in fewer transgender youths, but simply more dead youths we could have saved.

1262. Luke fernandez (*ZIP code:*)

1263. HEIDI LUCKEN (*ZIP code:*)

LEAVE THESE KIDS ALONE!

1264. Mary Roadarmel (*ZIP code:*)

1265. Ludi Laws (*ZIP code:*)

1266. Ludwig Vogel (*ZIP code:*)

This proposed "standard of care" is a stain on the good name of your state. The registration of transgender kids will go down as a civil liberties abomination.

1267. Coleen Summey (*ZIP code:*)

1268. Luna Plaza (*ZIP code:*)

1269. Sara Smith (*ZIP code:*)

1270. Patricia Rardin (*ZIP code:*)

1271. Lisa Villalobos (*ZIP code:*)

1272. Lance Veneruso (*ZIP code:*)

1273. Laura Whiting (*ZIP code:*)

You'll literally be killing trans kids by enacting these hateful, ignorant laws. Shame on you all.

1274. Liam Westgate (*ZIP code:*)

1275. Lauren Wranosky (*ZIP code:*)

1276. Lycorys Ocha (*ZIP code:*)

1277. Lydia Ash (*ZIP code:*)

I support the right of trans people to safe health care. I ask the Florida Board of Medicine to block this rule.

1278. Jason Lynch (*ZIP code:*)

Healthcare is a right for everyone, not just white religious zealots.

1279. Shelley Lynch (*ZIP code:*)

1280. Elizabeth Engelhardt (*ZIP code:*)

Do not fall into the trap of the evangelicals.
Help these kids. Do not force them to suffer and die.

1281. Michael-Ann Veziroglu (*ZIP code:*)

1282. Micaela Moriarty (*ZIP code:*)

1283. Madeline Mesa (*ZIP code:*)

1284. Merle Clark (*ZIP code:*)

1285. Mary Catanzaro (*ZIP code:*)

1286. Colleen Waite (*ZIP code:*)

1287. Kayla Mack (*ZIP code:*)

As the parent of an adult transgender child - these gender affirming surgeries are necessary and lifesaving. These decisions should be made by individuals and (if they are minors) their parents. Not lawmakers.

1288. Maddi Castaldi (*ZIP code:*)

1289. Madeline Clark (*ZIP code:*)

Trans rights are human rights.

1290. Madeline Joosten (*ZIP code:*)

1291. Madeline Ng (*ZIP code:*)

1292. Maria Acosta (*ZIP code:*)

1293. Maggie Olivia (*ZIP code:*)

1294. Bluebird Mack (*ZIP code:*)

1295. Michael Alexander-Luz (*ZIP code:*)

1296. Stormy Hobbs (*ZIP code:*)

1297. Julien Drake (*ZIP code:*)

1298. Christina Wheet (*ZIP code:*)

1299. Amanda Anderson (*ZIP code:*)

Protect transgender people through supporting transgender rights!

1300. Michael Andrews (*ZIP code:*)

1301. Mara Yasí Sánchez Valencia (*ZIP code:*)

1302. Mara Ross (*ZIP code:*)

1303. Marcus Solbes-Moran (*ZIP code:*)

1304. Margaret M Ledford (*ZIP code:*)

1305. Margeaux Miller (*ZIP code:*)

1306. Mari Mennel-Bell (*ZIP code:* 33062-7372)

1307. Maria Teresa Molina (*ZIP code:*)

1308. Maria Camacho (*ZIP code:*)

1309. Maria Morales (*ZIP code:*)

1310. Zayda Hernandez (*ZIP code:*)

1311. Mariana Andrade (*ZIP code:*)

1312. Marianne Pink (*ZIP code:*)

Keep gender-affirming care for trans youth and any trans person!!!

1313. Andrea Oliveras (*ZIP code:*)

1314. Marie Luce Suckle (*ZIP code: 33133*)

1315. Marie (*ZIP code:*)

Trans youth deserve to be provided with care that helps them, which is affirming care. They don't need politicians to boss around what isn't good for them when doctors and parents are there to support them. Please protect trans kids

1316. Mariko Bigler (*ZIP code:*)

1317. Marilyn Smith (*ZIP code:*)

1318. Marina Zogalis (*ZIP code:*)

Please treat trans people like people. Equal rights for all.

1319. Marion Blohm (*ZIP code:*)

1320. Alex Gallagher (*ZIP code:*)

Trans youth deserve health care rights

1321. Mark Houston (*ZIP code:*)

1322. Renee Barone (*ZIP code:*)

1323. Marni Henry (*ZIP code:*)

1324. Roberta Martin (*ZIP code:*)

1325. Marq Mitchell (*ZIP code:*)

1326. Karl Houser (*ZIP code:*)

Let the kids be who they are

1327. Martha Asbury (*ZIP code:*)

1328. Marthe Hjortshoj (*ZIP code:*)

1329. Marti Derow (*ZIP code:*)

1330. Cody Martin (*ZIP code:*)

Please, please, support your fellow HUMANS; of all genders and orientations. When you deny the humanity of one group of people, you de-humanize the people who are actively in your life. They may not be "out" to you, but the people who are within these groups will know you want them dead and/or suffering. You only isolate yourselves and show your bigotry if you support the banning of healthcare for ANYONE, especially the banning of gender affirming care for the transgender youth of YOUR

communities.

Florida Board of Medicine, you will be held accountable for your bigotry.

1331. Sarah Marti (*ZIP code:*)

1332. Mary Ann Toal (*ZIP code:*)

1333. Mary Morris (*ZIP code:*)

1334. mary kaplan (*ZIP code:*)

1335. Mason Berrios (*ZIP code:*)

1336. Mateo Cristiani (*ZIP code:*)

Ron DeSantis and his followers have no business in people's medical decisions, or those they make for their children.

1337. An anonymous signer (*ZIP code:*)

1338. MATTHEW BURCH (*ZIP code:*)

1339. Morgan Matthews (*ZIP code:*)

1340. Matthew Menendez (*ZIP code:*)

1341. Matthew Silverman (*ZIP code:*)

1342. Matthew Singer (*ZIP code:*)

1343. Michelle Augustus (*ZIP code:*)

1344. Maxwell Petcoff (*ZIP code:*)

1345. Maxine McKinnell (*ZIP code:*)

1346. Max Preston (*ZIP code:*)

1347. Maxwell Matchim (*ZIP code:*)

1348. Maureen Kinlaw (*ZIP code:*)

As a resident of Florida I am disgusted by the efforts to block and legislate care for Trans youth and adults by people with no understanding of this issue. This should be between an individual and their

Healthcare team. No exceptions.

1349. Maya Saunders (ZIP code:)

How about you guys like, don't ban it?

1350. Jennifer Mayer (ZIP code:)

1351. Gwyn Petersen (ZIP code:)

1352. Michael Binford (ZIP code:)

Trans people need our care and support

1353. An anonymous signer (ZIP code:)

1354. Marcais Jackson II (ZIP code:)

1355. Janet Brown (ZIP code:)

1356. Maureen Lee Cote (ZIP code:)

1357. Debra McConnaughey (ZIP code:)

1358. Molly McGoldrick (ZIP code:)

1359. Michael Collins (ZIP code:)

1360. McKenna Vanhorn (ZIP code:)

My cousin is transgender. Without gender affirming care, he would not be happy, healthy, and thriving today. All individuals deserve access to care to help them thrive.

1361. MARIA MANDRY (ZIP code:)

1362. Maria Mejia (ZIP code:)

What if it's your kid that wants to kill himself because of this restriction to the freedom to be who they are?

1363. Matthew McNutt (ZIP code:)

1364. Aiden McRoberts (ZIP code:)

1365. Sujatha Prabhakaran (ZIP code:)

Gender affirming care is truly life saving. Restricting care only serves to hurt patients & does nothing to protect some of the most vulnerable people in our society.

1366. Maryann D'Aquino- Tearle (*ZIP code:*)

1367. Meagan Cahuasqui (*ZIP code:*)

1368. Mechi Luna (*ZIP code:*)
Let's move forward not backwards

1369. Mead Overbeck (*ZIP code:*)

1370. Abbey Crnich (*ZIP code:*)

1371. Mary-Elizabeth Estrada (*ZIP code:*)

1372. Jeremiah Villarreal (*ZIP code:*)

1373. Megan Titcomb (*ZIP code:*)

1374. Meghan Harvey (*ZIP code:*)

1375. Jennifer Meksraitis (*ZIP code:*)

1376. Melanie Lock (*ZIP code:*)

1377. Melanie Lachs (*ZIP code:*)

1378. Melanie Sutterfield (*ZIP code:*)
Why are people afraid of us? Why do you fear different? If it's for religion reasons then please read your book again. As in your own book... Fear is the tool of the devil and so is hate. Trans people just want to exist. They don't want to be in your lives or force themselves on you. Just visible, just living.

1379. Mackenzie Steele (*ZIP code:*)

1380. Melissa Kelley (*ZIP code:*)

1381. Melissa Lyon (*ZIP code:*)

1382. Martha Padilla (*ZIP code:*)
I support this important issue

1383. Meta Ellis (*ZIP code:*)

1384. Luke Metzger (*ZIP code:*)

1385. Mindy Grimes-Festge (ZIP code:)

1386. Gabriela Contreras (ZIP code:)

1387. Maude Hamer (ZIP code:)

You leave my precious grandchild alone!

What you are doing to these children's medical access is not what this gal was taught in church on Sunday.

Trans people are children of God and deserve healthcare!

1388. Michael Hunter (ZIP code:)

1389. Mica Ravan (ZIP code:)

They have no right telling us or anyone what too call our selfs we need our own country

1390. Michael Ducharme (ZIP code:)

I have personally read this petition and I support it in the strongest possible terms.

Using cherry-picked, unscientifically collected research conducted by organizations with known transphobic agendas to inform trans healthcare is deplorable.

Conducting "public" meetings regarding the future of trans healthcare in locations where trans individuals are harassed and not provided safe restrooms is deplorable.

Reducing trans youth freedom and access to life-saving healthcare is deplorable and will **kill young members of your own community**.

I beg you to examine your conscience and have an impartial review conducted on the effects and benefits of gender affirming healthcare, or consult one of the existing meta-analyses of such research. Please make your policy understanding that gender affirming healthcare improves trans youth wellbeing and quality of life.

1391. Michael Eidson (ZIP code:)

1392. Michael Galvez (ZIP code:)

1393. Michaela Kerls (ZIP code:)

An outright ban takes important decision making ability away from the doctors and patients who know and understand their own needs best.

1394. MICHELE DRUCKER (ZIP code:)

This is such an egregious safety violation for families and children. This is what happens in totalitarian regimes. Are you going to put a numbered tattoo on these children next?

1395. Michele Castania (ZIP code:)

1396. Michelle Knight (*ZIP code:*)

1397. michelle isgut (*ZIP code:*)

1398. Michelle Kenoyer (*ZIP code:*)

1399. Carol Jennings (*ZIP code:*)

1400. Michelle Piasecki (*ZIP code:*)

1401. Michelle Waldron (*ZIP code:*)

1402. Michele Horan (*ZIP code:*)

1403. Sophie Blaire Cuya (*ZIP code:*)

1404. Miguel Sandoval (*ZIP code:*)

1405. Michael Cohen (*ZIP code:*)

1406. Michael Riordan (*ZIP code:*)

Do not ban gender affirming healthcare for ANYONE no matter their age. This is a parental rights decision to be made with their children and medical professionals.

1407. Karen Clay (*ZIP code:*)

1408. Michael Goodmark (*ZIP code:*)

1409. Miles Callico (*ZIP code:*)

Help stop this legislation. They are an attack on human rights.

1410. Rebecca Millar (*ZIP code:*)

1411. miriam Lopez (*ZIP code:*)

1412. MELISSA CRAWFORD (*ZIP code:*)

1413. Melita Curphy (*ZIP code:*)

1414. Missy Coffin (*ZIP code:*)

1415. Misty Brady (*ZIP code:*)

1416. Mivia Dominguez (*ZIP code:*)

1417. Melina Julia Van Riet (*ZIP code:*)

1418. Marc Yacht MD (*ZIP code:*)

1419. Karina Batchelor (*ZIP code:*)

1420. Michelle Krabill (*ZIP code:*)

1421. Marsha Ladin (*ZIP code:*)

With the constant attacks on the gay community, it is imperative that we support gay youth. When I was 13 and knew that I was different...I had no one to turn to. That was in 1963. We have to do way more for the thousands of gay youth.

1422. Molly Powers (*ZIP code:*)

1423. Michele Matthews (*ZIP code:*)

1424. Mary McIntyre (*ZIP code:*)

1425. Meredith Mechanik (*ZIP code:*)

1426. Elizabeth Holley (*ZIP code:*)

1427. Mary Margaret Healy (*ZIP code:*)

1428. Marcia Missick (*ZIP code:*)

1429. Nicole van Klaveren (*ZIP code:*)

1430. Molly Maffeo (*ZIP code:*)

1431. Molly Wolterstorff (*ZIP code:*)

1432. Jennifer Solomon (*ZIP code:*)

1433. Mona-Rose Bedard (*ZIP code:*)

1434. Monica Steine (*ZIP code:*)

1435. Monica Barquin-Giarraffa (*ZIP code:*)

1436. Monty Cheffer (*ZIP code:*)

1437. Erin Johnson (*ZIP code:*)

Children deserve to feel safe being who they are.

1438. Morgan Danyi-Burton (*ZIP code:*)

1439. Morgan Speiser (*ZIP code:*)

1440. Emmy Pelish (*ZIP code:*)

I'm trans, and I believe that we should be able to exist within society without fearing that our identities are going to be used against us. This is literally like the Mutant Registration Act in Marvel, and we all know that's bullshit.

1441. Trisha Klaus (*ZIP code:*)

1442. Mark Haggett (*ZIP code:*)

1443. Yenisbel Vilorio (*ZIP code:*)

1444. Michael Scarcella (*ZIP code:*)

1445. Marcia Halpern (*ZIP code:*)

1446. Sarah Batcheller (*ZIP code:*)

1447. Jillian Cherry (*ZIP code:*)

1448. Mattea Spielbauer (*ZIP code:*)

1449. Marian Starkey (*ZIP code:*)

1450. Meredith Thigpen (*ZIP code:*)

1451. Andy Dawkins (*ZIP code:*)

1452. Carrington Boyd (*ZIP code:*)

1453. Muse Sawyer (*ZIP code:*)

1454. Sonia Battrell (*ZIP code:*)

There is no legitimate reason to withhold appropriate affirming care from transgender people of any age.

1455. Gerald Johnson (*ZIP code:*)

I don't have a trans child and yet my concern is parental rights - for all parents. We have a Florida Constitutional right to privacy and government mandating the type of health care anyone's children must or must not receive is the very definition of an unconstitutional governmental intrusion. Which freedoms will you take away next?

I believe that Florida Board of Medicine must abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to such care because it is blatantly unconstitutional and a step down a very slippery slope we don't want to traverse.

1456. Marsha Fisher (*ZIP code:*)

1457. Malaclypse Codie (*ZIP code:*)

Trans rights are human rights

1458. Anne Barela (*ZIP code:*)

I support gender affirming care for all

1459. Dan Stein (*ZIP code:*)

1460. Nache Atkins (*ZIP code:*)

1461. Nadley Nazaire (*ZIP code:*)

1462. Nafiza Sinha Ray (*ZIP code:*)

1463. Abby Herman (*ZIP code:*)

I'm a trans educator who interacts with youth on a regular basis. They are absolutely fully capable of understanding what it means to be trans. Make the correct and humane choice to protect trans youth's access to gender-affirming care.

1464. Nancy Ellman (*ZIP code:*)

1465. Nancy McLain (*ZIP code:*)

1466. Nancy Metayer (*ZIP code:*)

1467. Nancy Rojas (*ZIP code:*)

1468. Nan Moorman (*ZIP code:*)

1469. Naomi Kauffman (*ZIP code:*)

1470. Stephanie Evans (*ZIP code:*)

1471. Narcisse Morningstar (*ZIP code:*)

1472. Denielle EVERSON (*ZIP code:*)

1473. nastasia nastic (*ZIP code:*)

1474. Natalia Andino-Rivera (*ZIP code:*)

1475. Natalie Kaufman (*ZIP code:*)

1476. natalie Gonzalez (*ZIP code:*)

1477. Natalie Stipe (*ZIP code:*)

1478. Natalie Andre (*ZIP code:*)

1479. Natasha Kleeba (*ZIP code:*)

1480. Nathan Thompson (*ZIP code:*)

Denying medical care and exposing people to more harm is exactly the opposite of what the U.S. is all about! Seriously though, trans rights are human rights

1481. Nat Versluys (*ZIP code:*)

1482. Natalia Giordano (*ZIP code:*)

1483. Natja Melendez (*ZIP code:*)

1484. Nick Eaddy (*ZIP code:*)

1485. Neal Deschain (*ZIP code:*)

1486. Nicole Coppage (*ZIP code:*)

If you truly care about the children in your state, you will NOT pass this ruling. Suicide and mental health problems are already higher than average in LGBTQ+ kiddos than their heterosexual counterparts, and a ruling like this will only make the disparity worse.

1487. Nei Phillips (*ZIP code:*)

1488. Nell Pepper (*ZIP code:*)

1489. Vanessa Walker-Wilfong (*ZIP code:*)

1490. Netalie Mongonia (*ZIP code:*)

gender-care is healthcare.

1491. Rachel Rebovich (*ZIP code:*)

1492. Mindy Faciane (*ZIP code:*)

Trans rights are human rights!

1493. Vae Fields (*ZIP code:*)

1494. Kite Ross (*ZIP code:*)

Trans youth should be supported!

1495. Ross McDonough (*ZIP code:*)

1496. Natalie Fiertz (*ZIP code:*)

1497. Abigael Hart (*ZIP code:*)

Not one more child! No one should have to spend their lives in misery because the world makes them feel less or unsafe to be themselves. MAGAts, go wet hump a wall outlet!!

1498. Nancy Fry (*ZIP code:*)

1499. Sanne Irene Roozeboom (*ZIP code:*)

1500. Nicholas Jennings (*ZIP code:*)

1501. Alex Brown (*ZIP code:*)

1502. Nicole Nolan (*ZIP code:*)

1503. Nicole Graves (*ZIP code:*)

1504. Nicole Fava (*ZIP code:*)

1505. Nicole Pike (*ZIP code:*)

1506. Nicole Cox (*ZIP code:*)

1507. Nicole Browning (*ZIP code:*)

Hi, I am a licensed telehealth provider for the State of Florida.

Thanks!

1508. Nicole Perry (ZIP code:)

1509. Nicole Suddard (ZIP code:)

1510. Niki Lopez (ZIP code:)

1511. Nil Venet (ZIP code:)

1512. Georgie Lomba (ZIP code:)

1513. Nina Austin (ZIP code:)

1514. Nisa Birnbaum (ZIP code:)

1515. Timothy Todd (ZIP code:)

1516. Nicole Carroll (ZIP code:)

1517. Nan Mulrine (ZIP code:)

Please listen to the medical professionals. Support trans youth.

1518. Noelle Howey (ZIP code:)

1519. Noelle Tagupa (ZIP code:)

Protect trans youth!

1520. NOEMI MARQUEZ (ZIP code:)

These treatments are life saving for those that want/need them. suicide prevention, finally feeling right in your own skin

1521. Noelle Delacruz (ZIP code:)

1522. Andre Carter (ZIP code:)

Trans rights are one of the most important things this generation and others can grow up with

please accept this petition :) ??_____

1523. Jac S (ZIP code:)

Leave the poor kids alone and let them live their lives.

1524. nova starks (ZIP code:)

1525. Pam Escarcega (ZIP code:)

1526. Nadia Panasky (ZIP code:)

1527. Nikki Pinzon (ZIP code:)

1528. A Ball (ZIP code:)

1529. caine R. (ZIP code:)

1530. Naomi Singer (ZIP code:)

1531. Mickey Garrote (ZIP code:)

1532. Dorothy Spell (ZIP code:)

1533. Isabella C. (ZIP code:)

1534. Olivia Buckoski (ZIP code:)

Olivia Buckoski, PharmD

1535. Lin Coolidge (ZIP code:)

1536. Chantal Miller (ZIP code:)

1537. Mari Arroyave (ZIP code:)

This is fucking bullshit. All this ban will do is kill kids. Fuck you and whoever came up with the dumbfuck idea of denying healthcare to children

1538. James Price (ZIP code:)

1539. Whitney Guevara (ZIP code:)

1540. MAE ARONHALT (ZIP code:)

Trans kids deserve just as much liberation as the rest of the trans community.

1541. Olivia Westone (ZIP code:)

I knew it a very young age I was transfeminine! It wasn't until later in life that I was able to access the medically necessary care! Let's not deprive others of their gender affirmation the way I was!

1542. Jack Onderdonk (ZIP code:)

1543. Kristi Cowles (ZIP code:)

Keep stupid christians out of the mix!! Support Gender Affirming Care

1544. Kathy Brown (ZIP code:)

1545. Tony SanFilippo (ZIP code:)

1546. Drew Amelia (ZIP code:)

Screw these bigots I'm furious trans kids need so much more support and access to help than they're currently getting

1547. Selene Padilla (ZIP code:)

1548. Paul Waijman (ZIP code:)

1549. Paige Reckenwald (ZIP code:)

1550. Pamela Pegahi (ZIP code:)

1551. Paola Linares (ZIP code:)

1552. Sharad Davis (ZIP code:)

1553. Joy Weiss (ZIP code:)

Florida, you are not the sole authority on gender care. Please, listen to the guidance of the wider medical community and protect the mental health of transgender, non-binary, and intersex youth by supporting their gender affirming care

1554. MacKenzie Finnegan (ZIP code:)

Trans rights are human rights

1555. Patrice Yang (ZIP code:)

1556. Patrice Harris (ZIP code:)

This shouldn't ever be a discussion. Everyone deserves healthcare including Trans youth.

1557. Patrick Mckee (ZIP code:)

Medical decision belong between a patient and their doctor. Gender affirming care is essential for mental health and wellness.

1558. Patrick Dassow (ZIP code:)

1559. Patti Johnston (ZIP code:)

1560. Pat Zanger (ZIP code:)

Gender-affirming care is part of comprehensive health care which should be available to all without prejudice. Creating a "registry" of anyone undergoing medical treatment violates patient/ doctor

privilege!

1561. Paulette Vélez (*ZIP code:*)

These continuous homophobic and transphobic acts, policies, and laws are despicable.

1562. Rev. Robert Townsend (*ZIP code:*)

1563. Peter Easton (*ZIP code:*)

Support strongly

1564. Penny Cooke (*ZIP code:*)

1565. Laura Perkins (*ZIP code:*)

1566. Peter Lorenzo (*ZIP code:*)

1567. Peter Butzin (*ZIP code:*)

I have already signed the petition as an individual, but am trying to now sign on as the United Church in Tallahassee, for which I serve as its Moderator.

1568. Peter Horstman (*ZIP code:*)

1569. Eleanor Cuallado-Keltsch (*ZIP code:*)

1570. Peyton Byers (*ZIP code:*)

1571. An anonymous signer (*ZIP code:*)

1572. PFLAG Sarasota (*ZIP code:*)

We stand for trans.

1573. Patricia Sardina (*ZIP code:*)

1574. Patricia Moore (*ZIP code:*)

1575. Phillip Carter (*ZIP code:*)

1576. Phoenix Artifex (*ZIP code:*)

Gender affirming care is necessary health care and saves lives

1577. Amber Soler (*ZIP code:*)

1578. Sarah Lehoux (*ZIP code:*)

1579. Pierre Hendricks (*ZIP code:*)

1580. Pilar Siman (*ZIP code:*)

1581. Berryman Pillow (*ZIP code:*)

1582. Tammy Ford (*ZIP code:*)

All kids deserve health care

1583. Jade Day (*ZIP code:*)

1584. Rachel Piven (*ZIP code:*)

Gender affirming care is pro life. Gender affirming care is pro physical, mental, psychological, and emotional health. Withholding gender affirming care is abuse and leads to irreparable harm.

1585. Persephone Koziol (*ZIP code:*)

1586. Paula Kalakowski (*ZIP code:*)

1587. Pam Koerke (*ZIP code:*)

1588. Jake Caine (*ZIP code:*)

1589. Phillip Whitt (*ZIP code:*)

This is essential and life saving healthcare....period!!

1590. Toni Pollock (*ZIP code:*)

1591. David Poole (*ZIP code:*)

Healthcare barriers to anyone is a threat to healthcare for all.

1592. Katlyn Rojas (*ZIP code:*)

As a trans woman this is super important to me and my family

1593. Timothy White (*ZIP code:*)

1594. Martha Harnit (*ZIP code:* 34711)

1595. An anonymous signer (*ZIP code:*)

1596. Jessica Lenkova (*ZIP code:*)

1597. Dave Cutler (*ZIP code:*)

1598. Eileen Koch (*ZIP code:*)

1599. Alfredo Olvera (*ZIP code:*)
Signing in support: Dolphin Democrats

1600. Joel Price (*ZIP code:*)

1601. Elisabeth Price (*ZIP code:*)
Treating someone as though they belong to a gender that is not theirs is abuse. Don't do it!

1602. PRISCILLA RICHARDSON (*ZIP code:*)

1603. Frank Mueller (*ZIP code:*)

1604. Prudence Gill (*ZIP code:*)
Protect all of God's children and all of our beautiful incredible ways of being! We have no right to cause harm to anyone just because they are different from earth. God loves all his children, and so should we.

1605. Prue Ricci (*ZIP code:*)

1606. Skye Boyd (*ZIP code:*)
If you do this you're violating your hippocratic oath

1607. Lucas Navarro (*ZIP code:*)

1608. Paul Rafferty (*ZIP code:*)

1609. Otto Norton (*ZIP code:*)

1610. An anonymous signer (*ZIP code:*)

1611. Paul Wolfson (*ZIP code:*)

1612. Katherine Walton-Elliott (*ZIP code:*)
Blocking gender affirming care would be a breach of the hippocratic oath. We know that gender affirming care is incredibly effective at treating gender dysphoria, we know that reversible puberty blockers given in childhood are safe. We also know that without this care trans kids and teens experience massively increased self harm and suicide rates. To block this care being given would be an appalling breach of trust, and as a nurse would force me to chose between what is right for my patients and what medical professional organizations are demanding for political purposes. It would be abhorrent.

1613. Em M (*ZIP code:*)
It is abhorrent that you are even considering this ban seriously. Trans youth exist. They deserve

healthcare. Leave this issue to them, their guardians, and doctors.

1614. Quinn Cowan (*ZIP code:*)

1615. Nat Hemel (*ZIP code:*)

1616. Tiago Quintana (*ZIP code:*)

1617. Rebecca Fiore (*ZIP code:*)

1618. Rachelle DeBevits (*ZIP code:*)

1619. Matthew Raab (*ZIP code:*)

1620. Rachel DiPietro (*ZIP code:*)

1621. Rachel Lumpkins (*ZIP code:*)

1622. Rachel Logan (*ZIP code:*)

1623. Rachel Sallustio (*ZIP code:*)

1624. Rachel Godfrey (*ZIP code:*)

1625. An anonymous signer (*ZIP code:*)

1626. Rachel Bernard (*ZIP code:*)

I support gender care for trans people!!! Ron Desantis is nuts!!!!

1627. Rachle Sullivan (*ZIP code:*)

1628. Patricia Racz (*ZIP code:*)

1629. Santina Lampman (*ZIP code:*)

Gender affirming care has been shown to reduce suicides. Regardless of your "personal" feelings, anything we can do to give kids a better shot at living is great in my book. And at the end of the day. Their gender identity, has no effect on you personally, but a huge impact on them. Let them be them, and give them the care they need between them and their doctors.

1630. Amanda Nguyen (*ZIP code:*)

1631. Rachel Fisher (*ZIP code:*)

1632. Raven Ash (*ZIP code:*)

Trans rights are human rights.

1633. Randee Lefkow (*ZIP code:*)

1634. Rocky Ramirez (*ZIP code:*)

1635. Ashley Hall (*ZIP code:*)

Gender affirming care is life saving and should not get ripped away and doom transgender people to severe depression and suicide. You should be ashamed for even considering removing it.

1636. Krysta Lepinski (*ZIP code:*)

1637. Raven Lyden (*ZIP code:*)

There is no scientific basis for removing gender affirming care from hundreds of people in the state. This care saves and improved lives, and it's removal does nothing for anyone.

1638. Ray Simms (*ZIP code:*)

1639. Ruth Batista (*ZIP code:*)

1640. Ronnie Boerner (*ZIP code:*)

1641. Rebecca Charvet (*ZIP code:*)

Medical care is not about personal beliefs.

Medical care is private between a patient & their medical team.

Appropriate medical care is a human right.

1642. Rachael Huntington (*ZIP code:*)

1643. Rob Wilson (*ZIP code:*)

1644. Rachel Coldbreath (*ZIP code:*)

Trans kids will exist whether you like it or not. The only question is: are you going to help them exist, or make them suffer?

1645. Rebecca Davis (*ZIP code:*)

Stop oppressing and killing Trans people.

1646. Robyn Dawson (*ZIP code:*)

1647. Robyn Dawson (*ZIP code:*)

1648. Rebecca Yarnold (*ZIP code:*)

1649. Becky Darnell (*ZIP code:*)

1650. Rebekah Prieto (*ZIP code:*)

1651. Riley Brannian (*ZIP code:*)

1652. Kairos Coyer (*ZIP code:*)

1653. Shannon Kelly (*ZIP code:*)

Protect trans kids!!

1654. Reed Semedo-Strauss (*ZIP code:*)

It is so important that all young people can truly be who they are without fear.

1655. Regina Walther (*ZIP code:*)

1656. Reinder Dijkhuis (*ZIP code:*)

1657. Rebecca Lamey (*ZIP code:*)

1658. Rachael Harnum (*ZIP code:*)

1659. Ellen Klowden (*ZIP code:*)

1660. Guerdy Remy (*ZIP code:*)

1661. Renée Lenore (*ZIP code:*)

1662. Renee Martin (*ZIP code:*)

1663. Renee Debroka (*ZIP code:*)

1664. Rene Laney (*ZIP code:*)

1665. Maureen Powers (*ZIP code:*)

1666. Reni McLemore (*ZIP code:*)

1667. Xavier lopez (*ZIP code:*)

1668. Rev. Holly Brown (*ZIP code:*)

1669. Richard Murphy (*ZIP code:*)

1670. Reverend Tom Capo (*ZIP code:*)

1671. Rev Craig Cranston (*ZIP code:*)

1672. Nancy Wilson (*ZIP code:*)

1673. Rev. Gene Hutter (*ZIP code:*)

1674. Morgan Rewis (*ZIP code:*)

1675. Russell Giambrone (*ZIP code:*)

1676. Robin Gordon (*ZIP code:*)

1677. Rachel Young (*ZIP code:*)

Protect trans kids! Protect trans rights! They need our support and help!

1678. Robin Hernandez (*ZIP code:*)

1679. Rachael Letter (*ZIP code:*)

1680. Rhodge Odiaman (*ZIP code:*)

1681. Riana Angwin (*ZIP code:*)

1682. Luna Gutierrez (*ZIP code:*)

1683. Anna Rice (*ZIP code:*)

1684. Madeline Lastname (*ZIP code:*)

1685. Season Stark (*ZIP code:*)

1686. Christopher Riegel (*ZIP code:*)

1687. Ari Quigg (*ZIP code:*)

Healthcare is healthcare

1688. R Hudson (*ZIP code:*)

1689. Mya Bell (*ZIP code:*)

1690. Cynthia Rios (*ZIP code:*)

1691. Rita Abraldes (*ZIP code:*)

1692. Rita Garvey (*ZIP code:* 33756)

1693. River Rowan (*ZIP code:*)

1694. Anastasia Middleton (*ZIP code:*)

1695. Bobb Miles (*ZIP code:*)

All trans people have the right to privacy, decent gender-affirming care and dignity. It is a human right!

1696. Rhonda Kesling (*ZIP code:*)

1697. Roberta Klarreich (*ZIP code:*)

1698. Rebecca Barnett (*ZIP code:*)

1699. Raymond McClory (*ZIP code:*)

Without gender affirming care, many will turn to suicide. I though Gov. DESANTIS was pro life.

1700. Renee Lessard Moreshead (*ZIP code:*)

1701. Roxanne Schwoch (*ZIP code:*)

1702. Rohith Chandramouli (*ZIP code:*)

1703. Nancy Lambert (*ZIP code:*)

Everyone deserves safe spaces and equal access.

1704. Robyn Williams (*ZIP code:*)

1705. Robert Hawes (*ZIP code:*)

1706. Robert Marnell (*ZIP code:*)

Medical decisions need to be made by patients/parents and their doctors, not oversight committee or board.

1707. Robin Brooks (ZIP code:)

1708. Robin Bea (ZIP code:)

1709. Robin Griffith (ZIP code:)

All trans youth need protection, support and to live their true selves completely.

1710. Kimmy Robinson (ZIP code:)

1711. Deborah Cahan (ZIP code:)

1712. Robyn Persons (ZIP code:)

Stop trans genocide

1713. Erin Williams (ZIP code:)

I sign this to oppose the harmful and dangerous actions of the Florida Board of Medicine based on corrupted and misleading science being used to create rules to annihilate and exterminate transgender children, teens and adults by preventing us from coming into existence.

Trans people have existed as an amazing part of the human adventure in cultures around the world across all of history emerging naturally and independently of one another.

The actions taken by the Florida Board of Medicine are driven whole by greed and politics and hatred.

Accepting myself as trans, now and always, has led me back to spirituality, love and family and healing

I don't have much to fight back with, but I can say my peace for vitriol, hate & corruption of the Florida Board of Medicine ends me. maybe it'll change your minds, maybe not.

But I grew up hearing the living memory of holocaust survivors and soldiers that fought the nazis

AND

I know exactly what kind of people you folks on the Florida Board of Medicine are

1714. Rodney Asahara (ZIP code:)

1715. crystal rodgers (ZIP code:)

1716. Sandra Rohde (ZIP code:)

1717. Carol Trout (ZIP code:)

1718. Romy Panayiotis (ZIP code:)

1719. Ronda Roubanis (*ZIP code:*)

Health care is a human right.

1720. Ronnie Johnson (*ZIP code:*)

1721. Erik Comstock (*ZIP code:*)

1722. Rose Cano (*ZIP code:*)

1723. Rose Fontanet (*ZIP code:*)

1724. Liz B (*ZIP code:*)

1725. Shirley Roseman (*ZIP code:*)

1726. Rosemary Ciotti (*ZIP code:*)

1727. Ross Evans (*ZIP code:*)

1728. Roxanne Blask (*ZIP code:*)

its already so damn expensive to get top surgery, then the medicaid thing THEN this?? moving out to get surgery would double the cost. i could ramble on about all the specifics on how this is beyond evil, but id rather not waste my breath on transphobes whove made up their mind on doing their damnedest to eradicate trans people.

1729. Reesa Roberts (*ZIP code:*)

1730. Rayanne Stemmler (*ZIP code:*)

1731. Roxanne Sutocky (*ZIP code:*)

1732. Rebecca Wilson (*ZIP code:*)

1733. An anonymous signer (*ZIP code:*)

1734. Rudy Morr (*ZIP code:*)

1735. Russell Patterson (*ZIP code:*)

Let's be considerate, not hateful or bigoted.

1736. Ru Everett (*ZIP code:*)

1737. Abigail Wilson (*ZIP code:*)

Trans rights are human rights

1738. Nathan White (*ZIP code:*)

It is so important for youth to be able to be who they are. It is not a political issue, this is life or death for these kids. If I was unable to be myself, I would not be here today. Please open your hearts and open your minds to learn more about what you do not understand.

1739. Ryan Willard (*ZIP code:*)

1740. Ryan Lewis (*ZIP code:*)

1741. Monica Grimm (*ZIP code:*)

1742. shawn McFadden (*ZIP code:*)

1743. Sareet Taylor (*ZIP code:*)

1744. Sabina Sicuso (*ZIP code:*)

1745. Sabine Prather (*ZIP code:*)

1746. Suzanne Adams (*ZIP code:*)

Gender affirming and 'trans care' IS a life and death issue. These youth and others living this deserve our help and support so that they may live their lives. Too many succumb each year to ultimate despair. Denying they exist or refusing them medical support will not make them disappear.

1747. Lee B (*ZIP code:*)

1748. Luis Salazar (*ZIP code:*)

1749. Sally McDonough (*ZIP code:*)

1750. Ike Thompson (*ZIP code:*)

1751. Salvatore Vieira (*ZIP code:*)

1752. Sam Muentes (*ZIP code:*)

1753. Doreen Ellis (*ZIP code:*)

1754. Samantha Losinski (*ZIP code:*)

1755. Samantha Garcia (*ZIP code:*)

1756. Samantha Cullimore (ZIP code:)

1757. Samantha Jablonski (ZIP code:)

1758. Sam Lowry (ZIP code:)

1759. Samrawit Sisay (ZIP code:)

1760. Sam Collins (ZIP code:)

1761. Samael Terebessy (ZIP code:)

1762. Sandra Murado (ZIP code:)

1763. Sandy Moise (ZIP code:)

1764. Sandy Nojaim (ZIP code:)

1765. Rebecca Putman (ZIP code:)

Trans-affirming care for young children can be life-saving, both in helping the child to explore their gender and make their own decision. It doesn't always lead to being transgender. Stop trying to kill children.

1766. Sara McAlister (ZIP code:)

1767. Sara Carminati (ZIP code:)

1768. Sarah Sherman (ZIP code:)

1769. Sarah Stumbar (ZIP code:)

1770. Sarah Ducharme (ZIP code:)

1771. Sarah Dunn (ZIP code:)

1772. Sarahi Perez (ZIP code:)

1773. Raine Mayer (ZIP code:)

1774. Sarah Raney (ZIP code:)

For the love of God leave the kids the fuck alone

1775. Skye De Guzman (ZIP code:)

1776. Sara Stenman (ZIP code:)

1777. Sara Meyer (ZIP code:)

1778. Sara Cornelio (ZIP code:)

1779. Sasha Borron (ZIP code:)

1780. Sasha Maier (ZIP code:)

1781. Savanah Dehning (ZIP code:)

Lowering Florida's Standard of Care for transgender persons and making it more difficult to receive gender affirming treatment will cause real harm.

There always has been and always will be transgender people. They deserve respect and decency. They can not be legislated out of existence.

1782. Savanna Mannoia (ZIP code:)

KEEP TRANS KIDS SAFE

1783. Elijah Donal (ZIP code:)

1784. Stephanie Barajas (ZIP code:)

1785. Sharon Boyd (ZIP code:)

I was born in FL. Gender affirming care saves lives. Ending it will end lives!

1786. Bryant Jay (ZIP code:)

I'm a trans person born and raised in Florida for 24 years, and the actions of FDOH and FL Board of Medicine against trans people are criminal.

1787. Alexander Boydon (ZIP code:)

1788. Laura Chimera (ZIP code:)

1789. Scarlett Dimeloe (ZIP code:)

1790. Katie Schmarder (ZIP code:)

1791. scott starks (ZIP code:)

1792. Samuel Russo (ZIP code:)

1793. Julie Mearon (ZIP code:)

1794. Sebastian Ballester (*ZIP code:*)

1795. Lisa Sedelnik (*ZIP code:*)

This is so very important! I support trans youth in any and every way possible.

1796. Leslie Taylor (*ZIP code:*)

Gender affirming care is suicide prevention!!!

1797. Deborah Selwyn (*ZIP code:*)

1798. Sarah Nichols (*ZIP code:*)

Gender affirming care is suicide prevention.

1799. Serena Zamora (*ZIP code:*)

1800. Rosann Caraker-Jentes (*ZIP code:*)

Stop thing you know more than the Experts! Policy statements and guidance from expert bodies of medical and mental health professionals including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care.

1801. Fray Self (*ZIP code:*)

1802. Serra Reid (*ZIP code:*)

1803. Susan (*ZIP code:*)

1804. Seth Tigarian (*ZIP code:*)

As a trans person who grew up in Florida, I can tell you that denying trans kids even the most basic care will result in dead trans kids, not cis kids.

1805. Chelsy Almeda (*ZIP code:*)

1806. Theodore Hunter (*ZIP code:*)

1807. Julie Torkomian (*ZIP code:*)

1808. Susan Haines (*ZIP code:*)

1809. Shaquille Davis (*ZIP code:*)

1810. Shalvia Verdell (*ZIP code:*)

Trans youth have a right to self-determination and agency over their own bodies. Taking away gender-affirming care is taking away their right to that agency. It is life-saving care.

1811. Shana Friedman (*ZIP code:*)

1812. shane soria (*ZIP code:*)

1813. Shane Horsman (*ZIP code:*)

Gender affirming care is life saving. Banning it would not protect youth, only harm them.

1814. Elizabeth Bennet (*ZIP code:*)

Gender affirming care IS LIFE SAVING CARE

1815. Shannon Fortner (*ZIP code:*)

Access to affirming care is crucial for. our LGBTQ+ folk. We are trying to stop suicidal attempts and yet we are trying to take access away. This is discrimination in full effect. This is not a choice of red or blue, this about life saving care for our communities. We have come so far and now a political platform is erasing the lives being saved over power.

1816. Shannon Gardner (*ZIP code:*)

1817. Seneca Harberger (*ZIP code:*)

1818. sharon mirabal (*ZIP code:*)

1819. Sheila Allison-Wells (*ZIP code:*)

1820. Phoenix Cantu (*ZIP code:*)

Transgender folks regardless of age are the gender they identify as. For many like my spouse knew who they were when they were children and preventing gender affirming care and not having acceptance for transgender folks has been shown to increase suicide rates. Any legislation against LGBT+ folks is telling people to kill themselves.

1821. Shed Boren (*ZIP code:*)

Let us be guided by the science and not the vitriol

1822. sheila jaffe (*ZIP code:*)

Where are Parental Rights now for their children?

1823. Sheila Gluck (*ZIP code:*)

1824. Sheila Weiss (*ZIP code:*)

1825. Shelley Markus (*ZIP code:*)

1826. Shelley Hill (*ZIP code:*)

1827. Michelle Vallet (*ZIP code:*)

Let trans kids access the care they need to live their best lives. These decisions belong with children and their families. Nobody else.

1828. Shelly Hodgson (*ZIP code:*)

1829. Sheree Rust (*ZIP code:*)

Stop removing healthcare from Americans. LGBTQ+ folks deserve equal protection under the law.

1830. Sherilyn M Adler, Ph.D. (*ZIP code:*)

1831. Aaron Collins (*ZIP code:*)

Trans rights are human rights!!! Trans health care is a basic human right!! Protect trans youth!! Help prevent trans and trans youth suicide!!

1832. Sherry McKee (*ZIP code:*)

1833. Sherry Rogers (*ZIP code:*)

Come to your senses. Medical care should not be adjudicated by bureaucrats.

1834. Jo Shim (*ZIP code:*)

1835. Shimon Cohen (*ZIP code:*)

Trans youth should be supported and not used as political pawns. The health profession has a duty to do no harm. That means providing support for trans youth.

1836. Shirley Herman (*ZIP code:*)

1837. Andrew Hjortshoj (*ZIP code:*)

1838. Alex Bann (*ZIP code:*)

1839. Sue Hurtado (*ZIP code:*)

One day it may be your child or grandchild who may NEED this medical care to save their life. When you know better, do better!

1840. Sidney Torres (*ZIP code:*)

1841. Sidonie McDowell (*ZIP code:*)

1842. Silvia Mantilla (*ZIP code:*)

1843. Heather Simpson (*ZIP code:*)

I am a proud mother of a transgendered child. This policy will hurt my child. Please listen to scientists and parents and physicians and stop.

1844. Katie Rodrigues (*ZIP code:*)

I grew up in a Christian, conservative home, in a Christian, conservative school and, for a time, held Christian, conservative beliefs myself. I was not exposed to the LGBTQ community except for hateful jokes or derogatory comments. Despite all of this, I am still a member of the LGBTQ community. Coming out of that sheltered life and realizing LGBTQ people were just like myself and others I knew, was rattling and it changed me.

LGBTQ youth and adults just want to be happy, healthy and of sound mind.

People who are non-LGBTQ are allowed to get surgery to change their appearance (BBL, boob jobs, Botox) but there's an imaginary line you decide others can't cross?

Denying us access to basic rights regardless of our identity is unethical and morally corrupt.

1845. Michaela Sisitsky (*ZIP code:*)

1846. Sarah Robertson (*ZIP code:*)

It only hurts when care is DENIED. It hurts absolutely NO ONE to allow kids to be themselves. Love will win!!!!!!!!!!!!

1847. Susan Jenik (*ZIP code:*)

1848. Sarah Milewski (*ZIP code:*)

1849. Skarlett Board (*ZIP code:*)

1850. Sara Treadwell (*ZIP code:*)

1851. Skyler Grey (*ZIP code:*)

1852. Jill Merola (*ZIP code:*)

1853. Morgan Brown (*ZIP code:*)

1854. Serena Labrecque (*ZIP code:*)

1855. Slate Spicer (*ZIP code:*)

1856. Sara Levine (*ZIP code:*)

1857. Stephanie Ferrara-zimmerman (*ZIP code:*)

1858. Stacy Frazier (*ZIP code:*)

1859. Stephanie Haines (ZIP code:)

1860. Steven Lowe (ZIP code:)

1861. Sarah Pezan (ZIP code:)

1862. Marianne Silverstein (ZIP code:)

1863. Sarah Suhey (ZIP code:)

1864. Sheila Marshall (ZIP code:)

1865. Carol Miller (ZIP code:)

Do not deny Healthcare to young people. It is prejudice, discrimination, and fearmongering based. Healthcare is not denied to any other citizen, so this is unjustified and cruel.

1866. Sophia Gonzalez (ZIP code:)

1867. Sheila Moore (ZIP code:)

1868. Reina Watt (ZIP code:)

1869. Seth Patterson (ZIP code:)

1870. Sarah Rising (ZIP code:)

1871. scott w (ZIP code:)

1872. Sneha Kapil (ZIP code:)

1873. Barbara Bareno (ZIP code:)

1874. Jeffrey Jones (ZIP code:)

1875. Sarah Shalvoy (ZIP code:)

1876. Sofia Villamizar (ZIP code:)

1877. Sofia Barrios (ZIP code:)

1878. solange aguilara (ZIP code:)

1879. An anonymous signer (*ZIP code:*)

1880. JENNIFER Herrington (*ZIP code:*)

1881. Sonia Brnson (*ZIP code:*)

1882. Bastian Poranski (*ZIP code:*)

1883. Sonia Patel (*ZIP code:*)

1884. Sophia Nealon (*ZIP code:*)

1885. Sophia Zisook (*ZIP code:*)

1886. Sophie Shatford (*ZIP code:*)

1887. Sophie Clayton (*ZIP code:*)

Gender affirming care saves lives.

1888. PFLAG South Miami (*ZIP code:*)

1889. Cynthia Disanto (*ZIP code:* 34952)

this attack on Trans Youth is disgusting, cruel and evil!!!

1890. Sarah Pajek (*ZIP code:*)

1891. Willow Hemlock (*ZIP code:*)

As a trans person from Florida, I moved out because of these horrible decisions. I hope Florida can pull it together.

1892. S J (*ZIP code:*)

1893. Sarah Swartz (*ZIP code:*)

1894. Jazmine Harvey (*ZIP code:*)

1895. Steven Digena (*ZIP code:*)

1896. Tim Spears (*ZIP code:*)

1897. Lisa Brazzle (*ZIP code:*)

Actual medical providers understand the real need for this care. Don't let bigotry get in the way of doing what's best for patients.

1898. Charlie Regimbal (*ZIP code:*)

1899. Sarah Pinto (*ZIP code:*)

1900. Matthew Martinez (*ZIP code:*)

1901. Sara-Beth Plummer (*ZIP code:*)

1902. Samantha Marshall (*ZIP code:*)

The only harm being perpetuated here is coming from the behaviour of the people behind this decision.

1903. Nic Hendrick (*ZIP code:*)

1904. Kyah Hildebrand (*ZIP code:*)

1905. An anonymous signer (*ZIP code:*)

1906. Susan Riddle (*ZIP code:*)

Live & let live. I support this health care.

1907. Samantha Sack (*ZIP code:*)

1908. Shannon Shapiro (*ZIP code:*)

1909. Stacy Sechrist (*ZIP code:*)

1910. Anne Martinelli (*ZIP code:*)

1911. Kim Corallo (*ZIP code:*)

Everyone deserves proper care no matter what they are facing. There is no one size fits all for humans, so the idea that one size health care fits all is absurd. How one chooses to live their life has little to no impact on most of us, so why are we deciding how they should live?

1912. Emily Jackson (*ZIP code:*)

1913. Angela Rodenfels (*ZIP code:*)

1914. L. Thackeray (*ZIP code:*)

1915. Jennifer Walters (*ZIP code:*)

This is important to me and my gf, who is a trans woman, and I want every trans person to feel safe, included and valid in every way. It's disgusting how there's so much anti trans bills out there.

1916. Seth Riker (*ZIP code:*)

Please don't allow them to legislate hate

1917. Kyle Steen (*ZIP code:*)

1918. Jeff White (*ZIP code:*)

1919. Stephanie Tidwell (*ZIP code:*)

1920. Stephanie Burton (*ZIP code:*)

1921. Stephanie Rubanowice (*ZIP code:*)

1922. Stephanie Adamson (*ZIP code:*)

1923. Stephen Ryan (*ZIP code:*)

1924. Stephanie Ellis (*ZIP code:*)

1925. Stephane Leforestier (*ZIP code:*)

1926. Elizabeth Innello (*ZIP code:*)

1927. Sharon Stern (*ZIP code:*)

1928. Steven Wilson (*ZIP code:*)

1929. Steve Hawes (*ZIP code:*)

Government should protect the vulnerable.

1930. Steven Ripley (*ZIP code:*)

1931. Steven Rocha (*ZIP code:*)

Do NOT take away Transgender Floridians' right to healthcare away from them. Their blood will be on your hands if you do.

1932. Stevie Campbell (*ZIP code:*)

1933. Jenna Marsh (*ZIP code:*)

1934. Kathy Stomber (*ZIP code:*)

Doctors took an oath to help, not hinder a person.
Who a person is is none of your business.

1935. Stephanie Holt (ZIP code:)

1936. Peter Stonehill (ZIP code:)

1937. Glenda Streeter (ZIP code:)

1938. Ian N (ZIP code:)

1939. Phoebe Stubbs (ZIP code:)

1940. Jason White (ZIP code: 33403)
Ron DeSantis is not a governor I support.

1941. Michael Sinnreich (ZIP code:)
Trans rights are human rights.

1942. Liam Suase (ZIP code:)
This is outrageous, banning of supporting trans people will only make things worse.

1943. Beatriz Costa (ZIP code:)

1944. Sarah Singleton (ZIP code:)

1945. Sel Lochmiller (ZIP code:)
As a trans person living in Florida, this is a rule that would set us back by years and damage numerous trans youth.

1946. Ray Winter (ZIP code:)

1947. Summer Little (ZIP code:)
Stop attacking children!

1948. Kristen Bozard (ZIP code:)

1949. Clara Arbelaez (ZIP code:)

1950. Sunnie Chappell (ZIP code:)
Protect trans kids! You belong and you are LOVED!

1951. Yvonne Gibson-Serrette (ZIP code:)

1952. Susan Robertson (ZIP code:)

1953. Susana Darwin (ZIP code:)

Freedom means agency, the ability to be who you are, without government interfering.

1954. Susan Aertker (ZIP code:)

1955. Susan Lachman (ZIP code:)

1956. Susan Nasrani (ZIP code:)

I am a retired social worker who did counsel a transgender youth. Having access to gender affirming medical care kept this young person from deep depression and suicide.

1957. Suzanne Loeb (ZIP code:)

1958. Steven Wetstein (ZIP code:)

1959. Madelene Otero (ZIP code:)

1960. Sarah Wiley (ZIP code:)

DeSantis is an obscene aberration of humanity. Vote him out!!!

1961. Sydney Marquez (ZIP code:)

1962. Sydney Morris (ZIP code:)

1963. sarah Rahman (ZIP code:)

1964. Trixx Steel (ZIP code:)

1965. Jason Foster (ZIP code:)

I support my trans siblings. I'm appalled at measures taken in numerous state legislatures targeting trans people, particularly young trans people. Here in FL is one of the worst in its treatment of trans people. We need to support our trans family and make them feel safe.

1966. Takeata King Pang (ZIP code: 33417-1112)

1967. Lisia Haueter (ZIP code:)

Please protect those who NEED this to be themselves!!!

1968. Talyn Brown-Wolf (ZIP code:)

Taking away gender affirming care will lead to young people taking their own lives. Gender affirming care is live saving.

1969. Tamara Bauza (ZIP code:)

1970. Tami Roadarmel (*ZIP code:*)

Stop the bigotry

1971. Tania Andino (*ZIP code:*)

1972. Tangelene Ramsay (*ZIP code:*)

1973. Tanya Anim (*ZIP code:*)

1974. Tara Felten (*ZIP code:*)

1975. Taria Gillette (*ZIP code:*)

Don't take health care away from kids (or any trans person, regardless of age)!

1976. Toni Saul (*ZIP code:*)

1977. Natasha Shipe (*ZIP code:*)

1978. Nina Tatlock (*ZIP code:*)

1979. Taylee Boyd (*ZIP code:*)

1980. Taylor Lawson (*ZIP code:*)

1981. Taylor Jordan (*ZIP code:*)

1982. Bianca Zellner (*ZIP code:*)

1983. Tara Rao (*ZIP code:*)

1984. Tina Dolly (*ZIP code:*)

1985. Transgender Empowerment Alliance (*ZIP code:*)

1986. Casey Stone (*ZIP code:*)

1987. Erika Davis (*ZIP code:*)

1988. Lee McCarthy (*ZIP code:*)

1989. Kathleen Huber (*ZIP code:*)

1990. Templa Davis (*ZIP code:*)

Do not ruin young peoples lives because of uneducated adults who do not understand. Instead, educate adults and fight for the rights of those who need you the most!

1991. Lindsay McClelland (*ZIP code:*)

1992. Angela Terrell (*ZIP code:*)

1993. Nancy Terreri (*ZIP code:*)

These children and families should be allowed to make decisions based on discussions with medical professionals. Denying coverage will lead to more suicides.

1994. Terri Falbo (*ZIP code:*)

1995. Terri Crawford (*ZIP code:*)

1996. Terri Mitchell (*ZIP code:*)

1997. An anonymous signer (*ZIP code:*)

1998. Terry Lowman (*ZIP code:*)

What? As if transpeople don't have enough issues and you want to make it worse? You don't have to understand anything to know that every human is precious and deserves respect.

Shame!

1999. Tesa Rigel Hines (*ZIP code:*)

2000. K Deller (*ZIP code:*)

2001. Thomas Felke (*ZIP code:*)

2002. Danielle Van Boxel (*ZIP code:*)

2003. Rielly DeMasters (*ZIP code:*)

2004. Calvin Kuchta (*ZIP code:*)

2005. An anonymous signer (*ZIP code:*)

2006. Elizabeth Antaudun (*ZIP code:*)

I knew that I was trans when I was seven. Of course that wasn't remotely possible then, but it's caused me a lifetime worth of traumas because it wasn't. Support healthcare for all transgender people.

2007. Jen Cousins (*ZIP code:*)

2008. Crystal Glover (*ZIP code:*)

2009. Evie Roe (*ZIP code:*)

2010. Midnight Moon (*ZIP code:*)

2011. Theo Brombacher (*ZIP code:*)

2012. Theo Smith (*ZIP code:*)

Preventing children from accessing the care they need (which is proven to be safe) will brutally steal a whole generation from this world. We not only need to protect trans lives, we also need to respect children as autonomous beings and not quasi-property.

2013. Freedom Hall (*ZIP code:*)

trans rights are human rights

2014. Emma Shock (*ZIP code:*)

2015. Aurelia Grey (*ZIP code:*)

Gender affirming care for our trans youth is a human right.

2016. Thomas van Oosterbosch (*ZIP code:*)

2017. Megan Cepull (*ZIP code:*)

I attended the August BOM meeting and it was a farce. Van Meter lied to the board, and one board member had actual evidence of his lying and sat silent.

If the BOM changes the rules, it will cause the deaths of transgender youth and adults.

2018. Harvest Toman (*ZIP code:*)

Gender affirming healthcare is life saving healthcare!

2019. Alice Historia (*ZIP code:*)

2020. Wendy Ramirez (*ZIP code:*)

2021. Altaire Tripodi (*ZIP code:*)

We will fight for our rights, and no one can stop us!

2022. Timothy Vandover (*ZIP code:*)

There is no reason other than bigotry to attack trans healthcare!

2023. Christina Donataccio (*ZIP code:*)

2024. Tina Seitz (*ZIP code:*)

2025. Teddy Laury (*ZIP code:*)

As a Christian I strongly believe that God loves everyone, including lgbtq youth. Politicians and/or religious leaders should never be allowed to dictate healthcare decisions. Nor should they use religion for political purposes of divide & conquer tactics. Trans youth need our support. And they need medical doctors to treat them based on their medical needs, not on political and/or religious beliefs.

2026. Tyler Shortsleeves (*ZIP code:*)

2027. Terri Kanter (*ZIP code:*)

2028. Tamara Law (*ZIP code:*)

2029. Cee Jay Levine (*ZIP code:*)

2030. Trevor Chin (*ZIP code:*)

2031. Michele Rawolle-Gagne (*ZIP code:*)

2032. Todd Davis (*ZIP code:*)

2033. Tommy Murrell (*ZIP code:*)

Government should not get involved

2034. Jeremy Toner (*ZIP code:*)

2035. Toni Van Pelt (*ZIP code:*)

2036. Carmen Torbus (*ZIP code:*)

2037. Tori Miller (*ZIP code:*)

2038. Victoria Kuzmicki (*ZIP code:*)

2039. Tosha Thomas (*ZIP code:*)

Gender affirming care is life-saving for transgender children. Transgender children have extremely high risk of suicide, and gender affirming care is basic suicide prevention.

2040. Tracy Furr (*ZIP code:*)

2041. Tonya Retacco (*ZIP code:*)

2042. Edward Titcomb (*ZIP code:*)

2043. Triana Arnold James (*ZIP code:*)

2044. Kathy VenRooy (*ZIP code:*)
Stop this persecution of trans people.

2045. Tyler Sharkey (*ZIP code:*)

2046. Truly Rogers (*ZIP code:*)

2047. Teresa Smith (*ZIP code:*)

2048. Tayler Streeter (*ZIP code:*)
Trans healthcare saves lives!

2049. Tempie Taudte (*ZIP code:*)

2050. Rebecca Melnitsky (*ZIP code:*)
You wouldn't deny a diabetic kid insulin. Don't deny trans kids healthcare. They need it!

2051. River Petley (*ZIP code:*)
This ruling is discriminatory and dangerous. Keep all kids safe, not just cisgender kids.

2052. Dava Michelson (*ZIP code:*)

2053. Timothy Wagoner (*ZIP code:*)

2054. Angela McCann (*ZIP code:*)

2055. Jocelyn Fritts (*ZIP code:*)
Trans kids need treatment options and it cannot be ignored as a phase, or put off until adulthood. It will lead to kids committing suicide. They need support not condemnation.

2056. Tona Wiegel (*ZIP code:*)
Equal rights

2057. Tiffany Pervis (*ZIP code:*)

2058. Christine Abbott (*ZIP code:*)
Healthcare for all means NO exceptions.

2059. Riley Love (ZIP code:)
PROTECT TRANS YOUTH!! ? ____ ? ____ ? ____

2060. Tyler (ZIP code:)

2061. Tyler Dubbie (ZIP code:)

2062. Tyler Hamm (ZIP code:)

2063. Thomas Yarranton (ZIP code:)

2064. Young Democratic Socialists of America (UF) (ZIP code:)

2065. Parker Skubik (ZIP code:)

The Board should follow national recommendations rather than succumb to pressure from the Florida govt.

2066. Ume amen Khalid (ZIP code:)

I ume amen from pakistan would surely raise my voice fir such an issue whicj of gender inequality and lot more like feminism im really be appreciated to be the part of this to represnt my voice for this

2067. URSULA SEELIG (ZIP code:)

2068. Patricia Urso (ZIP code:)

2069. Joseph Palumbo (ZIP code:)

2070. Camila Ustarez (ZIP code:)

2071. Andrew Tapp (ZIP code:)

2072. Victoria Benson (ZIP code:)

My child deserves to be happy in his body. Stop using religion,hysteria, and misinformation to bully children.

2073. Lara Nokleby (ZIP code:)

2074. Valerie michel (ZIP code:)

2075. Valerie Travis (ZIP code:)

GOO are nothing but power hungry, manipulative evil people. Who feed their own pockets and EGOS.

2076. Danielle Rendleman (ZIP code:)

I knew I was trans when I was 4, now I'm 30 years old and still struggling to undo the damage that

was done by going through the “wrong” puberty. Transitioning changed my life for the better, allowing me to finally focus on contributing to the world around me. All the actual research shows that acceptance of transitioning among family and peers is suicide prevention, and people are statistically more likely to experience regret for literally every other surgery than any procedure performed on a trans person as a part of that person’s transition. Do you want trans people to be fully-functioning members of society? Because allowing people who experience gender dysphoria to have the option to safely—and privately—transition, is how you’ll accomplish that.

2077. Valerie Poole (*ZIP code:*)

2078. Vickie Lynn, PhD., MPH, MSW (*ZIP code:*)

Gender affirming care is health care and should be made available to those who seek it.

2079. D Slingsby (*ZIP code:*)

2080. Vanessa Anastacia (*ZIP code:*)

2081. Vanessa Capriles (*ZIP code:*)

I desperately wish I could have had gender affirming care when I was growing up. Being denied it ruined my life.

2082. Valerie Powell (*ZIP code:*)

2083. Victoria Brodie (*ZIP code:*)

Signing because, unlike some politicians, I care about children after they are born ?

2084. Meghan Vellotti (*ZIP code:*)

2085. Vanessa Ratcliff (*ZIP code:*)

2086. Vera Correa (*ZIP code:*)

2087. Kristin vestgote (*ZIP code:*)

2088. Victoria Gray (*ZIP code:*)

2089. Virginia Banks (*ZIP code:*)

2090. Victor Alvarado (*ZIP code:*)

2091. Victoria Ram (*ZIP code:*)

2092. jennifer Knight (*ZIP code:*)

Do not end health care for trans people in Florida

2093. Victoria Velazquez (*ZIP code:*)

2094. Ramona (*ZIP code:*)

2095. Vanessa Villaverde (*ZIP code:*)

2096. Lexi House (*ZIP code:*)

2097. Victoria Cabrera (*ZIP code:*)

2098. Violet-Jane Humphrey (*ZIP code:*)

2099. violet potts (*ZIP code:*)
quit trying to kill trans people pls

2100. Virgil Jensen (*ZIP code:*)

2101. Virginia Boliek (*ZIP code:*)

2102. Virginia Bloom II (*ZIP code:*)

2103. Lynn Polke (*ZIP code:*)

2104. Valerie Messina (*ZIP code:*)

2105. Vicki Malesza (*ZIP code:*)

2106. Susan Sparrow (*ZIP code:*)
We all should have a chance to live our true selves.

2107. Siobhan Ramos (*ZIP code:*)

2108. Cindy Banyai (*ZIP code:*)

2109. Walter Bradley (*ZIP code:*)
On behalf of the Neurology Department of the Miami Miller School of Medicine, I fully support to goals of this letter to urge the Florida Board of Medicine to desist in its efforts to ban gender-affirming health care.

2110. Isidore Manes (*ZIP code:*)

2111. William Fisk (*ZIP code:*)

2112. Jamie O'Connor (*ZIP code:*)

2113. Lorna Rankin (*ZIP code:*)

2114. Zeke Weed (*ZIP code:*)

2115. Pamela Weisbrod (*ZIP code:*)

2116. Alexander Ventura (*ZIP code:*)

2117. Wendy Snee (*ZIP code:*)

2118. Weston Lucas (*ZIP code:*)

Trans youth and adults have a fundamental right to SCIENCE-BACKED healthcare. Keep your religion and bigotry out of our government.

2119. weslee hancock (*ZIP code:*)

2120. Jasper Whirley (*ZIP code:*)

I support trans youth's right to adequate healthcare.

2121. Tahlia (*ZIP code:*)

2122. Lynn-anne Bruns (*ZIP code:*)

2123. Dawn Wightman (*ZIP code:*)

What Florida is doing to the LGBTQ community is horrible.

2124. Susan Wilde (*ZIP code:*)

2125. William David White (*ZIP code:*)

Take care of are youth and their personal needs!!!

2126. William Meaney (*ZIP code:*)

2127. Robin Winchester (*ZIP code:*)

Trans people have existed for millennia

Trans healthcare has existed for decades (in western med)

ASK yourself: why is any legitimate board of health choosing now to attack the basic rights & privacy of care?

2128. Elizabeth Winchester (*ZIP code:*)

DeSantis's campaign against our trans youth is shameful and a sham. He's willing to sacrifice our

marginalized children for his quest for power. I pray that the cruelty he is putting forth into the world comes back to him and his a thousand-fold.

2129. An anonymous signer (*ZIP code:*)

2130. Wendy Thompson (*ZIP code:*)

2131. William Phelan (*ZIP code:*)

Listen to the science, and to the Academies of Psychiatry, Endocrinology and Pediatrics. They know that gender affirming care can be life-saving.

Support gender-affirming care for transgender youth.

2132. Wendy McIntyre (*ZIP code:*)

2133. Katie Hofgard (*ZIP code:*)

2134. TERESA WHEELER (*ZIP code:*)

No surgery is involved. I don't see the problem.

2135. Joseph Santangelo (*ZIP code:*)

2136. Debra Kaplan (*ZIP code:*)

2137. Wayne Swanson (*ZIP code:*)

2138. Will Sturdavant (*ZIP code:*)

2139. Fred Tabor (*ZIP code:*)

This government mandate telling parents they have no control over the health care decisions for their children is severely misguided. Taking away our right to make health care decisions for our children is a slippery slope that opens the door to more and more incursions into how we raise our children.

Using trans children, of which there are only a tiny number in Florida, doesn't fool me. It's always easiest to set the precedent with "out" groups. That is why, despite not having a trans child, I am 100% aware of and against a government mandate vetoing parental rights over the health care decisions for their children.

Once you've infringed on something so fundamental as the health care decisions for our children, every other parental right is a legitimate target. When did Republicans become the party of government mandates and infringing on parental rights?

I recognize that you are political appointees placed there by the Governor to do his bidding but since he is seriously misguided on how this will play out, I hope that you will save him from himself and re-vote on the Aug 5 decision to take away parent rights, and terminate the rule-making process. Thank you.

2140. Jeffrey Jones (ZIP code:)

While I do not have a trans child, as a parent I am appalled at this attempted government mandate taking away parent's rights to decide the health care for their children. Next you'll be telling us we can't get our children vaccinated or they can't go to co-ed summer camp. Once you've infringed on something so fundamental as the health care of our children, everything else is a legitimate target. When did Republicans become the party of government mandates and infringing on parental rights?

2141. Lauren Wylonis (ZIP code:)

2142. Roxane Pickens (ZIP code:)

2143. Sarah Peterson (ZIP code:)

2144. Roxanne Ramirez-Searcy (ZIP code:)

2145. Kenneth Nguyen (ZIP code:)

2146. Chloe McDonough (ZIP code:)

2147. Xela David (ZIP code:)

2148. misha melnitsky (ZIP code:)

trans rights are human rights!

2149. Alison Yager (ZIP code:)

Please sign on Florida Health Justice Project

2150. Yara Cartagena (ZIP code:)

2151. An anonymous signer (ZIP code:)

2152. vikky alberts (ZIP code:)

2153. Noa Sinclair (ZIP code:)

2154. Yasmin McCready (ZIP code:)

2155. An anonymous signer (ZIP code:)

2156. Samantha Dendauw (ZIP code:)

2157. JoJo Manley (ZIP code:)

2158. Samantha Newell (*ZIP code:*)

2159. Youssef Slimani (*ZIP code:*)

Trans rights are human rights , any law passed to undermine them is a law against all people's freedom , if america likes to tout it's personal freedoms it's time they actually show something for it , not to forget you are a secular country and no religious beliefs no matter how hateful and unchristian like should be the basis to laws against any kind of minority

2160. Connor Salazar (*ZIP code:*)

2161. Yuri Tversky (*ZIP code:*)

2162. Yvonne Beckman (*ZIP code:*)

Yvonne Beckman

2163. Zachary Klein (*ZIP code:*)

2164. Zanne Boykin (*ZIP code:*)

Rules banning the abilities of doctors to provide life-saving gender healthcare to young people should not be accepted. In the wake of the current surge of anti-trans activism, an effort by the state to create a list of transgender adults is terrifying. The motivations and goals of these authoritarian transphobic politicians and political figures cannot be further denied. Their ambitions are genocidal. I urge anyone with any position of power to do whatever they can to fight back against this rising threat to trans people, their friends, and their families.

2165. Lillian Baker (*ZIP code:*)

Gender-Affirming Treatment for youth gives them a chance to be themselves and to live life to the fullest. To take this away from them is cruel. To take this away from them is dangerous. Block this rule from taking effect.

2166. Teddy Croaker (*ZIP code:*)

2167. Zayn Creed (*ZIP code:*)

2168. Peri Zeenkov (*ZIP code:*)

2169. Sara Eaton (*ZIP code:*)

2170. Zenoba Harris (*ZIP code:*)

2171. Kathleen Zidek (*ZIP code:*)

2172. Zoe Segarich (*ZIP code:*)

This is life saving healthcare that will keep kids alive. Please don't take this away from them

2173. An anonymous signer (*ZIP code:*)

2174. Jewel (*ZIP code:*)

2175. Kristin Joseff Gagajena (*ZIP code:*)

2176. Zach Quessenberry (*ZIP code:*)

Ron DeSantis' mother either loved him far too much or far too little, and I'm not sure which one is worse.

2177. Zachary Griffith (*ZIP code:*)

2178. Zara Zambrano (*ZIP code:*)

Trans youth should not have their ability to be properly treated removed under these fascist rules. I am appalled by these actions as an individual working for the State of Florida and highly suggest you reconsider.

From: [Sally Monroe](#)
To: [BOM Public Comment](#)
Subject: Treatment of Gender Dysphoria
Date: Monday, October 24, 2022 3:18:29 PM

You don't often get email from monroe401@comcast.net. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Committee Members,

I believe that all patients with gender dysphoria should be treated with counseling and support until they are adults. Many children have psychological issues and unhappiness. The increase in number of patients recently raises alarm about the etiology of this.

I am concerned that if radical treatment is taken at an early age that is not reversible, we will be sadly disappointed. This present day “fad” of irreversible treatment may turn out to be as regretted as frontal lobotomies in the last century.

Sara Z. Monroe, MD
1141 Shipwatch Dr. East
Jacksonville, FL 32225

From: [Paul Hruz](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Information for State Medical Board Meeting
Date: Tuesday, September 20, 2022 2:49:01 PM
Attachments: [Hruz Expert Report Florida Medical Board 2022.pdf](#)

You don't often get email from hruz_p007@att.net. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Paul A. Vazquez, J.D.
Executive Director
Florida Medical Board

Dear Mr. Vazquez,

I am attaching a detailed report for the Florida Medical Board as you discuss the safety and efficacy of medical interventions for those who experience sex-discordant gender identity, particularly adolescents with gender dysphoria. As you know, much of the public discussion on this issue is filled with unjustified ideological assertions and emotive arguments. The medical profession is called to base care decisions on objective scientific evidence for both safety and efficacy. In many areas of medicine, there is insufficient evidence to make definitive conclusions. In such circumstances, a cautious approach is deemed most prudent. When new experimental treatments are attempted, our profession has established standards for mitigating risk to study subjects. Unfortunately, in the field of gender medicine, ideology and politics have usurped these standard practices. I applaud the Medical Board of the State of Florida for their efforts to consider relative merits and concerns of the affirmative model of care to individuals suffering from gender dysphoria. As needed, I am happy to provide additional information to the board.

Sincerely,

Paul W Hruz MD PhD
Associate Professor of Pediatrics
Associate Professor of Cellular Biology and Physiology

**Expert Physician Report for the
State of Florida's Medical Board Meeting on September 30, 2022**

**PAUL W. HRUZ, M.D., Ph.D.
September 20, 2022**

This report provides information that is essential for the Medical Board of the State of Florida as it considers the best approach for the care of individuals who experience sex-discordant gender identity. For each of my opinions detailed below, I provide relevant published scientific literature and other publicly available information. Copies of cited sources can be provided on request.

- 1. In my opinion, there is a serious lack of quality scientific evidence regarding the safety and efficacy of gender affirming medical interventions for individuals who experience sex discordant gender identity. Use of such medical interventions remains a highly controversial and experimental approach.**

Pediatric patients referred to our practice for the evaluation and treatment of gender dysphoria are cared for by an interdisciplinary team of providers that includes a psychologist and pediatric endocrinologist who have been specifically chosen for this role based upon a special interest and professional knowledge and training in this previously rare patient population. Due to the documented, important, ethical concerns regarding the safety, efficacy, and scientific validity of controversial, unproven, and experimental treatment paradigms, I have not personally engaged in the delivery of gender affirming medical interventions to children with gender dysphoria. Given the unproven long-term benefits and the well-documented risks and harms of “transitioning” children, I decline to participate in such experimental treatments until the science has proven that the relative risks and benefits of this approach warrant such procedures.

My decision is strengthened by the knowledge that the vast majority of children who report gender dysphoria will, if left untreated, grow out of the problem — a natural coping-developmental process — and willingly accept their biological sex. Despite differences in country, culture, decade, follow-up length and method, multiple studies have come to a remarkably similar conclusion: very few gender dysphoric children still want to transition by the time they reach adulthood. Many turn out to have been struggling with sexual orientation issues rather than sex discordant “transgender” identity. The exact number of children who experience realignment of gender identity with biological sex by early adult life varies by study.

Estimates within the peer reviewed published literature range from 50-98%, with most reporting desistance in approximately 85% of children prior to the widespread adoption of the “gender affirmation only” approach. Thus, desistance (*i.e.*, the child accepting their natal, biological sex identity and declining “transitioning” treatments) is the outcome for the vast majority of affected children who are not actively encouraged to proceed with sex-discordant gender affirmation.

Since there are no reliable assessment methods for identifying the small percentage of children with persisting sex-gender identity discordance from the vast majority who will accept their biological sex, and since puberty blocking treatments, hormone transition treatments, and surgical transition treatments are all known to have potentially life-long devastating, negative effects on patients, I and many colleagues view it as unethical to treat children with an unknown future by using experimental, aggressive, and intrusive gender affirming medical interventions.¹

2. Peer-reviewed, published research in credible science-medical journals.

My opinions as detailed in this report are based upon my knowledge and direct professional experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that other experts in my field of clinical practice rely upon when forming opinions on the subject including hundreds of published, peer reviewed scientific research (and professional) articles.

As discussed in detail in this report, the extant published literature on the use of puberty blockers, cross-sex hormones and gender affirming surgeries are based, almost entirely, upon studies with major methodological limitations.²

This includes:

- Significant recruitment biases including internet-based convenience sampling;

¹ See Cantor, *Do Trans-Kids stay Trans- When The Group Up?*, Sexology Today, available at http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html (providing summary of multiple research studies); *see also infra*, publications reviewed in detail below.

² See Hruz, *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, Linacre Q 87(1): 34-42, doi: 10.1177/0024363919873762 (2020).

- Relatively small sample sizes for addressing a condition that is likely to be multifactorial;
- Short term follow-up;
- Lack of randomization to different treatment arms;
- Failure to even consider alternate hypotheses;
- Failure to include proper control groups and, in many studies *no* control group at all;
- Reliance on cross sectional sampling that may identify associations, but *cannot* establish causal relationships between intervention and outcome;
- A high rate of patients lost to follow up in longitudinal analyses which is relevant to questions of regret, desistance and completed suicide;
- Biased interpretation of study findings with a goal of validating *a priori* conclusions rather than seeking evidence to disprove the null hypothesis;
- Ignoring starkly contradictory research documenting the lack of effectiveness of “transitioning” procedures, the low quality of research in this area, and the ongoing contentions and disagreements over this highly controversial, experimental medical field.

3. Basis for my opinions.

My opinions documented in this report are based on my:

- (1) knowledge, training, and clinical experience in caring for thousands of patients over many years;
- (2) detailed methodological reviews of hundreds of relevant peer-reviewed science publications;
- (3) consults, discussions, and team analyses with colleagues and other experts in the field, including attendance and participation in various professional conferences;
- (4) publications in peer reviewed scientific journals;
- (5) editorial work for peer reviewed scientific journals; and
- (6) peer reviewed research grant receipt and review work.

The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study typically and regularly rely upon when forming opinions on these subjects.

In addition to peer reviewed published research articles related to gender affirming medical interventions (see specific citations below), I also cite a wide variety of peer reviewed, published, scientific journal evidence documenting the recent, very public, disclosures of the multiple and serious methodological errors, failures, and defects of “transitioning treatment” research. Specific examples include:

- *The Branstrom Long-Term Treatment Outcome Study*. The historic Branstrom report is a peer reviewed, published, scientific journal article that documents a long-term treatment (10+ years) outcome research investigation testing the effects of hormonal and surgical “transitioning” treatments on patients. This historic research found no reliable benefits from these disfiguring-sterilizing “treatments,” as well as evidence suggesting *increased* suicide attempts and anxiety disorders following the “gender transitioning” treatments. In addition, detailed methodological critiques discovered significant research errors by the authors that appear to support the investigative theory that the authors had initially attempted to manipulate and misreport the findings of the study.³ The authors ultimately recanted their initial misreporting and agreed that their study produced no reliable evidence of benefits for gender reassignment hormone and surgical treatments. This historic investigation has helped to generate a profound collapse of support for these experimental procedures across Europe.⁴

³ See, *infra* for detailed notes and review with multiple citations.

⁴ See SEGM, *Correction of a Key Study: No Evidence of “Gender-Affirming” Surgeries Improving Mental Health*, available at https://segm.org/ajp_correction_2020 (Aug. 30, 2020; last accessed June 29, 2021); Van Mol et al., *Gender-Affirmation Surgery Conclusion Lacks Evidence*. *Am. J. Psych.* 177(8): 765-66 (2020).

- *The National Finland Review Recommending Suspension of Transitioning Treatments for Children as they Remain Experimental and of Uncertain Benefit.* A National Science Review in Finland carefully examined all relevant science and suspended transition treatments for minors under age 16.⁵ This official peer review recommends that psychotherapy should be the first line of treatment for gender dysphoric youth.⁶ “Cross-sex identification in childhood, even in extreme cases, generally disappears during puberty . . . The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders . . . No gender confirmation surgeries are performed on minors . . . Potential risks of GnRH therapy include disruption in bone mineralization and the as yet unknown effects on the central nervous system . . . there are no medical treatments [for transitioning] that can be considered evidence-based . . . In cases of children and adolescents, ethical issues are concerned with the natural process of adolescent identity development, and the possibility that medical interventions may interfere with this process. It has been suggested that hormone therapy (e.g., pubertal suppression) alters the course of gender identity development; i.e., it may consolidate a gender identity that would have otherwise changed in some of the treated adolescents. The reliability of the existing studies with no control groups is highly uncertain, and because of this uncertainty, no decisions should be made that can permanently alter a still-maturing minor’s mental and physical development . . . A lack of recognition of co-morbid psychiatric disorders common among gender-dysphoric adolescents can also be detrimental. Since reduction of psychiatric symptoms

⁵ See SEGM, *One Year Since Finland Broke with WPATH “Standards of Care”* available at: https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors (July 2, 2021).

⁶ See Palveluvalikoima, *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors* (2020).

cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment. A young person's identity and personality development must be stable so that they can genuinely face and discuss their gender dysphoria, the significance of their own feelings, and the need for various treatment options. For children and adolescents, these factors are key reasons for postponing any interventions until adulthood... In light of available evidence, gender reassignment of minors is an experimental practice.”⁷

- *Sweden's Flagship Karolinska Hospital Suspends Transitioning Treatments for Children Under 16 and Requires Research Oversight for Patients Under 18.*

In Sweden, the world-renowned Karolinska Hospital reviewed the current research and suspended pediatric gender transitions for patients under 16 outside of experimental, monitored clinical trials settings as of May 2021. Treatment will focus on psychotherapy and assessment.⁸ The “Dutch protocol” for treating gender dysphoric minors has been discontinued over concerns of medical harm and uncertain benefits. This new Swedish policy is consistent with Finland's recently revised guidelines and changes in England's policies as well as the Arkansas legislation in the U.S. All have been changed to prioritize psychological interventions and social support in contrast to medical interventions, particularly for youth with no young childhood history of gender dysphoria (presently the most common patient presentation).⁹

⁷ See *id.*; *supra*, note 5.

⁸ See SEGM, *Sweden's Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies*, available at: https://segm.org/Sweden_ends_use_of_Dutch_protocol (May 5, 2021); see also, Karolinska Policy Change K2021-3343, translation available at: <https://segm.org/sites/default/files/Karolinska%20Policy%20Change%20K2021-3343%20March%202021%20%28English%2C%20unofficial%20translation%29.pdf> (March 2021); Karolinska Guideline K2021-4144, translation available at: <https://segm.org/sites/default/files/Karolinska%20Guideline%20K2021-4144%20April%202021%20%28English%2C%20unofficial%20translation%29.pdf> (April 2021).

⁹ See *id.*

- A Sweden National Review Documents “Low Quality Research” in this Experimental and Controversial Field.¹⁰ “This report was commissioned by the Swedish government and is a scoping review of the literature on gender dysphoria in children and adolescents. The report can be a basis for further evaluation of risk of bias and evidence.” The Swedish national review reported: “No relevant randomized controlled (treatment outcome) trials in children and adolescents were found.” The review also reported “Conclusions:”
 - We have not found any scientific studies which explains the increase in incidence in children and adolescents who seek the health care because of gender dysphoria.
 - We have not found any studies on changes in prevalence of gender dysphoria over calendar time, nor any studies on factors that can affect the societal acceptance of seeking for gender dysphoria.
 - There are few studies on gender affirming surgery in general in children and adolescents and only single studies on gender affirming genital surgery.
 - Studies on long-term effects of gender affirming treatment in children and adolescents are few, especially for the groups that have appeared during the recent decennium . . .
 - Almost all identified studies are observational, some with controls and some with evaluation before and after gender affirming treatment. No relevant randomized controlled trials in children and adolescents were found.
 - We have not found any composed national information from Sweden on: [] the proportion of those who seek health care for gender dysphoria that get a formal diagnosis [, nor] the proportion starting endocrine treatment to delay puberty [, nor] the proportion starting gender affirming hormonal treatment [, nor] the proportion subjected to different gender affirming surgery.
- UK Researchers, Courts, and Other Reviewers Highlighted the Paucity of Quality Research, Limitations, Defects, and Risks in the Still Experimental, Controversial “Gender Transitioning” Treatment Field. The British official

¹⁰ See Sweden SBU Policy Review, *Gender Dysphoria in Children and Adolescents: An Inventory of the Literature*, SBU Policy Support No. 307, available at: <https://www.sbu.se/307e> (2019).

medical review office (the National Institute of Health and Care Excellence, or “NICE”) published reports on transitioning science.¹¹ An official review found, “[t]he evidence for using puberty blocking drugs to treat young people struggling with their gender identity is ‘very low.’” NICE said existing studies of the drugs were small and “subject to bias and confounding.” The assessment of the evidence into the drugs was commissioned by NHS England. It is part of a review into gender identity services for children and young people.¹² The NICE review noted it was difficult to draw conclusions from existing studies because of the way they had been designed. They were “all small” and did not have control groups, which are used to directly compare the effect of different treatments. There were other issues with the studies too, such as not describing what other physical and mental health problems a young person may have alongside gender dysphoria.

The British NICE service also reviewed the evidence base for cross-sex hormones.¹³ The review found the evidence of clinical effectiveness and safety of cross-sex hormones was also of “very low” quality, explaining “[a]ny potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria.” Both documents were prepared by NICE in October 2020 and will now help inform Dr. Hilary Cass's independent review into NHS gender identity services for children and young people.¹⁴

This British study conclusion noted: “We found no evidence of change (no

¹¹ See Cohen & Barnes, *Evidence for Puberty Blockers Use Very Low, Says NICE*, BBC, available at <https://www.bbc.com/news/health-56601386> (Apr. 1, 2021).

¹² See <https://arms.nice.org.uk/resources/hub/1070905/attachment>; see also, *NHS Announces Independent Review into Gender Identity Services for Children and Young People*, available at: <https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/> (Sept. 22, 2020).

¹³ See <https://arms.nice.org.uk/resources/hub/1070871/attachment>.

¹⁴ See also Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK*, medRxiv, doi: 10.1101/2020.12.01.20241653 (published online Dec. 2, 2020).

improvement) in psychological function with GnRHa treatment as indicated by parent report (CBCL) or self-report (YSR) of overall problems, internalizing or externalizing problems or self-harm....”

Puberty blockers used to treat children aged 12 to 15 who have severe and persistent gender dysphoria had no significant effect on their psychological function, thoughts of self-harm, or body image, a study has found. However, as expected, the children experienced reduced growth in height and bone strength by the time they finished their treatment at age 16.¹⁵ Regarding the UK’s Tavistock and Portman NHS Trust’s Gender Identity Development Service’s experimental trial of puberty blockers for early teenagers with gender dysphoria, Oxford’s Professor Michael Biggs wrote, “To summarize, GIDS launched a study to administer experimental drugs to children suffering from gender dysphoria . . . After a year on GnRHa [puberty blockers] children reported greater self-harm, and girls experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers actually exacerbated gender dysphoria.”¹⁶

As Griffin et al. discussed, “[a]s there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties.” In addition,

¹⁵ See Dyer, *Puberty Blockers: Children Under 16 Should Not be Referred Without Court Order, Says NHS England*, BMJ 371:m4717, doi: 10.1136/bmj.m4717 (2020); Dyer, *Puberty Blockers Do Not Alleviate Negative Thoughts in Children with Gender Dysphoria, Finds Study*, BMJ 372:n356, doi: 10.1136/bmj.n356 (2021); Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort to 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK*, medRxiv, doi: 10.1101/2020.12.01.20241653 (2020); BBC Summary, available at: <https://www.bbc.com/news/uk-55282113journal.pone.0243894>; see also Transgender Trend, *Tavistock’s Experimentation with Puberty Blockers: Scrutinizing the Evidence*, available at: <https://www.transgendertrend.com/tavistock-experiment-puberty-blockers/> (Mar. 5, 2019).

¹⁶ See also Griffin et al., *Sex, Gender and Gender Identity: A Re-Evaluation of the Evidence*, BJPsych Bulletin 45(5):291-99, doi:10.1192/bjb.2020.73 (2021).

Griffin et al. wrote: “Transgender support groups have emphasized the risk of suicide. After controlling for coexisting mental health problems, studies show an increased risk of suicidal behaviour and self-harm in the transgender population, although underlying causality has not been convincingly demonstrated.”¹⁷ In sum, political activists and too many providers have used a fear of suicide to push experimental unproven, hazardous treatments.

- *Review of the World Professional Association for Transgender Health’s (WPATH) Controversial and Outdated Treatment “Standards”*. A 2021 review found WPATH standards “incoherent.”¹⁸ Both WPATH and Endocrine Society guidelines have recently been assessed for quality by a systematic review, which found them to be of low quality. Specific to WPATH, the reviewers noted the difficulty of even extracting clear recommendations, describing the WPATH guidelines as “incoherent.” Standards of care should provide practitioners with evidence-based standards by which they may reliably inform the patient of projected outcomes and do so with a known error rate. Such data is the starting point for obtaining informed consent, which is not provided by either of these guidelines. The WPATH current version 7 standards violate minimal ethical and quality standards set by national organizations that review and post medical treatment standards including the National Academy of Medicine. WPATH board members suffer from serious financial conflicts of interest (e.g., virtually all WPATH BD members obtain most of their personal income from performing the very same “treatments” they are supposed to evaluate objectively). In addition, the minimal length of time treatment standards must be refreshed is every five years and WPATH version 7 is now nearly *ten* years old and thus far past its useful “shelf life.”

¹⁷ See Marshall et al., *Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature*, Int. Rev. Psychiatry 28(1):58–69, doi: 10.3109/09540261.2015.1073143 (2016).

¹⁸ See Dahlen et al., *International Clinical Practice Guidelines for Gender Minority/Trans People: Systematic Review and Quality Assessment*, BMJ Open, 11(4):e048943, doi: 10.1136/bmjopen-2021-048943 (2021).

Given that the most current research¹⁹ are sharply critical of the ongoing failure of random control trials and the generally very low-quality evidence in this controversial field (the 10 year old WPATH version 7 standards have aged very poorly indeed and should be viewed as hazardous to patients.)

- *The UK High Court in the Bell Litigation – after hearing from multiple international expert witnesses – found transitioning treatments to be “experimental”.* In an internationally reported case, the High Court of London ruled these “gender transitioning” treatments were “experimental,” ordering protections for children who could not consent to such hazardous treatments given the lack of evidence of benefits and clear evidence of risks (*e.g.*, sterilization).

The court’s order that judges should oversee the consent of minors on a case-by-case basis was overturned on appeal — as the appeals court returned consent duties to medical providers — but left intact the trial court’s opinion that the evidence produced during the hearing demonstrated “gender transitioning treatments” remain controversial with serious risks of irreversible harm (including sterilization of the patient) and of unproven benefit.²⁰

“Children under 16 with gender dysphoria are unlikely to be able to give informed consent to undergo treatment with puberty-blocking drugs, three High Court judges have ruled . . . Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognize that clinicians may well regard these as cases where the authorization of the court should be sought prior to commencing the clinical treatment . . . The judges also pointed to the lack of evidence about the long-term effects of puberty blockers.”²¹

¹⁹ Including, *e.g.*, the long-term Branstrom and Hisle-Gorman treatment outcome studies, the British NICE review, the Sweden review, the Finland review, the British Dr. Cass national review and others.

²⁰ See BBC, *Puberty Blockers: Under-16s 'Unlikely to be Able to Give Informed Consent'*, available at: <https://www.bbc.com/news/uk-england-cambridgeshire-55144148> (Dec. 1, 2020).

²¹ *Id.*

- *The British Independent Review of Gender Identity Services for Children and Young People: Interim Report by National Expert, Dr. Hilary Cass, M.D., was Published in February 2022.* The Dr Cass interim review concluded that “Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally.” Dr. Cass notes that “There is lack of consensus and open discussion about the nature of gender dysphoria and therefore about the appropriate clinical response.”²²
- *The Society for Evidence Based Gender Medicine (SEGM) Review Summarizes the Health Risks of Transitioning.* Consistent with changes in policy in Sweden, Finland, England, and Arkansas — due to much negative research findings over recent years — SEGM, a collection of national and international experts in the field, published a research summary documenting the serious health risks of “transitioning treatments” compared to the well-known lack of evidence of reliable benefits for such treatments.²³
- *The Cochrane Review Found Insufficient Evidence of Benefits.* The widely respected Cochrane Review examined hormonal treatment outcomes for male-to-female transitioners over 16 years. They found “insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition.” It is remarkable that decades after the first transitioned male-to-female patient, quality evidence for the benefit of transitioning is still lacking.²⁴

²² See The Cass Review, *Interim Report*, available at: <https://cass.independent-review.uk/publications/interim-report/>).

²³ See SEGM, *Science Studies – Health Risks of Medical and Surgical Gender Reassignment*, available at <https://www.segm.org/studies>.

²⁴ See Haupt et al., *Antiandrogen or Estradiol Treatment or Both During Hormone Therapy in Transitioning Transgender Women*, Cochrane Database Sys. Rev. (Review – Intervention), doi: 10.1002/14651858.CD013138.pub2 (2020).

4. **A March 2021 study – with the largest sample yet – is consistent with the new direction for Finland, Sweden, the UK, and France – show that most young gender dysphoric children, if left alone, grow out of the problem with no medical intervention.²⁵**

“Watchful waiting” is the recommended treatment: in the past, 67% of children meeting the diagnostic criteria for gender dysphoria no longer had the diagnosis as adults, with an even higher 93% rate of natural resolution of gender-related distress for the less significantly impacted cases.²⁶

5. **Experts are uniformly concerned with, and baffled by, the unexplained rapid and extreme demographic shifts in patient age and sex. Such shifts produce serious concerns about whether decades of previous research—done on a very different population group—even apply to the current patient cohort.**

For decades, transgender patients were mostly older adults or very young boys. Over the last few years, a tsunami of teenaged girls has flipped the demographics of transgender patients—now up to 7 to 1 teen girls. Many experts have noted that the previous research on trans patients cannot be relied upon when the patient group has so rapidly and mysteriously been transformed. In sum, the newly presenting cases are vastly overrepresented by adolescent females, the majority of whom also have significant mental health problems and neurocognitive comorbidities such as autism-spectrum disorder or ADHD.²⁷ The most recent evidence supports the emerging theory of social

²⁵ See Devita et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, *Frontiers in Psychiatry* doi: 10.3389/fpsy.2021.632784 (March 2021).

²⁶ See also, e.g., Zucker, *The Myth of Persistence: Response to “A Critical Commentary on Follow-Up Studies and ‘Desistance’ Theories About Transgender and Gender Non-Conforming Children”* by Temple Newhook et al. (2018), *Int. J. Transgenderism* 19(2):231–24 (2018).

²⁷ See de Graaf & Carmichael, *Reflections on Emerging Trends in Clinical Work with Gender Diverse Children and Adolescents*, *Clin. Child Psychology & Psychiatry*, 24(2): 353-64 (2018).

contagion as estimates of sex-discordant gender identity are rocketing upwards from 1 in 10,000 to “the number of U.S. transgender-identified youth may be as high as 9%.”²⁸

This unexplained, radical transformations of demographics does not happen in actual illnesses (cancer, heart disease, anxiety disorders, etc.), but is tragically consistent with previous mental health system disasters such as the once very rare “multiple personality disorder” and “recovered repressed memory” patients that radically increased in the 1990s.

Dr. Thomas Steensma, a prominent investigator of the Dutch protocol—the original model for transitioning treatments—has recently noted, “[w]e don’t know whether studies we have done in the past can still be applied to this time,” specifically because of the unexplained surge in female adolescents reporting gender dysphoria. “Many more children are registering, but also of a different type . . . Suddenly there are many more girls applying who feel like a boy . . . now there are three times as many females as males.” He concluded with the warning that “[w]e conduct structural research in the Netherlands. But the rest of the world is blindly adopting our research.”²⁹

6. Examples of limited, low quality, and defective research.

The hazards of making treatment recommendations based on studies with major methodological weaknesses can be readily seen by considering representative studies used by advocates of medical gender affirmation to justify this approach. For example:

- The study by De Vries and colleagues³⁰ is often cited to support longitudinal evidence of benefit from pubertal blockade. Although improvements in mood were observed and changes in the risk of behavioral disorders with pubertal

²⁸ See Kidd et al., *Prevalence of Gender-Diverse Youth in an Urban School District*, *Pediatrics* 147(6):e2020049823, doi: 10.1542/peds.2020-049823 (2021).

²⁹ See Tetelepta, *More Research is Urgently Needed into Transgender Care for Young People*: “Where Does the Large Increase of Children Come From?” AD, translation available at: <https://www.voorzij.nl/more-research-is-urgently-needed-into-transgender-care-for-young-people-where-does-the-large-increase-of-children-come-from/> (Feb. 27, 2021).

³⁰ de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, *J. Sex, Med.* 8(8):2276-83, doi: 10.1111/j.1743-6109.2010.01943.x (2011).

blockade were found over baseline, this study had no control group. Thus, the authors were unable to determine the basis of this improvement. The authors acknowledge that psychological support or other reasons may have contributed to (or wholly caused) this observation. It is also important to note that gender dysphoria itself *did not diminish* in study subjects, and there were *no changes* in body image-related distress.

- The study by Turban and colleagues³¹ is often cited as proof that pubertal blockade prevents suicide in transgender youth. However, this study used an unreliable, biased sampling methodology. As stated in the paper, the authors considered “a cross-sectional online survey of 20,619 transgender adults aged 18 to 36 years” from the 2015 U.S. Transgender Survey. This was an online survey of transgender and “genderqueer” adults recruited from trans-friendly websites. Among the many problems with this sampling methodology, there is *no* evidence of study subject identities, *no* way to assess for potential false subjects, and *no* medical diagnosis for entry. *No causation can be determined from this retrospective, cross-sectional design.* Furthermore, the study failed to even assess desisters and regretters. Turban claimed that desisters and regretters would “not be likely” in this study group, which also only included adults. Thus, the study “does not include outcomes for people who may have initiated pubertal suppression and subsequently no longer identify as transgender.”

Turban’s misleading claim of lower suicidal ideation for treated patients excluded the most seriously mentally ill patients that would have been *denied* affirmation treatment. Those who received treatment with pubertal suppression, when compared with those who wanted pubertal suppression but did not receive it, had lower odds of lifetime suicidal ideation (adjusted odds ratio = 0.3; 95% confidence interval = 0.2– 0.6). In Table 3 of the paper, under

³¹ Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, Pediatrics 145(2):e20191724, doi: 10.1542/peds.2019-1725 (2020).

“Suicidality (past 12 months)” reductions for suppressed group vs. non-suppressed were seen for ideation (50.6% vs. 64.8%) and “ideation with plan” (55.6% vs. 58.2%). However, it is essential to note that suicidal “ideation with plan and suicide attempt” for the hormone suppressed group, in raw numbers, *increased* after treatment to 24.4% vs. 21.5% for the “non-treatment group.”

The most clinically significant result in this study — that Affirmation Treatments *did not prevent serious suicide attempts* — was *improperly and/or unethically ignored by the authors*. “Suicide attempts resulting in inpatient care” = 45.5% for suppression groups vs. 22.8% for those who did not receive pubertal suppression. Although the result of increased suicide attempts did not reach “statistical significance”, the clinical significance of this finding cannot be ignored. It would be most reasonable to conclude from an observation of 45% attempted suicide requiring hospitalization in the treated arm that the intervention was unsuccessful in improving health. Turban et al. ignored their own findings that a history of puberty suppression was associated with a persistence of serious suicide attempts. In sum, the Turban 2020 Pediatrics study, based on an unverified U.S. Transgender Online Survey, tells us little about the effects of puberty suppression on children with gender dysphoria.³²

- The 2021 study of Bustos et al.³³ attempts to provide a systematic review of 27 observational or interventional studies that report on regret or detransition following gender-transition surgeries. A total of 7,928 subjects were included in their meta-analysis. The authors concluded that only 1% or less of those who had gender-transition surgeries expressed regret. It is important to

³² See Biggs, *Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria*, Arch. Sex. Behav. 49:2227-29, doi: 10.1007/s10508-020-01743-6 (2020); and the multiple Letters to the Editor that criticized the multiple methodological errors in this study, available at: <https://pediatrics.aappublications.org/content/145/2/e20191725/tab-e-letters#re-pubertal-suppression-for-transgender-youth-and-risk-of-suicidal-ideation>.

³³ See Bustos et al., *Regret After Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence*, Plast. Reconstr. Surg. Global Open 9(3):e3477, doi: 10.1097/GOX.0000000000003477 (2021).

understand the serious methodological limitations and high risk of bias contained within the analysis in the 2021 Bustos et al. study.³⁴ This includes failure to include major relevant studies addressing this question,³⁵ inaccurate analysis within one of the studies considered,³⁶ and the general lack of controlled studies (thus no causal conclusions are possible), incomplete and generally short-term follow-up, large numbers of lost subjects, and lack of valid assessment measures in the published literature addressing this question. As noted by Expósito-Campos & D'Angelo (2021),³⁷ moderate to high risk of bias was present in 23 of the 27 studies included in the analysis. Furthermore, 97% of subjects analyzed were found within studies deemed to be of fair to poor scientific quality. Thus, this study cannot be used as strong support for the contention that regret is rare.

- The 2018 paper by Wiepjes et al.³⁸ is a retrospective review of records from all patients of the Center of Expertise on Gender Dysphoria gender clinic in Amsterdam from 1972-2015. While the study appears to report on the regret rates among a large cohort of adolescents (812) and children (548), regret is only reported for children and adolescents who had undergone gonadectomy once over 18 years of age. Of the adolescents, 41% started puberty suppression. Of those who started GnRH agonists, only 2% stopped this intervention (meaning that 98% of those who started puberty suppression progressed to cross-sex hormone therapy). An additional 32%, having already completed puberty, started cross-sex hormone therapy without use of a GnRH agonist. Classification of regret was oddly restricted, requiring physician

³⁴ See Expósito-Campos & D'Angelo, *Letter to the Editor: Regret after Gender-Affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence*, *Plast. Reconstr. Surg. Global Open* 9(11): e3951, doi: 10.1097/GOX.0000000000003951 (2021).

³⁵ See Dhejne et al., *An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960-2010: Prevalence, Incidence, and Regrets*, *Arch. Sex. Behav.* 43(8):1535-45 (2014).

³⁶ Wiepjes et al., *The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets*, *J. Sex. Med.* 15(4):582-90, doi: 10.1016/j.jsxm.2018.01.016 (2018).

³⁷ *Supra*, note 31.

³⁸ *Supra*, note 33.

documentation of patient verbalized regret after gonadectomy and start of sex-concordant hormones to treat the iatrogenic hypogonadism. This means there are significant limitations to the conclusions that can be drawn from 2018 paper by Wiepjes et al. There is no discussion in this paper regarding adolescent regret of use of puberty blockers, cross-sex hormones, or mastectomies. Importantly, 36% of patients were lost to follow-up. This is notable given that gonadectomy iatrogenically induces the pathologic state of primary hypogonadism. Affected patients have a lifelong dependency for exogenously administered sex-steroid hormones, and thus an acute need for ongoing follow-up. The number of lost subjects who experienced regret or completed suicides is simply unknown, a serious defect as most patients with “regret” are expected to just walk away and thus rarely come back to the clinic and express regrets to anyone much less the physician who “transitioned” them. It is also significant that the average time to regret was 130 months — far longer than virtually all transitioning studies followed patients. The authors themselves acknowledge that it may be too early to predict regret in patients who started hormone therapy in the past 10 years.

- The 2021 study by Narayan et al.³⁹ examines anonymous survey results from 154 surgeons affiliated with WPATH. The response rate for this survey was 30%. Of the respondents, 57% had encountered patients with surgical regret. It is important to recognize that this study was specifically directed toward patients who had undergone surgical transition. Acknowledged biases of this study included selection bias, recall bias, and response bias. This type of study cannot accurately identify the prevalence in the transgender population as a whole and is particularly limited in the ability to assess potential for regret in the pediatric population.

³⁹ Narayan et al., *Guiding the Conversation-Types of Regret After Gender-Affirming Surgery and Their Associated Etiologies*, Ann. Translational Med. 9(7):605, doi: 10.21037/atm-20-6204 (2021).

- The 2018 Olson-Kennedy paper⁴⁰ presents the results of a survey of biologically female patients with male gender identity at the lead author's institution using a novel rating system for "chest dysphoria" created by the study authors. There were an equal number (68) of nonsurgical and post-surgical subjects surveyed. Those who had undergone bilateral mastectomies were reported to have less chest dysphoria than those who did not receive this intervention. Limitations of this study include convenience sampling of nonsurgical study subjects with high potential for selection bias, cross-sectional design (*e.g.*, thus no causal conclusions are possible), and lack of validation of the primary outcome measure. Test validation is particularly relevant in assessing adolescent questionnaires due to a variety of cognitive and situational factors in this population.⁴¹ Rigorous validation methods have been previously used in several other established questionnaires addressing adolescent self-perception.⁴² As previously noted, this study cannot provide information about a causal relationship between the intervention and outcome observed.
- The 2021 Almazan study⁴³ attempts to address mental health outcomes in relation to gender-transition surgery. As previously noted, this study relies upon data from the highly unreliable 2015 U.S. Transgender Survey. Limitations and weaknesses of this survey tool include convenience sampling, recruitment of patients through transgender advocacy organizations, demand

⁴⁰ Olson-Kennedy et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts*, JAMA Pediatr. 172(5):431–36, doi: 10.1001/jamapediatrics.2017.5440 (2018).

⁴¹ See Brener et al., *Assessment of Factors Affecting the Validity of Self-Reported Health-Risk Behavior among Adolescents: Evidence from the Scientific Literature*, J. Adolesc. Health 33(6):436–57, doi: 10.1016/s1054-139x(03)00052-1 (2003).

⁴² See Palenzuela-Luis et al., *Questionnaires Assessing Adolescents' Self-Concept, Self-Perception, Physical Activity and Lifestyle: A Systematic Review*, Children (Basel) 9(1):91, doi: 10.3390/children9010091 (2022).

⁴³ Almazan & Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, JAMA Surgery 156(7):611–18, doi: 10.1001/jamasurg.2021.0952 (2021).

bias (a.k.a. the good subject effect), a high number of respondents who reported having not transitioned medically or surgically (and reported no desire to do so in the future), and several other serious data irregularities. One notable data irregularity was that a high number of respondents reported that their age was exactly 18 years — a highly unlikely result indicting fraudulent responses on the anonymous “survey” where no actual, living respondent was ever seen, heard, or evaluated. As noted by D’Angelo and colleagues, these irregularities raise serious questions about the reliability of all USTS data⁴⁴ and therefore, the reliability of conclusions based on that data.

- The paper by Mehringer⁴⁵ provides a summary of qualitative interviews with 30 transmasculine youth (biological females who identify as men) with comparison between those who underwent bilateral mastectomy (n=14) and those who did not receive this intervention (n=16). Mean time from surgery was only 19 months. No validated objective measures were used to assess mental health. There are numerous potential confounding variables (*e.g.*, psychological co-morbidities, testosterone exposure, family dynamics) that could be responsible for the subjective perceptions of the study subjects. As a cross-sectional survey at a single center, the study methodology cannot establish a causal relationship between intervention and outcome. At best, the study can be used for hypothesis generation. It does not establish the efficacy of this approach, nor does it consider whether alternate approaches could achieve the desired outcome.

⁴⁴ D’Angelo et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, Arch. Sex. Behav., 50(1):7–16, doi: 10.1007/s10508-020-01844-2 (2021).

⁴⁵ Mehringer et al., *Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth*, Pediatrics 147(3):e2020013300, doi: 10.1542/peds.2020-013300 (2021).

- The study by Julian et al.⁴⁶ is also often used as evidence of the efficacy of gender affirming surgery. This study is an internet based cross sectional survey of 684 transgender youth (mean age 16 years) who reported having "chest dysphoria" with 89% (n=608) reporting use of chest binding and 11% (n=76) who did not engage in this practice. The study utilized the non-validated chest dysphoria scale described above for the 2018 Olson -Kennedy study. This study methodology has high potential for recruitment bias. Furthermore, as a cross-sectional study, it cannot establish causal relationships in study parameters. Since it addressed breast binding and not surgery, it does not provide data on the safety and efficacy of bilateral mastectomies in gender dysphoric youth.
- The study by Sood et al.⁴⁷ is yet another study that is used to support treatment efficacy. This is a single cite cross-sectional survey of 156 adolescent female subjects who completed the unvalidated chest dysphoria rating scale of Olsen-Kennedy described above. The study reports an association between report of chest dysphoria and the presence of anxiety and depression. As noted above, this study cannot establish a causal relationship between these study parameters. Furthermore, it does not address whether or not gender-affirming surgery (specifically bilateral mastectomy) is safe or effective in resolving associated psychological distress.

7. There are major and highly significant differences between male and female responses to many drugs, including sex hormones.⁴⁸

⁴⁶ Julian et al., *The Impact of Chest Binding in Transgender and Gender Diverse Youth and Young Adults*, J. Adolesc. Health 68(6):1129-34, doi: 10.1016/j.jadohealth.2020.09.029 (2021).

⁴⁷ Sood et al., *Association of Chest Dysphoria with Anxiety and Depression in Transmasculine and Nonbinary Adolescents Seeking Gender-Affirming Care*, J. Adolesc. Health 68(6):1135-41, doi: 10.1016/j.jadohealth.2021.02.024 (2021).

⁴⁸ See, e.g., Madla et al., *Let's Talk About Sex: Differences in Drug Therapy in Males and Females*, Adv. Drug Deliv. Rev. 175:113804, doi: 10.1016/j.addr.2021.05.014 (2021).

Giving estrogen to a biological male is not equivalent to giving the same hormone to a biological female. Likewise, giving testosterone to a biological female is not equivalent to giving the same hormone to a biological male.⁴⁹ Differences are not limited to pharmacokinetic effects but are present even at the cellular level.⁵⁰ Failure to acknowledge these differences can have tragic consequences. For example, in addition to the inherent sterilizing effect of cross-sex hormone administration, non-physiological levels of estrogen in males has been shown to increase the risk of thromboembolic stroke above the incidence observed in females.⁵¹

8. Biological basis of sex.

Reliance upon external phenotypic expression of primary sexual traits is a highly accurate, reliable, and valid means to assign biologic sex. In over 99.9% of cases, this designation will correlate with internal sexual traits and capacity for normal biologic sexual function. Sex is therefore not “assigned at birth” but is rather recognized at birth. In my opinion, this view is generally accepted by the relevant scientific communities in endocrinology, psychiatry, neonatology, biology, genetics, gynecology, and other fields.

9. Disorders of sexual development are very rare.

Due to the complexity of the biological processes that are involved in normal sexual development, it is not surprising that a very small number of individuals are born with defects in this process (1 in 5,000 births). Defects can occur through either inherited or *de novo* mutations in genes that are involved in sexual determination or through environmental insults during critical states of sexual development. Persons who are born

⁴⁹ See, e.g., Soldin & Mattison, *Sex Differences in Pharmacokinetics and Pharmacodynamics*, Clin. Pharmacokinetics 48(3):143–57, doi: 10.2165/00003088-200948030-00001 (2009); Pogun & Yazarbas, *Sex Differences in Drug Effects*, Encyclop. Psychopharmacology (Springer, Stolerman, ed.), doi: 10.1007/978-3-540-68706-1_209 (2010).

⁵⁰ See, e.g., Walker et al., *Matters of the Heart: Cellular Sex Differences*, J. Mol. & Cell. Cardiology 160:42–55, doi: 10.1016/j.yjmcc.2021.04.010 (2021).

⁵¹ See, e.g., Getahun et al., *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, Ann. Inter. Med. 169(4): 205–13, doi: 10.7326/M17-2785 (2018).

with such abnormalities are considered to have a disorder of sexual development (DSD). Most often, this is first detected as ambiguity in the appearance of the external genitalia. Such detection measurements are reliable and valid and accepted by the relevant scientific community. In my opinion, this view is generally accepted by the relevant scientific communities in endocrinology, neonatology, gynecology, psychiatry, biology, genetics, and other fields.⁵²

10. The ethical foundations of medicine – “first do not harm.”

The fundamental purpose of the practice of medicine is to treat disease and alleviate suffering. An essential tenet of medical practice is to avoid doing harm in the process. Efforts to rely upon clear, valid, reliable, and definitive evidence on how to best accomplish treatment goals is the essential ethical, professional, scientific, and clinical goals of physicians. Proponents of gender reassignment surgery for adolescents violate this essential principle by using experimental treatments on vulnerable populations without properly informing them of the actual risks and limitations of the treatments.⁵³

11. The Endocrine Society recognizes that the quality of evidence for “affirmative” treatments is currently “low or very low” (“estimate of effect is very uncertain”).

There is no general acceptance of these treatments in the relevant scientific community. The error rate is unknown and could be very high. The Endocrine Society published 2009 clinical guidelines for the treatment of patients with persistent gender dysphoria.⁵⁴ The recommendations include temporary suppression of pubertal development of children with GnRH agonists (hormone blockers normally used for

⁵² See Sax, *How Common is Intersex? A Response to Anne Fausto-Sterling*, J. Sex Research 39(3);174-78, doi: 10.1080/00224490209552139 (2002).

⁵³ See Jonsen, *Clinical Ethics*, New York: McGraw Hill (9th ed., 2022).

⁵⁴ See Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, J. Clin. Endocrinology Metab. 102(11):3869-3902, doi:10.1210/jc.2017-01658 (2017).

children experiencing precocious puberty) followed by hormonal treatments to induce the development of secondary sexual traits consistent with one's gender identity. In developing these guidelines, the authors assessed the quality of evidence supporting the recommendations made with use of the GRADE (Recommendations, Assessment, Development, and Evaluation) system for rating clinical guidelines. As directly stated in the Endocrine Society publication, "the strength of recommendations and the quality of evidence was low or very low." According to the GRADE system, low recommendations indicate that "[f]urther research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate." Very low recommendations mean that "any estimate of effect is very uncertain."⁵⁵ An updated set of guidelines was published in September of 2017.⁵⁶ The low quality of evidence presented in this document persists to the current day, as the controversy over these "treatments" is accelerating in recent years.

12. Administering hormones to a child whose gender dysphoria highly likely (80%+) to resolve is risky, unscientific, and unethical.

Iatrogenic damages, including life-long sterility, stunted growth, increased heart attack risk, etc., are often irreversible. Treatment of gender dysphoric children who experience persistence of symptoms with hormones (pubertal suppression and cross-hormone therapy) carries significant risk. It is generally accepted, even by advocates of transgender hormone therapy, that hormonal treatment impairs fertility and often result in sterility, which in many cases is irreversible.⁵⁷

⁵⁵ See Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, BMJ 2008(336):924, doi:10.1136/bmj.39489.470347.AD (2008).

⁵⁶ See *supra*, note 52.

⁵⁷ See Nahata et al., *Low Fertility Preservation Utilization Among Transgender Youth*, J. Adolescent Health 61(1):40-44, doi:10.1016/j.jadohealth.2016.12.012 (2017).

Emerging data also show that treated patients have lower bone density which may lead to increased fracture risk later in life.⁵⁸ Other potential adverse effects include disfiguring acne, high blood pressure, weight gain, abnormal glucose tolerance, breast cancer, liver disease, thrombosis, and cardiovascular disease.⁵⁹

13. Long term effects are unknown.

Such treatments are not generally accepted by the relevant scientific community and have no known nor published error rate. Since strategies for the treatment of transgender children as summarized by the Endocrine Society guidelines are relatively new, long-term outcomes are unknown. Evidence presented as support for short-term reductions in psychological distress following social transition in a “gender affirming” environment remains inconclusive. When considered apart from advocacy-based agendas, multiple potential confounders are evident. The most notable deficiencies of existing research are the absence of proper control subjects and lack of randomization in study design.⁶⁰

Although appropriate caution is warranted in extrapolating the outcomes observed from prior studies with current treatments, adults who have undergone social transition with or without surgical modification of external genitalia continue to have *rates of depression, anxiety, substance abuse and suicide far above the background population*.⁶¹

⁵⁸ See Klink et al., *Bone Mass in Young Adulthood Following Gonadotropin-Releasing Hormone Analog Treatment and Cross-Sex Hormone Treatment in Adolescents with Gender Dysphoria*, J. Clin. Endocrinology Metab. 100(2):E270-75, doi:10.1210/jc.2014-2439 (2015).

⁵⁹ See Seal, *A Review of the Physical and Metabolic Effects of Cross-Sex Hormonal Therapy in the Treatment of Gender Dysphoria*, Ann. Clin. Biochem. 53(1):10-20, doi:10.1177/0004563215587763 (2016); Banks et al., *Blood Pressure Effects of Gender-Affirming Hormone Therapy in Transgender and Gender-Diverse Adults*, Hypertension 77(6):2066-74, doi: 10.1161/HYPERTENSIONAHA.120.16839 (2021); Getahun et al., *Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, Ann. Int. Med., 169(4), 205–213, doi: 10.7326/M17-2785 (2018); Maraka et al., *Sex Steroids and Cardiovascular Outcomes in Transgender Individuals: A Systematic Review and Meta-Analysis*, J. Clin. Endocrinology & Metabolism 102(11):3914–23, doi: 10.1210/jc.2017-01643 (2017).

⁶⁰ See Hruz, *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, Linacre Q 87:34-42, doi:10.1177/0024363919873762 (2020).

⁶¹ See Adams et al., *Varied Reports of Adult Transgender Suicidality: Synthesizing and Describing the Peer-Reviewed and Gray Literature*, Transgender Health 2(1):60-75, doi:10.1089/trgh.2016.0036 (2017);

14. Medical treatments contrary to the science could result in irreversible harms to many patients who would otherwise have recovered naturally from gender dysphoria.

Of particular concern is the likelihood that naively requested gender transition “treatments” and social changes could interfere with known very high rates of natural-untreated resolution of sex-gender discordance. Any activity that encourages or perpetuates transgender persistence for those who would otherwise desist could cause significant harm, particularly in light of the current treatment paradigm for persisting individuals. As noted, sterility can often be expected with hormonal or surgical disruption of normal gonadal function.⁶²

15. “Gender affirmative” treatments damage or destroy healthy bodily organs, leading to loss of essential bodily functions (e.g., medically induced sterilization).

Despite the fact that gender dysphoria represents a psychological condition (as catalogued in the DSM since the third edition of this publication), some conceptualize the condition as a medical illness similar to cancer. When considered from this viewpoint, the goal of “treatment” is to alter the appearance of the body to conform to a patient’s perceived sexual identity, including the physical removal of unwanted “diseased” sexual organs. Since undesired body parts are fully formed and functional prior to hormonal or surgical intervention, the result of these “therapies” is injury to innate sexual ability. In particular, loss or alteration of primary sexual organs leads directly to impairment of reproductive potential. Recognition of this obvious consequence is the basis for the

see also Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS One 6:e16885, doi:10.1371/journal.pone.0016885 (2011).

⁶² See Cheng et al., *Fertility Concerns of the Transgender Patient*. Translational Andrology & Urology 8(5):209-218. doi: 10.21037/tau.2019.05.09 (2019).

development of new arenas of medical practice where there is an attempt to restore what has been intentionally destroyed.⁶³

16. No competent, scientifically valid, and reliable cost-benefit analysis has been done on “gender affirmative” treatments.

When the FDA tests a drug, the safety analysis looks at all related risks. Specifically, the drug must not only be effective, but it must not cause side effects that are more damaging than the proposed treatment. This is a key weaknesses in the affirmation model of care. Not only have the “treatments” *not* been proven reliably effective compared to *no* treatment, they are proposed against the existing knowledge of well-documented, long-term health problems and damages (e.g., testosterone use by transgender men increases the risk of fatal heart disease, estrogen use by transgender women increases risk of blood clots and strokes, gender transition treatments—if completed—can cause life-long sterility, etc.).

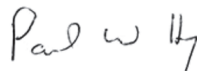
17. Summary opinions.

- There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions, including surgery, who are helped by such procedures.
- There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions, including surgery, who are injured or harmed by such procedures.
- Patients suffering from gender dysphoria or related issues have a right to be protected from experimental, potentially harmful treatments lacking reliable

⁶³ See, e.g., Ainsworth et al., *Fertility Preservation for Transgender Individuals: A Review*, Mayo Clin. Procs. 95(4):784-792, doi:10.1016/j.mayocp.2019.10.040 (2020).

and valid, peer reviewed, published, long-term scientific evidence of safety and effectiveness.

- Gender transition “affirmation” medical treatments, including surgery, for gender dysphoria and “transitioning” have no known, peer reviewed and published error rates—the treatments and assessment methods lack demonstrated, reliable and valid error rates.



Paul W. Hruz, M.D., Ph.D.

From: [Ken Fisher](#)
To: [BOM Public Comment](#)
Subject: Gender Affirming Care
Date: Monday, October 24, 2022 11:58:19 AM

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Members of the Committee,

The major gender affirming clinic in Great Britain has been closed. The reason was a lack of careful studies including sufficient followup and the sudden uptick of cases that looked more like a passing fancy in most children than a real phenomenon. Certainly any life altering treatments and surgery should be only undertaken after serious psychological evaluation and when the individual is no longer a minor.

Best Regards,

Kenneth A. Fisher, M.D.

Tweet@kennethafisher

Co-Founder, Michigan Chapter, Free Market Medicine Assoc.

Author, "Understanding Healthcare: A Historical Perspective"

amazon.com/author/kennethafishermd

From: [Jon Bignault](#)
To: [BOM Public Comment](#)
Subject: Gender Dysphoria
Date: Monday, October 24, 2022 11:32:35 AM

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The incidence of gender dysphoria is rapidly increasing in this ideological climate. Many disorders such as personality disorders which are often worse during teenage years are affected by this. For this reason and an appeal to simple common sense, as well as the principle of first do no harm, I would oppose gender affirming procedures under the age of 18. It is also my sad conclusion that the governing bodies of medicine have been affected by advocacy and ideology and cannot be fully trusted in these matters.

Jon Bignault M.D.

Sent from my iPhone

From: [AT&T Mail](#)
To: [BOM Public Comment](#)
Subject: Treatment of Gender Dysphoria in Florida
Date: Monday, October 24, 2022 11:43:39 AM

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Dear Members of the Boards:

I am a board-certified child and adolescent psychiatrist, a distinguished fellow of both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. I have worked in solo private practice for 34 years, but I teach pediatric residents and child and adolescent psychiatry fellows at University of California, Irvine/ Children's Hospital of Orange County.

Over the last five years, I have treated at least a dozen children and adolescents with gender dysphoria. My experience has been similar to that reported in the literature: almost all of them are gay and lesbian with depression and anxiety; many are on the autism spectrum, their focus on gender transition is fueled by their on-line activities, and the traditional treatment of "watchful waiting" combined with treating the other psychiatric conditions, as well as incorporating family therapy into our visits, has been helpful.

I also note that the literature on which treatment with puberty blockers and cross-sex hormones is based, is very thin. I don't believe this is a scientific basis for recommending social and medical treatment for minors.

Sincerely yours,

Lawrence J. Budner, M.D.

Lawrence J. Budner, M.D., F.A.A.C.A.P., F.A.P.A. 2101 N. Main St., Suite D Santa Ana, CA 92706
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From: [D.W](#)
To: [BOM Public Comment](#)
Subject: Gender dysphoria comments from an endocrinologist who has treated many
Date: Monday, October 24, 2022 9:21:21 PM
Attachments: [Dr Daniel Weiss .pdf](#)

You don't often get email from drdanweiss@gmail.com. [Learn why this is important](#)

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Please see my attached comments.

I strongly support Florida's efforts to protect minors from experimental medical interventions such as cross sex hormones, puberty blockers and surgery to remove normal body parts.

Thank you.

Daniel Weiss MD CDCES
Physician Nutrition Specialist
Board Certified: Diabetes/Endocrinology/Metabolism
Diplomate: American Board of Obesity Medicine

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I am a board-certified internist and endocrinologist. I have practiced in northern Ohio since 1986. I am also a Certified Physician Investigator. I have been the principal investigator for over 100 clinical trials involving both adults and children.

Physicians have 3 fundamental responsibilities: we must use our expertise to **diagnose** and to **care** for our patients. And we must be certain that our patients understand and fully **consent**.

Diagnosis of a medical condition is not delegated to the patient, because it requires expert medical evaluation. Physicians who see a child with distress, possibly related to gender, should not agree to the child's diagnosis any more than they would agree with a child who thinks he or she has diabetes or cancer.

Once the physician is confident in the diagnosis, he or she can weigh the best **care** or treatment for that patient. A cardinal principle is: "first do not harm".

Finally, physicians must obtain informed **consent**, especially for any experimental intervention. Ethical practice prohibits children from providing consent. Children cannot fully comprehend risks versus benefit, and at most can provide assent to a parental decision. Children must obtain consent from their legal guardian or parent for any medical treatment or surgery. Treatment for gender dysphoria should not be an exception to this requirement.

I stopped accepting new patients with gender dysphoria because I discovered that most had stories of traumatic childhoods and co-morbid depression. Most had inadequate psychologic evaluation before they were "cleared" for treatment. Hormonal treatment did not resolve those underlying psychologic issues.

Parents are often told if they fail to go along with hormonal interventions for their child with gender dysphoria, he or she will commit suicide. However, the best evidence proves this to be

completely false. A long-term study of adults in Sweden found that despite cross sex hormones and surgical reassignment surgery, there was a 19-fold higher suicide rate and a 3-fold higher overall mortality in transgender persons as compared to the control population.

The only study on hormonal treatment of gender dysphoria in minors is the so called the Dutch study. That study found no improvement in depression, anxiety or anger after treatment in a small group of 55 children.

To summarize, there are NO studies that demonstrate clear benefit with hormonal or surgical treatment for children with gender dysphoria. There is increasing evidence of harm with puberty blockers and cross sex hormones—damaging bone health, cardiovascular health and fertility. A paper published this year in the Endocrine Society's key journal described the evidence on hormonal interventions for "gender diverse adolescents" as sparse, of low quality and with potentially irreversible side effects.

And GnRH analogues, so called puberty blockers, are not FDA approved for treating gender dysphoria. All these facts mean that puberty blockers and cross sex hormones are experimental interventions for gender dysphoria. The SAFE Act aims to protect children from these experimental therapies.

There are an increasing number of people who were given hormonal or surgical treatment for gender dysphoria who later regret such treatment. I estimate that 75% of my adult patients failed to persist in their treatment with me. Recently, I saw a man who regretted having his testicles removed within one year of that surgery.

Reference List

1. Kaltiala R, Heino E, Tyolajarvi M, Suomalainen L. Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. Apr 2020;74(3):213-219. doi:10.1080/08039488.2019.1691260
2. Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;28(1):13-20. doi:10.3109/09540261.2015.1115754
3. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Langstrom N, Landen M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. Feb 22 2011;6(2):e16885. doi:10.1371/journal.pone.0016885
4. Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*. 2021;16(2):e0243894. doi:10.1371/journal.pone.0243894
5. D'Angelo R, Syrulnik E, Ayad S, Marchiano L, Kenny DT, Clarke P. One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria. *Arch Sex Behav*. Jan 2021;50(1):7-16. doi:10.1007/s10508-020-01844-2
6. Baram S, Myers SA, Yee S, Librach CL. Fertility preservation for transgender adolescents and young adults: a systematic review. *Hum Reprod Update*. Nov 5 2019;25(6):694-716. doi:10.1093/humupd/dmz026
7. Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. Jul 27 2021;34(7):937-939. doi:10.1515/jpem-2021-0180
8. Nota NM, Wiepjes CM, de Blok CJM, Gooren LJG, Kreukels BPC, den Heijer M. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*. Mar 12 2019;139(11):1461-1462. doi:10.1161/CIRCULATIONAHA.118.038584
9. Getahun D, Nash R, Flanders WD, et al. Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. Aug 21 2018;169(4):205-213. doi:10.7326/M17-2785
10. de Blok CJM, Wiepjes CM, van Velzen DM, et al. Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology*. 2021;9(10):663-670. doi:10.1016/s2213-8587(21)00185-6
11. O'Connell MA, Nguyen TP, Ahler A, Skinner SR, Pang KC. Approach to the Patient: Pharmacological Management of Trans and Gender-Diverse Adolescents. *J Clin Endocrinol Metab*. Jan 1 2022;107(1):241-257. doi:10.1210/clinem/dgab634

From: [DS MD](#)
To: [BOM Public Comment](#)
Subject: Gender care
Date: Monday, October 24, 2022 11:36:00 PM

You don't often get email from dschechtermd@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

I oppose anti-scientific politicized studies with predetermined outcomes that endangers the physical and mental health of children and instead call for true scientific research.

I believe that 'gender affirming care' has gotten way ahead of the science.

The evidence supports a social contagion phenomenon to explain the grouping of transgender kids, especially girls in certain schools and socioeconomic situations.

Assessment of gender dysphoria must be thorough and review all diagnostic options first, long before considering hormones or other irreversible medical and surgical approaches NOT supported by well documented research.

Truly,
David Schechter MD

From: [Carol Rogala](#)
To: [BOM Public Comment](#)
Subject: Medical Opinion regarding Gender Dysphoria
Date: Monday, October 24, 2022 2:37:43 PM

[You don't often get email from carolrogala23@gmail.com. Learn why this is important at <https://aka.ms/LearnAboutSenderIdentification>]

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To Who It May Concern:

First and foremost, any medical procedure that is elective and not a lifesaving emergency, should be discussed with and signed for by the legal parent of any minor. A minor should not have any legal authority to sign any consent form for any treatment, drug, injection, procedure, or surgery. There should be no exceptions to this.

Second, although Gender Dysphoria is a recognized diagnosis, it in no way mandates that injections, drugs, counseling, or any type of procedure, be it surgical or otherwise is the treatment.

Any type of coercion of a minor child that involves a discussion of permanent surgery, specifically the removal of sex organs and creation of gender altering appendages or hormone treatment is nothing less than child abuse.

LGBTQ+ clubs, phone lines on school websites and counselors should be banned from any school website, or printed matter, be it an email, text or other form of verbal or written discussion without full disclosure and written consent of the parent.

Regards,

Carol Rogala D.O., FACEP, FASAM

Sent from my iPad

From: drhammerman@gmail.com
To: [BOM Public Comment](#)
Subject: FW: Gender Dysphoria Hormone and Surgical Mistreatment
Date: Monday, October 24, 2022 5:05:58 PM

You don't often get email from drhammerman@gmail.com. [Learn why this is important](#)

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From: drhammerman@gmail.com <drhammerman@gmail.com>
Sent: Monday, October 24, 2022 4:57 PM
To: BOMPublicComment@flhealth.gov.
Subject: Gender Dysphoria Hormone and Surgical Mistreatment

I am writing in my capacity as a practicing Internist for over 40 years with extensive clinical experience.

Please consider:

1. There is no known gene or measurable laboratory parameter for the Gender Dysphoria (G.D.) condition
2. Accordingly, it is incorrect to label G.D. a medical disorder or disease.
3. As such, any labeling of self or someone as having G.D. is subjective, and subject to change based on knowledge and circumstances.
4. There are well-founded, longstanding psychologic and psychiatric disorders that are treated accordingly.
5. Gender Dysphoria, to the extent that it really exists within younger people, best fits in the realm of a psychologic and or psychiatric condition.
6. Other delusional conditions, such as anorexia nervosa and zoanthropy (where a person believes himself to be an animal) are treated for what they are, with cognitive and psychotropic therapy, not with surgery or medications aimed to irreversibly alter the physical body.
7. The general popular media explosion of articles about Gender Dysphoria should absolutely not distort the subject, nor control the narrative of what is its proper management and treatment.
8. G.D. patients are being subjected to unproven, irreversibly, hormone therapy and body-altering surgery. Simply put, this is harmful for those who can't or don't know better, and is gross malpractice.
9. That major medical organizations support any form of such treatment is of no consequence in this case. Such organizations supported lobotomies and other now-abandoned, ineffective, and harmful practices.
10. Please take a stand to protect those at risk from those advancing the distortion and misuse of Medicine and Surgery.

Stop this abuse before it affects more people, be it anyone, your constituents, or extended family.

Respectfully,

HILLEL S. HAMMERMAN, MD

DrHHammerman@gmail.com

From: [Jonathan Kates](#)
To: [BOM Public Comment](#)
Cc: reply@donoharmmedicine.org
Subject: "gender affirming care"
Date: Monday, October 24, 2022 11:51:51 AM

You don't often get email from jkatesmd@outlook.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

I have practiced over forty years in the field of Orthopaedic Surgery. While I do not treat children for gender dysphoria, I feel I can comment in general about potentially harmful treatment and disforming surgery being performed without proper grade I level study.

At best, use of puberty blockers and long term hormone in children is investigational. In other words experimental. Some proponents of this extreme treatment tell the patients and their parents that the effects are reversible. That is nonsense. For this reason alone, at least, there should be restrictions on who should be licensed to administer this treatment, and extremely close oversight. Someone has to tell these patients and their families the truth of irreversibility.

The fact that "top" and "bottom" surgery can be performed successfully is not in doubt. Surgeons can do remarkable things. However, **should** these mutilating procedures be performed on children is in great doubt. Again, some patients are told that this is reversible. Of course that is not true. The long term outcomes of these "gender affirming" procedures is unknown and could lead to horrendous consequences.

Activists and physicians motivated by profit have driven this harmful fad. These activists have also infiltrated formerly reliable organizations such as the AMA.

Since these venerable organizations have abandoned our axiom, by which all physicians should follow, "do no harm", I urge you to take up this rule when deciding whether Florida will protect our children, or let politicians and extremists take control away from parents and practicing physicians.

Jonathan Kates MD

October 24, 2022

To: Boards of Medicine and Osteopathic Medicine Joint Rules/Legislative Committee
From: Alberto Cairo PhD, Knight Chair and Associate Professor at the University of Miami

Dear board members,

I'm submitting the present letter and this recently published article
<https://www.thebulwark.com/the-people-he-needs-to-be-hurting/>
as my testimony. I'm also sending them both as PDF documents.

Your discussion on Friday, October 28, 2022 follows a request from Florida's Surgeon General, **Dr. Joseph A. Ladapo**. In this letter I'll be using him as a proxy for his team at the Department of Health. Because I'm the father of a minor diagnosed with gender dysphoria, I've thoroughly studied the same research about the benefits and possible side effects of youth gender-affirming care that Dr. Ladapo used in his request —and more. However, Dr. Ladapo and I have reached opposite interpretations.

Allow me first to discuss our respective qualifications. Dr. Ladapo holds an MD and PhD in Health Policy, but his work has been largely focused on cost-effectiveness analysis, particularly related to cardiovascular disease. He has no experience whatsoever in gender dysphoria or gender-affirming care. None.

I'm a PhD professor, chair, and an expert in the public understanding of statistics, science, and data visualization. I also have first-hand experience of what gender-affirming care looks like, which is very different to the caricatures, exaggerations, and carefully cherry-picked horror stories offered by extremist media.

Therefore, Dr. Ladapo and I are both reasonably qualified to assess research outside our respective areas of expertise. We're absolute equals. However, Dr. Ladapo's assessment of youth gender-affirming care might end up prevailing over mine. He may dictate what my family —and other families like mine— can or can't do. I find this prospect appalling and demeaning.

Dr. Ladapo claims that youth gender-affirming care should be banned as a treatment for gender dysphoria because there isn't "conclusive evidence" of its benefits. For the sake of brevity, I won't explain in depth why this statement is nonsense; I'll just say that evidence in many areas of medical research isn't —and won't ever be— fully "conclusive". Medical decisions are individualized, and always made under various degrees of uncertainty.

My interpretation of the most up-to-date research on gender dysphoria and gender-affirming care largely —but not entirely— aligns with every single major medical organization in this country: Current standards of care based on ever-evolving evidence are good enough for families to weigh uncertainties and make slow, deliberate, and cautious decisions about their children in conversation with their healthcare providers.

The state —meaning Dr. Ladapo, his DoH, and you, the Board of Medicine— ought not to interfere with this process by shrinking the range of choices families have. Or, much worse, by removing all choice.

Let me ask each of you, particularly those of you who have children: If you were in my position, and a type of healthcare your family might need one day were prohibited, wouldn't you be enraged by such blatant state overreach? As experts, wouldn't you feel insulted if another researcher who isn't more qualified than you to assess scientific evidence imposed his interpretation on you? Be honest; of course you would. I'm certain that you'd be where I am right now, writing a letter like this.

Dr. Ladapo and Governor Ron DeSantis like to boast about being advocates for parental rights and individual freedom. Unless both are being mightily hypocritical, they —and you, the Board of Medicine— must accept the rights of all parents to decide what is best for their children.

All the best,

A handwritten signature in black ink, appearing to read "Alberto Cairo", with a long, sweeping horizontal line extending to the right.

Alberto Cairo
Knight Chair at the University of Miami



CULTURE WAR

The People He Needs to Be Hurting

Understanding Ron DeSantis's crusade against transgender care.

by ALBERTO CAIRO · OCTOBER 24, 2022

There's a quote from a [2019 New York Times story](#) that haunts me to this day. The *Times* reporter was describing the negative economic impacts that President Donald Trump's [government shutdown](#) had on rural towns in the Florida Panhandle. A woman who had voted for Trump told the *Times*: "He [Trump]'s not hurting the people he needs to be hurting."

I remembered those words while reflecting on what the Florida Board of Medicine may do soon: [severely restrict or ban youth gender-affirming care](#). Today my son, a transgender boy, is among the "people he needs to be hurting"—though now the "he" is Governor Ron DeSantis, working through his [political hack](#) of a surgeon general, [Joseph Ladapo](#).

On October 28, the Florida Boards of Medicine and Osteopathic Medicine are [planning to discuss](#), and probably [confirm](#), [guidelines](#) that Ladapo issued in April prohibiting gender-affirming treatments for minors, including [social transitioning](#). Ladapo's recommendations are part of [a broader campaign against transgender care](#) which at times has been motivated by ignorance, zealotry, [and rank partisan politics](#).

Ladapo's guidelines, which go against [current standards](#) of care [used by all major medical organizations](#), are based on [cherry-picked](#) and [misrepresented](#) evidence as well as the testimony of [a few carefully chosen](#) anti-LGBTQ "[experts](#)." Ladapo's recommendations have already had a chilling effect on Florida hospitals; some have [stopped accepting new patients needing care for gender dysphoria](#) in anticipation of coming changes in state law.

The reason Ladapo is seeking to ban youth gender-affirming care is the "lack of conclusive evidence" of its benefits. This is one of the [oldest tricks](#) of [science deniers](#). Science—particularly medical and mental health science—is rarely "conclusive" in the sense of absolute certainty that Ladapo is using. Science—again, particularly medical and mental health science—is an ongoing process of managing uncertainties and trade-offs.

Research on gender-affirming care has many uncertainties, but a majority of up-to-date scholarship suggests that it is beneficial. As happens with any other medical treatment, there are potential side effects to puberty blockers—which have been used for decades with no public outrage about it—or hormone treatments that can be assessed and monitored for every person. From what research we have at the moment, their benefits outweigh possible side effects. And there are *no* negative medical side effects to social transitioning.

* * *

A handful of vocal right-wing grifters have been pushing the idea that youth gender-affirming care is some sort of free-for-all, where anything goes and there are no guidelines or best practices and the doctors are all woke activists.

This is not true. Let me tell you what youth gender-affirming care looks like based on my experience as a parent: It is a long, cautious, and individualized process that involves teams of therapists, psychologists, medical doctors, patients, and families. The recent book *A Girlhood*, by Carolyn Hays, is an excellent primer on what navigating this process looks like, and also on the fears and threats that families of transgender youth often endure.

Regret rates from gender-affirming care are small. There are people who have detransitioned, or wish to do so, and they should receive all the help they need. But the evidence suggests that there are many more people who'd benefit from the care that the Florida Board of Medicine may ban if it adheres to Ladapo's request. The fact that some people cease or revert treatments is not a reason to deny those treatments to a larger population.

Restricting gender-affirming care would take a broad brush to a complex reality. It would ignore differences between patients. And it would also deprive families of autonomy. I work at the intersection of data and scientific literacy, and I don't want someone as politically motivated as Joseph Ladapo to dictate what healthcare my family—or any other family—can or cannot access. I'd prefer to rely on actual standards and let families decide for themselves.

This is, after all, what “parents' rights” is all about.

* * *

The problem is that arguing about science, liberty, or autonomy is beside the point. What's happening in Florida has nothing to do with science; it's all about fueling political polarization. Ron DeSantis is a man of theoconservative and authoritarian inclinations, as his rhetoric and actions suggest, and he has presidential ambitions. He's also a keen observer of what his most ardent supporters want, such as the desire to attack those whose existence they find offensive while claiming that they do it for our own good.

Those who support DeSantis's crusade against families with trans kids should beware. History teaches that when you choose leaders to hurt people you hate, they eventually end up hurting the people you love, too.

Alberto Cairo

*Alberto Cairo is the Knight Chair in Visual Journalism at the University of Miami. He is the author of several books about statistics and visualization, including *How Charts Lie* (2019). Twitter: @AlbertoCairo.*

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From: [Jordan Rutledge](#)
To: [BOM Public Comment](#)
Subject: Science and History Supports Gender-Affirming Care
Date: Tuesday, October 18, 2022 5:17:21 PM

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Arguments of "protecting children" mean nothing when you blatantly ignore what the vast majority of experts and the children themselves are saying is ignored.

Restricting medical care for transgender individuals will undoubtedly put you on the wrong side of history. To do so would make you the same type of person as those who ignored and even stoked the flames of homophobia during the AIDS crisis, leading to stigmas against the gay community and thousands of unnecessary deaths, including my uncle's.

As a citizen of Florida, I demand the Florida Board of Medicine abandon all efforts to restrict access to gender-affirming care and ensure uninterrupted access to care for transgender and gender-diverse minors and adults throughout the state.

A robust body of research confirms the benefits, safety, and life-saving medical necessity of gender-affirming care. A Cornell University meta-analysis of 55 primary peer-reviewed research studies published from 1991 to 2017 found that "gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals."

Last year, the American Medical Association (AMA) formally urged governors to oppose state legislation that would prohibit medically necessary gender transition-related care for minor patients, calling such efforts "dangerous governmental intrusion into the practice of medicine." The AMA cited that "trans and non-binary gender identities are normal variations of human identity and expression" and that "evidence has demonstrated that forgoing gender-affirming care can have tragic consequences." Furthermore, the AMA asserted that "Decisions about medical care belong within the sanctity of the patient-physician relationship."

Additional policy statements and guidance from expert bodies of medical and mental health professionals, including the National Association of Social Workers, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Endocrine Society, the National Alliance on Mental Illness, and the United States Professional Association for Transgender Health recognize the evidence and myriad benefits of gender-affirming care and the importance and nature of the patient/provider relationship, which ensures clinically appropriate plans of care for each individual.

While Florida currently does not have state-specific standards for providing gender-affirming

care, that does not mean that such care is unregulated in the state. Providers follow extensive Standards of Care set by the World Professional Association for Transgender Health (WPATH). Developed over decades (beginning with Version 1 in 1979, with Version 8 released just this month) on the basis of sound research, ethical principles, and accumulated expert knowledge, these guidelines offer safeguards and insights for providing gender-affirming care for gender-diverse patients.

If Florida-specific standards of care are adopted, they must reflect the most current version of WPATH Standards of Care (Version 8), and be maintained and updated on an ongoing basis to reflect future updates to the WPATH Standards of Care.

Jordan Rutledge
jordieedits@gmail.com
4033 Mallard Point Court
Orlando, Florida 32810

From: [Patricia Faella](#)
To: [BOM Public Comment](#)
Subject: Gender Affirming Health Care
Date: Tuesday, October 18, 2022 5:29:32 PM

You don't often get email from protectourvulnerable@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Dear Florida Board of Medicine,
Good afternoon. Thanks for the board's commitment to Floridian's health care. My name is Patricia and writing from Protect Our Vulnerable. Teenagers need accessible care regarding improved mental health. We should draw the line at sex changes and if any hormone blockers might interfere with ability having families at a adult age. If a teenage can take a hormone blocker now have a family when fully grown for the sake of mental health care provide services. Thanks for listening.
Regards,



Patricia Ann Swaim Faella
Protect Our Vulnerable

From: [Mark Jones](#)
To: [BOM Public Comment](#)
Subject: Gender dysphoria
Date: Monday, October 24, 2022 11:56:38 AM

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At birth, each individual has the cell clusters in the hypothalamus that determine their gender-related preferences, including affinity for the same gender.
Initiating treatment at a young age to alter this is questionable, in view of how the individual is hard-wired in their brain.



**Florida Board of Medicine
Board Meeting**

**Marriott Fort Lauderdale Airport
166 North Compass Way
Fort Lauderdale, FL 33004
(954) 802-7543**

August 5, 2022

MEETING MINUTES

I. CALL TO ORDER

The meeting was called to order at 8:01 A.M. EST on Friday August 5, 2022, by Dr. David Diamond, M.D., Chair.

Participants in this public meeting were made aware that these proceedings were being recorded and that an audio file of the meeting would be posted to the Board's website.

A. ROLL CALL

Roll call was conducted by Cherise Strickland, Program Operations Administrator. Those present for all, or part of the meeting included the following:

Members Present:

David Diamond, M.D., Chair
Kevin Cairns, M.D., Vice-Chair
Scot Ackerman, M.D.
Ravi Chandra, M.D.
Amy Derick, M.D.
Patrick Hunter, M.D.
Luz Pages, M.D.
Eleonor Pimentel, M.D.
Hector Vila, M.D.
Michael Wasylik, M.D.
Zachariah Zachariah, M.D.
Nicole Justice, ESQ., Consumer Member

Members Absent:

Wael Barsoum, M.D.
Maria Garcia, Esq., Consumer Member
Nicholas Romanello, Esq., Consumer Member

Department of Health Prosecutors Present:

Chad Dunn, Esq. Kristen Suarez, Esq.
Kristen Summers, Esq. Andrew Pietrylo, Esq.
Hunter Pattison, Esq.

Staff Present:

Jenifer Wenhold, Division Director
John Wilson, General Counsel
Paul A. Vazquez, J.D., Executive Director
Edward Tellechea, Board Counsel
Cassandra Fullove, Paralegal
Bettye Cherise Strickland, Program Operations Administrator
Wendy Alls, Program Operations Administrator
Shaila Washington, Regulatory Supervisor
Cyra Williams, Regulatory Specialist III
Brad Dalton, Public Information Officer

Court Reporter:

Magnolia Court Reporting
Heather Howard
(888) 811-3048

B. OPENING REMARKS

Mr. Vazquez provided opening remarks. He reminded the audience that this is a publicly noticed meeting and is being recorded for the public record.

II. DISCIPLINARY CASE SCHEDULE

Jeng Y. Lin, M.D. – Settlement Agreement.....3

License Number: ME41890

(PCP: No current members)

Allegations of the Administrative Complaint: Violations of §458.331(1)(t)1, §458.331(1)(q), and §458.331(1)(m), F.S.

Action taken: A motion was made to accept the settlement agreement, seconded, and carried unanimously.

Costs: A motion was made to impose costs of \$5,000.00, seconded and carried unanimously.

Penalty imposed:

- Letter of concern.
- Fine \$5,000.
- Costs \$5,000.00
- CME – Laws, Rules, and Ethics (5 hours)
- Drug Course (5 hours)
- Records Course (3 hours)
- Risk Management (5 hours)
- Quality Assurance Consultation/Risk Management Assessment – Engage a certified professional independent risk manager to review Respondent’s current practice within 60 days, and to report the quality assurance report to the Board’s Probation Committee within six (6) months.

Jason J. H. Song, M.D. – Settlement Agreement.....6

License Number: ME123792

(PCP: Dr. Zachariah and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §456.072(1)(bb), F.S.

Action taken: A motion was made to accept the settlement agreement, seconded, and carried unanimously.

Costs: A motion was made to impose costs of \$1,941.38, seconded and carried unanimously.

Penalty imposed:

- Letter of Concern.
- Fine \$2,500.
- Costs \$1,919.81.
- CME - Lecture/Seminar on Wrong Site Surgeries to medical staff at an approved medical facility (1 hour).
- CME - Risk Management (5 hours).

Maxime J.M. Coles, M.D. – Settlement Agreement.....8

License Number: ME130590

(PCP Dr. Vila and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b) and §458.331(1)(kk), F.S.

Action taken: A motion was made to accept the settlement agreement, seconded, and carried unanimously.

Costs: A motion was made to impose cost of \$585.00, seconded, and carried unanimously.

Penalty imposed:

- Letter of concern.
- Fine \$1,500.
- Costs \$585.00.
- CME – Laws, Rules, and Ethics (5 hours).

Louis Gutierrez, M.D. – Settlement Agreement.....9

License Number: ME55602

(PCP: Dr. Vila)

Allegations of the Administrative Complaint: Violations of §458.331(1)(t)1, F.S.

Action taken: A motion was made to accept the settlement agreement, seconded, and carried unanimously.

Costs: A motion was made to impose cost of \$4,971.67, seconded, and carried unanimously.

Penalty imposed:

- Letter of concern.
- Fine \$4,000.
- Costs \$4,971.67.
- CME – Subjects related to Obstetrics and Gynecology, including discussions of hypoxic ischemic encephalopathy; Risk Management (5 hours).

Jennifer E. Payne, M.D. – Settlement Agreement.....22

License Number: ME118750

(PCP: Dr. Zachariah and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §456.072(1)(cc), F.S.

Action taken: A motion was made to accept the settlement agreement, seconded, and carried unanimously.

Costs: A motion was made to impose cost of \$3,309.63, seconded, and carried unanimously.

Penalty imposed:

- Letter of concern.
- Fine \$2,500.
- Costs \$3,309.63.

- CME - Risk Management (5 hours).
- Presentation of a one (1) hour lecture on Retained Foreign Bodies to medical staff at an approved medical facility within six (6) months of the date of the Final Order.

Raul D. D. Correa, M.D. – Recommended Order, Case Number 2021-21736.....1

Raul D. D. Correa, M.D. – Recommended Order, Case Number 2021-30940.....2

License Number: ME79321

(PCP: Dr. Pages and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §458.331(1)(nn), by violating §456.072(1)(ss), by committing an act that constitutes a violation of §794.011; §456.072(1)(v) through a violation of §456.063(1); §458.331(1)(j) as defined and/or prohibited in §458.329 through Rule 64B8-9.008. The same allegations were applied to both administrative complaint cases.

Dr. Diamond provided opening statements and instructions on how the proceedings would be conducted.

Dr. Correa was not present and was represented by Bruce Lamb, Esq.

Ms. Summers represented the Department.

Following opening remarks, Mr. Lamb proceeded summarizing their 35 exceptions to the proposed recommended order.

Action taken: Each exception was heard individually with respondent’s counsel and Department’s counsel given testimony. All 35 exceptions were denied by the Board by individual vote.

Ms. Summers requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact to the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion to adopt the Administrative Law Judge’s Conclusions of Law as the Board Conclusions of Law.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion that the Board enter a final order complying with the Administrative Law Judge’s recommendation of revocation of license, imposing a fine of \$10,000, and imposing cost for the investigation and prosecution of this case.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers request a motion to bifurcate the cost of the case and come back at later date for a cost motion.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Respondent’s counsel requested a stay pending a potential appeal. The Department requested the Board deny the request as the physician constitutes a danger to the public.

Action taken: A motion was made to deny the Respondent’s counsel’s request, seconded, and carried unanimously.

Penalty imposed:

- Revocation of license.

Jeffery D. Morgan, M.D. – Recommended Order.....28

License Number: ME103348

(PCP: No current members)

Dr. Diamond provided opening statements and instructions on how the proceedings would be conducted.

Dr. Morgan was not present and was not represented by counsel.

Mr. Dunn and Ms. Suarez represented the Department.

Following opening remarks, Ms. Suarez proceeded with summarizing the proposed recommended order and case details.

Ms. Suarez requested a motion to deny all of respondent’s exceptions due to §120, F.S., for failing to notate page number or paragraph of the exceptions.

Action taken: A motion was made to reject respondent’s exceptions in total, seconded, and carried unanimously.

Ms. Suarez requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact to the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion to adopt the Administrative Law Judge’s Conclusions of Law as the Board Conclusions of Law.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion that the Board enter a final order complying with the Administrative Law Judge’s recommendation of revocation of license and impose cost for the investigation and prosecution of this case.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion to impose costs of \$54,939.39.

Action taken: A motion was made to impose costs, seconded, and carried unanimously.

Penalty imposed:

- Revocation of license.
- Costs \$54,939.39.

John A. G. Sampson, M.D. – Settlement Agreement.....4

License Number: ME121890

(PCP: Mr. Romanello)

Allegations of the Administrative Complaint: Violations of §458.331(1)(t), F.S., §458.331(1)(nn), F.S. by violating Rule 64B88-9.009(2)(f), F.A.C., and §458.331(1)(k), F.S., and §458.331(1)(nn) and/or 458.328(1)(g) by violating Rule 64B8-9.001, F.A.C.

Dr. Sampson was present and was represented by Monica Felder, Esq.

Ms. Summers represented the Department.

After opening remarks and discussion, the following action was taken:

Action taken: A motion was made to reject the settlement agreement as presented, seconded, and carried unanimously.

Action taken: A motion was made to accept amended settlement agreement, seconded, and carried unanimously.

Respondent chose to respond to the agreement within 7 days of filing.

Penalty imposed:

- Fine \$20,000.
- Costs \$4,626.65.
- CME - Laws, Rules, and Ethics (5 hours).
- CME - Medical Records (5 hours).
- CME - Lecture/Seminar on complications related to liposuction and gluteal fat grafting at an approved medical facility (1 hour).
- Restriction on Practice – Permanently restricted from performing gluteal fat grafting.
- Restriction on Practice – Permanently restricted from serving as the Designed Physician of an office surgery center.
- Quality Assurance Consultation/Risk Management Assessment – Engage a certified professional independent risk manager to review Respondent's current practice within 60 days, and to report the quality assurance report to the Board's Probation Committee within six (6) months.

Herbert M. Bertram, III, M.D. – Settlement Agreement.....5

License Number: ME78271

(PCP: Dr. Zachariah and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §456.072(1)(bb), F.S.

Dr. Bertram was present and represented by Mandy Smith, Esq.

Ms. Suarez represented the Department.

After opening remarks and discussion, the following action was taken:

Action taken: A motion was made to accept the settlement agreement, seconded, and carried unanimously.

Penalty imposed:

- Letter of Concern.
- Fine \$7,500.

- Costs \$4,146.01.
- CME - Lecture/Seminar on Wrong Site Surgeries (1 hour).
- CME - Risk Management (5 hours).

Roger S. Gorman, M.D. – Settlement Agreement.....7

License Number: ME50540

(PCP: Dr. Chandra)

Allegations of the Administrative Complaint: Violations of §458.331(1)(t), F.S. and §458.331(1)(m), F.S.

Dr. Gorman was present and represented by Matthew M. Fischer, Esq.

Mr. Pietrylo represented the Department.

After opening remarks and discussion, the following action was taken:

Action taken: A motion was made to reject the proposed settlement agreement and amend the terms, seconded, and carried unanimously.

Action taken: A motion was made to accept the amended settlement agreement, seconded, and carried unanimously.

Respondent chose to respond to the agreement within 7 days of filing.

Penalty imposed:

- Letter of Reprimand.
- Fine \$10,000.
- Costs \$6,836.68.
- CME - Medical Records (3 hours).
- CME - Managing Hypotension During Surgical Procedures (10 hours).
- CME - Anesthesiology During Surgical Procedures (10 hours).
- CME - Risk Management (5 hours).
- Evaluation by Florida CARES, Center for Personalized Education for Professional (CPEP), the UC San Diego PACE program, or another equivalent program preapproved by the Board (within 9 months).
- Probation with direct supervision (until evaluation).

Yvelice A. Villaman-Bencosme, M.D. – Determination of Waiver.....10

License Number: ME64482

(PCP: Dr. Barsoum and Mr. Romanello)

Allegations of the Administrative Complaint: Violations of §458.331(1)(c), F.S.

Dr. Villaman-Bencosme was not present and not represented by counsel.

Mr. Dunn represented the Department.

Mr. Dunn requested a motion from the Board that no Election of Rights had been received and finding that Respondent waived his right to elect his avenue of resolution by failing to timely reply to the properly noticed Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact to the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Dunn requested a motion to adopt the Conclusions of Law.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion for imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Mr. Dunn request a motion for imposition of costs total \$554.97.

Action taken: A motion was made to impose costs, seconded, and carried unanimously.

Penalty imposed:

- Revocation of license.
- Costs \$554.97.

Kathleen A Cullen, M.D. – Determination of Waiver.....11

License Number: ME70549

(PCP: Dr. Wasylik and Mr. Romanello)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S.

Dr. Cullen was not present and not represented by counsel.

Mr. Pietrylo represented the Department.

Mr. Pietrylo requested a motion from the Board that no Election of Rights had been received and finding that Respondent waived his right to elect his avenue of resolution by failing to timely reply to the properly noticed Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pietrylo requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact to the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pietrylo requested a motion to adopt the Conclusions of Law.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pietrylo requested a motion for imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to reject the Departments recommended penalty, seconded, and carried unanimously.

Action taken: A motion was made to amend the penalty imposed, seconded, and carried unanimously.

Mr. Pietrylo requestion a motion for imposition of costs.

Action taken: A motion was made to waive costs, seconded, and carried unanimously.

Penalty imposed:

- Revocation of license.

Thomas D. Nielson, M.D. – Determination of Waiver.....12

License Number: ME124462

(PCP: Dr. Zachariah)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S. and §456.072(1)(w), F.S.

Dr. Nielson was not present and not represented by counsel.

Ms. Summers represented the Department.

Ms. Summers requested a motion from the Board that no Election of Rights had been received and finding that Respondent waived his right to elect his avenue of resolution by failing to timely reply to the properly noticed Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact to the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion to adopt the Conclusions of Law.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion for imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Ms. Summers requestion a motion for imposition of costs.

Action taken: A motion was made to waive costs, seconded, and carried unanimously.

Penalty imposed:

- Revocation of license.

Arthur D. Barnes, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....13

License Number: ME30183

(PCP: Dr. Wasylik and Mr. Romanello)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S. and §456.072(1)(w), F.S.

Dr. Barnes was not present and not represented by counsel.

Mr. Dunn represented the Department.

Mr. Dunn requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Mr. Dunn requested a motion to impose costs of \$109.85.

Action taken: A motion was made to waive costs, seconded, and carried unanimously.

Penalty imposed:

- Letter of Concern.

Joan C. McTigue, P.A. – Hearing Not Involving Disputed Issues of Material Fact.....14

License Number: PA1763

(PCP: Dr. Vila)

Allegations of the Administrative Complaint: Violations of §458.331(1)(s), F.S. and §456.072(1)(hh), F.S.

Ms. McTigue was not present and not represented by counsel.

Ms. Summers represented the Department.

Ms. Summers requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Ms. Summers requested a motion to impose costs of \$3,696.63.

Action taken: A motion was made to impose costs, seconded, and carried unanimously.

Penalty imposed:

- Fine \$5,000.
- Costs \$3,696.63.
- Respondent's license to practice medicine in the State of Florida is hereby SUSPENDED until such time as she demonstrates the ability to practice medicine with reasonable skill and safety.

Yao C. Ong, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....15

License Number: ME52118

(PCP: Dr. Wasylik and Mr. Romanello)

Allegations of the Administrative Complaint: Violations of §458.331(1)(t), F.S.

Dr. Ong was not present and represented by William D. Bonezzi, Esq.

Mr. Dunn represented the Department.

Mr. Dunn requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Bonezzi was recognized by Dr. Diamond and presented to testimony on behalf of Dr. Ong.

Mr. Dunn requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Mr. Dunn requested a motion to impose costs of \$6,242.84

Action taken: A motion was made to impose costs upon reinstatement of license, seconded, and carried unanimously.

Penalty imposed:

- Letter of concern.
- Fine \$5,000.
- Costs \$6,242.84 to be paid after the license is reinstated.
- CME - Risk Management (5 hours).
- CME - Pathological Interpretation & Diagnosis (3 hours).

Seth L. Matarasso, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....16

License Number: ME147296

(PCP: Dr. Zachariah and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S. and §456.072(1)(w), F.S.

Dr. Matarasso was not present and not represented by counsel.

Ms. Suarez represented the Department.

Ms. Suarez requested, on behalf of the Department, a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion for the imposition of penalty.

Following discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Ms. Suarez requested a motion to impose costs of \$91.54.

Action taken: A motion was made to impose costs, seconded, and carried unanimously.

Penalty imposed:

- Letter of concern.
- Fine \$1,000.
- Costs \$91.54.
- CME - Laws, Rules, and Ethics (5 hours).

Roy Hammonds, P.A. – Hearing Not Involving Disputed Issues of Material Fact.....17

License Number: PA9110400

(PCP: Dr. Zachariah and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S.

Mr. Hammonds was present and not represented by counsel.

Ms. Suarez represented the Department.

Ms. Suarez requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Hammonds presented his case before the Board.

Ms. Suarez requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Ms. Suarez requested a motion to impose costs of \$307.24.

Action taken: A motion was made to impose costs, seconded, and carried unanimously.

Penalty imposed:

- Letter of reprimand
- Fine \$1,000
- Costs \$307.24
- CME – Laws, Rules, and Ethics (5 hours).

Francesco Cabrera, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....18

License Number: ME64467

(PCP: No current members)

Allegations of the Administrative Complaint: Violations of §456.072(1)(II), F.S.

Dr. Cabrera was present and represented by Allen R. Grossman, Esq.

Mr. Dunn represented the Department.

Mr. Dunn requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Grossman was recognized by Dr. Diamond and presented testimony on behalf of Dr. Cabrera.

Mr. Dunn requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Dunn requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Mr. Dunn requested a motion to impose costs of \$61.03.

Action taken: A motion was made to waive cost, seconded, and carried unanimously.

Penalty imposed:

- Revocation of license.

Mircea A. Morariu, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....19

License Number: ME78844

(PCP: Mr. Romanello)

Allegations of the Administrative Complaint: Violations of §458.331(1)(c), F.S.

Dr. Morariu was present and not represented by counsel.

Mr. Pattison represented the Department.

Mr. Pattison requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pattison requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Dr. Morariu provided his testimony about his case.

Mr. Pattison requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pattison requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Mr. Pattison requested a motion to impose costs of \$4,052.90.

Action taken: A motion was made to waive cost, seconded, and carried unanimously.

Penalty imposed:

- Revocation of license.

Richard M. Wolff, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....20

License Number: ME36950

(PCP: Dr. Zachariah and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S. and §458.331(1)(kk), F.S.

Dr. Wolff was not present and not represented by counsel.

Ms. Suarez represented the Department.

Ms. Suarez requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Suarez requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Ms. Suarez requested a motion to impose costs of \$61.03.

Action taken: A motion was made to impose cost, seconded, and carried unanimously.

Penalty imposed:

- Letter of concern.
- Fine \$2,000.
- Costs \$61.03.
- CME – Laws, Rules, and Ethics (5 hours).

Weilee Yeh, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....21

License Number: ME72540

(PCP: Dr. Pimentel and Ms. Garcia)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S. and §456.072(1)(w), F.S.

Dr. Yeh was not present and not represented by counsel.

Ms. Summers represented the Department.

Ms. Summers requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Ms. Summers requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Ms. Summers requested a motion to impose costs of \$73.24.

Action taken: A motion was made to impose cost, seconded, and carried unanimously.

Penalty imposed:

- Letter of concern
- Fine \$2,000
- Costs \$73.24
- CME – Laws, Rules, and Ethics (5 hours)
- Respondent’s license to practice medicine in the State of Florida is hereby SUSPENDED until such time as he demonstrates to the Board that his license is unencumbered and free from any restrictions or conditions in any and all jurisdictions where he is licensed.

Jorge I. Gaviria, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....23
License Number: ME94318
(PCP: Dr. Ackerman and Mr. Romanello)

CONTINUED TO THE OCTOBER MEETING

Ted D. Friehling, M.D. – Hearing Not Involving Disputed Issues of Material Fact.....24
License Number: ME150732
(PCP: Dr. Pages)

Allegations of the Administrative Complaint: Violations of §458.331(1)(b), F.S. and §456.072(1)(w), F.S.

Dr. Friehling was not present and not represented by counsel.

Mr. Pietrylo represented the Department.

Mr. Pietrylo requested a motion to accept the exhibits of the case into evidence.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pietrylo requested a motion to adopt the allegations of fact in the Administrative Complaint as the findings of fact of the Board.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pietrylo requested a motion finding the respondent in violation of Florida Statutes as charged in the Administrative Complaint.

Action taken: A motion was made in the affirmative, seconded, and carried unanimously.

Mr. Pietrylo requested a motion for the imposition of penalty.

After discussion, the following action was taken:

Action taken: A motion was made to impose penalty, seconded, and carried unanimously.

Mr. Pietrylo requested a motion to impose costs of \$21.80.

Action taken: A motion was made to impose cost, seconded, and carried unanimously.

Penalty imposed:

- Costs \$21.80.
- CME – Laws, Rules, and Ethics (5 hours).
- Respondent’s license to practice medicine in the State of Florida is hereby **SUSPENDED** until such time as he demonstrates to the Board that his license is unencumbered and free from any restrictions or conditions in any and all jurisdictions where he is licensed.

Donald M. Botta, Jr., M.D. – Voluntary Relinquishment.....25

License Number: ME110682

(PCP: Dr. Pimentel)

Action taken: A motion was made to accept the voluntary relinquishment, seconded, and carried unanimously.

Robert Weinstein, M.D. – Motion to Vacate Final Order.....29

License Number: ME27163

Mr. Pietrylo represented the Department and provided an overview of the reasoning to vacate the final order.

Action taken: A motion was made to vacate the final order, seconded, and carried unanimously.

Jorge A. Gallo, M.D. – Petition for Modification of Final Order.....30

License Number: ME58146

(PCP: Dr. Vila)

Dr. Gallo was not present and represented by William Carcioppolo, Esq.

Mr. Pietrylo represented the Department.

After discussion, the following action was taken:

Action taken: A motion was made to deny the petition to amend the final order, seconded, and carried unanimously.

Andre M. Brooks, M.D. – Petition to Lift Practice Restriction (WITHDRAWN).....	31
License Number: ME59444	
(PCP: No current members)	

III. REPORTS & REMARKS (Part I)

Department Remarks.....	36
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Mr. Dunn presented an update to the Department’s staffing.

Mr. Pietrylo presented the Appellate Report and Year-Old Case Report to the Board members.

Action taken: A motion was made to continue the prosecution of one year old or older cases, seconded, and carried unanimously.

Chair Recognition Award.....	40
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- Daniel R. Bergholz – University of Miami Miller School of Medicine
- Allison Chin – Florida International University Herbert Wertheim College of Medicine
- Zaimary Meneses – Charles E. Schmidt College of Medicine at Florida Atlantic University
- Amr El-Talla – Nova Southeastern University College of Allopathic Medicine

IV. EXEMPTIONS

Timothy J. Davis, P.A. – AHCA Exemptions.....	33
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Mr. Davis’ counsel provided statements on behalf of Mr. Davis for the AHCA exemptions.

Action taken: A motion was made to accept the AHCA exemption, seconded, and carried unanimously.

Gilberto Vega, M.D. – AHCA Exemptions.....	34
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Dr. Vega provided statements for the AHCA exemptions.

Action taken: A motion was made to accept the AHCA exemption, seconded, and carried unanimously.

V. PETITION FOR DECLARATORY STATEMENT

Andres I. Beregovich, Esq. – RE: 64B8-9.009(2)(e), (f), F.A.C. Standard of Care for Office Surgery.....	32
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Mr. Beregovich provided statements for clarification for a declaratory statement on the referenced rule.

Action taken: A motion was made to deny the declaratory statement on grounds of lack of standing, seconded, and carried unanimously.

VI. DISCUSSION

Discussion on Letter from Dr. Joseph A. Ladapo, M.D. Ph.D., State Surgeon General, dated June 2, 2022, Related to Gender Dysphoria in Children and Adolescents.....	26
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Petition to Initiate Rulemaking Setting the Standard of Care for Treatment of Gender Dysphoria.....39

Mr. Vazquez provided statements on the conduct of the discussion and reminded everyone that this is a publicly noticed meeting and is being recorded.

Dr. Diamond provided opening statements on the purpose of the discussion.

Dr. Ladapo begin the discussion by thanking the Board for the work that has been done and that continues to be done. Dr. Ladapo provided the Board and public with statements regarding gender dysphoria.

Mr. Wilson was recognized to present the petition to initiate rulemaking setting the standard of care for the treatment of gender dysphoria. Mr. Wilson wanted to remind all in attendance that this is the start of the rulemaking process, and nothing will be set in rules based on this vote.

Dr. Diamond recognized Dr. Michael Haller, M.D., Pediatric Endocrinologist, to provided statements and present his research on gender dysphoria.

Dr. Diamond recognized Dr. Quentin Van Meter, M.D., Pediatric Endocrinologist, to provided statement and present his research on gender dysphoria.

After a robust discussion between the Board and the invited physicians, Dr. Diamond invited the public to make statements. Individuals were called randomly from the speaker cards completed prior to the discussion. There were multiple individuals who spoke for and against the petition.

After public comments, the following action was taken:

Action taken: A motion was made to accept the petition, seconded, and carried with one vote in opposition.

VII. REMARKS & REPORTS (Part II)

Board Chair's Remarks.....No tab

No comments.

Board Counsel's Remarks.....No tab

No comments.

Board Director's Remarks.....35

No comments.

Council on Physician Assistants Report.....No tab

Dr. Chandra provided the report from the July 28, 2022, Council of Physician Assistants meeting.

Action taken: A motion was made to approve the minutes, seconded, and carried unanimously.

Credentials Committee Report.....No tab

Dr. Ackerman provided the report from the August 4, 2022, Credentials Committee meeting.

Action taken: A motion was made to approve the minutes, seconded, and carried unanimously.

Boards of Medicine and Osteopathic Medicine's Joint Committee on Surgical Care/Quality Assurance Committee Report.....37

Dr. Cairns provided the report from the August 4, 2022, Joint Committee on Surgical Care/Quality Assurance meeting.

Action taken: A motion was made to approve the minutes, seconded, and carried unanimously.

Rules/Legislative Committee Report.....No tab

Dr. Zachariah was not present at the time of the report discussion.

Action taken: A motion was made to table the report, seconded, and carried unanimously.

Probation Committee Report.....No tab

Dr. Pages provided the report from the July 28, 2022, Probation Committee meeting.

Action taken: A motion was made to approve the minutes, seconded, and carried unanimously.

Finance & Process Accountability Meeting Report.....No tab

Ms. Justice provided the report from the July 28, 2022, Finance & Process Accountability meeting.

Action taken: A motion was made to approve the minutes, seconded, and carried unanimously.

Approval of Meeting Minutes.....27

Action taken: A motion was made to approve the minutes, seconded, and carried unanimously.

Ratification of Applicants Pursuant to Chapter 458, F.S.....38

Action taken: A motion was made to approve the ratification list of applicants, seconded, and carried unanimously.

VIII. OTHER BUSINESS

IX. NEW BUSINESS

Adjournment at 4:02 P.M. EST.

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

**Ron DeSantis**

Governor

Joseph A. Ladapo, MD, PhD

State Surgeon General

Vision: To be the Healthiest State in the Nation

June 2, 2022

Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Members of the Board,

On April 20, 2022, the Florida Department of Health (Department) released guidance on the treatment of gender dysphoria for children and adolescents. As State Surgeon General, I recommended against certain pharmaceutical, non-pharmaceutical, and surgical treatments for gender dysphoria. The recommendations are based on a lack of conclusive evidence and the high risk for long-term, irreversible harms from these treatments.

Since then, the Agency for Health Care Administration (Agency) has conducted a full review to determine if these treatments are "consistent with generally accepted professional medical standards (GAPMS) and not experimental or investigational." The Agency's review included an overview of systematic reviews on puberty blockers, cross-sex hormones, surgeries, or a combination of interventions.

While some professional organizations, such as the American Academy of Pediatrics and the Endocrine Society, recommend these treatments for "gender affirming" care, the scientific evidence supporting these complex medical interventions is extraordinarily weak. For instance, the overview conducted by Dr. Brignardello-Peterson and Dr. Wiercioch states that "there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria."

The current standards set by numerous professional organizations appear to follow a preferred political ideology instead of the highest level of generally accepted medical science. Florida must do more to protect children from politics-based medicine. Otherwise, children and adolescents in our state will continue to face a substantial risk of long-term harm.

The Agency ultimately concluded that "Available medical literature provides insufficient evidence that sex reassignment through medical interventions is a safe and effective treatment for gender dysphoria." I encourage the Board to review the Agency's findings and the Department's guidance to establish a standard of care for these complex and irreversible procedures.

Sincerely,

Joseph A. Ladapo, MD, PhD
State Surgeon General

Florida Department of Health**Office of the State Surgeon General**

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April 20, 2022

FLORIDA DEPARTMENT OF HEALTH RELEASES GUIDANCE ON TREATMENT OF GENDER DYSPHORIA FOR CHILDREN AND ADOLESCENTS



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Tallahassee, Fla. — Today, the Florida Department of Health released guidance regarding the treatment of gender dysphoria for children and adolescents. This guidance uses the most up-to-date scientific data available, and it prioritizes the overall health and well-being of Florida's children and adolescents. The [Department's guidance is available here](#).

"The federal government's medical establishment releasing guidance failing at the most basic level of academic rigor shows that this was never about health care," said State Surgeon General Joseph Ladapo. "It was about injecting political ideology into the health of our children. Children experiencing gender dysphoria should be supported by family and seek counseling, not pushed into an irreversible decision before they reach 18."

Countries such as Sweden, Finland, France, and the United Kingdom are currently reviewing, reevaluating, stopping, or advising caution on the treatment of gender dysphoria in children and adolescents.

The Department crafted this guidance using published and peer-reviewed data that calls into question the motives of the federal HHS. Guidance of this magnitude requires a full, diligent understanding of the scientific evidence.

The current evidence does not support the use of puberty blockers, hormone treatments, or surgical procedures for children and adolescents, considering:

- 80% of those seeking clinical care will lose their desire to identify with the non-birth sex,
- the importance of puberty to brain development, with the pre-frontal cortex (which is responsible for executive functions, such as decision making) continuing to develop until [approximately 25 years of age](#),
- and the potentially irreversible consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis.

Alongside the guidance released today, the [Department released a fact check that details the claims made by HHS, available here](#).

About the Florida Department of Health

The Florida Department of Health, nationally accredited by the [Public Health Accreditation Board](#), works to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

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Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

Treatment of Gender Dysphoria for Children and Adolescents

April 20, 2022

The Florida Department of Health wants to clarify evidence recently cited on a [fact sheet](#) released by the US Department of Health and Human Services and provide guidance on treating gender dysphoria for children and adolescents.

Systematic reviews on hormonal treatment for young people show a trend of [low-quality evidence](#), small sample sizes, and medium to high risk of bias. A paper published in the [International Review of Psychiatry](#) states that 80% of those seeking clinical care will lose their desire to identify with the non-birth sex. [One review concludes](#) that "hormonal treatments for transgender adolescents can achieve their intended physical effects, but **evidence regarding their psychosocial and cognitive impact is generally lacking.**"

According to the [Merck Manual](#), "gender dysphoria is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the sex assigned at birth."

Due to the lack of conclusive evidence, and the potential for long-term, irreversible effects, the Department's guidelines are as follows:

- [Social gender transition](#) should not be a treatment option for children or adolescents.
- Anyone under 18 should not be [prescribed puberty blockers](#) or [hormone therapy](#).
- [Gender reassignment surgery](#) should [not be a treatment option](#) for children or adolescents.
 - Based on the [currently available evidence](#), "encouraging mastectomy, ovariectomy, uterine extirpation, penile disablement, tracheal shave, the prescription of hormones which are out of line with the genetic make-up of the child, or puberty blockers, are all clinical practices which run an **unacceptably high risk of doing harm.**"
- Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider.

These guidelines do not apply to procedures or treatments for children or adolescents born with a genetically or biochemically verifiable [disorder of sex development](#) (DSD). These disorders include, but are not limited to, 46, XX DSD; 46, XY DSD; sex chromosome DSDs; XX or XY sex reversal; and ovotesticular disorder.

The Department's guidelines are consistent with the federal Centers for Medicare and Medicaid Services [age requirement for surgical and non-surgical treatment](#). These guidelines are also in line with the guidance, reviews, and [recommendations](#) from [Sweden](#), [Finland](#), the [United Kingdom](#), and [France](#).

Parents are encouraged to reach out to their child's health care provider for more information.

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Governor

Joseph A. Ladapo, MD, PhD

State Surgeon General

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Treatment of Gender Dysphoria for Children and Adolescents - Fact Check -

This fact check covers the claims made by the Health and Human Services (HHS) Offices of Population Affairs (OASH) [fact sheet](#).

HHS Claims that treatments including irreversible surgeries, such as mastectomies and penectomies, "improves mental health and overall well-being."

Facts:

- The [research used to support](#) cannot infer causation; the researchers state as much in the Limitations. The researchers stated, "it is possible that those who historically have higher rates of depression and suicidal thoughts and behaviors are also less able to seek or obtain GAHT [hormone treatment]."
- A [systematic review on hormonal treatment](#) of young people with gender dysphoria concludes that "low-quality evidence suggests that hormonal treatments for transgender adolescents can achieve their intended physical effects, but evidence regarding their psychosocial and cognitive impact are generally lacking." The cited evidence had small sample sizes and medium to high risk of bias.
- A [small study](#) on 44 patients in the United Kingdom failed to show any psychological benefit to puberty blockers on children aged 12 to 15.

HHS Claims that surgeries and other potentially permanent pharmaceutical interventions "have been demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life..."

Facts:

- A paper published in [International Review of Psychiatry](#) states that **80% of those seeking clinical care will lose their desire to identify with the non-birth sex.**
- The cited [psychosocial overview](#) is a **case study of a single patient**, and it outlines the authors' views.
- The [second article cited](#) is an online survey completed by 288 U.S. transgender adults, not children and adolescents.
- In May of 2021, Sweden's Karolinska Institute [suspended the use of puberty blockers](#) for those under the age of 18 due to the potentially irreversible consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis.

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- [According to a study in Neurolmage](#), “pubertal development was significantly related to structural volume in all six regions [in brain regions of interest] in both sexes,” meaning that the process of puberty is important to brain development.
- A November 2020 [systematic review published in Cochrane](#) “found insufficient evidence to determine the efficacy and safety of hormonal treatment for transgender women in transition.”

HHS Claims that their approach “is critical in fostering better outcomes.”

Facts:

- According to the [first resource cited](#) in the OHSA fact sheet, of “those who received [GAHT]... a greater proportion reported that they struggled to meet basic needs or were just able to meet them, compared to those who wanted GAHT but did not receive it.”
- “[A recent Finnish study](#)... reported on the effect of initiating cross-sex hormone therapy on functioning, progression of developmental tasks of adolescence, and psychiatric symptoms. This study found that during cross-sex hormone therapy, problems in these areas did not decrease”
- The second study cited in this section is partly refuted by the third. The third [study states](#) that “transitioning socially is beneficial for children with GD **could not be supported from the present results.**”

Conclusion:

The current evidence does not support the use of puberty blockers, hormone treatments, or surgical procedures for children and adolescents, considering:

- 80% of those seeking clinical care will lose their desire to identify with the non-birth sex,
- the importance of puberty to brain development, with the pre-frontal cortex (which is responsible for executive functions, such as decision making) continuing to develop until [approximately 25 years of age](#),
- and the potentially irreversible consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis.

**OASH**Office of
Population Affairs

Gender-Affirming Care and Young People

What is gender-affirming care?

Gender-affirming care is a supportive form of healthcare. It consists of an array of services that may include medical, surgical, mental health, and non-medical services for transgender and nonbinary people.

For transgender and nonbinary children and adolescents, early gender-affirming care is crucial to overall health and well-being as it allows the child or adolescent to focus on social transitions and can increase their confidence while navigating the healthcare system.

Why does it matter?

Research demonstrates that gender-affirming care improves the mental health and overall well-being of gender diverse children and adolescents.¹ Because gender-affirming care encompasses many facets of healthcare needs and support, it has been shown to increase positive outcomes for transgender and nonbinary children and adolescents. Gender-affirming care is patient-centered and treats individuals holistically, aligning their outward, physical traits with their gender identity.

Gender diverse adolescents, in particular, face significant health disparities compared to their cisgender peers. Transgender and gender nonbinary adolescents are at increased risk for mental health issues, substance use, and suicide.^{2,3} The Trevor Project's 2021 *National Survey on LGBTQ Youth Mental Health* found that 52 percent of LGBTQ youth seriously considered attempting suicide in the past year.⁴

A safe and affirming healthcare environment is critical in fostering better outcomes for transgender, nonbinary, and other gender expansive children and adolescents. Medical and psychosocial gender affirming healthcare practices have been demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life for transgender and gender diverse youth.^{5,6} Familial and peer support is also crucial in fostering similarly positive outcomes for these populations. Presence of affirming support networks is critical for facilitating and arranging gender affirming care for children and adolescents. Lack of such support can result in rejection, depression and suicide, homelessness, and other negative outcomes.^{7,8,9}

Common Terms:

(in alphabetical order)

Cisgender: Describes a person whose gender identity aligns with their sex assigned at birth.

Gender diverse or expansive: An umbrella term for a person with a gender identity and/or expression broader than the male or female binary. Gender minority is also used interchangeably with this term.

Gender dysphoria: Clinically significant distress that a person may feel when sex or gender assigned at birth is not the same as their identity.

Gender identity: One's internal sense of self as man, woman, both or neither.

Nonbinary: Describes a person who does not identify with the man or woman gender binary.

Transgender: Describes a person whose gender identity and/or expression is different from their sex assigned at birth, and societal and cultural expectations around sex.

Additional Information

- [Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline](#)
- [Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents | American Academy of Pediatrics](#)
- [Standards of Care \(SOC\) for the Health of Transsexual, Transgender, and Gender Nonconforming People | World Professional Association for Transgender Health](#)

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Gender-Affirming Care and Young People

Affirming Care	What is it?	When is it used?	Reversible or not
Social Affirmation	Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities	At any age or stage	Reversible
Puberty Blockers	Using certain types of hormones to pause pubertal development	During puberty	Reversible
Hormone Therapy	Testosterone hormones for those who were assigned female at birth	Early adolescence onward	Partially reversible
Gender-Affirming Surgeries	<p>Estrogen hormones for those who were assigned male at birth</p> <p>“Top” surgery – to create male-typical chest shape or enhance breasts</p> <p>“Bottom” surgery – surgery on genitals or reproductive organs</p> <p>Facial feminization or other procedures</p>	Typically used in adulthood or case-by-case in adolescence	Not reversible

Resources

- [Discrimination on the Basis of Sex | HHS Office of Civil Rights](#)
- [Lesbian, Gay, Bisexual, and Transgender Health | Healthy People 2030](#)
- [Lesbian, Gay, Bisexual, and Transgender Health: Health Services | Centers for Disease Control and Prevention](#)
- [National Institutes of Health Sexual & Gender Minority Research Office](#)
- [Family Support: Resources for Families of Transgender & Gender Diverse Children | Movement Advancement Project](#)
- [Five Things to Know About Gender-Affirming Health Care | ACLU](#)
- [Gender-Affirming Care is Trauma-Informed Care | The National Child Traumatic Stress Network](#)
- [Gender-Affirming Care Saves Lives | Columbia University](#)
- [Gender Identity | The Trevor Project](#)
- [Genderspectrum.org](#)
- [Glossary of Terms | Human Rights Campaign](#)
- [Health Care for Transgender and Gender Diverse Individuals | ACOG](#)
- [Transgender and Gender Diverse Children and Adolescents | Endocrine Society](#)

¹ Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2021). Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health*, 70(4). <https://doi.org/https://doi.org/10.1016/j.jadohealth.2021.10.036>

² Rimes, K., Goodship N., Ussher, G., Baker, D. and West, E. (2019). Non-binary and binary transgender youth: Comparison of mental health, self-harm, suicidality, substance use and victimization experiences. *International Journal of Transgenderism*, 20 (2-3); 230-240.

³ Price-Feeney, M., Green, A. E., & Dorison, S. (2020). Understanding the mental health of transgender and nonbinary youth. *Journal of Adolescent Health*, 66(6), 684–690. <https://doi.org/10.1016/j.jadohealth.2019.11.314>

⁴ Trevor Project. (2021). *National Survey on LGBTQ Youth Mental Health 2021*. Trevor Project. <https://www.thetrevorproject.org/survey-2021/>.

⁵ Wagner J, Sackett-Taylor AC, Hodax JK, Forcier M, Rafferty J. (2019). Psychosocial Overview of Gender-Affirmative Care. *Journal of pediatric and adolescent gynecology*, (6):567-573. doi: 10.1016/j.jpag.2019.05.004. Epub 2019 May 17. PMID: 31103711.

⁶ Hughto JMW, Gunn HA, Rood BA, Pantalone DW. (2020). Social and Medical Gender Affirmation Experiences Are Inversely Associated with Mental Health Problems in a U.S. Non-Probability Sample of Transgender Adults. *Archives of sexual behavior*, 49(7):2635-2647. doi: 10.1007/s10508-020-01655-5. Epub 2020 Mar 25. PMID: 32215775; PMCID: PMC7494544.

⁷ Brown, C., Porta, C. M., Eisenberg, M. E., McMorris, B. J., & Sieving, R. E. (2020). Family relationships and the health and well-being of transgender and gender-diverse youth: A critical review. *LGBT Health*, 7, 407-419. <https://doi.org/10.1089/lgbt.2019.0200>

⁸ Seibel BL, de Brito Silva B, Fontanari AMV, Catelan RF, Bercht AM, Stucky JL, DeSousa DA, Cerqueira-Santos E, Nardi HC, Koller SH, Costa AB. (2018). The Impact of the Parental Support on Risk Factors in the Process of Gender Affirmation of Transgender and Gender Diverse People. *Front Psychol*, 27:9:399. doi: 10.3389/fpsyg.2018.00399. Erratum in: *Front Psychol*. 2018 Oct 12;9:1969. PMID: 29651262; PMCID: PMC5885980.

⁹ Sievert ED, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I. (2021). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria. *Clin Child Psychol Psychiatry*, 26(1):79-95. doi: 10.1177/1359104520964530. Epub 2020 Oct 20. PMID: 33081539.

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Gender-Affirming Care for Transgender and Gender Diverse People

What is gender-affirming care?

Gender-affirming care is a supportive form of healthcare. It consists of an array of services that may include medical, surgical, mental health, and non-medical services for transgender and nonbinary people.

FALSE

Most children identifying as transgender will detransition following the onset of puberty.

For transgender and nonbinary children and adolescents, early gender-affirming care is crucial to overall health and well-being as it allows the child or adolescent to focus on social transitions and can increase their confidence while navigating the healthcare system.

Truth**Common Terms:**
(in alphabetical order)

Cisgender: Describes a person with their sex assigned at birth.

Gender diverse or expansive: An umbrella term for a person with a gender identity and/or expression broader than the male or female binary. Gender minority is also used interchangeably with this term.

Gender dysphoria: Clinically significant distress that a person may feel when sex or gender assigned at birth is not the same as their identity.

Gender identity: One's internal

Why does it matter?

Research demonstrates that gender-affirming care improves the mental health and overall well-being of gender diverse children and adolescents.¹ Because gender-affirming care encompasses many facets of healthcare needs and support, it has been shown to increase positive outcomes for transgender and nonbinary children and adolescents.

Gender-affirming care is patient-centered and treats individuals holistically, aligning their outward, physical traits with their gender identity.

Truth

"Gender affirming" care is not the standard of care. It consists of experimental and investigational medical treatments that will cause irreversible changes and long-term side

MISLEADING

effects. Transgender and gender diverse adolescents, in particular, face significant health disparities compared to their cisgender peers. Transgender and gender nonbinary adolescents are at increased risk for mental health issues, substance use, and suicide.^{2,3} The Trevor Project's 2021 *National Survey on LGBTQ Youth Mental Health* found that 52 percent of LGBTQ youth seriously considered attempting suicide in the past year.⁴

Nonbinary: Describes a person who does not identify with the man or woman gender binary.

Transgender: Describes a person whose gender identity and or expression differs from their sex assigned at birth, and societal and cultural expectations around sex.

LOW QUALITY

No reliable evidence shows that gender dysphoria significantly increases the risk of suicide.

Healthcare environments increases the risk of suicide. Outcomes for transgender, nonbinary, and other gender expansive children and adolescents. Medical and psychosocial gender affirming healthcare practices have been demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life for transgender and gender diverse youth.^{5,6} Familial and peer support is also crucial in fostering similarly positive outcomes for these populations. Presence of affirming support networks is critical for facilitating and arranging gender affirming care for children and adolescents. Lack of such support can result in rejection, depression and homelessness.^{7,8}

Truth**Truth****FALSE**

No high — or even moderate — quality studies exist demonstrating the long-term benefits of "gender affirming" care. In fact, evidence to the contrary show that these treatments worsen mental health and increase suicidality.

Additional Information

- [Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline](#)
- [Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents | American Academy of Pediatrics](#)
- [Standards of Care \(SOC\) for the Health of Transsexual, Transgender, and Gender Nonconforming People | World Professional Association for Transgender Health](#)

The references that AAP cites as the basis for its policy outright contradict that policy and instead repeatedly endorse

The Appraisal of Guidelines for Research and Evaluation ("AGREE II") method *unanimously* recommended *against* the WPATH guidelines.

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Gender Affirming Care and Young People

Truth

There is no verifiable research showing the safety of puberty blockers for non-FDA approved uses. Nor do any studies *guarantee* the reversibility in this age group. Rather, evidence shows that normal bone density cannot fully be reestablished.

Affirming Care	What is it?	When is it used?	Reversible or not
Social Affirmation	Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities	At any age or stage	Reversible
Puberty Blockers	Using certain types of hormones to pause pubertal development	During puberty	Reversible
Hormone Therapy	Testosterone hormones for those who were assigned female at birth Estrogen hormones for those who were assigned male at birth	Early adolescence onward	Partially reversible
Gender-Affirming Surgeries	"Top" surgery – to create male-typical chest shape or enhance breasts "Bottom" surgery – surgery on genitals or reproductive organs Facial feminization or other procedure	Typically used in adulthood or case-by-case in adolescence	Not reversible

FALSE

MISLEADING

Truth

The use of cross-sex hormones can cause permanent infertility.

Lack of credible evidence for adults and children.

Resources

- [Discrimination on Basis of Sex | HHS Office of Civil Rights](#)
- [Lesbian, Gay, Bisexual, and Transgender Health | Healthy People 2030](#)
- [Lesbian, Gay, Bisexual, and Transgender Health: Health Services | Centers for Disease Control and Prevention](#)
- [National Institute of Minority Health and Health Disparities | Minority Research Office](#)
- [Federal Support: Research and Statistics on Gender & Gender Diverse Children | Department of Health and Human Services](#)
- [Know About: Gender Affirming Care | ACLU](#)
- [The Endocrine Society's Clinical Guidelines for the Use of Sex Reassignment Hormones | Endocrine Society](#)
- [Glossary of Terms | Endocrine Society](#)
- [Health Care for Transgender and Gender Diverse Individuals | Endocrine Society](#)
- [Transgender and Gender Diverse Individuals | Endocrine Society](#)

The Endocrine Society concedes that its practice guidelines for sex reassignment treatment do *not* constitute a "standard of care" and that its grades for available services are low or very low quality.

LOW QUALITY

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- Green, A. E., DeChants, J. P., Price, M. E., & Bailey, M. (2020). Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender Youth. *Journal of Adolescent Health*, 70(4). <https://doi.org/10.1016/j.jadohealth.2020.04.001>
- Rimes, K., Goodship N., Ussher, G., Baker, D. and West, E. (2020). Transgender youth: Comparison of mental health, self-harm, suicidality, substance use and victimization experiences. *International Journal of Transgenderism*, 20 (2-3): 230-240.
- Price-Feeney, M., Green, A. E., & Dorison, S. (2020). Understanding the mental health of transgender and nonbinary youth. *Journal of Adolescent Health*, 66(6), 684–690. <https://doi.org/10.1016/j.jadohealth.2019.11.311>
- Trevor Project. (2021). *National Survey on LGBTQ Youth Mental Health 2021*. Trevor project. <https://www.thetrevorproject.org/survey-2021/>
- Wagner J, Sackett-Taylor AC, Hodax JK, Forcier M, Rafferty J. (2019). Psychosocial Overview of Gender-Affirmative Care. *Journal of pediatric and adolescent gynecology*, (6):567-573. doi: 10.1016/j.jpag.2019.05.004. Epub 2019 May 17. PMID: 31103711.
- Hughto JMW, Gunn HA, Rood BA, Pantalone DW. (2020). Social and Medical Gender Affirmation Experiences Are Inversely Associated with Mental Health Problems in a U.S. Non-Probability Sample of Transgender Adults. *Archives of sexual behavior*, 49(7):2635-2647. doi: 10.1007/s10508-020-01655-5. Epub 2020 Mar 25. PMID: 32215775; PMCID: PMC7494544.
- Brown, C., Porta, C. M., Eisenberg, M. E., McMorris, B. J., & Sieving, R. E. (2020). Family relationships and the health and well-being of transgender and gender-diverse youth: A critical review. *LGBT Health*, 7, 407-419. <https://doi.org/10.1089/lgbt.2019.0200>
- Seibel BL, de Brito Silva B, Fontanari AMV, Catelan RF, Bercht AM, Stucky JL, DeSousa DA, Cerqueira-Santos E, Nardi HC, Koller SH, Costa AB. (2018). The Impact of the Parental Support on Risk Factors in the Process of Gender Affirmation of Transgender and Gender Diverse People. *Front Psychol*, 27:9:399. doi: 10.3389/fpsyg.2018.00399. Erratum in: *Front Psychol*. 2018 Oct 12;9:1969. PMID: 29651262; PMCID: PMC5885980.
- Sievert ED, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I. (2021). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria. *Clin Child Psychol Psychiatry*, 26(1):79-95. doi: 10.1177/1359104520964530. Epub 2020 Oct 20. PMID: 33081539.

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REVIEW ARTICLE

Gender dysphoria in childhood

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ABSTRACT

Gender dysphoria (GD) in childhood is a complex phenomenon characterized by clinically significant distress due to the incongruence between assigned gender at birth and experienced gender. The clinical presentation of children who present with gender identity issues can be highly variable; the psychosexual development and future psychosexual outcome can be unclear, and consensus about the best clinical practice is currently under debate.

In this paper a clinical picture is provided of children who are referred to gender identity clinics. The clinical criteria are described including what is known about the prevalence of childhood GD. In addition, an overview is presented of the literature on the psychological functioning of children with GD, the current knowledge on the psychosexual development and factors associated with the persistence of GD, and explanatory models for psychopathology in children with GD together with other co-existing problems that are characteristic for children referred for their gender. In light of this, currently used treatment and counselling approaches are summarized and discussed, including the integration of the literature detailed above.

ARTICLE HISTORY

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KEYWORDS

Gender identity; gender dysphoria; childhood; psychosexual development; persistence; treatment

Introduction

Children can vary in the extent to which they show gender role expressions, behaviours, interests, and preferences. For most children these expressions are largely congruent with their experience of being male or female – their gender identity – and in line with the gender assigned at birth. This is in contrast to children who experience gender dysphoria (GD). These children show extreme and enduring forms of gender nonconforming/gender variant behaviours, preferences, and interests because they do not identify with their birth-assigned gender. Because of the incongruence between their assigned gender and experienced gender, these children may experience clinically significant distress and are consequently often in need of clinical attention (American Psychiatric Association, 2013).

Although there has been much opposition against diagnosing GD in prepubescent children, primarily due to the stigmatizing effect of having a mental disorder (e.g. Drescher, 2013), the condition is included in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013) as well as in the *International Classification of Diseases* (ICD-10; World Health Organization, 1992). The World Health Organization

(WHO) is, however, in the process of revising the tenth version of the ICD; but instead of removal of the childhood diagnosis the terminology will most likely be changed from ‘gender identity disorder of childhood’ into ‘gender incongruence of childhood’ (Drescher, Cohen-Kettenis, & Winter, 2012).

According to the DSM-5, a diagnosis of GD of childhood can be made if a child experiences a marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by six out of eight criteria. One *sine qua non* criterion must be the experience of a strong desire to be of another gender or an insistence to be another gender. In addition to this, there are two criteria focusing on anatomic dysphoria; a dislike of one’s sexual anatomy and the desire for primary/secondary sex characteristics of the experienced gender. In addition there are five behavioural criteria. The behavioural criteria concern the preference for cross-dressing; adopting cross-gender roles in fantasy play; a strong preference for toys, games and activities of the other gender; a preference for playmates of the other gender; and a strong aversion or rejection of typically gender congruent roles, interests, preferences and behaviours. Furthermore, the condition is associated with clinically

significant distress or impairment in social, school, or other important areas of functioning (American Psychiatric Association, 2013).

Valid information on the prevalence of childhood GD is not available yet due to the absence of formal prevalence studies. An estimate of the prevalence of gender nonconforming/gender variant behaviours can, however, be made on the basis of studies where the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1983) was used. On the CBCL – a parent-report questionnaire on behavioural problems – two items are related to gender variance: Item 5 ('Behaves like opposite sex') and item 110 ('Wishes to be of opposite sex'). Information from the Dutch normative sample of the CBCL shows that in children, both items are more frequently endorsed by parents of girls than of boys; 'Behaves like opposite sex' in 2.6% of the boys and 5.0% of the girls, 'Wishes to be of opposite sex' in 1.4% of the boys and 2.0% of the girls (Verhulst, van der Ende, & Koot, 1996). These findings are in concordance with data from the normative sample of the CBCL in North-America (Achenbach & Edelbrock, 1981; Zucker, Bradley, & Sanikhani, 1997), and are largely replicated in a study of Dutch twins ($N=23,393$) at ages 7 and 10 (Van Beijsterveldt, Hudziak, & Boomsma, 2006). Therefore, gender variance/gender nonconformity seems to be present in a small percentage of children and is more prominent in girls than in boys.

Interestingly, from what we know about the referrals to specialized gender identity clinics, the sex ratios for referred prepubescent children have always been in favour of natal men, which may be a direct effect of a difference in increased acceptance of masculinity in girls compared to femininity in boys (e.g. Blakemore, 2003; Cohen-Kettenis et al., 2003; Steensma et al., 2014; Wallien, Veenstra, Kreukels, & Cohen-Kettenis, 2010; Zucker, Wilson-Smith, Kurita, & Stern, 1995). Over the last decades the reported sex ratios have, however, gradually changed. For example, in the period before 2000 the ratio between boys and girls was 5.75:1 in Canada and 2.93:1 in the Netherlands (Cohen-Kettenis et al., 2003). In the period after 2000, the sex ratios decreased in Canada to 3.41:1 (2008–2011) for boys and girls respectively (Wood et al., 2013); and a similar pattern was observed in the Netherlands with a sex ratio of 1.68:1 between 2008 and 2011 (Steensma, 2013). For both countries this change in ratios is caused by fewer referrals of boys. Although empirical evidence is currently not available, the decrease of referrals in boys may indicate an increasing tolerance over time towards gender nonconforming behaviours in both countries.

Psychological functioning, social tolerance, and other co-existing problems

Besides the gender nonconforming presentation, children with GD who are referred to clinical settings have been shown to be more psychologically vulnerable in comparison to non-referred controls (Bates, Bentler, & Thompson, 1973, 1979) and in comparison to the general population (e.g. Cohen-Kettenis et al., 2003; Singh, Bradley, & Zucker, 2011; Steensma et al., 2014). Furthermore, these studies show that these psychological problems are more of an internalized nature (such as depression, social withdrawal, and anxiety), instead of an externalizing nature (such as aggression) (Bates et al., 1973, 1979; Coates & Person, 1985; Rekers & Morey, 1989; Zucker & Bradley, 1995; Cohen-Kettenis et al., 2003; Steensma et al., 2014). However, as Zucker, Wood, and VanderLaan (2014) recently concluded from their summary of studies reporting on the psychological functioning of gender-referred children, there is a considerable variability across the different studies. For example, the percentage of clinical-range cases reported in studies using the total behaviour problem score of the CBCL, ranged from 12.5% up to 84% of the described children over the different studies (for an overview see Zucker et al., 2014).

To understand this association between GD and the variability of psychological functioning within the population of children with GD, the empirical literature indicates the effect is largely mediated through social (in)tolerance towards gender nonconformity/gender variance. Indeed, a wide range of studies in children from the general population showed that gender nonconforming behaviour is often evaluated negatively by other children (e.g. Carter & McCloskey, 1984; Levy, Taylor, & Gelman, 1995; Ruble et al., 2007; Signorella, Bigler, & Liben, 1993; Stoddart & Turiel, 1985). Peer relations in general are therefore poorer for clinically referred children with GD than for non-referred children/youth (e.g. Cohen-Kettenis et al., 2003; Zucker et al., 1997, 2012); and, as we might expect, poor peer relations are associated with a negative well-being and poor psychological functioning in children with GD (e.g. Cohen-Kettenis et al. 2003; Steensma et al., 2014). Consequently the variability in psychological functioning detailed within the literature is likely inversely correlated with the intensity of social intolerance experienced by the children with GD. For example, a cross-national study between children referred for their gender from Canada and from the Netherlands showed a much higher prevalence of emotional and behavioural problems in the Canadian children than in the Dutch children. Interestingly, quality of peer relations rather

than IQ, parental social class, marital status, or ethnicity, turned out to be the strongest predictor in both countries. Furthermore, the quality of peer relations was lower in Canada than in the Netherlands. This indicates that psychological functioning is highly dependent upon how gender nonconformity is accepted within a certain culture or environment (Steensma et al., 2014).

However, this may not be the only factor that results in poorer psychological functioning. Over the years other models postulated in the literature focused, for example, upon generic risk factors for psychopathology and behavioural problems (such as parental psychopathology, social class background) in relation to GD; and considered them as an inherent cause of psychological problems in children with GD. Evidence for these relations is, however, still scarce and both models are under-studied in comparison to other factors such as social (in)tolerance (Zucker et al., 2014).

As far as co-occurring problems in children with GD are concerned, the relationship between Autistic Spectrum Disorders (ASD) and GD is important to mention. Although there are few studies investigating the relationship between the two, one study by de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers (2010) showed that in a sample of 108 gender-referred children ASD was present in 6.4% of the children. This is significantly higher than the prevalence of 0.6–1% of ASD in the general population (Fombonne, 2005). Corresponding with these findings, a study by VanderLaan et al. (2015) of children referred for gender studied obsessional interests – which may be an indication of ASD – and showed that obsessions were more frequently reported by children referred for their gender in comparison with the general population. With regard to how ASD and GD are related, the question arises as to whether GD is an expression of ASD, or whether ASD is a symptom of GD; alternatively, of course, the two may be present without being related to each other (see van der Miessen et al., this issue).

Psychosexual development and related factors for persistence of GD

A central question in the counselling of children with GD is what their psychosexual outcome will be. Will the child grow up and identify as a gay man, lesbian woman, bisexual man or woman, or heterosexual man or woman without experiencing feelings of gender incongruence which require any intervention; or will the child need medical treatment in the future because the gender dysphoric feelings will persist and further intensify?

To date, there are 10 prospective follow-up studies described in the literature, together reporting on 317 gender nonconforming children who were followed-up in adolescence or early adulthood. The follow-up information in Zucker & Bradley (1995) is not included in this summary. In personal correspondence with Dr. Zucker it became clear that the 45 cases described are also included in the samples of Drummond, Bradley, Peterson-Badali, & Zucker (2008) (5 natal girls) and Singh (2012) (40 natal boys).

The conclusion from these studies is that childhood GD is strongly associated with a lesbian, gay, or bisexual outcome and that for the majority of the children (85.2%; 270 out of 317) the gender dysphoric feelings remitted around or after puberty (see Table 1).

However, there may be a number of arguments to nuance this high percentage of desistence. As is shown in Table 1 there is much variation in the reported persistence rates between the studies, ranging from 2% to 39%. Interestingly the studies before the year 2000 reported much lower persistence rates in comparison to the more recent studies after the year 2000. Furthermore, the persistence rates reported in two Canadian studies (Drummond et al., 2008; Singh, 2012) were identical (12%) but clearly lower in comparison to the follow-up study by Wallien & Cohen-Kettenis (2008) from the Netherlands. The explanation for these differences may be threefold:

First, the variation in intensity of GD in the children included differs across studies: The lower persistence rates in the earlier studies, compared to the more recent studies after 2000, may be the result of the inclusion of less extreme cases in the earlier studies than in later studies. For example, before the publication of DSM-III in 1980 there was no formal diagnosis of GD for children (Drescher, 2014). It could therefore be that the children included in the studies before 1980 would in retrospect not meet the full criteria for a diagnosis. Also, the recent

Table 1. Follow-up studies in children with GD.

Study	Sample	Age at follow-up (range)	Persistence rate
Bakwin (1968) Lebovitz (1972) Zuger (1984) Money & Russo (1979) Davenport (1986) Kosky (1987)	55 natal boys	13–36	9% (5 out of 55)
Green (1987)	44 natal boys	19 (14–24)	2% (1 out of 44)
Drummond et al. (2008)	25 natal girls	23 (15–37)	12% (3 out of 25)
Wallien & Cohen-Kettenis (2008) Singh (2012)	40 natal boys 14 natal girls 139 natal boys	19 (16–28) 21 (13–39)	39% (21 out of 54) 12% (17 out of 139)

studies consisted of clinically referred samples of children, which was not the case for the earlier studies. For example, in the study by Green (1987) the sample of feminine boys was recruited through advertisement.

Secondly, and in line with the intensity explanation, there are possible cultural differences in referral: As described earlier, the sex ratios of child referrals in Canada are historically in greater favour of boys than girls as compared to the Netherlands. This may indicate that femininity in boys is experienced as more problematic in Canada –resulting in more referrals of boys with less extreme GD than in the Netherlands. As a result, the persistence rates are higher in the Netherlands compared to Canada.

Thirdly, we can consider the time of follow-up: As can be seen in Table 1, the time of follow-up differed across the studies and one could hypothesize that the studies with a later follow-up age (of older adolescents or adults) and those having a longer follow-up time, would report higher persistence rates than the studies where the follow-up took place at a younger age (i.e. shorter follow-up time). This trend is however not observed over the reported studies. To test this hypothesis, Steensma & Cohen-Kettenis (2015) recently published a report on the first 150 childhood cases from Amsterdam, the Netherlands, and checked whether a longer follow-up period would result in higher persistence rates. The children were at the time of first assessment – between 5 to 12 years old and between 19 to 38 years of age at the time of follow-up. Out of the 150 cases, 40 re-entered the clinic during adolescence (12–18 years of age) and turned out to be persisters (26.7%). However, after checking the files of the adult clinic (which sees nearly all adults with gender dysphoria in the Netherlands), it appeared that five individuals applied for treatment after the age of 18, raising the persistence rate to 30% and showing the importance of long-term follow-ups. Based on this information, it seems reasonable to conclude that the persistence of GD may well be higher than 15%. However, desistence of GD still seems to be the case in the majority of children with GD.

Two other clinically relevant questions are (1) whether we know anything with regard to the factors that are associated with the persistence or desistence of childhood GD and (2) how the process of persistence or desistence is experienced.

As to the factors associated with the persistence of GD, knowledge is still limited but fortunately slowly increasing. A central finding from all quantitative studies focusing on the topic is that the persistence of GD is most closely linked to the intensity of the GD in childhood and the amount of reported cross-gendered behaviour; in other words the more intense GD is in

childhood, and the more cross-gendered behaviour is reported by parents or through self-report, the higher the chance that the GD persists (Drummond et al., 2008; Singh, 2012; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). In addition to this, several other factors are linked to persistence of GD: For example, Steensma et al. (2013) and Wallien & Cohen-Kettenis (2008) showed that the persistence rate is generally higher in natal girls than in natal boys; And Steensma et al. (2013) and Singh (2012) found that the assessment age in childhood was higher in children where the GD persisted than for desisters; Further, Singh (2012) reported a higher social class in the parents of desisters compared to the parents of persisters.

In addition, Steensma et al. (2013) found that a social transition in childhood, especially in natal boys, and verbal identification with the desired/experienced gender was predictive for the persistence of GD. Interestingly, the identification finding was reported in an earlier qualitative study by Steensma, Biemond, de Boer & Cohen-Kettenis (2011) who observed differences in reported experiences of GD between persisters and desisters who were interviewed. For example, the persisters explicitly indicated that they felt they *were* the 'other' sex and the desisters indicated that they only *wished* they were the 'other' sex. The primary aim of the Steensma et al. (2011) study was to get a better understanding of the processes that contribute to the persistence and desistence of childhood GD. By interviewing adolescents (14 persisters, 11 desisters) who all fulfilled the DSM-IV or DSM-IV-TR criteria of a gender identity diagnosis in childhood (APA, 1994, 2000), it became clear that the period between 10 and 13 years was considered crucial. Both persisters and desisters stated that the changes in their social environment, the anticipated and actual feminization or masculinization of their bodies, and the first experiences of falling in love and sexual attraction in this period, contributed to an increase (in the persisters) or decrease (in the desisters) of their gender related interests, behaviours, and feelings of gender discomfort.

Treatment and counselling of children with GD

Over the last decade, the care for prepubescent children with GD has been rapidly changing and there is a growing number of specialized gender clinics for young people (Hsieh & Leininger, 2014; Khatchadourian, Ahmed, & Metzger, 2014; Riittakerttu, Sumia, Työläjärvä, & Lindberg, 2015). Best clinical practice in gender referred children is still controversial and raises debates among dedicated professionals. General agreement does, however, exist that the care for children with

GD should be focused on reducing the child's distress related to their GD; on help with other psychological difficulties; and optimizing psychological adjustment and wellbeing (e.g. Byne et al., 2012; Coleman et al., 2011). As for the counselling of the gender dysphoric feelings in children with GD; empirical treatment models do not exist and general consensus between clinicians is not always easy to obtain (Byne et al., 2012). In the current professional literature, three treatment models for the care of gender variant children can be distinguished (e.g. Byne et al., 2012; Drescher, 2013) and it is these to which we now turn.

The first approach focuses on working with the child and caregivers to lessen cross-gender behaviour and identification, to persuade the child that the 'right gender' is the one assigned at birth (Giordano, 2012), to decrease the likelihood that GD will persist into adolescence, and prevent adult transsexualism. Critics of this approach have linked it to 'reparative therapy', a term more commonly used to describe efforts to change same sex attraction to heterosexuality in gay adults or 'pre-homosexual' children (Drescher, 2013). In the past, such behavioural and psychodynamic therapies to lessen the GD have been largely used in children with GD with overall unsatisfactory results (Byne et al., 2012; Möller, Schreier, Li, & Romer, 2009). Instead, children often seem to become distressed if their preferences and/or behaviours are blocked (Richardson, 1999). At present, interventions aimed to lessen GD are referred to as unethical by the World Professional Association for Transgendered Health (WPATH: Coleman et al., 2011) and many other international professional organizations. The American Academy of Child & Adolescent Psychiatry, for example, has explicitly formulated their position against any psychological treatment aimed to change gender nonconforming behaviours (Adelson, 2012).

The second approach is focused on dealing with the potential social risks for the child (Byne et al., 2012). Because its aim is to allow the progress of the GD in the child to unfold in a natural way, it is often referred to as 'watchful waiting' (Drescher, 2013). Counselling based on this approach may include interventions that focus on the co-existing problems of the child and/or the family; helping parents and the child to bear the uncertainty of the child's psychosexual outcome; and providing psycho-education to help the child and the family to make balanced decisions regarding topics such as the child's coming out, early social transitioning, and/or how to handle peer rejection or social ostracism. In practice, the child and parents are encouraged to find a balance between an accepting and supportive attitude toward GD, while at the same time protecting the child against

any negative reactions and remaining realistic about the chance that GD feelings may desist in the future. Parents are encouraged to provide enough space for their child to explore their gender dysphoric feelings, while at the same time keeping all future outcomes open (e.g., de Vries & Cohen-Kettenis, 2012; Di Ceglie, 1998, 2014).

The third approach is focused on affirming the child's (trans)gender identification and helps the child to build a positive self-identity and gender resilience. In particular, the child is supported in transitioning to the desired/experienced gender role. The rationale for supporting social transition before puberty is that children can revert to their originally assigned gender if necessary since the transition is solely at a social level and without medical intervention (e.g. Byne et al., 2012; Drescher, 2013; Hill, Menvielle, Sica, & Johnson, 2010). Critics of this approach believe that supporting gender transition in childhood may indeed be relieving for children with GD but question the effect on future development. The debate thereby focuses on whether a transition may increase the likelihood of persistence because, for example, a child may 'forget' how to live in the original gender role and therefore will no longer be able to feel the desire to change back; or that transitioned children may repress doubts about the transition out of fear that they have to go through the process of making their desire to socially (re)transition public for a second time (Steensma, 2013). The fact that transitioning for a second time can be difficult was indeed shown in the qualitative study by Steensma et al. (2011) where children who transitioned early in childhood reported a struggle with changing back to their original gender role when their feelings desisted, with the fear of being teased or excluded by their peers reported as the main reason for this.

Unfortunately, empirical answers about the best way to counsel children with GD and their caregivers are currently not available. The WPATH have therefore formulated a balanced position in their Standards of Care (Coleman et al., 2011), where clinicians are encouraged to help families by providing information about what is known about the development of children with GD and to help them to make decisions where the potential benefits and challenges of particular choices are weighted.

Conclusion

According to the DSM-5 diagnostic criteria for gender dysphoria, children with GD experience clinically significant distress because of the incongruence between their assigned gender at birth and experienced gender (APA, 2013). The clinical presentation of children who

present with gender identity issues is characterized by gender-nonconformity and a vulnerability to having psychological problems – primarily of an internalized nature (e.g. Cohen-Kettenis et al., 2003; Steensma et al., 2014), and an increased likelihood of ASD symptomatology (de Vries et al., 2010; VanderLaan et al., 2015). The extent and intensity of all three characteristics can be variable.

When considering the development of children with GD; studies show that gender dysphoric feelings eventually desist for the majority of children with GD, and that their psychosexual outcome is strongly associated with a lesbian, gay, or bisexual sexuality which does not require any medical intervention, instead of an outcome where medical intervention is required (e.g. Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Singh, 2012). Factors predictive for the persistence of GD have been identified on a group level, with higher intensity of GD in childhood identified as the strongest predictor for a future gender dysphoric outcome (Steensma et al., 2013). The predictive value of the identified factors for persistence are, however, on an individual level less clear cut, and the clinical utility of currently identified factors is low.

Taken together this shows that there can be a great variability with regard to presentation of children with GD and their psychosexual outcome. The counselling of children with GD can therefore be complex and clinically challenging. To date, there is general agreement that the care for children with GD should not be aimed at avoiding adult same sex attraction or transsexualism; that no medical intervention should be provided in childhood (before puberty); that counselling should therefore be focused on reducing the child's distress related to the GD, on help with other psychological difficulties, and on optimizing psychological adjustment and wellbeing (e.g. Byne et al., 2012; Coleman et al., 2011).

However, besides these basic clinical values, there is currently no general consensus about the best approach to dealing with the (uncertain) future development of children with GD, and making decisions that may influence the functioning and/or development of the child – such as a social transition. Different clinical approaches are presented in the literature, and indeed taking the variability in presentation of children with GD into account, it seems important to underline that a 'one size fits all' approach is not best practice for children with GD. Therefore, different kinds of treatment options should be available which respect the unique needs of every child. In particular, the child's clinical psychological profile and gender development, as well as the contextual psychosocial characteristics of the child's

family (e.g. belief system, supportive behaviours, access to health care) should always be taken into account in order to make balanced decisions. Currently, the limited empirical evidence in favour of a particular treatment makes treatment of teenagers with GD a controversial issue that raises intense, and often polarized, debate. Therefore, studies comparing different psychological treatment options are needed as well as research which aims to identify the factors involved in the persistence process of GD on an individual level. The primary goal is therefore to determine the safest and most efficacious mental and medical approach for the individual child with GD.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

- Achenbach, T.M., & Edelbrock, C.S. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. *Monographs of the Society for Research in Child Development*, 46(1), Serial No.188.
- Achenbach, T.M., & Edelbrock, C.S. (1983). *Manual for the child behavior checklist and revised child behavior profile*. Burlington, VT: University of Vermont, Department of Psychiatry.
- Adelson, S.L. (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 51, 957–974.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Press.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Press.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (fifth edition). Washington, DC: American Psychiatric Press.
- Bakwin, H. (1968). Deviant gender-role behavior in children: Relation to homosexuality. *Pediatrics*, 41, 620–629.
- Bates, J.E., Bentler, P.M., Thompson, S.P. (1973). Measurement of deviant gender development in boys. *Child Development*, 44, 591–598.
- Bates, J.E., Bentler, P.M., Thompson, S.P. (1979). Gender-deviant boys compared with normal and clinical control boys. *Journal of Abnormal Child Psychology*, 7, 243–259.
- Blakemore, J. E. O. (2003). Children's beliefs about violating gender norms: Boys shouldn't look like girls, and girls shouldn't act like boys. *Sex Roles*, 48, 411–419.
- Byne, W., Bradley, S.J., Coleman, E., Eyler, A.E., Green, R., Menvielle, E.J., ... Tompkins, D.A. (2012). Report of the American Psychiatric Association Task Force on Treatment

- of Gender Identity Disorder. *Archives of Sexual Behavior*, 41, 759–796.
- Carter, D.B., & McCloskey, L.A. (1984). Peers and the maintenance of sex-typed behavior: The development of children's conceptions of cross-gender behavior in their peers. *Social Cognition*, 2, 294–314.
- Coates, S., & Person, E.S. (1985). Extreme boyhood femininity: Isolated behavior or pervasive disorder? *Journal of the American Academy of Child Psychiatry*, 24, 702–709.
- Cohen-Kettenis, P.T., Owen, A., Kaijser, V.G., Bradley, S.J., & Zucker, K.J. (2003). Demographic characteristics, social competence, and problem behavior in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, 31, 41–53.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Zucker, K. (2011). Standards of care for the health of transsexual, transgender and gender non-conforming people, version 7. *International Journal of Transgenderism*, 13, 165–232.
- Davenport, C.W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior*, 15, 511–517.
- de Vries, A. L. C., Noens, I.L., Cohen-Kettenis, P.T., van Berckelaer-Onnes, I.A., & Doreleijers, T. A. H. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, 40, 930–936.
- de Vries, A.L., & Cohen-Kettenis, P.T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59, 301–320.
- Di Ceglie, D. (1998). Management and therapeutic aims with children and adolescents with gender identity disorders and their families. In: D. Di Ceglie & D. Freedman (Eds.), *A Stranger in my own body: Atypical gender identity development and mental health*. London: Karnac Books, pp. 185–197.
- Di Ceglie, D. (2014). Care for Gender-Dysphoric Children. In: B.P.C. Kreukels, T.D. Steensma, A.L.C. de Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in Care and Knowledge*. New York: Springer Science + Business Media, pp. 151–169.
- Drescher, J. (2013). Controversies in Gender Diagnoses. *LGBT Health*, 1, 10–14.
- Drescher, J. (2014). Gender identity diagnoses: History and controversies. In: B.P.C. Kreukels, T.D. Steensma, A.L.C. de Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in Care and Knowledge*. New York: Springer Science + Business Media, pp. 137–150.
- Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry*, 24, 568–577.
- Drummond, K.D., Bradley, S.J., Peterson-Badali, M., Zucker, K.J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, 44, 34–45.
- Fombonne, E. (2005). Epidemiology of autistic disorder and other pervasive developmental disorders. *Journal of Clinical Psychiatry*, 66(Suppl 10), 3–8.
- Giordano, S. (2012). *Children with gender identity disorder, a clinical, ethical and legal analysis*. London and New York: Routledge.
- Green, R. (1987). *The 'sissy boy syndrome' and the development of homosexuality*. New Haven, CT: Yale University Press.
- Hill, D.B., Menvielle, E., Sica, K.M., & Johnson, A. (2010). An affirmative intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy*, 36, 6–23.
- Hsieh, S., & Leininger, J. (2014). Resource list: Clinical care programs for gender-nonconforming children and adolescents. *Pediatric Annals*, 43, 238–244.
- Khatchadourian, K., Ahmed, S., & Metzger, D.L. (2014). Clinical management of youth with gender dysphoria in Vancouver. *The Journal of Pediatrics*, 164, 906–911.
- Kosky, R.J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia*, 146, 565–569.
- Lebovitz, P.S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry*, 128, 1283–1289.
- Levy, G.D., Taylor, M.G., & Gelman, S.A. (1995). Traditional and evaluative aspects of flexibility in gender roles, social conventions, moral rules, and physical laws. *Child Development*, 66, 515–531.
- Möller, B., Schreier, H., Li, A., & Romer, G. (2009). Gender Identity Disorder in Children and Adolescents. *Current Problems in Pediatric and Adolescent Health Care*, 39(5), 117–143.
- Money, J., & Russo, A.J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology*, 4, 29–41.
- Rekers, G.A., & Morey, S.M. (1989). Relationship of maternal report of feminine behaviors and extraversion to clinician's rating of gender disturbance. *Perceptual and Motor Skills*, 69, 387–394.
- Richardson, J. (1999). Response: finding the disorder in gender identity disorder. *Harvard Review of Psychiatry*, 7, 43–50.
- Riittakerttu, K., Sumia, M., Työläjärvä, M., & Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, 9, 9–9.
- Ruble, D.N., Taylor, L., Cyphers, L., Greulich, F.K., Lurye, L.E. & Shrout, P.E. (2007). The role of gender constancy in early gender development. *Child Development*, 78, 1121–1136.
- Signorella, M.L., Bigler, R.S., & Liben, L.S. (1993). Developmental differences in children's gender schemata about others: A meta-analytic review. *Developmental Review*, 13, 147–183.
- Singh, D. (2012). A follow-up study of boys with gender identity disorder. Unpublished doctoral dissertation, University of Toronto.
- Singh, D., Bradley, S.J., & Zucker, K.J. (2011). Commentary on 'An Affirmative Intervention for Families with Gender Variant Children: Parental Ratings of Child Mental Health and Gender' by Hill, Menvielle, Sica, and Johnson (2010). *Journal of Sex and Marital Therapy*, 37, 151–157.
- Steensma, T.D. (2013). From gender variance to gender dysphoria: Psychosexual development of gender atypical children and adolescents. Dissertation, VU University, Amsterdam, the Netherlands.
- Steensma, T.D., Biemond, R., de Boer, F., & Cohen-Kettenis, P.T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, 16, 499–516.

- Steensma, T.D., & Cohen-Kettenis, P.T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child and Adolescent Psychiatry*, 54, 147–148.
- Steensma, T.D., McGuire, J.K., Kreukels, B.P., Beekman, A.J., & Cohen-Kettenis, P.T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 582–590.
- Steensma, T.D., Zucker, K.J., Kreukels, B. P. C., VanderLaan, D.P., Wood, H., Fuentes, A., & Cohen-Kettenis, P.T. (2014). Behavioral and emotional problems on the Teacher's Report Form: A cross-national, cross-clinic comparative analysis of gender dysphoric children and adolescents. *Journal of Abnormal Child Psychology*, 42, 635–647.
- Stoddart, T., & Turiel, E. (1985). Children's concepts of cross-gender activities. *Child Development*, 56, 1241–1252.
- Van Beijsterveldt, C.E., Hudziak, J.J., & Boomsma, D.I. (2006). Genetic and environmental influences on cross-gender behavior and relation to behavior problems: A study of Dutch twins at ages 7 and 10 years. *Archives of Sexual Behavior*, 35, 647–658.
- VanderLaan, D.P., Postema, L., Wood, H., Singh, D., Fantus, S., Hyun, J., ... Leef, J., (2015). Do Children With Gender Dysphoria Have Intense/Obsessional Interests? *Journal of Sex Research*, 52, 213–219.
- Verhulst, F.C., van der Ende, J., & Koot, H.M. (1996). *Handleiding voor de CBCL/4-18 [Manual for the CBCL/4-18]*. Erasmus University, Department of Child and Adolescent Psychiatry, Sophia Children's Hospital: Rotterdam, Netherlands.
- Wallien, M.S., & Cohen-Kettenis, P.T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 1413–1423.
- Wallien, M. S. C., Veenstra, R., Kreukels, B. P. C., & Cohen-Kettenis, P.T. (2010). Peer Group status of gender dysphoric children: A sociometric study. *Archives of Sexual Behavior*, 39, 553–560.
- Wood, H., Sasaki, S., Bradley, S.J., Singh, D., Fantus S., Owen-Anderson, A., & Singh, D. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy*, 39, 1–6.
- World Health Organization (1992). *International statistical classification of diseases and related health problems* (10th edition). Geneva: World Health Organization.
- Zucker, K.J., & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.
- Zucker, K.J., Bradley, S.J., Owen-Anderson, A., Kibblewhite, S.J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex and Marital Therapy*, 38, 151–189.
- Zucker, K.J., Bradley, S.J., & Sanikhani, M. (1997). Sex differences in referral rates of children with gender identity disorder: Some hypotheses. *Journal of Abnormal Child Psychology*, 25, 217–227.
- Zucker, K.J., Wilson-Smith, D.N., Kurita, J.A., & Stern, A. (1995). Children's appraisals of sextyped behavior in their peers. *Sex Roles*, 33, 703–725.
- Zucker, K.J., Wood, H., & VanderLaan, D.P. (2014). Models of psychopathology in children and adolescents with gender dysphoria. In: B.P.C. Kreukels, T.D. Steensma, A.L.C. de Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in Care and Knowledge*. New York: Springer Science + Business Media, pp. 171–192.
- Zuger, B. (1984). Early effeminate behavior in boys. Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease*, 172, 90–97.

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Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review

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CONTEXT: Hormonal interventions are being increasingly used to treat young people with gender dysphoria, but their effects in this population have not been systematically reviewed before.

OBJECTIVE: To review evidence for the physical, psychosocial, and cognitive effects of gonadotropin-releasing hormone analogs (GnRHa), gender-affirming hormones, antiandrogens, and progestins on transgender adolescents.

DATA SOURCES: We searched Medline, Embase, and PubMed databases from January 1, 1946, to June 10, 2017.

STUDY SELECTION: We selected primary studies in which researchers examined the hormonal treatment of transgender adolescents and assessed their psychosocial, cognitive, and/or physical effects.

DATA EXTRACTION: Two authors independently screened studies for inclusion and extracted data from eligible articles using a standardized recording form.

RESULTS: Thirteen studies met our inclusion criteria, in which researchers examined GnRHas ($n = 9$), estrogen ($n = 3$), testosterone ($n = 5$), antiandrogen (cyproterone acetate) ($n = 1$), and progestin (lynestrenol) ($n = 1$). Most treatments successfully achieved their intended physical effects, with GnRHas and cyproterone acetate suppressing sex hormones and estrogen or testosterone causing feminization or masculinization of secondary sex characteristics. GnRHa treatment was associated with improvement across multiple measures of psychological functioning but not gender dysphoria itself, whereas the psychosocial effects of gender-affirming hormones in transgender youth have not yet been adequately assessed.

LIMITATIONS: There are few studies in this field and they have all been observational.

CONCLUSIONS: Low-quality evidence suggests that hormonal treatments for transgender adolescents can achieve their intended physical effects, but evidence regarding their psychosocial and cognitive impact are generally lacking. Future research to address these knowledge gaps and improve understanding of the long-term effects of these treatments is required.

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Transgender is a term used to describe an individual whose inner gender identity differs from their sex assigned at birth. This mismatch can cause distress and functional impairment, resulting in gender dysphoria (GD) or what was previously termed “gender identity disorder” (GID).^{1,2}

Several hormonal treatment options are available for GD, the appropriateness of which depends on developmental stage. For instance, puberty can frequently exacerbate GD because of the development of unwanted secondary sexual characteristics,³ which can be reversibly suppressed by using gonadotropin-releasing hormone analogs (GnRHAs).^{4,5} In comparison, gender-affirming hormones (GAHs; also known as cross-sex hormonal therapy) allow individuals to actively masculinize or feminize their physical appearance to be more consistent with their gender identity. As GAHs are only partially reversible, they are generally used only once an individual reaches the legal age of medical consent, which varies across countries.⁵ In addition, antiandrogens, such as spironolactone and cyproterone acetate, can be used to counter the effects of testosterone in birth-assigned male individuals,^{6,7} whereas progestins, such as norethisterone and medroxyprogesterone, are often employed to suppress menses in younger birth-assigned female individuals.

Authors of multiple studies have investigated the physical and psychosocial effects of different hormonal interventions in adults with GD. GAHs have been examined most extensively, with authors of systematic reviews indicating that GAHs improve multiple aspects of psychosocial functioning,^{8,9} although they also increase serum triglycerides and risk of cardiovascular disease (including venous thrombosis, stroke, myocardial infarction, and

pulmonary embolism).^{10–12} Studies of antiandrogens in transfemale adults have revealed that cyproterone acetate is able to reduce levels of testosterone, whereas spironolactone has a synergistic effect with estrogen in improving both physical and hormonal outcomes.¹³

In contrast, studies of different hormonal treatments in young people with GD are scarce, meaning that clinicians have often had to extrapolate from adult studies. This is problematic for several reasons. Firstly, adolescence is a period of rapid development across multiple domains,¹⁴ and studies of hormonal treatments in adults with GD may not readily translate to adolescents. Secondly, some hormone treatments used in young people with GD (eg, GnRHAs and progestins) are either not commonly used in adults with GD or are used in adults for different reasons (eg, GnRHAs for prostate cancer).¹⁵ Finally, hormonal dosing regimens in adolescents with GD are frequently different from those used in adults, which is likely to affect outcomes.

Our purpose in this systematic review is, therefore, to evaluate the currently available evidence about the physical, psychosocial, and cognitive effects of different hormonal therapies in transgender youth. By doing so, we can directly inform clinical practice involving this population and highlight existing knowledge gaps.

METHODS

Eligibility Criteria

Studies were considered eligible if participants were given hormonal treatment (GnRHAs, GAHs, antiandrogens, or progestins) and if analysis of psychosocial, cognitive, and/or physical effects of these hormones were included. Participants had to be younger than 25 years of age and described

as transgender or diagnosed with GD and/or GID according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; or *International Classification of Diseases* criteria. This age range was selected to be consistent with the definition of adolescence used by the recent *Lancet* Commission on Adolescent Health.¹⁶ Studies were excluded if the effects of hormonal therapy could not be separated from gender-affirming surgery, which could cause potential issues related to interpretation of results. We included all published study designs in any language, but conference abstracts or studies in which researchers failed to report results at the group level with at least 10 individuals were excluded.

Study Identification

The Medline (Ovid) and Embase (Ovid) databases were searched for references from January 1, 1946, to June 10, 2017, by using thesauri and/or keywords. PubMed was searched by using keywords to retrieve electronic publications and items not indexed in Medline. The Medline search strategy was adapted for use in Embase and PubMed with the main search terms as follows: (GD or transsexualism or “sexual and gender disorders” or transgender persons or gender identity), (drug therapy or therapeutic use or [hormonal or hormone*] or *steroids or exp gestagen or exp antiandrogen), and (adolescen* or pediatric* or pediatric* or youth* or teen or teens or teenage*). Detailed search histories are available on request. Additional items were identified by manually searching reference lists of relevant retrieved articles. Two reviewers independently assessed all study titles and abstracts to determine inclusion, with the full text being subsequently retrieved for potentially eligible studies to assess final suitability. Any disagreements

were resolved with discussion and consensus was reached for final articles.

Data Extraction

Two reviewers, working independently and in duplicate, used a standardized form to extract methodological, demographic, and outcome data. Data extracted included reported youth characteristics (number of participants pre- and posttreatment, participant age range, diagnosis of GD, birth-assigned sex, and gender identity), hormonal therapy features (type, dose, route, duration of treatment), study design, and outcomes of interest (length of follow-up duration, follow-up outcome measures, and treatment effect on outcome measures).

Quality Assessment

Risk of bias in studies was assessed by 2 authors working independently using a modified version of the Quality in Prognosis Studies (QUIPS) tool from a previous study.¹⁷ The original QUIPS tool¹⁸ was modified because confounders or prognostic factors were not analyzed in this review and thus did not apply.

Review Protocol

A detailed protocol is available at PROSPERO (identifier 42017056670).

Statistical Analysis

Effect sizes were calculated for results with reported means and SDs,^{19–27} according to a previous study.²⁸ Unadjusted effect sizes using the posttest SD were calculated for the majority of studies, with an adjusted effect size using the experimental SD calculated only for 1 study with comparison between groups.²⁴

Meta-analysis

Meta-analysis was planned for outcomes examined by 3 or more studies but was unable to be

conducted because individual outcome effect sizes were available for a maximum of 2 studies.

RESULTS

Study Selection

The study selection process is depicted in Fig 1. Eighty-three potentially relevant studies were retrieved, of which 13^{19–27,29–32} met the inclusion criteria and were systematically analyzed. In Table 1, we summarize the main characteristics of these 13 studies, and their key physical, psychosocial, and cognitive findings are outlined in Tables 2, 3 and 4, respectively. Because research from the same cohort was described in 2 of the studies,^{26,27} they were considered as 1 study.

Quality Appraisal

In all studies, there was a medium to high risk of bias (Table 5). In most studies, there were only small sample sizes (minimum of 21 and maximum of 201), with <50 participants in 38.5% of the studies. There were controls in only 2 studies, and all studies were conducted in clinical populations. There was often significant loss to follow-up, attributed partially to most studies being retrospective with missing data. Overall, the tools used to measure the specific outcomes were valid and reliable, although there was no blinding or randomization in any of the studies.

PHYSICAL EFFECTS

All relevant results are shown in Table 2.

Sex Hormones and Secondary Sexual Characteristics

GnRHs

GnRHs were successful in suppressing sex hormone secretion with significant decreases in gonadotropin,²⁹ estradiol,

and testosterone^{19,21,29} levels, although 1 study only revealed a significant decrease in transfemale adolescents (birth-assigned male individuals identifying as female individuals).¹⁹ There was decreased testicular volume in transfemale adolescents^{19,21,29} and cessation of menses in transmale adolescents (birth-assigned female individuals identifying as male individuals),²¹ although the latter often occurred after a withdrawal bleed in postmenarchal individuals. Furthermore, GnRHs were shown to decrease luteinizing hormone (LH) and follicle-stimulating hormone (FSH).^{19,21}

Progestin

Researchers in 1 study examined the effects of the progestin lynestrenol³⁰ in transmale adolescents. Although there was no report of the efficacy of lynestrenol in stopping menses, there were significant reductions in levels of serum sex-hormone binding globulin (SHBG) and LH, in addition to a significant increase in free testosterone (fT). FSH, estradiol, testosterone, and anti-Müllerian hormone had nonsignificant decreases.³⁰

Antiandrogen

In one study, researchers studied the effects of the antiandrogen cyproterone acetate alone in transfemale adolescents.²² It was effective in significantly suppressing endogenous sex hormones with significant reductions in testosterone and dehydroepiandrosterone in addition to nonsignificant decreases in estradiol and fT after 12 months, with no significant changes in LH, FSH, and SHBG. Cyproterone acetate was associated with a marked increase in prolactin of ~2.5-fold that exceeded the normal reference range after 6 months but returned to the normal range after 12 months. No clinical consequences, including galactorrhea, were reported. Furthermore, 55.6% of participants

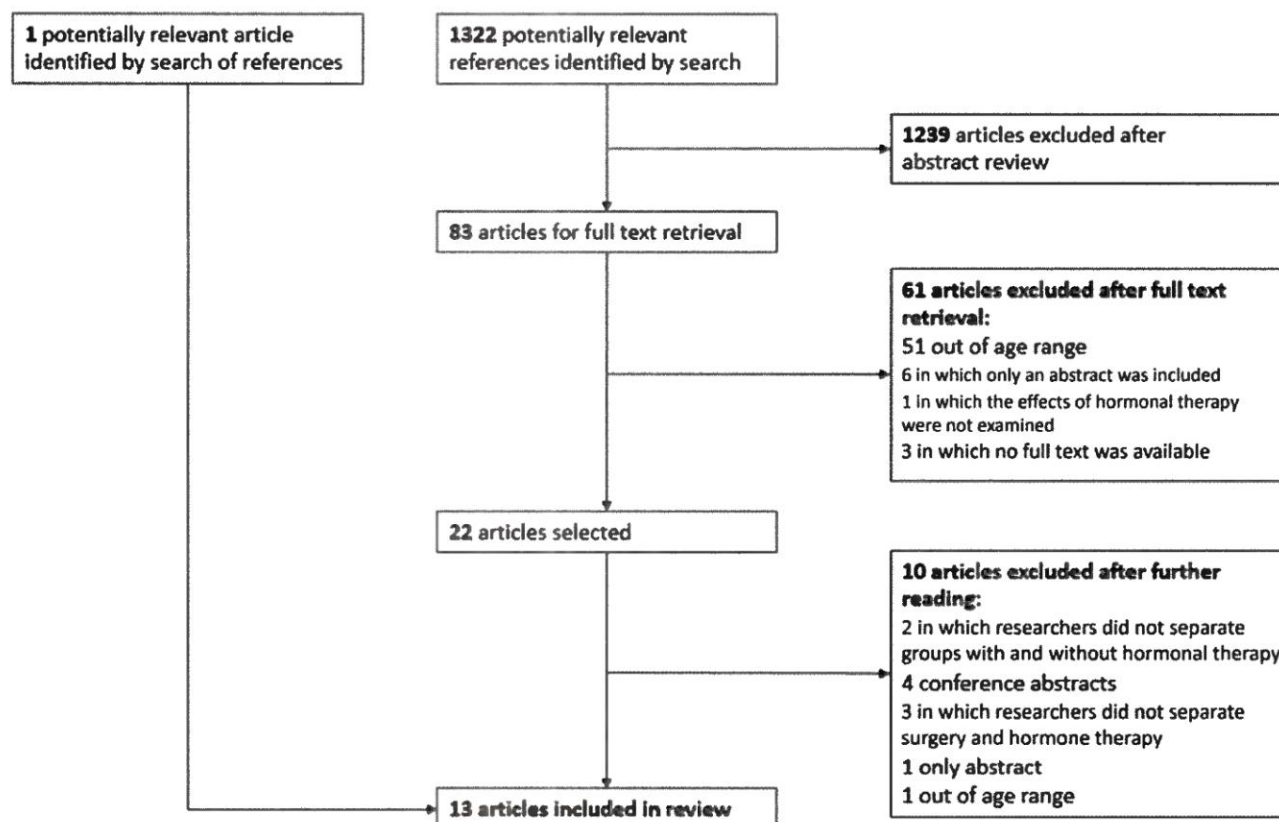


FIGURE 1
Flow diagram of study selection.

also reported decreased facial shaving frequency.²²

Estrogen

Estrogen was successful in feminizing physical sex characteristics.^{22,29} In 1 study, 66.7% of participants reached Tanner B3 stage (increase in breast and areola size), and 9.5% reached Tanner B4 (secondary mound created by areola and papilla) after treatment with cyproterone acetate and estrogen for at least 6 months.²² However, breast development was found to be objectively dissatisfactory and subjectively less in size than expected for the majority.²² There was a significant increase in serum estradiol after 6 months that reached the female reference range, whereas total testosterone decreased after 1 to 3 months to be outside of the male reference range.^{22,32} Prolactin was unchanged.²²

Testosterone

Testosterone resulted in virilization, including lower voice, clitoral enlargement, and body hair growth in a masculinized pattern.²⁹ Menses ceased in most transmale adolescents within 6 months, with an average time to cessation of 2.9 months.²⁰ Testosterone resulted in increased total testosterone and FT,^{20,30,32} with most participants reaching levels within the normal male range after 6 months,^{20,30} as well as significant decreases in LH and FSH.³⁰ This was accompanied by a decline in estradiol levels after 6 months,^{20,30,32} which was statistically significant in 2 studies^{20,30} but nonsignificant in 1 study.³²

Side Effects

GnRHAs

Hot flashes were a common side effect in transmale adolescents

treated in late puberty (Tanner stages B4 and B5), although these decreased in frequency over time.²⁹ No other short-term side effects, including local reactions, were reported.

Progestin

Lynestrenol was evaluated as relatively safe, with the most common side effects being initial metrorrhagia (48.7%), headaches (12.1%), hot flashes (9.8%), and acne (which increased from 14.6% to 28.6%).³⁰

Antiandrogens

Treatment with cyproterone acetate was evaluated to be relatively safe, with the most common side effect being fatigue (37%).²²

Estrogen

Side effects reported with combined estrogen and cyproterone acetate

TABLE 1 Characteristics of 13 Studies on Hormonal Treatments in Transgender Youth

Study	Type of Study	Sample (N)	Gender Identity	Age, y \pm SD	Loss to Follow-up, %	Effects Analyzed	Treatment	Duration of Treatment, y	Outcomes Examined
Delemarre-van de Waal and Cohen-Kettenis ²³	Prospective, longitudinal	21	11 transmale adolescents with GID, 10 transfemale adolescents with GID	Not mentioned	0	Physical	GnRHa	2 y or longer	Sex hormones and secondary sexual characteristics, safety profile, BMD, growth, and body composition
de Vries et al ²⁷ (de Vries et al ²⁵) ^a	Prospective, longitudinal	70 (55)	37 (33) transmale adolescents with GID, 33 (22) transfemale adolescents with GID	Baseline: 13.65 \pm 1.85, at start of GnRHa: 14.75 \pm 1.92, at start of GAH: 16.64 \pm 1.90	Variable: 18–42 ^b	Psychosocial	GnRHa, GAH (not assessed in de Vries et al ²⁵)	GnRHa: average: 1.88 \pm 1.05, range: 0.42–5.06	Psychological functioning, GD
Klink et al ¹⁹	Retrospective, longitudinal	34	15 transfemale adolescents with GID, 19 transmale adolescents with GID	At start of GnRHa: transfemale adolescents: 14.9 \pm 1.9, transmale adolescents: 5.0 \pm 2.0; at start of GAH: transfemale adolescents: 16.6 \pm 1.4, transmale adolescents: median of 16.4 and interquartile range of 2.3	Variable	Physical	GnRHa (only treatment studied), GAH	GnRHa: transfemale adolescents: average: 1.3, range: 0.5–3.8; transmale adolescents: average: 1.5, range: 0.25–5.2; GAH: transfemale adolescents: average: 5.8, range: 3–8; transmale adolescents: average: 5.4, range: 2.8–7.8	Sex hormones and secondary sexual characteristics, BMD, growth, body composition, and other physical effects
Olson et al ²⁰	Prospective, longitudinal	36	36 transmale transgender adolescents	18.7 \pm 2.6	3	Physical	GAH (only testosterone)	Not mentioned	Sex hormones and secondary sexual characteristics, body composition, and other physical effects
Costa et al ²⁵	Prospective, longitudinal	201	124 transmale adolescents with GID, 77 transfemale adolescents with GID	Baseline: 15.52 \pm 1.41, start of GnRHa: 16.48 \pm 1.26	Variable: 0–65 ^a	Psychosocial	GnRHa	Immediately eligible for GnRHa: average: 0.75 \pm 0.59	GD-related discomfort, global psychosocial functioning

TABLE 1 Continued

Study	Type of Study	Sample (N)	Gender Identity	Age, y \pm SD	Loss to Follow-up, %	Effects Analyzed	Treatment	Duration of Treatment, y	Outcomes Examined
Staphorsius et al ²⁴	Cross-sectional	116	22 transmale adolescents with GID, 18 transfemale adolescents with GID, 21 male control subjects, 24 female control subjects	Transmale adolescents: 15.8 ± 1.9 , transfemale adolescents: 15.1 ± 2.4 , male adolescents: 14.9 ± 1.5 , female adolescents: 14.4 ± 1.8	26	Cognitive	GnRHa	GnRHa: average: 1.6 ± 1.0	Executive functioning
Burke et al ²³	Prospective, fMRI	62	21 transmale adolescents with GD, 20 male control subjects, 21 female control subjects	Transmale adolescents: 16.1 ± 0.8 , control male subjects: 15.9 ± 0.6 , control female subjects: 16.3 ± 1.0	8.1	Cognitive	GnRHa, GAH (testosterone)	GnRHa: average: 2, range: 0.17–4; testosterone: average: 0.83, range: 0.5–1.25	Mental rotation
Schagen et al ²¹	Prospective, longitudinal	128	67 transmale adolescents with GID, 49 transfemale adolescents with GID	Transmale adolescents: 14.2, transfemale adolescents: 13.6	9	Physical	GnRHa	At least 0.25	Sex hormones and secondary sexual characteristics, growth, body composition, and other physical effects
Tack et al ³⁰	Retrospective, longitudinal	45	38 transmale adolescents with GID	15.8 at start of treatment	16	Physical	Androgenic progestin (lynestrenol), combination of androgenic progestin (lynestrenol) and GAH (testosterone)	Average of 10.5 for lynestrenol, average of 0.95 for lynestrenol and testosterone	Sex hormones and secondary sexual characteristics, safety profile, body composition, and other physical effects
Vlot et al ³¹	Retrospective, longitudinal	70	42 transmale adolescents with GID, 28 transfemale adolescents with GID	GnRHa at start of treatment: transmale adolescents: 15.1, transfemale adolescents: 13.5; GAH at start of treatment: transmale adolescents: 16.3, transfemale adolescents: 16.0	20	Physical	GnRHa, GAH (testosterone and estrogen)	Not mentioned	Bone turnover, BMD, and growth

TABLE 1 Continued

Study	Type of Study	Sample (N)	Gender Identity	Age, y \pm SD	Loss to Follow-up, %	Effects Analyzed	Treatment	Duration of Treatment, y	Outcomes Examined
Jarin et al ³²	Retrospective, longitudinal	116	72 transmale adolescents with GD, 44 transfemale adolescents with GD	Transmale adolescents: average of 16 (range of 13–22) at start of treatment, Transfemale adolescents: average of 18 (range of 14–25) at start of treatment	Variable	Physical	GAH (testosterone and estrogen treatment)	Not mentioned	Sex hormones and secondary sexual characteristics, body composition, and other physical effects
Tack et al ²²	Retrospective, longitudinal	27	27 transfemale adolescents with GD	Antiandrogen: 16.5 at start of treatment, combination of antiandrogen and GAH: 17.6 at start of treatment	22.2 (variable)	Physical	Antiandrogen (cyproterone acetate), combination of antiandrogen (cyproterone acetate) and GAH (estrogen treatment)	Antiandrogen: minimum of 0.5 (mean of 1.0), combination of antiandrogen and GAH: minimum of 0.5 (mean of 1.3)	Sex hormones and secondary sexual characteristics, safety profile, growth, body composition, and other physical effects

Note that transmale adolescents are birth-assigned female individuals who identify as male individuals, whereas transfemale adolescents are birth-assigned male individuals who identify as female individuals.

^a These 2 studies involved the same cohort and were therefore considered as 1 study. The values in parenthesis are used to indicate the results of the earlier study,²⁶ in which researchers examined a smaller subset of the cohort subsequently examined in de Vries et al.²⁷

^b Variable loss to follow-up depending on test.

TABLE 2 Physical Effects of Hormonal Treatments in Transgender Youth

Study	Treatment	Outcome					
		Testosterone, Estradiol, and Gonadotropin Levels	Anthropometric Measurements	BMD	Body Composition	Safety Profile	Other Physical Effects
Delemarre-van de Waal and Cohen-Kettenis ²⁹	GnRHa	Decrease ^a in gonadotropin and sex hormone levels, decrease ^a in testicular volume in transfemale adolescents	Decrease ^a in height velocity, decrease ^a in height SDSs in youth who still have growth potential (related to bone age)	No change in bone density actual values but decrease ^a in standardized score (z score)	Increase ^a in fat mass percentage, decrease ^a in lean body mass percentage	Frequent hot flashes in transmale adolescents (when treated in late pubertal stages)	—
Delemarre-van de Waal and Cohen-Kettenis ²⁹	GAH (testosterone and estrogen)	Virilization of transmale adolescents (low voice, clitoris enlarged, facial and body hair growth) and transfemale adolescents (induced breast development)	Increase ^a in height (growth spurt) with androgen substitution therapy	Increase ^a in bone density (actual and z scores)	No effect on fasting glucose, insulin, cholesterol, HDL, and LDL levels	—	—
Klink et al ¹⁹	GnRHa (only treatment studied), GAH	Decrease ^b in estradiol, decrease ^b in testosterone in transfemale adolescents with no change in transmale adolescents, decrease ^b in testicular volume in transfemale adolescents, decrease ^c in androstenedione, decrease ^b in LH and FSH	Increase ^b in height actual values, decrease ^b in height standardized values for transfemale adolescents, decrease ^c in height standardized values for transmale adolescents	Transfemale adolescents: Lumbar spine: no significant changes in actual score and decrease ^c in z score Femoral nondominant: decrease ^c in actual and z scores Transmale adolescents: Lumbar spine: decrease ^c in actual score and decrease ^b in z score Femoral nondominant: decrease ^c in actual and z scores	Increase ^b in wt for transfemale adolescents and transmale adolescents, increase ^b in BMI actual score for transfemale adolescents and transmale adolescents, nonsignificant changes in BMI SDSs for transfemale adolescents and transmale adolescents	—	—
Olson et al ²⁰	GAH (testosterone)	Increase ^b in total and FT levels, decrease ^b in normal and serum estradiol levels	—	—	Increase ^b in BMI, decrease ^c in total cholesterol	—	Increase ^b in Hb (but not to clinically significant levels), increase ^b in systolic BP and ALT (but not to clinically significant levels), decrease ^c in diastolic BP, increase ^c in AST

TABLE 2 Continued

Study	Treatment	Outcome					
		Testosterone, Estradiol, and Gonadotropin Levels	Anthropometric Measurements	BMD	Body Composition	Safety Profile	Other Physical Effects
Schagen et al ²¹	GnRHa	Transmale adolescents: menses ceased; Transfemale adolescents: decrease ^c in testicular volume, decrease ^c in LH and FSH, and decrease ^c in gonadotropin, estradiol, and testosterone	Decrease ^b in height SDSs and increase ^b in height values in transfemale adolescents and transmale adolescents	—	Increase ^b in wt scores, increase ^b in BMI scores, increase ^b in BMI SDSs, increase ^b in fat percentage, decrease ^b in lean body mass percentage in transfemale adolescents and transmale adolescents	—	Decrease ^b in transmale creatinine levels; no significant change in γ -glutamyl transferase, AST, and ALT; and decrease ^b in ALP in transfemale adolescents and transmale adolescents
Tack et al ³⁰	Androgenic progestin (lynestrenol)	Decrease ^b in LH; decrease ^c in FSH, estradiol, testosterone and AMH; decrease ^b in SHBG; increase ^b in fT	—	—	Increase ^b in wt and BMI during first 6 mo but back to baseline after 12 mo, no significant changes in total cholesterol and triglyceride levels, no significant change in HbA1c and HOMA, decrease ^b in mean HDL, increase ^c in mean LDL	Metrorrhagia mainly reported in first 6 mo, increase ^a in acne, most common safety profile of headache and hot flashes	Increase ^b in mean Hb and Hct, increase ^b in ALT, increase ^c in creatinine, increase ^b in fT4, no significant changes in AST and thyrotropin
Tack et al ³⁰	Combination of androgenic progestin (lynestrenol) and GAH (testosterone)	Decrease ^b in LH and FSH, decrease ^c in SHBG, increase ^b in testosterone and fT (reaching levels within male reference ranges), increase ^c in estradiol	Increase ^a in height and wt	—	Increase ^b in wt and BMI; no significant changes in total cholesterol, triglyceride levels, HDL and LDL mean levels, HbA1c, glucose levels, insulin levels, or HOMA index	Few had fatigue; increase ^a in acne and menorrhagia	Increase ^b in mean Hb and Hct levels, increase ^b in ALT and AST (but remained within male reference range), increase ^b in creatinine, decrease ^c in thyrotropin, decrease ^b in fT4

TABLE 2 Continued

Study	Treatment	Outcome					
		Testosterone, Estradiol, and Gonadotropin Levels	Anthropometric Measurements	BMD	Body Composition	Safety Profile	Other Physical Effects
Vlot et al ³¹	GnRHa	—	Increase ^c in height and wt (significance level not reported)	Transmale adolescents Decrease ^b in bone density in hip for older bone age (actual and z scores) Decrease ^b in bone density in lumbar spine for older bone age (actual and z scores) Decrease ^b in bone density in lumbar spine for young bone age (z scores) Transfemale adolescents Decrease ^b in bone density in lumbar spine for young bone age (z scores)	—	—	—
Vlot et al ³¹	GAH (testosterone and estrogen)	—	Increase ^a in height and wt	Transmale adolescents Increase ^b in bone density in hip and lumbar spine (actual and z scores) Transfemale adolescents Increase ^b in bone density in lumbar spine (actual and z scores) No significant changes in bone density in hip	—	—	—
Jarin et al ³²	GAH (testosterone)	Increase ^c in total testosterone after 1–3 mo, decrease ^c in estradiol	—	—	Increase ^c in BMI (no results for height and/or wt); no significant changes in LDL, total cholesterol, triglycerides, triglyceride to HDL ratio, and HbA1c; decrease ^b in HDL	—	Increase ^b in Hct and Hb; no significant changes in SUN, creatinine, prolactin, or AST; decrease ^c in ALT after 4–6 mo but returned to baseline

TABLE 2 Continued

Study	Treatment	Outcome					
		Testosterone, Estradiol, and Gonadotropin Levels	Anthropometric Measurements	BMD	Body Composition	Safety Profile	Other Physical Effects
Jarin et al ³²	GAH (estrogen)	Increase ^b in estradiol levels, decrease ^b in testosterone levels	—	—	No significant change in BMI (no results for height and/or wt), no significant changes in LDL, HDL, total cholesterol, triglycerides, and triglyceride to HDL ratio	—	No significant changes in BP (systolic and diastolic); initial decrease in Hct and Hb but returned to baseline; no significant changes in SUN, creatinine, prolactin, AST, or HbA1c; decrease ^b in ALT
Tack et al ²²	Antiandrogen (cyproterone acetate)	No significant changes in LH and FSH, decrease ^a in SHBG, decrease ^b in testosterone, nonsignificant decrease ^c in estradiol and fT, decrease ^b in dehydroepiandrosterone, decreased facial shaving frequency (55.60%). Breast development: Tanner B2 (14.8%) and B3 (14.8%)	Increase ^b in height, decrease ^b in height compared with male peers	—	No clinically important or statistically significant changes in wt and BMI, decrease ^b in triglycerides, no significant changes in total cholesterol, HDL, and LDL	Breast tenderness (7.4%), emotionality (11.10%), fatigue (36%), hot flashes (3.7%)	Increase ^b in prolactin (no clinical galactorrhea); decrease ^b in creatinine, Hb and Hct, but not outside of reference ranges; no significant changes in AST and ALT; no significant change in thyrotropin and fT4
Tack et al ²²	Combination of antiandrogen (cyproterone acetate) and GAH (estrogen treatment)	Decrease ^b in LH, decrease ^c in FSH, increase ^b in SHBG, increase ^b in estradiol, decrease ^b in testosterone and fT, no significant change in dehydroepiandrosterone, decreased shaving need (71.40%). Breast development: Tanner B3 (66.7%) and B4 (9.50%)	Increase ^b in height, decrease ^b in height compared with male peers	—	Breast tenderness (57.1%), emotionality (28.60%), hunger (24%), fatigue (14%), hot flashes (14.3%)	Increase ^b in BMI after 6–12 mo but BMI still less compared with Flemish male peers, increase ^c in wt, no significant changes in LDL, total cholesterol, HDL, and triglyceride levels	No significant changes in Hb and Hct, increase ^b in creatinine after 12 mo, no significant changes in AST and ALT, no significant change in thyrotropin and free thyroxine, decrease ^b in prolactin

Note that transmale adolescents are birth-assigned female individuals who identify as male individuals, whereas transfemale adolescents are birth-assigned male individuals who identify as female individuals. AMH, anti-Müllerian hormone; SUN, serum urea nitrogen; —, not applicable.

^a Indicates that a *P* value was not calculated.

^b Indicates significant change (*P* < .05).

^c Indicates nonsignificant change (*P* > .05).

TABLE 3 Psychosocial Effects of Hormonal Treatments in Transgender Youth

Study	Treatment	Outcome					
		Global Functioning	Depression	Anger and Anxiety	Behavioral and Emotional Problems		GD and Body Image
de Vries et al ²⁷ (de Vries et al ²⁶) ^a	GnRHa, GAH (not assessed)	Increase ^b (increase ^c)	Decrease ^b	Decrease ^c	CBCL: decrease ^b in total and internalizing scores, decrease ^b (decrease ^c) in externalizing scores	YSR: decrease ^b in total and internalizing scores, decrease ^b (decrease ^c) in externalizing scores	No significant effect ^d
Costa et al ²⁵	GnRHa	Increase ^e	—	—	—	—	—

Although influential articles in this field, Cohen-Kettenis and Van Goozen³³ and Smith et al³⁴ were unable to be included in our study because of their focus on patients after sex reassignment surgery. CBCL, Child Behavior Checklist; YSR, Youth Self Report; —, not applicable.

^a These 2 studies involved the same cohort and were therefore considered as 1 study. Parentheses are used to indicate the results of the earlier study²⁶ in which researchers examined a smaller subset of the cohort subsequently examined in the previous study.²⁷

^b Indicates significant change ($P < .05$).

^c Indicates nonsignificant change ($P > .05$).

^d It is important to note that the Utrecht Gender Dysphoria Scale that was used to measure GD in this study has various limitations, especially in relation to individuals who have already undergone social transition. Thus, the reported lack of improvement in GD here may reflect a lack of sensitivity in detecting psychological benefits. For example, it has been indicated in clinical experience that GnRHs help to satisfy the desire to prevent development of unwanted secondary sex characteristics (which is a criterion for GD under the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* in young adolescents), but the Utrecht Gender Dysphoria Scale does not have any items that address this issue.

^e Indicates that a P value was not calculated.

TABLE 4 Cognitive Effects of Hormonal Treatments in Transgender Youth

Study	Treatment	Outcome	
		Executive Functioning	Mental Rotation
Staphorsius et al ²⁴	GnRHa	No significant effect on Tower of London performance scores except for decrease ^a in accuracy in suppressed transfemale adolescents (but this was thought to be chance finding because of small sample size), no significant change in overall global functioning, exaggerated sex-typical brain activation of regions of interest	—
Burke et al ²³	GnRHa, GAH (testosterone treatment)	—	Inferred effect of GnRHa (transmale adolescents) At baseline, showed masculinized mental rotation—associated brain activation Testosterone treatment (transmale adolescents) Increase ^b in performance in mental rotation tasks, similar to control girls; increase ^a in bilateral parietal and left frontal activation

Note that transmale adolescents are birth-assigned female individuals who identify as male individuals, whereas transfemale adolescents are birth-assigned male individuals who identify as female individuals. —, not applicable.

^a Indicates significant change ($P < .05$).

^b Indicates that a P value was not calculated.

included breast tenderness (57.1%), emotionality (28.6%), hunger (23.8%), fatigue (14.3%), and hot flashes (14.3%).²²

Testosterone

Few side effects were reported with testosterone treatment, with localized injection reactions (5.6%)²⁰ and fatigue (8%)³⁰ all relatively uncommon. However, acne (37.5%) and menorrhagia (25%) were common complaints.³⁰

Bone Mineral Density

GnRHs in Transfemale Adolescents

Lumbar spine bone mineral density (BMD) z scores decreased after treatment with GnRHa monotherapy,^{19,29,31} and this reduction was statistically significant in all^{29,31} but 1 study.¹⁹ When results were stratified by bone age, the mean reduction in z score was only significant (1.32) for individuals with a bone age <15 years.³¹ Absolute lumbar spine BMD did not change over time, and thus the decrease in z scores after GnRHs likely reflects a failure to accrue BMD compared with age-matched peers. In 2 studies, researchers also examined BMD at the hip and femoral regions, which

TABLE 5 Risk of Bias for Studies of Effects of Hormonal Treatments in Transgender Youth

Study	Study Participation (Overall)	Study Attrition (Overall)	Outcome Measures (Overall)
Delemarre-van de Waal and Cohen-Kettenis ²⁹	High	High	Medium
de Vries et al ^{26,27}	High	High	Medium
Klink et al ¹⁹	Medium	High	Medium
Olson et al ²⁰	Medium	High	Medium
Costa et al ²⁵	Medium	Medium	Medium
Staphorsius et al ²⁴	Medium	High	Medium
Burke et al ²³	Medium	Medium	Medium
Schagen et al ²¹	High	High	Medium
Tack et al ³⁰	High	High	Medium
Vlot et al ³¹	Medium	High	Medium
Jarin et al ³²	High	High	Medium
Tack et al ²²	Medium	High	Medium

A modified version of the QUIPS tool was used to assess risk of bias according to 3 domains of bias, with each domain having 3 potential ratings of low, medium, or high.¹⁸ These domains of bias included study participation (study sample adequately represents population of interest), study attrition (available study data adequately represents the study sample), and outcome measurement (outcomes of interest are measured in a similar way for all participants). Use of the QUIPS tool has been described previously.¹⁷

revealed nonsignificant decreases in absolute and *z* scores for BMD.^{19,31} However, the duration of treatment varied significantly in these studies, being unknown in 1 study³¹ and at least 1 year¹⁹ and 2 years²⁹ in the others.

GnRHs in Transmale Adolescents

There was a greater reduction in BMD in transmale adolescents treated with GnRHs than transfemale adolescents. Two studies revealed a significant decrease in absolute and *z* scores for lumbar spine BMD,^{19,31} whereas another study revealed a significant reduction in only *z* scores.²⁹ In 1 study, researchers quantified the reduction in BMD *z* scores as being 0.79 for individuals with a bone age <14 years and 0.56 for individuals with bone ages ≥14 years.³¹ Two studies also revealed statistically significant reductions in BMD *z* scores at the hip and femoral regions in transmale adolescents.^{19,31}

Estrogen

Estrogen monotherapy was associated with significant increases in both absolute BMD and *z* scores in the lumbar spine,^{29,31} but not the hip,³¹ of transfemale adolescents previously treated with GnRHs. Furthermore, their *z* scores after 2

years of estrogen were still below that of age- and birth-assigned sex-matched norms.³¹ Specifically, *z* scores in the spine were −1.10 and −0.66 in those with younger (<15 years) and older (≥15 years) bone ages, respectively.

Testosterone

Testosterone monotherapy led to a significant increase in both absolute BMD and *z* scores in the lumbar spine^{29,31} and hip³¹ of transmale adolescents, who had previously been on GnRHs. However, their *z* scores did not reach that of age- and birth-assigned sex-matched controls, aside from the *z* scores in the hip of individuals with older bone ages. Specifically, *z* scores in the spine and hip were −0.15 and −0.37, respectively, in those with younger (<15 years old) bone ages and −0.06 and 0.02, respectively, in those with older (≥15 years old) bone ages.

Growth and Body Composition

GnRHs

Growth velocity decreased during treatment with GnRHs²⁹ in all transgender youth compared with pubertal-matched peers.²¹ In particular, younger individuals, who had greater growth potential, had significantly lower height

standard deviation scores (SDSs) after treatment.^{21,29} One study revealed significantly lower height standardized values for transfemale adolescents only.¹⁹ No researchers have examined whether individuals given GnRHs achieved their predicted final height after GAHs. After 1 year on GnRHs, individuals had a significant increase in body fat percentage²⁹ and BMI,^{19,21} which was accompanied by a decrease in lean body mass.²⁹

Progestins

Lynestrenol resulted in significant increases in weight and BMI absolute and *z* scores during the first 6 months with a return to baseline after 12 months of treatment.³⁰

Antiandrogens

Cyproterone acetate resulted in a decrease in growth velocity compared with age-matched peers,²² with a final height after 12 months of treatment also being significantly lower than age-matched peers with a mean standardized score of −0.309. There were no clinically significant changes in body weight and BMI after 12 months.

Estrogen

It is unclear whether differences in the pubertal stage and bone age at which estrogen was commenced contributed to the variable outcomes found because these data were not collected.²⁹ Estrogen in combination with cyproterone acetate resulted in reduced growth compared with age-matched peers in 1 study,²² whereas another study revealed no change in growth velocity after estrogen.²⁹ Total BMI was significantly increased after estrogen in 1 study,^{22,32} although another revealed that total BMI did not change after 6 months.³²

Testosterone

Testosterone monotherapy resulted in increased growth velocity compared with age-matched peers in 1 study,²⁹ but the impact on final

height (nor the age and pubertal stage at commencement) was not specified. Testosterone was also associated with weight gain,³⁰ resulting in a significantly raised absolute BMI^{20,30} from an average baseline of 20.7 to 22.4 within 6 months.²⁰ This increase in BMI was less than that of age-matched male adolescents.³²

Other Physical Effects

GnRHs

After 1 year of GnRHa, there were no changes in carbohydrate or lipid metabolism as measured by fasting glucose, insulin, cholesterol, low-density lipoprotein (LDL), and high-density lipoprotein (HDL) levels.²⁹ In 1 study, researchers observed that alkaline phosphatase (ALP) was decreased as a likely secondary result of decreased bone turnover, whereas all other liver enzymes were unchanged.²¹ In this same study, researchers also reported lower levels of creatinine and hypothesized that this might be due to reduced muscle mass but found that there was no correlation between change in muscle mass and creatinine.²¹

Progestin

Progestins were associated with an adverse lipid profile, with a significant decrease in HDL cholesterol by an average of 0.46 mmol/L and an elevation of LDL cholesterol by 0.37 mmol/L after 1 year.³⁰ There were no significant changes in hemoglobin A1c (HbA1c), glucose levels, insulin levels, or homeostasis model assessment (HOMA) index.³⁰ Alanine aminotransferase (ALT) increased after 12 months, but this was not clinically significant.³⁰ Mean hemoglobin (Hb) and hematocrit (Hct) levels increased in the first 6 months and subsequently remained stable.³⁰

Antiandrogens

Cyproterone acetate was associated with a significant reduction in only triglycerides, but total cholesterol, LDL cholesterol, HDL cholesterol, HbA1c, glucose, insulin, and HOMA index were unaffected.²² There was no change in liver enzymes or thyrotropin.²² There was a slight decrease in Hb and Hct after 12 months, but this was not clinically significant.²²

Estrogen

Apart from 1 study in which a significant decrease in HDL after 4 to 6 months was observed,³² estrogen had no effect on carbohydrate and lipid metabolism.^{22,29,32} Similarly, no significant changes in liver enzymes,^{22,32} thyrotropin, or free thyroxine (fT4)²² were noted with estrogen treatment. A significant increase in serum creatinine was seen after 12 months with combined estrogen and cyproterone acetate treatment.²² Hb and Hct were found to have decreased initially but returned to baseline after approximately 6–12 months.³² However, when estrogen was used in combination with a progestin, Hb and Hct levels did not change any further after 12 months.²² Blood pressure (BP) was unchanged after 6 months of estrogen.³²

Testosterone

Testosterone had no significant effect on carbohydrate and lipid metabolism.^{29,30,32} Although in 1 study researchers observed raised liver enzymes (aspartate aminotransferase [AST] and ALT) after a year,³⁰ another study revealed no significant change in AST and a decrease in ALT after 4 to 6 months.³² Testosterone treatment decreased thyrotropin and fT4 to be outside of the normal reference ranges, although these changes were not clinically relevant because there was no clinical or biochemical hypo- or hyperthyroidism in participants.³⁰

Serum creatinine increased after 6 months of testosterone with no subsequent change thereafter and was thought to reflect an increase in muscle mass.³⁰ Hb²⁰ and Hct³⁰ were increased after 6 months but remained stable during the next 6 months within the male reference ranges,^{20,30} whereas another study revealed no significant change in these parameters at any stage.³² Systolic BP was elevated in treated individuals, with an average rise of 5 mm Hg after 6 months.²⁰

PSYCHOSOCIAL EFFECTS

All relevant results are shown in Table 3.

GnRHs

GnRHa treatment was associated with significant improvements in multiple psychological measures, including global functioning,^{25–27} depression,^{26,27} and overall behavioral and/or emotional problems.^{26,27} The effects of GnRHs on anger and anxiety remain unclear with conflicting results.^{26,27} Moreover, GnRHa treatment had no significant effect on symptoms of GD,^{26,27} with researchers in 1 study observing a nonsignificant increase in GD and body image difficulties.²⁶

Progestin, Antiandrogens, Estrogen, and Testosterone

Critically, no researchers have examined the psychosocial effects of these hormonal therapy types in transgender youth.

COGNITIVE EFFECTS

All relevant results are shown in Table 4.

GnRHs

In one study, researchers examined the effect of GnRHs on executive functioning using the Tower of London test, which is used to assess mental planning ability.²⁴

After GnRHa treatment, there was significantly reduced accuracy in transfemale adolescents.²⁴ There was also exaggerated regional brain activation typical of birth-assigned sex on functional magnetic resonance imaging (fMRI).²⁴ However, given the small sample size (8 participants), these results should be interpreted cautiously.

In another study, researchers examined the effect of GnRHa treatment on mental rotation in transmale adolescents,²³ exploring whether rotated pairs of three-dimensional shapes were identical images of each other.^{35,36} Because men significantly perform better on this task compared with women, this result has also previously been suggested as evidence for the classic theory of the organizational and activational effects of sex hormones on the brain.^{37,38} Interestingly, GnRHa suppression in transmale adolescents was associated with male brain activation patterns, with reduced activity in the right frontal area.²³

Progestin, Antiandrogens, and Estrogen

No researchers have examined the cognitive effects of these treatments.

Testosterone

In the same study, researchers also examined the effects of testosterone in transmale adolescents on mental rotation tasks, in which they observed moderate to strong improvements in accuracy and reaction time.²³ Similar to control boys, treated transmale adolescents also demonstrated increased activation of brain regions implicated in mental rotation on fMRI.²³

DISCUSSION

This is the first systematic review of the effects of hormonal treatment in transgender youth; authors of previous systematic reviews in this field, including those commissioned

by the recent Endocrine Society Clinical Practice Guidelines, focused on the use of GAHs in adults.^{8–11,15}

GnRHs successfully suppressed endogenous puberty, consistent with the primary objective of this treatment, although there was only a single study in which researchers actually recorded these data.²⁹ GnRHs were observed to be associated with significant improvements in global functioning,^{25–27} depression,^{26,27} and overall behavioral and/or emotional problems^{26,27} but had no significant effect on symptoms of GD. The latter is probably not surprising, because GnRHs cannot be expected to lessen the dislike of existing physical sex characteristics associated with an individual's birth-assigned sex nor satisfy their desire for the physical sex characteristics of their preferred gender. Like GnRHs, the antiandrogen cyproterone acetate effectively suppressed testosterone in transfemale adolescents,²² but its potential psychosocial benefits remain unclear. Meanwhile, GAHs increased estrogen and testosterone levels and thus induced feminization and masculinization, respectively, of secondary sex characteristics.^{22,29} However, in the case of breast development, the outcomes were subjectively less in size than expected in the majority of recipients,²² and the potential psychosocial benefits of GAHs remain unknown. Finally, although the use of the progestin (lynestrenol) has been studied in transmale adolescents,³⁰ its effects were predominantly examined in the context of potential adverse effects, so the therapeutic impact of progestins for menses suppression and psychosocial outcomes cannot be understood from the current literature.

Overall, hormonal treatments for transgender youth were observed to be relatively safe but not without potential adverse effects. For GnRHs, a significant concern in

clinical practice is their potential effects on BMD accrual; their use was associated with a significant reduction in BMD,^{19,29,31} which appeared to be worse for transmale adolescents^{19,31} and is consistent with previous studies of nontransgender youth^{39,40} and adults⁴¹ who received GnRHs. However, given the relatively short follow-up duration of the studies reviewed here, it will be important for future researchers to better establish if this reduction in bone density is long-lasting or transient, as observed in nontransgender youth after GnRHa cessation.^{39,40} It is notable that BMD increased after estrogen and testosterone, which suggests potential compensation by GAHs. However, for estrogen treatment, the BMD of those who had previously received GnRHs still remained lower than age-matched peers 2 years after estrogen treatment,³¹ so compensation may only be partial. Furthermore, there is a lack of reporting of pubertal stage at treatment commencement, which makes interpretation of some changes difficult, especially BMD.

Clinically, patients who receive GnRHs and still have significant growth potential are counseled about the risk of the treatment affecting their final height. Although researchers in 2 studies have now examined growth and height characteristics in transgender youth receiving GnRHs,^{21,29} their relatively short follow-up times (≤ 3 years) precluded determination of the effects of GnRHs on final height, and future researchers should address this knowledge gap. Another clinical concern in the use of GnRHs is the induction of menopausal-like symptoms due to the withdrawal of sex steroids, especially in postpubertal individuals. GnRHs were commonly observed to cause hot flashes in transmale adolescents in late puberty, but these decreased in frequency over time.²⁹ For

potentially similar reasons, one of the main complaints after cyproterone acetate administration in transmale adolescents was fatigue.

Hormonal treatment of transgender adults is known to be associated with various metabolic and cardiovascular effects.^{10–12} GnRHs significantly increased both body fat percentage²⁹ and BMI^{19,21} while decreasing lean body mass.²⁹ Similarly, testosterone significantly increased both body fat and BMI.^{20,29} Although lynestrenol also increased BMI, this was transient, with BMI returning to baseline after 12 months.³⁰ Cyproterone acetate was not associated with any changes in BMI.²² In terms of lipid metabolism, neither testosterone nor estrogen had any observable impact, but lynestrenol was associated with lower HDL and higher LDL cholesterol after 1 year,³⁰ whereas cyproterone acetate significantly reduced triglycerides.²²

The findings from this review are subject to limitations. Firstly, the current literature has a limited number of studies in which the different hormonal treatments in transgender youth is examined. Secondly, for any given class of hormonal treatments, there is a variety of different agents, formulations, and administration routes that are being used clinically in transgender youth. For example, the physical effects of 1 antiandrogen and 1 progestin have been studied in only 1 study each, with no confirmation of results or further exploration. Thirdly, in existing studies there is a medium to high risk of bias, given small sample sizes, retrospective nature, and lack of

long-term follow-up. In this regard, although randomized controlled trials are often considered gold standard evidence for judging clinical interventions, it should be noted that, in the context of GD in which current guidelines highlight the important role of hormonal treatments,¹⁵ conducting such trials would raise significant ethical and feasibility concerns. Fourthly, authors of existing studies have neglected several key outcomes. These include the following: psychological symptoms related to GD, which is a critical knowledge gap given the high rates of mental health problems observed in transgender youth and justification of these treatments as treating GD⁴²; the impact of hormonal treatments on fertility, which is an integral part of the counseling recommended by current guidelines¹⁵; and potential adverse effects such as arterial hypertension, which was reported in a recent case series in association with GnRHs.⁴³ Finally, there are no known studies to date in which researchers have reported the rates and circumstances under which transgender youth cease their hormonal therapy in an unplanned manner or the risk of subsequent regret, which would be of great clinical utility.

Notwithstanding these limitations, collectively, the studies reviewed provide qualified support for the use of GnRHs, GAHs, cyproterone acetate and, to a lesser extent, lynestrenol in transgender youth. Overall, these hormonal treatments appear to provide some therapeutic benefits in terms of physical effects and are generally well-tolerated on the basis of current evidence.

CONCLUSIONS

Looking ahead, it will be essential for future researchers to reassess and expand on the findings of the existing studies. Large, prospective longitudinal studies, such as have been recently initiated,⁴⁴ with sufficient follow-up time and statistical power and the inclusion of well-matched controls will be important, as will the inclusion of outcome measures that investigate beyond the physical manifestations.

ABBREVIATIONS

ALT:	alanine aminotransferase
AST:	aspartate aminotransferase
BMD:	bone mineral density
BP:	blood pressure
fMRI:	functional magnetic resonance imaging
FSH:	follicle-stimulating hormone
FT:	free testosterone
FT4:	free thyroxine
GAH:	gender-affirming hormone
GD:	gender dysphoria
GID:	gender identity disorder
GnRHa:	gonadotropin-releasing hormone analog
Hb:	hemoglobin
HbA1c:	hemoglobin A1c
Hct:	hematocrit
HDL:	high-density lipoprotein
HOMA:	homeostasis model assessment
LDL:	low-density lipoprotein
LH:	luteinizing hormone
QUIPS:	Quality in Prognosis Studies
SDS:	standard deviation score
SHBG:	sex-hormone binding globulin

Ms Chew screened studies for inclusion and exclusion, conducted the data extraction, conducted the analyses, drafted the initial manuscript, and revised the manuscript; Dr May screened studies for inclusion and exclusion, conceptualized and designed the study, and reviewed and revised the manuscript; Dr Anderson conducted the data extraction, conducted the analyses, and revised the manuscript; Prof Williams reviewed and revised the protocol and manuscript; Dr Pang conceptualized and designed the study and reviewed and revised the manuscript; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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REFERENCES

- Cohen-Kettenis PT, Pfäfflin F. The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Arch Sex Behav*. 2010;39(2):499–513
- Zucker KJ, Cohen-Kettenis PT, Drescher J, Meyer-Bahlburg HF, Pfäfflin F, Womack WM. Memo outlining evidence for change for gender identity disorder in the DSM-5. *Arch Sex Behav*. 2013;42(5):901–914
- Giordano S. Lives in a chiaroscuro. Should we suspend the puberty of children with gender identity disorder? *J Med Ethics*. 2008;34(8):580–584
- Shalev E, Leung PC. Gonadotropin-releasing hormone and reproductive medicine. *J Obstet Gynaecol Can*. 2003;25(2):98–113
- Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *Int J Transgenderism*. 2012;13(4):165–232
- Basson RJ, Prior JC. Hormonal therapy of gender dysphoria: the male-to-female transsexual. In: Denny D, ed. *Current Concepts in Transgender Identity*. New York, NY: Garland Publishing; 1998:277–296
- Oriel KA. Clinical update: medical care of transsexual patients. *J Gay Lesbian Med Assoc*. 2000;4(4):185–194
- Costa R, Colizzi M. The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. *Neuropsychiatr Dis Treat*. 2016;12:1953–1966
- White Hughto JM, Reisner SL. A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgend Health*. 2016;1(1):21–31
- Elamin MB, Garcia MZ, Murad MH, Erwin PJ, Montori VM. Effect of sex steroid use on cardiovascular risk in transsexual individuals: a systematic review and meta-analyses. *Clin Endocrinol (Oxf)*. 2010;72(1):1–10
- Moore E, Wisniewski A, Dobs A. Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects. *J Clin Endocrinol Metab*. 2003;88(8):3467–3473
- Stadel BV. Oral contraceptives and cardiovascular disease (second of two parts). *N Engl J Med*. 1981;305(12):672–677
- Prior JC, Vigna YM, Watson D. Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Arch Sex Behav*. 1989;18(1):49–57
- World Health Organization. Adolescent development. Available at: http://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/. Accessed May 3, 2017
- Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869–3903
- Patton GC, Sawyer SM, Santelli JS, et al. Our future: a Lancet commission on adolescent health and wellbeing. *Lancet*. 2016;387(10036):2423–2478
- Brignell A, Albein-Urios N, Woolfenden S, Hayen A, Iorio A, Williams K. Overall prognosis of preschool autism spectrum disorder diagnoses. *Cochrane Database Syst Rev*. 2017(8):CD012749
- Hayden JA, van der Windt DA, Cartwright JL, Côté P, Bombardier C. Assessing bias in studies of prognostic factors. *Ann Intern Med*. 2013;158(4):280–286
- Klink D, Caris M, Heijboer A, van Trotsenburg M, Rottevel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab*. 2015;100(2):E270–E275
- Olson J, Schragger SM, Clark LF, Dunlap SL, Belzer M. Subcutaneous testosterone: an effective delivery mechanism for masculinizing young transgender men. *LGBT Health*. 2014;1(3):165–167
- Schagen SE, Cohen-Kettenis PT, Delemarre-van de Waal HA, Hannema SE. Efficacy and safety of gonadotropin-releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *J Sex Med*. 2016;13(7):1125–1132
- Tack LJW, Heyse R, Craen M, et al. Consecutive cyproterone acetate and estradiol treatment in late-pubertal transgender female adolescents. *J Sex Med*. 2017;14(5):747–757
- Burke SM, Kreukels BP, Cohen-Kettenis PT, Veltman DJ, Klink DT, Bakker J. Male-typical visuospatial functioning in gynephilic girls with gender dysphoria - organizational and activation effects of testosterone. *J Psychiatry Neurosci*. 2016;41(6):395–404
- Staphorsius AS, Kreukels BP, Cohen-Kettenis PT, et al. Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria. *Psychoneuroendocrinology*. 2015;56:190–199
- Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M.

- Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *J Sex Med.* 2015;12(11):2206–2214
26. de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics.* 2014;134(4):696–704
 27. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med.* 2011;8(8):2276–2283
 28. Bernard R, Abrami PC. *Statistical Applications in Meta-Analysis: Extracting, Synthesizing and Exploring Variability in Effect Sizes.* Montreal, Canada: Concordia University; 2014
 29. Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *Eur J Endocrinol.* 2006;155(suppl 1):S131–S137
 30. Tack LJ, Craen M, Dhondt K, Vanden Bossche H, Laridaen J, Cools M. Consecutive lynestrenol and cross-sex hormone treatment in biological female adolescents with gender dysphoria: a retrospective analysis. *Biol Sex Differ.* 2016;7:14
 31. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone.* 2017;95:11–19
 32. Jarin J, Pine-Twaddell E, Trotman G, et al. Cross-sex hormones and metabolic parameters in adolescents with gender dysphoria. *Pediatrics.* 2017;139(5):e20163173
 33. Cohen-Kettenis PT, van Goozen SH. Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry.* 1997;36(2):263–271
 34. Smith YL, van Goozen SH, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry.* 2001;40(4):472–481
 35. Linn MC, Petersen AC. Emergence and characterization of sex differences in spatial ability: a meta-analysis. *Child Dev.* 1985;56(6):1479–1498
 36. Voyer D, Voyer S, Bryden MP. Magnitude of sex differences in spatial abilities: a meta-analysis and consideration of critical variables. *Psychol Bull.* 1995;117(2):250–270
 37. Phoenix CH, Goy RW, Gerall AA, Young WC. Organizing action of prenatally administered testosterone propionate on the tissues mediating mating behavior in the female guinea pig. *Endocrinology.* 1959;65(3):369–382
 38. Manson JE. Prenatal exposure to sex steroid hormones and behavioral/cognitive outcomes. *Metabolism.* 2008;57(suppl 2):S16–S21
 39. Park HK, Lee HS, Ko JH, Hwang IT, Lim JS, Hwang JS. The effect of gonadotrophin-releasing hormone agonist treatment over 3 years on bone mineral density and body composition in girls with central precocious puberty. *Clin Endocrinol (Oxf).* 2012;77(5):743–748
 40. Pasquino AM, Pucarelli I, Accardo F, Demiraj V, Segni M, Di Nardo R. Long-term observation of 87 girls with idiopathic central precocious puberty treated with gonadotropin-releasing hormone analogs: impact on adult height, body mass index, bone mineral content, and reproductive function. *J Clin Endocrinol Metab.* 2008;93(1):190–195
 41. Smith MR. UpToDate. 2016. Available at: <https://www.uptodate.com/contents/side-effects-of-androgen-deprivation-therapy>. Accessed December 2016
 42. Hillier L, Jones T, Monagle M, et al. *Writing Themselves in 3: The Third National Study on the Sexual Health and Wellbeing of Same Sex Attracted and Gender Questioning Young People.* Melbourne, Australia: Australian Research Center in Sex, Health and Society, La Trobe University; 2010
 43. Klink D, Bokenkamp A, Dekker C, Rotteveel J. Arterial hypertension as a complication of triptorelin treatment in adolescents with gender dysphoria. *Endocrinol Metab Int J.* 2015;2(1):00008
 44. Reardon S. Largest ever study of transgender teenagers set to kick off. *Nature.* 2016;531(7596):560

Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria

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Abstract

Research provides inconclusive results on whether a social gender transition (e.g. name, pronoun, and clothing changes) benefits transgender children or children with a Gender Dysphoria (GD) diagnosis. This study examined the relationship between social transition status and psychological functioning outcomes in a clinical sample of children with a GD diagnosis. Psychological functioning (Child Behavior Checklist; CBCL), the degree of a social transition, general family functioning (GFF), and poor peer relations (PPR) were assessed via parental reports of 54 children (range 5–11 years) from the Hamburg Gender Identity Service (GIS). A multiple linear regression analysis examined the impact of the social transition status on psychological functioning, controlled for gender, age, socioeconomic status (SES), PPR and GFF. Parents reported significantly higher scores for all CBCL scales in comparison to the German age-equivalent norm population. Peer problems and worse family functioning were significantly associated with impaired psychological functioning, whilst the degree of social transition did not significantly predict the outcome. Therefore, claims that gender affirmation through transitioning socially is beneficial for children with GD could not be supported from the present results. Instead, the study highlights the importance of individual social support provided by peers and family, independent of exploring additional possibilities of gender transition during counseling.

Keywords

Gender dysphoria, transgender, peer support, family acceptance, social transition, gender affirmation, social support

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Introduction

Children with a Gender Dysphoria (GD) diagnosis experience an incongruence between their birth-assigned sex and their experienced gender with which they identify (also referred to as Gender Incongruence or Transgender). The clinical condition is referred to as *Gender Dysphoria* in the DSM 5 (American Psychiatric Association, 2013). Gender Identity Services around the world are facing the challenge to provide optimal treatment for individuals and their families to promote psychological well-being. While pubertal transgender adolescents with a GD diagnosis are eligible for puberty suppressing and gender affirming hormonal medication to medically support a gender transition, prepubescent children are not advised to receive any medical treatment before the onset of puberty (Tanner stage 2; Coleman et al., 2012). However, they often transition socially from one gender to another during childhood (Coleman et al., 2012). This reversible non-medical step towards a life in the identified gender may include changing one's name or pronoun, being introduced as the experienced gender in public, as well as gender typical appearance in terms of e.g., hair length and clothing (Steensma et al., 2013; Wong et al., 2019).

Social transition is often the first possibility to align with one's experienced gender and to living in the preferred gender role different from the one assigned at birth in almost all aspects of life (gender affirmation). If the wish to transition persists, this can be followed by medical, surgical and legal procedures during adolescence and adulthood (Coleman et al., 2012; Ehrensaft et al., 2018; Hill et al., 2010). Some clinicians consider a social transition as a necessary precondition for puberty suppressing or gender affirming hormonal therapy, and therefore as a first step towards an affirmation of a child's gender identity (Hill et al., 2010). However, according to the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (SoC 7; Coleman et al., 2012), vice versa a puberty suppression does not always or inevitably lead to social transition or to gender affirmation.

To this date, the possible benefits or disadvantages of an "early" social transition for a child's future development are among the most controversially discussed topics in Transgender Health Care (Coleman et al., 2012; Giordano, 2019; Steensma & Cohen-Kettenis, 2015; Wong et al., 2019); especially bearing in mind the developmental trajectories of persistence versus desistance into adolescence and adulthood (Ristori & Steensma, 2016). Children with either a GD diagnosis or so-called gender nonconforming or gender variant experiences often do not continue to experience a clinical GD as adolescents and adults (Ristori & Steensma, 2016; Steensma et al., 2013). This developmental pathway is referred to as a desisting GD ("desisters"), in contrast to "persisters," whose GD continues to persist into adolescence and adulthood (Steensma et al., 2011). This research has been criticized for including gender variant children despite not meeting the diagnostic criteria for a GD (Giordano, 2019; Temple Newhook et al., 2018). Furthermore, it has been argued that the number of desisters has been overestimated due to the timing of follow-up (Ehrensaft et al., 2018; Giordano, 2019). In a response to these critiques, Steensma and Cohen-Kettenis (2018) have subsequently described limitations and also highlighted the possibilities for more than these two developmental pathways of either persisting or desisting. Hence, the actual percentages of desistance and persistence remain uncertain, and so does the degree to which clinicians support a social transition in childhood.

In the general population, gender experiences may appear more fluctuating during childhood: according to a Germany study on high-school students, a relatively higher degree of younger adolescents (around the age of 11) presented gender variant experiences compared to older adolescents (around the age of 15), and compared to clearly incongruent gender experiences (Becker et al., 2017). Because of such possible fluctuations in gender experience during childhood and the

assumed relatively lower persistence of GD from childhood into adolescence, many researchers and clinicians have suggested to follow a so-called “supportive watchful-waiting” approach (e.g. Cohen-Kettenis et al., 2008; Steensma et al., 2013). This approach refers to providing a safe place for children to explore their gender, but advises to withhold complete social transitions until puberty. For example, de Vries and Cohen-Kettenis (2012) recommended for young children to not yet make a complete social transition before the very early stages of puberty. In contrast to this clinical management, a more gender affirmative approach freely endorses social transitions when they are perceived as appropriate (Ehrensaft et al., 2018; Giordano, 2019).

There are experts arguing, that an affirmation of the gender status and support of a complete social transition during childhood and adolescence may be associated with better psychosocial health (Durwood et al., 2017; Ehrensaft et al., 2018; Olson et al., 2016). Durwood et al. (2017) and Olson et al. (2016) reported relatively low levels of depression, anxiety and better self-worth in community samples of 63 young adolescents (9–14 years) and of 73 children (3–12 years) who had already undergone a complete social transition, and thus were supported in their experienced gender by parents. These findings were underlined in another community-based sample, where children with a GD diagnosis who had fully completed a social transition scored within the norm range for behavioral and emotional problems (Kuvalanka et al., 2017).

In contrast to the US-American studies from Durwood et al. (2017), Olson et al. (2016) and Wong et al. (2019), most clinical European studies report higher levels of psychological problems in clinical samples of both children and adolescents with a GD diagnosis (e.g. Cohen-Kettenis et al., 2003; de Vries et al., 2016; Steensma et al., 2013, 2014). On average, these populations of children presented more behavioral and emotional problems than their siblings and other control groups on parent- and teacher report questionnaires, assessed via the Child Behavior Checklist (CBCL Achenbach, 1991). These clinical studies indicated that children with GD are more likely to experience internalizing problems, such as anxiety and depression, than externalizing problems (Cohen-Kettenis et al., 2003; Steensma et al., 2014). Similarly, a Canadian community-based sample among gender-nonconforming children aged 6–12 years found impaired psychological functioning comparable to the results reported in clinical studies (Van der Miesen et al., 2018).

At the same time, however, most of this previous clinical research from Europe has not explored the possible role of the social transition status for psychological functioning outcomes. Nowadays, the two main explanations for elevated vulnerability and distress within this group are the state of conflict between one’s self-understanding of one’s gender and physical appearance on the one hand (Aitken et al., 2016), and lacking social support or poor peer relations (PPR) on the other hand (Aitken et al., 2016; Cohen-Kettenis et al., 2003; de Vries et al., 2016; Levitan et al., 2019; Steensma et al., 2014). Considering that gender nonconforming behavior is often evaluated negatively by peers, children with a GD diagnosis often experience a lack of social support from their peers or PPR, which in turn is associated with poorer psychological functioning. Family support or good general family functioning (GFF) levels on the contrary, may act as a protective factor against such health risks in youth with a GD diagnosis (Levitan et al., 2019; Simons et al., 2013). For example, in a population of 66 American adolescent transgender youth, parental support was significantly associated with higher life satisfaction, lower perceived burden related to being transgender and fewer depressive symptoms (Simons et al., 2013).

The aforementioned studies from Durwood et al. (2017) and Olson et al. (2016) indicate that internalizing problems, such as depression, were less present than previously assumed when children with a GD diagnosis had undergone a social transition. These findings suggest a positive association between family support, particularly in terms of affirming one’s child wish to transition, and better psychological functioning outcomes. Yet, the comparison of depression and anxiety measures in the statistical model among participants and controls in the study by Olson et al.

(2016) did not justify the conclusion that a social transition was directly linked to better psychological functioning outcomes. In contrast, the comparison of psychological functioning in socially transitioned children versus cisgendered gender-variant children by Wong et al. (2019) provide evidence for similar levels of behavioral problems regardless of their transition status. This study assessed different online assessed community samples of gender-variant children and highlights the importance of peer relationships for psychological well-being, instead of the social transition status or the degree of parental acceptance towards a child's gender experience. Hence, it remains unsolved whether the results of Durwood et al. (2017) and Olson et al. (2016) can be transferred to other samples, other families with different social transitioning pathways and support, and whether it is social transition status per se that explains the differences in psychological functioning.

Aim of the study and research questions

There is currently a lack of evidence in how far and to which degree a social transition during childhood impacts psychological functioning among children with a GD diagnosis. Previous studies have resulted in inconclusive results regarding the effects of support and the status of transitioning socially on psychological functioning outcomes. Thus, the present study examines two main research objectives: Firstly, psychological functioning of children diagnosed with GD in a clinical sample from Germany will be assessed. Secondly, the impact of transitioning socially on psychological functioning as an outcome will be examined, while controlling for age, gender, SES, PPR, and GFF.

Method

Procedure

The present study was conducted using a cross-sectional, questionnaire-based design. Data collection took place between September 2013 and December 2018 at the Hamburg Gender Identity Service for Children and Adolescents (Hamburg GIS) via parental reports of clinically referred children. All families that attended the Hamburg GIS during the aforementioned period were kindly invited to voluntarily complete a set of self- and parent-report questionnaires during their first appointment (see Figure 1). Hence, all data collection was conducted before undergoing any form of counseling or treatment. The study was granted approval by the local ethical committee. Written informed consent was collected from every study participant according to institutional guidelines.

Clinical protocol at the Hamburg GIS

The Hamburg GIS for Children and Adolescents at the University Medical Center Hamburg-Eppendorf was founded in 2006 (Möller et al., 2014). All treatment performed at the clinic comply to the international guidelines for the SoC 7 released by the World Professional Association for Transgender Health (WPATH) in 2012 by Coleman et al. (2012). Clinicians follow a diagnostic and treatment protocol that was developed and in the past referred to as the "Dutch Model" (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006; de Vries & Cohen-Kettenis, 2012). This clinical management approach suggests a watchful-waiting approach which differentiates counseling in contrast to a more gender affirmative treatment approach during adolescence (Cohen-Kettenis et al., 2008; Edwards-Leeper, 2016; Giordano, 2019). Sessions may include clinical diagnostics, counseling, psychotherapy and psychoeducation during childhood, as well as the possibility of referral to an endocrinology specialist for medical interventions after the onset of

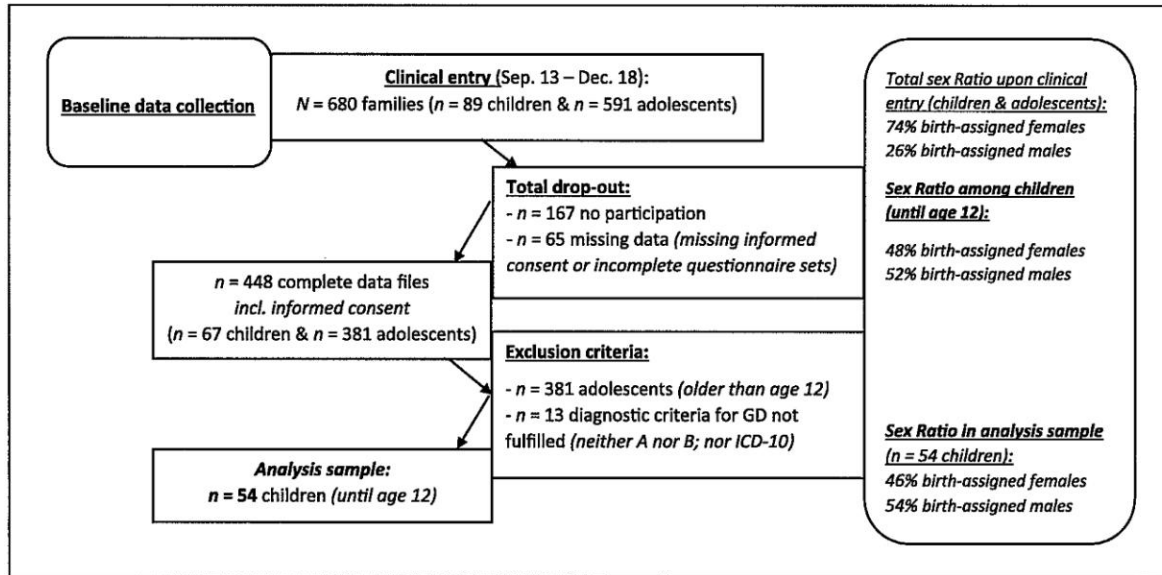


Figure 1. Participants and sex ratios at clinical entry (children and adolescents) and in analysis sample (children only).

puberty. After a comprehensive diagnostic and psychological evaluation over multiple sessions, medical interventions are currently recommended in Hamburg if GD during adolescence is persistent (without strict onset criteria) and accompanied by distress, if adolescents present the ability to consider and anticipate treatment options as well as possible consequences of a life in the preferred gender role. The psychosocial treatment modalities are based on a psychodynamic and developmental perspective and similar to a supportive watchful-waiting approach. This means that steps of social transition during childhood are supported in individual cases, when the family is open to such a step and if a child clearly expresses the desire to proceed to live in their experienced gender. Decisions are never being made by a clinician alone, but in line with current SoC7, where clinicians, children and parents identify the best individual pathway together (informed consent), and in relation to the personal social circumstances (Coleman et al., 2012). Psychotherapy offered include psychodynamic individual and family sessions with a frequency tailored to the child's individual needs.

Participants

This study was targeted towards clinically referred children under the age of 12 living in Germany and fulfilling the diagnostic criteria for GD according to the DSM 5 (American Psychiatric Association, 2013) and/or the ICD-10 (World Health Organization, 1992). During their first appointment, all families with initial visits to the clinic were invited to complete a set of questionnaires (see Figure 1). In total, 680 families and their children aged 5 to 18 visited the clinic during this period, with 74% of them being assigned female at birth (AFAB) and 26% being assigned male at birth (AMAB; cf. Levitan et al., 2019). Information was obtained upon clinical entry from parents, adolescents (aged 11 and above) as well as from clinicians. As this study aims to evaluate the situation of children under the age of 12, adolescent participants (12 years and older) were excluded from the present analysis. Thus, a distinction between children and adolescents was made based on age in this study (rather than on puberty status). In addition, $n = 13$ children had to be excluded because they did not fulfil any diagnostic criteria for GD according to either the DSM 5 or the ICD-10. Therefore,

parental reports of $n = 54$ (46% AFAB and 54% AMAB) children up to and including the age of 11 were included in the present analysis.

Measures

Sociodemographic variables

To describe the sample, the following sociodemographic measures were evaluated: birth-assigned sex, age at clinical entry (age at assessment), nationality, and the socioeconomic status (SES). To measure the SES based on the Winkler-Index (Winkler & Stolzenberg, 1999), education, income, and job position of both parents were included (similar to a previous study; cf. Levitan et al., 2019). Educational background of the parent with the higher status was coded as 1 (no or lower education), 2 (middle or technical school) and 3 (higher education or university). The household income was coded as 1 (less than 2.000€ per month), 2 (2.000–4.000€ per month) and 3 (more than 4.000€ per month). The job position of the parent with the higher status was coded as 1 (lower occupation or unemployed), 2 (skilled occupation or self-employed) and 3 (executive or academic occupation). Eventually, the score for the SES was the sum score of these three 3-point variables, therefore the SES ranged from 3 to 9.

Social transition status

The degree to which a child had transitioned socially was assessed via three items asking whether they lived in their preferred gender role in the following three everyday life areas: at home/with family, with friends/peers, and at school. Taking into consideration that multiple answers were possible, the final variable was summed up and then recoded as 1 (no social transition, yet, and living in birth-assigned gender role); 2 (partial social transition in at least 1 out of 3 life areas or in-between gender roles); 3 (almost complete social transition, living in the new gender role in at least 2 out of 3 life areas); 4 (complete social transition in all life areas). This measure was introduced in a previous study from Levitan et al. (2019) and allows for a more nuanced assessment of possible variance within the steps or the status of transitioning socially in multiple life domains (before undergoing any kind of transition-related medical intervention). In addition, parents were asked on a scale from 1 (not at all) to 5 (completely) in how far they supported their child's current gender role or social transition.

Psychological Functioning

Parents completed the German version of the Child Behavior Checklist (CBCL) for children and adolescents (ranging between 4 to 18 years of age; Achenbach et al., 1991; Döpfner et al., 1998) to measure behavioral and emotional problems. The original version of the CBCL consists of 113 items. Responses are rated on a 3-point scale ranging from 0 (not true) to 2 (very true or often true), with a higher score indicating a greater degree of the interrogated problems.

The CBCL provides a Total Problem Score which reflects the sum of problems and two main scales that allow to separate Internalizing and Externalizing problems. The Internalizing scale consists of items assessing anxiety and depression, somatic complaints and withdrawal problems. The Externalizing scale consists of items assessing externalizing problems, such as aggressive and rule breaking behavior. Scores above the 90th percentile or T -scores above 63 indicate clinically relevant problems. Birth-assigned sex-specific T -scores for all three scales of the German norm

population (aged 4–11; Döpfner et al., 1998) allow to determine whether the scores of the transgender sample lie within the German birth-assigned sex- and age-equivalent norm range.

Four items were not included in the Total Problem Score according to the manual and in order to avoid conflation due to extreme scores: two health-related items (“allergies” and “asthma”), and two items regarding cross-gender identification (item 5: “behaves like the opposite sex”; item 110: “wishes to be the other sex”). Additionally, if the answer given to item 85 (“has strange thoughts or ideas”) had a reference to the child’s gender identity or GD, the item was excluded from the Total Problem Score. In the present sample, Cronbach’s alpha for the Internalizing, Externalizing and Total Problem scales ranged between $\alpha = 0.90$ and 0.98 , respectively.

Poor Peer Relations (PPR)

Three items from the CBCL were used to create an index for problematic social interactions with peers, items 25 (“doesn’t get along with other kids”), 38 (“gets teased a lot”) and 48 (“is not liked by other kids”). This measure has been extensively used in previous research to assess the quality of peer relations of children and adolescents referred for GD (e.g. Aitken et al., 2016; Cohen-Kettenis et al., 2003; de Vries et al., 2016; Kuvalanka et al., 2017; Levitan et al., 2019). The answer range was between 0 and 6, with a greater score indicating higher degrees of peer related problems or more problematic peer interactions. Cronbach’s alpha for the PPR in the present sample was $\alpha = .73$.

General Family Functioning (GFF)

Based on the McMasters’ Model of Family Functioning, the Family Assessment Device (MFAD; Epstein et al., 1983) is an instrument designed to evaluate several aspects of family relationships. The seventh and so-called General Family Functioning Scale (GFF) evaluates family functioning in terms of how far family members feel supported by one another and feel like they can rely on each other. It consists of 12 items on a 4-point Likert-scale with response options from 1 (“strongly agree”) to 4 (“strongly disagree”). The sum of values is divided by the number of items, so that the total score ranges from 1 to 4. A higher score on the GFF reflects higher levels of problematic family functioning or lower perceived family support. The cut-off for problematic family functioning is set at 2.17 (Byles et al., 1988). In the present sample, Cronbach’s alpha for the GFF scale was $\alpha = .68$.

Statistical analysis

Missing values were replaced using the expectation-maximization (EM) algorithm method in cases where less than 20% of the items per scale and per participant were missing at random (Little & Rubin, 2014).

To identify characteristics of the population, *mean scores (M)* and *standard deviations (SD)*, as well as frequencies for the sociodemographic variables were assessed and possible gender group differences between AFAB and AMAB children were explored using independent samples *t*-tests.

To be able to compare psychological functioning scores of our sample with the German-age equivalent population-based norm, *T*-scores provided by Döpfner et al. (1998; $M = 50$, $SD = 10$) were assigned to the raw scores of the CBCL scales (Internalizing, Externalizing and Total Problem Score). Furthermore, *95%-confidence intervals* for the three scales were calculated. If confidence intervals do not include the mean of the norm *T*-distribution ($M = 50$), it can be assumed that they significantly differ from the birth-assigned sex and age equivalent reference group (Cumming & Finch, 2005).

Table 1. Sociodemographic and clinical characteristics.

	AFAB (<i>n</i> =25)		AMAB (<i>n</i> =29)		Total (<i>n</i> =54)		Group comparisons			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>p</i>	<i>d</i>
Age	9.98	1.53	8.25	2.17	9.05	2.08	3.321	52	.002**	0.93
SES mean score ^a	6.63	1.55	6.51	1.34	6.56	1.43	0.299	52	.766	0.08
Poor peer relations (PPR) ^b	0.94	1.18	1.03	1.50	0.99	1.35	-0.266	52	.791	0.07
General family functioning (GFF) ^c	1.46	0.30	1.48	0.41	1.47	0.36	-0.182	52	.856	0.06
Social transition status ^d	2.58	1.32	2.61	1.26	2.60	1.27	-0.088	52	.930	0.02

Note. AFAB = assigned female at birth; AMAB = assigned male at birth.

^aRange 3–9 (sum score based on parent's educational background, household income, and parental job position; a higher score reflects a higher SES).

^bRange 0–6 (sum score of CBCL items 25, 38, and 48; a higher score reflects higher levels of peer related problems).

^cRange 1 (better family functioning)–4 (higher levels of problematic family functioning).

^dRange 1 (no social transition)–4 (complete social transition in all life areas).

***p* < .01.

The second research question was performed using a multiple linear regression analysis. The raw score of the CBCL Total Problem Score was chosen as an outcome to assess possible predictors for overall psychological functioning. A modified version of the Total Problem score excluded one of the predictors in the model, the PPR scale (items 25, 38, and 48). In the first step of the regression analysis, the sociodemographic variables age, birth-assigned sex and SES were entered into the model as control variables. Afterwards, the variables assessing the degrees of PPR and GFF were included. Subsequently, the effect of social transition status on the outcome was determined by adding this variable into the model. In a multiple regression with *n*=54 cases and six predictors, an average effect (*f* = 0.15) can be tested with a power of 88% (calculated with GPower). In addition, a second and third exploratory data analysis were conducted to assess the impact of the six predictors of the main regression analysis on the Internalizing and Externalizing scales, separately. All data analyses were conducted using SPSS 25.

Results

Results of the clinical and sociodemographic characteristics are provided in Table 1. AFAB were on average older (*M* = 9.98, *SD* = 1.53) at the time of the first clinical referral than AMAB (*M* = 8.25, *SD* = 2.17). This difference was statistically significant, but no other gender differences were found.

Most children came from a family with a middle (50%) or high (48%) socioeconomic background. Around 96% of the sample were German citizens. 70% of the children with GD had undergone a social transition in at least one life area and 39% had undergone a complete social transition (lived in their preferred gender role in all life areas). Parental support of the social transition was generally high (with 87% of parents supporting their child's current gender role or social transition completely). GFF reported by the parents was above the cut-off or within the healthy range for 96% of the sample according to the cut-off provided by Byles et al. (1988); thus only 4% of the sample presented problematic GFF scores. 43% of the parents reported problematic peer interactions for their children in at least one domain of PPR. For both items 25 ("doesn't get along with other kids") and 38 ("gets teased a lot"), more than a third (31 and 32%, respectively) of the parents reported PPR for their children sometimes or often.

Table 2. Psychological Functioning Compared to German Norm.

CBCL scales	T-scores (children with GD with reference to the German norm)		
	M	SD	95% CI of the M
Internalizing scale (31 items)			
AFAB	60.68	10.20	[56.47; 64.89]
AMAB	59.17	12.80	[54.30; 64.04]
Total	59.87	11.59	[56.71; 63.03]
Externalizing scale (33 items)			
AFAB	55.60	14.57	[49.57; 61.61]
AMAB	55.86	9.34	[52.31; 59.42]
Total	55.74	11.93	[52.49; 59.00]
Total problem score (109 items)			
AFAB	59.20	12.26	[54.14; 64.26]
AMAB	59.52	10.68	[55.45; 63.58]
Total	59.37	11.33	[56.28; 62.46]

Note. AFAB = assigned female at birth; AMAB = assigned male at birth.

Age and birth-assigned sex equivalent German norm T-scores with $M = 50$, $SD = 10$ derived from Döpfner et al. (1998).

Psychological functioning in comparison to the German norm

An overview of the raw scores and T-scores for the three CBCL scales is presented in Table 2. Significant deviations from the norm population measured in T-Scores ($M = 50$, $SD = 10$) could be found via non-overlapping 95% confidence intervals for all groups, except for externalizing problems among AFAB.

In general, internalizing problems were more strongly elevated in all groups compared to externalizing problems. Both AFAB and AMAB presented scores for internalizing problems around one standard deviation higher than their age-equivalent German norm group. Internalizing problems within the clinical range (> 90 th percentile; T -scores > 63) were reported by 46% of the sample.

Both AMAB and AFAB also showed elevated scores for externalizing problems (around half a standard deviation above the norm mean), although AFAB were closer to the norm range. 40% of AMAB' parents reported clinically relevant scores, whereas only 28% of AFAB' parents reported the same.

The Total Problem Score for overall psychological functioning was significantly elevated in both groups in comparison to the German norm: 39% of the sample scored above the clinical range. Post-hoc t -tests confirmed the significant results of the non-overlapping 95%-confidence intervals for almost all scales, thus confirming that T-scores in this sample significantly differed from the norm, except for externalizing problems in AFAB.

Predictors of psychological functioning

The results of the regression analysis are reported in Table 3. An overview of the correlations for predictor variables in the regression analyses can be found in Table 4.

The results of the first model indicate that the three control variables birth-assigned sex, age and SES explained in total 11.1% of the variance. The SES significantly predicted psychological functioning, whereas birth-assigned sex and age did not. In the second model, birth-assigned sex, age, SES, PPR, and GFF in total explained 63.2% of the variance. It was found that both PPR and GFF

Table 3. Linear regression analysis for variables predicting psychological functioning (CBCL total problem score).

Variable	Model 1						Model 2						Model 3					
	B	SE B	95% CI B	β	t	p	B	SE B	95% CI B	β	t	p	B	SE B	95% CI B	β	t	p
Intercept	39.53	22.30	[-5.27; 84.32]		1.772	.082	7.60	15.43	[-23.43; 38.63]		0.492	.625	-0.98	15.97	[-33.10; 31.15]		-0.061	.951
Birth-assigned sex ^a	4.75	6.67	[-8.65; 18.16]	.102	0.713	.479	-0.86	4.39	[-9.60; 7.88]	-.018	-0.197	.844	-0.63	4.27	[-9.21; 7.96]	-.013	0.250	.804
Age	2.74	1.62	[-0.51; 5.99]	.242	1.695	.096	0.10	1.09	[-2.09; 2.29]	.009	0.090	.929	0.27	1.07	[-1.89; 2.43]	.024	-0.147	.884
SES	-5.38	2.13	[-9.67; -1.10]	-.327	-2.522	.015*	-2.24	1.48	[-5.15; 0.67]	-.136	-1.549	.128	-1.92	1.43	[-4.80; .97]	-.117	-1.337	.188
Poor peer relations (PPR)							11.01	1.64	[7.72; 14.30]	.631	6.728	.000***	11.53	1.64	[8.24; 14.82]	.661	7.052	.000***
General family functioning (GFF)							18.56	5.85	[6.81; 30.31]	.284	3.175	.003**	16.79	5.83	[5.06; 28.52]	.257	2.879	.006**
Social transition status													2.64	1.56	[-0.50; 5.78]	.143	1.692	.097
Adjusted R ²	0.111						0.632						0.646					
F	1.97*						8.71						7.26					
Sig. (p)	.031*						.000***						.000***					

Note. ^aDummy-coded (0 = AFAB; 1 = AMAB).

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4. Correlation matrix of variables for regression analyses.

Variable	2.	3.	4.	5.	6.	7.	8.	9.
1. Age	-0.418**	-0.018	-0.199	0.214	-0.089	0.205	0.225	0.191
2. Birth-assigned sex		-0.041	0.037	0.025	0.012	0.014	-0.033	0.014
3. SES			-0.308*	-0.019	-0.075	-0.336*	-0.288*	-0.251
4. Poor peer relations (PPR)				0.310*	-0.128	0.763**	0.669**	0.616**
5. General family functioning (GFF)					0.105	0.484**	0.362**	0.473**
6. Social transition status						0.508	0.134	0.047
7. Total problem score							0.796**	0.856**
8. Internalizing problems								0.419*
9. Externalizing problems								

Note. * $p < .05$. ** $p < .01$.

significantly predicted psychological functioning, but the control variables did not. In the third model, however, the social transition status variable did not significantly explain additional variance, and thus psychological functioning outcomes. The results of the final third model indicate that the six predictors together explained 64.6% of the variance.

The value for the Durbin-Watson statistic was 1.751. With the assumption that a value of 2 is an indicator for perfect independence, no autocorrelations in the residua were expected. The variance inflation factor (VIF) in all three models was not substantially greater than 1 (range between 1.003 and 1.343), therefore no multicollinearity was expected. Furthermore, the histogram of standardized residuals indicated that the data contained approximately normally distributed errors, as did the normal P-P plot of standardized residuals, which showed points that were not completely on the line, but close. Regarding homogeneity of variance and linearity, the scatterplot of standardized residuals showed that the data met these assumptions.

Exploratory data analysis

Exploratory data analysis was conducted to assess the impact of the six predictors of the main regression analysis on the Internalizing and Externalizing CBCL scales as an outcome. For the Internalizing scale, it was found that only SES ($\beta = -.282, p = .037$) and PPR ($\beta = .614, p = .000$) significantly predicted internalizing problems. For the Externalizing scale, it was found that only PPR ($\beta = .500, p = .000$) and GFF ($\beta = .302, p = .012$) significantly predicted externalizing problems.

Additionally, to investigate potential effect modifiers, interaction terms for all 15 possible combinations of the six predictor variables in the regression analysis were entered and excluded one by one the model. Only the interaction term of birth-assigned sex and GFF ($\beta = -.309, p = .032$) significantly predicted psychological functioning. For AMAB, lower GFF was reported when having higher behavioral problems. Interestingly, for AFAB, higher GFF was reported despite the presence of higher behavioral problems.

Discussion

The purpose of the present study was to describe psychological functioning and its association with the status of transitioning socially in clinically referred children with a GD diagnosis in Germany.

A significantly impaired psychological functioning compared to the same-aged German norm population was reported by parents on the CBCL. Especially internalizing problems were elevated in comparison to the German norm, similar to most previous research reporting more internalizing than externalizing problems for youth with GD (Cohen-Kettenis et al., 2003; de Vries et al., 2016; Steensma et al., 2014). Both AMAB and AFAB also showed elevated scores for externalizing problems, although AFAB were closer to the norm range. This finding is not conclusively in line with previous studies on youth with GD: most of them report Internalizing and Externalizing problem scores to be comparable to the problems that are “typically” reported for the sex opposite of the sex-assigned at birth or with the experienced gender (e.g. Levitan et al., 2019; Steensma et al., 2014; van der Miesen et al., 2020).

From the present results, it can be concluded that clinically referred children with a GD diagnosis from Germany show significantly elevated levels of emotional and behavioral problems, especially internalizing problems, similar to most previous research on children with GD from Europe (e.g. Aitken et al., 2016; Cohen-Kettenis et al., 2003; Steensma et al., 2014). These results are contradicting recent findings from North American studies using community based samples (Durwood et al., 2017; Kuvalanka et al., 2017; Olson et al., 2016), though not all of them (Van der Miesen et al., 2018).

The second research question of the present study was to assess the impact of the degree to which a child had already transitioned socially on psychological functioning outcomes among these children. In the present study, the social transition status (living in the preferred gender role in different everyday life areas) was not significantly associated with psychological functioning. Hence, the results are in contrast with the most prominent results so far provided by Olson et al. (2016), who argued that a complete social transition in childhood may lead to improved psychological functioning. Another recent study comparing transgender children who had completely transitioned to gender variant children who had not transitioned found that PPR, but not transition status, predicted psychological functioning (Wong et al., 2019). Likewise, our study found that, social support in general (from family and peers), but not necessarily in terms of affirming one's child gender status, plays a role for the psychological outcomes. This finding is in line with previous studies assessing similar relationships with psychological functioning (e.g. Aitken et al., 2016; de Vries et al., 2016; Levitan et al., 2019; Steensma et al., 2014; Wong et al., 2019).

Therefore, another result relates to the role of the family and support in the present analysis: next to PPR, a higher degree of problematic GFF significantly predicted higher degrees of problematic psychological functioning (especially for externalizing problems). Previous research has shown that, among transgender adolescents, a communicative and satisfactory family climate is associated with less suicidality, self-harm, depression and anxiety and more self-esteem and resilience (Katz-Wise et al., 2018), and less emotional and behavioral problems (Levitan et al., 2019). On the other hand, family support can promote self-esteem (Katz-Wise et al., 2018) and lead to higher quality of life, and less perceived burden of being transgender (Simons et al., 2013). Another recent study on transgender adolescents and their caregivers indicates that family functioning should not be assessed as a general construct, but as a more detailed pattern, as there can be differences in acceptance and rejection towards transgender adolescents between family members (Pariseau et al., 2019).

Limitations

In general, it is not possible to draw causal conclusions from the present results, since this study was conceptualized with a cross-sectional design.

Because of the small sample size, this study does not provide sufficient power for multiple hypothesis testing. However, there are various other factors that may explain the increased psychological vulnerability in children with GD. The intensity of experienced GD may lead to more emotional and behavioral problems, as well as the likelihood to transition socially, and should thus be considered as another potential confounder in future research. However, all children from this sample were referred to the Hamburg GIS for their GD, experienced more or less intense GD and a wish to transition, which is usually why their families reached out to the center.

Furthermore, the present sample was selected based on age (younger than age 12) and not on pubertal status. Onset of puberty may have had an effect on the degree to which individuals already transitioned in the present study and on their psychological functioning, especially in the significantly older sub-sample of AFAB. Future studies should therefore also consider possible relationships between puberty status and the outcome.

In consideration of the age of the children assessed in this study, no self-report was available and parental reports were used for the analyses. Parental ratings are a common method to measure children's behavior. However, parents may be limited in evaluating their children's situation compared to the child itself (Achenbach et al., 1987). Thus, it is possible that parental evaluations regarding their child's emotional and behavior problems in this sample were biased.

Caution is also warranted in generalizing the results to all children with a GD because of the small and relative unique sample. All 54 children in the analysis sample were referred to the clinic for their GD, most of them came from families with a medium or high socio-economic background and the family support of the children's gender identity was generally high. Due to the health care situation in Germany for children and adolescents with a GD diagnosis, some families go to considerable length to get access to treatment which they probably would not do if they did not generally support their child's personal situation. At the same time, the clinical guidelines of the Hamburg GIS are quite liberal and allow for individual treatment pathways. Thus, these findings might not apply to a more diverse sample of transgender children who are not supported in their gender identity or expression by parents or clinicians, or children who identify themselves on a broader gender spectrum.

Conclusion and Future Directions

This study provides additional evidence that children with a GD diagnosis from Germany experience impaired psychological functioning, which is in line with many results for children from other gender clinics worldwide.

At the same time, transitioning socially did not significantly affect the degree of emotional and behavioral problems in this population — contrary to previous studies looking at community based samples carried out by Durwood et al. (2017) and Olson et al. (2016), but in line with recent findings from a comparison of different online assessed community samples by Wong et al. (2019). Instead of social transition status itself, the individual social support was a significant predictor in the present study with regard to psychological functioning among children with GD. While further research is needed to address the possible impact of a “complete” social transition versus the degree of social transition on psychological functioning, the present study highlights the importance of both social interactions with peers and within the family for the psychological functioning in children with GD.

Clinicians can help children to deal with potential emotional and behavioral problems, and should aim to strengthen their resilience towards possible negative interactions, for example by teaching them strategies to cope with experiences of stigmatization and enhancing self-efficacy or self-esteem (Levitan et al., 2019; Steensma et al., 2013). Interventions targeted at reducing stigmatization among

children and adolescents in the general population and at schools are essential, since children with a GD diagnosis often lack peer support (Cohen-Kettenis et al., 2003; Steensma et al., 2014) and transgender adolescents are more likely to be bullied at school (Toomey et al., 2010). Both peers and family should be incorporated in the psychosocial treatment of this population as early as possible, because incorporating parents' needs and feelings in the psychotherapeutic process could improve the child's situation as well. Parents themselves can be affected by their child's GD and may experience parenting stress (Kolbuck et al., 2019).

Although claims that gender affirmation through transitioning socially is beneficial during this early stage could not be supported from the present results, supporting this step may still be considered in individual cases and together with the whole family. A clinical approach that considers children to explore their identity without strict criteria, but with an open mind, may allow for a discussion of all possible outcomes and individual strategies of exploring gender identity during childhood. This may include both persisting and desisting pathways (Giordano, 2019), possibilities of living in another (non-binary) gender, as well as the possibility that there are more than two future developmental pathways (Steensma & Cohen-Kettenis, 2015).

Due to the young age of the children investigated here, it is very likely that the long-term development these children undergo regarding their gender identity and the possible problems they may experience will be largely influenced by their parents' support in terms of access to treatment. Children may be encouraged in taking a lead in discussing possible social transitions and retransitions with their parents (Ehrensaft et al., 2018; Hidalgo et al., 2013; Olson et al., 2019). This is particularly important since transitioning socially should not only be viewed as a form of treatment, but can be understood as a possibility for children to explore their own individual developmental pathways (Giordano, 2019).

The present study highlights the importance of considering every case individually, as well as making decisions about a gender transition together with the whole family, as currently suggested by the SoC 7 of the WPATH (Coleman et al., 2012). Further longitudinal studies are urgently needed to draw more specific conclusions regarding the current clinical management of GD in childhood, advantages and disadvantages of social transition, long-term developmental outcomes from childhood throughout adolescence to young adulthood, and the interactions between children and their social environments — as well as the interactions between all of these aspects.

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References

- Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/ 4-18 and 1991 profile*. Burlington: University of Vermont, Department of Psychology.
- Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin*, 101(2), 213–232. <https://doi.org/10.1037/0033-2909.101.2.213>
- Aitken, M., VanderLaan, D. P., Wasserman, L., Stojanovski, S., & Zucker, K. J. (2016). Self-harm and suicidality in children referred for gender dysphoria. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55(6), 513–520. <https://doi.org/10.1016/j.jaac.2016.04.001>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing, Inc.
- Becker, I., Ravens-Sieberer, U., Ottová-Jordan, V., & Schulte-Markwort, M. (2017). Prevalence of adolescent gender experiences and gender expression in Germany. *The Journal of Adolescent Health*, 61(1), 83–90. <https://doi.org/10.1016/j.jadohealth.2017.02.001>
- Byles, J., Byrne, C., Boyle, M. H., & Offord, D. R. (1988). Ontario child health study: Reliability and validity of the general functioning subscale of the McMaster family assessment device. *Family Process*, 27(1), 97–104. <https://doi.org/10.1111/j.1545-5300.1988.00097.x>
- Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. (2008). The treatment of adolescent transsexuals: Changing insights. *The Journal of Sexual Medicine*, 5(8), 1892–1897. <https://doi.org/10.1111/j.1743-6109.2008.00870.x>
- Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, 31(1), 41–53.
- Cohen-Kettenis, P. T., Steensma, T. D., & de Vries, A. L. (2011). Treatment of adolescents with gender dysphoria in the Netherlands. *Child and Adolescent Psychiatric Clinics of North America*, 20(4), 689–700.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., & Monstrey, S. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13(4), 165–232. <https://doi.org/10.1080/15532739.2011.700873>
- Cumming, G., & Finch, S. (2005). Inference by eye: Confidence intervals and how to read pictures of data. *American Psychologist*, 60(2), 170–180. <https://doi.org/10.1037/0003-066X.60.2.170>
- Delemarre-van de Waal, H., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155, 131–137. <https://doi.org/10.1530/eje.1.02231>
- de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59(3), 301–320.
- de Vries, A. L. C., Steensma, T. D., Cohen-Kettenis, P. T., VanderLaan, D. P., & Zucker, K. J. (2016). Poor peer relations predict parent- and self-reported behavioral and emotional problems of adolescents with gender dysphoria: A cross-national, cross-clinic comparative analysis. *European Child & Adolescent Psychiatry*, 25(6), 579–588. <https://doi.org/10.1007/s00787-015-0764-7>
- Döpfner, M., Plück, J., Bölte, S., Lenz, K., Melchers, P., & Heim, K. (1998). Elternfragebogen über das Verhalten von Kindern und Jugendlichen: Deutsche Bearbeitung der Child Behavior Checklist (CBCL/4-18). Einführung und Anleitung zur Handauswertung mit deutschen Normen (2. Aufl.). Arbeitsgruppe Kinder-, Jugend- und Familiendiagnostik (KJFD).
- Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(2), 116–123.
- Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (2016). Affirmative practice with transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*, 3(2), 165. <https://doi.org/10.1037/sgd0000167>
- Ehrensaft, D., Giammattei, S. V., Storck, K., Tishelman, A. C., & Keo-Meier, C. (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative

- lens. *International Journal of Transgenderism*, 19(2), 251–268. <https://doi.org/10.1080/15532739.2017.1414649>
- Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy*, 9(2), 171–180. <https://doi.org/10.1111/j.1752-0606.1983.tb01497.x>
- Giordano, S. (2019). Importance of being persistent. Should transgender children be allowed to transition socially? *Journal of Medical Ethics*, 45(10), 654–661. <https://doi.org/10.1136/medethics-2019-105428>
- Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., Spack, N. P., & Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development*, 56(5), 285–290. <https://doi.org/10.1159/000355235>
- Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex & Marital Therapy*, 36(1), 6–23. <https://doi.org/10.1080/00926230903375560>
- Katz-Wise, S. L., Ehrensaft, D., Vettors, R., Forcier, M., & Austin, S. B. (2018). Family functioning and mental health of transgender and gender-nonconforming youth in the trans teen and family narratives project. *The Journal of Sex Research*, 55(4–5), 582–590. <https://doi.org/10.1080/00224499.2017.1415291>
- Kolbuck, V. D., Muldoon, A. L., Rychlik, K., Hidalgo, M. A., & Chen, D. (2019). Psychological functioning, parenting stress, and parental support among clinic-referred prepubertal gender-expansive children. *Clinical Practice in Pediatric Psychology*, 7(3), 254–266. <https://doi.org/10.1037/cpp0000293>
- Kuvalanka, K. A., Weiner, J. L., Munroe, C., Goldberg, A. E., & Gardner, M. (2017). Trans and gender-nonconforming children and their caregivers: Gender presentations, peer relations, and well-being at baseline. *Journal of Family Psychology*, 31(7), 889. <https://doi.org/10.1037/fam0000338>
- Leviton, N., Barkmann, C., Richter-Appelt, H., Schulte-Markwort, M., & Becker-Hebly, I. (2019). Risk factors for psychological functioning in German adolescents with gender dysphoria: Poor peer relations and general family functioning. *European Child & Adolescent Psychiatry*, 28(11), 1487–1498. <https://doi.org/10.1007/s00787-019-01308-6>
- Little, R. J. A., & Rubin, D. B. (2014). *Statistical analysis with missing data*. New York, NY: Wiley.
- Möller, B., Nieder, T. O., Preuss, W., Becker-Hebly, I., Fahrenkrug, S., Wüsthof, A., Briken, P., Romer, G., & Richter-Appelt, H. (2014). Versorgung von Kindern und Jugendlichen mit Geschlechtsdysphorie im Rahmen einer interdisziplinären Spezialsprechstunde. *Praxis der Kinderpsychologie und Kinderpsychiatrie*, 63(6), 465–485. <https://doi.org/10.13109/prkk.2014.63.6.465>
- Olson, K. R., Blotner, C., Alonso, D., Lewis, K., Edwards, D., & Durwood, L. (2019). Family discussions of early childhood social transitions. *Clinical Practice in Pediatric Psychology*, 7(3), 229–240. <https://doi.org/10.1037/cpp0000289>
- Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, 137(3). <https://doi.org/10.1542/peds.2015-3223>
- Pariseau, E. M., Chevalier, L., Long, K. A., Clapham, R., Edwards-Leeper, L., & Tishelman, A. C. (2019). The relationship between family acceptance rejection and transgender youth psychosocial functioning. *Clinical Practice in Pediatric Psychology*, 7(3), 267–277. <https://doi.org/10.1037/cpp0000291>
- Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. *International Review of Psychiatry*, 28, 13–20. <https://doi.org/10.3109/09540261.2015.1115754>
- Simons, L., Schrager, S. M., Clark, L. F., Belzer, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *Journal of Adolescent Health*, 53(6), 791–793. <https://doi.org/10.1016/j.jadohealth.2013.07.019>
- Steensma, T. D., & Cohen-Kettenis, P. T. (2018). A critical commentary on “A critical commentary on follow-up studies and “desistence” theories about transgender and gender non-conforming children”. *International Journal of Transgenderism*, 19(2), 225–230. <https://doi.org/10.1080/15532739.2018.1468292>
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, 16(4), 499–516. <https://doi.org/10.1177/1359104510378303>
- Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child & Adolescent Psychiatry*, 54(2), 147–148. <https://doi.org/10.1016/j.jaac.2014.10.016>
- Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up

- study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(6), 582–590. <https://doi.org/10.1016/j.jaac.2013.03.016>
- Steensma, T. D., Zucker, K. J., Kreukels, B. P. C., Vanderlaan, D. P., Wood, H., Fuentes, A., & Cohen-Kettenis, P. T. (2014). Behavioral and emotional problems on the teachers report form: A cross-national, cross-clinic comparative analysis of gender dysphoric children and adolescents. *Journal of Abnormal Child Psychology*, 42(4), 635–647. <https://doi.org/10.1007/s10802-013-9804-2>
- Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M. L., Jamieson, A., & Pickett, S. (2018). A critical commentary on follow-up studies and “desistance” theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, 19(2), 212–224. <https://doi.org/10.1080/15532739.2018.1456390>
- Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, 46(6), 1580–1589. <https://doi.org/10.1037/a0020705>
- Van der Miesen, A. I., Nabbijohn, A. N., Santarossa, A., & VanderLaan, D. P. (2018). Behavioral and emotional problems in gender-nonconforming children: A Canadian community-based study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 57(7), 491–499. <https://doi.org/10.1016/j.jaac.2018.03.015>
- Van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender affirmative care compared to cisgender general population peers. *Journal of Adolescent Health*. Advance online publication. <https://doi.org/10.1016/j.jadohealth.2019.12.018>
- Winkler, J., & Stolzenberg, H. (1999). Social class index in the Federal Health Survey. *Gesundheitswesen (Bundesverband der Ärzte des Öffentlichen Gesundheitsdienstes (Germany))*, 61, 178.
- Wong, W. I., van der Miesen, A. I. R., Li, T. G. F., MacMullin, L. N., & VanderLaan, D. P. (2019). Childhood social gender transition and psychosocial well-being: A comparison to cisgender gender-variant children. *Clinical Practice in Pediatric Psychology*, 7(3), 241–251. <https://doi.org/10.1037/cpp0000295>
- World Health Organization (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

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RESEARCH ARTICLE

Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK

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Abstract

Background

In adolescents with severe and persistent gender dysphoria (GD), gonadotropin releasing hormone analogues (GnRHa) are used from early/middle puberty with the aim of delaying irreversible and unwanted pubertal body changes. Evidence of outcomes of pubertal suppression in GD is limited.

Methods

We undertook an uncontrolled prospective observational study of GnRHa as monotherapy in 44 12–15 year olds with persistent and severe GD. Prespecified analyses were limited to key outcomes: bone mineral content (BMC) and bone mineral density (BMD); Child Behaviour Checklist (CBCL) total t-score; Youth Self-Report (YSR) total t-score; CBCL and YSR self-harm indices; at 12, 24 and 36 months. Semistructured interviews were conducted on GnRHa.

Results

44 patients had data at 12 months follow-up, 24 at 24 months and 14 at 36 months. All had normal karyotype and endocrinology consistent with birth-registered sex. All achieved suppression of gonadotropins by 6 months. At the end of the study one ceased GnRHa and 43 (98%) elected to start cross-sex hormones.

There was no change from baseline in spine BMD at 12 months nor in hip BMD at 24 and 36 months, but at 24 months lumbar spine BMC and BMD were higher than at baseline (BMC +6.0 (95% CI: 4.0, 7.9); BMD +0.05 (0.03, 0.07)). There were no changes from baseline to 12 or 24 months in CBCL or YSR total t-scores or for CBCL or YSR self-harm indices, nor for CBCL total t-score or self-harm index at 36 months. Most participants reported

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positive or a mixture of positive and negative life changes on GnRHa. Anticipated adverse events were common.

Conclusions

Overall patient experience of changes on GnRHa treatment was positive. We identified no changes in psychological function. Changes in BMD were consistent with suppression of growth. Larger and longer-term prospective studies using a range of designs are needed to more fully quantify the benefits and harms of pubertal suppression in GD.

Introduction

Gender dysphoria (GD) describes the experience of incongruence between an individual's experienced gender and the sex they were assigned at birth. GD [1] in children and young people, also known as Gender Incongruence [2] and previously known as Gender Identity Disorder (GID), is associated with considerable distress or impairment in social, school or other important areas of functioning [3,4]. Interventions include psychosocial support, therapy and medical or surgical interventions to align the body with the identified gender [3,5]. Terminology in this field can be challenging [6]. Here we use birth-registered sex to refer to the sex assigned at birth by clinicians based upon external genitalia [6]. Gender identity refers to a young person's personal sense of their gender. We use the terms 'continuation' and 'discontinuation' to refer to GD across childhood and adolescence.

GD in adolescence is highly likely to continue into adult life where gender dysphoria persists after the onset of puberty [3]. Those with earlier onset or more intense GD and those in whom the development of secondary sexual characteristics in puberty is associated with increasing gender dysphoria or psychological distress are more likely to have persistent GD [3,7]. In adolescents with severe and persistent GD, international [8] and national [9–11] guidelines recommend the use of treatments to suppress the rise in sex hormones (oestradiol or testosterone) in young people during puberty. Gonadotropin releasing hormone analogues (GnRHa) are synthetic peptides that work by stimulating gonadotropin release in a tonic fashion which desensitises the gonadotropin receptors, resulting in reversible suppression of sex hormone production.

In GD, GnRHa can be used from the early/middle stages of puberty with the aim of delaying irreversible and unwanted pubertal body changes and giving young people the opportunity to explore their gender identity during a period when puberty is not advancing [3]. This period also allows clinicians more time to assess the stability of young people's gender identity [6]. Despite this treatment being given in mid-puberty it is also called early puberty suppression, where 'early' refers to earlier than the historic practice of suppression after completion of puberty.

Pubertal suppression is currently practised in the majority of international centres across Europe, the Americas and Australasia, as evidenced by a recently published survey of 25 international centres by the European Society of Paediatric Endocrinology (ESPE) [12]. Pubertal suppression with GnRHa as monotherapy is a time-limited strategy, due to the potential for side effects with long-term use. In the UK, for those commencing under age 15 years, use of GnRHa alone ceases after 16 years when young people face a decision to return to the sex hormones produced by their body or begin cross-sex hormones [5]. There are limited data on the outcomes of pubertal suppression in the treatment of young people with GD [3,13]. A recent

systematic review included data on the physical and mental health outcomes of pubertal suppression using GnRHa in over 500 young people [4]. Longer-term follow-up data on pubertal suppression in GD are limited to individuals from four cohorts [14–19].

In 2011 a study was begun to evaluate the proximal outcomes of mid-pubertal suppression using GnRHa in young people with persistent GD (see <http://gids.nhs.uk/our-early-intervention-study>). Use in the UK began after mid-pubertal suppression had been incorporated into international guidelines [20] and had become available in the USA [21,22], the Netherlands [15], Australia [23] and a number of European countries. The Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust, London, is a national service for children and young people with GD, drawing from England, Wales and Ireland. Mid-pubertal suppression was offered by the GIDS from 2011 initially only within an ethically approved uncontrolled observational research study with prospective data collection, where all participants received GnRHa. We anticipated that we would recruit 10–15 young people per year for 3 years and follow them up to the end of monotherapy with GnRHa. At the time, a randomised controlled study was not considered feasible due to very small numbers and inability to retain participants in the control arm, as the control treatment would have resulted in progression into near complete puberty and an increasing number of UK families were accessing mid-pubertal suppression internationally. Allocation blinding was also not considered feasible in young people using a product requiring monthly injections.

Here we describe the short-term outcomes of 44 young people with GD from this research cohort, recruited aged 12–15 years and followed to the end of GnRHa monotherapy after age 16 years. This paper describes their medical, psychological and social outcomes during the GnRHa treatment pathway up to the point of decisions about whether or not to undertake further physical treatment. The aims of the study as defined at inception in 2011 were:

1. To evaluate the benefits and risks for physical and mental health and wellbeing of mid-pubertal suppression in adolescents with GD
2. To add to the evidence base regarding the efficacy of GnRHa treatment for young people with GD
3. To evaluate continuation and discontinuation of GD and the continued wish for gender reassignment within this group.

Methods

We undertook an uncontrolled prospective observational study of GnRHa monotherapy in a highly selected group of young people with persistent and severe GD.

Participants

The cohort consisted of 44 sequentially eligible young people, aged 12 to 15 years, who were recruited between April 2011 and April 2014 and who commenced GnRHa treatment between June 2011 and April 2015. They were all recruited from patients referred to the GIDS.

Eligibility criteria were chosen to match those used for a Netherlands cohort [24], namely that the young person:

- A. is aged 12–15 years
- B. Psychological criteria

1. has been seen by the GIDS for at least 6 months and attended at least 4 interviews for assessment and therapeutic exploration of their gender identity development.

2. psychological stability sufficient to withstand the stresses of medical treatment for GID.
3. fulfils the following criteria relating to GID:
 - a. Throughout childhood (defined as over 5 years) the adolescent has demonstrated an intense pattern of cross-gendered behaviours and cross-gender identity.
 - b. The adolescent has gender dysphoria that is significantly increased with the onset of puberty. Following assessment the clinician(s) working with the young person deem that there is a high likelihood of the young person experiencing severe psychological distress consequent on experiencing full pubertal development before pubertal suppression is implemented.
4. The young person and their parents/guardians are actively requesting pubertal suppression.
5. is able to give informed consent.

C. Physical/medical criteria

1. is in established puberty:
 - For birth-registered males Tanner (genital and pubic hair (PH)) stage 3 and above.
 - For birth-registered females Tanner (breast and PH) stage 2 and above.

The rationale for the sex difference was that the pubertal growth spurt which early intervention aims to avoid occurs typically two years earlier in females (Tanner stage 2–3) than in males (Tanner stage 3–4), thus earlier intervention is required in females.
 2. has normal endocrine function and karyotype consistent with birth registered sex.
- Note that the presence of mildly elevated androgens in birth registered females consistent with polycystic ovarian syndrome is not an exclusion criterion.
- Exclusion criteria:
1. Inability to participate with full investigatory protocol e.g. needle phobia, failure to attend for tests and scans.
 2. Body mass index (BMI) <2nd centile for age and birth-registered sex [20].
 3. Serious psychiatric conditions (e.g. psychosis, bipolar condition, anorexia nervosa, severe body-dysmorphic disorder unrelated to GD).
 4. Inability to give informed consent according to the Fraser/Gillick guidelines.
 5. Low spine or hip bone mineral density (BMD) on DXA scan: more than 2 SD below expected BMD for age and birth-registered sex. In exceptional circumstances a low BMD was acceptable if:
 - i. it was felt to be clinically appropriate by the treating clinicians, who felt that on the balance of risks, pubertal suppression was justified despite the later risk of osteoporosis
 - ii. the young person and parents understood the risks of GnRHa treatment for bone density (i.e. potential risks of later osteoporosis)
 - iii. The young person and parents consented to more frequent monitoring of BMD (repeat DXA scans 6 months after starting GnRHa and yearly thereafter while on GnRHa) despite the small DXA radiation dose

- iv. The young person and parents consented to stopping treatment if raw BMD fell whilst on GnRHa.

The treatment

The treatment under study was suppression of puberty using the GnRHa *triptorelin* together with psychosocial support and therapy, from study entry until the end of the GnRHa monotherapy pathway at age 16 years or older. GnRHa monotherapy ceased when young people either started cross-sex hormones (and continued on GnRHa) or stopped GnRHa. Treatment duration was therefore from 1 to 4 or 5 years depending on age at study entry. Consenting young people were given triptorelin 3.75mg by intramuscular injection every 28 days during the treatment period. Two participants who found monthly injections difficult were moved to a ten-weekly preparation of 11.25mg of triptorelin. The aim of treatment was to suppress gonadotropins and sex hormones to near pre-pubertal levels [13]. Continued regular attendance for psychological support and therapy throughout the study was a precondition of GnRHa prescription. In addition local psychological services provided support for co-occurring difficulties for participants as required.

Procedures and pathway

All young people and families attending the GIDS during the study period were provided with an information leaflet about research underway within the unit. Those wishing to find out more about the study discussed it with their GIDS clinicians and those deemed likely to be eligible were given detailed written study information. Those wanting to participate were invited to a medical clinic at UCLH for an initial discussion. At the first medical clinic, young people and families were seen by a senior paediatric endocrinology clinician together with a senior GIDS clinician, who discussed with the family the then current state of knowledge and rationale for treatment, eligibility criteria and potential risks and benefits of participation. Risks included the anticipated side-effects of GnRHa treatment including symptoms resulting from the withdrawal of sex steroids (headaches, hot flushes), fatigue, loss of libido and low mood, the potential that treatment could influence the continuation of their GD and the potential for unknown risks. It was emphasised that young people needed to continue with both regular medical and psychosocial follow-up during the study and that treatment would cease if they did not comply with the treatment or monitoring requirements. A full medical history was elicited and the clinicians also reviewed a summary of the psychological history and assessment from the GIDS. In this visit information sheets were re-provided if families had lost them or forgotten details of the study. If young people and families remained interested in participation, medical investigations were organised and families were invited for a repeat discussion and a formal evaluation of eligibility at a second medical clinic visit approximately 3 months later. Families were asked to think about the issues raised in the meeting and to discuss with their GIDS clinicians if necessary, in order to discuss further at the second visit.

At the second medical clinic visit, the same clinicians repeated the discussion of risks and benefits and explored understanding with the young person and family. A chaperoned medical examination was undertaken including pubertal assessment and the results of medical investigations were reviewed. Endocrine and GIDS clinicians jointly reviewed eligibility and offered participation in the study to those deemed eligible.

The implications of treatment for fertility were discussed at the first and second medical visits and all young people were urged to consider storing gametes before starting GnRHa. Access to storage depended on regional availability within the NHS. Note that counselling on fertility

continued across the study, and clinicians periodically checked with young people who had decided against storage whether they wished to revisit their decision.

Informed consent was obtained in writing from both the young person and a parent or carer holding parental responsibility. The ability of the young person and parents to give informed consent was assessed jointly by the senior adolescent endocrine and GIDS clinicians, informed by written notes from the GIDS team. The consent forms were read with the young person and the parent by the clinicians to be sure they fully understood the information on the forms before signing.

48 young people and families attended the medical clinics for discussion of participation in the trial, of whom 44 wished to participate. Eight young people (7 birth assigned males) were not eligible for participation at the second medical visit as they were not yet sufficiently advanced in puberty. They were followed up every 3–6 months and entered the study subsequently when sufficiently advanced in puberty (median waiting time 7 months).

The date of signing the consent form was taken as the start of study treatment, although it frequently took one to three months for GnRHa treatment to start due to administrative requirements. Participants were followed up in the endocrine clinic, 3–6 monthly in the first 18 months and 12-monthly thereafter, till the end of the treatment pathway, defined as the date on or after the 16th birthday when a decision was made to either cease GnRHa or start cross-sex hormones. The final participant completed the pathway in February 2019.

Outcomes

The following data were collected:

A. Baseline explanatory variables

1. Sex and gender: Young people were classified by their sex assigned at birth (birth-registered sex) and self-identified gender.
2. Ethnicity: Ethnicity was obtained from clinic records. For analysis, ethnicity was grouped as white, South Asian, black or mixed.
3. Puberty: Pubertal status at baseline was classified using information on genital/breast and pubic hair Tanner stages as appropriate. This was summarized into a single pubertal stage, with the breast/genital stage taking precedence if there was discrepancy between breast/genital and pubic hair stage.
4. Clinical data: These consisted of a) identification of normal phenotype on physical examination for birth-registered sex; b) venepuncture assessment of endocrinology (gonadotropins, prolactin, oestrogen or testosterone, adrenal androgens, thyroid function; and a short synacthen test in birth-registered females only), karyotype, full blood count, renal and liver function, calcium and vitamin D; and c) imaging including wrist bone age and (in birth-registered females only) pelvic ultrasound scan. Medical assessment at baseline and follow-up was consistent with Endocrine Society guidelines [8,20].

B. Study outcomes

Study outcomes concerned domains including response to treatment, bone health, safety indicators and adverse events, psychological function; participant experience and satisfaction; and decisions regarding treatment following GnRHa. Outcome data were collected at routine clinic visits to GIDS or medical clinics at UCLH and timings therefore varied. For the purposes of these analyses, data for each participant were assigned to baseline (before treatment) and to the closest of the following outcome periods: 12, 24, 36 and 48 months on treatment. For safety and response to pubertal suppression outcomes, data were also examined at 6 months.

1. Response to pubertal suppression

Gonadotropins (LH, FSH), testosterone (in birth-registered males) and oestrogen (birth-registered females) were measured after venepuncture. Height, weight and blood pressure were recorded by trained clinic staff. BMI z-score for age and birth-registered sex was calculated [25]. Menarcheal status and presence/absence of menstrual periods was obtained by report from birth-registered females.

2. Bone health

Bone mineral content (BMC) and bone mineral density (BMD) in the lumbar (L1 to L4) spine and hip (total hip) were measured by dual energy X-ray absorptiometry (DEXA) scans using a Hologic Discovery QDR series model 010–1549 (Hologic Inc, Bedford, MA, USA). BMD z-scores for age and birth-registered sex appropriate to this machine were calculated [26]. BMD z-scores for spine and hip were further adjusted for height (height-adjusted z-scores) using published formulae [27].

3. Safety indicators and adverse events

Blood samples were collected by venepuncture for liver and renal function, full blood count, calcium and vitamin D, prolactin, adrenal androgens and thyroid function. Participants were routinely questioned about adverse events at medical clinic visits, including anticipated events such as headaches, hot flushes or fatigue plus any other unanticipated events.

4. Psychological function

Psychological outcomes included a clinical outcome routinely collected after GIDS appointments and a range of outcomes assessed using questionnaires. A standardised set of psychological questionnaires used in the GIDS clinic was completed at the time young people were deemed potentially eligible and referred to the medical clinic. Questionnaires were completed at home by the young person and parent between GIDS clinical meetings, and a research assistant followed up families to ensure their completion. Questionnaires were repeated approximately every 12 months on treatment.

i. General psychological functioning

The Child Behaviour Checklist (CBCL) (parent report) and Youth Self Report (YSR) (self-report) are general measures of psychological functioning and part of the Achenbach System of Empirically Based Assessment (ASEBA; www.aseba.org). The CBCL consists of 113 questions and is validated for children aged 6–18 years in international population samples [28]. The YSR consists of 112 questions and is validated in international populations of young people aged 11–18 years [29]. Questions in both are scored on a three-point Likert scale (0 = absent, 1 = occurs sometimes, 2 = occurs often), with the time frame for item responses being the past six months. Scoring for both instruments provides a total problems score, an internalizing problems score (items which assess anxious/depressed, withdrawn-depressed, and somatic complaints) and an externalizing score (focusing on rule-breaking and aggressive behaviours). Each questionnaire was scored with Assessment Data Manager Software using ASEBA standard norms and t-scores were generated based on reference data for birth-registered sex and broad age-ranges (here 12–18 years). Higher scores indicate greater morbidity. To account for normative change within our age-range, we used international reference data [29] to transform YSR raw scores into z-scores for year of age. As reference data from the UK were not available, reference data from both Australia and the Netherlands were used.

ii. Self-harm index

Self-harm actions and thoughts were assessed through two questions in each of the CBCL (parent report) and YSR (self-report): Item 18 (I deliberately try to hurt or kill myself) and Item 91 (I think about killing myself). Possible responses for each question were 0 = not true, 1 = somewhat or sometimes true, or 2 = very true or often true. We followed previous studies in calculating a self-harm index score to avoid multiple statistical comparisons across

correlated categorical-response variables. The index was calculated as the sum of the two items in each scale to create an index from 0 to 4 for each of the CBCL and YSR [30–32], a higher score indicating greater self-harm thoughts and behaviour.

iii. Health related quality of life (HRQoL)

This was assessed through separate young person and parent Kidscreen-52 questionnaires, each consisting of 52 items which assess HRQoL across ten dimensions: physical well-being; psychological well-being; moods and emotions; self-perception; autonomy; relations with parents and home life; social support and peers; school environment; social acceptance (bullying); and financial resources. All items use five-point Likert-style scales to assess either the frequency (never-seldom-sometimes-often-always) of certain behaviours/feelings or the intensity of an attitude (not at all-slightly-moderately-very-extremely). The measure was developed for young people aged 8–18 years, with the recall period of one week. The questionnaires provide scores in the form of continuous t-scores for the ten subscales derived from a multinational European sample [33]. Lower scores indicate lower HRQoL, i.e. greater morbidity.

iv. Body image

The Body Image Scale (BIS) is a self-report measure of 30 items used to assess body image satisfaction or dissatisfaction validated for age 12+. The instrument considers 30 body features which the respondent is asked to rate in terms of satisfaction on a five-point scale (1 = very satisfied, 2 = satisfied, 3 = neutral, 4 = dissatisfied, and 5 = very dissatisfied). The BIS provides a total score in the form of a continuous score for the total scale as well as for three subscales assessing primary sexual characteristics, secondary sexual characteristics and 'neutral' characteristics (i.e. non-sexual characteristics, e.g. nose) [34]. Higher scores represent higher degrees of body dissatisfaction.

v. Gender dysphoria

The Utrecht Gender Dysphoria Scale (UGDS) is a self-report measure used to assess the intensity of GD validated for age 12+. It comprises of 12 statements with agreement on a five-point scale (1 = agree completely, 2 = agree somewhat, 3 = neutral, 4 = disagree somewhat, and 5 = disagree completely). There are separate versions for birth-registered males and females. Items are summed to give a single total score, with higher scores indicating greater GD.

vi. Clinical outcomes

The Children's Global Assessment Scale (CGAS) is a rating of functioning in children and young people aged 6–17 years, extensively used as a routine clinical measure in child and adolescent mental health services in the UK. Treating clinicians assign young people a single score between 1 and 100, based on a clinician's assessment of a range of aspects related to a child's psychological and social functioning, with the time period being the previous month. Higher scores indicate better functioning, with categories ranging from 'extremely impaired' (1–10) to 'doing very well' (91–100) [35].

5. Participant experience and satisfaction with GnRHa

Young people were invited to participate in semi-structured qualitative interviews at 6–15 months and 15–24 months after starting GnRHa. Interviews were conducted in person or by telephone with a research assistant. If young people were unavailable, questions were posted to be completed and returned. The interview consisted of 12 questions related to changes young people had experienced in ten domains since starting on GnRHa: life overall, memory, focus, sense of direction, mood, energy levels, relationships with friends, relationships with family, gender role and sexuality. For each domain, young people were asked first about the general direction of change in that domain (whether changes were positive, neutral, negative or mixed positive and negative) and then asked for examples of changes experienced and why they assigned the chosen change rating. At the end of the interview two further questions were asked about change in any other experiences (i.e. allowing open ended responses) and whether

young people wished to continue on GnRHa treatment. Note there was no interview conducted before young people started GnRHa. Interviews were recorded in contemporaneous written notes by the researcher. The questionnaire is provided in the [S1 Appendix](#).

6. Further treatment decisions

Decisions made at the end of the GnRHa pathway were recorded in terms of which if any further treatment for GD young people chose.

Note that other measures of gender dysphoria (Gender Identity Interview; Recalled Childhood Gender Identity Scale) were specified in our original protocol, however they were discontinued during the study as: a) they were historical instruments with poor construct validity and the binary references to male and female roles were challenging for some participants; and b) repeated questioning about gender dysphoria resulted in some distress to respondents. Our protocol had originally included the ASEBA Teacher Report Form (TRF), however we were unable to obtain data from teachers so this outcome was dropped. The Social Responsiveness Scale (SRS) was a baseline only assessment of autistic traits; these data will be analysed in the future.

Analysis plan

Analyses were conducted according to the Statistical Analysis and Dissemination Plan, lodged with the ethics committee that approved the study before the analysis started (see [S2 Appendix: Statistical Analysis Plan](#)). The analysis plan was designed to report data on all outcomes but to minimise the likelihood of chance findings due to the large number of outcomes and small sample size. Sample sizes necessarily varied across follow-up as young people were recruited at different ages (12–15 years) but left the study soon after their 16th birthday. All 44 participants had data at 12 months follow-up. As participants necessarily left the study soon after their 16th birthday, numbers reduced after 12 months follow-up as participants could no longer remain in the study. Note this does not represent drop-out. There were 24 left at 24 months, 14 at 36 months and 4 at 48 months. In view of this, outcome reporting was restricted to change from baseline to 12, 24 and 36 months. We made no attempt to account for missing data due to the small sample size and the likelihood of the data missing not at random.

We restricted analyses to primarily descriptive statistics, with formal statistical testing of change across the study restricted to six pre-specified outcomes, i.e.:

1. Overall psychological functioning
 - a. parent report: CBCL total t-score
 - b. young person self-report: YSR total t-score
2. Self-harm index
 - a. parent report: CBCL self-harm index
 - b. young person self-report: YSR self-harm index
3. Bone health
 - a. BMD and BMC for lumbar spine
 - b. BMD and BMC for hip

Assessment of change was through paired t-tests for normally distributed data and the Wilcoxon matched-pairs sign-rank test for non-normal data. The number of formal statistical tests conducted in the study was 16; with overall significance at $p = 0.05$ and a Bonferroni correction, the appropriate threshold for statistical significance is about $p = 0.003$.

In our results and conclusions we refer to change in outcomes only for those that were formally tested. Reporting for other continuous outcomes was restricted to mean and 95% confidence intervals (95%CI) or median and interquartile range (IQR). For categorical outcomes, simple proportions were reported. We reported laboratory tests as normal or abnormal based upon laboratory reference data for age, with the exception of gonadotropins. We did not report data where the sample size was less than 8.

Analysis of potential predictors of outcome was confined a priori to two factors, birth-registered sex and pubertal stage at baseline. Three pre-specified continuous outcomes were examined at 12 months, namely:

1. BMD for lumbar spine
2. YSR total t-score
3. CGAS score

Associations were examined using linear regression of follow-up score on baseline score, adding each baseline factor separately to the model and considering the interaction of predictor with baseline score. All analyses were conducted using Stata 16 (Statacorp, College Station TX).

Responses to the semi-structured interview questionnaires were analysed simply for thematic content in terms of the direction and amount of change that young people experienced in each domain. This involved coding responses about experiences since starting GnRHa into categories; i.e. either positive/improving, negative/deteriorating, both positive and negative, no change or not known. The question on change in sexuality was coded as yes change, no change or not known. Wishes to continue with GnRHa were coded as yes, no or don't know.

To compare our findings with the literature, we drew upon recent reviews [3,4,6,13] and updated a recent review [4] from 1 June 2017 to 31 December 2019 using the same search terms in Medline (see [S1 Appendix](#)).

Ethics

Ethical approval for the study was obtained from the National Research Ethics Service (NRES: reference 10/H0713/79) in February 2011. Study consent allowed the use of routinely collected clinical data (medical and psychological) as part of clinical treatment for the study. Study procedures including consent were reviewed by the UK Health Research Authority.

Data sharing. These are highly sensitive data from a small group of vulnerable young people treated in a single service and the risk of identification and disclosure is high. Research ethics permissions at the time the study was undertaken did not include permission to share data. After discussions with the Health Research Authority, UK, an anonymised dataset modified to remove sensitive data and minimise disclosure risk of personal information has been deposited with the UK Data Service.

Results

Participants received psychosocial assessment and support within the GIDS before entering the study for a median of 2.0 years (IQR 1.4 to 3.2; range 0.7 to 6.6). The median time between first medical assessment at UCLH and starting treatment was 3.9 months (IQR 3.0 to 8.4; range 1.6 to 25.7). Median time in the study was 31 months (IQR 20 to 42, range 12 to 59).

Baseline characteristics of the participants by birth-registered sex are shown in [Table 1](#). Median age at consent was 13.6 years (IQR 12.8 to 14.6, range 12.0 to 15.3). A total of 25 (57%) were birth-registered as male and 19 (43%) as female. At study entry, birth-registered males

Table 1. Participant characteristics at baseline.

		Total sample	Birth-registered sex	
		n = 44	male n = 25	female n = 19
Age at consent (years)	Median (IQR)	13.6 (12.8, 14.6)	13.4 (12.7, 14.1)	13.9 (13.5, 14.7)
Ethnic group n (%)	white	39 (89)	24 (96)	15 (79)
	South Asian	1 (2)	1 (4)	0
	black	2 (5)	0	2 (11)
	Mixed ethnicity	2 (5)	0	2 (11)
Pubertal status n (%)	Stage 2	0	0	0
	Stage 3	19 (43)	17 (68)	2 (10)
	Stage 4	16 (36)	5 (20)	11 (58)
	Stage 5	9 (21)	3 (12)	6 (32)
Menarcheal status n (%)	Premenarcheal	-	-	4 (21)
	Post-menarcheal	-	-	15 (79)
Time in study (months)	Median (IQR)	31 (20, 42)	37 (24, 43)	29 (17, 36)
Age at end of pathway (years)	Median (IQR)	16.1 (16.0, 16.4)	16.1 (16.0, 16.5)	16.1 (16.0, 16.3)

At baseline, all participants had normal endocrinology, karyotype, imaging and clinical phenotype on physical examination for birth-registered sex and normal full blood count and liver and renal function. No participants had evidence of disorders of sexual differentiation. Eight participants (18%) had vitamin D insufficiency at baseline and were given vitamin D supplements.

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were predominantly in stage 3 puberty (68%) whilst birth-registered females were predominantly in stages 4 (58%) or 5 (32%) with 79% (15/19) post-menarcheal. 89% of participants were of white ethnicity. Birth-registered females were on average 6 months older than birth-registered males at study entry.

Response to treatment

All participants achieved adequate suppression of gonadotropins and sex hormones by 6 months (mean LH 0.5IU/L; mean FSH 1.4IU/L) and maintained it throughout the study (see Table 2). Liver function, basic haematology and biochemistry were normal in all participants at 3–6 months. All post-menarcheal birth-registered females reported amenorrhoea in the 3 months after starting GnRHa treatment and remained so throughout treatment. No participants reported progression in pubertal development. Height and weight were normal at baseline. Height growth continued through the study but more slowly than expected for age, thus

Table 2. Growth and gonadotropin levels at baseline, 12, 24 and 36 months.

Growth		Baseline		12 months		24 months		36 months	
		n	Mean (95% CI)	n	Mean (95% CI)	n	Mean (95% CI)	n	Mean (95% CI)
Height	z-score	44	0.4 (0.1, 0.7)	44	0.2 (-0.1, 0.4)	24	0.0 (-0.4, 0.4)	14	0.0 (-0.5, 0.5)
Weight	z-score	44	0.8 (0.4, 1.3)	44	0.8 (0.3, 1.3)	24	0.6 (-0.1, 1.3)	14	1.0 (0.1, 1.9)
BMI	z-score	44	0.7 (0.2, 1.1)	44	0.7 (0.2, 1.2)	24	0.6 (-0.1, 1.3)	14	1.1 (0.3, 1.9)
Gonadotropins									
LH	IU/L	42*	4.2 (2.8, 5.6)	44	0.60 (0.42, 0.68)	17	0.40 (0.22, 0.60)	7	0.30 (0.14, 0.46)
FSH	IU/L	42*	3.9 (3.2, 4.5)	44	1.3 (1.0, 1.7)	17	1.0 (0.6, 1.5)	7	1.4 (0.7, 2.2)

*In two participants data recorded as normal at baseline were not available.

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height z-score fell over time (Table 2). Weight and BMI z-scores were stable from baseline to 24 months but increased at 36 months.

Three participants had brief periods off GnRHa prior to their 16th birthday. In one, treatment was withdrawn by clinicians due to non-attendance at clinics and restarted 4 months later. Another requested a period off GnRHa to think further about treatment in view of other things happening in their life; they restarted 4 months later. A third, birth-registered male, stopped GnRHa for 9 months to attempt to store sperm, contrary to their earlier decision not to, and restarted afterwards.

Median age at the end of the GnRHa pathway was 16.1 years (Table 1). A quarter of participants made their decision more than six months later, either because they wished to delay due to school exams or other events or because clinicians felt they were not yet ready to make the decision. One young person decided to stop GnRHa and not start cross-sex hormones, due to continued uncertainty and some concerns about side-effects of cross-sex hormones. The remaining 43 (98%) elected to start cross-sex hormones.

Bone mineral density. BMD was available on 44 participants at baseline, 43 at 12 months, 24 at 24 months and 12 at 36 months (Table 3). Numbers were lower for hip than for spine as some hip scans were not done for technical reasons. The table shows mean values at baseline and 12, 24 and 36 months, along with mean baseline values corresponding to the paired samples at each time point. There was no change from baseline in spine or hip at 12 months nor in hip at 24 and 36 months, but at 24 months lumbar spine BMC and BMD were higher than at baseline, as was lumbar BMC at 36 months. Lumbar and hip BMD age-adjusted z-scores were in the normal range at baseline but point-estimates fell at 12 and 24 months but not at 36 months. Point-estimates for height-adjusted z-scores for lumbar and hip BMD also fell at 12 and 24 months but not at 36 months.

Psychological outcomes. For the standardised questionnaires, baseline assessments were conducted at a median of 0.5 (IQR 0.4, 0.8) years before starting treatment, and were available for all 44 participants by self-report and 43 by parental report. Data on the CBCL, YSR, Kidscreen-52, BIS and CGAS were normally distributed whilst those for UGDS and the CBCL and YSR self-harm indices were skewed.

The first psychological follow-up was at a median of 13 (IQR 12, 14) months after start of treatment, with ASEBA data available for 41 participants (parent and self-report). ASEBA data at 24 months (median 25 (21, 28)) were available on 20 young people by parent report and 15 by self-report, and at 36 months (median 36 (29, 39)) on 11 by parent report and 6 by self-report.

Formal testing was undertaken only for key ASEBA outcomes (Table 4). For the CBCL total t-scores, there was no change from baseline to 12, 24 or 36 months. Similarly for the YSR total t-score, there was no change from baseline to 12 or 24 months; YSR data at 36 months ($n = 6$) were not analysed. There were no significant changes in parent-report CBCL self-harm index scores from baseline to 12, 24 or 36 months, nor for self-report YSR self-harm index scores.

Other psychological outcomes are described in Table 5. Point-estimates of scores on the Kidscreen-52, BIS, UGDS and CGAS showed little change over time."

The pre-specified outcomes of BMD at lumbar spine, YSR total t-score and CGAS score at 12 months, adjusted separately for birth-registered sex and baseline pubertal status, along with the baseline level of the outcome, are shown in Table 6. None of the outcomes were associated with birth-registered sex or pubertal status, and there were no important interactions.

Participant experience, satisfaction and side effects. 41 participants completed interviews at 6–15 months (median 9) and 29 at 15–24 months (median 21); 3 missed both. Fig 1 shows proportions with positive or negative changes for life overall, mood and friendships, with summary data for all questions shown in S1 Appendix (S1 and S2 Tables).

Table 3. Bone mineral density outcomes at baseline, 12, 24 and 36 months.

		12 months							24 months				
		Baseline		Baseline for those followed up		Follow-up	Change	p	Baseline for those followed up		Follow-up	Change	p
		n	Mean (95% CI)	n	Mean (95% CI)	Mean (95% CI)	Mean (95% CI)		n	Mean (95% CI)	Mean (95% CI)	Mean (95% CI)	
Lumbar	BMC	44	39.5 (35.9, 43.1)	42	39.6 (35.8, 43.4)	41.2 (38.2, 44.2)	1.6 (0.2, 3.1)	0.03	24	34.1 (30.3, 37.9)	40.1 (36.7, 43.5)	6.0 (4.0, 7.9)	<0.0001
	BMD	44	0.76 (0.71, 0.80)	43	0.76 (0.71, 0.80)	0.77 (0.72, 0.81)	0.01 (-0.00, 0.03)	0.17	24	0.68 (0.63, 0.74)	0.73 (0.68, 0.78)	0.05 (0.03, 0.07)	0.0001
Hip	BMC	43	25.2 (23.2, 27.1)	39	25.5 (23.4, 27.6)	26.1 (24.4, 27.9)	0.7 (-0.2, 1.5)	0.13	22	23.9 (21.2, 26.6)	26.3 (24.1, 28.6)	2.4 (0.7, 4.1)	0.008
	BMD	43	0.80 (0.75, 0.86)	39	0.81 (0.75, 0.87)	0.82 (0.78, 0.86)	0.01 (-0.02, 0.05)	0.6	22	0.76 (0.68, 0.85)	0.79 (0.74, 0.84)	0.03 (-0.04, 0.10)	0.4
BMD z-scores	Spine	44	-0.3 (-0.7, 0.0)	43	-0.3 (-0.7, 0.1)	-1.0 (-1.3, -0.7)			24	-0.5 (-1.1, 0.0)	-1.5 (-2.1, -0.8)		
	HAZ spine	44	-0.5 (-0.8, -0.1)	43	-0.4 (-0.8, -0.1)	-1.0 (-1.3, -0.6)			24	-0.7 (-1.2, -0.1)	-1.3 (-1.9, -0.7)		
	Hip	43	-0.5 (-0.9, -0.1)	39	-0.5 (-0.9, -0.1)	-1.0 (-1.3, -0.6)			21	-0.5 (-1.1, 0.1)	-1.4 (-2.0, -0.9)		
	HAZ hip	43	-0.7 (-1.0, -0.3)	39	-0.6 (-1.0, -0.2)	-0.9 (-1.3, -0.5)			21	-0.5 (-1.1, 0.1)	-1.2 (-1.7, -0.6)		
36 months													
				Baseline for those followed up		Follow-up	Change	p					
				n	Mean (95% CI)	Mean (95% CI)	Mean (95% CI)						
Lumbar	BMC			12	37.05 (31.0, 43.1)	42.4 (37.4, 47.4)	5.3 (2.8, 7.8)	0.0007					
	BMD			12	0.72 (0.65, 0.80)	0.76 (0.70, 0.82)	0.03 (.00, 0.07)	0.05					
Hip	BMC			12	26.1 (22.1, 30.0)	26.8 (21.2, 32.3)	0.7 (-3.8, 5.2)	0.7					
	BMD			12	(0.82, 0.73, 0.91)	0.81 (0.74, 0.88)	-0.009 (-0.05, 0.03)	0.6					
BMD z-scores	Spine			12	-0.2 (-1.0, 0.6)	-1.5 (-2.2, -0.8)							
	HAZ spine			12	-0.4 (-1.2, 0.3)	-1.3 (-2.2, -0.5)							
	Hip			12	-0.3 (-1.3, 0.6)	-1.1 (-1.8, -0.5)							
	HAZ hip			12	-0.5 (-1.5, 0.5)	-1.0 (-1.8, -0.2)							

BMD: bone mineral density; BMC bone mineral content; HAZ height adjusted z-score.

BMD z-scores were not formally tested—see [Methods](#).

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Most participants reported positive or a mix of positive-negative changes in their life at both time points. At 6–15 months 46% reported only positive changes, including feeling happier, relieved, less facial hair or stopping periods. A further 37% reported both positive and negative changes such as feeling happier but also experiencing hot flushes and headaches. In addition 12% reported overall negative changes namely hot flushes, tiredness, and feeling more emotional, while 5% reported no change. At 15–24 months, 55% reported solely positive changes such as feeling happier, no longer experiencing side effects and feeling more

Table 4. ASEBA outcomes at baseline, 12, 24 and 36 months.

		12 months							24 months				
		Baseline		Baseline for those followed up		Follow-up	Change	p	Baseline for those followed up		Follow-up	Change	p
		n	mean (95% CI)	n	mean (95% CI)	mean (95% CI)	mean (95% CI)		n	mean (95% CI)	mean (95% CI)	mean (95% CI)	
Parent report CBCL	Total problems t-score	43	61.6(58.4, 64.7)	41	61.5(58.2, 64.7)	61.8(58.4, 65.1)	0.3(-2.0, 2.6)	0.8	20	61.2(56.5, 65.8)	60.2(54.6, 65.8)	-1.0(-4.0, 2.1)	0.5
	Externalising problems t-score	43	55.8(52.4, 59.3)	41	55.7(52.1, 59.3)	55.4(51.8, 59.0)			20	55.4(49.9, 60.9)	55.2(48.9, 61.5)		
	Internalising problems t-score	43	62.1(58.7, 65.5)	41	61.8(58.3, 65.3)	62.9(59.5, 66.3)			20	60.4(55.7, 65.1)	60.1(54.6, 65.6)		
Self-report YSR	Total problems t-score	44	57.9(55.0, 60.8)	41	57.6(54.5, 60.6)	58.4(54.6, 62.2)	0.8(-3.1, 4.8)	0.7	15	55.1(50.9, 59.2)	56.5(50.6, 62.5)	1.5(-3.4, 6.3)	0.5
	Total problems z-score (ref: Netherlands)	44	1.01(0.67, 1.36)	41	0.97(0.62, 1.33)	0.99(0.55, 1.42)			15	0.66(0.17,1.15)	0.65(-0.05, 1.36)		
	Total problems z-score (ref: Australia)	44	0.72(0.37, 1.06)	41	0.68(0.32, 1.03)	0.68(0.24, 1.12)			15	0.39(-0.11,0.89)	0.37(-0.32, 1.07)		
	Externalising problems t-score	44	52.3(49.2, 55.5)	41	52.3(49.2, 55.4)	52.5(48.7, 56.3)			15	53.1(48.5, 57.6)	52.3(45.3, 59.4)		
	Internalising problems t-score	44	58.0(54.9, 61.2)	41	57.7(54.3, 61.0)	60.1(55.9, 64.3)			15	53.9(49.9, 58.0)	55.9(50.8, 61.1)		
Self-harm scores													
Parent report CBCL	Median (IQR)	43	0(0, 1)	40	0(0, 1)	0(0, 1)		0.3	20	0(0, 1)	0(0, 1)		>0.9
Self-report YSR	Median (IQR)	43	0(0, 1)	39	0(0, 1)	0(0, 2)		0.4	15	0(0, 0)	0(0, 0)		0.3
36 months													
					Baseline for those followed up	Follow-up	Change	p					
			n	mean (95% CI)	mean (95% CI)	mean (95% CI)							
Parent report CBCL	Total problems t-score			11	62.4(55.1, 69.6)	61.1(52.3, 69.9)	-1.3(-6.6, 4.0)	0.6					
	Externalising problems t-score			11	56.8(48.0, 65.6)	56.2(48.3, 64.1)							
	Internalising problems t-score			11	60.4(53.5, 67.2)	62.5(53.6, 71.5)							
Self-harm scores													
Parent report CBCL	Median (IQR)			11	0(0, 1)	0(0, 1)		0.8					

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comfortable with puberty suspended. A further 17% reported both positive and negative changes including less body hair but continued growth in height, or having clearer skin but also experiencing more hunger, weight gain and tiredness. 17% reported largely negative changes such as mood swings, tiredness and hot flushes whilst 10% reported no change.

Reports of change in mood were mixed. At 6–15 months, the majority reported mood to be improved (49%), mixed changes (such as both feeling happier but experiencing some mood swings; 15%) or no change (7%), however 24% reported negative changes in mood such as

Table 5. Other psychological outcomes at baseline, 12, 24 and 36 months.

			Baseline		12 months		24 months		36 months
		n	mean (95% CI)	n	mean (95% CI)	n	mean (95% CI)	n	mean (95% CI)
Kidscreen-52 HRQOL									
Parent report CBCL t-scores	Physical wellbeing	42	44.9(41.4, 48.5)	36	40.4(37.5, 43.3)	14	40.5(36.8, 44.2)		
	Psychological Wellbeing	41	39.8(36.7, 42.8)	36	39.0(35.4, 42.6)	14	42.4(36.9, 48)		
	Moods and Emotions	41	40.6(37.6, 43.6)	36	41.2(37.3, 45.1)	14	42.5(36.3, 48.7)		
	Self-perception	42	34.6(32.6, 36.5)	36	34.8(32.0, 37.5)	14	34.8(31.3, 38.2)		
	Autonomy	42	46.2(43.2, 49.2)	36	48.2(45.0, 51.4)	14	46.7(41, 52.4)		
	Parent relations and home life	42	48.1(44.5, 51.6)	35	46.7(42.9, 50.5)	14	49.5(44.1, 54.9)		
	Social support and peers	39	48.0(44.7, 51.4)	36	51.9(48.4, 55.3)	13	51.4(45.6, 57.2)		
	School environment	42	38.2(35.0, 41.4)	35	39.4(35.3, 43.4)	13	43.7(36, 51.3)		
	Social acceptance	39	44.7(40.7, 48.7)	32	42.3(38.1, 46.4)	13	43.5(35.9, 51.2)		
	Financial resources	42	37.9(33.9, 41.9)	36	35.8(31.5, 40.2)	14	36.3(26.4, 46.3)		
Self-report t-scores	Physical wellbeing	42	45.1(41.8, 48.5)	36	41.5(38.0, 45.0)	13	43.9(38.9, 48.9)		
	Psychological Wellbeing	42	43.0(39.6, 46.4)	36	41.1(37.0, 45.2)	14	51(45.8, 56.2)		
	Moods and Emotions	42	46.3(42.7, 49.9)	36	43.9(40.4, 47.3)	14	50.1(45.5, 54.7)		
	Self-perception	42	38.8(36.7, 40.9)	36	37.9(35.1, 40.6)	14	43.1(39.9, 46.2)		
	Autonomy	42	46.6(43.6, 49.6)	36	46.7(42.9, 50.5)	13	51.9(47.4, 56.4)		
	Parent relations and home life	42	49.7(46.2, 53.2)	36	48.7(45.2, 52.3)	14	58.4(53.3, 63.5)		
	Social support and peers	37	45.6(42.5, 48.7)	35	48.1(44.6, 51.6)	14	49.7(44.3,55.1)		
	School environment	41	45.9(42.3, 49.4)	36	44.7(39.7, 49.7)	14	49(43.6, 54.3)		
	Social acceptance	41	47.4(43.5, 51.3)	33	45.5(40.9, 50.1)	13	53.6(46.3, 60.8)		
	Financial resources	42	42.2(38.1, 46.3)	34	43.2(38.2, 48.1)	14	46.3(39.1, 53.5)		
Body image scale	Overall score	42	3.1(2.8, 3.3)	40	3.2(3.0, 3.4)	16	3(2.7, 3.2)	8	3.1(2.4, 3.7)
	Primary characteristics score	42	4.5(4.2, 4.7)	39	4.3(4.2, 4.5)	16	4.5(4.3, 4.7)	8	4.2(3.9, 4.5)
	Secondary characteristics score	41	2.9(2.6, 3.1)	40	3(2.8, 3.3)	16	2.9(2.5, 3.2)	8	2.9(2, 3.8)
	Neutral characteristics score	42	2.5(2.203, 2.707)	40	2.7(2.5, 3.0)	-	-		
Utrecht Gender dysphoria score	Median (IQR)	41	4.8(4.6, 5.0)	40	4.7(4.6, 5.0)	18	4.7(4.3, 5.0)		
Clinical outcome									
CGAS global score	Mean (95% CI)	42	62.9(59.6, 66.2)	35	64.1(59.9, 68.3)	18	65.7(59.6, 71.8)	12	66.0(58.1, 73.9)

Note: Change in outcomes in this Table were not formally tested.

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Table 6. Associations between birth-registered sex and baseline pubertal status and outcomes at 12 months.

		Outcomes at 12 months adjusted for baseline								
		BMD at lumbar spine			YSR total t-score			GCAS score		
		n	Coefficient (95% CI)	p	n	Coefficient (95% CI)	p	n	Coefficient (95% CI)	p
Birth-registered sex										
Main effect (baseline value of outcome)		43	0.86 (0.75, 0.97)	<0.0001	41	0.43 (0.05, 0.82)	0.03	33	0.74 (0.42, 1.06)	<0.0001
Birth-registered sex	Male (ref)		0			0			0	
	Female		-0.02 (-0.05, 0.01)	0.2		2.1 (-5.2, 9.4)	0.6		-3.2 (-10.0, 3.5)	0.3
Pubertal status										
Main effect (baseline value of outcome)		43	0.85 (0.72, 0.97)	<0.0001	41	0.43 (0.01, 0.84)	0.04	33	0.69 (0.37, 1.00)	<0.0001
Pubertal stage at baseline	3		0.008 (-0.03, 0.04)	0.7		0.2 (-8.3, 8.7)	0.9		1.6 (-5.5, 8.8)	0.6
	4 (ref)		0			0			0	
	5		-0.009 (-0.05, 0.03)	0.7		0.4 (-9.9, 10.8)	0.9		-7.9 (-17.6, 1.8)	0.11

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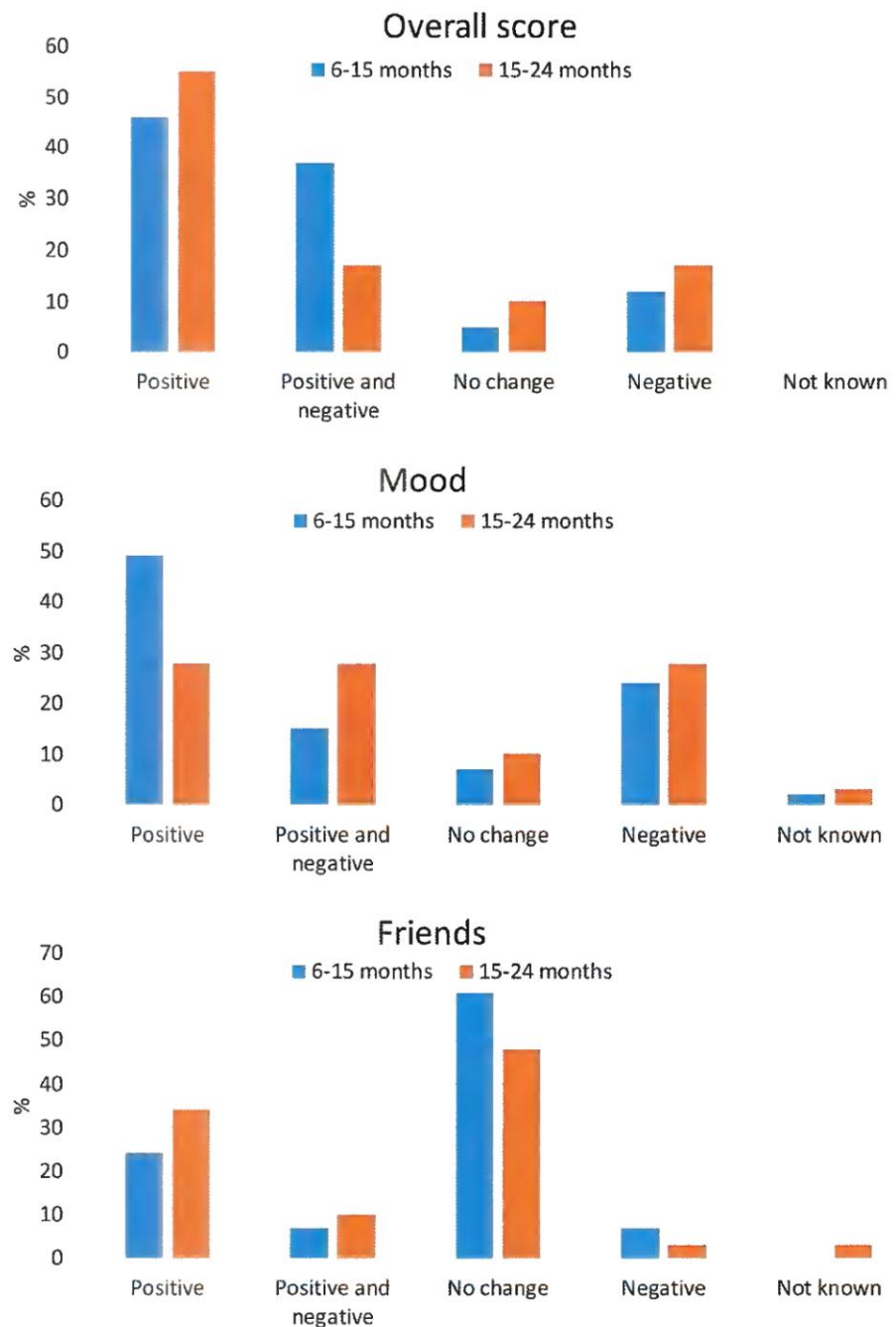


Fig 1. Ratings of change in life overall, mood and friendships at 6–15 months (n = 41) and 15–24 months (n = 29).

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experiencing more mood swings or feeling low. Findings at 15–24 months were similar. The most common negative change was reduced energy levels, reported by 29% at 6–15m and 38% at 15–24m.

Young people's reports of change in family and peer relationships were predominantly positive or neutral at both time points. Positive changes included feeling closer to the family,

Table 7. Adverse events reported across the study.

Participants	0–6m	7–12m	13–24m	25+m
	n = 44	n = 44	n = 36	n = 24
	n (%)	n (%)	n (%)	n (%)
Mild headaches or hot flushes	11 (25%)	10 (23%)	8 (22%)	4 (17%)
Moderate or severe headaches and hot flushes	2 (5%)	4 (9%)	1 (3%)	0
Fatigue—mild	2 (5%)	3 (7%)	3 (8%)	1 (4%)
Fatigue—moderate or severe	0	0	0	0
Mood swings	1 (2%)	0	0	0
Weight gain	1 (2%)	0	1 (3%)	0
Sleep problems	1 (2%)	0	1 (3%)	0
Other events	0	0	0	0
Total events recorded*	18	17	14	5

* individuals may have more than 1 event.

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feeling more accepted and having fewer arguments. Those reporting both positive and negative change reported feeling closer to some family members but not others. At 6–15 months, negative family changes were largely from family members not accepting their trans status or having more arguments. But by 15–24 months only one young person reported this. Improved relationships with peers related to feeling more sociable or confident and widening their circle of friends; negative changes related to bullying or disagreements at school. Again, at 15–24 months only one young person reported negative change, related to feelings of not trusting friends.

At 6–15 months, changes in gender role were reported by 66% as positive, including feeling more feminine/masculine, living in their preferred gender identity in more (or all) areas of life and feeling more secure in their gender identity, with no negative change reported. At 15–24 months, most reported no change although 41% reported positive changes including experimenting more with physical appearance and changing their details on legal documents.

All young people affirmed at each interview that they wished to continue with GnRHa treatment. Note that this was also the case when asked routinely at medical clinics (excepting those who briefly ceased GnRHa as noted above).

Adverse events. Adverse events are shown in Table 7. All adverse events were minor and anticipated, i.e. they were previously described in study participant information and/or noted in the triptorelin medication package inserts. Anticipated adverse events were common in the first two years, particularly mild headaches or hot flushes which were reported in 25% at 0–6m, 23% at 7–12m and 22% at 13–24m. Moderate or severe headaches and/or hot flushes were uncommon. Birth-registered females with distressing headaches or hot flushes were offered ‘add-back’ oestrogen therapy, and two accepted treatment briefly with very small doses of oestradiol, which was effective in reducing symptoms. Mild fatigue was reported by 5–8% over the first two years and no participants reported moderate or severe fatigue. Sleep problems, mood swings and weight gain were reported by very small numbers and in each case symptoms were mild. Adverse events were less common after 12 months of treatment.

Discussion

We report the short and medium-term outcomes of a prospective cohort of 44 young people with persistent and severe GD treated with GnRHa resulting in pubertal suppression from mid-puberty for 1–4 years. Young people were considered for recruitment after lengthy

assessment, spending an average of 2 years and up to 6 years within the GIDS psychological service before being referred to the endocrine clinic for assessment to enter the study. Medical assessment found no endocrine abnormalities at baseline. GnRHa treatment started in the majority of participants in later stages of puberty, with 57% in puberty stages 4 and 5 and 79% of birth-registered females being post-menarcheal. After starting GnRHa all quickly achieved and maintained suppression of pubertal hormones and none experienced pubertal progression. At the end of the study, 43 (98%) chose to start cross-sex hormones whilst one young person chose to stop GnRHa and continue with puberty consistent with their birth-registered sex.

As anticipated, pubertal suppression reduced growth that was dependent on puberty hormones, i.e. height and BMD. Height growth continued for those not yet at final height, but more slowly than for their peers so height z-score fell. Similarly for bone strength, BMD and BMC increased in the lumbar spine indicating greater bone strength, but more slowly than in peers so BMD z-score fell. These anticipated changes had been discussed with all participants before recruitment to the study. Young people experienced little change in mean weight or BMI z-score in the first two years. The rise in weight and BMI z-score at 36 months may represent a trend towards greater adiposity in those on GnRHa for a prolonged period, or reflect a higher baseline in this group.

Information on side-effects was available through routine reporting in medical clinics and in the participant experience interviews. Anticipated side effects of treatment were common, particularly mild symptoms directly related to suppression of sex hormones. Severe symptoms were uncommon. Fatigue or low energy was reported rarely in medical clinic assessments but frequently at interview (38% at 15–24m). The relationship of symptoms such as headaches, fatigue and sleep disturbance to GnRHa treatment is unclear as they are all very common in early adolescence [36,37], although a conservative perspective would regard them as side-effects of treatment.

Young people experienced little change in psychological functioning across the study. We found no differences between baseline and later outcomes for overall psychological distress as rated by parents and young people, nor for self-harm. Outcomes that were not formally tested also showed little change.

Participant experience of treatment as reported in interviews was positive for the majority, particularly relating to feeling happier, feeling more comfortable, better relationships with family and peers and positive changes in gender role. Smaller numbers reported having mixed positive and negative changes. A minority (12% at 6–15 months and 17% at 15–24 months) reported only negative changes, which were largely related to anticipated side effects. None wanted to stop treatment due to side effects or negative changes. We are not aware of comparative patient experience data from other cohorts.

The median age at consent in our study was very similar to that in the earliest published outcome study of mid-pubertal suppression using GnRHa treatment in Dutch young people (13.6 years) [24]. Similarly to this Dutch cohort, all but one of our participants elected to start cross-sex hormones after completing the GnRHa pathway. However they spent an average of 31 months on GnRHa compared with 23 months in the Dutch cohort [24]. In our study, the successful suppression of puberty and cessation of menses with GnRHa, the impact on height growth [4,16,38] and BMD [4,16] and the normality of liver and renal function through treatment were each consistent with previous reports [4,16].

Our findings that BMD increased over time in the lumbar spine but more slowly than in same age peers, resulting in a fall in z-score, are similar to others [4,14,39,40]. The fall in height-adjusted BMD z-score was consistent with but larger than the fall in height z-score. We found that birth-registered sex and pubertal status at baseline were not associated with later BMD. There is evidence that accretion of bone mass resumes and that BMD increases with the

start of cross-sex hormone therapy [4,14,39,41]. Future research needs to examine longer-term change in BMD in young people treated with mid-pubertal suppression.

We reported a range of adverse events previously described to be associated with pubertal suppression [42], with the exception of mild sleep disturbance although this is a known association with triptorelin use. As anticipated, the withdrawal of sex hormones produces symptoms such as headaches and lack of energy, although in the great majority (11 of 13 at 0–6 months; 10 of 14 at 7–12 months; 8 of 9 at 13–24 months) the symptoms were minor. Symptoms diminished over time as has previously been noted [4], and no young people chose to cease treatment due to the side-effects.

Our finding that 1 participant ceased pubertal suppression and did not commence cross-sex hormones is somewhat similar to the experience of one US cohort and a second Dutch cohort; Kuper et al. described that 2 of approximately 57 young people aged 10–15 years who commenced pubertal suppression treatment stopped this treatment without commencing cross-sex hormones [17]. Brik et al. reported that in a cohort of 137 young people who began GnRHa between 10 and 18 years and were followed until eligible to commence cross-sex hormones, 5 (3.6%) ceased treatment and did not later commence cross-sex hormones [19].

Three longitudinal studies from the Netherlands and the USA have examined psychological function over time in cohorts of young people treated with GnRHa and then cross-sex hormones [17,18,24], although the two US cohorts were of limited size. Our study adopted the same psychological outcome measures as the Dutch cohort, to facilitate comparison [24]. Mean baseline YSR scores in our cohort were similar to those previously reported in 141 young people aged 12–18 years from the London GIDS [43], and baseline CBCL and YSR scores were close to those at baseline from the original Dutch cohort [24]. A number of other studies have shown that young people with GD have higher scores on the CBCL or YSR than same-age population peers, and that they are similar to young people referred to clinical services for a range of mental health problems [44–46]. Population-based studies in America support higher baseline levels of mental health problems amongst young people with GD, with the prevalence of self-harm notably higher than for male or female peers [47,48]. Young people in our study had baseline YSR scores 0.7–1.0 SD higher than norms for age in comparable countries [29,46].

We found no evidence of change in psychological function with GnRHa treatment as indicated by parent report (CBCL) or self-report (YSR) of overall problems, internalising or externalising problems or self-harm. This is in contrast to the Dutch study which reported improved psychological function across total problems, externalising and internalising scores for both CBCL and YSR and small improvements in CGAS [24]. It also contrasts with a previous study from the UK GIDS of change in psychological function with GnRHa treatment in 101 older adolescents with GD (beginning > 15.5 years) which reported moderate improvements in CGAS score over 12 months of GnRHa treatment [49]. CGAS scores in this previous study increased from 61 to 67 with GnRHa treatment, similar to those (63 at baseline, 66 at 24 months) in our study. Follow-up of the Kuper et al. cohort found non-significant changes in depression and anxiety scores in those ($n = 25$) who had only pubertal suppression treatment, although improvements were seen in the whole sample combining these with those receiving cross-sex hormones [17]. A second US cohort reported that in 23 young people who had received pubertal suppression (using GnRHa or anti-androgens in birth-registered males and either GnRHa or medroxyprogesterone in birth-registered females), there was a reduction in depression scores in birth-registered males but not females.

A recent large US survey found that those who received pubertal suppression in early or mid adolescence had lower odds of lifetime suicidal ideation when studied in adulthood compared with those who did not, regardless of whether they later received cross-sex hormones

and after adjustment for a range of confounding factors [50]. This implies an enduring benefit of pubertal suppression on psychological function, however the cross-sectional design and retrospective exposure classification means the findings require replication. Data are also available from other conditions in which GnRHa is used to suppress puberty during adolescence. A trial of GnRHa suppression of puberty during early adolescence in young people born small-for-gestational-age (SGA) who were also treated with human growth hormone (GH) reported that those treated with GnRHa had similar cognitive and psychological function in adult life to those treated only with GH [51].

The differences between our findings and the previous GIDS study re change in psychological function may relate simply to sample size. But why our findings differ from those of the Dutch study is unclear. They may relate to the timing of assessments; we assessed young people multiple times whereas in the Dutch study the second assessment was shortly before starting cross-sex hormone treatment. Alternatively, there may have been baseline differences in the two cohorts. Whilst some aspects of psychological function were similar, as noted above, the baseline CGAS scores were notably higher in the Dutch group (indicating better function). A previous international comparison study has found that young people aged 12–18 years with GD from the UK have higher scores indicating greater problems on the CBCL and YSR than those from the Netherlands, Belgium and Switzerland [52].

Psychological distress and self-harm are known to increase across early adolescence. Normative data show rising YSR total problems scores with age from age 11 to 16 years in non-clinical samples from a range of countries [29]. Self-harm rates in the general population in the UK and elsewhere increase markedly with age from early to mid-adolescence, being very low in 10 year olds and peaking around age 16–17 years [53–56]. Our finding that psychological function and self-harm did not change significantly during the study is consistent with two main alternative explanations. The first is that there was no change, and that GnRHa treatment brought no measurable benefit nor harm to psychological function in these young people with GD. This is consonant with the action of GnRHa, which only stops further pubertal development and does not change the body to be more congruent with a young person's gender identity. The second possibility is that the lack of change in an outcome that normally worsens in early adolescence may reflect a beneficial change in trajectory for that outcome, i.e. that GnRHa treatment reduced this normative worsening of problems. In the absence of a control group, we cannot distinguish between these possibilities. We aimed to use normative reference data to examine this issue. However age- and gender-standardised t-scores for ASEBA and other outcomes cannot answer this question as they cover a very broad age range (e.g. 12–18 years). We had anticipated that z-scores on the YSR available by calendar year for two comparable countries (Netherlands; Australia) might be informative however confidence intervals were too wide to draw reliable inferences.

Gender dysphoria and body image changed little across the study. This is consistent with some previous reports [24] and was anticipated, given that GnRHa does not change the body in the desired direction, but only temporarily prevents further masculinization or feminization. Other studies suggest that changes in body image or satisfaction in GD are largely confined to gender affirming treatments such as cross-sex hormones or surgery [57]. We found that birth-registered sex and baseline pubertal status were not associated with later psychological functioning on GnRHa, consistent with previous reports [24,49].

These data correct reports from a recent letter by Biggs [58] which used preliminary data from our study which were uncleaned and incomplete data used for internal reporting. In addition there were many statistical comparisons which inflated the risk of type 1 error. Our statistical analysis plan restricted testing all outcomes for differences by sex due to the type 1

error risk. Contrary to Biggs's letter, we found no evidence of reductions over time in any psychological outcomes, and no material differences by sex.

Strengths and limitations

Our study provides comprehensive data on this cohort during follow-up, with an anonymised dataset containing standardised scores deposited to allow other researchers to replicate our findings where data-sharing allows. The study size and uncontrolled design were key limitations. The small sample size limited our ability to identify small changes in outcomes. This was an uncontrolled observational study and thus cannot infer causality. Further, many of the outcomes studied here, including psychological function, self-harm and BMD, undergo normative changes by age and developmental stage during puberty that could confound any observed effect of GnRHa treatment in an uncontrolled study. The analysis plan aimed to take these issues into account as far as possible, however this particularly limits the potential for the study to show benefits or harms from treatment. However, some conclusions can be drawn. It is unlikely that the reported adverse events such as headaches do not relate directly to GnRHa treatment. Equally, given that there were no changes in psychological function and differences in point estimates were minimal for nearly all outcomes, it is unlikely that the treatment resulted in psychological harm. Observational studies are important sources of data on harms of treatment [59–61].

Our data are subject to a number of other limitations. This was an unfunded study undertaken within a clinical service and we were dependent on the clinical service for data collection. There were varying sample sizes for differing tests as some participants did not attend certain investigations and some follow-up medical tests were processed locally to patients; these data are reported as normal or otherwise. Missing items on psychological questionnaires resulted in some unusable data. Some young people found repeated completion of questionnaires about gender issues intrusive and refused to complete them at later follow-ups, as has been reported in other studies [62]. This questionnaire fatigue also affected parent responses. Scoring of psychological questionnaire data was rechecked at the completion of the study however this was not possible in very small numbers of participants in whom only scale scores rather than individual item data were preserved during data migration in hospital clinical information systems. In sensitivity analyses, repeat analysis of ASEBA psychological outcomes restricted to those with rescored data showed highly similar findings to the full sample (see S3 Table in S1 Appendix).

A more detailed qualitative evaluation of participant experience was not possible due to lack of interviewer time, and reporting of interview data was restricted to perceptions of positive or negative change and the giving of examples.

Implications and conclusions

Treatment of young people with persistent and severe GD aged 12–15 years with GnRHa was efficacious in suppressing pubertal progression. Anticipated effects of withdrawal of sex hormones on symptoms were common and there were no unexpected adverse events. BMD increased with treatment in the lumbar spine and was stable at the hip, and BMD z-score fell consistent with delay of puberty. Overall participant experience of changes on GnRHa treatment was positive. We identified no changes in psychological function, quality of life or degree of gender dysphoria.

The great majority of this cohort went on to start cross-sex hormones, as was hypothesized given the severity and continuation of their GD. However one young person did not, providing some evidence that development of gender identity continues on GnRHa treatment and

confirming the importance of continuing supportive psychological therapy to allow further exploration of gender identity and a range of future pathways whilst on GnRHa.

This cohort will be followed up longer term to examine physical and mental health outcomes into early adulthood. However larger and longer-term prospective studies using a range of designs are needed to more fully quantify the harms and benefits of pubertal suppression in GD and better understand factors influencing outcomes [3]. These are beginning to be funded in a number of countries [63]. (<https://logicstudy.uk>) Given that pubertal suppression may be both a treatment in its own right and also an intermediate step in a longer treatment pathway, it is essential for such studies to examine benefits and harms across the longer pathway including pubertal suppression and initiation of cross-sex hormones.

Supporting information

S1 Appendix.
(DOCX)

S2 Appendix. Statistical analysis plan.
(DOCX)

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References

1. Diagnostic and statistical manual of mental disorders (DSM-V). 5th ed. Arlington, VA: American Psychiatric Association; 2013.
2. International Statistical Classification of Diseases and Related Health Problems (ICD-11). Geneva: World Health Organisation, 2019.
3. Mahfouda S, Moore JK, Siafarikas A, Zepf FD, Lin A. Puberty suppression in transgender children and adolescents. *Lancet Diabetes Endocrinol.* 2017; 5(10):816–26. Epub 2017/05/27. [https://doi.org/10.1016/S2213-8587\(17\)30099-2](https://doi.org/10.1016/S2213-8587(17)30099-2) PMID: 28546095.
4. Chew D, Anderson J, Williams K, May T, Pang K. Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review. *Pediatrics.* 2018; 141(4). Epub 2018/03/09. <https://doi.org/10.1542/peds.2017-3742> PMID: 29514975.

5. Butler G, De Graaf N, Wren B, Carmichael P. Assessment and support of children and adolescents with gender dysphoria. *Arch Dis Child*. 2018; 103(7):631–6. Epub 2018/04/14. <https://doi.org/10.1136/archdischild-2018-314992> PMID: 29650510.
6. Turban JL, Ehrensaft D. Research Review: Gender identity in youth: treatment paradigms and controversies. *J Child Psychol Psychiatry*. 2018; 59(12):1228–43. Epub 2017/10/27. <https://doi.org/10.1111/jcpp.12833> PMID: 29071722.
7. Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2013; 52(6):582–90. Epub 2013/05/25. <https://doi.org/10.1016/j.jaac.2013.03.016> PMID: 23702447.
8. Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017; 102(11):3869–903. Epub 2017/09/26. <https://doi.org/10.1210/jc.2017-01658> PMID: 28945902.
9. Oliphant J, Veale J, Macdonald J, Carroll R, Johnson R, Harte M, et al. Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa, New Zealand. *N Z Med J*. 2018; 131(1487):86–96. Epub 2018/12/14. PMID: 30543615.
10. Telfer MM, Tollit MA, Pace CC, Pang KC. Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. *Med J Aust*. 2018; 209(3):132–6. Epub 2018/06/16. <https://doi.org/10.5694/mja17.01044> PMID: 29902964.
11. Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018; 142(4). Epub 2018/09/19. <https://doi.org/10.1542/peds.2018-2162> PMID: 30224363.
12. Skordis N, Butler G, de Vries MC, Main K, Hannema SE. ESPE and PES International Survey of Centers and Clinicians Delivering Specialist Care for Children and Adolescents with Gender Dysphoria. *Hormone research in paediatrics*. 2018; 90(5):326–31. Epub 2019/01/30. <https://doi.org/10.1159/000496115> PMID: 30695784.
13. Agana MG, Greydanus DE, Indyk JA, Calles JL Jr., Kushner J, Leibowitz S, et al. Caring for the transgender adolescent and young adult: Current concepts of an evolving process in the 21st century. *Dis Mon*. 2019; 65(9):303–56. Epub 2019/08/14. <https://doi.org/10.1016/j.disamonth.2019.07.004> PMID: 31405516.
14. Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab*. 2015; 100(2):E270–5. Epub 2014/11/27. <https://doi.org/10.1210/jc.2014-2439> PMID: 25427144.
15. Cohen-Kettenis PT, Schagen SE, Steensma TD, de Vries AL, Delemarre-van de Waal HA. Puberty suppression in a gender-dysphoric adolescent: a 22-year follow-up. *Arch Sex Behav*. 2011; 40(4):843–7. Epub 2011/04/20. <https://doi.org/10.1007/s10508-011-9758-9> PMID: 21503817.
16. Schagen SE, Cohen-Kettenis PT, Delemarre-van de Waal HA, Hannema SE. Efficacy and Safety of Gonadotropin-Releasing Hormone Agonist Treatment to Suppress Puberty in Gender Dysphoric Adolescents. *J Sex Med*. 2016; 13(7):1125–32. Epub 2016/06/19. <https://doi.org/10.1016/j.jsxm.2016.05.004> PMID: 27318023.
17. Kuper LE, Stewart S, Preston S, Lau M, Lopez X. Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics*. 2020; 145(4). Epub 2020/03/30. <https://doi.org/10.1542/peds.2019-3006> PMID: 32220906.
18. Achille C, Taggart T, Eaton NR, Osipoff J, Tafuri K, Lane A, et al. Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *International Journal of Pediatric Endocrinology*. 2020; 2020(1):8. <https://doi.org/10.1186/s13633-020-00078-2> PMID: 32368216
19. Brik T, Vrouenraets L, de Vries MC, Hannema SE. Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. *Arch Sex Behav*. 2020; 49(7):2611–8. Epub 2020/03/11. <https://doi.org/10.1007/s10508-020-01660-8> PMID: 32152785.
20. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009; 94(9):3132–54. Epub 2009/06/11. <https://doi.org/10.1210/jc.2009-0345> PMID: 19509099.
21. Spack NP, Edwards-Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012; 129(3):418–25. Epub 2012/02/22. <https://doi.org/10.1542/peds.2011-0907> PMID: 22351896.

22. Meyer WJ 3rd. Gender identity disorder: an emerging problem for pediatricians. *Pediatrics*. 2012; 129(3):571–3. Epub 2012/02/22. <https://doi.org/10.1542/peds.2011-3696> PMID: 22351880.
23. Hewitt JK, Paul C, Kasiannan P, Grover SR, Newman LK, Warne GL. Hormone treatment of gender identity disorder in a cohort of children and adolescents. *Med J Aust*. 2012; 196(9):578–81. Epub 2012/05/25. <https://doi.org/10.5694/mja12.10222> PMID: 22621149.
24. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011; 8(8):2276–83. Epub 2010/07/22. <https://doi.org/10.1111/j.1743-6109.2010.01943.x> PMID: 20646177.
25. Cole TJ, Freeman JV, Preece MA. Body mass index reference curves for the UK, 1990. *Arch Dis Child*. 1995; 73(1):25–9. <https://doi.org/10.1136/adc.73.1.25> PMID: 7639544
26. Kalkwarf HJ, Zemel BS, Gilsanz V, Lappe JM, Horlick M, Oberfield S, et al. The bone mineral density in childhood study: bone mineral content and density according to age, sex, and race. *J Clin Endocrinol Metab*. 2007; 92(6):2087–99. Epub 2007/02/22. <https://doi.org/10.1210/jc.2006-2553> PMID: 17311856.
27. Zemel BS, Leonard MB, Kelly A, Lappe JM, Gilsanz V, Oberfield S, et al. Height adjustment in assessing dual energy x-ray absorptiometry measurements of bone mass and density in children. *J Clin Endocrinol Metab*. 2010; 95(3):1265–73. Epub 2010/01/28. <https://doi.org/10.1210/jc.2009-2057> PMID: 20103654.
28. Crijnen AA, Achenbach TM, Verhulst FC. Comparisons of problems reported by parents of children in 12 cultures: total problems, externalizing, and internalizing. *J Am Acad Child Adolesc Psychiatry*. 1997; 36(9):1269–77. Epub 1997/09/18. <https://doi.org/10.1097/00004583-199709000-00020> PMID: 9291729.
29. Verhulst FC, Achenbach TM, van der Ende J, Erol N, Lambert MC, Leung PW, et al. Comparisons of problems reported by youths from seven countries. *Am J Psychiatry*. 2003; 160(8):1479–85. Epub 2003/08/06. <https://doi.org/10.1176/appi.ajp.160.8.1479> PMID: 12900311.
30. Aitken M, VanderLaan DP, Wasserman L, Stojanovski S, Zucker KJ. Self-Harm and Suicidality in Children Referred for Gender Dysphoria. *J Am Acad Child Adolesc Psychiatry*. 2016; 55(6):513–20. Epub 2016/05/31. <https://doi.org/10.1016/j.jaac.2016.04.001> PMID: 27238070.
31. Van Meter AR, Algorta GP, Youngstrom EA, Lechtman Y, Youngstrom JK, Feeny NC, et al. Assessing for suicidal behavior in youth using the Achenbach System of Empirically Based Assessment. *Eur Child Adolesc Psychiatry*. 2018; 27(2):159–69. Epub 2017/07/28. <https://doi.org/10.1007/s00787-017-1030-y> PMID: 28748484.
32. Deutz MH, Geeraerts SB, van Baar AL, Dekovic M, Prinzie P. The Dysregulation Profile in middle childhood and adolescence across reporters: factor structure, measurement invariance, and links with self-harm and suicidal ideation. *Eur Child Adolesc Psychiatry*. 2016; 25(4):431–42. Epub 2015/08/01. <https://doi.org/10.1007/s00787-015-0745-x> PMID: 26226917.
33. Ravens-Sieberer U, Gosch A, Rajmil L, Erhart M, Bruil J, Power M, et al. The KIDSCREEN-52 quality of life measure for children and adolescents: psychometric results from a cross-cultural survey in 13 European countries. *Value Health*. 2008; 11(4):645–58. Epub 2008/01/09. <https://doi.org/10.1111/j.1524-4733.2007.00291.x> PMID: 18179669.
34. Lindgren TW, Pauly IB. A body image scale for evaluating transsexuals. *Arch Sex Behav*. 1975; 4(6):639–56. Epub 1975/11/01. <https://doi.org/10.1007/BF01544272> PMID: 1212093.
35. Shaffer D, Gould MS, Brasic J, Ambrosini P, Fisher P, Bird H, et al. A children's global assessment scale (CGAS). *Arch Gen Psychiatry*. 1983; 40(11):1228–31. Epub 1983/11/01. <https://doi.org/10.1001/archpsyc.1983.01790100074010> PMID: 6639293.
36. Viner RM, Clark C, Taylor S, Bhui K, Klineberg E, Head J, et al. Risk factors for persistent fatigue in adolescents: A population-based study. *Journal of Adolescent Health*. 2006; 38(2):113–4. <https://doi.org/10.1016/j.jadohealth.2005.11.080>
37. Krogh AB, Larsson B, Linde M. Prevalence and disability of headache among Norwegian adolescents: A cross-sectional school-based study. *Cephalalgia*. 2015; 35(13):1181–91. Epub 2015/02/28. <https://doi.org/10.1177/0333102415573512> PMID: 25720767.
38. Ghelani R, Lim C, Brain C, Fewtrell M, Butler G. Sudden sex hormone withdrawal and the effects on body composition in late pubertal adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. 2019. Epub 2019/12/14. <https://doi.org/10.1515/jpem-2019-0045> PMID: 31834861.
39. Viot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*. 2017; 95:11–9. Epub 2016/11/16. <https://doi.org/10.1016/j.bone.2016.11.008> PMID: 27845262.
40. Joseph T, Ting J, Butler G. The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: findings from a large national cohort. *J Pediatr Endocrinol Metab*. 2019; 32(10):1077–81. Epub 2019/09/01. <https://doi.org/10.1515/jpem-2019-0046> PMID: 31472062.

41. Rothman MS, Iwamoto SJ. Bone Health in the Transgender Population. *Clin Rev Bone Miner Metab*. 2019; 17(2):77–85. Epub 2019/08/28. <https://doi.org/10.1007/s12018-019-09261-3> PMID: 31452648.
42. Panagiotakopoulos L. Transgender medicine—puberty suppression. *Rev Endocr Metab Disord*. 2018; 19(3):221–5. Epub 2018/08/17. <https://doi.org/10.1007/s11154-018-9457-0> PMID: 30112593.
43. Skagerberg E, Davidson S, Carmichael P. Internalizing and Externalizing Behaviors in a Group of Young People with Gender Dysphoria. *Int J Transgenderism*. 2013; 13(3):105–12. <https://doi.org/10.1080/15532739.2013.822340>
44. Zucker KJ. Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues. *Arch Sex Behav*. 2019; 48(7):1983–92. Epub 2019/07/20. <https://doi.org/10.1007/s10508-019-01518-8> PMID: 31321594.
45. Zucker KJ, Bradley SJ, Owen-Anderson A, Kibblewhite SJ, Wood H, Singh D, et al. Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *J Sex Marital Ther*. 2012; 38(2):151–89. Epub 2012/03/07. <https://doi.org/10.1080/0092623X.2011.611219> PMID: 22390530.
46. Levitan N, Barkmann C, Richter-Appelt H, Schulte-Markwort M, Becker-Hebly I. Risk factors for psychological functioning in German adolescents with gender dysphoria: poor peer relations and general family functioning. *Eur Child Adolesc Psychiatry*. 2019; 28(11):1487–98. Epub 2019/03/17. <https://doi.org/10.1007/s00787-019-01308-6> PMID: 30877477.
47. Becerra-Culqui TA, Liu Y, Nash R, Cromwell L, Flanders WD, Getahun D, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. *Pediatrics*. 2018; 141(5). Epub 2018/04/18. <https://doi.org/10.1542/peds.2017-3845> PMID: 29661941.
48. Taliaferro LA, McMorris BJ, Rider GN, Eisenberg ME. Risk and Protective Factors for Self-Harm in a Population-Based Sample of Transgender Youth. *Arch Suicide Res*. 2019; 23(2):203–21. Epub 2018/02/21. <https://doi.org/10.1080/13811118.2018.1430639> PMID: 29461934.
49. Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *J Sex Med*. 2015; 12(11):2206–14. Epub 2015/11/12. <https://doi.org/10.1111/jsm.13034> PMID: 26556015.
50. Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020. Epub 2020/01/25. <https://doi.org/10.1542/peds.2019-1725> PMID: 31974216.
51. Goedegebuure WJ, van der Steen M, de With JL, Hokken-Koelega A. Cognition, Health-Related Quality of Life, and Psychosocial Functioning After GH/GnRHa Treatment in Young Adults Born SGA. *J Clin Endocrinol Metab*. 2018; 103(11):3931–8. Epub 2018/08/24. <https://doi.org/10.1210/je.2018-01463> PMID: 30137415.
52. de Graaf NM, Cohen-Kettenis PT, Carmichael P, de Vries ALC, Dhondt K, Laridaen J, et al. Psychological functioning in adolescents referred to specialist gender identity clinics across Europe: a clinical comparison study between four clinics. *Eur Child Adolesc Psychiatry*. 2018; 27(7):909–19. Epub 2017/12/20. <https://doi.org/10.1007/s00787-017-1098-4> PMID: 29256158.
53. Nock MK, Green JG, Hwang I, McLaughlin KA, Sampson NA, Zaslavsky AM, et al. Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement. *JAMA Psychiatry*. 2013; 70(3):300–10. Epub 2013/01/11. <https://doi.org/10.1001/2013.jamapsychiatry.55> PMID: 23303463.
54. Jung KY, Kim T, Hwang SY, Lee TR, Yoon H, Shin TG, et al. Deliberate Self-harm among Young People Begins to Increase at the Very Early Age: a Nationwide Study. *Journal of Korean medical science*. 2018; 33(30):e191. Epub 2018/07/24. <https://doi.org/10.3346/jkms.2018.33.e191> PMID: 30034304.
55. Morey Y, Mellon D, Dailami N, Verne J, Tapp A. Adolescent self-harm in the community: an update on prevalence using a self-report survey of adolescents aged 13–18 in England. *J Public Health (Oxf)*. 2017; 39(1):58–64. Epub 2016/02/20. <https://doi.org/10.1093/pubmed/fdw010> PMID: 26892623.
56. Stallard P, Spears M, Montgomery AA, Phillips R, Sayal K. Self-harm in young adolescents (12–16 years): onset and short-term continuation in a community sample. *BMC psychiatry*. 2013; 13:328. Epub 2013/12/04. <https://doi.org/10.1186/1471-244X-13-328> PMID: 24294921.
57. Becker I, Auer M, Barkmann C, Fuss J, Moller B, Nieder TO, et al. A Cross-Sectional Multicenter Study of Multidimensional Body Image in Adolescents and Adults with Gender Dysphoria Before and After Transition-Related Medical Interventions. *Arch Sex Behav*. 2018; 47(8):2335–47. Epub 2018/08/09. <https://doi.org/10.1007/s10508-018-1278-4> PMID: 30088234.
58. Biggs M. Gender Dysphoria and Psychological Functioning in Adolescents Treated with GnRHa: Comparing Dutch and English Prospective Studies. *Arch Sex Behav*. 2020; 49(7):2231–6. Epub 2020/07/01. <https://doi.org/10.1007/s10508-020-01764-1> PMID: 32594279.

59. Vandenbroucke JP. What is the best evidence for determining harms of medical treatment? CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne. 2006; 174(5):645–6. Epub 2006/03/01. <https://doi.org/10.1503/cmaj.051484> PMID: 16505461.
60. Anglemeyer A, Horvath HT, Bero L. Healthcare outcomes assessed with observational study designs compared with those assessed in randomized trials. The Cochrane database of systematic reviews. 2014;(4):MR000034. Epub 2014/05/02. <https://doi.org/10.1002/14651858.MR000034.pub2> PMID: 24782322.
61. Golder S, Loke YK, Bland M. Meta-analyses of adverse effects data derived from randomised controlled trials as compared to observational studies: methodological overview. PLoS Med. 2011; 8(5): e1001026. Epub 2011/05/12. <https://doi.org/10.1371/journal.pmed.1001026> PMID: 21559325.
62. Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, et al. Creating the Trans Youth Research Network: A Collaborative Research Endeavor. Transgend Health. 2019; 4(1):304–12. Epub 2019/11/09. <https://doi.org/10.1089/trgh.2019.0024> PMID: 31701011.
63. Olson J, Chan Y-M, Garofalo R, Spack NP, Chen D, Clark L, et al. Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study. JMIR research protocols. 2019; 8(7):e14434. <https://doi.org/10.2196/14434> PMID: 31290407

Neuroimage. 2014 Mar; 88: 242–251.

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The influence of puberty on subcortical brain development

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Abstract

Puberty is characterized by hormonal, physical and psychological transformation. The human brain undergoes significant changes between childhood and adulthood, but little is known about how puberty influences its structural development. Using a longitudinal sample of 711 magnetic resonance imaging scans from 275 individuals aged 7–20 years, we examined how subcortical brain regions change in relation to puberty. Our regions of interest included the amygdala, hippocampus and corpus striatum including the nucleus accumbens (NA), caudate, putamen and globus pallidus (GP). Pubertal development was significantly related to structural volume in all six regions in both sexes. Pubertal development and age had both independent and interactive influences on volume for the amygdala, hippocampus and putamen in both sexes, and the caudate in females. There was an interactive puberty-by-age effect on volume for the NA and GP in both sexes, and the caudate in males. These findings suggest a significant role for puberty in structural brain development.

Abbreviations: NA, Nucleus Accumbens; GP, Globus Pallidus**Keywords:** Puberty, Adolescence, MRI, Subcortex

Introduction

The past 15 years have seen a major expansion in research on the structural development of the human adolescent brain, based largely on the results of cross-sectional and longitudinal magnetic resonance imaging (MRI) studies ([Brain Development Cooperative Group, 2012](#); [Giedd et al., 1996](#); [Lenroot et al., 2007](#); [Østby et al., 2009](#); [Raznahan et al., 2011](#); [Sowell et al., 2002](#)). Studies of brain growth trajectories over adolescence to date have predominantly considered growth in relation to chronological age, with few exceptions ([Paus et al., 2010](#); [Raznahan et al., 2010](#)). However, this approach ignores the cascade of developmental processes during adolescence that are related to puberty, including sexual maturation, linear (height) growth, body fat re-distribution and maturation of many other physiological systems ([Patton and Viner, 2007](#); [Wheeler, 1991](#)). Since there is a normal variation of 4–5 years in the timing of onset of puberty in healthy humans ([Parent et al., 2003](#)), pubertal development is partially dissociable from chronological age. Examining brain development in relation to pubertal maturation may provide additional information regarding the mechanisms associated with adolescent brain development. In this study, we investigated how the developmental trajectories of subcortical regions that are linked to stereotypical behaviours are associated with pubertal development ([Forbes and Dahl, 2010](#); [Steinberg, 2008](#)): the amygdala and hippocampus, which play an important role in emotion and mood regulation ([Davidson et al., 2002](#)); and the corpus striatum including the nucleus accumbens (NA), caudate, putamen and globus pallidus (GP), which are involved in decision-making and reward-seeking behaviours ([Gottfried, 2011](#)).

It has been hypothesised that the brain restructuring and development seen in adolescence may be specifically related to the hormonal influences that control the onset of and progression through puberty ([Giedd et al., 1999](#); [Lenroot et al., 2007](#); [Peper et al., 2011](#); [Sowell et al., 2002](#)). Sex steroids such as testosterone (an androgen) and oestradiol (an oestrogen) have been shown to be capable of inducing both synaptogenesis and synaptic pruning in rats and nonhuman primates ([Ahmed et al., 2008](#); [Hajszan et al., 2008](#); [Sato et al., 2008](#)) with differential effects of androgens and oestrogens on different brain areas, which may be related to hormone receptor distribution ([Clark et al., 1988](#); [Sholl and Kim, 1989](#)). These differential effects across brain areas may provide an explanation for the diverging growth trajectories of particular brain structures between males and females documented across studies, and the resultant increasing sexual dimorphism in adolescence reported in some regions ([Brain Development Cooperative Group, 2012](#); [Lenroot et al., 2007](#); [Neufang et al., 2009](#); [Sowell et al., 2002](#)).

Cross-sectional studies have reported that puberty is associated with aspects of brain development in adolescence. A study focussing on the association between brain volumes and both pubertal stage and testosterone concentration found that males and females in later stages of puberty, and with higher circulating testosterone concentration, had larger amygdala volumes and smaller hippocampal volumes than their less well developed peers (Neufang et al., 2009). In contrast, a second study investigating puberty and pubertal hormone correlations with grey matter volume replicated the positive association between amygdala volume and pubertal stage in boys, but showed decreasing amygdala volume with increasing testosterone levels in girls (Bramen et al., 2011). These studies have limited power due to their relatively small sample sizes and cross-sectional methods. To date, no longitudinal studies incorporating pubertal measures have been published. Longitudinal analysis allows comparison of brain volumes both between-subjects and also within each subject over time, and therefore can provide a measure not just of brain volume at a particular time-point, but also of developmental trajectories for each of these subcortical brain regions by following what happens to each participant. This is particularly advantageous when looking at brain volumes, which vary substantially between individuals (Brain Development Cooperative Group, 2012; Giedd et al., 1999; Tamnes et al., 2013).

Using a large sample of scans from 275 individuals scanned longitudinally, we examined how subcortical brain regions change in relation to puberty as measured by Tanner stage (Tanner and Whitehouse, 1976), and compared developmental trajectories in females and males. We used a large dataset containing information on pubertal stage and chronological age to examine growth trajectories over adolescence in each of these subcortical regions. Based on previous cross-sectional findings, we predicted that the volume of the amygdala and hippocampus would increase between 7 and 20 years (Giedd et al., 1999; Østby et al., 2009), whilst the volumes of the corpus striatum – the NA, caudate, putamen and GP – would decrease (Brain Development Cooperative Group, 2012; Østby et al., 2009; Sowell et al., 2002). We hypothesized that volume change for all structures of interest would be related to pubertal development as measured by Tanner stage, and that puberty and age would have independent effects on volume in these regions. Therefore, we hypothesized that models incorporating both Tanner stage and chronological age as explanatory variables for volume change would provide a significant fit for the developmental data from the structures examined.

Experimental procedures

Participants

The sample used for the analysis was taken from the NIMH Child Psychiatry Branch Section on Brain Imaging longitudinal dataset of structural MRI scans (Giedd et al., 1996). This large dataset consists of more than 6500 scans from more than 3000 participants of which approximately half are typically developing and half are from various diagnostic groups. Inclusion and exclusion criteria for the overall dataset can be found on the NIMH website (http://clinicalstudies.info.nih.gov/cgi/detail.cgi?A_1989-M-0006.html). For each participant, the outcomes of interest that were measured included ethnicity, socioeconomic status (using Hollingshead scales), IQ (estimated using age-appropriate Wechsler Intelligence Scales) and handedness (using Physical and Neurological Examination of Soft Signs inventory (Denckla, 1985)), each of which was collected at the time of the first scan, and pubertal status, ascertained at the time of each scan using Tanner stage diagrams (Taylor et al., 2001). Tanner staging is the most widely used technique for assessing physical puberty stage. For each participant at each time-point, a single combined Tanner stage score was assigned based on the overall stage that the participant felt best described themselves from looking at the separate breast/genital and pubic hair scores.

The subgroup used for the current analysis consisted of 275 unrelated individuals (117 females), and incorporated the scans of all individuals who met the following criteria:

1. Healthy individuals at the time of scanning. Participants were screened for neurological or psychiatric illness using a telephone screening interview and completion of a parent-report screening questionnaire (CBCL) at each time-point, and only healthy participants were included in the analysis as established by standardized scoring (Achenbach, 1991). All participants included had an IQ of greater than 80.
2. Two or more MRI scans between the ages of 7.0 and 20.0 years. This age range was estimated using two large US population-based studies on pubertal timing (Herman-Giddens et al., 1997; Sun et al., 2002), and incorporating ages from two 2 SD below the mean age of being in Tanner stage 2 (6.3–7.8 years for females and 6.9–9.7 years for males depending on the measure (breast/pubic hair/gonadal development) used), to 2 SD above the mean age of being in Tanner stage 5 (20.5–21.0 years for females, 19.6–20.1 years for males depending on the measure used). This range was refined based on our dataset to 7.0 to 20.0 years, as this incorporated the ages at which there was variation in Tanner stage between individuals.
3. Complete data for age and self-reported Tanner stage for each MRI scan. Individuals who reported regression of puberty during adolescence (as indicated by reducing Tanner score) were excluded from the analysis ($N = 1$; female), since pubertal regression is essentially biologically implausible and likely represents error. Pubertal arrest, which may be perceived as regression, is associated with significant systemic illness or malnutrition.
4. Only one individual per family. The original dataset incorporates a high number (> 400 individuals) of monozygous and dizygous twin pairs, as well as siblings. The heritability of brain structure and development is still not well-understood, but there are likely to be both genetic and environmental effects on structural brain volume and developmental trajectory, as well as pubertal timing, which are not independent between family members, and therefore might bias the analysis. Where data were available for more than one family member, only one individual was included in the analysis; the family member included was determined by the participant with a higher number of high quality scans, more complete demographic data, or, if these were equal, by random selection.

Of the 275 participants whose data were included in the study, 87.3% were right-handed (7.3% left-handed, 5.4% mixed). The majority (89.5%) were Caucasian (5.1% African-American; 2.2% Hispanic; 0.7% Asian; 2.5% other). Details of socioeconomic status, IQ, puberty status and number of scans can be seen in Table 1.

Participants were recruited from the community through local advertisement and reimbursed for their participation in the study. The study research protocol was approved by the Institutional Review Board of the National Institutes of Health and written informed consent and assent to participate in the study were obtained from parents/adult participants and children respectively.

Image acquisition

All MRI scans were T-1 weighted images with contiguous 1.5 mm axial slices and 2.0 mm coronal slices, obtained on the same 1.5-T General Electric Signa scanner (Milwaukee, WI) using a 3D spoiled gradient recalled echo sequence with the following parameters: echo time: 5 ms; repetition time: 24 ms; flip angle: 45°; acquisition matrix: 256 × 192; field of view: 24 cm. The same scanner, hardware and software were used throughout the scanning period. All scans were assessed by a clinical neuroradiologist for gross abnormalities. All scans performed as part of the NIH project have been rated for motion-related quality by trained technicians. Only scans given a high-quality rating were included in the analysis.

Image processing

Subcortical volume estimation was performed with the Freesurfer 5.1 image analysis suite using the programme's automated segmentation procedure (<http://surfer.nmr.mgh.harvard.edu/>). This procedure has been described in detail previously (Fischl et al., 2002), and is summarized here. An optimal linear transform is computed that maximises the likelihood of the input image, given an atlas constructed from manually labelled images. A nonlinear transform is then initialized with the linear one, and the image is allowed to further deform to better match the atlas. Finally, a Bayesian segmentation procedure is carried out, and the maximum a posteriori estimate of the labelling is computed. The segmentation uses three pieces of information to disambiguate labels: (1) the prior probability of a given tissue class occurring at a specific atlas location; (2) the likelihood of the image given that tissue class; and (3) the probability of the local spatial configuration of labels given the tissue class. The automated segmentations have been found to be statistically indistinguishable from manual labelling (Fischl et al., 2002), and correlations between Freesurfer segmentation and manual labelling of hippocampal volume by trained researchers reached 0.85 in a study by Tae et al. (2008).

Our analysis focussed on the following subcortical brain regions, based on a priori hypotheses regarding changes in volume over adolescence and pubertal effects: the amygdala, hippocampus, NA, caudate, putamen and GP. Each of these regions is defined by the automated Freesurfer segmentation procedure based on location, likelihood of tissue class and spatial configuration. An example of T1W scans showing both the raw data and with Freesurfer's automated segmentation can be seen in the Supplementary information (Fig. S1).

Statistical analysis

We conducted our analysis using the average volume across hemispheres, to produce one value for each ROI. Previous studies have demonstrated no evidence of developmental difference between hemisphere in these regions (Brain Development Cooperative Group, 2012; Østby et al., 2009), and our own dataset shows high correlations between hemispheres for all volumes ($r = 0.5-0.9$, $p < 0.001$). We analysed raw volumes for each region and percentage change for each volume over time. Mixed effects modelling was used (R version 3.1-102; nlme package (Pinheiro et al., 2011)) to analyse the data, thereby allowing an estimation of the fixed effects of measured variables on volume change, whilst incorporating the longitudinal nature of the data by including within-person variation as nested random effects. Age was centred on 7 years, which represented the minimum age included in the sample. Tanner stage was treated as a continuous variable for this analysis, allowing the model to incorporate changing Tanner stage and changing brain volume for each individual.

For each structure, volume was first modelled against Tanner stage (Tanner-only model), and linear, quadratic or cubic developmental trajectories were modelled. Males and females were modelled separately, to allow for different trajectories of growth through adolescence (Lenroot et al., 2007). Tanner stage was treated as a continuous variable to allow the model to account for movement of individuals between stages and to maintain the ordinal nature of the data. The equations for volume growth of a structure in relation to Tanner stage are:

$$\text{Linear model: Volume} = \text{Intercept} + \beta_1 \text{Tanner} \quad \text{Quadratic model: Volume} = \text{Intercept} + \beta_1 \text{Tanner} + \beta_2 \text{Tanner}^2 \quad \text{Cubic model: Volume} = \text{Intercept} + \beta_1 \text{Tanner} + \beta_2 \text{Tanner}^2 + \beta_3 \text{Tanner}^3$$

where β_1 , β_2 and β_3 represent the constant terms defining the effects of each fixed term. To determine whether a cubic, quadratic or linear growth model with Tanner stage best fit the sample, an F test was performed on models where the marginal p-value of the highest order variable was significant ($p < 0.05$).

Given that pubertal development is a developmental process, Tanner stage is necessarily highly correlated with chronological age, and this was found to be the case in our sample ($r = 0.89$ for males and $r = 0.88$ for females). It was therefore necessary to consider the effects of age on the developmental trajectories of the subcortical volumes, to see whether this could explain all of the puberty-related effects, and to establish whether models including age with puberty were a better fit than puberty models alone. Therefore, age was incorporated into the model to ascertain whether there were (i) dissociable main effects of Tanner stage and age, and/or (ii) a Tanner stage by age interactive effect. The model including the main effects of both Tanner stage and age and the tanner by age interaction is referred to as the *combined model* ($\text{Volume} = \text{Intercept} + \beta_1 (\text{Tanner}) + \beta_2 (\text{Age}) + \beta_3 (\text{Tanner} * \text{Age})$), whilst the model including only the Tanner stage by age interaction is referred to as the *interaction-only model* ($\text{Volume} = \beta_1 (\text{Tanner} * \text{Age})$). Lastly, an age-only model was estimated (using linear, quadratic and cubic growth options as above).

Comparison of Tanner-only, combined, interaction-only and age-only models was undertaken using likelihood ratio tests where possible. Where LR tests could not be performed, i.e. if the models were not nested, Akaike Information Criterion (AIC) values were used to compare models. Models were considered to be a significantly improved fit if the difference between AIC values was 5.9 or greater, equating to an Akaike weight of the poorer model of less than 0.05. If the difference exceeded this, the inferior model was discarded, leaving only the models that were equally valid based on relative likelihood (Wagenmakers and Farrell, 2004).

Results

Demographic details for all participants are included in [Table 1](#) and [Fig. 1](#). The raw data for each sex and each structure are displayed in Fig. S2 (Supporting Information).

Models using Tanner stage as an explanatory variable for subcortical volume change

Pubertal development, as measured by Tanner stage, was significantly related to the structural development of all six subcortical regions in both males and females (See [Table 2](#) and [Fig. 2](#)). In both sexes, amygdala and hippocampus volume increased across puberty, whilst the other structural volumes (NA, caudate, putamen and GP) decreased (See [Fig. 2](#)). In females, the growth trajectories were either linear (NA, GP) or quadratic (amygdala, hippocampus, caudate and putamen), whilst in males the trajectories were linear (hippocampus, GP), quadratic (putamen) or cubic (amygdala, NA, caudate) (See [Table 2](#)). The proportional volume change over puberty varied between structures from a 7.5% increase in male amygdala volume, to a 9.9% reduction in female GP volume, with some regions showing more modest volume changes e.g. caudate 2.3% reduction in males. See [Table 2](#) and [Fig. 2](#) for full results.

Models using Tanner stage and chronological age as explanatory variables for subcortical volume change

For the amygdala, hippocampus and putamen in both sexes, as well as the caudate in females, a combined model (including Tanner stage and age as main effects, and a Tanner stage by age interaction) provided a significantly better fit than the Tanner-only model (See [Table 3](#)). For each of these structures, individuals in later stages of puberty (i.e. higher Tanner stage score) than their age-matched peers had volumes that are further along the developmental trajectory than peers in earlier stages of puberty. For females, individuals who were more pubertally mature than their age-matched peers had a larger volume in these structures in late childhood and early adolescence, an earlier peak volume and then a smaller volume until the end of puberty than their less mature, age-matched peers (see [Fig. 3](#)). In males, for the amygdala and hippocampus, individuals in later stages of puberty (i.e. higher Tanner stage score than age-matched peers) had larger structural volumes throughout our studied age range (7–20 years) than age-matched peers in earlier stages of puberty (see [Fig. 3](#)). In contrast, for the putamen in males, individuals in later stages of puberty had smaller structural volumes throughout our studied age range than age-matched peers in earlier stages of puberty (see [Fig. 3](#)).

For the NA and GP in both sexes, and for the caudate in males, an interaction-only model provided a significant fit to the data, but the model was no improvement over the Tanner stage only model (See [Table 3](#)). Based on this interaction model, individuals in a later stage of puberty than their age-matched peers had a smaller NA or GP (both sexes) or caudate (males only) volume throughout the age range investigated (7–20 years) ([Fig. 3](#)).

Models using chronological age as an explanatory variable for subcortical volume change

For some structures in males, the hippocampus and the GP, age-only models gave a significantly better fit of the data than models incorporating Tanner stage (hippocampus LR test compared to interactive model = 4.69, $p = 0.030$; GP LR test compared to interactive model = 9.29, $p = 0.002$). There was no statistically significant age-only model for volume change in the caudate in males over our age range. For the remaining structures in males (amygdala, NA and putamen) and all the six investigated structures in females, an age-only model did not improve the model fit over the models incorporating puberty measures.

Discussion

In the current study, we examined the relationship between puberty and growth trajectories of subcortical regions during adolescence using a large longitudinal dataset. Each of the regions studied showed significant longitudinal associations with puberty ([Fig. 2](#)). For many of the structures (Females: amygdala, hippocampus, caudate, putamen; Males: amygdala, putamen), models including both age and Tanner stage modelled development better than Tanner-only models. This suggests that both variables are important factors when modelling volume change over adolescent development. Some structures in males (hippocampus, GP) were best modelled using only age as an explanatory variable, whilst the caudate in males was best modelled using only Tanner stage.

Despite the close proximity of the subcortical structures explored, there were clear differences in their structural development during adolescence. In both males and females, the amygdala and hippocampus continued to increase in volume during puberty, whilst the other structures examined decreased in volume, with structures changing between 2.3% and 9.9% across adolescence ([Fig. 2](#)). These results may reflect the different mechanisms that influence macroscopic volume changes between structures. Alternatively, the regions may undergo similar growth patterns, but do so at different chronological time-points, resulting in different growth patterns within our restricted age and developmental range.

Observation of pubertal development during adolescence provides an indirect marker of an individual's systemic sex steroid hormone exposure. The principal hormones involved are testosterone and dehydroepiandrosterone (DHEA), both androgens, and oestradiol, an oestrogen. Rising hormone levels, triggered by re-activation of the hypothalamic-pituitary-gonadal axis, leads to the series of physical changes classically associated with puberty. Androgens signal the development of adult-type body hair and skin changes in both females and males, in addition to gonadal development in males, whilst oestradiol primarily affects females, and causes breast and gonadal development. Tanner staging categorises pubertal maturation by describing five stages of development from pre-pubertal to full maturation for each of pubic hair development, genital development and breast development. An individual's puberty stage is related both to how long they have been exposed to the sex steroid hormones, and to their current level of hormones ([Dorn and Biro, 2011](#); [Shirtcliff et al., 2009](#)). Our results, showing that growth trajectories of subcortical structures were related to pubertal development, suggest that these same pubertal hormones influence structural brain growth.

Systemic pubertal hormones cross the blood-brain barrier in small concentrations ([Marynick et al., 1976](#)), and systemic concentrations of testosterone have been shown to be related to amygdala volume in both males and females ([Neufang et al., 2009](#)). Both androgens and oestrogens induce synaptogenesis and synaptic pruning in rat and non-human primates ([Ahmed et al., 2008](#); [Hajszan et al., 2008](#); [Sato et al., 2008](#)) and it is likely that this process also occurs in humans, modulating brain growth across puberty ([Matsumoto, 1991](#)). Sex hormone receptors for both oestrogens and androgens are found throughout the brain in varying concentrations, with high levels in subcortical regions, particularly the hippocampus and amygdala ([Abdelgadir et al., 1999](#); [Clark et al., 1988](#); [Sholl and Kim, 1989](#)). The difference in regional receptor concentrations in the brain potentially helps to explain why different patterns of growth are seen across structures, and the resultant sexual dimorphism reported to emerge during adolescence in some regions ([Brain Development Cooperative Group, 2012](#); [Lenroot et al., 2007](#); [Neufang et al., 2009](#); [Sowell et al., 2002](#)).

We found that both males and females demonstrated pubertal effects related to amygdala growth, with increases in volume over puberty in both sexes. Although the overall volume change was similar between the sexes, the growth trajectories were quite different ([Fig. 2](#)), with females showing a large increase in volume in early puberty before peaking and decreasing, and males showing an increasing volume until the end of puberty. This is consistent with the different patterns of testosterone concentration in puberty, with males showing larger increases in concentration and a longer period of increase, and females showing a much smaller rise and earlier plateau of testosterone concentration ([Ankarberg and Norjavaara, 1999](#)). The smaller increase and earlier peak in testosterone concentration in females compared with males might explain the differences in trajectories between the two sexes, where the changes in neural structure that are seen are being modulated by systemic testosterone concentrations ([Zuloaga et al., 2008](#)). This connection might reflect a direct effect of testosterone on amygdala volume, via the testosterone receptors found in high concentrations in the amygdala, or indirect effects e.g. via aromatisation and effects on oestrogen receptors ([Schwarz and McCarthy, 2008](#)), or through interaction with growth hormone ([Meinhardt and Ho, 2006](#)) and its receptors present in the brain. Previous cross-sectional studies investigating changes in amygdala volume with puberty have reported volume increases with increasing pubertal stage (and testosterone level) in males ([Bramen et al., 2011](#); [Neufang et al., 2009](#)), but have had conflicting results in females, where both increases ([Neufang et al., 2009](#)) and decreases ([Bramen et al., 2011](#)) in amygdala volume have been reported. The different findings between these two papers may result from the relatively small sample sizes or the differing age ranges of the two studies ([Neufang et al., 2009](#): $n = 46$, 23 male, age 8–15 years; [Bramen et al., 2011](#): $n = 80$, 32 male, ages 10.7–14.0 years). As our sample shows, there is large variation in brain volumes between participants, and small samples may not be able to reflect the variation in the population, and within each group (early vs late puberty or Tanner stages 1–5). Our results indicate that both age and puberty impact on the structural development of the amygdala in males and females, and differences in the findings of these two previous studies may reflect that they were sampling participants of different ages.

In the hippocampus, the best model to explain growth in females was the combined model incorporating puberty and age, whilst in males the age-only model provided a better fit. This is consistent with an oestrogen-modulated growth pattern. During puberty, oestrogen concentrations in females increase by 4–9 times ([Ikegami et al., 2001](#)), and oestrogens are dominant in many pubertal changes. In contrast among males, relatively minor rises in oestrogens are seen during puberty due to aromatization of testosterone. The hippocampus in non-human primates has high levels of oestrogen receptors ([Sholl and Kim, 1989](#)), and the increasing concentration of oestrogen that occurs predominantly in females coincides with the growth trajectories seen in the hippocampus in this study.

In our analysis, both males and females showed a decrease in NA volume with puberty (see [Fig. 2](#)), and both sexes show on-going development throughout adolescence. Both androgens and oestrogens modulate the function of the NA, changing levels of dopamine release ([Thompson and Moss, 1994](#)), and these results are consistent with the existence of macroscopic structural effects of both hormones on NA volume. For the NA, there was no statistical difference between the amount of volume change explained by the model based on puberty status alone, the model based on chronological age alone, or the model incorporating the interactive effects of both puberty and age. This may relate to the high correlation between age and pubertal stage. Note that such collinearity reduces the precision of the estimates of coefficients but does not affect estimates of model fit. Importantly, all the models appear to show on-going structural changes across adolescence in the NA.

The caudate, putamen, and GP lie in close proximity to one another, and have related functions. Growth trajectories of these three regions across puberty are similar, with decreases in volume seen with greater pubertal development. The relative changes in volume for the caudate and putamen are the smallest of all the structures over the course of puberty ([Fig. 2](#)). The caudate in males was the only structure analysed that showed no significant relationship with age, emphasizing the importance of considering alternative variables that influence development over this age range. Previous cross-sectional studies of the caudate have shown similar findings, with weak or no age-related changes ([Brain Development Cooperative Group, 2012](#); [Østby et al., 2009](#); [Sowell et al., 2002](#)); our results using a longitudinal dataset support this. Less is known about the sex hormone receptor concentrations in the caudate, putamen and GP. Sex hormones have been shown to impact upon receptor densities in these regions ([Sumner and Fink, 1998](#)), giving one potential indirect mechanism for the changes in structure seen, but further work exploring how sex hormones influence macroscopic structural changes is needed to help ascertain this.

One of the major strengths of this study is the longitudinal nature of the dataset, which enabled us to model growth trajectories based on the trajectories of real individuals instead of using cross-sectional points. There is wide variability in structural volumes in the brain between individuals, and repeated measurements of the same individual will therefore produce more accurate trajectories than assuming that cross-sectional data can be extrapolated to define trajectories, making the analysis more powerful to detect small but significant changes in brain volume. The structural development of the brain is likely to be affected by a number of variables and the use of a large longitudinal dataset maximises our ability to characterise the relationships of different variables with changing structural volume. The longitudinal nature of the data, the replication of previous cross-sectional findings and the presence of plausible biological mechanisms allow us to hypothesize that puberty may have causal effects on brain development. However our study does not allow us to address whether the effects of puberty on structural brain growth are direct, via hormonal action on the brain tissue, or indirect, with the brain structure being shaped by how young people undergoing puberty may be treated differently in society than their less well-developed peers, or how they might perceive themselves differently (Blakemore et al., 2010). To our knowledge, previous research has not tackled this subject, and further work exploring how pubertal hormones influence brain structural development in both animal and human studies, and combining hormonal and pubertal stage variables, may help to establish how this relationship is modulated.

Our data are subject to a number of limitations. Self-reported Tanner stage, whilst the most widely used and clinically validated measure of pubertal development, is nevertheless a relatively crude measure which subjectively categorises puberty into broad developmental stages. It is therefore limited in its capacity to document accurately small developmental changes, and has significantly poorer resolution than age as an explanatory variable. This may mean that our puberty-related effects on growth trajectories are in fact underestimates, and further studies may help to validate our results and explore further their implications. Despite the large sample size, and longitudinal nature of the current dataset, there are limited numbers of participants at the extreme ages for each Tanner stage. This would be expected because our dataset is representative of a normal population undergoing typical development, with a normal distribution of ages for each puberty stage, and therefore relatively small numbers of individuals at the extreme ends of normal puberty timing. These smaller numbers may reduce the accuracy of the model at these extreme ages and further research targeting narrower age ranges, and focusing on these extremes of normal pubertal development, and using different methods to measure pubertal maturation, would help to validate and further expand on our findings. Polynomial models, as used in this study, have been shown to be susceptible to the age range and age-centring used (Fjell et al., 2010) when performing age-based analyses of development. For this reason, we developed a clear a priori method for our analysis, based on our primary aim to explore the relationship between puberty and structural development of subcortical regions. Our age range was clearly defined, based on the largest available recent US-population based studies of pubertal timing (see page 6) to incorporate the reasonable ages associated with pubertal development. We included the full range of pubertal variation, our primary variable of interest, in the analysis, which should reduce any impact on the reliability of the model fit. A further limitation is our use of automated segmentation software to extract structural volumes for our six regions of interest. This method was chosen in view of the large number of scans (711) included in the study, and is widely accepted to be appropriate for very large scale-studies where manual tracing techniques are prohibitively time-consuming and resource intensive. Correlations between amygdala and hippocampus volumes for Freesurfer vs. manual tracing are high (Fischl et al., 2002; Morey et al., 2009; Tae et al., 2008).

Conclusion

We have shown that the structural development of subcortical brain regions is related to pubertal development during adolescence. This relationship likely reflects the effects of systemic sex hormones on structural brain development. Examining brain development in relation to pubertal development may provide additional information regarding the control mechanisms behind adolescent brain development, and in particular may shed light on how many of the behaviours classically associated with puberty come to arise. It may also help explain the development of a marked sexual dimorphism in psychiatric disorders around the time of puberty (Zahn-Waxler et al., 2008), as there is emerging evidence of associations between volumes of subcortical structures and psychiatric diagnoses (Karchemskiy et al., 2011; Rigucci et al., 2010).

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Footnotes

Appendix A Supplementary data to this article can be found online at <http://dx.doi.org/10.1016/j.neuroimage.2013.09.073>.

Appendix A. Supplementary data

Supplementary figures.

References

Abdelgadir S.E., Roselli C.E., Choate J.V.A., Resko J.A. Androgen receptor messenger ribonucleic acid in brains and pituitaries of male rhesus monkeys: studies on distribution, hormonal control, and relationship to luteinizing hormone secretion. *Biol. Reprod.* 1999;60:1251–1256. [PubMed: 10208992]

Achenbach T.M. University of Vermont; Burlington: 1991. Child behavior checklist/4–18.

Ahmed E.I., Zehr J.L., Schulz K.M., Lorenz B.H., DonCarlos L.L., Sisk C.L. Pubertal hormones modulate the addition of new cells to sexually dimorphic brain regions. *Nat. Neurosci.* 2008;11:995–997. [PMCID: PMC2772186] [PubMed: 19160494]

Ankarberg C., Norjavaara E. Diurnal rhythm of testosterone secretion before and throughout puberty in healthy girls: correlation with 17 β -estradiol and dehydroepiandrosterone sulfate. *JCEM.* 1999;84:975–984. [PubMed: 10084582]

Blakemore S.-J., Burnett S., Dahl R.E. The role of puberty in the developing adolescent brain. *Hum. Brain Mapp.* 2010;31:926–933. [PMCID: PMC3410522] [PubMed: 20496383]

Brain Development Cooperative Group Total and regional brain volumes in a population-based normative sample from 4 to 18 years: the NIH MRI study of normal brain development. *Cereb. Cortex.* 2012;22:1–12. [PMCID: PMC3236790] [PubMed: 21613470]

Bramen J.E., Hranilovich J.A., Dahl R.E., Forbes E.E., Chen J., Toga A.W., Dinov I.D., Worthman C.M., Sowell E.R. Puberty influences medial temporal lobe and cortical gray matter maturation differently in boys than girls matched for sexual maturity. *Cereb. Cortex.* 2011;21:636–646. [PMCID: PMC3041011] [PubMed: 20713504]

Clark A.S., MacLusky N.J., Goldman-Rakic P.S. Androgen binding and metabolism in the cerebral cortex of the developing rhesus monkey. *Endocrinology.* 1988;123:932–940. [PubMed: 3260856]

Davidson R.J., Lewis D.A., Alloy L.B., Amaral D.G., Bush G., Cohen J.D., Drevets W.C., Farah M.J., Kagan J., McClelland J.L., Nolen-Hoeksema S., Peterson B.S. Neural and behavioral substrates of mood and mood regulation. *Biol. Psychiatry.* 2002;52:478–502. [PubMed: 12361665]

Denckla M.B. Revised neurological examination for subtle signs (1985) *Psychopharmacol. Bull.* 1985;21:773–800. [PubMed: 4089106]

Dorn L.D., Biro F.M. Puberty and its measurement: a decade in review. *J. Res. Adolesc.* 2011;21:180–195.

Fischl B., Salat D.H., Busa E., Albert M., Dieterich M., Haselgrove C., van der Kouwe A., Killiany R., Kennedy D., Klaveness S., Montillo A., Makris N., Rosen B., Dale A.M. Whole brain segmentation: automated labeling of neuroanatomical structures in the human brain. *Neuron.* 2002;33:341–355. [PubMed: 11832223]

Fjell A.M., Walhovd K.B., Westlye L.T., Østby Y., Tamnes C.K., Jernigan T.L., Gamst A., Dale A.M. When does brain aging accelerate? Dangers of quadratic fits in cross-sectional studies. *Neuroimage.* 2010;50:1376–1383. [PubMed: 20109562]

Forbes E.E., Dahl R.E. Pubertal development and behavior: hormonal activation of social and motivational tendencies. *Brain Cogn.* 2010;72:66–72. [PMCID: PMC3955709] [PubMed: 19942334]

Giedd J.N., Snell J.W., Lange N., Rajapakse J.C., Casey B.J., Kozuch P.L., Vaituzis A.C., Vauss Y.C., Hamburger S.D., Kaysen D., Rapoport J.L. Quantitative magnetic resonance imaging of human brain development: ages 4–18. *Cereb. Cortex.* 1996;6:551–560. [PubMed: 8670681]

Giedd J.N., Blumenthal J., Jeffries N.O., Castellanos F.X., Liu H., Zijdenbos A., Paus T., Evans A.C., Rapoport J.L. Brain development during childhood and adolescence: a longitudinal MRI study. *Nat. Neurosci.* 1999;2:861–863. [PubMed: 10491603]

Gottfried J.A. CRC Press; Boca Raton (FL): 2011. Neurobiology of Sensation and Reward, Frontiers in Neuroscience.

Hajszan T., MacLusky N.J., Leranath C. Role of androgens and the androgen receptor in remodeling of spine synapses in limbic brain areas. *Horm. Behav.* 2008;53:638–646. [PMCID: PMC2408746] [PubMed: 18262185]

Herman-Giddens M.E., Slora E.J., Wasserman R.C., Bourdony C.J., Bhapkar M.V., Koch G.G., Hasemeier C.M. Secondary sexual characteristics and menses in young girls seen in office practice: a study from the pediatric research in office settings network. *Pediatrics.* 1997;99:505–512. [PubMed: 9093289]

Ikegami S., Moriwake T., Tanaka H., Inoue M., Kubo T., Suzuki S., Kanzakili S., Seino Y. An ultrasensitive assay revealed age-related changes in serum oestradiol at low concentrations in both sexes from infancy to puberty. *Clin. Endocrinol. (Oxf.)* 2001;55:789–795. [PubMed: 11895221]

Karchemskiy A., Garrett A., Howe M., Adleman N., Simeonova D.J., Alegria D., Reiss A., Chang K. Amygdalar, hippocampal, and thalamic volumes in youth at high risk for development of bipolar disorder. *Psychiatry Res.* 2011;194:319–325. [PMCID: PMC3225692] [PubMed: 22041532]

Lenroot R.K., Gogtay N., Greenstein D.K., Wells E.M., Wallace G.L., Clasen L.S., Blumenthal J.D., Lerch J., Zijdenbos A.P., Evans A.C., Thompson P.M., Giedd J.N. Sexual dimorphism of brain developmental trajectories during childhood and adolescence. *Neuroimage.* 2007;36:1065–1073. [PMCID: PMC2040300] [PubMed: 17513132]

Marynick S.P., Havens W.W., II, Ebert M.H., Loriaux D.L. Studies on the transfer of steroid hormones across the blood–cerebrospinal fluid barrier in the rhesus monkey. *Endocrinology.* 1976;99:400–405. [PubMed: 954639]

Matsumoto A. Synaptogenic action of sex steroids in developing and adult neuroendocrine brain. *Psychoneuroendocrinology.* 1991;16:25–40. [PubMed: 1961842]

Meinhardt U.J., Ho K.K.Y. Modulation of growth hormone action by sex steroids. *Clin. Endocrinol. (Oxf.)* 2006;65:413–422. [PubMed: 16984231]

Morey R.A., Petty C.M., Xu Y., Hayes J.P., Wagner H.R., Lewis D.V., LaBar K.S., Styner M., McCarthy G. A comparison of automated segmentation and manual tracing for quantifying hippocampal and amygdala volumes. *Neuroimage.* 2009;45:855–866. [PMCID: PMC2714773] [PubMed: 19162198]

Neufang S., Specht K., Hausmann M., Güntürkün O., Herpertz-Dahlmann B., Fink G.R., Konrad K. Sex differences and the impact of steroid hormones on the developing human brain. *Cereb. Cortex.* 2009;19:464–473. [PubMed: 18550597]

Østby Y., Tamnes C.K., Fjell A.M., Westlye L.T., Due-Tønnessen P., Walhovd K.B. heterogeneity in subcortical brain development: a structural magnetic resonance imaging study of brain maturation from 8 to 30 years. *J. Neurosci.* 2009;29:11772–11782. [PMCID: PMC6666647] [PubMed: 19776264]

Parent A.-S., Teilmann G., Juul A., Skakkebaek N.E., Toppari J., Bourguignon J.-P. The timing of normal puberty and the age limits of sexual precocity: variations around the world, secular trends, and changes after migration. *Endocr. Rev.* 2003;24:668–693. [PubMed: 14570750]

Patton G.C., Viner R. Pubertal transitions in health. *Lancet.* 2007;369:1130–1139. [PubMed: 17398312]

Paus T, Nawaz-Khan I, Leonard G, Perron M, Pike G.B., Pitiot A., Richer L., Susman E., Veillette S., Pausova Z. Sexual dimorphism in the adolescent brain: role of testosterone and androgen receptor in global and local volumes of grey and white matter. *Horm. Behav.* 2010;**57**:63–75. [PubMed: 19703457]

Peper J.S., Hulshoff Pol H.E., Crone E.A., van Honk J. Sex steroids and brain structure in pubertal boys and girls: a mini-review of neuroimaging studies. *Neuroscience.* 2011;**191**:28–37. [PubMed: 21335066]

Pinheiro J., Bates D., DebRoy S., Sarkar D. 2011. nlme: Linear and Nonlinear Mixed Effects Models. R package version 3. 1-104.

Raznahan A., Lee Y., Stidd R., Long R., Greenstein D., Clasen L., Addington A., Gogtay N., Rapoport J.L., Giedd J.N. Longitudinally mapping the influence of sex and androgen signaling on the dynamics of human cortical maturation in adolescence. *Proc. Natl. Acad. Sci. U. S. A.* 2010;**107**:16988–16993. [PMCID: PMC2947865] [PubMed: 20841422]

Raznahan A., Lerch J.P., Lee N., Greenstein D., Wallace G.L., Stockman M., Clasen L., Shaw P.W., Giedd J.N. Patterns of coordinated anatomical change in human cortical development: a longitudinal neuroimaging study of maturational coupling. *Neuron.* 2011;**72**:873–884. [PMCID: PMC4870892] [PubMed: 22153381]

Rigucci S., Serafini G., Pompili M., Kotzalidis G.D., Tatarelli R. Anatomical and functional correlates in major depressive disorder: the contribution of neuroimaging studies. *World J. Biol. Psychiatry.* 2010;**11**:165–180. [PubMed: 19670087]

Sato S.M., Schulz K.M., Sisk C.L., Wood R.I. Adolescents and androgens, receptors and rewards. *Horm. Behav.* 2008;**53**:647–658. [PMCID: PMC2435368] [PubMed: 18343381]

Schwarz J.M., McCarthy M.M. Cellular mechanisms of estradiol-mediated masculinization of the brain. *J. Steroid Biochem. Mol. Biol.* 2008;**109**:300–306. [PMCID: PMC2493288] [PubMed: 18430566]

Shirtcliff E.A., Dahl R.E., Pollak S.D. Pubertal development: correspondence between hormonal and physical development. *Child Dev.* 2009;**80**:327–337. [PMCID: PMC2727719] [PubMed: 19466995]

Sholl S.A., Kim K.L. Estrogen receptors in the rhesus monkey brain during fetal development. *Brain Res. Dev. Brain Res.* 1989;**50**:189–196. [PubMed: 2611982]

Sowell E.R., Trauner D.A., Gamst A., Jernigan T.L. Development of cortical and subcortical brain structures in childhood and adolescence: a structural MRI study. *Dev. Med. Child Neurol.* 2002;**44**:4–16. [PubMed: 11811649]

Steinberg L. A social neuroscience perspective on adolescent risk-taking. *Dev. Rev.* 2008;**28**:78–106. [PMCID: PMC2396566] [PubMed: 18509515]

Sumner B.E.H., Fink G. Testosterone as well as estrogen increases serotonin2A receptor mRNA and binding site densities in the male rat brain. *Mol. Brain Res.* 1998;**59**:205–214. [PubMed: 9729388]

Sun S.S., Schubert C.M., Chumlea W.C., Roche A.F., Kulin H.E., Lee P.A., Himes J.H., Ryan A.S. National estimates of the timing of sexual maturation and racial differences among US children. *Pediatrics.* 2002;**110**:911–919. [PubMed: 12415029]

Tae W.S., Kim S.S., Lee K.U., Nam E.-C., Kim K.W. Validation of hippocampal volumes measured using a manual method and two automated methods (FreeSurfer and IBASPM) in chronic major depressive disorder. *Neuroradiology.* 2008;**50**:569–581. [PubMed: 18414838]

Tamnes C.K., Walhovd K.B., Dale A.M., Ostby Y., Grydeland H., Richardson G., Westlye L.T., Roddey J.C., Hagler D.J., Jr., Due-Tønnessen P., Holland D., Fjell A.M. Brain development and aging: overlapping and unique patterns of change. *Neuroimage.* 2013;**68**C:63–74. [PMCID: PMC5378867] [PubMed: 23246860]

Tanner J.M., Whitehouse R.H. Clinical longitudinal standards for height, weight, height velocity, weight velocity, and stages of puberty. *Arch. Dis. Child.* 1976;**51**:170–179. [PMCID: PMC1545912] [PubMed: 952550]

Taylor S.J., Whincup P.H., Hindmarsh P.C., Lampe F., Odoki K., Cook D.G. Performance of a new pubertal self-assessment questionnaire: a preliminary study. *Paediatr. Perinat. Epidemiol.* 2001;**15**:88–94. [PubMed: 11237120]

Thompson T.L., Moss R.L. Estrogen regulation of dopamine release in the nucleus accumbens: genomic-and nongenomic-mediated effects. *J. Neurochem.* 1994;**62**:1750–1756. [PubMed: 8158125]

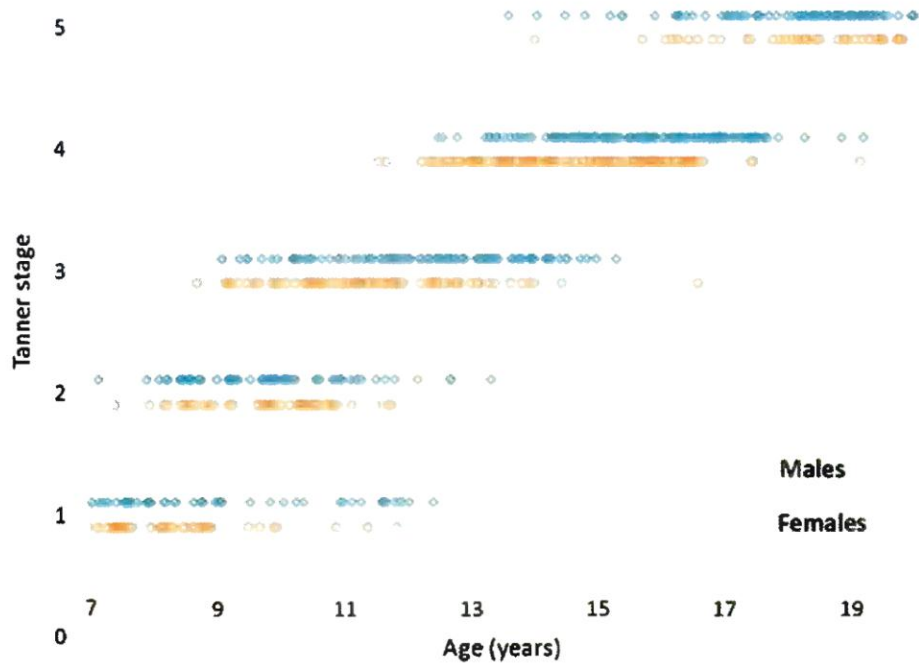
Wagenmakers E.-J., Farrell S. AIC model selection using Akaike weights. *Psychon. Bull. Rev.* 2004;**11**:192–196. [PubMed: 15117008]

Wheeler M.D. Physical changes of puberty. *Endocrinol. Metab. Clin. North Am.* 1991;**20**:1–14. [PubMed: 2029881]

Zahn-Waxler C., Shirtcliff E.A., Marceau K. Disorders of childhood and adolescence: gender and psychopathology. *Annu. Rev. Clin. Psychol.* 2008;**4**:275–303. [PubMed: 18370618]

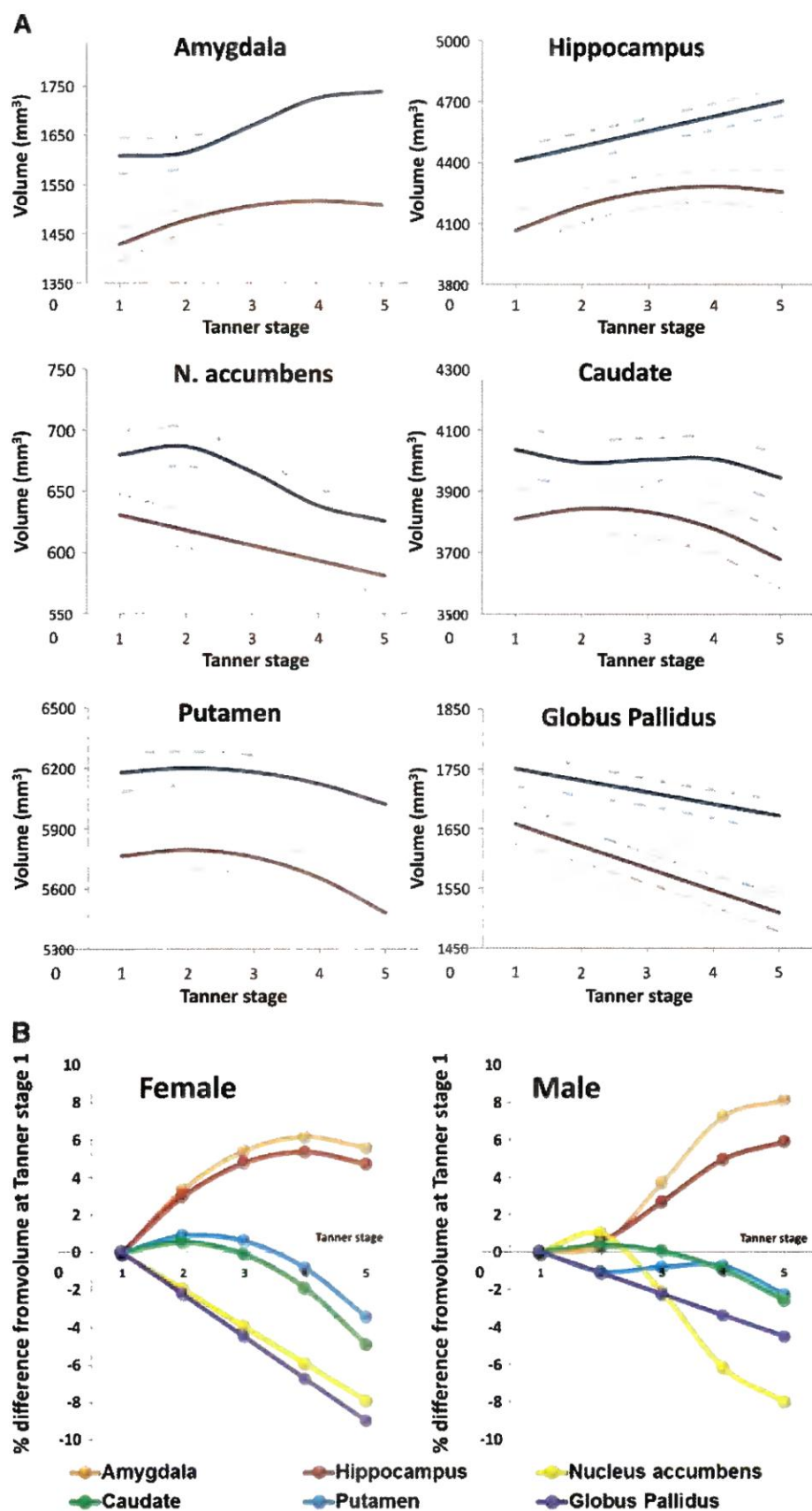
Zuloaga D.G., Puts D.A., Jordan C.L., Breedlove S.M. The role of androgen receptors in the masculinization of brain and behavior: what we've learned from the testicular feminization mutation. *Horm. Behav.* 2008;**53**:613–626. [PMCID: PMC2706155] [PubMed: 18374335]

Fig. 1



Showing the age and Tanner stage of each participant at each study time-point. Males are shown in turquoise, and females are shown in orange.

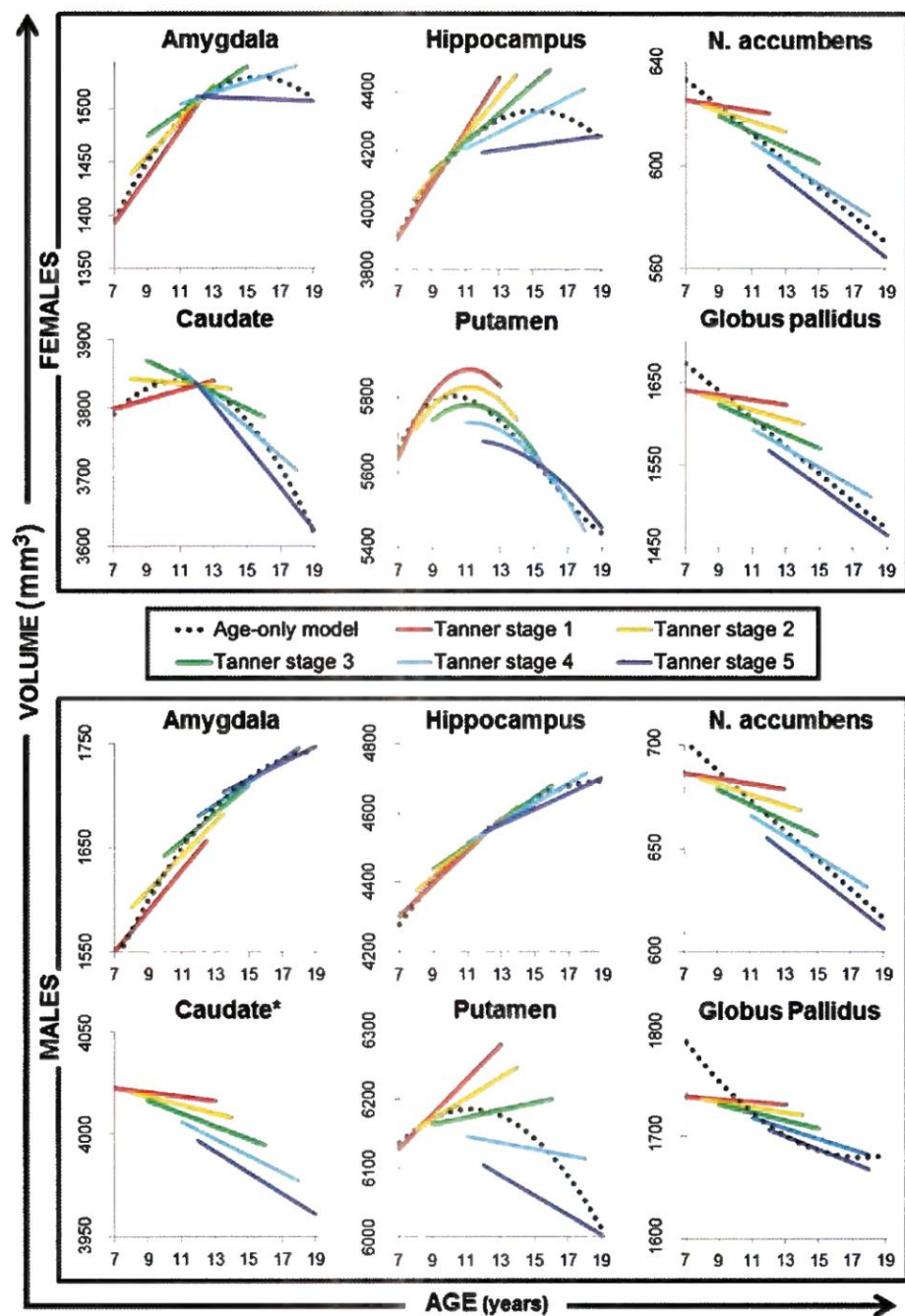
Fig. 2A



Showing the growth trajectories for each subcortical region modelled against Tanner stage in females and males. For both sexes, the amygdala and hippocampus increase in volume over puberty, whilst the NA, caudate, putamen and GP decrease in volume. Shows the models for each region separately. Pink lines represent females and blue lines represent males. The solid line represents the best model fit, with 95% confidence intervals shown by the dashed lines.

Fig. 2B. Showing the growth trajectories for each subcortical region modelled against Tanner stage in females and males. For both sexes, the amygdala and hippocampus increase in volume over puberty, whilst the NA, caudate, putamen and GP decrease in volume. Shows the models in terms of % volume change to allow comparison between structures. For each structure, the percentage volume was calculated for each pubertal stage as a proportion of prepubertal volume (at Tanner stage 1).

Fig. 3



Showing how subcortical volumes change with age and puberty stage in (A) females and (B) males using the best-fit combined or interactive model for each structure.

Age is presented on the x-axis, whilst puberty stage is indicated by the coloured lines (Red — Tanner stage 1, Yellow — Tanner stage 2, Green — Tanner stage 3, Blue — Tanner stage 4, Purple — Tanner stage 5). Data for each graph were extracted from the combined models by calculating Intercept + (coefficient for main effect of Tanner x Tanner stage) + (coefficient for main effect of Age-centred x Age-centred) + (coefficient for interactive effect of Tanner-by-age x Tanner stage x Age). Age ranges for each Tanner stage line were decided using the ages and pubertal variation in our sample (see Fig. 1 for range). The age-only model for each structure is included (black dotted line) to aid interpretation.

*For the caudate in males, there is no significant model that explains the developmental trajectory.

Table 1

Showing participants' demographics.

*This shows the number of participants who underwent an MRI scan at each Tanner stage, and the total number of scans collected of participants at each Tanner stage. Since some participants had more than one scan at a single Tanner stage, there are more scans than participants.

Females	Total sample	Tanner stage				
		1	2	3	4	5
N subjects/scans	117/296	36/41	37/42	57/72	79/105	30/36
	Mean (SD)					
Age (years)	12.8 (3.3)	8.6 (1.3)	9.8 (1.1)	11.5 (1.5)	14.6 (1.5)	18.1 (1.4)
Height (metres)	1.52 (0.14)	1.30 (0.09)	1.40 (0.09)	1.47 (0.09)	1.63 (0.06)	1.65 (0.06)
Weight (kilograms)	46.7 (14.8)	28.1 (5.5)	35.4 (7.9)	42.2 (9.2)	57.2 (10.3)	61.7 (10.2)
IQ	113 (12.0)	117 (12.9)	112 (10.3)	111 (12.5)	113 (11.5)	112 (12.7)
SES	41 (17.2)	41 (18.2)	44 (15.8)	41 (16.4)	41 (17.2)	39 (19.7)
Males	Total sample	Tanner stage				
		1	2	3	4	5
N subjects/scans	158/415	41/45	51/56	82/104	110/136	59/74
	Mean (SD)					
Age (years)	13.8 (3.4)	9.2 (1.7)	10.0 (1.3)	12.3 (1.4)	15.7 (1.3)	18.0 (1.5)
Height (metres)	1.60 (0.18)	1.35 (0.12)	1.40 (0.08)	1.55 (0.10)	1.73 (0.08)	1.78 (0.07)
Weight (kilograms)	55.6 (19.3)	32.3 (9.3)	35.8 (8.0)	47.6 (10.3)	66.7 (12.8)	76.2 (14.2)
IQ	115 (11.1)	120 (10.5)	115 (11.3)	116 (10.5)	113 (11.2)	117 (11.1)
SES	40 (19.1)	30 (15.8)	44 (18.6)	41 (19.7)	43 (19.7)	36 (17.0)

Table 2

Showing the Tanner-only best fit model for each of the six subcortical regions in females and males with the F test and p-value of the highest order variable. For each region, volume change across puberty is given in absolute (mm³) and relative (% change for the structure compared to initial volume) terms.

Absolute (mm ³)	Best-fitting model	Volume change across puberty		Significance of highest order variable	p-value
	% change				
Females					
Amygdala	Quadratic	80	5.3%	$F_{(1,177)} = 6.38$	0.012
Hippocampus	Quadratic	191	5.1%	$F_{(1,177)} = 6.26$	0.013
Nucleus accumbens	Linear	-50	-8.6%	$F_{(1,178)} = 18.73$	< 0.0001
Caudate	Quadratic	-131	-3.6%	$F_{(1,177)} = 10.78$	0.001
Putamen	Quadratic	-282	-5.5%	$F_{(1,177)} = 16.15$	0.0001
Globus pallidus	Linear	-149	-9.9%	$F_{(1,178)} = 45.02$	< 0.0001
Males					
Amygdala	Cubic	130	7.5%	$F_{(1,254)} = 7.40$	0.007
Hippocampus	Linear	296	6.3%	$F_{(1,256)} = 69.01$	< 0.0001
Nucleus accumbens	Cubic	-55	-8.7%	$F_{(1,254)} = 4.44$	0.036
Caudate	Cubic	-92	-2.3%	$F_{(1,254)} = 4.21$	0.041
Putamen	Quadratic	-159	-2.6%	$F_{(1,255)} = 7.91$	0.005
Globus pallidus	Linear	-79	-4.7%	$F_{(1,256)} = 19.22$	< 0.0001

Table 3

Showing best fit models using a combination of Tanner stage and chronological age variables, with likelihood ratios and differences in AIC. **Structures in BOLD** show structures where the mixed Tanner stage and age model is a significantly better fit than the Tanner stage only model.

a: Combined model refers to a model incorporating independent effects of Tanner stage and chronological age as well as an interactive Tanner stage by age effect. Interactive model refers to a model using only an interactive Tanner stage by age effect.

b: In females, the best fit model for the putamen was a combined model including independent effects of Tanner stage, linear and quadratic chronological age as well as an interactive Tanner stage by age effect.

* For these structures, a likelihood ratio test is not valid as the models are not nested and have the same number of degrees of freedom. Therefore, significance of the models has been judged using AIC differences. If AIC difference ≥ 5.9 , the model is a significantly better fit (equivalent to Akaike weight of < 0.05).

Structure	Best-fitting Tanner and age model ^a	Likelihood ratio test compared to Tanner only model	p-value	Difference between AIC
Females				
Amygdala	Combined	7.67	0.006	
Hippocampus	Combined	23.96	< 0.0001	
Nucleus accumbens	Interactive	3.21*	*	3.21
Caudate	Combined	14.16	0.0002	
Putamen	Combined^b	28.13	< 0.0001	
Globus pallidus	Interactive	3.43*	*	3.43
Males				
Amygdala	Combined	9.48*	*	9.48
Hippocampus	Combined	23.06	< 0.0001	
Nucleus accumbens	Interactive	4.63	0.099	
Caudate	Interactive	5.29	0.071	
Putamen	Combined	5.16	0.023	
Globus pallidus	Interactive	1.51*	*	1.51

Commentary: The Signal and the Noise—questioning the benefits of puberty blockers for youth with gender dysphoria—a commentary on Rew et al. (2021)

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In less than a decade, there has been a sharp rise in the numbers of young people presenting with gender dysphoria (GD). Today, the majority are adolescents, many with post-puberty adolescent-onset transgender histories, and suffering from mental health and neurodevelopmental comorbidities (De Vries, 2020; Zucker, 2019). Furthermore, there is controversy and heated debate in the literature on this topic (Dubicka, 2021). This lack of scientific consensus highlights the need for any published literature on the topic of GD to be carefully evaluated.

In this commentary, we critically examine a systematic review of the evidence for puberty blockers for GD youth that was recently published in this journal (Rew, Young, Monge, & Bogucka, 2021). Our aim is to highlight problems with this review that compromise its findings and conclusions.

Brief description of Rew et al.'s (2021) study

Rew et al. described undertaking a "critical" and "systematic" literature review on the topic of puberty blockers for GD youth. They identified nine studies for review and, on the basis of these, concluded that puberty blockers have "few serious adverse outcomes," and "several potential positive ones." Rew et al.'s abstract highlighted two key conclusions: the "potentially life-saving benefits" of puberty blockers; and a need for rigorous research. Their "implications," "conclusion," and "key practitioner message" sections appeared to claim that the literature supports the use of puberty blockers for the early puberty subgroup of GD youth.

Overview of our concerns

We agree with Rew et al.'s conclusion that more rigorous research is required in the area of management of GD in youth. However, in our view, their review suffers from methodological oversights, including the omission of relevant studies and suboptimal analysis of the quality of the included studies. As a result, the authors overstate the certainty of the potential positive outcomes and minimize the potential adverse outcomes of puberty blockers. Importantly, their statement, that a "positive

outcome" of puberty blockers is "decreased suicidality in adulthood," is a misinterpretation of a single cross-sectional study. This study's design was incapable of determining causation, and adult suicidality was not one of the measured outcomes (Turban, King, Carswell, & Keuroghlian, 2020).

Contrast Rew et al.'s (2021) conclusions with another recently completed systematic review of puberty blockers for GD youth, commissioned by England's NHS and conducted by The National Institute for Health and Care Excellence (NICE) (2020). The NICE review concluded that studies investigating the benefits or adverse effects of GnRH analogs (puberty blockers) were of "very low certainty using modified GRADE." They noted that any outcome differences that were found could have represented changes of "questionable clinical value," or, as the studies themselves were "not reliable," could have been "due to confounding, bias or chance." They suggest that if controlled studies are not possible, then reliable comparative studies are required.

These findings came just after NHS England suspended the use of puberty blockers for new patients under the age of 16, following the High Court's judgment that children so young could not consent to the unknown risks of these drugs. The Karolinska Institute in Sweden suspended the use of puberty blockers as treatment for GD youth outside of clinical trials following this review, citing multiple physical risks, including to bone development (Nainggolan, 2021). Finland also sharply curtailed the use of these drugs after their systematic review arrived at similar conclusions about the uncertain risk/benefit profile (COHERE, 2020).

We are concerned that Rew et al.'s review will mislead clinicians unfamiliar with the literature into prescribing puberty blockers to GD youth with confidence, when the only clinical stance supported by the evidence is that of extreme caution. This is also underscored by the fact that the research literature in this field is rapidly evolving. For example, a recently published study, that attempted to demonstrate the benefits of the Dutch puberty suppression protocol in the UK setting, failed to show any psychological benefit (Carmichael et al., 2021).

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Limitations in study selection strategy

The review published by Rew et al. has important limitations that compromise its usefulness for clinical decision-making. Rew et al. identified only 151 potentially eligible studies, while the NICE review found 525 studies. One possible explanation for this could be their limited study search strategy. Another possible explanation is that Rew et al. did not conduct a comprehensive search so that, in omitting one of the largest electronic databases—EMBASE, they may have overlooked relevant evidence.

Notably, the final set of nine studies reviewed by Rew et al. is missing at least one key study on puberty blockers and psychosocial functioning (Costa et al., 2015), and two other studies examining the risks of puberty blockers on bone density (Joseph, Ting, & Butler, 2019; Klink, Caris, Heijboer, van Trotsenburg, & Rotteveel, 2015). It is unclear to us whether these studies were omitted due to the limited database search or whether the evaluators decided to exclude these studies, and if so for what reason. These three studies were all included in the NICE (2020) review. Although it has to be kept in mind that all the NICE reviewed studies' findings were assessed as "very low certainty," the Costa et al. study provided comparative evidence and found no significant difference in psychosocial functioning between a group of adolescents receiving puberty blockers plus psychosocial support, and a group receiving only psychosocial support, at eighteen months (the study end period) (Biggs, 2019). In addition, the Costa study was cited by the Finnish gender identity services in their policy change, which now recommends psychotherapy alone as first-line treatment.

Failure to adequately assess certainty of the study findings

It is our contention that the reviewers did not adequately assess the certainty of the reviewed studies' findings. For example, they used the Joanna Briggs Institute checklist to assess Turban et al. (2020), the study from which their message that puberty blockers reduce adult suicidality and have "potentially life-saving benefits" derives. This checklist can overemphasize whether studies report information and underemphasize the assessment of study validity. Below, we show how Rew et al. applied this tool to Turban et al. (2020), and the important study limitations it overlooked.

Was the exposure measured in a valid and reliable way? (Q3) Rew et al. answered "yes" to this question. We believe it should be "no." The exposure to puberty blockers was based on a self-report, with 73% of those respondents, who answered yes, claiming they began to use puberty blockers after the age of 18. It was noted that the respondents likely confused puberty blockers with other hormonal interventions (Biggs, 2020; D'Angelo et al., 2020). Although Turban et al. attempted to reduce the effects of this confusion by excluding certain participants from the sample, no adequate correction was possible. This introduced a significant risk of bias.

Were confounding factors identified and strategies to deal with them stated? (Q5, Q6) Rew et al. answered "yes" to both questions. We believe the answer to the latter question should be "no." For example, while one key confounding factor—prior mental health status—was indeed correctly identified by Turban et al., no strategy

was articulated to deal with it. When discussing their finding that puberty suppression is associated with lower lifetime suicidality, they acknowledged that "reverse causation cannot be ruled out: it is plausible that those without suicidal ideation had better mental health when seeking care and thus were more likely to be considered eligible for pubertal suppression" (Turban et al., 2020). This is one of the most serious limitations of the study, introducing a high risk of bias, and reducing the certainty of the findings.

In addition, while two questions ask about the subject selection criteria and whether the subjects and the setting were described in detail (Q1, Q2), these questions do not attempt to assess the impact of the sample composition. Affirmative ("yes") and "not applicable" answers to these questions, respectively, masked the fact that the study participants were not required to have a diagnosis of GD, and that the participant demographics were markedly different from the US population of transgender adults (D'Angelo et al., 2020), which negatively impacts the study's applicability/generalizability.

Rew et al. aggregated the answers to the checklist questions, with the Turban et al.'s study earning an 86% mark and a "good quality" rating. Even if we sideline the issue of any scoring inaccuracy, using such a simplistic scoring category is misleading since it implies that all questions are equally important, which is clearly not the case.

We also note, what appears to be, at least one error in Rew et al.'s assessment and reporting of study outcomes. In Table 2, they reported that Turban et al.'s positive outcome findings included decreased past-month psychological distress, past-month binge drinking, and lifetime illicit drug use. However, Turban et al.'s univariate analysis showed only one of these three outcomes, past-month psychological distress, showed any significant difference, and this significance disappeared once demographic variables were controlled for in the multivariable analysis.

A more rigorous tool to assess Turban et al.'s study would be ROBINS-I (The Risk of Bias of Non-randomized Studies of Interventions) (Sterne et al., 2016). This tool focuses on confounding, selection bias, classification and deviations from intervention, measurement of outcome, missing data, and selective reporting, and the extent to which the study design minimized biases and yielded trustworthy results. Given this, applying the ROBINS-I tool would find that the Turban et al.'s study is at a critical risk of bias.

Misleading statements regarding puberty blockers and suicidality

We are concerned that Rew et al.'s discussion of evidence about suicidality is unbalanced and misleading. Reading that puberty blockers had "positive outcomes [of] decreased suicidality in adulthood" will likely be understood as indicating causation. However, Turban et al. (2020), where this claim originates, noted that their study design did not allow for determination of causation, and "reverse causation" (individuals without suicidal ideation had better mental health and were more likely to be considered eligible for puberty blockers) was a plausible alternative explanation.

Further, there is a critical difference in meaning between "lifetime," and "adulthood." Not only does the

latter erroneously imply a pre-post effect (i.e., access to puberty blockers in childhood reduces suicidality in adults), which was not detectable in the study, but a measure of "adulthood suicidality," which Rew et al. claim was impacted, was never included in the original study (Turban et al., 2020).

There is also unclear use of the term suicidality, which exaggerates the implication of Turban et al.'s findings. Suicidality is a broad term, which is comprised of suicide attempts, plans, and ideation, and indeed this was the manner it was used by Turban et al. It is also important to note that Turban et al. made no assessment of completed suicides. Turban et al. assessed six areas of suicidality (including recent and lifetime suicide attempts, recent ideation with plans, recent and lifetime ideation) and found no association between puberty blockers and suicidality measures on five of the six areas. The only association was with "lifetime suicidal ideation." Of course, any suicidal ideation is concerning, but suicide attempts are generally considered of higher concern, in terms of suicide risk assessment, than suicidal ideation (Ryan & Oquendo, 2020).

Rew et al.'s inaccurate language further intensifies in the final sentence of their abstract, which described puberty blockers as "potentially life-saving." This exaggerated claim is misleading, since there is no evidence to support it.

Absence of an appropriate process for making clinical recommendations

Finally, the authors appear to recommend the use of puberty blockers in the "key practitioner messages" box and in the "implications" section of their paper. Making recommendations requires not only evidence about benefits and harms on all health outcomes that are important for decision-making (which this review provides in a suboptimal way), but also considerations about patients' values and preferences, ethics, acceptability, resources, costs, etc. (Andrews et al., 2013). All these considerations are balanced by making value judgments, which should be documented and reported explicitly and transparently. Rew et al. failed to do this, which, in our view, further undermines the credibility of their clinical practice recommendations.

Clinician reflections on the state of the GD literature

Rew et al.'s review illustrates a concerning trend, that we have observed in the GD literature, to overstate the evidence underpinning clinical practice recommendations for youth with GD. New publications reference prior ones with increasing and unwarranted confidence, and with the risk of misleading clinicians regarding the state of evidence. There is also a marked asymmetry in outcomes reporting: findings of positive outcomes of medical interventions are trumpeted in abstracts, while their profound limitations remain behind the paywall, thus, below the radar of busy clinicians.

Rew et al.'s paper demonstrates these types of issues. To start, the Turban et al.'s paper described a noncausal association between puberty blockers and "lifetime suicidal ideation," carefully avoiding making a causal claim (although, arguably, implying it). Then, Rew et al., whose findings on suicidality are based solely on this Turban et al.' study, rewrite this finding to create the strong

impression of causality—that puberty blockers reduce adult suicidality and are "potentially life-saving." Subsequently, a recent Commentary and Editorial in the *Lancet* both directly state that puberty blockers reduce suicidality, and the latter adds the extraordinary claim that "removing these treatments is to deny life." The only reference provided for these claims is the Rew et al. (2021) paper (Baams, 2021; *Lancet* editorial, 2021).

This resembles the game of "Telephone," in which a message is whispered from person to person distorting the original meaning of the message. However, this is not a game, and these types of errors can cause harm. Clinicians relying on Rew et al.'s review are likely to misinform patients and families about the risk/benefit profile of puberty blockers. Can such patients really be considered as giving informed consent?

The clear signals emerging from the various reviews of the available evidence of the use of puberty blockers for GD youth are that there is very low certainty of the benefits of puberty blockers, an unknown risk of harm and there is need for more rigorous research. The clinically prudent thing to do, if we aim to "first, do no harm," is proceed with extreme caution, especially given the rapidly rising case numbers and novel GD presentations. We must also, collectively, raise the bar on the quality of publications, in order to accurately educate clinicians and help patients make truly informed decisions that may impact for the rest of their lives.

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Ethical information

No ethical approval was required for this commentary.

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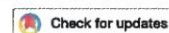
References

- Andrews, J.C., Schünemann, H.J., Oxman, A.D., Pottie, K., Meerpohl, J.J., Coello, P.A., ... & Guyatt, G. (2013). GRADE guidelines: 15. Going from evidence to recommendation. Determinants of a recommendation's direction and strength. *Journal of Clinical Epidemiology*, 66, 726–735.
- Baams, L. (2021). Equity in paediatric care for sexual and gender minority adolescents. *The Lancet Child & Adolescent Health*, 5, 389–391.
- Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 16, 2043.

- Biggs, M. (2020). Puberty blockers and suicidality in adolescents suffering from gender dysphoria. *Archives of Sexual Behavior*, 49, 2227–2229.
- Carmichael, P., Butler, G., Masic, U., Cole, T.J., De Stavola, B.L., Davidson, S., ... & Viner, R.M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*, 16, e0243894.
- COHERE. (2020). Medical treatment methods for dysphoria associated with variations in gender identity in minors recommendation. *Palveluvalikoimaneuvosto*. Available from: <https://palveluvalikoima.fi/en/recommendations> [last accessed 23 May 2021].
- Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The Journal of Sexual Medicine*, 12, 2206–2214.
- D'Angelo, R., Syrnulnik, E., Ayad, S., Marchiano, L., Kenny, D.T., & Clarke, P. (2020). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50, 7–16.
- de Vries, A.L.C. (2020). Challenges in timing puberty suppression for gender-nonconforming adolescents. *Pediatrics*, 146, e2020010611.
- Dubicka, B. (2021). Editorial: Evidence, policy and practice gold standard, good enough or doing it differently? *Child and Adolescent Mental Health*, 26, 1–2.
- Joseph, T., Ting, J., & Butler, G. (2019). The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *Journal of Pediatric Endocrinology and Metabolism*, 32, 1077–1081.
- Klink, D., Caris, M., Heijboer, A., van Trotsenburg, M., & Rottevel, J. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *The Journal of Clinical Endocrinology & Metabolism*, 100, E270–E275.
- Nainggolan, L. (2021). Hormonal Tx of youth with gender dysphoria stops in Sweden. *Medscape*. Available from: <https://medscape.com>
- National Institute for Health and Care Excellence (NICE). (2020). Evidence Review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Available from: <http://evidence.nhs.uk>
- Rew, L., Young, C., Monge, M., & Bogucka, R. (2021). Review: Puberty blockers for transgender and gender diverse youth: a critical review of the literature. *Child and Adolescent Mental Health*, 26, 3–14.
- Ryan, E.P., & Oquendo, M.A. (2020). Suicide risk assessment and prevention: Challenges and opportunities. *Focus*, 18, 88–99.
- Sterne, J.A.C., Hernán, M.A., Reeves, B.C., Savović, J., Berkman, N.D., Viswanathan, M., ... & Higgins, J.P.T. (2016). ROBINS-I: A tool for assessing risk of bias in non-randomised studies of interventions. *BMJ*, 355, i4919.
- The Lancet Child Adolescent Health. (2021). A flawed agenda for trans youth. *The Lancet Child & Adolescent Health*, 5, 385.
- Turban, J.L., King, D., Carswell, J.M., & Keuroghlian, A.S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145, e20191725.
- Zucker, K.J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*, 48, 1983–1992.

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ARTICLE



Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria

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ABSTRACT

Purpose: To assess how adolescent development progresses and psychiatric symptoms develop among transsexual adolescents after starting cross-sex hormone treatment.

Materials and methods: Retrospective chart review among 52 adolescents who came into gender identity assessment before age 18, were diagnosed with transsexualism and started hormonal gender reassignment. The subjects were followed over the so-called real-life phase of gender reassignment.

Results: Those who did well in terms of psychiatric symptoms and functioning before cross-sex hormones mainly did well during real-life. Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems during real-life.

Conclusion: Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development.

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Introduction

Adolescence starts from puberty and ends approximately ten years later with the consolidation of adulthood personality structures [1,2]. The upsurge of steroid hormones in puberty initiates the maturation of the reproductive system and secondary sexual characteristics, and also vast structural and functional developments in the brain [3]. These biological changes are accompanied by extensive cognitive, emotional and social changes characteristic of adolescent development. The psychosocial developmental tasks of adolescence comprise sexual maturation (including adopting to the sexually maturing body and becoming capable of mutually satisfying, reciprocal romantic and sexual relationships), achieving independence from parents, and assuming an identity and responsible social role [1,4–6].

Gender Dysphoria (GD) refers to a marked discrepancy between the experienced gender and biological sex, causing clinically significant distress or impairment in functioning (DSM-5) [7]. Individuals with GD often wish to obtain hormonal and surgical treatments to align their body with the experiences gender. In ICD-10 the corresponding diagnosis is Transsexualism (ICD-10) [8].

Favourably progressing adolescent development manifests in the adolescent's functioning in relation to her/his own sexually maturing body, parents, peers, romance and sexuality, and school/future career [4,9,10]. The literature exploring adolescent development and functioning among adolescents

with gender dysphoria and/or transgender identity is scarce and scattered. The sexually maturing body is a core challenge for adolescents suffering from gender dysphoria. A recent review suggested that adolescent gender dysphoria/transgender identity is associated with both negative (rejection, bullying) and positive (closer relationship, inclusion, attention) features in parent and peer relationships, both delayed and advanced for age or risky sexual behaviours, and with school-related challenges that are primarily assumed to relate to prejudice and peer rejection [10].

Psychiatric comorbidities, particularly depression, anxiety disorders and autism spectrum disorders as well as suicidality and self-harming behaviours are common among adolescents seeking gender reassignment [10]. Psychiatric comorbidities cannot automatically be assumed to be secondary to gender dysphoria [11] and do not necessarily remit due to sex reassignment [12].

During the past ten years the number of adolescents contacting gender identity services in order to seek for medical gender reassignment has increased across Western countries [13–16]. The reasons for this are not known [10].

Medical approaches to adolescent gender dysphoria may comprise halting/delaying the physical maturation (puberty blocking), and cross-sex hormonal treatments. Surgical treatments are mainly available for legal adults [17,18]. Medical gender reassignment is expected to alleviate gender dysphoria, psychiatric comorbidities and related

psychosocial problems. Initial studies have suggested that puberty blocking with GnRH analogues may reduce psychiatric symptoms and improve functioning in gender dysphoric adolescents [19,20], but follow-up studies assessing the effectiveness and safety of hormonal interventions initiated during the developmental years are, however, scarce and biased by methodological problems to the extent that a recent meta-analysis concluded that they must be considered experimental [21,22]. There is an urgent need for follow-up studies on the outcomes of gender identity based hormonal interventions initiated during adolescent development.

The aim of this study was to evaluate the adolescent development of young people diagnosed with transsexualism and offered cross-sex hormonal interventions in one of the two gender identity units for minors in the period 2011–2017. We set out to evaluate the psychosocial functioning and need for psychiatric treatment of this patient group during the gender identity diagnostic phase and after about a year on cross-sex hormone treatment. We expected to see improvements in psychosocial functioning and a decrease in need for psychiatric treatment after starting the hormonal treatment that results in the desired changes in secondary sexual characteristics, which expectedly alleviates gender dysphoria.

Materials and methods

In Finland, the gender identity assessments required in order to proceed to medical sex reassignment interventions are centralized to two of the five university hospitals in the country. After the diagnostic assessments, legal sex change can take place after a period of about a year on cross-sex hormonal treatments, the so-called real-life phase of living in the desired role. Diagnostic assessments in Finnish health care take place according to ICD-10 [8]. Legal sex change and surgical treatments require the patient to have achieved legal majority (18 years). To proceed to legal sex change, the patient has to obtain a certificate from the gender identity unit that carried out the primary diagnostic assessments and from the other gender identity service (second opinion). Gender identity assessments for minors were initiated in 2011.

The study comprises a retrospective chart review of adolescents referred to one of the two gender identity service facilities for minors in Finland (Tampere University Hospital, Department of Adolescent Psychiatry) before age 18, who had been diagnosed with transsexualism and proceeded to cross-sex hormonal treatments and who had completed a follow-up of approximately a year after starting on cross-sex hormones (real-life phase).

The assessments conducted by the gender identity team comprise structured and free format assessments and interviews by a multi-disciplinary team and an evaluation of the adolescent's existing psychiatric and medical files [11]. Two of the authors (RK, MT) were involved in the clinical assessments of all the gender-referred adolescents during the study period. The research data was collected retrospectively

from the case files by a junior researcher (EH) trained and supervised by the first author. All information available after the clinical evaluations was used and the data was collected with help of a structured data collection form until the referral for the second opinion in the other adolescent gender identity unit was written. The study received approval from the ethics committee of Tampere University Hospital.

Between 2011 and 2017, 57 adolescents had been diagnosed with F64.0, transsexualism, and had been offered an opportunity to start hormonal sex reassignment. One of them did not want any treatment, two withdrew and two had started hormonal treatments but had not yet completed the real-life phase at the end of 2017. Thus, 52 patients were included in the study. Of these 11 were birth assigned males (transfemales) and 41 birth assigned females (transmales). They had a mean (sd) age of 18.1 (1.1) years at diagnosis, range 15.2–19.9 years (no difference between sexes).

Measures

Indicators of adolescent development

Adolescent development was evaluated in terms of age-appropriate living arrangements, peer relationships, school/work participation, romantic involvement, competence in managing everyday matters and need for psychiatric treatment.

Living arrangements were classified as (1) living with at least one parent/guardian, (2) living in a boarding school, with an adult relative, in some form of supported accommodation or the like, where supervision and guidance by a responsible adult is provided, (3) independently alone or in a shared household with a peer, (4) with a romantic partner. In the analyses dichotomized living arrangements (a) during gender identity assessment and (b) during the real-life phase living with (a) parent(s)/guardian(s) vs. in other arrangements. In Finnish culture, minors younger than 18 years usually live in the parental home, but leaving the parental home takes place earlier than in the majority of EU countries. Of young people aged 20–24, about a fourth are living in the parental home in Finland [23,24].

Peer relationships were classified as follows: (1) socializes with friends in leisure time, outside of activities supervised by adults, (2) socializes with peers only at school or in the context of rehabilitative activity, (3) spends time close to peers, for example in school or rehabilitative activity, but does not connect with them, (4) does not meet peers at all. In the analyses, peer relationships during (a) gender identity assessment and (b) the real-life phase were dichotomized to age-appropriate (normative) [1] vs. restricted or lacking [2–4].

School/work participation was classified as (1) age appropriate participation in mainstream curriculum, progresses without difficulties, (2) participates in mainstream curriculum with difficulty, (3) participates in rehabilitative educational or work activity, (4) not involved in education and working life. Age-appropriate participation during [1] was recorded if the adolescent attended mainstream secondary education or upper secondary education at a regular rate (a class per year in comprehensive school; has not changed more than once

between tracks in upper secondary education) or had proceeded to work life after completing vocational education. Participation with difficulty [2] was recorded if the adolescent was enrolled in mainstream education but had to repeat a class, studied with special arrangements (for example, in a special small group), or followed some form of adjusted curriculum. In the analyses, school/work life during (a) gender identity assessment and (b) real-life phase was dichotomized to normative [1] vs. any other (2, 3 or 4).

Romantic involvement was recorded (1) has or has had a dating or steady relationship, not only online, (2) has had a romantic relationship only online, (3) has not had dating or steady relationships. In the analyses we compared has or has had [1] vs. has not had [2,3] a dating or steady relationship during (a) gender identity assessment and (b) real-life phase. Sexual history was recorded in more detail in case histories during gender identity assessment, and for this period we also collected the experiences of (French) kissing (yes/no), intercourse (yes/no) and experience of any genitally intimate contact with a partner (petting under clothes or naked, intercourse, oral sex) (yes/no).

In recording age-appropriate competence in managing everyday matters we expected that early adolescents (up to 14 years) would be able, for example, to do shopping and travel alone on local public transport, and to help with household duties assigned by their parents. Middle adolescents (15–17 years) were further assumed, for example, to be able make telephone calls in matters important to them (for example, when seeking a summer job), to deal with school-related issues with school personnel without parental participation, to select and start new hobbies independently and to fulfil their role in summer jobs and in similar responsibilities of young people. Late adolescents (18+ years), legally adults, were expected to have, in addition to the above, competence to talk to authorities such as professionals in health and social services, employment or educational institutions, to deal with banks or health insurance, to manage their financial issues and to manage their housekeeping if they chose to move to live independently of parents/guardians. Competence in managing everyday matters was recorded as follows: (1) the adolescent is able to cope age-appropriately outside home, (2) the adolescent needs support in age-appropriate matters outside home but functions age-appropriately in the home (manages her/his own hygiene, clothing and nutrition, participates in (younger subjects) or takes responsibility for (older subjects) housekeeping) and (3) the adolescent's functioning is inadequate both at home and outside home. In the analyses we focused in being age-appropriately able cope with matters outside of the home [1] vs. not [2,3].

Psychiatric disorders (depression, anxiety, suicidality/self-harm, conduct problems, substance abuse problems, psychoses, ADHD, autism, eating disorders) were recorded a) if they had required specialist level psychiatric treatment during or before the gender identity assessment, (i.e. the adolescent was in treatment, or treatment had been recommended but the adolescent refused it) and b) if they required specialist level psychiatric treatment during the real-life phase (i.e. the

adolescent was in treatment or the psychiatrist in the gender identity unit recorded that treatment was recommended or made a referral to psychiatric treatment irrespective of whether or not the adolescent complied with the recommendation).

Statistical analyses

Distributions of variables illustrating adolescent development are given for (a) the time of the gender identity assessment and (b) the real-life phase. Differences in proportions displaying age-appropriate functioning were compared using chi-square statistics/Fisher's exact test as appropriate. Cross-tabulations with chi-square statistics/Fisher's exact test as appropriate were used to explore functioning on a domain during the real-life phase according to functioning therein during assessment (i.e. school/work during real-life phase according to school/work during assessment etc.).

Need for specialist level psychiatric treatment before or during the gender identity assessment and during the real-life phase was compared using cross-tabulations with chi square statistics. Similarly, need for treatment according to the nine disorder dimensions recorded was compared between the two time periods. The associations between need for specialist level psychiatric treatment a) before or during the gender identity assessment, and b) during the real life-phase and functioning in the domains studied were explored using cross-tabulation with chi-square statistics/Fisher's exact test where appropriate.

The role of sex/gender and age were analysed by logistic regression. Functioning in peer relationships, school/work, managing everyday matters and dating/going steady were entered each in turn as the dependent variable with age and sex/gender as independent variables. Odds Ratios (OR) with 95% confidence intervals (CI) were calculated.

Results

Adolescent development and need for treatment during assessment and during real-life phase

During the gender identity assessment, three quarters of the adolescents lived with their parents. About three out of five displayed age-appropriate progress in school/work, four out of five functioned age-appropriately in dealing with matters outside home, and almost all had normative peer contacts. About three out of five had experienced dating/steady relationships before the end of the gender identity assessment (Table 1). In more detail about sexual development, 83% (43/52) had been in love/had a crush on someone, 56% (29/52) had experienced kissing, 8% (4/52) intercourse and 64% (33/52) any genitally intimate sexual contact with a partner by the end of the gender identity assessment.

During and before the gender identity assessment, half of the adolescents required specialist level psychiatric treatment, most commonly because of depression, anxiety, and suicidality/self-harm (Table 2).

In the end of the real-life phase, a majority had moved on to live independently of parents/guardians. The shares of

Table 1. Functioning in different domains of adolescent development during gender identity assessment and real-life phase among 52 young people diagnosed with transsexualism after starting gender identity assessments before age 18 [% (n/N)].

	During gender identity assessment	During real life phase	p Value
Living with parent(s)/guardians	73% (38/52)	40% (21/50)	0.001
Normative peer contacts	89% (46/52)	81% (42/52)	<0.001
Progresses normatively in school/ work	64% (33/52)	60% (31/52)	0.69
Has had dating or steady relationships	62% (32/50)	58% (30/52)	0.51
Is age-appropriately able to deal with matters outside of the home	81% (42/52)	81% (42/52)	1.0

Table 2. Need for specialist level psychiatric treatment, and disorder/symptom dimensions requiring this treatment during and before gender identity assessment, and during real life phase [% (n/N)].

	During and before gender identity assessment	During real life phase	p Value
Need for psychiatric treatment	50% (26/52)	46% (24/51)	0.77
Need for treatment due to ...			
depression	54% (28/52)	15% (8/52)	<0.001
anxiety	48% (25/52)	15% (8/52)	<0.001
suicidality/self-harm	35% (18/52)	4% (2/52)	<0.001
conduct problems/antisocial	14% (7/52)	6% (3/52)	0.18
psychotic symptoms/psychosis	2% (1/52)	4% (2/52)	0.56
substance abuse	4% (2/52)	2% (1/52)	0.56
autism	12% (6/52)	6% (3/52)	0.30
ADHD	10% (5/52)	2% (1/52)	0.09
eating disorder	2% (1/52)	2% (1/52)	1.0

those progressing age-appropriately in school/work, dealing age-appropriately with matters outside of home and being involved in dating/steady relationships did not change from the assessment phase to the end of the real-life phase. The proportion of those functioning age-appropriately in peer relationships decreased from the assessment period to the real-life phase (Table 1). The share of those requiring specialist level psychiatric treatment during real-life due to any reason was similar to that during and before the assessment, but treatment needs due to depression, anxiety and suicidality/self-harm had diminished (Table 2).

Changes within different domains of functioning

Of those adolescents with age appropriate peer contacts during assessment (46/52), 91% (42/46) continued to have age-appropriate peer contacts during the real-life phase while 9% (4/46) no longer had these. Of those with difficulties in peer contacts (6/52), all continued to have difficulties in this field. ($p < 0.001$)

Of those who progressed age-appropriately at school (working life) during assessment (33/52), 85% (28/33) continued to do so during the real-life phase, but 15% (5/33) did not. Of those with problems at school (work) (19/52), 84% (16/19) continued to have problems, but 16% (3/19) ceased to have problems in this field. ($p < 0.001$)

Of those who had had age-appropriate skills in dealing with matters outside home (42/52), 88% (37/42) continued to be able to do so but 12% (5/42) functioned below the age-appropriate level during the real-life phase. Of those who

had had difficulties in dealing with matters outside home (10/52), half (5/10) continued to do so, but half (5/10) no longer had problems in this field ($p = 0.02$).

Of those who had experiences of dating/steady relationships during the assessment (32/50), 66% (21/32) had dating/steady relationships during the real-life phase, and 34% (11/32) did not. Of those who had not had any dating/steady relationships by the end of the gender identity assessment, 44% (8/18) had and 56% (10/18) did not have these during the real-life phase. ($p = 0.12$)

Of those not needing psychiatric treatment before or during the assessment (26/52), 73% (19/26) did not need any during the real-life phase but in 27% (7/26), a need had emerged. Of those who had needed (25/51) psychiatric treatment during or before the assessment, 68% (17/25) still needed it during the follow-up but 32% (8/25) did not. ($p = 0.004$)

The role of psychiatric comorbidities for functioning during real life

Need for psychiatric treatment before or during the real-life phase was not associated with functioning in peer relationships or romantic relationships during the real-life phase. Those needing psychiatric treatment before or during gender identity assessment were more likely to not function age-appropriately in school/work (47% (15/32) vs. 82% (14/17) functioned well, $p = 0.02$), and borderline significantly less likely to cope well with managing everyday matters outside home (72% (23/32) vs. 94% (16/17) managed well, $p = 0.06$) during the real-life phase.

Concurrent need for psychiatric treatment during the real-life phase was associated with a smaller proportion functioning well at school/work [42% (10/24) vs. 74% (20/27), $p = 0.02$] and in taking care of everyday matters [67% (16/24) vs. 93% (25/27), $p = 0.02$].

No associations were found between age and sex (gender) and functional outcomes.

Discussion

The aim of this study was to assess the adolescent development of those adolescents who were diagnosed with transsexualism and offered cross-sex hormonal interventions during the subsequent real-life phase, when the cross-sex hormonal treatment was initiated and started to produce the desired changes in physical appearance. Moving to live independently, relationships with peers, romantic involvement, ability to take care of everyday issues age-appropriately outside home and need for psychiatric treatment were assessed as proxies for adolescent development. Earlier empirical research on outcomes of medical sex reassignment interventions initiated during developmental years was scarce and offered little advice on the impact of treatments on adolescent development [10,21,22].

We observed that the majority of the adolescents diagnosed with transsexualism and offered cross-sex hormonal treatments displayed age-appropriate functioning in the

domains studied during the gender identity assessment, as is to be expected given that severe psychopathology and markedly lowered functioning may complicate the possibilities to assess identity achievement and may constitute a contraindication for medical treatment. Nevertheless, a considerable share also had difficulties in different domains of functioning. What is more, even if the majority also functioned well in the domains studied during the first year on cross-sex hormones, no statistically significant improvements in functioning were observed in the group as a whole, and in the domain of peer relationships the share of those with normative contacts decreased. This is in disagreement with earlier studies suggesting improved functioning and reduced psychiatric symptoms in adolescent onset hormonal treatment of gender dysphoria [19,20], and likely due to older age, more difficult psychopathology and different intervention (cross-sex hormones vs. GnRH analogues) in our sample. Our subjects were all post-pubertal and halting of development was thus not possible.

The majority of the adolescents diagnosed with transsexualism were still living in the parental home during the gender identity assessment, which is to be expected and culturally normal as they were in the age range of 15.2–19.9 years. During the subsequent real-life phase, the share of those living in the parental home decreased. This concurs with progression of adolescent development. Given the knowledge of normative timing of leaving the parental home in Finland [21,22], the increasing proportion of those no longer living with their parents likely indicates positive progress in adolescent development instead of, for example, negative parental reactions to sex reassignment, which has also been reported in the literature [25], particularly as most of those leaving the parental home went to live with romantic partners (data not shown). Due to excellent social security benefits, moving to live independently does not necessitate regular income from employment and is therefore not a proxy for good functioning in other domains of life.

The difficulties in peer relationships commonly reported among adolescents with transgender identities have been associated with prejudice and discrimination [10,26]. Anxiety disorders, particularly social anxiety, could relate both to victimization and distress created by not being able to satisfactorily present oneself according to one's perceived gender. With the appearance of the desired physical characteristics, passing in the desired role is expected to be facilitated and self-confidence to increase. Positive changes in connection with peers could be expected. However, of those who had difficulties in peer relationships during the gender identity assessment, all continued to have them in the follow-up, and almost one in ten of those functioning well in this domain during the assessment developed difficulties in follow-up. This was contrary to our expectations and suggests that difficulties in peer relationships cannot be attributed to difficulties in passing in the desired role.

About two out of five of the adolescents diagnosed with transsexualism had experienced dating or steady relationships by the end of the gender identity assessments, and an equal share during the real-life phase. For comparison, recent

Finnish data on 15-year-old adolescents reveals that about a half of them have experienced dating/steady relationships (unpublished observation). Steady relationships in adolescence may be short and not dating/going steady exactly during the real-life phase cannot be taken as an indicator of delayed development. Earlier studies have shown that clinically referred adolescents with gender dysphoria display normative emotional development in regard to romance and dating but show slight delays in behavioural level sexual development [27,28]. Compared to earlier findings on all gender-referred adolescents, the adolescents now studied had experienced falling in love and dating/steady relationships about equally frequently but had slightly less often engaged in sexually intimate behaviours than both all gender-referred adolescents and same aged adolescents in general population (Kaltiala-Heino et al. [28]). These observations do not suggest remarkable delays in sexual development. During the real-life phase, a considerable share also gained their first experiences of dating/steady relationships, which suggests favourable progression of adolescent development.

If the adolescents diagnosed with transsexualism had had difficulties at school/work as during the gender identity assessment, they mainly continued to have difficulties during the real-life phase. Only a minority moved from progressing with difficulties to progressing normatively, and equally many deteriorated during follow-up. Improved functioning as a consequence of alleviating gender dysphoria and passing better in the desired role is commonly assumed but has not previously been researched in relation to education/work. Our findings suggest that treatment of gender dysphoria does not suffice to improve functioning in education and working life. Difficulties in school adjustment and learning are common among gender-referred adolescents and often not properly addressed, on the assumption that treatment of gender dysphoria would relieve an array of problems [11,29]. Educational difficulties need to be fully addressed during adolescence regardless of gender identity.

On their developmental path towards emotional, social and economic independence from parents, adolescents gain competence in taking care of increasingly demanding matters outside home. Delays in this could be associated with gender dysphoria through psychiatric symptoms secondary to gender dysphoria and lack of self-confidence related to challenges in self-presentation. Such problems could be expected to be alleviated with gender affirming hormonal treatments. In taking care of matters at an age-appropriate level, a greater share had improved than had declined during the real-life phase. Thus, favourable progression of adolescent development was seen in the group studied, even if a fifth of the subjects continued to function on a lower than age-appropriate level during the real-life phase.

Need for treatment due to depression, anxiety and suicidality/self-harm was recorded less frequently during the real-life phase than before it. This is in line with the conclusion of a relatively recent meta-analysis [30] that in adults with gender dysphoria, cross-sex hormonal treatment alleviates anxiety, and may also reduce depression or depressive symptoms. However, need for psychiatric treatment overall did

not decrease from the level before and during the gender identity assessment to the real-life phase. New needs had also emerged about as frequently as need for treatment diminished. Cross-sex hormonal treatment is not enough to alleviate psychiatric comorbidities which in adolescents with gender dysphoria may also precede gender identity concerns [11] and will likely have equally many and complex underpinnings as they have in any population. A large-scale register study among adults likewise found that psychiatric needs were not alleviated with gender reassignment [12]. Depression, anxiety and suicidality/self-harm are often assumed to be secondary to gender dysphoria, and our findings may be interpreted as lending some support to that assumption among adolescents, similarly as earlier research seems to imply for adults [30].

Both earlier and concurrent need for psychiatric treatment were associated with not progressing age-appropriately at school/work and in taking care of matters outside home during the real-life phase, even though need for psychiatric treatment was, somewhat unexpectedly, not associated with functioning in peer relationships and romantic relationships. This further underlines the need to actively address psychiatric comorbidities among adolescents with gender dysphoria.

The study was based on file information on all adolescents diagnosed with transsexualism and proceeding to cross-sex hormone treatment after entering gender identity earlier than age 18 in one of the two centralized gender identity service facilities for minors in Finland. The two gender identity units for minors operate on similar principles, receive equal numbers of referrals and during the study period prescribed cross-sex hormones to similar numbers of adolescents. The follow-up period was approximately only a year, which inhibits drawing conclusions on long-term outcomes. However, as during adolescence, both physical, cognitive, emotional and social aspects of development are in a constant state of change [3], one year is a very relevant period.

Collected from medical files, the data is as accurate as clinical documentation can be. Because gender identity assessments and medical gender reassignments in minors involve numerous controversies (Kaltiala-Heino et al. [10]), the documentation is likely to be done particularly meticulously. The study unit operates within the field of adolescent psychiatry, and particular attention is always paid to adolescent development illustrated in age-appropriate functioning. Data collection was carried out in a structured way, which adds to the reliability of the study. Most of the recorded issues are clear-cut and concrete (living arrangements; progressing one class per year at school or having a job; socializing with peers in leisure time; being in (an offline) steady relationship). Age-appropriate capacity taking care of matters outside home may be somewhat more abstract and difficult to quantify. Ambiguous details were discussed between the authors and rated in consensus.

The disorders that were the reason for need for psychiatric treatment were recorded as they appeared in the documentation produced by the gender identity team or were

recorded in case files obtained by the gender identity team from the adolescent's local services and classified on a robust level. They were not always systematically recorded with ICD-codes, and we were not able to ascertain the accuracy of the diagnostic work. However, the diagnoses mentioned in this paper represent problem categories that are the basis for treatment offered. A better understanding of psychiatric comorbidities could have been obtained by using structured diagnostic interviews.

Conclusion

Among adolescents diagnosed with transsexualism, difficulties in adolescent development and functioning in life domains appropriate to late adolescence do not disappear with cross-sex hormone treatment. Cross-sex hormone treatment may alleviate depression and anxiety but does not have a positive impact on psychiatric comorbidities at large. Even deterioration as regards psychiatric treatment needs and functioning occurs during the first year of cross-sex hormone treatment. Not all psychiatric and psychosocial problems in adolescents displaying gender dysphoria are secondary to gender identity issues and will not be relieved by medical gender reassignment. An adolescent's gender identity concerns must not become a reason for failure to address all her/his other relevant problems in the usual way.

Disclosure statement

No potential conflict of interest was reported by the authors.

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References

- [1] Blos P. The adolescent passage: developmental issues. New York: International Universities Press; 1979.
- [2] Steinberg L. Cognitive and affective development in adolescence. *Trends Cogn Sci*. 2005;9:69–74.
- [3] Paus T, Keshavan M, Giedd JN. Why do many psychiatric disorders emerge during adolescence? *Nat Rev Neurosci*. 2008;9: 947–957.
- [4] Havighurst RJ. Developmental tasks and education. Chicago (IL): University of Chicago Press; 1948.

- [5] Palombo J, Bendicksen HK, Koch BJ. Guide to psychoanalytic developmental theories. New York: Springer; 2009.
- [6] Erikson EH. Childhood and society. New York: W. W. Norton; 1950.
- [7] American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington (DC): American Psychiatric Association; 2013.
- [8] World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization; 1992.
- [9] Seiffge-Krenke I, Gelhaar T. Does successful attainment of developmental tasks lead to happiness and success in later developmental tasks? A test of Havighurst's (1948) theses. *J Adolesc*. 2008;31:33–52.
- [10] Kaltiala-Heino R, Bergman H, Tyolajarvi M, et al. Gender dysphoria in adolescence: current perspectives. *AHMT*. 2018;9:31–41.
- [11] Kaltiala-Heino R, Sumia M, Tyolajarvi M, et al. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child Adolesc Psychiatry Ment Health*. 2015;9:9.
- [12] Dhejne C, Lichtenstein P, Boman M, et al. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6:e16885.
- [13] Wood H, Sasaki S, Bradley SJ, et al. Patterns of referral to a gender identity service for children and adolescents (1976–2011): age, sex ratio, and sexual orientation. *J Sex Marital Ther*. 2013;39:1–6.
- [14] Aitken M, Steensma TD, Blanchard R, et al. Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. *J Sex Med*. 2015;12:756–763.
- [15] Kaltiala-Heino R, Työlajärvi M, Lindberg N. Gender dysphoria in adolescent population: a 5-year replication study. *Clin Child Psychol Psychiatry*. 2019;24:379–387.
- [16] Kaltiala-Heino R, Lindberg N. Gender identities in adolescent population: methodological issues and prevalence across age groups. *Eur Psychiatry*. 2019;55:61–66.
- [17] Cohen-Kettenis PT, Klink D. Adolescents with gender dysphoria. *Baillieres Best Pract Res Clin Endocrinol Metab*. 2015;29:485–495.
- [18] Coleman E, Bockting W, Botzer M, et al. The Standards of Care of the World Professional Association for Transgender Health, 7th version. *Int J Transgend*. 2012;13:165–232.
- [19] Costa R, Dunsford M, Skagerberg E, et al. Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *J Sex Med*. 2015;12:2206–2214.
- [20] de Vries AL, Steensma TD, Doreleijers TA, et al. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011;8:2276–2283.
- [21] Chew D, Anderson J, Williams K, et al. Hormonal treatment in young people with gender dysphoria: a systematic review. *Pediatrics*. 2018;141:e20173742.
- [22] Heneghan C, Mahtani K BMJ. Gender-affirming hormone in children and adolescents – evidence review. 2019 [cited 2019 Feb 25]. Available from: <https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/>
- [23] Tilastokeskus a. Perheet 2014 [cited 2019 Feb 25]. Available from: https://www.tilastokeskus.fi/til/perh/2014/02/perh_2014_02_2015-11-27_tie_001_fi.html
- [24] Nikander T. Nuoret muuttavat omilleen yhä nuorempina. 2009 [cited 2019 Feb 25]. Available from: https://www.stat.fi/artikkelit/2009/art_2009-03-16_004.html?s=0
- [25] Mayer KH, Garofalo R, Makadon HJ. Promoting the successful development of sexual and gender minority youths. *Am J Public Health*. 2014;104:976–981.
- [26] de Vries ALC, Steensma TD, Cohen-Kettenis PT, et al. Poor peer relations predict parent- and self-reported behavioral and emotional problems of adolescents with gender dysphoria: a cross-national, cross-clinic comparative analysis. *Eur Child Adolesc Psychiatry*. 2016;25:579–588.
- [27] Bungener SL, Steensma TD, Cohen-Kettenis PT, et al. Sexual and romantic experiences of transgender youth before gender-affirmative treatment. *Pediatrics*. 2017;139:e20162283.
- [28] Kaltiala-Heino R, Työlajärvi M, Lindberg N. Sexual experiences of clinically referred adolescents with features of gender dysphoria. *Clin Child Psychol Psychiatry*. 2019;24:365–378.
- [29] Holt V, Skagerberg E, Dunsford M. Young people with features of gender dysphoria: demographics and associated difficulties. *Clin Child Psychol Psychiatry*. 2016;21:108–118.
- [30] Costa M, Colizzi R. The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. *Neuropsychiatr Dis Treat*. 2016;12:1953–1966.

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Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women (Review)

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[Intervention Review]

Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women

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ABSTRACT

Background

Gender dysphoria is described as a mismatch between an individual's experienced or expressed gender and their assigned gender, based on primary or secondary sexual characteristics. Gender dysphoria can be associated with clinically significant psychological distress and may result in a desire to change sexual characteristics. The process of adapting a person's sexual characteristics to their desired sex is called 'transition.'

Current guidelines suggest hormonal and, if needed, surgical intervention to aid transition in transgender women, i.e. persons who aim to transition from male to female. In adults, hormone therapy aims to reverse the body's male attributes and to support the development of female attributes. It usually includes estradiol, antiandrogens, or a combination of both. Many individuals first receive hormone therapy alone, without surgical interventions. However, this is not always sufficient to change such attributes as facial bone structure, breasts, and genitalia, as desired. For these transgender women, surgery may then be used to support transition.

Objectives

We aimed to assess the efficacy and safety of hormone therapy with antiandrogens, estradiol, or both, compared to each other or placebo, in transgender women in transition.

Search methods

We searched MEDLINE, the Cochrane Central Register of Controlled Trials (CENTRAL), Embase, Biosis Previews, PsycINFO, and PSYDEX. We carried out our final searches on 19 December 2019.

Selection criteria

We aimed to include randomised controlled trials (RCTs), quasi-RCTs, and cohort studies that enrolled transgender women, age 16 years and over, in transition from male to female. Eligible studies investigated antiandrogen and estradiol hormone therapies alone or in combination, in comparison to another form of the active intervention, or placebo control.

Data collection and analysis

We used standard methodological procedures expected by Cochrane to establish study eligibility.

Main results

Our database searches identified 1057 references, and after removing duplicates we screened 787 of these. We checked 13 studies for eligibility at the full text screening stage. We excluded 12 studies and identified one as an ongoing study. We did not identify any completed studies that met our inclusion criteria. The single ongoing study is an RCT conducted in Thailand, comparing estradiol valerate plus cyproterone treatment with estradiol valerate plus spironolactone treatment. The primary outcome will be testosterone level at three month follow-up.

Authors' conclusions

We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition. This lack of studies shows a gap between current clinical practice and clinical research. Robust RCTs and controlled cohort studies are needed to assess the benefits and harms of hormone therapy (used alone or in combination) for transgender women in transition. Studies should specifically focus on short-, medium-, and long-term adverse effects, quality of life, and participant satisfaction with the change in male to female body characteristics of antiandrogen and estradiol therapy alone, and in combination. They should also focus on the relative effects of these hormones when administered orally, transdermally, and intramuscularly. We will include non-controlled cohort studies in the next iteration of this review, as our review has shown that such studies provide the highest quality evidence currently available in the field. We will take into account methodological limitations when doing so.

PLAIN LANGUAGE SUMMARY

Does hormone therapy help transgender women undergoing gender reassignment to transition?

Background

Transgender women may feel that they have been born in a body with the wrong sexual characteristics. This may result in significant psychological distress (gender dysphoria) and the desire to adapt their male physical and sexual characteristics to be more consistent with their experienced female gender. This is a process called transition. If measures to aid transition are not taken, this can result in greater psychological distress. One of the medical treatments given to help transgender women with male bodies to achieve transition is synthetic female hormones. These hormones can be taken by mouth, absorbed through the skin or injected into muscle.

Study characteristics

We looked for randomised controlled trials (RCTs) that included transgender women (age 16 and over) in transition from male to female. RCTs are a type of research study that can reduce the possibility of several types of bias. To be included in this review, studies needed to compare different hormone treatments used to support transgender women to transition (oestrogen alone, testosterone blockers alone, or oestrogen in combination with testosterone blockers), or compare these hormone treatments to placebos (fake or dummy treatments that appear to be the same as the actual treatment, but have no medical effects). We wanted to see whether hormone treatments help transgender women to make a transition that they are happy with. We also wanted to look at whether there were any health risks of the treatment.

Key results

We searched for studies up to 19 December 2019. We were unable to find any relevant completed studies that we could include. We did find one ongoing study that aimed to recruit all of the people taking part in the study by the end of 2020. This study is comparing the effects of estradiol valerate plus cyproterone treatment with estradiol valerate plus spironolactone treatment in transitioning transgender women in Thailand.

Quality of evidence

Our review found no RCTs that looked at whether hormone therapies are effective and safe when used to help transgender women to transition. Therefore, high-quality RCTs are needed to research these questions.

BACKGROUND

Description of the condition

There is a growing trend towards de-psychopathologisation of transgenderism (Drescher 2014; ATME 2015). There is an emerging consensus that transgenderism is not a psychiatric disorder (WPATH 2011). For instance, the 11th Revision of the International Classification of Diseases (ICD-11) (WHO 2018) no longer classifies transgenderism as a behavioural and personality disorder, but has instead drafted the term "gender incongruence" to describe gender dysphoria.

In contrast, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (DSM-5 2013) describes gender dysphoria as a "marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration, as manifested by at least two of the following" characteristics:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics);
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics);
- A strong desire for the primary and/or secondary sex characteristics of the other gender;
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender);
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

Gender dysphoria has been defined as associated with "clinically significant distress or impairment in social, occupational or other important areas of functioning" (Zucker 2016), which may lead to substantial suffering in affected people (Deutsch 2016a; Soll 2018). Gender dysphoria may result in the desire to modify one's physical and sexual characteristics to be consistent with those of the experienced gender. This process of adaptation is called transition.

The treatments applied in transition differ from those used for maintenance of the new sexual characteristics. Currently, there is uncertainty about the value of hormone therapy as a sole intervention, or when combined with surgery, for transition from male to female. This Cochrane Review specifically focuses on 'transgender women in transition from male to female,' a definition that includes biological males aiming to adapt their sexual characteristics to be consonant with those of females.

A meta-analysis that analyzed 21 studies on the prevalence of gender dysphoria (of which 12 studies contained evaluable data) estimated an overall prevalence of transgender women with gender dysphoria at 6.8 per 100,000 individuals (Arcelus 2015).

Description of the intervention

Current guidelines suggest hormonal and, if needed, surgical treatment of gender dysphoria in transgender women (WPATH 2011). Hormone therapy aims to suppress the development of, or to reverse, male attributes that have already developed. At the same time, hormones aim to develop female attributes. However, where male characteristics have already developed in adult males, such as in the bone structure of the face, hormones are not effective. Other treatments, such as surgery, would be required to change these (WPATH 2011).

The guidelines of the Endocrine Society working group suggest treatment with both oestrogens and antiandrogens (Hembree 2017). Oestrogens can be administered as either oral oestrogen, absorbed through transdermal estradiol patches, or by injection of estradiol valerate or estradiol cypionate. The application frequency differs depending on the patient's reaction to the agent and the administration regimen; it could be multiple times per day or once every two weeks. Meanwhile, antiandrogens such as spironolactone or cyproterone acetate (CPA) are commonly taken orally. Additionally, it is possible to block male puberty by treatment with gonadotropin-releasing hormone (GnRH) agonist injections (Hembree 2017).

While not every transgender woman undergoes hormone therapy in her transition, this intervention is still widely used (Hembree 2017). We know of no studies identifying the ratio of patients who undergo hormone therapy, nor do we know of studies investigating how much time passes between the start of transition (the decision to transition) and the start of hormone therapy. We are not aware of any studies on how often antiandrogens are being prescribed in addition to or instead of 17-beta-estradiol, how often they are being taken, or which kinds of androgens are in use besides CPA and spironolactone.

How the intervention might work

Several hormonal substances and combinations are used clinically for hormone therapy in transitioning women. CPA is a progestin, steroidal anti-androgen and anti-gonadotropin that blocks the receptors for testosterone (T) and dihydrotestosterone (DHT), and thereby prevents these steroidal hormones from exerting their androgenic effects. Hence, it stops processes like body hair growth, hair loss on the head, male body fat distribution and others (Figg 2010; WPATH 2011). According to the World Professional Association for Transgender Health (WPATH) guidelines, it is possible to suppress puberty with GnRH analogues or progestins such as medroxyprogesterone (WPATH 2011).

Spironolactone acts as a weak androgen receptor antagonist (Wenqing 2005). It also causes an increase in oestradiol levels (Thompson 1993), so that further virilisation is prevented and feminisation occurs (WPATH 2011).

17-beta-estradiol is used to feminise the external appearance (WPATH 2011). It binds to oestrogen receptors and thus ensures gene expression, which in turn feminises appearance (Hye-Rim 2012). In addition, estradiol suppresses gonadal testosterone production via the control systems of the hypothalamus (Hayes 2000).

Feminisation therapy aims to adapt the physical appearance and experience of the male body to that of a female body, by

inducing breast growth, softening facial features, and inducing other physical changes commonly considered to comprise a feminine appearance (WPATH 2011). For this purpose, oral or transdermal oestrogen is recommended, and therapy with oestrogen in combination with antiandrogens is most common. Co-treatment with antiandrogens minimises the required dose of oestrogen, and thereby reduces the potential risks of oestrogen identified in previous studies (Schürmeyer 1986; Prior 1989). Some antiandrogens are approved by WPATH, such as spironolactone, cyproterone acetate, GnRH analogues like goserelin, and 5-alpha-reductase inhibitors like finasteride (WPATH 2011).

Why it is important to do this review

Antiandrogens like CPA and spironolactone are prescribed to transgender women in transition by clinicians, including gynaecologists and endocrinologists (Schnelder 2006; Flütsch 2015), and they are commonly considered to be valuable drugs to support transition (WPATH 2011; Hembree 2017). However, clinical evidence suggests that taking these drugs can result in adverse events; for example, CPA has significant potential for causing depression and for worsening depressive symptoms (Seal 2012). There is also some concern that CPA can lead to other psychiatric, neurological, and metabolic disorders (Grlard 1978; Ramsay 1990; Oberhammer 1996; Giltay 2000; Calderón 2009; Bessone 2015). The most common adverse effects of spironolactone are hyperkalaemia, dehydration and hyponatraemia (Greenblatt 1973). Furthermore, spironolactone might have an influence on feelings of anxiety (Fox 2016).

Other studies from the 1980s and 90s reported that there were adverse effects from high-dose estradiol, but these studies used ethinyl estradiol or equine premarin (equine estradiol) instead of bioidentical 17-beta-estradiol; and used progestins, instead of bioidentical progesterone. This may have contributed to the adverse effect profile of these specific treatments (Prior 1989). Unlike the bioidentical alternatives used today (hormone preparations made from plant sources that are similar or identical to human hormones), substances administered in the past (e.g. equine oestrogens, ethinyl estradiol) were associated with more diverse adverse effects like thrombophilia, cardiovascular problems, breast and prostate cancer, as well as liver, adrenal gland and neural dysfunction (Grlard 1978; Calderón 2009; Asscheman 2011). The health risks attributed to estradiol doses high enough to suppress androgens have not been found in the parenteral or transdermal application of bioidentical estradiol (Hembree 2017). Thus, it is unclear why those estradiol doses should be kept low in order to make the addition of androgen antagonists like CPA or spironolactone necessary.

In light of discussions among experts (Seal 2012; Wierckx 2014), and current recommendations for hormonal gender affirmation treatment (WPATH 2011) (which are strongly based on the values and preferences of health consumers), it is necessary to review the evidence from trials that show results for outcomes such as feminisation, satisfactory sexual function, reduced gender dysphoria, and improved quality of life (e.g. Murad 2010).

In 2017, the overall quality of evidence relating to these outcomes was classified as low (Hembree 2017). In 2011, WPATH summarised the situation as follows: "There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminisation or masculinisation" (WPATH

2011). It is necessary to determine whether subsequent trials have provided additional evidence for efficacy, or whether there is still a lack of evidence for these desired outcomes.

OBJECTIVES

We aimed to assess the efficacy and safety of hormone therapy with antiandrogens, estradiol, or both, compared to each other or placebo, in transgender women in transition.

METHODS

Criteria for considering studies for this review

Types of studies

We aimed to include randomised controlled trials (RCTs), quasi-RCTs and controlled cohort studies.

We chose to include quasi-RCTs and cohort studies due to the low prevalence of the condition and the consequent current scarcity of RCTs (WPATH 2011).

Types of participants

We aimed to include studies that enrolled transgender women, age 16 years and over, in transition from male to female. Transitioning is defined as the process of changing one's gender profile or sexual characteristics (or both) to accord with one's sense of gender identity (WPATH 2011). Transition as a concept thus encompasses several aspects, e.g. social, psychological, or physical aspects, or a combination of these. There is consistency in the literature on when the transition begins: namely, with the decision to change a person's gender assignment (Brown 1996). However, we did not differentiate among any supposed phases of the respective types of transitions. Depending on the personal situation, the process of transition (which may include the decision to transition, gathering of information, gathering of experience, medical treatment and change of social role), can take very different periods of time, usually several months to years. Therefore, it is difficult to distinguish certain 'phases' of this process. When focusing on hormone therapy, the transition term can be more precisely defined. The transition process lasts as long as patients are in the process of changing their sexual characteristics (WPATH 2011).

We aimed to include studies with participants age 16 years and older because, according to currently applied guidelines, this is the age when patients start being treated with hormone therapy. Patients below this age are usually being treated with puberty blockers, which are outside the scope of this review (WPATH 2011).

Types of interventions

We considered studies evaluating hormone-based interventions only, excluding those that examined combined hormonal and either psychological or surgical treatments. We aimed to include studies reporting treatment with the following experimental interventions.

- Antiandrogens (cyproterone acetate or spironolactone) and estradiol
- Antiandrogens (cyproterone acetate or spironolactone) alone
- Estradiol alone

For the above interventions, we considered all types of administration: oral, sublingual, transdermal, subdermal and intramuscular. For estradiol, we also considered bioidentical 17-beta-estradiol, as well as synthetic derivatives.

We aimed to include the following comparator interventions.

- Any of the active interventions listed above
- Placebo

Although we consider placebo-controlled studies to be unethical (Bostick 2008), we made them eligible for inclusion in this review so that we could consider the evidence in its entirety. We did not consider interventions consisting purely of psychological treatment, spiritual support, or conversion therapy.

Types of outcome measures

For studies with repeated follow-up (i.e. reporting of outcomes at multiple time points), we regarded follow-up at three to six months as short term, six months to two years as medium term, and more than two years as long term (WPATH 2011).

We intended to include in the descriptive section of the review all studies that met the criteria for type of study, participants, intervention and comparator, regardless of outcomes reported or missing data.

Primary outcomes

- Quality of life (QoL) as measured by validated generic instruments, e.g. Quality of Life Inventory (QOLI) (Frisch 2005); or specific instruments, e.g. for body image, the Body Image Quality of Life Inventory (BIQLI) (Cash 2004); or for sexual life the Sexual Satisfaction Scale for Women (SSS-W) (Meston 2005).
- Satisfaction with change of male to female body characteristics, as measured with validated instruments
- Adverse events specific to hormone therapy, including serious adverse events

Secondary outcomes

- Severity of gender dysphoria/gender incongruence, e.g. as measured with the Utrecht Gender Dysphoria Scale (UGDS) (Schneider 2016)
- Measures of specific body changes, including:
 - * breast size, e.g. by measurement of bust girth;
 - * skin thickness, e.g. by echographic measurement (Laurent 2007);
 - * skin sebum production, e.g. as measured by three-hour sebum collection with absorbent paper (Downing 1981; Giltay 2008; Ezerskaia 2016); and
 - * hair growth, including hair density, diameter, growth rate and anagen/telogen ratio (Giltay 2000; Hoffmann 2013).
- Incidence or severity of depression.

We did not include surrogate outcomes, such as serum hormone levels (e.g. 17-beta-estradiol or testosterone). While these measures can help with monitoring the progress of hormone therapy, they are of little interest of themselves, especially since individuals require varying levels of these hormones to achieve a certain level of feminisation (Gooren 2017).

Search methods for identification of studies

Electronic searches

We searched the following electronic databases for relevant trials up to 19 December 2019 with no restrictions based on language of publication, date of publication, or publication status:

- MEDLINE via PubMed
- Cochrane Central Register of Controlled Trials (CENTRAL)
- Embase
- Biosis Preview
- PsycINFO
- PSYNDEX

Our search strategy is outlined in Appendix 1. We have successfully tested the screening methods for abstracts and titles.

Searching other resources

Had we identified any eligible studies through the electronic searches above we would have searched the reference lists of these in order to find additional relevant studies. We also searched the scientific abstracts of the last two meetings of each of the following organisations:

- American Association of Clinical Endocrinologists
- American Society of Andrology
- Berufsverband der deutschen Endokrinologen (Professional Association of the German Endocrinologists)
- Berufsverband der Frauenärzte e.V. (Professional Association of the Gynaecologists)
- Dachverband Reproduktionsbiologie und Medizin e.V. (Federal Association Reproductive Biology and Medicine)
- Deutsche Gesellschaft für Endokrinologie (German Society for Endocrinology)
- Deutsche Gesellschaft für Gynäkologie und Geburtshilfe (German Society for Gynaecology and Obstetrics)
- Endocrine Society
- European Society of Gynaecological Oncology
- European Thyroid Association
- Nordrhein-Westfälische Gesellschaft für Endokrinologie und Diabetologie (North Rhine-Westphalian Society for Endocrinology and Diabetology)
- Royal College of Obstetricians and Gynaecologists
- Society for Endocrinology
- Society for Gynaecologic Investigation

We also searched the following grey literature databases:

- The New York Academy of Medicine Grey Literature Report (www.greylit.org/)
- OAlster (www.oclc.org/oalster/en.html)
- OpenGrey (www.opengrey.eu/)

Finally, in order to identify completed but unpublished or ongoing studies, we searched the following trial registries.

- ClinicalTrials.gov (www.clinicaltrials.gov/)
- metaRegister of Controlled Trials (mRCT; www.controlledtrials.com/mrct/)

- World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) Search Portal (www.who.int/trialsearch/)
- Drugs@FDA (www.accessdata.fda.gov/scripts/cder/drugsatfda/)
- European Public Assessment Reports (EPAR; www.ema.europa.eu/ema/index.jsp?curi=pages/medicines/landing/epar_search.jsp)

We contacted fifteen manufacturers of hormonal agents and experts in the field to identify unpublished or ongoing trials.

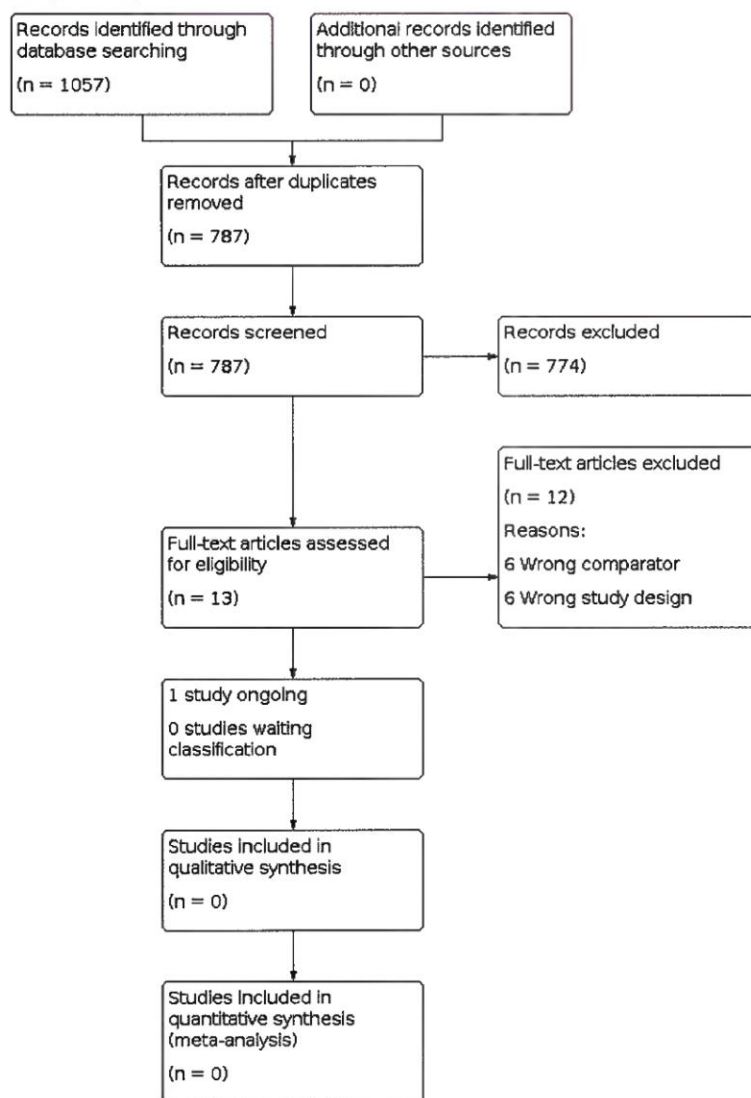
Data collection and analysis

Selection of studies

We used the reference management tool Covidence to identify and remove potential duplicate records of relevant studies (www.covidence.org). Two review authors (AKU and MHE)

independently scanned titles and abstracts of the remaining records to compile a list of potential papers to potentially be included in the review. After this, the same review authors investigated the references in detail (as full text articles or matched records to studies), and categorised these as 'included studies,' 'excluded studies,' 'studies awaiting classification' and 'ongoing studies.' We executed this task in accordance with the criteria provided in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011a). If there had been discrepancies or if a consensus could not be reached, a third review author would have adjudicated (CHA). There were no disagreements that could not be thus resolved. Had this been the case, we would have designated the study as 'awaiting classification' and contacted the study authors for clarification. We listed studies excluded during the full text review stage, and documented the reasons for exclusion in *Characteristics of excluded studies*. We included an adapted PRISMA flow diagram outlining the study selection process (Moher 2009) (Figure 1).

Figure 1. Study Flow Diagram



Data extraction and management

If we had found relevant studies, two review authors (AKU and MHE) would have extracted data from all studies deemed eligible for inclusion independently, with the help of a standardized data extraction form that would have been pilot tested according to Chapter 7 of the *Cochrane Handbook* (Higgins 2011a). We have used Google Spreadsheets to manage all data gathered.

We would have collected data on the following items:

- General information on the study: first author, date of publication, study dates, publication type (full text article, abstract, unpublished), citation.
- Study methods: study design (e.g. parallel, factorial), number of study arms, study setting (single institution, multi-centre national, multi-centre international), study location, and length of follow-up.
- Participant characteristics: study inclusion/exclusion criteria, age (mean/median with range), ethnic distribution, number of participants randomised and included in analysis, participants lost to follow-up.
- Interventions: type of hormonal agents (for example CPA, estradiol, progesterone, spironolactone), dose, administration route, dosing schedule and any other associated therapies. We would have extracted data on the sample size for each intervention group.
- Outcomes: definition and method of assessment for each outcome (including the adverse event classification system used in individual studies), as well as any relevant subgroups. We would have extracted the number of events and participants per treatment group for dichotomous outcomes. We would also extract the mean, standard deviation or median and range, and number of participants per treatment group for continuous outcomes.
- Study funding sources.
- Declarations of potential conflicts of interest reported by study authors.

For each included study, we would have extracted the outcome data relevant for this review, and which would be required for the calculation of summary statistics and measures of variance. If there had been disagreements, we would have resolved them by discussion. If necessary, we would have consulted a third review author (CHA). We provided key information about potentially relevant ongoing studies, including trial identifiers, in the table of *Characteristics of ongoing studies*. We would have attempted to contact authors of included studies to obtain missing key data if needed.

Assessment of risk of bias in included studies

If relevant studies had been found, two review authors (AKU and MHE) would have examined all included studies to assess risk of bias (assessment of methodological quality) independently. We would have used the Cochrane 'Risk of bias' tool for assessing risk of bias in RCTs, as described in the *Cochrane Handbook* (Higgins 2011b). We would have resolved disagreements by consensus or by consulting a third review author (CHA). Our summary judgement would have included a rating (low, high or unclear risk of bias) for each domain (Higgins 2011b). We would have assessed the risk of bias for the following domains:

- Random sequence generation
- Allocation concealment
- Blinding of participants and personnel
- Blinding of outcome assessment
- Incomplete outcome data
- Selective reporting
- Other bias

We would have evaluated the risks of performance bias (blinding of participants and personnel) and detection bias (blinding of outcome assessment) separately for each outcome.

For any relevant cohort studies we would have used the ROBINS-I tool to assess risk of bias (Sterne 2016). We would have assessed each individual study in accordance with the guidance, documenting the results using a spreadsheet and providing details in 'Risk of bias' tables. We would have documented the reasons for our judgements, and would have included relevant quotations from the full-text articles or from information about the study provided by authors in the notes section of the 'Risk of bias' tables. We would have summarised the risk of bias across domains for each primary outcome in every included study, as well as across studies and domains for each primary outcome.

Measures of treatment effect

Dichotomous data

We planned to summarise dichotomous data using risk ratios (RRs), reported with 95% confidence intervals (CIs).

Continuous data

For continuous outcomes with a standard measure, we would have summarised the obtained data as mean differences (MDs) with 95% CIs. For continuous outcomes without a standard measure, we would have summarised data as standardized mean differences (SMDs) with 95% CIs. Alternatively, if the mean value and variance were missing, we would have estimated them using the methods described in Hozo 2005, which allows estimations for mean value and variance of a sample when only the median, range and size of the sample are known. We would also have considered the guidance in the *Cochrane Handbook* where appropriate (Higgins 2011c).

Unit of analysis issues

We planned to treat recurring events in individual participants as single events occurring in one participant (e.g. three episodes of major depressive disorder in one participant would have been recorded as one participant with major depressive disorder). We did not expect to include studies with interventions delivered at the cluster level.

Dealing with missing data

For studies with missing data, we would have followed the recommendations of the *Cochrane Handbook* (Higgins 2011d). We would have collected dropout rates for each study group and would have reported these in the 'Risk of bias' table. Our preferred option would have been to contact study authors in cases of missing data or statistics that were not due to participant dropout (e.g. missing statistics such as standard deviation (SD)). If missing outcome data were not provided, then we would have attempted to impute

data where possible and appropriate, and conduct sensitivity analyses to assess the effect of this on the analysis. However, where imputation is not appropriate, we would not have included the study in the respective meta-analysis, and would have discussed the potential impact of this in the text of the review. In the case of participants lost to follow-up, we would have performed meta-analyses on an intention-to-treat basis. We would have performed sensitivity analyses, excluding studies with missing outcome data, to evaluate the impact of missing data. We would have discussed the potential impact of missing data on review findings in the 'Discussion' section of the full review, using a summary table if appropriate.

Assessment of heterogeneity

We would have compared the characteristics of included studies to identify heterogeneity of content or methodology, and to determine the feasibility of performing a meta-analysis. We would have deemed meta-analyses unsuitable in cases where there was substantial content-related or methodological heterogeneity across studies. Instead, we would have used a narrative approach to data synthesis. Had meta-analyses been deemed appropriate, we would have assessed statistical heterogeneity by visually inspecting the scatter of individual study effect estimates on forest plots and by calculating the I^2 statistic (Higgins 2011c), which gives the percentage of variability in effect estimations that can be attributed to heterogeneity rather than to chance. We would have considered an I^2 of more than 50% to represent substantial heterogeneity. In the case of statistical heterogeneity, we would have conducted the prespecified subgroup and sensitivity analyses described below to investigate the source.

Assessment of reporting biases

If we had included 10 or more studies that investigated the same outcome, we would have used funnel plots to assess small-study effects and publication bias. Given that several explanations are possible for funnel plot asymmetry, we would have interpreted results carefully (Sterne 2011).

Data synthesis

Had we identified any eligible studies, we would have provided a narrative summary of the included studies. We would also have conducted meta-analyses of RCTs for all relevant outcomes, where possible, using data from studies that 1) compared the actual hormone therapy-relevant agents or combinations of agents to placebo, and 2) compared the actual hormone therapy-relevant agents or combinations of agents to other hormone therapy-agents or combinations of agents. Studies comparing two variations on the intervention would have been pooled separately to studies comparing the intervention to placebo. However, if there had been significant variability in the definition of outcomes across trials, we would have decided not to pool data.

Had we conducted meta-analyses, we would have used the Mantel-Haenszel approach to combine dichotomous data and calculate RRs with 95% CIs (Higgins 2011c). For continuous outcomes (e.g. quality of life) we would have calculated MDs or SMDs, with 95% CIs, using the inverse variance approach. Had studies reported the same outcome measure but some studies had reported data on the change from baseline (e.g. mean values and standard deviations) and others for final measurements of outcomes, they would have been placed in subgroups in the meta-analysis and

pooled according to guidance in the *Cochrane Handbook* (Higgins 2011c).

For meta-analyses, we would have used a random-effects model, expecting the true effects to be related, but not the same, across all studies. We would have interpreted random-effects meta-analyses with due consideration of the whole distribution of effects, ideally by presenting a prediction interval (Higgins 2009). A prediction interval specifies a predicted range for the true treatment effect in an individual study (Riley 2011). In addition, we would have performed statistical analyses according to the statistical guidelines contained in the *Cochrane Handbook* (Higgins 2011c).

We would have summarised outcome data from cohort studies (e.g. change scores) narratively.

Subgroup analysis and investigation of heterogeneity

Wherever possible, we would have considered subgroup analyses that are structured by the following characteristics.

- Type of application of intervention (oral, transdermal, intramuscular, subcutaneous)
- Orchiectomy before or during hormone therapy

The justification for these analyses is as follows. Pharmacokinetic mechanisms lead to significant differences in the absorption and metabolism of an active substance depending on the type of application. Therefore, we would, if possible, have formed appropriate subgroups based on the application method of the intervention. Also, patients who have undergone an orchiectomy could have different outcomes than those patients without orchiectomy (Defreyne 2017).

Sensitivity analysis

We would have conducted sensitivity analyses to investigate any potential effect of removing studies judged to be at high risk of bias from meta-analyses. We would have classified studies as being at high risk of bias overall if one or more domains were judged to be at high risk. If appropriate, we would also have conducted sensitivity analyses excluding studies with missing outcome data, or where missing data have been imputed by the review author team. We would also have conducted a sensitivity analysis to compare a fixed-effect model to a random effects model where the studies in a meta-analysis appear more homogeneous than expected.

Summary of findings and assessment of the certainty of the evidence

Following standard Cochrane methodology, had we identified any included studies, we would have created a 'Summary of findings' table for all three primary outcomes. Also following standard Cochrane methodology, we would have used the five GRADE considerations (risk of bias, consistency of effect, imprecision, indirectness and publication bias) to assess the quality of the body of evidence for each outcome, and to draw conclusions about the quality of evidence within the text of the review.

RESULTS

Description of studies

Results of the search

We conducted our searches on 18 January 2019 and updated them on 19 December 2019. Through the database searches, we identified a total of 1057 references. After removing duplicates, we screened the titles and abstracts of 787 references. Through this screening, we identified 13 studies to assess as full text articles. We fully inspected these articles, and excluded 12 studies. The remaining study was still ongoing. Therefore, we did not include any studies in this review (Figure 1).

Of the manufacturers and experts in the field whom we contacted, 15 responded but did not report any additional studies.

Included studies

None of the reports retrieved met the inclusion criteria for this review. Suggestions for future studies are given in Table 1

Excluded studies

We excluded all 12 of the full-text articles that we had assessed for eligibility, either because they used an ineligible comparator or because they used an ineligible study design. See [Characteristics of excluded studies](#) for further details.

Ongoing studies

We identified one ongoing RCT in Thailand, comparing spironolactone with CPA (Krusean 2019). This study started in April 2019. We describe this study in [Characteristics of ongoing studies](#).

Risk of bias in included studies

As no studies met the inclusion criteria, it was not possible to assess risk of bias.

Effects of interventions

As no studies met the inclusion criteria, we were unable to calculate any effects of the interventions.

DISCUSSION

Summary of main results

No study met the inclusion criteria for this review. A total of 13 potentially eligible studies were identified, but ultimately all but one was excluded after we assessed the full text articles. The one remaining RCT is ongoing, and we are awaiting its publication (Krusean 2019). We conducted a comprehensive search to identify eligible studies for inclusion in this review. Despite more than four decades of ongoing efforts to improve the quality of hormone therapy for women in transition, we found that no RCTs or suitable cohort studies have yet been conducted to investigate the efficacy and safety of hormonal treatment approaches for transgender women in transition.

Overall completeness and applicability of evidence

The evidence is incomplete because no studies met the inclusion criteria for the review. This lack of studies shows a gap between current clinical practice and clinical research, which has

been repeatedly emphasised (Hembree 2009; Hembree 2017). If hormone therapy is highly valued in the treatment of gender dysphoria (Hembree 2009; WPATH 2011; Hembree 2017), then this raises the question: why are there no RCTs or appropriate cohort studies for this clinical condition? There is also an ethical need for research into the efficacy and safety of hormone therapy, particularly comparing combination therapy with CPA/estradiol and spironolactone/estradiol to monotherapy with estradiol alone. In view of the reported but rather alarming side-effect profiles of CPA and spironolactone in other populations (De Bastos 2014; Khan 2016; PG12 2019), long-term clinical studies that aim to achieve adequate outcomes are urgently needed for the population of transgender women in transition. The lack of reliable data on hormone therapy for transitioning transgender women should encourage the development of well-planned RCTs and cohort studies to evaluate widespread empirical practice in the treatment of gender dysphoria.

The most common reason for the exclusion of studies from this review was the lack of a control group. We excluded some studies because they did not meet the eligibility requirements for study design (e.g. case series or case-control studies). Further, interventions were not clearly defined.

Among guideline developers in the field of transgender medicine, it has been discussed in recent years why the available evidence remains limited (Deutsch 2016a Reilly 2019). Deutsch 2016a has identified three main reasons, which they believe have hindered the development of evidence based healthcare guidelines. Firstly, a lack of research funding and institutional stigma means that the evidence currently centres around less robust study designs, such as retrospective studies, case series, and individual case reports (Bockting 2016 Reisner 2016a); secondly variation in the collection of gender identity data in observational data sets makes it difficult to identify relevant populations and monitor their health outcomes (Deutsch 2013 Bauer 2009); and finally, academic programmes focused on transgender medicine are in their infancy and few exist (Reisner 2016b), meaning there is a general lack of research and training on this topic.

Against this background, methodological problems such as inconsistent and missing comparison groups, uncontrolled confounding factors, small sample size, short follow-up time and difficulties in recording and evaluating a broad spectrum of health outcomes (physical and mental health, social functioning and QoL) have become apparent in hormone therapy (Deutsch 2016b). The performance of RCTs is controversial, especially with regard to placebo studies, and ethical and methodological objections have been raised (e.g. violation of the principle of equipoise, Miller 2003). However, the positive research potential of active-controlled RCTs is acknowledged, in order to compare different types, dosages and methods of administration of active treatments. Overall, there is a trend in the discussion to favour not only RCTs and quasi-RCTs, but also high-quality cohort studies conducted in a network of health centres, hospitals and practices (Deutsch 2016a; Deutsch 2016b).

Quality of the evidence

We could not appraise the quality of the evidence because no studies met our review's inclusion criteria.

Potential biases in the review process

We consider our search to have been consistent and comprehensive (including the fifteen contacts with manufacturers and experts in the field). At each stage, the review authors independently applied the inclusion criteria before comparing their judgements. Reliability testing was performed in the screening phase. Even though we were unable to test for publication bias, we think it is unlikely that there are studies that have been conducted but remained unpublished. The experts in the field we interviewed believed that there was a general lack of research activity by treatment manufacturers, and considered it very likely that no phase IV studies have ever been conducted in this population. For example, one expert stated that there was probably "nothing to be kept secret."

Agreements and disagreements with other studies or reviews

There are currently no systematic reviews in the Cochrane Library that evaluate the effectiveness of hormone therapy for transgender women in transition, nor are there systematic reviews that evaluate the clinical and economic impact of hormone therapy on transgender women in transition. The Endocrine Society's 2009 and 2017 guidelines addressed endocrine treatment of gender-dysphoric/gender-incongruent persons (Hembree 2009; Hembree 2017). The literature search included in these guidelines did not identify any RCTs of hormone therapy in transitioning transgender women. In the context of the preparation of UK National Health Service (NHS) guidelines (PG12 2019), the NHS Guideline Panel also found no RCTs. However, PG12 2019 includes a recommendation for the prescription of hormone therapy for transitioning transgender women.

Of the potentially relevant studies we excluded, some reported on relevant questions. Asscheman 2011 focused on the important outcome of mortality. Fisher 2016 investigated the important relationship between hormone therapy-related body changes and psychobiological well-being. Giltay 2000 focused on body related outcomes such as hormone therapy's effects on the skin (hair growth rate, density, and shaft diameter by image analysis; and sebum production). Toorians 2003 focused on the outcomes of different interventions (estradiol alone compared with combination therapy estradiol and antiandrogens). Miles 2006 was based on a cross-over design with the intention of comparing groups of individuals on and off oestrogen. Due to the reported deficits, we excluded these studies, although they addressed important questions.

AUTHORS' CONCLUSIONS

Implications for practice

We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches (estradiol alone or

in combination with cyproterone acetate or spironolactone) for transgender women in transition. The evidence is very incomplete, demonstrating a gap between current clinical practice and clinical research.

Implications for research

This systematic review has shown that well-designed, sufficiently robust randomised controlled trials (RCTs) and controlled-cohort studies do not exist, and are needed, to assess the benefits and harms of hormone therapies (used alone or in combination) for transgender women in transition. The following questions should be addressed via RCTs and cohort studies:

1. What are the short-, medium-, and long-term effects (including adverse effects, benefits, and prognoses) of estradiol therapy alone, as opposed to combination therapy using estradiol together with cyproterone acetate or spironolactone?
2. What is the short-, medium-, and long-term clinical efficacy of hormone therapy when applied orally, transdermally, and intramuscularly?

Table 1 presents design components that we suggest could be used in future studies. Studies should be structured and reported according to the CONSORT Statement or the STROBE Statement in order to improve the quality of reporting on efficacy and to obtain better reports on harms in clinical research (von Elm 2007; Schulz 2010). There is an urgent need for research in this area, not least for ethical reasons.

We will include non-controlled cohort studies in the next iteration of this review, as this review has demonstrated that this is the highest quality evidence currently available in the field. We will take methodological limitations into account when doing so.

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REFERENCES

References to studies excluded from this review

Asscheman 2011 [published data only]

Asscheman H, Giltay EJ, Megens JA, de Ronde WP, van Trotsenburg MA, Gooren LJ. A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology* 2011;**164**(4):635-42. [DOI: 1530/EJE-10-1038]

Colizzi 2015 [published data only] 10.1016/j.jpsychores.2015.02.001

Colizzi M, Costa R, Scaramuzzi F. Concomitant psychiatric problems and hormonal treatment induced metabolic syndrome in gender dysphoria individuals: A 2 year follow-up study. *Journal of Psychosomatic Research* 2015;**78**:399-406. [DOI: 10.1016/j.jpsychores.2015.02.001]

Figuera 2018 [published data only] 10.1111/cen.13607

Figuera TM, da Silva E, Lindenau JD, Spritzer PM. Impact of cross-sex hormone therapy on bone mineral density and body composition in transwomen. *Clinical Endocrinology* 2018;**88**(6):856-862. [DOI: 10.1111/cen.13607] [PMID: 29630732]

Fisher 2014 [published data only] 10.1111/jsm.12413

Fisher AD, Castellini G, Bandini E, Casale H, Fanni E, Benni L, et al. Cross-sex hormonal treatment and body uneasiness in individuals with gender dysphoria. *International Society for Sexual Medicine* 2014;**11**:709-19.

Fisher 2016 [published data only] 10.1210/jc.2016-1276

Fisher AD, Castellini G, Ristori J, Casale H, Cassioli E, Sensi C, et al. Cross-sex hormone treatment and psychobiological changes in transsexual persons: two-year follow-up data. *The Journal of Clinical Endocrinology and Metabolism* 2016;**101**:0000-0000.

Giltay 2000 [published data only]

Giltay EJ, Gooren L. Effects of sex steroid deprivation/administration on hair growth and skin sebum production in transsexual males and females. *The Journal of Clinical Endocrinology & Metabolism* 2000;**85**(8):2913-21. [DOI: 10.1210/jc.85.8.2913]

Haraldsen 2005 [published data only]

Haraldsen IR, Egeland T, Haug E, Finset A, Opjordsmoen S. Cross-sex hormone treatment does not change sex-sensitive cognitive performance in gender identity disorder patients. *Psychiatry Research* 2005;**137**:161-74. [DOI: 10.1016/j.psychres.2005.05.014]

Haraldsen 2007 [published data only] 10.1016/j.yhbeh.2007.05.012

Haraldsen IR, Haug E, Falch J, Egeland T, Opjordsmoen S. Cross-sex pattern of bone mineral density in early onset gender identity disorder. *Hormones and Behavior* 2007;**52**:334-43. [DOI: 10.1016/j.yhbeh.2007.05.012]

Miles 2006 [published data only] 10.1016/j.yhbeh.2006.06.008

Miles C, Green R, Hines M. Estrogen treatment effects on cognition, memory and mood in male-to-female transsexuals.

Hormones and Behavior 2006;**50**:708-17. [DOI: 10.1016/j.yhbeh.2006.06.008]

Schlatterer 1998 [published data only]

Schlatterer K, Auer DP, Yassouridis A, Von Werder K, Stalla GK. Transsexualism and osteoporosis. *Archives of Sexual Behavior* 1998;**27**(5):475-92. [0004-0002/98/1000-0475]

Toorians 2003 [published data only]

Toorians AW, Thomassen MCLGD, Zweegman S, Magdeleyns EJP, Tans G, Gooren L, et al. Venous thrombosis and changes of hemostatic variables during cross-sex hormone treatment in transsexual people. *The Journal of Clinical Endocrinology & Metabolism* 2003;**88**(12):5723-29. [DOI: 10.1210/jc.2003-030520]

Van Goozen 1995 [published data only]

Van Goozen SHM. Gender differences in behaviour: activating effects of cross-sex hormones. *Psychoneuroendocrinology* 1995;**20**(4):343-63. [DOI: 10.1016/0306-4530(94)2900076-X]

References to ongoing studies

Krasean 2019 [published data only]

TCTR20190404001. Anti-androgenic effects comparison between Cyproterone acetate and Spironolactone in transgender women: a randomized controlled trial. Thai Clinical Trials Registry 2019. [THAI CLINICAL TRIALS REGISTRY: TCTR20190404001]

Additional references

Arcelus 2015

Arcelus J, Bouman WP, Van Den Noortgate W, Claes L, Witcomb G, Fernandez-Aranda F. Systematic review and meta-analysis of prevalence studies in transsexualism. *European Psychiatry* 2015;**30**(6):807-15.

ATME 2015

Aktion Transsexualität und Menschenrecht eV (ATME). Alternative recommendations for treatment in the presence of so-called "sex/gender variance". Medicine and psychotherapy without gender stereotyping. [STUTT GARTER ERKLÄRUNG - Alternative Handlungsempfehlungen bei geschlechtlichen Normvariationen]. In: In: v. Schreiber G editor(s). *Transsexualität in Theologie und Neurowissenschaften - Ergebnisse, Kontroversen, Perspektiven*. Vol. 1. Berlin: De Gruyter, 2015:77-8. [ISBN: 978-3110440805]

Bauer 2009

Bauer GR, Hammond R, Travers R, Kaay M, Hohenadel KM, Boyce M. "I don't think this is theoretical; this is our lives": how erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care* 2009;**20**(5):348-61. [DOI: 10.1016/j.jana.2009.07.004]

Bessone 2015

Bessone F, Lucena MI, Roma MG, Stephens C, Medina-Cáliz I, Frider B, et al. Cyproterone acetate induces a wide spectrum of acute liver damage including corticosteroid-responsive hepatitis: report of 22 cases. *Liver International: Official Journal of the International Association for the Study of the Liver*. 2015;36(2):302-10. [DOI: 1111/liv.12899]

Bockting 2016

Bockting W, Coleman E, Deutsch MB, Guillaumon A, Meyer I, Meyer III W, et al. Adult development and quality of life of transgender and gender nonconforming people. *Current Opinion in Endocrinology, Diabetes, and Obesity* 2016;23(2):188. [DOI: 10.1097/MED.0000000000000232]

Bostick 2008

Bostick NA, Sade R, Levine MA, Stewart Jr DM. Placebo use in clinical practice: report of the American Medical Association Council on Ethical and Judicial Affairs. *The Journal of Clinical Ethics* 2008;19(1):58-61. [PMID: 18552054]

Brown 1996

Brown ML, Rounsley CA. True Selves: Understanding Transsexualism - For Families, Friends, Coworkers, and Helping Professionals. 1 edition. Vol. 1. San Francisco: Jossey-Bass, 1996. [ISBN: 0-7879-6702-5]

Calderón 2009

Calderón GD, Bratoeff E, Ramírez LE, Osnaya BN, García AR, Barragán MG, et al. Effects of two new steroids and cyproterone on some biomarkers of oxidative stress and serotonergic system on rat prostate and brain. *Andrologie* Feb 2009;41(1):29-34. [DOI: 1111/j.1439-0272.2008.00886.x]

Cash 2004

Cash TF, Jakatdar TA, Williams EF. The body image quality of life inventory: further validation with college men and women. *Body Image* 2004;1(3):279-87. [DOI: 1016/S1740-1445(03)00023-8]

De Bastos 2014

de Bastos M, Stegeman B, Rosendaal F. Combined oral contraceptives: venous thrombosis. *Cochrane Database of Systematic Reviews* 2014;3(Issue ID 2351):Art. No.: CD010813. [DOI: 10.1002/14651858.CD010813.pub2.] [PMID: 24590565]

Defreyne 2017

Defreyne J, Nota N, Pereira C, Schreiner T, Fisher AD, den Heijer M, et al. Transient elevated serum prolactin in trans women is caused by cyproterone acetate treatment. *LBGT Health* 2017;4(5):328-36. [DOI: 1089/lgbt.2016.0190]

Deutsch 2013

Deutsch MB, Green J, Keatley J, Mayer G, Hastings J, Hall AM, et al. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health. *Journal of the American Medical Informatics Association* 2013;20(4):700-3. [10.1136/amiajnl-2012-001472]

Deutsch 2016a

Deutsch M. Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people. Center of Excellence for Transgender Health June 17th 2016;2nd Edition.

Deutsch 2016b

Deutsch MB, Radix A, Reisner S. What's in a guideline? Developing collaborative and sound research designs that substantiate best practice recommendations for transgender health care. *AMA Journal of Ethics* 2016;18(11):1098-106. [DOI: 10.1001/journalofethics.2016.18.11.stas1-1611]

Downing 1981

Downing DT, Stewart ME, Strauss JS. Estimation of sebum production rates in man by measurement of the squalene content of skin biopsies. *Journal of Investigative Dermatology* 1981;77(4):358-60. [PMID: 7276619]

Drescher 2014

Drescher J. Controversies in gender diagnoses. *LBGT Health* 2014;1(1):10-14. [DOI: 1089/lgbt.2013.1500]

DSM-5 2013

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition. 1 edition. Vol. 1. Göttingen: Hogrefe, 2013. [ISBN: 9783801725990]

Ezerskaia 2016

Ezerskaia A, Pereira SF, Urbach HP, Verhagen R, Varghese B. Infrared spectroscopic measurement of skin hydration and sebum levels and comparison to corneometer and sebumeter. *Proceedings SPIE* 2016;9887(98872G):552-6. [DOI: 1117/12.2225434]

Figg 2010

Figg W, Chau CH, Cindy H, Small EJ. Drug Management of Prostate Cancer. 1 edition. New York: Springer, 2010. [ISBN: 978-1-60327-829-4]

Flütsch 2015

Flütsch N. Endocrinological treatment of the gender dysphoria in people with gender incongruence. [Endokrinologische Behandlung der Geschlechtsdysphorie bei Menschen mit Geschlechtsinkongruenz]. *Journal of Clinical Endocrinology and Metabolism* 2015;8(2):42-8.

Fox 2016

Fox LC, Davies DR, Scholl JL, Watt MJ, Forster GL. Differential effects of glucocorticoid and mineralocorticoid antagonism on anxiety behavior in mild traumatic brain injury. *Behavioural Brain Research* 2016;312:362-5. [DOI: 1016/j.bbr.2016.06.048]

Frisch 2005

Frisch MB, Clark MP, Rouse SV, Rudd MD, Pawelek JK, Greenstone A, et al. Predictive and treatment validity of life satisfaction and the quality of life inventory. *Assessment* 2005;12(1):66-78. [DOI: 1177/1073191104268006]

Giltay 2008

Giltay EJ, Bunck MC, Gooren L, Zitman FG, Diamant M, Teerlink T. Effects of sex steroids on the neurotransmitter-

specific aromatic amino acids phenylalanine, tyrosine, and tryptophan in transsexual subjects. *Neuroendocrinology* 2008;**88**(2):103-10. [DOI: 1159/000135710]

Gooren 2017

den Heijer M, Bakker A, Gooren L. Long term hormonal treatment for transgender people. *The BMJ* 2017;**359**(j5027):n/a. [DOI: 1136/bmj.j5027]

Greenblatt 1973

Greenblatt DJ, Koch-Weser J. Adverse reactions to spironolactone. *JAMA* 1973;**225**(1):40-3. [DOI: 1001/jama.1973.03220280028007]

Griard 1978

Griard J, Bühler U, Zuppinger K, Haas HG, Staub JJ, Wyss HI. Cyproterone acetate and ACTH adrenal function. *The Journal of Clinical Endocrinology and Metabolism* 1978;**47**(3):581-6. [DOI: 10.1210/jcem-47-3-581]

Hayes 2000

Hayes FJ, Seminara SB, Decruz S, Boepple PA, Crowley WF Jr. Aromatase inhibition in the human male reveals a hypothalamic site of estrogen feedback. *The Journal of Clinical Endocrinology & Metabolism* 2000;**85**(9):3027-35. [DOI: 0021-972X/00/503.00/0]

Hembree 2009

Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer III WJ, Spack NP, et al. Endocrine treatment of transsexual persons: an endocrine society clinical practice guideline. *Journal of Clinical Endocrinology and Metabolism* 2009;**94**(9):3132-54. [DOI: 10.1210/jc.2009-0345]

Hembree 2017

Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren L, Hannema SE, Meyer III WJ, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism* 2017;**102**(11):3869-903. [DOI: 10.1210/clinem.2017-01658]

Higgins 2009

Higgins JPT, Thompson SG, Spiegelhalter DJ. A re-evaluation of random-effects meta-analysis. *Journal of the Royal Statistical Society: Series A (Statistics in Society)* 2009;**172**(1):137-59. [DOI: 172(1):137-159]

Higgins 2011a

Higgins JPT, Deeks JJ. Chapter 7: Selecting studies and collecting data. In: Higgins JPT, Deeks JJ, editor(s). *Cochrane Handbook for Systematic Reviews of Interventions* Version 5.1.0 (updated March 2011). The Cochrane Collaboration, 2011. Available from handbook.cochrane.org.

Higgins 2011b

Higgins JPT, Deeks JJ. Chapter 8: Assessing risk of bias in included studies. In: Higgins JPT, Altman DG, Sterne JAC, editor(s). *Cochrane Handbook for Systematic Reviews of Interventions* Version 5.1.0 (updated March 2011). The Cochrane Collaboration, 2011. Available from handbook.cochrane.org.

Higgins 2011c

Higgins JPT, Deeks JJ. Chapter 9: Analysing data and undertaking meta-analyses. In: Deeks JJ, Higgins JPT, Altman DG, editor(s). *Cochrane Handbook for Systematic Reviews of Interventions* Version 5.1.0 (updated March 2011). The Cochrane Collaboration, 2011. Available from handbook.cochrane.org.

Higgins 2011d

Higgins JPT, Deeks JJ. Chapter 16: General principles for dealing with missing data. In: Higgins JPT, Deeks JJ, Altman DG, editor(s). *Cochrane Handbook for Systematic Reviews of Interventions* Version 5.1.0 (updated March 2011). The Cochrane Collaboration, 2011. Available from handbook.cochrane.org.

Hoffmann 2013

Hoffman R. TrichoScan: a novel tool for the analysis of hair growth in vivo. *Journal of Investigative Dermatology Symposium Proceedings* 2003;**8**(1):109-15. [DOI: 1046/j.1523-1747.2003.12183.x]

Hozo 2005

Hozo SP, Djulibegovic B, Iztok I. Estimating the mean and variance from the median, range, and the size of a sample. *BMC Medical Research Methodology* 2005;**13**(5). [DOI: 1186/1471-2288-5-13]

Hye-Rim 2012

Hye-Rim L, Tae-Hee K, Kyung-Chul C. Functions and physiological roles of two types of estrogen receptors, ER α and ER β , identified by estrogen receptor knockout mouse. *Laboratory Animal Research* 2012;**28**(2):71-6. [DOI: 5625/lar.2012.28.2.71]

Khan 2016

Khan O, Mashru A. The efficacy, safety and ethics of the use of testosterone-suppressing agents in the management of sex offending. *Current Opinion in Endocrinology, Diabetes and Obesity* 2016;**23**(3):271-8. [DOI: 10.1097/MED.0000000000000257]

Laurent 2007

Laurent A, Mistretta F, Bottiglioli D, Dahel K, Goujon C, Nicolas JF, et al. Echographic measurement of skin thickness in adults by high frequency ultrasound to assess the appropriate microneedle length for intradermal delivery of vaccines. *Vaccine* 2007;**25**(34):6423-30. [DOI: 25(34):6423-6430]

Meston 2005

Meston C, Trapnell P. Development and validation of a five-factor sexual satisfaction and distress scale for women: the Sexual Satisfaction Scale for Women (SSS-W). *The Journal of Sexual Medicine* 2005;**2**(1):66-81.

Miller 2003

Miller FG, Brody H. A critique of clinical equipoise: therapeutic misconception in the ethics of clinical trials. *Hastings Center Report* 2003;**33**(3):19-28. [PMID: 12854452]

Moher 2009

Moher D, Liberati A, Tetzlaff J, Altman DG. The PRISMA Group (2009). Preferred reporting items for systematic

reviews and meta analyses: The PRISMA statement.
Annals of Internal Medicine 2009;**151**(4):264-9. [DOI: 7326/0003-4819-151-4-200908180-00135]

Murad 2010

Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ, et al. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology* 2010;**72**(2):214-31. [DOI: 1111/j.1365-2265.2009.03625.x]

Oberhammer 1996

Oberhammer F, Nagy P, Tiefenbacher R, Fröschl G, Bouzahzah B, Thorgeirsson SS, et al. The antiandrogen cyproterone acetate induces synthesis of transforming growth factor beta 1 in the parenchymal cells of the liver accompanied by an enhanced sensitivity to undergo apoptosis and necrosis without inflammation. *Hepatology* 1996;**23**(2):329-37. [DOI: 1002/hep.510230220]

PG12 2019

Sullivan C, Dean J. Prescribing Guideline PG12 Pharmacological Treatment of Gender Dysphoria. Devon Partnership NHS Trust 2019.

Prior 1989

Prior CJ, Vigna YM, Watson D. Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Archives of Sexual Behavior* 1989;**18**(1):49-57. [DOI: 18(1):49-57]

Ramsay 1990

Ramsay ID, Rushton DH. Reduced serum vitamin B12 levels during oral cyproterone-acetate and ethinyl-oestradiol therapy in women with diffuse androgen-dependent alopecia. *Clinical and Experimental Dermatology* 1990;**15**(4):277-81. [DOI: 1111/j.1365-2230.1990.tb02089.x]

Reilly 2019

Reilly ZP, Fruhauf TF, Martin SJ. Barriers to evidence-based transgender care: knowledge gaps in gender-affirming hysterectomy and oophorectomy. *Obstetrics & Gynecology* 2019;**134**(4):714-17. [DOI: 10.1097/AOG.0000000000003472]

Reisner 2016a

Reisner SL, Deutsch MB, Bhasin S, Bockting W, Brown GR, Feldman J, et al. Advancing methods for US transgender health research. *Current opinion in endocrinology, diabetes, and obesity* 2016;**23**(2):198. [DOI: 10.1097/MED.0000000000000229]

Reisner 2016b

Reisner SL, Radix A, Deutsch MB. Integrated and gender-affirming transgender clinical care and research. *Journal of acquired immune deficiency syndromes* 1999;**72**(3):235. [DOI: 10.1097/QAI.0000000000001088]

Riley 2011

Riley RD, Higgins JP, Deeks JJ. Interpretation of random effects meta-analyses. *BMJ* 2011;**342**. [DOI: 1136/bmj.d549.]

Schneider 2006

Schneider H, Stalla G. Hormonal Therapy [Hormonelle Therapie]. In: *Therapieleitfaden Transsexualität*. 1 edition. Bremen: Uni-Med Science, 2006:85-9. [ISBN: 3-89599-888-5]

Schneider 2016

Schneider C, Cerwenka S, Nieder TO, Briken P, Cohen-Kettenis PT, de Cuypere G, et al. Measuring gender dysphoria: a multicenter examination and comparison of the Utrecht gender dysphoria scale and the gender identity/gender dysphoria questionnaire for adolescents and adults. *Archives of Sexual Behavior* 2013;**45**(3):551-8. [DOI: 1007/s10508-016-0702-x]

Schulz 2010

Schulz KF, Altman DG, Moher D. CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials. *The BMJ* 2010;**340**:698-702. [DOI: 10.1136/bmj.c332]

Schürmeyer 1986

Schürmeyer T, Graff J, Senge T, Nieschlag E. Effect of oestrogen or cyproterone acetate treatment on adrenocortical function in prostate carcinoma patients. *Acta Endocrinologica* 1986;**111**(3):360-7. [PMID: 2421511]

Seal 2012

Seal LJ, Franklin S, Richards C, Shishkareva A, Sinclair C, Barret J. Predictive markers for mastoplasty and a comparison of side effect profiles in transwomen taking various hormonal regimens. *The Journal of Clinical Endocrinology & Metabolism* 2012;**97**(12):4422-8. [DOI: 1210/jc.2012-2030]

Soll 2018

Soll BM, Robles-García R, Brandelli-Costa A, Mori D, Mueller A, Valters-Fontanari AM, et al. Gender incongruence: a comparative study using ICD-10 and DSM-5 diagnostic criteria. *Brazilian Journal of Psychiatry* 2018;**40**(2):174-80.

Sterne 2011

Sterne JA, Sutton AJ, Ioannidis JP, Terrin N, Jones DR, Lau J, et al. Recommendations for examining and interpreting funnel plot asymmetry in meta-analyses of randomised controlled trials. *BMJ* 2011;**343**. [343:d4002]

Sterne 2016

Sterne JAC, Hernán MA, Reeves BC, Savović J, Berkman ND, Viswanathan M, et al. ROBINS-I: a tool for assessing risk of bias in non-randomised studies of interventions. *BMJ* 2016;**355**:i4919. [DOI: 10.1136/bmj.i4919]

Thompson 1993

Thompson DF, Carter JR. Drug-induced gynecomastia. *Pharmacotherapy* Jan-Feb 1993;**13**(1):37-45. [PMID: 8094898]

von Elm 2007

von Elm E, Altman DG, Egger M, Pocock SJ, Gøtzsche PC, Vandenbroucke JP, STROBE Initiative. The Strengthening of Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *Annals of Internal Medicine* 2007;**147**(8):573-7. [DOI: 10.7326/0003-4819-147-8-200710160-00010] [PMID: 17938396]

Wenqing 2005

Wenqing G, Bohl CE, Dalton JT. Chemistry and structural biology of androgen receptor. *Chemical Reviews* 2005;**105**(9):3352-70. [DOI: 10.1021/cr020456u]

WHO 2018

World Health Organisation. International classification of diseases for mortality and morbidity statistics (11th Revision). icd.who.int/en/ (accessed 30 October 2020).

Wierckx 2014

Wierckx K, van Caenegem E, Schreiner T, Haraldsen I, Fisher AD, Toye K, et al. Cross-sex hormone therapy in trans persons is safe and effective at short-time follow-up: results from the European network for the investigation of gender incongruence. *International Society for Sexual Medicine* 2014;**11**(8):1999-2011. [DOI: 10.1111/jsm.12571]

WPATH 2011

Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, et al. Standards of care for the health

of transsexual, transgender, and gender-nonconforming people version 7. *International Journal of Transgenderism* 2011;**13**(4):165-232. [DOI: 10.1080/15532739.2011.700873]

Zucker 2016

Zucker KJ. The DSM-5 diagnostic criteria for gender dysphoria. In: Trombetta C, Liguori G, Bertolotto M, editors(s). *Management of Gender Dysphoria - A Multidisciplinary Approach*. First edition. Vol. 1. Mailand: Springer, 2016:33-7. [ISBN: 978-88-470-5695-4]

References to other published versions of this review

Haupt 2018

Haupt C, Henke M, Kutschmar A, Hauser B, Baldinger S, Schreiber G. Antiandrogens or estradiol treatments or both during hormone replacement therapy in transitioning transgender women. *Cochrane Database of Systematic Reviews* 2018, Issue 10. Art. No: CD013138. [DOI: 10.1002/14651858.CD013138]

CHARACTERISTICS OF STUDIES

Characteristics of excluded studies [ordered by study ID]

Study	Reason for exclusion
Asscheman 2011	Mortality rates in transgender people receiving long-term cross-sex hormones. A cohort study. Adequate controls are missing. Interventions are not clearly defined
Colizzi 2015	Increased prevalence of metabolic syndrome among individuals with gender dysphoria treated by cross-sex hormonal treatment. Study without adequate comparator group.
Figuera 2018	Hormone therapy has been associated with changes in bone and lean/fat mass. This study assessed bone mineral density, appendicular lean mass, and total fat mass in transwomen undergoing cross-sex hormone therapy. Study without adequate comparator group.
Fisher 2014	This study aimed to assess differences in body uneasiness and psychiatric symptoms between gender dysphoria clients taking hormone therapy and those not taking hormones (no hormone therapy). A second aim was to assess whether length of hormone treatment and daily dose provided an explanation for levels of body uneasiness and psychiatric symptoms. Cross-sectional design.
Fisher 2016	The objective of the study was to assess whether hormone therapy-related body changes affect psychobiological well-being in gender dysphoria. Study without adequate comparator group.
Giltay 2000	Hormone therapy effects on the skin (hair growth rate, density, and shaft diameter by image analysis; and sebum production) of transsexual patients receiving cross-sex hormones. It is a case series, adequate controls are missing.
Haraldsen 2005	Hormone therapy effects on cognitive performance. Study without adequate comparator group.
Haraldsen 2007	The effects of cross-sex hormones on bone metabolism (bone mineral density, total body fat, total lean body mass) in patients with early onset gender identity disorder. Study without adequate comparator group.
Miles 2006	The study was designed to examine associations between oestrogen and cognition (memory, including visual, spatial, object and location memory, other cognitive abilities that show reliable sex

Study	Reason for exclusion
	differences, including verbal and visual-spatial abilities, and mood variables). The cross-over design used was comparative, but did not used randomization or quasi-randomisation.
Schlatterer 1998	This follow-up study was carried out to validate the effectiveness of cross-gender hormone therapy embedded in a multistep treatment concept for transgender patients. Study without adequate comparator group. This study lacks adequate controls.
Toorians 2003	To find an explanation for the different thrombotic risks of oral ethinyl estradiol and transdermal 17-beta-estradiol use, the researchers compared the effects of treatment of male-to-female transgender people with cyproterone acetate only, and with cyproterone acetate in combination with transdermal 17-beta-estradiol, oral ethinyl estradiol, or oral 17-beta-estradiol on a number of haemostatic variables. There is no adequate control group.
Van Goozen 1995	Effects of sex hormones to the establishment of gender differences in behaviour, a large battery of tests on aggression, sexual motivation and cognitive functioning was administered twice: shortly before and three months after the start of cross-sex hormone treatment. The study does not have an adequate comparator group.

Characteristics of ongoing studies [ordered by study ID]

Krasean 2019

Study name	Anti-androgenic effects comparison between cyproterone acetate and spironolactone in transgender women: a randomised controlled trial (Trial ID: TCTR20190404001)
Methods	Allocation: randomised Study design: randomised controlled trial Control: active Study endpoint classification: efficacy study Intervention model: Parallel Number of arms: 2 Masking: double blind (Masked roles: participant caregiver, investigator) Primary purpose: treatment Study phase: phase 4
Participants	Gender: male Age limit: minimum 18 years: maximum 40 years Condition: Gender dysphoria patients diagnosed from DSM V Male to female transgender Not undergone orchidectomy No psychological disease or mental disability
Interventions	Arm 1: Intervention name: cyproterone acetate Type: active comparator

Krasean 2019 (Continued)

Classification: drug

Descriptions: participants (gender dysphoria patients) will receive estradiol valerate (4 mg daily) combined with cyproterone acetate (25 mg daily) for cross-sex hormone treatment.

Arm: 2

Intervention name: spironolactone

Type: experimental

Classification: drug

Descriptions: participants (gender dysphoria patients) will be received estradiol valerate (4 mg daily) combined with spironolactone (100 mg daily) for cross-sex hormone treatment.

Outcomes

Primary outcome(s):

Outcome name: testosterone level

Measurement: Electrochemiluminescent Immunoassay (ECLIA) of total testosterone level

Time point: three months after intervention

Safety issue: no

Key secondary outcomes:

Outcome name: physical and metabolic changes

Measurement: physical examination, metabolic profile parameters

Time point: three months after intervention

Safety Issue: no

Starting date

April 3, 2019 (estimated end date: June 16, 2020)

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Declarations of interest not reported

ADDITIONAL TABLES

Table 1. Suggested design of future studies

Methods	RCT or controlled cohort study
Participants	Transgender women experiencing gender dysphoria, in transition N* Age: from the age of 16 years
Intervention	<ul style="list-style-type: none"> • Antiandrogens (cyproterone acetate or spironolactone) and estradiol • Antiandrogens (cyproterone acetate or spironolactone) alone • Estradiol alone <p>All types of administration: oral, sublingual, transdermal, subdermal and intramuscular. For estradiol and bioidentical 17-beta-estradiol, as well as synthetic derivatives.</p>
Comparator	Any of the active interventions listed above
Outcomes	<p>Primary outcomes</p> <ul style="list-style-type: none"> • Quality of life (QoL) • Satisfaction with change of male to female body characteristics, • Adverse events specific to hormone therapy, including serious adverse events
Notes	* Size of study with sufficient power to detect a ~ 10% difference between the two groups for primary outcome

APPENDICES

Appendix 1. OvidSP search strategy

Search	Query
#1	(transsexual* OR transgender OR "gender dysphoria" OR transident* OR "trans women" OR "trans woman").mp.
#2	("cyproterone acetate" OR CPA OR androcur).mp. or cyproterone Acetate/
#3	(spironolactone OR Aldactone OR Jenaspiron OR Osyrol OR Spirobene OR Verospiron OR Xenalon).mp. or spironolactone/
#4	(estradiol* OR oestradiol* OR estrifam OR gynocadin OR neofollin OR lenzetto).mp. or Estradiol/
#5	2 OR 3 OR 4
#6	1 AND 5

HISTORY

Protocol first published: Issue 10, 2018

Review first published: Issue 11, 2020

CONTRIBUTIONS OF AUTHORS

All authors contributed to the Abstract, Background, Methods, Results, Discussion, and Authors' conclusions. Claudia Haupt, Alexia Kutschmar and Miriam Henke conducted the study selection.

DECLARATIONS OF INTEREST

Claudia Haupt declares no competing interest.

Miriam Henke declares no competing interest.

Alexia Kutschmar declares no competing interest.

Birgit Hauser (BH) declares no competing interest. BH is a clinical practitioner in private practice, who also prescribes hormone therapy.

Sandra Baldinger declares no competing interest.

Sarah Rafaela Saenz declares no competing interest.

Gerhard Schreiber declares no competing interest.

None of the review authors' incomes depends on the prescription of drugs. The review authors did not receive any financial support for this project, but paid for all related expenses themselves. They worked voluntarily and free of charge.

INDEX TERMS

Medical Subject Headings (MeSH)

Androgen Antagonists [*therapeutic use]; Drug Therapy, Combination [methods]; Estradiol [*therapeutic use]; Estrogens [*therapeutic use]; Placebos [therapeutic use]; Sex Reassignment Procedures [*methods]; *Transgender Persons

MeSH check words

Female; Humans; Male

Gender dysphoria in children and adolescents: an inventory of the literature

A systematic scoping review

SBU POLICY SUPPORT | EVIDENCE ASSESSMENT TO SUPPORT DECISION MAKERS IN SWEDEN

DECEMBER 2019 | WWW.SBU.SE/307E

Executive summary

This report was commissioned by the Swedish government and is a scoping review of the literature on gender dysphoria in children and adolescents. The report can be a basis for further evaluation of risk of bias and evidence.

Conclusions

- ▶ We have not found any scientific studies which explains the increase in incidence in children and adolescents who seek the health care because of gender dysphoria.
- ▶ We have not found any studies on changes in prevalence of gender dysphoria over calendar time, nor any studies on factors that can affect the societal acceptance of seeking for gender dysphoria.
- ▶ There are few studies on gender affirming surgery in general in children and adolescents and only single studies on gender affirming genital surgery.
- ▶ Studies on long-term effects of gender affirming treatment in children and adolescents are few, especially for the groups that have appeared during the recent decennium.
- ▶ The scientific activity in the field seems high. A large part of the identified studies are published during 2018 and 2019.
- ▶ Almost all identified studies are observational, some with controls and some with evaluation before and after gender affirming treatment. No relevant randomised controlled trials in children and adolescents were found.

- ▶ We have not found any composed national information from Sweden on:
 - the proportion of those who seek health care for gender dysphoria that get a formal diagnosis
 - the proportion starting endocrine treatment to delay puberty
 - the proportion starting gender affirming hormonal treatment
 - the proportion subjected to different gender affirming surgery

Background

The number of persons below age 18 who seeks the health care for gender dysphoria in Sweden has increased during the last decade. There is a debate as to why this happens and how it should be managed.

Aim

To assess the scientific literature for explanations of the increased number of children and adolescents seeking for gender dysphoria and to make an inventory of the literature on management and long-term effects.

Method

The following questions were assessed.

Are there any scientific studies explaining the increase in numbers seeking for gender dysphoria?

Population: Children and adolescents with gender dysphoria up to 18 years of age.

Intervention: Not applicable.

Control: Not applicable.

Outcome: Studies on incidence and prevalence of gender dysphoria and pattern of self-referral or referral.

Are there any scientific studies on long-term effects of treatment for gender dysphoria?

Population: Persons with gender dysphoria.

Intervention: Treatment for gender dysphoria.

Control: Any.

Outcome: Studies reporting long-term effects such as mental health, suicide attempts, suicide, cardiovascular effects, cancer development, bone health and regrets.

What scientific papers on diagnosis and treatment of gender dysphoria has been published after the National Board of Health and Welfare in Sweden issued its national support for managing children and adolescents with gender dysphoria in 2015?

Population: Children and adolescents with gender dysphoria up to 18 years of age.

Intervention: Diagnosis and treatment for gender dysphoria.

Control: Any.

Outcome: Studies on diagnosis and treatment.

This review is limited to peer reviewed papers with primary data and systematic reviews following PRISMA-standards. Case studies, meeting abstracts and editorials were not included. Only studies written in English or Scandinavian languages were eligible.

A structured systematic literature search in the following databases CINAHL (EBSCO), Cochrane Library (Wiley), EMBASE (Embase.com), PsycINFO (EBSCO), PubMed (NLM), Scopus (Elsevier), SocINDEX (EBSCO). The searches were finalised September 19, 2019.

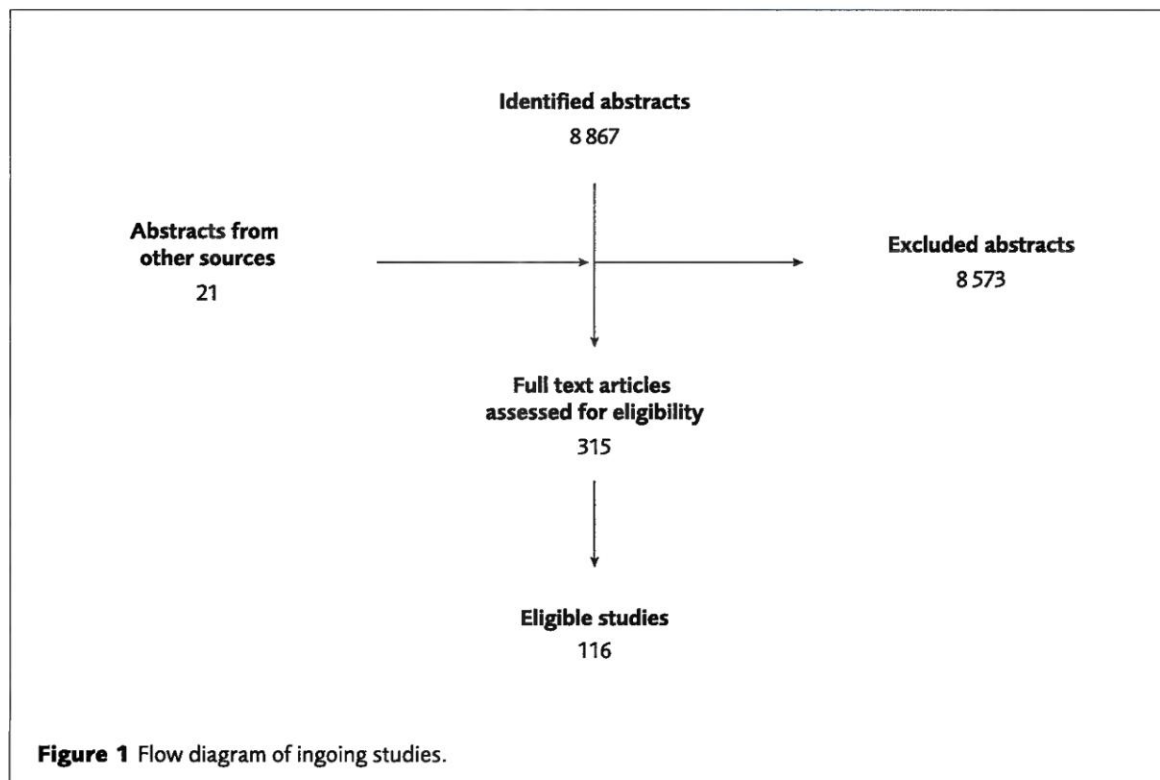
The studies were assessed for their relevance to the questions by two reviewers independently. Assessment of risk of bias, compilation of data or grading of evidence was not done.

Results/discussion

No studies explaining the increase of children and adolescents seeking for gender dysphoria were identified. The literature on management and long-term effects in children and adolescents is sparse, particularly regarding gender affirming surgery. All identified studies are observational, and few are controlled or followed-up over time. Much of the data in the literature are from the University Medical Centre in Amsterdam based on their management tradition. A large part of the literature that was considered relevant was published during 2018 and 2019.

Appendices

For search strategies, excluded articles, references and tables, see www.sbu.se/307e



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Patient representatives were not involved in the work.

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SBU Policy Support no 307, 2019

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Summary of a recommendation by COHERE 16.6.2020
Finland

Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation

In its meeting on 11 June 2020, the Council for Choices in Health Care in Finland (COHERE Finland) adopted a recommendation on medical treatment methods for dysphoria associated with variations in the gender identity of minors

The recommendation clarifies the roles of different healthcare operators in a situation where a minor is uncertain about their gender identity. The recommendation presents the medical treatment methods that fall within the range of public healthcare services when it comes to the medical treatment of gender dysphoria in minors.

In COHERE's view, psychosocial support should be provided in school and student healthcare and in primary healthcare for the treatment of gender dysphoria due to variations in gender identity in minors, and there must be sufficient competency to provide such support. Consultation with a child or youth psychiatrist and the necessary psychiatric treatment and psychotherapy should be arranged locally according to the level of treatment needed. If a child or young person experiencing gender-related anxiety has other simultaneous psychiatric symptoms requiring specialised medical care, treatment according to the nature and severity of the disorder must be arranged within the services of their own region, as no conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development.

In Finland, the diagnostics of gender identity variation, the assessment of the need for medical treatments and the planning of their implementation are centralised by law in the multi-professional research clinics of Helsinki University Central Hospital (HUS) and Tampere University Hospital (TAYS). The consultation, evaluation periods and treatments provided by the TAYS or HUS working group on the gender identity of minors shall be carried out in accordance with the following principles.

Children who have not started puberty and are experiencing persistent, severe anxiety related to gender conflict and/or identification as the other sex may be sent for a consultation visit to the research group on the gender identity of minors at TAYS or HUS. Any need for support beyond the consultation visit or need for other psychiatric treatment should be addressed by local services according to the nature and severity of the problem.

If a child is diagnosed prior to the onset of puberty with a persistent experience of identifying as the other sex and shows symptoms of gender-related anxiety, which increases in severity in puberty, the child can be guided at the onset of puberty to the research group on the gender identity of minors at TAYS or HUS for an assessment of the need for treatment to suppress puberty. Based on these assessments, puberty suppression treatment may be initiated on a case-by-case basis after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are present and there are no contraindications. Therapeutic amenorrhea, i.e. prevention of menstruation, is also medically possible.

A young person who has already undergone puberty can be sent to the research clinic on the gender identity of minors at TAYS or HUS for extensive gender identity studies if the variation in gender identity and related dysphoria do not reflect the temporary search for identity typical of the development stage of adolescence and do not subside once the young person has had the opportunity to reflect on their identity but rather their identity and personality development appear to be stable.



Summary of a recommendation by COHERE 16.6.2020
Finland

Based on thorough, case-by-case consideration, the initiation of hormonal interventions that alter sex characteristics may be considered before the person is 18 years of age only if it can be ascertained that their identity as the other sex is of a permanent nature and causes severe dysphoria. In addition, it must be confirmed that the young person is able to understand the significance of irreversible treatments and the benefits and disadvantages associated with lifelong hormone therapy, and that no contraindications are present.

If a young person experiencing gender-related anxiety has experienced or is simultaneously experiencing psychiatric symptoms requiring specialised medical care, a gender identity assessment may be considered if the need for it continues after the other psychiatric symptoms have ceased and adolescent development is progressing normally. In this case, a young person can be sent by the specialised youth psychiatric care in their region for an extensive gender identity study by the TAYS or HUS research group on the gender identity of minors, which will begin the diagnostic studies. Based on the results of the studies, the need for and timeliness of medically justified treatments will be assessed individually.

Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors. The initiation and monitoring of hormonal treatments must be centralised at the research clinics on gender identity at HUS and TAYS.

Research data on the treatment of dysphoria due to gender identity conflicts in minors is limited. COHERE considers that, moving forward, multi-professional clinics specialising in the diagnostics and treatment of gender identity conflicts at HUS and TAYS should collect extensive information on the diagnostic process and the effects of different treatment methods on the mental wellbeing, social capacity and quality of life of children and youth. There is also a need for more information on the disadvantages of procedures and on people who regret them.

Link to the COHERE website: <https://palveluvalikoima.fi/en/frontpage>

The Council for Choices in Health Care in Finland (COHERE Finland) works in conjunction with the Ministry of Social Affairs and Health, and its task is to issue recommendations on services that should be included in the range of public health services. Further information: www.palveluvalikoima.fi.



Clinical and Ethical Considerations in the Treatment of Gender Dysphoric Children and Adolescents: When Doing Less Is Helping More

David Schwartz, Ph.D.

ABSTRACT

Through an analysis of recently published treatment protocols, research findings and clinical experience, and guided by the principle of “first, do no harm,” the author argues that the use of pharmacological and surgical interventions in the treatment of gender dysphoric youth, especially in light of what is known about the transience of cross-gender identification in children, is mistaken both clinically and ethically. He further argues that psychotherapy, neglected by most of those advocating pharmacological and surgical interventions, is the best treatment option for these patients. The author elaborates some of the modifications of psychotherapeutic technique with both patients and their parents that he has found to be most effective with this population.

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David Schwartz, Ph.D. is a psychologist in private practice in Westchester. He received his Ph.D. in psychology from the City University of New York and holds a certificate in psychoanalysis from the Westchester Center for the Study of Psychoanalysis and Psychotherapy. Dr. Schwartz is on the editorial boards of *Psychoanalysis, Culture and Society* and *The Gay and Lesbian Journal of Mental Health*. He has written on the subjects of sexuality and gender for the past thirty years.

Originally presented at a scientific meeting of the Westchester Center for the Study of Psychoanalysis and Psychotherapy, November 21, 2020 and a version was presented at a meeting of the New York State Psychological Association on October 29, 2017.

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I imagine that it is safe to say that the frequency with which you will encounter the word “gender” or “gender identity” – colloquially, in mass media, in clinical literature – has dramatically increased of late. When that happens, when previously uncommonly used terms proliferate rapidly across disciplines and media, as “gender” and “gender identity” have, you can bet that misunderstandings of the terms will soon be fueling controversy about them. This is no surprise: the more widely and frequently any term is used, the more likely it is for the occurrence of errors, or for the recruitment of the term for unintended or inappropriate purposes. It’s like a giant game of telephone. So I want to introduce what I have to say about gender *dysphoria* today, by defining “gender identity.” I am hoping to start fresh, so to speak, with a sense of what gender *is*, apart from the ways it has become entangled in cultural developments and controversies. I think a clear understanding of what gender and gender identity *are*, may go some distance toward establishing a best clinical approach to it. And I am concerned that the spread of a particular misunderstanding about what gender identity is, may be having significant negative consequences for clinical practice.

So what is gender identity? This is from William Byne (2010), an expert in the field, chief editor of a journal that focuses on the health issues of minority communities, and an eminent researcher: “*Gender identity* refers to the persistent sense of belonging to a particular gender category. In the majority of cases, this reduces to one’s sense of belonging to the male gender category (comprising boys and men) or the female gender category (comprising girls and women). **It is a sense of belonging.**” In other words, *gender identity* is psychological, made up of expectations and self-perceptions. Gender does not exist in the body or in any bodily structure or process. This is in contrast to *sex*, which is determined exclusively by bodily data: genitals and chromosomes. Gender exists in the mind, happily or dysphorically. Gender identity, like many high level psychological phenomena such as attachment and affection, has no known specific, demarcated correlate in the nervous system. It is experienced by the individual and by observers of an individual, mentally, as a subjectivity. Gender is an opinion about oneself that others may learn by observation. To put it starkly: if a person is not moving, speaking or clothed, it is not possible to **know** its gender. But, if she *acts* like a female, which is to say, like our cultural notion of a female, her gender is female. The philosopher, Judith Butler (1990) has put this succinctly: gender is a performance. And I will add: a performance that signifies a psychological condition, an intrapsychic condition. My emphasis on the psychological nature of gender should not be taken to diminish the well-known power of gender to influence a person’s experience and behavior, as any state of mind can do. But I underline the psychological nature of gender because the recent use of physical interventions in response to gender *dysphoria* – hormones, surgery, alterations of secondary sex characteristics – may have subtly altered our sense of what gender is. Those physical procedures may or may not help a person’s unhappiness with their sex or their gender, but they do not directly affect their gender. They can’t, because as with any other aspect of identity, i.e. a person’s sense of him or her self, the person has ultimate power over it. This principle of the autonomy of identity, of the individual’s power over their own sense of themselves, applies to gender, and is fundamental to all psychotherapeutic work and human growth.

So I ask you to keep in mind the purely psychological nature of gender and gender identity. I think the importance of this axiom will become plainer later, after I acquaint you with my intellectual and clinical journey into the treatment of gender dysphoria. To that I now turn.

About nine years ago Jack Drescher, a psychiatrist and psychoanalyst, and William Byne, the neuroanatomist mentioned above, were editing a volume on the treatment protocols of various leading clinical groups around the world that were providing services to, trans and gender dysphoric kids. They wanted multi-disciplinary commentaries on these treatment protocols – from philosophy, anthropology and, among other disciplines, from psychoanalysis. They asked me to comment from the perspective of psychoanalysis, and since I have long been concerned with the ways that gender affects human psychology for better and for worse, and I believe deeply in the psychoanalytic approach to mental health treatment, I agreed. I read the protocols and as much as possible, using videos and other material on the internet, familiarized myself with what was going on in the community of children who identified as transgender or who complained of gender dysphoria. Coincidentally, I was treating an eighteen year-old young woman who identified as *trans*, in her words. I was disturbed, provoked and stimulated by all of the material – the protocols, all but one of which were enthusiastic about encouraging the use of hormones, puberty blockers and surgery to facilitate early transitioning of kids with gender trouble, the videos of the kids and their parents, which were intriguing and very ambiguous, (how to interpret filmed performances that were made to persuade and provoke) and sometimes by my patient. I wrote a paper which reflected how troubling I found most of the treatment protocols to be. I was disturbed by what seemed to be a rush to surgical and pharmacological interventions with children and adolescents. I also noticed that in most of these treatment protocols, psychological treatment, i.e. psychotherapy, was very much neglected. After much stimulating dialogue with the editors, my paper (Schwartz, 2012) was published in the anachronistically titled *Journal of Homosexuality*. So I looked forward to getting a free copy of the journal and thought that was the end of it. Who was going to read this, in the *Journal of Homosexuality*, of all places, I naively thought. I thought maybe some, trans activists would call to read me the riot act because I was critical of the use of cross-sex hormones and surgery. Was I ever wrong. Apparently my commentary was picked up by various blogs and I started getting phone calls and e-

mails from literally all over the country; but *not from, trans activists*. Instead the calls came principally from parents of kids with gender trouble, and from therapists. These calls repeated a similar story: my kid thinks she's a boy, or says she's thinks she's, trans and she read on the internet, or talked to a school counselor who told her yes, you're probably trans, and so for her birthday she wants help getting T (testosterone) and a double mastectomy. Or, Someone gave us your paper or told us about it. Can you help us? With great reluctance (back then treating adolescents was not a specialty for me) I started to see the kids who lived nearby and their parents, and for some kids farther away, I used electronic media. What I seemed to have discovered, I suppose unsurprisingly, was that the treatment protocols on which I had commented in my article, which touted the value of hormones and surgery, were what parents of, trans kids were being offered as *standard treatment* much of the time. Clinics and some individual therapists, were describing themselves as "gender specialists," performing assessments that varied widely, but could be quite brief, sometimes a single session, and then declaring that a given child was indeed "trans," and urging parents to accept this and cooperate with the administration of hormones and plan on surgery. The parents who called me exhibited varying degrees of desperation. Apparently there wasn't much out there to resonate with their understandable reluctance to sign on with these recommendations. (My own informal polling of colleagues tells me that the average therapist thinks of themselves as "not knowing much about this," and are inclined to pass such patients on in one way or another.) The parents were often being encouraged to feel guilty for regarding these clinical suggestions with antipathy and dread. Their anxieties were often dismissed as "transphobia." Frequently school psychologists and pediatricians were accepting a simple, but for parents, disturbing, narrative: if a kid says they're, trans and they are not obviously psychotic, "affirm" it and they'll probably need surgery and hormones. Tell the parents that they have to adjust. These parents were very upset, had no place to turn, but knew, from what I had written, that I might present an alternative.

For me, these calls were an opportunity to go beyond theory and have a direct window into the community of children and young adolescents with gender trouble and their parents – an opportunity to know some of them first-hand and to see how the ideas I'd written about played out in the lives of actual families. Actually put my money where my mouth had been. I was also struck by the terrible dilemma these parents were facing: they were being offered a prescription by putative experts for the welfare of their children that went against their deepest instincts. So that's how I began this – but before telling you how it then went, I want to outline my central purpose for today. It is to make a few narrow, clinical points. They are narrow, first, in the sense of having to do exclusively with treatment: I am deliberately side-stepping any theoretical and political issues that the question of transgender experience in children raises. (For examples, what causes, trans phenomena, is it wrong to think of transgendered aspirations as pathological, and is there a "right" to hormones and surgery for those who want them?) Second, I am speaking only of *children and adolescents*, people whom we do not regard as capable of making treatment decisions for themselves, whom we consider to be at risk of suffering the consequences of poor judgments, judgments about themselves and about the world. We are their stewards, not their mouthpieces. We protect them and help them to grow, quite apart from their opinions, though not in disregard of them. Nothing I say today is meant to apply to adults. Adults are free to struggle with gender as they see fit whether that be in a radical manipulation of their bodies or simply in what they say. They are responsible for the consequences of their chosen methods of struggle, and for that, we must respect them. And perhaps I need to add, on the question of struggling with gender: nothing I say today should be construed as favoring gender conformity in either children or adults. (Later, I will take a strong position against certain interventions that some see as embodying gender flexibility. It is the specific interventions with children, not the flexibility, that I oppose.) Children are not free; we adults are responsible for the consequences of the choices they are *allowed* and encouraged to make. This may seem obvious, but as my story unfolds, and you hear the subtle ways that some would alter the appropriate asymmetry between adult and child freedoms, you may agree that it needs re-stating.

A second sense in which my argument is narrow, is that its central clinical recommendation is offered in service to one apparently unambitious, but bedrock principle of all clinical practice: First, do no harm. I define "harm" as physical or mental damage, which I would elaborate slightly to include a diminishing of known functionality. A further word about the principle of "do no harm." We will apply it best if we grasp this principle in its depth. To me, what lies behind the cryptic aphorism of *do no harm*, is an implicit injunction in favor of the humility that the limits of our knowledge mandates. We must be wary of the possibility of doing harm precisely because often, and especially often when we administer chemical agents, we don't know the real consequences of what we are doing. Consider the possibility of harm, because chemicals can be powerful and without carefully controlled longitudinal studies, we really don't know what we are instigating. To do no harm, enter an area of ignorance at a sharply reduced speed, with your hands in your pockets and your eyes open. And to do no harm, be frank with yourself and with your patient, with respect to what you know and don't know, and what cannot be known.

So my narrow purpose today is to persuade you that in the treatment of children and adolescents, no matter what the diagnosis, encouraging mastectomy, ovariectomy, uterine extirpation, penile disablement, tracheal shave, the prescription of hormones which are out of line with the genetic make-up of the child, or puberty blockers, are all clinical practices which run an unacceptably high risk of doing harm. I want to briefly highlight the use of puberty blockers, which I include in my list of high-risk treatments. Puberty blockers are pharmacological agents given to children that interfere with the action of testosterone and estrogen so that the emergence of secondary sex characteristics that usually accompanies the onset of puberty does not happen. Virtually all of those who promote physical interventions for gender dysphoric children point to the use of puberty blockers as a safe way for an uncertain child to have time to consider whether they want to go ahead with more irreversible procedures. They describe puberty blockers as providing a respite from the stress of puberty and a pause. This is mistaken on two counts: First, we do not have certainty about the harmful effects of puberty blockers as we do have for cross-sex hormone administration, because we do not have good longitudinal data on their effects in general. But we do know that puberty blockers adversely affect bone density, can instigate excessive height and adversely affect fertility. (Mahfouda et al., 2017). It is false to say that we know them to be physiologically benign. And second, what about the psychological consequences of this maneuver? The claim of providing a respite, or pause, suggests that puberty suppression is a benign, non-prejudicial move in the life of a gender dysphoric child. It seems to me that this is extremely misleading. Consider: what is the implicit message we give a child when we offer puberty blockers? We are validating the idea that the advent of puberty is a fearsome thing that calls for a prophylactic *medical* intervention. That is the last message I want to send to a gender dysphoric child. Advocates of the use of blockers argue that for some gender dysphoric children the onset of puberty with its incontrovertible news as to the sex of the subject, is so traumatic that the child *needs* such an intervention. They are taking the subjective narrative of the dysphoric child literally, and feeding it back to the child as a medicalized truth, reifying it and likely exacerbating his or her preoccupation with gender. And what about the social situation of the child who has undergone puberty suppression? Here is a child, side-by-side with other children of his or her own age who are showing secondary sex traits and behaving sexually, while he or she is not. To my knowledge no one has studied the ramifications of this psycho-social situation, but to me it hardly reads as a respite, with its potential to magnify difference and stigma, albeit in a suppressed form.

Puberty is challenging for all children, and for the child with conflict about gender it may be especially challenging. But it is not *intrinsically* traumatic to any child and I want to communicate to the child that, as with all inexorable developmental phenomena, it is manageable: you can do it, I'll help. Encourage ego strength; don't amplify fantasized vulnerability and anxiety. The encouragement of puberty blockers as an alleged pause, is ultimately the encouragement of hormones and surgery, just not openly. In fact, the clinical articles in Drescher and Byne's volume (2013), assert that most adolescents

who undergo puberty suppression do tend to proceed to transition away from their natal sex (Stein, 2013), in contrast to the fact that the large majority of gender dysphoric children in general do not (Singh et al., 2021). It would seem that the use of puberty blockers promotes transition.

You have no doubt noticed that I have gone out of my way to name the procedures that hormonal and surgical transitioning entails. I do this deliberately to avoid the obfuscating euphemisms which tend to hamper a clear view of what we are talking about. I recently reviewed a research paper by a group employing these procedures wherein, unsatisfied with the term “sex re-assignment surgery,” (what they were literally doing) they insisted on calling their procedures “gender-affirming surgery.” Unsurprisingly their research report was as misleading and prejudicial as their terminology. The proliferation of euphemisms in this area is noteworthy: mastectomy is “top surgery.” However you may regard the value of these procedures in a cost/benefit analysis, there can be no disputing what they are: removing healthy tissue, disabling functional organs, impeding the development and operation of inborn neuro-chemical systems and by consequence, turning previously fertile individuals into sterile, post-surgical, chronically medicated ones.

Besides the obvious losses, costs and risks of these procedures, there are problems that are less immediately apparent and insufficiently emphasized in the literature of those who promote them: the surgeries are not uncomplicated. I am not aware of any tabulation of the frequency of serious complications, including fatalities; but I am aware of at least one documented fatality from my incomplete reading of the literature (de Vries et al., 2014). Testosterone is associated with significant acne (Braun et al., 2021; Thoreson et al., 2021; Turrión-Merino et al., 2015) and much more ominously, may exacerbate preexisting affective illness (Elboga & Sayiner, 2018) (a not uncommon condition in the relevant population), both of which I have observed clinically, sometimes with serious consequences; and estrogen administration to genetic males significantly increases their chances of getting breast cancer (de Blok et al., 2019).

What is the other side of this story? Or perhaps a better question would be, what should the other side of this story be? What clinical situation could offset the serious downside of surgery and drugs? Surely it could not be that these children simply *want* these procedures, that they find the *anticipated* results appealing. Children want all sorts of things from time to time that we deny them out of concern for their welfare and we endure their frustration and protests. It would have to be that the clinicians who recommend these procedures believe that some children *need* them. They would have to argue that without these procedures, these children are likely doomed to lives of unremitting misery, and that these procedures are known to be the only reliable and enduring antidote to that misery. And that is indeed what some clinicians claim. Implicitly, as evidenced by their recommendations, and explicitly.

Well, there is research that is pertinent to the validity of the first half of that claim. We have longitudinal studies of what happens to children who complain of gender dysphoria or experience themselves as having a cross-sex identification, and do not receive such interventions. There are five such papers. These are Green (1987), Drummond et al. (2008), Singh et al. (2010), Wallien and Cohen-Kettenis (2008), and Zucker (2008), and Singh et al. (2021).

Here is the conclusion of those studies: the great majority of the children, (80% is the summary figure usually given) simply stop having the complaint or making the identification by late adolescence, and a large proportion of *them* become gay and lesbian adults. This giving up of the transgender complaint has become known as “desisting” in the literature. Its frequency varies from study to study, but never sinks below a majority (from as much as 96% to as few as 50%). Let me clarify what “desisting” means. It does *not* mean that a gender non-conforming child starts to conform, that a little boy, for example, starts conforming to male gender norms that he had previously resisted. It does mean that children who previously insisted they were a different gender from what their parents saw at birth, no longer make that insistence. The little boy stops insisting that he is in fact a little girl, or that he cannot be happy unless something is done to make him one. It means that children who were previously so uncomfortable in their own skins, that they were willing to consider exotic medical procedures and drugs, were no longer so uncomfortable. Operationally, they stopped meeting criteria for GID or gender dysphoria. In simplest terms: they got better. Gender dysphoria in pre-adolescent children is a condition that ameliorates by itself *in most cases* if you are just patient. I have to tell you that when I read that finding I was taken by surprise, because it was mentioned so infrequently in what I was reading in most of the protocols. But what it said did not surprise me at all. Middle school children are among the most unreliable people on earth. They should be. They are going through the work of establishing identities, consolidating their values and struggling with burgeoning desiring systems while around them the world is judging, pressuring and tempting. Of late this pressuring that children in middle childhood endure, has intensified, due principally to the media revolution: it is arguable that the ten year old's of today have access to a wealth of unmodulated information unimaginable thirty years ago, and this has powerfully affected them, cognitively and emotionally. Are they thus in a better or worse position to make life-altering decisions about themselves? Their enhanced vocabularies and expanded knowledge bases can be impressive, but also misleading: I recently sat with a sixteen year old whose command of post-modern theory startled me, but whose life experience of course remained that of a child. Should he be permitted to make irreversible decisions about his reproductive possibilities, among other things? There is no easy answer, but to return to my point here, of course such a person is likely to change his mind about many things of which he was recently certain. What is surprising is that some adults could not foresee that these children's outlandish claims and self diagnoses would likely alter and adjust with time. But that many adults failed to anticipate this changeability also does not surprise those of us who have worked with transgender kids: the earnest emotionality with which these claims are made, sometimes accompanied by threats and dramatizations, especially in the hands of a very intelligent and/or creative child, will move even the most detached adults, not to mention the parents, to a state of very intense distress, possibly impairing their usual ability to anticipate. If only we could be patient. But more on that shortly. Certainly for *these* children, who will likely change their minds while still young, surgery and hormone administration cannot be justified.

But what about the others, those who will persist, who at the age of eighteen will continue to find the body and social expectations into which they were born intolerable? Should they not have been given a chance to avail themselves of surgery and hormones? To begin to answer that question permit me to offer the following anecdote. A few years ago I attended a presentation by a psychologist who is a prolific contributor to the transgender literature. Her work emphasizes what she sees as the particular value of listening to and validating young children's literal accounts of their experience of gender. At the end of her presentation, which stressed interventions that followed the lead of the child with respect to both medical and social gender transitioning, I pressed her on the question of how to modify those interventions in light of the fact that most gender dysphoric children are likely to have no significant gender trouble by late adolescence. She said you should only promote transition if that is where the child is headed. So I asked her how do we know “where the child is headed,” i.e. which children will desist and which will persist? Her reply was: “I know.” This bold but uninformative response highlights the very difficult truth of the matter. Neither she, nor we, know. There is no way to know. We do not have reliable correlates of future persistence when they would matter the most, i.e. early on (Singh et al., 2021). I believe this leaves us with my earlier injunction: First, do no harm.

But wait, just because we can't *know*, doesn't mean we can't think about it. And we should think about it. Right? We're clinicians. We are capable, and obliged to think of what variables might increase the likelihood of a child desisting. We want the child to desist, right? Well you would certainly think so. And that brings us to something very interesting and important: Remember what desisting is: the child becomes *comfortable* in his or her skin. The child stops insisting that he or she *is* really another gender, or that she or he cannot be happy unless she or he is in the body of another gender. The child is at relative peace with the body he or she has. By what logic could the child's acquisition of peace and comfort not be a desirable outcome? Perhaps if the desistance were an unreliable compliance with external pressure, a coerced submission. In this situation the acquisition of peace would be transient and

misleading. But if you have any direct familiarity with, trans kids, you know how unlikely that scenario is. In my experience, trans kids do not comply. Their insistence on self-definition is impressive. So I think we must conclude that desistance, when it happens, is desirable. And therefore, my view is that we should think of every, trans aspiring child as a potential desister. I believe this is more accurate than thinking that he or she will need surgery and/or hormones. This way of thinking would also have the effect of engendering more optimism and less panic in the parents of any given, trans child.

But here is the interesting and important part: I have noticed a disturbing pattern in the literature of the clinical groups that employ surgical and hormonal interventions. Desistance is touched on almost not at all. In a recent paper (Tishelman et al., 2015) by a group out of Boston Children's Hospital that calls itself "the gender multi-specialty service" their sole reference to desistance is as follows: in the context of noting the absence of evidence-based clinical precedent in the field of transgender health generally, they note that some other workers in the field have raised the question of "whether early intervention with gender variant youth can encourage desistance, and whether that [encouraging desistance] is an appropriate practice." I want to repeat that: they are asking *whether encouraging desistance is appropriate*. So their only reference to desistance is not to note its high frequency, nor to explore how it might be promoted, but rather to suggest that an intervention that encourages desistance might *not* be appropriate, that it may be somehow unethical. How can any clinician fail to encourage the desisting child? Why would they actively exclude it from their interventions? For certainly the child who is no longer preoccupied with the idea that his or her welfare depends on a non-medical surgery and the ingestion of hormones should be encouraged. He or she has overcome an inhibiting and unhappy preoccupation. In fact we clinicians should try to figure out the mechanism through which desistance happens and to promote it. Which may turn out to be less mysterious than initially thought. To that I will turn in a moment.

But first, an additional moment of thought on this erasure of one of the most significant and established data points in the whole transgender story, that most, trans kids will get over it. How can this be left out or minimized in the clinical protocols of those who proffer surgery and hormones? Well it is said that to someone with a hammer, everything looks like a nail, and perhaps to the physician who just bought a cat scan, everyone's brain needs examining. Is this a case of technology and a new "discipline" (gender medicine) driving theory and practice? I fear that it may well be. Certainly the less invasive, technology-free options are given very short shrift by these protocols including that of the Boston group, and without explanation. They certainly cannot say that psychotherapy won't work: they don't try it. The authors repeatedly make it clear that psychotherapy is offered as an adjunct to medical intervention, part of the effort to smooth the path of what they call medical treatment, never as a primary intervention. Indeed, they say that for the child close to puberty three to six months of psychotherapy prior to medical intervention (rather short-term) "*is recommended*," but (quoting them) that if the child feels a compelling sense of urgency, "*this can be modified*." They are saying that the child's increased sense of urgency means less need for psychotherapy. I think this is backwards. A child's sense of urgency is a symptom, not a mandate. That child's need for psychotherapy is *greater*, not less. The child's sense of urgency leads to a modification of the need for psychotherapy? Is the child dictating the treatment, or is it that psychotherapy is not seen as treatment at all, it is there to promote the real treatments, surgery and hormones? The authors' opinion is clear, if not clearly stated. Now in my perhaps overheated critique of those who are emphasizing hormones, puberty blockers and surgery, it may seem that I am defensively angry at those clinicians (That is what occurred to me when I read this over.) Well perhaps I am a bit. But here is my real point and perhaps the source of my anger: do not be intimidated into drinking the proffered kool-aid of "gender science." Psychotherapy has much to offer these children, as it does to all children, (gender dysphoric children are not "different") and it will certainly "do no harm."

And now, to create the right mind-set for my discussion of psychotherapy, permit me to suggest a useful thought experiment: what if there were no hormones or surgery? After all, not too long ago this was in fact the case. What would the clinical situation for gender dysphoric children look like then? I am trying to bring your consciousness to a heightened awareness of the likely role of technology that is in play here, so that you can entertain the following speculation: Is it possible that the extraordinary increase in the frequency of youngsters feeling that they are in the wrong body, may have been fostered by the spreading awareness that technologies for changing bodies exists? Is it possible that the internet disseminated knowledge that there is a scientifically validated path to bodily metamorphosis, has encouraged some young people to claim that path, which they might not have even imagined otherwise? I am not suggesting that *all* gender dysphoria is simply the product of an internet contagion. But we are seeing a veritable explosion of cases, for which we really have no explanation. And so what I *will* insist on as you hear my approach to psychotherapy with these youngsters, is that we appreciate the role of contemporary culture in the dynamics of their psychology and their lives and consider how that culture may be distorting their self-narrations. These children and adolescents, perhaps more than any generation before them, because of the information revolution, are deeply enmeshed in the changing tropes of our culture. To reach them we must keep that fact and the contemporary content of our culture at the forefront of *our* consciousness.

So, I am recommending psychotherapy, a decidedly low-tech treatment option. How can we clinicians help children to become comfortable in their own skin, children, who, one way or another have become preoccupied with something wrong with their bodies and with their place in the gendered world. I confronted this clinical problem under significant pressure: parents, urgently wanted to know what to do with very distressed children, and were themselves under intense cultural pressure and inner pressure concerning the welfare of their children, while their children were depressed and anxious, and under myriad pressures themselves. All of these would in some way be my patients. Years of psychoanalytic supervision told me I was in a dangerous countertransference situation, the kind of interpersonal situation where the temptation to give answers, to imagine a quick fix, was terribly alive. Help them (as you wrote about, as they are expecting) or you are a failure, my thinly veiled superego said to me. At clinical moments like that, experience has taught me not to fear depth, but rather to assume a depth approach is what is needed, and that it is the surface that will distract. So I turned to two bodies of depth theory for guidance: social constructivism and psychoanalytic theory. Social constructivist theory (offered by the philosopher, Judith Butler, in particular, but also by various feminist psychoanalytic writers) tells us that gender is a social psychological construction, a soft assembly, a useful fiction, in the words of one writer (Goldner, 1991). Gender is a performance that must vary with the dynamics of the individual and the cultural situation in which a person is transiently located. The *experience* of gender emerges out of a dynamically learned performance, is structured by the actions and consequences of the performance, and the performance in turn reacts to the created gender experience, in a continuous balletic feedback loop. The real boy and the real girl do not exist, they are ideals: but children (as well as the rest of us) live alternately tormented and rewarded by the shadows of these inflated imagoes, the genders.

Psychoanalytic theory tells us that manifest symptomatology conceals an unspoken story, the true outlines of which are only hinted at, or symbolized by the story the patient at *first* tells – the old iceberg problem. To discover the real story and the conflict it may represent, the psychotherapist must make a relationship with the patient, a relationship in which the patient is encouraged to play freely, but mindfully, and the therapist adopts a stance of maximal attention and empathy. The ship will be steered by the patient while the therapist will describe what he or she sees on the journey in a spirit of such complete acceptance and appreciation that the patient feels safe enough to reveal the story that holds the keys to greater freedom, the unconscious story.

These two theoretical frameworks – social constructivism and psychoanalysis – mate well with each other; and here is how I put them together to evolve a *psychological* treatment. I began by recognizing that the preoccupation with gender that these children and their parents were manifesting was only that, a preoccupation, and often, an obsessional preoccupation, which means that the patient felt compelled to return to it, anticipating intense anxiety if he or she didn't, unconsciously anticipating relief when they did. Gender, an ideational configuration only, was being centralized and reified (with cultural

cooperation) to function as a defense against other, unspoken fears. This means that in each case the preoccupation with gender conceals something different, something idiosyncratic. **There is no common underlying meaning to gender dysphoria.** The therapeutic move I had to make was to open a space of relatedness outside of gender. In my interactions with patients I would never bring gender up, nor would I talk about it more than absolutely necessary. If the patient wanted to talk about gender I would welcome it, listen and respond enough so I didn't seem to be evasive, but spend very little time with it in my own mind, thinking all the while of what might really be going on for that patient. In addition I actually made an effort to experience the patient as having no gender, which I guess really meant trying to effect a kind of gender neutralizing in the way I paid attention. This is, of course, impossible, but turns out to be an excellent way of paying better attention to the aspects of a, trans child that he or she is neglecting in his or her hypercathexis of gender: intelligence, creativity, unspoken emotions, friendships. I became deeply involved with all the details of each child's interests – TV shows, movies, songs, other kids, etc. Interestingly, the unanticipated material that has come up has at times been marked by a high frequency of body preoccupations: a young woman is distressed at the feeling of her breasts tugged by gravity when she lies on her side; another is disturbed by the feel of her thighs touching one another while walking; a young woman hates her vagina and feels the face she sees in the mirror does not belong to her. My speculation about the role of obsessiveness is receiving confirmation: I am repeatedly seeing significant obsessive-compulsive symptoms in these patients, e.g., needing to sit perfectly centered on a couch. Parenthetically, it is my impression that greater than once weekly frequency of sessions has been helpful in solidifying my empathic connection to these patients. And I would add the importance of never imposing my conversational agenda on the session. The patient says she doesn't want to talk about difficult things today. I say fine, or more likely, I joke about it. My emphasis is not interpretation, though dynamic meanings are always on my mind – e.g., I am acutely aware that this girl experiences her mother as needing her to be a girl. But rather I emphasize relating, connecting, showing that I don't need her to be anything. Her every new move makes me happy, which I do not conceal.

To the parents, with whom I meet when they feel the need, and which I always encourage, I gave the emphatic advice to give intense and plentiful attention to their child, but not speak about gender at all. Listen to whatever your child has to say on the subject if they bring it up, be interested, but make no contribution of your own and never initiate it. (I am telling them to be like me.) They have found this surprisingly hard to do. I was somewhat surprised to learn how preoccupied with gender some of these parents were – wanting to bombard their children with e-mails about the negative effects of surgery and hormones, among other things. I would receive late night phone calls begging my permission to send such destructive missives. On the question of pronouns and names, my advice was to avoid them as much as possible. There is rarely a need for the noun of address when the child is in the room, and artful dodging can elide gendered pronouns more often than you think. I do not favor explicitly agreeing to a, trans child's requests to modify language and naming. Such agreements are usually infested with dishonesty – parents have not really agreed to a name or gender change, they are just succumbing to pressure – and the unconscious meanings behind the linguistic surrender are very hard to disentangle. Punting and honesty are usually better.

In presentations of this sort, where I specifically and strongly argue against a current, controversial practice, I am reluctant to offer much in the way of clinical examples: it is too easy to re-call and shape examples to support a given cherished imperative. But shared experience can be valuable, and I have been struck by some patterns that have emerged in my almost ten years of experience with transgendered and gender dysphoric youth. So here are some observations, not in any particular order:

A very high proportion of the gender troubled youth with whom I have worked are in families where there is some issue of immigration or national identity. In almost every case at least one parent was born outside the US and speaks accented English. Moreover, the significance of ethnic identity figures in the family psychology: the way experience in the country of origin has distorted the orientation of the non-American parent or parents, is a theme, though not necessarily a source of devaluing. I engage with issues of ethnicity with great eagerness.

The theme of the uncertainty of future life has emerged prominently for many of these kids. They tend to be acutely aware of the troubled condition of our planet and our nation. In some cases this is associated with a denial of the future, the child who lives obsessively in the present and will not plan, the obsessive video gamer, for example; in other cases a depressive, but not unproductive emphasis on the deprivations and injustices that youth in particular, are likely to suffer in our troubled world and nation, is pre-occupying. These are politicized kids, educated through the internet and deeply engaged with the social questions of our time. Now it is certainly true that this sort of anxiety is present for many adolescents, not just for those who are gender dysphoric. But I believe that what I am observing is that often the, trans experience functions, in part for some kids, as a personalization of their perception of the political situation. It makes their participation as political actors more real, urgent and validated. Once again, I jump into discussing politics with both feet, sharing my views and eagerly asking for the details of their thinking.

A final clinical note: The complaint of gender dysphoria, and the claim of transgender identity, are vivid, graphic and captivating. Because of this, they (the complaint and the claim) can function to conceal what might otherwise be obvious. Parents and clinicians alike can be distracted and misled when they are present. So: In a significant number of cases where young people were brought to me with gender as the only designated problem, other, more serious psychiatric conditions were present and not mentioned by any of the parties involved – previous clinicians, school officials, parents or the child in question. I do not have to tell you how calamitous the consequences of ignoring an incipient schizophrenia or affective disorder can be. I have seen both tragic errors, including a case where a young woman succeeded in persuading a surgeon to perform a mastectomy while she was in a manic state, and a case where a fatally suicidal youth persuaded a divorced parent that he would be alright so long as his chosen gender was affirmed. Much has been made of the frequency of suicidality among transgender youth as part of an effort to advance nondiscriminatory practices, an obviously valid concern, but also as part of efforts to justify surgical and hormonal transitioning. The argument in the latter case is that transgender individuals may be driven to suicide if they are denied these options. This is an especially pernicious and dangerous line of reasoning. If I am right in my observation that a fair amount of severe psychopathology may be hidden behind a presentation of gender trouble, that might explain some of the increased suicidality seen in transgender youth. The solution is not to therefore hasten the provision of surgery and hormones, but rather to examine gender dysphoric youth more carefully for the psychopathologies that are known correlates of suicide: schizophrenia and affective illness. I offer this last note in part because of how deeply shaken I was by the two examples I referenced: terrible outcomes that I could not help but imagine could have been averted; but also because of how frequently I am encountering clinicians, who, confronted with a transgendered or gender dysphoric child and their freaked out family, start to doubt themselves, lose track of their established tools of empathic, psychodynamically informed listening and reasoning, and imagine themselves to be in *terra incognita* where the usual rules of safety and value no longer apply and extraordinary measures must be taken. I am here to tell you that the psychotherapeutic relationship is still the safest and best of methods even with these seemingly unusual children. The times indeed are a'changin.' But humans, not so much.

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References

- Braun, H., Zhang, Q., Getahun, D., Silverberg, M., Tangpricha, V., Goodman, M., & Yeung, H. (2021). Moderate-to-severe acne and mental health symptoms in transmasculine persons who have received testosterone. *JAMA Dermatology*, 157(3), 344–346. Crossref. PubMed. ISI.

- Butler, J. (1990). *Gender trouble*. Routledge.
- Byne, W. (2010). The sexed and gendered brain. In M. J. Legato (Ed.), *Gender specific medicine* (pp. 101–112). Academic Press. [Crossref](#).
- de Blok, C., Wiepjes, C. M., Nota, N. M., van Engelen, K., Adank, M. A., Dreijerink, K. M. A., Barbé, E., Konings, I. R. M. H., & den Heijer, M. (2019). Breast cancer risk in transgender people receiving hormone treatment: Nationwide cohort study in the Netherlands. *British Medical Journal*, 365, 11652.
- de Vries, A., McGuire, J. K., Steensma, T. D., Wagenaar, E., Doreleijers, T., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender re-assignment. *Pediatrics*, 134(4), 696–704. [Crossref](#). [PubMed](#). [ISI](#).
- Drescher, J., & Byne, W. (Eds.). (2013). *Treating transgender children and adolescents: An interdisciplinary discussion*. Routledge.
- Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, 44(1), 34–45. [Crossref](#). [PubMed](#). [ISI](#).
- Elboga, G., & Sayiner, Z. A. (2018). Rare cause of manic period trigger in bipolar mood disorder: testosterone replacement. *British Medical Journal Case Reports*.
- Goldner, V. (1991). Toward a critical relational theory of gender. *Psychoanalytic Dialogues*, 1(3), 249–272. [Crossref](#).
- Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. Yale University Press. [Crossref](#).
- Mahfouda, S., Moore, J. K., Siafarikas, A., Zepf, F. D., & Lin, A. (2017). Puberty suppression in transgen-der children and adolescents. *The Lancet Diabetes & Endocrinology*, 5(10), 816–826. [Crossref](#). [PubMed](#). [ISI](#).
- Schwartz, D. (2012). Listening to children imagining gender: Observing the inflation of an idea. *The Journal of Homosexuality*, 59(3), 460–479. [Crossref](#). [PubMed](#). [ISI](#).
- Singh, D., Bradley, S. J., & Zucker, K. J. (2010, June). *A follow-up study of boys with gender identity disorder* [Poster presented]. The University of Lethbridge Workshop, The Puzzle of Sexual Orientation: What Is It and How Does It Work?, Lethbridge, Alberta, Canada.
- Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry*, 12, 287. [Crossref](#). [ISI](#).
- Stein, E. (2013). Commentary on the treatment of gender variant and gender dysphoric children and adolescents: Common themes and ethical reflections. In J. Drescher, and W. Byne (Eds.), *Treating transgender children and adolescents: An interdisciplinary discussion* (pp. 186–206). Routledge.
- Thoreson, N., Park, J. A., Grasso, C., Potter, J., King, D. S., Marc, L. G., Changu, S., Peebles, J. K., & Dommasch, E. D. (2021). Incidence and factors associated with acne among transgender patients receiving masculinizing hormone therapy. *JAMA Dermatology*, 157(3), 290–295. [Crossref](#). [PubMed](#). [ISI](#).
- Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel, F. H., Shumer, D., & Spack, N. P. (2015). Serving transgender youth: Challenges, dilemmas and clinical examples. *Professional Psychology, Research and Practice*, 46(1), 37–45. [Crossref](#). [PubMed](#). [ISI](#).
- Turrion-Merino, L., Urech-García-de-la-Vega, M., Miguel-Gomez, L., Harto-Castaño, A., & Jaen-olaso Lo, P. (2015). Severe acne in female-to-male transgender patients. *JAMA Dermatology*, 151(11), 1260–1261. [Crossref](#). [PubMed](#). [ISI](#).
- Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(12), 1413–1423. [Crossref](#). [PubMed](#). [ISI](#).
- Zucker, K. J. (2008). On the "natural history" of gender identity disorder in children [Editorial]. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(12), 1361–1363. [Crossref](#). [PubMed](#). [ISI](#).



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DISORDERS OF SEX DEVELOPMENT

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Abstract

Normal sex development depends on the precise spatio-temporal sequence and coordination of mutually antagonistic activating and repressing factors. These factors regulate the commitment of the unipotential gonad into the binary pathways governing normal sex development. Typically, the presence of the SRY gene on the Y chromosome triggers the cascade of molecular events leading to male sex development. Disorders of sex development comprise a heterogeneous group of congenital conditions associated with atypical development of internal and external genitalia. These disorders are generally attributed to deviations from the typical progression of sex development. Disorders of sex development can be classified into several categories including chromosomal, gonadal, and anatomic abnormalities. Genetic tools such as microarray analyses and next-generation sequencing techniques have identified novel genetic variants among patients with DSD. Most importantly, patient management needs to be individualized especially for decisions related to sex of rearing, surgical interventions, hormone treatment, and potential for fertility preservation.

Keywords

Disorders of sex development; Ambiguous genitalia; congenital adrenal hyperplasia; urogenital anomalies

INTRODUCTION

Disorders of sexual development (DSD) encompass a group of congenital conditions associated with atypical development of internal and external genital structures. These conditions can be associated with variations in genes, developmental programming, and hormones. Affected individuals may be recognized at birth due to ambiguity of the external genitalia. Others may present later with postnatal virilization, delayed/absent puberty, or infertility. The estimated frequency of genital ambiguity is reported to be in the range of

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CONFLICT OF INTEREST: NONE

1:2000-1:4500 [1]. According to the Danish Cytogenetic Central Registry, the prevalence of XY females is 6.4 per 100,000 live born females. In this registry, the prevalence of androgen insensitivity was 4.1 per 100,000 live born with median age at diagnosis of 7.5 years. The prevalence of XY gonadal dysgenesis was 1.5 per 100,000 live born females with median age at diagnosis of 17 years [2]. The incidence of DSD varies among ethnic groups with the highest incidence in the southern African population.

International stakeholders representing multiple disciplines continue to modify the terminology used to categorize specific DSDs to emphasize the underlying genetic etiologies [3]. Ongoing development and use of novel molecular cytogenetic techniques have enriched understanding regarding the genomic alterations associated with DSDs. In addition, analyses regarding these genomic alterations have illuminated novel genetic regulatory mechanisms associated with DSDs [4].

When presented with a child with ambiguous genitalia, unique decision-making challenges can occur regarding sex of rearing, parent and patient education, and medical management [5]. It is important to note that sex does not indicate gender; sex refers to the biology of the internal and external genital structures that is traditionally considered to be a binary categorization. Gender identity is the self-defined experience of one's gender. Tales from Greco-Roman cultures, e.g. Hermaphrodite and Daphne, have documented and celebrated transformations and fluidity in sex and gender identity [5].

EMBRYOLOGY

Sexually dimorphic development of the reproductive tracts is influenced by multiple factors. Normal sex development is dependent on the synergistic orchestration of activating and repressing factors interacting in a precise spatio-temporal pattern [6]. Sex determination is governed by the sex chromosomes. The Sex Determining Region on the Y chromosome (SRY) gene located on the short arm of the Y chromosome is the binary switch that initiates the male developmental program [7]. The pivotal experiments performed by Dr. Alfred Jost established the relevance of testosterone for male sexual differentiation [8].

The urogenital ridges develop by 4-6 weeks of gestation as outgrowths of the coelomic epithelium. Subsequently, the urogenital ridges develop into the kidneys, adrenal cortices, gonads, and reproductive tracts. SRY functions as a transcription factor to trigger the developmental trajectory that directs differentiation of the bipotential gonad into a testis during the 6th week of human gestation. SRY induces SOX9 expression; SOX9 activates and maintains the male gonadal differentiation pathway. With differentiation of the Sertoli cells, the developing testis becomes organized into two compartments. One compartment consists of the testis cords that are aggregates of the germ cells surrounded by Sertoli cells and encased by the peritubular myoid cells. The other compartment is the testis interstitium, which contains the Leydig cells and testis vasculature.

Initially, both Wolffian and Müllerian ducts develop. The Wolffian ducts originate as the excretory ducts of the mesonephros. Testosterone, secreted by the fetal Leydig cells, stabilizes the Wolffian ducts resulting in the development of the epididymis, vas deferens,

ejaculatory duct, and seminal vesicle. Another hormone secreted by the testis, insulin-like factor 3 (INSL3), mediates testicular descent from the original perinephric location through the abdomen. Testosterone promotes testicular descent into the scrotum. Testicular descent is generally completed by 32 weeks' gestation. Sertoli cells secrete Anti-Müllerian Hormone (AMH), which induces regression of the Müllerian ducts.

Ovarian differentiation occurs slightly later than testicular differentiation. In the absence of SRY in the female fetus, the ovary specific transcription factors, Forkhead transcription factor 2 (FOXL2), Wingless type MMTV integration site family, member 4 (WNT4), R-spondin 1 (RSPO1), and the activated β -catenin pathway, initiate and maintain ovarian differentiation [9]. In the absence of testosterone and dihydrotestosterone (DHT), the external genital structures develop into the clitoris, vagina, and labia. Both the urethra and the vagina open onto the perineum.

In peripheral target tissues, testosterone is converted to DHT. DHT promotes fusion of the urethral folds to form the corpus spongiosum and penile urethra. DHT also promotes development of the genital tubercle into the corpora cavernosa of the penis and fusion of the labioscrotal folds to form the scrotum.

Primordial germ cells migrate from the allantois to the fetal gonads. Differentiation of germ cells to a spermatogenic or an oogenic fate does not depend on their XY or XX karyotype. Rather, the neighboring somatic cells in the gonads influence germ cell differentiation. In the female embryo, germ cells are exposed to high levels of retinoic acid which induce the expression of STRA8 leading to germ cell meiosis and development of oocytes. In the developing testis, the absence of retinoic acid causes the germ cells to develop into gonocytes that differentiate into spermatogonia and proliferate by mitosis; meiosis only starts at puberty in the male gonad.

GENETICS OF SEX DIFFERENTIATION AND DEVELOPMENT

Sex development is achieved by the precise synergistic temporal-spatial expression of numerous activating and repressing factors. Deviations from this established developmental sequence can result in disorders of sex development. Investigations into the molecular basis of DSDs in patients have elucidated many genes and genetic regulatory mechanisms involved in this process. Gene expression reflects tissue specificity, programming, and relative dosages to influence cell fate decisions.

Genes involved in the initial differentiation of the bipotential gonad include empty spiracles homeobox2 (EMX2), chromobox homolog2 (CBX2), Wilms' tumor 1 (WT1), steroidogenic factor 1(NR5A1), LIM homeobox factor 9 (LHX9), sine oculis-related homeobox 1/4 (SIX 1/4), and GATA binding protein 4 (GATA4) [10]. Subsequently, cell fate decisions influence the differentiation of the bipotential genital ridge towards male or female phenotype. This process involves a complex regulatory network in which activation of one pathway, i.e., testicular, leads to repression of the other pathway, ovarian, and vice versa [11].

In the developing testis, SRY promotes SOX9 expression. In conjunction with SRY and NR5A1, SOX9 generates a positive feedback loop for maintaining its expression and to

promote Sertoli cell development. Two paracrine signaling molecules downstream of SOX9, fibroblast growth factor 9 (FGF9) and prostaglandin D2 synthase (PGD2) promote maintenance of testicular development [12]. FGF9 signals from the central region of the gonad to promote SOX9 expression and antagonize WNT4 signaling. Other genes relevant for testicular differentiation include CITED4 and other members of the *SOX* family, i.e. SOX3, SOX10, and SOX13 [13].

Rather than being the “default pathway”, differentiation of the ovary is an active process dependent on the activity of specific factors. WNT4 suppresses SOX9 expression in the pre-granulosa cell of the developing ovary. WNT4 and RSPO1 stabilize β -catenin expression. FOXL2 is another ovarian transcription factor and nuclear protein crucial for differentiation and maintenance of ovarian differentiation [14]. The proteins, WNT4 and RSPO1, promote β -catenin accumulation in the nucleus where it interacts with LEF1 to promote transcription of other genes. FOXL2 and β -catenin also repress SOX9 expression. The WNT4 pathway upregulates follistatin, which inhibits activin B and prevents formation of the testis-specific vasculature [15]. Recent data derived from mouse studies suggest that the orphan nuclear receptor, chicken ovalbumin upstream promoter transcription factor II (COUP-TFII) may play an active role in eliminating the Wolffian ducts in females [16].

CLASSIFICATION OF DSD

DSDs are classified into several categories (Table 1). The category of 46,XX DSD includes virilized females such as girls with a virilizing congenital adrenal hyperplasia and girls with aberrant ovarian development. The category of 46,XY DSD patients includes patients with abnormal testicular differentiation, defects in testosterone biosynthesis, and impaired testosterone action. Sex chromosome DSDs include Turner Syndrome, Klinefelter Syndrome, and 45,X/46,XY gonadal dysgenesis. In general, patients with Turner Syndrome and Klinefelter Syndrome do not present with genital ambiguity. Other DSDs include XX sex reversal, XY sex reversal, and ovotesticular disorder.

A. XX, DSD

The most common form of virilizing congenital adrenal hyperplasia is 21-hydroxylase deficiency due to mutations in the 21-hydroxylase (CYP21A2) gene. Infant girls with classic salt-losing 21-hydroxylase deficiency usually present in the immediate neonatal period due to genital ambiguity. For affected female infants, virilization of the external genitalia ranges from clitoromegaly to perineal hypospadias with chordee to complete fusion of labiourethral and labioscrotal folds. The magnitude of external genital virilization may be so extensive that affected female infants appear to be males with bilateral undescended testes [17]. Unless identified by neonatal screening, infant boys with congenital adrenal hyperplasia typically present at 2 to 3 weeks of age with failure to thrive, poor feeding, lethargy, dehydration, hypotension, hyponatremia, hyperkalemia, and normal male sexual development. Hyperpigmentation of the scrotum may be apparent. When the diagnosis is delayed or missed, congenital adrenal hyperplasia is potentially fatal. Newborn screening programs decrease the morbidity and mortality associated with acute adrenal insufficiency or with assignment of affected female infants to male sex of rearing [18].

Other disorders of steroidogenesis associated with 46,XX DSD include 11-beta hydroxylase deficiency, 3-beta hydroxysteroid dehydrogenase deficiency, P450 oxidoreductase deficiency, and aromatase deficiency due to mutations in CYP11B1, HSD3B2, POR, and CYP19A1, respectively. Paradoxically, male infants with HSD3B2 and POR mutations may present with undervirilization due to impaired testosterone biosynthesis [19]. Maternal hyperandrogenism during gestation can be due to luteomas of pregnancy, androgen secreting tumors, and exposure to exogenous androgen.

Loss of function mutations in the genes coding for ovarian factors are associated with ovarian dysgenesis and/or accelerated loss of primordial follicles resulting in premature ovarian failure. After birth, WNT4 is detected in oocytes and granulosa cells [20]. SERKAL syndrome is characterized by female to male sex reversal associated with renal, adrenal, and lung dysgenesis; this disorder is associated with a homozygous recessive missense mutation in WNT4 [21]. Mutations in FOXL2 are associated with blepharophimosis-ptosis-epicanthis inversus syndrome that can be associated with premature ovarian failure (BPES I). Continued FOXL2 expression in the ovary is essential to maintain an ovarian phenotype because loss of FOXL2 expression in adult mice reprograms granulosa and theca cells into cells that are similar to Sertoli and Leydig cells, respectively [22]. Other genes associated with ovarian dysgenesis and premature ovarian failure include LHX8, MCM8, MCM9, NOBOX, and FSHR [23,24,25].

B. XY, DSD

This category includes patients with abnormal testicular differentiation, defects in testosterone biosynthesis, and impaired testosterone action. The phenotype may be limited to aberrant testicular differentiation or may include other anomalies. Loss of function SOX9 mutations are typically associated with gonadal dysgenesis and campomelic dysplasia. Mutations in GATA4 may also be associated with congenital heart disease in addition to testicular anomalies. Patients with Smith-Lemli-Opitz associated with 7-dehydrocholesterol reductase (DHCR7) mutations typically manifest characteristic facial features, and syndactyly of the second and third toes. Several phenotypes have been described for patients with WT1 mutations including Denys-Drash, Frasier, Meacham, and WAGR syndromes. Other genes associated with XY gonadal dysgenesis include CBX2, DHH, DMRT1, DMRT2, MAP3K1, and SOX8 [26]. In XY individuals, MAP3K1 mutations appear to shift signaling pathways to suppress SOX9 and promote ovarian differentiation [27].

Mutations in the proteins necessary for testosterone biosynthesis are associated with undervirilization. The genes encoding these proteins include SF1 (NR5A1), LH receptor (LHR), steroidogenic acute regulatory peptide (StAR), cholesterol desmolase (CYP11A1), 17 α -hydroxylase/17,20-lyase (CYP17A1), 3 β -hydroxysteroid dehydrogenase type 2 (HSD3B2), 17 β -hydroxysteroid dehydrogenase type 3 (HSD17B3), 3 α -hydroxysteroid dehydrogenase (AKR1C2/4), P450-oxidoreductase (POR), and 5 α -reductase type 2 (SRD5A2) [28,29,30].

Mutations in the androgen receptor gene (AR/NR3C4), which is located on the long arm of the X chromosome at Xq12, interfere with testosterone signaling [31]. The phenotype of patients with AR/NR3C4 mutations ranges from normal female external genitalia, labial

masses, and absence of a uterus to partial forms that may present with male infertility in adulthood.

C. Sex chromosome DSD

Turner syndrome describes the phenotype of patients with aneuploidy or structural rearrangements of the X chromosomes. Structural rearrangements include isochromosome Xq, partial deletions, and ring X chromosome. The reported incidence is 1 in 2500 live-born female birth [32]. Patients with Turner syndrome may be diagnosed in the neonatal period due to low birth weight, short neck, and lymphedema of hands and feet. Other typical presentations include short stature and delayed puberty. Characteristic features include epicanthal folds, downslanting palpebral fissures, low set ears, micrognathia, left-sided cardiac anomalies, and horseshoe kidneys. The cardiac anomalies include coarctation of the aorta, bicuspid aortic valve, and aortic stenosis. Girls suspected of having Turner syndrome should have a standard 20-cell karyotype. If mosaicism for Turner syndrome is suspected, FISH can be performed, additional metaphases can be counted, or a second tissue can be analyzed. Genetic analysis that detects Y chromosomal material warrants further evaluation because these girls may develop virilization and have an increased risk for gonadoblastoma and dysgerminoma. Girls with Turner syndrome have an increased risk to develop other disorders such as Hashimoto's thyroiditis, celiac disease, neurosensory hearing loss, hypertension, and diabetes mellitus. Approximately 50% of girls have congenital heart disease including coarctation of the aorta, bicuspid aortic valve, and increased risk for aortic dissection. The likelihood for development of these co-morbidities is greatest in the girls with 45,X karyotype [33]. Growth hormone therapy improves final height. Estrogen and progesterone hormone therapy are essential to promote development of secondary sexual characteristics and prevent osteopenia [34]. A large series of British women with Turner Syndrome reported a decreased incidence of breast cancer, but an increased risk for gonadoblastoma, corpus uteri cancer, and possibly childhood brain cancers [35].

Klinefelter syndrome is characterized by 47,XXY karyotype. The incidence is approximately 1 in 500 males. Affected boys have normal external genital development. They may present with tall stature, small testes, delayed puberty, infertility, and gynecomastia. Boys with Klinefelter syndrome often manifest dyslexia, behavior difficulties, and defects in executive function [36]. Autism spectrum disorders are more common among boys with Klinefelter syndrome than the general population [37].

D. XX, Sex Reversal, Ovotesticular Disorder, and XY, Sex Reversal Disorder

Patients with XX sex reversal can be classified into two major groups. One group (SRY+) is positive for SRY due to the translocation of the SRY gene to another location, which is usually the X chromosome or, rarely, an autosome. The other group consists of SRY negative XX (SRY-) males.

Ovotesticular disorder is defined by the presence of both ovarian follicles and seminiferous tubules in the same patient. The specific phenotype depends on relative gene expression patterns and the function of the gonads particularly related to hormone secretion. Gonadal histology can include ovarian, testicular, ovotesticular, and dysgenetic patterns. Potential

mechanisms responsible for ovotesticular disorder in the XX (SRY⁻) individual could involve activation of testis specifying genes in the absence of SRY and/or inadequate expression of pro-ovary/anti-testis genes. Duplications involving the SOX9 locus or potential SOX9 regulatory elements have been associated with XX testicular and XX ovotesticular DSD [13]. Genes associated with ovotesticular DSD include NR5A1, SOX3, SOX10, WNT4, and RSPO1 [38]. Considerations regarding sex assignment in the XX patient with ovotesticular disorder are similar to other patients with DSD with the caveat that sufficient ovarian tissue with follicles may be present to allow for pregnancy.

Duplication of a region on the Xp21.2 region of the X chromosome containing the DAX1 gene is associated with XY sex reversal. Deletion of this region in an XY individual is associated with congenital adrenal hypoplasia. However, a microdeletion of this region was associated with XX sex reversal underlining the genetic complexity of this locus [39].

Persistent Müllerian Duct Syndrome (PMDS)—PMDS is a rare autosomal recessive disorder characterized by the persistence of Müllerian structures in a boy. Typically, phallic development and testicular function are normal. This disorder is typically diagnosed during surgery for inguinal hernia and/or cryptorchidism. Often, both testes are on the same side (transverse testicular ectopia) and may be embedded in the broad ligament. Abnormal development of male excretory ducts is common. Although most men are infertile, fertility may be possible if at least one testis is scrotal with intact excretory ducts. Most cases are due to either AMH or AMHR2 mutations [40].

Urogenital anomalies—Some patients initially appear similar to patients with DSDs, but have disorders of urogenital tract development. Examples of malformations include cloacal and bladder exstrophy. The prevalence of uterine malformations has been reported to range from 5.5-9.8% [41]. Uterine developmental anomalies can range from complete aplasia, fusion defects, and septal absorption defects [42]. Associated findings can include renal, spinal, and cardiac anomalies. Uterine anomalies can be associated with MODY 5 diabetes, renal cysts, and HNF1B mutations. Mutations in the HOX genes have been associated with uterine anomalies. The hand-foot-genital syndrome associated with HOXA13 mutations is characterized by limb malformations and urogenital anomalies in both males and females [43]. In addition to HOX genes, other genes associated with uterine anomalies include WNT genes, GATA3, FRAS1, FREM, and other genes associated with syndromic ciliopathies [44].

GENETIC TESTING IN DSD

Genetic testing plays an important role in the evaluation of a patient with a possible DSD because knowing the genetic etiology improves the ability to predict the patient's phenotype, clarifies recurrence risk, and can be utilized in medical decision-making.

Peripheral blood karyotype analyses can be useful to detect the X and Y chromosomes, balanced chromosomal rearrangements, and large structural rearrangements. Fluorescence in situ hybridization (FISH) analysis using X and Y centromere-specific probes can be used to assess for sex chromosome mosaicism. Probes specific for the SRY gene can be used to

ascertain for Yp rearrangements. Unknown marker chromosomes and chromosomal rearrangements should be identified using FISH analyses to discern Y chromosomal material and establish recurrence risk.

Chromosomal microarray analyses such as array CGH or SNP microarrays can detect submicroscopic gene variations. CGH may identify novel candidate genes associated with DSD. The use of customized CGH focused on DSDs can interrogate multiple genes simultaneously which can accelerate the diagnostic process and limit the financial burden associated with testing multiple individual genes [45]. One caveat is that CGH may fail to detect balanced chromosomal translocations and low level mosaicism.

Genome-wide association studies (GWAS) offer a hypothesis free approach for the detection of novel loci associated with DSD. Many loci detected in GWAS are located outside of the coding region of a gene which confounds the interpretation regarding the functional impact of the variant on the phenotype. These variants may influence gene regulatory elements, affect co-factor recruitment, or modulate local chromatin structure. The need to replicate GWAS findings limits its usefulness in DSDs because of phenotypic and genetic heterogeneity and the low incidences for specific disorders.

The use of next generation sequencing (NGS) techniques such as whole exome sequencing (WES) simultaneously targets the coding regions of thousands of genes. Whole genome sequencing (WGS) targets the entire genome. These techniques are useful, but neither technique adequately detects large copy number variants, repetitive sequences, e.g. trinucleotide repeats, aneuploidy, or epigenetic changes.

Variations such as translocations, inversions, duplications, and deletions can modify the normal chromatin structure and alter spatiotemporal relationships with gene regulatory elements [46]. Non-coding genomic changes near *SOX9* have been associated with several phenotypes including XY male to female DSD associated with campomelic dwarfism and XX female to male sex reversal [47]. Genomic rearrangements involving long-range regulatory elements may result in ectopic and/or disrupted spatiotemporal expression of relevant genes. Two examples of *AR* mutations located outside of the coding region and associated with AIS include a mutation located in the 5'-untranslated region associated with reduced protein levels and an intronic mutation that created a novel 5'-splice site resulting in aberrant splicing and decreased *AR* protein levels [48,49]. A synonymous *AR* mutation, p.S510S, changed the exon 1 donor splice site generating a premature stop codon and truncated protein [50]. In some instances, no *AR* mutations have been detected suggesting that other proteins located beyond *AR* influence testosterone signaling [51].

ETHICS OF GENETIC TESTING

WES and WGS are powerful tools that are being used to identify the molecular basis of many diseases. However, these tests can detect genetic variants unrelated to sexual differentiation. Hence, counseling and informed consent need to precede these genetic studies; parents and patients should be alerted and counseled about the possibility of incidental findings with the potential for significant medical impact. Additional existing

limitations of NGS include the inability to completely characterize the functional significance of all variants and false assignment of causality detected by these tools [52].

GONADAL TUMORS

The decision to pursue gonadectomy needs to be individualized with active participation of a multidisciplinary team and, if possible, knowledge of the specific molecular etiology [53]. Considerations include risk of malignant degeneration, fertility potential, and ability to bring the gonads into a location for repeated physical examinations. The presence of a Y chromosome in a dysgenetic gonad is associated with high risk for neoplastic transformation into gonadoblastoma or dysgerminoma. Germ cell neoplasia in situ (GCNIS) in the testis represents a pre-malignant change. The neoplastic cells in these lesions are derived from primordial germ cells that arrested at an early stage of development and typically express OCT3/4.

Removal of testes in patients with complete androgen insensitivity is controversial. Most recent data indicate that the risk for tumor development is low until early adult years [54,55]. For patients with CAIS, the risks of neoplastic changes, risks of the surgical procedure, and need for long term hormone replacement should be discussed. Hence, many women with CAIS elect to keep gonads *in situ*. Laparoscopic gonadopexy to situate the gonads in a fixed position near the anterior abdominal wall with gonadal biopsy, molecular screening with SNP and micro-RNA testing, and ultrasound surveillance may be an option for patients wishing to avoid gonadectomy [56,57]. Delayed surgery promotes shared decision making with the patient, family, and healthcare providers [58].

SURGERY IN DSD

No uniform consensus regarding the indications, timing, and extent of the operation is applicable for individuals with DSD. Each patient warrants individual contemplation and attention by a multidisciplinary team at experienced centers. Considerations include future fertility, risk for gonadal tumors, propensity for urinary tract infections, avoiding stigmatization related to atypical genital anatomy, and ensuring functional genital anatomy to allow future penetrative intercourse [59]. For girls with CAH, favorable outcome was reported with early genital surgery [60,61]. Available outcome reports are largely small clinical series with diagnostic heterogeneity. Importantly, data regarding outcome for non-treated DSD are even more limited.

FERTILITY POTENTIAL AND PRESERVATION

Fertility preservation via embryo, oocyte, or sperm banking has become an option for those who face a loss of fertility due to a chronic illness such as cancer. Experimental protocols are being developed for preservation of fertility for prepubertal children with cancer. Apart from individuals with virilizing congenital adrenal hyperplasias, most individuals with DSDs have traditionally been considered to be infertile. Finlayson and colleagues propose a paradigm shift to this traditional notion because they detected germ cells in the gonads of patients with CAIS, ovotesticular disorder, Denys-Drash syndrome, and other disorders

associated with DSD [62]. Limitations of their report include small sample size and incomplete knowledge regarding the functional competence of these germ cells. Currently, most protocols for cryopreservation of immature gonadal tissues are experimental. Ethical considerations include false hope, potential transmission of genetic disorders to future offspring, financial burden, and provision of consent/assent for a minor child [63]. Nevertheless, optimism regarding potential assisted reproductive technologies may be justified following a report of a live birth following a uterine allograft transplantation in a female with uterine agenesis and successful intracytoplasmic sperm injection (ICSI) procedure with a subsequent live birth after testicular sperm extraction from a 46,XX/46,XY azoospermic male [64,65]. The multidisciplinary team involved in the care of children with DSDs should discuss fertility potential and possible role of assisted reproductive techniques [66].

APPROACH TO THE PATIENT

The birth of a child with a DSD is generally not a medical emergency. Rather, the birth of a baby with ambiguous genitalia is bewildering, alarming, and is considered to be a social emergency. Everyone wants to know if the baby is a boy or a girl. In many instances, the parents have been told the sex of the infant based on prenatal ultrasound findings. Until the sex of rearing has been established, the infant should be referred to as “your baby”.

Following review of the pregnancy and family histories and a thorough physical examination, it is appropriate to congratulate the parents on the birth of their child, show them the physical findings on their baby, and review that the gonadal structures are bipotential. Most importantly, “guessing” whether the child is a boy or a girl is inappropriate. A multidisciplinary team comprised of pediatric endocrinologists, pediatric urologists/surgeons/ob-gyn specialists, geneticists, pediatric radiologists, neonatologists, pediatric nurse educators, and behavioral health professionals should be involved in the care of infants, children, and adolescents with DSDs [67]. It is important to include the parents in discussions regarding sex of rearing and be cognizant of their level of understanding and cultural/religious perspectives and traditions [68,69].

The infant needs to be carefully examined for evidence of other anomalies [70]. The symmetry of the external genitalia, presence of palpable gonads, genital pigmentation, and extent of labioscrotal fusion should be assessed. The length and diameter of the phallus should be measured. The location of the urethral meatus and number of perineal openings need to be noted. The presence of posterior labial fusion and estimation of the ano-genital ratio can be helpful. For normal girls, the distance from the base of the phallus to the posterior forchette should be approximately 2/3 of the distance from the base of the phallus to the anus [71].

Individualized laboratory evaluations provide optimal information to ascertain the likely etiology and select the initial management recommendations. Bloodwork may include electrolytes, 17-hydroxyprogesterone, testosterone, LH, FSH, AMH, plasma renin activity, androstenedione, and DHT. Karyotype analysis and additional genetic testing are essential. Determination of urinary steroids and/or stimulation tests may be use to clarify the specific

diagnosis [72]. Ultrasound studies to assess for the presence of a uterus can be helpful. Ovaries are often too small to be accurately visualized on ultrasound; the lack of visualization of ovaries does not indicate absence of ovaries. Renal anomalies can be assessed by renal ultrasound.

The infant's history and physical examination can direct the course of the laboratory investigations. Significant virilization of the external genitalia with bilateral non-palpable gonads offers a clue that the infant is a virilized female with a virilizing form of congenital adrenal hyperplasia. Apparently normal symmetric female external genitalia with labial masses suggest the possibility of complete androgen insensitivity syndrome. Asymmetric external genital development can be associated with gonadal dysgenesis and ovotesticular disorder.

Upon completion of all studies, this information can be shared with the parents. The tone of this encounter should be positive and optimistic to promote bonding between the parents and their infant. During this discussion, sex of rearing, medical management plans, gonadal development, results of genetic testing, recurrence risks, and follow-up plans can be discussed. As the child transitions to an adolescent and young adult, specific details regarding their medical condition, karyotype, and potential for fertility need to be openly discussed.

For the older child or adolescent patient, an evaluation for delayed puberty, primary amenorrhea, or virilization can lead to the diagnosis of a DSD. A thorough evaluation including linear growth patterns, presence and sequence of secondary sexual characteristics, and family history is essential. On physical examination, the external genital appearance, pubertal features typical of estrogen effect such as breast development, and characteristics of androgen effect such as pubic hair and virilization should be noted. In this instance, the patient and parents play active roles in the diagnostic evaluation and decision-making process. Confidentiality and privacy are essential because the diagnosis of a DSD can be devastating to the patient and family. Discussion regarding karyotype and likely infertility are essential aspects of medical care for these patients.

SUMMARY

Disorders of sex development are variations in reproductive tract development. Novel genetic techniques have introduced a new era of the diagnosis of DSDs and elucidation of the molecular factors involved in sex development. Thoughtful respectful care is critical for the management of infants, children, adolescents, and their families to ensure positive and meaningful quality of life. Goals for individuals with DSDs include psychosocial well-being, sexual satisfaction, and fertility options [73].

References

1. Hughes IA, Nihoul-Fékété C, Thomas B, et al. Consequences of the ESPE/LWPES guidelines for diagnosis and treatment of disorders of sex development. *Best Pract Res Clin Endocrinol Metab.* 2007; 21:351–65. [PubMed: 17875484]

2. Berglund A, Johannsen TH, Stochholm K, et al. Incidence, Prevalence, Diagnostic Delay, and Clinical Presentation of Female 46,XY Disorders of Sex Development. *J Clin Endocrinol Metab*. 2016; 101:4532–40. [PubMed: 27603905]
3. Lee PA, Nordenström A, Houk CP, et al. Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care. *Horm Res Paediatr*. 2016; 85:158–80. [PubMed: 26820577]
4. Ono M, Harley VR. Disorders of sex development: new genes, new concepts. *Nat Rev Endocrinol*. 2013; 9:79–91. [PubMed: 23296159]
5. Chen MJ, McCann-Crosby B, Gunn S, et al. Fluidity models in ancient Greece and current practices of sex assignment. *Semin Perinatol*. 2017; 41:206–13. [PubMed: 28478088]
6. Biason-Lauber A. Control of sex development. *Best Pract Res Clin Endocrinol Metab*. 2010; 24:163–86. [PubMed: 20541146]
7. Koopman P, Gubbay J, Vivian N, Goodfellow P, et al. Male development of chromosomally female mice transgenic for Sry. *Nature*. 1991; 351(6322):117–21. [PubMed: 2030730]
8. Josso N. Professor Alfred Jost: the builder of modern sex differentiation. *Sex Dev*. 2008; 2:55–63. [PubMed: 18577872]
9. Biason-Lauber A. WNT4, RSPO1, and FOXL2 in sex development. *Semin Reprod Med*. 2012; 30:387–95. [PubMed: 23044875]
10. Rudigier LJ, Dame C, Scholz H, Kirschner KM. Ex vivo cultures combined with vivo-morpholino induced gene knockdown provide a system to assess the role of WT1 and GATA4 during gonad differentiation. *PLoS One*. 2017; 12:e0176296. [PubMed: 28426816]
11. Lin YT, Capel B. Cell fate commitment during mammalian sex determination. *Curr Opin Genet Dev*. 2015; 32:144–52. [PubMed: 25841206]
12. Kim Y, Bingham N, Sekido R, et al. Fibroblast growth factor receptor 2 regulates proliferation and Sertoli differentiation during male sex determination. *Proc Natl Acad Sci U S A*. 2007; 104:16558–63. [PubMed: 17940049]
13. Grinspon RP, Rey RA. Disorders of Sex Development with Testicular Differentiation in SRY-Negative 46,XX Individuals: Clinical and Genetic Aspects. *Sex Dev*. 2016; 10:1–11. [PubMed: 27055195]
14. Georges A, Auguste A, Bessière L, et al. FOXL2: a central transcription factor of the ovary. *J Mol Endocrinol*. 2013; 52:R17–33. [PubMed: 24049064]
15. Yao HH. The pathway to femaleness: current knowledge on embryonic development of the ovary. *Mol Cell Endocrinol*. 2005; 230:87–93. [PubMed: 15664455]
16. Zhao F, Franco HL, Rodriguez KF, et al. Elimination of the male reproductive tract in the female embryo is promoted by COUP-TFII in mice. *Science*. 2017; 357(6352):717–20. [PubMed: 28818950]
17. Witchel SF. Congenital Adrenal Hyperplasia. *J Pediatr Adolesc Gynecol*. 2017 Apr 24. pii: S1083-3188(16)30343-6.
18. Pearce M, DeMartino L, McMahon R, et al. Newborn screening for congenital adrenal hyperplasia in New York State. *Mol Genet Metab Rep*. 2016; 7:1–7. [PubMed: 27331001]
19. Krone N, Reisch N, Idkowiak J, et al. Genotype-phenotype analysis in congenital adrenal hyperplasia due to P450 oxidoreductase deficiency. *J Clin Endocrinol Metab*. 2012; 97:E257–67. [PubMed: 22162478]
20. Jääskeläinen M, Prunskaitė-Hyyryläinen R, Naillat F, et al. WNT4 is expressed in human fetal and adult ovaries and its signaling contributes to ovarian cell survival. *Mol Cell Endocrinol*. 2010; 317:106–11. [PubMed: 19962424]
21. Mandel H, Shemer R, Borochowitz ZU, et al. SERKAL syndrome: an autosomal-recessive disorder caused by a loss-of-function mutation in WNT4. *Am J Hum Genet*. 2008; 82:39–47. [PubMed: 18179883]
22. Uhlenhaut NH, Jakob S, Anlag K, et al. Somatic sex reprogramming of adult ovaries to testes by FOXL2 ablation. *Cell*. 2009; 139:1130–42. [PubMed: 20005806]
23. Ren Y, Suzuki H, Jagarlamudi K, et al. Lhx8 regulates primordial follicle activation and postnatal folliculogenesis. *BMC Biol*. 2015 Jun 16;13:39. [PubMed: 26076587]

24. Desai S, Wood-Trageser M, Matic J, et al. MCM8 and MCM9 Nucleotide Variants in Women with Primary Ovarian Insufficiency. *J Clin Endocrinol Metab.* 2017; 102:576–82. [PubMed: 27802094]
25. Katari S, Wood-Trageser MA, Jiang H, et al. A Novel Inactivating Mutation of the FSH Receptor in Two Siblings of Indian Origin with Premature Ovarian Failure. *J Clin Endocrinol Metab.* 2015; 100:2154–7. [PubMed: 25875778]
26. Yatsenko SA, Witchel SF. Genetic approach to ambiguous genitalia and disorders of sex development: What clinicians need to know. *Semin Perinatol.* 2017; 41:232–43. [PubMed: 28545654]
27. Loke J, Pearlman A, Radi O, et al. Mutations in MAP3K1 tilt the balance from SOX9/FGF9 to WNT/ β -catenin signaling. *Hum Mol Genet.* 2014; 23:1073–83. [PubMed: 24135036]
28. Mendonça BB, Gomes NL, Costa EM, et al. 46,XY disorder of sex development (DSD) due to 17 β -hydroxysteroid dehydrogenase type 3 deficiency. *J Steroid Biochem Mol Biol.* 2017; 165:79–85. [PubMed: 27163392]
29. Mendonça BB, Batista RL, Domenice S, et al. Steroid 5 α -reductase 2 deficiency. *J Steroid Biochem Mol Biol.* 2016; 163:206–11. [PubMed: 27224879]
30. Flück CE, Meyer-Böni M, Pandey AV, Kempná P, et al. Why boys will be boys: two pathways of fetal testicular androgen biosynthesis are needed for male sexual differentiation. *Am J Hum Genet.* 2011; 89:201–18. [PubMed: 21802064]
31. Mongan NP, Tadokoro-Cuccaro R, Bunch T, Hughes IA. Androgen insensitivity syndrome. *Best Pract Res Clin Endocrinol Metab.* 2015; 29:569–80. [PubMed: 26303084]
32. Nielsen J, Wohler M. Chromosome abnormalities found among 34,910 newborn children: results from a 13-year incidence study in Arhus, Denmark. *Hum Genet.* 1991; 87:81–3. [PubMed: 2037286]
33. Cameron-Pimblett A, La Rosa C, King TFJ, et al. The Turner syndrome life course project: Karyotype-phenotype analyses across the lifespan. *Clin Endocrinol (Oxf).* 2017 Jun 15. [Epub ahead of print]. doi: 10.1111/cen.13394
34. Gravholt CH, Andersen NH, Conway GS, et al. Clinical practice guidelines for the care of girls and women with Turner syndrome: proceedings from the 2016 Cincinnati International Turner Syndrome Meeting. *Eur J Endocrinol.* 2017; 177:G1–G70. [PubMed: 28705803]
35. Schoemaker MJ, Swerdlow AJ, Higgins CD, et al. Cancer incidence in women with Turner syndrome in Great Britain: a national cohort study. *Lancet Oncol.* 2008; 9:239–46. [PubMed: 18282803]
36. Davis S, Howell S, Wilson R, et al. Advances in the Interdisciplinary Care of Children with Klinefelter Syndrome. *Adv Pediatr.* 2016; 63:15–46. [PubMed: 27426894]
37. Tartaglia NR, Wilson R, Miller JS, et al. Autism Spectrum Disorder in Males with Sex Chromosome Aneuploidy: XXY/Klinefelter Syndrome, XYY, and XYYY. *J Dev Behav Pediatr.* 2017; 38:197–207. [PubMed: 28333849]
38. Swartz JM, Ciarlo R, Guo MH, et al. A 46,XX Ovotesticular Disorder of Sex Development Likely Caused by a Steroidogenic Factor-1 (NR5A1) Variant. *Horm Res Paediatr.* 2017; 87:191–5. [PubMed: 27855412]
39. Dangle P, Touzon MS, Reyes-Múgica M, et al. Female-to-male sex reversal associated with unique Xp21.2 deletion disrupting genomic regulatory architecture of the dosage-sensitive sex reversal region. *J Med Genet.* 2017; 54:705–9. [PubMed: 28483799]
40. Picard JY, Cate RL, Racine C, Josso N. The Persistent Müllerian Duct Syndrome: An Update Based Upon a Personal Experience of 157 Cases *Sex Dev.* 2017; 11:109–25. [PubMed: 28528332]
41. Dreisler E, Stampe Sørensen S. Müllerian duct anomalies diagnosed by saline contrast sonohysterography: prevalence in a general population. *Fertil Steril.* 2014; 102:525–9. [PubMed: 24875399]
42. Watanabe K, Kobayashi Y, Banno K, et al. Recent advances in the molecular mechanisms of Mayer-Rokitansky-Küster-Hauser syndrome. *Biomed Rep.* 2017; 7:123–7. [PubMed: 28804623]
43. Tas E, Sebastian J, Madan-Khetarpal S, et al. Familial deletion of the HOXA gene cluster associated with Hand-Foot-Genital syndrome and phenotypic variability. *Am J Med Genet A.* 2017; 173:221–4. [PubMed: 27649277]

44. Jacquinet A, Millar D, Lehman A. Etiologies of uterine malformations. *Am J Med Genet A*. 2016; 170:2141–72. [PubMed: 27273803]
45. Tannour-Louet M, Han S, Corbett ST, et al. Identification of de novo copy number variants associated with human disorders of sexual development. *PLoS One*. 2010 Oct 26;5(10):e15392. doi: 10.1371/journal.pone.0015392 [PubMed: 21048976]
46. Baetens D, Mendonça BB, Verdin H, Cools M, et al. Non-coding variation in disorders of sex development. *Clin Genet*. 2017; 91:163–72. [PubMed: 27801941]
47. Vetro A, Dehghani MR, Kraoua L, et al. Testis development in the absence of SRY: chromosomal rearrangements at SOX9 and SOX3. *Eur J Hum Genet*. 2015; 23:1025–32. [PubMed: 25351776]
48. Hornig NC, de Beaufort C, Denzer F, et al. A Recurrent Germline Mutation in the 5'UTR of the Androgen Receptor Causes Complete Androgen Insensitivity by Activating Aberrant uORF Translation. *PLoS One*. 2016 Apr 25;11(4):e0154158. [PubMed: 27110943]
49. Käsäkoski J, Jääskeläinen J, Jääskeläinen T, et al. Complete androgen insensitivity syndrome caused by a deep intronic pseudoexon-activating mutation in the androgen receptor gene. *Sci Rep*. 2016 Sep 9;6:32819. [PubMed: 27609317]
50. Batista RL, di Santi Rodrigues A, Nishi MY, et al. A recurrent synonymous mutation in the human androgen receptor gene causing complete androgen insensitivity syndrome. *J Steroid Biochem Mol Biol*. 2017 Jul 22. [Epub ahead of print]. doi: 10.1016/j.jsbmb.2017.07.020
51. Hornig INC, Ukati M, Schweikert HU, et al. Identification of an AR Mutation-Negative Class of Androgen Insensitivity by Determining Endogenous AR Activity. *J Clin Endocrinol Metab*. 2016; 101:4468–77. [PubMed: 27583472]
52. Richards S, Aziz N, Bale S, et al. Standards and guidelines for the interpretation of sequence variants: a joint consensus recommendation of the American College of Medical Genetics and Genomics and the Association for Molecular Pathology. *Genet Med*. 2015; 17:405–24. [PubMed: 25741868]
53. Pyle LC, Nathanson KL. A practical guide for evaluating gonadal germ cell tumor predisposition in differences of sex development. *Am J Med Genet C Semin Med Genet*. 2017; 175:304–14. [PubMed: 28544305]
54. Chaudhry S, Tadokoro-Cuccaro R, Hannema SE, et al. Frequency of gonadal tumours in complete androgen insensitivity syndrome (CAIS): A retrospective case-series analysis. *J Pediatr Urol*. 2017 Mar 14. pii: S1477-5131(17)30099-2.
55. Döhnert U, Wünsch L, Hiort O. Gonadectomy in Complete Androgen Insensitivity Syndrome: Why and When? *Sex Dev*. 2017; 11:171–4. [PubMed: 28719904]
56. Wünsch L, Holterhus PM, Wessel L, Hiort O. Patients with disorders of sex development (DSD) at risk of gonadal tumour development: management based on laparoscopic biopsy and molecular diagnosis. *BJU Int*. 2012 Dec;110:E958–65. [PubMed: 22540217]
57. Cools M, Looijenga L. Update on the Pathophysiology and Risk Factors for the Development of Malignant Testicular Germ Cell Tumors in Complete Androgen Insensitivity Syndrome. *Sex Dev*. 2017; 11:175–81. [PubMed: 28719895]
58. Patel V, Casey RK, Gomez-Lobo V. Timing of Gonadectomy in Patients with Complete Androgen Insensitivity Syndrome-Current Recommendations and Future Directions. *J Pediatr Adolesc Gynecol*. 2016; 29(4):320–5. [PubMed: 26428189]
59. Mouriquand PD, Gorduza DB, Gay CL, et al. Surgery in disorders of sex development (DSD) with a gender issue: If (why), when, and how? *J Pediatr Urol*. 2016; 12:139–49. [PubMed: 27132944]
60. Binet A, Lardy H, Geslin D, et al. Should we question early feminizing genitoplasty for patients with congenital adrenal hyperplasia and XX karyotype? *J Pediatr Surg*. 2016; 51:465–8. [PubMed: 26607969]
61. Fagerholm R, Santtila P, Miettinen PJ, et al. Sexual function and attitudes toward surgery after feminizing genitoplasty. *J Urol*. 2011; 185:1900–4. [PubMed: 21439585]
62. Finlayson C, Fritsch MK, Johnson EK, et al. Presence of Germ Cells in Disorders of Sex Development: Implications for Fertility Potential and Preservation. *J Urol*. 2017; 197:937–43. [PubMed: 27840018]

63. Campo-Engelstein L, Chen D, Baratz AB, Johnson EK, et al. The Ethics of Fertility Preservation for Pediatric Patients with Differences (Disorders) of Sex Development. *J Endocr Soc.* 2017; 1:638–45. [PubMed: 28944319]
64. Brännström M. Womb transplants with live births: an update and the future. *Expert Opin Biol Ther.* 2017; 17:1105–12. [PubMed: 28683576]
65. Sugawara N, Kimura Y, Araki Y. Successful second delivery outcome using refrozen thawed testicular sperm from an infertile male true hermaphrodite with a 46, XX/46, XY karyotype: case report. *Hum Cell.* 2012; 25:96–9. [PubMed: 23203848]
66. Guercio G, Costanzo M, Grinspon RP, Rey RA. Fertility Issues in Disorders of Sex Development. *Endocrinol Metab Clin North Am.* 2015; 44:867–81. [PubMed: 26568498]
67. Ahmed SF, Achermann JC, Arlt W, et al. Society for Endocrinology UK guidance on the initial evaluation of an infant or an adolescent with a suspected disorder of sex development (Revised 2015). *Clin Endocrinol (Oxf).* 2016; 84:771–88. [PubMed: 26270788]
68. Wilson JD, Rivarola MA, Mendonça BB, et al. Advice on the management of ambiguous genitalia to a young endocrinologist from experienced clinicians. *Semin Reprod Med.* 2012; 30:339–50. [PubMed: 23044870]
69. Zainuddin AA, Mahdy ZA. The Islamic Perspectives of Gender-Related Issues in the Management of Patients with Disorders of Sex Development. *Arch Sex Behav.* 2017; 46:353–60. [PubMed: 27102604]
70. Mazen I, Amin H, Kamel A, et al. Homozygous Mutation of the FGFR1 Gene Associated with Congenital Heart Disease and 46,XY Disorder of Sex Development. *Sex Dev.* 2016; 10:16–22. [PubMed: 27055092]
71. Thankamony A, Ong KK, Dunger DB, et al. Anogenital distance from birth to 2 years: a population study. *Environ Health Perspect.* 2009; 117:1786–90. [PubMed: 20049133]
72. Krone N, Hughes BA, Lavery GG, et al. Gas chromatography/mass spectrometry (GC/MS) remains a pre-eminent discovery tool in clinical steroid investigations even in the era of fast liquid chromatography tandem mass spectrometry (LC/MS/MS). *J Steroid Biochem Mol Biol.* 2010; 121:496–504. [PubMed: 20417277]
73. Raveenthiran V. Neonatal Sex Assignment in Disorders of Sex Development: A Philosophical Introspection. *J Neonatal Surg.* 2017; 6:58–64. [PubMed: 28920018]

PRACTICE POINTS

- Normal sexual development is dependent on the synergistic orchestration of numerous activating and repressing factors interacting in a precise spatio-temporal pattern.
- Disorders of sex development can be classified into several categories and are associated with atypical development of chromosomal, gonadal, or anatomic sex.
- Patients with DSDs can present in infancy with ambiguous genitalia or at older chronological ages with aberrant pubertal development.
- The healthcare team needs to provide patients with comprehensive medical information regarding their specific condition as appropriate for age, developmental stage and cognitive abilities. Patients and their parents benefit from review of this information as they pass from childhood to adolescence to adulthood.
- Karyotype analyses, microarray analyses, and next generation sequencing techniques are helpful in the diagnostic and genetic evaluation of patients; these techniques may identify novel genes involved in sex development.
- The benefits and potential risks of surgical interventions need to be carefully reviewed and assessed with parents and patients.
- Multidisciplinary individualized health care is essential for all patients with DSDs. Goals include fostering the individual's healthy sexual and gender identity development while minimizing risks for deleterious physical and psychosocial consequences.
- Shared decision making and open communication are vital for optimal health and quality of life. This approach needs to respect the wishes, beliefs, and cultural traditions of patients and their families.

RESEARCH AGENDA

- Current evidence-based data remain inadequate to address assignment of male or female sex for some infants.
- Elucidation of the factors and processes involved in gender identity development is needed because our current knowledge of the structures and functions of the CNS underlying gender identity is extremely limited.
- Evidence-based data to address issues related to timing, techniques and consent for surgical interventions.
- Exploration of fertility preservation

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Highlights

- Normal sex development depends on the precise spatio-temporal sequence and coordination of mutually antagonistic activating and repressing factors.
- Disorders of sex development can be classified into several categories including chromosomal, gonadal, and anatomic abnormalities.
- Genetic tools such as microarray analyses and next-generation sequencing techniques have identified novel genetic variants among patients with DSD.
- Patient management needs to be individualized especially for decisions related to sex of rearing, surgical interventions, hormone treatment, and potential for fertility preservation.

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Table 1**Classification of Disorders of Sex Development Associated with Ambiguous Genitalia****XX, DSD**

Androgen-induced
 Virilizing Congenital Adrenal Hyperplasias
 Placental Aromatase Deficiency
 Glucocorticoid Receptor Mutation
 Maternal androgen secreting Tumor
 Virilizing luteoma of Pregnancy
 Androgen Exposure (Norethindrone, Ethisterone, Norethynodrel,
 Medroxyprogesterone, Danazol)
 Ovotesticular Disorders

XY DSD

Impaired Testosterone Synthesis
 Leydig cell agenesis
 LH/HCG receptor (LHCGR) mutations
 Congenital lipoid adrenal hyperplasia (StAR)
 Cholesterol side chain cleavage mutations (CYP11A1)
 3 β -hydroxysteroid dehydrogenase type 2 (HSD3B2) mutations
 17 α -hydroxylase/17,20 lyase (CYP17A1) mutations
 P450 oxidoreductase (POR) mutations
 Smith-Lemli-Opitz (DHCR7) mutations
 17 β -hydroxysteroid dehydrogenase type 3 (HSD17B3) mutations
 5 α -reductase type 2 (SRD5A2) mutations
 Cytochrome b5 (CYB5A)
 3 α -hydroxysteroid dehydrogenase deficiency (AKR1C2 and AKR1C3)
 Denys-Drash syndrome (WT1)

Sex Chromosome DSD

Turner Syndrome
 Klinefelter Syndrome
 Mosaicism, e.g. 45,X/46,XY
 Triple XXX Syndrome
 XXYY Syndrome

XX or XY Disorder of Gonadal Development

Complete gonadal dysgenesis
 Partial gonadal dysgenesis Gonadal regression
 Ovotesticular DSD

XY Persistent Mullerian Duct Syndrome

Low AMH (AMH)
 Normal or High AMH (AMHR2)

Malformation Syndrome

CHARGE syndrome

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Hand-foot-genital syndrome
MRKH Syndrome
MURCS Association
McKusick-Kaufman Syndrome
Aphallia
Cloacal/Bladder Exstrophy
Isolated Hypospadias
Penoscrotal Transposition

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Article - Billing and Coding: Gender Reassignment Services for Gender Dysphoria (A53793)

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Palmetto GBA	A and B MAC	10111 - MAC A	J - J	Alabama
Palmetto GBA	A and B MAC	10112 - MAC B	J - J	Alabama
Palmetto GBA	A and B MAC	10211 - MAC A	J - J	Georgia
Palmetto GBA	A and B MAC	10212 - MAC B	J - J	Georgia
Palmetto GBA	A and B MAC	10311 - MAC A	J - J	Tennessee
Palmetto GBA	A and B MAC	10312 - MAC B	J - J	Tennessee
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
Palmetto GBA	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

Article Information

General Information

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Article Guidance**Article Text**

Gender Dysphoria (GD) is defined by the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, DSM-5™ as a condition characterized by the "distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" also known as "natal gender", which is the individual's sex determined at birth. Individuals with gender dysphoria experience confusion in their biological gender during their childhood, adolescence or adulthood. These individuals demonstrate clinically significant distress or impairment in social, occupational, or other important areas of functioning.

GD is characterized by the desire to have the anatomy of the other sex, and the desire to be regarded by others as a member of the other sex. Individuals with GD may develop social isolation, emotional distress, poor self-image, depression and anxiety. The diagnosis of GD is not made if the individual has a congruent physical intersex condition such as congenital adrenal hyperplasia.

Gender Reassignment Therapy

GD cannot be treated by psychotherapy or through medical intervention alone. Integrated therapeutic approaches are used to treat GD, including psychological interventions and gender reassignment therapy. Gender reassignment therapy, either as male-to-female transsexuals (transwomen) or as female-to-male transsexuals (transmen), consists of medical and surgical treatment that changes primary or secondary sex characteristics.

Initially, the individual may go through the real-life experience in the desired role, followed by cross-sex hormone therapy and gender reassignment surgery to change the genitalia and other sex characteristics. The difference between cross-sex hormone therapy and gender reassignment surgery is that the surgery is considered an irreversible physical intervention.

Gender reassignment surgical procedures are not without risk for complications; therefore, individuals should undergo an extensive evaluation to explore psychological, family, and social issues prior to and post surgery.

Additionally, certain surgeries may improve gender- appropriate appearance but provide no significant improvement in physiological function. These surgeries are considered cosmetic and are non-covered.

NON-SURGICAL TREATMENT

Initiation of cross-sex hormone therapy may be provided after a psychosocial assessment has been conducted and informed consent has been obtained by a health professional.

The criteria for cross sex hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Member must be at least 18 years of age;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

The presence of co-existing mental health concerns does not necessarily preclude access to cross-sex hormones. These concerns should be managed prior to or concurrent with treatment of gender dysphoria.

Cross-sex hormonal interventions are not without risk for complications, including irreversible physical changes. Medical records should indicate that an extensive evaluation was completed to explore psychological, family and social issues prior to and post treatment. Providers should also document that all information has been provided and understood regarding all aspects associated with the use of cross-sex hormone therapy, including both benefits and risks.

READINESS FOR THE TREATMENT OF GENDER DYSPHORIA

Readiness criteria for gender reassignment surgery includes the individual demonstrating progress in consolidating gender identity, and demonstrating progress in dealing with work, family, and interpersonal issues resulting in an improved state of mental health. In order to check the eligibility and readiness criteria for gender reassignment surgery, it is important for the individual to discuss the matter with a professional provider who is well-versed in the relevant medical and psychological aspects of GD. The mental health and medical professional providers responsible for the individual's treatment should work together in making a decision about the use of cross-sex hormones during the months before the gender reassignment surgery. Transsexual individuals should regularly participate in psychotherapy in order to have smooth transitions and adjustments to the new social and physical outcomes.

TRANS-SPECIFIC CANCER SCREENINGS

Professional organizations such as the American Cancer Society, American College of Obstetricians and Gynecologists and the US Preventive Services Task Force provide recommended cancer screening guidelines to facilitate clinical decision-making by professional providers. Some cancer screening protocols are sex/gender specific based on assumptions about the genitalia for a particular gender. There is little data on cancer risk specifically in transsexual individuals.

There is difficulty in recommending sex/gender specific screenings (e.g., breast, cervix, ovaries, penis, prostate, testicles and uterus) for transsexual individuals because of their physiologic changes. For example, transmen who have not undergone a mastectomy have the same risks for breast cancer as natal women. In transwomen, the prostate typically is not removed as part of genital surgery, so individuals who do not take feminizing hormones may be at the same risk for prostate cancer as natal men. Therefore, cancer screenings (e.g., mammograms, prostate screenings) may be indicated based on the individual's original gender.

Gender specific screenings may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for transmen who have not undergone a mastectomy.
2. Prostate cancer screening may be medically necessary for transwomen who have retained their prostate.

Claims for gender reassignment surgery will be reviewed on a case by case basis. Surgical treatment of gender reassignment surgery for gender dysphoria may be eligible when medical necessity and documentation requirements outlined within this article are met.

Surgical treatment for gender dysphoria may be considered medically necessary when **ALL** of the following criteria are met:

- The individual is at least 18 years of age.
- A gender reassignment treatment plan is created specific to an individual beneficiary
- The individual has a documented Diagnostic and Statistical Manual of Mental Disorders -Fifth Edition, DSM-5™ diagnosis of GD:

A. *A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:*

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. *The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.*

- One letter from a mental health professional that the patient has had, at minimum, twelve months of psychotherapy sessions attesting to all of the following clinical criteria:
 1. That any co-morbid psychiatric or other medical conditions are stable and that the individual is prepared to undergo surgery.
 2. That the patient has had persistent and chronic gender dysphoria.
 3. That the patient has completed twelve months of continuous, full-time, real-life experience (i.e., the act of fully adopting a new or evolving gender role or gender presentation in everyday life) in the desired gender.
- The individual, if required by the mental health professional provider, has regularly participated in psychotherapy throughout the real-life experience at a frequency determined jointly by the individual and the mental health professional provider.
- Unless medically contraindicated (or the individual is otherwise unable to take cross-sex hormones), there is documentation that the individual has participated in twelve consecutive months of cross-sex hormone therapy of the desired gender continuously and responsibly (e.g., screenings and follow-ups with the professional provider).
- The individual has knowledge of all practical aspects (e.g., required lengths of hospitalizations, likely complications, and post-surgical rehabilitation) of the gender reassignment surgery.

SURGICAL TREATMENTS FOR GENDER REASSIGNMENT

When all of the above criteria are met for gender reassignment surgery, the following genital surgeries may be considered for transwomen (male to female):

- Orchiectomy - removal of testicles
- Penectomy - removal of penis
- Vaginoplasty - creation of vagina
- Clitoroplasty - creation of clitoris
- Labiaplasty - creation of labia
- Mammoplasty - breast augmentation
- Prostatectomy - removal of prostate
- Urethroplasty - creation of urethra

When all of the above criteria are met for gender reassignment surgery, the following genital/breast surgeries may be considered for transmen (female to male):

- Breast reconstruction (e.g., mastectomy) - removal of breast
- Hysterectomy - removal of uterus
- Salpingo-oophorectomy - removal of fallopian tubes and ovaries
- Vaginectomy - removal of vagina
- Vulvectomy - removal of vulva
- Metoidioplasty - creation of micro-penis, using clitoris
- Phalloplasty - creation of penis, with or without urethra
- Urethroplasty - creation of urethra within the penis
- Scrotoplasty - creation of scrotum
- Testicular prostheses - implantation of artificial testes

Services or procedures may not be covered when the criteria and documentation requirements outlined within this article are not met.

Services that are considered cosmetic for the treatment of gender dysphoria are not covered.

This list is not all-inclusive:

- Liposuction: removal of fat
- Rhinoplasty: reshaping of nose
- Rhytidectomy: face lift
- Blepharoplasty: removal of redundant skin of upper and/or lower eyelids and protruding periorbital fat
- Hair removal/ hair transplantation
- Facial feminizing (e.g., facial bone reduction)
- Chin augmentation: reshaping or enhancing the size of the chin
- Collagen injections
- Lip reduction/enhancement: decreasing/enlarging lip size
- Cricothyroid approximation: voice modification that raises the vocal pitch by simulating contractions of the cricothyroid muscle with sutures
- Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage
- Laryngoplasty: reshaping of laryngeal framework (voice modification surgery)
- Mastopexy: breast lift

For a list of additional services that are considered cosmetic and therefore, non-covered, please refer to LCD L33428-

Cosmetic and Reconstructive Surgery.

Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt [i.e., as soon as medically feasible] repair of accidental injury or for the improvement of the functioning of a malformed body member.

The individual's medical record must be submitted along with the claim and support the services billed. These medical records may include, but are not limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

When reporting procedure code 55970 (Intersex surgery; male to female), the following staged procedures to remove portions of the male genitalia and form female external genitals are included:

- The penis is dissected, and portions are removed with care to preserve vital nerves and vessels in order to fashion a clitoris-like structure.
- The urethral opening is moved to a position similar to that of a female.
- A vagina is made by dissecting and opening the perineum. This opening is lined using pedicle or split-thickness grafts.
- Labia are created out of skin from the scrotum and adjacent tissue.
- A stent or obturator is usually left in place in the newly created vagina for three weeks or longer.

When reporting CPT® code 55980 (Intersex surgery; female to male), the following staged procedures to form a penis and scrotum using pedicle flap grafts and free skin grafts are included:

- Portions of the clitoris are used, as well as the adjacent skin.
- Prostheses are often placed in the penis to create a sexually functional organ.
- Prosthetic testicles are implanted in the scrotum.
- The vagina is closed or removed.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

Transwoman procedures (male to female)

*NOTE: For Part A services only, the provider should bill the appropriate procedure code(s) for inpatient services.

The following CPT® codes will be considered when applicable criteria have been met:

Group 1 Codes: (14 Codes)

CODE	DESCRIPTION
19325	BREAST AUGMENTATION WITH IMPLANT
54125	AMPUTATION OF PENIS; COMPLETE

CODE	DESCRIPTION
54520	ORCHIECTOMY, SIMPLE (INCLUDING SUBCAPSULAR), WITH OR WITHOUT TESTICULAR PROSTHESIS, SCROTAL OR INGUINAL APPROACH
54690	LAPAROSCOPY, SURGICAL; ORCHIECTOMY
55866	LAPAROSCOPY, SURGICAL PROSTATECTOMY, RETROPUBIC RADICAL, INCLUDING NERVE SPARING, INCLUDES ROBOTIC ASSISTANCE, WHEN PERFORMED
55970	INTERSEX SURGERY; MALE TO FEMALE
56800	PLASTIC REPAIR OF INTROITUS
56805	CLITOROPLASTY FOR INTERSEX STATE
57291	CONSTRUCTION OF ARTIFICIAL VAGINA; WITHOUT GRAFT
57292	CONSTRUCTION OF ARTIFICIAL VAGINA; WITH GRAFT
57295	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT; VAGINAL APPROACH
57296	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT; OPEN ABDOMINAL APPROACH
57335	VAGINOPLASTY FOR INTERSEX STATE
57426	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT, LAPAROSCOPIC APPROACH

Group 2 Paragraph:

Transman procedures (female to male)

*NOTE: For Part A services only, the provider should bill the appropriate procedure code(s) for inpatient services.

The following CPT® codes will be considered when applicable criteria have been met:

Group 2 Codes: (31 Codes)

CODE	DESCRIPTION
19303	MASTECTOMY, SIMPLE, COMPLETE
53420	URETHROPLASTY, 2-STAGE RECONSTRUCTION OR REPAIR OF PROSTATIC OR MEMBRANOUS URETHRA; FIRST STAGE
53425	URETHROPLASTY, 2-STAGE RECONSTRUCTION OR REPAIR OF PROSTATIC OR MEMBRANOUS URETHRA; SECOND STAGE
53430	URETHROPLASTY, RECONSTRUCTION OF FEMALE URETHRA
54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)
55175	SCROTOPLASTY; SIMPLE
55180	SCROTOPLASTY; COMPLICATED
55980	INTERSEX SURGERY; FEMALE TO MALE

CODE	DESCRIPTION
56625	VULVECTOMY SIMPLE; COMPLETE
57106	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL;
57110	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL;
58150	TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S);
58180	SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL HYSTERECTOMY), WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S)
58260	VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58262	VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S), AND/OR OVARY(S)
58275	VAGINAL HYSTERECTOMY, WITH TOTAL OR PARTIAL VAGINECTOMY;
58290	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58291	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58542	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58543	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58544	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58550	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58552	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58553	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58554	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58570	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58571	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58572	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;

CODE	DESCRIPTION
58573	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58720	SALPINGO-OOPHORECTOMY, COMPLETE OR PARTIAL, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)

Group 3 Paragraph:

All unlisted procedure codes will suspend for medical review.

The following CPT® codes are considered cosmetic. When billed with any Covered ICD-10 Codes listed below, the service will not be covered (list may not be all-inclusive):

Group 3 Codes: (50 Codes)

CODE	DESCRIPTION
11950	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1 CC OR LESS
11951	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC
11952	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC
11954	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); OVER 10.0 CC
15769	GRAFTING OF AUTOLOGOUS SOFT TISSUE, OTHER, HARVESTED BY DIRECT EXCISION (EG, FAT, DERMIS, FASCIA)
15771	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; 50 CC OR LESS INJECTATE
15772	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 50 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15773	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, AND/OR FEET; 25 CC OR LESS INJECTATE
15774	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, AND/OR FEET; EACH ADDITIONAL 25 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS
15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS
15820	BLEPHAROPLASTY, LOWER EYELID;
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD
15822	BLEPHAROPLASTY, UPPER EYELID;

CODE	DESCRIPTION
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID
15824	RHYTIDECTOMY; FOREHEAD
15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, P-FLAP)
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES
15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK
15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); THIGH
15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); LEG
15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); HIP
15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); BUTTOCK
15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ARM
15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); FOREARM OR HAND
15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); SUBMENTAL FAT PAD
15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); OTHER AREA
15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK
15877	SUCTION ASSISTED LIPECTOMY; TRUNK
15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY
15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY
17380	ELECTROLYSIS EPILATION, EACH 30 MINUTES
19316	MASTOPEXY
19350	NIPPLE/AREOLA RECONSTRUCTION
21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, 2 OR MORE OSTEOTOMIES (EG, WEDGE

CODE	DESCRIPTION
	EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)
21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)
21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL
21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT)
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR
30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

The following diagnosis codes are considered covered when applicable criteria have been met:

Group 1 Codes: (5 Codes)

CODE	DESCRIPTION
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified

CODE	DESCRIPTION
Z87.890	Personal history of sex reassignment

ICD-10-CM Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

All other diagnosis codes will be denied as non-covered.

Group 1 Codes:

N/A

Additional ICD-10 Information

N/A

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2021	R13	Under CPT/HCPCS Codes Group 1: Codes descriptor was revised for 19325. This revision is due to the Q1 2021 CPT/HCPCS Code Update and is retroactive effective for dates of service on or after 1/1/2021.
01/01/2020	R12	Under CPT/HCPCS Codes Group 2: Codes CPT® code 19304 was deleted. CPT® was inserted throughout the article where applicable. Under CPT/HCPCS Codes Group 3: Codes added 15769, 15771, 15772, 15773 and 15774. This revision is due to the 2020 Annual CPT/HCPCS Code Update and is effective on January 1, 2020.
10/03/2019	R11	This article is being revised in order to adhere to CMS requirements per chapter 13, section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs and incorporate into related Billing and Coding Articles.
11/15/2018	R10	Under Article Text added the verbiage "be submitted along with the claim and" after the verbiage "The individual's medical record must" in the third paragraph from the bottom of the section.
02/26/2018	R9	The Jurisdiction "J" Part A and Part B Contracts for Alabama (10111/10112), Georgia (10211/10212) and Tennessee (10311/10312) are now being serviced by Palmetto GBA. Effective 02/26/18, these 6 contract numbers are being added to this article. No coverage, coding or other substantive changes (beyond the addition of the 6 Part A and B contract numbers) have been completed in this revision.
04/27/2017	R8	Under Article Text – Grammatical and punctuation changes were made throughout text. Revised sentence under B. to read "One letter from a mental health professional that the patient has had, at minimum, twelve months of psychotherapy therapy sessions attesting to all of the following clinical criteria:"
10/01/2016	R7	Under Covered ICD-10 Codes the description was revised for ICD-10 code F64.1. This revision is due to the Annual ICD-10 Code Update and becomes effective 10/01/16.
10/01/2015	R6	Under CPT/HCPCS Codes-Group 3 Paragraph the bolded verbiage was removed for the Group 3 CPT codes.
10/01/2015	R5	Under Article Text in the first sentence of the first paragraph corrected "DSM-V-TR, 2013" to now read "Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, DSM-5™". Under Non-Surgical Treatment , deleted "also" found in the third sentence of the last paragraph as this was redundant. Under Trans-Specific Cancer Screenings in the third bullet of the fifth paragraph corrected "DSM-IV-TR" to now read "Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, DSM-5™". Under Surgical Treatments for Gender Reassignment corrected the title of the specific LCD cited in the sixth paragraph. Under CPT/HCPCS Codes-Group 1 Paragraph revised the verbiage in the *Note and deleted the following, "See Article Text for included surgeries." Under CPT/HCPCS Codes-Group 2 Paragraph added the *Note. Under CPT/HCPCS Codes-Group 3 Paragraph the verbiage was revised in the second sentence. Under

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Covered ICD-10 Codes Paragraph added the first sentence. Under Non-Covered ICD-10 Codes corrected the spelling of "diagnosis."
06/11/2015	R4	Per CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 13, §13.1.3 LCDs consist of only "reasonable and necessary" information. All bill type and revenue codes have been removed from the LCDs. For consistency, they are also being removed from the articles.
10/01/2015	R3	Under Covered ICD-10 codes added ICD-10 codes F64.2, F64.8, F64.9 and Z87.890 per TDL-150320. Under Associated Documents , subheading Statutory Requirements URL(s) added Title XVIII of the Social Security Act §1862(a)(1)(A).
10/01/2015	R2	Under Article Text deleted the following statement and replaced it with the definition of cosmetic surgery as defined by manual instruction: "Cosmetic services may improve an individual's physical appearance but provide no significant improvement in physiologic function. Emotional and/or psychological improvement alone does not constitute improvement in physiologic function."
10/01/2015	R1	Under CPT/HCPCS Codes added the NOTE . Under Covered ICD-10 Codes deleted the paragraph related to Z87.890 and deleted ICD-10 code Z87.890 as this code was redundant with F64.1.

Associated Documents

Related Local Coverage Documents

N/A

Related National Coverage Documents

N/A

Statutory Requirements URLs

Title XVIII of the Social Security Act §1862(a)(1)(A)

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

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Keywords

- Gender Reassignment
- Gender Dysphoria

The Cass Review

**Independent review
of gender identity
services for children
and young people:
Interim report**

February 2022



Independent review of gender identity services for children and young people: Interim report

February 2022

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About this report

This interim report represents the work of the independent review of gender identity services for children and young people to date. It reflects a point in time. It does not set out final recommendations; these will be developed over the coming months, informed by our formal research programme.

This Review is forward looking. Its role is to consider how to improve and develop the future clinical approach and service model. However, in order to do this, it is first necessary to understand the current landscape and the reasons why change is needed, so that any future model addresses existing challenges, whilst retaining those features that service users and the professionals supporting them most value.

This report is primarily for the commissioners and providers of services for children and young people needing support around their gender. However, because of the wide interest in this topic, we have included some explanations about how clinical service development routinely takes place in the NHS, which sets the context for some of our interim advice.

The care of this group of children and young people is everyone's business. We therefore encourage the wider clinical community to take note of our work and consider their own roles in providing the best holistic support to this population.

Since the Review began, it has focused on hearing a wide range of perspectives to better understand the challenges within the current system and aspirations for how these could be addressed. This report does not contain all that we have heard during our listening sessions but summarises consistent themes. These conversations will continue throughout the course of the Review and there will be further opportunities for stakeholders to engage and contribute.

It is important to note that the references cited in this report do not constitute a comprehensive literature review and are included only to clarify why specific lines of enquiry are being pursued, and where there are unanswered questions that will be addressed more fully during the life of the Review. A formal literature review is one strand of the Review's commissioned work, and this will be reported in full when complete.

A note about language

There is sometimes no consensus on the best language to use relating to this subject. The language surrounding this area has also changed rapidly and young people have developed varied ways of describing their experiences using different terms and constructs that are relevant to them.

The Review tries as far as possible to use language and terms that are respectful and acknowledge diversity, but that also accurately illustrate the complexity of what we are trying to describe and articulate.

The terms we have used may not always feel right to some; nevertheless, it is important to emphasise that the language used is not an indication of a position being taken by the Review. A glossary of terms is included.

The Review is cognisant of the broader cultural and societal debates relating to the rights of transgender adults. It is not the role of the Review to take any position on the beliefs that underpin these debates. Rather, this Review is strictly focused on the clinical services provided to children and young people who seek help from the NHS to resolve their gender-related distress.

A letter to children and young people

Children and young people accessing the NHS deserve safe, timely and supportive services, and clinical staff with the training and expertise to meet their healthcare needs.



Dr Hilary Cass

I understand that as you read this letter some of you may be anxious because you are waiting to access support from the NHS around your gender identity. Maybe you have tried to get help from your local services, or from the Gender Identity Development Service (GIDS), and because of the long waiting lists they have not yet been able to see you. I hope that some of you have had help – maybe from a supportive GP, a local Child and Adolescent Mental Health Service (CAMHS), or from GIDS.

I have heard that young service users are particularly worried that I will suggest that services should be reduced or stopped. I want to assure you that this is absolutely not the case – the reverse is true. I think that more services are needed for you, closer to where you live. The GIDS staff are working incredibly hard and doing their very best to see you as quickly as possible but providing supportive care is not something that can be rushed – each young person needs enough time and space for their personal needs to be met. So, with the best will in the world, one service is not going to be able to respond to the growing demand in a timely way.

I am advising that more services are made available to support you. But I must be honest; this is not something that can happen overnight, and I can't come up with a solution that will fix the problems immediately. However, we do need to start now.

The other topic that I know is worrying some of you is whether I will suggest that hormone treatments should be stopped. On this issue, I have to share my thoughts as a doctor. We know quite a bit about hormone treatments, but there is still a lot we don't know about the long-term effects.

Independent review of gender identity services for children and young people

Whenever doctors prescribe a treatment, they want to be as certain as possible that the benefits will outweigh any adverse effects so that when you are older you don't end up saying 'Why did no-one tell me that that might happen?' This includes understanding both the risks and benefits of having treatment and not having treatment.

Therefore, what we will be doing over the next few months is trying to make sense of all the information that is available, as well as seeing if we can plug any of the gaps in the research. I am currently emphasising the importance of making decisions about prescribing as safe as possible. This means making sure you have all the information you need – about what we do know and what we don't know.

Finally, some of you may want the chance to talk to me and share your thoughts about how services should look in the future. Over the coming months we will need your help and there will be opportunities to get involved with the Review, so please keep an eye on our website (www.cass.independent-review.uk), where we will provide updates on our work.

A handwritten signature in black ink, appearing to read 'Hilary'.

Dr Hilary Cass, OBE

Introduction from the Chair

Anyone with an interest in the care of gender-questioning children and young people, as well as those with lived experience, may have wondered what qualifies me to take on this Review, and whether I have a pre-existing position on this subject.

I am a paediatrician who was in clinical practice until 2018, my area of specialism being children and young people with disability. I have also held many management and policy roles throughout my career, most notably as President of the Royal College of Paediatrics and Child Health (RCPCH) from 2012-15.

Children's services are often at a disadvantage in healthcare because health services are usually designed around the needs of adults. As President of RCPCH, a key part of my role was to advocate for services to be planned with children and families at their heart.

I have not worked in gender services during my career, but my strong focus on hearing the voice of service users, supporting vulnerable young people, equity of access, and strong clinical standards applies in this area as much as in my other work.

With this in mind, the aim of the Review is to ensure that children and young people who are experiencing gender incongruence or gender-related distress receive a high standard of NHS care that meets their needs and is safe, holistic and effective.

I have previously set out the principles governing this Review process, namely that:

- The welfare of the child and young person will be paramount in all considerations.
- Children and young people must receive a high standard of care that meets their needs.
- There will be extensive and purposeful stakeholder engagement, including ensuring that children and young people can express their own views through a supportive process.
- The Review will be underpinned by research and evidence, including international models of good practice where available.
- There will be transparency in how the Review is conducted and how recommendations are made.
- There are no pre-determined outcomes with regards to the recommendations the Review will make.

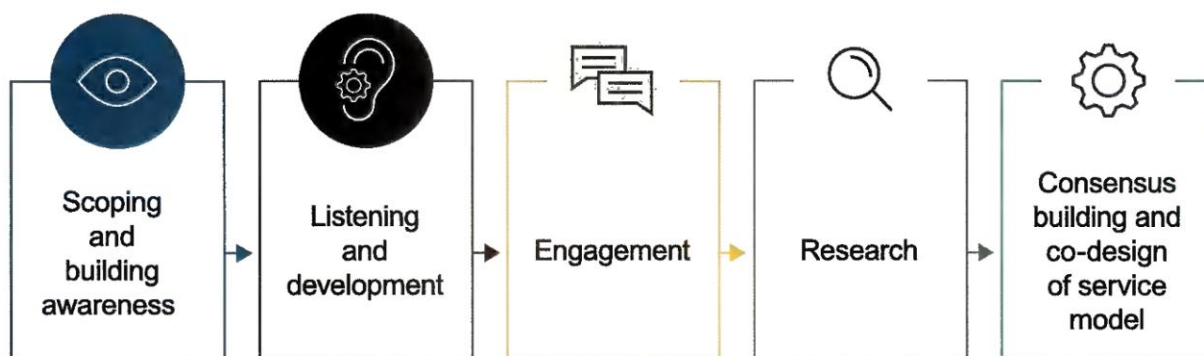
Independent review of gender identity services for children and young people

The Review's terms of reference (**Appendix 1**) are wide ranging in scope, looking at different aspects of gender identity services across the whole pathway through primary, secondary and specialist services, up to the point of transition to adult services. This includes consideration of referral pathways, assessment, appropriate clinical management and workforce recommendations.

I have also been asked to explore the reasons for the considerable increase in the number of referrals, which have had a significant impact on waiting times, as well as the changing case-mix of gender-questioning children and young people presenting to clinical services.

The Review is taking an investigative approach to understanding what the future service model should look like for children and young people. This means that its outcomes are not being developed in isolation or by committee but rather through an ongoing dialogue aimed at building a shared understanding of the current situation and how it can and should be improved.

The key aspects of the approach to the Review are:



My starting point has been to hear from a variety of experts with relevant expertise and those with lived experience to understand as many perspectives as possible. To date, this has included hearing directly from those with lived experience, from professionals and support and advocacy groups. This listening process will continue.

We have been very fortunate in the generosity of all those who have been prepared to talk to the Review and share their experiences. In addition to some divergent opinions, there are also some themes and views which seem to be widely shared. The commitment of professionals at all levels is striking and I genuinely believe that with collective effort we can improve services for the children and young people who are at the heart of this Review.

These discussions have been valuable to get an in-depth sense of the current situation and different viewpoints on how it may be improved. However, it is essential that this initial understanding is underpinned by more detailed data and an enhanced evidence base, which is being delivered through the Review's academic research programme.

Providing this evidence base for the Review is going to take some time. I recognise there is a pressing need to enhance the services currently available for children, young people, their

parents and carers, some of whom are experiencing considerable distress. Clinicians providing their treatment and care are also under pressure and cannot sustain the current workload. As such, I know the time I am taking to complete this Review and make recommendations will be difficult for some, but it is necessary.

I wrote to NHS England in May 2021 (**Appendix 2**) setting out some more immediate considerations whilst awaiting my full recommendations. This report builds on that letter and looks to provide some further interim advice.

Through our research programme, the Review team will continue to examine the literature and, where possible, will fill gaps in the existing evidence base. However, there will be persisting evidence gaps and areas of uncertainty. We need the engagement of service users, support and advocacy groups, and professionals across the wider workforce to work with us in the coming months in a collaborative and open-minded manner in order to reach a shared understanding of the problems and an agreed way forward that is in the best interests of children and young people.

My measure of success for this Review will be that this group of children and young people receive timely, appropriate and excellent care, not just from specialists but from every healthcare professional they encounter as they take the difficult journey from childhood to adulthood.

1. Summary and interim advice



Summary

1.1. In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust. This has contributed to long waiting lists and growing concern about how the NHS should most appropriately assess, diagnose and care for this population of children and young people.

1.2. Within the UK, the single specialist service has developed organically, and the clinical approach has not been subjected to some of the usual control measures that are typically applied when new or innovative treatments are introduced. Many of the challenges and knowledge gaps that we face in the UK are echoed internationally,¹ and there are significant gaps in the research and evidence base.

1.3. This Review was commissioned by NHS England to make recommendations on how to improve services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence and ensure that the best model for safe and effective services is commissioned (**Appendix 1**).

1.4. This interim report represents the Review's work to date. It sets out what we have heard so far and the approach we are taking moving forward. There is still much evidence to be gathered, questions to be answered, and voices to be heard, and our perspective will evolve as more evidence comes to light. However, there is sufficient clarity on several areas for the Review to be able to offer advice at this stage so that action can be taken more quickly.

1.5. The Review is not able to provide definitive advice on the use of puberty blockers and feminising/masculinising hormones at this stage, due to gaps in the evidence base; however, recommendations will be developed as our research programme progresses.

Every gender-questioning child or young person who seeks help from the NHS must receive the support they need to get on the appropriate pathway for them as an individual.

Children and young people with gender incongruence or dysphoria must receive the same standards of clinical care, assessment and treatment as every other child or young person accessing health services.

¹ Vrouwenraets LJ, Fredriks AM, Hannema SE, Cohen-Kettenis PT, de Vries MC (2015). [Early medical treatment of children and adolescents with gender dysphoria: an empirical ethical study](#). J Adolesc Health 57(4): 367-73. DOI: 10.1016/2015.04.004.

Conceptual understanding and consensus about the meaning of gender dysphoria

1.6. In clinical practice, a diagnosis of gender dysphoria is currently based on an operational definition, using the criteria set out in DSM-5 (**Appendix 3**). Some of these criteria are seen by some as outdated in the context of current understanding about the flexibility of gender expression.

1.7. At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual, or a more fluid and temporal response to a range of developmental, social, and psychological factors. Professionals' experience and position on this spectrum may determine their clinical approach.

1.8. Children and young people can experience this as a 'clinician lottery', and failure to have an open discussion about this issue is impeding the development of clear guidelines about their care.

Service capacity and delivery

1.9. A rapid change in epidemiology and an increase in referrals means that the number of children seeking help from the NHS is now outstripping the capacity of the single national specialist service, the Gender Identity Development Service (GIDS) at The Tavistock and Portman NHS Foundation Trust.

1.10. The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress.

1.11. Until very recently, any local professional, including non-health professionals, could refer to GIDS, which has meant that the quality and appropriateness of referrals lacks consistency, and local service provision has remained patchy and scarce.

1.12. The staff working within the specialist service demonstrate a high level of commitment to the population they serve. However, the waiting list pressure and lack of consensus development on the clinical approach, combined with criticism of the service, have all resulted in rapid turnover of staff and inadequate capacity to deal with the increasing workload. Capacity constraints cannot be addressed through financial investment alone; there are some complex workforce (recruitment; retention; and training) and cultural issues to address.

1.13. Our initial work has indicated that many professionals working at primary and secondary level feel that they have the transferable skills and the commitment to offer more robust support to this group of children and young people, but are nervous about doing so, partly because of the lack of formal clinical guidance, and partly due to the broader societal context.

1.14. Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters.

1.15. Children and young people are waiting lengthy periods to access GIDS, during which time some may be at considerable risk. By the time they are seen, their distress may have worsened, and their mental health may have deteriorated.

1.16. Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be overlooked.

1.17. The current move to adult services at age 17-18 may fall at a critical time in the young person's gender management. In contrast, young people with neurodiversity often remain under children's services until age 19 and some other clinical services continue to mid-20s. Further consideration will be needed regarding the age of transfer to adult services.

Service standards

1.18. The Multi-Professional Review Group (MPRG), set up by NHS England to ensure that procedures for assessment and for informed consent have been properly followed, has stated that the following areas require consideration:

- From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision.
- From documentation provided to the MPRG, there does not appear to be a standardised approach to assessment or progression through the process, which leads to potential gaps in necessary evidence and a lack of clarity.
- There is limited evidence of mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic or psychological formulation.
- Of 44 submissions received by the MPRG, 31% were not initially assured due to lack of safeguarding information. And in a number of cases there were specific safeguarding concerns. There do not appear to be consistent processes in place to work with other agencies to identify children and young people and families who may be vulnerable, at risk and require safeguarding.

- Appropriate clinical experts need to be involved in informing decision making.

1.19. Many of these issues were also highlighted by the Care Quality Commission (CQC) in 2020.²

International comparisons

1.20. The Netherlands was the first country to provide early endocrine interventions (now known internationally as the Dutch Approach). Although GIDS initially reported its approach to early endocrine intervention as being based on the Dutch Approach,³ there are significant differences in the NHS approach. Within the Dutch Approach, children and young people with neurodiversity and/or complex mental health problems are routinely given therapeutic support in advance of, or when considered appropriate, instead of early hormone intervention. Whereas criteria to have accessed therapeutic support prior to starting hormone blocking treatment do not appear to be integral to the current NHS process.

1.21. NHS endocrinologists do not systematically attend the multi-disciplinary meetings where the complex cases that may be referred to them are discussed, and until very recently did not routinely have

direct contact with the clinical staff member who had assessed the child or young person. This is not consistent with some international approaches for this group of children and young people, or in other multi-disciplinary models of care across paediatrics and adult medicine where challenging decisions about life-changing interventions are made.^{4,5}

1.22. In the NHS, once young people are started on hormone treatment, the frequency of appointments drops off rather than intensifies, and review usually takes place quarterly. Again, this is different to the Dutch Approach.⁶ GIDS staff would recommend more frequent contact during this period, but the fall-off in appointments reflects a lack of service capacity, with the aspiration being for more staff time to remedy this situation.

Existing evidence base

1.23. Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally.

² Care Quality Commission (2021). [The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report](#). London: CQC.

³ de Vries ALC, Cohen-Kettenis PT (2012). [Clinical management of gender dysphoria in children and adolescents: the Dutch approach](#). J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

⁴ Ibid.

⁵ Kyriakou A, Nicolaides NC, Skordis N (2020). [Current approach to the clinical care of adolescents with gender dysphoria](#). Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

⁶ de Vries ALC, Cohen-Kettenis PT (2012). [Clinical management of gender dysphoria in children and adolescents: the Dutch approach](#). J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

1.24. A lack of a conceptual agreement about the meaning of gender dysphoria hampers research, as well as NHS clinical service provision.

1.25. There has not been routine and consistent data collection within GIDS, which means it is not possible to accurately track the outcomes and pathways that children and young people take through the service.

1.26. Internationally as well as nationally, longer-term follow-up data on children and young people who have been seen by gender identity services is limited, including for those who have received physical interventions; who were transferred to adult services and/or accessed private services; or who desisted, experienced regret or detransitioned.

1.27. There has been research on the short-term mental health outcomes and physical side effects of puberty blockers for this cohort, but very limited research on the sexual, cognitive or broader developmental outcomes.⁷

1.28. Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly

birth-registered females presenting in early teens, particularly in relation to treatment and outcomes.

1.29. Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint.

The mismatch between service user expectations and clinical standards

1.30. By the time children and young people reach GIDS, they have usually had to experience increasingly long, challenging waits to be seen.⁸ Consequently, some feel they want rapid access to physical interventions and find having a detailed assessment distressing.

1.31. Clinical staff are governed by professional, legal and ethical guidance which demands that certain standards are met before a treatment can be provided. Clinicians carry responsibility for their assessment and recommendations, and any harm that might be caused to a patient under their care. This can create a tension between the aspirations of the young person and the responsibilities of the clinician.

⁷ National Institute for Health and Care Excellence (2020). [Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria](#).

⁸ Care Quality Commission (2021). [The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report](#). London: CQC.

Interim advice

1.32. The Review considers that there are some areas where there is sufficient clarity about the way forward and we are therefore offering some specific observations and interim advice. The Review will work with NHS England, providers and the broader stakeholder community to progress action in these areas.

Service model

1.33. It has become increasingly clear that a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand.

1.34. Additionally, children and young people with gender-related distress have been inadvertently disadvantaged because local services have not felt adequately equipped to see them. It is essential that they can access the same level of psychological and social support as any other child or young person in distress, from their first encounter with the NHS and at every level within the service.

1.35. A fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity. This must include support for any other clinical presentations that they may have.

1.36. The Review supports NHS England's plan to establish regional services, and welcomes the move from a single highly specialist service to regional hubs.

1.37. Expanding the number of providers will have the advantages of:

- creating networks within each area to improve early access and support;
- reducing waiting times for specialist care;
- building capacity and training opportunities within the workforce;
- developing a specialist network to ensure peer review and shared standards of care; and
- providing opportunities to establish a more formalised service improvement strategy.

Service provision

1.38. The primary remit of NHS England's proposed model is for the regional hubs to provide support and advice to referrers and professionals. However, it includes limited provision for direct contact with children and young people and their families.

1: The Review advises that the regional centres should be developed, as soon as feasibly possible, to become direct service providers, assessing and treating children and young people who may need specialist care, as part of a wider pathway. The Review team will work with NHS England and stakeholders to further define the proposed model and workforce implications.

2: Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children and young people who are in early stages of experiencing gender distress.

3: Clear criteria will be needed for referral to services along the pathway from primary to tertiary care so that gender-questioning children and young people who seek help from the NHS have equitable access to services.

4: Regional training programmes should be run for clinical practitioners at all levels, alongside the online training modules developed by Health Education England (HEE). In the longer-term, clearer mapping of the required workforce, and a series of competency frameworks will need to be developed in collaboration with relevant professional organisations.

Data, audit and research

1.39. A lack of routine and consistent data collection means that it is not possible to accurately track the outcomes and pathways children and young people take through the service. Standardised data collection is required in order to audit service standards and inform understanding of the epidemiology, assessment and treatment of this group. This, alongside a national network which brings providers together, will help build knowledge and improve outcomes through shared clinical standards and systematic data collection. In the longer-term, formalisation of such a network into a learning health system⁹ with an academic host would mean that there was systematised use of data to produce a continuing research programme with rapid translation into clinical practice and a focus on training.

⁹ Scobie S, Castle-Clarke S (2019). [Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics](#). Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

5: The regional services should have regular co-ordinated national provider meetings and operate to shared standards and operating procedures with a view to establishing a formal learning health system.

6: Existing and future services should have standardised data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.

7: Prospective consent of children and young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children and young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.

Clinical approach

Assessment processes

1.40. We have heard that there are inconsistencies and gaps in the assessment process. Our work to date has also demonstrated that clinical staff have different views about the purpose of assessment and where responsibility lies for different components of the process within the pathway of care. The Review team has commenced discussions with clinical staff across primary, secondary and tertiary care to develop a framework for these processes.

8: There needs to be agreement and guidance about the appropriate clinical assessment processes that should take place at primary, secondary and tertiary level.

9: Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiverse children and young people.

Hormone treatment

1.41. The issues raised by the Multi-Professional Review Group echo several of the problems highlighted by the CQC. It is essential that principles of the General Medical Council's Good Practice in Prescribing and Managing Medicine's and Devices¹⁰ are closely followed, particularly given the gaps in the evidence base regarding hormone treatment. Standards for decision making regarding endocrine treatment should also be consistent with international best practice.^{11,12,13}

10: Any child or young person being considered for hormone treatment should have a formal diagnosis and formulation, which addresses the full range of factors affecting their physical, mental, developmental and psychosocial wellbeing. This formulation should then inform what options for support and intervention might be helpful for that child or young person.

11: Currently paediatric endocrinologists have sole responsibility for treatment, but where a life-changing intervention is given there should also be additional medical responsibility for the differential diagnosis leading up to the treatment decision.

1.42. Paediatric endocrinologists develop a wide range of knowledge within their paediatric training, including safeguarding, child mental health, and adolescent development. Being party to the discussions and deliberations that have led up to the decision for medical intervention supports them in carrying out their legal responsibility for consent to treatment and the prescription of hormones.

12: Paediatric endocrinologists should become active partners in the decision making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.

¹⁰ General Medical Council (2021). [Good practice in prescribing and managing medicines and devices \(76-78\)](#).

¹¹ Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). [Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline](#). J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.

¹² Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). [Treatment of adolescents with gender dysphoria in the Netherlands](#). Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.

¹³ Kyriakou A, Nicolaides NC, Skordis N (2020). [Current approach to the clinical care of adolescents with gender dysphoria](#). Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

1.43. Given the uncertainties regarding puberty blockers, it is particularly important to demonstrate that consent under this circumstance has been fully informed and to follow GMC guidance¹⁴ by keeping an accurate record of the exchange of information leading to a decision in order to inform their future care and to help explain and justify the clinician's decisions and actions.

13: Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer-term outcomes.

14: In the immediate term the Multi-Professional Review Group (MPRG) established by NHS England should continue to review cases being referred by GIDS to endocrine services.

¹⁴ General Medical Council (2020). [Decision making and consent](#).

2. Context



Transgender, non-binary and gender fluid adults

2.1. NHS clinical services to support transgender adults with hormone treatment and subsequent surgery began in 1966.

2.2. Services were initially established within a mental health model, in conjunction with endocrinology and surgical services.

2.3. Currently, NHS services for transgender adults do not have adequate capacity to cope with demand.¹⁵ In addition, the broader healthcare needs of this group are not well met. This is important in the context of the current generation of gender-questioning children and young people in that there are now two inflows into adult services – individuals transitioning in adulthood, and those moving through from children's services.

2.4. Legal rights and protections for transgender people lagged behind the provision of medical services, with the Gender Recognition Act 2004 coming into force in April 2005. Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus.

2.5. It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services.

Terminology and diagnostic frameworks

2.6. The Office for National Statistics defines sex as “referring to the biological aspects of an individual as determined by their anatomy, which is produced by their chromosomes, hormones and their interactions; generally male or female; something that is assigned at birth”.¹⁶

2.7. The Office for National Statistics defines gender as “a social construction relating to behaviours and attributes based on labels of masculinity and femininity; gender identity is a personal, internal perception of oneself and so the gender category someone identifies with may not match the sex they were assigned at birth”.¹⁷

2.8. Societal attitudes towards gender roles and gender expression are changing. Children, teenagers and younger adults may more commonly see gender as a fluid, multi-faceted phenomenon which

¹⁵ Gender Identity Clinic, The Tavistock and Portman NHS Foundation Trust. [Waiting times](#).

¹⁶ Office for National Statistics (2019). [What is the difference between sex and gender?](#)

¹⁷ Ibid.

does not have to be binary, whereas older generations have tended to see gender as binary and fixed. It is not unusual for young people to explore both their sexuality and gender as they go through adolescence and early adulthood before developing a more settled identity. Many achieve this without experiencing significant distress or requiring support from the NHS, but this is not the case for all.

2.9. For those who require support from the NHS, there are two widely used frameworks which provide diagnostic criteria. The International Classification of Diseases (ICD), which is the World Health Organization (WHO) mandated health data standard, and the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the classification system for mental health disorders produced by the American Psychiatric Association. The current editions of these manuals – ICD-11 and DSM-5 – came into effect in January 2022 and 2013 respectively.

2.10. ICD-11¹⁸ has attempted to depathologise gender diversity, removing the term 'gender identity disorders' from its mental health section and creating a new section for gender incongruence and transgender identities in a chapter on sexual health. These changes are part of a much broader societal drive to remove the stigma previously associated with transgender healthcare. ICD-11

defines gender incongruence as being "characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex." Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis. The full criteria for gender incongruence of childhood and gender incongruence of adolescence or adulthood are listed in **Appendix 3**.

2.11. DSM-5¹⁹ is currently the framework used to diagnose gender dysphoria. This diagnostic category describes gender dysphoria as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender". A diagnosis of gender dysphoria is usually deemed necessary before a young person can access hormone treatment, and criteria are listed in **Appendix 3**.

Conceptual understanding of gender incongruence in children and young people

2.12. Children and young people presenting to gender identity services are not a homogeneous group. They vary in their age at presentation, their cultural background, whether they identify as binary, non-binary, or gender fluid, whether they are neurodiverse and in a host of other ways.

¹⁸ World Health Organization (2022). [International Classification of Diseases Eleventh Revision](#).

¹⁹ American Psychiatric Association (2013). [Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5™, 5th ed.](#)

2.13. Some children and young people may thrive during a period of gender-questioning whilst for others it can be accompanied with a level of distress that can have a significant impact on their functioning and development.

2.14. Alongside these very varied presentations, it is highly unlikely that a single cause for gender incongruence will be found. Many authors view gender expression as a result of a complex interaction between biological, cultural, social and psychological factors.

2.15. Despite a high level of agreement about these points, there are widely divergent and, in some instances, quite polarised views among service users, parents, clinical staff and the wider public about how gender incongruence and gender-related distress in children and young people should be interpreted, and this has a bearing on expectations about clinical management.

2.16. These views will be influenced by how each individual weighs the balance of factors that may lead to gender incongruence, and the distress that may accompany it. Beliefs about whether it might be inherent and/or immutable, whether it might be a transient response to adverse experiences, whether it might be highly fluid and/or likely to change in later adolescence/early adulthood, etc will have

a profound influence on expectations about treatment options.²⁰

2.17. All of these views may be overlaid with strongly held concerns about children's and young people's rights, autonomy, and/or protection.

2.18. The disagreement and polarisation is heightened when potentially irreversible treatments are given to children and young people, when the evidence base underlying the treatments is inconclusive, and when there is uncertainty about whether, for any particular child or young person, medical intervention is the best way of resolving gender-related distress.

2.19. As with many other contemporary polarised disagreements, the situation is exacerbated when there is no space to have open, non-judgemental discussions about these differing perspectives. A key aim of this review process will be to encourage such discussions in a safe and respectful manner so that progress can be made in finding solutions.

²⁰ Wren B (2019). Notes on a crisis of meaning in the care of gender-diverse children. In: Hertzmann L, Newbigin J (eds) *Sexuality and Gender Now: Moving Beyond Heteronormativity*. Routledge.

3. Current services



Current service model for gender-questioning children and young people

3.1. Currently there are no locally or regionally commissioned services for children and young people who seek help from the NHS in managing their gender-related distress. Within primary and secondary care, some clinical staff have more interest and expertise in initial management of this group of young people, but such individuals are few and far between.

3.2. The pathway for NHS support around gender identity for children and young people is designated as a highly specialised service.²¹ The Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust is commissioned by NHS England to provide specialist assessment, support and, where appropriate, hormone intervention for children and young people with gender dysphoria. It is the only NHS provider of specialist gender services for children and young people in England. The Trust runs satellite bases in Leeds and Bristol. Until recently GIDS accepted referrals from multiple sources, for example, GPs, secondary care, social care, schools, and support and advocacy groups, which is unusual for a specialist service.

3.3. Children and young people are assessed by two members of the GIDS team who may be any combination of psychologists, psychotherapists, family therapists, or social workers. If there is uncertainty about the right approach, individual cases may be discussed in a complex case meeting. Those deemed appropriate for physical interventions are referred on to the endocrine team; under the current Standard Operating Procedure (SOP), this decision requires a multi-disciplinary team (MDT) discussion within GIDS. A member of the GIDS team attends new appointments in the endocrine clinic, but they will not routinely be the member of staff who saw the young person for assessment. However, very recently a triage meeting has been piloted to enable endocrinologists to discuss upcoming appointments with the clinician who saw the young person for assessment. The young person then attends an education session prior to their endocrine appointment. The endocrinologist will assess any medical contraindications prior to seeking consent from the patient for any hormone treatments.

3.4. For many years, the GIDS approach was to offer assessment and support, and to only start puberty blockers when children reached sexual maturity at about age 15 (Tanner Stage 5) as the first step in the treatment process to feminise or masculinise the young person, with

²¹ [National Health Service Commissioning Board and Clinical Commissioning Groups \(Responsibilities and Standing Rules\) Regulations 2012.](#)

oestrogen or testosterone given from age 16. Feminising/masculinising hormones are not given at an earlier stage because of the irreversibility of some of their actions in developing secondary sex characteristics of the acquired gender.^{22,23}

3.5. In 1998, a new protocol was published by the Amsterdam gender identity clinic.²⁴ It was subsequently named the Dutch Approach.²⁵ This involved giving puberty blockers much earlier, from the time that children showed the early signs of puberty (Tanner Stage 2), to pause further pubertal changes of the sex at birth. This stage of pubertal development was chosen because it was felt that although many younger children experienced gender incongruence as a transient developmental phenomenon, those who expressed early gender incongruence which continued into puberty were unlikely to desist at that stage.

3.6. It was felt that blocking puberty would buy time for children and young people to fully explore their gender identity and help with the distress caused by the development of their secondary sexual characteristics. The Dutch criteria

for treating children with early puberty blockers were: (i) a presence of gender dysphoria from early childhood; (ii) an increase of the gender dysphoria after the first pubertal changes; (iii) an absence of psychiatric comorbidity that interferes with the diagnostic work-up or treatment; (iv) adequate psychological and social support during treatment; and (v) a demonstration of knowledge and understanding of the effects of gonadotropin-releasing hormones (puberty blockers), feminising/masculinising hormones, surgery, and the social consequences of sex reassignment.²⁶

3.7. Under the Dutch Approach, feminising/masculinising hormones were started at age 16 and surgery was permitted to be undertaken from age 18, as in England.

3.8. From 2011, early administration of puberty blockers was started in England under a research protocol, which partially paralleled the Dutch Approach (the Early Intervention Study). From 2014, this protocol was adopted by GIDS as routine clinical practice. Results of the Early Intervention Study were published in December 2021.²⁷

²² Delemarre-van de Wall HA, Cohen-Kettenis PT (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol 155 (Suppl 1): S131–7. DOI: 10.1530/eje.1.02231.

²³ de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

²⁴ Cohen-Kettenis PT, Van Goozen S (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. Eur Child Adolesc Psychiatry 7: 246–8. DOI: 10.1007/s007870050073.

²⁵ de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

²⁶ Ibid.

²⁷ Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.

3.9. However, the Dutch Approach differs from the GIDS approach in having stricter requirements about provision of psychological interventions. For example, under the Dutch Approach, if young people have gender confusion, aversion towards their sexed body parts, psychiatric comorbidities or Autism Spectrum Disorder (ASD) related diagnostic difficulties, they may receive psychological interventions only, or before, or in combination with medical intervention. Of note, in 2011, the Amsterdam team were reporting that up to 10% of their referral base were young people with ASD.²⁸

Changing epidemiology

3.10. In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS.²⁹ From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years

to first appointment.³⁰ This has severely impacted on the capacity of the existing service to manage referrals in the safe and responsive way that they aspire to and has led to considerable distress for those on the waiting list.

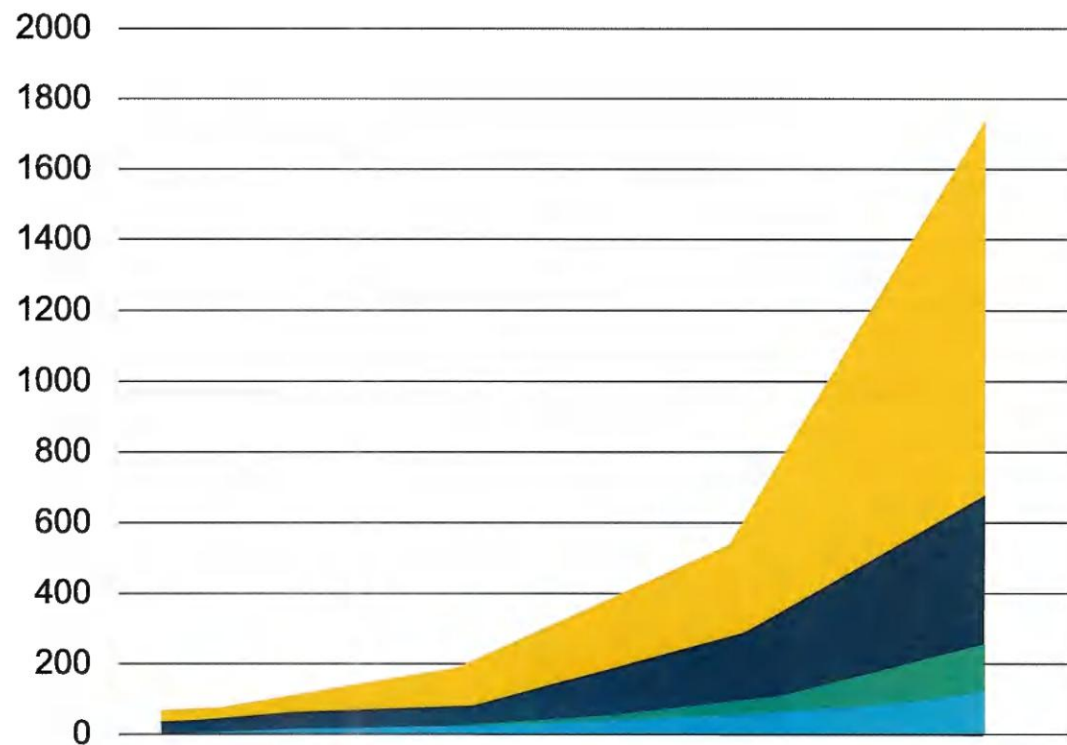
3.11. This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years. In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children.³¹

²⁸ Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). [Treatment of adolescents with gender dysphoria in the Netherlands](#). Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.

²⁹ de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). [Sex ratio in children and adolescents referred to the gender identity development service in the UK \(2009-2016\)](#). Arch Sex Behav 47(5): 1301–4.

³⁰ Care Quality Commission (2021). [The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report](#). London: CQC.

³¹ Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). [Gender Dysphoria in looked-after and adopted young people in a gender identity development service](#). Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

Figure 1: Sex ratio in children and adolescents referred to GIDS in the UK (2009-16)

	2009	2010	2011	2012	2013	2014	2015	2016
Adolescents F	15	48*	78*	141*	221*	314*	689*	1071*
Adolescents M	24	44*	41	77*	120*	185*	293*	426*
Children F	2	7	12	17	22	36	77*	138*
Children M	10	19	29	30	31	55*	103*	131

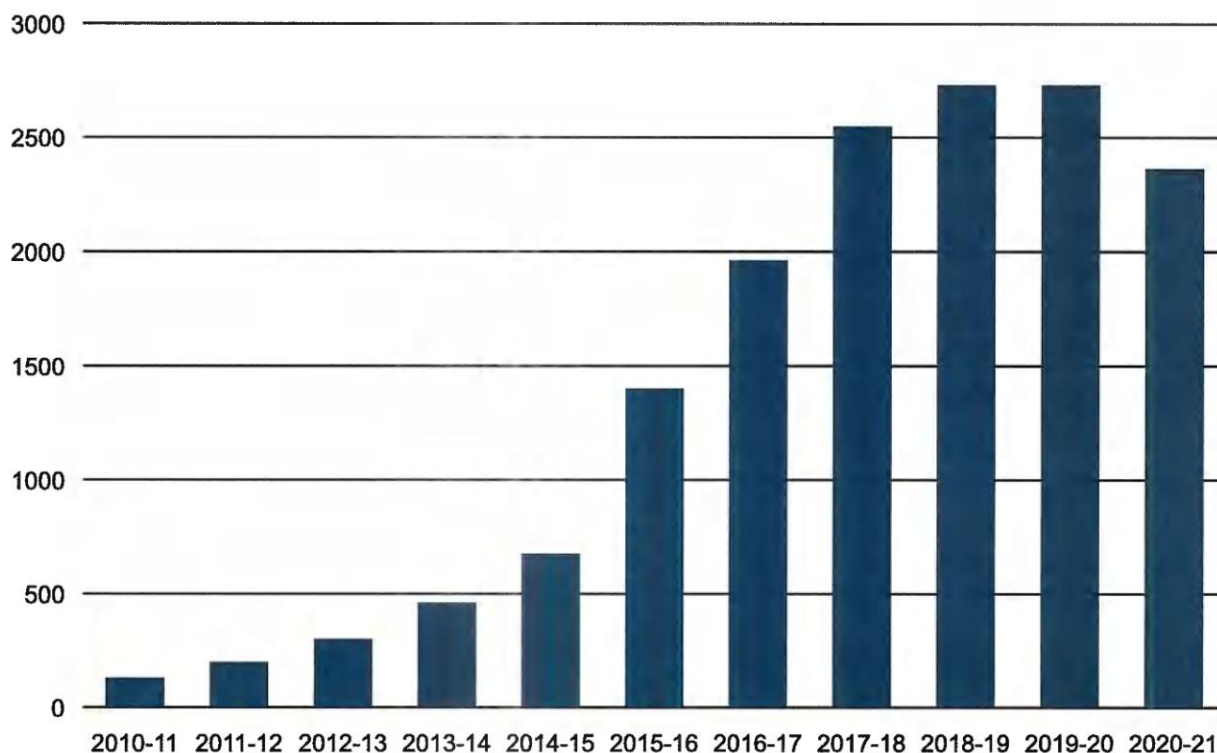
AFAB = assigned female at birth; **AMAB** = assigned male at birth

***Indicates** $p < .05$ which shows a significant increase of referrals compared to the previous year

Source: de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018).³²

³² de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.

Figure 2: Referrals to GIDS, 2010-11 to 2020-21



Source: Gender Identity Development Service.³³

3.12. In 2019, GIDS reported that about 200 children and young people from a referral base of 2,500 were referred on to the endocrine pathway. There is no published data on how the other children and young people from this referral baseline were managed, for example if: their gender dysphoria was resolved; they were still being assessed or receiving ongoing psychological support and input; they were not eligible for puberty blockers due to age; they were referred to endocrine services at a later stage; they were transferred to adult services; or they accessed private services.

Challenges to the service model and clinical approach

3.13. Over a number of years, in parallel with the increasing numbers of referrals, GIDS faced increasing challenges, both internally and externally. There were different views held within the staff group about the appropriate clinical approach, with some more strongly affirmative and some more cautious and concerned about the use of physical intervention. The complexity of the cases had also increased, so clinical decision making had become more difficult. There was also a high staff

³³ Gender Identity Development Service. [Referrals to GIDS, financial years 2010-11 to 2020-21](#).

turnover, and accounts from staff concerned about the clinical care, which were picked up in both mainstream and social media. This culminated in 2018 with an internal report by a staff governor.

3.14. Following that report, a review was carried out in 2019 by the Trust's medical director. This set out the need for clearer processes for the service's referral management, safeguarding, consent, and clinical approach, and an examination of staff workload and support, and a new Standard Operating Procedure (SOP) was put in place.

NHS England Policy Working Group

3.15. In January 2020, a Policy Working Group (PWG) was established by NHS England to undertake a review of the published evidence on the use of puberty blockers and feminising/masculinising hormones in children and young people with gender dysphoria to inform a policy position on their future use. Given the increasingly evident polarisation among clinical professionals, Dr Cass was asked to chair the group as a senior clinician with no prior involvement or fixed views in this area. The PWG comprised an expert group including endocrinologists, child and adolescent psychiatrists and paediatricians representing their respective Royal

Colleges, an ethicist, a GP, senior clinicians from the NHS GIDS, a transgender adult and parents of gender-questioning young people. The process was supported by a public health consultant and policy, pharmacy and safeguarding staff from NHS England.

3.16. NHS England uses a standardised protocol for developing clinical policies. The first step of this involves defining the PICO (the Population being treated, the Intervention, a Comparator treatment, and the intended Outcomes). This of itself was challenging, with a particular difficulty being definition of the intended outcomes of puberty blockers, and suitable comparators for both hormone interventions. However, agreement was reached on what should be included in the PICO and subsequently the National Institute for Health and Care Excellence (NICE) was commissioned to review the published evidence,^{34,35} again following a standardised protocol which has strict criteria about the quality of studies that can be included.

3.17. Unfortunately, the available evidence was not strong enough to form the basis of a policy position. Some of the challenges and outstanding uncertainties are summarised as follows.

³⁴ National Institute for Health and Care Excellence (2020). [Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria](#).

³⁵ National Institute for Health and Care Excellence (2020). [Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria](#).

Feminising/masculinising hormones

3.18. Sex hormones have been prescribed for transgender adults for several decades, and the long-term risks and side effects are well understood. These include increased cardiovascular risk, osteoporosis, and hormone-dependent cancers.

3.19. In young people, consideration also needs to be given to the impact on fertility, with the need for fertility counselling and preservation.

3.20. The additional physical risk of starting these treatments at age 16+ rather than age 18+ is unlikely to add significantly to the total lifetime risk, although data on this will not be available for many years. However, as evidenced by take-up of treatment with feminising/masculinising hormones, where there is a high level of certainty that physical transition is the right option, the child or young person may be more accepting of these risks, which can seem remote from the immediate gender distress.

3.21. The most difficult question in relation to feminising/masculinising hormones therefore is not about long-term physical risk which is tangible and easier to understand. Rather, given the irreversible nature of many of the changes, the greatest difficulty centres on the decision to proceed to physical transition; this relies on the effectiveness of the assessment, support and counselling processes, and ultimately the shared decision making between

clinicians and patients. Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally.

3.22. Regardless of the nature of the assessment process, some children and young people will remain fluid in their gender identity up to early to mid-20s, so there is a limit as to how much certainty one can achieve in late teens. This is a risk that needs to be understood during the shared decision making process with the young person.

3.23. It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group.

Puberty blockers

3.24. The administration of puberty blockers is arguably more controversial than administration of the feminising/masculinising hormones, because there are more uncertainties associated with their use.

3.25. There has been considerable discussion about whether the treatment is 'experimental'; strictly speaking an experimental treatment is one that is being given as part of a research protocol, and this is not the case with puberty blockers, because the GIDS research protocol was stopped in 2014. At that time, the treatment was experimental and innovative, because the drug was licensed for use in children, but specifically for children with precocious puberty. This was therefore the first time it was used 'off-label' in the UK for children with gender dysphoria. If a drug is used 'off-label' it means it is being used for a condition that is different from the one for which it was licensed. The many uncertainties around the 'off-label' use were recognised, but given that this was not a new drug, it did not need Medicines and Healthcare products Regulatory Agency (MHRA) approval at that time.

3.26. The important question now, as with any treatment, is whether the evidence for the use and safety of the medication is strong enough as judged by reasonable clinical standards.

3.27. One of the challenges that NHS England's PWG faced in considering this question was the lack of clarity about intended outcomes, several of which have been proposed including:

- providing time/space for the young person to make a decision about continuing with transition;
- reducing or preventing worsening of distress;
- improving mental health; and
- stopping potentially irreversible pubertal changes which might later make it difficult for the young person to 'pass' in their intended gender role.

3.28. Proponents for the use of puberty blockers highlight the distress that young people experience through puberty and the risk of self-harm or suicide.³⁶ However, some clinicians do not feel that distress is actually alleviated until children and young people are able to start feminising/masculinising hormones. The Review will seek to gain a better understanding of suicide data and the impact of puberty blockers through its research programme.

3.29. On the other hand, it has been asserted that starting puberty blockers at an older age provides children and young people with more time to achieve fertility preservation. In the case of birth-registered males, there is an argument that it also

³⁶ Turban JL, King D, Carswell JM, et al (2020). [Pubertal suppression for transgender youth and risk of suicidal ideation](#). *Pediatrics* 145 (2): e20191725. DOI: 10.1542/peds.2019-1725.

allows more time to achieve adequate penile growth for successful vaginoplasty.

3.30. In the short-term, puberty blockers may have a range of side effects such as headaches, hot flushes, weight gain, tiredness, low mood and anxiety, all of which may make day-to-day functioning more difficult for a child or young person who is already experiencing distress. Short-term reduction in bone density is a well-recognised side effect, but data is weak and inconclusive regarding the long-term musculoskeletal impact.³⁷

3.31. The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminates in progression to feminising/masculinising hormones by impeding the usual process of sexual orientation and gender identity development. Data from both the Netherlands³⁸ and the study conducted by GIDS³⁹ demonstrated that almost all children and young people who are put on puberty blockers go on to sex hormone treatment (96.5% and 98%

respectively). The reasons for this need to be better understood.

3.32. A closely linked concern is the unknown impacts on development, maturation and cognition if a child or young person is not exposed to the physical, psychological, physiological, neurochemical and sexual changes that accompany adolescent hormone surges. It is known that adolescence is a period of significant changes in brain structure, function and connectivity.⁴⁰ During this period, the brain strengthens some connections (myelination) and cuts back on others (synaptic pruning). There is maturation and development of frontal lobe functions which control decision making, emotional regulation, judgement and planning ability. Animal research suggests that this development is partially driven by the pubertal sex hormones, but it is unclear whether the same is true in humans.⁴¹ If pubertal sex hormones are essential to these brain maturation processes, this raises a secondary question of whether there is a critical time window for the processes to take place, or whether catch up is possible when oestrogen or testosterone is introduced later.

³⁷ National Institute for Health and Care Excellence (2020). [Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria](#).

³⁸ Brik T, Vrouwenraets LJ, de Vries MC, Hannema SE (2020). [Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria](#). Arch Sex Behav 49: 2611–8. DOI: 10.1007/s10508-020-01660-8.

³⁹ Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). [Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK](#). PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.

⁴⁰ Delevichab K, Klinger M, Nana OJ, Wilbrecht L (2021). [Coming of age in the frontal cortex: The role of puberty in cortical maturation](#). Semin Cell Dev Biol 118: 64–72. DOI: 10.1016/j.semcdb.2021.04.021.

⁴¹ Goddings A-L, Beltz A, Jiska S, Crone EA, Braams BR (2019). [Understanding the role of puberty in structural and functional development of the adolescent brain](#). J Res Adolesc 29(1): 32–53. DOI: 10.1111/jora.12408.

3.33. An international interdisciplinary panel⁴² has highlighted the importance of understanding the neurodevelopmental outcomes of pubertal suppression and defined an appropriate approach for investigating this further. However, this work has not yet been undertaken.

Initiation of Cass Review

3.34. Dr Cass' own reflections on the PWG process, the available literature, and the issues it highlighted were as follows:

- Firstly, that hormone treatment is just one possible outcome for gender-questioning children and young people. A much better understanding is needed about: the increasing numbers of children and young people with gender-related distress presenting for help; the appropriate clinical pathway for each individual; their support needs; and the full range of potential treatment options.
- Secondly, there is very limited follow-up of the subset of children and young people who receive hormone treatment, which limits our understanding about the long-term outcomes of these treatments and this lack of follow up data should be corrected.

- Thirdly, the assessment process is inconsistent across the published literature. The outcome of hormone treatment is highly influenced by whether the assessment process accurately selects those children and young people most likely to benefit from medical treatment. This makes it difficult to draw conclusions from published studies.

3.35. In light of the above, NHS England commissioned this independent review to make recommendations on how the clinical management and service provision for children and young people who are experiencing gender incongruence or gender-related distress can be improved.

CQC inspection

3.36. In October and November 2020, the Care Quality Commission (CQC) inspectors carried out an announced, focused inspection of GIDS due to concerns reported to them by healthcare professionals and the Children's Commissioner for England. Concerns related to clinical practice, safeguarding procedures, and assessments of capacity and consent to treatment.

⁴² Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, et al (2020). Consensus parameter: research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. Transgender Health 5(4). DOI: 10.1089/trgh.2020.0006.

3.37. The CQC report, published in January 2021,⁴³ gave the service an overall rating of inadequate. The report noted the high level of commitment and caring approach of the staff but identified a series of issues that needed improvement. In addition to the growing waiting list pressures, the CQC identified problems in several other areas including: the assessment and management of risk; the variations in clinical approach; the lack of clarity and consistency of care plans; the lack of any clear written rationale for decision making in individual cases; and shortfalls in the multidisciplinary mix required for some patient groups. Recording of capacity, competency and consent had improved since the new SOP in January 2020; however, there remained a culture in which staff reported feeling unable to raise concerns.

3.38. The CQC reported that when it inspected GIDS, there did not appear to be a formalised assessment process, or standard questions to explore at each session, and it was not possible to tell from the notes why an individual child might have been referred to endocrinology whilst another had not. Current GIDS data demonstrate that a majority of children and young people seen by the service do not get referred for endocrine treatment, but there is no clear information about what

other diagnoses they receive, and what help or support they might need.

3.39. Since the CQC report, NHS England and The Tavistock and Portman NHS Foundation Trust management team have been working to address the issues raised. However, whilst some problems require a focused Trust response, the waiting list requires a system-wide response. This was noted in the letter from the Review to NHS England in May 2021 (**Appendix 2**).

Legal background

3.40. This section sets out the chronology of recent case law. In October 2019, a claim for Judicial Review was brought against The Tavistock and Portman NHS Foundation Trust. The claimants' case was summarised by the High Court as follows: "The claimants' case is that children and young persons under 18 are not competent to give consent to the administration of puberty blocking drugs. Further, they contend that the information given to those under 18 by the defendant [GIDS] is misleading and insufficient to ensure such children or young persons are able to give informed consent. They further contend that the absence of procedural safeguards, and the inadequacy of the information provided, results in an infringement of the rights of such children and young persons under Article 8 of the European Convention

⁴³ Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

for the Protection of Human Rights and Fundamental Freedoms.”⁴⁴

3.41. In December 2020, three judges in the High Court of England and Wales handed down judgment in *Bell v Tavistock*.⁴⁵ (Most cases in the High Court are heard by a single judge sitting alone, and when a case is heard by more than one judge in the High Court, it is described as the Divisional Court.) The Divisional Court recognised that the Tavistock’s policies and practices as set out in the service specification were not unlawful. However, the Court made a declaration that set out in detail a series of implications of treatment that a child would need to understand to be *Gillick* competent⁴⁶ to consent to puberty blockers. Specifically, because most children put on puberty blockers go on to have feminising/masculinising hormones, the judgment said a child would need to understand not only the full implications of puberty blocking drugs, but also the implications of the full pathway of medical and surgical transition. The judges concluded that it will be “very doubtful” that 14-15 year-olds have such competence, and “highly unlikely” that children aged 13 or under have competence for that decision. Under the Mental Capacity Act 2005, 16-17 year-olds are presumed to have capacity, and they are effectively treated as adults for consent to medical treatment under the Family Law Reform Act 1969 section 8, but the judges

suggested that it would be appropriate for clinicians to involve the court in any case where there were doubts as to whether the proposed treatment would be in the long term best interests of a 16-17 year-old.

3.42. Following the Divisional Court judgment in *Bell v Tavistock*, a claim was brought against the Tavistock in the High Court Family Division by the mother of a child for a declaration that she and the child’s father had the ability in law to consent on behalf of their child to the administration of puberty blockers (*AB v CD*).⁴⁷ The Court concluded that “the parents’ right to consent to treatment on behalf of the child continues even when the child is *Gillick* competent to make the decision, save where the parents are seeking to override the decision of the child” [para 114] and that there is no “general rule that puberty blockers should be placed in a special category by which parents are unable in law to give consent” [para 128].

⁴⁴ *Bell v Tavistock*. [2020] EWHC 3274 (Admin).

⁴⁵ *Ibid*.

⁴⁶ *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112.

⁴⁷ *AB v CD & Ors* [2021] EWHC 741.

3.43. Subsequently, the Tavistock appealed the Divisional Court's earlier decision in *Bell v Tavistock* and was successful.⁴⁸ The Court of Appeal held that it was not appropriate for the Divisional Court to provide the guidance about the likelihood of having *Gillick* competence at particular ages, or about the need for court approval [para 91]. The Court of Appeal went on to say "The Divisional Court concluded that Tavistock's policies and practices (as expressed in the service specification and the SOP) were not unlawful and rejected the legal criticism of its materials. In those circumstances, the claim for judicial review is dismissed." [para 91]. However, clinicians should "take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed" [para 92].

3.44. The Court of Appeal in *Bell v Tavistock* recognised the lawfulness of treating children for gender dysphoria in this jurisdiction. Recognising the divergences in medical opinion, morality and ethics, it indicated that the question of whether treatment should be made available is a matter of policy "for the National Health Service, the medical profession and its regulators and Government and Parliament" [para 3].

3.45. Following the Divisional Court decision in *Bell v Tavistock*, new referrals for puberty blockers were suspended and a requirement was put in place that children currently on puberty blockers were reviewed with a view to court proceedings for a judge to determine the best interests for children in whom these medications were considered essential. This requirement was changed following *AB v CD*, with the reinstatement of the hormone pathway in March 2021. However, an external panel, the Multi Professional Review Group (MPRG), was established to ensure that procedures for assessment and for informed consent had been properly followed. The outcome of the *Bell* appeal has not changed this requirement, which is contingent not just on the legal processes but on the concerns raised by CQC regarding consent, documentation and clarity about decision making within the service.⁴⁹

⁴⁸ [EWCA \[2021\] Civ 1363](#).

⁴⁹ Care Quality Commission (2021). [The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report](#). London: CQC.

The Multi-Professional Review Group

3.46. NHS England has established a Multi-Professional Review Group (MPRG) to review whether the agreed process has been followed for a child to be referred into the endocrinology clinic and to be prescribed treatment. The Review has spoken directly to the MPRG, which has reported its observations of current practice.

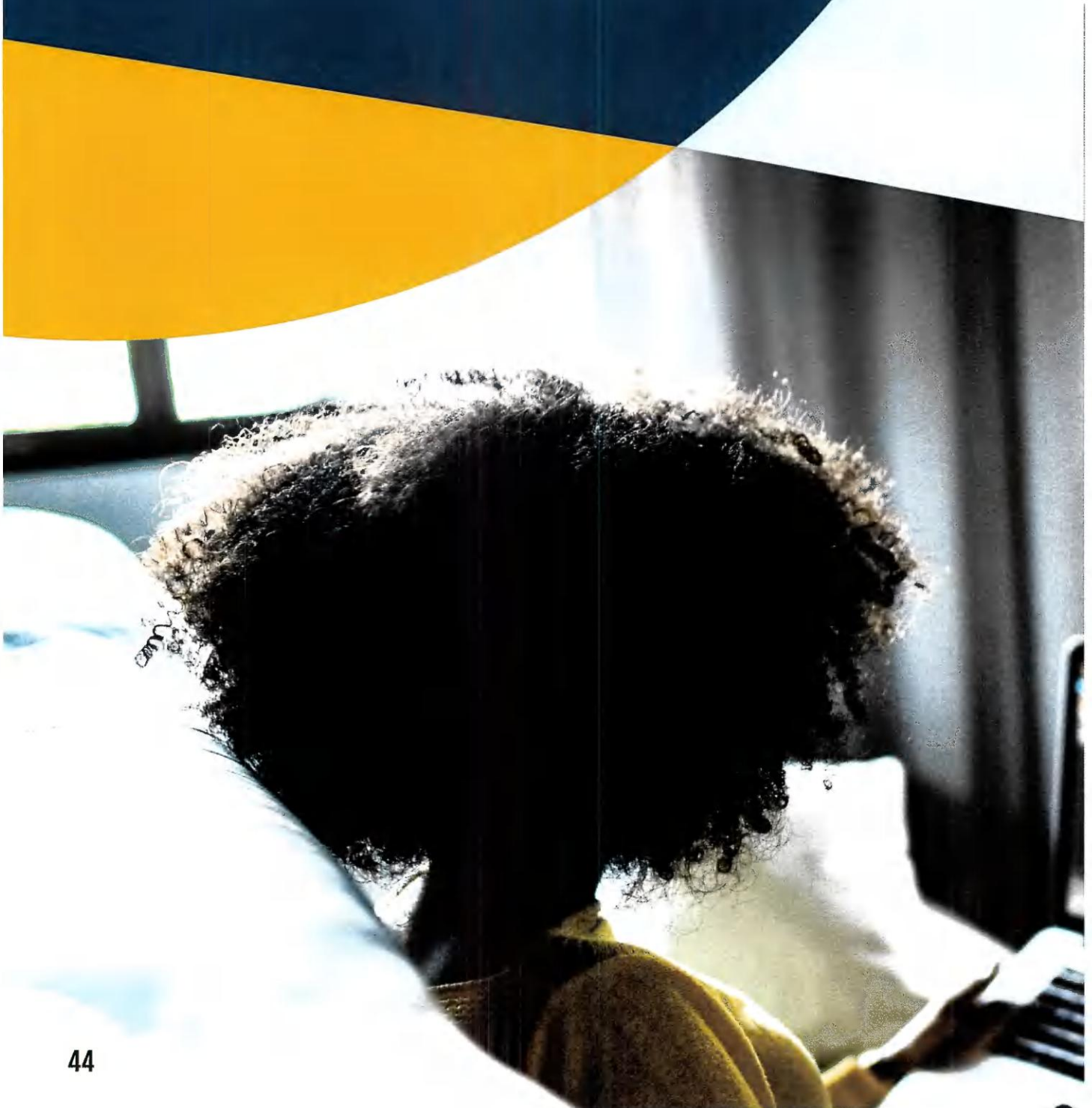
3.47. The MPRG has stated that its work has been impeded by delays in the provision of clinical information, the lack of structure in the documentation received, and gaps in the necessary evidence. This means that when reviewing the documents provided it is not always easy to determine if the process for referral for endocrine treatment has been fully or safely followed for a particular child or young person.

3.48. The MPRG indicates that there does not appear to be a standardised approach to assessment. They are particularly concerned about safeguarding shortfalls within the assessment process. There is also limited evidence of systematic, formal mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic formulation in relation to co-occurring mental health difficulties. This issue was also highlighted by the Care Quality Commission (CQC).⁵⁰

3.49. Additionally, there is concern that communications to GPs and parents regarding prescribed treatment with puberty blockers sometimes come from non-medical staff.

⁵⁰ Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

4. What the review has heard so far



Listening sessions

4.1. Since its establishment, the Review has met with an extensive range of stakeholders, including professionals, their respective governing organisations and those with lived experience, both directly and through support and advocacy groups, to understand the broad range of views and experiences surrounding the delivery of gender identity services.

What we have heard from service users, their families and support and advocacy groups

Issues for children and young people

4.2. What we understand most clearly from all we have heard is that at the centre of a difficult and complex debate are children, young people and families in great distress. We have heard concerns about children and young people facing the stress of being on a prolonged waiting list with limited support available from statutory services, lack of certainty about when and if they might reach the top of that list and subsequent impacts on mental health. Also, the particular issues that have followed the *Bell v Tavistock* litigation.

4.3. We have heard about the anxiety that birth-registered males face as they come closer to the point where they will grow facial hair and their voice drops, and the fear that it will make it harder for them to pass as a transgender woman in later life. We have also heard about the distress

experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts.

4.4. When children and young people are able to access the service, there is often a sense of frustration with what several describe as the “gatekeeping” medical model and a “clinician lottery”. This can feel like a series of barriers and hurdles designed to add to, rather than alleviate, distress. Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria. By the time they are seen in the GIDS clinic, they may feel very certain of their gender identity and be anxious to start hormone treatment as quickly as possible. However, they can then face a period of what can seem like intrusive, repetitive and unnecessary questioning. Some feel that this undermines their autonomy and right to self-determination.

4.5. We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation. We have also heard that many of those seeking NHS support identify as non-binary, gender non-conforming, or gender fluid. We understand that some

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young people who identify as non-binary feel their needs are not met by clinical services unless they give a binary narrative about their gender preferences.

Issues for parents

4.6. We have also heard about the distress parents may feel as they try to work out how best to support their children and how tensions and conflict may arise where parents and their children have different views. For example, some parents have highlighted the importance of ensuring that children and young people are able to keep their options fluid until such time as it becomes essential to commit to a hormonal course of action, whilst their children may want more rapid hormone intervention.

4.7. We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment.

4.8. Parents have also raised concerns about the vulnerability of neurodiverse children and young people and expressed that the communication needs of these children and young people are not adequately reflected during assessment processes or treatment planning.

4.9. GIDS has always required consent/assent from both the child and parents/carers and has sought ways to resolve family conflict, which in the worst-case scenario can lead to family breakdown. It has been highlighted to us that the future

service model should provide more targeted support for parents and carers.

Service issues

4.10. Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria. This issue is compounded by the waiting list, which means that there can be a significant period of time without appropriate assessment, treatment or care.

4.11. Stakeholders have spoken of the need for appropriate assessment when first accessing NHS services to aid both the exploration of the child or young person's wellbeing and gender distress and any other challenges they may be facing.

Information

4.12. We have also heard about the lack of access to accurate, balanced information upon which children, young people and their families/carers can inform their decisions.

4.13. We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long

children and young people are waiting to access services.

Other issues

4.14. Several issues that were raised with us are not explored further in this interim report, but we have taken note of them. These will be considered further during the lifetime of the Review and include:

- The important role of schools and the challenges they face in responding appropriately to gender-questioning children and young people.
- The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as lesbian rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years.
- The issues faced by detransitioners highlight the need for better services and pathways for this group, many of whom are living with irreversible effects of transition but for whom there is no clear access to services as they fall outside the responsibility of NHS gender identity services.
- The age at which adult gender identity clinics can receive referrals, with concerns about the inclusion of 17-year-olds. The service offer in adult services

is perceived to be quite different from that of GIDS, and young people presenting later may therefore not be afforded the same level of therapeutic input under the adult service model. There is also concern about the impact on the young person of changing clinicians at a crucial point in their care. The movement of young people with special educational needs between children's and adult services raises particular concerns.

What we have heard from healthcare professionals

Lack of professional consensus

4.15. Clinicians and associated professionals we have spoken to have highlighted the lack of an agreed consensus on the different possible implications of gender-related distress – whether it may be an indication that the child or young person is likely to grow up to be a transgender adult and would benefit from physical intervention, or whether it may be a manifestation of other causes of distress. Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach.

4.16. Speaking to current and ex-GIDS staff, we have heard about the pressure on GIDS clinicians, many of whom feel overwhelmed by the numbers of children and young people being referred and who are demoralised by the media coverage of their service. Although the clinical team attempt to manage risk on the waiting list by engaging with local services, there is limited capacity and/or capability to respond appropriately to the needs of this group in primary and secondary care. The Review has already referred to this issue as the most pressing priority in its letter to NHS England (**Appendix 2**), alongside potential risks relating to safeguarding and/or mental health issues, and diagnostic overshadowing.

4.17. With respect to GIDS, we have been told that although there are forums for staff to discuss difficult cases with senior colleagues, it is still difficult for staff to raise concerns about the clinical approach. Also that many individuals who are more cautious and advocate the need for an exploratory approach have left the service.

Consistency and standards

4.18. GIDS staff have confirmed that judgements are very individual, with some clinicians taking a more gender-affirmative approach and others emphasising the need for caution and for careful exploration of broader issues. The Review has been told that there is considerable variation in the approach taken between the London, Leeds and Bristol teams.

4.19. Speaking to professionals outside GIDS, we have heard widespread concern about the lack of guidance and evidence on how to manage this group of young people.

4.20. Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach. Some clinicians feel that they are not supported by their professional body on this matter. Hence the practice of passing referrals straight through to GIDS is not just a reflection of local service capacity problems, but also of professionals' practical concerns about the appropriate clinical management of this group of children and young people.

4.21. GPs have expressed concern about being pressurised to prescribe puberty blockers or feminising/masculinising hormones after these have been initiated by private providers.

4.22. This also links to professional concerns about parents being anxious for hormone treatment to be initiated when the child or young person does not seem ready.

Other issues

4.23. We have also heard that parents and carers play a huge role and are instrumental in helping young people

to keep open their developmental opportunities. In discussion with social workers, we heard concerns about how looked after children are supported in getting the help and support they need.

4.24. Therapists who work with detransitioners and people with regret have highlighted a lack of services and pathways and a need for services to support this population. There is also the need for more research to understand what factors contribute to the decision to detransition.

4.25. The importance of broad holistic interventions to help reduce distress has been emphasised to the Review, with therapists and other clinicians advocating the importance of careful developmentally informed assessment and of showing children and young people a range of different narratives, experiences and outcomes.

4.26. Clinicians have raised concerns about children and young people's NHS numbers being changed inconsistently, as there is no specific guidance for GPs and others as to when this should be done for this population and under what consent. This has implications for safeguarding and clinical management of these children and young people and it also makes it difficult to do research exploring long-term outcomes.

4.27. As with the comments made by service users, their families and support and advocacy groups, we have heard similar views from professionals about the

transition from children's to adult services, and the role of schools.

Structured engagement with primary, secondary and specialist clinicians

4.28. The Review's letter to NHS England (**Appendix 2**) set out some of the immediate issues with the current provision of gender identity services for children and young people and suggested how its work might help with the challenging problem of establishing an infrastructure outside GIDS. This included looking at the capacity, capability and confidence of the wider workforce and how this could be built and sustained, and the establishment of potential assessment frameworks for use in primary and/or secondary care.

Professional panel – primary and secondary care

4.29. In order to understand the challenges and establish a picture of current competency, capacity and confidence among the workforce outside the specialist gender development service, an online professional panel was established to explore issues around gender identity services for children and young people. The role of the panel was aimed at better comprehending how it looks and feels for clinicians and other professionals working with these young people, as well as any broader thoughts about the work, and to start exploring how the care of these

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children and young people can be better managed in the future.

4.30. The project was designed to capture a broad mix of professional views and experiences, recruiting from the professional groups that are most likely to have a role in the care pathway – GPs, paediatricians, child psychiatrists, child psychologists and child psychotherapists, nurses and social workers.

4.31. A total of 102 clinicians and other professionals were involved in the panel. The panel represented a balanced professional mix, and participant ages and gender were broadly representative of the overall sector workforce. Participants were self-selecting and were recruited via healthcare professional networks and Royal Colleges.

4.32. Each week the panel was set an independent activity comprised of two or more tasks. Additionally, a sub-set of the panel was invited to participate in focus groups at the midway and endpoint of the project. Activities were designed to capture an understanding of:

- experiences of working with gender-questioning children and young people and panel members' confidence and competence to manage their care;
- changes they may have experienced in the presentation of children and young people with gender-related distress;
- areas where professionals feel they require more information in order to

support gender-questioning children and young people;

- where professionals currently go to find that information;
- the role of different professions in the care pathway;
- the role of professionals in the assessment framework; and
- what participants felt should be included in an assessment framework across the whole service pathway.

Gender specialist questionnaire

4.33. Having concluded the professional panel exercise, we wanted to triangulate what we had heard with the thoughts and views of professionals working predominantly or exclusively with gender-questioning children and young people.

4.34. To do this in a systematic way, we conducted an online survey which contained some service-specific questions, but also reflected and sought to test some of what we had heard from primary and secondary care professionals.

Findings

4.35. This structured engagement has yielded valuable insights from clinicians and professionals with experience working with gender-questioning children and young people both within and outside the specialist gender service. It has contributed to the thinking of the Review and informed some of the interim advice set out in this report.

4.36. There are a number of consistent messages arising from these activities:

- The current long waiting lists that gender-questioning children and young people and their families/carers face are unacceptable for all parties involved, including professionals.
- Many professionals in our sample said that not only are gender-questioning children and young people having to wait a long time before receiving treatment, but they also do not receive appropriate support during this waiting period.
- Another impact of the long wait that clinicians reported is that when a child or young person is seen at GIDS, they may have a more fixed view of what they need and are looking for action to be taken quickly. This reportedly can lead to frustration with the assessment process.
- When considering the more holistic support that children and young people may need, gender specialists further highlighted the difficulties that children and young people face accessing local support, for example, from CAMHS, whilst being seen at GIDS.
- It is clear from the professionals who took part in these activities that there is a strong professional commitment to provide quality care to gender-questioning children and young people and their families/carers. However, this research indicates that levels of confidence and competence do vary

among primary and secondary care professionals in our sample.

- Concerns were expressed by professionals who took part in this research about the lack of consensus among the clinical community on the right clinical approach to take when working with a gender-questioning child or young person and their families/carers.
- In order to support clinicians and professionals more widely, participants felt there is a need for a robust evidence base, consistent legal framework and clinical guidelines, a stronger assessment process and different pathway options that holistically meet the needs of each gender-questioning child or young person and their families/carers.

4.37. There are also several areas where further discussion and consensus is needed:

- There is not a consistent view among the professionals participating in the panel and questionnaire about the nature of gender dysphoria and therefore the role of assessment for children and young people experiencing gender dysphoria.

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- Some clinicians felt that assessment should be focused on whether medical interventions are an appropriate course of action for the individual. Other clinicians believe that assessment should seek to make a differential diagnosis, ruling out other potential causes of the child or young person's distress.
- There are different perspectives on the roles of primary, secondary and specialist services in the care pathway(s) and what support or action might best be provided at different levels.
- While there was general consensus that diagnostic or psychological formulation needs to form part of the assessment process, there were differing views as to whether a mental state assessment is needed, and should it be, where in the pathway and by whom this should be done.

4.38. It is important to note that the information gathered represents the views and insights of the panel participants and survey respondents at a moment in time and findings should be read in the context of a developing narrative on the subject, where perspectives may evolve. This relates to both the experiences of professionals, but also the extent to which this subject matter is discussed in the public sphere.

4.39. The Review is grateful to all the participants for their time and high level of engagement. The Review will build on the work we have undertaken and, alongside our academic research, will continue with a programme of engagement with professionals, service users and their families, which will help to further develop the evidence base.

The full reports from the professional panel and gender specialist questionnaire are on the Review's website (<https://cass.independent-review.uk/>).

5. Principles of evidence based service development



Evidence based service development

5.1. This chapter integrates the information regarding the development of the current service (see Chapter 3) with the views we have heard to date (see Chapter 4) and sets this in the context of how evidence is routinely used to develop and improve services in the NHS.

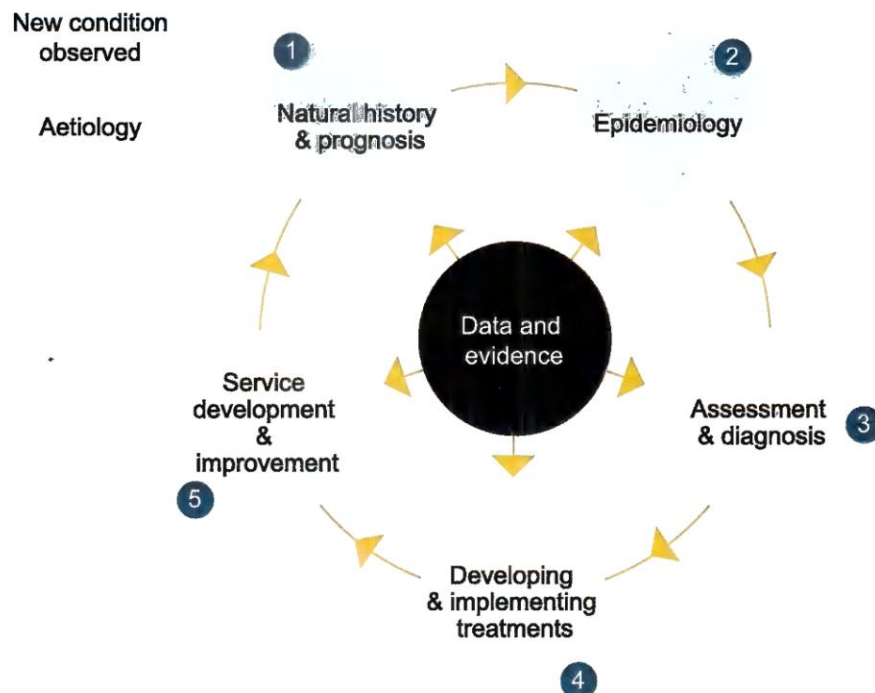
5.2. Some earlier information is necessarily repeated here, but this is with the intention of providing a more accessible explanation of the standards and processes which govern clinical service development. This is essential to an understanding of the rationale for the Review's recommendations.

5.3. Because the specialist service has evolved rapidly and organically in response to demand, the clinical approach and overall service design has not been subjected to some of the normal quality controls that are typically applied when new or innovative treatments are introduced. This Review now affords everyone concerned the opportunity to step back and consider from first principles what this cohort of children and young people now need from NHS services, based on the evidence that exists, or additional evidence that the Review hopes to collect.

5.4. In **Appendix 4** we have described the service development process for three different conditions which may help to illustrate what would be expected to happen at each different stage of developing a clinical service. The steps may proceed in a different sequence for different conditions, but each step is important in the development of evidence based care.

5.5. We recognise that for some of those reading this report it may feel wrong to compare gender incongruence or dysphoria to clinical conditions, and indeed this approach would not be justified if individuals presenting with these conditions did not require clinician intervention. However, where a clinical intervention is given, the same ethical, professional and scientific standards have to be applied as to any other clinical condition.

Key stages of service development



New condition observed: This often begins with a few case reports and then clinicians begin to recognise a recurring pattern and key clinical features, and to develop fuller descriptions of the condition.

Aetiology: Clinicians and scientists try to work out the cause of the condition or the underlying physical or biological basis. Sometimes the answers to this are never found.

Natural history and prognosis: It is important to understand how a condition usually evolves over time, with or without treatment. The latter is important if treatment has limited efficacy and the condition is 'self-limiting' (that is, it resolves without treatment), because otherwise there is a risk that treatments create more difficulties than the condition itself.

5.6. The first UK service for gender-questioning children and young people was established in 1989. At that time there were very few children and young people being

seen by medical services internationally. The most common presentation in the early years of the service was of birth-registered

boys who had demonstrated gender incongruence from an early age.^{51,52,53}

5.7. There is extensive literature discussing the possible aetiology of gender incongruence. Based on the available evidence, many authors would suggest that it is likely that biological, cultural, social and psychological factors all contribute. The examples in **Appendix 4** show that this is not an uncommon situation; many conditions do not have a single clear causation – they are in other words ‘multifactorial’.

5.8. Regardless of aetiology, the more contentious and important question is how fixed or fluid gender incongruence is at different ages and stages of development, and whether, regardless of aetiology, can be an inherent characteristic of the individual concerned. There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may

sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies. Previous literature has indicated that if gender incongruence continues into puberty, desistance is unlikely.^{54,55} However, it should be noted that these older studies were not based on the current changed case-mix or the different socio-cultural climate of recent years, which may have led to different outcomes. Having an open discussion about these questions is essential if a shared understanding of how to provide appropriate assessment and treatment is to be reached.

⁵¹ Zucker KJ (2017). [Epidemiology of gender dysphoria and transgender identity](#). Sex Health 14(5): 404–11. DOI:10.1071/SH1.

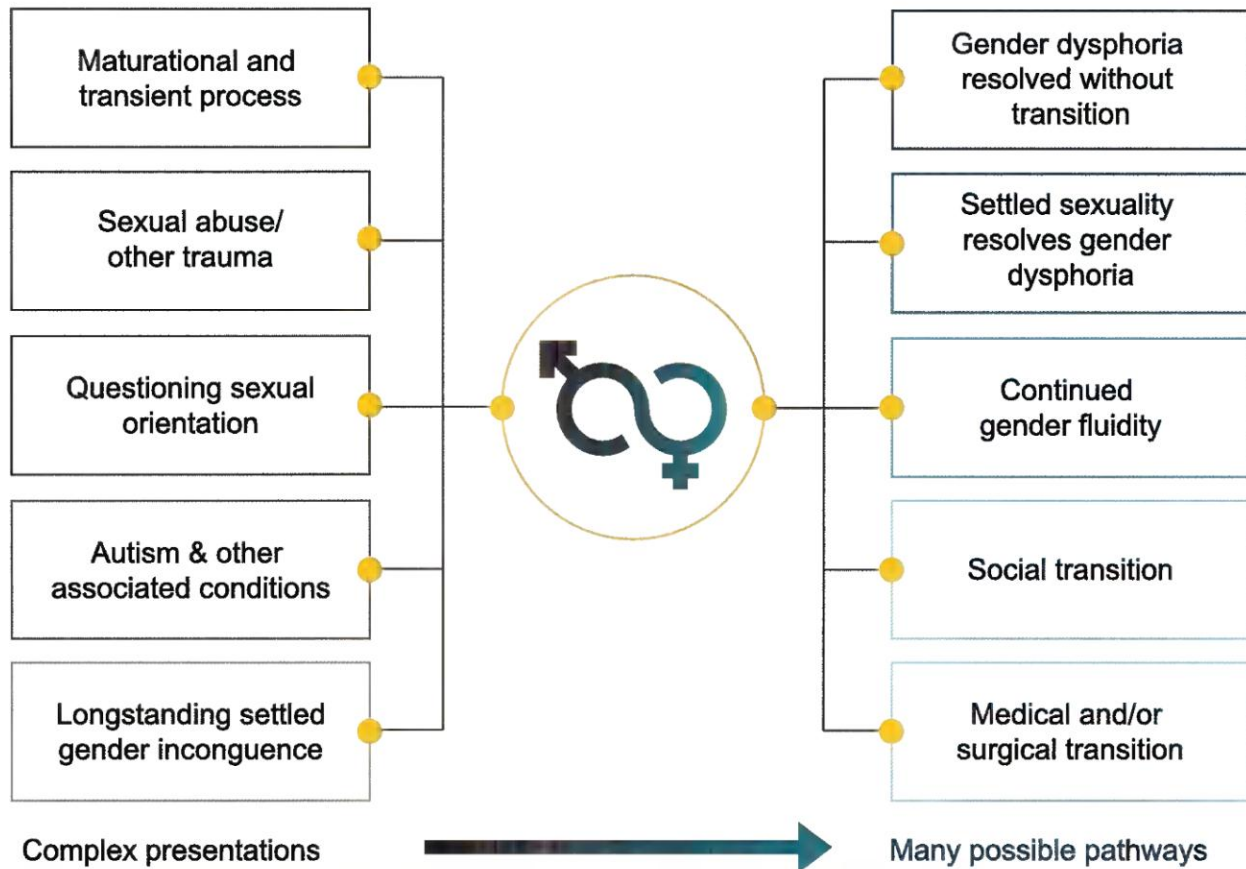
⁵² Zucker KJ, Lawrence AA (2009). [Epidemiology of gender identity disorder: recommendations for the Standards of Care of the World Professional Association for Transgender Health](#). Int J Transgend 11(1): 8-18. DOI: 10.1080/15532730902799946.

⁵³ de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). [Sex ratio in children and adolescents referred to the gender identity development service in the UK \(2009-2016\)](#). Arch Sex Behav 47(5): 1301–4.

⁵⁴ Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT (2011). [Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study](#). Clin Child Psychol Psychiatry 16(4): 485-97. DOI: 10.1177/135910451037803.

⁵⁵ Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT (2013). [Factors associated with desistance and persistence of childhood gender dysphoria: a quantitative follow-up study](#). J Am Acad Child Adolesc Psychiatry 52: 582-590. DOI: 10.1016/j.jaac.2013.03.016.

Complex presentations and complex pathways – exemplars, not comprehensive lists



Epidemiology: Epidemiologists collect data to find out how common a condition is, who is most likely to be affected, what the age distribution is and so on. This allows health service planners to work out how many services are needed, where they should be established, and what staff are needed.

They also report on changes in who is most affected, which may mean that either the disease is changing, or the susceptibility of the population is changing.

5.9. As previously indicated, the epidemiology of gender dysphoria is changing, with an increase in the numbers of birth-registered females presenting in early teens.^{56,57} In addition, the majority of children and young people presenting to GIDS have other complex mental health issues and/or neurodiversity.⁵⁸ There is also an over-representation of looked after children.⁵⁹

5.10. There are several implications arising from the change in epidemiology:

- Firstly, the speed of change in the numbers presenting means that services have not kept pace with demand.
- Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group.
- Thirdly, different subgroups may have quite different needs and outcomes, and these must be built into any service design, so that it works for all children and young people.

5.11. At present we have the least information for the largest group of patients – birth-registered females first presenting in early teen years. Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing.

⁵⁶ Steensma TD, Cohen-Kettenis PT, Zucker KJ (2018). [Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam \(1988-2016\)](#). Journal of Sex & Marital Therapy 44(7): 713–5. DOI: 10.1080/0092623X.2018.1437580.

⁵⁷ de Graaf NM, Carmichael P, Steensma TD, Zucker KJ (2018). [Evidence for a change in the sex ratio of children referred for Gender Dysphoria: Data from the Gender Identity Development Service in London \(2000–2017\)](#). J Sex Med 15(10): 1381–3. DOI: 10.1016/j.jsxm.2018.08.002.

⁵⁸ Van Der Miesen AIR, Hurley H, De Vries ALC (2016). [Gender dysphoria and autism spectrum disorder: A narrative review](#). Int Rev Psychiatry 28: 70-80. DOI: 10.3109/09540261.2015.1111199.

⁵⁹ Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). [Gender Dysphoria in looked-after and adopted young people in a gender identity development service](#). Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

Assessment and diagnosis: Clinicians will usually take a history from (that is, of their symptoms) and examine the patient (that is, for signs and symptoms), and where appropriate undertake a series of investigations or tests, to help them reach an accurate diagnosis.

Sometimes the whole process of making a diagnosis through talking to the patient and asking them to complete formal questionnaires, examining them and/or undertaking investigations is called 'clinical assessment'.

As well as diagnosing and ruling out a particular condition, clinicians often need to consider and exclude other, sometimes more serious, conditions that present in a similar way but may need quite different treatment – this process is called 'differential diagnosis'.

5.12. For children and young people with gender-related distress, many people would dispute the notion that 'making a diagnosis' is a meaningful concept, arguing that gender identity is a personal, internal perception of oneself. However, there are several reasons to why a diagnostic framework is used:

- Firstly, the clinician will seek to determine whether the child or young person has a stable transgender identity, or whether there might be other causes for the gender-related distress.
- Secondly, the clinician will determine whether there are other issues or diagnoses that might be having an impact on the young person's mental health. The Dutch Approach suggesting that these should be addressed prior to or alongside initiation of any medical treatments.
- Thirdly, in any situation where life-altering treatments are being administered, the clinician holds the

responsibility for ensuring that they are being administered based on an appropriate decision making process. Therefore, it is usual practice for a diagnosis of gender dysphoria to be made prior to referring for any physical treatments.

5.13. When the word 'diagnosis' is used, people often associate this with the use of blood tests, X-rays, or other laboratory tests. As set out in the **Appendix 4**, the public is very familiar with diagnosis of Covid-19 and understands that there need to be tests that give a high degree of certainty about whether an individual is Covid-19 positive or not. False positive lateral flow tests are rare, but caused problems for schools, while PCR has been treated as the 'gold standard' test for accuracy.

5.14. When it comes to gender dysphoria, there are no blood tests or other laboratory tests, so assessment and diagnosis in children and young people with gender-related distress is reliant on the judgements of experienced clinicians. Because medical, and subsequently possibly surgical treatments will follow, it may be argued that a highly sensitive and specific assessment process is required. The assessment should be able to accurately identify those children or young people for whom physical intervention is going to be the best course of action, but it is equally important that it identifies those who need an alternative pathway or treatment.

5.15. The formal criteria for diagnosing gender dysphoria (DSM-5) are listed in **Appendix 3**. However, there are two problems associated with the use of these criteria:

- Firstly, several of the criteria are based on gender stereotyping which may not be deemed relevant in current society, although the core criteria remain valid.
- Secondly, and more importantly, these criteria give a basis on which to make a diagnosis that a young person is clinically distressed by the incongruence between their birth-registered and their experienced gender, but they do not help in determining which factors may have led to this distress and how they might best be resolved.

5.16. At present, the assessment process varies considerably, dependent on the perceptions, experience and beliefs of different clinicians. There are some existing measurement tools, but it is suggested that these have substantial limitations.⁶⁰

5.17. The challenges are similar to the early difficulties in diagnosing autism, as set out in **Appendix 4**. As with autism, the framework for assessment needs to become formalised so there are clearer criteria for diagnosis and treatment pathways which are shared more widely. These should incorporate not just whether the child or young person meets DSM-5 criteria for gender dysphoria, but how a broader psychosocial assessment should be conducted and evaluated, and what other factors need to be considered to gain a holistic understanding of the child or young person's experience. Professional judgement and experience will still be important, but if the frameworks and criteria for assessment and diagnosis were more consistent and reproducible, there would be a greater likelihood that two different people seeing the same child or young person would come to the same conclusion. This would also mean that any research on interventions or long-term outcomes would be more reliable because the criteria on which a diagnosis was made, and hence the patients within the sample, would have the same characteristics.

⁶⁰ Bloom TM, Nguyen TP, Lami F, Pace CC, Poulakis Z, Telfer N (2021). [Measurement tools for gender identity, gender expression, and gender dysphoria in transgender and gender-diverse children and adolescents: a systematic review](#). *Lancet Child Adolescent Health*. 5: 582-588. DOI: 10.1016/s2352-4642(21)00098-5.

5.18. As outlined above, it is standard clinical practice to undertake a process called differential diagnosis. This involves summarising the main points of the clinical assessment, the most likely diagnosis, other possible diagnoses and the reasons for including or excluding them, as well as any further assessments that may be required to clarify the diagnosis and the treatment options and plan. This is important when a medical intervention is being provided on the basis of the assessment, so the process

is robust, explicit and reproducible. These considerations need to be applied to the assessment of children and young people presenting with gender-related distress. In mental health services, practitioners may also undertake a diagnostic or psychological formulation, which is a holistic summary of how the patient is feeling and why, and how to make sense of it, and a plan for moving forward with management or treatment.

Developing and implementing new treatments: Clinicians and scientists work on developing treatments. This involves clinical trials and, where there are new treatments, comparing them to any existing treatments. Questions include: What are the intended outcomes or benefits of treatment? What are the complications or side effects? What are the costs? To initiate a new treatment, it must be both safe and effective. Questions of affordability can sometimes become controversial.

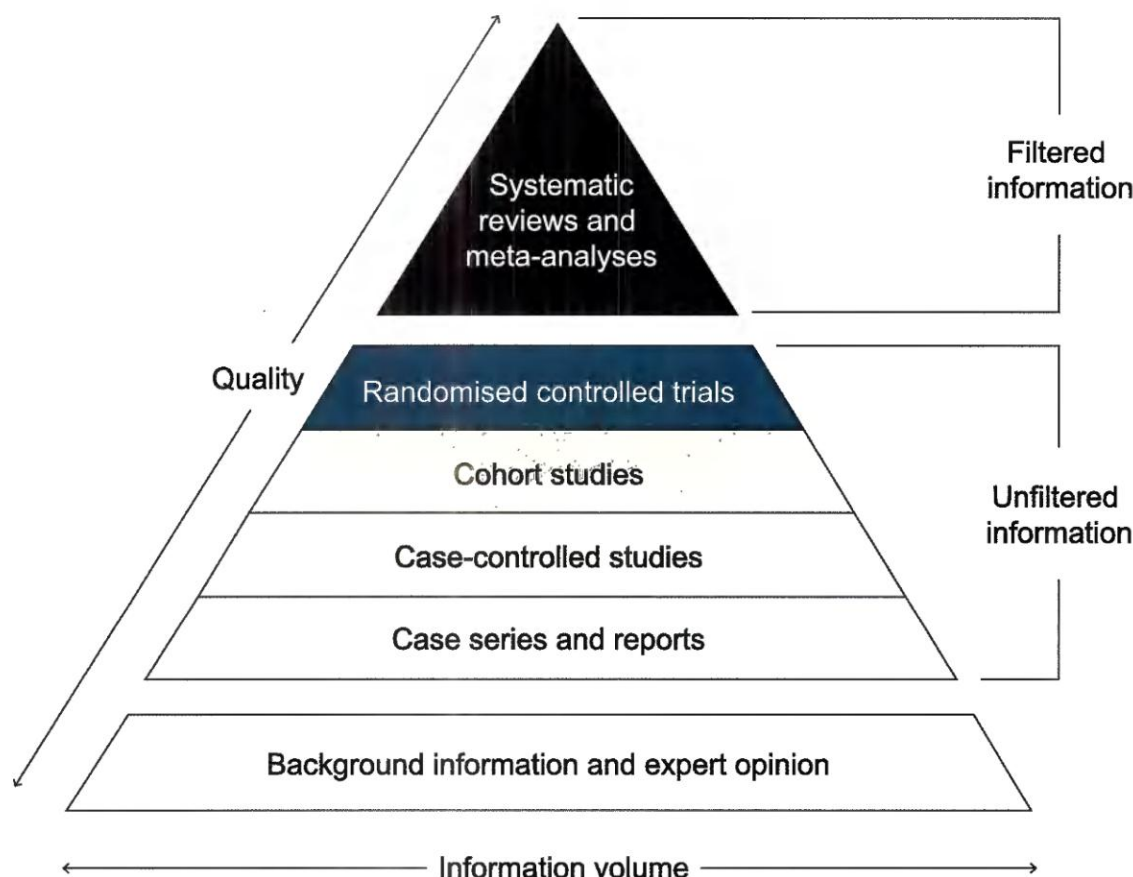
The best type of single study is considered to be the randomised controlled trial (RCT), but sometimes this is not feasible. Even where RCTs are not available, it is usual to at least have data on the outcomes of sufficient cases or cohorts to understand the risk/benefit of the treatment under consideration. As demonstrated in Fig. 4, the highest level of evidence is when the results of several different studies are pooled, but this is only useful if the individual studies themselves are of high quality.

In many instances, evidence is not perfect and difficult decisions have to be made. Where treatments are innovative or life-changing, the whole multi-disciplinary team will usually meet to consider the available options, and how to advise the child or young person and family so that a shared decision can be made. Sometimes an ethics committee is involved. This is one of the most challenging areas of medicine and is underpinned by GMC guidance.^{61,62}

⁶¹ General Medical Council (2020). [Decision making and consent](#).

⁶² National Institute for Health and Care Excellence (2021). [Shared decision making](#).

Figure 3: Pyramid of standards of evidence



Source: Levels of evidence pyramid, OpenMD. Reproduced with permission⁶³

5.19. There are three types of intervention or treatment for children and young people with gender-related distress, which may be introduced individually or in combination with one another:

- **Social transition** – this may not be thought of as an intervention or treatment, because it is not something

that happens within health services.

However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning.^{64,65} There are different views on the benefits versus the harms of early social transition. Whatever position one

⁶³ OpenMD (2021). [New Evidence in Medical Research](#).

⁶⁴ Sievert EDC, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I (2020). [Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria](#). Clin Child Psychol Psychiatry 26(1): 79–95. DOI: 10.1177/1359104520964530

⁶⁵ Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). [Prepubertal social gender transitions: What we know: what we can learn—A view from a gender affirmative lens](#). Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes.

- **Counselling, social or psychological interventions** – these may be offered before, instead of, or alongside physical interventions. Again, they should be viewed as active interventions which require robust evaluation in their own right.
- **Physical treatments** – these comprise puberty blockers and feminising/masculinising hormones (administered by endocrinologists) and surgery. The latter is not considered as part of this Review since it is not available to those under age 18.

5.20. It should also be recognised that 'doing nothing' cannot be considered a neutral act.

5.21. The lack of available high-level evidence was reflected in the recent NICE review into the use of puberty blockers and feminising/masculinising hormones commissioned by NHS England, with the evidence being too inconclusive to form the basis of a policy position.^{66,67} Assessing treatments for gender dysphoria has many of the same problems as assessing treatment for children with autism – it can take many years to get a full appreciation of outcomes and there may be other complicating factors in the child or young

person's life during this period. However, this of itself is not an adequate reason for the major gaps in the international literature.

5.22. It is still common that drugs are not specifically licensed for children because the trials have only taken place on adults. This does not preclude their use or make their use inherently unsafe, particularly if they are used very commonly in children. However, where their use is innovative, patients receiving the drug should ideally do so under trial conditions.

5.23. The same considerations apply to 'off-label' drugs, where the drug is used for a condition different to the one for which it was licensed. This is the case for puberty blockers, which are licensed for use in precocious puberty, but not for puberty suppression in gender dysphoria. Again, it is important that it is not assumed that outcomes for, and side effects in, children treated for precocious puberty will necessarily be the same in children or young people with gender dysphoria.

5.24. As outlined above, in other areas of practice where complex or potentially life-altering treatment is being considered for a child or young person, it is usual for the case to be discussed by an MDT including all professionals involved in their care. In gender services for children and young people in the Netherlands, as well as a number of other countries, there are full

⁶⁶ National Institute for Health and Care Excellence (2020). [Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria](#)

⁶⁷ National Institute for Health and Care Excellence (2020). [Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria](#).

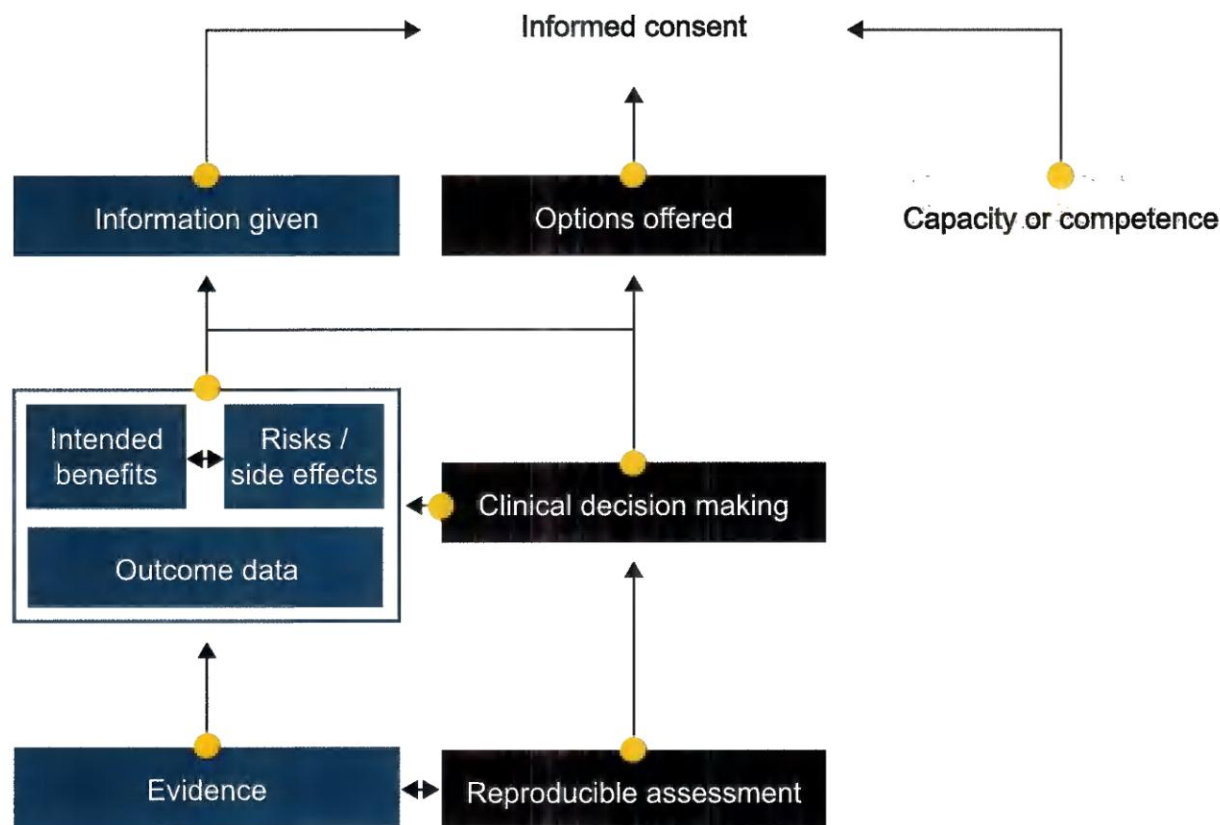
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MDT meetings, including psychiatrists and endocrinologists, to make decisions about suitability for hormone intervention and to review progress.^{68,69}

5.25. Recent legal proceedings have examined the question of the competence and capacity of children and young people to consent to hormone treatment. However, there are some essential components that underpin informed consent; the robustness

of the options offered to the patient, the information provided to them about those options, and their competence and capacity to consider them. The courts have given consideration to competence and capacity, and it is incumbent on this Review to consider the soundness of the decision making which underpins the options offered, and the quality and accuracy of the information provided about those options.

Elements of informed consent



⁶⁸ Kyriakou A, Nicolaides NC, Skordis N (2020). [Current approach to the clinical care of adolescents with gender dysphoria](#). Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

⁶⁹ Cohen-Kettenis PT, Steensma TD, de Vries ALC. [Treatment of adolescents with gender dysphoria in the Netherlands](#). Child Adolesc Psychiatr Clin N Am 20. 689–700. 2001. DOI: 10.1016/j.chc.2011.08.001.

Service development and service improvement: Central to any service improvement is the systematic and consistent collection of data on outcomes of treatment. There is a process of continuous service improvement as new presentations or variations on the original condition are recognised, diagnosis or screening improves and/or trials on new treatments or variations on existing treatments are ongoing.

There should be consistent treatment protocols or guidelines in place, in order to make sense of variations in outcomes. Where possible, these should be compared between and across multiple different centres.

As time passes, services need to be changed or extended based on patient need, and on what resources are needed to deliver the available treatments. They need to be accessible where the prevalence of the condition is highest. The relevant workforce to deliver the service needs to be recruited and trained, contingent on the type of treatments or therapy that is required.

5.26. When a pioneering treatment or specialist service starts, it is often delivered in a single centre. Thereafter, additional centres take on the work as increasing numbers of patients need to access the treatment. Current provision of NHS specialist gender identity services for children and young people has remained concentrated within a single organisation, but demand has grown dramatically.

5.27. The situation has been exacerbated because there are not many local services seeing gender-questioning children at an earlier stage in their journey, which means that GIDS is carrying an unsustainable workload of increasingly complex young people.

5.28. As a condition evolves, rigorous data collection and quantitative research is an essential prerequisite to refining understanding and treatment. Historically, The Tavistock and Portman NHS

Foundation Trust built its international reputation as the home of psychoanalysis, psychotherapy and family therapy, with a strong track record of publishing qualitative rather than quantitative research; consequently its approach to quantitative data collection about this important group of children and young people has been weak.

5.29. A further anomaly is a public perception that The Tavistock and Portman NHS Foundation Trust is the responsible organisation for leading the management of children receiving hormone treatment for their gender dysphoria. In reality, the hormone treatment is delivered by paediatric services in University College London Hospitals NHS Foundation Trust and The Leeds Teaching Hospitals NHS Trust.

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5.30. In practice, it is important that for children and young people who need physical intervention, paediatric and mental health services are seen as equal partners, with seamless joint working and shared responsibility. When there were very small numbers of patients, it was easier for this to be achieved, but cross-site working with a very large caseload has made this more difficult to achieve, despite the best intentions of the staff.

5.31. Over the last two years there have been strong efforts on the part of The Tavistock and Portman NHS Foundation Trust to make practice within GIDS more consistent, with tighter procedures for case management, consent, and safeguarding. However, although this has resulted in better documentation, variations and inconsistencies in clinical decision making remain. In responding to a changing legal framework, some processes have become more cumbersome and complex, and the team are working hard to streamline the process.

5.32. Overall, GIDS faces a daunting task as a single provider in managing risk on the waiting list, seeing new referrals, reviewing and supporting those on hormone treatment, undertaking an ongoing transformation programme, recruiting and training new staff and trying to retain existing staff. This suggests that the current model is not sustainable and that another model is needed.

6. Interim advice, research programme and next steps



Dealing with uncertainty

6.1. As outlined throughout this report, there are major gaps in the research base underpinning the clinical management of children and young people with gender incongruence and gender dysphoria, including the appropriate approaches to assessment and treatment.

6.2. As with any other area of medicine, where there are gaps in the evidence base and uncertainties about the correct clinical approach, three tasks must be undertaken:

- Clinical services must be run as safely and effectively as possible, within the constraints of current knowledge; treatment options must be weighed carefully; and treatment decisions must be made in partnership between the clinicians and the children, young people and their families and carers, based on our current understanding about outcomes.
- Consistent data must be collected by clinical services, for both audit and research purposes so that knowledge gaps can be filled, alongside an active research programme.
- Where there is not an immediate prospect of filling research gaps, professional consensus should be developed on the correct way to proceed pending clearer research evidence, supported by input from service users.

6.3. The additional problem with the current service model is that safety and access are further compromised by the pace at which referrals have grown and outstripped capacity at tertiary level, and the lack of service availability at local level.

6.4. The Review's approach to these tasks is as follows:

- Our **interim advice** focuses on the issues of capacity, safety, and standards around treatment decisions, as well as data and audit.
- Our **research streams** will provide the Review with an independent collation of published evidence relevant to epidemiology, clinical management, models of care, and outcomes, as well as delivering qualitative and quantitative research relevant to the Terms of Reference of the Review. This offers a real opportunity to contribute to the international evidence base for this service area.
- There will be an ongoing and wide-ranging **programme of engagement** to address areas on which we will not be able to obtain definitive evidence during the lifetime of the Review.

Interim advice

6.5. The Review considers that there are some areas where there is sufficient clarity about the way forward and we are therefore offering some specific observations and interim advice. The Review will work with NHS England, providers and the broader stakeholder community to progress action in these areas.

Service model

6.6. It has become increasingly clear that a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand.

6.7. Additionally, children and young people with gender-related distress have been inadvertently disadvantaged because local services have not felt adequately equipped to see them. It is essential that they can access the same level of psychological and social support as any other child or young person in distress, from their first encounter with the NHS and at every level within the service.

6.8. A fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity. This must include support for any other clinical presentations that they may have.

6.9. The Review supports NHS England's plan to establish regional services, and

welcomes the move from a single highly specialist service to regional hubs.

6.10. Expanding the number of providers will have the advantages of:

- creating networks within each area to improve early access and support;
- reducing waiting times for specialist care;
- building capacity and training opportunities within the workforce;
- developing a specialist network to ensure peer review and shared standards of care; and
- providing opportunities to establish a more formalised service improvement strategy.

Service provision

6.11. The primary remit of NHS England's proposed model is for the regional hubs to provide support and advice to referrers and professionals. However, it includes limited provision for direct contact with children and young people and their families.

- 1:** The Review advises that the regional centres should be developed, as soon as feasibly possible, to become direct service providers, assessing and treating children and young people who may need specialist care, as part of a wider pathway. The Review team will work with NHS England and stakeholders to further define the proposed model and workforce implications.

2: Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children and young people who are in early stages of experiencing gender distress.

3: Clear criteria will be needed for referral to services along the pathway from primary to tertiary care so that gender-questioning children and young people who seek help from the NHS have equitable access to services.

4: Regional training programmes should be run for clinical practitioners at all levels, alongside the online training modules developed by Health Education England (HEE). In the longer-term, clearer mapping of the required workforce, and a series of competency frameworks will need to be developed in collaboration with relevant professional organisations.

through the service. Standardised data collection is required in order to audit service standards and inform understanding of the epidemiology, assessment and treatment of this group. This, alongside a national network which brings providers together, will help build knowledge and improve outcomes through shared clinical standards and systematic data collection. In the longer-term, formalisation of such a network into a learning health system⁷⁰ with an academic host would mean that there was systematised use of data to produce a continuing research programme with rapid translation into clinical practice and a focus on training.

5: The regional services should have regular co-ordinated national provider meetings and operate to shared standards and operating procedures with a view to establishing a formal learning health system.

6: Existing and future services should have standardised data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.

Data, audit and research

6.12. A lack of routine and consistent data collection means that it is not possible to accurately track the outcomes and pathways children and young people take

⁷⁰ Scobie S, Castle-Clarke S (2019). [Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics](#). Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

7: Prospective consent of children and young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children and young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.

8: There needs to be agreement and guidance about the appropriate clinical assessment processes that should take place at primary, secondary and tertiary level.

9: Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiverse children and young people.

Clinical approach

Assessment processes

6.13. We have heard that there are inconsistencies and gaps in the assessment process. Our work to date has also demonstrated that clinical staff have different views about the purpose of assessment and where responsibility lies for different components of the process within the pathway of care. The Review team has commenced discussions with clinical staff across primary, secondary and tertiary care to develop a framework for these processes.

Hormone treatment

6.14. The issues raised by the Multi-Professional Review Group echo several of the problems highlighted by the CQC. It is essential that principles of the General Medical Council's Good Practice in Prescribing and Managing Medicine's and Devices⁷¹ are closely followed, particularly given the gaps in the evidence base regarding hormone treatment. Standards for decision making regarding endocrine treatment should also be consistent with international best practice.^{72,73,74}

⁷¹ General Medical Council (2021). [Good practice in prescribing and managing medicines and devices \(76-78\)](#).

⁷² Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). [Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline](#). J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.

⁷³ Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). [Treatment of adolescents with gender dysphoria in the Netherlands](#). Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.

⁷⁴ Kyriakou A, Nicolaidis NC, Skordis N (2020). [Current approach to the clinical care of adolescents with gender dysphoria](#). Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

10: Any child or young person being considered for hormone treatment should have a formal diagnosis and formulation, which addresses the full range of factors affecting their physical, mental, developmental and psychosocial wellbeing. This formulation should then inform what options for support and intervention might be helpful for that child or young person.

11: Currently paediatric endocrinologists have sole responsibility for treatment, but where a life-changing intervention is given there should also be additional medical responsibility for the differential diagnosis leading up to the treatment decision.

6.15. Paediatric endocrinologists develop a wide range of knowledge within their paediatric training, including safeguarding, child mental health, and adolescent development. Being party to the discussions and deliberations that have led up to the decision for medical intervention supports them in carrying out their legal responsibility for consent to treatment and the prescription of hormones.

12: Paediatric endocrinologists should become active partners in the decision making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.

6.16. Given the uncertainties regarding puberty blockers, it is particularly important to demonstrate that consent under this circumstance has been fully informed and to follow GMC guidance⁷⁵ by keeping an accurate record of the exchange of information leading to a decision in order to inform their future care and to help explain and justify the clinician's decisions and actions.

13: Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer-term outcomes.

⁷⁵ General Medical Council (2020). [Decision making and consent](#).

14: In the immediate term the Multi-Professional Review Group (MPRG) established by NHS England should continue to review cases being referred by GIDS to endocrine services.

Research programme

6.17. The Review's formal academic research programme, comprising a literature review, quantitative analysis and primary qualitative research, has been based on the identified gaps in the evidence and the feasibility of filling them within the lifetime of the Review.

6.18. Initial work has identified the existing evidence base on epidemiology, natural history, and the treatment and outcomes of children and young people with gender dysphoria/gender-related distress. It has also assessed the feasibility of linking data between local, regional or national datasets in order to assess intermediate and longer-term outcomes.

Literature review

6.19. A literature review is being undertaken, which will interface with evidence gathering from the professional community (see qualitative research section below). Its aim is to systematically identify, collate and synthesise the existing evidence on the changing epidemiology of gender-related distress in children and young people and the appropriate social, clinical,

psychological and medical management of that distress.

6.20. The literature review will capture primary studies of any design, including experimental, observational, survey and qualitative, and is looking to answer the following questions:

1. How has the population of children and young people presenting with gender dysphoria and/or gender-related distress changed over time?
2. What are the appropriate referral, assessment and treatment pathways for children and young people with gender dysphoria and/or gender-related distress?
3. What are the short-, medium- and long-term outcomes for children and young people with gender dysphoria and/or gender-related distress?
4. How do children and young people and their families negotiate distress, present this distress to services, and what are their expectations, following presentation?
5. How do children, young people and their families/carers experience referral, assessment and treatment? And how are these negotiated among children and young people, parents/carers, families and healthcare professionals?

6.21. A separate synthesis for each question will be undertaken. The systematic review has been registered on PROSPERO [ID:289659].

Quantitative research

6.22. The National Institute for Health and Care Excellence (NICE) recently published two evidence reviews.^{76,77} These highlight shortcomings in the follow-up data collected about children and young people, when they are referred to a specialist gender identity service. The quantitative research will therefore focus on the collection and analysis of data to uncover patterns and quantify problems, thereby helping the Review to address some of these shortcomings.

6.23. The aim of the quantitative study is to supplement the material collected by the literature review, further examining the changing epidemiology of gender-related distress in children and young people, in addition to exploring the appropriate social, clinical, psychological and medical management. Its objectives are to:

- a) describe the clinical and demographic characteristics of this population of children and young people and their clinical management in the GIDS service; and

- b) assess the intermediate and longer-term outcomes of this population of children and young people utilising national healthcare data.

6.24. This research will provide an evidence base to facilitate informed decision making among children and young people and their families. It will also provide an evidence base for those responsible for commissioning, delivering and managing services.

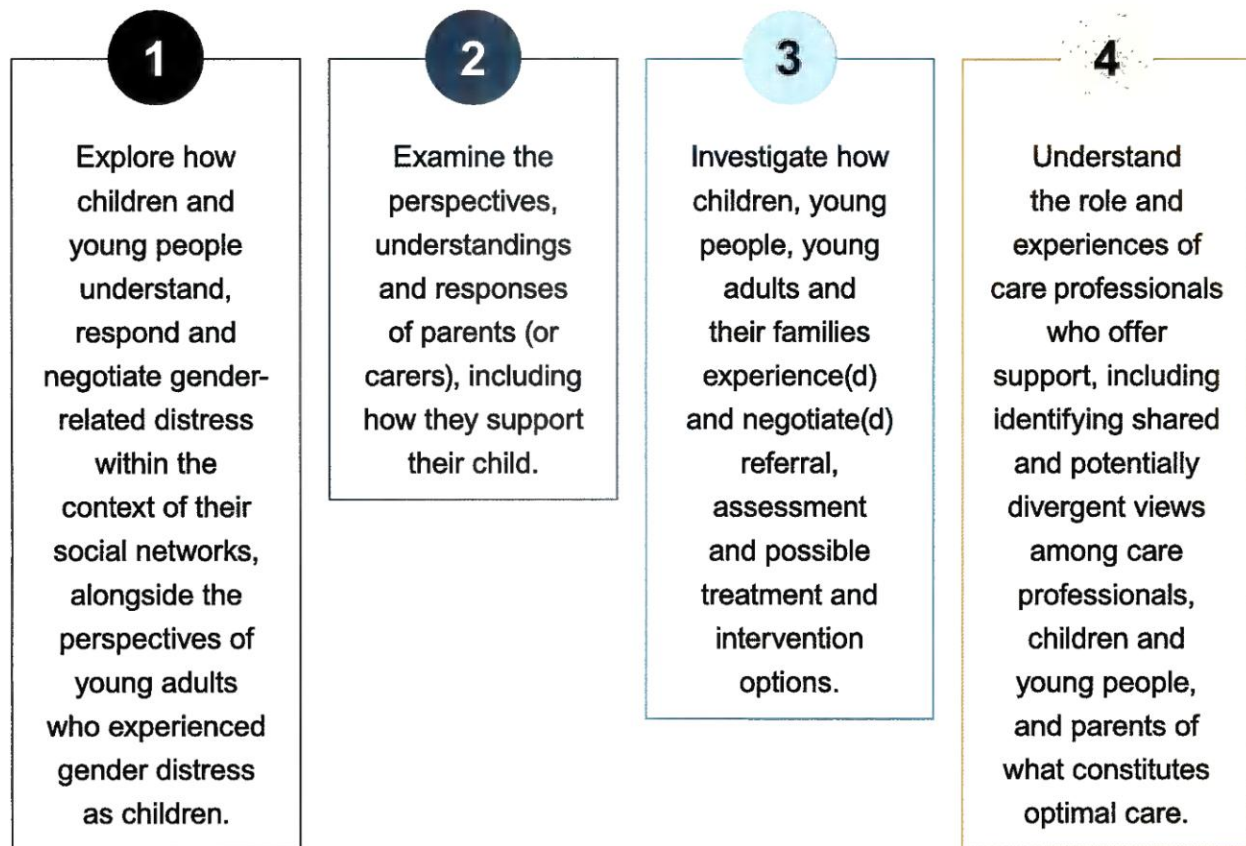
Qualitative research

6.25. The qualitative research will capture a diverse range of trajectories experienced by gender-questioning children and young people, exploring a range of different experiences and outcomes. This will include talking to children and young people and their families/carers who are currently negotiating gender-related distress, young adults who have gone through the process of resolving their distress and care professionals.

⁷⁶ National Institute for Health and Care Excellence (2020). [Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria](#).

⁷⁷ National Institute for Health and Care Excellence (2020). [Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria](#).

The objectives of the qualitative research are to:



Progress

6.26. The literature review is already underway and is identifying relevant studies. Initial meetings have also taken place with voluntary organisations and other researchers working in the area to ensure there is no duplication and in recognition of research fatigue among this population.

6.27. Children and young people and young adults who have experienced gender-related distress are involved in the research programme. Their advice has been, and will continue to be, sought throughout this work, including in relation to the focus of the research and interpretation

of findings and the design and content of dissemination materials.

6.28. Three research protocols have been produced setting out how the research will be undertaken, and the research team is currently gaining the necessary ethical and governance approvals to progress the study. The systematic review is published on the PROSPERO website and will be published on the Review website in due course, along with the qualitative and quantitative research proposals once ethical and governance approvals have been received.

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6.29. The research findings will be subject to peer review through the publication process and various summaries, aimed at different audiences, will be available on the project website and distributed via support organisations. These summaries will also be made available on the Review website.

Ongoing engagement

6.30. In recognition that not all the published evidence is likely to be of high enough quality to form the sole basis for our recommendations, a consensus development approach will be used to synthesise the published evidence and research outputs of the academic work with stakeholder submissions and expert opinion.

6.31. Over the coming months, the Review will build on its engagement to date and, alongside the academic research programme, will continue informal and structured engagement with service users, their families, support and advocacy groups and professionals to test emerging thinking, provide opportunities for challenge and further develop the evidence base.

6.32. This review is an iterative process and we will share important findings when they become available. For the latest updates, please visit our website: <https://cass.independent-review.uk/>

6.33. We thank those who have participated in the Review to date and welcome engagement with us as work progresses towards final recommendations.

Glossary



Glossary

There is sometimes no consensus on the best language to use relating to this subject. The language surrounding this area has also changed rapidly and young people have developed varied ways of describing their experiences using different terms and constructs that are relevant to them.

The Review tries as far as possible to use language and terms that are respectful and acknowledge diversity, but that also accurately illustrate the complexity of what we are trying to describe and articulate.

The terms we have used may not always feel right to some; nevertheless, it is important to emphasise that the language used is not an indication of a position being taken by the Review. The glossary below sets out a description of some of the terms we have used in the Review.

Term	Description
Affirmative model	A model of gender healthcare that originated in the USA ^{78,79,80,81} which affirms a young person's subjective gender experience while remaining open to fluidity and changes over time. This approach is used in some key child and adolescent clinics across the Western world.
Assent	To agree to or approve of something (idea, plan or request), especially after thoughtful consideration.
Autonomy	Personal autonomy is the ability of a person to make their own decisions. In health this refers specifically to decisions about their care.

⁷⁸ Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, et al (2013). [The gender affirmative model: What we know and what we aim to learn](#) [Editorial]. *Human Dev* 56(5): 285–290. DOI:10.1159/000355235.

⁷⁹ Chen D, Abrams M, Clark L, Ehrensaft D, Tishelman AC, Chan YM, et al (2021). [Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: baseline findings from the trans youth care study](#). *J Adol Health* 68(6): 1104–11.

⁸⁰ Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, et al (2019). [Creating the Trans Youth Research Network: A collaborative research endeavor](#). *Transgend Health* 4(12): 304–12. DOI: 10.1089/trgh.2019.0024.

⁸¹ Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). [Prepubertal social gender transitions: What we know: what we can learn—A view from a gender affirmative lens](#). *Int J Transgend* 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

Term		Description
Best interests		<p>Clinicians and the courts seek to act in the best interests of children and young people. For the Mental Capacity Act (MCA) 2005, decisions for someone who cannot decide for themselves must be made in their best interests. Under the Children Act 1989, in any decision of the court about a child (under 18), the welfare of the child must be paramount. For these purposes, there is little or no material difference between the welfare and best interests, and we have used “best interests” throughout the report.</p> <p>Although there is no standard definition of “best interests of the child,” the General Medical Council advises that an assessment of best interests will include what is clinically indicated as well as additional factors such as the child or young person’s views, the views of parents and others close to the child or young person and cultural, religious and other beliefs and values of the child or young person.⁸²</p>
		<p>The MCA s4,⁸³ and extensive Court of Protection case law, deals with the approach to best interests under that legislation. Whether in the Court of Protection or the High Court, when the court is asked to make an assessment of a child or young person’s best interests, it will consider their welfare/best interests in the widest sense. This will include not just medical factors but also social and psychological factors.</p>
Case-mix		The mix of patients within a particular group.
Child and adolescent mental health services	CAMHS	NHS children and young people’s mental health services. ⁸⁴

⁸² General Medical Council (2018). [0-18 years – guidance for all doctors](#).

⁸³ Mental Health Law Online. [MCA 2005 s4](#).

⁸⁴ Young Minds. [Guide to CAMHS: a guide for young people](#).

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Term		Description
Child and/or young person		<p>In law, everyone under 18 years of age is a child (Children Act 1989) but we recognise that it may be more appropriate to refer to those approaching the age of 18 as a young person, and that such young people may not recognise themselves as a “child”.</p> <p>In places, we have referred only to “young person”, or only to “child”, for example where treatment in question is only given towards the later stages of childhood, closer to the age of 18, or in reference to the parent/child relationship, in which they remain the parents’ child, regardless of their age.</p> <p>Otherwise, we have used the phrase “child and/or young person” throughout the report for this reason only, and do not intend there to be a material difference between them other than that.</p>
Cognitive		<p>Relating to, or involving, the process of thinking and reasoning.</p>
Consent		<p>Permission for a clinical intervention (such as an examination, test or treatment) to happen. For consent to be ‘informed’, information must be disclosed to the person about relevant risks, benefits and alternatives (including the option to take no action), and efforts made to ensure that the information is understood.</p> <p>In legal terms, consent is seen as needing:</p> <ol style="list-style-type: none"> 1 – capacity (or <i>Gillick</i> competence under 16) to make the relevant decision; 2 – to be fully informed (ie the information provided about the available options, the material risks and benefits of each option, and of doing nothing, “material” meaning (per the Montgomery Supreme Court judgment in 2015) what a reasonable patient would want to know, and what this patient actually wants to know, NOT what a reasonable doctor would tell them); and 3 – to be freely given (that is, without coercion).
Contraindications		<p>A condition or circumstance that suggests or indicates that a particular technique or drug should not be used in the case in question.</p>

Term		Description
Court of Appeal		(England and Wales) The Court of Appeal hears appeals against both civil and criminal judgments from the Crown Courts, High Court and County Court. It is second only to the Supreme Court.
Detransition/ detransitioners		Population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both. ⁸⁵
Diagnostic and Statistical Manual of Mental Disorders Fifth edition	DSM-5	The American diagnostic manual used to diagnose mental health disorders, and commonly used in UK practice. See Appendix 3 .
Diagnostic formulation		The comprehensive assessment that includes a patient's history, results of psychological tests, and diagnosis of mental health difficulties.
Divisional Court		(England and Wales) When the High Court of Justice of England and Wales hears a case with at least two judges sitting, it is referred to as the Divisional Court. This is typically the case for certain judicial review cases (as well as some criminal cases).
Dutch Approach		Protocol published in 1998 by the Amsterdam child and adolescent gender identity clinic. ⁸⁶
Endocrine treatment		In relation to this clinical area, this term is used to describe the use of gonadotropin-releasing hormones (see below) and feminising and masculinising hormones (see below).
Endocrinologist		An endocrinologist is a medical doctor specialising in diagnosing and treating disorders relating to problems with the body's hormones.
Endocrinology		The study of hormones.

⁸⁵ Littman L (2021). [Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners](#). Arch Sex Abuse 50: 3353–69. DOI: 10.1007/s10508-021-02163-w

⁸⁶ de Vries ALC, Cohen-Kettenis PT (2012). [Clinical management of gender dysphoria in children and adolescents: The Dutch approach](#). J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

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Term		Description
Epidemiology		Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems. ⁸⁷
Exploratory approaches		Therapeutic approaches that acknowledge the young person's subjective gender experience, whilst also engaging in an open, curious, non-directive exploration of the meaning of a range of experiences that may connect to gender and broader self-identity. ^{88,89,90,91}
Feminising and masculinising hormones (also known as cross-sex hormones, and gender affirming hormones).		Hormones given as part of a medical transition for gender dysphoric individuals, where sex hormones (testosterone for transgender males and oestrogen for transgender females).
Gender dysphoria		Diagnostic term used in DSM-5. ⁹² Gender dysphoria describes "a marked incongruence between one's experienced/expressed gender and assigned gender of at least 6 months duration" which must be manifested by a number of criterion – see Appendix 3 for further detail.
Gender fluid		An experience of gender that is not fixed, but changes between two or more identities.
Gender identity		This term is used to describe an individual's internal sense of being male or female or something else.
Gender identity development		The developmental experience of a child or young person in seeking to understand their gender identity over time.
Gender Identity Development Service	GIDS	The service that NHS England commissions for children and adolescents with gender dysphoria.

⁸⁷ Centers for Disease Control and Prevention (2012). [Principles of Epidemiology in Public Health Practice: An introduction to Applied Epidemiology and Biostatistics](#), 3rd ed.

⁸⁸ Di Ceglie D (2009). [Engaging young people with atypical gender identity development in therapeutic work: A developmental approach](#). J Child Psychother 35(1): 3–12. DOI: 10.1080/00754170902764868.

⁸⁹ Spiliadis A (2019). [Towards a gender exploratory model: Slowing things down, opening things up and exploring identity development](#). Metalogos Systemic Ther J 35: 1–9.

⁹⁰ Churcher Clarke A, Spiliadis A (2019). [‘Taking the lid off the box’: The value of extended clinical assessment for adolescents presenting with gender identity difficulties](#). Clin Child Psychol Psychiatry 24(2): 338–52. DOI:10.1177/1359104518825288.

⁹¹ Bonfatto M, Crasnow E (2018). [Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service](#). J Child Psychother 44(1): 29–46. DOI:10.1080/0075417X.2018.1443150.

⁹² American Psychiatric Association (2013). [Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5™, 5th ed.](#)

Term		Description
Gender incongruence		Diagnostic term used in ICD-11. ⁹³ Gender incongruence is characterised by “a marked and persistent incongruence between an individual’s experienced gender and the assigned sex”. See Appendix 3 for further detail.
Gender-questioning		A broader term that might describe children and young people who are in a process of working out how they want to present in relation to their gender.
Gender-related distress		A way of describing distress that may arise from a broad range of experiences connected to a child or young person’s gender identity development. Often used for young people whereby any formal diagnosis of gender dysphoria has not yet been made.
Gillick competence/ Fraser guidelines		A term derived from <i>Gillick v West Norfolk And Wisbech AHA</i> , 1984 that is used to decide whether a child or young person up to the age of 16 years is able to consent to their own medical treatment, without the need for parental permission or knowledge. A child or young person will be ‘Gillick competent’ for that decision if they have the necessary maturity and understanding to make the decision.
Gonadotropin-releasing hormone analogues (also known as the hormone blocker/s and puberty blocker/s)	GnRH	GnRH analogues competitively block GnRH receptors to prevent the spontaneous release of two gonadotropin hormones, Follicular Stimulating Hormone (FSH) and Luteinising Hormone (LH) from the pituitary gland. This arrests the progress of puberty.
General Practitioner	GP	GPs deal with a whole range of health problems and manage the care of their patients, referring onto specialists as appropriate. ⁹⁴
High Court		The third highest court in the UK. It deals with all high value and high importance civil law (non-criminal) cases and appeals of decisions made in lower courts. When the High Court sits with more than one judge, as required for certain kinds of cases, it is called the Divisional Court.
International Classification of Diseases, Version 11	ICD-11	ICD-11 ⁹⁵ is the World Health Organization (WHO) mandated health data standard used for medical diagnosis.

⁹³ World Health Organization (2022). [International Classification of Diseases Eleventh Revision](#).

⁹⁴ NHS. [GP services](#).

⁹⁵ World Health Organization (2022). [International Classification of Diseases Eleventh Revision](#).

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Term		Description
Looked after children		Children who are in the care of their Local Authority who may be living with foster parents or in a residential care setting.
Multi-disciplinary-team	MDT	The identified group of professional staff who provide a clinical service.
Neurodiverse		Displaying or characterised by autistic or other neurologically atypical patterns of thought or behaviour; not neurotypical.
Non-binary		A gender identity that does not fit into the traditional gender binary of male and female. ⁹⁶
Paediatrics		The branch of medicine dealing with children and their medical conditions.
Pass/passing		A person's gender being seen and read in the way they identify.
Precocious puberty		This is when a child's body begins changing into that of an adult (puberty) too soon – before age 8 in girls and before age 9 in boys.
Primary care		Primary care includes general practice, community pharmacy, dental and optometry (eye health) services. This tends to be the first point of access to healthcare.
Psychological formulation		A structured approach to understanding the factors underlying distressing states in a way that informs the changes needed and the therapeutic intervention for these changes to occur.
Psychosocial		Describes the psychological and social factors that encompass broader wellbeing.
Puberty blockers		See gonadotropin-releasing hormone above.
Secondary care		Hospital and community health care services that do not provide specialist care and are usually relatively close to the patient. For children this will include Child and Adolescent Mental Health Services (CAMHS), child development and general paediatric services.
Tanner Stage		Classification of puberty by stage of development. This ranges from Stage 1, before physical signs of puberty appear, to Stage 5 at full maturity.

⁹⁶ Twist J, de Graaf NM (2019). [Gender diversity and non-binary presentations in young people attending the United Kingdom's National Gender Identity Development Service](#). Clin Child Psychol Psychiatry 24(2): 277–90. DOI: 10.1177/1359104518804311.

Term		Description
Tertiary care		Tertiary care is the specialist end of the NHS. These services relate to complex or rare conditions. Services are usually delivered in a number of hospitals/centres.
Transgender	trans	This is an umbrella term that includes a range of people whose gender identity is different from the sex they were registered at birth.
Transition		These are the steps a person may take to live in the gender in which they identify. This may involve different things, such as changing elements of social presentation and role and/or medical intervention for some.

Appendix 1

Terms of reference



TERMS OF REFERENCE FOR REVIEW OF GENDER IDENTITY DEVELOPMENT SERVICE FOR CHILDREN AND ADOLESCENTS

INTRODUCTION

1. NHS England is the responsible commissioner for specialised gender identity services for children and adolescents. The Gender Identity Development Service for children and adolescents is currently managed by the Tavistock and Portman NHS Foundation Trust.
2. In recent years there has been a significant increase in the number of referrals to the Gender Identity Development Service, and this has occurred at a time when the service has moved from a psychosocial and psychotherapeutic model to one that also prescribes medical interventions by way of hormone drugs. This has contributed to growing interest in how the NHS should most appropriately assess, diagnose and care for children and young people who present with gender incongruence and gender identity issues.
3. It is in this context that NHS England and NHS Improvement's Quality and Innovation Committee has asked Dr Hilary Cass to chair an independent review, and to make recommendations on how to improve services for children and young people experiencing issues with their gender identity or gender incongruence, and ensure that the best model/s for safe and effective services are commissioned.

REVIEW SCOPE

The independent review, led by Dr Cass, will be wide ranging in scope and will conduct extensive engagement with all interested stakeholders. The review is expected to set out findings and make recommendations in relation to:

- i. Pathways of care into local services, including clinical management approaches for individuals with less complex expressions of gender incongruence who do not need specialist gender identity services;
- ii. Pathways of care into specialist gender identity services, including referral criteria into a specialist gender identity service; and referral criteria into other appropriate specialist services;
- iii. Clinical models and clinical management approaches at each point of the specialised pathway of care from assessment to discharge, including a description of objectives, expected benefits and expected outcomes for each clinical intervention in the pathway;
- iv. Best clinical approach for individuals with other complex presentations.
- v. The use of gonadotropin-releasing hormone analogues and gender affirming drugs, supported by a review of the available evidence by the National Institute for Health and Care Excellence; any treatment recommendations will include a description of treatment objectives, expected benefits and expected outcomes, and potential risks, harms and effects to the individual;
- vi. Ongoing clinical audit, long term follow-up, data reporting and future research priorities;
- vii. Current and future workforce requirements;
- viii. Exploration of the reasons for the increase in referrals and why the increase has disproportionately been of natal females, and the implications of these matters; and,

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TERMS OF REFERENCE FOR REVIEW OF GENDER IDENTITY DEVELOPMENT SERVICE FOR CHILDREN AND ADOLESCENTS

- ix.** Any other relevant matters that arise during the course of the review
- 4. In addition, and with support from the Royal College of Paediatrics and Child Health and other relevant professional associations, the Chair will review current clinical practice concerning individuals referred to the specialist endocrine service. It is expected that findings and any recommendations on this aspect of the review will be reported early in 2021 with the review's wider findings and recommendations delivered later in 2021.
- 5. The review will not immediately consider issues around informed consent as these are the subject of an ongoing judicial review. However, any implications that might arise from the legal ruling could be considered by the review if appropriate or necessary.

Appendix 2

Letter to NHS England from
Dr Cass – May 2021



Independent review of gender identity services for children and young people



Independent review
into gender identity
services for children
and young people

Dr Hilary Cass
Chair
Review of GIDS for Children and Young People

John Stewart
National Director
Specialised Commissioning
NHS England and NHS Improvement

Sent by email

10 May 2021

Dear John

INDEPENDENT REVIEW INTO GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE

I am writing to update you on my current approach to the work of the independent review into gender identity services for children and young people. However, the most pressing issue is how we augment the immediate support for children and young people currently needing assessment and treatment, some of whom have already been waiting for an extended period for an appointment. I will therefore also make some suggestions about interim arrangements and ways in which the review team could help to support and strengthen these.

Commissioned research programme

As you know, a key principle of the review is that it should be evidence-based, and that final conclusions will be developed through a consensus development process contingent on the synthesised evidence.

I am pleased to see that the National Institute for Health and Care Excellence (NICE) evidence reviews of gonadotrophin releasing hormone analogues and gender affirming hormones for children and adolescents with gender dysphoria have now been published. Although this is a helpful starting point, despite following a standard and robust process the NICE review findings are not conclusive enough to inform policy decisions. As part of my review, I am therefore exploring other methodologies to give increased confidence and clarity about the optimal treatment approaches.

My team is commissioning a broader literature review of the existing evidence base on the epidemiology, management and outcomes of children with gender dysphoria. We are also commissioning qualitative and quantitative research, including considering other approaches which might be employed to understand the intermediate and longer-term outcomes of children with gender dysphoria. We intend to include a review of international models and data in this programme of work.

Addressing the immediate situation

Recognising that the outcome of the review is going to take some time, I have been reflecting on the recent court rulings on puberty blockers and consent and the Care Quality Commission (CQC) report on the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust. These significant developments have changed the context in which the review is taking place, and further added to the service pressures.

I note the proposal to establish an independent multidisciplinary professional review group to confirm decision-making has followed a robust process, which seems an appropriate interim measure pending further clarification of the legal situation.

I know that everyone concerned with the delivery of services – both commissioners and providers – are worried about the increasing number of children on the waiting list for assessment by the GIDS service and the resulting distress for the children and young people and their families. The difficulty in managing risk for those on the waiting list is exacerbated by the staff vacancies at GIDS, the increasing volume of new referrals, and the fact that the support and engagement from local services is highly variable and, in some cases, very limited.

Having a single provider may have been a logical position when the GIDS service was first set up, given that this is a highly specialised service that was seeing a relatively small number of cases each year. As the epidemiology has changed and there has been an exponential increase in numbers of children with gender incongruence or dysphoria, concentration of expertise within a single service has become unsustainable. At the same time, local services have not developed the skills and competencies to provide support for children on the waiting list and those with lesser degrees of gender incongruence who may not wish to pursue specialist medical intervention, and / or to provide help for children with additional complex needs.

I know from discussions we have had that your team is working hard to find some practical alternative arrangements, and that you have been in discussion with relevant professional bodies to come up with creative interim solutions while awaiting the outcome of my review.

The review team has also been in discussion with CQC, with the Tavistock and Portman NHS Foundation Trust and with colleagues within and external to NHS England and NHS Improvement to consider which aspects of this situation we can help with in the short to medium term, whilst keeping our focus on the longer-term questions of the appropriate clinical management and whole care pathway for these children and young people. In the past months I have also met with many groups and individuals with expertise and lived experience relevant to the review, including charities and support groups, Royal Colleges and healthcare professionals.

Recommendations to NHS England and NHS Improvement

I would encourage you to consider the following when developing an interim pathway for children and young people experiencing gender dysphoria:

- **Access and referral:** Children and young people need ready access to services. However, it is unusual for a specialist service to take direct referrals. The risk of having a national service as the first point of access is that assessment and treatment of children and young people who have the greatest need for specialist care is delayed because of the lack of differentiation of those on the waiting list. In addition, many children and

Independent review of gender identity services for children and young people

young people have complex needs, but once they are identified as having gender dysphoria, other important healthcare issues which would normally be managed by local services can sometimes be overlooked.

- **Assessment and management:** All children and young people who are referred to specialist services should have a competent local multi-disciplinary assessment and should remain under active holistic local management until they are seen at a specialist centre.

I recognise that developing capacity and capability outside of the existing GIDS service to provide such initial assessment and support will be difficult to achieve at speed and will be incremental. This means that there will likely be a range of different models and options around the country, dependent on local resources, with some of the work being delivered through existing secondary service teams, and some being delivered at regional level. The support of wider services is vital.

- **Data:** The lack of systematic data collection is a significant issue. Therefore, when employing interim measures, I would suggest that particular attention is paid to the gathering of good quality data, which can then be used to inform the evidence base and future model of provision.

Actions for the review team

I would like to suggest how the review team might help with the challenging problem of growing an infrastructure outside of GIDS. From my conversations to date, I believe there are three barriers to the involvement of local services:

- **Capacity** – the staff most appropriately trained to be involved in initial assessment are those who are already most stretched within Child and Adolescent Mental Health Services (CAMHS) and paediatric services, and this situation has been significantly worsened through the impact of the Covid-19 pandemic on children's mental health. However, I know that there is substantial investment in CAMHS services, so close engagement with the relevant national policy teams at NHS England and NHS Improvement and at Health Education England (HEE) will be crucial.
- **Capability and confidence** – clinical teams outside of GIDS do not feel confident in initial assessment and support of children and young people with gender incongruence and dysphoria, in large part because they have not had the necessary training and experience, but also because of the societal polarisation and tensions surrounding the management of this group.
- **Lack of an explicit assessment framework** – currently expertise in assessment of children and young people presenting to GIDS is held in a small body of clinicians and their assessment processes have not been made explicit. The CQC report drew attention to the lack of structured assessment in the GIDS notes, and this is something that the Tavistock and Portman NHS Foundation Trust is already working to address internally. However, it is equally important to develop an initial assessment approach that can be used by first contact professionals, not just those working in the specialist service.

In the first instance, it is important that we test these assumptions with a range of clinical staff and ascertain whether there are other barriers that are preventing local engagement in this work. Then we would plan to prioritise a series of workshops, in collaboration with relevant professional groups, service users and close engagement with HEE. The purpose of these workshops would be to address identified barriers and develop:

- A framework for initial assessment of children and young people presenting with gender dysphoria.
- An approach to training for professionals at local and regional level.
- Some preliminary workforce recommendations, which will be particularly important in meeting the timelines of the three-year Comprehensive Spending Review.

These workshops will serve multiple purposes – firstly to support NHS England and NHS Improvement in the establishment of local and / or regional teams; secondly as an essential component of the work needed to inform the questions that the review is tackling; and thirdly to form the professional networks that will be needed to underpin future service and research networks.

Timelines

As you will recognise, setting up a complex national review is difficult and time consuming at the best of times. It requires a team to support the work and mechanisms for stakeholders to engage safely and with confidence. Starting a review in the midst of a pandemic is even more challenging.

I have committed to a review approach which is participative, consensus-based, evidence-based, transparent, and informed by lived and professional experience. This requires extensive engagement. Pending the appointment of our research team, the review has now launched its website and I have been proactively engaging with the stakeholder community.

It is critical that we get the approach right, particularly the engagement, the evidence review and the quantitative research given the gaps in the evidence highlighted through the NICE review, and this will take time.

My intention is that an interim report will be delivered in the summer, with a report next year setting out my final recommendations.

Yours sincerely



Dr Hilary Cass
Chair, Independent Review into Gender Identity Services for Children and Young People

Cc: Care Quality Commission
Health Education England
Tavistock and Portman NHS Foundation Trust

Appendix 3

Diagnostic criteria for
gender dysphoria



DSM-5 diagnostic criteria for gender dysphoria

Gender Dysphoria in Children

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.

7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome).

Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

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3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome).

Specify if:

Post transition: the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-

sex medical procedure or treatment regimen – namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

ICD-11: HA60 Gender incongruence of adolescence or adulthood

Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions:

Paraphilic disorders.

ICD-11: HA61 Gender incongruence of childhood

Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions:

Paraphilic disorders.

Appendix 4

The standard approach to
clinical service development



The standard approach to clinical service development

The three examples below illustrate the usual process of developing a clinical service: Covid-19 is included because this is a new condition that everyone is familiar with; childhood epilepsy because it is a complex condition with physical manifestations; and autism because it is a condition with neuro-behavioural manifestations.

By comparing these examples of clinical service development, it is possible to demonstrate some of the challenges in developing services for children and young people with gender incongruence or dysphoria, and to identify where there are gaps and questions that need to be addressed for this population, in order to ensure any future service model delivers the highest possible standards of care.

The stages below may proceed in a different sequence for different conditions, but each stage is important in the development of evidence based care.

Stage	Covid-19	Childhood Epilepsy	Autism
New condition is observed This often begins with a few case reports and then clinicians begin to recognise a recurring pattern and key clinical features, and to develop fuller descriptions of the condition.	Covid-19 is an example of a recent new condition that we all recognise, and this started with a few unusual cases of respiratory illness being described in Wuhan.	Childhood epilepsy has been recognised for centuries, but over the last century there has been growing understanding of the many different subtypes.	Individuals with autism have probably also existed for an indefinite period, but it wasn't until 1943 and 1944 that Leo Kanner and Hans Asperger wrote the first scientific accounts about the condition.

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Stage	Covid-19	Childhood Epilepsy	Autism
Aetiology Clinicians and scientists try to work out the cause of the condition or the underlying physical or biological basis. Sometimes the answers to this are never found.	The cause of Covid-19 was identified at a very early stage as being due to a novel coronavirus, although it remains unclear where and how this originated.	It is now known that there are numerous different types of epilepsy, with many different causes – for example, epilepsy can be caused by specific epilepsy genes, by birth trauma, by metabolic conditions, by brain tumours and many other mechanisms. Epilepsies due to a change in the brain structure which occur after birth are called 'symptomatic' – they are a symptom of something else. Epilepsies for which there is no identified cause are called 'idiopathic'.	The first theory about the aetiology of autism was that it was caused by so called 'refrigerator parents'. This was inaccurate and damaging. It has subsequently been shown that there are many complex genetic and physical or chemical brain changes underpinning this condition.
Natural history and prognosis It is important to understand how a condition usually evolves over time, with or without treatment. The latter is important if treatment has limited efficacy and the condition is 'self-limiting' (that is, it resolves without treatment), because otherwise there is a risk that treatments create more difficulties than the condition itself.	Covid-19 is an example of a condition where there are quite polarised views about management based on its prognosis and natural history. A relatively small proportion of people are seriously affected and need treatment, and for the majority the natural history is that it will get better by itself. This has led some people to question the need for lockdowns, vaccinations and other measures which they see as impacting personal freedoms.	In epilepsy the natural history is very important. Some epilepsies get better through puberty and into adulthood, and some can get worse with hormonal changes. This is important to know when monitoring and reviewing drug treatment.	

Stage	Covid-19	Childhood Epilepsy	Autism
<p>Epidemiology</p> <p>Epidemiologists collect data to find out how common a condition is, who is most likely to be affected, what the age distribution is and so on. This allows health service planners to work out how many services are needed, where they should be established, and what staff are needed.</p> <p>They also report on changes in who is most affected, which may mean that either the disease is changing, or the susceptibility of the population is changing.</p>	<p>Epidemiologists have been crucial in supporting the management of Covid-19 because they have extracted and analysed the data on which patients are at greater risk from the virus. This has been fundamental to planning a vaccination strategy and other protective measures.</p>		<p>The epidemiology of autism has changed considerably, with a dramatic increase in the numbers of children diagnosed over the last 20 years. This has had major implications for service provision. There is ongoing debate about the cause of the increase – whether it is because of greater awareness and better diagnosis, or because there are more children with autism. Current opinion favours the first option.</p>

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Stage	Covid-19	Childhood Epilepsy	Autism
<p>Assessment and diagnosis</p> <p>Clinicians will usually take a history from (that is, of their symptoms) and examine the patient (that is, for signs and symptoms), and where appropriate undertake a series of investigations or tests, to help them reach an accurate diagnosis.</p> <p>Sometimes the whole process of making a diagnosis through talking to the patient and asking them to complete formal questionnaires, examining them and/or undertaking investigations is called 'clinical assessment'.</p> <p>As well as diagnosing and ruling out a particular condition, clinicians often need to consider and exclude other, sometimes more serious, conditions that present in a similar way but may need quite different treatment – this process is called 'differential diagnosis'.</p>	<p>PCR has been used as a 'gold standard' test for diagnosis of Covid-19 since the beginning of the pandemic. Lateral flow testing was developed to provide a quicker and cheaper option, but it demonstrates the limitations of testing; it is 99.68% specific, which is a very high specificity. This means there are only a tiny number of false positives. It has lower sensitivity at 76.8%, which means it will miss about a quarter of all cases, so giving many more false negatives, BUT it will only miss 5% of cases with high viral load.</p>	<p>Epilepsy can only be definitively diagnosed by either getting a really clear description of the events from a parent or carer, or seeing the child or young person having a seizure on a video. An EEG (brain wave tracing) and other tests can provide information about the type of epilepsy, but unless a seizure happens during the recording, it does not demonstrate that they actually have seizures – only that they may be susceptible to seizures.</p>	<p>In autism there are no blood tests or X-rays to make the diagnosis. It is a 'clinical' diagnosis, which means it is dependent on taking a standardised history from the parents, and performing standardised assessments on the child or young person to distinguish between autism and other possible diagnoses (for example, language disorder, social anxiety). In the early days, these standardised measures did not exist; the diagnosis was very dependent on experts who were used to diagnosing autism by making a clinical judgement about each child. This made it difficult to teach new people how to do this without a long apprenticeship, and also made it difficult to know whether two different experts would come to the same conclusion about the same child or young person. Standardisation of the questions and process made diagnosis more reliable and consistent, as did an improved evidence base.</p> <p>At the same time, because children with autism all present differently, the assessment had to be flexible enough to accommodate, for example, non-verbal children with severe learning disability, as well as high-functioning children with strong verbal skills.</p>

Stage	Covid-19	Childhood Epilepsy	Autism
Differential diagnosis As well as making a positive diagnosis, clinicians often need to exclude other, sometimes more serious conditions that present in a similar way, but may need quite different treatment.		There are conditions that can be mistaken for epilepsy, so it is important to accurately diagnose whether seizures are happening and exclude other conditions (differential diagnoses) by carrying out relevant tests.	There are many conditions that may be mistaken for autism – for example, children who have language disorders, learning disability, severe social anxiety for other reasons, or ADHD can all appear to have autism. It is important to exclude these other conditions as well as making a positive diagnosis of autism. Sometimes these conditions can exist alongside autism, and management must then be planned to address all the child's difficulties.

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Stage	Covid-19	Childhood Epilepsy	Autism
<p>Developing and implementing new treatments</p> <p>Clinicians and scientists work on developing treatments. This involves clinical trials and, where there are new treatments, comparing them to any existing treatments. Questions include: What are the intended outcomes or benefits of treatment? What are the complications or side effects? What are the costs? To initiate a new treatment, it must be both safe and effective. Questions of affordability can sometimes become controversial.</p> <p>The best type of single study is considered to be the randomised controlled trial (RCT), but sometimes this is not feasible. Even where RCTs are not available, it is usual to at least have data on the outcomes of sufficient cases or cohorts to understand the risk/benefit of the treatment under consideration. As demonstrated in Fig. 3, the highest level of evidence is when the results of several different studies are pooled, but this is only useful if the individual studies themselves are of high quality.</p>	<p>Developing treatments for Covid-19 has been possible at speed because of the large numbers of patients, and the fact that outcomes can be observed on each patient within a matter of days to weeks. Because Covid-19 was a new condition, clinicians also started in a position of 'equipoise' which means that they did not have reason to believe any one treatment might be more effective than another; this made it ethical to have one group having a treatment and another group having a different treatment or a placebo. There are also really clear outcome measures, such as whether or not patients survive or need hospitalisation. This has facilitated a high level of evidence through randomised controlled trials (see diagram below).</p>	<p>Similar considerations apply to the treatment of epilepsy in that there are 'hard' outcome measures (for example, frequency of seizures), but it can take several months to determine whether a new drug is better than an existing one for any one patient, and some side effects may be longer-term, so trials can take several years. In addition, children with epilepsy may have very different conditions causing their seizures which can also make trials more challenging.</p> <p>In the most severe cases of epilepsy, surgery may be the best option for controlling seizures. This can be very radical in certain cases and have lifelong implications for how they function. These options, which have a cost as well as a benefit to the child, will only be offered after a multi-disciplinary team meeting, including the paediatricians, therapists, neuropsychologists, radiologists, neurophysiologists and neurosurgeons have all discussed whether the benefits will outweigh the costs.</p>	<p>Evaluating interventions for autism is the most difficult of these three examples. This is because it can take many years to see developmental outcomes; it is hard to get uniform groups of children; outcomes are extremely sensitive to the social (and historical) response of others; and many other things happen in children's lives (such as changes of school, other medications, new diets). Isolating the effect of the target treatment is therefore challenging.</p>

Stage	Covid-19	Childhood Epilepsy	Autism
<p>In many instances, evidence is not perfect and difficult decisions have to be made. Where treatments are innovative or life-changing, the whole multi-disciplinary team will usually meet to consider the available options, and how to advise the child or young person and family so that a shared decision can be made. Sometimes an ethics committee is involved. This is one of the most challenging areas of medicine and is underpinned by GMC guidance.^{97, 98}</p>	<p>The UK has been internationally recognised for its Recovery Trial, led by Oxford University. This has recruited over 46,000 participants, and resulted in several treatments being approved. A key factor in this success was the willingness of patients to participate in these studies – with over 46,000 being recruited and consented.</p>		

⁹⁷ General Medical Council (2020). Decision making and consent.

⁹⁸ National Institute for Health and Care Excellence (2021). Shared decision making.

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Stage	Covid-19	Childhood Epilepsy	Autism
<p>Service development and service improvement</p> <p>Central to any service improvement is the systematic and consistent collection of data on outcomes of treatment. There is a process of continuous service improvement as new presentations or variations on the original condition are recognised, diagnosis or screening improves and/or trials on new treatments or variations on existing treatments are ongoing.</p> <p>There should be consistent treatment protocols or guidelines in place, in order to make sense of variations in outcomes. Where possible, these should be compared between and across multiple different centres.</p> <p>As time passes, services need to be changed or extended based on patient need, and on what resources are needed to deliver the available treatments. They need to be accessible where the prevalence of the condition is highest. The relevant workforce to deliver the service needs to be recruited and trained, contingent on the type of treatments or therapy that is required.</p>	<p>Service development to manage Covid-19 has been on a scale unlike any normal new service development ever experienced. It has also demonstrated how other non-Covid services have had to evolve alongside, including the need for isolation, and/or PCR testing prior to routine clinical appointments, use of remote consultation and an array of other changes across the NHS. Continuous audit and monitoring of outcomes has resulted in major improvements in survival – for example, changing ventilation approach to include ‘proning’ (putting patients on their front while on the ventilator) and delaying fully intubated ventilation by giving mask ventilation for as long as possible.</p>	<p>Paediatric epilepsy is a good example of how a national approach can be taken to service improvement through the Epilepsy12 programme.⁹⁹ This is a nationally co-ordinated audit which collects a standardised dataset, incorporating NICE standards, and is used to drive up standards of care for children and young people with epilepsy.</p>	<p>Improvement in autism services has been driven by the changing epidemiology, NICE standards, extensive training of the workforce and attempts to improve public understanding. Where previously diagnosis was undertaken in a few specialist centres, the rising waiting times and NICE standards on access, assessment and appropriate multi-professional provision have led to almost every community child development service having an autism assessment clinic or team. Services are able to self-assess against national standards to inform local improvement strategies.</p>

⁹⁹ Royal College of Paediatrics and Child Health (2021). [Epilepsy 12 – national organisational audit and clinical audit](#).

References

AB v CD & Ors [2021] EWHC 741.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5TM, 5th ed.

Bell v Tavistock [2020] EWHC 3274 (Admin).

Bloom TM, Nguyen TP, Lami F, Pace CC, Poulakis Z, Telfer N (2021). Measurement tools for gender identity, gender expression, and gender dysphoria in transgender and gender-diverse children and adolescents: a systematic review. Lancet Child Adolescent Health. 5: 582-588. DOI: 10.1016/s2352-4642(21)00098-5.

Bonfatto M, Crasnow E (2018). Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service. J Child Psychother 44(1): 29–46. DOI:10.1080/0075417X.2018.1443150.

Brik T, Vrouenraets LJJJ, de Vries MC, Hannema SE (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. Arch Sex Behav 49: 2611–8. DOI: 10.1007/s10508-020-01660-8.

Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.

Centers for Disease Control and Prevention (2012). Principles of Epidemiology in Public Health Practice: An introduction to Applied Epidemiology and Biostatistics, 3rd ed.

Chen D, Abrams M, Clark L, Ehrensaft D, Tishelman AC, Chan YM, et al (2021). Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: baseline findings from the trans youth care study. J Adol Health 68(6): 1104–11.

Independent review of gender identity services for children and young people

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, et al (2020). Consensus parameter: research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. Transgender Health 5(4). DOI: 10.1089/trgh.2020.0006.

Churcher Clarke A, Spiliadis A (2019). 'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties. Clin Child Psychol Psychiatry 24(2): 338–52. DOI:10.1177/1359104518825288.

Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatry Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.

Cohen-Kettenis PT, Van Goozen S (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. Eur Child Adolesc Psychiatry 7: 246–8. DOI: 10.1007/s007870050073.

de Graaf NM, Carmichael P, Steensma TD, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for Gender Dysphoria: Data from the Gender Identity Development Service in London (2000–2017). J Sex Med 15(10): 1381–3. DOI: 10.1016/j.jsxm.2018.08.002.

de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.

de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

Delemarre-van de Wall HA, Cohen-Kettenis PT (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol 155 (Suppl 1): S131–7. DOI: 10.1530/eje.1.02231.

Delevichab K, Klinger M, Nana OJ, Wilbrecht L (2021). Coming of age in the frontal cortex: The role of puberty in cortical maturation. Semin Cell Dev Biol 118: 64–72. DOI: 10.1016/j.semcdb.2021.04.021.

Di Ceglie D (2009). Engaging young people with atypical gender identity development in therapeutic work: A developmental approach. J Child Psychother 35(1): 3–12. DOI: 10.1080/00754170902764868.

Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). Prepubertal social gender transitions: What we know: what we can learn—A view from a gender affirmative lens. Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

EWCA [2021] Civ 1363.

Gender Identity Clinic, The Tavistock and Portman NHS Foundation Trust. Waiting times.

Gender Identity Development Service. Referrals to GIDS, financial years 2010-11 to 2020-21.

General Medical Council (2018). 0-18 years – guidance for all doctors.

General Medical Council (2020). Decision making and consent.

General Medical Council (2021). Good practice in prescribing and managing medicines and devices (76-78).

Gillick v West Norfolk and Wisbech AHA [1986] AC 112.

Goddings A-L, Beltz A, Jiska S, Crone EA, Braams BR (2019). Understanding the role of puberty in structural and functional development of the adolescent brain. J Res Adolesc 29(1): 32–53. DOI: 10.1111/jora.12408.

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.

Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, et al (2013). The gender affirmative model: What we know and what we aim to learn [Editorial]. Human Dev 56(5): 285–290. DOI:10.1159/000355235.

Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

Littman L (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch Sex Abuse 50: 3353–69. DOI: 10.1007/s10508-021-02163-w

Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. Clinical Child Psychol Psychiatry 24: 112–128. DOI: 10.1177/1359104518791657.

Mental Health Law Online. MCA 2005 s4.

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.

Independent review of gender identity services for children and young people

National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

National Institute for Health and Care Excellence (2021). Shared decision making.

NHS. GP services.

Office for National Statistics (2019). What is the difference between sex and gender?

Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, et al (2019). Creating the Trans Youth Research Network: A collaborative research endeavor. Transgend Health 4(12): 304–12. DOI: 10.1089/trgh.2019.0024.

OpenMD (2021). New Evidence in Medical Research.

Royal College of Paediatrics and Child Health (2021). Epilepsy 12 – national organisational audit and clinical audit – 2021.

Scobie S, Castle-Clarke S (2019). Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

Sievert EDC, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I (2020). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria. Clin Child Psychol Psychiatry 26(1): 79–95. DOI: 10.1177/1359104520964530

Spiliadis A (2019). Towards a gender exploratory model: Slowing things down, opening things up and exploring identity development. Metalogos Systemic Ther J 35: 1–9.

Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry 16(4): 485–97. DOI: 10.1177/135910451037803.

Steensma TD, Cohen-Kettenis PT, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988–2016). Journal of Sex & Marital Therapy 44(7): 713–5. DOI: 10.1080/0092623X.2018.1437580.

Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry 52: 582–590. DOI: 10.1016/j.jaac.2013.03.016.

Turban JL, King D, Carswell JM, et al (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics* 145 (2): e20191725. DOI: 10.1542/peds.2019-1725.

Twist J, de Graaf NM (2019). Gender diversity and non-binary presentations in young people attending the United Kingdom's National Gender Identity Development Service. *Clin Child Psychol Psychiatry* 24(2): 277–90. DOI: 10.1177/1359104518804311.

Van Der Miesen AIR, Hurley H, De Vries ALC (2016). Gender dysphoria and autism spectrum disorder: A narrative review. *Int Rev Psychiatry* 28: 70-80. DOI: 10.3109/09540261.2015.1111199.

Vrouenraets LJ, Fredriks AM, Hannema SE, Cohen-Kettenis PT, de Vries MC (2015). Early medical treatment of children and adolescents with gender dysphoria: an empirical ethical study. *J Adolesc Health* 57(4): 367-73. DOI: 10.1016/.2015.04.004.

World Health Organization (2022). International Classification of Diseases Eleventh Revision.

Wren B (2019). Notes on a crisis of meaning in the care of gender-diverse children. In: Hertzmann L, Newbigin J (eds) *Sexuality and Gender Now: Moving Beyond Heteronormativity*. Routledge.

Young Minds. Guide to CAMHS: a guide for young people.

Zucker KJ (2017). Epidemiology of gender dysphoria and transgender identity. *Sex Health* 14(5): 404–11. DOI:10.1071/SH1.

Zucker KJ, Lawrence AA (2009). Epidemiology of gender identity disorder: recommendations for the Standards of Care of the World Professional Association for Transgender Health. *Int J Transgend* 11(1): 8-18. DOI: 10.1080/15532730902799946.

Medicine and gender transidentity in children and adolescents

Press release of the French National Academy of Medicine¹

February 25, 2022

Gender transidentity is the strong sense, for more than 6 months, of identification with a gender different from that assigned at birth. This feeling can cause a significant and prolonged suffering, which can lead to a risk of suicide (a). No genetic predisposition has been found.

The recognition of this disharmony is not new, but a very strong increase in the demand for physicians for this reason has been observed (1, 2) in North America, then in the countries of northern Europe and, more recently, in France, particularly in children and adolescents. For example, a recent study within a dozen high schools in Pittsburgh revealed a prevalence that was much higher than previously estimated in the United States (3): 10% of students declared themselves to be transgender or non-binary or of uncertain gender (b). In 2003, the Royal Children's Hospital in Melbourne had diagnosed gender dysphoria in only one child, while today it treats nearly 200.

Whatever the mechanisms involved in the adolescent – overuse of social networks, greater social acceptability, or example in the entourage - this epidemic-like phenomenon results in the appearance of cases or even clusters in the immediate surroundings (4). This primarily social problem is based, in part, on a questioning of an excessively dichotomous vision of gender identity by some young people.

The medical demand is accompanied by an increasing supply of care, in the form of consultations or treatment in specialized clinics, because of the distress it causes rather than a mental illness per se. Many medical specialties in the field of pediatrics are concerned. First of all psychiatry, then, if the transidentity appears real or if the malaise persists, endocrinology gynecology and finally surgery are concerned.

However, a great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause. In this respect, it is important to recall the recent decision (May 2021) of the Karolinska University Hospital in Stockholm to ban the use of hormone blockers.

Although, in France, the use of hormone blockers or hormones of the opposite sex is possible with parental authorization at any age, the greatest reserve is required in their use, given the

¹ This Press release, adopted by the French Academy of Medicine on February 25, 2022, by 59 votes for, 20 against and 13 abstentions, was approved, in its revised version, by the Board of Directors on February 28, 2022.

side effects such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause.

As for surgical treatments, in particular mastectomy, which is authorized in France from the age of 14, and those involving the external genitalia (vulva, penis), their irreversible nature must be emphasized.

Therefore, faced with a request for care for this reason, it is essential to provide, first of all, a medical and psychological support to these children or adolescents, but also to their parents, especially since there is no test to distinguish a "structural" gender dysphoria from transient dysphoria in adolescence. Moreover, the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to "detransition". It is therefore advisable to extend as much as possible the psychological support phase.

The National academy of medicine draws the attention of the medical community to the increasing demand for care in the context of gender transidentity in children and adolescents and recommends:

- A psychological support as long as possible for children and adolescents expressing a desire to transition and their parents;
- In the event of a persistent desire for transition, a careful decision about medical treatment with hormone blockers or hormones of the opposite sex within the framework of Multi-disciplinary Consultation Meetings;
- The introduction of an appropriate clinical training in medical studies to inform and guide young people and their families;
- The promotion of clinical and biological as well as ethical research, which is still too rare in France on this subject.
- The vigilance of parents in response to their children's questions on transidentity or their malaise, underlining the addictive character of excessive consultation of social networks which is both harmful to the psychological development of young people and responsible, for a very important part, of the growing sense of gender incongruence.

Glossary:

- a. Gender dysphoria is the medical term used to describe the distress resulting from the incongruence between the felt gender and the gender assigned at birth (5).
- b. A non-binary person is a person whose gender identity is neither male nor female.
- c. A transgender person adopts the appearance and lifestyle of a sex different from that assigned at birth. Whether born male or female, the transgender persons changes, or even rejects, their original gender identity. The sex registered on his or her civil status does not correspond to the appearance he or she sends back. This does not necessarily lead to a therapeutic approach.

References

1. NHS, The Tavistock and Portman, Referrals to the Gender Identity Development Services (GIDS) for children and adolescents' level off in 2018-19, 28 June 2019 (<https://tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/>);
 2. Swedish national health Council, Report on the prevalence of persons diagnosed with gender dysphoria since 1998 among registered citizens of Sweden, 2020, www.socialstyrelsen.se;
 3. Kidd K.M., Sequeira G.M., Douglas C. et al, Prevalence of gender diverse youth in an urban school district, *Pediatrics*, 2021, vol 147, issue 6
 4. Littman, L., Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE*, 2018, 13(8), e0202330. <https://doi.org/10.1371/journal.pone.0202330>;
- Correction: *PLoS ONE* 2019; 14(3): e0214157. Published online 2019 Mar
19. doi: 10.1371/journal.pone.0214157
5. Martinerie L., Condat A., Bargiacchi A., et al. Management of endocrine disease. Approach to the management of children and adolescents with gender dysphoria, *European Journal of Endocrinology*, 2018, 179, p. 1219-123

Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria

This document will help inform Dr Hilary Cass' independent review into gender identity services for children and young people. It was commissioned by NHS England and Improvement who commissioned the Cass review. It aims to assess the evidence for the clinical effectiveness, safety and cost-effectiveness of gender-affirming hormones for children and adolescents aged 18 years or under with gender dysphoria.

The document was prepared by NICE in October 2020.

The content of this evidence review was up to date on 21 October 2020. See [summaries of product characteristics](#) (SPCs), [British National Formulary](#) (BNF) or the [Medicines and Healthcare products Regulatory Agency](#) (MHRA) or [NICE](#) websites for up-to-date information.

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1. Introduction

This review aims to assess the evidence for the clinical effectiveness, safety and cost-effectiveness of gender-affirming hormones for children and adolescents aged 18 years or under with gender dysphoria. The review follows the NHS England Specialised Commissioning process and template and is based on the criteria outlined in the PICO framework (see [appendix A](#)). This document will help inform Dr Hilary Cass' independent review into gender identity services for children and young people.

Gender dysphoria in children, also known as gender identity disorder or gender incongruence of childhood ([World Health Organisation 2020](#)), refers to discomfort or distress that is caused by a discrepancy between a person's gender identity (how they see themselves¹ regarding their gender) and that person's sex assigned at birth and the associated gender role, and/or primary and secondary sex characteristics ([Diagnostic and Statistical Manual of Mental Disorders 2013](#)).

Gender-affirming hormones are oestradiol for sex assigned at birth males (transfemales) and testosterone for sex assigned at birth females (transmales). The aim of gender-affirming hormones is to induce the development of the physical sex characteristics congruent with the individual's gender expression while aiming to improve mental health and quality of life outcomes.

No oestradiol-containing products are licensed for gender dysphoria and therefore any use for children and adolescents with gender dysphoria is off-label.

The only testosterone-containing product licensed for gender dysphoria is Sustanon 250 mg/ml solution for injection, which is indicated as supportive therapy for transmales, use of all other testosterone-containing products for children and adolescents with gender dysphoria is off-label.

For children and adolescents with gender dysphoria it is recommended that management plans are tailored to the needs of the individual and aim to ameliorate the potentially negative impact of gender dysphoria on general developmental processes, to support young people and their families in managing the uncertainties inherent in gender identity development and to provide ongoing opportunities for exploration of gender identity. The plans may also include psychological support and exploration and, for some individuals, the use of gonadotrophin releasing hormone (GnRH) analogues in adolescence to suppress puberty; this may be followed later with gender-affirming hormones of the desired sex ([NHS England 2013](#)).

Currently NHS England, as part of the Gender Identity Development Service for Children and Adolescents, routinely commissions gender-affirming hormones for young people with continuing gender dysphoria from around their 16th birthday subject to individuals meeting the eligibility and readiness criteria ([Clinical Commissioning Policy 2016](#)).

¹ Gender refers to the roles, behaviours, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men ([World Health Organisation, Health Topics: Gender](#)).

2. Executive summary of the review

Ten observational studies were included in the evidence review. Seven studies were retrospective observational studies ([Allen et al. 2019](#), [Kaltiala et al. 2020](#), [Khatchadourian et al. 2014](#), [Klaver et al. 2020](#), [Klink et al. 2015](#), [Stoffers et al. 2019](#), [Vlot et al. 2017](#)) and 3 studies were prospective longitudinal observational studies ([Achille et al. 2020](#), [Kuper et al. 2020](#), [Lopez de Lara et al. 2020](#)). No studies directly compared gender-affirming hormones to a control group (either placebo or active comparator). Follow-up was relatively short across all studies, with an average duration of treatment with gender-affirming hormones between around 1 year and 5.8 years.

The terminology used in this topic area is continually evolving and is different depending on stakeholder perspectives. In this evidence review we have used the phrase 'people's assigned sex at birth' rather than saying natal or biological sex and 'cross sex hormones' are now referred to as 'gender-affirming hormones'. The research studies may use historical terms which are no longer considered appropriate.

In children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Critical outcomes

The critical outcomes for decision making are impact on gender dysphoria, impact on mental health and quality of life. The quality of evidence for all these outcomes was assessed as very low certainty using modified GRADE.

Impact on gender dysphoria

The study by [Lopez de Lara et al. 2020](#) in 23 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, gender dysphoria (measured using the Utrecht Gender Dysphoria Scale [UGDS]) was statistically significantly reduced (improved) from a mean [\pm SD] score of 57.1 (\pm 4.1) points at baseline to 14.7 (\pm 3.2) points at 12 months, which is below the threshold (40 points) for gender dysphoria ($p < 0.001$).

Impact on mental health

Depression

The study by [Lopez de Lara et al. 2020](#) in 23 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, depression (measured using the Beck Depression Inventory-II [BDI-II]) was statistically significantly reduced from a mean [\pm SD] score of 19.3 (\pm 5.5) points at baseline to 9.7 (\pm 3.9) points at 12 months ($p < 0.001$).

The study by [Achille et al. 2020](#) in 50 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, depression was statistically significantly reduced from baseline to about 12 months follow-up:

- The Center for Epidemiologic Studies Depression (CESD-R) improved from a mean score of 21.4 points at baseline to 13.9 points ($p < 0.001$).
- The Patient Health Questionnaire (PHQ 9) Modified for Teens improved, although absolute scores were not reported numerically ($p < 0.001$).

The study by [Kuper et al. 2020](#) in 148 adolescents with gender dysphoria (of whom 123 received gender-affirming hormones) found that during treatment with gender-affirming hormones for an average of 10.9 months, the impact on depression (measured using the Quick Inventory of Depressive Symptoms [QIDS]) was unclear as no statistical analysis was reported. The mean (\pm SD) self-reported score was 9.6 points (\pm 5.0) at baseline and 7.4 (\pm 4.5) at follow-up. The mean (\pm SD) clinician-reported score was 5.9 points (\pm 4.1) at baseline and 6.0 (\pm 3.8).

The study by [Kaltiala et al. 2020](#) in 52 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, statistically significantly fewer participants needed treatment for depression (54% at initial assessment compared with 15% at 12-month follow-up, $p < 0.001$). No details of the treatments for depression are reported.

Anxiety

The study by [Lopez de Lara et al. 2020](#) in 23 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, state anxiety (measured using the State-Trait Anxiety Inventory [STAI] – State subscale) was statistically significantly reduced from a mean (\pm SD) score of 33.3 points (\pm 9.1) at baseline to 16.8 points (\pm 8.1) at 12 months ($p < 0.001$). Trait anxiety (measured using STAI – Trait subscale) was also statistically significantly reduced from a mean (\pm SD) score of 33.0 (\pm 7.2) points at baseline to 18.5 (\pm 8.4) points at 12 months ($p < 0.001$).

The study by [Kuper et al. 2020](#) in 148 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, small reductions were seen in anxiety, panic, generalised anxiety, social anxiety and separation anxiety symptoms and school avoidance (measured using the Screen for Child Anxiety Related Emotional Disorders [SCARED] questionnaire) from baseline to follow-up (mean duration of treatment 10.9 months). The statistical significance of these findings are unknown as no statistical analyses were reported.

The study by [Kaltiala et al. 2020](#) in 52 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, statistically significantly fewer participants needed treatment for anxiety (48% at initial assessment compared with 15% at 12-month follow-up, $p < 0.001$). No details of treatments for anxiety are reported.

Suicidality and self-injury

The study by [Allen et al. 2019](#) in 47 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, suicide risk (measured using the Ask Suicide-Screening Questions [ASQ]) was statistically significantly reduced from an adjusted mean (\pm SE) score of 1.11 points (\pm 0.22) at baseline to 0.27 points (\pm 0.12) after about 12 months ($p < 0.001$).

The study by [Achille et al. 2020](#) in 50 adolescents with gender dysphoria (of whom 35 received gender-affirming hormones at follow-up) found that during treatment with gender-affirming hormones, the impact on suicidal ideation was unclear (measured using the PHQ 9_Modified for Teens with additional questions for suicidal ideation). At baseline 10% of participants had suicidal ideation and 6% had suicidal ideation after about 12 months, but it is unclear if these participants received gender-affirming hormones. No statistical analyses were reported.

The study by [Kuper et al. 2020](#) in 148 adolescents with gender dysphoria reported the impact on suicidal ideation, suicide attempts and non-suicidal self-injury during treatment with gender-affirming hormones, after mean 10.9 months follow-up. The statistical significance of these findings are unknown as no statistical analyses were reported:

- Suicidal ideation was reported in 25% of participants 1 month before the initial assessment and in 38% of participants during follow-up.
- Suicide attempts were reported in 2% of participants at 3 months before the initial assessment and in 5% during follow-up.
- Self-injury was reported in 10% of participants at 3 months before the initial assessment and in 17% during follow-up.

The study by [Kaltiala et al. 2020](#) in 52 adolescents with gender dysphoria reported that during treatment with gender-affirming hormones, statistically significantly fewer participants needed treatment for suicidal ideation or self-harm (35% at initial assessment compared with 4% at 12-month follow-up, $p<0.001$). No details of treatments for suicidal ideation or self-harm are reported.

Other related symptoms

The study by [Kaltiala et al. 2020](#) in 52 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, there was no statistically significant difference in the number of people needing treatment for either psychotic symptoms or psychosis, conduct problems or antisocial behaviour, substance abuse, autism, attention deficit hyperactivity disorder (ADHD) or eating disorders during the 12-month 'real life' phase compared with before or during the assessment. No details of the treatments received are reported.

Impact on quality of life

The study by [Achille et al. 2020](#) in 50 adolescents with gender dysphoria (of whom 35 were receiving gender-affirming hormones at follow-up) found that during treatment with gender-affirming hormones, quality of life (measured using the Quality of Life Enjoyment and Satisfaction Questionnaire [QLES-Q-SF]) was statistically significantly improved from baseline to about 12 months, but absolute scores were not reported numerically ($p<0.001$).

The study by [Allen et al. 2019](#) in 47 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, quality of life (measured using the General Well-Being Scale [GWBS] of the Paediatric Quality of Life Inventory) was statistically significantly improved from an adjusted mean (\pm SE) score of 61.70 (\pm 2.43) points at baseline to 70.23 (\pm 2.15) points at about 12 months ($p<0.002$).

Important outcomes

The important outcomes for decision making are impact on body image, psychosocial impact, engagement with healthcare services, impact on extent of and satisfaction with surgery and de-transition. The quality of evidence for all these outcomes was assessed as very low certainty using modified GRADE.

Impact on body image

The study by [Kuper et al. 2020](#) in 148 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, the impact on body image is unclear (measured using the Body Image Scale [BIS]). The mean (\pm SD) BIS score was 70.7 points (\pm 15.2) at baseline and 51.4 points (\pm 18.3) at follow-up (mean duration of treatment 10.9 months; no statistical analysis was reported).

Psychosocial impact

The study by [Lopez de Lara et al. 2020](#) in 23 adolescents with gender dysphoria found that during treatment with gender affirming hormones, family functioning is unchanged (measured using the Family Adaptability, Partnership, Growth, Affection and Resolve [APGAR] test). The mean score was 17.9 points at baseline and 18.0 points at 12-month follow-up (no statistical analysis was reported).

The study by [Lopez de Lara et al. 2020](#) in 23 adolescents with gender dysphoria found that during treatment with gender affirming hormones, behavioural problems (measured using the Strengths and Difficulties Questionnaire [SDQ]) were statistically significantly improved from a mean (\pm SD) of 14.7 (\pm 3.3) points at baseline to 10.3 points (\pm 2.9) at 12-month follow-up ($p < 0.001$).

The study by [Kaltiala et al. 2020](#) in 52 adolescents with gender dysphoria found that about 12-months after starting treatment with gender-affirming hormones:

- Statistically significantly fewer participants were living with parents or guardians (73% versus 40%, $p = 0.001$) and statistically significantly fewer participants had normal peer contacts (89% versus 81%, $p < 0.001$).
- There were no statistically significant differences in:
 - progress in school or work (64% versus 60%, $p = 0.69$),
 - the number of participants who had been dating or in steady relationships (62% versus 58%, $p = 0.51$)
 - the ability to cope with matters outside of the home (for example, shopping and travelling alone on local public transport; 81% versus 81%, $p = 1.0$)

Engagement with health care services

No evidence was identified.

Impact on extent of and satisfaction with surgery

No evidence was identified.

De-transition

No evidence was identified.

In children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Important outcomes

The important outcomes for decision making are short- and long-term safety outcomes and adverse effects. The quality of evidence for all these outcomes was assessed as very low certainty using modified GRADE.

Bone density

The study by [Klink et al. 2015](#) in 34 adolescents with gender dysphoria (who were previously treated with a GnRH analogue) found that gender-affirming hormones may increase lumbar spine and femoral neck bone density. However, not all results are statistically significant (particularly in transfemales). Z-scores suggest the average bone density at the end of follow-up was generally lower than in the equivalent cisgender population (transfemales compared with cis-males and transmales compared with cis-females). From starting gender-affirming hormones to age 22 years:

- There was no statistically significant difference in lumbar spine bone mineral apparent density (BMAD) z-score in transfemales, but this was statistically significantly higher in transmales (z-score [\pm SD]: start of hormones -0.50 [\pm 0.81], age 22 years -0.033 [\pm 0.95], $p=0.002$).
- There was no statistically significant difference in lumbar spine bone mineral density (BMD) z-score in transfemales or transmales.
- Actual lumbar spine BMAD and BMD values were statistically significantly higher in transfemales and transmales.
- There was no statistically significant difference in femoral neck BMD z-score in transfemales, but this was statistically significantly higher in transmales (z-score [SD]: start of hormones -0.35 [0.79], age 22 years -0.35 [0.74], $p=0.006$).
- There was no statistically significant difference in actual femoral neck BMAD values in transfemales, but this was statistically significantly higher in transmales.
- Actual femoral neck BMD values were statistically significantly higher in transfemales and transmales.

The study by [Vlot et al. 2017](#) in 70 adolescents with gender dysphoria (who were previously treated with a GnRH analogue) found that gender-affirming hormones may increase lumbar spine and femoral neck bone density. However, not all results are statistically significant. Z-scores suggest the average bone density at the end of follow-up was generally lower than the equivalent cisgender population (transfemales compared with cis-males and transmales compared with cis-females). From starting gender-affirming hormones to 24-month follow-up:

- The z-score for lumbar spine BMAD was statistically significantly higher in transfemales with a bone age of less than 15 years (z-score [range]: start of hormones -1.52 [-2.36 to 0.42], 24-month follow-up -1.10 [-2.44 to 0.69], $p\leq 0.05$) and 15 years and older (z-score [range]: start of hormones -1.15 [-2.21 to 0.08], 24-month follow-up -0.66 [-1.66 to 0.54], $p\leq 0.05$).
- The z-score for lumbar spine BMAD was statistically significantly higher in transmales with a bone age of less than 14 years (z-score [range]: start of hormones -0.84 [-2.2 to 0.87], 24-month follow-up -0.15 [-1.38 to 0.94], $p\leq 0.01$) and 14 years and older (z-score [range]: start of hormones -0.29 [-2.28 to 0.90], 24-month follow-up -0.06 [-1.75 to 1.61], $p\leq 0.01$).
- Actual lumbar spine BMAD values were statistically significantly higher in transfemales and transmales of all bone ages.
- There was no statistically significant difference in femoral neck BMAD z-score in transfemales (all bone ages).

- The z-score for femoral neck BMAD was statistically significantly higher in transmales with a bone age of less than 14 years (z-score [range]: start of hormones -0.37 [-2.28 to 0.47], 24-month follow-up -0.37 [-2.03 to 0.85], $p \leq 0.01$) and 14 years and older (z-score [range]: start of hormones -0.27 [-1.91 to 1.29], 24-month follow-up 0.02 [-2.1 to 1.35], $p \leq 0.05$).
- There was no statistically significant difference in actual femoral neck BMAD values in transfemales (all bone ages), but this was statistically significantly higher in transmales (all bone ages).

The study by [Stoffers et al. 2019](#) in 62 sex assigned at birth females (transmales) with gender dysphoria (who were previously treated with a GnRH analogue) found that during treatment with gender-affirming hormones there was no statistically significant difference in lumbar spine or femoral neck bone density (measured as BMD z-scores or actual values) from starting gender-affirming hormones to any timepoint (6, 12 and 24 months).

Change in clinical parameters

The study by [Klaver et al. 2020](#) in 192 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, from starting treatment to age 22 years:

- Glucose levels, insulin levels and insulin resistance were largely unchanged in transfemales and transmales.
- Total cholesterol, HDL cholesterol and LDL cholesterol levels were unchanged in transfemales, and there was a statistically significant improvement in triglyceride levels.
- Total cholesterol, HDL cholesterol, LDL cholesterol and triglyceride levels significantly worsened in transmales, but mean levels were within the UK reference range at the end of treatment.
- Diastolic blood pressure was statistically significantly increased in transfemales and transmales. Systolic blood pressure was also statistically significantly increased in transmales, but not in transfemales. The absolute increases in blood pressure were small.
- Body mass index was statistically significantly increased in transfemales and transmales, although most participants were within the healthy weight range (18.5 to 24.9 kg/m).

The study by [Stoffers et al. 2019](#) in 62 sex assigned at birth females (transmales) with gender dysphoria found that during treatment with gender affirming hormones, from starting treatment to 24-month follow-up:

- There was no statistically significant change in glycosylated haemoglobin (HbA1c).
- There was no statistically significant change in aspartate aminotransferase (AST), alanine aminotransferase (ALT) and gamma-glutamyltransferase (GCT).
- There was a statistically significant increase in alkaline phosphatase (ALP) at some timepoints, but the difference was not statistically significant by 24-months.
- There was a statistically significant increase in serum creatinine levels at all timepoints up to 24 months, but these were within the UK reference range. Serum urea levels were unchanged (follow-up duration not reported).

Treatment discontinuation and adverse effects

The study by [Khatchadourian et al. 2014](#) in 63 adolescents (24 transfemales and 39 transmales) with gender dysphoria found that during treatment with gender affirming hormones (duration of treatment not reported):

- No participants permanently discontinued treatment.
- No transfemales temporarily discontinued treatment, but 3 transmales temporarily discontinued treatment due to mental health comorbidities (n=2) and androgenic alopecia (n=1). All 3 participants eventually resumed treatment, although timescales were not reported
- No severe complications were reported.
- No transfemales reported minor complications, but 12 transmales developed minor complications which were: severe acne (n=7), androgenic alopecia (n=1), mild dyslipidaemia (n=3) and significant mood swings (n=1).

In children and adolescents with gender dysphoria, what is the cost-effectiveness of gender-affirming hormones compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?

No cost-effectiveness evidence was found for gender-affirming hormones for children and adolescents with gender dysphoria.

From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria?

Some studies reported data separately for the following subgroups of children and adolescents with gender dysphoria:

- Sex assigned at birth males (transfemales).
- Sex assigned at birth females (transmales).
- Tanner stage at which GnRH analogue or gender-affirming hormones started.
- Diagnosis of a mental health condition.

Some direct comparisons of transfemales and transmales were included. No evidence was found for other specified subgroups.

Sex assigned at birth males (transfemales)

Impact on mental health

In the study by [Kuper et al. 2020](#) in 33 to 45 (number varies by outcome) sex assigned at birth males (transfemales) with gender dysphoria found that during treatment with gender-affirming hormones changes were seen in depression, anxiety and anxiety-related symptoms from baseline to follow-up (mean duration of treatment 10.9 months). The authors did not report any statistical analyses, so it is unclear if any changes were statistically significant.

The study by [Allen et al. 2019](#) in 47 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, suicide risk (measured using the ASQ) is not statistically significant different in transfemales compared with transmales, between baseline and the final assessment at about 12 months (p=0.79).

The study by [Achille et al. 2020](#) in 17 transfemales with gender dysphoria found that during treatment with gender-affirming hormones, suicidal ideation (measured using the PHQ 9_Modified for Teens with additional questions for suicidal ideation) was reported in 11.8% (2/17) of transfemales at baseline compared with 5.9% (1/17) at about 12-months follow-up (no statistical analysis was reported).

Impact on quality of life

The study by [Allen et al. 2019](#) in 47 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, quality of life (measured using the GWBS of the Paediatric Quality of Life Inventory) was not statistically significant different in transfemales compared with transmales, between baseline and the final assessment at about 12 months ($p=0.32$).

Bone density

The studies by [Klink et al. 2015](#) and [Vlot et al. 2017](#) provided evidence on bone density in transfemales; see above for details.

Change in clinical parameters

The study by [Klaver et al. 2020](#) provided evidence on the following clinical parameters in transfemales:

- Glucose levels, insulin levels and insulin resistance.
- Total cholesterol, HDL cholesterol and LDL cholesterol and triglycerides.
- Blood pressure.
- Body mass index.

See above for details.

Treatment discontinuation and adverse effects

The study by [Khatchadourian et al. 2014](#) provided evidence on treatment discontinuation and adverse effects in transfemales; see above for details.

Sex assigned at birth females (transmales)

Impact on mental health

In the study by [Kuper et al. 2020](#) in 65 to 78 (number varies by outcome) sex assigned at birth females (transmales) with gender dysphoria found that during treatment with gender-affirming hormones, changes were seen in depression, anxiety and anxiety-related symptoms from baseline to 10.9 month follow-up. The authors did not report any statistical analyses, so it is unclear if any changes were statistically significant.

The study by [Allen et al. 2019](#) in 47 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, suicide risk (measured using the ASQ) is not statistically significantly different in transmales compared with transfemales, between baseline and the final assessment ($p=0.79$).

The study by [Achille et al. 2020](#) in 33 transmales with gender dysphoria found that during treatment with gender-affirming hormones, suicidal ideation (measured using the PHQ 9_Modified for Teens with additional questions for suicidal ideation) was reported in 9.1% (3/33) of transmales at baseline compared with 6.1% (2/33) at about 12-months follow-up (no statistical analysis reported).

Impact on quality of life

The study by [Allen et al. 2019](#) in 47 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, quality of life (measured using the GWBS of the Paediatric Quality of Life Inventory) was not statistically significantly different in transmales compared with transfemales, between baseline and the final assessment at about 12 months ($p=0.32$).

Bone density

The studies by [Klink et al. 2015](#), [Stoffers et al. 2019](#) and [Vlot et al. 2017](#) provided evidence on bone density in transmales; see above for details.

Change in clinical parameters

The study by [Klaver et al. 2020](#) provided evidence on the following clinical parameters in transmales:

- Glucose levels, insulin levels and insulin resistance.
- Total cholesterol, HDL cholesterol and LDL cholesterol and triglycerides.
- Blood pressure.
- Body mass index.

See above for details.

The study by [Stoffers et al. 2019](#) provided evidence on HbA1c, liver enzymes and renal function in transmales; see above for details.

Treatment discontinuation and adverse effects

The study by [Khatchadourian et al. 2014](#) provided evidence on treatment discontinuation and adverse effects in transmales; see above for details.

Tanner stage at which GnRH analogues or gender-affirming hormones started

The study by [Kuper et al. 2020](#) stated that the impact of Tanner stage on outcomes was considered, but it is unclear if this refers to Tanner stage at the initial assessment, at the start of GnRH analogue treatment or another timepoint. No results were reported.

Diagnosis of a mental health condition

Impact on mental health

The study by [Achille et al. 2020](#) in 50 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, there was no statistically significant difference in depression (measured using the CESD-R and PHQ 9_Modified for Teens) when the results were adjusted for engagement in counselling and medicines for mental health problems, from baseline to about 12-months follow-up.

Impact on quality of life

The study by [Achille et al. 2020](#) in 50 adolescents with gender dysphoria found that during treatment with gender-affirming hormones, there was no statistically significant difference in quality of life (measured using the QLES-Q-SF) when the results were adjusted for engagement in counselling and medicines for mental health problems, from baseline to about 12-months follow-up.

From the evidence selected,

- (a) **what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?**
- (b) **what were the ages at which participants commenced treatment with gender-affirming hormones?**
- (c) **what was the duration of treatment with GnRH analogues?**

The most commonly reported diagnostic criteria for gender dysphoria was the DSM criteria in use at the time (5/10 studies). In 3 studies ([Klaver et al. 2020](#), [Klink et al. 2015](#) and [Vlot et al. 2017](#)) DSM-IV-TR criteria was used. In 2 studies ([Kuper et al. 2020](#) and [Stoffers et al. 2019](#)) DSM-V criteria was used. One study from Finland ([Kaltiala et al. 2020](#)) used the ICD-10 diagnosis of 'transsexualism'. It was not reported how gender dysphoria was defined in the remaining 4 studies.

In the studies, treatment with gender-affirming hormones started at about 16 to 17 years, with a range of about 14 to 19 years. Most studies did not report the duration of treatment with GnRH analogues, but where this was reported there was a wide variation ranging from a few months up to about 5 years ([Klaver et al. 2020](#), [Klink et al. 2015](#) and [Stoffers et al. 2019](#)).

Discussion

The key limitation to identifying the effectiveness and safety of gender-affirming hormones for children and adolescents with gender dysphoria is the lack of reliable comparative studies.

All the studies included in the evidence review are uncontrolled observational studies, which are subject to bias and confounding and were of very low certainty using modified GRADE. A fundamental limitation of all the uncontrolled studies included in this review is that any changes in scores from baseline to follow-up could be attributed to a regression-to-the-mean.

The included studies have relatively short follow-up, with an average duration of treatment with gender-affirming hormones between around 1 year and 5.8 years. Further studies with a longer follow-up are needed to determine the long-term effect of gender-affirming hormones for children and adolescents with gender dysphoria.

Most studies included in this review did not report comorbidities (physical or mental health) and no study reported concomitant treatments in detail. Because of this it is not clear whether any changes seen were due to gender-affirming hormones or other treatments the participants may have received.

There is a degree of indirectness in some studies, with some participants included that fall outside of the population of this evidence review. Furthermore, participant numbers are poorly reported in some studies, with high numbers lost to follow-up or outcomes not reported for some participants. The authors provide no explanation for this incomplete reporting.

Details of the gender-affirming hormone treatment regimen are poorly reported in most of the included studies, with limited information provided about the medicines, doses and routes of administration used. It is not clear whether the interventions used in the studies are reflective of current UK practice for children and adolescents with gender dysphoria.

It is difficult to draw firm conclusions for many of the effectiveness and safety outcomes reported in the included studies because many different scoring tools and methods were used to assess the same outcome, often with conflicting results. In addition to this, most outcomes reported across the included studies do not have an accepted minimal clinically important difference (MCID), making it difficult to determine whether any statistically significant changes seen are clinically meaningful. However, the authors of some studies report thresholds to interpret the results of the scoring tools (for example, by linking scores to symptom severity), so some conclusions can be made.

Conclusion

Any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria.

Results from 5 uncontrolled, observational studies suggest that, in children and adolescents with gender dysphoria, gender-affirming hormones are likely to improve symptoms of gender dysphoria, and may also improve depression, anxiety, quality of life, suicidality, and psychosocial functioning. The impact of treatment on body image is unclear. All results were of very low certainty using modified GRADE.

Safety outcomes were reported in 5 observational studies. Statistically significant increases in some measures of bone density were seen following treatment with gender-affirming hormones, although results varied by bone region (lumber spine versus femoral neck) and by population (transfemales versus transmales). However, z-scores suggest that bone density remained lower in transfemales and transmales compared with an equivalent cisgender population. Results from 1 study of gender-affirming hormones started during adolescence reported statistically significant increases in blood pressure and body mass index, and worsening of the lipid profile (in transmales) at age 22 years, although longer term studies that report on cardiovascular event rates are required. Adverse events and discontinuation rates associated with gender-affirming hormones were only reported in 1 study, and no conclusions can be made on these outcomes.

This review did not identify sub-groups of patients who may benefit more from gender-affirming hormones.

No cost-effectiveness evidence was found to determine whether gender-affirming hormones are a cost-effective treatment for children and adolescents with gender dysphoria.

3. Methodology

Review questions

The review question(s) for this evidence review are:

1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

2. For children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?
3. For children and adolescents with gender dysphoria, what is the cost-effectiveness of gender-affirming hormones compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?
4. From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria?
5. From the evidence selected,
 - (a) what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?
 - (b) what were the ages at which participants commenced treatment with gender-affirming hormones?
 - (c) what was the duration of GnRH analogues treatment?

See [appendix A](#) for the full review protocol.

Review process

The methodology to undertake this review is specified by NHS England in their 'Guidance on conducting evidence reviews for Specialised Services Commissioning Products' (2020).

The searches for evidence were informed by the PICO and were conducted on 21 July 2020.

See [appendix B](#) for details of the search strategy.

Results from the literature searches were screened using their titles and abstracts for relevance against the criteria in the PICO framework. Full text references of potentially relevant evidence were obtained and reviewed to determine whether they met the inclusion criteria for this evidence review.

See [appendix C](#) for evidence selection details and [appendix D](#) for the list of studies excluded from the review and the reasons for their exclusion.

Relevant details and outcomes were extracted from the included studies and were critically appraised using a checklist appropriate to the study design. See [appendix E](#) and [appendix F](#) for individual study and checklist details.

The available evidence was assessed by outcome for certainty using modified GRADE. See [appendix G](#) for GRADE Profiles.

4. Summary of included studies

Ten observational studies were included in the evidence review. Seven studies were retrospective observational studies ([Allen et al. 2019](#), [Kaltiala et al. 2020](#), [Khatchadourian et al. 2014](#), [Klaver et al. 2020](#), [Klink et al. 2015](#), [Stoffers et al. 2019](#), [Vlot et al. 2017](#)) and three studies were prospective longitudinal observational studies ([Achille et al. 2020](#), [Kuper et al. 2020](#), [Lopez de Lara et al. 2020](#)).

The terminology used in this topic area is continually evolving and is different depending on stakeholder perspectives. In this evidence review we have used the phrase 'people's assigned sex at birth' rather than saying natal or biological sex and 'cross sex hormones' are now referred to as 'gender-affirming hormones'. The research studies may use historical terms which are no longer considered appropriate.

Table 1 provides a summary of these included studies and full details are given in [appendix E](#).

Table 1 Summary of included studies

Study	Population	Intervention and comparison	Outcomes reported
Achille et al. 2020 Prospective longitudinal study Single centre, New York, United States	50 children, adolescents and young adults with gender dysphoria; 17 transfemales and 33 transmales Mean age at baseline was 16.2 years (SD 2.2)	Intervention Endocrine interventions (the collective term used for puberty suppression and gender-affirming hormones) were introduced as per Endocrine Society and the World Professional Association for Transgender Health (WPATH) guidelines Puberty suppression was: <ul style="list-style-type: none"> GnRH analogue and/or anti-androgens (transfemales) GnRH analogue or medroxyprogesterone (transmales) Once eligible, gender-affirming hormones were offered, these were: <ul style="list-style-type: none"> Oestradiol (transfemales) 	Critical Outcomes <i>Impact on mental health</i> <ul style="list-style-type: none"> Depression- The Center for Epidemiologic Studies Depression Scale (CESD-R) Depression- The Patient Health Questionnaire Modified for Teens (PHQ 9_Modified for Teens) <i>Impact on quality of life</i> <ul style="list-style-type: none"> Quality of Life Enjoyment and Satisfaction Questionnaire (QLES-Q-SF) Important Outcomes <i>None reported</i>

Study	Population	Intervention and comparison	Outcomes reported
		<ul style="list-style-type: none"> • Testosterone (transmales) <p>Doses and formulations not reported</p> <p>After about 12-months treatment ('wave 3'):</p> <ul style="list-style-type: none"> • 24 people (48%) were on gender-affirming hormones alone • 12 people (24%) were on puberty suppression alone • 11 people (22%) were on both gender-affirming hormones and puberty suppression • 3 people (6%) were on no endocrine intervention <p>Comparison No comparison group. Change over time reported</p>	
Allen et al. 2019 Retrospective longitudinal study Single centre, Kansas City, USA	47 adolescents and young adults with gender dysphoria: 14 transfemales and 33 transmales Mean age at administration (start of treatment) 16.5 years	<p>Intervention 39 participants received gender-affirming hormones only 8 participants received hormones and a GnRH analogue</p> <p>Mean duration of treatment with gender-affirming hormones was 349 days (range 113 to 1,016)</p> <p>Comparison No comparison group. Comparison over time reported</p>	<p>Critical Outcomes <i>Impact on mental health</i></p> <ul style="list-style-type: none"> • Suicidality- Ask Suicide-Screening Questions (ASQ) instrument <p><i>Impact on quality of life</i></p> <ul style="list-style-type: none"> • General Well-Being Scale (GWBS) of the Pediatric Quality of Life Inventory <p>Important Outcomes <i>None reported</i></p>
Kaltiala et al. 2020	52 adolescents with gender dysphoria: 11 transfemales and 41 transmales.	<p>Intervention Hormonal sex assignment treatment – details of</p>	<p>Critical Outcomes <i>Impact on mental health</i></p>

Study	Population	Intervention and comparison	Outcomes reported
<p>Retrospective chart review</p> <p>Single centre, Tampere, Finland</p>	<p>Mean age at diagnosis 18.1 years (range 15.2 to 19.9)</p>	<p>intervention not reported, although all patients received gender-affirming hormones.</p> <p>Comparison No comparison group. Comparison over time reported</p>	<ul style="list-style-type: none"> • Need for mental health treatment <p>Important Outcomes <i>Psychosocial Impact</i> Measure of functioning in different domains of adolescent development, which were:</p> <ul style="list-style-type: none"> • Living with parent(s)/ guardians • Normative peer contacts • Progresses normatively in school/ work • Has been dating or had steady relationships • Is age-appropriately able to deal with matters outside of the home
<p>Khatchadourian et al. 2014</p> <p>Retrospective chart review</p> <p>Single centre, Vancouver, Canada</p>	<p>84 young people with gender dysphoria, of whom 63 received gender-affirming hormones.</p> <p>Median age at start of gender-affirming hormones was:</p> <ul style="list-style-type: none"> • 17.3 years (range 13.7-19.8) for testosterone • 17.9 years (range 13.3-22.3) for oestrogen 	<p>Intervention Transfemales: Oestrogen (oral micronized 17β-oestradiol) Transmales: Testosterone (injectable testosterone enanthate and/or cypionate)</p> <p>19 participants (30%) had previously received a GnRH analogue</p> <p>Comparison No comparison group. Comparison over time reported.</p>	<p>Critical Outcomes <i>None reported</i></p> <p>Important Outcomes <i>Safety:</i></p> <ul style="list-style-type: none"> • Adverse events • Discontinuation rates
<p>Klaver et al. 2020</p> <p>Retrospective chart review</p> <p>Single centre, Amsterdam, Netherlands</p>	<p>192 people with gender dysphoria who started GnRH analogues before the age of 18 years, and started gender-affirming hormones within 1.5 years of their 22nd birthday.</p>	<p>Intervention Oral oestrogen or intramuscular (IM) testosterone</p> <p>Comparison</p>	<p>Critical Outcomes <i>None reported</i></p> <p>Important Outcomes <i>Safety</i></p> <ul style="list-style-type: none"> • Body mass index (BMI)

Study	Population	Intervention and comparison	Outcomes reported
	Mean age at start of gender-affirming hormones: <ul style="list-style-type: none"> • Transfemale – 16.4 years (SD 1.1) • Transmale – 16.9 years (SD 1.9) 	No comparison group. Comparison over time reported	<ul style="list-style-type: none"> • Systolic blood pressure • Diastolic blood pressure • Glucose • Insulin • HOMA-IR • Total cholesterol • HDL cholesterol • LDL cholesterol • Triglycerides
Klink et al. 2015 Retrospective longitudinal study Single centre, Amsterdam, Netherlands	34 young people with gender dysphoria who had received GnRH analogues, gender-affirming hormones and gonadectomy. The study included 15 transfemales and 19 transmales; mean age at start of gender-affirming hormones was 16.6 years (SD 1.4) and 16.4 years (SD 2.3) respectively. At the start of gender-affirming hormone treatment, in the transfemale subgroup the median Tanner P was 4 (IQR 2) and the median Tanner G was 12 (IQR 11) In the transmale subgroup the median Tanner B was 5 (IQR 2) and the median Tanner P was 5 (IQR 0)	Intervention Transfemales – oral 17- β oestradiol (incremental dosing) Transmales – IM testosterone (Sustanon 250 mg/ml; incremental dosing) Median duration of treatment with gender-affirming hormones for transfemales was 5.8 years (range 3.0 to 8.0) and for transmales was 5.4 years (range 2.8 to 7.8) The GnRH analogue was subcutaneous (SC) triptorelin 3.75 mg every 4 weeks No details of gonadectomy reported Comparison No comparison group. Comparison over time reported.	Critical Outcomes None Important Outcomes <i>Safety</i> <ul style="list-style-type: none"> • Bone mineral apparent density (BMAD) • Bone mineral density (BMD) Measures reported at 3 timepoints: start of GnRH analogue treatment, start of gender-affirming hormone treatment and age 22 years.
Kuper et al. 2020 Prospective longitudinal study	Children and adolescents with gender dysphoria (9 to 18 years), n=148, of whom: <ul style="list-style-type: none"> • 25 received puberty suppression only 	Intervention Gender-affirming hormones, guided by Endocrine Society Clinical Practice Guidelines	Critical Outcomes <i>Impact on mental health</i> <ul style="list-style-type: none"> • Depression- Quick Inventory of Depressive

Study	Population	Intervention and comparison	Outcomes reported
<p>Single centre, Texas, USA</p>	<ul style="list-style-type: none"> 93 received gender-affirming hormone therapy only 30 received both <p>Mean age 14.9 years</p>	<p>Comparison</p> <p>No comparison group. Comparison over time reported.</p>	<p>Symptoms (QIDS), self-reported</p> <ul style="list-style-type: none"> Depression- QIDS, clinician-reported Anxiety- Screen for Child Anxiety Related Emotional Disorders (SCARED) Panic- specific questions from SCARED Generalised anxiety-specific questions from SCARED Social anxiety - specific questions from SCARED Separation anxiety-specific questions from SCARED School avoidance-specific questions from SCARED <p>Important Outcomes</p> <p><i>Impact on body image</i></p> <ul style="list-style-type: none"> Body Image Scale (BIS)
<p>Lopez de Lara et al. 2020</p> <p>Prospective analytical study</p> <p>Single centre, Madrid, Spain</p>	<p>23 adolescents with gender dysphoria: 7 transfemales and 16 transmales.</p> <p>Mean age at baseline was 16 years (range 14 to 18)</p>	<p>Intervention</p> <p>Gender-affirming hormones:</p> <ul style="list-style-type: none"> Oral oestradiol Intramuscular testosterone <p>Participants had previously received GnRH analogues in the intermediate pubertal stages (Tanner 2 to 3).</p> <p>Participants were assessed twice:</p> <ul style="list-style-type: none"> pre-treatment (T0), after 12 months treatment with gender-affirming hormones (T1) 	<p>Critical Outcomes</p> <p><i>Impact on gender dysphoria</i></p> <ul style="list-style-type: none"> Utrecht Gender Dysphoria Scale (UGDS) <p><i>Impact on mental health</i></p> <ul style="list-style-type: none"> Depression- Beck Depression Inventory II (BDI-II) Anxiety- State-Trait Anxiety Inventory <p>Important Outcomes</p> <p><i>Psychosocial Impact</i></p> <ul style="list-style-type: none"> Family functioning- Family APGAR test Patient strengths and difficulties- Strengths and Difficulties Questionnaire,

Study	Population	Intervention and comparison	Outcomes reported
		Comparison No comparison group. Comparison over time reported.	Spanish Version (SDQ-Cas).
Stoffers et al. 2019 Retrospective chart review Single centre, Leiden, Netherlands	62 transmales with gender dysphoria. Patients had received a GnRH analogue and more than 6 months of testosterone treatment. Median age at start of testosterone was 17.23 years (range 14.9 to 18.4) Median treatment duration was 12 months (range 5 to 33) Change over time	Intervention Testosterone intramuscular injections (Sustanon 250 mg). Dose was titrated to a maintenance dose of 125 mg every 2 weeks. Participants who started GnRH analogues at 16 years or older had their dose increased more rapidly. Some participants chose to receive testosterone every 3-4 weeks, and participants could switch to transdermal preparations if needed. Comparison No comparison group. Comparison over time reported.	Critical Outcomes None Important Outcomes Safety <ul style="list-style-type: none"> • Body mass index (BMI) • Blood pressure • BMD • Acne • Liver enzymes • Creatinine • Urea • HbA1c
Vlot et al. 2017 Retrospective chart review Single centre, Amsterdam, Netherlands	70 children and adolescents with gender dysphoria Median age at baseline – <ul style="list-style-type: none"> • 13.5 years (11.5-18.3) for transfemales • 15.1 years (range 11.7-18.6) for transmales Comparison is change over time. 24 month follow-up.	Intervention Oestrogen or testosterone (had previously received triptorelin for puberty suppression) Comparison No comparison group. Comparison over time reported.	Critical Outcomes None Important Outcomes Safety <ul style="list-style-type: none"> • Bone mineral apparent density (BMAD)

5. Results

In children and adolescents with gender dysphoria, what is the clinical effectiveness of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Outcome	Evidence statement
Clinical Effectiveness	

Critical outcomes	
<p>Impact on gender dysphoria</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because gender dysphoria in children and adolescents is associated with significant distress and problems with functioning.</p> <p>One uncontrolled, prospective, observational study (Lopez de Lara et al. 2020) provided evidence relating to the impact on gender dysphoria, measured using the Utrecht Gender Dysphoria Scale (UGDS) score during the first year of treatment with gender-affirming hormones. The UGDS is a validated, screening tool for both adolescents and adults, used to assess gender dysphoria. It consists of 12 items, to be answered on a 1- to 5-point scale, resulting in a sum score between 12 and 60. The authors state that the cut-off point to identify gender dysphoria is 40 points. The higher the UGDS score the greater the gender dysphoria.</p> <p>In this study (n=23), the mean (\pmSD) UGDS score was statistically significantly reduced (improved) from 57.1 (\pm4.1) points at baseline to 14.7 points (\pm3.2) at 12 months ($p < 0.001$). A UGDS score below 40 suggests an absence of gender dysphoria (VERY LOW).</p> <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly improve gender dysphoria from baseline to 12 months follow-up. The mean UGDS score was below the threshold for gender dysphoria at follow-up.</p>
<p>Impact on mental health: depression</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because depression may impact on social, occupational, or other areas of functioning in children and adolescents.</p> <p>Four observational studies (Achille et al. 2020; Kaltiala et al. 2020; Kuper et al. 2020; Lopez de Lara et al. 2020) provided evidence relating to the impact on depression in children and adolescents with gender dysphoria, with follow-up of around 12 months. Five different outcome measures for depression were reported.</p> <p>Beck Depression Inventory (BDI-II) One uncontrolled, prospective, analytical study (Lopez de Lara et al. 2020) reported the change in BDI-II. The BDI-II is a valid, reliable, and widely used tool for assessing depressive symptoms. There are no specific scores to categorise depression severity, but it is suggested that 0 to 13 is minimal symptoms, 14 to 19 is mild depression, 20 to 28 is moderate depression, and severe depression is 29 to 63.</p> <p>In Lopez de Lara et al. 2020 (n=23) the mean (\pmSD) BDI-II score was statistically significantly reduced (improved) from 19.3 (\pm5.5) points at baseline to 9.7 (\pm3.9) points at 12 months ($p < 0.001$) (VERY LOW).</p> <p>Center for Epidemiologic Studies Depression (CESD-R) One uncontrolled, prospective, longitudinal study (Achille et al. 2020) reported the change in CESD-R scale. The CESD-R is a valid, widely used tool to assess depressive symptoms. Total score ranges from 0 to 60, with higher scores indicating more depressive symptoms. There are no specific scores to categorise depression severity, although the authors of the study suggest that a total CESD-R score less than 16 suggests no clinical depression.</p>

In Achille et al. 2020 (n=50), the mean CESD-R score statistically significantly reduced (improved) from 21.4 points at baseline to 13.9 points at about 12 months follow-up ($p<0.001$; standard deviation not reported) (**VERY LOW**).

Patient Health Questionnaire (PHQ 9) Modified for Teens

One uncontrolled, prospective, longitudinal study ([Achille et al. 2020](#)) reported the change in PHQ 9_Modified for Teens score. The PHQ 9_Modified for Teens is a validated tool to assess depression, dysthymia and suicide risk. The tool consists of 9 questions scored from 0 to 3 (total score 0 to 27), plus an additional 4 questions that are not scored. A score of 0 to 4 suggests no or minimal depressive symptoms, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe, and 20-27 severe symptoms.

In Achille et al. 2020 (n=50), the mean PHQ 9_Modified for Teens score statistically significantly reduced (improved) from baseline to around 12 months follow-up, although absolute scores were not reported numerically ($p<0.001$). From the visual representation of results, the PHQ-9_Modified for Teens score is about 9 at baseline and about 5 at final follow-up (**VERY LOW**).

Quick Inventory of Depressive Symptoms (QIDS)

One uncontrolled, prospective, longitudinal study ([Kuper et al. 2020](#)) reported the change in QIDS, clinician-reported and self-reported. Both the clinician-reported and self-reported QIDS are validated tools to assess depressive symptoms. The tool consists of 16 items, with the highest score for 9 domains (sleep, weight, psychomotor changes, depressed mood, decreased interest, fatigue, guilt, concentration, and suicidal ideation) added to give a total score ranging from 0 to 27. A score of 0 to 5 suggests no depression, 6 to 10 mild symptoms, 11 to 15 moderate symptoms, 16 to 20 severe symptoms, and 21 to 27 very severe symptoms.

In Kuper et al. 2020 (n=105), the mean (\pm SD) QIDS self-reported score was 9.6 points (± 5.0) at baseline and 7.4 (± 4.5) after 10.9 months of treatment with gender-affirming hormones (no statistical analysis reported). The mean (\pm SD) QIDS clinician-reported score was 5.9 points (± 4.1) at baseline and 6.0 (± 3.8) after 10.9 months of treatment with gender-affirming hormones (no statistical analysis was reported) (**VERY LOW**).

Participants needing treatment for depression

One observational study ([Kaltiala et al. 2020](#)) reported the proportion of participants needing treatment for depression before or during the initial assessment and during the 12-month follow-up period after starting gender-affirming hormones.

In Kaltiala et al. 2020 (n=52), statistically significantly fewer participants needed treatment for depression during the 12-month 'real life' phase (15%, 8/52) compared with before or during the assessment (54%, 28/52; $p<0.001$). No details of what treatments for depression the participants received are reported (**VERY LOW**).

	<p>These studies provide very low certainty evidence that during treatment with gender-affirming hormones depression is reduced from baseline to about 12 months follow-up. However, most participants had mild symptoms at the start of treatment.</p>
<p>Impact on mental health: anxiety</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because anxiety may impact on social, occupational, or other areas of functioning in children and adolescents.</p> <p>Three observational studies (Kaltiala et al. 2020; Kuper et al. 2020; Lopez de Lara et al. 2020) provided evidence relating to the impact on anxiety in children and adolescents with gender dysphoria.</p> <p>State-Trait Anxiety Inventory (STAI) One uncontrolled, prospective, analytical study (Lopez de Lara et al. 2020) reported the change in STAI scores. STAI is a validated and commonly used measure of trait and state anxiety. It has 20 items and can be used in clinical settings to diagnose anxiety and to distinguish it from depressive illness. Higher scores indicate greater anxiety.</p> <p>In Lopez de Lara et al. 2020 (n=23), the mean (\pmSD) STAI-State subscale was statistically significantly reduced (improved) with gender-affirming hormones from 33.3 points (\pm9.1) at baseline to 16.8 points (\pm8.1) at 12 months ($p<0.001$). The mean STAI-Trait subscale scores also statistically significantly reduced (improved) from 33.0 points (\pm7.2) at baseline to 18.5 points (\pm8.4) at 12 months ($p<0.001$) (VERY LOW).</p> <p>Screen for Child Anxiety Related Emotional Disorders (SCARED) One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) reported anxiety symptoms using the SCARED questionnaire. Other anxiety-related symptoms using specific questions from the SCARED questionnaire were also reported: panic, generalised anxiety, social anxiety, separation anxiety and school avoidance. SCARED is a validated, 41-point questionnaire, with each item scored 0 to 2. A total score of 25 or more is suggestive of anxiety disorder, with scores above 30 being more specific. Certain scores for specific questions may indicate the presence of other anxiety-related disorders:</p> <ul style="list-style-type: none"> • A score of 7 or more in questions related to panic disorder or significant somatic symptoms may indicate the presence of these. • A score of 9 or more in questions related to generalised anxiety disorder may indicate the presence of this. • A score of 5 or more in questions related to separation anxiety may indicate the presence of this. • A score of 8 or more in questions related to social anxiety disorder may indicate the presence of this. • A score of 3 or more in questions related to significant school avoidance may indicate the presence of this. <p>In Kuper et al. 2020 (n=80 to 82, varies by outcome), small reductions were seen in anxiety, panic, generalised anxiety, social anxiety and separation anxiety and school avoidance symptoms (measured using the SCARED questionnaire) from baseline to follow-up (mean duration of treatment 10.9 months). The statistical significance of these findings are unknown as no statistical analyses were reported (VERY LOW).</p>

	<p>Participants needing treatment for anxiety</p> <p>One observational study (Kaltiala et al. 2020) reported the proportion of participants needing treatment for anxiety before or during initial assessment and during the 12-month follow-up period after starting gender-affirming hormones.</p> <p>In Kaltiala et al. 2020 (n=52), statistically significantly fewer participants needed treatment for anxiety during the 12-month 'real life' phase (15%, 8/52) compared with before or during the assessment (48%, 25/52; $p<0.001$). No details of what treatments for anxiety the participants received are reported (VERY LOW).</p> <p>These studies provide very low certainty evidence that during treatment with gender-affirming hormones anxiety symptoms may be reduced from baseline to around 12 months follow-up.</p>
<p>Impact on mental health: suicidality and self-injury</p> <p>Certainty of evidence: very low</p>	<p>These are critical outcomes because self-harm and thoughts of suicide have the potential to result in significant physical harm and, for completed suicides, the death of the young person.</p> <p>Four observational studies (Achille et al. 2020; Allen et al. 2019; Kaltiala et al. 2020; Kuper et al. 2020) provided evidence relating to suicidal ideation in children and adolescents with gender dysphoria, with an average follow-up of around 12 months.</p> <p>Ask Suicide-Screening Questions (ASQ)</p> <p>One uncontrolled, retrospective, longitudinal study (Allen et al. 2019) reported the change in ASQ. This is a 4-item dichotomous (yes/no) response measure designed to identify risk of suicide. The authors of Allen et al. 2019 amended 1 question in the ASQ ("Have you ever tried to kill yourself?") by prefacing it with "In the past few weeks . . ." as they were not investigating lifetime incidence. A response of 'no' is scored as 0 and a response of 'yes' is scored as 1; each item is summed to give an overall score for suicidal ideation ranging from 0 to 4. A person is considered to have screened positive if they answer 'yes' to any item with higher scores indicating higher levels of suicidal ideation.</p> <p>In Allen et al. 2019 (n=39), the adjusted mean (\pmSE) ASQ score statistically significantly reduced from 1.11 points (± 0.22) at baseline to 0.27 points (± 0.12) after a mean duration of treatment of about 12 months ($p<0.001$) (VERY LOW).</p> <p>PHQ 9_Modified for Teens (additional questions for suicidal ideation)</p> <p>One uncontrolled, prospective, longitudinal study (Achille et al. 2020) reported the change in suicidal ideation measured using additional questions from the PHQ 9_Modified for Teens. This is a validated tool to assess depression, dysthymia and suicide risk (see above for detailed description). In addition to the 9 scored questions, the PHQ 9_Modified Teens asked 4 additional questions relating to suicidal ideation and difficulty dealing with problems of life. Responses to the PHQ 9_Modified for Teens were used to determine if the participant had suicidal ideation or not, but specific details of how this was determined are not reported.</p>

	<p>In Achille et al. 2020 (n=50), 10% (5/50) of participants had suicidal ideation at baseline and 6% (3/50) had suicidal ideation after about 12 months treatment with gender-affirming hormones (no statistical analysis reported) (VERY LOW).</p> <p>Suicidality and non-suicidal self-injury One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) reported on suicidal ideation, suicide attempts and non-suicidal self-injury, although it was unclear how and when this outcome was measured.</p> <p>In Kuper et al. 2020 (n=130), 25% of participants reported suicidal ideation 1 month before the initial assessment and 38% reported this during the follow-up period (no statistical analysis reported). Suicide attempts were reported in 2% of participants at 3 months before the initial assessment and 5% during follow-up. Self-injury was reported in 10% of participants at 3 months before the initial assessment and 17% during follow-up. No statistical analysis was reported for any outcomes. Mean duration of gender-affirming hormone treatment was 10.9 months (VERY LOW).</p> <p>Participants needing treatment for suicidality or self-harm One observational study (Kaltiala et al. 2020) reported the proportion of participants requiring treatment for suicidality or self-harm before or during initial assessment and during the 12-month follow-up period after starting gender-affirming hormones.</p> <p>In Kaltiala et al. 2020 (n=52) statistically significantly fewer participants needed treatment for suicidality or self-harm during the 12-month 'real life' phase (4%, 2/52) compared with before or during the assessment (35%, 18/52; $p<0.001$). No details of what treatments for suicidal ideation or self-harm the participants received are reported (VERY LOW).</p> <p>These studies provide very low certainty evidence that gender-affirming hormones may reduce suicidality from baseline to about 12 months follow-up. However, results are inconsistent and it is difficult to draw conclusions.</p>
<p>Impact on mental health: other</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because mental health problems may impact on social, occupational, or other areas of functioning in children and adolescents.</p> <p>One observational study (Kaltiala et al. 2020) reported the proportion of participants needing treatment for either psychotic symptoms or psychosis, substance abuse, autism, attention deficit hyperactivity disorder (ADHD) or eating disorders before or during initial assessment and during the 12-month follow-up period after starting gender-affirming hormones.</p> <p>In Kaltiala et al. 2020 (n=52) there was no statistically significant difference in the number of people needing treatment for either psychotic symptoms / psychosis, substance abuse, autism, attention deficit hyperactivity disorder (ADHD) or eating disorders during the 12-month 'real life' phase compared with before or during the assessment.</p>

	<p>No details of which specific treatments the participants received are reported (VERY LOW).</p> <p>This study provides very low certainty evidence on the need for treatment for either psychotic symptoms or psychosis, conduct problems or antisocial behaviour, substance abuse, autism, attention deficit hyperactivity disorder (ADHD) or eating disorders during treatment with gender-affirming hormones. No conclusions could be drawn.</p>
<p>Impact on quality of life score</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because gender dysphoria in children and adolescents may be associated with a significant reduction in health-related quality of life.</p> <p>Two uncontrolled longitudinal studies Achille et al. 2020; Allen et al. 2019) provided evidence relating to quality of life in children and adolescents with gender dysphoria.</p> <p>Quality of Life Enjoyment and Satisfaction Questionnaire (QLES-Q-SF) One uncontrolled, prospective, longitudinal study (Achille et al. 2020) reported the change in QLES-Q-SF scores from baseline to about 12 months of treatment with gender-affirming hormones. QLES-Q-SF is a validated questionnaire, consisting of 15 questions that rate quality of life on a scale of 1 (poor) to 5 (very good).</p> <p>In Achille et al. 2020 (n=50), the mean QLES-Q-SF score was statistically significantly reduced from baseline to about 12 months ($p<0.001$). However, absolute scores are not reported numerically (VERY LOW).</p> <p>General Well-Being Scale (GWBS) of the Paediatric Quality of Life Inventory One uncontrolled, retrospective, longitudinal study (Allen et al. 2019) reported the change in adjusted mean GWBS of the Paediatric Quality of Life Inventory score from baseline to about 12 months of treatment with gender-affirming hormones. The GWBS of the Paediatric Quality of Life Inventory contains 7 items that measure two dimensions: general wellbeing (6 items) and general health (1 item). Each item is scored from 0 to 4, and the total score is linearly transformed to a 0 to 100 scale. Higher scores reflect fewer perceived problems and greater well-being.</p> <p>In Allen et al. 2019 (n=47), the adjusted mean (\pmSE) GWBS of the Paediatric Quality of Life Inventory score was statistically significantly increased (improved) from 61.70 (\pm2.43) points at baseline to 70.23 (\pm2.15) points at about 12 months ($p<0.002$) (VERY LOW).</p> <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly improve quality of life and well-being from baseline to 12 months follow-up.</p>
Important outcomes	
Impact on body image	<p>This is an important outcome because some children and adolescents with gender dysphoria may want to take steps to suppress features of</p>

<p>Certainty of evidence: very low</p>	<p>their physical appearance associated with their sex assigned at birth or accentuate physical features of their desired gender.</p> <p>One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) provided evidence relating to the impact on body image in children and adolescents with gender dysphoria who started treatment with gender-affirming hormones (median duration 10.9 months; range 1 to 18), measured by the change in Body Image Scale (BIS) score. BIS is a validated 30-item scale covering 3 aspects: primary, secondary and neutral body characteristics. Higher scores represent a higher degree of body dissatisfaction.</p> <p>In Kuper et al. 2020 (n=86), the mean (\pmSD) BIS score was 70.7 points (\pm15.2) at baseline and 51.4 points (\pm18.3) at follow-up (no statistical analysis reported) (VERY LOW).</p> <p>This study provides very low certainty evidence on the effects of gender-affirming hormones on body image during treatment with gender-affirming hormones (mean duration of treatment 10.9 months). No conclusions could be drawn.</p>
<p>Psychosocial impact</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because gender dysphoria in children and adolescents is associated with internalising and externalising behaviours, and emotional and behavioural problems which may impact on social and occupational functioning.</p> <p>Two uncontrolled, observational studies (Kaltiala et al. 2020; Lopez de Lara et al. 2020) provided evidence related to psychosocial impact in children and adolescents with gender dysphoria.</p> <p>Family APGAR (Adaptability, Partnership, Growth, Affection and Resolve) test</p> <p>One uncontrolled, prospective, analytical study (Lopez de Lara et al. 2020) reported the Family APGAR test. The Family APGAR test is a 5-item questionnaire, with higher scores indicating better family functioning. The authors reported the following interpretation of the test: functional, 17 to 20 points; mildly dysfunctional, 16 to 13 points; moderately dysfunctional, 12 to 10 points; severely dysfunctional, <9 points.</p> <p>In Lopez de Lara et al. 2020 (n=23), the mean Family APGAR test score was unchanged from baseline (17.9 points) to 12-month follow-up (18.0 points; no statistical analysis or standard deviations reported) (VERY LOW).</p> <p>Strengths and Difficulties Questionnaire (SDQ)</p> <p>One uncontrolled, prospective, analytical study (Lopez de Lara et al. 2020) reported on behaviour using the Strengths and Difficulties Questionnaire (SDQ, Spanish version). The SDQ includes 25-items covering emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. The authors state that a score of more than 20 suggests having a behavioural disorder (normal 0 to 15, borderline 16 to 19, abnormal 20 to 40).</p>

	<p>In Lopez de Lara et al. 2020 (n=23), the mean (\pmSD) SDQ score was statistically significantly reduced (improved) from 14.7 points (\pm3.3) at baseline to 10.3 points (\pm2.9) at 12-month follow-up ($p<0.001$) (VERY LOW).</p> <p>Psychosocial functioning</p> <p>One uncontrolled, retrospective chart review (Kaltiala et al. 2020) reported various markers of functioning in adolescent development, covering living arrangements, peer contacts, school or work progress, relationships, and ability to cope with matters outside the home. These measures were reported during the gender identity assessment and at about 12 months after starting gender-affirming hormones (referred to as the 'real-life phase').</p> <p>In Kaltiala et al. 2020 (n=52), from the gender identity assessment to the 12-month follow-up period:</p> <ul style="list-style-type: none"> • statistically significantly fewer participants were living with parents or guardians (73% versus 40%, $p=0.001$) • statistically significantly fewer participants had normal peer contacts (89% versus 81%, $p<0.001$) • there was no statistically significant difference in progress in school or work (64% versus 60%, $p=0.69$) • there was no statistically significant difference in the number of participants who had been dating or in steady relationships (62% versus 58%, $p=0.51$) • there was no statistically significant difference in the participant's ability to cope with matters outside of the home (81% versus 81%, $p=1.00$) (VERY LOW). <p>These studies provide very low certainty evidence that gender-affirming hormones statistically significantly improve behavioural problems (measured by SDQ score). However, the SDQ score was in the 'normal' range at baseline and at 12-month follow up. There was no significant impact on other measures of psychosocial functioning.</p>
Engagement with health care services	<p>This is an important outcome because patient engagement with health care services will impact on their clinical outcomes.</p> <p>No evidence was identified.</p>
Impact on extent of and satisfaction with surgery	<p>This is an important outcome because some children and adolescents with gender dysphoria may proceed to transitioning surgery.</p> <p>No evidence was identified.</p>
De-transition	<p>This is an important outcome because there is uncertainty about the short- and long-term safety and adverse effects of gender-affirming hormones in children and adolescents with gender dysphoria</p> <p>No evidence was identified.</p>

Abbreviations: APGAR: Adaptability, Partnership, Growth, Affection and Resolve; ASQ: Ask Suicide-Screening Questions; BDI-II: Beck Depression Inventory II; BIS: Body Image Scale; CESD-R: Center for Epidemiologic Studies Depression; GWBS: General Well-Being Scale; p: p-value; PHQ 9_Modified for Teens: Patient Health Questionnaire Modified for Teens; QIDS: Quick Inventory of Depressive Symptoms; QLES-Q-SF: Quality of Life Enjoyment and Satisfaction Questionnaire; SCARED: Screen for Child Anxiety Related Emotional Disorders;

SD: standard deviation; SE: standard error; SDQ: Strengths and Difficulties Questionnaire; STAI: State-Trait Anxiety Inventory; UGDS: Utrecht Gender Dysphoria Scale.

In children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Outcome	Evidence statement
Safety	
Change in bone density: lumbar spine Certainty of evidence: very low	<p>This is an important outcome because childhood and adolescence is a key time for bone development and gender-affirming hormones may affect bone development, as shown by changes in lumbar spine bone density.</p> <p>Three uncontrolled, observational studies (2 retrospective and 1 prospective) provided evidence related to bone density: lumbar spine in children and adolescents with gender dysphoria. This was reported as either bone mineral density (BMD), bone mineral apparent density (BMAD), or both. One study reported change in bone density from start of treatment with gender-affirming hormones to age 22 years (Klink et al. 2015). Two studies reported change in bone density from start of gender-affirming hormones up to 24-month follow-up (Stoffers et al. 2019 and Vlot et al. 2017). All participants had previously been treated with a GnRH analogue. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>Bone mineral apparent density (BMAD) Two uncontrolled, observational studies reported change in lumbar BMAD (Klink et al. 2015; Vlot et al. 2017). BMAD is a size adjusted value of BMD, incorporating bone size measurements using a UK reference population of growing cis-gender adolescents (up to age 17 years). BMAD is used to correct for height and height gain and may provide a more accurate estimate of bone density in growing adolescents. BMAD was reported as g/cm³ and as z-scores. Z-scores report how many standard deviations from the mean a measurement sits. A z-score of 0 is equal to the mean, a z-score of -1 is equal to 1 standard deviation below the mean, and a z-score of +1 is equal to 1 standard deviation above the mean. A cis-gender population was used to calculate the bone density z-score, meaning transfemales were compared with cis-males and transmales were compared with cis-females.</p> <p>In Klink et al. 2015 (n=34):</p> <ul style="list-style-type: none"> • There was no statistically significant difference in lumbar spine BMAD z-score from starting gender-affirming hormones to age 22 years in transfemales. • The z-score for lumbar spine BMAD was statistically significantly higher at age 22 years compared with the start of gender-affirming hormones in transmales (z-score [±SD]: start of hormones -0.50 [±0.81], age 22 years -0.033 [±0.95], p=0.002).

- Actual lumbar spine BMAD values in g/cm³ were statistically significantly higher at age 22 years compared with the start of gender-affirming hormones in transfemales and transmales (**VERY LOW**).

In [Vlot et al. 2017](#) (n=70):

- The z-score for lumbar spine BMAD in transfemales with a bone age of <15 years was statistically significantly higher at 24-month follow-up compared with start of gender-affirming hormones (z-score [range]: start of hormones -1.52 [-2.36 to 0.42], 24-month follow-up -1.10 [-2.44 to 0.69], p≤ 0.05). Statistically significant improvements in z-score for lumbar spine BMAD in transfemales with a bone age of ≥15 years were also seen (z-score [range]: start of hormones -1.15 [-2.21 to 0.08], 24-month follow-up -0.66 [-1.66 to 0.54], p≤ 0.05).
- The z-score for lumbar spine BMAD in transmales with a bone age of <14 years was statistically significantly higher at 24-month follow-up compared with start of gender-affirming hormones (z-score [range]: start of hormones -0.84 [-2.2 to 0.87], 24-month follow-up -0.15 [-1.38 to 0.94], p≤ 0.01). Statistically significant improvements in z-score for lumbar spine BMAD in transmales with a bone age of ≥14 years were also seen (z-score [range]: start of hormones -0.29 [-2.28 to 0.90], 24-month follow-up -0.06 [-1.75 to 1.61], p≤ 0.01).
- Actual lumbar spine BMAD values in g/cm³ were statistically significantly higher at 24-month follow-up compared with start of gender-affirming hormones in transfemales and transmales of all bone ages (**VERY LOW**).

Bone mineral density (BMD)

Two uncontrolled, observational studies reported change in lumbar BMD ([Klink et al. 2015](#); [Stoffers et al. 2019](#)). BMD was determined using dual energy x-ray absorptiometry (DXA-scan; HologicQDR4500, Hologic). BMD was reported as g/cm² and as z-scores – see BMAD above for more details).

In [Klink et al. 2015](#) (n=34):

- There was no statistically significant difference in lumbar spine BMD z-score from starting gender-affirming hormones to age 22 years in transfemales or transmales.
- Actual lumbar spine BMD values in g/cm² were statistically significantly higher at age 22 years compared with the start of gender-affirming hormones in transfemales and transmales (**VERY LOW**).

In [Stoffers et al. 2019](#) (n=62 at 6-month follow-up; n=15 at 24-month follow-up):

- There was no statistically significant difference in lumbar spine BMD z-score in transmales from starting gender-affirming hormones to any timepoint (6, 12 and 24 months).
- There was also no statistically significant difference in actual lumbar spine BMD values in g/cm² from starting gender-affirming hormones to any timepoint (6, 12 and 24 months) (**VERY LOW**).

	<p>These studies provide very low certainty evidence that lumbar spine bone density (measured by BMAD) increases during treatment with gender-affirming hormones (from baseline to follow-up of 2 to 5 years). Z-scores at the end of follow-up suggest the average lumbar spine bone density was generally lower than the equivalent cisgender population (transfemales compared with cis-males and transmales compared with cis-females). The results for bone density (measured by BMD) were inconsistent.</p>
<p>Change in bone density: femoral neck</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because childhood and adolescence is a key time for bone development and gender-affirming hormones may affect bone development, as shown by changes in femoral neck bone density.</p> <p>Three uncontrolled, observational studies (2 retrospective and 1 prospective) provided evidence related to bone density: femoral neck in children and adolescents with gender dysphoria. This was reported as either bone mineral density (BMD), bone mineral apparent density (BMAD), or both. One study reported change in bone density from start of gender-affirming hormones to age 22 years (Klink et al. 2015). Two studies reported change in bone density from start of gender-affirming hormones up to 24-month follow-up (Stoffers et al. 2019 and Vlot et al. 2017). All participants had previously been treated with a GnRH analogue. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>Bone mineral apparent density (BMAD)</p> <p>Two uncontrolled, observational studies reported change in femoral neck BMAD (Klink et al. 2015; Vlot et al. 2017). See above for more details on BMAD.</p> <p>In Klink et al. 2015 (n=34):</p> <ul style="list-style-type: none"> • The z-score for femoral neck BMAD was reported for the start of gender-affirming hormones but not at age 22 years in transfemales or transmales. No statistical analysis reported. • In transfemales there was no statistically significant difference in actual femoral neck BMAD values in g/cm³ at age 22 years compared with start of gender-affirming hormones. In transmales actual lumbar spine BMAD values in g/cm³ were statistically significantly higher at age 22 years compared with start of gender-affirming hormones (mean [±SD]: start of hormones 0.31 [±0.04], age 22 years 0.33 [±0.05], p=0.010) (VERY LOW). <p>In Vlot et al. 2017 (n=70):</p> <ul style="list-style-type: none"> • In transfemales (all bone ages), there was no statistically significant difference in femoral neck BMAD z-score from start of gender-affirming hormones to 24-month follow-up. • The z-score for femoral neck BMAD in transmales with a bone age of <14 years was statistically significantly higher at 24-month follow-up compared with start of gender-affirming hormones (z-score [range]: start of hormones -0.37 [-2.28 to 0.47], 24-month follow-up -0.37 [-2.03 to 0.85], p≤0.01). Statistically significant improvements in z-score for lumbar spine BMAD in transmales with a bone age of ≥14 years were also

	<p>seen (z-score [range]: start of hormones -0.27 [-1.91 to 1.29], 24-month follow-up 0.02 [-2.1 to 1.35], $p \leq 0.05$).</p> <ul style="list-style-type: none"> In transfemales of all bone ages, there was no statistically significant change in actual femoral neck BMAD values in g/cm^3 from start of gender-affirming hormones to 24-month follow-up. In transmales of all bone ages, actual femoral neck BMAD values in g/cm^3 were statistically significantly higher at 24-month follow-up compared with start of gender-affirming hormones (VERY LOW). <p>Bone mineral density (BMD)</p> <p>Two uncontrolled, observational studies reported change in femoral neck BMD (Klink et al. 2015; Stoffers et al. 2019). See above for more details on BMD.</p> <p>In Klink et al. 2015 (n=34):</p> <ul style="list-style-type: none"> In transfemales, there was no statistically significant difference in femoral neck BMD z-score from start of gender-affirming hormones to age 22 years. In transmales, femoral neck BMD z-score was statistically significantly higher at age 22 years compared with start of gender-affirming hormones (z-score [SD]: start of hormones -0.35 [0.79], age 22 years -0.35 [0.74], $p=0.006$). Actual femoral neck BMD values in g/cm^2 were statistically significantly higher at age 22 years compared with start of gender-affirming hormones in transfemales and transmales (VERY LOW). <p>In Stoffers et al. 2019 (n=62 at 6-month follow-up; n=15 at 24-month follow-up):</p> <ul style="list-style-type: none"> there was no statistically significant difference in right or left femoral neck BMD z-score in transmales, from the start of gender-affirming hormones to any timepoint (6, 12 and 24 months). There was also no statistically significant difference in transmales in right or left actual femoral neck BMD values in g/cm^2 from start of gender-affirming hormones to any timepoint (6, 12 and 24 months) (VERY LOW). <p>These studies provide very low certainty evidence that during treatment with gender-affirming hormones from baseline to follow-up of 2 to 5 years, femoral neck bone density (measured by BMAD) was unchanged in transfemales but was statistically significantly increased in transmales (although the absolute change was small). Z-scores at the end of follow-up suggest that average femoral neck bone density was lower in both transfemales and transmales than in the equivalent cisgender population (transfemales compared with cis-males and transmales compared with cis-females). The results for bone density (measured by BMD) were inconsistent.</p>
<p>Change in clinical parameters: glucose, insulin and HbA1c</p>	<p>This is an important outcome because the effect of gender-affirming hormones on insulin sensitivity and cardiovascular risk in children and adolescents with gender dysphoria is unknown.</p>

<p>Certainty of evidence: very low</p>	<p>Two uncontrolled, retrospective chart reviews (Klaver et al. 2020; Stoffers et al. 2019) provided evidence on glucose, insulin and HbA1c. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>Glucose levels, insulin levels and insulin resistance</p> <p>One retrospective chart review (Klaver et al. 2020) reported non-comparative evidence on the change in glucose levels, insulin levels and insulin resistance (measured using Homeostatic Model Assessment of Insulin Resistance [HOMA-IR]) between starting gender-affirming hormones and age 22 years.</p> <p>In Klaver et al. 2020 (n=192):</p> <ul style="list-style-type: none"> • There was no statistically significant change in glucose levels, insulin levels and insulin resistance in transfemales. • There was no statistically significant change in glucose levels in transmales. • There was a statistically significant decrease in insulin levels in transmales (mean change [95% CI] -2.1 mU/L [-3.9 to -0.3], $p<0.05$; mean insulin level at 22 years [95% CI] 8.6 mU/L [6.9 to 10.2]). • There was a statistically significant decrease in insulin resistance in transmales (HOMA-IR; mean change [95% CI] -0.5 [-1.0 to -0.1], $p<0.05$; mean HOMA-IR at 22 years [95% CI] 1.8 [1.4 to 2.2]) (VERY LOW). <p>HbA1c</p> <p>One retrospective chart review (Stoffers et al. 2019; n=62) reported non-comparative evidence on the change in HbA1c in transmales between starting gender-affirming hormones and 24-month follow-up. There was no statistically significant change in HbA1c (VERY LOW).</p> <p>These studies provide very low certainty evidence that gender-affirming hormones do not affect HbA1c, glucose levels, insulin levels and insulin resistance.</p>
<p>Change in clinical parameters: lipids</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because the effect of gender-affirming hormones on lipid profiles and cardiovascular risk in children and adolescents with gender dysphoria is unknown.</p> <p>One retrospective chart review (Klaver et al. 2020) provided non-comparative evidence on the change in lipids (total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides) between starting gender-affirming hormones and age 22 years. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>In Klaver et al. 2020 (n=192):</p> <ul style="list-style-type: none"> • There was no statistically significant change in total cholesterol, HDL cholesterol and LDL cholesterol in transfemales. • There was a statistically significant decrease (improvement) in triglycerides in transfemales (mean change [95% CI] +0.2 mmol/L [0.0 to 0.5], $p<0.05$; mean triglyceride level at 22 years [95% CI] 1.1 mmol/L [0.9 to 1.4]). • There was a statistically significant increase in total cholesterol in transmales (mean change [95% CI] +0.4 mmol/L [0.2 to 0.6],

	<p>p<0.001; mean total cholesterol at 22 years [95% CI] 4.6 mmol/L [4.3 to 4.8]).</p> <ul style="list-style-type: none"> • There was a statistically significant decrease (worsening) in HDL cholesterol (mean change in transmales [95% CI] -0.3 mmol/L [-0.4 to -0.1], p<0.001; mean HDL cholesterol at 22 years [95% CI] 1.3 mmol/L [1.2 to 1.3]). • There was a statistically significant increase (worsening) in LDL cholesterol in transmales (mean change [95% CI] +0.4 mmol/L [0.2 to 0.6], p<0.001; mean LDL cholesterol at 22 years [95% CI] 2.6 mmol/L [2.4 to 2.8]). • There was a statistically significant increase (worsening) in triglycerides in transmales (mean change [95% CI] +0.5 mmol/L [0.3 to 0.7], p<0.001; mean triglyceride level at 22 years [95% CI] 1.3 mmol/L [1.1 to 1.5]) (VERY LOW). <p>This study provides very low certainty evidence that gender-affirming hormones do not affect lipid profiles in transfemales. In transmales, there was a small but statistically significant worsening in cholesterol levels from start of gender-affirming hormone treatment to age 22 years, but mean cholesterol and triglyceride levels were within the UK reference range at the end of treatment.</p>
<p>Change in clinical parameters: blood pressure</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because the effect of gender-affirming hormones on blood pressure and cardiovascular risk in children and adolescents with gender dysphoria is unknown.</p> <p>One retrospective chart review (Klaver et al. 2020) provided non-comparative evidence on the change in blood pressure between starting gender-affirming hormones and at age 22 years. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>In Klaver et al. 2020 (n=192):</p> <ul style="list-style-type: none"> • There was no statistically significant change in systolic blood pressure (SBP) in transfemales. However, there was a statistically significant increase in diastolic blood pressure (DBP) in transfemales (mean change [95% CI] +6 mmHg [3 to 10], p<0.001; mean DBP at 22 years [95% CI] 75 [72 to 78]). • In transmales, there was a statistically significant increase in SBP (mean change [95% CI] +5 mmHg [1 to 9], p<0.05; mean SBP at 22 years [95% CI] 126 [122 to 130]), and DBP (mean change [95% CI] +6 mmHg [4 to 9], p<0.001; mean DBP at 22 years [95% CI] 74 [72 to 77]) (VERY LOW). <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly increase blood pressure from start of treatment to age 22 years, although the absolute increase was small.</p>
<p>Change in clinical parameters: body mass index (BMI)</p>	<p>This is an important outcome because the effect of gender-affirming hormones on weight gain and cardiovascular risk in children and adolescents with gender dysphoria is unknown.</p> <p>One retrospective chart review (Klaver et al. 2020) provided non-comparative evidence on the change in body mass index (BMI) between starting gender-affirming hormones and age 22 years. All</p>

<p>Certainty of evidence: very low</p>	<p>outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>In Klaver et al. 2020 (n=192):</p> <ul style="list-style-type: none"> • There was a statistically significant increase in BMI in transfemales from the start of gender-affirming hormones to age 22 years (mean change [95% CI] +1.9 [0.6 to 3.2], $p<0.005$; mean BMI at 22 years [95% CI] 23.2 [21.6 to 24.8]. At age 22 years, 9.9% of transfemales were obese, compared with 3.0% in a reference population of cisgender men. • There was a statistically significant increase in BMI in transmales from the start of gender-affirming hormones to age 22 years (mean change [95% CI] +1.4 [0.8 to 2.0], $p<0.005$; mean BMI at 22 years [95% CI] 23.9 [23.0 to 24.7]). At age 22 years, 6.6% of transmales were obese, compared with 2.2% in a reference population of cisgender women (VERY LOW). <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly increase BMI from start of treatment to age 22 years, although most participants were within the healthy weight range.</p>
<p>Change in clinical parameters: liver function</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because if treatment-induced liver injury (raised liver enzymes are a marker of this) is suspected, gender-affirming hormones may need to be stopped.</p> <p>One retrospective chart review (Stoffers et al. 2019) provided non-comparative evidence on the change in liver enzymes in transmales between starting gender-affirming hormones and up to 24-months follow-up.</p> <p>In Stoffers et al. 2019 (n=62):</p> <ul style="list-style-type: none"> • There was no statistically significant change in aspartate aminotransferase (AST), alanine aminotransferase (ALT) and gamma-glutamyltransferase (GCT) in transmales. • There was a statistically significant increase in alkaline phosphatase (ALP) levels from starting gender-affirming hormones to 6- and 12-months follow-up, although by 24-months the difference was not statistically significant (median [IQR]: start of hormones 102 [78 to 136], 6-month follow-up 115 [102 to 147] $p<0.001$, 12-month follow-up 112 [88 to 143] $p<0.001$) (VERY LOW). <p>This study provides very low certainty evidence that gender-affirming hormones do not affect liver function in transmales from baseline to 24 months follow-up.</p>
<p>Change in clinical parameters: kidney function</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because if renal damage (raised serum creatinine and urea are markers of this) is suspected, treatment with gender-affirming hormones may need to be stopped.</p> <p>One retrospective chart review (Stoffers et al. 2019) provided non-comparative evidence on the change in serum creatinine and serum urea levels in transmales between starting gender-affirming hormones and up to 24-months follow-up.</p> <p>In Stoffers et al. 2019 (n=62):</p>

	<ul style="list-style-type: none"> • There was a statistically significant increase in creatinine levels in transmales at all timepoints up to 24 months (mean [SD]: start of hormones 62 umol/L [7], 6 months 70 umol/L [9], 12 months 74 umol/L [10], 24 months 81 umol/L [10], $p < 0.001$). • There was no statistically significant change in urea in transmales (follow-up duration not reported) (VERY LOW). <p>This study provides very low certainty evidence on the effects of gender-affirming hormones on kidney function in transmales from baseline to 24 months follow-up. A statistically significant increase in creatinine levels was seen, but these were within the UK reference range. Urea levels were unchanged.</p>
Treatment discontinuation Certainty of evidence: very low	<p>This is an important outcome because there is uncertainty about the short- and long-term impact of stopping treatment with gender-affirming hormones in children and adolescents with gender dysphoria.</p> <p>One uncontrolled, retrospective chart review (Khatchadourian et al. 2014) provided evidence relating to permanent or temporary treatment discontinuation in children and adolescents with gender dysphoria.</p> <p>Khatchadourian et al. 2014 narratively reported treatment discontinuation in a cohort of 63 adolescents (24 transfemales and 39 transmales) who received gender-affirming hormones:</p> <ul style="list-style-type: none"> • No participants permanently discontinued gender-affirming hormones. • No transfemales temporarily discontinued gender-affirming hormones. • Three transmales temporarily discontinued gender-affirming hormones due to: <ul style="list-style-type: none"> ◦ mental health comorbidities (n=2) ◦ androgenic alopecia (n=1). <p>All 3 participants eventually resumed treatment, although timescales were not reported (VERY LOW).</p> <p>This study provides very low certainty evidence that the rates of discontinuation during treatment with gender-affirming hormones are low (duration of treatment not reported).</p>
Adverse effects Certainty of evidence: very low	<p>This is an important outcome because if there are adverse effects, gender-affirming hormones may need to be stopped.</p> <p>One uncontrolled, retrospective chart review (Khatchadourian et al. 2014) provided evidence relating to adverse effects from gender-affirming hormones in children and adolescents with gender dysphoria.</p> <p>Khatchadourian et al. 2014 narratively reported adverse effects in a cohort of 63 adolescents (24 transfemales and 39 transmales) receiving treatment with gender-affirming hormones:</p> <ul style="list-style-type: none"> • No severe complications were reported. • No transfemales reported minor complications. • Twelve transmales developed minor complications, which were: <ul style="list-style-type: none"> ◦ severe acne, requiring isotretinoin treatment (n=7) ◦ androgenic alopecia (n=1) ◦ mild dyslipidaemia (further details not provided; n=3) ◦ significant mood swings (n=1) (VERY LOW).

	This study provides very low certainty evidence about the potential adverse effects of gender-affirming hormones (duration of treatment not reported). No conclusions could be drawn.
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Abbreviations: ALP: alkaline phosphatase; ALT: alanine aminotransferase; AST: aspartate aminotransferase; BMAD: bone mineral apparent density; BMD: bone mineral density; BMI: body mass index; DBP: diastolic blood pressure; GGT: gamma-glutamyl transferase; HbA1c: glycated haemoglobin; HDL: high-density lipoproteins; HOMA-IR: Homeostatic Model Assessment of Insulin Resistance; IQR: interquartile range; LDL: low-density lipoproteins; p: p-value; SBP: systolic blood pressure; SD: standard deviation.

In children and adolescents with gender dysphoria, what is the cost-effectiveness of gender-affirming hormones compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Outcome	Evidence statement
Cost-effectiveness	No studies were identified to assess the cost-effectiveness of gender-affirming hormones for children and adolescents with gender dysphoria.

From the evidence selected, are there any subgroups of children and adolescents with gender dysphoria that may benefit from gender-affirming hormones more than the wider population of interest?

Subgroup	Evidence statement
Sex assigned at birth males (transfemales) Certainty of evidence: Very low	<p>Some studies reported data separately for sex assigned at birth males (transfemales). This included some direct comparisons with sex assigned at birth females (transmales).</p> <p>Impact on mental health: depression and anxiety One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) reported the change in depression (measured using QIDS clinician-reported and self-reported), anxiety and anxiety-related symptoms (measured using SCARED) in transfemales. See the clinical effectiveness results above for full details.</p> <p>In Kuper et al. 2020 (n=33 to 45, varies by outcome), changes were seen in depression, anxiety and anxiety-related symptoms from baseline to follow-up but the authors did not report any statistical analyses, so it is unclear if any changes were statistically significant (VERY LOW).</p> <p>This study provides very low certainty evidence on the effects of gender-affirming hormones on depression, anxiety and anxiety-related symptoms over time in sex assigned at birth males (transfemales; mean duration of treatment 10.9 months). No conclusions could be drawn.</p> <p>Impact on mental health: suicidality</p>

	<p>One uncontrolled, retrospective, longitudinal study (Allen et al. 2019) reported the change in Ask Suicide-Screening Questions (ASQ) in transfemales compared with transmales. See the clinical effectiveness results above for full details.</p> <p>Between baseline and the final assessment, there was no statistically significant difference in change in ASQ score for transfemales compared with transmales ($p=0.79$; $n=47$) (VERY LOW).</p> <p>One uncontrolled, prospective, longitudinal study (Achille et al. 2020) reported the change in suicidal ideation in transfemales measured using additional questions from the PHQ 9_Modified for Teens. See the clinical effectiveness results above for full details.</p> <p>At baseline, 11.8% (2/17) of transfemales had suicidal ideation, compared with 5.9% (1/17) at about 12-months follow-up (no statistical analysis reported) (VERY LOW).</p> <p>These studies provide very low certainty evidence that any change in suicidal ideation is not different between sex assigned at birth males (transfemales) and sex assigned at birth females (transmales) from baseline to follow-up of about 12 months.</p> <p>Impact on quality of life</p> <p>One uncontrolled, retrospective, longitudinal study (Allen et al. 2019) reported the change in the GWBS of the Paediatric Quality of Life Inventory in transfemales compared with transmales. See the clinical effectiveness results above for full details.</p> <p>Between baseline and final assessment, there was no statistically significant difference in change in GWBS of the Paediatric Quality of Life Inventory for transfemales compared with transmales ($p=0.32$; $n=47$) (VERY LOW).</p> <p>This study provides very low certainty evidence that any change in general wellbeing is not different between sex assigned at birth males (transfemales) and sex assigned at birth females (transmales) from baseline to follow-up of about 12 months.</p> <p>Impact on body image</p> <p>One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) reported change in Body Image Scale (BIS) in transfemales. See the clinical effectiveness results above for full details.</p> <p>In Kuper et al. 2020 ($n=30$), the mean (\pmSD) BIS score was 67.5 points (± 19.5) at baseline and 49.0 points (± 21.6) at follow-up (no statistical analysis reported) (VERY LOW).</p> <p>This study provides very low certainty evidence on the effects of gender-affirming hormones on body image over time in transfemales (mean duration of treatment 10.9 months). No conclusions could be drawn.</p> <p>Change in bone density: lumbar spine</p>
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	<p>Two uncontrolled, observational, retrospective studies provided evidence relating to the effect of gender-affirming hormones on lumbar spine bone density in transfemales (Klink et al. 2015 and Vlot et al. 2017). See the safety results table above for a full description of the results.</p> <p>These studies provide very low certainty evidence that lumbar spine bone density (measured by BMAD) increases during treatment with gender-affirming hormones in sex assigned at birth males (transfemales). Z-scores at the end of follow-up suggest average lumbar spine bone density was generally lower than in the equivalent cisgender population. The results for lumbar spine bone density (measured by BMD) were inconsistent.</p> <p>Change in bone density: femoral neck Two uncontrolled, observational, retrospective studies provided evidence relating to the effect of gender-affirming hormones on femoral neck bone density in transfemales (Klink et al. 2015 and Vlot et al. 2017). See the safety results table above for a full description of the results.</p> <p>These studies provide very low certainty evidence that femoral neck bone density (measured by BMAD) was unchanged in sex assigned at birth males (transfemales) during treatment with gender-affirming hormones (follow-up between 2 and 5 years). Z-scores at the end of follow-up suggest and the average femoral neck bone density was lower than in the equivalent cisgender population. The results for femoral neck bone density (measured by BMD) were inconsistent.</p> <p>Change in clinical parameters: glucose, insulin and HbA1c One uncontrolled, retrospective chart review (Klaver et al. 2020) provided evidence on glucose, insulin and HbA1c in transfemales. See the safety results table above for a full description of the results.</p> <p>This study provided very low certainty evidence that gender-affirming hormones do not affect HbA1c, glucose levels, insulin levels and insulin resistance in sex assigned at birth males (transfemales) from the start of treatment to age 22 years.</p> <p>Change in clinical parameters: lipids One retrospective chart review (Klaver et al. 2020) provided evidence on the change in lipids (total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides) in transfemales. See the safety results table above for a full description of the results.</p> <p>This study provides very low certainty evidence that gender-affirming hormones do not affect lipid profiles in sex assigned at birth males (transfemales) from the start of treatment to age 22 years.</p> <p>Change in clinical parameters: blood pressure</p>
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	<p>One retrospective chart review (Klaver et al. 2020) provided evidence on the change in blood pressure in transfemales. See the safety results table above for a full description of the results.</p> <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly increase blood pressure in sex assigned at birth males (transfemales), although the absolute increase was small from the start of treatment to age 22 years.</p> <p>Change in clinical parameters: body mass index (BMI) One retrospective chart review (Klaver et al. 2020) provided evidence on the change in BMI in transfemales. See the safety results table above for a full description of the results.</p> <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly increase BMI in sex assigned at birth males (transfemales), although most participants were within the healthy weight range from the start of treatment to age 22 years.</p> <p>Treatment discontinuation One uncontrolled, retrospective chart review provided evidence relating to permanent or temporary discontinuation of gender-affirming hormones in transfemales (Khatchadourian et al. 2014).</p> <p>This study provides very low certainty evidence that the rates of discontinuation during treatment with gender-affirming hormones in sex assigned at birth males (transfemales) are low. Duration of treatment with gender-affirming hormones was not reported.</p> <p>Adverse effects One uncontrolled, retrospective chart review provided evidence relating to adverse effects from gender-affirming hormones in transfemales (Khatchadourian et al. 2014).</p> <p>This study provides very low certainty evidence about the potential adverse effects of gender-affirming hormones in sex assigned at birth males (transfemales). No conclusions could be drawn. Duration of treatment with gender-affirming hormones was not reported.</p>
<p>Sex assigned at birth females (transmales)</p> <p>Certainty of evidence: Very low</p>	<p>Some studies reported data separately for sex assigned at birth females (transmales). This included some direct comparisons with sex assigned at birth males (transfemales).</p> <p>Impact on mental health: depression and anxiety One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) reported the change in depression (measured using QIDS clinician-reported and self-reported), anxiety and anxiety-related symptoms (measured using SCARED) in transmales. See the clinical effectiveness results above for full details.</p> <p>In Kuper et al. 2020 (n=65 to 78, varies by outcome), changes were seen in depression, anxiety and anxiety-related symptoms from</p>

	<p>baseline to follow-up but the authors did not report any statistical analysis, so it is unclear if any changes are statistically significant (VERY LOW).</p> <p>This study provides very low certainty evidence on the effects of gender-affirming hormones on depression, anxiety and anxiety-related symptoms over 10.9 months in transmales. No conclusions could be drawn.</p> <p>Impact on mental health: suicidality One uncontrolled, retrospective, longitudinal study (Allen et al. 2019) reported the change in Ask Suicide-Screening Questions (ASQ) in transmales compared with transfemales. See the sex assigned at birth males (transfemales) row above for full details of the results.</p> <p>One uncontrolled, prospective, longitudinal study (Achille et al. 2020) reported the change in suicidal ideation in transmales measured using additional questions from the PHQ 9 Modified for Teens. See the clinical effectiveness results above for full details.</p> <p>At baseline, 9.1% (3/33) of transmales had suicidal ideation, compared with 6.1% (2/33) at about 12-months follow-up (no statistical analysis reported) (VERY LOW).</p> <p>These studies provide very low certainty evidence that any change in suicidal ideation is not different between sex assigned at birth females (transmales) and sex assigned at birth males (transfemales). Mean duration of treatment about 12 months.</p> <p>Impact on quality of life One uncontrolled, retrospective, longitudinal study (Allen et al. 2019) reported the change in the GWBS of the Paediatric Quality of Life Inventory in transmales compared with transfemales. See the sex assigned at birth males (transfemales) row above for full details of the results.</p> <p>This study provides very low certainty evidence that any change in general wellbeing is not different between sex assigned at birth females (transmales) and sex assigned at birth males (transfemales). Mean duration of treatment about 12 months.</p> <p>Impact on body image One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) reported change in Body Image Scale (BIS) in transmales. See the clinical effectiveness results above for full details.</p> <p>In Kuper et al. 2020 (n=66), the mean (\pmSD) BIS score was 71.1 points (\pm13.4) at baseline and 52.9 points (\pm16.8) at follow-up (no statistical analysis reported) (VERY LOW).</p> <p>This study provides very low certainty evidence on the effects of gender-affirming hormones on body image over 10.9 months in transmales. No conclusions could be drawn.</p> <p>Change in bone density: lumbar spine</p>
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	<p>Three uncontrolled, observational, retrospective studies provided evidence relating to the effect of gender-affirming hormones on lumbar spine bone density in transmales (Klink et al. 2015, Stoffers et al. 2019 and Vlot et al. 2017). See the safety results table above for a full details of the results.</p> <p>These studies provide very low certainty evidence that lumbar spine bone density (measured by BMAD) increases during 2 to 5 years treatment with gender-affirming hormones in sex assigned at birth females (transmales). Z-scores at the end of follow-up suggest the average lumbar spine bone density was generally lower than in the equivalent cisgender population. The results for lumbar spine bone density (measured by BMD) were inconsistent.</p> <p>Change in bone density: femoral neck</p> <p>Three uncontrolled, observational, retrospective studies provided evidence relating to the effect of gender-affirming hormones on femoral neck bone density in transmales (Klink et al. 2015, Stoffers et al. 2019 and Vlot et al. 2017). See the safety results table above for a full details of the results.</p> <p>These studies provide very low certainty evidence that femoral neck bone density (measured by BMAD) statistically significantly increased in sex assigned at birth females (transmales) during 2 to 5 years treatment with gender-affirming hormones. Z-scores at the end of follow-up suggest the average femoral neck bone density was generally lower than in the equivalent cisgender population. The results for femoral neck bone density (measured by BMD) were inconsistent.</p> <p>Change in clinical parameters: glucose, insulin and HbA1c</p> <p>Two uncontrolled, retrospective chart reviews (Klaver et al. 2020; Stoffers et al. 2019) provided evidence on glucose, insulin and HbA1c in transmales. See the safety results table above for full details of the results.</p> <p>This study provided very low certainty evidence that gender-affirming hormones do not affect HbA1c, glucose levels, insulin levels and insulin resistance in sex assigned at birth females (transmales). Reported from start of treatment to age 22 years.</p> <p>Change in clinical parameters: lipids</p> <p>One retrospective chart review (Klaver et al. 2020) provided evidence on the change in lipids (total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides) in transmales. See the safety results table above for full details of the results.</p> <p>This study provides very low certainty evidence that treatment with gender-affirming hormones is associated with a small but statistically significant worsening of cholesterol levels in sex assigned at birth females (transmales), but mean cholesterol and triglyceride levels were within the UK reference range at end of treatment, from start of treatment to age 22 years.</p>
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	<p>Change in clinical parameters: blood pressure One retrospective chart review (Klaver et al. 2020) provided evidence on the change in blood pressure in transmales. See the safety results table above for full details of the results.</p> <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly increase blood pressure in sex assigned at birth females (transmales), although the absolute increase was small, from start of treatment to age 22 years.</p> <p>Change in clinical parameters: body mass index (BMI) One retrospective chart review (Klaver et al. 2020) provided evidence on the change in body mass index (BMI) in transmales. See the safety results table above for full details of the results.</p> <p>This study provides very low certainty evidence that gender-affirming hormones statistically significantly increase BMI in sex assigned at birth females (transmales), although most participants were within the healthy weight range, from start of treatment to age 22 years.</p> <p>Change in clinical parameters: liver function One retrospective chart review (Stoffers et al. 2019) provided non-comparative evidence on the change in liver enzymes in transmales between starting gender-affirming hormones and up to 24-months follow-up. See the safety results table above for full details of the results.</p> <p>This study provides very low certainty evidence that gender-affirming hormones for about 12 months do not affect liver function in sex assigned at birth females (transmales).</p> <p>Change in clinical parameters: kidney function One retrospective chart review (Stoffers et al. 2019) provided non-comparative evidence on the change in serum creatinine and serum urea levels in transmales between starting gender-affirming hormones and up to 24-months follow-up. See the safety results table above for full details of the results.</p> <p>This study provides very low certainty evidence on the effects of gender-affirming hormones on kidney function in sex assigned at birth females (transmales). A statistically significant increase in creatinine levels was seen at about 12 months follow-up, but these were within the UK reference range. Urea levels were unchanged.</p> <p>Treatment discontinuation One uncontrolled, retrospective chart review provided evidence relating to permanent or temporary discontinuation of gender-affirming hormones in transmales (Khatchadourian et al. 2014). See the safety results table above for full details of the results.</p> <p>This study provides very low certainty evidence that the rates of treatment discontinuation with gender-affirming hormones in sex</p>
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	<p>assigned at birth females (transmales) is low. Duration of gender-affirming hormones not reported.</p> <p>Adverse effects One uncontrolled, retrospective chart review provided evidence for adverse effects from gender-affirming hormones in transmales (Khatchadourian et al. 2014). See the safety results table above for full details of the results.</p> <p>This study provides very low certainty evidence about the potential adverse effects of gender-affirming hormones in sex assigned at birth females (transmales). No conclusions could be drawn. Duration of gender-affirming hormones not reported.</p>
Duration of gender dysphoria	No evidence was identified.
Age at onset of gender dysphoria	No evidence was identified.
Age at onset of puberty	No evidence was identified.
Tanner stage at which GnRH analogue or gender-affirming hormones started	One uncontrolled, prospective, longitudinal study (Kuper et al. 2020) reported the impact of Tanner stage on outcomes, although it is not clear whether this is referring to Tanner stage at initial assessment, at the start of GnRH analogues or at another timepoint.
Diagnosis of autistic spectrum disorder	No evidence was identified.
Diagnosis of a mental health condition	<p>One uncontrolled, prospective, longitudinal study (Achille et al. 2020) reported outcomes that were adjusted for engagement in counselling and medicines for mental health problems. Information about diagnoses and treatment were not provided. Rates of mental health issues appear to be high in the cohort.</p> <p>Impact on mental health Achille et al. 2020 reported the change in depression scores, controlled for engagement in counselling and medicines for mental health problems (measured using the Center for Epidemiologic Studies Depression [CESD-R] scale and Patient Health Questionnaire Modified for Teens [PHQ 9_Modified for Teens] score:</p> <ul style="list-style-type: none"> • There was no statistically significant change in CESD-R from baseline to about 12-months follow-up. • There was no statistically significant change in PHQ 9_Modified for Teens score from baseline to about 12-months follow-up (VERY LOW). <p>Impact on quality of life Achille et al. 2020 reported the change in quality of life scores, controlled for engagement in counselling and medicines for mental health problems (measured using the Quality of Life Enjoyment and Satisfaction Questionnaire [QLES-Q-SF] score:</p> <ul style="list-style-type: none"> • There was no statistically significant change in QLES-Q-SF score from baseline to about 12-months follow-up (VERY LOW).

	This study provides very low certainty evidence about outcomes that were adjusted for engagement in counselling and medicines for mental health problems. No conclusions could be drawn.
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Abbreviations: ASQ: Ask Suicide-Screening Questions; CESD-R: Center for Epidemiologic Studies Depression; GnRH: Gonadotrophin releasing hormone; GWBS: General Well-Being Scale; HDL: high-density lipoproteins; LDL: low-density lipoproteins; p: p-value; PHQ 9_Modified for Teens: Patient Health Questionnaire Modified for Teens; QLES-Q-SF: Quality of Life Enjoyment and Satisfaction Questionnaire.

From the evidence selected,

- (a) **what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?**
- (b) **what were the ages at which participants commenced treatment with gender-affirming hormones?**
- (c) **what was the duration of treatment with GnRH analogues?**

Outcome	Evidence statement												
Diagnostic criteria	<p>The DSM-IV-TR criteria was used in 3 studies (Klaver et al. 2020, Klink et al. 2015 and Vlot et al. 2017).</p> <p>The DSM-V criteria was used in 2 studies (Kuper et al. 2020 and Stoffers et al. 2019). The DSM-V has one overarching definition of gender dysphoria with separate specific criteria for children and for adolescents and adults. The general definition describes a conflict associated with significant distress and/or problems functioning associated with this conflict between the way they feel and think of themselves which must have lasted at least 6 months.</p> <p>The ICD-10 diagnosis of 'transsexualism' was used in 1 study (Kaltiala et al. 2020). The authors state that this is the corresponding diagnosis to 'gender dysphoria' in the DSM-V, and that diagnostic assessments in the study location (Finland) take place according to ICD-10.</p> <p>It was not reported how gender dysphoria was defined in the remaining 4 studies (VERY LOW).</p> <p>From the evidence selected, the most commonly reported diagnostic criteria for gender dysphoria (5/10 studies) was the DSM criteria in use at the time the study was conducted.</p>												
Age when gender-affirming hormones started	<p>8/10 studies reported the age at which participants started treatment with gender-affirming hormones, either as the mean age (with SD) or median age (with the range):</p> <table border="1"> <thead> <tr> <th>Study</th><th>Mean age (± SD)</th></tr> </thead> <tbody> <tr> <td>Allen et al. 2019</td><td>16.7 years (not reported)</td></tr> <tr> <td>Khatchadourian et al. 2014</td><td>17.4 years (1.9)</td></tr> <tr> <td>Klaver et al. 2020</td><td>16.4 years (1.1) in transfemales 16.9 years (0.9) in transmales</td></tr> <tr> <td>Kuper et al. 2020</td><td>16.2 (1.2)</td></tr> <tr> <td>Klink et al. 2015</td><td>16.6 years (1.4) in transfemales 16.4 years (2.3) in transmales</td></tr> </tbody> </table>	Study	Mean age (± SD)	Allen et al. 2019	16.7 years (not reported)	Khatchadourian et al. 2014	17.4 years (1.9)	Klaver et al. 2020	16.4 years (1.1) in transfemales 16.9 years (0.9) in transmales	Kuper et al. 2020	16.2 (1.2)	Klink et al. 2015	16.6 years (1.4) in transfemales 16.4 years (2.3) in transmales
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	<table><tr><th>Study</th><th>Median age (range)</th></tr><tr><td>Stoffers et al. 2019</td><td>17.2 years (15 to 19.5)</td></tr><tr><td>Vlot et al. 2017</td><td>16.3 years (15.9 to 19.5) in transfemales 16.0 years (14.0 to 18.9) in transmales</td></tr></table> <p>Age at the start of treatment was not reported in 3 studies:</p> <ul style="list-style-type: none">• In Achille et al. 2020 the mean age at initial assessment (baseline) was 16.2 years (SD ±2.2)• In Kaltiala et al. 2020 the mean age at diagnosis was 18.1 years (range 15.2 to 19.9)• In Lopez de Lara et al. 2020 the mean age of participants was 16 years (range 14 to 18), although it is not clear if this is at the initial assessment or at the start of gender-affirming hormones. <p>The evidence included showed that most children and adolescents started treatment with gender-affirming hormones at about 16 to 17 years, with a range of about 14 to 19 years.</p>	Study	Median age (range)	Stoffers et al. 2019	17.2 years (15 to 19.5)	Vlot et al. 2017	16.3 years (15.9 to 19.5) in transfemales 16.0 years (14.0 to 18.9) in transmales		
Study	Median age (range)								
Stoffers et al. 2019	17.2 years (15 to 19.5)								
Vlot et al. 2017	16.3 years (15.9 to 19.5) in transfemales 16.0 years (14.0 to 18.9) in transmales								
Duration of treatment with GnRH analogues	<p>The duration of treatment with GnRH analogues was reported in 3/10 studies:</p> <table><tr><th>Study</th><th>Median duration</th></tr><tr><td>Klaver et al. 2020</td><td>2.1 years (IQR 1.0 to 2.7) in transfemales 1.0 years (IQR 0.5 to 2.9) in transmales</td></tr><tr><td>Klink et al. 2015</td><td>1.3 years (range 0.5 to 3.8) in transfemales 1.5 years (range 0.25 to 5.2) in transmales (GnRH analogue monotherapy)</td></tr><tr><td>Stoffers et al. 2019</td><td>8 months (range 3 to 39)</td></tr></table> <p>The evidence included showed wide variation in the duration of treatment with gender-affirming hormones, but most studies did not report this information. Treatment duration ranged from a few months up to about 5 years.</p>	Study	Median duration	Klaver et al. 2020	2.1 years (IQR 1.0 to 2.7) in transfemales 1.0 years (IQR 0.5 to 2.9) in transmales	Klink et al. 2015	1.3 years (range 0.5 to 3.8) in transfemales 1.5 years (range 0.25 to 5.2) in transmales (GnRH analogue monotherapy)	Stoffers et al. 2019	8 months (range 3 to 39)
Study	Median duration								
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Stoffers et al. 2019	8 months (range 3 to 39)								

Abbreviations: DSM, Diagnostic and Statistical Manual of Mental Disorders criteria; GnRH, Gonadotrophin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; IQR, interquartile range; SD, standard deviation.

6. Discussion

A key limitation to identifying the effectiveness and safety of gender-affirming hormones for children and adolescents with gender dysphoria is the lack of reliable comparative studies. All the studies included in this evidence review are uncontrolled observational studies, which are subject to bias and confounding and were of very low certainty using modified GRADE. The size of the population with gender dysphoria means conducting a prospective trial may be unrealistic, at least on a single centre basis. There may also be ethical issues with a 'no treatment arm' in comparative trials of gender-affirming hormones, where there may be poor mental health outcomes if treatment is withheld. However, the use of an active comparator such as close psychological support may reduce ethical concerns in future trials. A fundamental limitation of all the uncontrolled studies included in this review is that any changes in scores from baseline to follow-up could be attributed to a regression-to-the-mean.

The included studies have relatively short follow-up, with an average duration of treatment with gender-affirming hormones between around 1 year and 5.8 years. Further studies with a longer follow-up are needed to determine the long-term effect of gender-affirming hormones for children and adolescents with gender dysphoria.

Most studies included in this review did not report comorbidities (physical or mental health) and no study reported concomitant treatments in detail. Because of this it is not clear whether any changes observed were due to gender-affirming hormones or other treatments the participants may have received. For example, we do not know if any improvement in depression symptom score over time was the result of gender-affirming hormones or the mental health support the person may be receiving (including medicines or counselling). This may be of particular importance for the mental health outcomes discussed in this review, since depression, anxiety and other related symptoms are common in children and adolescents with gender dysphoria. In [Achille et al. 2020](#), at baseline around one-third of participants were taking medicines for mental health problems and around two-thirds reported being depressed in the past year. In [Kaltiala et al. 2020](#), half the participants needed mental health treatment during and before gender identity assessment, with the most common reasons for treatment being depression, anxiety and suicidality. Only 1 study reported outcomes adjusted for engagement in counselling and medicines for mental health problems (Achille et al. 2020). This study found that gender-affirming hormones had no significant impact on depression and quality of life when adjusted for mental health care, despite significant improvements reported for the unadjusted results. However, it is not possible to draw conclusions on the impact of concurrent mental health treatment on the effect of gender-affirming hormones based on this study alone. Details of the mental health care provided are not reported in the study and results are presented for transfemales and transmales separately, resulting in small patient numbers and possible underpowering.

In most of the included studies, details of the gender-affirming hormone treatment regimens are poorly reported, with limited information provided about the medicines, doses and routes of administration used. It is not clear whether the interventions used in the studies are reflective of current UK practice for children and adolescents with gender dysphoria. There is also the suggestion that the hormone dose used in 1 study may have been too low; the authors of [Klink et al. 2015](#) suggest that the relatively low initial dose of oestrogen for transfemales may be the reason for the observed lack of effect on lumbar spine bone density. Duration of treatment with a GnRH analogue is also poorly reported and is only stated in 3/10 studies.

There is a degree of indirectness in some studies, with some participants included that fall outside of the population of this evidence review. For example, in [Kuper et al. 2020](#) 17% of participants received puberty suppression alone, and in Achille et al. 2020, 30% of participants received no treatment or puberty suppression alone. Some results and statistical analyses are only reported for the whole cohort in these studies and not the subgroup of participants who received gender-affirming hormones.

Participant numbers are poorly reported in some of the included studies. In [Achille et al. 2020](#), 47% (45/95) of the people who entered the study did not have follow-up data and were excluded from the analyses, with no explanation or description of those people lost to follow-up. In Kuper et al. 2020, the number of participants varied by outcome, with less than

two-thirds of participants providing data for some outcomes. The authors provide no explanation for this incomplete reporting.

It is not clear whether some outcome measures, specifically those related to psychosocial functioning, are relevant to the UK population. In Kaltiala et al. 2020, an observational study conducted in Finland, the proportion of participants living with parents or guardians is reported as marker of appropriate functioning. The authors state that in Finnish culture young people tend to leave the parental home early, with only around one-quarter of 20 to 24 year olds still living at home. This is lower than in the UK, where around half of 20 to 24 year olds live with their parents or guardians ([ONS: Why are more young people living with their parents?](#)).

It is difficult to draw firm conclusions for many of the effectiveness and safety outcomes reported in the included studies because many different scoring tools and methods were used to assess the same outcome, often with conflicting results. For example, bone density is reported as bone mineral density (BMD) and bone mineral apparent density (BMAD) in the same study, the latter being a size-adjusted measure often useful for people whose bones are still growing. For some populations (transfemale versus transmale) and bone regions (lumber spine versus femoral neck), statistically significant differences in BMD are reported but not for BMAD, and vice versa.

In addition to this, most outcomes reported across the included studies do not have an accepted minimal clinically important difference (MCID), making it difficult to determine whether any observed statistically significant changes are clinically meaningful. However, the authors of some studies report thresholds to interpret the results of the scoring tools, so some conclusions can be made. For example, the mean Utrecht Gender Dysphoria Scale (UGDS) score (a measure of gender dysphoria symptoms) reduced to about 15 points after treatment with gender-affirming hormones ([Lopez de Lara et al. 2020](#)). The authors state that scores of 40 points or above signify gender dysphoria, suggesting that after about 12 months of treatment with gender-affirming hormones, the majority of participants did not have symptoms of gender dysphoria.

The impact of gender-affirming hormones on bone density was reported in 3 studies (Klink et al. 2015, [Stoffers et al. 2019](#) and [Vlot et al. 2017](#)). Although these studies did not include a control group, comparisons to a reference population are reported using z-scores. Comparisons were made to a cisgender population, meaning for example that bone density in transfemales was compared with bone density in cisgender males. The authors of Klink et al. 2015 note that this may not be the ideal comparison, because androgens and oestrogens affect bone differently, and that bone properties in a trans population differ from their age- and sex assigned at birth-matched controls. Beyond this, a major limitation when trying to determine the impact of gender-affirming hormones on the short- and long-term bone health of children and adolescents is the lack of data on fracture rates and other patient-orientated outcomes, including rates of osteoporosis. Studies of GnRH analogues in children and adolescents with gender dysphoria suggest that GnRH analogue treatment may reduce the expected increase in bone density (which is expected during puberty). Although improvements in bone density were reported following treatment with gender-affirming hormones, Z-scores suggest that bone density remained lower in transfemales and transmales compared with an equivalent cisgender population.

One study reported on cardiovascular risk factors at age 22 years in people who started gender-affirming hormones for gender dysphoria as adolescents. While glucose levels, insulin levels and insulin resistance were broadly unchanged at 22 years, statistically significant increases in blood pressure and body mass index were seen. A small but statistically significant worsening of the lipid profile in transmales who received testosterone was also seen at age 22 years. However, further studies with a considerably longer follow-up and a focus on patient-oriented outcomes, including cardiovascular events and mortality are needed to determine the long-term impact on cardiovascular health of starting gender-affirming hormones during childhood and adolescence.

Only 1 study reported adverse events and discontinuation rates with gender-affirming hormones in children and adolescents. Conclusions on these outcomes cannot be made based on this study alone.

This review did not identify sub-groups of people who may benefit more from gender-affirming hormones. Limited evidence from 2 studies suggests there was no difference in response to treatment between transfemales and transmales for mental health and quality of life (Achille et al. 2020 and [Allen et al. 2019](#)).

7. Conclusion

This evidence review found limited evidence for the effectiveness and safety of gender-affirming hormones in children and adolescents with gender dysphoria, with all studies being uncontrolled, observational studies, and all outcomes of very low certainty. Any potential benefits of treatment must be weighed against the largely unknown long-term safety profile of these treatments.

The results from 5 uncontrolled, observational studies ([Achille et al. 2020](#), [Allen et al. 2019](#), [Kaltiala et al. 2020](#), [Kuper et al. 2020](#), [Lopez de Lara et al. 2020](#)) suggest that, in children and adolescents with gender dysphoria, gender-affirming hormones are likely to improve symptoms of gender dysphoria, and may also improve depression, anxiety, quality of life, suicidality, and psychosocial functioning. The impact of treatment on body image is unclear. All results were of very low certainty. The clinical relevance of any improvements to the person is difficult to determine because most outcomes do not have a recognised minimal clinically important difference, and the authors do not present statistical analysis for some outcomes.

A further 5 uncontrolled, observational studies ([Khatchadourian et al. 2014](#), [Klaver et al. 2020](#), [Klink et al. 2015](#), [Stoffers et al. 2019](#) and [Vlot et al. 2017](#)) reported on safety outcomes, all of which provided very low certainty evidence. Statistically significant increases in some measures of bone density were seen following treatment with gender-affirming hormones, although results varied by bone region (lumber spine versus femoral neck) and by population (transfemales versus transmales). However, z-scores suggest that bone density remained lower in transfemales and transmales compared with an equivalent cisgender population. Results from 1 study of gender-affirming hormones started during adolescence reported statistically significant increases in blood pressure and body mass index, and worsening of the lipid profile (in transmales) at age 22 years, although longer term studies that report on cardiovascular event rates are needed. Adverse events and discontinuation rates associated with gender-affirming hormones were only reported in 1 study, and no conclusions can be made on these outcomes.

This review did not identify sub-groups of people who may benefit more from gender-affirming hormones. Limited evidence from 2 studies suggests there was no difference in response to treatment between transfemales and transmales for mental health and quality of life (Achille et al. 2020 and Allen et al. 2019).

No cost-effectiveness evidence was found to determine whether gender-affirming hormones are a cost-effective treatment for children and adolescents with gender dysphoria.

Appendix A PICO

The review questions for this evidence review are:

1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?
2. For children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?
3. For children and adolescents with gender dysphoria, what is the cost-effectiveness of gender-affirming hormones compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?
4. From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria?
5. From the evidence selected,
 - (a) what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?
 - (b) what were the ages at which participants commenced treatment with gender-affirming hormones?
 - (c) what was the duration of GnRH analogues treatment?

PICO table

P –Population and Indication	<p>Children and adolescents aged 18 years or less who have gender dysphoria, gender identity disorder or gender incongruence of childhood as defined by the study.</p> <p>The following subgroups of children and adolescents with gender dysphoria, gender identity disorder or gender incongruence of childhood need to be considered:</p>
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	<ul style="list-style-type: none"> • Sex assigned at birth males • Sex assigned at birth females • The duration of gender dysphoria: less than 6 months, 6-24 months, and more than 24 months) • The age at which treatment was initiated with GnRH analogues and with gender-affirming hormones. • The age of onset of gender dysphoria • The age of onset of puberty • Adolescents with gender dysphoria who have a pre-existing diagnosis of autistic spectrum disorder. • Adolescents with gender dysphoria who had a significant mental health symptom load at diagnosis including anxiety, depression (with or without a history of self-harm and suicidality), psychosis, personality disorder, Attention Deficit Hyperactivity Disorder and eating disorders.
I – Intervention	<p>Gender-affirming hormone treatments:</p> <ul style="list-style-type: none"> • A testosterone preparation for sex assigned at birth female patients which may include testosterone in the form of Sustanon injections*; testosterone enantate injections; Tostran gel*; Testogel; Testim gel; oral testosterone capsules in the form of testosterone undecanoate (Restandol); Andriol testocaps; Nebido • An oestradiol preparation** for sex assigned at birth male patients which may include: oral estradiol valerate*; oestrogen patches (7β-oestradiol patches e.g. Evorel or Estradem); Estradot patches; ethinyloestradiol *** <p>*These are the used by Leeds Hospital, England. ** Be aware that the American spelling is oestrogen without the 'o'. ***Ethinyloestradiol is rarely used.</p>
C – Comparator(s)	<p>One or a combination of:</p> <ul style="list-style-type: none"> • Psychological support • Social transitioning to the gender with which the individual identifies. <p>No intervention</p>
O – Outcomes	<p>There are no known minimal clinically important differences and there are no preferred timepoints for the outcome measures selected.</p> <p>All outcomes should be stratified by:</p> <ul style="list-style-type: none"> • The age at which treatment with gender-affirming hormones was initiated • The length of treatment with GnRH analogues where possible. <p><u>A: Clinical Effectiveness</u></p> <p><i>Critical to decision making</i></p> <ul style="list-style-type: none"> • Impact on gender dysphoria <p>This outcome is critical because gender dysphoria in adolescents and children is associated with significant distress and problems functioning. Impact on gender</p>

	<p>dysphoria may be measured by the Utrecht Gender Dysphoria Scale. Other measures as reported in studies may be used as an alternative to the stated measure.</p> <ul style="list-style-type: none"> Impact on mental health Examples of mental health problems include self-harm, thoughts of suicide, suicide attempts, suicide, eating disorders, depression/low mood and anxiety. These outcomes are critical because self-harm and thoughts of suicide have the potential to result in significant physical harm and for completed suicides the death of the young person. Disordered eating habits may cause significant morbidity in young people. Depression and anxiety are also critical outcomes because they may impact on social, occupational, or other areas of functioning of children and adolescents. The Child and Adolescent Psychiatric Assessment (CAPA) may be used to measure depression and anxiety. The impact on self-harm and suicidality (ideation and behaviour) may be measured using the Suicide Ideation Questionnaire Junior. Other measures may be used as an alternative to the stated measure. Impact on Quality of Life This outcome is critical because gender dysphoria in children and adolescents may be associated with a significant reduction in health-related quality of life. Quality of Life may be measured by the KINDL questionnaire, Kidscreen 52. Other measures as reported in studies may be used as an alternative to the stated measures. <i>Important to decision making</i> Impact on body image This outcome is important because some young people with gender dysphoria may desire to take steps to suppress features of their physical appearance associated with their sex assigned at birth or accentuate physical features of their experienced gender. The Body Image Scale could be used as a measure. Other measures as reported in studies may also be used as an alternative to the stated measure. Psychosocial Impact Examples of psychosocial impact are: coping mechanisms which may impact on substance misuse; family relationships; peer relationships. This outcome is important because gender dysphoria in adolescents and children is associated with internalising and externalising behaviours and emotional and behavioural problems which may impact on social and occupational functioning. The child behavioural check list (CBCL) may be used to measure the impact on psychosocial functioning. Other measures as reported in studies may be used as an alternative to the stated measure. Engagement with health care services This outcome is important because patient engagement with healthcare services will impact on their clinical outcomes. Engagement with health care services may be measured using the Youth Health Care measure-satisfaction, utilization, and needs (YHC-SUN) questionnaire. Loss to follow up and
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	<p>should also be ascertained as part of this outcome. Alternative measures to the YHC-SUN questionnaire may be used as reported in studies.</p> <ul style="list-style-type: none"> • Transitioning surgery - Impact on extent of and satisfaction with surgery This outcome is important because some children and adolescents with gender dysphoria may in adulthood proceed to transitioning surgery. Stated measures of the extent of surgery and satisfaction with surgery in studies may be reported. • De-transition The proportion of patients who de-transition following the commencement of gender-affirming hormone treatment and the reasons why. This outcome is important to patients because there is uncertainty about the short and long term safety and adverse effects of gender-affirming hormones in children and adolescents with gender dysphoria. <p><u>B: Safety</u></p> <ul style="list-style-type: none"> • Short and long -term safety and adverse effects of taking gender-affirming hormones is important to assess whether treatment causes acute side effects that may lead to withdrawing the treatment or long term effects that may impact on decisions for transitioning or de-transitioning. <p>Aspects to be reported on should include Impact of the drug use such as clinically relevant derangement in renal and liver function tests, lipids, glucose, insulin and glycosylated haemoglobin, cognitive development and functioning.</p> <p>The clinical and physical impact of temporary and permanent withdrawal the drug such as when patients decide to de-transition – e.g. delay in the attainment of peak bone mass, attenuation of peak bone mass, permanent physical effects.</p> <p><u>C: Cost effectiveness</u></p> <p>Cost effectiveness studies should be reported.</p>
Inclusion criteria	
Study design	Systematic reviews, randomised controlled trials, controlled clinical trials, cohort studies. If no higher level quality evidence is found, case series can be considered.
Language	English only
Patients	Human studies only
Age	18 years or less
Date limits	2000-2020

Exclusion criteria	
Publication type	Conference abstracts, non-systematic reviews, narrative reviews, commentaries, letters, editorials, guidelines and pre-publication prints
Study design	Case reports, resource utilisation studies

Appendix B Search strategy

Medline, Embase, the Cochrane Library, HTA and APA PsycInfo were searched on 21 July 2020, limiting the search to papers published in English language in the last 20 years. Conference abstracts, non-systematic reviews, narrative reviews, commentaries, letters, editorials, guidelines, pre-publication prints, case reports and resource utilisation studies were excluded.

Database: Medline

Platform: Ovid

Version: Ovid MEDLINE(R) <1946 to July 17, 2020>

Search date: 21 Jul 2020

Number of results retrieved: 650

Search strategy:

Database: Ovid MEDLINE(R) <1946 to July 17, 2020>

Search Strategy:

-
- 1 Gender Dysphoria/ (485)
 - 2 Gender Identity/ (18431)
 - 3 "Sexual and Gender Disorders"/ (75)
 - 4 Transsexualism/ (3758)
 - 5 Transgender Persons/ (3134)
 - 6 Health Services for Transgender Persons/ (136)
 - 7 exp Sex Reassignment Procedures/ (835)
 - 8 (gender* adj3 (dysphori* or incongru* or identi* or disorder* or confus* or minorit* or queer*)).tw. (7223)
 - 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (12665)
 - 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (102312)
 - 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (6969)
 - 12 (male-to-female or m2f or female-to-male or f2m).tw. (114785)
 - 13 or/1-12 (252562)
 - 14 exp Infant/ or Infant Health/ or Infant Welfare/ (1137237)
 - 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (852126)
 - 16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (1912796)
 - 17 Minors/ (2572)
 - 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (2360626)
 - 19 exp pediatrics/ (58102)
 - 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (835833)
 - 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (2023650)
 - 22 Puberty/ (13277)

23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (424041)

24 Schools/ (38087)

25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (7199)

26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (468784)

27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (89314)

28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (887443)

29 or/14-28 (5532185)

30 13 and 29 (79220)

31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (7)

32 30 or 31 (79220)

33 Hormones/ad, tu, th (4514)

34 exp Progesterone/ad, tu, th (10899)

35 exp Estrogens/ad, tu, th (28936)

36 exp Gonadal Steroid Hormones/ad, tu, th (34137)

37 (progesteron* or oestrogen* or estrogen*).tw. (196074)

38 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medic* or drug* or intervention* or care)).tw. (544)

39 exp Estradiol/ad, tu, th (10823)

40 exp Testosterone/ad, tu, th (8318)

41 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).tw. (74936)

42 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle).tw. (90464)

43 or/33-42 (304239)

44 32 and 43 (3183)

45 limit 44 to yr="2000 -Current" (2019)

46 animals/ not humans/ (4685420)

47 45 not 46 (1194)

48 limit 47 to english language (1155)

49 (MEDLINE or pubmed).tw. (163678)

50 systematic review.tw. (121198)

51 systematic review.pt. (130231)

52 meta-analysis.pt. (117148)

53 intervention\$.ti. (123904)

54 or/49-53 (380217)

55 randomized controlled trial.pt. (509468)

56 randomi?ed.mp. (796957)

57 placebo.mp. (194937)

58 or/55-57 (848627)

59 exp cohort studies/ or exp epidemiologic studies/ or exp clinical trial/ or exp evaluation studies as topic/ or exp statistics as topic/ (5562241)

60 ((control and (group* or study)) or (time and factors)).mp. (3274107)

61 (program or survey* or ci or cohort or comparative stud* or evaluation studies or follow-up*).mp. (4624419)

62 or/59-61 (9030680)

63 Observational Studies as Topic/ (5177)

64 Observational Study/ (81866)

65 Epidemiologic Studies/ (8358)

66 exp Case-Control Studies/ (1090891)
 67 exp Cohort Studies/ (2011414)
 68 Cross-Sectional Studies/ (332273)
 69 Controlled Before-After Studies/ (526)
 70 Historically Controlled Study/ (185)
 71 Interrupted Time Series Analysis/ (913)
 72 Comparative Study.pt. (1866044)
 73 case control\$.tw. (112152)
 74 case series.tw. (59119)
 75 (cohort adj (study or studies)).tw. (170281)
 76 cohort analy\$.tw. (6758)
 77 (follow up adj (study or studies)).tw. (45131)
 78 (observational adj (study or studies)).tw. (86247)
 79 longitudinal.tw. (204239)
 80 prospective.tw. (495367)
 81 retrospective.tw. (442876)
 82 cross sectional.tw. (284856)
 83 or/63-82 (4368140)
 84 54 or 58 or 62 or 83 (9402123)
 85 48 and 84 (683)
 86 limit 85 to (letter or historical article or comment or editorial or news or case reports)
 (33)
 87 85 not 86 (650)

Database: Medline in-process

Platform: Ovid

Version: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations <1946 to July 17, 2020>

Search date: 21 July 2020

Number of results retrieved: 122

Search strategy:

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations <1946 to July 17, 2020>

Search Strategy:

1 Gender Dysphoria/ (0)
 2 Gender Identity/ (0)
 3 "Sexual and Gender Disorders"/ (0)
 4 Transsexualism/ (0)
 5 Transgender Persons/ (0)
 6 Health Services for Transgender Persons/ (0)
 7 exp Sex Reassignment Procedures/ (0)
 8 (gender* adj3 (dysphori* or incongru* or identi* or disorder* or confus* or minorit* or queer*)).tw. (1473)
 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (2315)
 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (20821)
 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (963)
 12 (male-to-female or m2f or female-to-male or f2m).tw. (15453)
 13 or/1-12 (39735)
 14 exp Infant/ or Infant Health/ or Infant Welfare/ (0)
 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (80295)

16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (0)
 17 Minors/ (0)
 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (320315)
 19 exp pediatrics/ (0)
 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (119124)
 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (0)
 22 Puberty/ (0)
 23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert*
 or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn.
 (59969)
 24 Schools/ (0)
 25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (0)
 26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or
 pupil* or student*).ti,ab,jn. (68979)
 27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen"
 or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or
 aged)).ti,ab. (10287)
 28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19")
 adj2 (year or years or age or ages or aged)).ti,ab. (112220)
 29 or/14-28 (523053)
 30 13 and 29 (9143)
 31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw.
 (3)
 32 30 or 31 (9144)
 33 Hormones/ad, tu, th (0)
 34 exp Progesterone/ad, tu, th (0)
 35 exp Estrogens/ad, tu, th (0)
 36 exp Gonadal Steroid Hormones/ad, tu, th (0)
 37 (progesteron* or oestrogen* or estrogen*).tw. (13291)
 38 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or
 treatment* or prescri* or pharm* or medici* or drug* or intervention* or care)).tw. (241)
 39 exp Estradiol/ad, tu, th (0)
 40 exp Testosterone/ad, tu, th (0)
 41 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or
 testocaps* or nebido or testavan).tw. (5458)
 42 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or
 progynova or zumenon or bedol or femseven or nuvelle).tw. (4772)
 43 or/33-42 (19706)
 44 32 and 43 (316)
 45 limit 44 to yr="2000 -Current" (303)
 46 animals/ not humans/ (1)
 47 45 not 46 (303)
 48 limit 47 to english language (303)
 49 (MEDLINE or pubmed).tw. (36030)
 50 systematic review.tw. (29830)
 51 systematic review.pt. (1007)
 52 meta-analysis.pt. (49)
 53 intervention\$.ti. (21354)
 54 or/49-53 (68976)
 55 randomized controlled trial.pt. (277)
 56 randomi?ed.mp. (74978)
 57 placebo.mp. (18290)
 58 or/55-57 (81427)
 59 exp cohort studies/ or exp epidemiologic studies/ or exp clinical trial/ or exp evaluation
 studies as topic/ or exp statistics as topic/ (455)

60 ((control and (group* or study)) or (time and factors)).mp. (214372)
 61 (program or survey* or ci or cohort or comparative stud* or evaluation studies or follow-up*).mp. (339764)
 62 or/59-61 (507046)
 63 Observational Studies as Topic/ (0)
 64 Observational Study/ (91)
 65 Epidemiologic Studies/ (0)
 66 exp Case-Control Studies/ (1)
 67 exp Cohort Studies/ (1)
 68 Cross-Sectional Studies/ (0)
 69 Controlled Before-After Studies/ (0)
 70 Historically Controlled Study/ (0)
 71 Interrupted Time Series Analysis/ (0)
 72 Comparative Study.pt. (46)
 73 case control\$.tw. (14451)
 74 case series.tw. (13070)
 75 (cohort adj (study or studies)).tw. (29119)
 76 cohort analy\$.tw. (1039)
 77 (follow up adj (study or studies)).tw. (3540)
 78 (observational adj (study or studies)).tw. (17421)
 79 longitudinal.tw. (34485)
 80 prospective.tw. (63689)
 81 retrospective.tw. (73761)
 82 cross sectional.tw. (60195)
 83 or/63-82 (250805)
 84 54 or 58 or 62 or 83 (687622)
 85 48 and 84 (126)
 86 limit 85 to (letter or historical article or comment or editorial or news or case reports) (4)
 87 85 not 86 (122)

Database: Medline epubs ahead of print

Platform: Ovid

Version: Ovid MEDLINE(R) Epub Ahead of Print <July 17, 2020>

Search date: 21 July 2020

Number of results retrieved: 32

Search strategy:

Database: Ovid MEDLINE(R) Epub Ahead of Print <July 17, 2020>

Search Strategy:

1 Gender Dysphoria/ (0)
 2 Gender Identity/ (0)
 3 "Sexual and Gender Disorders"/ (0)
 4 Transsexualism/ (0)
 5 Transgender Persons/ (0)
 6 Health Services for Transgender Persons/ (0)
 7 exp Sex Reassignment Procedures/ (0)
 8 (gender* adj3 (dysphori* or incongru* or identi* or disorder* or confus* or minorit* or queer*)).tw. (430)
 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (637)
 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (1499)
 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (179)
 12 (male-to-female or m2f or female-to-male or f2m).tw. (2460)

13 or/1-12 (4883)
 14 exp Infant/ or Infant Health/ or Infant Welfare/ (0)
 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (15416)
 16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (0)
 17 Minors/ (0)
 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (53285)
 19 exp pediatrics/ (0)
 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (22649)
 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (0)
 22 Puberty/ (0)
 23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (13005)
 24 Schools/ (0)
 25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (0)
 26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (12420)
 27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (1407)
 28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (20083)
 29 or/14-28 (87968)
 30 13 and 29 (1618)
 31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (1)
 32 30 or 31 (1618)
 33 Hormones/ad, tu, th (0)
 34 exp Progesterone/ad, tu, th (0)
 35 exp Estrogens/ad, tu, th (0)
 36 exp Gonadal Steroid Hormones/ad, tu, th (0)
 37 (progesteron* or oestrogen* or estrogen*).tw. (1876)
 38 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medic* or drug* or intervention* or care)).tw. (63)
 39 exp Estradiol/ad, tu, th (0)
 40 exp Testosterone/ad, tu, th (0)
 41 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).tw. (846)
 42 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle).tw. (665)
 43 or/33-42 (2850)
 44 32 and 43 (64)
 45 limit 44 to yr="2000 -Current" (61)
 46 animals/ not humans/ (0)
 47 45 not 46 (61)
 48 limit 47 to english language (61)
 49 (MEDLINE or pubmed).tw. (7948)
 50 systematic review.tw. (7508)
 51 systematic review.pt. (28)
 52 meta-analysis.pt. (37)
 53 intervention\$.ti. (4267)
 54 or/49-53 (15048)
 55 randomized controlled trial.pt. (1)

56 randomi?ed.mp. (14113)
 57 placebo.mp. (3097)
 58 or/55-57 (15128)
 59 exp cohort studies/ or exp epidemiologic studies/ or exp clinical trial/ or exp evaluation
 studies as topic/ or exp statistics as topic/ (34)
 60 ((control and (group* or study)) or (time and factors)).mp. (31615)
 61 (program or survey* or ci or cohort or comparative stud* or evaluation studies or follow-
 up*).mp. (65735)
 62 or/59-61 (88222)
 63 Observational Studies as Topic/ (0)
 64 Observational Study/ (4)
 65 Epidemiologic Studies/ (0)
 66 exp Case-Control Studies/ (0)
 67 exp Cohort Studies/ (0)
 68 Cross-Sectional Studies/ (0)
 69 Controlled Before-After Studies/ (0)
 70 Historically Controlled Study/ (0)
 71 Interrupted Time Series Analysis/ (0)
 72 Comparative Study.pt. (0)
 73 case control\$.tw. (2577)
 74 case series.tw. (2480)
 75 (cohort adj (study or studies)).tw. (7959)
 76 cohort analy\$.tw. (287)
 77 (follow up adj (study or studies)).tw. (632)
 78 (observational adj (study or studies)).tw. (3763)
 79 longitudinal.tw. (7079)
 80 prospective.tw. (12148)
 81 retrospective.tw. (16600)
 82 cross sectional.tw. (9459)
 83 or/63-82 (48534)
 84 54 or 58 or 62 or 83 (119752)
 85 48 and 84 (32)
 86 limit 85 to (letter or historical article or comment or editorial or news or case reports) (0)
 87 85 not 86 (32)

Database: Medline daily update

Platform: Ovid

Version: Ovid MEDLINE(R) Daily Update <July 21, 2020>

Search date: 22 July 2020

Number of results retrieved: 3

Search strategy

Database: Ovid MEDLINE(R) Daily Update <July 21, 2020>

Search Strategy:

1 Gender Dysphoria/ (4)
 2 Gender Identity/ (38)
 3 "Sexual and Gender Disorders"/ (0)
 4 Transsexualism/ (2)
 5 Transgender Persons/ (26)
 6 Health Services for Transgender Persons/ (1)
 7 exp Sex Reassignment Procedures/ (3)
 8 (gender* adj3 (dysphori* or incongru* or identi* or disorder* or confus* or minorit* or
 queer*)).tw. (22)

9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (39)
 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (87)
 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (15)
 12 (male-to-female or m2f or female-to-male or f2m).tw. (181)
 13 or/1-12 (358)
 14 exp Infant/ or Infant Health/ or Infant Welfare/ (932)
 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (981)
 16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (1756)
 17 Minors/ (3)
 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (3672)
 19 exp pediatrics/ (75)
 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (1658)
 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (2006)
 22 Puberty/ (8)
 23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (732)
 24 Schools/ (56)
 25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (5)
 26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,in. (622)
 27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (98)
 28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (1301)
 29 or/14-28 (6705)
 30 13 and 29 (130)
 31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (0)
 32 30 or 31 (130)
 33 Hormones/ad, tu, th (3)
 34 exp Progesterone/ad, tu, th (3)
 35 exp Estrogens/ad, tu, th (8)
 36 exp Gonadal Steroid Hormones/ad, tu, th (22)
 37 (progesteron* or oestrogen* or estrogen*).tw. (161)
 38 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medic* or drug* or intervention* or care)).tw. (3)
 39 exp Estradiol/ad, tu, th (8)
 40 exp Testosterone/ad, tu, th (8)
 41 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).tw. (79)
 42 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or progyanova or zumenon or bedol or femseven or nuvelle).tw. (61)
 43 or/33-42 (261)
 44 32 and 43 (7)
 45 limit 44 to yr="2000 -Current" (7)
 46 animals/ not humans/ (3647)
 47 45 not 46 (6)
 48 limit 47 to english language (6)
 49 (MEDLINE or pubmed).tw. (529)
 50 systematic review.tw. (512)

51 systematic review.pt. (522)
 52 meta-analysis.pt. (370)
 53 intervention\$.ti. (247)
 54 or/49-53 (1065)
 55 randomized controlled trial.pt. (595)
 56 randomi?ed.mp. (1203)
 57 placebo.mp. (219)
 58 or/55-57 (1234)
 59 exp cohort studies/ or exp epidemiologic studies/ or exp clinical trial/ or exp evaluation
 studies as topic/ or exp statistics as topic/ (7958)
 60 ((control and (group* or study)) or (time and factors)).mp. (4307)
 61 (program or survey* or ci or cohort or comparative stud* or evaluation studies or follow-
 up*).mp. (5828)
 62 or/59-61 (11814)
 63 Observational Studies as Topic/ (27)
 64 Observational Study/ (449)
 65 Epidemiologic Studies/ (7)
 66 exp Case-Control Studies/ (2173)
 67 exp Cohort Studies/ (3287)
 68 Cross-Sectional Studies/ (837)
 69 Controlled Before-After Studies/ (1)
 70 Historically Controlled Study/ (0)
 71 Interrupted Time Series Analysis/ (6)
 72 Comparative Study.pt. (768)
 73 case control\$.tw. (182)
 74 case series.tw. (139)
 75 (cohort adj (study or studies)).tw. (561)
 76 cohort analy\$.tw. (22)
 77 (follow up adj (study or studies)).tw. (40)
 78 (observational adj (study or studies)).tw. (253)
 79 longitudinal.tw. (429)
 80 prospective.tw. (778)
 81 retrospective.tw. (1032)
 82 cross sectional.tw. (739)
 83 or/63-82 (5471)
 84 54 or 58 or 62 or 83 (12581)
 85 48 and 84 (3)
 86 limit 85 to (letter or historical article or comment or editorial or news or case reports) (0)
 87 85 not 86 (3)

Database: Embase

Platform: Ovid

Version: Embase <1974 to 2020 July 22>

Search date: 23 July 2020

Number of results retrieved: 1207

Search strategy:

Database: Embase <1974 to 2020 July 22>

Search Strategy:

1 exp Gender Dysphoria/ (5399)
 2 Gender Identity/ (16820)
 3 "Sexual and Gender Disorders"/ (24689)
 4 Transsexualism/ (3869)
 5 exp Transgender/ (6597)

6 Health Services for Transgender Persons/ (158848)
 7 exp Sex Reassignment Procedures/ (1108)
 8 (gender* adj3 (dysphori* or incongru* or identi* or disorder* or confus* or minorit* or queer*)).tw. (12470)
 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (22509)
 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (154446)
 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (10327)
 12 (male-to-female or m2f or female-to-male or f2m).tw. (200166)
 13 or/1-12 (581748)
 14 exp juvenile/ or Child Behavior/ or Child Welfare/ or Child Health/ or infant welfare/ or "minor (person)"/ or elementary student/ or adolescent health/ or middle school student/ or high school student/ (3440943)
 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (1186161)
 16 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (3586795)
 17 exp pediatrics/ (106214)
 18 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (1491597)
 19 exp adolescence/ or exp adolescent behavior/ or adolescent health/ or high school student/ or middle school student/ (105108)
 20 (adolescen* or pubescen* or prepubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (641660)
 21 school/ or high school/ or kindergarten/ or middle school/ or primary school/ or nursery school/ or day care/ (103791)
 22 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (687437)
 23 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (138908)
 24 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (1562903)
 25 or/14-24 (7130881)
 26 13 and 25 (181778)
 27 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (17)
 28 26 or 27 (181778)
 29 hormone/bd, ad, an, cr, do, it, dt, to, ei, ih, ia, ar, cv, dl, im, na, ip, ut, va, iv, ve, vi, po, pa, pr, sc, li, th, tp, td (5160)
 30 exp progesterone derivative/bd, ad, an, cr, do, it, dt, to, ei, ih, ia, ar, cv, dl, im, na, ip, ut, va, iv, ve, vi, po, pa, pr, sc, li, th, tp, td (23479)
 31 exp estrogen/bd, ad, an, cr, do, it, dt, to, ei, ih, ia, ar, cv, dl, im, na, ip, ut, va, iv, ve, vi, po, pa, pr, sc, li, th, tp, td (57641)
 32 steroid hormone/bd, ad, an, cr, do, it, dt, to, ei, ih, ia, ar, cv, dl, im, na, ip, ut, va, iv, ve, vi, po, pa, pr, sc, li, th, tp, td (372)
 33 sex hormone/bd, ad, an, cr, do, it, dt, to, ei, ih, ia, ar, cv, dl, im, na, ip, ut, va, iv, ve, vi, po, pa, pr, sc, li, th, tp, td (1984)
 34 hormonal therapy/ (42222)
 35 (progesteron* or oestrogen* or estrogen*).tw. (254142)
 36 ((cross-sex or crossex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medici* or drug* or intervention* or care)).tw. (1224)
 37 exp estradiol derivative/bd, ad, an, cr, do, it, dt, to, ei, ih, ia, ar, cv, dl, im, na, ip, ut, va, iv, ve, vi, po, pa, pr, sc, li, th, tp, td (30740)

38 exp testosterone derivative/bd, ad, an, cr, do, it, dt, to, ei, ih, ia, ar, cv, dl, im, na, ip, ut,
 va, iv, ve, vi, po, pa, pr, sc, li, th, tp, td (15868)
 39 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or
 testocaps* or nebido or testavan).tw. (99596)
 40 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or
 progynova or zumenon or bedol or femseven or nuvelle).tw. (114290)
 41 or/29-40 (438737)
 42 28 and 41 (6053)
 43 limit 42 to yr="2000 -Current" (4741)
 44 nonhuman/ not human/ (4649157)
 45 43 not 44 (3636)
 46 limit 45 to english language (3513)
 47 (MEDLINE or pubmed).tw. (261145)
 48 exp systematic review/ or systematic review.tw. (302985)
 49 meta-analysis/ (191173)
 50 intervention\$.ti. (200041)
 51 or/47-50 (660206)
 52 random:.tw. (1552336)
 53 placebo:.mp. (455979)
 54 double-blind:.tw. (210671)
 55 or/52-54 (1807280)
 56 cohort analysis/ (596360)
 57 exp epidemiology/ (3434332)
 58 exp clinical trial/ (1504711)
 59 evaluation study/ (45870)
 60 statistics/ (301181)
 61 ((control and (group* or study)) or (time and factors)).mp. (3324555)
 62 (program or survey* or ci or cohort or comparative stud* or evaluation studies or follow-
 up*).mp. (6067112)
 63 or/56-62 (11048972)
 64 Clinical study/ (155444)
 65 Case control study/ (157943)
 66 Family study/ (26047)
 67 Longitudinal study/ (141660)
 68 Retrospective study/ (937696)
 69 comparative study/ (859061)
 70 Prospective study/ (613138)
 71 Randomized controlled trials/ (182542)
 72 70 not 71 (606604)
 73 Cohort analysis/ (596360)
 74 cohort analy\$.tw. (13020)
 75 (Cohort adj (study or studies)).tw. (302159)
 76 (Case control\$ adj (study or studies)).tw. (137432)
 77 (follow up adj (study or studies)).tw. (63423)
 78 (observational adj (study or studies)).tw. (168428)
 79 (epidemiologic\$ adj (study or studies)).tw. (106448)
 80 (cross sectional adj (study or studies)).tw. (220073)
 81 case series.tw. (104089)
 82 prospective.tw. (861922)
 83 retrospective.tw. (886445)
 84 or/64-69,72-83 (4047788)
 85 51 or 55 or 63 or 84 (12494560)
 86 46 and 85 (2151)
 87 86 not (letter or editorial).pt. (2137)

88 87 not (conference abstract or conference paper or conference proceeding or "conference review").pt. (1207)

Database: APA PsycInfo

Platform: Ovid

Version: APA PsycInfo <1806 to July Week 2 2020>

Search date: 22 July 2020

Number of results retrieved: 581

Search strategy:

Database: APA PsycInfo <1806 to July Week 2 2020>

Search Strategy:

-
- 1 Gender Dysphoria/ (936)
 - 2 Gender Identity/ (8648)
 - 3 Transsexualism/ (2825)
 - 4 Transgender/ (5257)
 - 5 exp Gender Reassignment/ (568)
 - 6 (gender* adj3 (dysphori* or incongruen* or identi* or disorder* or confus* or minorit* or queer*)).tw. (15276)
 - 7 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (13028)
 - 8 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (7679)
 - 9 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (5796)
 - 10 (male-to-female or m2f or female-to-male or f2m).tw. (63688)
 - 11 or/1-10 (99498)
 - 12 exp Infant Development/ (21841)
 - 13 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (150219)
 - 14 Child Characteristics/ or exp Child Behavior/ or Child Psychology/ or exp Child Welfare/ or Child Psychiatry/ (23423)
 - 15 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (984230)
 - 16 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (78962)
 - 17 Adolescent Psychiatry/ or Adolescent Behavior/ or Adolescent Development/ or Adolescent Psychology/ or Adolescent Characteristics/ or Adolescent Health/ (62142)
 - 18 Puberty/ (2753)
 - 19 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (347604)
 - 20 Schools/ (29181)
 - 21 Child Day Care/ or Nursery Schools/ (2836)
 - 22 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (772814)
 - 23 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (21475)
 - 24 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (285697)
 - 25 or/12-24 (1765408)
 - 26 11 and 25 (49560)
 - 27 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (14)

28 26 or 27 (49561)
 29 hormones/ (8408)
 30 sex hormones/ (1777)
 31 exp progestational hormones/ (2409)
 32 estrogens/ (3889)
 33 steroids/ (3797)
 34 (progesteron* or oestrogen* or estrogen*).tw. (11188)
 35 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medici* or drug* or intervention* or care)).tw. (457)
 36 estradiol/ (3120)
 37 testosterone/ (5606)
 38 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).tw. (9625)
 39 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle).tw. (6741)
 40 or/29-39 (30344)
 41 28 and 40 (1005)
 42 limit 41 to yr="2000 -Current" (749)
 43 limit 42 to english language (692)
 44 limit 43 to ("0200 book" or "0240 authored book" or "0280 edited book" or "0300 encyclopedia" or "0400 dissertation abstract") (111)
 45 43 not 44 (581)

Database: Cochrane Library – incorporating Cochrane Database of Systematic Reviews (CDSR); CENTRAL

Platform: Wiley

Version:

CDSR – Issue 7 of 12, July 2020

CENTRAL – Issue 7 of 12, July 2020

Search date: 22 July 2020

Number of results retrieved: CDSR 0 ; CENTRAL 67.

ID	SearchHits
#1	MeSH descriptor: [Gender Dysphoria] this term only 3
#2	MeSH descriptor: [Gender Identity] this term only 227
#3	MeSH descriptor: [Sexual and Gender Disorders] this term only 2
#4	MeSH descriptor: [Transsexualism] this term only 27
#5	MeSH descriptor: [Transgender Persons] this term only 36
#6	MeSH descriptor: [Health Services for Transgender Persons] this term only 0
#7	MeSH descriptor: [Sex Reassignment Procedures] explode all trees 4
#8	(gender* near/3 (dysphori* or incongru* or identi* or disorder* or confus* or minorit* or queer*)):ti,ab,kw 702
#9	(transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*):ti,ab,kw 959
#10	(trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*):ti,ab,kw 3969
#11	((sex or gender*) near/3 (reassign* or chang* or transform* or transition*)):ti,ab,kw 524
#12	(male-to-female or m2f or female-to-male or f2m):ti,ab,kw 516
#13	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 6413
#14	MeSH descriptor: [Infant] explode all trees 28440
#15	MeSH descriptor: [Infant Health] this term only 49
#16	MeSH descriptor: [Infant Welfare] this term only 82

#17 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*):ti,ab,kw,so 89530

#18 MeSH descriptor: [Child] explode all trees 44089

#19 MeSH descriptor: [Child Behavior] explode all trees 2061

#20 MeSH descriptor: [Child Health] this term only 98

#21 MeSH descriptor: [Child Welfare] this term only 325

#22 MeSH descriptor: [Minors] this term only 8

#23 (child* or minor or minors or boy* or girl* or kid or kids or young*):ti,ab,kw,so 265417

#24 MeSH descriptor: [Pediatrics] explode all trees 661

#25 (pediatric* or paediatric* or peadiatric*):ti,ab,kw,so 57725

#26 MeSH descriptor: [Adolescent] this term only 102154

#27 MeSH descriptor: [Adolescent Behavior] this term only 1358

#28 MeSH descriptor: [Adolescent Health] this term only 29

#29 MeSH descriptor: [Puberty] this term only 295

#30 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*):ti,ab,kw,so 140927

#31 MeSH descriptor: [Schools] this term only 1914

#32 MeSH descriptor: [Child Day Care Centers] this term only 231

#33 MeSH descriptor: [Nurseries, Infant] explode all trees 17

#34 MeSH descriptor: [Schools, Nursery] this term only 37

#35 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*):ti,ab,kw,so 97810

#36 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") near/2 (year or years or age or ages or aged)):ti,ab 6710

#37 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") near/2 (year or years or age or ages or aged)):ti,ab 196881

#38 #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37 516067

#39 #13 and #38 2488

#40 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*):ti,ab,kw 0

#41 #39 or #40 2488

#42 MeSH descriptor: [Hormones] this term only 2241

#43 MeSH descriptor: [Progesterone] explode all trees 3135

#44 MeSH descriptor: [Estrogens] explode all trees 1841

#45 MeSH descriptor: [Gonadal Steroid Hormones] explode all trees 10747

#46 (progesteron* or oestrogen* or estrogen*):ti,ab,kw 18387

#47 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medic* or drug* or intervention* or care)):ti,ab,kw 24

#48 MeSH descriptor: [Estradiol] explode all trees 4434

#49 MeSH descriptor: [Testosterone] explode all trees 2945

#50 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan):ti,ab,kw 7386

#51 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle):ti,ab,kw 11410

#52 #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 31870

#53 #41 and #52 121

#54 "conference":pt or (clinicaltrials or trialsearch):so 492465

#55 #53 not #54 72

Database: HTA

Platform: Wiley
Version: up to 2018
Search date: 22nd July 2020
Number of results retrieved: 4
Search strategy:

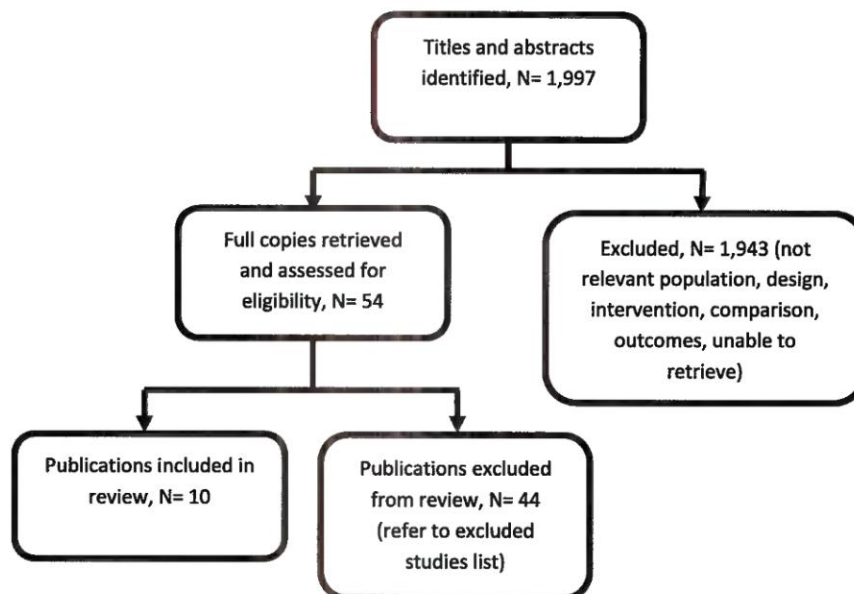
```
#1  MeSH DESCRIPTOR Gender Dysphoria      0
#2  MeSH DESCRIPTOR Gender Identity        12
#3  MeSH DESCRIPTOR Sexual and Gender Disorders      2
#4  MeSH DESCRIPTOR Transsexualism         12
#5  MeSH DESCRIPTOR Transgender Persons 3
#6  MeSH DESCRIPTOR Health Services for Transgender Persons  0
#7  MeSH DESCRIPTOR Sex Reassignment Procedures EXPLODE ALL TREES  1
#8  ((gender* near3 (dysphori* or incongru* or identi* or disorder* or confus* or minorit*
or queer*))) 28
#9  ((transgend* or transex* or transsex* or transfem* or transwom* or transma* or
transmen* or transperson* or transpeopl*)) 76
#10 ((trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*))
83
#11 (((sex or gender*) near3 (reassign* or chang* or transform* or transition*))) 24
#12 ((male-to-female or m2f or female-to-male or f2m)) 86
#13 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12
261
#14 MeSH DESCRIPTOR Infant EXPLODE ALL TREES      2964
#15 MeSH DESCRIPTOR Infant Health 0
#16 MeSH DESCRIPTOR Infant Welfare 22
#17 ((prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-
born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*))
5510
#18 MeSH DESCRIPTOR Child EXPLODE ALL TREES 4935
#19 MeSH DESCRIPTOR Child Behavior EXPLODE ALL TREES      64
#20 MeSH DESCRIPTOR Child Health 2
#21 MeSH DESCRIPTOR Child Welfare 80
#22 MeSH DESCRIPTOR Minors 2
#23 ((child* or minor or minors or boy* or girl* or kid or kids or young*)) 13575
#24 MeSH DESCRIPTOR Pediatrics EXPLODE ALL TREES 119
#25 ((pediatric* or paediatric* or peadiatric*)) 2842
#26 MeSH DESCRIPTOR Adolescent 4594
#27 MeSH DESCRIPTOR Adolescent Behavior 94
#28 MeSH DESCRIPTOR Adolescent Health 0
#29 MeSH DESCRIPTOR Puberty 3
#30 ((adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or
prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or
under*age*)) 5621
#31 MeSH DESCRIPTOR Schools 168
#32 MeSH DESCRIPTOR Child Day Care Centers 12
#33 MeSH DESCRIPTOR Schools, Nursery 3
#34 ((pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school*
or pupil* or student*)) 4454
#35 (((("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen"
or "sixteen" or "seventeen" or "eighteen" or "nineteen") near2 (year or years or age or ages
or aged))) 380
#36 (((("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or
"19") near2 (year or years or age or ages or aged))))7996
```

#37 #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR
 #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR
 #35 OR #36 22640
 #38 #13 AND #37 116
 #39 (#13 AND #37) IN HTA 4

Appendix C Evidence selection

The literature searches identified 1,997 references. These were screened using their titles and abstracts and 54 references were obtained and assessed for relevance. Of these, 10 references are included in the evidence review. The remaining 44 references were excluded and are listed in [appendix D](#).

Figure 1 – Study selection flow diagram



References submitted with Preliminary Policy Proposal

There is no preliminary policy proposal for this policy.

Appendix D Excluded studies table

Study reference	Reason for exclusion
Aranda G, Mora M, Hanzu FA et al. (2019) Effects of sex steroids on cardiovascular risk profile in transgender men under gender affirming hormone therapy. <i>Endocrinologia, diabetes y nutricion</i> 66(6): 385–392	Excluded on population – adult study, participants not 18 years or less (mean age 27.1 years).
Arnold, Justin D, Sarkodie, Eleanor P, Coleman, Megan E et al. (2016) Incidence of Venous Thromboembolism in Transgender Women	Excluded on population – adult study, participants not 18 years or less (mean age 33.2 years).

Study reference	Reason for exclusion
Receiving Oral Estradiol. The journal of sexual medicine 13(11): 1773–1777	
Asscheman, Henk, Giltay, Erik J, Megens, Jos A J et al. (2011) A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. European journal of endocrinology 164(4): 635–42	Excluded on population – although some participants started gender-affirming hormones when young, the study does not report the proportion who started treatment when 18 years or less. Mean ages at start of treatment were 31.4 years (transfemales) and 26.1 years (transmales), suggesting the majority of participants were older than 18 years at the start of treatment. Outcomes not reported separately for people aged 18 years or less.
Author not, found (2014) Hormone therapy for the treatment of gender dysphoria. Lansdale, PA: HAYES, Inc	Full text paper not available.
Baba, T., Endo, T., Honnma, H. et al. (2007) Association between polycystic ovary syndrome and female-to-male transsexuality. Human Reproduction 22(4): 1011–1016	Excluded on population – although study included some younger people (age range 17 to 47), most participants were adults (mean age around 25 years) and the proportion who started treatment when 18 years or less is not reported. Outcomes not reported separately for people aged 18 years or less.
Becerra-Fernandez A, Perez-Lopez G, Roman MM et al. (2014) Prevalence of hyperandrogenism and polycystic ovary syndrome in female to male transsexuals. Endocrinologia y Nutricion: Organo de la Sociedad Espanola de Endocrinologia y Nutricion 61(7): 351–8	Excluded on population – although study included some younger people (age range 18 to 45), most participants were adults (mean age around 25 years) and the proportion who started treatment when 18 years or less is not reported. Outcomes not reported separately for people aged 18 years or less.
Becker I, Auer M, Barkmann C et al. (2018) A Cross-Sectional Multicenter Study of Multidimensional Body Image in Adolescents and Adults with Gender Dysphoria Before and After Transition-Related Medical Interventions. Archives of Sexual Behavior 47(8): 2335–2347	Excluded on population – study included people aged 14 to 21 years. Outcomes not reported separately for people aged 18 years or less. Better evidence available – only 11 participants received gender-affirming hormones. The majority of the study cohort were either pre-treatment, received puberty suppression alone, or received hormones and underwent surgery.
Chew D, Anderson J, Williams K et al. (2018) Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review. Pediatrics 141(4): e20173742	Excluded on better available evidence - systematic review did not meta-analyse results from. Individual studies from this systematic review are either

Study reference	Reason for exclusion
	included, or excluded because they did not meet the PICO criteria.
Connolly MD, Zervos MJ, Barone CJ 2nd et al. (2016) The Mental Health of Transgender Youth: Advances in Understanding. The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 59(5): 489–495	Excluded on intervention - review did not investigate gender-affirming hormones
de Vries ALC, McGuire JK, Steensma TD et al. (2014) Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 134(4): 696–704	Exclude on intervention – all participants had surgery after gender-affirming hormones. Unable to determine whether changes were due to hormones or surgery. Complete data only available for 40 patients. Details of gender-affirming hormones are poorly reported. Outcomes reported in other study (with a population that more closely matches PICO)
Elamin MB, Garcia MZ, Murad MH et al. (2010) Effect of sex steroid use on cardiovascular risk in transsexual individuals: a systematic review and meta-analyses. Clinical Endocrinology 72(1): 1–10	Exclude on population – all included studies conducted in adult population. Unclear whether hormones were started when participants were aged 18 years or less. Outcomes not reported by age at treatment initiation.
Fernandez JD and Tannock LR (2016) Metabolic effects of hormone therapy in transgender patients. Endocrine Practice: Official Journal of the American College of Endocrinology and the American Association of Clinical Endocrinologists 22(4): 383–8	Excluded on population – adult study, participants not 18 years or less (mean ages 31 and 27 years).
Figuera TM, Ziegelmann PK, Da Silva TR et al. (2019) Bone mass effects of cross-sex hormone therapy in transgender people: Updated systematic review and meta-analysis. Journal of the Endocrine Society 3(5): 943–964	Excluded on population – all included studies conducted in adult population. Unclear whether hormones were started when participants were aged 18 years or less. Outcomes not reported by age at treatment initiation.
Getahun D, Nash R, Flanders WD et al. (2018) Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. Annals of Internal Medicine 169(4): 205–213	Excluded on population – adult study, participants not 18 years or less.
Gomez-Gil E, Zubiaurre-Elorza L, de Antonio IE et al. (2014) Determinants of quality of life in Spanish transsexuals attending a gender unit before genital sex reassignment surgery. Quality of Life Research: an International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation 23(2): 669–76	Excluded on population – although study included some younger people (age range 16 to 67), most participants were adults (mean age 31.2 years) and the proportion who started treatment when 18 years or less is not reported. Outcomes not reported separately for people aged 18 years or less.
Gomez-Gil E, Zubiaurre-Elorza L, Esteva I et al. (2012) Hormone-treated transsexuals report less	Excluded on population – adult study, participants not 18 years or less (mean age 24.6 years).

Study reference	Reason for exclusion
social distress, anxiety and depression. Psychoneuroendocrinology 37(5): 662–70	
Gooren LJ, van Trotsenburg MAA, Giltay EJ et al. (2013) Breast cancer development in transsexual subjects receiving cross-sex hormone treatment. The Journal of Sexual Medicine 10(12): 3129–34	Excluded on population – study reports on cancer rates in people aged 18–80 years. The 3 cases of cancer all started gender-affirming hormone treatment >18 years.
Grimstad FW, Boskey E, Grey M (2020) New-Onset Abdominopelvic Pain After Initiation of Testosterone Therapy Among TransMasculine Persons: A Community-Based Exploratory Survey. LGBT health 7(5): Published Online:13 Jul 2020 https://doi.org/10.1089/lgbt.2019.0258	Excluded on population – adult study, participants not 18 years or less.
Hannema SE, Schagen SEE, Cohen-Kettenis PT et al. (2017) Efficacy and Safety of Pubertal Induction Using 17beta-Estradiol in Transgirls. The Journal of Clinical Endocrinology and Metabolism 102(7): 2356–2363	Excluded on better evidence available – small study (n=28) with high drop-out rate (n=16 at final follow-up). Same outcomes reported in larger studies.
Jarin J, Pine-Twaddell E, Trotman G et al. (2017) Cross-Sex Hormones and Metabolic Parameters in Adolescents With Gender Dysphoria. Pediatrics 139(5)	Excluded on population and better evidence available. Although the study included some younger people (age range 13 to 25; mean age 16 and 18), the proportion who started treatment when 18 years or less is not reported. Outcomes not reported separately for people aged 18 years or less. Outcomes were limited to physiological results (including haemoglobin, lipids and BMI). Follow-up only 6 months, other included studies report same outcomes with longer follow-up (12 to 31 months).
Keo-Meier CL, Herman LI, Reisner SL et al. (2015) Testosterone treatment and MMPI-2 improvement in transgender men: a prospective controlled study. Journal of consulting and clinical psychology 83(1): 143–56	Excluded on population – although study included some younger people (age range 18 to 54), most participants were adults (mean age 26.6 years) and the proportion who started treatment when 18 years or less is not reported. Outcomes not reported separately for people aged 18 years or less.
Klaver M, de Mutsert R, Wiepjes CM et al. (2018) Early Hormonal Treatment Affects Body Composition and Body Shape in Young Transgender Adolescents. The Journal of Sexual Medicine 15(2): 251–260	Excluded on outcomes – reported outcomes not included in PICO document. The risk of obesity with gender-affirmed hormones was reported in an included study.
McFarlane T, Zajac JD, Cheung AS (2018) Gender-affirming hormone therapy and the risk of sex hormone-dependent tumours in transgender individuals-A systematic review. Clinical Endocrinology 89(6): 700–711	Exclude on population – all included studies conducted in adult population.

Study reference	Reason for exclusion
Meriggiola MC, Armillotta F, Costantino A et al. (2008) Effects of testosterone undecanoate administered alone or in combination with letrozole or dutasteride in female to male transsexuals. The Journal of Sexual Medicine 5(10): 2442–53	Excluded on population – adult study, participants not 18 years or less.
Nota NM, Wiepjes CM, de Blok, CJM et al. (2018) The occurrence of benign brain tumours in transgender individuals during cross-sex hormone treatment. Brain: A Journal of Neurology 141(7): 2047–2054	Excluded on population – adult study, participants not 18 years or less.
Oda H and Kinoshita T (2017) Efficacy of hormonal and mental treatments with MMPI in FtM individuals: Cross-sectional and longitudinal studies. BMC Psychiatry 17(1): 256	Excluded on population – although study included some younger people (age range 15 to 43), most participants were adults (mean age around 25.6 years) and the proportion who started treatment when 18 years or less is not reported. Outcomes not reported separately for people aged 18 years or less.
Olson-Kennedy J, Okonta V, Clark LF et al. (2018) Physiologic Response to Gender-Affirming Hormones Among Transgender Youth. The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 62(4): 397–401	Excluded on population – although study included some younger people (age range 12 to 23; mean age 18 years). Outcomes not reported separately for people aged 18 years or less. Outcomes limited to physiological results (including haemoglobin, lipids, liver enzymes and BMI). Same outcomes reported in included studies that had a less indirect population and a longer follow-up.
Ott J, Kaufmann U, Bentz K et al. (2010) Incidence of thrombophilia and venous thrombosis in transsexuals under cross-sex hormone therapy. Fertility and sterility 93(4): 1267–72	Excluded on population – adult study, participants not 18 years or less.
Pakpoor J, Wotton CJ, Schmierer K et al. (2016) Gender identity disorders and multiple sclerosis risk: A national record-linkage study. Multiple sclerosis. Multiple Sclerosis Journal. 22(13): 1759–1762	Excluded on population – although study included some younger people, outcomes not reported separately for people aged 18 years or less. Also exclude for intervention – unclear if people received gender-affirming hormones.
Pyra M, Casimiro I, Rusie L et al. (2020) An Observational Study of Hypertension and Thromboembolism among Transgender Patients Using Gender-Affirming Hormone Therapy. Transgender Health 5(1): 1–9	Excluded on population – adult study (age range 20–70). Age at which gender-affirming hormones started not reported.
Quiros C, Patrascioiu I, Mora M et al. (2015) Effect of cross-sex hormone treatment on cardiovascular risk factors in transsexual individuals. Experience in a specialized unit in Catalonia. Endocrinología y nutrición : organo de la Sociedad Espanola de Endocrinología y Nutricion 62(5): 210–6	Excluded on population – adult study, participants not 18 years or less.

Study reference	Reason for exclusion
Rowniak S, Bolt L, Sharifi C (2019) Effect of cross-sex hormones on the quality of life, depression and anxiety of transgender individuals: A quantitative systematic review. JBI Database of Systematic Reviews and Implementation Reports 17(9): 1826–1854	Exclude on population – all included studies conducted in adult population.
Sequeira GM, Kidd K, El Nokali NE et al. (2019) Early Effects of Testosterone Initiation on Body Mass Index in Transmasculine Adolescents. Journal of Adolescent Health 65(6): 818–820	Exclude on outcome - study only reports BMI z-score over 12 month testosterone treatment. BMI not listed as an outcome of interest in the PICO document. Other included studies have investigated the impact of gender-affirming hormone treatment on CV risk profile, including longer term obesity rates, with a longer follow-up and more participants.
Shim JY, Laufer MR, Grimstad FW (2020) Dysmenorrhea and Endometriosis in Transgender Adolescents. Journal of Pediatric and Adolescent Gynecology. Available online 11 June 2020. https://doi.org/10.1016/j.jpog.2020.06.001	Exclude on population – only 2 participants taking testosterone before diagnosis of dysmenorrhea.
Slabbekoorn D, Van Goozen SHM, Gooren, LJG et al. (2001) Effects of cross-sex hormone treatment on emotionality in transsexuals. International Journal of Transgenderism 5(3): http://www.symposion.com/ijt/ijtvo05no03_02.htm	Excluded on population – adult study (age range 21 to 28 years)
Smith YLS., Van Goozen SHM, Kuiper AJ et al. (2005) Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. Psychological Medicine 35(1): 89–99	Excluded on population – results on adults only used to assess hormone treatment.
Sutherland N, Espinel W, Grotzke M et al. (2020) Unanswered Questions: Hereditary breast and gynecological cancer risk assessment in transgender adolescents and young adults. Journal of Genetic Counseling 29(4): 625–633	Excluded on study type – narrative review of 3 case reports.
van Velzen DM, Paldino A, Klaver M et al. (2019) Cardiometabolic Effects of Testosterone in Transmen and Estrogen Plus Cyproterone Acetate in Transwomen. The Journal of Clinical Endocrinology and Metabolism 104(6): 1937–1947	Excluded on population – adult study, participants not 18 years or less.
White Hughto JM and Reisner SL (2016) A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals. Transgender Health 1(1): 21–31	Exclude on population – all included studies conducted in adult population.
Wiepjes CM, de Blok CJM, Staphorsius AS et al. (2020) Fracture Risk in Trans Women and Trans Men Using Long-Term Gender-Affirming Hormonal Treatment: A Nationwide Cohort Study. Journal of Bone and Mineral Research 35(1): 64–70	Excluded on population – adult study, all participants started gender-affirming hormones after 18 years.
Wierckx K, Mueller S, Weyers S et al. (2012) Long-term evaluation of cross-sex hormone treatment in	Excluded on population – adult study, participants not 18 years or less.

Study reference	Reason for exclusion
transsexual persons. The Journal of Sexual Medicine 9(10): 2641–51	
Wierckx K, Van Caenegem E, Schreiner T et al. (2014) Cross-sex hormone therapy in trans persons is safe and effective at short-time follow-up: results from the European network for the investigation of gender incongruence. The journal of sexual medicine 11(8): 1999–2011	Excluded on population – adult study, participants not 18 years or less.
Wilson R, Jenkins C, Miller H et al. (2006) The effect of oestrogen on cytokine and antioxidant levels in male to female transsexual patients. Maturitas 55(1): 14–8	Excluded on population – adult study, participants not 18 years or less.
Witcomb GL, Bouman WP, Claes L et al. (2018) Levels of depression in transgender people and its predictors: Results of a large matched control study with transgender people accessing clinical services. Journal of Affective Disorders 235: 308–315	Excluded on population – although study included some younger people (age range 15 to 79), most participants were adults (mean age around 30.4 years) and the proportion who started treatment when 18 years or less is not reported. Outcomes not reported separately for people aged 18 years or less.

Appendix E Evidence tables

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Achille, C., Taggart, T., Eaton, N.R. et al. (2020) Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. International Journal of Pediatric Endocrinology 2020(1): 8</p> <p>Study location Single centre, New York, United States</p> <p>Study type Prospective longitudinal study</p> <p>Study aim To assess the psychological wellbeing and quality of life in children and adolescents who have sought endocrine</p>	<p>Inclusion and exclusion not reported- it appears from the description in the publication that all people referred for gender dysphoria were invited to participate, and the vast majority agreed. Of the 95 treatment naïve people who entered the study, 50 people completed all follow-up questionnaires and were included in the analysis. No description of the 45 people without follow-up data reported.</p> <p>The study included 50 children, adolescents and young adults with gender dysphoria.</p>	<p>Intervention</p> <p>Endocrine interventions (the collective term used by authors for puberty suppression and gender-affirming hormones) were introduced as per Endocrine Society and the World Professional Association for</p>	<p>Critical Outcomes</p> <p>Impact on mental health</p> <p>Depression symptoms were assessed using the Center for Epidemiologic Studies Depression Scale (CESD-R). Statistically significant improvements in CESD-R score were observed from baseline (initial assessment; 21.4 points) to about 12 months follow-up (13.9 points; $p < 0.001$).</p> <p>Regression analysis, controlling for reported medicines for mental health problems and engagement in counselling, found no statistically significant change from baseline in transfemales ($p = 0.27$) and transmales ($p = 0.43$).</p> <p>The Patient Health Questionnaire Modified for Teens (PHQ 9_Modified for Teens) was also used to assess depression symptoms. Depression scores improved from baseline ($p < 0.001$; absolute scores not reported numerically).</p> <p>Regression analysis, controlling for reported medicines for mental health problems and engagement in counselling, found no statistically significant change from baseline in transfemales ($p = 0.07$) and transmales ($p = 0.67$).</p> <p>Suicidal ideation measured using the additional questions from the PHQ 9_Modified for Teens, was presented in 10% (5/50) of</p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> b) somewhat representative c) no-non exposed cohort a) secure record b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> c) no comparator <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> c) self-report a) yes – 6 monthly assessment up to 12 months (preliminary results from an ongoing study) c) Follow up rate less than 80% and no description of those lost <p>Overall quality is assessed as poor</p> <p>Other comments: Although regression analysis results for some outcomes were controlled for use of medicines for mental health problems,</p>

<p>intervention to help with gender dysphoria.</p> <p>Study dates Study recruitment ran from December 2013 to December 2018; study is ongoing</p>	<p>17 transfemales and 33 transmales.</p> <p>Diagnostic criteria for gender dysphoria not reported.</p> <p>Mean age at baseline was 16.2 years (SD 2.2).</p> <p>Mean age at the start of gender-affirming hormone treatment not reported.</p>	<p>Transgender Health (WPATH) guidelines.</p> <p>Puberty suppression was:</p> <ul style="list-style-type: none"> GnRH agonist and/or anti-androgens (transfemales) GnRH agonist or medroxyprogesterone (transmales) <p>Average duration of GnRH analogue treatment not reported.</p> <p>Once eligible, gender-affirming hormones were offered, these were:</p> <ul style="list-style-type: none"> Oestradiol (transfemales) Testosterone (transmales) <p>Doses and route of administration not reported.</p> <p>After about 12-months treatment ('wave 3' in the study):</p> <ul style="list-style-type: none"> 24 people (48%) were on gender-affirming hormones alone 12 people (24%) were on puberty suppression alone 	<p>participants at baseline and 6% (3/50) at about 12-month follow-up, no statistical analysis reported.</p> <p>The study also reported results by gender:</p> <p>In transfemales, 11.8% (2/17) had suicidal ideation at baseline compared with 5.9% (1/17) at 12-month follow-up (no statistically analysis reported)</p> <p>In transmales, 9.1% (3/33) had suicidal ideation at baseline compared with 6.1% (2/33) at 12-month follow-up (no statistically analysis reported)</p> <p>Impact on quality of life</p> <p>Quality of Life Enjoyment and Satisfaction Questionnaire (QLES-Q-SF) scores: there was no statistically significant change in score from baseline to about 12-months ($p=0.085$; absolute scores not reported numerically).</p> <p>Regression analysis, controlling for reported medicines for mental health problems and engagement in counselling, found not statistically significant change from baseline in transfemales ($p=0.06$) and transmales ($p=0.08$).</p> <p><i>No other critical or important outcomes reported</i></p>	<p>details of these is not reported. Other co-morbidities not reported.</p> <p>Source of funding: None</p>
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Study details	Population	Interventions	Study outcomes	Appraisal and Funding
		<ul style="list-style-type: none"> 11 people (22%) were on both gender-affirming hormones and puberty suppression 3 people (6%) were on no endocrine intervention <p>Results not represented separately for the subgroup of people who received gender-affirming hormones.</p> <p>Average duration of treatment with gender-affirming hormones not reported.</p> <p>Comparison</p> <p>No comparison group. Change overtime reported.</p>		

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Allen, LR, Watson, LB, Egan, AM et al. (2019) Well-being and suicidality among transgender youth after gender-affirming hormones. Clinical Practice in Pediatric</p>	<p>The study included adolescents and young adults (age range 13-20 years) who received services for gender dysphoria in a clinic in the United States. Participants were required to have received gender-</p>	<p>39 participants received gender-affirming hormones only</p> <p>8 participants received a GnRH analogue followed by gender-affirming hormones.</p>	<p>Critical Outcomes Impact on mental health The Ask Suicide-Screening Questions (ASQ) instrument was used to assess suicidality. Following an average of about 12 months treatment with gender-affirming hormones, adjusted mean ASQ score was statistically significantly lower (from 1.11 [standard error</p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain 1. b) somewhat representative 2. c) no-non exposed cohort</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Psychology 7(3): 302-311</p> <p>Study location Single centre, Kansas City, United States</p> <p>Study type Retrospective longitudinal study</p> <p>Study aim To examine suicidality and general well-being following administration of gender-affirming hormones.</p> <p>Study dates Participants first presented to the clinic between 2015 and 2018.</p>	<p>affirming hormones for at least 3 months, and have pre-test and final assessment data points. No exclusion criteria reported.</p> <p>In total 47 adolescents and young adults with gender dysphoria were included: 14 transfemales (sex assigned at birth male) and 33 transmales (sex assigned at birth female).</p> <p>Diagnostic criteria for gender dysphoria not reported.</p> <p>Mean age at pre-test (before administration of gender-affirming hormones) was 16.59 years (range 13.73 to 19.04).</p> <p>Mean age at the start of treatment in the sub-group who received gender-affirming hormones-only was 16.72 years.</p> <p>Mean age at the start of treatment with gender-affirming hormones in people who previously</p>	<p>Mean duration of treatment in the gender-affirming hormones only subgroup was 366 days.</p> <p>Mean duration of gender-affirming hormone treatment in people who had previously received a GnRH analogue was not reported.</p> <p>Mean duration of treatment with a GnRH analogue was not reported.</p> <p>Participants were assessed at the start of treatment and at least 3 months after treatment.</p>	<p>(SE) 0.22] at baseline to 0.27 [SE 0.12] at final assessment; $p < 0.001$).</p> <p>The authors also reported change in ASQ separately for transfemales (from 1.21 [SE 0.36] at baseline to 0.24 [SE 0.19] at final assessment) and transmales (from 1.01 [SE 0.36] at baseline to 0.29 [0.13] at final assessment). There was no statistically significant difference in change from baseline between transfemales and transmales ($p = 0.79$)</p> <p>Impact on quality of life Assessed using the General Well-Being Scale (GWBS) of the Pediatric Quality of Life Inventory. Following an average of about 12 months treatment with gender-affirming hormones, adjusted mean GWBS score was statistically significantly higher (from 61.7 [SE 2.43] at baseline to 70.23 [2.15] at final assessment; $p < 0.002$).</p> <p>The authors also reported change in GWBS of the Pediatric Quality of Life Inventory for transfemales (from 58.44 [SE 4.09] at baseline to 69.52 [SE 3.62] at final assessment) and transmales (from 64.95 [SE 2.66] at baseline to 70.94 [2.35] at final assessment). There was no statistically significant difference in change from baseline between transfemales and transmales ($p = 0.32$)</p> <p><i>No other critical or important outcomes reported</i></p>	<p>3. a) secure record 4. b) no</p> <p>Domain 2: Comparability 2. c) no comparator</p> <p>Domain 3: Outcome 1. b) record linkage 2. a) yes – mean duration of treatment was 366 days 3. a) complete follow up - all subjects accounted for</p> <p>Overall quality is assessed as poor</p> <p>Other comments: None</p> <p>Source of funding: Not reported</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
	received a GnRH analogue was not reported.			

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Kaltiala, R., Heino, E., Tyolajarvi, M. et al. (2020) Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. Nordic Journal of Psychiatry 74(3): 213-219</p> <p>Study location Single centre, Tampere, Finland</p> <p>Study type Retrospective chart review</p> <p>Study aim To evaluate the psychosocial functioning and need for mental health treatment during the gender identity diagnostic phase and after about</p>	<p>The study included adolescents who were referred to the gender identity service before they 18 years old, were diagnosed with gender dysphoria, received gender-affirming hormones and completed a follow-up of approximately 12 months after starting hormones.</p> <p>In total 52 adolescents were included, comprising of 11 transfemales and 41 transmales.</p> <p>Gender dysphoria was diagnosed according to International Classification of Disease 10 (ICD-10). The authors state that the corresponding diagnosis to 'gender dysphoria' in</p>	<p>Intervention referred to as 'hormonal sex reassignment treatment' – details of intervention not reported, although gender-affirming hormones were prescribed to all participants. It is not clear from the study whether additional interventions were prescribed.</p> <p>Medical records reviewed for the 'real-life phase' – the approximately 12 months follow-up period for this population in Finland.</p>	<p>Critical Outcomes <i>Impact on mental health</i></p> <p>Of the 52 people who received gender-affirming hormones, 50% (26/52) needed mental health treatment before or during the assessment and 46% (24/51) needed mental health treatment during the 12-month 'real life' phase (no statistically significant difference).</p> <p>For specific symptoms / conditions:</p> <ul style="list-style-type: none"> • depression: 54% (28/52) needed treatment before or during the assessment and 15% (8/52) needed treatment during the 12-month 'real life' phase (statistically significant reduction, $p<0.001$) • anxiety: 48% (25/52) needed treatment before or during the assessment and 15% (8/52) needed treatment during the 12-month 'real life' phase (statistically significant reduction, $p<0.001$) • suicidality/self-harm: 35% (18/52) needed treatment before or during the assessment and 4% (2/52) needed treatment during the 12-month 'real life' phase (statistically significant reduction, $p<0.001$) • conduct problems/antisocial: 14% (7/52) needed treatment before or during the 	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> 1. b) somewhat representative 2. c) no-non exposed cohort 3. a) secure record 4. b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> 1. c) cohorts are not comparable on the basis of the design or analysis controlled for confounders <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> 1. b) record linkage 2. a) yes – 12 month follow-up 3. a) complete follow up - all subjects accounted for <p>Overall quality is assessed as poor</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>a year on gender-affirming hormones.</p> <p>Study dates 2011 to 2017</p>	<p>the ICD-10 is 'transsexualism'.</p> <p>Mean age at diagnosis 18.1 years (range 15.2 to 19.9)</p>		<p>assessment and 6% (3/52) needed treatment during the 12-month 'real life' phase (no statistically significant difference, $p = 0.18$)</p> <ul style="list-style-type: none"> • psychotic symptoms/psychosis: 2% (1/52) needed treatment before or during the assessment and 4% (2/52) needed treatment during the 12-month 'real life' phase (no statistically significant difference, $p = 0.56$) • substance abuse: 4% (2/52) needed treatment before or during the assessment and 2% (1/52) needed treatment during the 12-month 'real life' phase (no statistically significant difference, $p = 0.56$) • autism: 12% (6/52) needed treatment before or during the assessment and 6% (3/52) needed treatment during the 12-month 'real life' phase (no statistically significant difference, $p = 0.30$) • ADHD: 10% (5/52) needed treatment before or during the assessment and 2% (1/52) needed treatment during the 12-month 'real life' phase (no statistically significant difference, $p = 0.09$) • eating disorder: 2% (1/52) needed treatment before or during the assessment and 2% (1/52) needed treatment during the 12-month 'real life' phase (no statistically significant difference, $p = 1.0$). <p>No details of actual treatment reported.</p> <p>Important Outcomes <i>Psychosocial Impact</i> Study reported on measures of functioning in different domains of adolescent development,</p>	<p>Other comments: None</p> <p>Source of funding: No source of funding reported</p>

			<p>reported over the approximately 12-month period after starting gender-affirming hormones (referred to as the 'real-life phase' in Finland)</p> <p>Significantly fewer participants were living with parent(s)/ guardians during the real-life phase (40%; 21/50) compared with during gender identity assessment (73%; 38/52; $p=0.001$))</p> <p>There was a statistically significant reduction in the number of participants with normative peer contacts, from gender identity assessment (89%; 46/52) to the real-life phase (81%; 42/52; $p<0.001$).</p> <p>There was no significant difference in the number of participants who were progressing normally in school or work during gender identity assessment (64%; 33/52) compared with the real-life phase (60%; 31/52).</p> <p>There was no significant difference in the number of participants who have been dating or were in steady relationships during gender identity assessment (62%; 32/50) compared with the real-life phase (58%; 30/52).</p> <p>There was no significant difference in the number of participants who were able to deal with matters outside of the home in an age-appropriate manner during gender identity assessment (81% (42/52) compared with the real-life phase (81%; 42/52)</p>	
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Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			No other critical or important outcomes reported	

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Khatchadourian K, Amed S, Metzger DL (2014) Clinical management of youth with gender dysphoria in Vancouver. The Journal of pediatrics 164(4): 906-11</p> <p>Study location Single centre study, Vancouver, Canada</p> <p>Study type Retrospective chart review</p> <p>Study aim To describe the patient characteristics, clinical management, and response to treatment in a cohort of people seen in a single clinic.</p> <p>Study dates 1998 to 2011</p>	<p>Inclusion criteria were at least Tanner stage 2 pubertal development, previous assessment by a mental health professional and a confirmed diagnosis of gender dysphoria (diagnostic criteria not specified). No exclusion criteria are specified.</p> <p>63 children, adolescents and young people with gender dysphoria who started gender-affirming hormones, out of 84 young people seen in the unit between 1998 and 2011. 39 transfemales and 24 transmales.</p> <p>Diagnostic criteria for gender dysphoria not reported.</p> <p>Mean age at the start of gender-affirming hormone treatment was 17.4 years (SD 1.9).</p>	<p>Intervention Transfemales: Oestrogen (oral micronized 17β-oestradiol) Transmales: Testosterone (injectable testosterone enanthate and/or cypionate)</p> <p>19 participants (30%) had previously received a GnRH analogue. The median time from start of GnRH analogue to start of gender-affirming hormones was 11.3 months (range 2.2 to 42.0). 11 participants continued GnRH analogues after starting gender-affirming hormones.</p> <p>Average duration of treatment with a GnRH analogue not reported</p> <p>Comparison No comparator</p>	<p>Critical Outcomes No critical outcomes assessed.</p> <p>Important outcomes</p> <p>Safety Of the 63 participants who received gender-affirming hormones:</p> <ul style="list-style-type: none"> No participants permanently discontinued gender-affirming hormones 3 participants (5%) temporarily discontinued treatment: <ul style="list-style-type: none"> 2 transmales due to concomitant mental health comorbidities 1 transmale due to androgenic alopecia. No transfemale stopped treatment. <p>The authors report that all patients eventually restarted gender-affirming hormones, although they do not report how long treatment was</p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> b) somewhat representative c) no-non exposed cohort a) secure record* b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> c) cohorts are not comparable on the basis of the design or analysis controlled for confounders <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> b) record linkage b) no – although follow-up time is reported for patients with more than 1 clinic visit, duration of treatment with gender-affirming hormones is not reported c) incomplete - missing data <p>Overall quality is assessed as poor</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>stopped for, or what the effect of stopped treatment was.</p> <ul style="list-style-type: none"> No participants reported major complications 12 participants (19%) had minor complications: <ul style="list-style-type: none"> 7 transmales had severe acne (requiring isotretinoin) 1 transmale had androgenic alopecia 3 transmales had mild dyslipidaemia (levels not reported) 1 transmale had significant mood swings No transfemales had minor complications 	<p>Other comments: Mental health comorbidity was reported for all participants but not for the gender-affirming hormone cohort separately. Concomitant use of other medicines was not reported.</p> <p>Source of funding: No source of funding identified.</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Klaver, Maartje, de Mutsert, Renee, van der Loos, Maria A T C et al. (2020) Hormonal Treatment and Cardiovascular Risk Profile in Transgender Adolescents. Pediatrics 145(3)</p> <p>Study location Single centre, Amsterdam, Netherlands</p>	<p>Participants were included if i) they had started GnRH analogue treatment before 18 years, ii) if whole body dual-energy radiograph absorptiometry was performed at least once during treatment (4 months before or after the start of GnRH analogues or gender-affirming hormones, or</p>	<p>Transfemales: Oestrogen (17-β oestradiol [E2]) orally, starting with 5 mcg/kg body weight per day, which was increased every 6 months until the maintenance dose of 2 mg per day was reached.</p> <p>Transmales: mixed testosterone esters (Sustanon), 25 mg/m² body surface area every 2 weeks intramuscularly,</p>	<p>Critical Outcomes</p> <p>No critical outcomes assessed.</p> <p>Important outcomes</p> <p>Safety Safety outcomes reported separately for transfemales and transmales.</p> <p>For transfemales, from the start of gender-affirming hormone treatment to age 22 years:</p> <ul style="list-style-type: none"> Mean BMI statistically significantly increased (mean change +1.9, 95% CI 0.6 to 3.2, p<0.005; mean BMI at 	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> b) somewhat representative c) no-non exposed cohort a) secure record* b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> c) cohorts are not comparable on the basis

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Study type Retrospective chart review</p> <p>Study aim To examine the effects of treatment on changes in cardiovascular risk factors, including BMI, blood pressure, insulin sensitivity, and lipid levels.</p> <p>Study dates 1998-2015</p>	<p>within 1.5 years before or after the 22nd birthday), iii) if they were likely to have had at least 1 medical consultation in young adulthood.</p> <p>The study included 192 young people with dysphoria who met the above inclusion criteria: 71 transfemales and 121 transmales.</p> <p>Gender dysphoria was diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria.</p> <p>Mean age at the start of gender-affirming hormones was 16.4 years (SD 1.1) for transfemales and 16.9 years (SD 0.9) for transmales.</p>	<p>increased every 6 months to maintenance dose of 250 mg every 3 to 4 weeks.</p> <p>When GnRH analogues were started after the age of 16 years a different hormone starter dose was used (1 mg oestrogen daily and 75 mg testosterone weekly).</p> <p>Median (IQR) duration of GnRH analogue (monotherapy) was 2.1 years (1.0 to 2.7) in transfemales and 1.0 (0.5 to 2.9) for transmales.</p>	<p>22 years= 23.2, 95% CI 21.6 to 24.8). At age 22 years, 9.9% of the cohort were obese, compared with 3.0% in reference cisgender population¹.</p> <ul style="list-style-type: none"> • Mean systolic blood pressure (SBP) did not significantly change (mean change - 3 mmHg, 95% CI -8 to 2; mean SBP at 22 years= 117 mmHg, 95% CI 113 to 122) • Mean diastolic blood pressure (DBP) statistically significantly increased (mean change +6 mmHg, 95% CI 3 to 10, $p < 0.001$; mean DBP at 22 years= 75 mmHg, 95% CI 72 to 78) • Mean glucose level did not significantly change (mean change +0.1 mmol/L, 95% CI -0.1 to 0.2; mean glucose level at 22 years= 5.0 mmol/L, 95% CI 4.8 to 5.1) • Mean insulin level did not significantly change (mean change +2.7 mU/L, 95% CI -1.7 to 7.1; mean insulin level at 22 years= 5.0 mU/L (4.8 to 5.1)) • Insulin resistance (mean Homeostatic Model Assessment of Insulin Resistance [HOMA-IR]) did not significantly change (mean change +0.7, 95% CI -0.2 to 1.5; mean HOMA-IR at 22 years 2.9, 95% CI 1.9 to 3.9) • Mean total cholesterol did not significantly change (mean change +0.1 mmol/L, 95% CI -0.2 to 0.4; mean total cholesterol at 22 years 4.1 mmol/L, 95% CI 3.8 to 4.4) • Mean HDL cholesterol did not significantly change (mean change +0.0 mmol/L, 95% CI -0.1 to 0.2; mean HDL cholesterol at 22 years 1.6 mmol/L, 95% CI 1.4 to 1.7) • Mean LDL cholesterol did not significantly change (mean change +0.0 mmol/L, 95% 	<p>of the design or analysis controlled for confounders</p> <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> 1. b) record linkage 2. a) yes- follow-up from start of gender-affirming hormones to age 22 years, around 5 years 3. a) complete follow up - all subjects accounted for <p>Overall quality is assessed as poor</p> <p>Other comments: None</p> <p>Source of funding: No external funding</p>

			<p>CI -0.3 to 0.2; mean LDL cholesterol at 22 years 2.0 mmol/L, 95% CI 1.8 to 2.3)</p> <ul style="list-style-type: none"> • Mean triglycerides statistically significantly increased (mean change +0.2 mmol/L, 95% CI 0.0 to 0.5, $p < 0.05$; triglyceride level at 22 years 1.1 mmol/L, 95% CI 0.9 to 1.4) <p>For transmales, from the start of gender-affirming hormone treatment to age 22 years:</p> <ul style="list-style-type: none"> • Mean BMI statistically significantly increased (mean change +1.4, 95% CI 0.8 to 2.0, $p < 0.005$; mean BMI at 22 years = 23.9, 95% CI 23.0 to 24.7). At age 22 years, 6.6% of the cohort were obese, compared with 2.2% in reference cisgender population¹. • Mean systolic blood pressure (SBP) statistically significantly increased (mean change +5 mmHg, 95% CI 1 to 9; mean SBP at 22 years = 126 mmHg, 95% CI 122 to 130) • Mean diastolic blood pressure (DBP) statistically significantly increased (mean change +6 mmHg, 95% CI 4 to 9, $p < 0.001$; mean DBP at 22 years = 74 mmHg, 95% CI 72 to 77) • Mean glucose level did not significantly change (mean change 0.0 mmol/L, 95% CI -0.2 to 0.2; mean glucose level at 22 years = 4.8 mmol/L, 95% CI 4.7 to 5.0) • Mean insulin level statistically significantly decreased (mean change -2.1 mU/L, 95% CI -3.9 to -0.3, $p < 0.05$; mean insulin level at 22 years = 8.6 mU/L (6.9 to 10.2) • Insulin resistance (mean Homeostatic Model Assessment of Insulin Resistance [HOMA-IR]) statistically significantly 	
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Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>decreased (mean change -0.5, 95% CI -1.0 to -0.1, $p < 0.05$; mean HOMA-IR at 22 years 1.8, 95% CI 1.4 to 2.2)</p> <ul style="list-style-type: none"> • Mean total cholesterol statistically significantly increased (mean change +0.4 mmol/L, 95% CI 0.2 to 0.6, $p < 0.001$; mean total cholesterol at 22 years 4.6 mmol/L, 95% CI 4.3 to 4.8) • Mean HDL cholesterol statistically significantly decreased (mean change -0.3 mmol/L, 95% CI -0.4 to -0.2, $p < 0.001$; mean HDL cholesterol at 22 years 1.3 mmol/L, 95% CI 1.2 to 1.3) • Mean LDL cholesterol statistically significantly increased (mean change +0.4 mmol/L, 95% CI 0.2 to 0.6, $p < 0.001$; mean LDL cholesterol at 22 years 2.6 mmol/L, 95% CI 2.4 to 2.8) • Mean triglycerides statistically significantly increased (mean change +0.5 mmol/L, 95% CI 0.3 to 0.7, $p < 0.001$; triglyceride level at 22 years 1.3 mmol/L, 95% CI 1.1 to 1.5) 	

¹ Reference population taken from [Fredriks et al. \(2000\)](#)

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Klink D, Caris M, Heijboer A et al. (2015) Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. The Journal of Clinical Endocrinology and Metabolism 100(2): e270-5</p> <p>Study location Single centre, Amsterdam, Netherlands</p> <p>Study type Retrospective longitudinal study</p> <p>Study aim To assess peak bone mass in young adults with gender dysphoria who had received GnRH analogues and gender-affirming hormones during their pubertal years.</p> <p>Study dates</p>	<p>34 young people with gender dysphoria who received GnRH analogues, gender-affirming hormones and gonadectomy.</p> <p>The study included 15 transfemales and 19 transmales; mean age at start of gender-affirming hormones was 16.6 years (SD 1.4) and 16.4 years (SD 2.3) respectively.</p> <p>Participants were required to meet the DSM-IV-TR criteria for gender identity disorder of adolescence. Participants were included if they had undergone gonadectomy between June 1998 and August 2012, and they were at least 21 years old when they had the surgery. Bone mineral density data were also required at the start of GnRH analogue, gender-affirming hormones and at the age of 22 years.</p> <p>No concomitant treatments were reported.</p>	<p>Intervention</p> <p>Transfemales - oral 17-β oestradiol (incremental dosing)</p> <p>Transmales – IM testosterone (Sustanon 250 mg/ml; incremental dosing)</p> <p>Median duration of treatment with gender-affirming hormones for transfemales was 5.8 years (range 3.0 to 8.0) and for transmales was 5.4 years (range 2.8 to 7.8).</p> <p>The GnRH analogue was SC triptorelin 3.75 mg every 4 weeks.</p> <p>No details of gonadectomy reported.</p> <p>Comparison</p> <p>No comparison group. Comparison over time reported.</p>	<p>Critical outcomes</p> <p>No critical outcomes reported</p> <p>Important outcomes</p> <p>Safety</p> <p>Bone density: lumbar spine</p> <p>Lumbar spine bone mineral apparent density (BMAD) Change from starting gender-affirming hormones to age 22 years in transfemales-Mean (SD); g/m³</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.22 (0.02) Age 22 years: 0.23 (0.03) p=0.003 <p>z-score (range)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.90 (0.80) Age 22 years: -0.78 (1.03) No statistically significant difference <p>Change from starting gender-affirming hormones to age 22 years in transmales-Mean (SD); g/m³</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.24 (0.02) Age 22 years: 0.25 (0.28) p=0.001 <p>z-score (SD)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.50 (0.81) Age 22 years: -0.033 (0.95) p=0.002 	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> b) somewhat representative c) no-non exposed cohort a) secure record* b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> c) cohorts are not comparable on the basis of the design or analysis controlled for confounders <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> b) record linkage a) yes – mean duration of gender-affirming hormone treatment was 5.8 and 5.4 years. c) follow-up rate variable across timepoints and no description of those lost <p>Overall quality is assessed as poor</p> <p>Other comments: Within person comparison. Small numbers of participants in each subgroup. No</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
Gonadectomy took place between June 1998 and August 2012	At the start of gender-affirming hormone treatment, in the transfemale subgroup the median Tanner P was 4 (IQR 2) and the median Tanner G was 12 (IQR 11). In the transmale subgroup the median Tanner B was 5 (IQR 2) and the median Tanner P was 5 (IQR 0).		<p>Lumbar spine bone mineral density (BMD) Change from starting gender-affirming hormones to age 22 years in transfemales-Mean (SD); g/m²</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.84 (0.11) Age 22 years: 0.93 (0.10) p<0.001 <p>z-score (range)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -1.01 (0.98) Age 22 years: -1.36 (0.83) No statistically significant difference <p>Change from starting gender-affirming hormones to age 22 years in transmales-Mean (SD); g/m²</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.91 (0.10) Age 22 years: 0.99 (0.13) P<0.001 <p>z-score (range)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.72 (0.99) Age 22 years: -0.33 (1.12) No statistically significant difference <p>Bone density: femoral region, nondominant side</p> <p>Femoral region, nondominant side BMAD Change from starting gender-affirming hormones to age 22 years in transfemales-Mean (SD); g/m³</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.26 (0.04) Age 22 years: 0.28 (0.05) 	<p>concomitant treatments or comorbidities were reported.</p> <p>Source of funding: None disclosed</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<ul style="list-style-type: none"> No statistically significant difference z-score (SD) Start of gender-affirming hormones: -1.57 (1.74) Age 22 years: Not reported No statistical analysis reported <p>Change from starting gender-affirming hormones to age 22 years in transmales-Mean (SD); g/m³</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.31 (0.04) Age 22 years: 0.33 (0.05) p=0.010 <p>z-score (SD)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.28 (0.74) Age 22 years: Not reported No statistical analysis reported <p>Femoral region, nondominant side BMD</p> <p>Change from starting gender-affirming hormones to age 22 years in transfemales-Mean (SD); g/m²</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.87 (0.08) Age 22 years: 0.94 (0.11) P=0.009 <p>z-score (SD)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.95 (0.63) Age 22 years: -0.69 (0.74) No statistically significant difference <p>Change from starting gender-affirming hormones to age 22 years in transmales-Mean (SD); g/m²</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.88 (0.09) Age 22 years: 0.95 (0.10) 	

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<ul style="list-style-type: none"> • $P < 0.001$ • z-score (SD) • Start of gender-affirming hormones: -0.35 (0.79) • Age 22 years: -0.35 (0.74) • $p = 0.006$ 	

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Kuper, Laura E, Stewart, Sunita, Preston, Stephanie et al. (2020) Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. Pediatrics 145(4)</p> <p>Study location Single centre, Texas, USA</p> <p>Study type Prospective longitudinal study</p> <p>Study aim To:</p> <ul style="list-style-type: none"> • explore how baseline body dissatisfaction, depression, and anxiety symptoms vary by gender, 	<p>148 children and adolescents with gender dysphoria, n=148, of whom:</p> <ul style="list-style-type: none"> • 25 received puberty suppression only • 93 received gender-affirming hormone therapy only • 30 received both <p>Results for treatments reported separately.</p> <p>Mean age at initial assessment was 15.4 years (range 9 to 18).</p> <p>Mean age at start of gender-affirming hormone therapy was 16.2 years (range 13.2 to 18.6).</p> <p>All participants met the Diagnostic and Statistical</p>	<p>Hormone therapy, guided by Endocrine Society Clinical Practice Guidelines</p> <p>Follow-up at least 18 months from initial assessment at the clinic.</p> <p>Mean duration of gender-affirming hormone therapy before follow-up was 10.9 months (range 1 to 18; SD 3.3)</p>	<p>Critical Outcomes</p> <p>Impact on mental health</p> <p>Mean depression score, assessed using the Quick Inventory of Depressive Symptoms (QIDS), self-reported was 9.6 (SD 5.0) at baseline and 7.4 (SD 4.5) at follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>Mean depression score, assessed using the QIDS, clinician-reported was 5.9 (SD 4.1) at baseline and 6.0 (SD 3.8) at follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>Mean anxiety score, assessed using the Screen for Child Anxiety Related Emotional Disorders (SCARED) questionnaire was 32.6 (SD 16.3) at baseline and 28.4 (SD 15.9) at</p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> 1. b) somewhat representative 2. c) no-non exposed cohort 3. a) secure record 4. b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> 1. c) cohorts are not comparable on the basis of the design or analysis controlled for confounders <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> 1. d) assessors not blinded to treatment 2. a) yes – follow-up at least 18 months from initial assessment. Mean duration of gender-affirming hormone

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>age at initial assessment, and Tanner stage at first medical visit</p> <ul style="list-style-type: none"> examine how body dissatisfaction, depression, and anxiety symptoms change over the first year of gender-affirming hormone treatment explore how any changes vary by affirmed gender, Tanner stage, age, type of treatment, months on gender-affirming hormone therapy, mental health treatment received, and whether chest surgery was also obtained (among transmales). <p>Study dates Initial participant assessments took place between August 2014 and March 2018.</p>	<p>Manual of Mental Disorders, Fifth Edition criteria for gender dysphoria.</p> <p>Specific inclusion and exclusion criteria for the study are not reported. It would appear that all children and adolescents eligible for gender-affirming hormones were considered eligible for the study. The authors state that before initial assessment with a psychologist, psychiatrist, and/or clinical therapist, parents completed a phone intake survey. Around one-third of families did not follow-up after the phone intake.</p>		<p>follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>Mean panic score, assessed using specific questions from the SCARED questionnaire was 8.1 (SD 6.3) at baseline and 7.1 (SD 6.5) at follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>Mean generalised anxiety score, assessed using specific questions from the SCARED questionnaire was 10.0 (SD 5.1) at baseline and 8.8 (SD 6.5) at follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>Mean social anxiety score, assessed using specific questions from the SCARED questionnaire was 8.5 (SD 4.1) at baseline and 7.7 (SD 4.2) at follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>Mean separation anxiety score, assessed using specific questions from the SCARED</p>	<p>treatment was 10.9 months.</p> <p>3. c) patient numbers vary by outcome with no explanation</p> <p>Overall quality is assessed as poor</p> <p>Other comments: None</p> <p>Source of funding: Supported by Children's Health. The Research Electronic Data Capture database was funded by the Clinical and Translational Science Awards program</p>

			<p>questionnaire was 3.5 (SD 3.0) at baseline and 3.1 (SD 2.5) at follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>Mean school avoidance score, assessed using specific questions from the SCARED questionnaire was 2.6 (SD 2.1) at baseline and 2.0 (SD 2.0) at follow-up. The authors did not present statistical analysis for the sub-group of participants receiving gender-affirming hormones and it is unclear whether the change in score was statistically significant.</p> <p>The authors also reported results separately for transfemales and transmales:</p> <p>Transfemales No statistical analyses were reported for this sub-group and it is unclear whether any changes in score were statistically significant.</p> <ul style="list-style-type: none"> • Mean depression symptoms, assessed using the QIDS, self-reported was 7.5 (SD 4.9) at baseline and 6.6 (SD 4.4) at follow-up. • Mean depression symptoms, assessed using the QIDS, clinician-reported was 4.2 (SD 3.2) at baseline and 5.4 (SD 3.4) at follow-up. • Mean anxiety symptoms, assessed using the SCARED questionnaire was 26.4 (SD 14.2) at baseline and 24.3 (SD 15.4) at follow-up. 	
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			<ul style="list-style-type: none"> • Mean panic symptoms, assessed using specific questions from the SCARED questionnaire was 5.7 (SD 4.9) at baseline and 5.1 (SD 4.9) at follow-up. • Mean generalised anxiety symptoms, assessed using specific questions from the SCARED questionnaire was 8.6 (SD 5.1) at baseline and 8.0 (SD 5.1) at follow-up. • Mean social anxiety symptoms, assessed using specific questions from the SCARED questionnaire was 7.1 (SD 3.9) at baseline and 6.8 (SD 4.4) at follow-up. • Mean separation anxiety symptoms, assessed using specific questions from the SCARED questionnaire was 3.4 (SD 3.3) at baseline and 2.7 (SD 2.3) at follow-up. • Mean school avoidance symptoms, assessed using specific questions from the SCARED questionnaire was 1.8 (SD 1.7) at baseline and 1.9 (SD 2.1) at follow-up. <p>Transmales No statistical analyses were reported for this sub-group and it is unclear whether any changes in score were statistically significant.</p> <ul style="list-style-type: none"> • Mean depression symptoms, assessed using the QIDS, self-reported was 10.4 (SD 5.0) at baseline and 7.5 (SD 4.5) at follow-up. • Mean depression symptoms, assessed using the QIDS, clinician-reported was 6.7 (SD 4.4) at baseline and 6.2 (SD 4.1) at follow-up. • Mean anxiety symptoms, assessed using the SCARED questionnaire was 35.4 (SD 	
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			<p>16.5) at baseline and 29.8 (SD 15.5) at follow-up.</p> <ul style="list-style-type: none"> • Mean panic symptoms, assessed using specific questions from the SCARED questionnaire was 9.3 (SD 6.5) at baseline and 7.9 (SD 6.5) at follow-up. • Mean generalised anxiety symptoms, assessed using specific questions from the SCARED questionnaire was 10.4 (SD 5.0) at baseline and 9.0 (SD 5.1) at follow-up. • Mean social anxiety symptoms, assessed using specific questions from the SCARED questionnaire was 8.5 (SD 4.0) at baseline and 7.8 (SD 4.1) at follow-up. • Mean separation anxiety symptoms, assessed using specific questions from the SCARED questionnaire was 4.2 (SD 3.4) at baseline and 3.4 (SD 2.6) at follow-up. • Mean school avoidance symptoms, assessed using specific questions from the SCARED questionnaire was 2.6 (SD 2.1) at baseline and 2.0 (SD 2.0) at follow-up. <p>No difference in impact on mental health found by Tanner age. Numerical results, statistical analysis and information on specific outcomes not reported. It is unclear from the paper whether Tanner age is at initial assessment, start of GnRH analogues, start of gender-affirming hormones, or another timepoint.</p> <p>Important Outcomes <i>Impact on body image</i></p>	
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Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>Mean Body Image Scale (BIS) score was 70.7 (SD 15.2) at baseline and 51.4 (SD 18.3) at follow-up. The authors do not present statistical analysis for this population and it is unclear whether the change in score was statistically significant.</p> <p>The authors also reported body image results separately for transfemales and transmales. No statistical analyses were reported for this sub-groups and it is unclear whether changes in score were statistically significant.</p> <ul style="list-style-type: none"> • In transfemales, BIS score was 67.5 (SD 19.5) at baseline and 49.0 (SD 21.6) at follow-up. • In transmales, BIS score was 71.1 (SD 13.4) at baseline and 52.9 (SD 16.8) at follow-up. <p>No difference in body image score found by Tanner age. Numerical results, statistical analysis and information on specific outcomes not reported. It is unclear from the paper whether Tanner age is at initial assessment, start of GnRH analogues, start of gender-affirming hormones, or another timepoint.</p> <p><i>No other critical or important outcomes reported</i></p>	

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Study dates Lopez de Lara, D., Perez Rodriguez, O., Cuellar Flores, I. et al. (2020) Psychosocial assessment in transgender adolescents. <i>Anales de Pediatria</i></p> <p>Study location Single centre in Madrid, Spain</p> <p>Study type Prospective analytical study</p> <p>Study aim To assess the psychosocial status of patients seeking care in the paediatric endocrinology clinic for gender dysphoria, and the impact on psychosocial status of gender-affirming hormone therapy at 12 months of treatment</p> <p>Study dates Not reported</p>	<p>23 adolescents with gender dysphoria; 16 transmale and 7 transfemale.</p> <p>Participants were required to be at a stage of pubertal development of Tanner 2 or higher. People with mental health comorbidity that could affect the experience of gender dysphoria were excluded.</p> <p>Mean age at baseline was 16 years (range 14 to 18).</p> <p>30 cisgender controls, matched for age, ethnicity, and socioeconomic status</p>	<p>Gender-affirming hormones-</p> <ul style="list-style-type: none"> • Oral oestradiol • Intramuscular testosterone <p>Participants had previously received gonadotropin-releasing hormone (GnRH) analogues in the intermediate pubertal stages (Tanner 2---3).</p>	<p>Critical Outcomes</p> <p>Impact on gender dysphoria Following gender-affirming hormones for 12 months, mean (\pmSD) Utrecht Gender Dysphoria Scale (UGDS) score statistically significantly improved, from 57.1 (\pm4.1) at baseline to 14.7 (\pm3.2; $p < 0.001$)</p> <p>Impact on mental health Mean depression score statistically significantly improved following treatment with gender-affirming hormones. Mean Beck Depression Inventory II (BDI-II) score (\pmSD) reduced from 19.3 points (\pm5.5) at baseline to 9.7 points (\pm3.9) at 12 months ($p < 0.001$).</p> <p>Mean anxiety scores statistically significantly improved following treatment with gender-affirming hormones. Mean (\pmSD) State-Trait Anxiety Inventory (STAI) State subscale score improved from 33.3 points (\pm9.1) at baseline to 16.8 points (\pm8.1) at 12 months ($p < 0.001$). Mean (\pmSD) State-Trait Anxiety Inventory (STAI) Trait subscale score improved from 33.0 points (\pm7.2) at baseline to 18.5 points (\pm8.4) at 12 months ($p < 0.001$).</p> <p>Important Outcomes</p> <p>Psychosocial Impact There was not change in family functioning, measured using the Family APGAR test, from baseline (17.9 points) to 1 year after starting</p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> 1. b) somewhat representative 2. Not applicable – although a control group is reported on, people in this group did not have gender dysphoria. 3. a) secure record* 4. b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> 1. Not applicable – although a control group is reported on, people in this group did not have gender dysphoria. <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> 1. d) assessors not blinded to treatment 2. a) yes – 12 months treatment with gender-affirming hormones 3. a) complete follow up - all subjects accounted for <p>Overall quality is assessed as poor</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>gender-affirming hormones (18.0 points; no statistical analysis reported).</p> <p>Results from the Strengths and Difficulties Questionnaire, Spanish Version (SDQ-Cas) showed statistically significant improvements from baseline (14.7 points; SD±3.3) to 12 months after gender-affirming hormones (10.3 points; SD±2.9; $p<0.001$)</p> <p><i>No other critical or important outcomes reported</i></p>	<p>Other comments: None</p> <p>Source of funding: Not reported</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Stoffers, Iris E; de Vries, Martine C; Hannema, Sabine E (2019) Physical changes, laboratory parameters, and bone mineral density during testosterone treatment in adolescents with gender dysphoria. The journal of sexual medicine 16(9): 1459-1468</p> <p>Study location Single centre, Leiden, Netherlands</p> <p>Study type Retrospective chart review</p> <p>Study aim To report changes in height, BMI, blood pressure, laboratory parameters and bone density.</p> <p>Study dates November 2010 to August 2018</p>	<p>62 transmales with gender dysphoria. participants were required to have been receiving testosterone therapy for at least 6 months. Further inclusion or exclusion criteria not reported.</p> <p>Gender dysphoria was diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition criteria.</p>	<p>Testosterone intramuscular injection (Sustanon 250 mg). Dose escalated every 6 months up to the standard adult dose of 125 mg every 2 weeks or 250 mg every 3-4 weeks. A more rapid dose escalation was using in patients who started GnRH analogue treatment at 16 years or older.</p> <p>Median age at start of testosterone treatment was 17.2 years (range 14.9 to 18.4)</p> <p>Median duration of testosterone treatment was 12 months (range 5 to 33)</p> <p>Median duration of GnRH analogue treatment was 8 months (range 3 to 39)</p>	<p>Critical Outcomes</p> <p>No critical outcomes assessed.</p> <p>Important outcomes</p> <p>Safety</p> <p>Bone mineral density (BMD): lumbar spine There was no statistically significant difference in lumbar spine bone mineral density (BMD) from start of testosterone treatment to any timepoint, up to 24 months follow-up. Mean (\pmSD), g/cm²:</p> <ul style="list-style-type: none"> Start of testosterone: 0.90 (\pm0.11) 6 months: 0.94 (\pm0.10) 12 months: 0.95 (\pm0.09) 24 months: 0.95 (\pm0.11) <p>z-score (\pmSD):</p> <ul style="list-style-type: none"> Start of testosterone: -0.81 (\pm1.02) 6 months: -0.67 (\pm0.95) 12 months: -0.66 (\pm0.81) 24 months: -0.74 (\pm1.17) <p>Bone mineral density (BMD): femoral neck (hip) There was no statistically significant difference in right or left femoral neck (hip) bone mineral density (BMD) from start of</p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p> <ol style="list-style-type: none"> b) somewhat representative c) no-non exposed cohort a) secure record* b) no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> c) cohorts are not comparable on the basis of the design or analysis controlled for confounders <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> b) record linkage a) yes – mean duration of gender-affirming hormone treatment was 5.8 and 5.4 years. a) complete follow up - all subjects accounted for <p>Overall quality is assessed as poor</p> <p>Other comments: None</p> <p>Source of funding: None</p>

			<p>testosterone treatment to any timepoint, up to 24 months follow-up.</p> <p>Right</p> <p>Mean (\pmSD), g/cm²:</p> <ul style="list-style-type: none"> • Start of testosterone: 0.77 (\pm0.08) • 6 months: 0.84 (\pm0.11) • 12 months: 0.82 (\pm0.08) • 24 months: 0.85 (\pm0.11) <p>z-score (\pmSD):</p> <ul style="list-style-type: none"> • Start of testosterone: -0.97 (0.79) • 6 months: -0.54 (\pm0.96) • 12 months: -0.80 (\pm0.69) • 24 months: -0.31 (\pm0.84) <p>Left</p> <p>Mean (\pmSD), g/cm²:</p> <ul style="list-style-type: none"> • Start of testosterone: 0.76 (\pm0.09) • 6 months: 0.83 (\pm0.12) • 12 months: 0.81 (\pm0.08) • 24 months: 0.86 (\pm0.09) <p>z-score (\pmSD):</p> <ul style="list-style-type: none"> • Start of testosterone: -1.07 (0.85) • 6 months: -0.62 (\pm1.12) • 12 months: -0.93 (\pm0.63) • 24 months: -0.20 (\pm0.70) <p>Other safety-related outcomes</p> <ul style="list-style-type: none"> • Alkaline phosphatase: statistically significant increases observed from start of testosterone treatment to 6 months and 12 months ($p < 0.001$), although difference at 24 months was not statistically significant. Median (IQR), U/L <ul style="list-style-type: none"> ○ Start of testosterone: 102 (78 to 136) ○ 6 months: 115 (102 to 147) ○ 12 months: 112 (88 to 143) ○ 24 months: 81 (range 69 to 98) • Creatinine: statistically significant increases observed from start of 	
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Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>testosterone treatment to 6, 12 and 24 months ($p < 0.001$). Mean (\pmSD), $\mu\text{mol/L}$</p> <ul style="list-style-type: none"> ○ Start of testosterone: 62 (± 7) ○ 6 months: 70 (± 9) ○ 12 months: 74 (± 10) ○ 24 months: 81 (± 10) <p>There was no statistically significant change from start of testosterone treatment in:</p> <ul style="list-style-type: none"> • HbA1c • Aspartate aminotransferase (AST) • Alanine aminotransferase (ALT) • Gamma-glutamyl transferase • Urea <p>Numerical results, follow-up duration and further details of statistical analysis not reported.</p>	

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Full citation Vlot MC, Klink DT, den Heijer M et al. (2017) Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. Bone 95: 11-19</p> <p>Study location Single centre, Amsterdam, Netherlands</p> <p>Study type Retrospective chart review</p> <p>Study aim To investigate the impact of GnRH analogues and gender-affirming hormones on bone mineral apparent density (BMAD) in transgender adolescents. The study also report on levels of bone turnover markers, although the authors concluded that the</p>	<p>70 adolescents with gender dysphoria (42 transmales and 28 transfemales).</p> <p>Median age (range) at the start of gender-affirming hormones was 16.3 years (15.9 to 19.5) for transmales and 16.0 years (14.0 to 18.9) for transfemales.</p> <p>Participants were included if they had a diagnosis of gender dysphoria according to DSM-IV-TR criteria who received GnRH analogues and then gender-affirming hormones.</p> <p>No concomitant treatments were reported.</p> <p>The study categorised participants into a young and old pubertal group, based on their bone age. The young transmales had a bone age of <14 years and the old transmales had a bone age of ≥14 years. The young transfemales</p>	<p>Transfemales: Oestradiol oral Dose escalated every 6 months until standard adult dose of 2 mg daily was reached</p> <p>Transmales: Testosterone intramuscular injection (Sustanon 250 mg). Dose escalated every 6 months up to the standard adult dose of 250 mg every 4 weeks or 250 mg every 3-4 weeks.</p> <p>All participants previously received a GnRH analogue (triptorelin 3.75 mg subcutaneously every 4 weeks)</p> <p>Median duration of GnRH analogue therapy not reported.</p>	<p>Critical outcomes No critical outcomes reported</p> <p>Important outcomes <i>Bone density: lumbar spine</i> Lumbar spine bone mineral apparent density (BMAD) Transfemales (bone age <15 years), change from starting gender-affirming hormones to 24 months follow-up. Median (range), g/m³ <ul style="list-style-type: none"> Start of gender-affirming hormones (C0): 0.20 (0.18 to 0.24) 24-month follow-up (C24): 0.22 (0.19 to 0.27) Statistically significant increase ($p \leq 0.01$) z-score (range) Start of gender-affirming hormones (C0): -1.52 (-2.36 to 0.42) 24-month follow-up (C24): Statistically significant increase ($p \leq 0.05$) </p> <p>Transfemales (bone age ≥15 years), change from starting gender-affirming hormones to 24 months follow-up. Median (range), g/m³ <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.22 (0.19 to 0.24) 24-months: 0.23 (0.21 to 0.26) Statistically significant increase ($p \leq 0.05$) z-score (range) Start of gender-affirming hormones: -1.15 (-2.21 to 0.08) 24-months: -0.66 (-1.66 to 0.54) </p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain <ol style="list-style-type: none"> b) somewhat representative c) no-non exposed cohort a) secure record* b) no </p> <p>Domain 2: Comparability <ol style="list-style-type: none"> c) cohorts are not comparable on the basis of the design or analysis controlled for confounders </p> <p>Domain 3: Outcome <ol style="list-style-type: none"> b) record linkage a) yes- 24 month follow-up a) complete follow up - all subjects accounted for </p> <p>Overall quality is assessed as poor.</p> <p>Other comments: None</p> <p>Source of funding: grant from Abbott diagnostics</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>added value of these seems to be limited.</p> <p>Study dates Participants started gender-affirming therapy between 2001 and 2011</p>	<p>group had a bone age of <15 years and the old transfemales group ≥15 years.</p>		<p>Statistically significant increase ($p \leq 0.05$)</p> <p>Transmales (bone age <14 years), change from starting gender-affirming hormones to 24 months follow-up. Median (range), g/m³</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.23 (0.19 to 0.28) 24-months: 0.25 (0.22 to 0.28) Statistically significant increase ($p \leq 0.01$) <p>z-score (range)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.84 (-2.2 to 0.87) 24-months: -0.15 (-1.38 to 0.94) <p>Statistically significant increase ($p \leq 0.01$)</p> <p>Transmales (bone age ≥14 years), change from starting gender-affirming hormones to 24 months follow-up. Median (range), g/m³</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.24 (0.20 to 0.28) 24-months: 0.25 (0.21 to 0.30) Statistically significant increase ($p \leq 0.01$) <p>z-score (range)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.29 (-2.28 to 0.90) 24-months: -0.06 (-1.75 to 1.61) <p>Statistically significant increase ($p \leq 0.01$)</p> <p>Bone density: femoral neck</p> <p>Femoral neck BMAD</p> <p>Transfemales (bone age <15 years), change from starting gender-affirming hormones to 24 months follow-up.</p>	

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>Median (range), g/m³</p> <ul style="list-style-type: none"> • Start of gender-affirming hormones: 0.27 (0.20 to 0.33) • 24-months: 0.27 (0.20 to 0.36) • No statistically significant change <p>z-score (range)</p> <ul style="list-style-type: none"> • Start of gender-affirming hormones: -1.32 (-3.39 to 0.21) • 24-months: -1.30 (-3.51 to 0.92) • No statistically significant change <p>Transfemales (bone age ≥15 years), change from starting gender-affirming hormones to 24 months follow-up.</p> <p>Median (range), g/m³</p> <ul style="list-style-type: none"> • Start of gender-affirming hormones: 0.30 (0.26 to 0.34) • 24-months: 0.29 (0.24 to 0.38) • No statistically significant change <p>z-score (range)</p> <ul style="list-style-type: none"> • Start of gender-affirming hormones: -0.36 (-1.50 to 0.46) • 24-months: -0.56 (-2.17 to 1.29) • No statistically significant change <p>Transmales (bone age <14 years), change from starting gender-affirming hormones to 24 months follow-up.</p> <p>Median (range), g/m³</p> <ul style="list-style-type: none"> • Start of gender-affirming hormones: 0.30 (0.22 to 0.35) • 24-months: 0.33 (0.23 to 0.37) • Statistically significant increase (p≤0.01) <p>z-score (range)</p> <ul style="list-style-type: none"> • Start of gender-affirming hormones: -0.37 (-2.28 to 0.47) • 24-months: -0.37 (-2.03 to 0.85) 	

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<ul style="list-style-type: none"> Statistically significant increase ($p \leq 0.01$) <p>Transmales (bone age ≥ 14 years), change from starting gender-affirming hormones to 24 months follow-up.</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: 0.30 (0.23 to 0.41) 24-months: 0.32 (0.23 to 0.41) Statistically significant increase ($p \leq 0.01$) <p>z-score (range)</p> <ul style="list-style-type: none"> Start of gender-affirming hormones: -0.27 (-1.91 to 1.29) 24-months: 0.02 (-2.1 to 1.35) Statistically significant increase ($p \leq 0.05$) 	

Appendix F Quality appraisal checklists

Newcastle-Ottawa Quality Assessment Form for Cohort Studies

Note: A study can be given a maximum of one star for each numbered item within the Selection and Outcome categories. A maximum of two stars can be given for Comparability.

Selection

- 1) Representativeness of the exposed cohort
 - a) Truly representative (one star)
 - b) Somewhat representative (one star)
 - c) Selected group
 - d) No description of the derivation of the cohort
- 2) Selection of the non-exposed cohort
 - a) Drawn from the same community as the exposed cohort (one star)
 - b) Drawn from a different source
 - c) No description of the derivation of the non exposed cohort
- 3) Ascertainment of exposure
 - a) Secure record (e.g., surgical record) (one star)
 - b) Structured interview (one star)
 - c) Written self report
 - d) No description
 - e) Other
- 4) Demonstration that outcome of interest was not present at start of study
 - a) Yes (one star)
 - b) No

Comparability

- 1) Comparability of cohorts on the basis of the design or analysis controlled for confounders
 - a) The study controls for age, sex and marital status (one star)
 - b) Study controls for other factors (list) _____
(one star)
 - c) Cohorts are not comparable on the basis of the design or analysis controlled for confounders

Outcome

- 1) Assessment of outcome
 - a) Independent blind assessment (one star)
 - b) Record linkage (one star)
 - c) Self report
 - d) No description
 - e) Other
- 2) Was follow-up long enough for outcomes to occur
 - a) Yes (one star)
 - b) No
Indicate the median duration of follow-up and a brief rationale for the assessment above: _____
- 3) Adequacy of follow-up of cohorts
 - a) Complete follow up- all subject accounted for (one star)

- b) Subjects lost to follow up unlikely to introduce bias- number lost less than or equal to 20% or description of those lost suggested no different from those followed. (one star)
- c) Follow up rate less than 80% and no description of those lost
- d) No statement

Thresholds for converting the Newcastle-Ottawa scales to AHRQ standards (good, fair, and poor):

Good quality: 3 or 4 stars in selection domain AND 1 or 2 stars in comparability domain AND 2 or 3 stars in outcome/exposure domain

Fair quality: 2 stars in selection domain AND 1 or 2 stars in comparability domain AND 2 or 3 stars in outcome/exposure domain

Poor quality: 0 or 1 star in selection domain OR 0 stars in comparability domain OR 0 or 1 stars in outcome/exposure domain

Appendix G Grade profiles

Table 2: Question 1: For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? - Gender dysphoria

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Impact on gender dysphoria (1 uncontrolled, prospective observational study)									
Change from baseline in mean gender dysphoria score, measured using the UGDS (duration of treatment 12 months). Higher scores indicate greater gender dysphoria.									
1 cohort study Lopez de Lara et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=23	None	T0 (baseline) = 57.1 (SD 4.1) T1 (12 months) = 14.7 (SD 3.2) Statistically significant improvement, p<0.001	Critical	VERY LOW

Abbreviations: p: p-value; SD: standard deviation; UGDS: Utrecht Gender Dysphoria Scale

¹ Downgraded 1 level - the cohort study by Lopez de Lara et al. 2020 was assessed at high risk of bias (poor quality overall; lack of blinding and no control group)

Table 3: Question 1: For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – Mental health

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Impact on mental health (3 uncontrolled, prospective observational studies and 2 uncontrolled, retrospective observational studies)									
Change from baseline in mean depression score, measured using the BDI-II (duration of treatment 12 months). Higher scores indicate more severe depression.									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 cohort study Lopez de Lara et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=23	None	T0 (baseline) = 19.3 (SD 5.5) T1 (12 months) = 9.7 (SD 3.9) Statistically significant improvement, p<0.001	Critical	VERY LOW
Change from baseline in mean depression score, measured using the CESD-R (approximately 12-month follow-up). Higher scores indicate more severe depression.									
1 cohort study Achille et al. 2020	Serious limitations ²	Serious indirectness ³	No serious inconsistency	Not calculable	N=50	None	Wave 1 (baseline) = 21.4 Wave 3 (approx. 12 months) = 13.9 Statistically significant improvement (p<0.001)	Critical	VERY LOW
Change from baseline in depression score, measured using the Patient Health Questionnaire Modified for Teens (PHQ 9_Modified for Teens) (approximately 12-month follow-up). Higher scores indicate more severe depression.									
1 cohort study Achille et al. 2020	Serious limitations ²	Serious indirectness ³	No serious inconsistency	Not calculable	N=50	None	Statistically significant reductions in mean score, p<0.001 Results presented diagrammatically, numerical results for mean score not reported	Critical	VERY LOW
Change from baseline in depression symptoms, measured using the Quick Inventory of Depressive Symptoms (QIDS), self-reported (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe depression.									
1 cohort study Kuper et al. 2020	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=105	None	Baseline = 9.6 (SD 5.0) Follow-up = 7.4 (SD 4.5) No statistical analysis reported for the sub-group of participants receiving gender-affirming hormones	Critical	VERY LOW
Change from baseline in depression symptoms, measured using the Quick Inventory of Depressive Symptoms (QIDS), clinician-reported (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe depression.									
1 cohort study	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=106	None	Baseline = 5.9 (SD 4.1) Follow-up = 6.0 (SD 3.8)	Critical	VERY LOW

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of events	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result	
Kuper et al. 2020							No statistical analysis reported for the sub-group of participants who received gender-affirming hormones	
Need for treatment due to depression, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)								
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 54% (28/52) During real life phase 15% (8/52) Statistically significant reduction (p<0.001)	Critical VERY LOW
Change from baseline in anxiety score, measured using the STAI-State subscale (duration of treatment 12 months). Higher scores indicate more severe anxiety.								
1 cohort study Lopez de Lara et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=23	None	T0 (baseline) = 33.3 (SD 9.1) T1 (12 months) = 16.8 (SD 8.1) Statistically significant improvement, p<0.001	Critical VERY LOW
Change from baseline in anxiety score, measured using the STAI-Trait subscale (duration of treatment 12 months). Higher scores indicate more severe anxiety.								
1 cohort study Lopez de Lara et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=23	None	T0 (baseline) = 33.0 (SD 7.2) T1 (12 months) = 18.5 (SD 8.4) Statistically significant improvement, p<0.001	Critical VERY LOW
Change from baseline in anxiety symptoms, measured using the SCARED questionnaire (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe anxiety.								
1 cohort study Kuper et al. 2020	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=80	None	Baseline = 32.6 (SD 16.3) Follow-up = 28.4 (SD 15.9) No statistical analysis reported for the sub-group of participants	Critical VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
							who received gender-affirming hormones		
Change from baseline in panic symptoms, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=82	None	Baseline = 8.1 (SD 6.3) Follow-up = 7.1 (SD 6.5) No statistical analysis reported for the sub-group of participants who received gender-affirming hormones	Critical	VERY LOW
Change from baseline in generalised anxiety symptoms, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=82	None	Baseline = 10.0 (SD 5.1) Follow-up = 8.8 (SD 5.0) No statistical analysis reported for the sub-group of participants who received gender-affirming hormones	Critical	VERY LOW
Change from baseline in social anxiety symptoms, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=82	None	Baseline = 8.5 (SD 4.1) Follow-up = 7.7 (SD 4.2) No statistical analysis reported for the sub-group of participants who received gender-affirming hormones	Critical	VERY LOW
Change from baseline in separation anxiety symptoms, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=81	None	Baseline = 3.5 (SD 3.0) Follow-up = 3.1 (SD 2.5) No statistical analysis reported for the sub-group of participants	Critical	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
							who received gender-affirming hormones		
Change from baseline in school avoidance, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=80	None	Baseline = 2.6 (SD 2.1) Follow-up = 2.0 (SD 2.0) No statistical analysis reported for the sub-group of participants who received gender-affirming hormones	Critical	VERY LOW
Need for treatment due to anxiety, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)									
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 48% (25/52) During real life phase 15% (8/52) Statistically significant reduction (p<0.001)	Critical	VERY LOW
Change from baseline in adjusted mean suicidality score, measured using the ASQ instrument (mean treatment duration 349 days). Higher scores indicate a greater degree of suicidality.									
1 cohort study Allen et al. 2019	Serious limitations ⁵	No serious indirectness	No serious inconsistency	Not calculable	N=39	None	T0 (baseline) = 1.11 (SE 0.22) T1 (final assessment) = 0.27 (SE 0.12) Statistically significant improvement in score from T0 to T1, p<0.001	Critical	VERY LOW
Change from baseline in percentage of participants with suicidal ideation, measured using the additional questions from the PHQ 9 Modified for Teens (approximately 12-month follow-up)									
1 cohort study Achille et al. 2020	Serious limitations ²	Serious indirectness ³	No serious inconsistency	Not calculable	N=50	None	Wave 1 (baseline) = 10% (5/50) Wave 3 (approx. 12 months) = 6% (3/50)	Critical	VERY LOW

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of events	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result	
							No statistical analysis reported	
<i>Change from baseline in suicidal ideation (passive), information on which was collected by clinician, exact methods / tools not reported (mean duration of gender-affirming hormone treatment was 10.9 months)</i>								
1 cohort study Kuper et al. 2020	Serious limitations ⁴	Serious indirectness ⁶	No serious inconsistency	Not calculable	N=130	None	Lifetime = 81% (105 people) 1 month before initial assessment = 25% (33 people) Follow-up period = 38% (51 people) No statistical analysis reported	Critical VERY LOW
<i>Change from baseline in suicide attempts, information on which was collected by clinician, exact methods / tools not reported (mean duration of gender-affirming hormone treatment was 10.9 months)</i>								
1 cohort study Kuper et al. 2020	Serious limitations ⁴	Serious indirectness ⁶	No serious inconsistency	Not calculable	N=130	None	Lifetime = 15% (20 people) 3 months before initial assessment = 2% (3 people) Follow-up period = 5% (6 people) No statistical analysis reported	Critical VERY LOW
<i>Change from baseline in non-suicidal self-injury, information on which was collected by clinician, exact methods / tools not reported (mean duration of gender-affirming hormone treatment was 10.9 months)</i>								
1 cohort study Kuper et al. 2020	Serious limitations ⁴	Serious indirectness ⁶	No serious inconsistency	Not calculable	N=130	None	Lifetime = 52% (68 people) 3 months before initial assessment = 10% (13 people) Follow-up period = 17% (23 people) No statistical analysis reported	Critical VERY LOW
<i>Need for treatment due to suicidality / self-harm, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)</i>								
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 35% (18/52) During real life phase	Critical VERY LOW

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of events	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result	
							4% (2/52) Statistically significant reduction ($p < 0.001$)	
Need for mental health treatment, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)								
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 50% (26/52) During real life phase 46% (24/51) No statistically significant difference ($p = 0.77$)	Critical VERY LOW
Need for treatment due to conduct problems / antisocial, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)								
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 14% (7/52) During real life phase 6% (3/52) No statistically significant difference ($p = 0.18$)	Critical VERY LOW
Need for treatment due to psychotic symptoms or psychosis, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)								
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 2% (1/52) During real life phase 4% (2/52) No statistically significant difference ($p = 0.56$)	Critical VERY LOW
Need for treatment due to substance abuse, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)								

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 4% (2/52) During real life phase 2% (1/52) No statistically significant difference (p= 0.56)	Critical	VERY LOW
<i>Need for treatment due to autism, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)</i>									
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 12% (6/52) During real life phase 6% (3/52) No statistically significant difference (p= 0.30)	Critical	VERY LOW
<i>Need for treatment due to ADHD, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)</i>									
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 10% (5/52) During real life phase 2% (1/52) No statistically significant difference (p= 0.09)	Critical	VERY LOW
<i>Need for treatment due to eating disorder, during and before gender identity assessment, and during real life phase (approximately 12 months follow-up)</i>									
1 cohort study Kaltiala et al. 2020	Serious limitations ⁷	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During and before gender identity assessment 2% (1/52)	Critical	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
							During real life phase 2% (1/52) No statistically significant difference (p=1.0)		

Abbreviations: ADHD: attention deficit hyperactivity disorder; ASQ: Ask Suicide-Screening Questions; CESD-R: Center for Epidemiologic Studies Depression Scale; BDI-II: Beck Depression Inventory II (BDI-II); p: p-value; PHQ 9_Modified for Teens: Patient Health Questionnaire Modified for Teens; SCARED: Screen for Child Anxiety Related Emotional Disorders; SD: standard deviation; STAI: State-Trait Anxiety Inventory

1 Downgraded 1 level - the cohort study by Lopez de Lara et al. (2020) was assessed at high risk of bias (poor quality; lack of blinding and no control group).

2 Downgraded 1 level - the cohort study by Achille et al (2020) was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

3 Serious indirectness in Achille 2020- Outcome reported for full study cohort, of whom 30% were taking no treatment or puberty suppression alone at follow-up. Results for people taking gender-affirming hormones not reported separately.⁴ Downgraded 1 level - the cohort study by Kuper et al. (2020) was assessed at high risk of bias (poor quality).

5 Downgraded 1 level - the cohort study by Allen et al. (2019) was assessed at high risk of bias (poor quality; lack of blinding and no control group).

6 Serious indirectness in Kuper et al. 2020- Outcome reported for full study cohort, of whom approximately 17% received puberty suppression alone and did not receive gender-affirming hormones

7 Downgraded 1 level - the cohort study by Kaltiala et al. (2020) was assessed at high risk of bias (poor quality; lack of blinding and no control group).

Table 4: Question 1: For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – Quality of life

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Impact on quality of life (1 uncontrolled, prospective observational study and 1 uncontrolled, retrospective observational study)									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Change from baseline in mean quality of life score, measured using the QLES-Q-SF (approximately 12-month follow-up). Higher scores indicated better quality of life.									
1 cohort study Achille et al. 2020	Serious limitations ¹	Serious indirectness ²	No serious inconsistency	Not calculable	N=50	None	Numerical improvements in mean score reported from wave 1 (baseline) to wave 3 (approx. 12 months), but difference not statistically significant (p = 0.085) Results presented diagrammatically, numerical results for mean score not reported	Critical	VERY LOW
Change from baseline in adjusted mean well-being score, measured using the GWBS of the Pediatric Quality of Life Inventory (mean treatment duration 349 days). Higher scores indicated better well-being.									
1 cohort study Allen et al. 2019	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=39	None	T0 (baseline) = 61.70 (SE 2.43) T1 (final assessment) = 70.23 (SE 2.15) Statistically significant improvement in well-being score, p<0.002	Critical	VERY LOW

Abbreviations: GWBS: General Well-Being Scale; p: p-value; QLES-Q-SF: Quality of Life Enjoyment and Satisfaction Questionnaire; SE: standard error

¹ Downgraded 1 level - the cohort study by Achille et al (2020) was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

² Serious indirectness in Achille et al. 2020 - Outcome reported for full study cohort, of whom 30% were taking no treatment or puberty suppression alone at follow-up. Results for people taking gender-affirming hormones not reported separately.

³ Downgraded 1 level - the cohort study by Allen et al. (2019) was assessed at high risk of bias (poor quality; lack of blinding and no control group).

Table 5: Question 1: For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – Body image

QUALITY	Summary of findings	IMPORTANCE	CERTAINTY
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					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Impact on body image (1 uncontrolled, prospective observational study)									
Change from baseline in mean body image, measured using the BIS (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores represent a higher degree of body dissatisfaction.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=86	None	Baseline = 70.7 (SD 15.2) Follow-up = 51.4 (SD 18.3) No statistical analysis reported for the sub-group of participants who received gender-affirming hormones	Important	VERY LOW

Abbreviations: BIS: Body Image Scale; p: p-value; SD: standard deviation

¹ Downgraded 1 level - the cohort study by Kuper et al. (2020) was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

Table 6: Question 1: For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – Psychological impact

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Psychosocial Impact (1 uncontrolled, prospective observational study and 1 uncontrolled, retrospective observational study)									
Change from baseline in family functioning, measured using the Family APGAR test. Higher scores suggest more family dysfunction.									
1 cohort study Lopez de Lara et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=23	None	T0 (baseline) = 17.9 T1 (12 months) = 18.0 No statistical analysis reported	Important	VERY LOW
Change from baseline in mean patient strengths and difficulties score, measured using the SDQ, Spanish Version (total difficulties score) (duration of treatment 12 months). Higher scores suggest the presence of a behavioural disorder.									
1 cohort study	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=23	None	T0 (baseline) = 14.7 (SD 3.3) T1 (12 months) = 10.3 (SD 2.9)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Lopez de Lara et al. 2020							Statistically significant improvement $p < 0.001$		
Functioning in adolescent development: Living with parent(s)/ guardians² (outcome reported for the approximately 12-month period after starting gender-affirming hormones; referred to as the 'real-life phase' in Finland). Not living with parent(s) or guardian in your early 20s is a marker of age-appropriate functioning in Finnish culture.									
1 cohort study Kaltiala et al. 2020	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During gender identity assessment = 73% (38/52) During real life phase = 40% (21/50) Statistically significant reduction ($p = 0.001$)	Important	VERY LOW
Functioning in adolescent development: Normative peer contacts⁴ (outcome reported for the approximately 12-month period after starting gender-affirming hormones; referred to as the 'real-life phase' in Finland)									
1 cohort study Kaltiala et al. 2020	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During gender identity assessment = 89% (46/52) During real life phase = 81% (42/52) Statistically significant reduction ($p < 0.001$)	Important	VERY LOW
Functioning in adolescent development: Progresses normatively in school/ work⁵ (outcome reported for the approximately 12-month period after starting gender-affirming hormones; referred to as the 'real-life phase' in Finland)									
1 cohort study Kaltiala et al. 2020	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During gender identity assessment = 64% (33/52) During real life phase = 60% (31/52) No statistically significant difference ($p = 0.69$)	Important	VERY LOW
Functioning in adolescent development: Has been dating or had steady relationships⁶ (outcome reported for the approximately 12-month period after starting gender-affirming hormones; referred to as the 'real-life phase' in Finland)									
1 cohort study	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During gender identity assessment = 62% (32/50)	Important	VERY LOW

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of patients	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)	
Kaltiala et al. 2020							During real life phase = 58% (30/52) No statistically significant difference (p=0.51)	
Functioning in adolescent development: Is age-appropriately able to deal with matters outside of the home⁷ (outcome reported for the approximately 12-month period after starting gender-affirming hormones; referred to as the 'real-life phase' in Finland)								
1 cohort study Kaltiala et al. 2020	Serious limitations ²	No serious indirectness	No serious inconsistency	Not calculable	N=52	None	During gender identity assessment = 81% (42/52) During real life phase = 81% (42/52) No statistically significant difference (p=1.00)	Important VERY LOW

Abbreviations: APGAR: Adaptability, Partnership, Growth, Affection and Resolve; p: p-value; SD: standard deviation; SDQ: Strengths and Difficulties Questionnaire

1 Downgraded 1 level - the cohort study by Lopez de Lara et al. (2020) was assessed at high risk of bias (poor quality; lack of blinding and no control group).

2 Living arrangements were classified as (1) living with at least one parent/guardian, (2) living in a boarding school, with an adult relative, in some form of supported accommodation or the like, where supervision and guidance by a responsible adult is provided, (3) independently alone or in a shared household with a peer, (4) with a romantic partner. In the analyses dichotomised living arrangements as (a) parent(s)/guardian(s) vs. in other arrangements.

3 Downgraded 1 level - the cohort study by Kaltiala et al. (2020) was assessed at high risk of bias (poor quality; lack of blinding and no control group).

4 Peer relationships were classified as: (1) socialises with friends in leisure time, outside of activities supervised by adults, (2) socialises with peers only at school or in the context of rehabilitative activity, (3) spends time close to peers, for example in school or rehabilitative activity, but does not connect with them, (4) does not meet peers at all. In the analyses, peer relationships during (a) gender identity assessment and (b) the real-life phase were dichotomized to age-appropriate (normative) (1) vs. restricted or lacking (2–4).

5 School/work participation was classified as (1) age appropriate participation in mainstream curriculum, progresses without difficulties, (2) participates in mainstream curriculum with difficulty, (3) participates in rehabilitative educational or work activity, (4) not involved in education and working life. Age-appropriate participation during (1) was recorded if the adolescent attended mainstream secondary education or upper secondary education at a regular rate (a class per year in comprehensive school; has not changed more than once between tracks in upper secondary education) or had proceeded to work life after completing vocational education. Participation with difficulty (2) was recorded if the adolescent was enrolled in mainstream education but had to repeat a class, studied with special arrangements (for example, in a special small group), or followed some form of adjusted curriculum. In the analyses, school/work life during (a) gender identity assessment and (b) real-life phase was dichotomised to normative (1) vs. any other (2, 3 or 4).

6 Romantic involvement was recorded (1) has or has had a dating or steady relationship, not only online, (2) has had a romantic relationship only online, (3) has not had dating or steady relationships. In the analyses we compared has or has had (1) vs. has not had (2,3) a dating or steady relationship during (a) gender identity assessment and (b) real-life phase. Sexual history was recorded in more detail in case histories during gender identity assessment, and for this period we also collected the experiences of (French) kissing (yes/no), intercourse (yes/no) and experience of any genitally intimate contact with a partner (petting under clothes or naked, intercourse, oral sex) (yes/no).

7 In recording age-appropriate competence in managing everyday matters it was expected that early adolescents (up to 14 years) would be able, for example, to do shopping and travel alone on local public transport, and to help with household duties assigned by their parents. Middle adolescents (15–17 years) were further assumed, for example, to be able make telephone calls in matters important to them (for example, when seeking a summer job), to deal with school-related issues with school personnel without parental participation, to select and start new hobbies independently and to fulfil their role in summer jobs and in similar responsibilities of young people. Late adolescents (18 years and over), legally adults, were expected to have, in addition to the above, competence to talk to authorities such as professionals in health and social services, employment or educational institutions, to deal with banks or health insurance, to manage their financial issues and to manage their housekeeping if they chose to move to live independently of parents/guardians. Competence in managing everyday matters was recorded as follows: (1) the adolescent is able to cope age appropriately outside home, (2) the adolescent needs support in age-appropriate matters outside home but functions age-appropriately in the home (manages her/his own hygiene, clothing and nutrition, participates in (younger subjects) or takes responsibility for (older subjects) housekeeping) and (3) the adolescent's functioning is inadequate both at home and outside home. For the analyses, participants were determined to be able to age-appropriately cope with matters outside of the home (1) vs. not (2,3).

Table 7: Question 2: For children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – Bone density

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Lumbar spine bone mineral apparent density (BMAD) (2 uncontrolled, retrospective observational studies)									
Change from start of gender-affirming hormones to age 22 years in lumbar spine BMAD in transfemales									
1 cohort study Klink et al. 2015	Serious limitations ¹	Serious indirectness ²	Not applicable	Not calculable	N=13 (Mean) N=14 (z-score)	None	Mean (SD), g/m ³ Start of gender-affirming hormones: 0.22 (0.02) Age 22 years: 0.23 (0.03) P=0.003 z-score (SD) Start of gender-affirming hormones: -0.90 (0.80) Age 22 years: -0.78 (1.03) No statistically significant difference	Important	VERY LOW
Change from baseline in lumbar spine BMAD in transfemales with a bone age less than 15 years ('young'; 24 months follow-up)									
1 cohort study Viot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=15	None	Median (range), g/m ³ Start of gender-affirming hormones (C0): 0.20 (0.18 to 0.24)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
							24-month follow-up (C24): 0.22 (0.19 to 0.27) Statistically significant increase (p<0.01) z-score (range) Start of gender-affirming hormones (C0): -1.52 (-2.36 to 0.42) 24-month follow-up (C24): -1.10 (-2.44 to 0.69) Statistically significant increase (p<0.05)		
Change from baseline in lumbar spine BMAD in transfemales with a bone age of 15 years or more ('old'; 24 months follow-up)									
1 cohort study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=5	None	Median (range), g/m ³ Start of gender-affirming hormones (C0): 0.22 (0.19 to 0.24) 24-month follow-up (C24): 0.23 (0.21 to 0.26) Statistically significant increase (p<0.05) z-score (range) Start of gender-affirming hormones (C0): -1.15 (-2.21 to 0.08) 24-month follow-up (C24): -0.66 (-1.66 to 0.54) Statistically significant increase (p<0.05)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in lumbar spine BMAD in transmales									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
1 cohort study Klink et al. 2015	Serious limitations ¹	Serious indirectness ²	Not applicable	Not calculable	N=19 (Mean and z-score)	None	Mean (SD), g/m ³ Start of gender-affirming hormones: 0.24 (0.02) Age 22 years: 0.25 (0.28) P=0.001 z-score Start of gender-affirming hormones: -0.50 (0.81) Age 22 years: -0.033 (0.95) P=0.002	Important	VERY LOW
Change from baseline in lumbar spine BMAD in transmales with a bone age of less than 14 years ('young'; 24 months follow-up)									
1 cohort study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=11	None	Median (range), g/m ³ Start of gender-affirming hormones (C0): 0.23 (0.19 to 0.28) 24-month follow-up (C24): 0.25 (0.22 to 0.28) Statistically significant increase (p≤0.01) z-score (range) Start of gender-affirming hormones (C0): -0.84 (-2.2 to 0.87) 24-month follow-up (C24): -0.15 (-1.38 to 0.94) Statistically significant increase (p≤0.01)	Important	VERY LOW
Change from baseline in lumbar spine BMAD in transmales with a bone age of 14 years or more ('old'; 24 months follow-up)									
1 cohort study	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=23	None	Median (range), g/m ³	Important	VERY LOW

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of patients	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)	
Vlot et al. 2017							No statistically significant change z-score (range) C0: -1.32 (-3.39 to 0.21) C24: -1.30 (-3.51 to 0.92) No statistically significant change	
Change from baseline in femoral neck BMAD in transfemales with a bone age of 15 years or more ('old'; 24 months follow-up)								
1 cohort study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=6	None	Median (range), g/m ³ C0: 0.30 (0.26 to 0.34) C24: 0.29 (0.24 to 0.38) No statistically significant change z-score (range) C0: -0.36 (-1.50 to 0.46) C24: -0.56 (-2.17 to 1.29) No statistically significant change	Important VERY LOW
Change from start of gender-affirming hormones to age 22 years in femoral neck BMAD in transmales								
1 cohort study Klink et al. 2015	Serious limitations ¹	Serious indirectness ²	Not applicable	Not calculable	N=19 (Mean) N=18 (z-score)	None	Mean (SD), g/m ³ Start of gender-affirming hormones: 0.31 (0.04) Age 22 years: 0.33 (0.05) P=0.010 z-score (SD) Start of gender-affirming hormones: -0.28 (0.74) Age 22 years: Not reported	Important VERY LOW
Change from baseline in femoral neck BMAD in transmales with a bone age of less than 14 years ('young'; 24 months follow-up)								

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	No of patients		Effect		
					Intervention	Comparator	Result (95% CI)		
1 cohort study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=10	None	Median (range), g/m ³ C0: 0.30 (0.22 to 0.35) C24: 0.33 (0.23 to 0.37) Statistically significant increase (p<0.01) z-score (range) C0: -0.37 (-2.28 to 0.47) C24: -0.37 (-2.03 to 0.85) Statistically significant increase (p<0.01)	Important	VERY LOW
Change from baseline in femoral neck BMAD in transmales with a bone age of 14 years or more ('old'; 24 months follow-up)									
1 cohort study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=23	None	Median (range), g/m ³ C0: 0.30 (0.23 to 0.41) C24: 0.32 (0.23 to 0.41) Statistically significant increase (p<0.01) z-score (range) C0: -0.27 (-1.91 to 1.29) C24: 0.02 (-2.1 to 1.35) Statistically significant increase (p<0.05)	Important	VERY LOW
Change in lumbar spine BMD (2 uncontrolled, retrospective observational studies)									
Change from start of gender-affirming hormones to age 22 years in lumbar spine BMD in transfemales									
1 cohort study Klink et al. 2015	Serious limitations ¹	Serious indirectness ²	Not applicable	Not calculable	N=15 (Mean) N=13 (z-score)	None	Mean (SD), g/m ² Start of gender-affirming hormones: 0.84 (0.11) Age 22 years: 0.93 (0.10) P<0.001 z-score (SD)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
							Start of gender-affirming hormones: -1.01 (0.98) Age 22 years: -1.36 (0.83) No statistically significant difference		
Change from start of gender-affirming hormones to age 22 years in lumbar spine BMD in transmales									
1 cohort study Klink et al. 2015	Serious limitations ¹	Serious indirectness ²	Not applicable	Not calculable	N=19 (Mean and z-score)	None	Mean (SD), g/m ² Start of gender-affirming hormones: 0.91 (0.10) Age 22 years: 0.99 (0.13) P<0.001 z-score (SD) Start of gender-affirming hormones: -0.72 (0.99) Age 22 years: -0.33 (1.12) No statistically significant difference	Important	VERY LOW
Change from start of testosterone treatment in lumbar spine BMD in transmen (follow-up 6 to 24 months)									
1 cohort study Stoffers et al. 2019	Serious limitations ⁴	No serious indirectness	Not applicable	Not calculable	N=62 (T0 and T6) N=37 (T12) N=15 (T24)	None	Mean (SD), g/cm ² T0: 0.90 (0.11) T6: 0.94 (0.10) T12: 0.95 (0.09) T24: 0.95 (0.11) No statistically significant difference from T0 to any timepoint z-score (SD) T0: -0.81 (1.02) T6: -0.67 (0.95) T12: -0.66 (0.81) T24: -0.74 (1.17)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	No of patients		Effect		
					Intervention	Comparator	Result (95% CI)		
							No statistically significant difference from T0 to any timepoint		
Change in femoral neck BMD (2 uncontrolled, retrospective observational studies)									
Change from start of gender-affirming hormones to age 22 years in femoral neck BMD in transfemales									
1 cohort study Klink et al. 2015	Serious limitations ¹	Serious indirectness ²	Not applicable	Not calculable	N=15 (Mean) N=11 (z-score)	None	Mean (SD), g/m ² Start of gender-affirming hormones: 0.87 (0.08) Age 22 years: 0.94 (0.11) P=0.009 z-score (SD) Start of gender-affirming hormones: -0.95 (0.63) Age 22 years: -0.69 (0.74) No statistically significant difference	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in femoral neck BMD in transmales									
1 cohort study Klink et al. 2015	Serious limitations ¹	Serious indirectness ²	Not applicable	Not calculable	N=19 (Mean) N=16 (z-score)	None	Mean (SD), g/m ² Start of gender-affirming hormones: 0.88 (0.09) Age 22 years: 0.95 (0.10) P<0.001 z-score (SD) Start of gender-affirming hormones: -0.35 (0.79) Age 22 years: -0.35 (0.74) P=0.006	Important	VERY LOW
Change from start of testosterone treatment in right femoral neck (hip) BMD in transmales (follow-up 6 to 24 months)									
1 cohort study	Serious limitations ⁴	No serious indirectness	Not applicable	Not calculable	N=62 (T0 and T6)	None	Mean (SD), g/cm ² T0: 0.77 (0.08)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Stoffers et al. 2019					N=37 (T12) N=15 (T24)		T6: 0.84 (0.11) T12: 0.82 (0.08) T24: 0.85 (0.11) No statistically significant difference from T0 to any timepoint z-score (SD) T0: -0.97 (0.79) T6: -0.54 (0.96) T12: -0.80 (0.69) T24: -0.31 (0.84) No statistically significant difference from T0 to any timepoint		
Change from start of testosterone treatment in left femoral neck (hip) BMD in transmales (follow-up 6 to 24 months)									
1 cohort study Stoffers et al. 2019	Serious limitations ⁴	No serious indirectness	Not applicable	Not calculable	N=62 (T0 and T6) N=37 (T12) N=15 (T24)	None	Mean (SD), g/cm ² T0: 0.76 (0.09) T6: 0.83 (0.12) T12: 0.81 (0.08) T24: 0.86 (0.09) No statistically significant difference from T0 to any timepoint z-score (SD) T0: -1.07 (0.85) T6: -0.62 (1.12) T12: -0.93 (0.63) T24: -0.20 (0.70) No statistically significant difference from T0 to any timepoint	Important	VERY LOW

Abbreviations: BMAD: bone mineral apparent density; BMD: bone mineral density; g: grams; m: metre; SD: standard deviation

1 Downgraded 1 level - the cohort study by Klink et al. (2015) was assessed as at high risk of bias (poor quality overall; lack of blinding, no control group and high number of participants lost to follow-up)

2 Outcomes reported after gender reassignment surgery and not after gender-affirming hormones alone. Unclear whether observed changes are due to hormones or surgery

3 Downgraded 1 level - the cohort study by Vlot et al. (2017) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control)

4 Downgraded 1 level - the cohort study by Stoffers et al. (2019) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group)

Table 8: Question 2: For children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – Cardiovascular risk factors

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Change in body mass index (1 uncontrolled, retrospective observational study)									
Change from start of gender-affirming hormones to age 22 years in BMI in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI) +1.9 (0.6 to 3.2) Statistically significant increase (p<0.005) Mean BMI at 22 years (95% CI): 23.2 (21.6 to 24.8)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in BMI in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI) +1.4 (0.8 to 2.0) Statistically significant increase (p<0.005) Mean BMI at 22 years (95% CI): 23.9 (23.0 to 24.7)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Obesity rates at age 22 years (1 uncontrolled, retrospective observational study)									
Obesity rates at age 22 years in transfemales who started gender-affirming hormones as adolescents (1 uncontrolled, retrospective observational study)									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	At 22 years, 9.9% of transfemales were obese, compared with 3.0% in reference cisgender population No statistically analysis reported	Important	VERY LOW
Obesity rates at age 22 years in transfemales who started gender-affirming hormones as adolescents (1 uncontrolled, retrospective observational study)									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	At 22 years, 6.6% of transmales were obese, compared with 2.2% in reference cisgender population No statistically analysis reported	Important	VERY LOW
Change in blood pressure (1 uncontrolled, retrospective observational study)									
Change from start of gender-affirming hormones to age 22 years in systolic blood pressure (SBP) in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI) -3 (-8 to 2) No statistically significant difference Mean SBP at 22 years (95% CI): 117 (113 to 122)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in diastolic blood pressure (DBP) in transfemales									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI) +6 (3 to 10) Statistically significant increase (p<0.001) Mean DBP at 22 years (95% CI): 75 (72 to 78)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in systolic blood pressure (SBP) in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI): +5 (1 to 9) Statistically significant increase (p<0.05) Mean SBP at 22 years (95% CI): 126 (122 to 130)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in diastolic blood pressure (DBP) in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI): +6 (4 to 9) Statistically significant increase (p<0.001) Mean DBP at 22 years (95% CI): 74 (72 to 77)	Important	VERY LOW
Change in glucose levels, insulin levels, insulin resistance and HbA1c (2 uncontrolled, retrospective observational studies)									
Change from start of gender-affirming hormones to age 22 years in glucose level (mmol/L) in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI): +0.1 (-0.1 to 0.2)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	No of patients		Effect		
					Intervention	Comparator	Result (95% CI)		
							No statistically significant difference Mean glucose level at 22 years (95% CI): 5.0 (4.8 to 5.1)		
Change from start of gender-affirming hormones to age 22 years in insulin level (mU/L) in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI) +2.7 (-1.7 to 7.1) No statistically significant difference Mean insulin level at 22 years (95% CI): 13.0 (8.4 to 17.6)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in insulin resistance (HOMA-IR) in transfemales. Higher scores indicate more insulin resistance.									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI) +0.7 (-0.2 to 1.5) No statistically significant difference Mean HOMA-IR at 22 years (95% CI): 2.9 (1.9 to 3.9)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in glucose level (mmol/L) in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI) 0.0 (-0.2 to 0.2) No statistically significant difference	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
							Mean glucose level at 22 years (95% CI): 4.8 (4.7 to 5.0)		
Change from start of gender-affirming hormones to age 22 years in insulin level (mU/L) in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI) -2.1 (-3.9 to -0.3) Statistically significant decrease (p<0.05) Mean insulin level at 22 years (95% CI): 8.6 (6.9 to 10.2)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in insulin resistance (HOMA-IR) in transmales. Higher scores indicate more insulin resistance.									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI): -0.5 (-1.0 to -0.1) Statistically significant decrease (p<0.05) Mean HOMA-IR at 22 years (95% CI): 1.8 (1.4 to 2.2)	Important	VERY LOW
Change from start of testosterone in HbA1c in transmales (up to 24 months follow-up)									
1 cohort study Stoffers et al. 2019	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N= Not reported	None	No statistically significant change from start of testosterone treatment Numerical results, follow-up duration and further details of	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
							statistical analysis not reported.		
Change in lipid profile (1 uncontrolled, retrospective observational study)									
Change from start of gender-affirming hormones to age 22 years in total cholesterol (mmol/L) in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI): +0.1 (-0.2 to 0.4) No statistically significant difference Mean total cholesterol at 22 years (95% CI): 4.1 (3.8 to 4.4)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in HDL cholesterol (mmol/L) in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI): 0.0 (-0.1 to 0.2) No statistically significant difference Mean HDL cholesterol at 22 years (95% CI): 1.6 (1.4 to 1.7)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in LDL cholesterol (mmol/L) in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI): 0.0 (-0.3 to 0.2) No statistically significant difference Mean LDL cholesterol at 22 years (95% CI): 2.0 (1.8 to 2.3)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Change from start of gender-affirming hormones to age 22 years in triglycerides (mmol/L) in transfemales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=71	None	Mean change (95% CI): +0.2 (0.0 to 0.5) Statistically significant increase (p<0.05) Mean triglycerides at 22 years (95% CI): 1.1 (0.9 to 1.4)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in total cholesterol (mmol/L) in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI): +0.4 (0.2 to 0.6) Statistically significant increase (p<0.001) Mean total cholesterol at 22 years (95% CI): 4.6 (4.3 to 4.8)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in HDL cholesterol (mmol/L) in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI) -0.3 (-0.4 to -0.2) Statistically significant decrease (p<0.001) Mean HDL cholesterol at 22 years (95% CI): 1.3 (1.2 to 1.3)	Important	VERY LOW
Change from start of gender-affirming hormones to age 22 years in LDL cholesterol (mmol/L) in transmales									
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI): +0.4 (0.2 to 0.6)	Important	VERY LOW

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of patients	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)	
							Statistically significant increase (p<0.001) Mean LDL cholesterol at 22 years (95% CI): 2.6 (2.4 to 2.8)	
Change from start of gender-affirming hormones to age 22 years in triglycerides (mmol/L) in transmales								
1 cohort study Klaver et al. 2020	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=121	None	Mean change (95% CI) +0.5 (0.3 to 0.7) Statistically significant increase (p<0.001) Mean triglycerides at 22 years (95% CI): 1.3 (1.1 to 1.5)	Important VERY LOW

Abbreviations: BMI: body mass index; CI: confidence interval; DBP: diastolic blood pressure; HbA1c: glycated haemoglobin; HDL: high-density lipoproteins; HOMA-IR: Homeostatic Model Assessment of Insulin Resistance; LDL: low-density lipoproteins; mmol/L: millimoles per litre; mU/L: milliunits per litre; SBP: systolic blood pressure; SD: standard deviation

¹ Downgraded 1 level - the cohort study by Klaver et al. (2020) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group)

² Downgraded 1 level - the cohort study by Stoffers et al. (2019) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group)

Table 9: Question 2: For children and adolescents with gender dysphoria, what is the short-term and long-term safety of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – Other safety outcomes

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of patients	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)	
Liver enzymes (1 uncontrolled, retrospective observational study)								

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	No of patients		Effect		
					Intervention	Comparator	Result (95% CI)		
Change from start of testosterone in aspartate aminotransferase (AST) level in transmales (up to 24 months follow-up)									
1 cohort study Stoffers et al. 2019	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N= Not reported	None	No statistically significant change from start of testosterone treatment Numerical results, follow-up duration and further details of statistical analysis not reported.	Important	VERY LOW
Change from start of testosterone in alanine aminotransferase (ALT) level in transmales (up to 24 months follow-up)									
1 cohort study Stoffers et al. 2019	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N= Not reported	None	No statistically significant change from start of testosterone treatment Numerical results, follow-up duration and further details of statistical analysis not reported.	Important	VERY LOW
Change from start of testosterone in gamma-glutamyl transferase (GGT) level in transmales (up to 24 months follow-up)									
1 cohort study Stoffers et al. 2019	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N= Not reported	None	No statistically significant change from start of testosterone treatment Numerical results, follow-up duration and further details of statistical analysis not reported.	Important	VERY LOW
Change from start of testosterone in alkaline phosphatase (ALP) level in transmales (up to 24 months follow-up)									
1 cohort study Stoffers et al. 2019	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=62 (T0 and T1) N=37 (T12)	None	Median (IQR), U/L T0: 102 (78 to 136) T6: 115 (102 to 147) T12: 112 (88 to 143) T24: 81 (range 69 to 98)	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
					N=15 (T24)		Statistically significant increase from T0 at T6 and T12 (p<0.001)		
Kidney markers (1 uncontrolled, retrospective observational study)									
Change from start of testosterone in serum creatinine level in transmales (up to 24 months follow-up)									
1 cohort study Stoffers et al. 2019	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=62 (T0 and T1) N=37 (T12) N=15 (T24)	None	Mean (SD), umol/L T0: 62 (7) T6: 70 (9) T12: 74 (10) T24: 81 (10) Statistically significant increase from T0 at all timepoints (p<0.001)	Important	VERY LOW
Change from start of testosterone in serum urea² level in transmales (up to 24 months follow-up)									
1 cohort study Stoffers et al. 2019	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N= Not reported	None	No statistically significant change from start of testosterone treatment Numerical results, follow-up duration and further details of statistical analysis not reported.	Important	VERY LOW
Adverse effects (1 uncontrolled, retrospective observational study)									
Permanent discontinuation of gender-affirming hormones (median follow-up 2.0 years (range 0.0 to 11.3))									
1 cohort study Khatchadorian et al. 2014	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=63	None	No participants permanently discontinued gender-affirming hormones.	Important	VERY LOW
Temporary discontinuation of gender-affirming hormones (median follow-up 2.0 years (range 0.0 to 11.3))									
1 cohort study	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=63	None	3/37 transmales receiving testosterone temporarily	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Khatchadorian et al. 2014							discontinued treatment, 2 due to concomitant mental health comorbidities and 1 due to androgenic alopecia. All eventually resumed treatment. No transfemales receiving oestrogen temporarily discontinued treatment		
Minor complications during treatment with gender-affirming hormones (median follow-up 2.0 years (range 0.0 to 11.3))									
1 cohort study Khatchadorian et al. 2014	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=63	None	12/63 participants had minor complications during treatment with gender-affirming hormones All 12 were transmales receiving testosterone. Complications were severe acne (n=7), androgenic alopecia (n=1) mild dyslipidaemia (n=3) and significant mood swings (n=1) No transfemales receiving oestrogen had minor complications	Important	VERY LOW
Severe complications during treatment with gender-affirming hormones (median follow-up 2.0 years (range 0.0 to 11.3))									
1 cohort study Khatchadorian et al. 2014	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=63	None	No severe complications reported during gender-affirming treatment	Important	VERY LOW

Abbreviations: ALP: alkaline phosphatase; ALT: alanine aminotransferase; AST: aspartate aminotransferase; GGT: gamma-glutamyl transferase; IQR: interquartile range; SD: standard deviation; U/L: units per litre; umol/L: micromole per litre

1 Downgraded 1 level - the cohort study by Stoffers et al. (2019) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group)

2 Referred to as 'ureum' in original publication

3 Downgraded 1 level - the cohort study by Khatchadourian et al. (2014) was assessed as at high risk of bias (poor quality overall; lack of blinding, no control group and high number of participants lost to follow-up)

Table 10: From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria? – Transfemales compared with transmales

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Transfemales	Transmales	Result (95% CI)		
Impact on mental health (1 uncontrolled, retrospective observational study)									
Change from baseline in adjusted mean suicidality score, measured using the ASQ tool (mean treatment duration 349 days). Higher scores indicate a greater degree of suicidality.									
1 cohort study Allen et al. 2019	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=14	N=33	Transfemales T0 (baseline) = 1.21 (SE 0.36) T1 (final assessment) = 0.24 (SE 0.19) Transmales T0 (baseline) = 1.01 (SE 0.23) T1 (final assessment) = 0.29 (SE 0.13) No statistically significant difference in change from baseline between transfemales and transmales (p=0.79)	Critical	VERY LOW
Impact on quality of life (1 uncontrolled, retrospective observational study)									
Change from baseline in adjusted mean well-being score, measured using the GWBS of the Pediatric Quality of Life Inventory (mean treatment duration 349 days). Higher scores indicate better well-being.									
1 cohort study Allen et al. 2019	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	N=14	N=33	Transfemales T0 (baseline) = 58.44 (SE 4.09) T1 (final assessment) = 69.52 (SE 3.62)	Critical	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Transfemales	Transmales	Result (95% CI)		
							<p>Transmales</p> <p>T0 (baseline) = 64.95 (SE 2.66)</p> <p>T1 (final assessment) = 70.94 (SE 2.35)</p> <p>No statistically significant difference in change from baseline between transfemales and transmales (p=0.32)</p>		

Abbreviations: ASQ: Ask Suicide-Screening Questions; GWBS: General Well-Being Scale; SE: standard error

¹ The cohort study by Allen et al. 2019 was assessed at high risk of bias (poor quality; lack of blinding and no control group).

Table 11: From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria? – Sex assigned at birth males (transfemales)

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study type and number of studies Author year	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Change from baseline in mean depression symptoms in transfemales, measured using the Quick Inventory of Depressive Symptoms (QIDS), self-reported (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more depression.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=40	None	Baseline = 7.5 (SD 4.9) Follow-up = 6.6 (SD 4.4) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in mean depression symptoms in transfemales, measured using the Quick Inventory of Depressive Symptoms (QIDS), clinician-reported (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe depression.									
1 cohort study	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=45	None	Baseline = 4.2 (SD 3.2) Follow-up = 5.4 (SD 3.4)	Critical	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study type and number of studies Author year	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Kuper et al. 2020							No statistical analysis reported for this sub-group		
Change from baseline in mean anxiety symptoms in transfemales, measured using the SCARED questionnaire (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe anxiety.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=33	None	Baseline = 26.4 (SD 14.2) Follow-up = 24.3 (SD 15.4) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in mean panic symptoms in transfemales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=34	None	Baseline = 5.7 (SD 4.9) Follow-up = 5.1 (SD 4.9) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in mean generalised anxiety symptoms in transfemales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=34	None	Baseline = 8.6 (SD 5.1) Follow-up = 8.0 (SD 5.1) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in mean social anxiety symptoms in transfemales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=34	None	Baseline = 7.1 (SD 3.9) Follow-up = 6.8 (SD 4.4) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in mean separation anxiety symptoms in transfemales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=34	None	Baseline = 3.4 (SD 3.3) Follow-up = 2.7 (SD 2.3) No statistical analysis reported for this sub-group	Critical	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study type and number of studies Author year	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
<i>Change from baseline in mean school avoidance symptoms in transfemales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.</i>									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=33	None	Baseline = 1.8 (SD 1.7) Follow-up = 1.9 (SD 2.1) No statistical analysis reported for this sub-group	Critical	VERY LOW
<i>Change from baseline in percentage of participants with suicidal ideation in transfemales, measured using the additional questions from the PHQ 9 Modified for Teens (approximately 12-month follow-up)</i>									
1 cohort study Achille et al. 2020	Serious limitations ²	Serious indirectness ²	No serious inconsistency	Not calculable	N=17	None	Wave 1 (baseline) = 11.8% (2/17) Wave 2 (approx. 12 months) = 5.9% (1/17) No statistical analysis reported	Critical	VERY LOW
<i>Impact on body image (1 uncontrolled, prospective observational study)</i>									
<i>Change from baseline in mean body image in transfemales, measured using the BIS (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores represent a higher degree of body dissatisfaction.</i>									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=30	None	Baseline = 67.5 (SD 19.5) Follow-up = 49.0 (SD 21.6) No statistical analysis reported for this sub-group	Important	VERY LOW

Abbreviations: BIS: Body Image Scale; PHQ 9: Patient Health Questionnaire 9; SCARED: Screen for Child Anxiety Related Emotional Disorders; SD: standard deviation

1 Downgraded 1 level - the cohort study by Kuper et al. (2020) was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

2 Downgraded 1 level - the cohort study by Achille et al. 2020 was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

3 Serious indirectness in Achille 2020- Approximately 30% of the full sample received puberty suppression alone or were receiving no treatment at final follow-up.

Table 12: From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria? – Sex assigned at birth females (transmales)

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
<i>Change from baseline in mean depression symptoms in transmales, measured using the Quick Inventory of Depressive Symptoms (QIDS), self-reported (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe depression.</i>									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=76	None	Baseline = 10.4 (SD 5.0) Follow-up = 7.5 (SD 4.5) No statistical analysis reported for this sub-group	Critical	VERY LOW
<i>Change from baseline in mean depression symptoms in transmales, measured using the Quick Inventory of Depressive Symptoms (QIDS), clinician-reported (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe depression.</i>									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=78	None	Baseline = 6.7 (SD 4.4) Follow-up = 6.2 (SD 4.1) No statistical analysis reported for this sub-group	Critical	VERY LOW
<i>Change from baseline in mean anxiety symptoms in transmales, measured using the SCARED questionnaire (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe anxiety.</i>									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=65	None	Baseline = 35.4 (SD 16.5) Follow-up = 29.8 (SD 15.5) No statistical analysis reported for this sub-group	Critical	VERY LOW
<i>Change from baseline in mean panic symptoms in transmales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment 10.9 months). Higher scores indicate more severe symptoms.</i>									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=66	None	Baseline = 9.3 (SD 6.5) Follow-up = 7.9 (SD 6.5) No statistical analysis reported for this sub-group	Critical	VERY LOW
<i>Change from baseline in mean generalised anxiety symptoms in transmales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.</i>									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=66	None	Baseline = 10.4 (SD 5.0) Follow-up = 9.0 (SD 5.1) No statistical analysis reported for this sub-group	Critical	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	No of patients		Effect		
					Intervention	Comparator	Result (95% CI)		
Change from baseline in mean social anxiety symptoms in transmales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=66	None	Baseline = 8.5 (SD 4.0) Follow-up = 7.8 (SD 4.1) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in mean separation anxiety symptoms in transmales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=65	None	Baseline = 4.2 (SD 3.4) Follow-up = 3.4 (SD 2.6) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in mean school avoidance symptoms in transmales, measured using specific questions from the SCARED questionnaire (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores indicate more severe symptoms.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=65	None	Baseline = 2.9 (SD 2.3) Follow-up = 2.0 (SD 2.3) No statistical analysis reported for this sub-group	Critical	VERY LOW
Change from baseline in percentage of participants with suicidal ideation in transmales, measured using the additional questions from the PHQ 9 Modified for Teens (approximately 12-month follow-up)									
1 cohort study Achille et al. 2020	Serious limitations ²	Serious indirectness ³	No serious inconsistency	Not calculable	N=33	None	Wave 1 (baseline) = 9.1% (3/33) Wave 2 (approx. 12 months) = 6.1% (2/33) No statistical analysis reported	Critical	VERY LOW
Impact on body image (1 uncontrolled, prospective observational study)									
Change from baseline in mean body image in transmales, measured using the BIS (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores represent a higher degree of body dissatisfaction.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=66	None	Baseline = 71.1 (SD 13.4) Follow-up = 52.9 (SD 16.8) No statistical analysis reported for this sub-group	Important	VERY LOW

Abbreviations: BIS: Body Image Scale; PHQ 9: Patient Health Questionnaire 9; SCARED: Screen for Child Anxiety Related Emotional Disorders; SD: standard deviation

1 Downgraded 1 level - the cohort study by Kuper et al. (2020) was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

2 Downgraded 1 level - the cohort study by Achille et al. 2020 was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

3 Serious indirectness in Achille 2020- Approximately 30% of the full sample received puberty suppression alone or were receiving no treatment at final follow-up.

Table 14: From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria? – Outcomes controlled for concurrent counselling and medicines for mental health problems

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Impact on mental health (1 uncontrolled, retrospective observational study)									
Change from baseline in mean depression score in transfemales, measured using the CESD-R (approximately 12-month follow-up; controlled for engagement in counselling and medicines for mental health problems). Higher scores indicate more depression.									
1 cohort study Achille et al. 2020	Serious limitations ¹	Serious indirectness ²	No serious inconsistency	Not calculable	N=17	None	No statistically significant change from baseline (p=0.27) Numerical scores not reported	Critical	VERY LOW
Change from baseline in mean depression score in transmales, measured using the CESD-R (approximately 12-month follow-up; controlled for engagement in counselling and medicines for mental health problems). Higher scores indicate more severe depression.									
1 cohort study Achille et al. 2020	Serious limitations ¹	Serious indirectness ²	No serious inconsistency	Not calculable	N=33	None	No statistically significant change from baseline (p=0.43) Numerical scores not reported	Critical	VERY LOW
Change from baseline in depression score in transfemales, measured using the Patient Health Questionnaire Modified for Teens (PHQ 9 Modified for Teens) (approximately 12-month follow-up; controlled for engagement in counselling and medicines for mental health problems). Higher scores indicate more severe depression.									
1 cohort study Achille et al. 2020	Serious limitations ¹	Serious indirectness ²	No serious inconsistency	Not calculable	N=17	None	No statistically significant change from baseline (p=0.07) Numerical scores not reported	Critical	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Change from baseline in depression score in transmales, measured using the Patient Health Questionnaire Modified for Teens (PHQ 9_Modified for Teens) (approximately 12-month follow-up; controlled for engagement in counselling and medicines for mental health problems). Higher scores indicate more severe depression.									
1 cohort study Achille et al. 2020	Serious limitations ¹	Serious indirectness ²	No serious inconsistency	Not calculable	N=33	None	No statistically significant change from baseline (p=0.67) Numerical scores not reported	Critical	VERY LOW
Impact on quality of life (1 uncontrolled, retrospective observational study)									
Change from baseline in mean quality of life score in transfemales, measured using the QLES-Q-SF (approximately 12-month follow-up; controlled for engagement in counselling and medicines for mental health problems). Higher scores indicated better quality of life.									
1 cohort study Achille et al. 2020	Serious limitations ¹	Serious indirectness ²	No serious inconsistency	Not calculable	N=17	None	No statistically significant change from baseline (p=0.06)	Critical	VERY LOW
Change from baseline in mean quality of life score in transmales, measured using the QLES-Q-SF (approximately 12-month follow-up; controlled for engagement in counselling and medicines for mental health problems). Higher scores indicated better quality of life.									
1 cohort study Achille et al. 2020	Serious limitations ¹	Serious indirectness ²	No serious inconsistency	Not calculable	N=33	None	No statistically significant change from baseline (p=0.08)	Critical	VERY LOW
Psychosocial Impact (1 uncontrolled, retrospective observational study)									
Functioning in adolescent development: Progresses normatively in school/ work during the real-life phase – impact on need for mental health treatment before or during gender identity assessment									
1 cohort study Kaltiala et al. 2020	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=49	None	Needed mental health treatment: 47% (15/32) functioning well Did not need mental health treatment: 82% (14/17) functioning well Statistically significant difference p=0.02	Important	VERY LOW
Functioning in adolescent development: Is age-appropriately able to deal with matters outside of the home during the real-life phase – impact on need for mental health treatment before or during gender identity assessment									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
1 cohort study Kaltiala et al. 2020	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=49	None	Needed mental health treatment: 72% (23/32) managing well Did not need mental health treatment: 94% (16/17) managing well No statistically significant difference p=0.06	Important	VERY LOW
Functioning in adolescent development: Progresses normatively in school/ work during the real-life phase – impact on need for mental health treatment during the real-life phase									
1 cohort study Kaltiala et al. 2020	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=51	None	Needed mental health treatment: 42% (10/24) functioning well Did not need mental health treatment: 74% (20/27) functioning well Statistically significant difference p=0.02	Important	VERY LOW
Functioning in adolescent development: Is age-appropriately able to deal with matters outside of the home during the real-life phase – impact on need for mental health treatment during the real-life phase									
1 cohort study Kaltiala et al. 2020	Serious limitations ³	No serious indirectness	No serious inconsistency	Not calculable	N=51	None	Needed mental health treatment: 67% (16/24) managing well Did not need mental health treatment: 93% (25/27) managing well Statistically significant difference p=0.02	Important	VERY LOW

Abbreviations: CESD-R: Center for Epidemiologic Studies Depression; p: p-value; PHQ 9: Patient Health Questionnaire 9; QLES-Q-SF: Quality of Life Enjoyment and Satisfaction Questionnaire

1 Downgraded 1 level - the cohort study by Achille et al 2020 was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

2 Serious indirectness in Achille 2020- Approximately 30% of the full sample received puberty suppression alone or were receiving no treatment at final follow-up.

3 Downgraded 1 level - the cohort study by Kaltiala et al. 2020 was assessed at high risk of bias (poor quality; lack of blinding and no control).

Table 15: From the evidence selected, are there particular sub-groups of children and adolescents with gender dysphoria that derive comparatively more (or less) benefit from treatment with gender-affirming hormones than the wider population of children and adolescents with gender dysphoria? – Tanner age

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of patients		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result (95% CI)		
Impact on mental health (1 uncontrolled, retrospective observational study)									
Change from baseline in mental health problems – depression, anxiety and anxiety-related symptoms (mean duration of gender-affirming hormone treatment was 10.9 months)									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=105	None	No difference in outcomes found by Tanner age. Numerical results, statistical analysis and information on specific outcomes not reported. It is unclear from the paper whether Tanner age is at initial assessment, start of GnRH analogues, start of gender-affirming hormones, or another timepoint	Critical	VERY LOW
Impact on body image (1 uncontrolled, prospective observational study)									
Change from baseline in mean body image, measured using the BIS (mean duration of gender-affirming hormone treatment was 10.9 months). Higher scores represent a higher degree of body dissatisfaction.									
1 cohort study Kuper et al. 2020	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=105	None	No difference in body image score found by Tanner age. Numerical results, statistical analysis and information on specific outcomes not reported.	Important	VERY LOW

							It is unclear from the paper whether Tanner age is at initial assessment, start of GnRH analogues, start of gender-affirming hormones, or another timepoint		
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Abbreviations: BIS: Body Image Scale

1 Downgraded 1 level - the cohort study by Kuper et al. 2020 was assessed at high risk of bias (poor quality; lack of blinding, no control group and high number of participants lost to follow-up).

Glossary

Ask Suicide-Screening Questions (ASQ)	ASQ is a four-item dichotomous (yes, no) response measure with high sensitivity, designed to identify risk of suicide. A patient is considered to have screened positive if they answered yes to any item. The authors of Allen et al. 2019 altered the fourth item of the ASQ ("Have you ever tried to kill yourself?") and prefaced it with "In the past few weeks . . ." as they were not investigating lifetime suicidality. A response of 'no' was scored as 0 and a response of 'yes' was scored as 1; each item was summed, generating an overall score for suicidality on a scale ranging from 0 to 4, with higher scores indicating greater levels of suicidal ideation.
Beck Depression Inventory-II (BDI-II)	The BDI-II is a tool for assessing depressive symptoms. There are no specific scores to categorise depression severity, but it is suggested that 0 to 13 is minimal symptoms, 14 to 19 is mild depression, 20 to 28 is moderate depression, and severe depression is 29 to 63.
Body Image Scale (BIS)	The BIS is used to measure body satisfaction. The scale consists of 30 body features, which the person rates on a 5-point scale. Each of the 30 items falls into one of 3 basic groups based on its relative importance as a gender-defining body feature: primary sex characteristics, secondary sex characteristics, and neutral body characteristics. A higher score indicates more dissatisfaction.
Bone mineral apparent density (BMAD)	BMAD is a size adjusted value of bone mineral density (BMD) incorporating bone size measurements using UK norms in growing adolescents.
Center for Epidemiologic Studies Depression scale (CESD-R)	The CESD-R is a valid, widely used tool to assess depressive symptoms. The CESD-R asks about how frequently a person has felt or behaved in a certain way; with 20 questions scored from 0 score is calculated as a sum of 20 questions, ranging from 0 ("not at all or less than one day") to 3 ("5–7 days" and/or "nearly every day for 2 weeks"). Total score ranges from 0 to 60, with higher scores indicating more depressive symptoms.
Cisgender	Cisgender is a term for someone whose gender identity matches their birth-registered sex.
Family APGAR (Adaptability, Partnership, Growth, Affection and Resolve) test	The Family APGAR test is a 5-item questionnaire, with higher scores indicating better family functioning. The authors reported the following interpretation of the score: functional, 17-20 points; mildly dysfunctional, 16-13 points; moderately dysfunctional, 12-10 point; severely dysfunctional, <9 points.
Gender	The roles, behaviours, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men.
Gender dysphoria	Discomfort or distress that is caused by a discrepancy between a person's gender identity (how they see themselves regarding their gender) and that person's sex assigned at birth (and the associated gender role, and/or primary and secondary sex characteristics).

General Well-Being Scale (GWBS) of the Pediatric Quality of Life Inventory score	The GWBS of the Pediatric Quality of Life Inventory uses a 5-point response scale, contains seven items, and measures two dimensions: general wellbeing (6 items) and general health (1 item). Each item is scored from 0 to 4, and the total score is linearly transformed to a 0 to 100 scale. High scores reflect fewer perceived problems and greater well-being.
GnRH analogue	GnRH analogues competitively block GnRH receptors to prevent the spontaneous release of two gonadotropin hormones, Follicular Stimulating Hormone (FSH) and Luteinising Hormone (LH) from the pituitary gland. The reduction in LH and FSH secretion reduces oestradiol secretion from the ovaries in those whose sex assigned at birth was female and testosterone secretion from the testes in those whose sex assigned at birth was male.
Patient Health Questionnaire Modified for Teens score (PHQ 9_Modified for Teens)	The PHQ 9_Modified for Teens is a validated tool to assess depression, dysthymia and suicide risk. The tool consists of 9 questions scored from 0 to 3 (total score 0 to 27), plus an additional 4 questions that are not scored. A score of 0 to 4 suggests no or minimal depressive symptoms, 5 to 9 mild, 10-14 moderate, 15-19 moderate and 20-27 severe symptoms.
Quick Inventory of Depressive Symptoms (QIDS)	Both the clinician- and self-reported QIDS are validated tools to assess depressive symptoms. The tool consists of 16 items, with the highest score for 9 items (sleep, weight, psychomotor changes, depressed mood, decreased interest, fatigue, guilt, concentration, and suicidal ideation) are added to give a total score ranging from 0 to 27. A score of 0 to 5 is suggestive of no depressive symptoms, 6 to 10 mild symptoms, 11 to 15 moderate symptoms, 16-20 severe symptoms and 21 to 27 very severe symptoms.
Quality of Life Enjoyment and Satisfaction Questionnaire (QLES-Q-SF)	QLES-Q-SF is a validated questionnaire, consisting of 15 questions that rate quality of life on a scale of 1 (poor) to 5 (very good).
Screen for Child Anxiety Related Emotional Disorders (SCARED) questionnaire	SCARED is a validated, 41-point questionnaire, with each item scored 0 to 2. A total score of 25 or more is suggestive of anxiety disorder, with scores above 30 being more specific. Certain scores for specific questions may indicate the presence of other anxiety-related disorders: A score of 7 or more in questions related to panic disorder or significant somatic symptoms may indicate the presence of these. A score of 9 or more in questions related to generalised anxiety disorder may indicate the presence of this. A score of 5 or more in questions related to separation anxiety may indicate the presence of this. A score of 8 or more in questions related to social anxiety disorder may indicate the presence of this. A score of 3 or more in questions related to significant school avoidance may indicate the presence of this.
State-Trait Anxiety Inventory (STAI) score	STAI is a validated and commonly used measure of state anxiety (current state of anxiety) and trait anxiety (general state of calmness, confidence and security). It has 40 items, the first 20 covering state anxiety, the second 20 covering trait anxiety. STAI

	can be used in clinical settings to diagnose anxiety and to distinguish it from depressive illness. Each subtest (state and trait) is scored between 20 and 80, with higher scores indicating greater anxiety. There is no published minimal clinically meaningful difference (MCID) for STAI or thresholds for anxiety severity.
Strengths and Difficulties Questionnaire (SDQ, Spanish version)	The SDQ, Spanish version includes 25-items covering emotional symptoms, conduct problems, hyperactivity/ inattention, peer relationship problems and prosocial behaviour. The authors state that a score of more than 20 is considered indicative of risk of having a disorder (normal: 0-15; borderline: 16-19, abnormal: 20-40).
Tanner stage	Tanner staging is a scale of physical development.
Transgender (including transmale and transfemale)	Transgender is a term for someone whose gender identity is not congruent with their birth-registered sex. A transfemale is a person who identifies as female and a transmale is a person who identifies as male.
Utrecht Gender Dysphoria Scale (UGDS)	The UGDS is a validated screening tool for both adolescents and adults to assess gender dysphoria. It consists of 12 items, to be answered on a 1- to 5-point scale, resulting in a sum score between 12 and 60. Higher scores indicate higher levels of gender dysphoria.

References

Included studies

- Achille, C., Taggart, T., Eaton, N.R. et al. (2020) [Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results](#). International Journal of Pediatric Endocrinology 2020(1): 8
- Allen, LR, Watson, LB, Egan, AM et al. (2019) [Well-being and suicidality among transgender youth after gender-affirming hormones](#). Clinical Practice in Pediatric Psychology 7(3): 302-311
- Kaltiala, R., Heino, E., Tyolajarvi, M. et al. (2020) [Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria](#). Nordic Journal of Psychiatry 74(3): 213-219
- Khatchadourian K, Amed S, Metzger DL (2014) [Clinical management of youth with gender dysphoria in Vancouver](#). The Journal of pediatrics 164(4): 906-11
- Klaver, Maartje, de Mutsert, Renee, van der Loos, Maria A T C et al. (2020) [Hormonal Treatment and Cardiovascular Risk Profile in Transgender Adolescents](#). Pediatrics 145(3)
- Klink D, Caris M, Heijboer A et al. (2015) [Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria](#). The Journal of Clinical Endocrinology and Metabolism 100(2): e270-5

- Kuper, Laura E, Stewart, Sunita, Preston, Stephanie et al. (2020) [Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy](#). *Pediatrics* 145(4)
- Lopez de Lara, D., Perez Rodriguez, O., Cuellar Flores, I. et al. (2020) [Psychosocial assessment in transgender adolescents](#). *Anales de Pediatría*
- Stoffers, Iris E; de Vries, Martine C; Hannema, Sabine E (2019) [Physical changes, laboratory parameters, and bone mineral density during testosterone treatment in adolescents with gender dysphoria](#). *The journal of sexual medicine* 16(9): 1459-1468
- Vlot MC, Klink DT, den Heijer M et al. (2017) [Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density \(BMAD\) in transgender adolescents](#). *Bone* 95: 11-19

Other references

- World Health Organisation (2018) International Classification of Diseases 11. Available from <https://icd.who.int/> [accessed 27 August 2020]
- American Psychiatric Association. (2013). *Diagnostic and statistical Manual of Mental Disorders (DSM-5)* (5th ed). Washington, DC and London: American Psychiatric Publishing. pp.451-460. Available from: <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> [accessed 27 August 2020]
- NHS England (2013). NHS Standard contract for gender identity development service for children and adolescents <https://www.england.nhs.uk/wp-content/uploads/2017/04/gender-development-service-children-adolescents.pdf> [accessed 27 August 2020]
- NHS England (2016). Clinical Commissioning Policy: Prescribing of Cross-Sex Hormones as part of the Gender Identity Development Service for Children and Adolescents <https://www.england.nhs.uk/wp-content/uploads/2018/07/Prescribing-of-cross-sex-hormones-as-part-of-the-gender-identity-development-service-for-children-and-adolesce.pdf> [accessed 27 August 2020]

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Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria

This document will help inform Dr Hilary Cass' independent review into gender identity services for children and young people. It was commissioned by NHS England and Improvement who commissioned the Cass review. It aims to assess the evidence for the clinical effectiveness, safety and cost-effectiveness of gonadotrophin releasing hormone (GnRH) analogues for children and adolescents aged 18 years or under with gender dysphoria.

The document was prepared by NICE in October 2020.

The content of this evidence review was up to date on 14 October 2020. See [summaries of product characteristics](#) (SPCs), [British National Formulary](#) (BNF) or the [Medicines and Healthcare products Regulatory Agency](#) (MHRA) or [NICE](#) websites for up-to-date information.

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1. Introduction

This review aims to assess the evidence for the clinical effectiveness, safety and cost-effectiveness of gonadotrophin releasing hormone (GnRH) analogues for children and adolescents aged 18 years or under with gender dysphoria. The review follows the NHS England Specialised Commissioning process and template and is based on the criteria outlined in the PICO framework (see [appendix A](#)). This document will help inform Dr Hilary Cass' independent review into gender identity services for children and young people.

Gender dysphoria in children, also known as gender identity disorder or gender incongruence of childhood ([World Health Organisation 2020](#)), refers to discomfort or distress that is caused by a discrepancy between a person's gender identity (how they see themselves¹ regarding their gender) and that person's sex assigned at birth and the associated gender role, and/or primary and secondary sex characteristics ([Diagnostic and Statistical Manual of Mental Disorders 2013](#)).

GnRH analogues suppress puberty by delaying the development of secondary sexual characteristics. The intention is to alleviate the distress associated with the development of secondary sex characteristics, thereby providing a time for on-going discussion and exploration of gender identity before deciding whether to take less reversible steps. In England, the GnRH analogue triptorelin (a synthetic decapeptide analogue of natural GnRH, which has marketing authorisations for the treatment of prostate cancer, endometriosis and precocious puberty [onset before 8 years in girls and 10 years in boys]) is used for this purpose. The use of triptorelin for children and adolescents with gender dysphoria is [off-label](#).

For children and adolescents with gender dysphoria it is recommended that management plans are tailored to the needs of the individual, and aim to ameliorate the potentially negative impact of gender dysphoria on general developmental processes, support young people and their families in managing the uncertainties inherent in gender identity development and provide on-going opportunities for exploration of gender identity. The plans may also include psychological support and exploration and, for some individuals, the use of GnRH analogues in adolescence to suppress puberty; this may be followed later with gender-affirming hormones of the desired sex ([NHS England 2013](#)).

2. Executive summary of the review

Nine observational studies were included in the evidence review. Five studies were retrospective observational studies ([Brik et al. 2020](#), [Joseph et al. 2019](#), [Khatchadourian et al. 2014](#), [Klink et al. 2015](#), [Vlot et al. 2017](#)), 3 studies were prospective longitudinal observational studies ([Costa et al. 2015](#), [de Vries et al. 2011](#), [Schagen et al. 2016](#)) and 1 study was a cross-sectional study ([Staphorsius et al. 2015](#)). Two studies (Costa et al. 2015

¹ Gender refers to the roles, behaviours, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men ([World Health Organisation, Health Topics: Gender](#)).

and Staphorsius et al. 2015) provided comparative evidence and the remaining 7 studies used within-person, before and after comparisons.

The terminology used in this topic area is continually evolving and is different depending on stakeholder perspectives. In this evidence review we have used the phrase 'people's assigned sex at birth' rather than natal or biological sex, gonadotrophin releasing hormone (GnRH) analogues rather than 'puberty blockers' and gender-affirming hormones rather than 'cross sex hormones'. The research studies included in this evidence review may use historical terms which are no longer considered appropriate.

In children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Critical outcomes

The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low certainty using modified GRADE.

Impact on gender dysphoria

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that treatment with GnRH analogues before starting gender-affirming hormones does not affect gender dysphoria (measured using the Utrecht Gender Dysphoria Scale [UGDS]). The mean (\pm SD) gender dysphoria (UGDS) score was not statistically significantly different at baseline compared with follow-up ($n=41$, 53.20 [± 7.91] versus 53.9 [± 17.42], $p=0.333$).

Impact on mental health

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that treatment with GnRH analogues before starting gender-affirming hormones may reduce depression (measured using the Beck Depression Inventory-II [BDI-II]). The mean (\pm SD) BDI score was statistically significantly lower (improved) from baseline compared with follow-up ($n=41$, 8.31 [± 7.12] versus 4.95 [± 6.72], $p=0.004$).

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that treatment with GnRH analogues before starting gender-affirming hormones does not affect anger (measured using the Trait Anger Scale [TPI]). The mean (\pm SD) anger (TPI) score was not statistically significantly different at baseline compared with follow-up ($n=41$, 18.29 [± 5.54] versus 17.88 [± 5.24], $p=0.503$).

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that treatment with GnRH analogues before starting gender-affirming hormones does not affect anxiety (measured using the Trait Anxiety Scale [STAI]). The mean (\pm SD) anxiety (STAI) score was not statistically significantly different at baseline compared with follow-up ($n=41$, 39.43 [± 10.07] versus 37.95 [± 9.38], $p=0.276$).

Impact on quality of life

No evidence was identified.

Important outcomes

The important outcomes for decision making are impact on body image, psychosocial impact, engagement with health care services, impact on extent of and satisfaction with surgery and stopping treatment. The quality of evidence for all these outcomes was assessed as very low certainty using modified GRADE.

Impact on body image

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that treatment with GnRH analogues before starting gender-affirming hormones does not affect body image (measured using the Body Image Scale [BIS]). The mean [\pm SD] body image (BIS) scores were not statistically significantly different from baseline compared with follow-up for primary sexual characteristics (n=57, 4.10 [\pm 0.56] versus 3.98 [\pm 0.71], p=0.145), secondary sexual characteristics (n=57, 2.74 [\pm 0.65] versus 2.82 [\pm 0.68], p=0.569) or neutral body characteristics (n=57, 2.41 [\pm 0.63] versus 2.47 [\pm 0.56], p=0.620).

Psychosocial impact

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that treatment with GnRH analogues before starting gender-affirming hormones may improve psychosocial impact over time (measured using the Children's Global Assessment Scale [CGAS]). The mean [\pm SD] CGAS score was statistically significantly higher (improved) from baseline compared with follow-up (n=41, 70.24 [\pm 10.12] versus 73.90 [\pm 9.63], p=0.005).

This study also found that psychosocial functioning may improve over time (measured using the Child Behaviour Checklist [CBCL] and the self-administered Youth Self-Report [YSR]). The mean [\pm SD] CBCL scores were statistically significantly lower (improved) from baseline compared with follow-up for Total T score (n=54, 60.70 [\pm 12.76] versus 54.46 [\pm 11.23], p<0.001), internalising T score (n=54, 61.00 [\pm 12.21] versus 52.17 [\pm 9.81], p<0.001) and externalising T score (n=54, 58.04 [\pm 12.99] versus 53.81 [\pm 11.86], p=0.001). The mean [\pm SD] YSR scores were statistically significantly lower (improved) from baseline compared with follow-up for Total T score (n=54, 55.46 [\pm 11.56] versus 50.00 [\pm 10.56], p<0.001), internalising T score (n=54, 56.04 [\pm 12.49] versus 49.78 [\pm 11.63], p<0.001) and externalising T score (n=54, 53.30 [\pm 11.87] versus 49.98 [\pm 9.35], p=0.009). The proportion of adolescents scoring in the clinical range decreased from baseline to follow up on the CBCL total problem scale (44.4% versus 22.2%, p=0.001) and the internalising scale of the YSR (29.6% versus 11.1%, p=0.017).

The study by [Costa et al. 2015](#) in 201 adolescents with gender dysphoria who had 6 months of psychological support followed by either GnRH analogues and continued psychological support or continued psychological support only, found that during treatment with GnRH analogues psychosocial impact in terms of global functioning may improve over time (measured using the CGAS). In the group receiving GnRH analogues, the mean [\pm SD] CGAS score was statistically significantly higher (improved) after 6 months (n=60, 64.70 [\pm 13.34]) and 12 months (n=35, 67.40 [\pm 13.39]) compared with baseline (n=101, 58.72 [\pm 11.38], p=0.003 and p<0.001, respectively). However, there was no statistically significant difference in global functioning (CGAS scores) between the group receiving GnRH analogues plus psychological support and the group receiving psychological support only at any time point.

The study by [Staphorsius et al. 2015](#) in 40 adolescents with gender dysphoria (20 of whom were receiving GnRH analogues) gave mean [\pm SD] CBCL scores for each group, but statistical analysis is unclear (transfemales receiving GnRH analogues 57.4 [\pm 9.8], transfemales not receiving GnRH analogues 58.2 [\pm 9.3], transmales receiving GnRH analogues 57.5 [\pm 9.4], transmales not receiving GnRH analogues 63.9 [\pm 10.5]).

Engagement with health care services

The study by [Brik et al. 2018](#) in 143 children and adolescents with gender dysphoria receiving GnRH analogues found that 9 adolescents in the original sampling frame (9/214, 4.2%) were excluded from the study because they stopped attending appointments.

The study by [Costa et al. 2015](#) in 201 adolescents with gender dysphoria who had 6 months of psychological support followed by either GnRH analogues and continued psychological support or continued psychological support only had a large loss to follow-up over time. The sample size at baseline and 6 months was 201, which dropped by 39.8% to 121 after 12 months and by 64.7% to 71 at 18 months follow-up. No explanation of the reasons for loss to follow-up are reported.

Impact on extent of and satisfaction with surgery

No evidence was identified.

Stopping treatment

The study by [Brik et al. 2018](#) in 143 children and adolescents with gender dysphoria receiving GnRH analogues reported the reasons for stopping GnRH analogues. During the follow-up period 6.2% (9/143) of adolescents had stopped GnRH analogues after a median duration of 0.8 years (range 0.1 to 3.0). Five adolescents stopped treatment because they no longer wished to receive gender-affirming treatment for various reasons. In 4 adolescents (all transmales), GnRH analogues were stopped mainly because of adverse effects (such as mood and emotional lability), although they wanted to continue treatments for gender dysphoria.

The study by [Khatchadourian et al. 2014](#) in 27 adolescents with gender dysphoria who started GnRH analogues reported the reasons for stopping them. Eleven out of 26 where data was available (42%) stopped GnRH analogues during follow up.

In children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Evidence was available for bone density, cognitive development or functioning, and other safety outcomes. The quality of evidence for all these outcomes was assessed as very low certainty using modified GRADE.

Bone density

The study by [Joseph et al. 2019](#) in 70 adolescents with gender dysphoria found that GnRH analogues may reduce the expected increase in lumbar or femoral bone density (measured with the z-score). However, the z-scores were largely within 1 standard deviation of normal,

and actual lumbar or femoral bone density values were not statistically significantly different between baseline and follow-up:

- The mean z-score [\pm SD] for lumbar bone mineral apparent density (BMAD) was statistically significantly lower at 1 year compared with baseline in transfemales (baseline 0.859 [\pm 0.154], 1 year -0.228 [\pm 1.027], $p=0.000$) and transmales (baseline -0.186 [\pm 1.230], 1 year -0.541 [\pm 1.396], $p=0.006$).
- The mean z-score [\pm SD] for lumbar BMAD was statistically significantly lower after receiving GnRH analogues for 2 years compared with baseline in transfemales (baseline 0.486 [\pm 0.809], 2 years -0.279 [\pm 0.930], $p=0.000$) and transmales (baseline -0.361 [\pm 1.439], 2 years -0.913 [\pm 1.318], $p=0.001$).
- The mean z-score [\pm SD] for femoral neck bone mineral density (BMD) was statistically significantly lower after receiving GnRH analogues for 2 years compared with baseline in transfemales (baseline 0.0450 [\pm 0.781], 2 years -0.600 [\pm 1.059], $p=0.002$) and transmales (baseline -1.075 [\pm 1.145], 2 years -1.779 [\pm 0.816], $p=0.001$).

The study by [Klink et al. 2015](#) in 34 adolescents with gender dysphoria found that GnRH analogues may reduce the expected increase in lumbar (transmales only), but not femoral bone density. However, the z-scores are largely within 1 standard deviation of normal. Actual lumbar or femoral bone density values were not statistically significantly different between baseline and follow-up (apart from BMD measurements in transmales):

- The mean z-score [\pm SD] for lumbar BMAD was not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales, but was statistically significantly lower when starting gender-affirming hormones in transmales (GnRH analogues 0.28 [\pm 0.90], gender-affirming hormones -0.50 [\pm 0.81], $p=0.004$).

The study by [Vlot et al. 2017](#) in 70 adolescents with gender dysphoria found that GnRH analogues may reduce the expected increase in lumbar or femoral bone density. However, the z-scores were largely within 1 standard deviation of normal. Actual lumbar or femoral bone density values were not statistically significantly different between baseline and follow-up (apart from in transmales with a bone age ≥ 14 years). This study reported change in bone density from starting GnRH analogues to starting gender-affirming hormones by bone age:

- The median z-score [range] for lumbar BMAD in transfemales with a bone age of <15 years was statistically significantly lower at starting gender-affirming hormones than at starting GnRH analogues (GnRH analogues -0.20 [-1.82 to 1.18], gender-affirming hormones -1.52 [-2.36 to 0.42], $p=0.001$) but was not statistically significantly different in transfemales with a bone age ≥ 15 years.
- The median z-score [range] for lumbar BMAD in transmales with a bone age of <14 years was statistically significantly lower at starting gender-affirming hormones than at starting GnRH analogues (GnRH analogues -0.05 [-0.78 to 2.94], gender-affirming hormones -0.84 [-2.20 to 0.87], $p=0.003$) and in transmales with a bone age ≥ 14 years (GnRH analogues 0.27 [-1.60 to 1.80], gender-affirming hormones -0.29 [-2.28 to 0.90], $p\leq 0.0001$).

- The median z-score [range] for femoral neck BMAD in transfemales with a bone age of <15 years was not statistically significantly lower at starting gender-affirming hormones than at starting GnRH analogues (GnRH analogues -0.71 [-3.35 to 0.37], gender-affirming hormones -1.32 [-3.39 to 0.21], $p \leq 0.1$) or in transfemales with a bone age ≥ 15 years (GnRH analogues -0.44 [-1.37 to 0.93], gender-affirming hormones -0.36 [-1.50 to 0.46]).
- The z-score for femoral neck BMAD in transmales with a bone age of <14 years was not statistically significantly lower at starting gender-affirming hormones than at starting GnRH analogues (GnRH analogues -0.01 [-1.30 to 0.91], gender-affirming hormone -0.37 [-2.28 to 0.47]) but was statistically significantly lower in transmales with a bone age ≥ 14 years (GnRH analogues 0.27 [-1.39 to 1.32], gender-affirming hormones -0.27 [-1.91 to 1.29], $p=0.002$).

Cognitive development or functioning

The study by [Staphorsius et al. 2015](#) in 40 adolescents with gender dysphoria (20 of whom were receiving GnRH analogues) measured cognitive development or functioning (using an IQ test, and reaction time and accuracy measured using the Tower of London task):

- The mean (\pm SD) IQ in transfemales receiving GnRH analogues was 94.0 (± 10.3) and 109.4 (± 21.2) in the control group. In transmales receiving GnRH analogues the mean (\pm SD) IQ was 95.8 (± 15.6) and 98.5 (± 15.9) in the control group.
- The mean (\pm SD) reaction time in transfemales receiving GnRH analogues was 10.9 (± 4.1) and 9.9 (± 3.1) in the control group. In transmales receiving GnRH analogue it was 9.9 (± 3.1) and 10.0 (± 2.0) in the control group.
- The mean (\pm SD) accuracy score in transfemales receiving GnRH analogues was 73.9 (± 9.1) and 83.4 (± 9.5) in the control group. In transmales receiving GnRH analogues it was 85.7 (± 10.5) and 88.8 (± 9.7) in the control group.

No statistical analyses or interpretation of the results was reported.

Other safety outcomes

The study by [Schagen et al. 2016](#) in 116 adolescents with gender dysphoria found that GnRH analogues do not affect renal or liver function:

- There was no statistically significant difference between baseline and 1 year results for serum creatinine in transfemales, but there was a statistically significant decrease between baseline and 1 year in transmales ($p=0.01$).
- Glutaryl transferase, alanine aminotransferase (ALT), and aspartate aminotransferase (AST) levels did not significantly change from baseline to 12 months of treatment.

The study by [Khatchadourian et al. 2014](#) in 27 adolescents with gender dysphoria who started GnRH analogues narratively reported adverse effects from GnRH analogues in 26 adolescents:

- 1 transmale developed sterile abscesses; they were switched from leuprolide acetate to triptorelin, and this was well tolerated
- 1 transmale developed leg pains and headaches, which eventually resolved
- 1 participant gained 19 kg within 9 months of starting GnRH analogues.

In children and adolescents with gender dysphoria, what is the cost-effectiveness of GnRH analogues compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?

No cost-effectiveness evidence was found for GnRH analogues in children and adolescents with gender dysphoria.

From the evidence selected, are there any subgroups of children and adolescents with gender dysphoria that may benefit from GnRH analogues more than the wider population of interest?

Some studies reported data separately for the following subgroups of children and adolescents with gender dysphoria: sex assigned at birth males (transfemales) and sex assigned at birth females (transmales). This included some direct comparisons of these subgroups, and differences were largely seen at baseline as well as follow up. No evidence was found for other specified subgroups.

Sex assigned at birth males (transfemales)

Impact on gender dysphoria

The study by [Costa et al. 2015](#) in 201 adolescents with gender dysphoria who had 6 months of psychological support followed by either GnRH analogues and continued psychological support or continued psychological support only, found that gender dysphoria (measured using the UGDS) in sex assigned at birth males is lower than in sex assigned at birth females. Sex assigned at birth males had a statistically significantly lower (improved) mean [\pm SD] UGDS score of 51.6 [\pm 9.7] compared with sex assigned at birth females (56.1 [\pm 4.3], $p < 0.001$), but it was not reported if this was at baseline or follow-up.

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that gender dysphoria (measured using the UGDS) in sex assigned at birth males is lower than in sex assigned at birth females at baseline and follow up. The mean [\pm SD] UGDS score was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at baseline (n =not reported, mean UGDS score: 47.95 [\pm 9.70] versus 56.57 [\pm 3.89]) and follow up (n =not reported, 49.67 [\pm 9.47] versus 56.62 [\pm 4.00]); between sex difference $p < 0.001$).

Impact on mental health

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that the impact on mental health (depression, anger and anxiety) may be different in sex assigned at birth males compared with sex assigned at birth females. Over time there was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for depression, but sex assigned at birth males had statistically significantly lower levels of anger and anxiety than sex assigned at birth females at baseline and follow up.

- The mean [\pm SD] depression (BDI-II) score was not statistically significantly different in sex assigned at birth males compared with sex assigned at birth females at baseline (n =not reported, mean BDI score [\pm SD]: 5.71 [\pm 4.31] versus 10.34 [\pm 8.24]) and follow-up (n =not reported, 3.50 [\pm 4.58] versus 6.09 [\pm 7.93]), between sex difference $p = 0.057$

- The mean [\pm SD] anger (TPI) score was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at baseline (n=not reported, mean TPI score [\pm SD]: 5.22 [\pm 2.76] versus 6.43 [\pm 2.78]) and follow-up (n=not reported, 5.00 [\pm 3.07] versus 6.39 [\pm 2.59]), between sex difference $p=0.022$
- The mean [\pm SD] anxiety (STAI) score was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at baseline (n=not reported, mean STAI score [\pm SD]: 4.33 [\pm 2.68] versus 7.00 [\pm 2.36]) and follow-up (n=not reported, 4.39 [\pm 2.64] versus 6.17 [\pm 2.69]), between sex difference $p<0.001$.

Impact on body image

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that the impact on body image may be different in sex assigned at birth males compared with sex assigned at birth females. Sex assigned at birth males are less dissatisfied with their primary and secondary sex characteristics than sex assigned at birth females at both baseline and follow up, but the satisfaction with neutral body characteristics is not different.

- The mean [\pm SD] BIS score for primary sex characteristics was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at baseline (n=not reported, mean BIS score [\pm SD]: 4.02 [\pm 0.61] versus 4.16 [\pm 0.52]) and follow up (n=not reported, 3.74 [\pm 0.78] versus 4.17 [\pm 0.58]) between sex difference $p=0.047$.
- The mean [\pm SD] BIS score for secondary sex was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at baseline (n=not reported, mean BIS score [\pm SD]: 2.66 [\pm 0.50] versus 2.81 [\pm 0.76]) and follow up (n=not reported, 2.39 [\pm 0.69] versus 3.18 [\pm 0.42]), between sex difference $p=0.001$.
- The mean [\pm SD] BIS score for neutral body characteristics was not statistically significantly different in sex assigned at birth males compared with sex assigned at birth females at baseline (n=not reported, 2.60 [\pm 0.58] versus 2.24 [\pm 0.62]), between sex difference $p=0.777$.

Psychosocial impact

The study by [Costa et al. 2015](#) in 201 adolescents with gender dysphoria who had 6 months of psychological support followed by either GnRH analogues and continued psychological support or continued psychological support only, found that sex assigned at birth males had statistically significant lower mean [\pm SD] CGAS scores at baseline compared with sex assigned at birth females (n=201, 55.4 [\pm 12.7] versus 59.2 [\pm 11.8], $p=0.03$), but no conclusions could be drawn.

The study by [de Vries et al. 2011](#) in 70 adolescents with gender dysphoria found that psychosocial impact in terms of global functioning (CGAS) and psychosocial functioning (CBCL and YSR) may be different in sex assigned at birth males compared with sex assigned at birth females, but no conclusions could be drawn.

- There was no statistically significant difference between sex assigned at birth males and sex assigned at birth females (at baseline or follow up) for the CBCL Total T

score, the CBCL internalising T score, the YSR Total T score or the YSR internalising T score.

- Sex assigned at birth males had statistically higher mean [\pm SD] CGAS scores compared with sex assigned at birth females at baseline (n=54, 73.10 [\pm 8.44] versus 67.25 [\pm 11.06]) and follow up (n=54, 77.33 [\pm 8.69] versus 70.30 [\pm 9.44]), between sex difference p=0.021.
- Sex assigned at birth males had statistically lower mean [\pm SD] CBCL externalising T scores compared with sex assigned at birth females at baseline (n=54, 54.71 [\pm 12.91] versus 60.70 [\pm 12.64]) and follow up (n=54, 48.75 [\pm 10.22] versus 57.87 [\pm 11.66]), between sex difference p=0.015.
- Sex assigned at birth males had statistically lower mean [\pm SD] YSR externalising T scores compared with sex assigned at birth females at both baseline (n=54, 48.72 [\pm 11.38] versus 57.24 [\pm 10.59]) and follow up (n=54, 46.52 [\pm 9.23] versus 52.97 [\pm 8.51]), between sex difference p=0.004.

Bone density

The studies by [Joseph et al. 2019](#), [Klink et al. 2015](#) and [Vlot et al. 2017](#) provided evidence on bone density in sex assigned at birth males (see above for details).

Cognitive development or functioning

The study by [Staphorsius et al. 2015](#) provided evidence on cognitive development or functioning in sex assigned at birth males (see above for details).

Other safety outcomes

The study by [Schagen et al. 2016](#) provided evidence on renal function in sex assigned at birth males (see above).

Sex assigned at birth females (transmales)

Impact on gender dysphoria

The studies by [de Vries et al. 2011](#) and [Costa et al. 2015](#) found that gender dysphoria (measured using the UGDS) in sex assigned at birth females is higher than in sex assigned at birth males at baseline and follow up (see above for details).

Impact on mental health

The study by [de Vries et al. 2011](#) found that the impact on mental health (depression, anger and anxiety) may be different in sex assigned at birth females compared with sex assigned at birth males. Over time there was no statistically significant difference between sex assigned at birth females and sex assigned at birth males for depression, but sex assigned at birth females had statistically significantly greater levels of anger and anxiety than sex assigned at birth males at both baseline and follow up (see above for details).

Impact on body image

The study by [de Vries et al. 2011](#) found that the impact on body image may be different in sex assigned at birth females compared with sex assigned at birth males. Sex assigned at birth females are more dissatisfied with their primary and secondary sex characteristics than sex assigned at birth males at both baseline and follow up, but the satisfaction with neutral body characteristics is not different (see above for details).

Psychosocial impact

The studies by [de Vries et al. 2011](#) and [Costa et al. 2015](#) found that psychosocial impact in terms of global functioning (CGAS) and psychosocial functioning (CBCL and YSR) may be different in sex assigned at birth females compared with sex assigned at birth males, but no conclusions could be drawn (see above for details).

Bone density

The studies by [Joseph et al. 2019](#), [Klink et al. 2015](#) and [Vlot et al. 2017](#) provided evidence on bone density in sex assigned at birth females (see above for details).

Cognitive development or functioning

The study by [Staphorsius et al. 2015](#) provided evidence on cognitive development or functioning in sex assigned at birth females (see above for details).

Other safety outcomes

The study by [Schagen et al. 2016](#) provided evidence on renal function in sex assigned at birth females (see above for details).

From the evidence selected:

- (a) **what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?**
- (b) **what were the ages at which participants commenced treatment with GnRH analogues?**
- (c) **what was the duration of treatment with GnRH analogues?**

All studies that reported diagnostic criteria for gender dysphoria (6/9 studies) used the version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria that was in use at the time. In 5 studies ([Costa et al. 2015](#), [Klink et al. 2015](#), [Schagen et al. 2016](#), [Staphorsius et al. 2015](#) and [Vlot et al. 2017](#)) the DSM-fourth edition, text revision (IV-TR) criteria were used. The study by [Brik et al. 2020](#) used DSM-V criteria. It was not reported how gender dysphoria was defined in the remaining 3 studies.

The studies show variation in the age (11 to 18 years old) at which children and adolescents with gender dysphoria started GnRH analogues.

Most studies did not report the duration of treatment with GnRH analogues ([Joseph et al. 2019](#), [Khatchadourian et al. 2014](#), [Vlot et al. 2017](#), [Costa et al. 2015](#), [de Vries et al. 2011](#), [Schagen et al. 2016](#)), but where this was reported ([Brik et al. 2020](#), [Klink et al. 2015](#), [Staphorsius et al. 2015](#)) there was a wide variation ranging from a few months to about 5 years.

Discussion

A key limitation to identifying the effectiveness and safety of GnRH analogues for children and adolescents with gender dysphoria is the lack of reliable comparative studies. The lack of clear, expected outcomes from treatment with a GnRH analogue (the purpose of which is to suppress secondary sexual characteristics which may cause distress from unwanted pubertal changes) also makes interpreting the evidence difficult.

The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding, and all the results are of very low certainty using modified GRADE. They all reported physical and mental health comorbidities and concomitant treatments very poorly. All the studies are from a limited number of, mainly European, care facilities. They are described as either tertiary referral or expert services but the low number of services providing such care and publishing evidence may bias the results towards the outcomes in these services only and limit extrapolation.

Many of the studies did not report statistical significance or confidence intervals. Changes in outcome scores for clinical effectiveness and bone density were assessed with regards to statistical significance. However, there is relatively little interpretation of whether the changes in outcomes are clinically meaningful.

In the observational, retrospective studies providing evidence on bone density, participants acted as their own controls and change in bone density was determined between starting GnRH analogues and follow up. Observational studies such as these can only show an association with GnRH analogues and bone density; they cannot show that GnRH analogues caused any differences in bone density seen. Because there was no comparator group and participants acted as their own controls, it is not known whether the findings are associated with GnRH analogues or due to changes over time.

Conclusion

The results of the studies that reported impact on the critical outcomes of gender dysphoria and mental health (depression, anger and anxiety), and the important outcomes of body image and psychosocial impact (global and psychosocial functioning), in children and adolescents with gender dysphoria are of very low certainty using modified GRADE. They suggest little change with GnRH analogues from baseline to follow-up.

Studies that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance. It is plausible, however, that a lack of difference in scores from baseline to follow-up is the effect of GnRH analogues in children and adolescents with gender dysphoria, in whom the development of secondary sexual characteristics might be expected to be associated with an increased impact on gender dysphoria, depression, anxiety, anger and distress over time without treatment. The study by [de Vries et al. 2011](#) reported statistically significant reductions in the Child Behaviour Checklist (CBCL) and Youth Self-Report (YSR) scores from baseline to follow up, which include measures of distress. As the aim of GnRH analogues is to reduce distress caused by the development of secondary sexual characteristics, this may be an important finding. However, as the studies all lack appropriate controls who were not receiving GnRH analogues, any positive changes could be a regression to mean.

The results of the studies that reported bone density outcomes suggest that GnRH analogues may reduce the expected increase in bone density (which is expected during puberty). However, as the studies themselves are not reliable, the results could be due to confounding, bias or chance. While controlled trials may not be possible, comparative studies are needed to understand this association and whether the effects of GnRH analogues on bone density are seen after they are stopped. All the studies that reported safety outcomes provided very low certainty evidence.

No cost-effectiveness evidence was found to determine whether or not GnRH analogues are cost-effective for children and adolescents with gender dysphoria.

The results of the studies that reported outcomes for subgroups of children and adolescents with gender dysphoria, suggest there may be differences between sex assigned at birth males (transfemales) and sex assigned at birth females (transmales).

3. Methodology

Review questions

The review question(s) for this evidence review are:

1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?
2. For children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?
3. For children and adolescents with gender dysphoria, what is the cost-effectiveness of GnRH analogues compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?
4. From the evidence selected, are there any subgroups of children and adolescents with gender dysphoria that may derive more (or less) advantage from treatment with GnRH analogues than the wider population of children and adolescents with gender dysphoria?
5. From the evidence selected,
 - a) what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?
 - b) what were the ages at which participants commenced treatment with GnRH analogues?
 - c) what was the duration of treatment with GnRH analogues?

See [appendix A](#) for the full review protocol.

Review process

The methodology to undertake this review is specified by NHS England in their 'Guidance on conducting evidence reviews for Specialised Services Commissioning Products' (2020).

The searches for evidence were informed by the PICO document and were conducted on 23 July 2020

See [appendix B](#) for details of the search strategy.

Results from the literature searches were screened using their titles and abstracts for relevance against the criteria in the PICO framework. Full text references of potentially

relevant evidence were obtained and reviewed to determine whether they met the inclusion criteria for this evidence review.

See [appendix C](#) for evidence selection details and [appendix D](#) for the list of studies excluded from the review and the reasons for their exclusion.

Relevant details and outcomes were extracted from the included studies and were critically appraised using a checklist appropriate to the study design. See appendices [E](#) and [F](#) for individual study and checklist details.

The available evidence was assessed by outcome for certainty using modified GRADE. See [appendix G](#) for GRADE Profiles.

4. Summary of included studies

Nine observational studies were identified for inclusion. Five studies were retrospective observational studies ([Brik et al. 2020](#), [Joseph et al. 2019](#), [Khatchadourian et al. 2014](#), [Klink et al. 2015](#), [Vlot et al. 2017](#)), 3 studies were prospective longitudinal observational studies ([Costa et al. 2015](#), [de Vries et al. 2011](#), [Schagen et al. 2016](#)) and 1 study was a cross-sectional study ([Staphorsius et al. 2015](#)).

The terminology used in this topic area is continually evolving and is different depending on stakeholder perspectives. In this evidence review we have used the phrase 'people's assigned sex at birth' rather than natal or biological sex, gonadotrophin releasing hormone (GnRH) analogues rather than 'puberty blockers' and gender-affirming hormones rather than 'cross sex hormones'. The research studies included in this evidence review may use historical terms which are no longer considered appropriate.

Table 1 provides a summary of these included studies and full details are given in [appendix E](#).

Table 1 Summary of included studies

Study	Population	Intervention and comparison	Outcomes reported
Brik et al. 2020 Retrospective observational single-centre study Netherlands	The study was conducted at the Curium-Leiden University Medical Centre gender clinic in Leiden, the Netherlands and involved adolescents with gender dysphoria. The sample size was 143 adolescents (median age at start of treatment was 15.0 years, range 11.1 to 18.6 years in transfemales; 16.1 years, range 10.1 to 17.9 years in transmales) from a sampling frame of 269 children and adolescents registered at the clinic between November 2010 and January 2018.	Intervention 143 children and adolescents receiving GnRH analogues (no specific treatment, dose, route or frequency of administration reported). The median duration was 2.1 years (range 1.6–2.8 years). Comparison No comparator.	Critical Outcomes <ul style="list-style-type: none"> No critical outcomes reported Important outcomes <ul style="list-style-type: none"> Stopping treatment

Study	Population	Intervention and comparison	Outcomes reported
	Participants were included in the study if they were diagnosed with gender dysphoria according to the DSM-5 criteria, registered at the clinic, were prepubertal and within the appropriate age range, and had started GnRH analogues. No concomitant treatments were reported.		
Costa et al. 2015 Prospective longitudinal observational single centre cohort study United Kingdom	The study was conducted at the Gender Identity Development Service in London and involved adolescents with gender dysphoria. The sample size was 201 adolescents (mean [±SD] age 15.52±1.41 years, range 12 to 17 years) from a sampling frame of 436 consecutive adolescents referred to the service between 2010 and 2014. The mean [±SD] age at the start of GnRH analogues was 16.48 [±1.26] years, range 13 to 17 years. Participants were invited to participate following a 6-month diagnostic process using DSM-IV-TR criteria. No concomitant treatments were reported.	Intervention 101 adolescents assessed as being immediately eligible for GnRH analogues (no specific treatment, dose or route of administration reported) plus psychological support. The average duration of treatment was approximately 12 months (no exact figure given). Comparison 100 adolescents assessed as not immediately eligible for GnRH analogues (more time needed to make the decision to start GnRH analogues) who had psychological support only. None received GnRH analogues throughout the study.	Critical Outcomes <ul style="list-style-type: none"> No critical outcomes reported Important outcomes <ul style="list-style-type: none"> Psychosocial impact
de Vries et al. 2011 Prospective longitudinal observational single centre before and after study Netherlands	The study was conducted at the Amsterdam gender identity clinic of the VU University Medical Centre and involved adolescents who were defined as "transsexual". The sample size was 70 adolescents receiving GnRH analogues (mean age [±SD] at assessment 13.6±1.8 years) from a sampling frame of 196 consecutive adolescents referred to the service between 2000 and 2008. Participants were invited to participate if they subsequently started gender-affirming hormones between 2003 and 2009. No diagnostic criteria or concomitant treatments were reported.	Intervention 70 individuals assessed at baseline (T0) before the start of GnRH analogues (no specific treatment, dose or route of administration reported). Comparison No comparator.	Critical Outcomes <ul style="list-style-type: none"> Gender dysphoria Mental health (depression, anger and anxiety) Important outcomes <ul style="list-style-type: none"> Body image Psychosocial impact

Study	Population	Intervention and comparison	Outcomes reported
Joseph et al. 2019 Retrospective longitudinal observational single centre study United Kingdom	This study was conducted at the Early intervention clinic at University College London Hospital (all participants had been seen at the Gender Identity Development Service in London) and involved adolescents with gender dysphoria. The sample size was 70 adolescents with gender dysphoria (no diagnostic criteria described) all offered GnRH analogues. The mean age at the start of treatment was 13.2 years (SD ± 1.4) for transfemales and 12.6 years (SD ± 1.0) for transmales. Details of the sampling frame were not reported. Further details of how the sample was drawn are not reported. No concomitant treatments were reported.	Intervention GnRH analogues. No specific treatment, duration, dose or route of administration reported. Comparison No comparator.	Critical Outcomes <ul style="list-style-type: none"> No critical outcomes reported Important outcomes <ul style="list-style-type: none"> Safety: bone density
Khatchadourian et al. 2014 Retrospective observational chart review single centre study Canada	This study was conducted at the Endocrinology and Diabetes Unit at British Columbia Children's Hospital, Canada and involved youths with gender dysphoria. The sample size was 27 young people with gender dysphoria who started GnRH analogues (at mean age 14.7 [SD ± 1.9] years) out of 84 young people seen at the unit between 1998 and 2011. Diagnostic criteria and concomitant treatments were not reported.	Intervention 84 young people with gender dysphoria. For GnRH analogues no specific treatment, duration, dose or route of administration reported. Comparison No comparator.	Critical Outcomes <ul style="list-style-type: none"> No critical outcomes reported Important outcomes <ul style="list-style-type: none"> Stopping treatment Safety: adverse effects
Klink et al. 2015 Retrospective longitudinal observational single centre study Netherlands	This study was conducted in the Netherlands at a tertiary referral centre. It is unclear which centre this was. The sample size was 34 adolescents (mean age 14.9 [SD ± 1.9] years for transfemales and 15.0 [SD ± 2.0] years for transmales at start of GnRH analogues). Details of the sampling frame are not reported. Participants were included if they met DSM-IV-TR criteria for gender identity disorder of adolescence and had been treated with GnRH analogues and gender-affirming hormones during their pubertal years. No concomitant treatments were reported.	Intervention The intervention was GnRH analogue monotherapy (triptorelin 3.75 mg subcutaneously every 4 weeks) followed by gender-affirming hormones with discontinuation of GnRH analogues after gonadectomy. Duration of GnRH analogues was 1.3 years (range 0.5 to 3.8 years) in transfemales and 1.5 years (0.25 to 5.2 years) in transmales. Comparison No comparator.	Critical Outcomes <ul style="list-style-type: none"> No critical outcomes reported Important outcomes <ul style="list-style-type: none"> Safety: bone density

Study	Population	Intervention and comparison	Outcomes reported
Schagen et al. 2016 Prospective longitudinal study Netherlands	<p>This study was conducted at the Centre of Expertise on Gender Dysphoria at the VU University Medical Centre (Amsterdam, Netherlands) and involved adolescents with gender dysphoria. The sample size was 116 adolescents (median age [range] 13.6 years [11.6 to 17.9] in transfemales and 14.2 years [11.1 to 18.6] in transmales during first year of GnRH analogues) out of 128 adolescents who started GnRH analogues.</p> <p>Participants were included if they met DSM-IV-TR criteria for gender dysphoria, had lifelong extreme gender dysphoria, were psychologically stable and were living in a supportive environment. No concomitant treatments were reported.</p>	<p>Intervention The intervention was GnRH analogue monotherapy (triptorelin 3.75 mg at 0, 2 and 4 weeks followed by intramuscular injections every 4 weeks, for at least 3 months).</p> <p>Comparison No comparator.</p>	<p>Critical Outcomes</p> <ul style="list-style-type: none"> No critical outcomes reported <p>Important outcomes</p> <ul style="list-style-type: none"> Safety: liver and renal function.
Staphorsius et al. 2015 Cross-sectional (single time point) assessment single centre study Netherlands	<p>This study was conducted at the VU University Medical Centre (Amsterdam, Netherlands) and involved adolescents with gender dysphoria. The sample size was 85, of whom 40 were adolescents with gender dysphoria (20 of whom were being treated with GnRH analogues) and 45 were controls without gender dysphoria (not further reported here). Mean (\pmSD) age 15.1 (\pm2.4) years in transfemales and 15.8 (\pm1.9) years in transmales. Details of the sampling frame are not reported.</p> <p>Participants were included if they were diagnosed with Gender Identity Disorder according to the DSM-IV-TR and at least 12 years old and Tanner stage of at least B2 or G2 to G3 with measurable oestradiol and testosterone levels in girls and boys, respectively. No concomitant treatments were reported.</p>	<p>Intervention The intervention was a GnRH analogue (triptorelin 3.75 mg every 4 weeks subcutaneously or intramuscularly). The mean duration of treatment was 1.6 years (SD \pm1.0).</p> <p>Comparison Adolescents with gender dysphoria not treated with GnRH analogues.</p>	<p>Critical Outcomes</p> <ul style="list-style-type: none"> No critical outcomes reported <p>Important outcomes</p> <ul style="list-style-type: none"> Psychosocial impact Safety: cognitive functioning
Vlot et al. 2017 Retrospective observational data analysis study	<p>This study was conducted at the VU University Medical Centre (Amsterdam, Netherlands) and involved adolescents with gender dysphoria. The sample size was 70 adolescents (median age [range] 15.1 years [11.7 to 18.6] for</p>	<p>Intervention The intervention was a GnRH analogue (triptorelin 3.75 mg every 4 weeks subcutaneously).</p> <p>Comparison No comparator.</p>	<p>Critical Outcomes</p> <ul style="list-style-type: none"> No critical outcomes reported <p>Important outcomes</p>

Study	Population	Intervention and comparison	Outcomes reported
Netherlands	transmales and 13.5 years [11.5 to 18.3] for transfemales at start of GnRH analogues). Details of the sampling frame are not reported. Participants were included if they had a diagnosis of gender dysphoria according to DSM-IV-TR criteria who were receiving GnRH analogues and then gender-affirming hormones. No concomitant treatments were reported.		<ul style="list-style-type: none"> Safety: bone density
Abbreviations: DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision; GnRH, Gonadotrophin releasing hormone; SD, Standard deviation.			

5. Results

In children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Outcome	Evidence statement
Clinical Effectiveness	
Critical outcomes	
Impact on gender dysphoria Certainty of evidence: very low	<p>This is a critical outcome because gender dysphoria in children and adolescents is associated with significant distress and problems with functioning.</p> <p>One uncontrolled, prospective observational longitudinal study (de Vries et al. 2011) provided evidence relating to the impact on gender dysphoria in adolescents, measured using the Utrecht Gender Dysphoria Scale (UGDS). The UGDS is a validated screening tool for both adolescents and adults to assess gender dysphoria. It consists of 12 items, to be answered on a 1- to 5-point scale, resulting in a sum score between 12 and 60. The higher the UGDS score the greater the gender dysphoria.</p> <p>The study measured the impact on gender dysphoria at 2 time points:</p> <ul style="list-style-type: none"> before starting a GnRH analogue (mean [\pmSD] age: 14.75 [\pm1.92] years), and shortly before starting gender-affirming hormones (mean [\pmSD] age: 16.64 [\pm1.90] years). <p>The mean (\pmSD) UGDS score was not statistically significantly different at baseline compared with follow-up (n=41, 53.20 [\pm7.91] versus 53.9 [\pm17.42], p=0.333) (VERY LOW).</p>

	<p>This study provides very low certainty evidence that treatment with GnRH analogues, before starting gender-affirming hormones, does not affect gender dysphoria.</p>
<p>Impact on mental health: depression</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because self-harm and thoughts of suicide have the potential to result in significant physical harm and, for completed suicides, the death of the young person.</p> <p>One uncontrolled, prospective observational longitudinal study (de Vries et al. 2011) provided evidence relating to the impact on depression in children and adolescents with gender dysphoria. Depression was measured using the Beck Depression Inventory-II (BDI-II). The BDI-II is a valid, reliable, and widely used tool for assessing depressive symptoms. There are no specific scores to categorise depression severity, but it is suggested that 0 to 13 is minimal symptoms, 14 to 19 is mild depression, 20 to 28 is moderate depression, and severe depression is 29 to 63.</p> <p>The study provided evidence for depression measured at 2 time points:</p> <ul style="list-style-type: none"> • before starting a GnRH analogue (mean [\pmSD] age: 14.75 [\pm1.92] years), and • shortly before starting gender-affirming hormones (mean [\pmSD] age: 16.64 [\pm1.90] years). <p>The mean (\pmSD) depression (BDI) score was statistically significantly lower (improved) from baseline compared with follow-up (n=41, 8.31 [\pm7.12] versus 4.95 [\pm6.72], p=0.004) (VERY LOW).</p> <p>This study provides very low certainty evidence that treatment with GnRH analogues, before starting gender-affirming hormones, may reduce depression.</p>
<p>Impact on mental health: anger</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because self-harm and thoughts of suicide have the potential to result in significant physical harm and, for completed suicides, the death of the young person.</p> <p>One uncontrolled, prospective observational longitudinal study (de Vries et al. 2011) provided evidence relating to the impact on anger in children and adolescents with gender dysphoria. Anger was measured using the Trait Anger Scale of the State-Trait Personality Inventory (TPI). This is a validated 20-item inventory tool which measures the intensity of anger as the disposition to experience angry feelings as a personality trait. Higher scores indicate greater anger.</p> <p>The study provided evidence for anger measured at 2 time points:</p> <ul style="list-style-type: none"> • before starting a GnRH analogue (mean [\pmSD] age: 14.75 [\pm1.92] years), and • shortly before starting gender-affirming hormones (mean [\pmSD] age: 16.64 [\pm1.90] years). <p>The mean (\pmSD) anger (TPI) score was not statistically significantly different at baseline compared with follow-up (n=41, 18.29 [\pm5.54] versus 17.88 [\pm5.24], p=0.503) (VERY LOW).</p> <p>This study provides very low certainty evidence that treatment with GnRH analogues, before starting gender-affirming hormones, does not affect anger.</p>

<p>Impact on mental health: anxiety</p> <p>Certainty of evidence: very low</p>	<p>This is a critical outcome because self-harm and thoughts of suicide have the potential to result in significant physical harm and, for completed suicides, the death of the young person.</p> <p>One uncontrolled, prospective observational longitudinal study (de Vries et al. 2011) provided evidence relating to the impact on anxiety in children and adolescents with gender dysphoria. Anxiety was measured using the Trait Anxiety Scale of the State-Trait Personality Inventory (STAI). This is a validated and commonly used measure of trait and state anxiety. It has 20 items and can be used in clinical settings to diagnose anxiety and to distinguish it from depressive illness. Higher scores indicate greater anxiety.</p> <p>The study provided evidence for anxiety at 2 time points:</p> <ul style="list-style-type: none"> • before starting a GnRH analogue (mean [\pmSD] age: 14.75 [\pm1.92] years), and • shortly before starting gender-affirming hormones (mean [\pmSD] age: 16.64 [\pm1.90] years). <p>The mean (\pmSD) anxiety (STAI) score was not statistically significantly different at baseline compared with follow-up (n=41, 39.43 [\pm10.07] versus 37.95 [\pm9.38], p=0.276) (VERY LOW).</p> <p>This study provides very low certainty evidence that treatment with GnRH analogues, before starting gender-affirming hormones, does not affect levels of anxiety.</p>
<p>Quality of life</p>	<p>This is a critical outcome because gender dysphoria in children and adolescents may be associated with a significant reduction in health-related quality of life.</p> <p>No evidence was identified.</p>
<p>Important outcomes</p>	
<p>Impact on body image</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because some children and adolescents with gender dysphoria may want to take steps to suppress features of their physical appearance associated with their sex assigned at birth or accentuate physical features of their desired gender.</p> <p>One uncontrolled, prospective observational longitudinal study provided evidence relating to the impact on body image (de Vries et al. 2011). Body image was measured using the Body Image Scale (BIS) which is a validated 30-item scale covering 3 aspects: primary, secondary and neutral body characteristics. Higher scores represent a higher degree of body dissatisfaction.</p> <p>The study (de Vries et al. 2011) provided evidence for body image measured at 2 time points:</p> <ul style="list-style-type: none"> • before starting a GnRH analogue (mean [\pmSD] age: 14.75 [\pm1.92] years), and • shortly before starting gender-affirming hormones (mean [\pmSD] age: 16.64 [\pm1.90] years). <p>The mean (\pmSD) body image (BIS) scores for were not statistically significantly different from baseline compared with follow-up for:</p>

	<ul style="list-style-type: none"> • primary sexual characteristics (n=57, 4.10 [\pm0.56] versus 3.98 [\pm0.71], p=0.145) • secondary sexual characteristics (n=57, 2.74 [\pm0.65] versus 2.82 [\pm0.68], p=0.569) • neutral body characteristics (n=57, 2.41 [\pm0.63] versus 2.47 [\pm0.56], p=0.620) (VERY LOW). <p>This study provides very low certainty evidence that treatment with GnRH analogues, before starting gender affirming hormones, does not affect body image.</p>
<p>Psychosocial impact: global functioning</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because gender dysphoria in children and adolescents is associated with internalising and externalising behaviours, and emotional and behavioural problems which may impact on social and occupational functioning.</p> <p>One uncontrolled, observational, prospective cohort study (de Vries et al 2011) and one prospective cross-sectional cohort study (Costa et al. 2015) provided evidence relating to psychosocial impact in terms of global functioning. Global functioning was measured using the Children's Global Assessment Scale (CGAS). The CGAS tool is a validated measure of global functioning on a single rating scale from 1 to 100. Lower scores indicate poorer functioning.</p> <p>One study (de Vries et al. 2011) provided evidence for global functioning (CGAS) at 2 time points:</p> <ul style="list-style-type: none"> • before starting a GnRH analogue (mean [\pmSD] age: 14.75 [\pm1.92] years), and • shortly before starting gender-affirming hormones (mean [\pmSD] age: 16.64 [\pm1.90] years). <p>The mean (\pmSD) CGAS score was statistically significantly higher (improved) from baseline compared with follow-up (n=41, 70.24 [\pm10.12] versus 73.90 [\pm9.63], p=0.005) (VERY LOW).</p> <p>One study (Costa et al. 2015) in adolescents with gender dysphoria who had 6 months of psychological support followed by either GnRH analogues and continued psychological support (the immediately eligible group) or continued psychological support only (the delayed eligible group who did not receive GnRH analogues) provided evidence for global functioning (CGAS) measured at 4 time points:</p> <ul style="list-style-type: none"> • at baseline (T0) in both groups, • after 6 months of psychological support in both groups (T1), • after 6 months of GnRH analogues and 12 months of psychological support in the immediately eligible group and 12 months of psychological support only in the delayed eligible group (T2), and • after 18 months of psychological support and 12 months of GnRH analogues in the immediately eligible group and after 18 months of psychological support only in the delayed eligible group (T3). <p>The mean [\pmSD] CGAS score was statistically significantly higher (improved) for all adolescents (including those not receiving GnRH analogues) at T1, T2 or T3 compared with baseline (T0).</p>

	<p>For the immediately eligible group (who received GnRH analogues) versus the delayed eligible group (who did not receive GnRH analogues) there were no statistically significant differences in CGAS scores between the 2 groups at baseline T0 (n=201, p=0.23), T1 (n=201, p=0.73), T2 (n=121, p=0.49) or T3 (n=71, p=0.14) time points.</p> <p>For the immediately eligible group (who received GnRH analogues), the mean (\pmSD) CGAS score was not statistically significantly different at:</p> <ul style="list-style-type: none"> • T1 compared with T0 • T2 compared with T1 • T3 compared with T2. <p>The mean (\pmSD) CGAS score was statistically significantly higher (improved) at:</p> <ul style="list-style-type: none"> • T2 compared with T0 (n=60, 64.70 [\pm13.34] versus n=101, 58.72 [\pm11.38], p=0.003) • T3 compared with T0 (n=35, 67.40 [\pm13.39] versus n=101, 58.72 [\pm11.38], p<0.001) • T3 compared with T1 (n=35, 67.40 [\pm13.93] versus n=101, 60.89 [\pm12.17], p<0.001) (VERY LOW). <p>These studies provide very low certainty evidence that during treatment with GnRH analogues, global functioning may improve over time. However, there was no statistically significant difference in global functioning between GnRH analogues plus psychological support compared with psychological support only at any time point.</p>
<p>Psychosocial impact: psychosocial functioning</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because gender dysphoria in children and adolescents is associated with internalising and externalising behaviours, and emotional and behavioural problems which may impact on social and occupational functioning.</p> <p>Two studies provided evidence for this outcome. One uncontrolled, observational, prospective cohort study (de Vries et al. 2011) and 1 cross-sectional observational study (Staphorsius et al. 2015) assessed psychosocial functioning using the Child Behaviour Checklist (CBCL) and the self-administered Youth Self-Report (YSR). The CBCL is a checklist parents complete to detect emotional and behavioural problems in children and adolescents. YSR is similar but is self-completed by the child or adolescent. The scales consist of a Total problems score, which is the sum of the scores of all the problem items. An internalising problem scale sums the anxious/depressed, withdrawn-depressed, and somatic complaints scores while the externalising problem scale combines rule-breaking and aggressive behaviour. The standard scores are scaled so that 50 is average for the child or adolescent's age and gender, with a SD of 10 points. Higher scores indicate greater problems, with a T-score above 63 considered to be in the clinical range.</p> <p>One study (de Vries et al. 2011) provided evidence for psychosocial functioning (CBCL and YSR scores) at 2 time points:</p> <ul style="list-style-type: none"> • before starting a GnRH analogue (mean [\pmSD] age: 14.75 [\pm1.92] years), and

	<ul style="list-style-type: none"> • shortly before starting gender-affirming hormones (mean [±SD] age: 16.64 [±1.90] years). <p>At follow up, the mean (±SD) CBCL scores were statistically significantly lower (improved) compared with baseline for:</p> <ul style="list-style-type: none"> • Total T score (n=54, 60.70 [±12.76] versus 54.46 [±11.23], p<0.001 • Internalising T score (n=54, 61.00 [±12.21] versus 52.17 [±9.81], p<0.001) • Externalising T score (n=54, 58.04 [±12.99] versus 53.81 [±11.86], p=0.001). <p>At follow up, the mean (±SD) YSR scores were statistically significantly lower (improved) compared with baseline for:</p> <ul style="list-style-type: none"> • Total T score (n=54, 55.46 [±11.56] versus 50.00 [±10.56], p<0.001) • Internalising T score (n=54, 56.04 [±12.49] versus 49.78 [±11.63], p<0.001) • Externalising T score (n=54, 53.30 [±11.87] versus 49.98 [±9.35], p=0.009). <p>The proportion of adolescents scoring in the clinical range decreased from baseline to follow up on the CBCL total problem scale (44.4% versus 22.2%, p=0.001) and the internalising scale of the YSR (29.6% versus 11.1%, p=0.017) (VERY LOW).</p> <p>One study (Staphorsius et al. 2015) assessed CBCL in a cohort of adolescents with gender dysphoria (transfemale: n=18, mean [±SD] age 15.1 [±2.4] years and transmale: n=22, mean [±SD] age 15.8 [±1.9] years) either receiving GnRH analogues (transfemale, n=8 and transmale, n=12), or not receiving GnRH analogues (transfemale, n=10 and transmale, n=10).</p> <p>The mean (±SD) CBCL scores for each group were (statistical analysis unclear):</p> <ul style="list-style-type: none"> • transfemales (total) 57.8 [±9.2] • transfemales receiving GnRH analogues 57.4 [±9.8] • transfemales not receiving GnRH analogues 58.2 [±9.3] • transmales (total) 60.4 [±10.2] • transmales receiving GnRH analogues 57.5 [±9.4] • transmales not receiving GnRH analogues 63.9 [±10.5] (VERY LOW). <p>These studies provide very low certainty evidence that during treatment with GnRH analogues psychosocial functioning may improve, with the proportion of adolescents in the clinical range for some CBCL and YSR scores decreasing over time.</p>
<p>Engagement with health care services</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because patient engagement with health care services will impact on their clinical outcomes.</p> <p>Two uncontrolled observational cohort studies provided evidence relating to loss to follow up, which could be a marker of engagement with health care services (Brik et al. 2018 and Costa et al. 2015).</p>

	<p>In one retrospective study (Brik et al. 2018), 9 adolescents (9/214, 4.2%) who had stopped attending appointments were excluded from the study between November 2010 and July 2019 (VERY LOW).</p> <p>One prospective study (Costa et al. 2015) had evidence for a large loss to follow-up over time. The sample size at baseline (T0) and 6 months (T1) was 201, which dropped by 39.8% to 121 after 12 months (T2) and by 64.7% to 71 at 18 months follow-up (T3). No explanation of the reasons for loss to follow-up are reported (VERY LOW).</p> <p>Due to their design there was no reported loss to follow-up in the other 3 effectiveness studies (de Vries et al 2011; Khatchadourian et al. 2014; Staphorsius et al. 2015).</p> <p>These studies provide very low certainty evidence about loss to follow up, which could be a marker of engagement with health care services, during treatment with GnRH analogues. Due to the large variation in rates between studies no conclusions could be drawn.</p>
Impact on extent of and satisfaction with surgery	<p>This is an important outcome because some children and adolescents with gender dysphoria may proceed to transitioning surgery.</p> <p>No evidence was identified.</p>
Stopping treatment Certainty of evidence: very low	<p>This is an important outcome because there is uncertainty about the short- and long-term safety and adverse effects of GnRH analogues in children and adolescents with gender dysphoria.</p> <p>Two uncontrolled, retrospective, observational cohort studies provided evidence relating to stopping GnRH analogues. One study had complete reporting of the cohort (Brik et al. 2018), the other (Khatchadourian et al. 2014) had incomplete reporting of its cohort, particularly for transfemales where outcomes for only 4/11 were reported.</p> <p>Brik et al. 2018 narratively reported the reasons for stopping GnRH analogues in a cohort of 143 adolescents (38 transfemales and 105 transmales). Median age at the start of GnRH analogues was 15.0 years (range, 11.1–18.6 years) in transfemales and 16.1 years (range, 10.1–17.9 years) in transmales. Of these adolescents, 125 (87%, 36 transfemales, 89 transmales) subsequently started gender-affirming hormones after 1.0 (0.5–3.8) and 0.8 (0.3–3.7) years of GnRH analogues. At the time of data collection, the median duration of GnRH analogue use was 2.1 years (1.6–2.8).</p> <p>During the follow-up period 6.3% (9/143) of adolescents had discontinued GnRH analogues after a median duration of 0.8 years (range 0.1 to 3.0). The percentages and reasons for stopping were:</p> <ul style="list-style-type: none"> • 2.8% (4/143) stopped GnRH analogues although they wanted to continue endocrine treatments for gender dysphoria: <ul style="list-style-type: none"> ○ 1 transmale stopped due to increase in mood problems, suicidal thoughts and confusion attributed to GnRH analogues ○ 1 transmale had hot flushes, increased migraines, fear of injections, stress at school and unrelated medical issues, and temporarily stopped treatment (after 4 months) and restarted 5 months later.

	<ul style="list-style-type: none"> ○ 1 transmale had mood swings 4 months after starting GnRH analogues. After 2.2 years had unexplained severe nausea and rapid weight loss and discontinued GnRH analogues after 2.4 years ○ 1 transmale stopped GnRH analogues because of inability to regularly collect medication and attend appointments for injections. ● 3.5% (5/143) stopped treatment because they no longer wished to receive gender-affirming treatment for various reasons (VERY LOW). <p>Khatchadourian et al. 2014 narratively reported the reasons for stopping GnRH analogues in a cohort of 26 adolescents (15 transmales and 11 transfemales), 42% (11/26) discontinued GnRH analogues during follow-up between 1998 and 2011.</p> <p>Of 15 transmales receiving GnRH analogues, 14 received testosterone during the observation period, of which:</p> <ul style="list-style-type: none"> ● 7 continued GnRH analogues after starting testosterone ● 7 stopped GnRH analogues after a median of 3.0 years (range 0.2 to 9.2 years), of which: <ul style="list-style-type: none"> ○ 5 stopped after hysterectomy and salpingo-oophorectomy ○ 1 stopped after 2.2 years (transitioned to gender-affirming hormones) ○ 1 stopped after <2 months due to mood and emotional lability (VERY LOW). <p>Of 11 transfemales receiving GnRH analogues, 5 received oestrogen during the observation period, of which:</p> <ul style="list-style-type: none"> ● 4 continued GnRH analogues after starting oestrogen ● 1 stopped GnRH analogues when taking oestrogen (no reason reported) (VERY LOW). <p>Of the remaining 6 transfemales taking GnRH analogues:</p> <ul style="list-style-type: none"> ● 1 stopped GnRH analogues after a few months due to emotional lability ● 1 stopped GnRH analogues before taking oestrogen (the following year delayed due to heavy smoking) ● 1 stopped GnRH analogues after 13 months due not to pursuing transition (VERY LOW). <p>These studies provide very low certainty evidence for the number of adolescents who stop GnRH analogues and the reasons for this.</p>
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Abbreviations: GnRH, gonadotrophin releasing hormone; SD, standard deviation.

In children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Outcome	Evidence statement
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Safety	
<p>Change in bone density: lumbar</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because puberty is an important time for bone development and puberty suppression may affect bone development, as shown by changes in lumbar bone density.</p> <p>Three uncontrolled, observational, retrospective studies provided evidence relating to the effect of GnRH analogues on bone density (based on lumbar BMAD) between starting with a GnRH analogue and at 1 and 2 year intervals (Joseph et al. 2019), and between starting GnRH analogues and starting gender-affirming hormones (Klink et al. 2015 and Vlot et al. 2017). All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>BMAD is a size adjusted value of BMD incorporating body size measurements using UK norms in growing adolescents. It was reported as g/cm³ and as z-scores. Z-scores report how many standard deviations from the mean a measurement sits. A z-score of 0 is equal to the mean, a z-score of -1 is equal to 1 standard deviation below the mean, and a z-score of +1 is equal to 1 standard deviation above the mean.</p> <p>One retrospective observational study (Joseph et al. 2019, n=70) provided non-comparative evidence on change in lumbar BMAD increase using z-scores.</p> <ul style="list-style-type: none"> • The z-score for lumbar BMAD was statistically significantly lower at 2 years compared with baseline in transfemales (z-score [±SD]: baseline 0.486 [0.809], 2 years -0.279 [0.930], p=0.000) and transmales (baseline -0.361 [1.439], 2 years -0.913 [1.318], p=0.001) (VERY LOW). • The z-score for lumbar BMAD was statistically significantly lower at 1 year compared with baseline in transfemales (baseline 0.859 [0.154], 1 year -0.228 [1.027], p=0.000) and transmales (baseline -0.186 [1.230], 1 year -0.541 [1.396], p=0.006) (VERY LOW). • Actual lumbar BMAD values in g/cm³ were not statistically significantly different between baseline and 1 or 2 years in transfemales or transmales (VERY LOW). <p>Two retrospective observational studies (Klink et al. 2015 and Vlot et al. 2017, n=104 in total) provided non-comparative evidence on change in lumbar BMAD between starting GnRH analogues and starting gender-affirming hormones. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>In Klink et al. 2015 the z-score for lumbar BMAD was not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales but was statistically significantly lower when starting gender-affirming hormones in transmales (z-score mean [±SD]: GnRH analogue 0.28 [±0.90], gender-affirming hormone -0.50 [±0.81], p=0.004). Actual lumbar BMAD values in g/cm³ were not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales or transmales (VERY LOW).</p>

Vlot et al. 2017 reported change from starting GnRH analogues to starting gender-affirming hormones in lumbar BMAD by bone age.

- The z-score for lumbar BMAD in transfemales with a bone age of <15 years was statistically significantly lower at starting gender-affirming hormone treatment than at starting GnRH analogues (z-score median [range]: GnRH analogue -0.20 [-1.82 to 1.18], gender-affirming hormone -1.52 [-2.36 to 0.42], $p=0.001$) but was not statistically significantly different in transfemales with a bone age ≥ 15 years (**VERY LOW**).
- The z-score for lumbar BMAD in transmales with a bone age of <14 years was statistically significantly lower at starting gender-affirming hormone treatment than at starting GnRH analogues (z-score median [range]: GnRH analogue -0.05 [-0.78 to 2.94], gender-affirming hormone -0.84 [-2.20 to 0.87], $p=0.003$) and in transmales with a bone age ≥ 14 years (GnRH analogue 0.27 [-1.60 to 1.80], gender-affirming hormone -0.29 [-2.28 to 0.90], $p\leq 0.0001$) (**VERY LOW**).
- Actual lumbar BMAD values in g/cm^3 were not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales or transmales with young or old bone age (**VERY LOW**).

Two uncontrolled, observational, retrospective studies provided evidence for the effect of GnRH analogues on bone density (based on lumbar BMD) between starting GnRH analogues and either at 1 or 2 year intervals ([Joseph et al. 2019](#)), or starting gender-affirming hormones ([Klink et al. 2015](#)). All outcomes were reported separately for transfemales and transmales; also see subgroups table below.

One retrospective observational study ([Joseph et al. 2019](#), $n=70$) provided non-comparative evidence on change in lumbar BMD increase using z-scores.

- The z-score for lumbar BMD was statistically significantly lower at 2 years compared with baseline in transfemales (z-score mean [\pm SD]: baseline 0.130 [0.972], 2 years -0.890 [± 1.075], $p=0.000$) and transmales (baseline -0.715 [± 1.406], 2 years -2.000 [1.384], $p=0.000$) (**VERY LOW**).
- The z-score for lumbar BMD was statistically significantly lower at 1 year compared with baseline in transfemales (z-score mean [\pm SD]: baseline -0.016 [± 1.106], 1 year -0.461 [± 1.121], $p=0.003$) and transmales (baseline -0.395 [± 1.428], 1 year -1.276 [± 1.410], $p=0.000$) (**VERY LOW**).
- With the exception of transmales, where lumbar BMD in kg/m^2 increased between baseline and 1 year (mean [\pm SD]: baseline 0.694 [± 0.149], 1 year 0.718 [± 0.124], $p=0.006$), actual lumbar BMD values were not statistically significantly different between baseline and 1 or 2 years in transfemales or between 0 and 2 years in transmales (**VERY LOW**).

One retrospective observational study ([Klink et al. 2015](#), $n=34$) provided non-comparative evidence on change in lumbar BMD between starting GnRH analogues and starting gender-affirming hormones.

- The z-score for lumbar BMD was not statistically significantly different between starting GnRH analogue and starting gender-affirming hormone treatment in transfemales, but was

	<p>statistically significantly lower when starting gender-affirming hormones in transmales (z-score mean [±SD]: GnRH analogue 0.17 [±1.18], gender-affirming hormone -0.72 [±0.99], $p < 0.001$) (VERY LOW).</p> <ul style="list-style-type: none"> Actual lumbar BMD in g/cm² was not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales but was statistically significantly lower when starting gender-affirming hormones in transmales (mean [±SD]: GnRH analogues 0.95 [±0.12], gender-affirming hormones 0.91 [±0.10], $p = 0.006$) (VERY LOW). <p>These studies provide very low certainty evidence that GnRH analogues reduce the expected increase in lumbar bone density (BMAD or BMD) compared with baseline (although some findings were not statistically significant). These studies also show that GnRH analogues do not statistically significantly decrease actual lumbar bone density (BMAD or BMD).</p>
<p>Change in bone density: femoral</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because puberty is an important time for bone development and puberty suppression may affect bone development, as shown by changes in femoral bone density.</p> <p>Two uncontrolled, observational, retrospective studies provided evidence relating to the effect of GnRH analogues on bone density (based on femoral BMAD) between starting treatment with a GnRH analogue and starting gender-affirming hormones (Klink et al. 2015 and Vlot et al. 2017). All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <p>One retrospective observational study (Klink et al. 2015, $n = 34$) provided non-comparative evidence on change in femoral area BMAD between starting GnRH analogues and starting gender-affirming hormones. All outcomes were reported separately for transfemales and transmales.</p> <ul style="list-style-type: none"> The z-score for femoral area BMAD was not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales or transmales (VERY LOW). Actual femoral area BMAD values were not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transmales or transfemales (VERY LOW). <p>One retrospective observational study (Vlot et al. 2017, $n = 70$) provided non-comparative evidence on change in femoral neck (hip) BMAD between starting GnRH analogues and starting gender-affirming hormones. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <ul style="list-style-type: none"> The z-score for femoral neck BMAD in transfemales with a bone age of <15 years was not statistically significantly lower at starting gender-affirming hormones than at starting GnRH analogues (z-score median [range]: GnRH analogue -0.71 [-3.35 to 0.37], gender-affirming hormone -1.32 [-3.39 to 0.21], $p \leq 0.1$) or in transfemales with a bone age ≥ 15 years (GnRH analogue -0.44 [-1.37 to 0.93], gender-affirming hormone -0.36 [-1.50 to 0.46]) (VERY LOW).

- The z-score for femoral neck BMAD in transmales with a bone age of <14 years was not statistically significantly lower at starting gender-affirming hormones than at starting GnRH analogues (z-score median [range]: GnRH analogue -0.01 [-1.30 to 0.91], gender-affirming hormone -0.37 [-2.28 to 0.47]) but was statistically significantly lower in transmales with a bone age ≥14 years (GnRH analogue 0.27 [-1.39 to 1.32], gender-affirming hormone -0.27 [-1.91 to 1.29], p=0.002) (**VERY LOW**).
- Actual femoral neck BMAD values were not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales or in transmales with a young bone age, but were statistically significantly lower in transmales with a bone age ≥14 years (GnRH analogue 0.33 [0.25 to 0.39], gender-affirming hormone 0.30 [0.23 to 0.41], p≤0.01) (**VERY LOW**).

Two uncontrolled, observational, retrospective studies provided evidence for the effect of GnRH analogues on bone density (based on femoral BMD) between starting GnRH analogues and either at 1 or 2 year intervals (Joseph et al. 2019), or starting gender-affirming hormones (Klink et al. 2015). All outcomes were reported separately for transfemales and transmales; also see subgroups table below.

One retrospective observational study (Joseph et al. 2019, n=70) provided non-comparative evidence on change in femoral neck BMD increase using z-scores. All outcomes were reported separately for transfemales and transmales.

- The z-score for femoral neck BMD was statistically significantly lower at 2 years compared with baseline in transfemales (z-score mean [±SD]: baseline 0.0450 [±0.781], 2 years -0.600 [±1.059], p=0.002) and transmales (baseline -1.075 [±1.145], 2 years -1.779 [±0.816], p=0.001) (**VERY LOW**).
- The z-score for femoral neck BMD was statistically significantly lower at 1 year compared with baseline in transfemales (z-score mean [±SD]: baseline 0.157 [±0.905], 1 year -0.340 [±0.816], p=0.002) and transmales (baseline -0.863 [±1.215], 1 year -1.440 [±1.075], p=0.000) (**VERY LOW**).
- Actual femoral neck BMD values in kg/m² were not statistically significantly different between baseline and 1 or 2 years in transmales or transfemales (**VERY LOW**).

One retrospective observational study (Klink et al. 2015, n=34) provided non-comparative evidence on change in femoral area BMD between starting GnRH analogues and starting gender-affirming hormones. All outcomes were reported separately for transfemales and transmales.

- The z-score for femoral area BMD was not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales, but was statistically significantly lower in transmales (z-score mean [±SD]: GnRH analogue 0.36 [±0.88], gender-affirming hormone -0.35 [±0.79], p=0.001) (**VERY LOW**).
- Actual femoral area BMD values were not statistically significantly different between starting GnRH analogues and starting gender-affirming hormones in transfemales, but were

	<p>statistically significantly lower in transmales (mean [±SD] GnRH analogue 0.92 [±0.10], gender-affirming hormone 0.88 [±0.09], $p=0.005$) (VERY LOW).</p> <p>These studies provide very low certainty evidence that GnRH analogues may reduce the expected increase in femoral bone density (femoral neck or area BMAD or BMD) compared with baseline (although some findings were not statistically significant). These studies also show that GnRH analogues do not statistically significantly decrease actual femoral bone density (femoral area BMAD or femoral neck BMD), apart from actual femoral area BMD in transmales.</p>
<p>Cognitive development or functioning</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because puberty is an important time for cognitive development and puberty suppression may affect cognitive development or functioning.</p> <p>One cross-sectional observational study (Staphorsius et al. 2015, $n=70$) provided comparative evidence on cognitive development or functioning in adolescents with gender dysphoria on GnRH analogues compared with adolescents with gender dysphoria not on GnRH analogues. Cognitive functioning was measured using an IQ test. Reaction time (in seconds) and accuracy (percentage of correct trials) were measured using the Tower of London (ToL) task. All outcomes were reported separately for transfemales and transmales; also see subgroups table below. No statistical analyses or interpretation of the results in these groups were reported:</p> <ul style="list-style-type: none"> • IQ in transfemales (mean [±SD] GnRH analogue 94.0 [±10.3], control 109.4 [±21.2]). IQ transmales (GnRH analogue 95.8 [±15.6], control 98.5 [±15.9]). • Reaction time in transfemales (mean [±SD] GnRH analogue 10.9 [±4.1], control: 9.9 [±3.1]). Reaction time transmales (GnRH analogue 9.9 [±3.1], control 10.0 [±2.0]). • Accuracy score in transfemales (GnRH analogue 73.9 [±9.1], control 83.4 [±9.5]). Accuracy score in transmales (GnRH analogue 85.7 [±10.5], control 88.8 [±9.7]). <p>This study provides very low certainty evidence (with no statistical analysis) on the effects of GnRH analogues on cognitive development or functioning. No conclusions could be drawn.</p>
<p>Other safety outcomes: kidney function</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because if renal damage (raised serum creatinine is a marker of this) is suspected, GnRH analogues may need to be stopped.</p> <p>One prospective observational study (Schagen et al. 2016, $n=116$) provided non-comparative evidence on change in serum creatinine between starting GnRH analogues and at 1 year. All outcomes were reported separately for transfemales and transmales; also see subgroups table below.</p> <ul style="list-style-type: none"> • There was no statistically significant difference between baseline and 1 year for serum creatinine in transfemales (mean [±SD] baseline 70 [±12], 1 year 66 [±13], $p=0.20$). • There was a statistically significant decrease between baseline and 1 year for serum creatinine in transmales (baseline 73 [±8], 1 year 68 [±13], $p=0.01$).

	<p>This study provides very low certainty evidence that GnRH analogues do not affect renal function.</p>
<p>Other safety outcomes: liver function</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because if treatment-induced liver injury (raised liver enzymes are a marker of this) is suspected, GnRH analogues may need to be stopped.</p> <p>One prospective observational study (Schagen et al. 2016, n=116) provided non-comparative evidence on elevated liver enzymes between starting GnRH analogues and during use. No comparative values or statistical analyses were reported.</p> <ul style="list-style-type: none"> • Glutaryl transferase was not elevated at baseline or during use in any person. • Mild elevations of AST and ALT above the reference range were present at baseline but were not more prevalent during use than at baseline. • Glutaryl transferase, AST, and ALT levels did not significantly change from baseline to 12 months of use. <p>This study provides very low certainty evidence (with no statistical analysis) that GnRH analogues do not affect liver function.</p>
<p>Other safety outcomes: adverse effects</p> <p>Certainty of evidence: very low</p>	<p>This is an important outcome because if there are adverse effects, GnRH analogues may need to be stopped.</p> <p>One uncontrolled, retrospective, observational cohort study (Khatchadourian et al. 2014) provided evidence relating to adverse effects from GnRH analogues. It had incomplete reporting of its cohort, particularly for transfemales where outcomes for only 4/11 were reported.</p> <p>Khatchadourian et al. 2014 reported adverse effects in a cohort of 26 adolescents (15 transmales and 11 transfemales) receiving GnRH analogues. Of these:</p> <ul style="list-style-type: none"> • 1 transmale developed sterile abscesses; they were switched from leuprolide acetate to triptorelin, and this was well tolerated. • 1 transmale developed leg pains and headaches, which eventually resolved • 1 participant gained 19 kg within 9 months of starting GnRH analogues. <p>This study provides very low certainty evidence about potential adverse effects of GnRH analogues. No conclusions could be drawn.</p>

Abbreviations: ALT, alanine aminotransferase; AST, aspartate aminotransferase; BMAD, bone mineral apparent density; BMD, bone mineral density; GnRH, gonadotrophin releasing hormone; IQ, intelligence quotient; NS, not significant; SD, standard deviation.

In children and adolescents with gender dysphoria, what is the cost-effectiveness of GnRH analogues compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?

Outcome	Evidence statement
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Cost-effectiveness	No studies were identified to assess the cost-effectiveness of GnRH analogues for children and adolescents with gender dysphoria.
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From the evidence selected, are there any subgroups of children and adolescents with gender dysphoria that may benefit from GnRH analogues more than the wider population of interest?

Subgroup	Evidence statement
Sex assigned at birth males (transfemales) Certainty of evidence: Very low	<p>Some studies reported data separately for sex assigned at birth males (transfemales). This included some direct comparisons with sex assigned at birth females (transmales).</p> <p>Impact on gender dysphoria One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) provided evidence for gender dysphoria in sex assigned at birth males. See the clinical effectiveness results table above for a full description of the study. The mean (\pmSD) UGDS score was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at both baseline (T0) (n=not reported, mean UGDS score [\pmSD]: 47.95 [\pm9.70] versus 56.57 [\pm3.89]) and T1 (n=not reported, 49.67 [\pm9.47] versus 56.62 [\pm4.00]); between sex difference $p < 0.001$ (VERY LOW).</p> <p>One further prospective observational longitudinal study (Costa et al. 2015) provided evidence for the impact on gender dysphoria in sex assigned at birth males. See the clinical effectiveness results table above for a full description of the study. Sex assigned at birth males had a statistically significantly lower (improved) mean (\pmSD) UGDS score of 51.6 [\pm9.7] compared with sex assigned at birth females (56.1 [\pm4.3], $p < 0.001$). However, it was not reported if this was baseline or follow-up (VERY LOW).</p> <p>These studies provide very low certainty evidence that in sex assigned at birth males (transfemales), gender dysphoria is lower than in sex assigned at birth females (transmales).</p> <p>Impact on mental health One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) provided evidence for the impact on mental health (depression, anger and anxiety) in sex assigned at birth males. See the clinical effectiveness results table above for a full description of the study.</p> <ul style="list-style-type: none"> • The mean (\pmSD) depression (BDI-II) score was not statistically significantly different in sex assigned at birth males compared with sex assigned at birth females at both baseline (T0) (n=not reported, mean BDI score [\pmSD]: 5.71 [\pm4.31] versus 10.34 [\pm8.24]) and T1 (n=not reported, 3.50 [\pm4.58] versus 6.09 [\pm7.93]), between sex difference $p = 0.057$ • The mean (\pmSD) anger (TPI) score was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at both baseline (T0) (n=not reported, mean TPI score [\pmSD]: 5.22 [\pm2.76]

	<p>versus 6.43 [± 2.78]) and T1 (n=not reported, 5.00 [± 3.07] versus 6.39 [± 2.59]), between sex difference $p=0.022$</p> <ul style="list-style-type: none"> • The mean (\pmSD) anxiety (STAI) score was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at both baseline (T0) (n=not reported, mean STAI score [\pmSD]: 4.33 [± 2.68] versus 7.00 [± 2.36]) and T1 (n=not reported, 4.39 [± 2.64] versus 6.17 [± 2.69]), between sex difference $p<0.001$ (VERY LOW). <p>This study provides very low certainty evidence that the impact on mental health (depression, anger and anxiety) may be different in sex assigned at birth males (transfemales) compared with sex assigned at birth females (transmales). Over time there was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for depression. However, sex assigned at birth males had statistically significantly lower levels of anger and anxiety than sex assigned at birth females at both baseline and follow up.</p> <p>Impact on body image</p> <p>One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) provided evidence relating to the impact on body image in sex assigned at birth males.</p> <ul style="list-style-type: none"> • The mean (\pmSD) BIS score for primary sex characteristics was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at both baseline (T0) (n=not reported, mean BIS score [\pmSD]: 4.02 [± 0.61] versus 4.16 [± 0.52]) and T1 (n=not reported, 3.74 [± 0.78] versus 4.17 [± 0.58]), between sex difference $p=0.047$ • The mean (\pmSD) BIS score for secondary sex was statistically significantly lower (improved) in sex assigned at birth males compared with sex assigned at birth females at both baseline (T0) (n=not reported, mean BIS score [\pmSD]: 2.66 [± 0.50] versus 2.81 [± 0.76]) and T1 (n=not reported, 2.39 [± 0.69] versus 3.18 [± 0.42]), between sex difference $p=0.001$ • The mean (\pmSD) BIS score for neutral body characteristics was not statistically significantly different in sex assigned at birth males compared with sex assigned at birth females at both baseline (T0) (n=not reported, mean BIS score [\pmSD]: 2.60 [± 0.58] versus 2.24 [± 0.62]) and T1 (n=not reported, 2.32 [± 0.59] versus 2.61 [± 0.50]), between sex difference $p=0.777$ (VERY LOW). <p>This study provides very low certainty evidence that the impact on body image may be different in sex assigned at birth males (transfemales) compared with sex assigned at birth females (transmales). Sex assigned at birth males are less dissatisfied with their primary and secondary sex characteristics than sex assigned at birth females at both baseline and follow up, but the satisfaction with neutral body characteristics is not different.</p> <p>Psychosocial impact</p> <p>One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) provided evidence for psychosocial impact in terms</p>
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of global functioning (CGAS) and psychosocial functioning (CBCL and YSR) in sex assigned at birth males.

- Sex assigned at birth males had statistically higher mean (\pm SD) CGAS scores compared with sex assigned at birth females at both baseline (T0) (n=54, 73.10 [\pm 8.44] versus 67.25 [\pm 11.06]) and T1 (n=54, 77.33 [\pm 8.69] versus 70.30 [\pm 9.44]), between sex difference p=0.021
- There was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for the CBCL Total T score at T0 or T1 (n=54, p=0.110)
- There was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for the CBCL internalising T score at T0 or T1 (n=54, p=0.286)
- Sex assigned at birth males had statistically lower mean (\pm SD) CBCL externalising T scores compared with sex assigned at birth females at both T0 (n=54, 54.71 [\pm 12.91] versus 60.70 [\pm 12.64]) and T1 (n=54, 48.75 [\pm 10.22] versus 57.87 [\pm 11.66]), between sex difference p=0.015
- There was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for the YSR Total T score at T0 or T1 (n=54, p=0.164)
- There was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for the YSR internalising T score at T0 or T1 (n=54, p=0.825)
- Sex assigned at birth males had statistically lower mean (\pm SD) YSR externalising T scores compared with sex assigned at birth females at both T0 (n=54, 48.72 [\pm 11.38] versus 57.24 [\pm 10.59]) and T1 (n=54, 46.52 [\pm 9.23] versus 52.97 [\pm 8.51]), between sex difference p=0.004 (**VERY LOW**).

One uncontrolled, observational, prospective cohort study ([Costa et al. 2015](#)) provided evidence for psychosocial impact in terms of global functioning (CGAS) in sex assigned at birth males.

- Sex assigned at birth males had statistically significant lower mean (\pm SD CGAS scores at baseline) compared with sex assigned at birth females (n=201, 55.4 [\pm 12.7] versus 59.2 [\pm 11.8], p=0.03) (**VERY LOW**).

These studies provide very low certainty evidence that psychosocial impact may be different in sex assigned at birth males (transfemales) compared with sex assigned at birth females (transmales). However, no conclusions could be drawn.

Change in bone density: lumbar

Three uncontrolled, observational, retrospective studies provided evidence relating to the effect of GnRH analogues on lumbar bone density in sex assigned at birth males ([Joseph et al. 2019](#), [Klink et al. 2015](#) and [Vlot et al. 2017](#)). See the safety results table above for a full description of the results.

These studies provide very low certainty evidence that GnRH analogues reduce the expected increase in lumbar bone density (BMAD or BMD) in sex assigned at birth males (transfemales; although some findings were not statistically significant). These studies also show that GnRH analogues do not statistically

	<p>significantly decrease actual lumbar bone density (BMAD or BMD) in sex assigned at birth males (transfemales).</p> <p>Change in bone density: femoral Three uncontrolled, observational, retrospective studies provided evidence for the effect of GnRH analogues on femoral bone density in sex assigned at birth males (Joseph et al. 2019, Klink et al. 2015 and Vlot et al. 2017). See the safety results table above for a full description of the results.</p> <p>These studies provide very low certainty evidence that GnRH analogues may reduce the expected increase in femoral bone density (femoral neck or area BMAD or BMD) in sex assigned at birth males (transfemales; although some findings were not statistically significant). These studies also show that GnRH analogues do not statistically significantly decrease actual femoral bone density (femoral area BMAD or femoral neck BMD) in sex assigned at birth males (transfemales).</p> <p>Cognitive development or functioning One cross-sectional observational study (Staphorsius et al. 2015) provided comparative evidence on cognitive development or functioning in sex assigned at birth males. See the safety results table above for a full description of the results.</p> <p>This study provides very low certainty evidence (with no statistical analysis) on the effects of GnRH analogues on cognitive development or functioning in sex assigned at birth males (transfemales). No conclusions could be drawn.</p> <p>Other safety outcomes: kidney function One prospective observational study (Schagen et al. 2016) provided non-comparative evidence on change in serum creatinine in sex assigned at birth males. See the safety results table above for a full description of the results.</p> <p>This study provides very low certainty evidence that GnRH analogues do not affect renal function in sex assigned at birth males (transfemales).</p>
<p>Sex assigned at birth females (transmales)</p> <p>Certainty of evidence: Very low</p>	<p>Some studies reported data separately for sex assigned at birth females (transmales). This included some direct comparisons with sex assigned at birth males (transfemales).</p> <p>Impact on gender dysphoria One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) and one prospective observational longitudinal study (Costa et al. 2015) provided evidence for gender dysphoria in sex assigned at birth females. See the sex assigned at birth males (transfemales) row above for a full description of the results.</p> <p>These studies provide very low certainty evidence that in sex assigned at birth females (transmales), gender dysphoria is higher than in sex assigned at birth males (transfemales) at both baseline and follow up.</p>

	<p>Impact on mental health</p> <p>One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) provided evidence relating to the impact on mental health (depression, anger and anxiety) in sex assigned at birth females. See the sex assigned at birth males (transfemales) row above for a full description of the results.</p> <p>This study provides very low certainty evidence that the impact on mental health (depression, anger and anxiety) may be different in sex assigned at birth females (transmales) compared with sex assigned at birth males (transfemales). Over time there was no statistically significant difference between sex assigned at birth females and sex assigned at birth males for depression. However, sex assigned at birth females had statistically significantly greater levels of anger and anxiety than sex assigned at birth males at baseline and follow up.</p> <p>Impact on body image</p> <p>One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) provided evidence relating to the impact on body image in sex assigned at birth females. See the sex assigned at birth males (transfemales) row above for a full description of the results.</p> <p>This study provides very low certainty evidence that the impact on body image may be different in sex assigned at birth females (transmales) compared with sex assigned at birth males (transfemales). Sex assigned at birth females are more dissatisfied with their primary and secondary sex characteristics than sex assigned at birth males at both baseline and follow up, but the satisfaction with neutral body characteristics is not different.</p> <p>Psychosocial impact</p> <p>One uncontrolled prospective observational longitudinal study (de Vries et al. 2011) provided evidence for psychosocial impact in terms of global functioning (CGAS) and psychosocial functioning (CBCL and YSR) in sex assigned at birth females. One uncontrolled, observational, prospective cohort study (Costa et al. 2015) provided evidence for psychosocial impact in terms of global functioning (CGAS) in sex assigned at birth females. See the sex assigned at birth males (transfemales) row above for a full description of the results.</p> <p>These studies provide very low certainty evidence that psychosocial impact may be different in sex assigned at birth females (transmales) compared with sex assigned at birth males (transfemales). However, no conclusions could be drawn.</p> <p>Change in bone density: lumbar</p> <p>Three uncontrolled, observational, retrospective studies provided evidence relating to the effect of GnRH analogues on lumbar bone density in sex assigned at birth females (Joseph et al. 2019, Klink et al. 2015 and Vlot et al. 2017). See the safety results table above for a full description of the results.</p>
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	<p>These studies provide very low certainty evidence that GnRH analogues reduce the expected increase in lumbar bone density (BMAD or BMD) in sex assigned at birth females (transmales; although some findings were not statistically significant). These studies also show that GnRH analogues do not statistically significantly decrease actual lumbar bone density (BMAD or BMD) in sex assigned at birth females (transmales).</p> <p>Change in bone density: femoral Three uncontrolled, observational, retrospective studies provided evidence relating to the effect of GnRH analogues on femoral bone density in sex assigned at birth females (Joseph et al. 2019, Klink et al. 2015 and Vlot et al. 2017). See the safety results table above for a full description of the results.</p> <p>These studies provide very low certainty evidence that GnRH analogues may reduce the expected increase in femoral bone density (femoral neck or area BMAD or BMD) in sex assigned at birth females (transmales; although some findings were not statistically significant). These studies also show that GnRH analogues do not statistically significantly decrease actual femoral bone density (femoral area BMAD or femoral neck BMD) in sex assigned at birth females (transmales), apart from actual femoral area.</p> <p>Cognitive development or functioning One cross-sectional observational study (Staphorsius et al. 2015) provided comparative evidence on cognitive development or functioning in sex assigned at birth females. See the safety results table above for a full description of the results.</p> <p>This study provides very low certainty evidence (with no statistical analysis) on the effects of GnRH analogues on cognitive development or functioning in sex assigned at birth females (transmales). No conclusions could be drawn.</p> <p>Other safety outcomes: kidney function One prospective observational study (Schagen et al. 2016) provided non-comparative evidence on change in serum creatinine in sex assigned at birth females (transmales). See the safety results table above for a full description of the results.</p> <p>This study provides very low certainty evidence that GnRH analogues do not affect renal function in sex assigned at birth females (transmales).</p>
Duration of gender dysphoria	No evidence was identified.
Age at onset of gender dysphoria	No evidence was identified.
Age at which GnRH analogue started	No evidence was identified.
Age at onset of puberty	No evidence was identified.

Tanner stage at which GnRH analogue started	No evidence was identified.
Diagnosis of autistic spectrum disorder	No evidence was identified.
Diagnosis of mental health condition	No evidence was identified.

Abbreviations: BDI-II, Beck Depression Inventory-II; BIS, Body Image Scale; CBCL, Child Behaviour Checklist; CGAS, Children's Global Assessment Scale; SD, standard deviation; STAI, Trait Anxiety Scale of the State-Trait Personality Inventory; TPI, Trait Anger Scale of the State-Trait Personality Inventory; UGDS, Utrecht Gender Dysphoria Scale; YSR, Youth Self-Report

From the evidence selected,

- (a) what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?
- (b) what were the ages at which participants commenced treatment with GnRH analogues?
- (c) what was the duration of treatment with GnRH analogues?

Outcome	Evidence statement										
Diagnostic criteria	<p>In 5 studies (Costa et al. 2015, Klink et al. 2015, Schagen et al. 2016, Staphorsius et al. 2015 and Vlot et al. 2017) the DSM-IV-TR criteria of gender identity disorder was used.</p> <p>The study by Brik et al. 2020 used DSM-V criteria. The DSM-V has one overarching definition of gender dysphoria with separate specific criteria for children and for adolescents and adults. The general definition describes a conflict associated with significant distress and/or problems functioning associated with this conflict between the way they feel and the way they think of themselves which must have lasted at least 6 months.</p> <p>It was not reported how gender dysphoria was defined in the remaining 3 studies (VERY LOW).</p> <p>From the evidence selected, all studies that reported diagnostic criteria for gender dysphoria (6/9 studies) used the DSM criteria in use at the time the study was conducted.</p>										
Age when GnRH analogues started	<p>8/9 studies reported the age at which participants started GnRH analogues, either as the mean age (with SD) or median age (with the range):</p> <table border="1"> <thead> <tr> <th>Study</th><th>Mean age (±SD)</th></tr> </thead> <tbody> <tr> <td>Costa et al. 2015</td><td>16.5 years (±1.3)</td></tr> <tr> <td>de Vries et al. 2011</td><td>13.6 years (±1.8)</td></tr> <tr> <td>Joseph et al. 2019</td><td>13.2 years (±1.4) in transfemales 12.6 years (±1.0) in transmales</td></tr> <tr> <td>Khatchadourian et al. 2014</td><td>14.7 years (±1.9)</td></tr> </tbody> </table>	Study	Mean age (±SD)	Costa et al. 2015	16.5 years (±1.3)	de Vries et al. 2011	13.6 years (±1.8)	Joseph et al. 2019	13.2 years (±1.4) in transfemales 12.6 years (±1.0) in transmales	Khatchadourian et al. 2014	14.7 years (±1.9)
Study	Mean age (±SD)										
Costa et al. 2015	16.5 years (±1.3)										
de Vries et al. 2011	13.6 years (±1.8)										
Joseph et al. 2019	13.2 years (±1.4) in transfemales 12.6 years (±1.0) in transmales										
Khatchadourian et al. 2014	14.7 years (±1.9)										

	Klink et al. 2015	14.9 years (± 1.9) in transfemales 15.0 years (± 2.0) in transmales
	Study	Median age (range)
	Brik et al. 2020	15.5 years (11.1–18.6) in transfemales 16.1 years (10.1–17.9) in transmales
	Schagen et al. 2016	13.6 years (11.6–17.9) in transfemales 14.2 years (11.1–18.6) in transmales
	Vlot et al. 2017	13.5 years (11.5–18.3) in transfemales 15.1 years (11.7–18.6) in transmales
<p>Age at the start of GnRH analogues was not reported in Staphorsius et al. 2015, but participants were required to be at least 12 years (VERY LOW).</p> <p>The evidence included showed wide variation in the age (11 to 18 years old) at which children and adolescents with gender dysphoria started GnRH analogues.</p>		
Duration of treatment	<p>The duration of treatment with GnRH analogues was reported in 3/9 studies. The median duration was:</p> <ul style="list-style-type: none"> • 2.1 years (range 1.6–2.8) in Brik et al. 2020. • 1.3 years (range 0.5–3.8) in transfemales and 1.5 years (range 0.25–5.2) in transmales in Klink et al. 2015. <p>In Staphorsius et al. 2015, the mean duration was 1.6 years (SD ± 1.0).</p> <p>In de Vries et al. 2011, the mean duration of time between starting GnRH analogues and gender-affirming hormones was 1.88 years (SD ± 1.05).</p> <p>The evidence included showed wide variation in the duration of treatment with GnRH analogues, but most studies did not report this information. Treatment duration ranged from a few months up to about 5 years.</p>	

Abbreviations: DSM, Diagnostic and Statistical Manual of Mental Disorders criteria; SD, standard deviation.

6. Discussion

A key limitation to identifying the effectiveness and safety of GnRH analogues for children and adolescents with gender dysphoria is the lack of reliable comparative studies. The lack of clear, expected outcomes from treatment with a GnRH analogue (the purpose of which is to suppress secondary sexual characteristics which may cause distress from unwanted pubertal changes) also makes interpreting the evidence difficult. The size of the population with gender dysphoria means conducting a prospective trial may be unrealistic, at least on a single centre basis. There may also be ethical issues with a 'no treatment arm' in comparative trials of GnRH analogues, where there may be poor mental health outcomes if treatment is withheld. However, the use of an active comparator such as close psychological support may reduce ethical concerns in future trials.

The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding, and are of very low certainty as

assessed using modified GRADE. All the included studies reported physical and mental health comorbidities and concomitant treatments very poorly. For example, very little data are reported on how many children and adolescents needed additional mental health support, and for what reasons, or whether additional interventions, and what form and duration (for example drug treatment or counselling) that took. This is a possible confounder for the treatment outcomes in the studies because changes in critical and important outcomes may be attributable to external care rather than the psychological support or GnRH analogues used in the studies.

The studies that reported diagnostic criteria for gender dysphoria (6/9 studies) used the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria in use at the time the study was conducted (either DSM-IV-TR or DSM-V). The definition was unclear in the remaining studies. There was wide variation in the ages at which participants started a GnRH analogue, typically ranging from about 11 to 18 years. Similarly, there was a wide variation in the duration of use, but few studies reported this.

Changes in outcome scores for clinical effectiveness were assessed for statistical significance in the 3 studies reporting these outcomes ([Costa et al. 2015](#); [de Vries et al. 2011](#); [Staphorsius et al. 2015](#)). However, there is relatively little interpretation of whether the changes in outcome scores seen in these studies are clinically meaningful.

For some outcomes there was no statistically significant difference from before starting GnRH analogues until just before starting gender-affirming hormones. These were the Utrecht Gender Dysphoria Scale (UGDS) (which was assessed in 1 study [de Vries et al. 2011](#)), the Trait Anger (TPI) and Trait Anxiety (STAI) Scales (which were assessed in 1 study [de Vries et al. 2011](#)), and Body Image Scale (BIS) which was assessed in 1 study ([de Vries et al. 2011](#)).

The Beck Depression Inventory (BDI-II) was used in 1 study ([de Vries et al. 2011](#)) to assess change in depression from before starting GnRH analogues to just before starting gender-affirming hormones. The result is statistically significant, with the mean (\pm SD) BDI-II score decreasing from 8.31 (\pm 7.12) at baseline to 4.95 (\pm 6.27) at follow up ($p=0.004$). However, both scores fall into the minimal range using the general guidelines for interpretation of BDI-II (0 to 13 minimal, 14 to 19 mild depression, 20 to 28 moderate depression and 29 to 63 severe depression), suggesting that while statistically significant, it is unclear if this is a clinically meaningful change.

Psychosocial outcomes were assessed in 3 studies ([Costa et al. 2015](#); [de Vries et al. 2011](#); [Staphorsius et al. 2015](#)) using the Children's Global Assessment Scale (CGAS) and Child Behavior Checklist/Youth Self-Report (CBCL/YSR). The CGAS score was assessed in 2 studies ([Costa et al. 2015](#); [de Vries et al. 2011](#)). In [de Vries et al. 2011](#) the mean (\pm SD) CGAS score statistically significantly increased over time from 70.24 [\pm 10.12] at baseline to 73.90 [\pm 9.63] at follow up. CGAS scores are clinically categorised into 10 categories (10 to 1, 20 to 11 and so on until 100 to 91) and both scores reported were in a single category (71 to 80, no more than slight impairment) suggesting that while statistically significant, it is unclear if this is a clinically meaningful change. The [Costa et al. 2015](#) study does highlight a larger change in CGAS scores from baseline to follow-up (mean [\pm SD] 58.72 [\pm 11.38] compared with 67.40 [\pm 13.39]), but whether this is clinically meaningful is unclear. The average score moved from the clinical category of 60 to 51 (variable functioning with sporadic difficulties) at baseline to 70 to 61 (some difficulty in a single area, but generally

functioning pretty well) at follow up, but the large standard deviations suggest clinically significant overlaps between the scores from baseline to follow-up.

Psychosocial functioning using the CBCL/YSR was assessed in 2 studies ([de Vries et al. 2011](#); [Staphorsius et al. 2015](#)). In de Vries et al. 2011 there was a statistically significant reduction in both CBCL and YSR scores from before starting GnRH analogues to just before starting gender-affirming hormones. The study interpreted the CBCL/YSR with a proportion of adolescents who scored in the clinical range (a T-score above 63), which allows changes in clinically meaningful scores to be assessed, and proportions of adolescents in the clinical range for some CBCL and YSR scores decreased over time. One cross-sectional study ([Staphorsius et al. 2015](#)) assessed CBCL scores only, but it was unclear if this was the Total T score, or whether subscales of internalising or externalising scores were also assessed, and whether the results were statistically significant.

The 2 prospective observational studies ([Costa et al. 2015](#); [de Vries et al. 2011](#)) are confounded by a number of common factors. Firstly, the single assessment of scores at baseline means it is unclear if scores were stable, already improving or declining before starting treatment. Secondly, in an uncontrolled study any changes in scores from baseline to follow-up could be attributed to a regression-to-mean, for example getting older has been positively associated with maturity and wellbeing. The studies use mean and standard deviations in the descriptive statistics and analyses; however, they do not report testing the normality of data which would support the use of parametric measures. The study by de Vries et al. 2011 used general linear models (regression) to examine between and within group variances (changes in outcomes). In using such models, the data is assumed to be balanced (measured at regular intervals and without missing data), but the large ranges in ages at which participants were assessed and started on various interventions suggests that ascertainment of outcome was unlikely to be regular and missing data was likely. Missing data was handled through listwise deletion (omits those cases with the missing data and analyses the remaining data) which is acceptable if data loss is completely random but for some outcomes where there was incomplete data for individual items this was not random (items were introduced by the authors after the first eligible adolescents had started GnRH analogues). The study provided no detail on whether these assumptions for the modeling were met, they also provided no adequate assessment of whether any regression diagnostics (analysis that seek to assess the validity of a model) or model fit (how much of the variance in outcome is explained by the between and within group variance) were undertaken.

The 2 retrospective observational studies ([Brik et al. 2020](#); [Khatchadourian et al. 2014](#)) both only report absolute numbers for each trajectory along with reasons for stopping GnRH analogues. It is difficult to assess outcomes from such single centre studies because there is little comparative data for outcomes from other such services. A lack of any critical or other important outcomes also means the success of the treatment across all the participants is difficult to judge.

Three uncontrolled, observational, retrospective studies provided evidence relating to the effect of GnRH analogues on bone density ([Joseph et al. 2019](#); [Klink et al. 2015](#); [Vlot et al. 2017](#)). In all 3 studies, the participants acted as their own controls and change in bone density was determined between starting GnRH analogues and either after 1 and 2 year follow-up timepoints ([Joseph et al. 2019](#)) or when gender-affirming hormones were started

(Klink et al. 2015 and Vlot et al. 2017). Observational studies such as these can only show an association with GnRH analogues and bone density; they cannot show that GnRH analogues caused any differences in bone density seen. Because there was no comparator group and participants acted as their own controls, it is unclear whether the findings are associated with GnRH analogues or due to changes over time. The authors reported z-scores which allows for comparison with the expected increase in bone density in the general population. However, because no concomitant treatments or comorbidities were reported it is possible that the findings may not be because of GnRH analogues and there is another way in which the study population differs from the general population.

All the studies are from a limited number of, mainly European, care facilities. They are described as either tertiary referral or expert services but the low number of services providing such care and publishing evidence may bias the results towards the outcomes in these services only and limit extrapolation.

The first study ([Brik et al. 2020](#)) was an uncontrolled, retrospective, observational study that assessed the outcome trajectories of adolescents receiving GnRH analogues for gender dysphoria. This study followed-up 143 individuals who had received GnRH analogues (38 transfemales and 105 transmales) using clinical records to show outcomes for up to 9 years (continuing use of GnRH analogues, reasons for stopping GnRH analogues and onward care such as gender-affirming hormone use). The methods and results are well reported, but no analysis of data was undertaken. The views of adolescents and their parents are particularly difficult to interpret because no data on how many responded to each question and in what ways are reported.

The second study ([Costa et al. 2015](#)) was an uncontrolled, prospective observational study which assessed global functioning in adolescents with gender dysphoria using CGAS every 6 months, including during the first 6 months where statistically significant improvements were seen without GnRH analogues. The study is confounded by significant unexplained loss to follow-up (64.7%: from n=201 adolescents to n=71 after 18 months). Missing data for those lost to follow-up maybe more than sufficient to change the direction of effects seen in the study if the reasons for loss to follow-up are systematic (such as deriving little or no benefit from treatment). The study uses clustered data in its analysis, a single outcome (CGAS) measured in clusters (at different visits), and the analysis does not take account of the correlation of scores (data at different time points are not independent) as a significant change in scores early in the study means the successive changes measured against baseline were also significant. The study relies on multiple (>20) pairwise independent *t*-tests to examine change in CGAS between the 4 time points, increasing the possibility of type-I error (a false positive which occurs when a researcher incorrectly rejects a true null hypothesis) because the more tests performed the more likely a statistically significant result will be observed by chance alone.

The [Costa et al. 2015](#) study compares immediately eligible and delayed eligible cohorts, however, it is highly likely that they are non-comparable groups because the immediately eligible group were those able to start GnRH analogues straight away whilst those in the delayed eligible group were either not ready to make a decision about starting treatment (no age comparison was made between the 2 groups so it is unclear if they were a younger cohort than the immediately eligible group) or had comorbid mental health or psychological difficulties. The authors report that those with concomitant problems (such as mental health

problems, substantial problems with peers, or conflicts with parents or siblings) were referred to local mental health services but no details are provided.

The third study ([de Vries et al. 2011](#)) was an uncontrolled, prospective observational study which assessed gender dysphoria and psychological functioning before and after puberty suppression in adolescents with gender dysphoria. Although the study mentions the DSM-IV-TR there is no explicit discussion of this, or any other criteria, being used as the diagnostic criteria for study entry. There are no details reported for how the outcomes in the study were assessed, and by whom. The length of follow-up for the outcomes in the model are questionable in relation to whether there was sufficient time for GnRH analogues to have a measurable effect. The time points used are start of GnRH analogues and start of gender-affirming hormones. Overall, the mean time between starting GnRH analogues and gender-affirming hormones was 1.88 (± 1.05) years, but the range is as low as just 5 months between the 2 time points, which may be insufficient for any difference in outcome to have occurred in some individuals.

The fourth study ([Joseph et al. 2019](#)) was a retrospective, longitudinal observational single centre study which assessed bone mineral density in adolescents with gender dysphoria in the UK. For inclusion in the study, participants had to have been assessed by the Gender Identity Development Service multi-disciplinary psychosocial health team for at least 4 assessments over a minimum of 6 months. No other diagnostic criteria, such as the DSM-IV-TR, are discussed. Bone density was assessed using dual energy X-ray absorptiometry (DAXA) scan of the lumbar spine (L1-L4) and the femoral neck at baseline (n=70), 1 year (n=70) and 2 years after starting GnRH analogues (n=39). The results suggest a possible association between GnRH analogues and bone mineral apparent density. However, the evidence is of poor quality, and the results could be due to bias or chance. No concomitant treatments or comorbidities were reported.

The fifth study ([Khatchadourian et al. 2014](#)) was an uncontrolled retrospective observational study which describes patient characteristics at presentation, treatment, and response to treatment in 84 adolescents with gender dysphoria, of whom 27 received GnRH analogues. The study used clinical records to show outcomes for up to 13 years (continuing use of GnRH analogues, reasons for stopping GnRH analogues and onward care such as gender-affirming hormone use). The methods are well reported but the results for those taking GnRH analogues are poorly and incompletely reported, particularly for transfemales, and no analysis of data was undertaken. It is difficult to assess the results for stopping GnRH analogues due to incomplete reporting of this outcome.

The sixth study ([Klink et al. 2015](#)) was a retrospective longitudinal observational single centre study which assessed bone mineral density in adolescents with gender dysphoria, diagnosed with the DSM-IV-TR criteria. Bone density was assessed when starting GnRH analogues and then when starting gender-affirming hormones. Results are reported for transmales and transfemales separately and no results for the whole cohort are given. Statistical analyses were reported for all outcomes of interest but, because there was no comparator group and participants acted as their own controls, it is not known whether the findings are associated with GnRH analogues or due to changes over time. The authors reported z-scores which allows for comparison with the expected increase in bone density in the general population. However, because no concomitant treatments or comorbidities were

reported it is possible that the findings may not be because of GnRH analogues and there is another way in which the study population differs from the general population.

The seventh study ([Schagen et al. 2016](#)) was a prospective observational study of 116 adolescents which provided very low certainty non-comparative evidence on change in serum creatinine between starting GnRH analogues and 1 year, and liver function during treatment. Statistical analyses were reported for changes in serum creatinine but not for liver function. Because there was no comparator group and participants acted as their own controls, it is not known whether the findings are associated with GnRH analogues or due to changes over time, or concomitant treatments.

The eighth study ([Staphorsius et al. 2015](#)) was a cross-sectional study of 85 adolescents, 40 with gender dysphoria (of whom 20 were receiving GnRH analogues) and 45 matched controls (not further reported in this evidence review). The study includes 1 outcome of interest for clinical effectiveness (CBCL) and 1 outcome of interest for safety (cognitive development or functioning). The mean (\pm SD) CBCL, IQ test, reaction time and accuracy scores were given for each group, but the statistical analysis is unclear. It is not reported what analysis was used or which of the groups were compared, therefore it is difficult to interpret the results.

The ninth study ([Vlot et al. 2017](#)) was a retrospective observational study which assessed bone mineral apparent density in adolescents with DSM-IV-TR gender dysphoria. Measurements were taken at the start of GnRH analogues and at the start of gender-affirming hormones. Results are reported for young bone age and old bone age in transmales and transfemales separately, and no results for the whole cohort are given. Statistical analyses were reported for all outcomes of interest but, because there was no comparator group and participants acted as their own controls, it is not known whether the findings are associated with GnRH analogues or due to changes over time. The authors reported z-scores which allows for comparison with the expected increase in bone density in the general population. However, because no concomitant treatments or comorbidities were reported it is possible that the findings may not be because of GnRH analogues and there is another way in which the study population differs from the general population.

7. Conclusion

The results of the studies that reported impact on the critical outcomes of gender dysphoria and mental health (depression, anger and anxiety), and the important outcomes of body image and psychosocial impact (global and psychosocial functioning) in children and adolescents with gender dysphoria are of very low certainty using modified GRADE. They suggest little change with GnRH analogues from baseline to follow-up.

Studies that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance. It is plausible, however, that a lack of difference in scores from baseline to follow-up is the effect of GnRH analogues in children and adolescents with gender dysphoria, in whom the development of secondary sexual characteristics might be expected to be associated with an increased impact on gender dysphoria, depression, anxiety, anger and distress over time without treatment. One study reported statistically significant reductions in the Child Behaviour Checklist/Youth Self-Report (CBCL/YSR) scores from

baseline to follow up, and given that the purpose of GnRH analogues is to reduce distress caused by the development of secondary sexual characteristics and the CBCL/YSR in part measures distress, this could be an important finding. However, as the studies all lack reasonable controls not receiving GnRH analogues, the natural history of the outcomes measured in the studies is not known and any positive changes could be a regression to mean.

The results of the studies that reported bone density outcomes suggest that GnRH analogues may reduce the increase in bone density which is expected during puberty. However, as the studies themselves are not reliable, the results could be due to confounding, bias or chance. While controlled trials may not be possible, comparative studies are needed to understand this association and whether the effects of GnRH analogues on bone density are seen after treatment is stopped. All the studies that reported safety outcomes provided very low certainty evidence.

No cost-effectiveness evidence was found to determine whether or not GnRH analogues are cost-effective for children and adolescents with gender dysphoria.

The results of the studies that reported outcomes for subgroups of children and adolescents with gender dysphoria, suggest there may be differences between sex assigned at birth males (transfemales) and sex assigned at birth females (transmales).

Appendix A PICO document

The review questions for this evidence review are:

1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?
2. For children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?
3. For children and adolescents with gender dysphoria, what is the cost-effectiveness of GnRH analogues compared to one or a combination of psychological support, social transitioning to the desired gender or no intervention?
4. From the evidence selected, are there any subgroups of children and adolescents with gender dysphoria that may derive more (or less) advantage from treatment with GnRH analogues than the wider population of children and adolescents with gender dysphoria?
5. From the evidence selected,
 - a) what are the criteria used by the research studies to define gender dysphoria, gender identity disorder and gender incongruence of childhood?
 - b) what were the ages at which participants commenced treatment with GnRH analogues?
 - c) what was the duration of treatment with GnRH analogues?

PICO table

<p>P – Population and Indication</p>	<p>Children and adolescents aged 18 years or less who have gender dysphoria, gender identity disorder or gender incongruence of childhood as defined by study:</p> <p>The following subgroups of children and adolescents with gender dysphoria, gender identity disorder or gender incongruence of childhood need to be considered:</p> <ul style="list-style-type: none"> • Sex assigned at birth males. • Sex assigned at birth females. • The duration of gender dysphoria: less than 6 months, 6-24 months, and more than 24 months. • The age of onset of gender dysphoria. • The age at which treatment was initiated. • The age of onset of puberty. • Tanner stage at which treatment was initiated. • Children and adolescents with gender dysphoria who have a pre-existing diagnosis of autistic spectrum disorder. • Children and adolescents with gender dysphoria who had a significant mental health symptom load at diagnosis including anxiety, depression (with or without a history of self-harm and suicidality), suicide attempts, psychosis, personality disorder, Attention Deficit Hyperactivity Disorder and eating disorders.
<p>I – Intervention</p>	<p>Any GnRH analogue including: triptorelin*; buserelin; histrelin; goserelin (Zoladex); leuporelin/leuprolide (Prostap); nafarelin.</p>

	<p>* Triptorelin (brand names Gonapeptyl and Decapeptyl) are used in Leeds Hospital, England. The search should include brand names as well as generic names.</p>
C – Comparator(s)	<p>One or a combination of:</p> <ul style="list-style-type: none"> • Psychological support. • Social transitioning to the gender with which the individual identifies. • No intervention.
O – Outcomes	<p>There are no known minimal clinically important differences and there are no preferred timepoints for the outcome measures selected.</p> <p>All outcomes should be stratified by:</p> <ul style="list-style-type: none"> • The age at which treatment with GnRH analogues was initiated. • The length of treatment with GnRH analogues where possible. <p><u>A: Clinical Effectiveness</u></p> <p><i>Critical to decision making</i></p> <ul style="list-style-type: none"> • Impact on Gender Dysphoria This outcome is critical because gender dysphoria in adolescents and children is associated with significant distress and problems functioning. Impact on gender dysphoria may be measured by the Utrecht Gender Dysphoria Scale. Other measures as reported in studies may be used as an alternative to the stated measure. • Impact on mental health Examples of mental health problems include self-harm, thoughts of suicide, suicide attempts, eating disorders, depression/low mood and anxiety. These outcomes are critical because self-harm and thoughts of suicide have the potential to result in significant physical harm and for completed suicides the death of the young person. Disordered eating habits may cause significant morbidity in young people. Depression and anxiety are also critical outcomes because they may impact on social, occupational, or other areas of functioning of children and adolescents. The Child and Adolescent Psychiatric Assessment (CAPA) may be used to measure depression and anxiety. The impact on self-harm and suicidality (ideation and behaviour) may be measured using the Suicide Ideation Questionnaire Junior. Other measures may be used as an alternative to the stated measures. • Impact on Quality of Life This outcome is critical because gender dysphoria in children and adolescents may be associated with a significant reduction in health-related quality of life. Quality of Life may be measured by the KINDL questionnaire, Kidscreen 52. Other measures as reported in studies may be used as an alternative to the stated measure. <p><i>Important to decision making</i></p> <ul style="list-style-type: none"> • Impact on body Image This outcome is important because some transgender young people may desire to take steps to suppress features of their physical appearance associated with their sex assigned at birth or accentuate physical features of their desired gender. The Body Image Scale could be used as a measure. Other measures

	<p>as reported in studies may also be used as an alternative to the stated measure.</p> <ul style="list-style-type: none"> Psychosocial Impact Examples of psychosocial impact are: coping mechanisms which may impact on substance misuse; family relationships; peer relationships. This outcome is important because gender dysphoria in adolescents and children is associated with internalising and externalising behaviours and emotional and behavioural problems which may impact on social and occupational functioning. The child behavioural check list (CBCL) may be used to measure the impact on psychosocial functioning. Other measures as reported in studies may be used as an alternative to the stated measure. Engagement with health care services This outcome is important because patient engagement with healthcare services will impact on their clinical outcomes. Engagement with health care services may be measured using the Youth Health Care measure-satisfaction, utilization, and needs (YHC-SUN) questionnaire. Loss to follow up should also be ascertained as part of this outcome. Alternative measures to the YHC-SUN questionnaire may be used as reported in studies. Transitioning surgery – Impact on extent of and satisfaction with surgery This outcome is important because some children and adolescents with gender dysphoria may proceed to transitioning surgery. Stated measures of the extent of transitioning surgery and satisfaction with surgery in studies may be reported. Stopping treatment The proportion of patients who stop treatment with GnRH analogues and the reasons why. This outcome is important to patients because there is uncertainty about the short- and long-term safety and adverse effects of GnRH analogues in children and adolescents being treated for gender dysphoria. <p><u>B: Safety</u></p> <ul style="list-style-type: none"> Short and long-term safety and adverse effects of taking GnRH analogues are important because GnRH analogues are not licensed for the treatment of adolescents and children with gender dysphoria. Aspects to be reported on should include: <ul style="list-style-type: none"> Impact of the drug use such as its impact on bone density, arterial hypertension, cognitive development/functioning Impact of withdrawing the drug such as, slipped upper femoral epiphysis, reversibility on the reproductive system, and any others as reported. <p><u>C: Cost effectiveness</u></p> <p>Cost effectiveness studies should be reported.</p>
Inclusion criteria	
Study design	<p>Systematic reviews, randomised controlled trials, controlled clinical trials, cohort studies.</p> <p>If no higher level quality evidence is found, case series can be considered.</p>

Language	English only
Patients	Human studies only
Age	18 years or less
Date limits	2000-2020
Exclusion criteria	
Publication type	Conference abstracts, non-systematic reviews, narrative reviews, commentaries, letters, editorials, guidelines and pre-publication prints
Study design	Case reports, resource utilisation studies

Appendix B Search strategy

Medline, Embase, the Cochrane Library, HTA and APA PsycInfo were searched on 23 July 2020, limiting the search to papers published in English language in the last 20 years. Conference abstracts and letters were excluded.

Database: Medline

Platform: Ovid

Version: Ovid MEDLINE(R) <1946 to July 21, 2020>

Search date: 23/7/2020

Number of results retrieved: 144

Search strategy:

- 1 Gender Dysphoria/ (485)
- 2 Gender Identity/ (18452)
- 3 "Sexual and Gender Disorders"/ (75)
- 4 Transsexualism/ (3758)
- 5 Transgender Persons/ (3143)
- 6 Health Services for Transgender Persons/ (136)
- 7 exp Sex Reassignment Procedures/ (836)
- 8 (gender* adj3 (dysphori* or affirm* or incongruen* or identi* or disorder* or confus* or minorit* or queer*).tw. (7435)
- 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (12678)
- 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (102343)
- 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*).tw. (6974)
- 12 (male-to-female or m2f or female-to-male or f2m).tw. (114841)
- 13 or/1-12 (252702)
- 14 exp Infant/ or Infant Health/ or Infant Welfare/ (1137479)
- 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (852400)
- 16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (1913257)

17 Minors/ (2574)
 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (2361686)
 19 exp pediatrics/ (58118)
 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (836269)
 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (2024207)
 22 Puberty/ (13278)
 23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert*
 or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn.
 (424246)
 24 Schools/ (38104)
 25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (7199)
 26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or
 pupil* or student*).ti,ab,jn. (468992)
 27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or
 "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or
 aged)).ti,ab. (89353)
 28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19")
 adj2 (year or years or age or ages or aged)).ti,ab. (887838)
 29 or/14-28 (5534171)
 30 13 and 29 (79263)
 31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (7)
 32 30 or 31 (79263)
 33 Gonadotropin-Releasing Hormone/ (27588)
 34 (pubert* adj3 block*).ti,ab. (78)
 35 ((gonadotrophin or gonadotropin) and releasing).ti,ab. (17299)
 36 (GnRH adj2 analog*).ti,ab. (2541)
 37 GnRH*.ti,ab. (20991)
 38 "GnRH agonist*".ti,ab. (4040)
 39 Triptorelin Pamoate/ (1906)
 40 triptorelin.ti,ab. (677)
 41 arvekap.ti,ab. (1)
 42 ("AY 25650" or AY25650).ti,ab. (1)
 43 ("BIM 21003" or BIM21003).ti,ab. (0)
 44 ("BN 52014" or BN52014).ti,ab. (0)
 45 ("CL 118532" or CL118532).ti,ab. (0)
 46 Debio.ti,ab. (83)
 47 diphereline.ti,ab. (17)
 48 moapar.ti,ab. (0)
 49 pamorelin.ti,ab. (0)
 50 trelstar.ti,ab. (3)
 51 triptodur.ti,ab. (1)
 52 ("WY 42422" or WY42422).ti,ab. (0)
 53 ("WY 42462" or WY42462).ti,ab. (0)
 54 gonapeptyl.ti,ab. (0)
 55 decapeptyl.ti,ab. (210)
 56 salvacyl.ti,ab. (0)
 57 Buserelin/ (2119)
 58 buserelin.ti,ab. (1304)

59 bigonist.ti,ab. (0)
 60 ("hoe 766" or hoe-766 or hoe766).ti,ab. (69)
 61 profact.ti,ab. (2)
 62 receptal.ti,ab. (30)
 63 suprecur.ti,ab. (4)
 64 suprefact.ti,ab. (22)
 65 tiloryth.ti,ab. (0)
 66 histrelin.ti,ab. (55)
 67 "LHRH-hydrogel implant".ti,ab. (1)
 68 ("RL 0903" or RL0903).ti,ab. (1)
 69 ("SPD 424" or SPD424).ti,ab. (1)
 70 goserelin.ti,ab. (875)
 71 Goserelin/ (1612)
 72 ("ici 118630" or ici118630).ti,ab. (51)
 73 ("ZD-9393" or ZD9393).ti,ab. (0)
 74 zoladex.ti,ab. (379)
 75 leuprorelin.ti,ab. (413)
 76 carcinil.ti,ab. (0)
 77 enanton*.ti,ab. (23)
 78 ginecrin.ti,ab. (0)
 79 leuplin.ti,ab. (13)
 80 Leuprolide/ (2900)
 81 leuprolide.ti,ab. (1743)
 82 lucrin.ti,ab. (11)
 83 lupron.ti,ab. (162)
 84 provren.ti,ab. (0)
 85 procrin.ti,ab. (3)
 86 ("tap 144" or tap144).ti,ab. (40)
 87 (a-43818 or a43818).ti,ab. (3)
 88 Trenantone.ti,ab. (1)
 89 staladex.ti,ab. (0)
 90 prostap.ti,ab. (6)
 91 Nafarelin/ (327)
 92 nafarelin.ti,ab. (251)
 93 ("76932-56-4" or "76932564").ti,ab. (0)
 94 ("76932-60-0" or "76932600").ti,ab. (0)
 95 ("86220-42-0" or "86220420").ti,ab. (0)
 96 ("rs 94991 298" or rs94991298).ti,ab. (0)
 97 synarel.ti,ab. (12)
 98 deslorelin.ti,ab. (263)
 99 gonadorelin.ti,ab. (201)
 100 ("33515-09-2" or "33515092").ti,ab. (0)
 101 ("51952-41-1" or "51952411").ti,ab. (0)
 102 ("52699-48-6" or "52699486").ti,ab. (0)
 103 cetorelix.ti,ab. (463)
 104 cetrotide.ti,ab. (41)
 105 ("NS 75A" or NS75A).ti,ab. (0)
 106 ("NS 75B" or NS75B).ti,ab. (0)

107 ("SB 075" or SB075).ti,ab. (0)
 108 ("SB 75" or SB75).ti,ab. (63)
 109 gonadoliberin.ti,ab. (143)
 110 kryptocur.ti,ab. (6)
 111 cetorelix.ti,ab. (463)
 112 cetrotide.ti,ab. (41)
 113 antagon.ti,ab. (17)
 114 ganirelix.ti,ab. (138)
 115 ("ORG 37462" or ORG37462).ti,ab. (3)
 116 orgalutran.ti,ab. (20)
 117 ("RS 26306" or RS26306).ti,ab. (5)
 118 ("AY 24031" or AY24031).ti,ab. (0)
 119 factrel.ti,ab. (11)
 120 fertagyl.ti,ab. (11)
 121 lutrelef.ti,ab. (5)
 122 lutrepulse.ti,ab. (3)
 123 relefact.ti,ab. (10)
 124 fertiral.ti,ab. (0)
 125 (hoe471 or "hoe 471").ti,ab. (6)
 126 relisorm.ti,ab. (4)
 127 cystorelin.ti,ab. (18)
 128 dirigestran.ti,ab. (5)
 129 or/33-128 (42216)
 130 32 and 129 (416)
 131 limit 130 to english language (393)
 132 limit 131 to (letter or historical article or comment or editorial or news or case reports)
 (36)
 133 131 not 132 (357)
 134 animals/ not humans/ (4686361)
 135 133 not 134 (181)
 136 limit 135 to yr="2000 -Current" (144)

Database: Medline in-process

Platform: Ovid

Version: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations <1946 to July 21, 2020>

Search date: 23/7/2020

Number of results retrieved:

Search strategy: 42

1 Gender Dysphoria/ (0)
 2 Gender Identity/ (0)
 3 "Sexual and Gender Disorders"/ (0)
 4 Transsexualism/ (0)
 5 Transgender Persons/ (0)
 6 Health Services for Transgender Persons/ (0)
 7 exp Sex Reassignment Procedures/ (0)

- 8 (gender* adj3 (dysphori* or affirm* or incongruen* or identi* or disorder* or confus* or minorit* or queer*).tw. (1645)
- 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (2333)
- 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (20884)
- 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*).tw. (968)
- 12 (male-to-female or m2f or female-to-male or f2m).tw. (15513)
- 13 or/1-12 (39905)
- 14 exp Infant/ or Infant Health/ or Infant Welfare/ (0)
- 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (80723)
- 16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (0)
- 17 Minors/ (0)
- 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (321871)
- 19 exp pediatrics/ (0)
- 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (119783)
- 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (0)
- 22 Puberty/ (0)
- 23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (60264)
- 24 Schools/ (0)
- 25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (0)
- 26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (69233)
- 27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (10319)
- 28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (112800)
- 29 or/14-28 (525529)
- 30 13 and 29 (9196)
- 31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (3)
- 32 30 or 31 (9197)
- 33 Gonadotropin-Releasing Hormone/ (0)
- 34 (pubert* adj3 block*).ti,ab. (19)
- 35 ((gonadotrophin or gonadotropin) and releasing).ti,ab. (1425)
- 36 (GnRH adj2 analog*).ti,ab. (183)
- 37 GnRH*.ti,ab. (1695)
- 38 "GnRH agonist".ti,ab. (379)
- 39 Triptorelin Pamoate/ (0)
- 40 triptorelin.ti,ab. (72)
- 41 arvekap.ti,ab. (0)
- 42 ("AY 25650" or AY25650).ti,ab. (0)
- 43 ("BIM 21003" or BIM21003).ti,ab. (0)
- 44 ("BN 52014" or BN52014).ti,ab. (0)
- 45 ("CL 118532" or CL118532).ti,ab. (0)

46 Debio.ti,ab. (11)
 47 diphereline.ti,ab. (6)
 48 moapar.ti,ab. (0)
 49 pamorelin.ti,ab. (0)
 50 trelstar.ti,ab. (0)
 51 triptodur.ti,ab. (0)
 52 ("WY 42422" or WY42422).ti,ab. (0)
 53 ("WY 42462" or WY42462).ti,ab. (0)
 54 gonaapeptyl.ti,ab. (0)
 55 decapeptyl.ti,ab. (8)
 56 salvacyl.ti,ab. (0)
 57 Buserelin/ (0)
 58 buserelin.ti,ab. (59)
 59 bigonist.ti,ab. (0)
 60 ("hoe 766" or hoe-766 or hoe766).ti,ab. (3)
 61 profact.ti,ab. (0)
 62 receptal.ti,ab. (0)
 63 suprecur.ti,ab. (1)
 64 suprefact.ti,ab. (2)
 65 tiloryth.ti,ab. (0)
 66 histrelin.ti,ab. (9)
 67 "LHRH-hydrogel implant".ti,ab. (0)
 68 ("RL 0903" or RL0903).ti,ab. (0)
 69 ("SPD 424" or SPD424).ti,ab. (0)
 70 goserelin.ti,ab. (68)
 71 Goserelin/ (0)
 72 ("ici 118630" or ici118630).ti,ab. (0)
 73 ("ZD-9393" or ZD9393).ti,ab. (0)
 74 zoladex.ti,ab. (6)
 75 leuprorelin.ti,ab. (47)
 76 carcinil.ti,ab. (0)
 77 enanton*.ti,ab. (1)
 78 ginecrin.ti,ab. (0)
 79 leuplin.ti,ab. (1)
 80 Leuprolide/ (0)
 81 leuprolide.ti,ab. (121)
 82 lucrin.ti,ab. (4)
 83 lupron.ti,ab. (10)
 84 provren.ti,ab. (0)
 85 procrin.ti,ab. (0)
 86 ("tap 144" or tap144).ti,ab. (0)
 87 (a-43818 or a43818).ti,ab. (0)
 88 Trenantone.ti,ab. (1)
 89 staladex.ti,ab. (0)
 90 prostap.ti,ab. (0)
 91 Nafarelin/ (0)
 92 nafarelin.ti,ab. (5)
 93 ("76932-56-4" or "76932564").ti,ab. (0)

94 ("76932-60-0" or "76932600").ti,ab. (0)
 95 ("86220-42-0" or "86220420").ti,ab. (0)
 96 ("rs 94991 298" or rs94991298).ti,ab. (0)
 97 synarel.ti,ab. (0)
 98 deslorelin.ti,ab. (14)
 99 gonadorelin.ti,ab. (13)
 100 ("33515-09-2" or "33515092").ti,ab. (0)
 101 ("51952-41-1" or "51952411").ti,ab. (0)
 102 ("52699-48-6" or "52699486").ti,ab. (0)
 103 cetorelix.ti,ab. (31)
 104 cetrotide.ti,ab. (5)
 105 ("NS 75A" or NS75A).ti,ab. (0)
 106 ("NS 75B" or NS75B).ti,ab. (0)
 107 ("SB 075" or SB075).ti,ab. (0)
 108 ("SB 75" or SB75).ti,ab. (2)
 109 gonadoliberin.ti,ab. (4)
 110 kryptocur.ti,ab. (1)
 111 cetorelix.ti,ab. (31)
 112 cetrotide.ti,ab. (5)
 113 antagon.ti,ab. (0)
 114 ganirelix.ti,ab. (8)
 115 ("ORG 37462" or ORG37462).ti,ab. (0)
 116 orgalutran.ti,ab. (3)
 117 ("RS 26306" or RS26306).ti,ab. (0)
 118 ("AY 24031" or AY24031).ti,ab. (0)
 119 factrel.ti,ab. (2)
 120 fertagyl.ti,ab. (1)
 121 lutrelef.ti,ab. (0)
 122 lutrepulse.ti,ab. (0)
 123 relefact.ti,ab. (0)
 124 fertiral.ti,ab. (0)
 125 (hoe471 or "hoe 471").ti,ab. (0)
 126 relisorm.ti,ab. (0)
 127 cystorelin.ti,ab. (1)
 128 dirigestran.ti,ab. (0)
 129 or/33-128 (2332)
 130 32 and 129 (45)
 131 limit 130 to english language (45)
 132 limit 131 to yr="2000 -Current" (42)

Database: Medline epub ahead of print

Platform: Ovid

Version: Ovid MEDLINE(R) Epub Ahead of Print <July 21, 2020>

Search date: 23/7/2020

Number of results retrieved: 8

Search strategy:

1 Gender Dysphoria/ (0)

2 Gender Identity/ (0)
 3 "Sexual and Gender Disorders"/ (0)
 4 Transsexualism/ (0)
 5 Transgender Persons/ (0)
 6 Health Services for Transgender Persons/ (0)
 7 exp Sex Reassignment Procedures/ (0)
 8 (gender* adj3 (dysphori* or affirm* or incongruen* or identi* or disorder* or confus* or
 minorit* or queer*)).tw. (486)
 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen*
 or transperson* or transpeopl*).tw. (640)
 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw.
 (1505)
 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (178)
 12 (male-to-female or m2f or female-to-male or f2m).tw. (2480)
 13 or/1-12 (4929)
 14 exp Infant/ or Infant Health/ or Infant Welfare/ (0)
 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or
 perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (15496)
 16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (0)
 17 Minors/ (0)
 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (53563)
 19 exp pediatrics/ (0)
 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (22796)
 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (0)
 22 Puberty/ (0)
 23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert*
 or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn.
 (13087)
 24 Schools/ (0)
 25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (0)
 26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or
 pupil* or student*).ti,ab,in,jn. (12443)
 27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or
 "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or
 aged)).ti,ab. (1416)
 28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19")
 adj2 (year or years or age or ages or aged)).ti,ab. (20166)
 29 or/14-28 (88366)
 30 13 and 29 (1638)
 31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (1)
 32 30 or 31 (1638)
 33 Gonadotropin-Releasing Hormone/ (0)
 34 (pubert* adj3 block*).ti,ab. (2)
 35 ((gonadotrophin or gonadotropin) and releasing).ti,ab. (176)
 36 (GnRH adj2 analog*).ti,ab. (30)
 37 GnRH*.ti,ab. (223)
 38 "GnRH agonist".ti,ab. (49)
 39 Triptorelin Pamoate/ (0)

40 triptorelin.ti,ab. (12)
 41 arvekap.ti,ab. (0)
 42 ("AY 25650" or AY25650).ti,ab. (0)
 43 ("BIM 21003" or BIM21003).ti,ab. (0)
 44 ("BN 52014" or BN52014).ti,ab. (0)
 45 ("CL 118532" or CL118532).ti,ab. (0)
 46 Debio.ti,ab. (2)
 47 diphereline.ti,ab. (1)
 48 moapar.ti,ab. (0)
 49 pamorelin.ti,ab. (0)
 50 trelstar.ti,ab. (0)
 51 triptodur.ti,ab. (0)
 52 ("WY 42422" or WY42422).ti,ab. (0)
 53 ("WY 42462" or WY42462).ti,ab. (0)
 54 gonapeptyl.ti,ab. (0)
 55 decapeptyl.ti,ab. (0)
 56 salvacyl.ti,ab. (0)
 57 Buserelin/ (0)
 58 buserelin.ti,ab. (7)
 59 bigonist.ti,ab. (0)
 60 ("hoe 766" or hoe-766 or hoe766).ti,ab. (0)
 61 profact.ti,ab. (0)
 62 receptal.ti,ab. (0)
 63 suprecur.ti,ab. (0)
 64 suprefact.ti,ab. (1)
 65 tiloryth.ti,ab. (0)
 66 histrelin.ti,ab. (2)
 67 "LHRH-hydrogel implant".ti,ab. (0)
 68 ("RL 0903" or RL0903).ti,ab. (0)
 69 ("SPD 424" or SPD424).ti,ab. (0)
 70 goserelin.ti,ab. (11)
 71 Goserelin/ (0)
 72 ("ici 118630" or ici118630).ti,ab. (0)
 73 ("ZD-9393" or ZD9393).ti,ab. (0)
 74 zoladex.ti,ab. (1)
 75 leuprorelin.ti,ab. (13)
 76 carcinil.ti,ab. (0)
 77 enanton*.ti,ab. (1)
 78 ginecrin.ti,ab. (0)
 79 leuplin.ti,ab. (0)
 80 Leuprolide/ (0)
 81 leuprolide.ti,ab. (22)
 82 lucrin.ti,ab. (0)
 83 lupron.ti,ab. (2)
 84 provren.ti,ab. (0)
 85 procrin.ti,ab. (0)
 86 ("tap 144" or tap144).ti,ab. (1)
 87 (a-43818 or a43818).ti,ab. (0)

88 Trenantone.ti,ab. (0)
 89 staladex.ti,ab. (0)
 90 prostap.ti,ab. (0)
 91 Nafarelin/ (0)
 92 nafarelin.ti,ab. (4)
 93 ("76932-56-4" or "76932564").ti,ab. (0)
 94 ("76932-60-0" or "76932600").ti,ab. (0)
 95 ("86220-42-0" or "86220420").ti,ab. (0)
 96 ("rs 94991 298" or rs94991298).ti,ab. (0)
 97 synarel.ti,ab. (0)
 98 deslorelin.ti,ab. (3)
 99 gonadorelin.ti,ab. (3)
 100 ("33515-09-2" or "33515092").ti,ab. (0)
 101 ("51952-41-1" or "51952411").ti,ab. (0)
 102 ("52699-48-6" or "52699486").ti,ab. (0)
 103 cetorelix.ti,ab. (6)
 104 cetrotide.ti,ab. (2)
 105 ("NS 75A" or NS75A).ti,ab. (0)
 106 ("NS 75B" or NS75B).ti,ab. (0)
 107 ("SB 075" or SB075).ti,ab. (0)
 108 ("SB 75" or SB75).ti,ab. (0)
 109 gonadoliberin.ti,ab. (0)
 110 kryptocur.ti,ab. (0)
 111 cetorelix.ti,ab. (6)
 112 cetrotide.ti,ab. (2)
 113 antagon.ti,ab. (1)
 114 ganirelix.ti,ab. (1)
 115 ("ORG 37462" or ORG37462).ti,ab. (0)
 116 orgalutran.ti,ab. (0)
 117 ("RS 26306" or RS26306).ti,ab. (0)
 118 ("AY 24031" or AY24031).ti,ab. (0)
 119 factrel.ti,ab. (0)
 120 fertagyl.ti,ab. (0)
 121 lutrelef.ti,ab. (0)
 122 lutrepulse.ti,ab. (0)
 123 relefact.ti,ab. (0)
 124 fertiral.ti,ab. (0)
 125 (hoe471 or "hoe 471").ti,ab. (0)
 126 relisorm.ti,ab. (0)
 127 cystorelin.ti,ab. (0)
 128 dirigestran.ti,ab. (0)
 129 or/33-128 (310)
 130 32 and 129 (8)
 131 limit 130 to english language (8)
 132 limit 131 to yr="2000 -Current" (8)

Database: Medline daily update

Platform: Ovid

Version: Ovid MEDLINE(R) Daily Update <July 21, 2020>

Search date: 23/7/2020

Number of results retrieved: 1

Search strategy

- 1 Gender Dysphoria/ (4)
- 2 Gender Identity/ (38)
- 3 "Sexual and Gender Disorders"/ (0)
- 4 Transsexualism/ (2)
- 5 Transgender Persons/ (26)
- 6 Health Services for Transgender Persons/ (1)
- 7 exp Sex Reassignment Procedures/ (3)
- 8 (gender* adj3 (dysphori* or affirm* or incongruen* or identi* or disorder* or confus* or minorit* or queer*)).tw. (24)
- 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (39)
- 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (87)
- 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (15)
- 12 (male-to-female or m2f or female-to-male or f2m).tw. (181)
- 13 or/1-12 (358)
- 14 exp Infant/ or Infant Health/ or Infant Welfare/ (932)
- 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (981)
- 16 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (1756)
- 17 Minors/ (3)
- 18 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (3672)
- 19 exp pediatrics/ (75)
- 20 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (1658)
- 21 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (2006)
- 22 Puberty/ (8)
- 23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (732)
- 24 Schools/ (56)
- 25 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (5)
- 26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (622)
- 27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (98)
- 28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (1301)
- 29 or/14-28 (6705)
- 30 13 and 29 (130)
- 31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (0)
- 32 30 or 31 (130)
- 33 Gonadotropin-Releasing Hormone/ (11)

34 (pubert* adj3 block*).ti,ab. (0)
 35 ((gonadotrophin or gonadotropin) and releasing).ti,ab. (10)
 36 (GnRH adj2 analog*).ti,ab. (2)
 37 GnRH*.ti,ab. (14)
 38 "GnRH agonist".ti,ab. (4)
 39 Triptorelin Pamoate/ (1)
 40 triptorelin.ti,ab. (1)
 41 arvekap.ti,ab. (0)
 42 ("AY 25650" or AY25650).ti,ab. (0)
 43 ("BIM 21003" or BIM21003).ti,ab. (0)
 44 ("BN 52014" or BN52014).ti,ab. (0)
 45 ("CL 118532" or CL118532).ti,ab. (0)
 46 Debio.ti,ab. (1)
 47 diphereline.ti,ab. (0)
 48 moapar.ti,ab. (0)
 49 pamorelin.ti,ab. (0)
 50 trelstar.ti,ab. (0)
 51 triptodur.ti,ab. (0)
 52 ("WY 42422" or WY42422).ti,ab. (0)
 53 ("WY 42462" or WY42462).ti,ab. (0)
 54 gonapeptyl.ti,ab. (0)
 55 decapeptyl.ti,ab. (0)
 56 salvacyl.ti,ab. (0)
 57 Buserelin/ (0)
 58 buserelin.ti,ab. (0)
 59 bigonist.ti,ab. (0)
 60 ("hoe 766" or hoe-766 or hoe766).ti,ab. (0)
 61 profact.ti,ab. (0)
 62 receptal.ti,ab. (0)
 63 suprecur.ti,ab. (0)
 64 suprefact.ti,ab. (0)
 65 tiloryth.ti,ab. (0)
 66 histrelin.ti,ab. (0)
 67 "LHRH-hydrogel implant".ti,ab. (0)
 68 ("RL 0903" or RL0903).ti,ab. (0)
 69 ("SPD 424" or SPD424).ti,ab. (0)
 70 goserelin.ti,ab. (1)
 71 Goserelin/ (2)
 72 ("ici 118630" or ici118630).ti,ab. (0)
 73 ("ZD-9393" or ZD9393).ti,ab. (0)
 74 zoladex.ti,ab. (0)
 75 leuprorelin.ti,ab. (0)
 76 carcinil.ti,ab. (0)
 77 enanton*.ti,ab. (0)
 78 ginecrin.ti,ab. (0)
 79 leuplin.ti,ab. (0)
 80 Leuprolide/ (0)
 81 leuprolide.ti,ab. (0)

82 lucrin.ti,ab. (0)
 83 lupron.ti,ab. (0)
 84 provren.ti,ab. (0)
 85 procrin.ti,ab. (0)
 86 ("tap 144" or tap144).ti,ab. (0)
 87 (a-43818 or a43818).ti,ab. (0)
 88 Trenantone.ti,ab. (0)
 89 staladex.ti,ab. (0)
 90 prostap.ti,ab. (0)
 91 Nafarelin/ (0)
 92 nafarelin.ti,ab. (0)
 93 ("76932-56-4" or "76932564").ti,ab. (0)
 94 ("76932-60-0" or "76932600").ti,ab. (0)
 95 ("86220-42-0" or "86220420").ti,ab. (0)
 96 ("rs 94991 298" or rs94991298).ti,ab. (0)
 97 synarel.ti,ab. (0)
 98 deslorelin.ti,ab. (0)
 99 gonadorelin.ti,ab. (0)
 100 ("33515-09-2" or "33515092").ti,ab. (0)
 101 ("51952-41-1" or "51952411").ti,ab. (0)
 102 ("52699-48-6" or "52699486").ti,ab. (0)
 103 cetorelix.ti,ab. (0)
 104 cetrotide.ti,ab. (0)
 105 ("NS 75A" or NS75A).ti,ab. (0)
 106 ("NS 75B" or NS75B).ti,ab. (0)
 107 ("SB 075" or SB075).ti,ab. (0)
 108 ("SB 75" or SB75).ti,ab. (0)
 109 gonadoliberin.ti,ab. (0)
 110 kryptocur.ti,ab. (0)
 111 cetorelix.ti,ab. (0)
 112 cetrotide.ti,ab. (0)
 113 antagon.ti,ab. (0)
 114 ganirelix.ti,ab. (0)
 115 ("ORG 37462" or ORG37462).ti,ab. (0)
 116 orgalutran.ti,ab. (0)
 117 ("RS 26306" or RS26306).ti,ab. (0)
 118 ("AY 24031" or AY24031).ti,ab. (0)
 119 factrel.ti,ab. (0)
 120 fertagyl.ti,ab. (0)
 121 lutrelef.ti,ab. (0)
 122 lutrepulse.ti,ab. (0)
 123 relefact.ti,ab. (0)
 124 fertiral.ti,ab. (0)
 125 (hoe471 or "hoe 471").ti,ab. (0)
 126 relisorm.ti,ab. (0)
 127 cystorelin.ti,ab. (0)
 128 dirigestran.ti,ab. (0)
 129 or/33-128 (23)

- 130 32 and 129 (1)
- 131 limit 130 to english language (1)
- 132 limit 131 to yr="2000 -Current" (1)

Database: Embase

Platform: Ovid

Version: Embase <1974 to 2020 July 22>

Search date: 23/7/2020

Number of results retrieved: 367

Search strategy:

- 1 exp Gender Dysphoria/ (5399)
- 2 Gender Identity/ (16820)
- 3 "Sexual and Gender Disorders"/ (24689)
- 4 Transsexualism/ (3869)
- 5 exp Transgender/ (6597)
- 6 Health Services for Transgender Persons/ (158848)
- 7 exp Sex Reassignment Procedures/ or sex transformation/ (3058)
- 8 (gender* adj3 (dysphori* or affirm* or incongru* or identi* or disorder* or confus* or minorit* or queer*)).tw. (13005)
- 9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (22509)
- 10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (154446)
- 11 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (10327)
- 12 (male-to-female or m2f or female-to-male or f2m).tw. (200166)
- 13 or/1-12 (582812)
- 14 exp juvenile/ or Child Behavior/ or Child Welfare/ or Child Health/ or infant welfare/ or "minor (person)"/ or elementary student/ (3437324)
- 15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (1186161)
- 16 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (3586795)
- 17 exp pediatrics/ (106214)
- 18 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (1491597)
- 19 exp adolescence/ or exp adolescent behavior/ or adolescent health/ or high school student/ or middle school student/ (105108)
- 20 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (641660)
- 21 school/ or high school/ or kindergarten/ or middle school/ or primary school/ or nursery school/ or day care/ (103791)
- 22 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (687437)
- 23 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (138908)
- 24 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (1562903)

25 or/14-24 (7130881)
 26 13 and 25 (182161)
 27 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw.
 (17)
 28 26 or 27 (182161)
 29 gonadorelin/ (37580)
 30 (pubert* adj3 block*).ti,ab. (142)
 31 ((gonadotrophin or gonadotropin) and releasing).ti,ab. (21450)
 32 (GnRH adj2 analog*).ti,ab. (4013)
 33 GnRH*.ti,ab. (29862)
 34 "GnRH agonist".ti,ab. (6719)
 35 exp gonadorelin agonist/ or gonadorelin derivative/ or gonadorelin acetate/ (23304)
 36 Triptorelin/ (5427)
 37 triptorelin.ti,ab. (1182)
 38 arvekap.ti,ab. (3)
 39 ("AY 25650" or AY25650).ti,ab. (1)
 40 ("BIM 21003" or BIM21003).ti,ab. (0)
 41 ("BN 52014" or BN52014).ti,ab. (0)
 42 ("CL 118532" or CL118532).ti,ab. (0)
 43 Debio.ti,ab. (185)
 44 diphereline.ti,ab. (51)
 45 moapar.ti,ab. (0)
 46 pamorelin.ti,ab. (0)
 47 trelstar.ti,ab. (5)
 48 triptodur.ti,ab. (1)
 49 ("WY 42422" or WY42422).ti,ab. (0)
 50 ("WY 42462" or WY42462).ti,ab. (0)
 51 gonapeptyl.ti,ab. (10)
 52 decapeptyl.ti,ab. (307)
 53 salvacyl.ti,ab. (1)
 54 buserelin acetate/ or buserelin/ (5164)
 55 buserelin.ti,ab. (1604)
 56 bigonist.ti,ab. (1)
 57 ("hoe 766" or hoe-766 or hoe766).ti,ab. (89)
 58 profact.ti,ab. (4)
 59 receptal.ti,ab. (37)
 60 suprecur.ti,ab. (8)
 61 suprefact.ti,ab. (30)
 62 tiloryth.ti,ab. (0)
 63 histrelin/ (446)
 64 histrelin.ti,ab. (107)
 65 "LHRH-hydrogel implant".ti,ab. (1)
 66 ("RL 0903" or RL0903).ti,ab. (1)
 67 ("SPD 424" or SPD424).ti,ab. (1)
 68 goserelin.ti,ab. (1487)
 69 Goserelin/ (7128)
 70 ("ici 118630" or ici118630).ti,ab. (49)
 71 ("ZD-9393" or ZD9393).ti,ab. (0)

72 zoladex.ti,ab. (501)
 73 leuprorelin/ (11312)
 74 leuprorelin.ti,ab. (727)
 75 carcinil.ti,ab. (0)
 76 enanton*.ti,ab. (38)
 77 ginecrin.ti,ab. (1)
 78 leuplin.ti,ab. (26)
 79 leuprolide.ti,ab. (2788)
 80 lucrin.ti,ab. (47)
 81 lupron.ti,ab. (361)
 82 provren.ti,ab. (0)
 83 procrin.ti,ab. (11)
 84 ("tap 144" or tap144).ti,ab. (63)
 85 (a-43818 or a43818).ti,ab. (3)
 86 Trenantone.ti,ab. (7)
 87 staladex.ti,ab. (0)
 88 prostap.ti,ab. (11)
 89 nafarelin acetate/ or nafarelin/ (1441)
 90 nafarelin.ti,ab. (324)
 91 ("76932-56-4" or "76932564").ti,ab. (0)
 92 ("76932-60-0" or "76932600").ti,ab. (0)
 93 ("86220-42-0" or "86220420").ti,ab. (0)
 94 ("rs 94991 298" or rs94991298).ti,ab. (0)
 95 synarel.ti,ab. (28)
 96 deslorelin/ (452)
 97 deslorelin.ti,ab. (324)
 98 gonadorelin.ti,ab. (338)
 99 ("33515-09-2" or "33515092").ti,ab. (0)
 100 ("51952-41-1" or "51952411").ti,ab. (0)
 101 ("52699-48-6" or "52699486").ti,ab. (0)
 102 cetorelix/ (2278)
 103 cetorelix.ti,ab. (717)
 104 cetrotide.ti,ab. (113)
 105 ("NS 75A" or NS75A).ti,ab. (0)
 106 ("NS 75B" or NS75B).ti,ab. (0)
 107 ("SB 075" or SB075).ti,ab. (1)
 108 ("SB 75" or SB75).ti,ab. (76)
 109 gonadoliberin.ti,ab. (152)
 110 kryptocur.ti,ab. (6)
 111 cetorelix.ti,ab. (717)
 112 cetrotide.ti,ab. (113)
 113 antagon.ti,ab. (32)
 114 ganirelix/ (1284)
 115 ganirelix.ti,ab. (293)
 116 ("ORG 37462" or ORG37462).ti,ab. (4)
 117 orgalutran/ (1284)
 118 orgalutran.ti,ab. (68)
 119 ("RS 26306" or RS26306).ti,ab. (6)

120 ("AY 24031" or AY24031).ti,ab. (0)
 121 factrel.ti,ab. (14)
 122 fertagyl.ti,ab. (20)
 123 lutrelef.ti,ab. (7)
 124 lutrepulse.ti,ab. (6)
 125 relefact.ti,ab. (10)
 126 fertiral.ti,ab. (0)
 127 (hoe471 or "hoe 471").ti,ab. (4)
 128 relisorm.ti,ab. (6)
 129 cystorelin.ti,ab. (26)
 130 dirigestran.ti,ab. (5)
 131 or/29-130 (80790)
 132 28 and 131 (988)
 133 limit 132 to english language (940)
 134 133 not (letter or editorial).pt. (924)
 135 134 not (conference abstract or conference paper or conference proceeding or "conference review").pt. (683)
 136 nonhuman/ not (human/ and nonhuman/) (4649157)
 137 135 not 136 (506)
 138 limit 137 to yr="2000 -Current" (420)
 139 elsevier.cr. (25912990)
 140 138 and 139 (372)
 141 remove duplicates from 140 (367)

Database: Cochrane Library – incorporating Cochrane Database of Systematic Reviews (CDSR); CENTRAL

Platform: Wiley

Version:

CDSR – Issue 7 of 12, July 2020

CENTRAL – Issue 7 of 12, July 2020

Search date: 23/7/2020

Number of results retrieved: CDSR – 1; CENTRAL - 8.

#1 [mh ^"Gender Dysphoria"] 3
 #2 [mh ^"gender identity"] 227
 #3 [mh ^"sexual and gender disorders"] 2
 #4 [mh ^transsexualism] 27
 #5 [mh ^"transgender persons"] 36
 #6 [mh ^"health services for transgender persons"] 0
 #7 [mh "sex reassignment procedures"] 4
 #8 (gender* NEAR/3 (dysphori* or affirm* or incongruen* or identi* or disorder* or confus* or minorit* or queer*)):ti,ab 308
 #9 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*):ti,ab 929
 #10 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*):ti,ab 3915
 #11 ((sex or gender*) NEAR/3 (reassign* or chang* or transform* or transition*)):ti,ab 493
 #12 (male-to-female or m2f or female-to-male or f2m):ti,ab 489

#13 {or #1-#12} 6142
 #14 [mh infant] or [mh ^"infant health"] or [mh ^"infant welfare"] 27769
 #15 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*):ti,ab 69476
 #16 [mh child] or [mh "child behavior"] or [mh ^"child health"] or [mh ^"child welfare"] 42703
 #17 [mh ^minors] 8
 #18 (child* or minor or minors or boy* or girl* or kid or kids or young*):ti,ab 175826
 #19 [mh pediatrics]661
 #20 (pediatric* or paediatric* or peadiatric*):ti,ab 30663
 #21 [mh ^adolescent] or [mh ^"adolescent behavior"] or [mh ^"adolescent health"] 102154
 #22 [mh ^puberty] 295
 #23 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*):ti,ab 34139
 #24 [mh ^schools] 1914
 #25 [mh ^"Child Day Care Centers"] or [mh nurseries] or [mh ^"schools, nursery"] 277
 #26 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*):ti,ab 54723
 #27 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") NEAR/2 (year or years or age or ages or aged)):ti,ab 6710
 #28 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") NEAR/2 (year or years or age or ages or aged)):ti,ab 196881
 #29 {or #14-#28} 469351
 #30 #13 and #29 2146
 #31 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*):ti,ab 0
 #32 #30 or #31 2146
 #33 [mh ^"Gonadotropin-Releasing Hormone"] 1311
 #34 (pubert* NEAR/3 block*):ti,ab 1
 #35 ((gonadotrophin or gonadotropin) and releasing):ti,ab 2095
 #36 (GnRH NEAR/2 analog*):ti,ab 493
 #37 GnRH*:ti,ab 3764
 #38 "GnRH agonist*":ti,ab 1399
 #39 [mh ^"Triptorelin Pamoate"] 451
 #40 triptorelin:ti,ab 451
 #41 arvekap:ti,ab 4
 #42 ("AY 25650" or AY25650):ti,ab 0
 #43 ("BIM 21003" or BIM21003):ti,ab 0
 #44 ("BN 52014" or BN52014):ti,ab 0
 #45 ("CL 118532" or CL118532):ti,ab 0
 #46 Debio:ti,ab 301
 #47 diphereline:ti,ab 25
 #48 moapar:ti,ab 0
 #49 pamorelin:ti,ab 5
 #50 trelstar:ti,ab 3

#51	triptodur:ti,ab	0	
#52	("WY 42422" or WY42422):ti,ab	0	
#53	("WY 42462" or WY42462):ti,ab	0	
#54	gonapeptyl:ti,ab	11	
#55	decapeptyl:ti,ab	135	
#56	salvacyl:ti,ab	0	
#57	[mh ^Buserelin]	290	
#58	Buserelin:ti,ab	339	
#59	bigonist:ti,ab	0	
#60	("hoe 766" or hoe-766 or hoe766):ti,ab	11	
#61	profact:ti,ab	1	
#62	receptal:ti,ab	4	
#63	suprecur:ti,ab	0	
#64	suprefact:ti,ab	28	
#65	tiloryth:ti,ab	0	
#66	histrelin:ti,ab	5	
#67	"LHRH-hydrogel implant":ti,ab	0	
#68	("RL 0903" or RL0903):ti,ab	0	
#69	("SPD 424" or SPD424):ti,ab	0	
#70	goserelin:ti,ab	761	
#71	[mh ^goserelin]	568	
#72	("ici 118630" or ici118630):ti,ab	7	
#73	("ZD-9393" or ZD9393):ti,ab	1	
#74	zoladex:ti,ab	318	
#75	leuprorelin:ti,ab	248	
#76	carcinil:ti,ab	0	
#77	enanton*:ti,ab	21	
#78	ginecrin:ti,ab	1	
#79	leuplin:ti,ab	7	
#80	[mh ^Leuprolide]	686	
#81	leuprolide:ti,ab	696	
#82	lucrin:ti,ab	21	
#83	lupron:ti,ab	77	
#84	provren:ti,ab	0	
#85	procrin:ti,ab	2	
#86	("tap 144" or tap144):ti,ab	24	
#87	(a-43818 or a43818):ti,ab	0	
#88	Trenantone:ti,ab	3	
#89	staladex:ti,ab	0	
#90	prostag:ti,ab	9	
#91	[mh ^Nafarelin]	77	
#92	nafarelin:ti,ab	114	
#93	("76932-56-4" or "76932564"):ti,ab	0	
#94	("76932-60-0" or "76932600"):ti,ab	2	
#95	("86220-42-0" or "86220420"):ti,ab	0	
#96	("rs 94991 298" or rs94991298):ti,ab	0	
#97	synarel:ti,ab	10	
#98	deslorelin:ti,ab	16	

#99 gonadorelin:ti,ab 11
 #100 ("33515-09-2" or "33515092"):ti,ab 0
 #101 ("51952-41-1" or "51952411"):ti,ab 0
 #102 ("52699-48-6" or "52699486"):ti,ab 0
 #103 cetorelix:ti,ab 221
 #104 cetrotide:ti,ab 111
 #105 ("NS 75A" or NS75A):ti,ab 0
 #106 ("NS 75B" or NS75B):ti,ab 0
 #107 ("SB 075" or SB075):ti,ab 0
 #108 ("SB 75" or SB75):ti,ab 10
 #109 gonadoliberin:ti,ab 5
 #110 kryptocur:ti,ab 0
 #111 cetorelix:ti,ab 221
 #112 cetrotide:ti,ab 111
 #113 antagon:ti,ab 12
 #114 ganirelix:ti,ab 142
 #115 ("ORG 37462" or ORG37462):ti,ab 4
 #116 orgalutran:ti,ab 45
 #117 ("RS 26306" or RS26306):ti,ab 0
 #118 ("AY 24031" or AY24031):ti,ab 0
 #119 factrel:ti,ab 1
 #120 fertagyl:ti,ab 0
 #121 lutrelef:ti,ab 0
 #122 lutrepulse:ti,ab 1
 #123 relefact:ti,ab 1
 #124 fertiral:ti,ab 0
 #125 (hoe471 or "hoe 471"):ti,ab 3
 #126 relisorm:ti,ab 0
 #127 cystorelin:ti,ab 0
 #128 dirigestran:ti,ab 0
 #129 {or #33-#128} 6844
 #130 #32 and #129 27
 #131 #130 with Cochrane Library publication date Between Jan 2000 and Jul 2020, in Cochrane Reviews 1
 #132 #130 27
 #133 "conference":pt or (clinicaltrials or trialsearch):so 492465
 #134 #132 not #133 9
 #135 #134 with Publication Year from 2000 to 2020, in Trials 8

Database: HTA

Platform: CRD

Version: HTA

Search date: 23/7/2020

Number of results retrieved: 26

Search strategy:

1 MeSH DESCRIPTOR Gender Dysphoria EXPLODE ALL TREES 0
 2 MeSH DESCRIPTOR Gender Identity EXPLODE ALL TREES 14

3 MeSH DESCRIPTOR Sexual and Gender Disorders EXPLODE ALL TREES 2

4 MeSH DESCRIPTOR Transsexualism EXPLODE ALL TREES 12

5 MeSH DESCRIPTOR Transgender Persons EXPLODE ALL TREES 3

6 MeSH DESCRIPTOR Health Services for Transgender Persons EXPLODE ALL TREES 0

7 MeSH DESCRIPTOR Sex Reassignment Procedures EXPLODE ALL TREES 1

8 ((gender* adj3 (dysphori* or affirm* or incongruen* or identi* or disorder* or confus* or minorit* or queer*))) 28

9 ((transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*)) 76

10 ((trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*)) 83

11 (((sex or gender*) adj3 (reassign* or chang* or transform* or transition*))) 24

12 (male-to-female or m2f or female-to-male or f2m) 86

13 ((transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*)) 0

14 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 262

15 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13) IN HTA 30

*26 results are from 200 onwards. Downloaded as a set to sift for drug terms rather than continuing with search strategy.

Database: APA PsycInfo

Search date: July 2020 (Week 2)

Search Strategy:

1 Gender Dysphoria/ (936)

2 Gender Identity/ (8648)

3 Transsexualism/ (2825)

4 Transgender/ (5257)

5 exp Gender Reassignment/ (568)

6 (gender* adj3 (dysphori* or affirm* or incongruen* or identi* or disorder* or confus* or minorit* or queer*)).tw. (15471)

7 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. (13028)

8 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. (7679)

9 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).tw. (5796)

10 (male-to-female or m2f or female-to-male or f2m).tw. (63688)

11 or/1-10 (99560)

12 exp Infant Development/ (21841)

13 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (150219)

- 14 Child Characteristics/ or exp Child Behavior/ or Child Psychology/ or exp Child Welfare/ or Child Psychiatry/ (23423)
- 15 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (984230)
- 16 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (78962)
- 17 Adolescent Psychiatry/ or Adolescent Behavior/ or Adolescent Development/ or Adolescent Psychology/ or Adolescent Characteristics/ or Adolescent Health/ (62142)
- 18 Puberty/ (2753)
- 19 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (347604)
- 20 Schools/ or exp elementary school students/ or high school students/ or junior high school students/ or middle school students/ (113053)
- 21 Child Day Care/ or Nursery Schools/ (2836)
- 22 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (772814)
- 23 (("eight" or "nine" or "ten" or "eleven" or "twelve" or "thirteen" or "fourteen" or "fifteen" or "sixteen" or "seventeen" or "eighteen" or "nineteen") adj2 (year or years or age or ages or aged)).ti,ab. (21475)
- 24 (("8" or "9" or "10" or "11" or "12" or "13" or "14" or "15" or "16" or "17" or "18" or "19") adj2 (year or years or age or ages or aged)).ti,ab. (285697)
- 25 or/12-24 (1772959)
- 26 11 and 25 (49612)
- 27 (transchild* or transyouth* or transteen* or transadoles* or transgirl* or transboy*).tw. (14)
- 28 26 or 27 (49613)
- 29 exp Gonadotropic Hormones/ (4226)
- 30 (pubert* adj3 block*).ti,ab. (29)
- 31 ((gonadotrophin or gonadotropin) and releasing).ti,ab. (1060)
- 32 (GnRH adj2 analog*).ti,ab. (49)
- 33 GnRH*.ti,ab. (998)
- 34 "GnRH agonist".ti,ab. (72)
- 35 triptorelin.ti,ab. (25)
- 36 arvekap.ti,ab. (0)
- 37 ("AY 25650" or AY25650).ti,ab. (0)
- 38 ("BIM 21003" or BIM21003).ti,ab. (0)
- 39 ("BN 52014" or BN52014).ti,ab. (0)
- 40 ("CL 118532" or CL118532).ti,ab. (0)
- 41 Debio.ti,ab. (7)
- 42 diphereline.ti,ab. (0)
- 43 moapar.ti,ab. (0)
- 44 pamorelin.ti,ab. (0)
- 45 trelstar.ti,ab. (0)
- 46 triptodur.ti,ab. (0)
- 47 ("WY 42422" or WY42422).ti,ab. (0)
- 48 ("WY 42462" or WY42462).ti,ab. (0)
- 49 gonapeptyl.ti,ab. (0)
- 50 decapeptyl.ti,ab. (3)
- 51 salvacyl.ti,ab. (1)

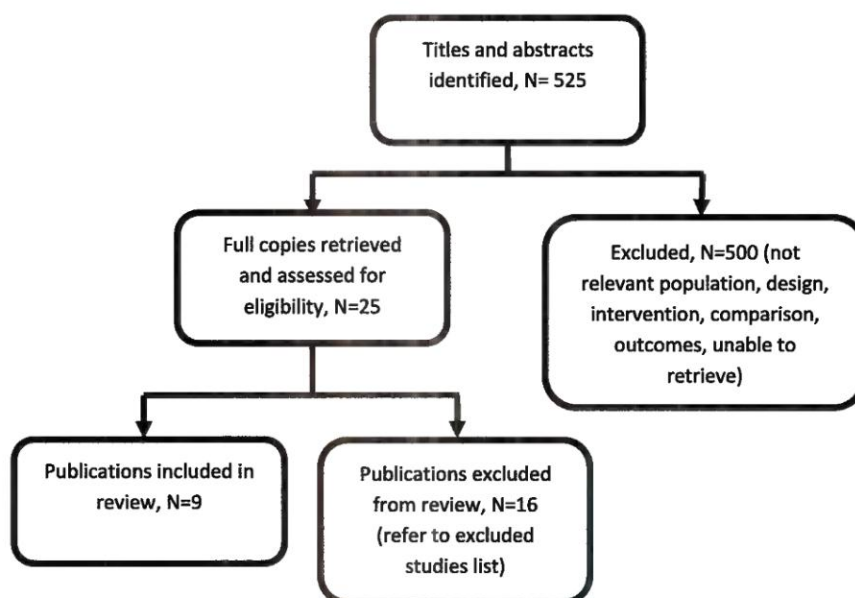
52 buserelin.ti,ab. (6)
 53 bigonist.ti,ab. (0)
 54 ("hoe 766" or hoe-766 or hoe766).ti,ab. (0)
 55 profact.ti,ab. (0)
 56 receptal.ti,ab. (0)
 57 suprecur.ti,ab. (0)
 58 suprefact.ti,ab. (0)
 59 tiloryth.ti,ab. (0)
 60 histrelin.ti,ab. (1)
 61 "LHRH-hydrogel implant".ti,ab. (0)
 62 ("RL 0903" or RL0903).ti,ab. (0)
 63 ("SPD 424" or SPD424).ti,ab. (0)
 64 goserelin.ti,ab. (30)
 65 ("ici 118630" or ici118630).ti,ab. (0)
 66 ("ZD-9393" or ZD9393).ti,ab. (0)
 67 zoladex.ti,ab. (3)
 68 leuprorelin.ti,ab. (12)
 69 carcinil.ti,ab. (0)
 70 enanton*.ti,ab. (1)
 71 ginecrin.ti,ab. (0)
 72 leuplin.ti,ab. (0)
 73 leuprolide.ti,ab. (79)
 74 lucrin.ti,ab. (1)
 75 lupron.ti,ab. (18)
 76 provren.ti,ab. (0)
 77 procrin.ti,ab. (0)
 78 ("tap 144" or tap144).ti,ab. (1)
 79 (a-43818 or a43818).ti,ab. (0)
 80 Trenantone.ti,ab. (0)
 81 staladex.ti,ab. (0)
 82 prostap.ti,ab. (0)
 83 nafarelin.ti,ab. (1)
 84 ("76932-56-4" or "76932564").ti,ab. (0)
 85 ("76932-60-0" or "76932600").ti,ab. (0)
 86 ("86220-42-0" or "86220420").ti,ab. (0)
 87 ("rs 94991 298" or rs94991298).ti,ab. (0)
 88 synarel.ti,ab. (0)
 89 deslorelin.ti,ab. (8)
 90 gonadorelin.ti,ab. (3)
 91 ("33515-09-2" or "33515092").ti,ab. (0)
 92 ("51952-41-1" or "51952411").ti,ab. (0)
 93 ("52699-48-6" or "52699486").ti,ab. (0)
 94 cetrotelix.ti,ab. (9)
 95 cetrotide.ti,ab. (0)
 96 ("NS 75A" or NS75A).ti,ab. (0)
 97 ("NS 75B" or NS75B).ti,ab. (0)
 98 ("SB 075" or SB075).ti,ab. (0)
 99 ("SB 75" or SB75).ti,ab. (1)

100 gonadoliberin.ti,ab. (1)
 101 kryptocur.ti,ab. (0)
 102 cetrotrel.ti,ab. (9)
 103 cetrotide.ti,ab. (0)
 104 antagon.ti,ab. (0)
 105 ganirelix.ti,ab. (0)
 106 ("ORG 37462" or ORG37462).ti,ab. (0)
 107 orgalutran.ti,ab. (0)
 108 ("RS 26306" or RS26306).ti,ab. (0)
 109 ("AY 24031" or AY24031).ti,ab. (0)
 110 factrel.ti,ab. (0)
 111 fertagyl.ti,ab. (0)
 112 lutrelef.ti,ab. (0)
 113 lutrepulse.ti,ab. (0)
 114 relefact.ti,ab. (0)
 115 fertiral.ti,ab. (0)
 116 (hoe471 or "hoe 471").ti,ab. (0)
 117 relisorm.ti,ab. (0)
 118 cystorelin.ti,ab. (0)
 119 dirigestran.ti,ab. (0)
 120 or/29-119 (4869)
 121 28 and 120 (130)
 122 limit 121 to english language (120)
 123 limit 122 to yr="2000 -Current" (93)

Appendix C Evidence selection

The literature searches identified 525 references. These were screened using their titles and abstracts and 25 references were obtained and assessed for relevance. Of these, 9 references are included in the evidence review. The remaining 16 references were excluded and are listed in [appendix D](#).

Figure 1 – Study selection flow diagram



References submitted with Preliminary Policy Proposal

There is no preliminary policy proposal for this policy.

Appendix D Excluded studies table

Study reference	Reason for exclusion
Achille, C., Taggart, T., Eaton, N.R. et al. (2020) Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. <i>International Journal of Pediatric Endocrinology</i> 2020(1): 8	Intervention – data for GnRH analogues not reported separately from other interventions
Bechard, Melanie, Vanderlaan, Doug P, Wood, Hayley et al. (2017) Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study. <i>Journal of sex & marital therapy</i> 43(7): 678-688	Population – no GnRH analogues at time of study
Chew, Denise, Anderson, Jemma, Williams, Katrina et al. (2018) Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review. <i>Pediatrics</i> 141(4)	All primary studies included apart from 1 conference abstract
de Vries, Annelou L C, McGuire, Jenifer K et al. (2014) Young adult psychological outcome after puberty suppression and gender reassignment. <i>Pediatrics</i> 134(4): 696-704	Population – relevant population included in de Vries et al. 2011
Ghelani, Rahul, Lim, Cheryl, Brain, Caroline et al. (2020) Sudden sex hormone withdrawal and the effects on body composition in late pubertal adolescents with gender dysphoria. <i>Journal of pediatric endocrinology & metabolism: JPEM</i> 33(1): 107-112	Outcomes – not in the PICO

Study reference	Reason for exclusion
Giovanardi, G, Morales, P, Mirabella, M et al. (2019) Transition memories: experiences of trans adult women with hormone therapy and their beliefs on the usage of hormone blockers to suppress puberty. <i>Journal of endocrinological investigation</i> 42(10): 1231-1240	Population – adults only
Hewitt, Jacqueline K, Paul, Campbell, Kasiannan, Porpavai et al. (2012) Hormone treatment of gender identity disorder in a cohort of children and adolescents. <i>The Medical journal of Australia</i> 196(9): 578-81	Outcomes – no data reported for relevant outcomes
Jensen, R.K., Jensen, J.K., Simons, L.K. et al. (2019) Effect of Concurrent Gonadotropin-Releasing Hormone Agonist Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients. <i>Transgender Health</i> 4(1): 300-303	Outcomes – not in the PICO
Klaver, Maartje, de Mutsert, Renee, Wiepjes, Chantal M et al. (2018) Early Hormonal Treatment Affects Body Composition and Body Shape in Young Transgender Adolescents. <i>The journal of sexual medicine</i> 15(2): 251-260	Outcomes – not in the PICO
Klaver, Maartje, de Mutsert, Renee van der Loos, Maria A T C et al. (2020) Hormonal Treatment and Cardiovascular Risk Profile in Transgender Adolescents. <i>Pediatrics</i> 145(3)	Outcomes – not in the PICO
Lopez, Carla Marisa, Solomon, Daniel, Boulware, Susan D et al. (2018) Trends in the use of puberty blockers among transgender children in the United States. <i>Journal of pediatric endocrinology & metabolism : JPEM</i> 31(6): 665-670	Outcomes – not in the PICO
Schagen, Sebastian E E, Lustenhouwer, Paul, Cohen-Kettenis, Peggy T et al. (2018) Changes in Adrenal Androgens During Puberty Suppression and Gender-Affirming Hormone Treatment in Adolescents With Gender Dysphoria. <i>The journal of sexual medicine</i> 15(9): 1357-1363	Outcomes – not in the PICO
Swendiman, Robert A, Vogiatzi, Maria G, Alter, Craig A et al. (2019) Histrelin implantation in the pediatric population: A 10-year institutional experience. <i>Journal of pediatric surgery</i> 54(7): 1457-1461	Population – less than 10% of participants had gender dysphoria; data not reported separately
Turban, Jack L, King, Dana, Carswell, Jeremi M et al. (2020) Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. <i>Pediatrics</i> 145(2)	Intervention – data for GnRH analogues not reported separately from other interventions
Vrouenraets, Lieke Josephina Jeanne Johanna, Fredriks, A Miranda, Hannema, Sabine E et al. (2016) Perceptions of Sex, Gender, and Puberty Suppression: A Qualitative Analysis of Transgender Youth. <i>Archives of sexual behavior</i> 45(7): 1697-703	Outcomes – not in the PICO
Zucker, Kenneth J, Bradley, Susan J, Owen-Anderson, Allison et al. (2010) Puberty-blocking hormonal therapy for adolescents with gender identity disorder: A descriptive clinical study. <i>Journal of Gay & Lesbian Mental Health</i> 15(1): 58-82	Intervention – data for GnRH analogues not reported separately from other interventions

Appendix E Evidence tables

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Brik T, Vrouwenraets L, de Vries M, et al. (2020) Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. Archives of Sexual Behaviour https://doi.org/10.1007/s10508-020-01660-8</p> <p>Netherlands</p> <p>Retrospective observational single-centre study</p> <p>To document trajectories after the initiation of GnRH analogue and explore reasons for extended use and discontinuation of GnRH analogues.</p> <p>Includes participants seen between November 2010 and January 1, 2018.</p>	<p>Inclusion criteria were adolescents with gender dysphoria, according to the DSM-5 criteria, seen at the single centre and treated with GnRH analogues between November 2010 and January 1, 2018.</p> <p>The study excluded adolescents without a diagnosis of gender dysphoria, those who had coexisting problems that interfered with the diagnostic process and/or might interfere with successful treatment (not further defined), those adolescents not wanting hormones, those with ongoing diagnostic evaluation and those who did not attend appointments.</p> <p>The sample consisted of 143 adolescents meeting the inclusion/exclusion criteria, 38 transfemales, 105 transmales, with median ages of 15.0 years (range 11.1 to 18.6 years) and 16.1 years</p>	<p>The study only reports that GnRH analogues were given, no specific drug, dose, route, or frequency of administration are reported.</p> <p>No comparator cohort was used in the study.</p> <p>Follow-up was at (up to) 9 years (last follow-up July 2019).</p>	<p>Critical outcomes No critical outcomes assessed.</p> <p>Important outcomes <i>Psychosocial impact</i> Not assessed.</p> <p>Engagement with health care services Not formally assessed but the study reported that out of 214 age and developmentally appropriate adolescents for potential inclusion in the study, 9 were excluded as they stopped attending appointments (4.2%).</p> <p>Stopping treatment Of the 143 adolescents, 9 (6.2%, 1 transfemale and 8 transmales) stopped taking GnRH analogues after a median duration of 0.8 years (range 0.1 to 3.0). Four adolescents (2.8%) discontinued GnRH analogues although they wanted to continue endocrine treatments for gender dysphoria:</p> <ul style="list-style-type: none"> 1 transmale stopped due to increase in mood problems, suicidal thoughts and confusion attributed to GnRH analogues (later had gender-affirming hormones at an adult gender clinic)¹ 1 transmale experienced hot flushes, increased migraines, had a fear of injections, stress at school and unrelated medical issues, and 	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection</p> <ol style="list-style-type: none"> somewhat representative no-non exposed cohort secure record yes <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> no comparator <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> record linkage yes complete follow-up <p>Overall quality is assessed as poor.</p> <p>Other comments: Physical and psychological comorbidity was poorly reported, concomitant use of other medicines was not reported.</p> <p>Source of funding: not reported.</p>

	<p>(range 10.1 to 17.9 years), respectively at commencement of GnRH analogues.</p> <p>Of the 143 adolescents in the study, 125 (87%, 36 transfemales and 89 transmales) subsequently started treatment with gender-affirming hormones after median 1.0 (range 0.5 to 3.8) years and 0.8 (0.3 to 3.7) years, respectively. Median age at the start of gender-affirming hormones was 16.2 years (range 14.5 to 18.6 years) in transfemales and 17.1 years (range 14.9 to 18.8 years) in transmales.</p> <p>Five adolescents who used GnRH analogues had not started gender-affirming hormones at the time of data collection as they were not yet eligible for this treatment due to age. At the time of data collection, they had used GnRH analogues for a median duration of 2.1 years (range 1.6 to 2.8). Tanner stage was not reported.</p> <p>Six adolescents had been referred to a gender clinic elsewhere for further</p>		<p>temporarily discontinued treatment (after 4 months)²</p> <ul style="list-style-type: none"> • 1 transmale experienced mood swings 4 months after commencing GnRH analogues. After 2.2 years he developed unexplained severe nausea and rapid weight loss and due to his general condition discontinued GnRH analogues after 2.4 years³ • 1 transmale stopped GnRH analogues as his parents were unable to regularly collect medication from the pharmacy and take him to appointments for the injections⁴ <p>Five adolescents (3.5%) stopped treatment as they no longer wished to continue with gender-affirming treatment.</p> <ul style="list-style-type: none"> • 1 adolescent had been very distressed about breast development at the start of GnRH analogues and later thought that she might want to live as a woman without breasts. She did not want to live as a boy and discontinued GnRH analogues, although dreaded breast development and menstruation. • 1 adolescent experienced concurrent psychosocial problems interfering with the exploration of gender identity and did not currently want treatment.⁵ • 1 adolescent felt more in between male and female and therefore did not want to continue with GnRH analogues.⁶ • 1 adolescent made a social transition while using GnRH 	
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	treatment, including 1 who had prolonged use.		analogues and shortly after decided to discontinue treatment. ⁷ <ul style="list-style-type: none"> 1 adolescent discontinued after using GnRH analogues as the treatment allowed them to feel who they were.⁸ 	
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¹ The adolescent later indicated "I was already fully matured when I started GnRH analogues, menstruations were already suppressed by contraceptives. For me, it had no added value" (transmale, age 19 years).

² The adolescent restarted endocrine treatment (testosterone) 5 months later.

³ The adolescent recovered over the next 2 years and subsequently started lynestrenol and testosterone treatment.

⁴ The adolescent subsequently started lynestrenol to suppress menses, he was not yet eligible for testosterone treatment.

⁵ The adolescent later reflected that "The decision to stop GnRH analogues to my mind was made by the gender team, because they did not think gender dysphoria was the right diagnosis. I do still feel like a man, but for me it is okay to be just me instead of a he or a she, so for now I do not want any further treatment" (adolescent assigned female sex at birth, age 16 years).

⁶ The adolescent stated "At the moment, I feel more like 'I am' instead of 'I am a woman' or 'I am a man'" (adolescent assigned female sex at birth, age 16 years).

⁷ The adolescent stated that "he had fallen in love with a girl and had never had such feelings, which made him question his gender identity. At subsequent visits, he indicated that he was happy living as a man.

⁸ The adolescent stated "After using GnRH analogues for the first time, I could feel who I was without the female hormones, this gave me peace of mind to think about my future. It was an inner feeling that said I am a woman" (adolescent assigned female sex at birth, age 18 years).

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
Costa R, Dunsford M, Skagerberg E, et al. (2015) Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria . Journal of Sexual Medicine 12(11):2206-14.	Adolescents with gender dysphoria who completed a 6-month diagnostic process using DSM-IV-TR criteria for gender dysphoria (comprising the gender dysphoria assessment and psychological interventions) either immediately eligible for treatment with GnRH analogues or delayed eligible for treatment with GnRH analogues (received psychological support without any physical intervention).	Intervention 101 individuals were assessed as being immediately eligible for use of GnRH analogues (no specific treatment, dose or route, or frequency of administration reported but all received psychological support).	Critical outcomes Impact on gender dysphoria The Utrecht gender dysphoria scale (UGDS) was used to assess adolescents' gender dysphoria related discomfort. The Cronbach's alpha (α) for the study was reported as 0.76 to 0.88, suggesting good internal consistency. UGDS was only reported once, for 160 adolescents (50 sex assigned at birth males and 110 sex assigned at birth females). The assessment time point is not reported (baseline or follow-up) and the comparison for gender related discomfort was between sex assigned at birth males and sex assigned at birth females. Sex assigned at birth males had a mean (\pm SD) UGDS score of 51.6 [\pm 9.7] versus sex assigned at birth	This study was appraised using the Newcastle-Ottawa tool for cohort studies. Domain 1: Selection 1. somewhat representative 2. drawn from the same community as the exposed cohort. 3. secure record 4. no Domain 2: Comparability 1. partial comparator Domain 3: Outcome 1. independent assessment (unclear if blinded) 2. yes 3. incomplete follow-up
United Kingdom	No exclusion criteria were reported.	Comparison The analyses were between the immediately eligible		
Prospective longitudinal observational single centre cohort study	The sample consisted of 201 adolescents (sex assigned at birth male to female ratio 1:1.6)			
Includes participants referred to the service between 2010 and 2014.				

	<p>mean (\pmSD) age 15.52\pm1.41 years) from a sampling frame of 436 consecutive adolescents referred to the service between 2010 and 2014. The mean (\pmSD) age (n=201) at the start of GnRH analogues was 16.48 [\pm1.26], range 13 to 17 years. The interval from the start of the diagnostic procedure to the start of puberty suppression took approximately 1.5 years [\pm0.63] from baseline.</p> <p>None of the delayed eligible individuals received puberty suppression at the time of this study. Tanner stage was not reported.</p>	<p>and delayed eligible (n=100) adolescents,</p> <p>Baseline assessment (following diagnostic procedure) was followed by follow-up at 6 months from baseline (T1), 12 months from baseline (T2) and 18 months from baseline (T3).</p>	<p>females score of 56.1 [\pm4.3], <i>t</i>-test 4.07; <i>p</i><0.001.</p> <p>Impact on mental health Not assessed.</p> <p>Impact on quality of life Not assessed.</p> <p>Important outcomes Psychosocial impact The Children's Global Assessment Scale (CGAS) was used to assess adolescents' psychosocial functioning. The CGAS was administered by psychologists, psychotherapists, and psychiatrists (intra-class correlation assessment was 0.76 \leq Cronbach's α \leq 0.94). At baseline, CGAS scores were not associated with any demographic variable, in both sex assigned at birth males and sex assigned at birth females (all <i>p</i>>0.1). In comparison with sex assigned at birth females, sex assigned at birth males had statistically significantly lower mean (\pmSD) baseline CGAS scores (55.4 [\pm12.7] versus 59.2 [\pm11.8]; <i>t</i>-test 2.15; <i>p</i>=0.03). There was no statistically significant difference in mean (\pmSD) CGAS scores at baseline (T0) between immediately eligible adolescents and delayed eligible adolescents (n=201, 58.72 [\pm11.38] versus 56.63 [\pm13.14]; <i>t</i>-test 1.21; <i>p</i>=0.23). Immediately eligible compared with delayed eligible participants At follow-up, there was no statistically significant difference in mean (\pmSD)</p>	<p>Overall quality is assessed as poor.</p> <p>Other comments: Physical and psychological comorbidity was poorly reported, concomitant use of other medicines was not reported. Large unexplained loss to follow-up (64.7%) at T3.</p> <p>Source of funding: not reported.</p>
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			<p>CGAS scores at any follow-up time point (T1, T2 or T3) between immediately eligible adolescents and delayed eligible adolescents:</p> <ul style="list-style-type: none"> • T1, n=201, 60.89 [±12.17] versus 60.29 [±12.81]; <i>t</i>-test 0.34; <i>p</i>=0.73 • T2, n=121, 64.70 [±13.34] versus 62.97 [±14.10]; <i>t</i>-test 0.69; <i>p</i>=0.49 • T3, n=71, 67.40 [±13.93] versus 62.53 [±13.54]; <i>t</i>-test 1.49; <i>p</i>=0.14. <p>All participants</p> <p>There was a statistically significant increase in mean (±SD) CGAS scores at any follow-up time point (T1, T2 or T3) compared with baseline (T0) for the all adolescents group:</p> <ul style="list-style-type: none"> • T0 (n=201) versus T1 (n=201), 57.73 [±12.27] versus 60.68 [±12.47]; <i>t</i>-test 4.87; <i>p</i><0.001 • T0 (n=201) versus T2 (n=121), 57.73 [±12.27] versus 63.31 [±14.41]; <i>t</i>-test 3.70; <i>p</i><0.001 • T0 (n=201) versus T3 (n=71), 57.73 [±12.27] versus 64.93 [±13.85]; <i>t</i>-test 4.11; <i>p</i><0.001 <p>There was a statistically significant increase in mean (±SD) CGAS scores when comparing the follow-up period T1 to T3 but not for the periods T1 to T2 and T2 to T3, for all adolescents:</p> <ul style="list-style-type: none"> • T1 (n=201) versus T2 (n=121), 60.68 [±12.47] versus 63.31 [±14.41]; <i>t</i>-test 1.73; <i>p</i><0.08 • T1 (n=201) versus T3 (n=71), 60.68 [±12.47] versus 64.93 [±13.85], <i>t</i>-test 2.40; <i>p</i><0.02 • T2 (n=121) versus T3 (n=71), 63.31 [±14.41] versus 64.93 [±13.85], <i>t</i>-test 0.76; <i>p</i>=0.45 	
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			<p>There were no statistically significant differences in CGAS scores between sex assigned at birth males and sex assigned at birth females with gender dysphoria in all the follow-up evaluations (all $p>0.1$). Delayed eligible and immediately eligible adolescents with gender dysphoria were not statistically significantly different for demographic variables (all $p>0.1$).</p> <p>Immediately eligible participants</p> <p>There was a statistically significant increase in mean (\pmSD) CGAS scores at follow-up times T2 and T3 compared with baseline (T0) but not for T0 versus T1, for the immediately eligible adolescents:</p> <ul style="list-style-type: none"> • T0 ($n=101$) versus T1 ($n=101$), 58.72 [± 11.38] versus 60.89 [± 12.17]; t-test 1.31; $p=0.19$ • T0 ($n=101$) versus T2 ($n=60$), 58.72 [± 11.38] versus 64.70 [± 13.34]; t-test 3.02; $p=0.003$ • T0 ($n=101$) versus T3 ($n=35$), 58.72 [± 11.38] versus 67.40 [± 13.93]; t-test 3.66; $p<0.001$ <p>There was a statistically significant increase in mean (\pmSD) CGAS scores when comparing the follow-up period T1 to T3 with each other but not for the periods T1 to T2 and T2 to T3, for the immediately eligible adolescents:</p> <ul style="list-style-type: none"> • T1 ($n=101$) versus T2 ($n=60$), 60.89 [± 12.17] versus 64.70 [± 13.34]; t-test 1.85; $p=0.07$ • T1 ($n=101$) versus T3 ($n=35$), 60.89 [± 12.17] versus 67.40 [± 13.93], t-test 2.63; $p<0.001$ 	
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			<ul style="list-style-type: none"> T2 (n=60) versus T3 (n=35), 64.70 [±13.34] versus 67.40 [±13.93], <i>t</i>-test 0.94; <i>p</i>=0.35 <p>The immediately eligible adolescents had a CGAS score which was not statistically significantly different compared to the sample of children/adolescents without observed psychological /psychiatric symptoms after 12 months of puberty suppression (T3, <i>t</i>=0.01, <i>p</i>=0.99).</p>	
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Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>de Vries A, Steensma T, Doreleijers T, et al. (2011) Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. The Journal of Sexual Medicine 8 (8):2276-83.</p> <p>Netherlands</p> <p>Prospective longitudinal observational single centre before and after study.</p>	<p>The sample size was 70 adolescents receiving GnRH analogues (mean age [±SD] at assessment 13.6±1.8 years) from a sampling frame of 196 consecutive adolescents referred to the service between 2000 and 2008. Inclusion criteria were if they subsequently started gender-affirming hormones between 2003 and 2009 (mean [±SD] age at start of GnRH analogues was 14.75 [±1.92] years)¹. No specific exclusion criteria were described.</p> <p>No diagnostic criteria or concomitant treatments were reported. Tanner stage of the included adolescents was not reported.</p>	<p>Intervention 70 adolescents were assessed at baseline (T0) before the start of GnRH analogues (no specific treatment, dose or route of administration reported).</p> <p>Comparison The same 70 adolescents were assessed again at follow-up (T1), shortly before starting gender-affirming hormones. Not all adolescents completed all assessments for all items².</p>	<p>Critical outcomes Impact on gender dysphoria Impact on gender dysphoria was assessed using the Utrecht Gender Dysphoria Scale (UGDS).</p> <ul style="list-style-type: none"> There was no statistically significant difference in UGDS scores between T0 and T1 (n=41). There was a statistically significant difference between sex assigned at birth males and sex assigned at birth females, with sex assigned at birth females reporting more gender dysphoria, <i>F</i> (<i>df</i>, <i>errdf</i>), <i>P</i>: 15.98 (1,39), <i>p</i><0.001. <p>Impact on mental health Depressive symptoms were assessed using the Beck Depression Inventory (BDI-II).</p> <ul style="list-style-type: none"> There was a statistically significant reduction in BDI score between T0 and T1, n=41, 8.31 [±7.12] versus 4.95 [±6.72], <i>F</i> (<i>df</i>, <i>errdf</i>), <i>P</i>: 9.28 (1,39), <i>p</i>=0.004. There was no statistically significant difference between sex assigned at 	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection</p> <ol style="list-style-type: none"> somewhat representative of children and adolescents who have gender dysphoria no non-exposed cohort no description no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> study controls for age, age at start of treatment, IQ, and parental factors <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> no description no/unclear complete <p>Overall quality is assessed as poor.</p> <p>Other comments: Physical and psychological comorbidity was not reported, concomitant use of</p>

			<p>birth males and sex assigned at birth females, $F(df, errdf), P: 3.85(1,39), p=0.057$.</p> <p>Anger and anxiety were assessed using Trait Anger and Anxiety (TPI and STAI, respectively) Scales of the State-Trait Personality Inventory.</p> <ul style="list-style-type: none"> There was no statistically significant difference in anger (TPI) scale scores between T0 and T1 ($n=41$). There was a statistically significant difference between sex assigned at birth males and sex assigned at birth females, with sex assigned at birth females reporting increased anger compared with sex assigned at birth males, $F(df, errdf), P: 5.70(1,39), p=0.022$. Similarly, there was no statistically significant difference in anxiety (STAI) scale scores between T0 and T1 ($n=41$). There was a statistically significant difference between sex assigned at birth males and sex assigned at birth females, with sex assigned at birth females reporting increased anxiety compared with sex assigned at birth males, $F(df, errdf), P: 16.07(1,39), p<0.001$. <p>Impact on quality of life Not assessed.</p> <p>Important outcomes Impact on body image Impact on body image was assessed using the Body Image Scale to measure body satisfaction (BIS).</p>	<p>other medicines was not reported.</p> <p>Source of funding: This study was supported by a personal grant awarded to the first author by the Netherlands Organization for Health Research and Development.</p>
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			<p>There was no statistically significant difference between T0 and T1 for any of the 3 BIS scores (primary sex characteristics, secondary sex characteristics or neutral characteristics, n=57). There were statistically significant differences between sex assigned at birth males and sex assigned at birth females, with sex assigned at birth females reporting more dissatisfaction, for:</p> <ul style="list-style-type: none"> • primary sexual characteristics, $F(df, errdf)$, P: 4.11 (1,55), $p=0.047$. • secondary sexual characteristics, $F(df, errdf)$, P: 11.57 (1,55), $p=0.001$. <p>But no statistically significant difference between sex assigned at birth males and sex assigned at birth females was found for neutral characteristics. However, there was a significant interaction effect between sex assigned at birth sex and the changes of gender dysphoria between T0 and T1; sex assigned at birth females became more dissatisfied with their secondary sex characteristics compared with sex assigned at birth males, $F(df, errdf)$, P: 14.59 (1,55), $p<0.001$ and neutral characteristics, $F(df, errdf)$, P: 15.26 (1,55), $p<0.001$).</p> <p>Psychosocial impact Psychosocial impact was assessed using both the Child Behaviour Checklist (CBCL) and the Youth Self-Report (YSR) to parents and adolescents, respectively. The Children's Global Assessment Scale was also reported.</p> <p>There was a statistically significant decrease in mean (\pmSD) total, internalising, and externalising³ parental</p>	
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			<p>CBCL scores between T0 and T1⁴ for all adolescents (n=54):</p> <ul style="list-style-type: none"> • Total score (T0 – T1) 60.70 [± 12.76] versus 54.46 [± 11.23], $F(df, errdf)$, P: 26.17 (1,52), $p < 0.001$. • Internalising score (T0 – T1) 61.00 [± 12.21] versus 54.56 [± 10.22], $F(df, errdf)$, P: 22.93 (1,52), $p < 0.001$. • Externalising score (T0 – T1) 58.04 [± 12.99] versus 53.81 [± 11.86], $F(df, errdf)$, P: 12.04 (1,52), $p = 0.001$. <p>There was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for total and internalising CBCL score but there was a significant difference for the externalising score:</p> <ul style="list-style-type: none"> • Externalising score, $F(df, errdf)$, P: 6.29 (1,52), $p = 0.015$. <p>There was a statistically significant decrease in mean ($\pm SD$) total, internalising, and externalising³ YSR scores between T0 and T1 for all adolescents (n=54):</p> <ul style="list-style-type: none"> • Total score (T0 – T1) 55.46 [± 11.56] versus 50.00 [± 10.56], $F(df, errdf)$, P: 16.24 (1,52), $p < 0.001$. • Internalising score (T0 – T1) 56.04 [± 12.49] versus 49.78 [± 11.63], $F(df, errdf)$, P: 15.05 (1,52), $p < 0.001$. • Externalising score (T0 – T1) 53.30 [± 11.87] versus 49.98 [± 9.35], $F(df, errdf)$, P: 7.26 (1,52), $p = 0.009$. <p>There was no statistically significant difference between sex assigned at birth males and sex assigned at birth females for total and internalising YSR score but there was a significant difference for the externalising score:</p>	
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			<ul style="list-style-type: none"> Externalising score, $F(df, errdf), P: 9.14(1,52), p=0.004$. There was a statistically significant increase in CGAS mean ($\pm SD$) score between T0 and T1 ($n=41$), $70.24[\pm 10.12]$ versus $73.90[\pm 9.63]$, $F(df, errdf), P: 8.76(1,39), p=0.005$. There was a statistically significant difference between sex assigned at birth males and sex assigned at birth females, with sex assigned at birth females reporting lower score for global functioning compared with sex assigned at birth males, $F(df, errdf), P: 5.77(1,52), p=0.021$. The proportion of adolescents scoring in the clinical range significantly decreased between T0 and T1, on the CBCL total problem scale (44.4% versus 22.2%, $X^2[1] = 6.00, p=0.001$), and the internalising scale (29.6% versus 11.1%, $X^2[1] = 5.71, p=0.017$) of the YSR. 	
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¹ There were statistically significant mean age ($\pm SD$) differences between sex assigned at birth males and sex assigned at birth females for age at assessment ($13.14[\pm 1.55]$ versus $14.10[\pm 1.99]$ years, $p=0.028$), age at start of GnRH analogues ($14.25[\pm 1.79]$ versus $15.21[\pm 1.95]$ years, $p=0.036$) and age at the start of gender-affirming hormones ($16.24[\pm 1.21]$ versus $16.99[\pm 1.09]$ years, $p=0.008$). No statistically significant differences were seen for other baseline characteristics, time between GnRH analogue and gender-affirming hormones, full scale IQ, parental marital status, education, and sexual attraction to own, other or both sexes.

² Independent t-tests between mean scores on the CBCL, YSR, BDI, TPI, STAI, CGAS, UGS, and BIS of adolescents who completed both assessments and mean scores of adolescents who completed only one of the assessments revealed no significant differences on all used measures, at neither T0 or at T1.

³ The CBCL/YSR has 2 components: Internalising score which sums the anxious/depressed, withdrawn-depressed, and somatic complaints scores; externalising score which sums rule-breaking and aggressive behaviour. The total problems score is the sum of the scores of all the problem items. The YSR is a child self-report version of the CBCL.

⁴ A repeated measures ANOVA (analysis of variance) was used.

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
Joseph T, Ting J, Butler G. (2019) The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: findings from a large national cohort . Journal of pediatric endocrinology & metabolism 32(10): 1077-1081	Adolescents (12 to 14 years) with gender dysphoria (no diagnostic criteria described), $n=70$, including 31 transfemales and 39 transmales.	Treatment with a GnRH analogue for at least 1 year or ongoing until they reached 16 years. No specific treatment, dose or route of	Critical outcomes No critical outcomes assessed. Important outcomes Bone density: lumbar¹ Lumbar spine bone mineral apparent density (BMAD)² 0 to 1 year Transfemales (mean [$\pm SD$]):	This study was appraised using the Newcastle-Ottawa quality assessment checklist for cohort studies. Domain 1: Selection

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>United Kingdom</p> <p>Retrospective longitudinal observational single centre study</p> <p>To investigate whether there is any significant loss of bone mineral density (BMD) and bone mineral apparent density (BMAD) for up to 3 years of GnRH analogues. To investigate whether there was a significant drop after 1 year of treatment following abrupt withdrawal.</p> <p>2011 to 2016</p>	<p>All had been seen and assessed by a Gender Identity Development Service multi-disciplinary psychosocial health team for at least 4 assessments over a minimum of 6 months. All participants had entered puberty and all but 2 of the transmales were postmenarchal.</p> <p>57% of the transfemales were in early puberty (G2–3 and testicular volume >4 mL) and 43% were in late puberty (G4–5).</p> <p>Details of the sampling frame were not reported.</p> <p>Further details of how the sample was drawn are not reported.</p>	<p>administration reported.</p> <p>No concomitant treatments were reported.</p> <p>No comparator.</p>	<p>0.235 (0.030) g/cm³ at baseline, 0.233 g/cm³ (0.029) at 1 year (p=0.459); z-score 0.859 (0.154) at baseline, -0.228 (1.027) at 1 year (p=0.000)</p> <p>Transmales (mean [±SD]):</p> <p>0.196 (0.035) g/cm³ at baseline, 0.201 (0.033) g/cm³ at 1 year (p=0.074); z-score -0.186 (1.230) at baseline, -0.541 (1.396) at 1 year (p=0.006)</p> <p>Lumbar spine BMAD 0 to 2 years</p> <p>Transfemales (mean [±SD]):</p> <p>0.240 (0.027) g/cm³ at baseline, 0.240 (0.030) g/cm³ at 2 years (p=0.865); z-score 0.486 (0.809) at baseline, -0.279 (0.930) at 2 years (p=0.000)</p> <p>Transmales (mean [±SD]):</p> <p>0.195 (0.058) g/cm³ at baseline, 0.198 (0.055) at 2 years (p=0.433); z-score -0.361 (1.439) at baseline, -0.913 (1.318) at 2 years (p=0.001)</p> <p>Lumbar spine bone mineral density (BMD) 0 to 1 year</p> <p>Transfemales (mean [±SD]):</p> <p>0.860 (0.154) kg/m² at baseline, 0.859 (0.129) kg/m² at 1 year (p=0.962); z-score -0.016 (1.106) at baseline, -0.461 (1.121) at 1 year (p=0.003)</p> <p>Transmales (mean [±SD]):</p> <p>0.694 (0.149) kg/m² at baseline, 0.718 (0.124) kg/m² at 1 year (p=0.006); z-score -0.395 (1.428) at baseline, -1.276 (1.410) at 1 year (p=0.000)</p> <p>Lumbar spine BMD 0 to 2 years</p> <p>Transfemales (mean [±SD]):</p> <p>0.867 (0.141) kg/m² at baseline, 0.878 (0.130) kg/m² at 2 years (p=0.395); z-score 0.130 (0.972) at baseline, -0.890 (1.075) at 2 years (p=0.000)</p> <p>Transmales (mean [±SD]):</p>	<p>1. Somewhat representative of children and adolescents who have gender dysphoria</p> <p>2. Not applicable</p> <p>3. Via routine clinical records</p> <p>4. No</p> <p>Domain 2: Comparability</p> <p>1. No control group</p> <p>Domain 3: Outcome</p> <p>1. Via routine clinical records</p> <p>2. Yes</p> <p>3. No statement</p> <p>Overall quality is assessed as poor.</p> <p>Other comments: although the evidence is of poor quality, the results suggest a possible association between GnRH analogues and BMAD. However, the results are not reliable and could be due to bias or chance. Further details of how the sample was drawn are not reported. No concomitant treatments were reported.</p> <p>Source of funding: None disclosed</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>0.695 (0.220) kg/m² at baseline, 0.731 (0.209) kg/m² at 2 years (p=0.058); z-score -0.715 (1.406) at baseline, -2.000 (1.384) at 2 years (p=0.000)</p> <p>Bone density: femoral Femoral neck (hip) BMD 0 to 1 year Transfemales (mean [±SD]): 0.894 (0.118) kg/m² at baseline, 0.905 (0.104) kg/m² at 1 year (p=0.571); z-score 0.157 (0.905) at baseline, -0.340 (0.816) at 1 year (p=0.002) Transmales (mean [±SD]): 0.772 (0.137) kg/m² at baseline, 0.785 (0.120) kg/m² at 1 year (p=0.797); z-score -0.863 (1.215) at baseline, -1.440 (1.075) at 1 year (p=0.000) Femoral neck (hip) BMD 0 to 2 years Transfemales (mean [±SD]): 0.920 (0.116) kg/m² at baseline, 0.910 (0.125) kg/m² at 2 years (p=0.402); z-score 0.450 (0.781) at baseline, -0.600 (1.059) at 2 years (p=0.002) Transmales (mean [±SD]): 0.766 (0.215) kg/m² at baseline, 0.773 (0.197) at 2 years (p=0.604); z-score -1.075 (1.145) at baseline, -1.779 (0.816) at 2 years (p=0.001)</p>	

¹ Lumbar spine (L1-L4) BMD was measured by yearly dual energy X-ray absorptiometry (DXA) scans at baseline (n=70), 1 year (n=70), and 2 years (n=31).

² BMAD is a size adjusted value of BMD incorporating body size measurements using UK norms in growing adolescents. Reported as g/cm³ and z-scores. Hip BMAD z-scores were not calculated as there were no available reference ranges.

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
Khatchadourian K, Shazhan A, Metzger D. (2014) Clinical management of youth with gender dysphoria in	27 young people with gender dysphoria who started GnRH analogues (at mean age [±SD] 14.7±1.9 years) out of 84 young	Intervention 84 young people with gender dysphoria were included. For GnRH analogues no	<p>Critical Outcomes No critical outcomes assessed.</p> <p>Important outcomes <i>Stopping treatment</i></p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection</p>

<p>Vancouver. The Journal of Pediatrics 164 (4): 906-11.</p> <p>Canada</p> <p>Retrospective observational chart review single centre study</p>	<p>people seen at the unit between 1998 and 2011.</p> <p>Note: the transmale and transfemale subgroups reported in the paper is discrepant, 15 transmales and 11 transfemales (n=26) reported in the outcomes section rather than the n=27 stated in the paper; complete outcome reporting is also incomplete for the transfemale group.</p> <p>Inclusion criteria were at least Tanner stage 2 pubertal development, previous assessment by a mental health professional and a confirmed diagnosis of gender dysphoria (diagnostic criteria not specified). No exclusion criteria are specified.</p>	<p>specific treatment, dose or route of administration reported.</p> <p>Comparison No comparator.</p>	<p>The authors report that of 15 transmales taking GnRH analogues:</p> <ul style="list-style-type: none"> • 14 transitioned to testosterone treatment during the observation period • 7 continued taking GnRH analogues after starting testosterone • 7 discontinued GnRH analogues after a median of 3.0 years (range 0.2 to 9.2 years), of which: <ul style="list-style-type: none"> ○ 5 discontinued after hysterectomy and salpingo-oophorectomy ○ 1 discontinued after 2.2 years (transitioned to gender-affirming hormone) ○ 1 discontinued after <2 months due to mood and emotional lability <p>The authors report that of 11 transfemales taking GnRH analogues:</p> <ul style="list-style-type: none"> • 5 received oestrogen treatment during the observation period • 4 continued taking GnRH analogues during oestrogen treatment • 1 discontinued GnRH analogues during oestrogen treatment (no reason reported) • 1 stopped GnRH analogues after a few months due to emotional lability • 1 stopped GnRH analogues before oestrogen treatment (the following year delayed due to heavy smoking) • 1 discontinued GnRH analogues after 13 months due to choosing not to pursue transition <p>Safety Of the 27 patients treated with GnRH analogues:</p>	<ol style="list-style-type: none"> 1. not reported 2. no non-exposed cohort 3. secure record 4. no <p>Domain 2: Comparability 1. not applicable</p> <p>Domain 3: Outcome 1. record linkage 2. yes 3. in complete missing data</p> <p>Overall quality is assessed as poor.</p> <p>Other comments: mental health comorbidity was reported for all participants but not for the GnRH analogue cohort separately. Concomitant use of other medicines was not reported.</p> <p>Source of funding: No source of funding identified.</p>
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			<ul style="list-style-type: none"> • 1 transmale participant developed sterile abscesses; they were switched from leuprolide acetate to triptorelin, and this was well tolerated. • 1 transmale participant developed leg pains and headaches on GnRH analogues, which eventually resolved without treatment. • 1 participant gained 19 kg within 9 months of initiating GnRH analogues, although their body mass index was >85 percentile before GnRH analogues. 	
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Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Klink D, Caris M, Heijboer A et al. (2015) Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. The Journal of clinical endocrinology and metabolism 100(2): e270-5</p> <p>Netherlands</p> <p>Retrospective longitudinal observational single centre study</p> <p>To assess BMD development during GnRH analogues and at age 22 years in adolescents with gender dysphoria who started treatment for gender dysphoria during adolescence.</p>	<p>34 adolescents (mean age \pmSD 14.9\pm1.9 for transfemales and 15.0\pm2.0 for transmales at start of GnRH analogues).</p> <p>Participants were included if they met DSM-IV-TR criteria for gender identity disorder of adolescence and had been treated with GnRH analogues and gender-affirming hormones during their pubertal years. No concomitant treatments were reported.</p>	<p>The intervention was GnRH analogue monotherapy (triptorelin pamoate 3.75 mg subcutaneously every 4 weeks) followed by gender-affirming hormones from 16 years with discontinuation of GnRH analogue after gonadectomy.</p> <p>Median duration of GnRH analogue monotherapy in transfemales was 1.3 years (range, 0.5 to 3.8 years), and in transmales was 1.5 years</p>	<p>Critical outcomes No critical outcomes assessed.</p> <p>Important outcomes Bone density: lumbar Lumbar spine bone mineral apparent density (BMAD)¹ Change from starting GnRH analogue (mean age 14.9\pm1.9) to starting gender-affirming hormones (mean age 16.6\pm1.4) in transfemales (mean [\pmSD]): GnRH analogue: 0.22 (0.03) g/cm³, gender-affirming hormones: 0.22 (0.02) g/cm³ (NS); z-score GnRH analogue: -0.44 (1.10), gender-affirming hormones: -0.90 (0.80) (p=NS) Change from starting GnRH analogue (mean age 15.0\pm2.0) to starting gender-affirming hormones (mean age 16.4\pm2.3) in transmales (mean [\pmSD]): GnRH analogue: 0.25 (0.03) g/cm³, gender-affirming hormones: 0.24 (0.02) g/cm³ (NS);</p>	<p>This study was appraised using the Newcastle-Ottawa quality assessment checklist for cohort studies.</p> <p>Domain 1: Selection 1. somewhat representative of children and adolescents who have gender dysphoria 2. not applicable 3. via routine clinical records 4. no</p> <p>Domain 2: Comparability 1. no control group</p> <p>Domain 3: Outcome 1. via routine clinical records 2. yes 3. follow-up rate variable across timepoints and no description of those lost</p> <p>Overall quality is assessed as poor.</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
1998 to 2012		(range, 0.25 to 5.2 years).	<p>z-score GnRH analogue: 0.28 (0.90), gender-affirming hormones: -0.50 (0.81) (p=0.004)</p> <p>Lumbar spine bone mineral density (BMD)¹</p> <p>Change from starting GnRH analogue (mean age 14.9±1.9) to starting gender-affirming hormones (mean age 16.6±1.4) in transfemales (mean [±SD]): GnRH analogue: 0.84 (0.13) g/m2, gender-affirming hormones: 0.84 (0.11) g/m2 (NS); z-score GnRH analogue: -0.77 (0.89), gender-affirming hormones: -1.01 (0.98) (NS)</p> <p>Change from starting GnRH analogue (mean age 15.0±2.0) to starting gender-affirming hormones (mean age 16.4±2.3) in transmales (mean [±SD]): GnRH analogue: 0.95 (0.12) g/m2, gender-affirming hormones: 0.91 (0.10) g/m2 (p=0.006); z-score GnRH analogue: 0.17 (1.18), gender-affirming hormones: -0.72 (0.99) (p<0.001)</p> <p>Bone density; femoral</p> <p>Femoral area BMAD¹</p> <p>Change from starting GnRH analogue (mean age 14.9±1.9) to starting gender-affirming hormones (mean age 16.6±1.4) in transfemales (mean [±SD]), GnRH analogue: 0.28 (0.04) g/cm3, gender-affirming hormones: 0.26 (0.04) g/cm3 (NS); z-score GnRH analogue: -0.93 (1.22), gender-affirming hormones: -1.57 (1.74) (p=NS)</p> <p>Change from starting GnRH analogue</p>	<p>Other comments: Within person comparison. Small numbers of participants in each subgroup. No concomitant treatments or comorbidities were reported.</p> <p>Source of funding: None disclosed</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>(mean age 15.0±2.0) to starting gender-affirming hormones (mean age 16.4±2.3) in transmales (mean [±SD]), GnRH analogue: 0.32 (0.04) g/cm³, gender-affirming hormones: 0.31 (0.04) (NS);</p> <p>z-score GnRH analogue: 0.01 (0.70), gender-affirming hormones: -0.28 (0.74) (NS)</p> <p>Femoral area BMD¹</p> <p>Change from starting GnRH analogue (mean age 14.9±1.9) to starting gender-affirming hormones (mean age 16.6±1.4) in transfemales (mean [±SD]), GnRH analogue: 0.88 (0.12) g/m², gender-affirming hormones: 0.87 (0.08) (NS);</p> <p>z-score GnRH analogue: -0.66 (0.77), gender-affirming hormones: -0.95 (0.63) (NS)</p> <p>Change from starting GnRH analogue (mean age 15.0±2.0) to starting gender-affirming hormones (mean age 16.4±2.3) in transmales (mean [±SD]), GnRH analogue: 0.92 (0.10) g/m², gender-affirming hormones: 0.88 (0.09) (p=0.005);</p> <p>z-score GnRH analogue: 0.36 (0.88), gender-affirming hormones: -0.35 (0.79) (p=0.001)</p>	

¹ BMD and BMAD of the lumbar spine and femoral region (nondominant side) measured by DXA scans at start of GnRH analogues, (n=32), start of gender-affirming hormones (n=34), and at 22 years (n=34).

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
Schagen SEE, Cohen-Kettenis PT, Delemarre-van de Waal HA et al. (2016)	Adolescents with gender dysphoria (n=116), median age (range) 13.6 years (11.6 to 17.9) in transfemales and 14.2 years (11.1 to	GnRH analogue monotherapy (triptorelin pamoate 3.75 mg at 0, 2 and 4	<p>Critical outcomes</p> <p>No critical outcomes assessed.</p> <p>Important outcomes</p>	This study was appraised using the Newcastle-Ottawa quality assessment checklist for cohort studies.

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Efficacy and Safety of Gonadotropin-Releasing Hormone Agonist Treatment to Suppress Puberty in Gender Dysphoric Adolescents. The journal of sexual medicine 13(7): 1125-32</p> <p>Netherlands</p> <p>Prospective longitudinal study</p> <p>To describe the changes in Tanner stage, testicular volume, gonadotropins, and sex steroids during GnRH analogues of adolescents with gender dysphoria to evaluate the efficacy. To report on liver enzymes, renal function and changes in body composition.</p> <p>1998 to 2009</p>	<p>18.6) in transmales during first year of GnRH analogues.</p> <p>Participants were included if they met DSM-IV-TR criteria for gender dysphoria, had lifelong extreme gender dysphoria, were psychologically stable and were living in a supportive environment. No concomitant treatments were reported.</p>	<p>weeks followed by injections every 4 weeks, route of administration not described) for at least 3 months.</p>	<p>Other safety outcomes: liver function Glutamyl transferase was not elevated at baseline or during treatment in any subject. Mild elevations of aspartate aminotransferase (AST) and alanine aminotransferase (ALT) above the reference range were present at baseline but were not more prevalent during treatment than at baseline. Glutamyl transferase, AST, and ALT levels did not significantly change from baseline to 12 months of treatment. No values or statistical analyses were reported.</p> <p>Other safety outcomes: kidney function Change in serum creatinine between 0 and 1 year Transfemales (mean [\pmSD]): 70 (12) micromol/l at baseline, 66 (13) micromol/l at 1 year ($p=0.20$)</p> <p>Transmales (mean [\pmSD]): 73 (8) micromol/l at baseline, 68 (13) micromol/l at 1 year ($p=0.01$)</p>	<p>Domain 1: Selection 1. somewhat representative of children and adolescents who have gender dysphoria 2. not applicable 3. via routine clinical records 4. no</p> <p>Domain 2: Comparability 1. no control group</p> <p>Domain 3: Outcome 1. via routine clinical records 2. yes 3. no statement</p> <p>Overall quality is assessed as poor.</p> <p>Other comments: Within person comparison. No concomitant treatments or comorbidities were reported.</p> <p>Source of funding: Ferring pharmaceuticals (triptorelin manufacturer)</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Staphorsius A, Baudewijntje P, Kreukels P, et al. (2015) Puberty suppression and executive functioning: an fMRI-study</p>	<p>The inclusion criteria were diagnosed with Gender Identity Disorder according to the DSM-IV-TR and at least 12 years old and Tanner stage of at least B2 or G2 to G3 with</p>	<p>Intervention GnRH analogues (triptorelin pamoate 3.75 mg every 4 weeks</p>	<p>Critical Outcomes No critical outcomes assessed.</p> <p>Important outcomes Psychosocial impact</p>	<p>This study was appraised using the Newcastle-Ottawa tool for cohort studies.</p> <p>Domain 1: Selection domain</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>in adolescents with gender dysphoria. Psychoneuroendocrinology 565:190-9.</p> <p>Netherlands</p> <p>Cross-sectional (single time point) assessment single centre study</p>	<p>measurable oestradiol and testosterone levels in girls and boys, respectively.</p> <p>For all group's exclusion criteria were an insufficient command of the Dutch language (how assessed not reported), unadjusted endocrine disorders, neurological or psychiatric disorders that could lead to deviant test results (details not reported) use of psychotropic medication, and contraindications for an MRI scan. Additionally, adolescents receiving puberty delaying medication or any form of hormones besides oral contraceptives were excluded as controls.</p> <p>The sample size was 85 of whom 41 were adolescents (the numbers are discrepant with the number for whom outcomes are reported n=40) with gender dysphoria (20 of whom were being treated with GnRH analogues); 24 girls and 21 boys without gender dysphoria acted as controls (not further reported here). Details of the sampling frame are not reported.</p> <p>The ages at which GnRH analogues were started was not reported. The mean duration of treatment was 1.6 years (SD 1.0)</p> <p>Mean (\pmSD) Tanner stage for each group was reported:</p> <ul style="list-style-type: none"> • Transfemales 3.9 [\pm1.1] • Transfemales on GnRH analogues 4.1 [\pm1.0] 	<p>subcutaneously or intramuscularly).</p> <p>Comparison The comparison was between adolescents with gender dysphoria receiving GnRH analogues and those without GnRH analogues.</p>	<p>The Child Behaviour Checklist (CBCL) was used to assess psychosocial impact. The CBCL was administered once during the study. The reported outcomes for each group were (n, mean [\pmSD]):</p> <ul style="list-style-type: none"> • Transfemales (all, n=18) 57.8 [\pm9.2] • Transfemales on GnRH analogues (n=8) 57.4 [\pm9.8] • Transfemales without GnRH analogues (n=10) 58.2 [\pm9.3] • Transmales (all, n=22) 60.4 [\pm10.2] • Transmales on GnRH analogues (n=12) 57.5 [\pm9.4] • Transmales without GnRH analogues (n=10) 63.9 [\pm10.5] <p>The analysis of the CBCL data is not discussed, and statistical analysis is unclear.</p> <p>Cognitive development or functioning IQ¹</p> <ul style="list-style-type: none"> • Transfemales (mean [\pmSD]) on GnRH analogues: 94.0 (10.3) • Transfemales (mean [\pmSD]) without GnRH analogues: 109.4 (21.2) • Transmales (mean [\pmSD]) on GnRH analogues: 95.8 (15.6) • Transmales (mean [\pmSD]) without GnRH analogues: 98.5 (15.9) <p>Reaction time²</p> <ul style="list-style-type: none"> • Transfemales (mean [\pmSD]) on GnRH analogues: 10.9 (4.1) • Transfemales (mean [\pmSD]) without GnRH analogues: 9.9 (3.1) 	<ol style="list-style-type: none"> 1. somewhat representative of children and adolescents who have gender dysphoria 2. drawn from the same community as the exposed cohort 3. via routine clinical records 4. no <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> 1. study controls for age and diagnosis <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> 1. via clinical assessment 2. yes 3. unclear <p>Overall quality is assessed as poor.</p> <p>Other comments: Physical and psychological comorbidity was not reported, concomitant use of other medicines was not reported.</p> <p>Source of funding: This work was supported by an educational grant from the pharmaceutical firm Ferring BV, and by a VICI grant (453-08-003) from the Dutch Science Foundation. The authors state that funding sources did not play a role in any component of this study.</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
	<ul style="list-style-type: none"> • Transfemales without GnRH analogues 3.8 [\pm1.1] • Transmales 4.5 [\pm0.9] • Transmales on GnRH analogues 4.1 [\pm1.1] <p>Transmales without GnRH analogues 4.9 [\pm0.3]</p>		<ul style="list-style-type: none"> • Transmales (mean [\pmSD]) on GnRH analogues: 9.9 (3.1) • Transmales (mean [\pmSD]) without GnRH analogues: 10.0 (2.0) <p>Accuracy³</p> <ul style="list-style-type: none"> • Transfemales (mean [\pmSD]) on GnRH analogues: 73.9 (9.1) • Transfemales (mean [\pmSD]) without GnRH analogues: 83.4 (9.5) • Transmales (mean [\pmSD]) on GnRH analogues: 85.7 (10.5) • Transmales (mean [\pmSD]) without GnRH analogues: 88.8 (9.7) 	

¹ Estimated with 4 subscales (arithmetic, vocabulary, picture arrangement, and block design) of the Wechsler Intelligence Scale for Children, third edition (WISC-III®, Wechsler 1991) or the Wechsler Adult Intelligence Scale, third edition (WAIS-III®, Wechsler 1997), depending on the participant's age.

² Reaction time in seconds in the Tower of London task

³ Percentage of correct trials in the Tower of London task

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>Vlot, Mariska C, Klink, Daniel T, den Heijer, Martin et al. (2017) Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. Bone 95: 11-19</p> <p>Netherlands</p> <p>Retrospective observational data analysis study</p>	<p>Adolescents with gender dysphoria, n=70.</p> <p>Median age (range) 15.1 years (11.7 to 18.6) for transmales and 13.5 years (11.5 to 18.3) for transfemales at start of GnRH analogues.</p> <p>Participants were included if they had a diagnosis of gender dysphoria according to DSM-IV-TR criteria who were treated with GnRH analogues and then gender-affirming hormones. No concomitant treatments were reported.</p> <p>The study categorised</p>	<p>GnRH analogues (triptorelin pamoate 3.75 mg every 4 weeks subcutaneously).</p>	<p>Critical outcomes</p> <p>No critical outcomes reported</p> <p>Important outcomes</p> <p>Bone density: lumbar</p> <p>Lumbar spine bone mineral apparent density (BMAD)</p> <p>Change from starting GnRH analogue to starting gender-affirming hormones in transfemales (bone age of <15 years; median [range]), GnRH analogue: 0.21 (0.17 to 0.25) g/cm³, gender-affirming hormones: 0.20 (0.18 to 0.24) g/cm³ (NS); z-score GnRH analogue: -0.20 (-1.82 to 1.18), gender-affirming hormones: -1.52 (-2.36 to 0.42) (p=0.001)</p>	<p>This study was appraised using the Newcastle-Ottawa quality assessment checklist for cohort studies.</p> <p>Domain 1: Selection</p> <ol style="list-style-type: none"> 1. Somewhat representative of children and adolescents who have gender dysphoria 2. Not applicable 3. Via routine clinical records 4. No <p>Domain 2: Comparability</p> <ol style="list-style-type: none"> 1. No control group <p>Domain 3: Outcome</p> <ol style="list-style-type: none"> 1. Via routine clinical records 2. Yes

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
<p>To investigate the course of 3 bone turnover markers in relation to bonemineral density, in adolescents with gender dysphoria during GnRH analogue and gender-affirming hormones.</p> <p>2001 to 2011</p>	<p>participants into a young and old pubertal group, based on their bone age. The young transmales had a bone age of <14 years and the old transmales had a bone age of ≥14 years. The young transfemales group had a bone age of <15 years and the old transfemales group ≥15 years.</p>		<p>Change from starting GnRH analogue to starting gender-affirming hormones in transfemales (bone age of ≥15; median [range]), GnRH analogue: 0.22 (0.18 to 0.25) g/cm³, gender-affirming hormones: 0.22 (0.19 to 0.24) g/cm³ (NS); z-score GnRH analogue: -1.18 (-1.78 to 1.09), gender-affirming hormones: -1.15 (-2.21 to 0.08) (p≤0.1)</p> <p>Change from starting GnRH analogue to starting gender-affirming hormones in transmales (bone age of <15 years; median [range]), GnRH analogue: 0.23 (0.20 to 0.29) g/cm³, gender-affirming hormones: 0.23 (0.19 to 0.28) g/cm³ (NS); z-score GnRH analogue: -0.05 (-0.78 to 2.94), gender-affirming hormones: -0.84 (-2.20 to 0.87) (p=0.003)</p> <p>Change from starting GnRH analogue to starting gender-affirming hormones in transmales (bone age of ≥15; median [range]), GnRH analogue: 0.26 (0.21 to 0.29) g/cm³, gender-affirming hormones: 0.24 (0.20 to 0.28) g/cm³ (p≤0.01); z-score GnRH analogue: 0.27 (-1.60 to 1.80), gender-affirming hormones: -0.29 (-2.28 to 0.90) (p≤ 0.0001)</p> <p>Bone density; femoral Femoral neck BMAD</p> <p>Change from starting GnRH analogue to starting gender-affirming hormones in transfemales (bone age of <15 years; median [range]), GnRH analogue: 0.29 (0.20 to 0.33) g/cm³, gender-affirming hormones: 0.27 (0.20 to 0.33) g/cm³ (p≤0.1); z-score GnRH analogue: -0.71 (-3.35 to</p>	<p>3. Follow-up rate variable across outcomes and no description of those lost</p> <p>Overall quality is assessed as poor.</p> <p>Other comments: Within person comparison. No concomitant treatments were reported.</p> <p>Source of funding: grant from Abbott diagnostics</p>

Study details	Population	Interventions	Study outcomes	Appraisal and Funding
			<p>0.37), gender-affirming hormones: -1.32 (-3.39 to 0.21) ($p \leq 0.1$)</p> <p>Change from starting GnRH analogue to starting gender-affirming hormones in transfemales (bone age of ≥ 15; median [range]), GnRH analogue: 0.30 (0.26 to 0.36) g/cm³, gender-affirming hormones: 0.30 (0.26 to 0.34) g/cm³ (NS); z-score GnRH analogue: -0.44 (-1.37 to 0.93), gender-affirming hormones: -0.36 (-1.50 to 0.46) (NS)</p> <p>Change from starting GnRH analogue to starting gender-affirming hormones in transmales (bone age of < 15 years; median [range]), GnRH analogue: 0.31 (0.26 to 0.36) g/cm³, gender-affirming hormones: 0.30 (0.22 to 0.35) g/cm³ (NS); z-score GnRH analogue: -0.01 (-1.30 to 0.91), gender-affirming hormones: -0.37 (-2.28 to 0.47) (NS)</p> <p>Change from starting GnRH analogue to starting gender-affirming hormones in transmales (bone age of ≥ 15; median [range]), GnRH analogue: 0.33 (0.25 to 0.39) g/cm³, gender-affirming hormones: 0.30 (0.23 to 0.41) g/cm³ ($p \leq 0.01$); z-score GnRH analogue: 0.27 (-1.39 to 1.32), gender-affirming hormones: -0.27 (-1.91 to 1.29) ($p = 0.002$)</p>	

Appendix F Quality appraisal checklists

Newcastle-Ottawa tool for cohort studies

Question	
Domain: Selection	
1. Representativeness of the exposed cohort	<p>Truly representative of the average [describe] in the community</p> <p>Somewhat representative of the average [describe] in the community</p> <p>Selected group of users e.g. nurses, volunteers</p> <p>No description of the derivation of the cohort</p>
2. Selection of the non-exposed cohort	<p>Drawn from the same community as the exposed cohort</p> <p>Drawn from a different source</p> <p>No description of the derivation of the non-exposed cohort</p>
3. Ascertainment of exposure	<p>Secure record (e.g. surgical records)</p> <p>Structured interview</p> <p>Written self-report</p> <p>No description</p>
4. Demonstration that outcome of interest was not present at start of study	Yes / No
Domain: Comparability	
1. Comparability of cohorts on the basis of the design or analysis	<p>Study controls for [select most important factor]</p> <p>Study controls for any additional factor [this criteria could be modified to indicate specific control for a second important factor]</p>
Domain: Outcome	
1. Assessment of outcome	<p>Independent blind assessment</p> <p>Record linkage</p> <p>Self-report</p> <p>No description</p>
2. Was follow-up long enough for outcomes to occur	<p>Yes [select and adequate follow up period for outcome of interest]</p> <p>No</p>
3. Adequacy of follow up of cohorts	<p>Complete follow up (all subjects accounted for)</p> <p>Subjects lost to follow up unlikely to introduce bias (small number lost to follow up [select an adequate %] follow up or description provided of those lost)</p> <p>Follow up rate [select an adequate %] and no description of those lost</p> <p>No statement</p>

Appendix G Grade profiles

Table 2: Question 1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – gender dysphoria

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Impact on gender dysphoria									
Mean±SD Utrecht Gender Dysphoria Scale ¹ (version(s) not reported), time point at baseline (before GnRH analogues) versus follow-up (before gender-affirming hormones, higher scores indicate more gender dysphoria)									
1 cohort study de Vries et al 2011	Serious limitations ²	No serious indirectness	Not applicable	Not calculable	N=41	None	Baseline: 53.20±7.91 GnRH analogue: 53.9±17.42 P=0.333	Critical	VERY LOW

Abbreviations: GnRH, gonadotrophin releasing hormone; P, P-value; SD, Standard deviation.

¹ The UGDS is a validated screening tool for both adolescents and adults to assess gender dysphoria. It consists of 12 items, to be answered on a 1- to 5-point scale, resulting in a sum score between 12 and 60. The higher the UGDS score the greater the gender dysphoria.

² Downgraded 1 level - the cohort study by de Vries et al. (2011) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

Table 3: Question 1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – mental health

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Impact on mental health									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Mean±SD Beck Depression Inventory-II, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones). (Lower scores indicate benefit)									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=41	None	Baseline: 8.31±7.12 GnRH analogue: 4.95±6.72 P=0.004	Critical	VERY LOW
Mean±SD Trait Anger (TPI), time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit)									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=41	None	Baseline: 18.29±5.54 GnRH analogue: 17.88±5.24 P=0.503	Critical	VERY LOW
Mean±SD Trait Anxiety (STAI), time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit)									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=41	None	Baseline: 39.43±10.07 GnRH analogue: 37.95±9.38 P=0.276	Critical	VERY LOW

Abbreviations: GnRH, gonadotrophin releasing hormone; P, P-value; SD, Standard deviation.

1 Downgraded 1 level - the cohort study by de Vries et al. (2011) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

Table 4: Question 1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – body image

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Impact on body image									
Mean±SD Body Image Scale (primary sexual characteristics), time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit)									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=57	None	Baseline: 4.10±0.56 GnRH analogue: 3.98±0.71 P=0.145	Important	VERY LOW
Mean±SD Body Image Scale (secondary sexual characteristics), time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit)									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=57	None	Baseline: 2.74±0.65 GnRH analogue: 2.82±0.68 P=0.569	Important	VERY LOW
Mean±SD Body Image Scale (neutral characteristics), time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit)									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=57	None	Baseline: 2.41±0.63 GnRH analogue: 2.47±0.56 P=0.620	Important	VERY LOW

Abbreviations: GnRH, gonadotrophin releasing hormone; P, P-value; SD, Standard deviation.

1 Downgraded 1 level - the cohort study by de Vries et al. (2011) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

Table 5: Question 1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – psychosocial impact

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Psychosocial impact									
Mean [±SD] Children's Global Assessment Scale score, at baseline, higher scores indicate benefit)									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	n=101 58.72 [±11.38]	n=100 56.63 [±13.14]	P=0.23	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, at 6 months ² (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	n=101 60.89 [±12.17]	n=100 60.29 [±12.81]	P=0.73	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, at 12 months ³ (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	n=60 64.70 [±13.34]	n=61 62.97 [±14.10]	P=0.49	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, at 18 months ⁴ (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	n=35 67.40 [±13.93]	n=36 62.53 [±13.54]	P=0.14	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, participants at 6 months compared to baseline (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=101 N=101	None	Baseline: 58.72±11.38 6 months: 60.89±12.17 P=0.19	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, participants at 12 months compared to baseline (higher scores indicate benefit).									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=101 N=60	None	Baseline: 58.72±11.38 12 months: 64.70±13.34 P=0.003	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, participants at 18 months compared to baseline (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=101 N=35	None	Baseline: 58.72±11.38 18 months: 67.40±13.93 P<0.001	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, participants at 12 months compared to 6 months (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=101 N=60	None	6 months: 60.89±12.17 12 months: 64.70±13.34 P=0.07	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, participants at 18 months compared to 6 months (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=101 N=35	None	6 months: 60.89±12.17 18 months: 67.40±13.93 P<0.001	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, participants at 18 months compared to 12 months (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=60 N=35	None	12 months: 64.70±13.34 18 months: 67.40±13.93 P=0.35	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, in all participants (including those not treated with GnRH analogues) at 6 months² compared to baseline (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=201	None	Baseline: 57.73±12.27 6 months: 60.68±12.47 P<0.001	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, in all participants (including those not treated with GnRH analogues) at 12 months³ compared to baseline (higher scores indicate benefit).									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=201 N=121	None	Baseline: 57.73±12.27 12 months: 63.31±14.41 P<0.001	Important	VERY LOW
Mean±SD Children's Global Assessment Scale score, in all participants (including those not treated with GnRH analogues) at 18 months⁴ compared to baseline (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=201 N=71	None	Baseline: 57.73±12.27 18 months: 64.93±13.85 P<0.001	Important	VERY LOW
Mean±SD Children's Global Assessment Scale score, in all participants (including those not treated with GnRH analogues) at 12 months compared to 6 months (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=201 N=121	None	6 months: 60.68±12.47 12 months: 63.31±14.41 P<0.08	Important	VERY LOW
Mean±SD Children's Global Assessment Scale score, in all participants (including those not treated with GnRH analogues) at 18 months compared to 6 months (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=201 N=71	None	6 months: 60.68±12.47 18 months: 64.93±13.85 P<0.02	Important	VERY LOW
Mean±SD Children's Global Assessment Scale score, in all participants (including those not treated with GnRH analogues) at 18 months compared to 12 months (higher scores indicate benefit).									
1 cohort study Costa et al 2015	Serious limitations ¹	No serious indirectness	No serious inconsistency	Not calculable	N=121 N=71	None	12 months: 63.31±14.41 18 months: 64.93±13.85 P<0.45	Important	VERY LOW
Mean±SD Children's Global Assessment Scale score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, higher scores indicate benefit).									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=41	None	Baseline: 70.24±10.12 GnRH analogue: 73.90±9.63 P=0.005	Important	VERY LOW
Mean±SD Child Behaviour Checklist (total T) score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit).									
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 60.70±12.76 GnRH analogue: 54.46±11.23 P<0.001	Important	VERY LOW
Mean±SD Child Behaviour Checklist (internalising T) score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit).									
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 61.00±12.21 GnRH analogue: 52.1±9.81 P<0.001	Important	VERY LOW
Mean±SD Child Behaviour Checklist (externalising T) score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit).									
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 58.04±12.99 GnRH analogue: 53.81±11.86 P=0.001	Important	VERY LOW
Proportion of adolescents scoring in the clinical range Child Behaviour Checklist total problem scale, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit).									
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 44.4% GnRH analogue: 22.2% P=0.001	Important	VERY LOW
Mean±SD Youth Self-Report (total T) score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormone, lower scores indicate benefit).									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 55.46±11.56 GnRH analogue: 50.00±10.56 P<0.001	Important	VERY LOW
Mean±SD Youth Self-Report (internalising T) score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit).									
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 56.04±12.49 GnRH analogue: 49.78±11.63 P<0.001	Important	VERY LOW
Mean±SD Youth Self-Report (externalising T) score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit).									
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 53.30±11.87 GnRH analogue: 49.98±9.35 P=0.009	Important	VERY LOW
Proportion of adolescents scoring in the clinical range Youth Self-Report (internalising T) score, time point at baseline (before GnRH analogues) versus follow-up (just before gender-affirming hormones, lower scores indicate benefit).									
1 cohort study de Vries et al 2011	Serious limitations ⁵	No serious indirectness	Not applicable	Not calculable	N=54	None	Baseline: 29.6% GnRH analogue: 11.1% P=0.017	Important	VERY LOW
Mean±SD Child Behaviour Checklist score, transfemales (lower scores indicate benefit)									
1 cross-sectional study Staphorsius et al 2015	Serious limitations ⁶	No serious indirectness	Not applicable	Not calculable	N=8	N=10	GnRH analogue: 57.4 [±9.8] No GnRH analogue: 58.2 [±9.3]	Important	VERY LOW
Mean±SD Child Behaviour Checklist score, transmales (lower scores indicate benefit)									
1 cross-sectional study	Serious limitations ⁶	No serious indirectness	Not applicable	Not calculable	N=12	N=10	GnRH analogues: 57.5 [±9.4] No GnRH analogue: 63.9 [±10.5]	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Staphorsius et al 2015									

Abbreviations: GnRH, gonadotrophin releasing hormone; P, P-value; SD, Standard deviation.

1 Downgraded 1 level - the cohort study by Costa et al. (2015) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

2 6 months from baseline (after 6 months of psychological support – both groups).

3 12 months from baseline (delayed eligible gender dysphoria [GD] adolescents, after 12 months of psychological support; immediately eligible GD adolescents, after 12 months of psychological support + 6 months of puberty suppression).

4 18 months from baseline (delayed eligible gender dysphoria [GD] adolescents, after 12 months of psychological support; immediately eligible GD adolescents, after 12 months of psychological support + 6 months of puberty suppression).

5 Downgraded 1 level - the cohort study by de Vries et al. (2011) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

6 Downgraded 1 level - the cohort study by Staphorsius et al. (2015) was assessed as at high risk of bias (poor quality overall; lack of blinding and no randomisation).

Table 6: Question 1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – engagement with healthcare services

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Engagement with healthcare services									
Number (proportion) failing to engage with health care services (did not attend clinic), at (up to) 9 years follow-up									
1 cohort study Brik et al 2018	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	9/214 (4.2%)	None	9 adolescents out of 214 failed to attend clinic and were excluded from the study (4.2%)	Important	VERY LOW
Loss to follow-up									
1 cohort study	Serious limitations ²	No serious indirectness	Not applicable		201	None	The sample size at baseline and 6 months was 201, which dropped by 39.8% to 121 after	Important	VERY LOW

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result	
Costa et al 2015				Not calculable			12 months and by 64.7% to 71 at 18 months follow-up. No explanation of the reasons for loss to follow-up are reported.	

Abbreviations: GnRH, gonadotrophin releasing hormone.

1 Downgraded 1 level - the cohort study by Brik et al. (2018) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

2 Downgraded 1 level - the cohort study by Costa et al. (2015) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

Table 7: Question 1. For children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – stopping treatment

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result	
Stopping treatment								
Number (proportion) stopping GnRH analogues, at (up to) 9 years follow-up								
1 cohort study Brik et al 2018	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	9/143 (6.2%)	None	9/143 adolescents stopped GnRH analogues (6.2%) ²	Important VERY LOW
Number (proportion) stopping from GnRH analogues, at (up to) 13 years follow-up								
1 cohort study Khatchadourian et al 2014	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	11/27 (42%)	None	11/26 stopped GnRH analogues (42%) ⁴	Important VERY LOW
Number (proportion) stopping GnRH analogues but who wished to continue endocrine treatment, at (up to) 9 years follow-up								

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 cohort study Brik et al 2018	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	4/143 (2.8%)	None	4/143 adolescents stopped GnRH analogues but wished to continue treatment (2.8%)	Important	VERY LOW
Number (proportion) stopping GnRH analogues who no longer wished gender-affirming treatment, at (up to) 9 years follow-up									
1 cohort study Brik et al 2018	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	5/143 (3.5%)	None	5/143 adolescents stopped GnRH analogues and no longer wished to continue gender-affirming treatment (3.5%)	Important	VERY LOW

Abbreviations: GnRH, gonadotrophin releasing hormone.

1 Downgraded 1 level - the cohort study by Brik et al. (2018) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

2 Median duration of 0.8 years (range 0.1 to 3.0). Five adolescents stopped treatment because they no longer wished to receive gender-affirming treatment for various reasons. In 4 adolescents (all transmales), although they wanted to continue treatments for gender dysphoria, GnRH analogues were stopped mainly because of adverse effects (such as mood and emotional lability).

3 Downgraded 1 level - the cohort study by Khatchadourian et al. (2014) was assessed as at high risk of bias (poor quality overall; lack of blinding, no control group and high number of participants lost to follow-up).

4 Because of transitioning to gender-affirming hormones or gender-affirming surgery, adverse effects (such as mood and emotional lability) or no longer wishing to pursue transition.

Table 8. Question 2. For children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – bone density

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Bone density: change in lumbar BMAD									
Change in lumbar spine BMAD from baseline to 1 year in transfemales									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 observational study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=31	None	Mean (SD), g/cm ³ Baseline: 0.235 (0.030) 1 year: 0.233 (0.029) p=0.459 z-score Baseline: 0.859 (0.154) 1 year: -0.228 (1.027) p=0.000	IMPORTANT	VERY LOW
Change in lumbar spine BMAD from baseline to 1 year in transmales									
1 observational study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=39	None	Mean (SD), g/cm ³ Baseline: 0.196 (0.035) 1 year: 0.201 (0.033) p=0.074 z-score Baseline: -0.186 (1.230) 1 year: -0.541 (1.396) p=0.006	IMPORTANT	VERY LOW
Change in lumbar spine BMAD from baseline to 2 years in transfemales									
1 observational study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=10	None	Mean (SD), g/cm ³ Baseline: 0.240 (0.027) 2 years: 0.240 (0.030) p=0.865 z-score Baseline: 0.486 (0.809) 2 years: -0.279 (0.930) p=0.000	IMPORTANT	VERY LOW
Change in lumbar spine BMAD from baseline to 2 years in transmales									
1 observational study	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=21	None	Mean (SD), g/cm ³ Baseline: 0.195 (0.058) 2 years: 0.198 (0.055) p=0.433	IMPORTANT	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Joseph et al. (2019)							z-score Baseline: -0.361 (1.439) 2 years: -0.913 (1.318) p=0.001		
Change in lumbar BMAD from starting GnRH analogue (mean age 14.9±1.9) to starting gender-affirming hormones (mean age 16.6±1.4) in transfemales									
1 observational study Klink et al. 2015	Serious limitations ²	No serious indirectness	Not applicable	Not calculable	N=11 N=12	None	Mean (SD), g/cm ³ GnRH analogue: 0.22 (0.03) Gender-affirming hormones: 0.22 (0.02) NS z-score GnRH analogue: -0.44 (1.10) Gender-affirming hormones: -0.90 (0.80) p-value: NS	IMPORTANT	VERY LOW
Change in lumbar BMAD from starting GnRH analogue (mean age 15.0±2.0) to starting gender-affirming hormones (mean age 16.4±2.3) in transmales									
1 observational study Klink et al. 2015	Serious limitations ²	No serious indirectness	Not applicable	Not calculable	N=18	None	Mean (SD), g/cm ³ GnRH analogue: 0.25 (0.03) Gender-affirming hormones: 0.24 (0.02) NS z-score GnRH analogue: 0.28 (0.90) Gender-affirming hormones: -0.50 (0.81) p-value: 0.004	IMPORTANT	VERY LOW
Change in lumbar BMAD from starting GnRH analogue to starting gender-affirming hormones in transfemales (bone age of <15 years)									
1 observational study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=15	None	Median (range), g/cm ³ GnRH analogue: 0.21 (0.17 to 0.25) Gender-affirming hormones: 0.20 (0.18 to 0.24)	IMPORTANT	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
							NS z-score GnRH analogue: -0.20 (-1.82 to 1.18) Gender-affirming hormones: -1.52 (-2.36 to 0.42) p-value: <0.01		
Change in lumbar BMAD from starting GnRH analogue to starting gender-affirming hormones in transfemales (bone age of ≥15)									
1 observational study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=5	None	Median (range), g/cm ³ GnRH analogue: 0.22 (0.18 to 0.25) Gender-affirming hormones: 0.22 (0.19 to 0.24) NS z-score GnRH analogue: -1.18 (-1.78 to 1.09) Gender-affirming hormones: -1.15 (-2.21 to 0.08) p-value: p≤0.1	IMPORTANT	VERY LOW
Change in lumbar BMAD from starting GnRH analogue to starting gender-affirming hormones in transmales (bone age of <14 years)									
1 observational study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=11	None	Median (range), g/cm ³ GnRH analogue: 0.23 (0.20 to 0.29) Gender-affirming hormones: 0.23 (0.19 to 0.28) NS z-score GnRH analogue: -0.05 (-0.78 to 2.94) Gender-affirming hormones: -0.84 (-2.20 to 0.87) p-value: ≤0.01	IMPORTANT	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Change in lumbar spine BMD from baseline to 2 years in transfemales									
1 observational study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=10	None	Mean (SD), kg/m2 Baseline: 0.867 (0.141) 2 years: 0.878 (0.130) p=0.395 z-score Baseline: 0.130 (0.972) 2 years: -0.890 (1.075) p=0.000	IMPORTANT	VERY LOW
Change in lumbar spine BMD from baseline to 2 years in transmales									
1 observational study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=21	None	Mean (SD), kg/m2 Baseline: 0.695 (0.220) 2 years: 0.731 (0.209) p=0.058 z-score Baseline: -0.715 (1.406) 2 years: -2.000 (1.384) p=0.000	IMPORTANT	VERY LOW
Change in lumbar BMD from starting GnRH analogue (mean age 14.9±1.9) to starting gender-affirming hormones (mean age 16.6±1.4) in transfemales									
1 observational study Klink et al. 2015	Serious limitations ²	No serious indirectness	Not applicable	Not calculable	N=12 N=11	None	Mean (SD), g/m2 GnRH analogue: 0.84 (0.13) Gender-affirming hormones: 0.84 (0.11) NS z-score GnRH analogue: -0.77 (0.89) Gender-affirming hormones: -1.01 (0.98) NS	IMPORTANT	VERY LOW
Change in lumbar BMD from starting GnRH analogue (mean age 15.0±2.0) to starting gender-affirming hormones (mean age 16.4±2.3) in transmales									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 observatio nal study Klink et al. 2015	Serious limitations ²	No serious indirectness	Not applicable	Not calculable	N=18	None	Mean (SD), g/m2 GnRH analogue: 0.95 (0.12) Gender-affirming hormones: 0.91 (0.10) p-value: 0.006 z-score GnRH analogue: 0.17 (1.18) Gender-affirming hormones: -0.72 (0.99) p-value: <0.001	IMPORTANT	VERY LOW
Bone density: change in femoral neck (hip) BMD									
Change in femoral neck BMD from baseline to 1 year in transfemales									
1 observatio nal study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=31	None	Mean (SD), kg/m2 Baseline: 0.894 (0.118) 1 year: 0.905 (0.104) p=0.571 z-score Baseline: 0.157 (0.905) 1 year: -0.340 (0.816) p=0.002	IMPORTANT	VERY LOW
Change from baseline to 1 year in femoral neck BMD in transmales									
1 observatio nal study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=39	None	Mean (SD), kg/m2 Baseline: 0.772 (0.137) 1 year: 0.785 (0.120) p=0.797 z-score Baseline: -0.863 (1.215) 1 year: -1.440 (1.075) p=0.000	IMPORTANT	VERY LOW
Change from baseline to 2 years in femoral neck BMD in transfemales									

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result	
1 observational study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=10	None	Mean (SD), kg/m ² Baseline: 0.920 (0.116) 2 years: 0.910 (0.125) p=0.402 z-score Baseline: 0.450 (0.781) 2 years: -0.600 (1.059) p=0.002	IMPORTANT VERY LOW
Change from baseline to 2 years in femoral neck BMD in transmales								
1 observational study Joseph et al. (2019)	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=21	None	Mean (SD), kg/m ² Baseline: 0.766 (0.215) 2 years: 0.773 (0.197) p=0.604 z-score Baseline: -1.075 (1.145) 2 years: -1.779 (0.816) p=0.001	IMPORTANT VERY LOW
Bone density: change in femoral neck (hip) BMAD								
Change from starting GnRH analogue to starting gender-affirming hormones in femoral neck BMAD in transfemales (bone age of <15 years)								
1 observational study Vlot et al. 2017	Serious limitations ³	No serious indirectness	Not applicable	Not calculable	N=16	None	Median (range), g/cm ³ GnRH analogue: 0.29 (0.20 to 0.33) Gender-affirming hormones: 0.27 (0.20 to 0.33) p≤0.1 z-score GnRH analogue: -0.71 (-3.35 to 0.37) Gender-affirming hormones: -1.32 (-3.39 to 0.21) p≤0.1	IMPORTANT VERY LOW
Change in femoral neck BMAD from starting GnRH analogue to starting gender-affirming hormones in transfemales (bone age of ≥15)								

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY	
					No of events/No of patients% (n/N%)				Effect
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
							GnRH analogue: 0.27 (-1.39 to 1.32) Gender-affirming hormones: -0.27 (-1.91 to 1.29) p-value: ≤0.01		
Bone density: change in femoral area BMD									
Change in femoral BMD from starting GnRH analogue (mean age 14.9±1.9) to starting gender-affirming hormones (mean age 16.6±1.4) in transfemales									
1 observational study Klink et al. 2015	Serious limitations ²	No serious indirectness	Not applicable	Not calculable	N=14 N=6	None	Mean (SD), g/m2 GnRH analogue: 0.88 (0.12) Gender-affirming hormones: 0.87 (0.08) NS z-score GnRH analogue: -0.66 (0.77) Gender-affirming hormones: -0.95 (0.63) NS	IMPORTANT	VERY LOW
Change in femoral BMD from starting GnRH analogue (mean age 15.0±2.0) to starting gender-affirming hormones (mean age 16.4±2.3) in transmales									
1 observational study Klink et al. 2015	Serious limitations ²	No serious indirectness	Not applicable	Not calculable	N=18 N=13	None	Mean (SD), g/m2 GnRH analogue: 0.92 (0.10) Gender-affirming hormones: 0.88 (0.09) p-value: 0.005 z-score GnRH analogue: 0.36 (0.88) Gender-affirming hormones: -0.35 (0.79) p-value: 0.001	IMPORTANT	VERY LOW
Bone density: change in femoral area BMAD									
Change in femoral BMAD from starting GnRH analogue (mean age 14.9±1.9) to starting gender-affirming hormones (mean age 16.6±1.4) in transfemales									

Table 9 Question 2: For children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – cognitive development or functioning

QUALITY					Summary of findings		IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)	Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result	
Cognitive development or functioning (1 cross-sectional study)								
IQ (4 subscales: arithmetic, vocabulary, picture arrangement, and block design) at a single time point between GnRH analogue treated and untreated transfemales								
1 Cross-sectional study Staphorsius et al. 2015	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=8 Mean (SD) 94.0 (10.3)	N=10 Mean (SD) 109.4 (21.2)	NR	IMPORTANT VERY LOW
IQ (4 subscales: arithmetic, vocabulary, picture arrangement, and block design) at a single time point between GnRH analogue treated and untreated transmales								
1 Cross-sectional study Staphorsius et al. 2015	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=12 Mean (SD) 95.8 (15.6)	N=10 Mean (SD) 98.5 (15.9)	NR	IMPORTANT VERY LOW
Reaction time at a single time point between GnRH analogue treated and untreated transfemales								
1 Cross-sectional study Staphorsius et al. 2015	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=8 Mean (SD) 10.9 (4.1)	N=10 Mean (SD) 9.9 (3.1)	NR	IMPORTANT VERY LOW
Reaction time at a single time point between GnRH analogue treated and untreated transmales								
1 Cross-sectional study	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=12 Mean (SD) 9.9 (3.1)	N=10 Mean (SD) 10.0 (2.0)	NR	IMPORTANT VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Staphorsius et al. 2015									
Accuracy at a single time point between GnRH analogue treated and untreated transfemales									
1 cohort study Staphorsius et al. 2015	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=8 Mean (SD) 73.9 (9.1)	N=10 Mean (SD) 83.4 (9.5)	NR	IMPORTANT	VERY LOW
Accuracy at a single time point between GnRH analogue treated and untreated transmales									
1 cohort study Staphorsius et al. 2015	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=12 Mean (SD) 85.7 (10.5)	N=10 Mean (SD) 88.8 (9.7)	NR	IMPORTANT	VERY LOW

Abbreviations: GnRH, gonadotrophin releasing hormone; NR, not reported; P, P-value; SD, Standard deviation.

¹ Downgraded 1 level - the cohort study by Staphorsius et al. (2015) was assessed as at high risk of bias (poor quality overall; lack of blinding and no randomisation).

Table 10: Question 2: In children and adolescents with gender dysphoria, what is the short-term and long-term safety of GnRH analogues compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention? – other safety outcomes

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
Other safety outcomes: change in serum creatinine									
Change in serum creatinine (micromol/l) between baseline and 1 year in transfemales									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients% (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Intervention	Comparator	Result		
1 observational study Schagen et al. 2016	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=28	None	Mean (SD) Baseline: 70 (12) 1 year: 66 (13) p-value: 0.20	IMPORTANT	VERY LOW
Change in serum creatinine (μmol/l) between baseline and 1 year in transmales									
1 observational study Schagen et al. 2016	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	N=29	None	Mean (SD) Baseline: 73 (8) 1 year: 68 (13) p-value: 0.01	IMPORTANT	VERY LOW
Other safety outcomes: liver enzymes									
Presence of elevated liver enzymes (AST, ALT, and glutamyl transferase) between baseline and during treatment									
1 observational study Schagen et al. 2016	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	39	None	Glutamyl transferase was not elevated at baseline or during treatment in any subject. Mild elevations of AST and ALT above the reference range were present at baseline but were not more prevalent during treatment than at baseline. Glutamyl transferase, AST, and ALT levels did not significantly change from baseline to 12 months of treatment.	IMPORTANT	VERY LOW
Other safety outcomes: adverse effects									
Proportion of patients reporting adverse effects									
1 cohort study Khatchadourian et al 2014	Serious limitations ²	No serious indirectness	Not applicable	Not calculable ²	27	None	3/27 adolescents ³	Important	VERY LOW

Abbreviations: ALT, alanine aminotransferase; AST, aspartate aminotransferase; GnRH, gonadotrophin releasing hormone; P, P-value; SD, standard deviation.

1 Downgraded 1 level - the cohort study by Schagen et al. (2016) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control).

2 Downgraded 1 level - the cohort study by Khatchadourian et al. (2014) was assessed as at high risk of bias (poor quality overall; lack of blinding, no control group and high number of participants lost to follow-up).

3 1 transmale developed sterile abscesses; they were switched from leuprolide acetate to triptorelin, and this was well tolerated. 1 transmale developed leg pains and headaches, which eventually resolved without treatment. 1 participant gained 19 kg within 9 months of initiating GnRH analogues.

Table 11: Question 4. From the evidence selected, are there any subgroups of children and adolescents with gender dysphoria that may derive more (or less) advantage from treatment with GnRH analogues than the wider population of children and adolescents with gender dysphoria? – critical outcomes

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Sex assigned at birth males	Sex assigned at birth females	Result		
Subgroups: sex assigned at birth males compared with sex assigned at birth females									
Impact on gender dysphoria									
Mean [±SD] Utrecht Gender Dysphoria Scale (version(s) not reported), time point at baseline (before GnRHa) versus follow-up (just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ² score at T0 47.95 [±9.70] score at T1 49.67 [±9.47]	n-NR ² score at T0 56.57 [±3.89] score at T1 56.62 [±4.0]	F-ratio 15.98 (df, errdf: 1,39), P<0.001	Critical	VERY LOW
Impact on mental health									
Mean [±SD] Beck Depression Inventory-II, time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Sex assigned at birth males	Sex assigned at birth females	Result		
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ² score at T0 5.71 [±4.31] score at T1 3.50 [±4.58]	n-NR ² score at T0 10.34 [±8.24] score at T1 6.09 [±7.93]	F-ratio 3.85 (df, errdf: 1,39), P=0.057	Critical	VERY LOW
Mean [±SD] Trait Anger (TPI), time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ² score at T0 5.22 [±2.76] score at T1 5.00 [±3.07]	n-NR ² score at T0 6.43 [±2.78] score at T1 6.39 [±2.59]	F-ratio 5.70 (df, errdf: 1,39), P=0.022	Critical	VERY LOW
Mean [±SD] Trait Anxiety (STAI), time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ² score at T0 4.33 [±2.68] score at T1 4.39 [±2.64]	n-NR ² score at T0 7.00 [±2.36] score at T1 6.17 [±2.69]	F-ratio 16.07 (df, errdf: 1,39), P<0.001	Critical	VERY LOW

Abbreviations: GnRH, gonadotrophin releasing hormone; NR, not reported; P, P-value; SD, Standard deviation.

¹ Downgraded 1 level - the cohort study by de Vries et al. (2011) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

² The overall sample size completing the outcome at both time points was 41.

Table 11: Question: 4. From the evidence selected, are there any subgroups of children and adolescents with gender dysphoria that may derive more (or less) advantage from treatment with GnRH analogues than the wider population of children and adolescents with gender dysphoria? – important outcomes

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Sex assigned at birth males	Sex assigned at birth females	Result		
Subgroups: sex assigned at birth males compared with sex assigned at birth females									
Impact on body image									
Mean [\pmSD] Body Image Scale (primary sexual characteristics), time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ² score at T0 4.02 [\pm 0.16] score at T1 3.74 [\pm 0.78]	n-NR ² score at T0 4.16 [\pm 0.52] score at T1 4.17 [\pm 0.58]	F-ratio 4.11 (df, errdf: 1,55), P=0.047	Important	VERY LOW
Mean [\pmSD] Body Image Scale (secondary sexual characteristics), time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ² score at T0 2.66 [\pm 0.50] score at T1 2.39 [\pm 0.69]	n-NR ² score at T0 2.81 [\pm 0.76] score at T1 3.18 [\pm 0.42]	F-ratio 11.57 (df, errdf: 1,55), P=0.001 ³	Important	VERY LOW
Mean [\pmSD] Body Image Scale (neutral characteristics), time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
					Sex assigned at birth males	Sex assigned at birth females	Result		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision					
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ² score at T0 2.60 [±0.58] score at T1 2.32 [±0.59]	n-NR ² score at T0 2.24 [±0.62] score at T1 2.61 [±0.50]	F-ratio 0.081 (df, errdf: 1,55), P=0.777 ³	Important	VERY LOW
Psychosocial impact									
Mean [±SD] Children's Global Assessment Scale score, at baseline.									
1 cohort study Costa et al 2015	Serious limitations ⁴	No serious indirectness	No serious inconsistency	Not calculable	n=not reported 55.4 [±12.7]	n=not reported 59.2 [±11.8]	t-test 2.15; P=0.03 ⁵	Important	VERY LOW
Mean [±SD] Children's Global Assessment Scale score, time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ⁶ score at T0 73.10 [±8.84] score at T1 77.33 [±8.69]	n-NR ⁶ score at T0 67.25 [±11.06] score at T1 70.30 [±9.44]	F-ratio 5.77 (df, errdf: 1,39), P=0.021	Important	VERY LOW
Mean [±SD] Child Behaviour Checklist (total T) score, time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ⁷ score at T0 59.42 [±11.78] score at T1 50.38	n-NR ⁷ score at T0 61.73 [±13.60]	F-ratio 2.64 (df, errdf: 1,52), P=0.110	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Sex assigned at birth males	Sex assigned at birth females	Result		
					[±10.57]	score at T1 57.73 [±10.82]			
Mean [±SD] Child Behaviour Checklist (internalising T) score, time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ⁷ score at T0 60.00 [±9.51] score at T1 52.17 [±9.81]	n-NR ⁷ score at T0 61.80 [±14.12] score at T1 56.30 [±10.33]	F-ratio 1.16 (df, errdf: 1,52), P=0.286	Important	VERY LOW
Mean [±SD] Child Behaviour Checklist (externalising T) score, time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ⁷ score at T0 54.71 [±12.91] score at T1 48.75 [±10.22]	n-NR ⁷ score at T0 60.70 [±12.64] score at T1 57.87 [±11.66]	F-ratio 6.29 (df, errdf: 1,52), P=0.015	Important	VERY LOW
Mean [±SD] Youth Self-Report (total T) score, time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ⁷ score at T0 53.56 [±12.26] score at T1 47.84 [±10.86]	n-NR ⁷ score at T0 57.10 [±10.87] score at T1 51.86 [±10.11]	F-ratio 1.99 (df, errdf: 1,52), P=0.164	Important	VERY LOW

QUALITY					Summary of findings			IMPORTANCE	CERTAINTY
					No of events/No of patients (n/N%)		Effect		
Study	Risk of bias	Indirectness	Inconsistency	Imprecision	Sex assigned at birth males	Sex assigned at birth females	Result		
Mean [±SD] Youth Self-Report (internalising T) score, time point at baseline (T0 before GnRH analogues) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ⁷ score at T0 55.88 [±11.81] score at T1 49.24 [±12.24]	n-NR ⁷ score at T0 56.17 [±13.25] score at T1 50.24 [±11.28]	F-ratio 0.049 (df, errdf: 1,52), P=0.825	Important	VERY LOW
Mean [±SD] Youth Self-Report (externalising T) score, time point at baseline (T0 before GnRHa) versus follow-up (T1 just before gender-affirming hormones).									
1 cohort study de Vries et al 2011	Serious limitations ¹	No serious indirectness	Not applicable	Not calculable	n-NR ⁷ score at T0 48.72 [±11.83] score at T1 46.52 [±9.23]	n-NR ⁷ score at T0 57.24 [±10.59] score at T1 52.97 [±8.51]	F-ratio 9.14 (df, errdf: 1,52), P=0.004	Important	VERY LOW

Abbreviations: GnRH, gonadotrophin releasing hormone; NR, not reported; P, P-value; SD, Standard deviation.

1 Downgraded 1 level - the cohort study by de Vries et al. (2011) was assessed as at high risk of bias (poor quality overall; lack of blinding and no control group).

2 The overall sample size completing the outcome at both time points was 57.

3 There was a significant interaction effect between sex assigned at birth and BDI between T0 and T1; sex assigned at birth females became more dissatisfied with their secondary F (df, errdf), P: 14.59 (1,55), P<0.001) and neutral F (df, errdf), P: 15.26 (1,55), P<0.001) sex characteristics compared with sex assigned at birth males.

4 Serious limitations – the cohort study by Costa et al. 2015 was assessed as at high risk of bias (poor quality).

5 At baseline, CGAS scores were not associated with any demographic variable, in both sex assigned at birth males and females. There were no statistically significant differences in CGAS scores between gender dysphoric sex assigned at birth males and females in all follow-up evaluations (P>0.1; full data not reported).

6 The overall sample size completing the outcome at both time points was 41

7 The overall sample size completing the outcome at both time points was 54.

Glossary

Beck Depression Inventory-II (BDI-II)	The BDI-II is a tool for assessing depressive symptoms. There are no specific scores to categorise depression severity, but it is suggested that 0 to 13 is minimal symptoms, 14 to 19 is mild depression, 20 to 28 is moderate depression, and severe depression is 29 to 63.
Body Image Scale (BIS)	The BIS is used to measure body satisfaction. The scale consists of 30 body features, which the person rates on a 5-point scale. Each of the 30 items falls into one of 3 basic groups based on its relative importance as a gender-defining body feature: primary sex characteristics, secondary sex characteristics, and neutral body characteristics. A higher score indicates more dissatisfaction.
Bone mineral apparent density (BMAD)	BMAD is a size adjusted value of bone mineral density (BMD) incorporating body size measurements using UK norms in growing adolescents.
Child Behaviour Checklist (CBCL)	CBCL is a checklist parents complete to detect emotional and behavioural problems in children and adolescents.
Children's Global Assessment Scale (CGAS)	The CGAS tool is a validated measure of global functioning on a single rating scale from 1 to 100. Lower scores indicate poorer functioning.
Gender	The roles, behaviours, activities, attributes, and opportunities that any society considers appropriate for girls and boys, and women and men.
Gender dysphoria	Discomfort or distress that is caused by a discrepancy between a person's gender identity (how they see themselves regarding their gender) and that person's sex assigned at birth (and the associated gender role, and/or primary and secondary sex characteristics).
Gonadotrophin releasing hormone (GnRH) analogues	GnRH analogues competitively block GnRH receptors to prevent the spontaneous release of 2 gonadotropin hormones, Follicular Stimulating Hormone (FSH) and Luteinising Hormone (LH) from the pituitary gland. The reduction in FSH and LH secretion reduces oestradiol secretion from the ovaries in those whose sex assigned at birth was female and testosterone secretion from the testes in those whose sex assigned at birth was male.
Sex assigned at birth	Sex assigned at birth (male or female) is a biological term and is based on genes and how external and internal sex and reproductive organs work and respond to hormones. Sex is the label that is recorded when a baby's birth is registered.
Tanner stage	Tanner staging is a scale of physical development.
Trait Anger Spielberger scales of the State-Trait Personality Inventory (TPI)	The TPI is a validated 20-item inventory tool which measures the intensity of anger as the disposition to experience angry feelings as a personality trait. Higher scores indicate greater anger.
Transgender (including transmale and transfemale)	Transgender is a term for someone whose gender identity is not congruent with their birth-registered sex. A transmale is a person who identifies as male and a transfemale is a person who identifies as female.

Utrecht Gender Dysphoria Scale (UGDS)	The UGDS is a validated screening tool for both adolescents and adults to assess gender dysphoria. It consists of 12 items, to be answered on a 1- to 5-point scale, resulting in a sum score between 12 and 60. The higher the UGDS score the greater the impact on gender dysphoria.
Youth Self-Report (YSR)	The self-administered YSR is a checklist to detect emotional and behavioural problems in children and adolescents. It is self-completed by the child or adolescent. The scales consist of a Total problems score, which is the sum of the scores of all the problem items. An internalising problem scale sums the anxious/depressed, withdrawn-depressed, and somatic complaints scores while the externalising problem scale combines rule-breaking and aggressive behaviour.

References

Included studies

- [Brik T, Vrouwenraets L, de Vries M et al. \(2020\). Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. Archives of Sexual Behaviour. \[Accessed 6 August 2020\]](#)
- Costa R, Dunsford M, Skagerberg E et al. (2015) Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*. [online] Volume 12(11), Pages 2206-2214. Available at: <https://doi.org/10.1111/jsm.13034> [Accessed 7 August 2020]
- [de Vries A, Steensma T, Doreleijers T et al. \(2011\) Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study. The Journal of Sexual Medicine Volume 8, Issue 8, August, Pages 2276-2283. \[Accessed 11 August 2020\].](#)
- Joseph T, Ting J, Butler G (2019) The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: findings from a large national cohort. *Journal of pediatric endocrinology & metabolism* 32(10): 1077-1081
- [Khatchadourian K, Shazhan A, Metzger D. \(2014\) Clinical Management of Youth with Gender Dysphoria in Vancouver. The Journal of Pediatrics. Volume 164, Issue 4, April, Pages 906-911. \[Accessed 14 August 2020\]](#)
- Klink D, Caris M, Heijboer A et al. (2015) Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *The Journal of clinical endocrinology and metabolism* 100(2): e270-5
- Schagen SEE, Cohen-Kettenis PT, Delemarre-van de Waal HA et al. (2016) Efficacy and Safety of Gonadotropin-Releasing Hormone Agonist Treatment to Suppress Puberty in Gender Dysphoric Adolescents. *The journal of sexual medicine* 13(7): 1125-32
- [Staphorsius A, Baudewijntje P, Kreukels P, et al. \(2015\) Puberty suppression and executive functioning: An fMRI-study in adolescents with gender dysphoria. Psychoneuroendocrinology Volume 56. Pages 190-199. \[Accessed 10 August 2020\]](#)

- Vlot, Mariska C, Klink, Daniel T, den Heijer, Martin et al. (2017) Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. Bone 95: 11-19

Other references

- World Health Organisation (2018) International Classification of Diseases 11. Available from <https://icd.who.int/> [online; accessed 20 August 2020]
- [American Psychiatric Association. \(2013\). Diagnostic and statistical Manual of Mental Disorders \(DSM-5\) \(5th ed\).](#) Washington, DC and London: American Psychiatric Publishing. pp.451-460. [accessed 20 August 2020]
- [NHS England \(2013\). NHS Standard contract for gender identity development service for children and adolescents](#) [accessed 20 August 2020]

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Guideline Regarding Hormonal Treatment of Minors with Gender Dysphoria at Tema Barn - Astrid Lindgren Children's Hospital (ALB).

Background

The hormonal treatment of children and adolescents with gender dysphoria may consist of puberty-blocking treatment which may be initiated at the onset of puberty, and cross-sex hormones which may be initiated at the age of 16. These treatments are controversial and have recently become subject to increased attention and scrutiny both nationally and internationally.

In December 2019, the SBU (*Swedish Agency for Health Technology Assessment and Assessment of Social Services*) published an overview of the knowledge base which showed a lack of evidence for both the long-term consequences of the treatments, and the reasons for the large influx of patients in recent years. In October 2020, NICE (*The National Institute for Health and Care Excellence, UK*) also performed an evidence review of GnRHa (*puberty blocker*) and of cross-sex hormone treatments of children and adolescents with gender dysphoria. Taken together, they show that the studies conducted to date are small, uncontrolled observational studies providing low quality evidence that the treatments have the desired effect, and that we have very little knowledge about their safety in the long term.

A highly publicized court case from Great Britain has shed light on this issue and in a judgment from December 1st, 2020 the court establishes the overarching problem of puberty-blocking treatment and that informed consent for this treatment is highly doubtful, if at all possible, under 16 years of age. For ages between 16 and 18, the court considers it advisable to request a court approval before starting hormonal treatment, since the treatment should be regarded as experimental. As a result of this ruling, the NHS (*National Health Service*) discontinued initiating hormonal treatments in new cases of individuals under 16, while recommending a thorough review of ongoing actively treated cases. For patients between ages 16 and 18, it is recommended that the treating physician receives court approval before cross-sex hormones are initiated. During the Spring of 2020 the NHS changed its public stance regarding puberty blocking treatment, from considering it fully reversible, to now describing it as having uncertain long-term consequences. Following the above-mentioned ruling, the NHS changed their guidelines to no longer initiate hormonal treatment of gender dysphoria in patients under 16 years of age.

These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. This makes it challenging to assess the risk / benefit for the individual patient, and even more challenging for the minors or their guardians to be in a position of an informed stance regarding these treatments.

- In light of the above, and based on the precautionary principle, which should always be applied, the ALB will not initiate hormonal treatment (*i.e., puberty blocking and cross-sex hormones, see above*) for patients with gender dysphoria.
- Hormonal treatment will only be allowed to take place in a clinical trial setting that received ethical approval by the EPM (*Ethical Review Agency/Swedish Institutional Review Board*). The patient must receive comprehensive information about potential risks of the treatment, and a careful assessment of the patient's maturity level must be conducted to determine if the patient is capable of taking an informed stance on, and consenting to, the treatment.
- These changes are effective as of May 1, 2021.

For patients currently treated with puberty blockade or cross-sex hormones, a careful individual assessment to determine whether treatment should be stopped or continued must be performed by the physician responsible for the patient. In such an assessment, it is important to present adequate information about the uncertainty in the state of evidence regarding long-term effects and potential risks of the treatment, in order to make it possible for patients and guardians to make an assessment, and an as well-informed decision as possible, about consenting to a potential continued treatment. The young patients' degree of maturity in their ability to consent, and remaining indication should factor into this decision.

Signed by:

Fredrika Gauffin, Head of Operations, Högspecialiserad Barnmedicin 2 (*Highly Specialized Children's Medicine, Subgroup 2*)

Svante Norgren, Head of Astrid Lindgren Children's Hospital

Lars Sävendahl, Head of Research and Development, Astrid Lindgren Children's Hospital

References:

SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services). "[Könsdysfori hos barn och unga - En kunskapskartläggning" rapport 307](#). ("[Gender Dysphoria in Children and Adolescents - An overview of the literature" report 307](#).) Record Number: SBU 2019/427

Judgement in the Great Britain court case:

<https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf>

NHS change in procedure after the ruling:

<https://www.england.nhs.uk/wp-content/uploads/2020/12/Amendment-to-Gender-Identity-Development-Service-Specification-for-Children-and-Adolescents.pdf>

NICE reports:

Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria

<https://arms.nice.org.uk/resources/hub/1070905/attachment>

Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria

<https://arms.nice.org.uk/resources/hub/1070871/attachment>

Selection of articles where potential risks of the treatment are described:

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GO. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017 Nov 1; 102(11):3869-3903. doi: 10.1210/jc.2017-01658.

Nota NM, Wiepjes CM, de Blok CJM, Gooren LJG, Kreukels BPC, den Heijer M. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*. 2019 Mar 12;139(11):1461-1462. doi: 10.1161/CIRCULATIONAHA.118.038584. PMID: 30776252.

Meyer G, Boczek U, Bojunga J. Hormonal Gender Reassignment Treatment for Gender Dysphoria. *Dtsch Arztebl Int*. 2020 Oct 23; 117(43):725-732. doi: 10.3238/arztebl.2020.0725. PMID: 33559593; PMCID: PMC7871443.

Mayhew AC, Gomez-Lobo V. Fertility Options for the Transgender and Gender Nonbinary Patient. *J Clin Endocrinol Metab*. 2020 Oct 1;105(10):3335-45. doi: 10.1210/clinem/dgaa529. PMID: 32797184; PMCID: PMC7455280.

Cheng PJ, Pastuszak AW, Myers JB, Goodwin IA, Hotaling JM. Fertility concerns of the transgender patient. *Transl Androl Urol*. 2019 Jun;8(3):209-218. doi: 10.21037/tau.2019.05.09. PMID: 31380227; PMCID: PMC6626312.

Nota NM, Wiepjes CM, de Blok CJM, Gooren LJG, Peerdeman SM, Kreukels BPC, den Heijer M. The occurrence of benign brain tumours in trans gender individuals during cross-sex hormone treatment. *Brain*. 2018 Jul 1;141(7):2047-2054. doi: 10.1093/brain/awy108. PMID: 29688280.

Stevenson MO, Tangpricha V. Osteoporosis and Bone Health in Transgender Persons. *Endocrinol Metab Clin North Am*. 2019 Jun;48(2):421-427. doi: 10.1016/j.ecl.2019.02.006. Epub 2019 Mar 23. PMID: 31027549; PMCID: PMC6487870.



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Recommendation of the Council for Choices in Health Care in Finland (PALKO / COHERE Finland)

Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors



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Concepts

Suppression treatment	Pubertal suppression with GnRH analogues (drugs that inhibit gonadotropin-releasing hormone activity) to halt the development of secondary sex characteristics of the biological sex.
Cisgender/Cis person	A person whose gender identity matches the sex determined at birth (identifies, and is satisfied with, the sex determined at birth and generally expresses his/her gender accordingly).
Other gender identity	A person who does not identify as a man or a woman, but rather somewhere along the continuum or outside of it; genderless, nonbinary, or multigendered.
Transgender	A person whose gender identity differs from the legal and biological sex determined at birth but instead aligns with the opposite sex.



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1. Basis for Preparing These Recommendations

As the number of patients, including minors, referred to the Helsinki University Hospital (HUS) and the Tampere University Hospital (TAYS) multidisciplinary outpatient clinics for assessment and treatment of gender dysphoria has increased, PALKO (Council for Choices in Healthcare in Finland / COHERE Finland) decided to prepare recommendations for medical treatments of gender dysphoria, i.e., distress which is associated with a minor's gender variance and impairs function. Gender variance refers to a spectrum of gender experience anywhere on the male-female identity continuum or outside it, and is not exclusively confined to the dichotomized male/female conception of gender. Not all patients with gender variance experience significant suffering or functional impairments, and not all seek medical treatment.

These recommendations are based on the legislation in force at the time of the adoption of the recommendation, the available research evidence, and the clinical experience of multidisciplinary teams with expertise in gender dysphoria assessment and treatment at HUS and TAYS. The knowledge base supporting these recommendations is detailed in a separate Preparatory Memorandum and appendices and includes a description of planning and implementation of medical treatments, a literature review of medical treatments, an extensive ethical analysis, and feedback following meetings with patients and the advocacy groups who represent them.

Finnish legislation defines the requirements for the legal gender recognition of transsexuals (Act on Legal Recognition of the Gender of Transsexuals (Trans Act) 536/2002). The detailed requirements for providing the assessment and treatment to enable legal gender recognition are spelled out further in a Decree of the Ministry of Social Affairs and Health (1053/2002). The Trans Act and the related Decree apply to adults. For those who are not of legal age, there are no laws governing the provision and needs of transgender healthcare; however, these are subject to the Health Care Act of Finland (1326/2010), in particular section 7 (criteria for integrated care), section 7a (criteria for treatment options), section 8 (evidence-based, high quality, safe and appropriate care) and section 10 (rationale for centralization); and also to the Constitution of Finland (731/1999)'s section 6 on equality and section 19 on the right to adequate social and healthcare services. Finland's Act on the Status and Rights of Patients, (785/1992), and especially sections 5, 6, and 7, are also relevant.



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2. Recommendations' Target Population

These recommendations apply to minors suffering from dysphoria related to gender variance who are seeking a consultation regarding an evaluation of medical examination and treatment needs; the children and adolescents may identify with the opposite sex (transgender), or may identify as genderless, non-binary, or anywhere along or outside the male/female gender identity continuum (other gender).

3. Procedures Assessed

These recommendations focus on medical treatment procedures that aim to decrease suffering and functional impairment of gender-dysphoric minors.

4. Current Care

Cross-sex identification in childhood, even in extreme cases, generally disappears during puberty. However, in some cases, it persists or even intensifies. Gender dysphoria may also emerge or intensify at the onset of puberty. There is considerable variation in the timing of the onset of puberty in both sexes. The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders.

Consultation appointments (for parents / caregivers) regarding pre-pubescent children's cross-sex identification or gender dysphoria are provided by the research group on the gender identity of minors at TAYS or HUS. However, ongoing support or other treatment of psychiatric disorders are provided through the local municipal services.

In clear cases of pre-pubertal onset of gender dysphoria that intensified during puberty, a referral can be made for an assessment by the research group at TAYS or HUS regarding the appropriateness for puberty suppression. If no contraindications to early intervention are identified, pubertal suppression with GnRH analogues (to suppress the effect of gonadotropin-releasing hormone) may be considered to prevent further development of secondary sex characteristics of the biological sex.

Adolescents who have already undergone puberty, whose gender dysphoria occurs in the absence of co-occurring symptoms requiring psychiatric treatment, and whose experience of transgender identity failed to resolve following a period of reflection, can be referred for assessment by the research group on the gender identity of minors at TAYS or HUS. Hormone therapy (testosterone/estrogen and anti-androgen) can be started after the diagnostic evaluations, but no earlier than age 16. Additionally, patients under 18 receive three to six months of GnRH analogue treatment prior to the initiation of cross-sex hormones in order to suppress the hormonal activity of the gonads. No gender confirmation surgeries are performed on minors.



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5. Risks, Benefits and Uncertainty

The literature review identified two studies with the total of 271 persons diagnosed with childhood-onset gender identity disorder and associated gender or body dysphoria that intensified after the onset of puberty (Preparatory Memorandum Appendix 1, Tables 15 and 16, pages 46-48).

In a smaller study of 70 adolescents, puberty was suppressed with the GnRH analogue at the average age of 14.8 (12-18 years) and puberty blockade continued for an average of 2 years. During the treatment period, the adolescents' mood improved, and the risk of behavioral disorders diminished, but gender dysphoria itself did not diminish, and there were no changes in body image. In a larger study consisting of 201 adolescents, 101 patients with the average age of 15.5 (12-18 years) started an 18-month psychological supportive intervention, and, additionally at six months, pubertal development was suppressed by starting GnRH analogue treatment. The other cohort of 100 only received psychological supportive intervention for 18 months. In both groups, statistically significant increases in global psychosocial functioning were found at 12 and 18 months; among those having received psychological intervention alone, the improvement in global functioning was already significant at the 6-month mark. Both studies lack long-term treatment follow-up into adulthood.

A recent Finnish study, published after the completion of this literature review, reported on the effect of initiating cross-sex hormone therapy on functioning, progression of developmental tasks of adolescence, and psychiatric symptoms. This study found that during cross-sex hormone therapy, problems in these areas did not decrease.

Potential risks of GnRH therapy include disruption in bone mineralization and the as yet unknown effects on the central nervous system. In trans girls, early pubertal suppression inhibits penile growth, requiring the use of alternative sources of tissue grafts for a potential future vaginoplasty. The effect of pubertal suppression and cross-sex hormones on fertility is not yet known.

6. Ethical Assessment

Although the ethics analysis did not systematically address the issues pertaining to children and adolescents, they have been discussed in several areas in the related documents (Preparatory Memorandum pages 52-62; Appendix 5).

According to the Health Care Act (section 8), healthcare services must be based on evidence and recognized treatment and operational practices. As far as minors are concerned, there are no medical treatment that can be considered evidence-based. At the same time, the numbers of minors developing gender dysphoria has increased. In this situation, it is vital to assure that children and young people are able to talk about their feelings, and that their feelings are acknowledged. The opportunity to reflect on one's experience should be easily accessible through the local health system (i.e., school or student health care, primary care). A young

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person's feelings should not be interpreted as immediately requiring specialized medical examinations or treatments.

In cases of children and adolescents, ethical issues are concerned with the natural process of adolescent identity development, and the possibility that medical interventions may interfere with this process. It has been suggested that hormone therapy (e.g., pubertal suppression) alters the course of gender identity development; i.e., it may consolidate a gender identity that would have otherwise changed in some of the treated adolescents. The reliability of the existing studies with no control groups is highly uncertain, and because of this uncertainty, no decisions should be made that can permanently alter a still-maturing minor's mental and physical development.

From the point of view of patient advocacy groups, halting puberty is providing young people with a period of reflection, rather than consolidating their gender identity. This is based on the premise that halting the development of one's permanent sex characteristics will improve the minor's social interactions, while allowing more time for diagnostic evaluations. Additionally, patient advocacy groups assert that early intervention with hormonal treatments will lead to improved outcomes for the patients who do eventually pursue gender reassignment. Professionals, for their part, consider it important to ensure that irreversible interventions, which may also have significant adverse effects, both physical and mental, are only performed on individuals who are able to understand the permanence of the changes and the potential for harm, and who are unlikely to regret such interventions. It is not known how the hormonal suppression of puberty affects young people's judgement and decision-making.

The Act on the Status and Rights of Patients (1992/785) states that the patient shall be provided with information about his/her state of health, the significance of the treatment, various alternative forms of treatment and their effects, and about other factors concerning treatment that have an effect on treatment decision-making. In a situation where a minor's identification with the opposite sex causes long-term and severe dysphoria, it is important to make sure that he/she understands the realistic potential of gender reassignment treatments to alter secondary sex characteristics, the reality of a lifelong commitment to medical therapy, the permanence of the effects, and the possible physical and mental adverse effects of the treatments. Although patients may experience regret, after reassignment treatments, there is no going back to the non-reassigned body and its normal functions. Brain development continues until early adulthood – about age 25, which also affects young people's ability to assess the consequences of their decisions on their own future selves for rest of their lives.

A lack of recognition of comorbid psychiatric disorders common among gender-dysphoric adolescents can also be detrimental. Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment. A young person's identity and personality development must be stable so that they can genuinely face and discuss their gender dysphoria, the significance of their own feelings, and the need for various treatment options.

For children and adolescents, these factors are key reasons for postponing any interventions until adulthood.

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7. Conclusions

The first-line intervention for gender variance during childhood and adolescent years is psychosocial support and, as necessary, gender-explorative therapy and treatment for comorbid psychiatric disorders. Uncertainty related to gender identity should be dealt with according to the severity of symptoms and the need for treatment and should be handled at the school / student health care, primary health care at the local level, or in specialty care.

In adolescents, psychiatric disorders and developmental difficulties may predispose a young person to the onset of gender dysphoria. These young people should receive treatment for their mental and behavioral health issues, and their mental health must be stable prior to the determination of their gender identity.

Clinical experience reveals that autistic spectrum disorders (ASD) are overrepresented among adolescents suffering from gender dysphoria; even if such adolescents are presenting with gender dysphoria, rehabilitative interventions for ASD must be properly addressed.

In light of available evidence, gender reassignment of minors is an experimental practice. Based on studies examining gender identity in minors, hormonal interventions may be considered before reaching adulthood in those with firmly established transgender identities, but it must be done with a great deal of caution, and no irreversible treatment should be initiated. Information about the potential harms of hormone therapies is accumulating slowly and is not systematically reported. It is critical to obtain information on the benefits and risks of these treatments in rigorous research settings.

At a minimum, a consultation for a pre- pubescent child at the specialist setting at the TAYS includes an extensive assessment appointment costing EUR 369. If necessary, a day-long outpatient consultation can be arranged, costing EUR 1,408.

The consultation and assessment process for minors at the specialist settings of TAYS or HUS costs EUR 4,300. If it is determined that this process would be untimely, the minimum cost is EUR 640. An initial assessment / consultation by phone costs EUR 100.

The planning and monitoring costs for pubertal suppression are EUR 2,000 for the first year, and EUR 1,200 for subsequent years. The costs for the planning and monitoring of hormone treatments are a minimum of EUR 400 per year.

These costs do not take into account the additional costs of psychosocial support provided in the local level, the possible need for psychiatric treatment, or hormone treatment medication costs.



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8. Summary of the Recommendations

PALKO / COHERE maintains the following:

1. For the treatment of gender dysphoria due to variations in gender identity in minors, psychosocial support should be provided in school and student healthcare and in primary healthcare, and there must be sufficient competency to provide such support.
2. Consultation with a child or youth psychiatrist and the necessary psychiatric treatment and psychotherapy should be arranged locally according to the level of treatment needed.
3. If a child or young person experiencing gender-related anxiety has other simultaneous psychiatric symptoms requiring specialised medical care, treatment according to the nature and severity of the disorder must be arranged within the services of their own region, as no conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development.

PALKO / COHERE considers that the consultation, periods of assessment, and treatments by the research group on the gender identity of minors at TAYS or HUS must be carried out according to the following principles:

1. Children who have not started puberty and are experiencing persistent, severe anxiety related to gender conflict and/or identification as the other sex may be sent for a consultation visit to the research group on the gender identity of minors at TAYS or HUS. Any need for support beyond the consultation visit or need for other psychiatric treatment should be addressed by local services according to the nature and severity of the problem.
2. If a child is diagnosed prior to the onset of puberty with a persistent experience of identifying as the other sex and shows symptoms of gender-related anxiety, which increases in severity in puberty, the child can be guided at the onset of puberty to the research group on the gender identity of minors at TAYS or HUS for an assessment of the need for treatment to suppress puberty. Based on these assessments, puberty suppression treatment may be initiated on a case-by-case basis after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are present and there are no contraindications. Therapeutic amenorrhea, i.e. prevention of menstruation, is also medically possible.
3. A young person who has already undergone puberty can be sent to the research clinic on the gender identity of minors at TAYS or HUS for extensive gender identity studies if the variation in gender identity and related dysphoria do not reflect the temporary search for identity typical of the development stage of adolescence and do not subside once the young person has had the opportunity to reflect on their identity but rather their identity and personality development appear to be stable.
4. Based on thorough, case-by-case consideration, the initiation of hormonal interventions that alter sex characteristics may be considered before the person is 18 years of age only if it can be ascertained that their identity as the other sex is of a permanent nature and causes severe dysphoria. In addition, it must be confirmed that the young person is able to understand the significance of irreversible treatments and the



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benefits and disadvantages associated with lifelong hormone therapy, and that no contraindications are present.

5. If a young person experiencing gender-related anxiety has experienced or is simultaneously experiencing psychiatric symptoms requiring specialized medical care, a gender identity assessment may be considered if the need for it continues after the other psychiatric symptoms have ceased and adolescent development is progressing normally. In this case, a young person can be sent by the specialized youth psychiatric care in their region for an extensive gender identity study by the TAYS or HUS research group on the gender identity of minors, which will begin the diagnostic studies. Based on the results of the studies, the need for and timeliness of medically justified treatments will be assessed individually.

Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors. The initiation and monitoring of hormonal treatments must be centralized at the research clinics on gender identity at HUS and TAYS.

9. Additional Evidence Gathering and Monitoring the Effectiveness of Recommendations

Moving forward, the following information must be obtained about the patients diagnosed and receiving treatments in Finland before re-evaluating these recommendations:

- Number of new patient referrals
- Number of patients starting the assessment period, and numbers of new transgender (F64.0) vs "other gender" (F64.8) diagnoses
- Whether the diagnosis remains stable or changes during the assessment phase
- Number of patients discontinuing the assessment period and the reasons for the discontinuation
- Adverse effects of treatments (especially long-term effects and effect on fertility)
- Number of patients regretting hormone therapy
- Analysis of the effects of the assessment and the treatment period on gender dysphoria outcomes, as measured by the Gender Congruence and Life Satisfaction Scale (GCLS)
- Analysis of the effects of the assessment and the treatment period on functional capacity and quality of life
- The prevalence of co-occurring psychiatric diagnoses (especially neurodevelopmental diagnoses F80-F90) among those diagnosed with / seeking treatment for gender dysphoria, and whether the presence of these co-occurring diagnoses impacts the ability to achieve the desired outcome (e.g. decreased dysphoria) in the assessment or the treatment phase.
- Whether the assessment and treatment periods lead to a reduction of suicide attempts
- Whether the assessment and treatment periods lead to a reduction in depression and distress



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10. Appendices

Preparatory Memorandum, with Appendices 1-5.

January 19, 2022

Suicide by Adolescents Referred to the World's Largest Pediatric Gender Clinic

The suicide rate is higher than in the general population but much lower than implied by surveys

Adolescents who identify as transgender are vulnerable to suicidal thoughts and self-harming behaviors. This fact, frequently reported by the news media, is often used as the justification for the rapid provision of "gender-affirming" hormonal and surgical interventions to gender-dysphoric adolescents: "Fifty percent of transgender youth attempt suicide before they are at age 21," declared the mother of Jazz Jennings, the most famous transgender youth in the English-speaking world. Although the elevated rate of suicidality in trans-identified youth is [well-documented](#), a closer examination of the risk of suicide among reveals a more complex picture.

First off, there are [wide variations by country](#), which remain poorly understood. For example, gender-dysphoric youth in The Netherlands attempt suicide at about 1/3 the rate of the UK's gender-dysphoric youth. Secondly, the estimates collected [online](#) from youth themselves tend to be higher than those obtained from [more reliable clinic samples](#). And importantly, the data on suicidal thoughts and behaviors typically does not capture completed suicides, which represents a significant knowledge gap. [A recent study](#) by Dr. Michael Biggs fills this gap by calculating the rate of completed suicides among UK's gender-dysphoric youth.

[The new study](#) by Dr. Biggs uses the data from the world's largest pediatric gender clinic, the Gender Identity Development Service (GIDS), to estimate the rates of completed suicides among trans-identifying youth. The United Kingdom has a comprehensive surveillance system for every death classified as suicide or probable suicide and such deaths by patients—even of those on the waiting list—must be reported. In the eleven years from 2010 to 2020, four patients under the care of the GIDS committed suicide, equating to **0.03% of the total**. This translates into an annualized suicide rate of 13 per 100,000. For the general population of comparable age (14 to 17 years), the rate was 2.7 per 100,000. Thus, adolescents referred to the GIDS had a significantly higher rate of suicide, 5.5 times greater after adjusting for the clinic's sex ratio.

However, this greater risk is not necessarily attributable to transgender identity. Adolescents referred to the GIDS differ in many other ways from their peers of the same age: they are [more likely to suffer from depression and to be on the autism spectrum](#), for example. These conditions [increase the risk](#) of suicide. [Another recent study](#) revealed that while trans-identifying adolescents' suicidality (including thoughts and behaviors, but excluding completed suicides) is markedly higher than that found in the general population of youth, it is only somewhat higher than in youth referred to mental health services for non-gender-related concerns.

[The study](#) found no difference in suicide rates among those on the waitlist compared to those undergoing active care at GIDs. The lack of difference is likely due to the low total numbers of suicides (n=4) recorded.

SEGM Perspective

Much of the knowledge of suicidality in transgender-identifying youth comes from self-reported online surveys. However, survey data cannot be taken at face value. As demonstrated by [prior research](#) on the general public and of non-heterosexual youth in particular, when respondents who affirmatively answer a question on attempted suicide are asked follow-up questions, it turns out that many had not taken life-threatening actions. Moreover, “sexual-minority youths appear more inclined than other adolescents to reply in the affirmative when simplistic suicide attempt research instruments are used” ([Savin-Williams, 2001](#)). A recently published article likewise suggests that lesbian, bisexual, and gay youth might be “normalizing suicidality as a way to express distress and cope with life problems” ([Canetto et al. 2021](#)). The unreliability of simplistic survey questions make it imperative to collect data on deaths by suicide, as was done by Dr. Michael Biggs (an advisor to SEGM).

The most reassuring finding from this study of suicide mortality is that the absolute risk is low. The proportion of individual patients who died by suicide, 0.03%, is far lower than the proportion of transgender-identifying adolescents who report attempting suicide when surveyed. The finding, combined with the [evidence](#) that gender transition [may not reduce](#) suicide risk, calls into question the “transition or suicide” narrative promoted by news media and some gender clinicians. The fact that deaths by suicide are rare should provide some reassurance to gender dysphoric youth and their families, though of course this does not detract from the distress caused by self-harming behaviors. All self-harming youth should be carefully assessed and treated with evidence-based suicide prevention protocols, if indicated.

Given the wide variation in suicidality (thoughts and behaviors) by region, future research should focus on assessing the risk of suicide in trans-identified youth in each specific geography. In addition, given the [high rate of co-occurring mental illness](#) in transgender-identifying youth, future research should also focus on comparing suicide rates in trans-identified youth to the rates for patients treated by mental health services for issues other than gender dysphoria/gender incongruence.



Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom

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Introduction

Surveys show that adolescents who identify as transgender are vulnerable to suicidal thoughts and self-harming behaviors (Dickey & Budge, 2020; Hatchel et al., 2021; Mann et al., 2019). Little is known about death by suicide. This Letter presents data from the Gender Identity Development Service (GIDS), the publicly funded clinic for children and adolescents aged under 18 from England, Wales, and Northern Ireland. From 2010 to 2020, four patients were known or suspected to have died by suicide, out of about 15,000 patients (including those on the waiting list). To calculate the annual suicide rate, the total number of years spent by patients under the clinic's care is estimated at about 30,000. This yields an annual suicide rate of 13 per 100,000 (95% confidence interval: 4–34). Compared to the United Kingdom population of similar age and sexual composition, the suicide rate for patients at the GIDS was 5.5 times higher. The proportion of patients dying by suicide was far lower than in the only pediatric gender clinic which has published data, in Belgium (Van Cauwenberg et al., 2021).

Suicidality in Transgender Adolescents

"About half of young trans people... attempt suicide," declared the United Kingdom Parliament's Women and Equalities Committee (2015). Similar figures are cited by news media and campaigning organizations. The *Guardian* reported Stonewall's statistic that "almost half" of transgender young people "have attempted to kill themselves" (Weale, 2017). "Fifty percent of transgender youth attempt suicide before they are at age 21" stated the mother of the most famous transgender youth in the English-speaking world (Jennings & Jennings, 2016). As a transgender theologian has

observed, "the statistic about suicide attempts has, in essence, developed a life of its own" (Tanis, 2016).

Representative surveys of students in high schools provide one source of evidence for this statistic. In New Zealand, 20% of transgender students reported attempting suicide in the past 12 months, compared to 4% of all students (Clark et al., 2014). In the United States, 15% of transgender students reported a suicide attempt requiring medical treatment in the last 12 months, compared to 3% of all students (Centers for Disease Control & Prevention, 2018; Jackman et al., 2021; Johns et al., 2019). In another American survey, 41% of transgender students reported having attempted suicide during their lifetime, compared to 14% of all students (Toomey et al., 2018).

To what extent are self-reported suicide attempts reflected in fatalities? The connection is not straightforward. Respondents who report suicide attempts are not necessarily indicating an intent to die. One survey of the American population found that almost half the respondents who reported attempting suicide subsequently stated that their action was a cry for help and not intended to be fatal (Nock & Kessler, 2006). In two small samples of non-heterosexual youth, half the respondents who initially reported attempting suicide subsequently clarified that they went no further than imagining or planning it; for the remainder who did actually attempt suicide, their actions were usually not life-threatening. To an extent, then, "the reports were attempts to communicate the hardships of lives or to identify with a gay community" (Savin-Williams, 2001). Although such elaborate survey methods have not been used to study transgender populations, there is anecdotal evidence for a similar disjuncture. The pediatric endocrinologist who established the first clinic for transgender children in the United States stated that "the majority of self-harmful actions that I see in my clinic are not real suicide attempts and are not usually life threatening" (Spack, 2009).

Suicide mortality has been studied in the transgender population using registry data. The annual suicide rate is calculated by dividing the number of suicides by the total number of years each person was at risk. An individual who was observed for 20 years, for instance, contributes 20 person-years to the denominator. The

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largest study covers over 8,000 patients who visited the gender clinic in Amsterdam from 1972 to 2017 (Wiepjes et al., 2020). The annual suicide rate was 29 per 100,000 for transmen, quadruple the rate for the female population, and 64 for transwomen, quadruple the rate for the male population. A Swedish study of 324 individuals who had undergone genital surgery between 1973 and 2003 found much higher annual suicide rates: 250 per 100,000 for transmen, 43 times the rate for matched female controls, and 285 for transwomen, 16 times the rate for matched male controls (M. Boman, personal communication, 12 April 2021; Dhejne et al., 2011). Only one published study has reported suicide fatalities among transgender adolescents. Belgium's pediatric gender clinic provided counseling to 177 youth aged from 12 to 18 years, who had been referred between 2007 and 2016: five of them (2.8%) committed suicide (Van Cauwenberg et al., 2021). The mean age of referral was 15, implying a mean duration of 3 years before transition to an adult clinic, which translates to an annual suicide rate of 942 per 100,000. This is the highest suicide mortality recorded for any transgender population.

Method

This Letter estimates the suicide rate at the world's largest pediatric gender clinic. Based in London, the GIDS is part of the Tavistock and Portman NHS Foundation Trust, and serves youth under 18 from England, Wales, and Northern Ireland who are "experiencing difficulties with their gender identity development" (Carmichael & Davidson, 2009). Like all such services throughout Western Europe and North America, it has experienced enormous growth; referrals increased from 100 in 2009 to a peak of 2700 in 2019. The waiting list in April 2021 exceeded 5300.

The GIDS patients manifest typically high rates of self-harming behavior. In a sample of 900 adolescents (aged from 13 to 17) admitted to the clinic from 2009 to 2017 and given the Youth Self-Report questionnaire, 44% answered that they sometimes or very often "deliberately try to hurt or kill myself" (de Graaf et al., 2020). Unfortunately, both behaviors are combined in this question. In a different sample of over 700 children and adolescents (aged from 4 to 17) assessed by the GIDS in 2012 and 2015, 10% were flagged by clinicians as having attempted suicide (Morandini et al., 2021).

Suicides

Since the early 2000s, the National Health Service has implemented mandatory reporting of "serious incidents" (Department of Health, 2001, 2010). The death of any patient—including those on the waiting list—suspected to be suicide is reported to the Tavistock's Board of Directors. The Tavistock cooperates with a comprehensive surveillance system for every death

classified as suicide or (after an open verdict by the coroner) probable suicide in the United Kingdom (National Confidential Inquiry into Suicide & Homicide by People with Mental Illness, 1999; National Confidential Inquiry into Suicide and Safety in Mental Health, 2019). Papers for the Tavistock's Board meetings are available from April 2007 onwards; those not on the Trust's website were acquired by a Freedom of Information request. The pdf files of the *Agenda and Papers* (through September 2021) were searched for the keyword "suicid"; all 442 instances were inspected. From 2007 to 2020, four patients of the GIDS died by suspected suicide: two on the waiting list, in 2016 and 2017; and two after having been seen, in 2017 and 2020. The last case was described as "likely" to be suicide, because the inquest has not yet been held. These figures were confirmed by Freedom of Information requests to the Tavistock.

Triangulation is possible from two sources. Comprehensive mortality data on all adolescents aged from 10 to 19 who committed suicide in the United Kingdom from 2014 to 2016 include five transgender individuals (Rodway et al., 2020). Due to confidentiality restrictions, it is not possible to disaggregate these further by age or by country. Presumably, one of these is the patient of GIDS who died in 2016. The remaining four might have been 18 or 19—the risk of suicide increases significantly in the late teens—or might have lived in Scotland. Alternatively, they might have been eligible for the GIDS but had not sought a clinical referral (made by the local Child and Adolescent Mental Health Service, the child's general practitioner, social worker, or teacher) or had not obtained it.

Another source is the Transgender Day of Remembrance website, which aims to record all deaths by suicide or violence (Metcalf, 2021). For the United Kingdom between 2007 and 2020, the website names 3 adolescents under the age of 18 who committed suicide. One was one of the GIDS patients (the match is certain because they were named in the *Agenda and Papers*). The other two had no involvement with the GIDS (or any other gender clinician), as was evident from their inquests, though one was under the psychiatric care of another NHS Trust (BBC News, 2021; Bunyan, 2008). In addition, the website lists suicides by two "young" transgender people, sourced from Twitter, without information on their name or age. In one case, it is not clear whether the person lived in the United Kingdom.

Patients

With suicides as numerator, two denominators are relevant. Because comprehensive data on patient numbers became available from 2010, the period will be the 11 years from 2010 to 2020. (These are financial years; thus, 2020 runs from April 2020 to March 2021.) The first denominator is the total number of individual patients, estimated by summing the annual number of referrals to the GIDS from 2010 to 2020—excluding those aged 18 or over, as they are not accepted. The total number is 15,032. This sum omits patients at the clinic who had been referred before

2010, and so is a slight underestimate. (The Online Supplement provides full details.)

The second denominator is the total number of patient-years: the sum of the number of years spent by each individual as a patient of the GIDS. The number of patients seen by the GIDS each year was available from 2014 to 2020. Before 2014 only the number of patients first seen was available. From 2014 to 2016, the number of patients seen was consistently double the number first seen, and so the former number for 2010 to 2013 was estimated by doubling the latter. All these numbers exclude patients on the waiting list. The number waiting at the beginning of each year from 2016 to 2020 was obtained by Freedom of Information request. Before then the number was not available, and so must be treated as zero. This leads to an underestimate, of course, but the waiting list became appreciable only from 2015. The total number of patient-years over this period is estimated as 30,080. In other words, patients spent on average 2 years at the GIDS (including time on the waiting list). Time on the waiting list contributed 41% of the total patient-years.

Results

From 2010 to 2020, the four suicide deaths equate to 0.03% of the 15,032 patients. Taking the denominator as 30,080 patient-years, the annual suicide rate is calculated as 13 per 100,000 (95% confidence interval: 4 to 34 per 100,000). For comparison, the annual suicide rate in England and Wales between 2010 and 2020 for adolescents aged from 15 to 19 years averaged 4.7 (Office for National Statistics, 2021). This does not quite correspond to the age range of the GIDS patients, however. At referral, the patients ranged in age from 3 to 17 years; only 7% were younger than 10. The mean was 14 years and the median 15. Most patients stay with the GIDS until transitioning to an adult service. Therefore, the average age of patients at any point in time will lie somewhere between 14 and 17. A better comparison is therefore the overall suicide rate for adolescents aged from 14 to 17 (available only for the entire United Kingdom for 2015–2017), which was 2.7 per 100,000 (Office for National Statistics, 2018; Rodway et al., 2020). Comparison should also account for the difference between the sexes, because males are more likely to commit suicide than females. Of the GIDS patients, 69% were female. Adjusting for sex, the GIDS patients were 5.5 times more likely to commit suicide than the overall population of adolescents aged 14 to 17.

Discussion

How reliable are these estimates? The chief uncertainty about the numerator is whether the fourth death will be ruled as suicide when the inquest is eventually held. It could be speculated that there were further suicides unknown to the Tavistock and

to the National Confidential Inquiry into Suicide and Safety in Mental Health. All that can be said is that the single suicide by a GIDS patient from 2014 to 2016 is not out of line with comprehensive mortality data on suicides by transgender adolescents in the United Kingdom which counted five suicides in a longer age range and wider geographical area. The denominator for the annual suicide rate, however, is pieced together from various series and so is inevitably approximate. Statistics from the early 2010s are less reliable, though they make only a small contribution to the grand total; the last three years contribute more than half of the total number of patient-years. The most significant limitation is the lack of information on the age and sex of all the patients who committed suicide.

Direct comparison can be made with the Belgian pediatric gender clinic (Van Cauwenberg et al., 2021). Its annual suicide rate was about 70 times greater than the rate at the GIDS. This is especially puzzling because patients at the Belgian clinic scored better, on average, than those at the GIDS on tests of psychological functioning (de Graaf et al., 2018). The explanation for the huge disparity in suicide is not clear. The Amsterdam's clinic annual suicide rate was four times greater than the rate at the GIDS. The higher rate is not surprising, however, because the Dutch clinical population was dominated by older adults: the median age at first visit was 25 (Wiepjes et al., 2020). Suicide rates peak in middle age, and so a population of older adults would be at higher risk than a population of adolescents.

The suicide rate of the GIDS patients is not necessarily indicative of the rate among all adolescents who identify as transgender. On the one hand, individuals with more serious problems (and their families) would be particularly motivated to seek referral and more likely to obtain it, and so the clinical subset would be more prone to suicide. One study suggests that a child who frequently attempted suicide was more readily referred to the GIDS (Carlile et al., 2021). On the other hand, young people facing hostility from their families would be less able to seek referral, and this hostility could make them especially vulnerable to suicide.

Taking into account these limitations, the estimated suicide rate at the GIDS provides the strongest evidence yet published that transgender adolescents are more likely to commit suicide than the overall adolescent population. The higher risk could have various causes: gender dysphoria, accompanying psychological conditions, and ensuing social disadvantages such as bullying. Studies of young people referred to the GIDS in 2012 and 2015 found a high prevalence of eating disorders, depression, and autism spectrum conditions (ASC) (Holt et al., 2016; Morandini et al., 2021)—all known to increase the probability of suicide (Simon & VonKorff, 1998; Smith et al., 2018). Eating disorders and depression could be consequences of transgender identity and its ensuing social repercussions, but this is implausible for ASC insofar as it originates in genes or the prenatal environment. From a sample of over 700 referrals to the GIDS in 2012 and 2015, 14–15% were diagnosed with ASC (Morandini

et al., 2021). This compared to 0.8–1.1% of students in England (Department for Education, 2012, 2015). The association between autism and gender dysphoria is found in many populations (Socialstyrelsen, 2020; Warrier et al., 2020). Autism is known to increase the risk of suicide mortality, especially in females (Hirvikoski et al., 2016; Kirby et al., 2019; Socialstyrelsen, 2020). To some extent, therefore, the elevated suicide rate for transgender youth compared to their peers reflects the higher incidence of ASC. The same holds for other psychiatric disorders associated with gender dysphoria (Dhejne et al., 2016). Ideally, the suicide rate for patients of the GIDS would be compared to the suicide rate for patients in contact with other NHS mental health services, but the latter rate is not available.

One final caveat is that these data shed no light on the question of whether counseling or endocrinological interventions—gonadotropin-releasing hormone agonist or cross-sex hormones—affect the risk of suicide (Biggs, 2020; Turban et al., 2020). Although two out of the four suicides were of patients on the waiting list, and thus would not have obtained treatment, this is not disproportionate: the waiting list contributed nearly half of the total patient-years.

Conclusion

Data from the world's largest clinic for transgender youth over 11 years yield an estimated annual suicide rate of 13 per 100,000. This rate was 5.5 times greater than the overall suicide rate of adolescents of similar age, adjusting for sex composition. The estimate demonstrates the elevated risk of suicide among adolescents who identify as transgender, albeit without adjusting for accompanying psychological conditions such as autism. The proportion of individual patients who died by suicide was 0.03%, which is orders of magnitude smaller than the proportion of transgender adolescents who report attempting suicide when surveyed. The fact that deaths were so rare should provide some reassurance to transgender youth and their families, though of course this does not detract from the distress caused by self-harming behaviors that are non-fatal. It is irresponsible to exaggerate the prevalence of suicide. Aside from anything else, this trope might exacerbate the vulnerability of transgender adolescents. As the former lead psychologist at the Tavistock has warned, “when inaccurate data and alarmist opinion are conveyed very authoritatively to families we have to wonder what the impact would be on children's understanding of the kind of person they are...and their likely fate” (Wren, 2015).

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s10508-022-02287-7>.

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Declarations

Conflict of interest I acted as an expert witness (without payment) for the claimant in the case of Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274.

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References

- BBC News. (2021, June 4). Ellis Murphy-Richards: NHS care questioned over suicide. *BBC News*. <https://www.bbc.com/news/uk-england-kent-57358063>
- Biggs, M. (2020). Puberty blockers and suicidality in adolescents suffering from gender dysphoria [Letter to the Editor]. *Archives of Sexual Behavior*, 49, 2227–2229. <https://doi.org/10.1007/s10508-020-01743-6>
- Bunyan, N. (2008, February 15). Boy, 10, hangs himself after talking to his mother about craze. *Daily Telegraph*.
- Carlile, A., Butteriss, E., & Sansfaçon, A. P. (2021). “It’s like my kid came back overnight”: Experiences of trans and non-binary young people and their families seeking, finding and engaging with clinical care in England. *International Journal of Transgender Health*, 22, 412–424. <https://doi.org/10.1080/26895269.2020.1870188>
- Carmichael, P., & Davidson, S. (2009). A gender identity development service. *Psychologist*, 22, 916–917.
- Centers for Disease Control and Prevention. (2018). *2017 Youth Risk Behavior Survey*. <https://www.cdc.gov/healthyyouth/data/yrbs/data.htm>
- Clark, T. C., Lucassen, M. F. G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. (2014). The health and well-being of transgender high school students: Results from the New Zealand Adolescent Health Survey (Youth’12). *Journal of Adolescent Health*, 55, 93–99. <https://doi.org/10.1016/j.jadohealth.2013.11.008>
- de Graaf, N. M., Cohen-Kettenis, P. T., Carmichael, P., de Vries, A. L. C., Dhondt, K., Laridaen, J., Pauli, D., Ball, J., & Steensma, T. D. (2018). Psychological functioning in adolescents referred to specialist gender identity clinics across Europe: A clinical comparison study between four clinics. *European Child & Adolescent Psychiatry*, 27, 909–919. <https://doi.org/10.1007/s00787-017-1098-4>
- de Graaf, N. M., Steensma, T. D., Carmichael, P., VanderLaan, D. P., Aitken, M., Cohen-Kettenis, P. T., de Vries, A. L. C., Kreukels, B. P. C., Wasserman, L., Wood, H., & Zucker, K. J. (2020). Suicidality in clinic-referred transgender adolescents. *European Child & Adolescent Psychiatry*. <https://doi.org/10.1007/s00787-020-01663-9>
- Department for Education. (2012). *Special educational needs in England, January 2012*. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2012>
- Department for Education. (2015). *Special educational needs in England, January 2015*. <https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2015>

- Department of Health. (2001). *Building a safer NHS for patients: Implementing 'an organisation with a memory'*.
- Department of Health. (2010). *National framework for reporting and learning from serious incidents requiring investigation*. <https://web.archive.org/web/20101126102908/http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=68464&type=full&servicetype=Attachment>
- Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE*, 6, e16885. <https://doi.org/10.1371/journal.pone.0016885>
- Dhejne, C., Van Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, 28, 44–57. <https://doi.org/10.3109/09540261.2015.1115753>
- dickey, I. m., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. *American Psychologist*, 75, 380–390. <https://doi.org/10.1037/amp0000619>
- Hatchel, T., Polanin, J. R., & Espelage, D. L. (2021). Suicidal thoughts and behaviors among LGBTQ youth: Meta-analyses and a systematic review. *Archives of Suicide Research*, 25, 1–37. <https://doi.org/10.1080/13811118.2019.1663329>
- Hirvikoski, T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *British Journal of Psychiatry*, 208, 232–238. <https://doi.org/10.1192/bjp.bp.114.160192>
- Holt, V., Skagerberg, E., & Dunsford, M. (2016). Young people with features of gender dysphoria: Demographics and associated difficulties. *Clinical Child Psychology & Psychiatry*, 21, 108–118. <https://doi.org/10.1177/1359104514558431>
- Jackman, K. B., Caceres, B. A., Kreuze, E. J., & Bockting, W. O. (2021). Suicidality among gender minority youth: Analysis of 2017 Youth Risk Behavior Survey data. *Archives of Suicide Research*, 25, 208–223. <https://doi.org/10.1080/13811118.2019.1678539>
- Jennings, J., & Jennings, J. (2016). Trans teen shares her story. *Pediatrics in Review*, 37, 99–100. <https://doi.org/10.1542/pir.2016-002>
- Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students: 19 states and large urban school districts, 2017. *Morbidity and Mortality Weekly Report*, 68, 69–71.
- Kirby, A. V., Bakian, A. V., Zhang, Y., Bilder, D. A., Keshin, B. R., & Coon, H. (2019). A 20-year study of suicide death in a statewide autism population. *Autism Research*, 12, 658–666. <https://doi.org/10.1002/aur.2076>
- Mann, G. E., Taylor, A., Wren, B., & de Graaf, N. (2019). Review of the literature on self-injurious thoughts and behaviours in gender-diverse children and young people in the United Kingdom. *Clinical Child Psychology & Psychiatry*, 24, 304–321. <https://doi.org/10.1177/1359104518812724>
- Metcalf, A.-J. (2021). *Remembering our dead: Reports*. <https://tdor.translivesmatter.info/reports>
- Morandini, J. S., Kelly, A., de Graaf, N. M., Carmichael, P., & Dar-Nimrod, I. (2021). Shifts in demographics and mental health comorbidities among gender dysphoric youth referred to a specialist gender dysphoria service. *Clinical Child Psychology & Psychiatry*. <https://doi.org/10.1177/13591045211046813>
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (1999). *Safer services: National confidential inquiry into suicide and homicide by people with mental illness*.
- National Confidential Inquiry into Suicide and Safety in Mental Health. (2019). *Annual Report: England, Northern Ireland, Scotland and Wales*. Healthcare Quality Improvement Partnership. <https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-in-mental-health-annual-report-2019/#.YdQiOy-13KY>
- Nock, M. K., & Kessler, R. C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology*, 115, 616–623. <https://doi.org/10.1037/0021-843X.115.3.616>
- Office for National Statistics. (2018). *Population estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2012 to mid-2016*. <https://www.ons.gov.uk/file?uri=%2fpeoplepopulationandcommunity%2fpopulationandmigration%2fpopulationestimates%2fdatasets%2fpopulationestimatesforukenglandandwalescotlandandnorthernireland%2fmid2012tomid2016>
- Office for National Statistics. (2021). *Suicides in England and Wales*. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables>
- Rodway, C., Tham, S.-G., Ibrahim, S., Turnbull, P., Kapur, N., & Appleby, L. (2020). Children and young people who die by suicide: Childhood-related antecedents, gender differences and service contact. *BJPsych Open*, 6, e49. <https://doi.org/10.1192/bjo.2020.33>
- Savin-Williams, R. C. (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Consulting and Clinical Psychology*, 69, 983–991. <https://doi.org/10.1037/0022-006X.69.6.983>
- Simon, G. E., & VonKorff, M. (1998). Suicide mortality among patients treated for depression in an insured population. *American Journal of Epidemiology*, 147, 155–160. <https://doi.org/10.1093/oxfordjournals.aje.a009428>
- Smith, A. R., Zuromski, K. L., & Dodd, D. R. (2018). Eating disorders and suicidality: What we know, what we don't know, and suggestions for future research. *Current Opinion in Psychology*, 22, 63–67. <https://doi.org/10.1016/j.copsyc.2017.08.023>
- Socialstyrelsen. (2020). *Utvecklingen av diagnosen könsdysfori [The evolution of the diagnosis of gender dysphoria]*. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6600.pdf>
- Spack, N. P. (2009). An endocrine perspective on the care of transgender adolescents. *Journal of Gay & Lesbian Mental Health*, 13, 309–319. <https://doi.org/10.1080/19359700903165381>
- Tanis, J. (2016). The power of 41%: A glimpse into the life of a statistic. *American Journal of Orthopsychiatry*, 86, 373–377. <https://doi.org/10.1037/ort0000200>
- Toomey, R. B., Syvertsen, A. K., & Shramko, M. (2018). Transgender adolescent suicide behavior. *Pediatrics*, 142, e20174218. <https://doi.org/10.1542/peds.2017-4218>
- Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145, e20191725. <https://doi.org/10.1542/peds.2019-1725>
- Van Cauwenberg, G., Dhondt, K., & Motmans, J. (2021). Ten years of experience in counseling gender diverse youth in Flanders, Belgium: A clinical overview. *International Journal of Impotence Research*, 33, 671–678. <https://doi.org/10.1038/s41443-021-00441-8>
- Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M.-C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications*, 11(3959). <https://doi.org/10.1038/s41467-020-17794-1>
- Weale, S. (2017, June 27). Almost half of trans pupils in UK have attempted suicide, survey finds. *Guardian*. Retrieved from <https://www.theguardian.com/education/2017/jun/27/half-of-trans-pupils-in-the-uk-tried-to-take-their-own-lives-survey-finds>
- Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in

- suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica*, 141, 486–491. <https://doi.org/10.1111/acps.13164>
- Women and Equalities Committee, UK Parliament. (2015). *Transgender equality: First report of session 2015–16*. <https://publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf>
- Wren, B. (2015). *Making up people*. Presented at the meeting of the European Professional Association for Transgender Health, Ghent, Belgium.
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February 27, 2022

Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW)

February 2022 update

Background

In February 2022, the Swedish National Board of Health and Welfare (NBHW) issued an [update to its health care service guidelines](#) for children and youth <18 with gender dysphoria / gender incongruence. This update contains 14 distinct “recommendations,” with justification for each, referencing a recently completed [systematic review of evidence](#). Three of the recommendations provide guidance for social support for gender dysphoric youth and their families; nine focus on the assessment of gender dysphoria/gender incongruence; and two target hormonal interventions: puberty blockers and cross-sex hormones. Additional updates are anticipated later in 2022.

Key Changes in the Updated Guidelines

Following a comprehensive review of evidence, the NBHW concluded that the evidence base for hormonal interventions for gender-dysphoric youth is of low quality, and that hormonal treatments may carry risks. NBHW also concluded that the evidence for pediatric transition comes from studies where the population was markedly different from the cases presenting for care today. In addition, NBHW noted increasing reports of detransition and transition-related regret among youth who transitioned in recent years.

NBHW emphasized the need to treat gender dysphoric youth with dignity and respect, while providing high quality, evidence-based medical care that prioritizes long-term health. NBHW also emphasized that identity formation in youth is an evolving process, and that the experience of natural puberty is a vital step in the development of the overall identity, as well as gender identity.

In light of above limitations in the evidence base, the ongoing identity formation in youth, and in view of the fact that gender transition has pervasive and lifelong consequences, the NBHW has concluded that, at present, the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits.

As a result of this determination, the eligibility for pediatric gender transition with puberty blockers and cross-sex hormones in Sweden will be sharply curtailed. Only a minority of gender dysphoric youth—those with the “classic” childhood onset of cross-sex identification and distress, which persist and cause clear suffering in adolescence—will be considered as potentially eligible for hormonal interventions, pending additional, extensive multidisciplinary evaluation.

For all others, including the now-prevalent cohort of youth whose transgender identities emerged for the first time during or after puberty, psychiatric care and gender-exploratory psychotherapy will be offered instead. Exceptions will be made on a case-by-case basis, and the number of clinics providing pediatric gender transition will be [reduced to a](#)

Summary of Key Points (NBHW February 2022 Update)

Following a rigorous analysis of evidence base, there has been a marked change in treatment recommendations. The guidance has changed from a previously strong recommendation to treat youth with hormones, to new caution to avoid hormones except for "exceptional cases." A more cautious approach that prioritizes non-invasive interventions is now recommended, due to recognition of the importance of allowing ongoing maturation and identity formation of youth.

Currently, the NBHW assert that the risks of hormonal treatments outweigh the benefits for most gender-dysphoric youth:

Poor quality/insufficient evidence: The evidence for safety and efficacy of treatments remains insufficient to draw any definitive conclusions;

Poorly understood marked change in demographics: The sharp rise in the numbers of youth seeking to transition and the change in sex ratio toward a preponderance of females is not well-understood;

Growing visibility of detransition/regret: New knowledge about detransition in young adults challenges prior assumption of low regret, and the fact that most do not tell practitioners about their detransition could indicate that detransition rates have been underestimated.

Psychological and psychiatric care will become the first line of treatment for all gender dysphoric youth <18.

A substantial focus is placed on gender exploration that does not privilege any given outcome (desistance or persistence).

The presence of psychiatric diagnoses will lead to prolonged evaluation to ensure that these conditions are under control and that gender transition does not do more harm than good.

The diagnosis of ASD (autism spectrum disorder) will necessitate additional evaluation.

The well-known lack of adherence to gender norms among ASD individuals could lead them to misattribute their experience to being "transgender" and inappropriately transition.

The guidelines also posit that some youth on the autism spectrum who are suffering from gender dysphoria may not come across as genuinely suffering because they take little care to present in ways consistent with the gender they identify with.

Access to hormonal interventions for youth <18 will be tightly restricted. The goal is to administer these interventions in research settings only, and to restrict eligibility criteria to mirror those in the "Dutch protocol."

The key prerequisite for hormonal treatment of youth is the **prepubertal** onset of gender dysphoria that is long-lasting (5 year minimum is mentioned), persists into adolescence and causes clear suffering.

Some exceptions apply. Puberty blockade can be offered in extreme circumstances to those with post-pubertal onset of gender dysphoria, especially for biologically male patients. However, it does not appear that cross-sex hormones can be offered to the <18 youth with no childhood history of gender dysphoria.

Social transition may be recommended to some youths. Social transition may be recommended at the latter stage of assessments. The health care service may accommodate these young people by providing them with "aids" such as packers, binders, tucking devices, and breast and genital prosthesis.

Most youth will receive psychotherapeutic care in their home regions. Gender-affirming interventions will be provided at few highly specialized centers and in the context of research.

Home regions will need to develop competence in managing gender dysphoria with psychological and psychotherapeutic interventions.

Centers offering "gender-affirming" interventions will be centralized, and their number reduced.

Treatment eligibility will be based on the criterion of "distress," and not "identity."

The DSM diagnosis of "gender dysphoria" will be a prerequisite for eligibility for "gender-affirming" hormonal interventions.

The presence of a transgender identity that is not causing distress or functional impairments is not sufficient.

At the current time, youth who identify as nonbinary will not be eligible for hormonal interventions even in research settings. Future updates to these guidelines will address appropriate treatments for this patient population.

Limitations of the NBHW's Updated Guidelines

The updated guidelines leave several key questions open to interpretation. While more responsibility has been placed on local health services to provide gender exploration and psychotherapy, it is not clear how this expertise will be developed and scaled. Similarly, it is uncertain how the presence of autism-spectrum disorders, which are highlighted as

cause for significant caution, will impact eligibility for hormonal interventions. Further, is it not readily apparent how the guideline's requirement to provide pediatric transitions only in research settings will be practically implemented, given that there are no ongoing research trials in Sweden.

Another significant gap in the current guidelines is that they do not address the care for 18–25-year-olds. Like the 13–17-year-old cohort, which is the focus on the current update, the cohort of gender-dysphoric 18-25 year-olds with significant mental health comorbidities has risen rapidly in recent years as have reports of regret and detransition from this group. The need to safeguard this vulnerable cohort requires careful consideration because though they are recognized as “young adults,” this cohort is distinctly different from mature adults due to differences in terms of brain maturity and life experiences.

Comparison to WPATH Draft SOC8 Guidelines

There are several important differences between hormonal treatment eligibility criteria outlined by Sweden's NBHW and those put forth by WPATH in their recently released draft SOC 8 guidelines.

Some of the key differences are highlighted in a table below:

	Swedish National Board of Health and Welfare (NBHW), February 2022 update	World Professional Association for Transgender Health (WPATH), SOC8 draft
Management of gender dysphoria in youth	<p>First line of treatment is mental health support and exploratory psychological care. Hormonal interventions can be a last resort measure for some youth (see p.43, NBHW guidelines).</p> <p>Hormonal interventions should be restricted to research settings.</p> <p>Eligibility for hormonal treatment and ability to consent will be assessed by an interdisciplinary clinical team, with only a minority of patients expected to be treated hormonally.</p> <p>Only “gender dysphoria” (DSM-5) will qualify for hormonal interventions. A transgender identity or “gender incongruence” without distress is not sufficient.</p>	<p>There should be a general assumption to treat with hormones and surgeries. Mental health assessments are important but can also be abbreviated (see SOC8 draft “Assessment” section).</p> <p>Hormonal interventions should be widely available in general medical practice.</p> <p>Patient desire is the ultimate eligibility criterion. While ability to consent is important, inability to consent is not always a barrier to receiving “gender-affirming” interventions.</p> <p>All forms of gender incongruence are eligible for interventions, and all interventions should be available to bring the body in congruence with identity.</p>
Eligibility for hormonal interventions based on timing of gender dysphoria onset	<p>Prepubertal onset of gender dysphoria is required for eligibility for hormonal (GnRHa and cross-sex hormones) interventions.</p> <p>An exception may be made for selected post-pubertal onset cases for pubertal suppression, but not for cross-sex hormones.</p>	<p>The importance of long-lasting gender dysphoria is acknowledged, the timing of prepubertal vs post-pubertal onset is noted.</p> <p>However, hormonal transition is allowed even for those with post-pubertal onset for eligibility.</p>
Minimum age for puberty blockers (GnRH analogues)	Tanner Stage 3; suggested minimum age of 12.	Tanner Stage 2; no minimum age suggested.
Minimum age for cross-sex hormones (estrogen, testosterone)	Minimum age 16.	Minimum age 14.

SEGM Take-away

The update to the Swedish treatment guidelines represents an impressive step toward safeguarding the growing numbers of gender dysphoric youth from medical harm arising from inappropriate gender transition.

SEGM hopes that other countries will follow Sweden's example, independently examining the body of evidence and issuing evidence-based guidelines for medical care that respects young people's dignity, provides relief from suffering, safeguards them from medical harm, and ultimately, prioritizes long-term mental and physical health.

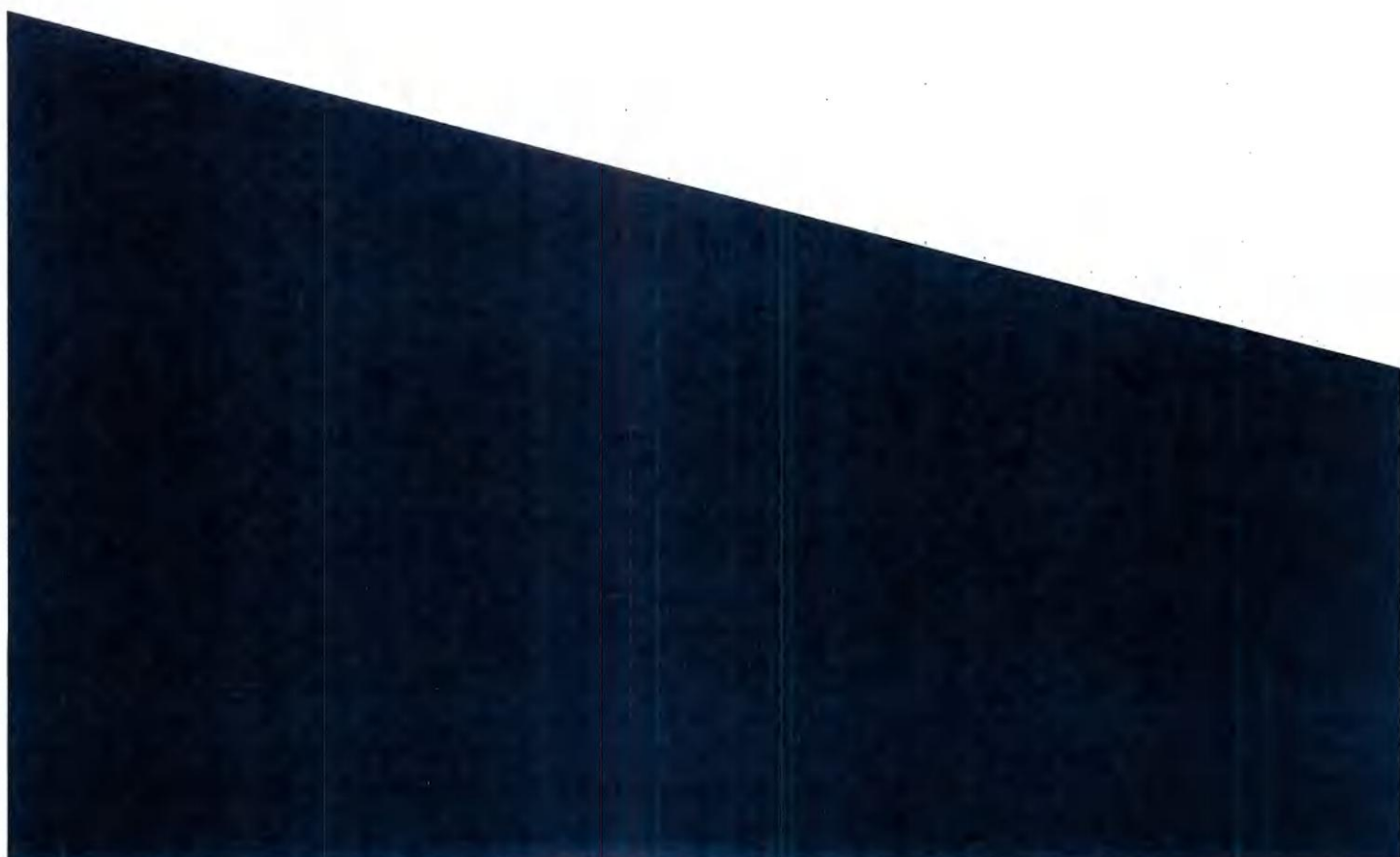
The official English translation of Sweden's updated guidelines is available [here](#).

Society for Evidence-based Gender Medicine

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Care of children and adolescents with gender dysphoria

Summary



Summary

The National Board of Health and Welfare (NBHW) has been commissioned by the Swedish government to update the national guidelines on care of children and adolescents with gender dysphoria, first published in 2015 [1]. Guidelines chapters are updated stepwise and this report contains revised guidance on psychosocial support and diagnostic assessment, and on puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment. This report thus replaces the corresponding chapters in the publication from 2015. Remaining chapters and the updated guidelines as a whole will be published later in 2022. In response to comments received during external review, two new chapters have been added, named *New recommendations on hormonal treatment – their reasons and consequences* and *Non-binary gender identity – current knowledge and a need for clarification*. Another difference compared to the guidelines from 2015 [1] is that the term “gender incongruence” is used alongside the term “gender dysphoria”. For explanations of terms and abbreviations, see Appendix 2. For a description of the scientific evidence and clinical experience underlying the recommendations and the work process, see Appendices 3 and 4.

The guidelines apply to children and adolescents, i.e. people under 18 years of age. In the medical text sections, the term children (barn) refers to persons who have not yet entered puberty, while the term adolescents (ungdomar) refers to people whose puberty has started. In the text sections relating to juridical regulations, only the term children (barn) is used and denotes people younger than 18 years of age. Finally, the term “young people” (unga) is sometimes used in text sections addressing both children and adolescents.

Introductory comment

The summary that follows and the introductory chapter describe that the updated recommendations for puberty suppression with GnRH-analogues and gender-affirming hormonal treatment have become more restrictive compared to 2015, and the reasons that they have changed. The new recommendations entail that a larger

proportion than before, among adolescents with gender incongruence referred for diagnostic assessment of gender dysphoria, will need to be offered other care than hormonal treatments. Questions on how to ensure that all young people suffering from gender dysphoria be taken seriously and confirmed in their gender identity, well received and offered adequate care are becoming increasingly relevant, and will need to be answered during the ongoing restructuring of certain care for gender dysphoria into three national specialised medical care services (NBHW decision in December 2020). The care for children, adolescents and adults with gender dysphoria in these three national specialised units aims to improve equality in care, coordination and dialogue, and may enhance the implementation of national guidelines.

Recommendations and criteria for hormonal treatment

For adolescents with gender incongruence, the NBHW deems that the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases. This judgement is based mainly on three factors: the continued lack of reliable scientific evidence concerning the efficacy and the safety of both treatments [2], the new knowledge that detransition occurs among young adults [3], and the uncertainty that follows from the yet unexplained increase in the number of care seekers, an increase particularly large among adolescents registered as females at birth [4].

A systematic review published in 2022 by the Swedish Agency for Health Technology Assessment and Assessment of Social Services [2] shows that the state of knowledge largely remains unchanged compared to 2015. High quality trials such as RCTs are still lacking and the evidence on treatment efficacy and safety is still insufficient and inconclusive for all reported outcomes. Further, it is not possible to determine how common it is for adolescents who undergo gender-affirming treatment to later change their perception of their gender identity or interrupt an ongoing treatment. An important difference compared to 2015 however, is that the occurrence of

detransition among young adults is now documented [3], meaning that the uncertain evidence that indicates a low prevalence of treatment interruptions or any aspects of regret is no longer unchallenged. Although the prevalence of detransition is still unknown, the knowledge that it occurs and that genderconfirming treatment thus may lead to a deteriorating of health and quality of life (i.e. harm), is important for the overall judgement and recommendation.

To minimize the risk that a young person with gender incongruence later will regret a gender-affirming treatment, the NBHW deems that the criteria for offering GnRH-analogue and gender-affirming hormones should link more closely to those used in the Dutch protocol, where the duration of gender incongruence over time is emphasized [5-7]. Accordingly, an early (childhood) onset of gender incongruence, persistence of gender incongruence until puberty and a marked psychological strain in response to pubertal development is among the recommended criteria. The publications that describe these criteria and the treatment outcomes when given in accordance [5, 6, 8] constitute the best available knowledge and should be used as guidance.

To ensure that new knowledge is gathered, the NBHW further deems that treatment with GnRH-analogues and sex hormones for young people should be provided within a research context, which does not necessarily imply the use of randomized controlled trials (RCTs). As in other healthcare areas where it is difficult to conduct RCTs while retaining sufficient internal validity, it is also important that other prospective study designs are considered for ethical review and that register studies are made possible. Until a research study is in place, the NBHW deems that treatment with GnRH-analogues and sex hormones may be given in exceptional cases, in accordance with the updated recommendations and criteria described in the guidelines. The complex multidisciplinary assessments will eventually be carried out in the three national units that are granted permission to provide highly specialized care services.

In accordance with the DSM-5, the recommendations in the guidelines from 2015 applied to young people with gender dysphoria in general, i.e. also young people with a non-binary gender identity. Another criterion within the Dutch protocol is that the child has had a binary ("cross-gender") gender identity since childhood [5, 6].

It has emerged during the review process, that the clinical experience and documentation of puberty-suppressing and hormonal treatment for young people with non-binary gender identity is lacking, and also that it is limited for adults. The NBHW still considers that gender dysphoria rather than gender identity should determine access to care and treatment. An urgent work thus remains, to clarify criteria under which adolescents with non-binary gender identity may be offered puberty-suppressing and gender-affirming hormonal treatment within a research framework.

References

1. Socialstyrelsen. God vård av barn och ungdomar med könsdysfori. Nationellt kunskapsstöd. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2015-4-6.pdf>; 2015.
2. Statens beredning för medicinsk och social utvärdering. Hormonbehandling vid könsdysfori - barn och unga. En systematisk översikt och utvärdering av medicinska aspekter: SBU; 2022.
3. Littman L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Arch Sex Behav*. 2021; 50(8):3353-69.
4. Socialstyrelsen. Utvecklingen av diagnosen könsdysfori - förekomst, samtidiga psykiatriska diagnoser och dödlighet i suicid. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6600.pdf>; 2020.
5. Cohen-Kettenis PT, van Goozen SH. Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*. 1997; 36(2):263-71.
6. Smith YL, van Goozen SH, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2001; 40(4):472-81.
7. Delemarre-van de Waal H, Cohen-Kettenis P. Clinical management of gender identity disorder in adolescents: a protocol on

psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*. 2006; 155:S131-7.

8. Schagen SE, Cohen-Kettenis PT, Delemarre-van de Waal HA, Hannema SE. Efficacy and Safety of Gonadotropin-Releasing Hormone Agonist Treatment to Suppress Puberty in Gender Dysphoric Adolescents. *J Sex Med*. 2016; 13(7):1125-32.

Florida Medicaid

Generally Accepted Professional
Medical Standards Determination on
the Treatment of Gender Dysphoria

June 2022

Ron DeSantis, Governor
Simone Marstiller, Secretary



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Introductory Remarks and Abstract

Generally Accepted Professional Medical Standards

The Secretary of the Florida Agency for Health Care Administration requested that the Division of Florida Medicaid review the treatment of gender dysphoria for a coverage determination pursuant to Rule 59G-1.035, Florida Administrative Code (F.A.C.) (See Attachment A for the Secretary's Letter to Deputy Secretary Tom Wallace). The treatment reviewed within this report included "sex reassignment treatment," which refers to medical services used to obtain the primary and/or secondary physical sexual characteristics of a male or female. As a condition of coverage, sex reassignment treatment must be "consistent with generally accepted professional medical standards (GAPMS) and not experimental or investigational" (Rule 59G-1.035, F.A.C., see Attachment B for the complete rule text).

The determination process requires that "the Deputy Secretary for Medicaid will make the final determination as to whether the health service is consistent with GAPMS and not experimental or investigational" (Rule 59G-1.035, F.A.C.). In making that determination, Rule 59G-1.035, F.A.C., identifies several factors for consideration. Among other things, the rule contemplates the consideration of "recommendations or assessments by clinical or technical experts on the subject or field" (Rule 59G-1.035(4)(f), F.A.C.). Accordingly, this report attaches five assessments from subject-matter experts:

- **Attachment C:** Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.
- **Attachment D:** James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.
- **Attachment E:** Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.
- **Attachment F:** Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.
- **Attachment G:** G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

Abstract

Available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased. Rather, the available evidence demonstrates that these treatments cause irreversible physical changes and side effects that can affect long-term health.

Five clinical and technical expert assessments attached to this report recommend against the use of such interventions to treat what is categorized as a mental health disorder (See attachments):

- **Health Care Research:** Brignardello-Petersen and Wiercioch performed a systematic review that graded a multitude of studies. They conclude

that evidence supporting sex reassignment treatments is low or very low quality.

- **Clinical Psychology:** Cantor provided a review of literature on all aspects of the subject, covering therapies, lack of research on suicidality, practice guidelines, and Western European coverage requirements.
- **Plastic Surgery:** Lappert provided an evaluation explaining how surgical interventions are cosmetic with little to no supporting evidence to improve mental health, particularly those altering the chest.
- **Pediatric Endocrinology:** Van Meter explains how children and adolescent brains are in continuous phases of development and how puberty suppression and cross-sex hormones can potentially affect appropriate neural maturation.
- **Bioethics:** Donovan provides additional insight on the bioethics of administering these treatments, asserting that children and adolescents cannot provide truly informed consent.

Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational.

Health Service Summary

Gender Dysphoria

Frequently used to describe individuals whose gender identity conflicts with their natural-born sex, the term gender dysphoria has a history of evolving definitions during the past decades (Note: This report uses the term “gender” in reference to the construct of male and female identities and the term “sex” when regarding biological characteristics). Prior to the publication of the *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), the American Psychiatric Association (APA) used the diagnosis of gender identity disorder (GID) to describe individuals who sought to transition to the opposite gender. However, behavioral health clinicians sought a revision after determining that using GID created stigma for those who received the diagnosis. This is despite the APA having adopted GID to replace the previous diagnosis of transsexualism for the exact same reason (APA, 2017).¹

When crafting its new definition and terminology, the APA sought to remove the stigma of classifying as a disorder the questioning of one’s gender identity by focusing instead on the psychological distress that such questioning can evoke. This approach argues that individuals seeking behavioral health and transition services are doing so due to experiencing distress and that gender non-conformity by itself is not a mental health issue. This led to the adoption of gender dysphoria in 2013 when the APA released the DSM-V. In addition to using a new term, the APA also differentiated the diagnosis between children and adolescents and adults, listing different characteristics for the two age groups (APA, 2017).

According to the DSM-V, gender dysphoria is defined as “the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.” As for the criteria to receive the diagnosis, the APA issued stricter criteria for children than adolescents and adults. For the former, the APA states that a child must meet six out of eight behavioral characteristics such as having “a strong desire to be of the other gender or an insistence that one is the other gender” or “a strong preference for cross-gender roles in make-believe or fantasy play.” The criteria for adults and adolescents are less stringent with individuals only having to meet two out of six characteristics that include “a strong desire to be the other gender” or “a strong desire to be rid of one’s primary and/or secondary sexual characteristics.” The APA further notes that these criteria can also apply to young adolescents (DSM-V, 2013).

In 2021, the Merck Manual released a slightly different definition for gender dysphoria, citing that the condition “is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the

¹ The concept of gender being part of identity and disconnected from biological sex originated during the mid-twentieth century and was publicized by psychologist John W. Money. His research asserted that gender was a complete social construct and separate from biology, meaning that parents and/or caregivers could imprint on a young child (under three years) the identity of a boy or girl. In 1967, Money’s theories led to a failed experiment on twin boys where physicians surgically transitioned one to appear as a girl. The twin that underwent sex reassignment never fully identified as a female. However, Money never publicly acknowledged this and reported the experiment as a success. Furthermore, he promoted his conclusions across the scientific community, concealing what actually unfolded. As a result, Money’s ideas on gender fluidity served as a basis for performing procedures on children with hermaphroditic features or genital abnormalities. The case reveals how the understanding of a concept (e.g., gender) at any given time can lead to incorrect medical decisions with irreversible consequences (Gaetano, 2015).

sex assigned at birth.” Additionally, the Merck Manual further states that “gender dysphoria is a diagnosis requiring specific criteria but is sometimes used more loosely for people in whom symptoms do not reach a clinical threshold” (Merck Manual, 2021). This definition is largely consistent with the DSM-V but does not emphasize the distress component to the same extent.²

Like other behavioral health diagnoses classified in the DSM-V, gender dysphoria has the following subtypes:

- **Early-Onset Gender Dysphoria:** This subtype begins during childhood and persists through adolescence into adulthood. It can be interrupted by periods where the individual does not experience gender dysphoria signs and may classify as homosexual (DSM-V, 2013).
- **Late-Onset Gender Dysphoria:** Occurring after puberty or during adulthood, this subtype does not begin until late adolescence and can emerge following no previous signs of gender dysphoria. The APA attributes this partially to individuals who did not want to verbalize their desires to transition (DSM-V, 2013).

Further studies have identified additional subtypes of gender dysphoria. In 2018, Lisa Littman introduced the concept of a rapid-onset subtype. Classified as rapid-onset gender dysphoria (ROGD), it features characteristics such as sudden beginnings during or following puberty. However, it differs from the DSM-V definitions because ROGD is associated with other causes such as social influences (e.g., peer groups, authority figures, and media). In other words, adolescents who had no history of displaying typical gender dysphoria characteristics go through a sudden change in identity following intense exposure to peers and/or media that heavily promotes transgender lifestyles (Littman, 2018). While more long-term studies are needed to confirm whether ROGD is a temporary or long-term condition, Littman’s study has initiated discussions regarding potential causes of gender dysphoria as well as introduced a potential subtype.

Additionally, the frequent use of gender dysphoria in clinical and lay discourse has led to a fracturing of the definition. Studies on the topic frequently do not apply the DSM-V’s criteria for the diagnosis and overlook certain key features such as distress. In a 2018 review by Zowie Davy and Michael Toze, the authors evaluated 387 articles that examine gender dysphoria and noted stark departures from the APA’s definition. They further asserted that the APA intended to “reduce pathologization” by establishing a new definition for gender dysphoria in the DSM-V. This in turn would reduce diagnoses, although as Davy and Toze note, the tendency for the literature to diverge from the APA’s definition may result in increased numbers of individuals classified as having gender dysphoria when they do not meet the DSM-V’s criteria (Davy and Toze, 2018). This further raises the question of whether individuals are receiving potentially irreversible treatments for the condition when they might not actually have it.

The current usage of gender dysphoria is the result of discussions spanning across decades as demonstrated in the past editions of the DSM. Until 2013, the APA considered having gender identity issues a mental disorder by itself regardless of the presence of psychological distress. That perspective has since shifted to only consider the adverse psychological effects of questioning one’s gender as a disorder. In addition, the APA considers gender as part of one’s identity, which is not subject to a diagnosis. Whether the APA has shifted its terminology and criteria for gender identity issues due to

² Following the release of the Florida Department of Health’s guidelines for treating gender dysphoria, Merck removed its definition for “gender dysphoria” from the Merck Manual (Fox News, 2022).

emerging clinical data or cultural changes is another question. In 1994, the APA replaced transsexualism with gender identity disorder as part of the “effort to reduce stigma” (APA, 2017). This raises questions about what influences decisions to revise definitions and criteria; is it social trends or medical evidence?

Behavioral Health Issues Co-Occurring with Gender Dysphoria

Because gender dysphoria pertains directly to the distress experienced by an individual who desires to change gender identities, secondary behavioral health issues can co-occur such as depression and anxiety. If left untreated, these conditions can lead to the inability to function in daily activities, social isolation, and even suicidal ideation. Studies do confirm that adolescents and adults with gender dysphoria report higher levels of anxiety, depression, and poor peer relationships than the general population (Kuper et al, 2019). Other associated conditions include substance abuse, eating disorders, and compulsivity. A significant proportion of individuals with gender dysphoria also have autism spectrum disorder (ASD) (Saleem and Rizvi, 2017). Although the number reporting secondary issues is increased, individuals diagnosed with gender dysphoria do not necessarily constitute the entire population that is gender non-conforming (i.e., does not identify with natal sex), and no information is available breaking down the percentage of those who are non-conforming with gender dysphoria and those who are non-conforming with no distress. Additionally, available research raises questions as to whether the distress is secondary to pre-existing behavioral health disorders and not gender dysphoria. This is evident in the number of adolescents who reported anxiety and depression diagnoses prior to transitioning (Saleem and Rizvi, 2017).

Furthermore, conventional treatments for secondary behavioral health issues are available. These include cognitive behavioral therapy, medication, and inpatient services. The APA reports that treatments for these are highly effective with 80% to 90% of individuals diagnosed with depression responding positively (APA, 2020). In addition, a high percentage of adolescents diagnosed with gender dysphoria had received psychiatric treatment for a prior or co-occurring mental health issue. A 2015 study from Finland by Kaltiala-Heino et al noted that 75% of children seeking sex reassignment services had been treated by a behavioral health professional (Kaltiala-Heino et al, 2015).

Diagnosing Gender Dysphoria

Prior to the publication of the DSM-V, diagnosing individuals experiencing gender identity issues followed a different process. Behavioral health clinicians could assign the diagnosis based on gender non-conformance alone. That has changed since 2013. Today, non-conforming to one’s gender is part of personal identity and not a disorder requiring treatment. This change has led professional associations to shift the diagnostic criteria for gender dysphoria to focus on the distress caused by shifting identities (DSM-V, 2013).

For adolescents, the APA identifies “a marked incongruence between one’s experienced/expressed gender and natal sex, of at least 6 months’ duration” as the core component of gender dysphoria (DSM-V, 2013). What the APA does not elucidate is the threshold for “marked.” This raises questions as to whether practitioners exercise uniformity when applying the diagnostic criteria or if they do so subjectively. For example, the WPATH’s *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People* provides guidance on the processes mental health practitioners should use when assessing for gender dysphoria but offers no benchmarks for meeting diagnostic criteria (WPATH, 2012).

Such processes include evaluating for gender non-conforming behaviors and other co-existing mental disorders like anxiety or depression. This involves not only interviewing the adolescent but also the family in addition to reviewing medical histories. WPATH also asserts that gender dysphoria assessments need to account for peer relationships, academic performance, and provide information of potential treatments. This last component is necessary because it might affect an individual's choices regarding transitioning, particularly if the information does not correspond to the desired outcome (WPATH, 2012).

The diagnosis of gender dysphoria is a relatively recent concept in mental health, being the product of decades of discussion and building upon previous definitions. Instead of treating gender non-conformity as a disorder, behavioral health professionals acknowledge it as part of one's identity and focus on addressing the associated distress. Considering the new criteria, this changes the dynamics of the population who would have qualified for a diagnosis before 2013 and those who would today. Given that desiring to transition into a gender different from natal sex no longer qualifies as a disorder, behavioral health professionals are treating distress and referring adolescents and adults to therapies that are used off-label and pose irreversible effects.

Current Available Treatments for Gender Dysphoria

At present, proposed treatment for gender dysphoria occurs in four stages, beginning with psychological services and ending with sex reassignment surgery. As an individual progresses through each stage, the treatments gradually become more irreversible with surgical changes being permanent. Because of the increasing effects, individuals must have attempted treatment at the previous stage before pursuing the next one (Note: late adolescents and adults have already completed puberty and do not require puberty blockers). Listed in order, the four stages are as follows:

- **Behavioral Health Services:** Psychologists and other mental health professionals are likely the first practitioners individuals with gender dysphoria will encounter. In accordance with clinical guidelines established by the World Professional Association for Transgender Health (WPATH)³, behavioral health professionals are supposed to "find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment." WPATH further discourages services for attempting to change someone's gender identity. Instead, it instructs practitioners to assess for the condition and readiness for puberty blockers or cross-sex hormones while offering guidance to function in a chosen gender. WPATH does assert that the clinicians do need to treat any other underlying mental health issues secondary or co-occurring with gender dysphoria (WPATH, 2012). However, the organization provides conflicting guidance because it also advises practitioners to prescribe cross-sex hormones on demand (Levine, 2018).
- **Puberty Suppression:** Used only on individuals in the earliest stages of puberty (Tanner stage 2), preventing pubertal onset provides additional time to explore gender identities before the physical characteristics of biological sex develop. This treatment is intended to reduce distress and anxiety related to the appearance of adult sexual physical features. To suppress puberty, pediatric endocrinologists inject gonadotropin releasing hormone (Gn-RH) at specific intervals (e.g., 4 weeks or 12 weeks). The Gn-RH suppresses gonadotropin receptors that allow for the

³ The World Professional Association for Transgender Health asserts that it is a professional organization. However, it functions like an advocacy group by allowing open membership to non-clinicians (WPATH, 2022).

development of primary and secondary adult sexual characteristics. Prior to receiving puberty suppression therapy, individuals must have received a diagnosis of gender dysphoria and have undergone a mental health evaluation (Kyriakou et al, 2020).

- **Cross-Sex Hormones:** For adults and late adolescents (16 years or older), the next treatment phase recommended is taking cross-sex hormones (e.g., testosterone or estrogen) to create secondary sex characteristics. In men transitioning into women, these include breast development and widening around the pelvis. Women who transition into men experience deeper voices, redistribution of fat deposits, and growing facial hair. According to the Endocrine Society, late adolescents who qualify for cross-sex hormones must have a confirmed diagnosis of gender dysphoria from a mental health practitioner with experience treating that population. Some physical changes induced by these hormones are irreversible (Endocrine Society, 2017).
- **Sex Reassignment Surgery:** Sometimes referred to as “gender affirming” surgery, this treatment does not consist of just one procedure but several, depending on the desires of the transitioning individual. Primarily, sex reassignment procedures alter the primary and secondary sexual characteristics. Men transitioning into women (trans-females) undergo a penectomy (removal of the penis), orchiectomy (removal of the testes), and vulvoplasty (creation of female genitals). Other procedures trans-females may undergo include breast augmentation and facial feminization. For women that transition into men (trans-males), procedures include mastectomy (removal of the breasts), hysterectomy (removal of the uterus), oophorectomy (removal of the ovaries), and phalloplasty (creation of male genitals). Because of the complexities involved in phalloplasty, many trans-males do not opt for this procedure and limit themselves to mastectomies. Additionally, the effects of sex reassignment surgery, such as infertility, are permanent (WPATH, 2012).

While some clinical organizations assert that they are the standard of care for gender dysphoria, the U.S. Food and Drug Administration (FDA) currently has not approved any medication as clinically indicated for this condition (Unger, 2018). Although puberty blockers and cross-sex hormones are FDA approved, the FDA did not approve them for treating gender dysphoria, meaning that their use for anything other than the clinical indications listed is off-label (American Academy of Pediatrics, 2014). As for surgical procedures, the FDA does not evaluate or approve them, but it does review all surgical devices (FDA, 2021). In addition, the Endocrine Society concedes that its practice guidelines for sex reassignment treatment does *not* constitute a “standard of care” and that its grades for available services are low or very low (Endocrine Society, 2017).⁴

⁴ Disagreement over how to treat gender dysphoria, gender identity disorder, and transsexualism has persisted since sex reassignment surgery first became available in the 1960s. In a 2006 counterargument, Paul McHugh highlights how individuals seeking surgery had other reasons that extended beyond gender identity, including sexual arousal and guilt over homosexuality. In addition, he asserts that undergoing sex reassignment procedures did not improve a patient’s overall behavioral health and that providing a “surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it” (McHugh, 2006).

Literature Review: Introduction

Currently, an abundance of literature and studies on gender dysphoria is available through academic journals, clinical guidelines, and news articles. Similar to other mental health issues, the material addresses a broad range of topics consisting of available treatments, etiology (i.e., causes), risks, benefits, and side effects. Although most stories reported by the media indicate that treatments such as cross-sex hormones and sex reassignment surgery are the most effective, research reveals that numerous questions still exist. These include what are the long-term health effects of taking cross-sex hormones, what are the real causes of gender dysphoria, and how many individuals that transition will eventually want to revert to their natal sex. Additionally, much of the available research is inconclusive regarding the effectiveness of sex reassignment treatments with multiple studies lacking adequate sample sizes and relying on subjective questionnaires. While much of the scientific literature leans in favor of cross-sex hormones and surgery as options for improving the mental health of individuals with gender dysphoria, it does not conclusively demonstrate that the benefits outweigh the risks involved, either short or long-term. What studies do reveal with certainty is that sex reassignment surgery and cross-sex hormones pose permanent effects that can result in infertility, cardiovascular disease, and disfigurement. All of this indicates that further research is necessary to validate available treatments for gender dysphoria. Thus, physicians, who recommend sex reassignment treatment, are not adhering to an evidence-based medicine approach and are following an eminence-based model.

The following literature review addresses the multiple facets of this condition and presents areas of ongoing debate and persisting questions. Beginning with the condition's etiology and continuing with evaluations of puberty blockers, cross-sex hormones, and surgery, the review explains each area separately and in context of gender dysphoria at large. Additionally, the review provides an analysis on available research on mental health outcomes as well as the condition's persistence into adulthood. Taken as a whole, the available studies demonstrate that existing gender dysphoria research is inconclusive and that current treatments are used to achieve cosmetic benefits while posing risky side effects as well as irreversible changes.

Literature Review: Etiology of Gender Dysphoria

What causes gender dysphoria is an ongoing debate among experts in the scientific and behavioral health fields. Currently, the research indicates that diagnosed individuals have higher proportions of autism spectrum disorder (ASD), history of trauma or abuse, fetal hormone imbalances, and co-existing mental illnesses. Also, experts acknowledge that genetics may factor into gender dysphoria. Another potential cause is social factors such as peer and online media influence. At the moment, none of the studies provides a definite cause and offer only correlations and weakly supported hypotheses. In addition, evidence favoring a biological explanation is highly speculative. However, the research does raise questions about whether treatments with permanent effects are warranted in a population with disproportionately high percentages of ASD, behavioral health problems, and trauma.

In a 2017 literature review by Fatima Saleem and Syed Rizvi, the authors examine gender dysphoria's numerous potential causes and the remaining questions requiring further research. In conclusion, the pair indicate that associations exist between the condition and ASD, schizophrenia, childhood abuse, genetics, and endocrine disruption chemicals but that more research is needed to improve understanding of how these underlying issues factor into a diagnosis. Throughout the review, Saleem and Rizvi identify the following as potential contributing elements to the etiology of gender dysphoria:

- **Neuroanatomical Etiology:** During fetal development, the genitals and brain develop during different periods of a pregnancy, the first and second trimesters respectively. Because the processes are separate, misaligned development is possible where the brain may have features belonging to the opposite sex. The authors identify one study where trans-females presented with a "female-like putamen" (structure at the base of the brain) when undergoing magnetic resonance imaging (MRI) scans.⁵
- **Psychiatric Associations:** Saleem and Rizvi identify multiple studies reporting that individuals with gender dysphoria have high rates of anxiety and depressive disorders with results ranging as high as 70% having a mental health diagnosis. In addition, the pair note that schizophrenia may also influence desires to transition. However, the review does not assess whether the mental health conditions are secondary to gender dysphoria.
- **Autism Spectrum Disorder:** Evidence suggests a significant percentage of individuals diagnosed with gender dysphoria also have ASD. The authors note that the available studies only establish a correlation and do not identify mechanisms for causation.
- **Childhood Abuse:** Like the above causes, Saleem and Rizvi note that those with gender dysphoria tended to experience higher rates of child abuse across all categories, including neglect, emotional, physical, and sexual.
- **Endocrine Disruptors:** Although this cause still requires substantial research, it is a valid hypothesis regarding how phthalates found in plastics can create an imbalance of testosterone in fetuses during gestation, which can potentially lead to gender dysphoria. The authors point to one study that makes this suggestion.

⁵ Research on neuroanatomical etiology for gender dysphoria remains highly speculative due to limitations of brain imaging (Mayer and McHugh, 2016). In addition, neuroscience demonstrates that exposures to certain environments and stimuli as well as behaviors can affect brain changes (Gu, 2014). Furthermore, available research indicates that male and female brains have different physical characteristics but cannot be placed in separate categories due to extensive overlap of white/grey matter and neural connections (Joel et al, 2015).

Saleem and Rizvi's review reveal that gender dysphoria's etiology can have multiple factors, most of which require treatments and therapies not consisting of cross-sex hormones or surgery. (Saleem and Rizvi, 2017).

Out of the research on the condition's etiology, a large portion focuses on the correlation with ASD. One of the more substantial studies by Van der Miesen et al published in 2018 evaluates 573 adolescents and 807 adults diagnosed with ASD and compares them to 1016 adolescents and 846 adults from the general population. The authors' findings note that adolescents and adults with ASD were approximately 2.5 times more likely to indicate a desire of becoming the opposite sex. Although the methodology used to reach this conclusion consisted of surveys where respondents had a choice of answering "never," "sometimes," or "often," the results correspond with those of similar studies. Van der Miesen et al also indicate that most responses favoring a change in gender responded with "sometimes." Additionally, the authors do not state how many in their sample group actually had a gender dysphoria diagnosis. (Van der Miesen et al, 2018).

Another study by Shumer et al from 2016 utilizes a smaller sample size (39 adolescents) referred to an American hospital's gender clinic. Unlike Van der Miesen et al's research, Shumer et al evaluate subjects with a diagnosis of gender dysphoria for possible signs of ASD or Asperger's syndrome. Their findings revealed that 23% of patients presenting at the clinic would likely have one of the two conditions. Possible explanations for the high percentage are the methods used to gather the data. Shumer et al requested a clinical psychologist to administer the Asperger Syndrome Diagnostic Scale to the parents of the sample patients, four of whom already had an ASD diagnosis. The authors conclude that the evidence to support high incidence of gender dysphoria in individuals with ASD is growing and that further research is needed to determine the specific cause (Shumer et al, 2016).

Research indicating a strong correlation between ASD and gender dysphoria is not the only area where new studies are emerging. Discussions about the effects of prenatal testosterone levels are also becoming more prevalent. One such example is Sadr et al's 2020 study that looks at the lengths of the index and ring fingers (2D:4D) of both left and right hands of 203 individuals diagnosed with gender dysphoria. The authors used this method because prenatal testosterone levels can affect the length ratios of 2D:4D. By comparing the ratios of a group with gender dysphoria to a cohort from the general population, Sadr et al could assess for any significant difference. Their results indicated a difference in trans-females who presented with more feminized hands. For trans-males, the difference was less pronounced. The results for both groups were slight, and the meta-analysis that accompanies the study notes no statistically significant differences in multiple groups from across cultures. However, Sadr et al further assert that the evidence strongly suggests elevated prenatal testosterone levels in girls and reduced amounts in boys may contribute to gender dysphoria, requiring additional research (Sadr et al, 2020).

In addition to biological factors and correlations with ASD, researchers are exploring psychological and social factors to assess their role in gender dysphoria etiology. This literature examines a range of potential causative agents, including child abuse, trauma, and peer group influences. One such study by Kozłowska et al from 2021 explores patterns in children with high-risk attachment issues who also had gender dysphoria. The authors wanted to assess whether past incidents of abuse, loss, or trauma are associated with higher rates of persons desiring to transition. As a basis, Kozłowska et al cite John Bowlby's research on childhood brain development, noting that the process is not linear and depends

heavily on lived experiences. The study further acknowledges that biological factors combined with life events serve as the foundation for the next developmental phase and that early poor-quality attachment issues increase the risk for psychological disorders in adolescence and adulthood. Such disorders include mood and affective disorders, suicidal ideations, and self-harm. Kozłowska et al also cite other studies that indicate a high correlation between gender dysphoria and “adverse childhood events” and further assert that the condition “needs to be conceptualized in the context of the child’s lived experience, and the many different ways in which lived experience is biologically embedded to shape the developing brain and to steer each child along their developmental pathway” (Kozłowska et al, 2021).

For their study, Kozłowska et al recruited 70 children diagnosed with gender dysphoria and completed family assessments going back three generations. This in-depth level was necessary to ascertain any and all events that could affect a child’s developmental phases. Additionally, the researchers individually assessed the diagnosed children. To establish comparisons, Kozłowska et al performed assessments on a non-clinical group and a mixed-psychiatric group. Their results demonstrate that children with gender dysphoria have significantly higher rates of attachment issues as well as increased reports of “adverse childhood events” such as trauma (e.g., domestic violence and physical abuse). Furthermore, the authors indicate that a high proportion of families reported “instability, conflict, parental psychiatric disorder, financial stress, maltreatment events, and relational ruptures.” These results led Kozłowska et al to conclude that gender dysphoria can be “associated with developmental pathways – reflected in at-risk patterns of attachment and high rates of unresolved loss and trauma – that are shaped by disruptions to family stability and cohesion.” The study also cites that treatment requires “a comprehensive biopsychosocial assessment with the child and family, followed by therapeutic interventions that address, insofar as possible, the breadth of factors that are interconnected with each particular child’s presentation” (Kozłowska et al, 2021).

This recent study raises questions regarding the medical necessity of gender dysphoria treatments such as puberty blockers and cross-sex hormones for adolescents. If high percentages of children diagnosed with gender dysphoria also have histories of trauma and attachment issues, should conventional behavioral health services be utilized without proposing treatments that pose irreversible effects? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects (i.e., the watchful waiting approach)?

Aside from the notion that childhood abuse and adversity can potentially cause gender dysphoria, other possible explanations such as social factors (e.g., peer influences and media) may be contributing factors. Research on rapid onset gender dysphoria (ROGD) links this phenomenon to peer and social elements. In an analysis utilizing parent surveys, Lisa Littman asserts that the rapid rise of ROGD is not associated with the traditional patterns of gender dysphoria onset (i.e., evidence of an individual’s gravitation to the opposite sex documented over multiple years) but rather exposure to “social and peer contagion.” Littman uses this term in the context of definitions cited in academic literature, stating that “social contagion is the spread of affect or behaviors through a population” and that “peer contagion is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially undermine their own development or harm others.” Examples of the latter’s negative effects include depression, eating disorders, and substance abuse. What prompted this study is a sudden increase of parents reporting their daughters declaring themselves to be transgender without any previous signs of gender dysphoria. Littman also indicates

that these parents cite that their daughters became immersed in peer groups and social media that emphasized transgender lifestyles (Littman, 2018).

In addition to identifying characteristics of ROGD, the study examines social media content that provides information to adolescents regarding how to obtain cross-sex hormones through deception of physicians, parents, and behavioral health professionals. Such guidance includes coaching on how to fit a description to correspond to the DSM-V and pressures to implement treatment during youth to avoid a potential lifetime of unhappiness in an undesirable body. Littman further states that "online content may encourage vulnerable individuals to believe that non-specific symptoms and vague feelings should be interpreted as gender dysphoria." The study also notes that none of the individuals assessed using the parental surveys qualified for a formal diagnosis using the DSM-V criteria (Littman, 2018).

The survey responses revealed similar data to Kozłowska et al's study with 62.5% of the adolescents having a mental health or neurodevelopmental disorder. Furthermore, the responses indicate a rapid desire to bypass behavioral health options and pursue cross-sex hormones. 28.1% of parents surveyed stated that their adolescents did not want psychiatric treatments. One parent even reported that their daughter stopped taking prescribed anti-depressants and sought advice only from a gender therapist. Littman's research further reveals that 21.2% of parents responded that their adolescent received a prescription for puberty blockers or cross-sex hormones at their first visit (Littman, 2018). These responses indicate that practitioners do not uniformly follow clinical guidelines when making diagnoses or prescribing treatment.

In the discussion, Littman proposes two hypotheses for the appearance of ROGD. The first states that social and peer contagion is one of the primary causes, and the second asserts that ROGD is a "maladaptive coping mechanism" for adolescents dealing with emotional and social issues. While the surveyed parents did not report early signs of gender dysphoria, a majority noted that their daughters had difficulty in handling negative emotions. Littman concludes that ROGD is distinct from gender dysphoria as described in the DSM-V and that further research is needed to assess whether the condition is short or long-term (Littman, 2018). What the study does not explore, but raises the question, is what proportion of those being treated for gender dysphoria are adolescents with ROGD.

Littman's study along with the others reveal that the causes of gender dysphoria are still a mystery and could have multiple biological and social elements. Because of this ongoing uncertainty, treatments that pose irreversible effects should not be utilized to address what is still categorized as a mental health issue. That allows adequate opportunity for individuals to receive treatment for co-existing mental disorders, establish their gender dysphoria diagnoses, and understand how cross-sex hormones and surgery will alter the appearance of their bodies as well as long-term health.

Literature Review: Desistance of Gender Dysphoria and Puberty Suppression

The World Professional Association for Transgender Health (WPATH) and the Endocrine Society both endorse the use of gonadotropin releasing hormones (Gn-RH) to suppress puberty in young adolescents who have gender dysphoria. Both organizations state that the treatment is safe and fully reversible. In addition, they state that delaying pubertal onset can provide extra time for adolescents to explore the gender in which they choose to live. The associations further state that puberty suppression is necessary to prevent the development of primary and secondary sexual characteristics that can inhibit successful transitions into adulthood (WPATH, 2012; Endocrine Society, 2017). Of the two groups, WPATH offers clinical criteria an individual should meet to qualify for puberty suppression such as addressing psychological co-morbidities and assessing whether gender dysphoria has intensified (WPATH, 2012).

Neither organization explains that the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that the puberty suppression can have side effects. Both organizations neglect to mention that using Gn-RH for gender dysphoria by altering the appearance is not an FDA-approved clinical indication. Furthermore, the research used to justify puberty suppression is low or very-low quality and little information is available on long-term effects (Hruz, 2019). Additionally, in his assessment, Quentin Van Meter explained that physical differences between central precocious puberty and natural onset puberty demonstrate that Gn-RH does not have permanent adverse effects for those treated for the former but can for the latter such as insufficient bone-mineral density and neural development (Van Meter, 2022). Also, as recently as May 17, 2022, during a U.S. Senate Committee on Appropriations hearing, Lawrence Tabak, acting director of the National Institutes of Health, responded to Senator Marco Rubio, acknowledging that no long-term studies are available evaluating the effects of puberty blockers when used for gender dysphoria (U.S. Senate Committee on Appropriations, 2022).

Currently, some studies provide weak support for this treatment but leave too many questions as to its effectiveness and medical necessity, especially considering how many children decide against transitioning. In addition, puberty blockers halt development of primary and secondary sexual characteristics and deny opportunities for adolescents to adapt and become comfortable with their natal sex. Instead, puberty blockers can serve as a potential “gateway drug” for cross-sex hormones by denying them the experience of physically maturing (Laidlaw et al, 2018).

A 2013 study by Steensma et al offers data on the percentage of children who opt not to transition after experiencing gender dysphoria. The authors follow 127 adolescents (mean age of 15 during the evaluation period) for four years who had been referred to a Dutch gender dysphoria clinic. Out of this cohort, 47 (37%; 23 boys and 24 girls) continued experiencing the condition and applied for sex reassignment treatment. The other 80 adolescents never returned to the clinic. Because this clinic was the only one that treated gender dysphoria in the Netherlands, Steensma et al assumed that those who did not return no longer desired transitioning. The study indicates one of the key predictors for persisting gender dysphoria was the age of first presentation. Older adolescents that started going to the clinic were more likely to persist, while younger adolescents tended not to follow through. Steensma et al provide further insight into other predicting factors, particularly on how each individual views his or her gender identity. The authors note that adolescents who “wished they were the other sex” were more likely to become desisters and that those who “believed that they were the other sex” persisted

and later sought sex reassignment treatment (Steensma et al, 2013). While the study focuses on factors that contribute to the condition's persistence or desistance, it raises the question as to whether puberty suppression is necessary when age plays such an important role regarding the decision to transition.

WPATH and the Endocrine Society state that the primary reason for initiating pubertal suppression is not to treat a physical condition but to improve the mental health of adolescents with gender dysphoria. However, available research does not yield definitive results that this method is effective at addressing a mental health issue. The "gold standard" for medical studies is the randomized-controlled trial (RCT). Because RCTs utilize large sample sizes, have blind testing groups (i.e, placebos), and use objective controls, they can offer concrete conclusions and shape the array of established treatments. In addition, RCTs require comparisons between cohort outcomes and ensure that participants are randomly assigned to each group. These measures further reduce the potential for bias and subjectivity (Hariton and Locascio, 2018).

Presently, no RCTs that evaluate puberty suppression as a method to treat gender dysphoria are available. Instead, the limited number of published studies on the topic utilize small sample sizes and subjective methods (Hruz, 2019). A 2015 article by Costa et al is one such example. The study asserts that "psychological support and puberty suppression were both associated with an improved global psychological functioning in gender dysphoric adolescents." To reach this conclusion, the authors selected 201 children diagnosed with the condition and divided them into two groups, one to receive psychological support only and the other to get puberty blockers in addition to psychological support. Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control. To assess whether puberty suppression is an effective treatment, the authors administered two self-assessments (Utrecht Gender Dysphoria Scale and Children's Global Assessment Scale)⁶ to the groups at 6-month intervals during a 12-month period. Because the study relies heavily on self-assessments, the conclusions are likely biased and invalid. Another problem that is also present and common throughout articles supporting puberty suppression is the short-term period of the study. Costa et al's conclusions may not be the same if additional follow-ups occurred three or five years later (Costa et al, 2015). This further raises the question whether low-quality studies like Costa et al's should serve as the basis for clinical guidelines advising clinicians to prescribe drugs for off-label purposes.

Aside from questionable research, information regarding the full physical effects of puberty suppression is incomplete. In a 2020 consensus parameter prepared by Chen et al, 44 experts in neurodevelopment, gender development, and puberty/adolescence reached a conclusion stating that "the effects of pubertal suppression warrant further study." The basis for this was that the "full consequences (both beneficial and adverse) of suppressing endogenous puberty are not yet understood." The participating experts emphasized that the treatment's impact on neurodevelopment in adolescents remains unknown. Chen et al explain that puberty-related hormones play a role in brain development as documented in animal studies and that stopping these hormones also prevents neurodevelopment in addition to sexual maturation. The authors further raise the question whether normal brain development resumes as if it had not been interrupted when puberty suppression ceases. Because this

⁶ Behavioral health practitioners use the Children's Global Assessment Scale (CGAS) to measure child functioning during the evaluation process to determine diagnoses. Available evidence indicates that the CGAS is not effective for evaluating children who experienced trauma and presented with mental health symptoms (Blake et al, 2006).

question remains unanswered, it casts doubt on the veracity of organizations' assertions that puberty suppression is "fully reversible" (Chen et al, 2020).

In addition to the unanswered questions and low-quality research, puberty suppression causes side effects, some of which have the potential to be permanent. According to a 2019 literature review by De Sanctis et al, most side effects associated with Gn-RH are mild, consisting mostly of irritation around injection sites. However, clinicians have linked the drug to long-term conditions such as polycystic ovarian syndrome, obesity, hypertension, and reduced bone mineral density. While reports of these events are low and the authors indicate that Gn-RH is safe for treating central precocious puberty (Note: De Sanctis et al do not consider gender dysphoria in their analysis), the review raises questions about whether off-label use to treat a psychological condition is worth the risks (De Sanctis et al, 2019).

Furthermore, De Sanctis et al cite studies noting increased obesity rates in girls who take Gn-RH but that more research is needed to gauge the consistency. Additionally, the authors note that evidence is strong regarding reduced bone mineral density during puberty suppression but indicate that the literature suggests it is reversible following treatment (De Sanctis et al, 2019). While research leans toward the reversibility of effects on bone mineral density, the quantity of studies available on this subject are limited. Also, no long-term research has been completed on how puberty suppression affects bone growth. This is significant because puberty is when bone mass accumulates the most (Kyriakou et al, 2020). One example of a complication involving bone growth and Gn-RH is slipped capital femoral epiphysis. This condition occurs when the head of the femur (i.e., thighbone) can slip out of the pelvis, which can eventually lead to osteonecrosis (i.e., bone death) of the femoral head. Although the complication is rare, its link to puberty suppression indicates that the "lack of adequate sex hormone exposure" could be a cause (De Sanctis et al, 2019).

The current literature on puberty suppression indicates that using it to treat gender dysphoria is off-label, poses potentially permanent side effects, and has questionable mental health benefits. The limited research and lack of FDA approval for that clinical indication prompt questions about whether medications with physically altering effects should be used to treat a problem that most adolescents who experience it will later overcome by conforming to their natal sex. Additional evidence is required to establish puberty suppression as a standard treatment for gender dysphoria.

Literature Review: Cross-Sex Hormones as a Treatment for Gender Dysphoria

Currently, the debate surrounding the use of cross-sex hormones to treat gender dysphoria revolves around their ability to improve mental health without causing irreversible effects. It is not about whether taking cross-sex hormones can alter someone's appearance. The evidence demonstrating the effectiveness of cross-sex hormones in achieving the secondary sexual characteristics of the opposite sex is abundant. Also, the overall scientific consensus concludes that individuals who take cross-sex hormones will reduce the primary sexual function of his or her natal sex organs. What researchers continue evaluating are the short and long-term effects on mental health, impacts on overall physical health, and how the changes affect the ability to detransition. Of these, benefits to mental health overshadow the other discussions. Prescribers of cross-sex hormones focus so heavily on behavioral health outcomes that they de-emphasize that these drugs cause permanent physical changes and side effects that can lead to premature death (Hruz, 2020). Some clinical guidelines such as WPATH's do not even indicate that some of the changes are irreversible.

Like puberty suppression, the Endocrine Society and WPATH provide guidance on administering cross-sex hormones to individuals with gender dysphoria. Both organizations state that this treatment should not be administered without a confirmed diagnosis of gender dysphoria and only after a full psychosocial assessment. In addition, behavioral health practitioners must ensure that any mental comorbidities are not affecting the individual's desire to transition. WPATH and the Endocrine Society further state that clinicians should administer hormone replacements such as testosterone and Estradiol (estrogen) in gradual phases, where the dose increases over several months. For trans-females, the organizations state that progesterone (anti-androgen) is also necessary to block the effects of naturally produced testosterone (WPATH, 2012; Endocrine Society, 2017). When taking cross-sex hormones, trans-males need increased doses for the first six months. After that, the testosterone's effects are the same on lower doses. Once started, individuals cannot stop taking hormones unless they desire to detransition (Unger, 2016).

Although the two groups provide similar guidance, they vary on statements that can have significant impact on long-term outcomes, particularly regarding age. According to WPATH's standards, 16 years is the general age for initiating cross-sex hormones, but the organization acknowledges that the treatment can occur for younger individuals depending on circumstances (WPATH, 2012). This differs from the Endocrine Society, which states no specific age for appropriateness and explains the disagreements in assigning a number. The group highlights that most adolescents have attained sufficient competence by age 16 but may not have developed adequate abilities to assess risk (Endocrine Society, 2017). This raises the question whether adolescents can make sound decisions regarding their long-term health. Additionally, the varying guidance raises an issue with WPATH not only using age 16 as a standard but also indicating that younger adolescents are capable of making that choice.

WPATH's guidance also does not stress the irreversible nature of cross-sex hormones, citing the treatment as "partially reversible" and not indicating which changes are permanent. Furthermore, parts of WPATH's information are misleading and directly conflict with guidance issued by clinics and other sources. One such example consists of WPATH stating that "hormone therapy *may* (emphasis added) lead to irreversible changes." This statement is misleading in light of existing research, which indicates that multiple physical changes are permanent. In addition, WPATH claims that certain effects of cross-

sex hormones such as clitoral enlargement can last one to two years when it is actually irreversible (UCSF, 2020). WPATH also does not explain the risks to male fertility, noting that lowered sperm count or sterility is “variable.” The University of California at San Francisco (UCSF) provides starkly different information by stating that trans-females should expect to become sterile within a few months of starting cross-sex hormones. UCSF also advises trans-females to consult a sperm bank if they may want to father children after transitioning (WPATH, 2012; UCSF, 2020). Below is a chart that outlines the effects of cross-sex hormones and identifies which ones are reversible or permanent.

Physical Changes Effectuated by Cross-Sex Hormones	
Physical Changes in Trans-Males (Female-to-Male Transitions)	
Physical Change	Reversible or Irreversible
Oily Skin or Acne	Reversible
Facial and Body Hair Growth	Irreversible
Male-Pattern Baldness	Irreversible
Increased Muscle Mass	Reversible
Body Fat Redistribution	Reversible
Ceasing of Menstruation	Reversible
Enlarged Clitoris	Irreversible
Vaginal Atrophy	Reversible
Deepening of Voice	Irreversible
Physical Changes in Trans-Females (Male-to-Female Transitions)	
Body Fat Redistribution	Reversible
Decreased Muscle Mass	Reversible
Skin Softening or Decrease in Oiliness	Reversible
Lower Libido	Reversible
Fewer Spontaneous Erections	Reversible
Male Sexual Dysfunction	Possibly Irreversible
Breast Growth	Irreversible
Decrease in Testicular Size	Reversible
Decrease in Sperm Production or Infertility	Likely Irreversible
Slower Facial and Body Hair Growth	Reversible

Sources: UCSF, 2020; WPATH, 2012; Endocrine Society, 2017⁷

The above chart demonstrates that trans-males and trans-females experience different effects from cross-sex hormones that can cause myriad issues in later life. For example, trans-males who opt to detransition may face challenges related to permanent disfigurement (e.g., facial hair and deepened voices). Trans-females, on the other hand, may not endure the same issues pertaining to visible physical changes but might become despondent over being unable to reproduce. This can occur regardless of whether the transitioning individual is satisfied with sex reassignment. Given that the clinical guidelines do not provide uniform information on the permanent effects of cross-sex hormones, clinicians are unable to make sound recommendations to patients. This treatment can supposedly alleviate symptoms

⁷ This chart consists of conclusions regarding physical changes made by three different clinical organizations. If one organization determined that a physical change was irreversible, that was sufficient to meet the criteria to be listed as “irreversible” in the chart.

of distress. However, cross-sex hormones' permanent effects also have the potential to cause psychological issues.

Arguments favoring cross-sex hormones assert that the desired physical changes can alleviate mental health issues in individuals with gender dysphoria but do not consider that hormones used in this manner, like puberty blockers, are off-label. While the FDA has approved estrogen and testosterone for specific clinical indications (e.g., hypogonadism), it has not cleared these drugs for treating gender dysphoria. Additionally, these arguments do not acknowledge that the U.S. Drug Enforcement Administration (DEA) lists testosterone as a Schedule III controlled substance, meaning that it has a high probability of abuse (DEA, 2022). Furthermore, evidence of psychological benefit from cross-sex hormones is low-quality and relies heavily on self-assessments taken from small sample groups (Hruz, 2020).

A 2019 study by Kuper et al seeks to demonstrate that adolescents desiring cross-sex hormones have elevated rates of depression, anxiety, and challenges with peer relationships. To make their findings, the authors provided questionnaires to 149 adolescents who presented at a gender clinic in Dallas, Texas and concluded that half of the sample group experienced increased psychological issues. One problem with the study is that it relies on parent or self-assessments such as the Youth-Self Report, Body-Image Scale, and the Child Behavior Checklist. While these assessments have strong reliability, the sample is cross-sectional, consisting of gender dysphoric individuals who presented for an initial visit at the clinic. Also, Kuper et al do not directly link these psychological symptoms to gender dysphoria but rather insinuate a strong connection. Without an analysis of the longitudinal histories of the participants, the study cannot demonstrate whether gender dysphoria was a direct cause of the psychological issues, which could possibly result from trauma, abuse, or family dysfunction. Kuper et al's study only presents weak correlation between adolescents who report symptoms of distress and gender dysphoria. While the authors do not claim that the participants' psychological problems caused the condition, they fail to explicitly state that no demonstrable relationship exists and explain that their findings are "broadly consistent with the previous literature" (Kuper et al, 2019).

Additionally, a more comprehensive literature review from 2019 by Nguyen et al evaluates the effect of cross-sex hormones on mental health outcomes. Although the authors argue that the evidence supports the treatment, they do note that available studies use "uncontrolled observational methods" and "rely on self-report." The review also asserts that "future research should focus on applying more robust study designs with large sample sizes, such as controlled prospective cohort studies using clinician-administered ratings and longitudinal designs with appropriately matched control groups." All of these are characteristics of RCTs. While Nguyen et al highlight flaws in the studies in their conclusion, they do not emphasize them in their analysis, opting to focus primarily on results. Another problem with the studies selected for the review is the short-term periods for evaluation. Out of 11 studies Nguyen et al discuss, only one tracks its participants for 24 months. The others only follow their cohorts for 6 or 12 months (Nguyen et al, 2019). Without long-term data to support assertions that cross-sex hormones substantially improve the mental health of individuals with gender dysphoria, the review cannot make definitive conclusions on the treatment's benefits.

Basing their stances on this low-quality evidence, clinical associations such as the American Academy of Pediatrics (AAP) and the American Psychology Association endorse the use of cross-sex hormones as treatments for gender dysphoria. In particular, the AAP discourages use of the term "transition" and

asserts that medical treatments used to obtain secondary characteristics of the opposite sex are “gender affirming.” This decision mirrors the DSM-V’s interpretation of gender being part of identity. The AAP further states that taking cross-sex hormones is an “affirmation and acceptance of who they (i.e., patient) have always been” (AAP, 2018). The American Psychological Association also takes a similar stance in its *Resolution on Gender Identity Change Efforts* by asserting that medical treatments such as puberty suppression, cross-sex hormones, and surgery improve mental health and quality of life and reinforce the notion that transitioning and seeking sex reassignment therapies do not constitute a psychological disorder (American Psychological Association, 2021). Stances like these can substantially influence practitioners and their treatment recommendations. Given that low-quality evidence serves as the basis for supportive positions, this raises questions about whether clinicians can make informed decisions for their patients that will promote the best outcomes.

James Cantor published a critique in 2020 of the AAP’s endorsement of “gender affirming” treatments, arguing that the organization did not base its recommendations on established medical evidence. He asserts that the AAP’s position is based on research that does not support intervention but rather supports “watchful waiting” because most transgender youths desist and identify as their natal sex during puberty. Cantor further argues that the AAP not only disregards evidence but also cites “gender affirming” interventions as the only effective method. To conclude, he states the organization is “advocating for something far in excess of mainstream practice and medical consensus” (Cantor, 2020).

Given those evidentiary problems, those who rely on the AAP’s endorsement as a basis for “gender affirming” treatments are practicing eminence-based medicine as opposed to evidence-based medicine. Eminence-based medicine refers to clinical decisions made by relying on the opinions of prominent health organizations rather than relying on critical appraisals of scientific evidence (Nhi Le, 2016). While it is true that the AAP has more knowledge than a lay person and a degree of credibility in the medical community, the opinions of such organizations are not valid unless they are based on quality evidence.

Research on sex reassignment also does not adequately address the reasons for and prevalence of detransitioning. Although no definite numbers are available regarding the percentage of transgender people who decide to detransition, research indicates that roughly 8% decide to return to their natal sex. The reasons range from treatment side effects to more self-exploration that provided insight on individuals’ gender dysphoria. In a 2020 study by Lisa Littman, 101 people who had detransitioned provided their basis for doing so. Out of the sample group, 96% had taken cross-sex hormones and 33% had sex reassignment surgery. The average age for transitioning was 22 years, and the mean duration for the transition was 4 years. This indicates that even allowing additional time beyond the recommended age of 16 years can still lead to regrets. The study also raises the question as to whether individuals who transitioned at 16 or younger wanted to detransition in greater numbers. The author further offers reasons why these individuals sought cross-sex hormones and surgery, which include having endured trauma (mental or sexual), homophobia (challenged to accept oneself as a homosexual), peer and media influences, and misogyny (applicable only to trans-males). To obtain the results, the participants responded to a survey that asked about their backgrounds (e.g., reasons for transitioning, mental health comorbidities), and motivations for detransitioning. Littman noted that half of the women (former trans-males) had a mental health disorder and/or had experienced trauma within a year of deciding to transition. Men (former trans-females) reported much lower numbers of behavioral health issues and trauma after de-transitioning. Additionally, 77% of men surveyed identified as the opposite gender prior to transition, whereas just 58% of women had (Littman, 2020).

Of the reasons cited for detransitioning, the majority (60%) noted that they became more comfortable with their natal sex. Other reasons included concerns over complications from the treatments, primarily cross-sex hormones, and lack of improved mental health. Other less-cited explanations include concerns about workplace discrimination and worsening physical health. The study also notes that approximately 36% of participants experienced worse mental health symptoms. Based on the findings, Littman concludes that more research is needed in tracking the transgender population to obtain accurate percentages of those who decide to detransition and that men and women reported varying reasons for deciding to transition and later return to their natal sex. The author notes that higher rates of trauma and peer group influences might have contributed to women's decisions, which Littman attributes partially to rapid onset gender dysphoria (Littman, 2020). What the study also indicates is that cross-sex hormones are not a validated treatment for gender dysphoria. Nearly all of the participants had taken them and decided against maintaining the physical changes. Given that the majority of surveyed detransitioners cited that they were comfortable with their biological sex, the study indicates that gender dysphoria is not necessarily a lifelong issue. This necessarily raises doubts about whether cross-hormones, which cause permanent physical damage, is justified.

In addition to the psychological factors, cross-sex hormones pose significant long-term health risks to transitioning individuals. Currently, little information is available given that researchers have not had adequate time to study the effects in this population. However, use of hormones for other conditions has yielded data on how these drugs can affect the body and the cardiovascular system in particular. Because of the high dosages required to achieve physical change and the need to continuously take the drugs, cross-sex hormones can potentially harm quality of life and reduce life expectancy for transitioning individuals. According to Dutra et al, trans-females are three times more likely to die from a cardiovascular event than the general population. In their 2019 literature review, Dutra et al examined the results of over 50 studies evaluating the effects of cross-sex hormones on not only transgender individuals but those with menopause and other endocrine disorders, all of which indicate that use of estrogen or testosterone can increase risks for cardiovascular disease. Throughout their review, Dutra et al cite examples of trans-females having higher triglyceride levels after 24 months of cross-sex hormones and how researchers halted a study on estrogen due to an increase in heart attacks among participants. Another article the authors reference indicates a higher risk for thromboembolisms (i.e., blood clots) in trans-females. For trans-males, Dutra et al explain that research shows significant increased risk for hypertension, high cholesterol, obesity, and heart attacks. One study noted that trans-males have a four times greater risk of heart attack compared to women identifying as their natal sex. Dutra et al conclude that most transgender individuals are younger than 50 and that more studies are needed as this population ages. They do note that available studies indicate that cross-sex hormones pose dangers to long-term cardiovascular health (Dutra et al, 2019).

In sum, the literature reveals that the evidence for cross-sex hormones as a treatment for gender dysphoria is weak and insufficient. Between the permanent effects, off-label use, and consequences to long-term health, cross-sex hormones are a risky option that does not promise a cure but does guarantee irreversible changes to both male and female bodies. Additionally, the inadequate studies serving as the basis for recommendations by clinical associations can lead to providers making poorly informed decisions for their patients. Research asserting that taking cross-sex hormones improves mental health is subjective and short-term. More studies that utilize large sample sizes and appropriate

methods is required before the medical profession should consider cross-sex hormones as one of gender dysphoria's standard treatments.

Literature Review: Sex Reassignment Surgery

The final phase of treatment for gender dysphoria is sex reassignment surgery. This method consists of multiple procedures to alter the appearance of the body to resemble an individual's desired gender. Some procedures apply to the genitals (genital procedures) while others affect facial features and vocal cords (non-genital procedures). While the surgery creates aesthetical aspects, it does not fully transform someone into the opposite biological sex. Transgender persons who undergo the procedures must continue taking cross-sex hormones to maintain secondary sexual characteristics. Additionally, all physical changes are irreversible, and the success rate of a surgery varies depending on the procedure and the population. For example, surgeries for trans-females have much better results than those for trans-males. Complications such as post-operative infections can also arise with the urinary tract system. However, sex reassignment surgery supposedly can provide drastic, if not complete, relief from gender dysphoria (Endocrine Society, 2017). The following is a list of procedures (both genital and non-genital) for trans-females and trans-males that create physical features of the desired sex.

Procedures for Trans-Females

- **Genital Surgeries:** These consist of penectomy (removal of the penis), orchiectomy (removal of the testicles), vaginoplasty (construction of a neo-vagina), clitoroplasty (construction of a clitoris), and vulvoplasty (construction of a vulva and labia). To perform, a surgeon begins by deconstructing the penis and removing the testicles. The penile shaft and glans are repurposed to serve as a neo-vagina and artificial clitoris (Note: These are not actual female genitalia but tissue constructed to resemble female anatomy). If the shaft tissue is insufficient, the surgeon may opt to use a portion of intestine to build a neo-vagina. The scrotum serves as material for fashioning a vulva and labia. In addition to constructing female genitalia, the surgeon reroutes the urethra to align with the neo-vagina. Genital surgeries for trans-females result in permanent sterility (Bizic et al, 2014).
- **Chest Surgery:** To attain full breasts, trans-females can undergo enlargement. The procedure is similar to breast augmentation for women where a surgeon places implants underneath breast tissue. Prior to surgery, trans-females need to take cross-sex hormones for roughly 24 months to increase breast size to get maximum benefit from the procedure (Endocrine Society, 2017).
- **Cosmetic and Voice Surgeries:** Designed to create feminine facial features, fat deposits, and vocal sounds, these procedures are secondary to genital procedures and intended to alter trans-females' appearances to better integrate into society as a member of the desired gender (WPATH, 2012).

Procedures for Trans-Males

- **Mastectomy:** This is the most performed sex reassignment surgery on trans-males because cross-sex hormones and chest-binding garments are often insufficient at diminishing breasts. To remove this secondary sexual characteristic, trans-males can undergo a mastectomy where a surgeon removes breast tissue subcutaneously (i.e., under the skin) and reconstructs the nipples to appear masculine. The procedure can result in significant scarring (Monstrey et al, 2011).
- **Genital Surgeries:** Unlike the procedures for trans-females, genital surgeries for trans-males are more complex and have lower success rates. Consisting of hysterectomy, oophorectomy

(removal of the ovaries), vaginectomy (removal of the vagina), phalloplasty (construction of a penis), and scrotoplasty (construction of prosthetic testicles), a team of surgeons must manufacture a penis using skin from the patient (taken from an appendage) while removing the vagina and creating an extended urethra. The functionality of the artificial penis can vary based on how extensive the construction was. Attaining erections requires additional surgery to implant a prosthesis, and the ability to urinate while standing is often not achieved. Genital procedures for trans-males result in irreversible sterility (Monstrey et al, 2011).

- **Cosmetic Surgeries:** Similar to trans-females, these procedures create masculine facial features, fat deposits, and artificial pectoral muscles. They aid trans-males with socially integrating as their desired gender. Surgery to deepen voices is also available but rarely performed (WPATH, 2012).

Because sex reassignment surgery is irreversible, the criteria for receiving these procedures is the strictest of all gender dysphoria treatments. WPATH and the Endocrine Society suggest rigorous reviews of patient history and prior use of other therapies before approving. Furthermore, the two organizations recommend that only adults (18 years old) undergo sex reassignment surgery.⁸ WPATH and the Endocrine Society also recommend ensuring a strongly documented diagnosis of gender dysphoria, addressing all medical and mental health issues, and at least 12 months of cross-sex hormones for genital surgeries. Although the organizations agree on most criteria, they differ on whether hormones should be taken prior to mastectomies. WPATH asserts that hormones should not be a requirement, whereas the Endocrine Society advises up to 2 years of cross-sex hormones before undergoing the procedure (WPATH, 2012; Endocrine Society, 2017). What this indicates is that trans-males might undergo breast removal without having first pursued all options if their clinician adheres to WPATH's guidelines, which can lead to possible regret over irreversible effects.

As with cross-sex hormones, sex reassignment surgery's irreversible physical changes can potentially show marked mental health improvements and prevent suicidality in people diagnosed with gender dysphoria. In April 2022, the chair of the University of Florida's pediatric endocrinology department, Dr. Michael Haller, advocated for the benefits of "gender affirming" treatments (WUSF, 2020). However, the available evidence calls such statements into question. Recent research assessing both cross-sex hormones and sex reassignment surgery indicate that the effects on "long-term mental health are largely unknown." In studies regarding the benefits of surgery, the results have the same weaknesses as the research for the effectiveness of cross-sex hormones. These include small sample sizes, self-report surveys, and short evaluation periods, all of which are insufficient to justify recommendations for irreversible treatments (Bränström et al, 2020).

Two studies conducted in Sweden provide insight on the effectiveness of sex reassignment surgery in improving the behavioral health of transgender persons. Because Sweden has a nationalized health system that collects data on all residents, this country can serve as a resource to assess service utilization and inpatient admissions. Both studies, one by Dhejne et al from 2011 and another by Bränström et al published in 2020, assessed individuals who had received sex reassignment surgery and examined outcomes over several decades. Dhejne et al's findings indicate that sex reassignment

⁸ Although practice guidelines indicate the minimum age to undergo sex reassignment surgery is 18, available evidence demonstrates that mastectomies have been performed on adolescent girls as young as 13 who experience "chest dysphoria" (Olson-Kennedy et al, 2018).

procedures do not reduce suicidality. The authors explained that individuals who underwent sex reassignment surgery were still more likely to attempt or commit suicide than those in the general population. This study is unique because it monitored the subjects over a long period of time. Dhejne et al note that the transgender persons tracked for the study did not show an elevated suicide risk until ten years after surgery (Dhejne et al, 2011). Given that a high proportion of research follows sex reassignment patients for much shorter timeframes, this evidence indicates that surgery might have little to no effect in preventing suicides in gender dysphoric individuals over the long run.

In addition to having an increased suicide risk, Dhejne et al discuss how individuals who underwent sex reassignment procedures also had higher mortality due to cardiovascular disease. The authors do not list the specific causes but establish the correlation. Given that cross-sex hormones can damage the heart, the increased risk could be related to the drugs and not the surgery. Furthermore, the study explains that the tracked population had higher rates of psychiatric inpatient admissions following sex reassignment. Dhejne et al established this by examining the rates of psychiatric hospitalizations in these individuals prior to surgery and noted higher utilization in the years following the procedures. These results are in comparison to the Swedish population at large. While the study contradicts other research emphasizing improvements in mental health issues, it has its limitations. For example, the sample size is small. Dhejne et al identified only 324 individuals who had undergone sex reassignment surgery between 1973 and 2003. In addition, the authors noted that while the tracked population had increased suicide risks when compared to individuals identifying as their natal sex, the rates could have been much higher if the procedures were not available (Dhejne et al 2011). What this study postulates is that sex reassignment surgery does not necessarily serve as a “cure” to the distress resulting from gender dysphoria and that ongoing behavioral health care may still be required even after a complete transition.

Bränström et al’s study evaluating the Swedish population used a larger sample (1,018 individuals who had received sex reassignment surgery) but tracked them for just a ten-year period (2005 to 2015).⁹ Unlike Dhejne et al, the authors did not track suicides and focused primarily on mood or anxiety disorder treatment utilization. Their results indicate that transgender persons who had undergone surgery utilized psychiatric outpatient services at lower rates and were prescribed medications for behavioral health issues at an annual decrease rate of 8%. Bränström et al also did not limit comparisons to Sweden’s overall population and factored in transgender persons who take cross-sex hormones but have not elected to have surgery. Those results still presented a decrease in outpatient mental health services. However, Bränström et al note that individuals only on cross-sex hormones showed no significant reduction in that category, which calls into question claims regarding effectiveness of cross-sex hormones in ameliorating behavioral issues.

The Bränström et al study prompted numerous responses questioning its methodology. The study lacked a prospective cohort or RCT design, and it did not track all participants for a full ten-year period (Van Mol et al, 2020). These criticisms resulted in a retraction, asserting that Bränström et al’s conclusions were “too strong” and that further analysis by the authors revealed that the new “results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related

⁹ Although Bränström et al claim to follow individuals for a ten-year period, peer reviews of the research revealed that this was not the case, noting the authors had varying periods of tracking, ranging from one to ten years (Van Mol et al, 2020).

health care visits or prescriptions or hospitalizations following suicide attempts in that comparison” (Kalin, 2020).

There are multiple explanations for why the Bränström et al study reached different results than the Dhejne et al study. For starters, Bränström et al tracked a larger sample group over a later period (2005 to 2015 as opposed to 1973 to 2003) during which gender dysphoria underwent a dramatic shift in definition. Also, Dhejne et al did not see elevated suicides until after ten years, raising the question as to whether sex reassignment surgery has temporary benefits on mental health rather than long-term or permanent benefits. Like the other Swedish study, Bränström et al’s findings are a correlation and do not specifically state that the procedures cause reduced psychiatric service utilization (Bränström et al, 2020).

A 2014 study by Hess et al in Germany evaluated satisfaction with sex reassignment procedures by attempting to survey 254 trans-females on their quality of life, appearance, and functionality as women. Out of the participants selected, only 119 (47%) returned completed questionnaires, which Hess et al indicate is problematic because dissatisfied trans-females might not have wanted to provide input. The results from the collected responses noted that 65.7% of participants reported satisfaction with their lives following surgery and that 90.2% indicated that the procedures fulfilled their expectations for life as women. While these results led Hess et al to conclude that sex reassignment surgery generally benefits individuals with gender dysphoria, the information is limited and raises questions (Hess et al, 2014). Such questions include whether the participants had mental health issues before or after surgery and did their satisfaction wane over time. Hess et al only sent out one questionnaire and not several to ascertain consistency over multiple years. Questions like these raise doubts about the validity of the study. Although Hess et al’s research is just one study, numerous others utilize the same subjective methods to reach their conclusions (Hruz, 2018).

In his assessment, Patrick Lappert contributes additional insight on the appropriate clinical indications for mastectomies, noting that removal of breast tissue is necessary following the diagnosis of breast cancer or as a prophylactic against that disease. He cites that this basis is verifiable through definitive laboratory testing and imaging, making it an objective diagnosis, whereas gender dysphoria has no such empirical methods to assess and depends heavily on the patient’s perspective. Also, Lappert notes that trans-males who make such decisions are doing so on the idea that the procedure will reduce their dysphoria and suicide risk. However, they are making an irreversible choice based on anticipated outcomes supported only by weak evidence, and thus cannot provide informed consent (Lappert, 2022).

The literature is inconclusive on whether sex reassignment surgery can improve mental health for gender dysphoric individuals. Higher quality research is needed to validate this method as an effective treatment. This includes studies that obtain detailed participant histories (e.g., behavioral diagnoses) and track participants for longer periods of time. These are necessary to evaluate the full effects of treatments that cause irreversible physical changes. In addition, sex reassignment procedures can result in severe complications such as infections in trans-females and urethral blockage in trans-males. Health issues related to natal sex can also persist. For example, trans-males who undergo mastectomy can still develop breast cancer and should receive the same recommended screenings (Trum et al, 2015). Until more definitive evidence becomes available, sex reassignment surgery should not qualify as a standard treatment for gender dysphoria.

Literature Review: Quality of Available Evidence and Bioethical Questions

Quality of Available Evidence

Clinical organizations that have endorsed puberty suppression, cross-sex hormones, and sex reassignment surgery frequently state that these treatments have the potential to save lives by preventing suicide and suicidal ideation. The evidence, however, does not support these conclusions. James Cantor notes that actual suicides (defined as killing oneself) are low, occur at higher rates for men, and that interpretations of available research indicate a blurring of numbers between those with gender dysphoria and homosexuals (Cantor, 2022). Although information exists that contradicts certain arguments, media outlets continue to report stories emphasizing the “lifesaving” potential of sex reassignment treatment. A May 2022 story by NBC announced survey results under the headline “Almost half of LGBTQ youths ‘seriously considered suicide in the past year’” (NBC, 2022). This is a significant claim that can have a sensational effect on patients and providers alike, but how strong is the evidence supporting it? Almost all of the data backing this assertion are based on surveys and cross-studies, which tend to yield low-quality results (Hruz, 2018). In addition, how many gender dysphoric individuals are seeing stories in the media and not questioning the narrative? Because research on the effectiveness of treatments is ongoing, a debate persists regarding their use in the adolescent and young-adult populations, and much of it is due to the low-quality studies serving as evidence.

In their assessment, Romina Brignardello-Petersen and Wojtek Wiercioch examined the quality of 61 articles published between 2020 and 2022 (Note: See Attachment A for the full study). They identified research on the effectiveness of puberty blockers, cross-sex hormones, and sex reassignment surgery and assigned a grade (high, moderate, low, or very low) in accordance with the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. Out of the articles reviewed, all with a few exceptions received grades of low or very low quality when demonstrating outcomes regarding improvements in mental health and overall satisfaction with transitioning. For puberty blockers, Brignardello-Petersen and Wiercioch identified low quality evidence for alleviating gender dysphoria and very low quality for reducing suicidal ideation. The authors also had nearly identical findings for cross-sex hormones. However, they noted moderate quality evidence for the likelihood of cardiovascular side effects. Regarding surgery, Brignardello-Petersen and Wiercioch graded articles that examined overall satisfaction and complication rates. None of the studies received grades higher than low quality. These findings led the authors to conclude that “there is great uncertainty about the effects” of sex reassignment treatments and that the “evidence alone is not sufficient to support” using such treatments. Among the studies graded was one the U.S. Department of Health and Human Services cited in its information on “gender affirming” treatments. The authors noted this research had a “critical risk of bias” and was of low quality (Brignardello-Petersen and Wiercioch, 2022).

For his part, James Cantor provided a review of available literature, which addresses studies on etiology, desistance, effectiveness of puberty blockers and cross-sex hormones, suicidal behaviors, and clinical association and international guidelines. Throughout his analysis, Cantor cites weak evidence, poor methodologies (e.g., retrospective versus prospective studies), and lack of professional endorsements in research that indicates the benefits of sex reassignment treatment. Additionally, he notes that improvements in the behavioral health of adolescents who take cross-sex hormones can be attributed to the counseling they receive concurrently and that suicidality is not likely to result from gender

dysphoria but from co-occurring mental disorders. The reasoning behind the third point is based on the blending of suicide and suicidality, which are two distinct concepts. The former refers specifically to killing oneself, and the second regards ideation and threats in attempts to receive help. Cantor specifically notes that actual suicides are highly unlikely among gender dysphoric individuals, particularly trans-males. His other conclusions indicate that young children who experience gender identity issues will most likely desist by puberty, that multiple phenomena can cause the condition, and that Western European health services are not recommending medical intervention for minors. The basis for these statements is the paucity of high to moderate quality evidence on the effectiveness of sex reassignment treatments and numerous studies demonstrating desistance (Cantor, 2022).

Despite the need for stronger studies that provide definitive conclusions, many practitioners stand by the recommendations of the AAP, Endocrine Society, and WPATH. This is evident in a letter submitted to the *Tampa Bay Times*, which was a rebuttal to the Florida Department of Health's (DOH) guidance on treatment for gender dysphoria (Note: The guidance recommends against using puberty blockers, cross-sex hormones, or surgery for minors) (DOH, 2022). The authors, led by six professors at the University of Florida's College of Medicine, state that recommendations by clinical organizations are based on "careful deliberation and examination of the evidence by experts." However, evaluations of these studies show otherwise. Not only does the available research use cross-sectional methods such as surveys, but it provides insufficient evidence based on momentary snapshots regarding mental health benefits. These weak studies are the foundation for the clinical organizations' guidelines that the University of Florida professors tout as a gold standard. In addition, the letter's authors state that DOH's guidance is based on a "non-representative sample of small studies and reviews, editorials, opinion pieces, and commentary" (Tampa Bay Times, 2022). That statement misses the point when it comes to evidence demonstrating whether treatments with irreversible effects are beneficial because the burden of proof is on those advocating for this treatment, not on those acknowledging the need for further research. This raises the question concerning how much academic rigor these professors are applying to practice guidelines released by clinical organizations and whether they also apply the same level of rigor to novel treatments for other conditions (e.g., drugs, medical devices).

Another example of a lack of rigor is a 2019 article by Herman et al from the University of California at Los Angeles (UCLA) that evaluated responses to a 2015 national survey on transgender individuals and suicide. Unlike other studies, this one utilized a large cohort with 28,000 participants from across the U.S. responding. However, the researchers used no screening criteria and did not randomly select individuals. In addition, responses consisted entirely of self-reports with no supporting evidence to even prove a diagnosis of gender dysphoria. Although Herman et al conclude that the U.S. transgender population is at higher risk for suicidal behaviors, the authors' supporting evidence is subjective and serves as a weak basis. Additionally, the survey results do not establish gender dysphoria as a direct cause of suicide or suicidal ideation. The questions required participants to respond about their overall physical and mental health. Out of those that indicated "poor" health, 77.7% reported suicidal thoughts or attempts during the previous year, whereas just 29.1% of participants in "excellent" health had. These percentages indicate that causes beyond gender dysphoria could be affecting suicidal behaviors. Other reasons cited include rejection by family or religious organizations and discrimination. The authors also acknowledge that their findings are broad, not nationally representative, and should serve as a basis for pursuing future research (Herman et al, 2019).

Yet another example is a study published in 2022 by Olson et al tracks 300 young children that identify as transgender over a 5-year period, and asserts low probabilities for detransitioning, while supporting interventions such as puberty blockers. The authors found that children (median age of 8 years) who identified as a gender that differed from their natal sex were unlikely to desist at a rate of 94% and conclude that “transgender youth who socially transitioned at early ages” will continue “to identify that way.” While this appears to contradict earlier studies that demonstrate most young adolescents who change gender identities return to their “assigned gender at birth,” the authors note differences and limitations with the results. For example, Olson et al notes that they did not verify whether the participants met the DSM-V’s diagnostic criteria for gender dysphoria and that the children’s families supported the decisions to transition. Instead, the authors relied on a child’s chosen pronouns to classify as transgender. Also, Olson et al acknowledged that roughly 66% of the sample was biologically male. This is particularly significant considering that the majority of transitioning adolescents in recent years were natal females. Another issue with the study includes the median age at the end of follow-up (13 years), which is when boys begin puberty. Furthermore, the authors cite that the participants received strong parental support regarding the transitions, which constitutes positive reinforcement (Olson et al, 2022). Other research demonstrates that such feedback on social transitioning from parents and peers can prevent desistance following pubertal onset (Zucker, 2019). Despite these limitations, the New York Times announced the study’s publication under the headline “Few Transgender Children Change Their Minds After 5 Years” (New York Times, 2022). Such a title can add to the public’s perception that gender dysphoria requires early medical intervention to address.

Bioethical Questions

The irreversible physical changes and potential side effects of sex reassignment treatment raise significant ethical questions. These questions concern multiple bioethical principles including patient autonomy, informed consent, and beneficence. In a 2019 article, Michael Laidlaw, Michelle Cretella, and Kevin Donovan argue that prescribing puberty blockers or cross-sex hormones on the basis that they will alleviate psychological symptoms should not be the standard of care for children with gender dysphoria. Additionally, the three authors assert that such treatments “constitute an unmonitored, experimental intervention in children without sufficient evidence of efficacy or safety.” The primary ethical question Laidlaw, Cretella, and Donovan pose is whether pushing physical transitioning, particularly without parental consent, violates fully informed consent (Laidlaw et al, 2019).

In accordance with principles of bioethics, several factors must be present to obtain informed consent from a patient. These consist of being able to understand and comprehend the service and potential risks, receiving complete disclosure from the physician, and voluntarily providing consent. Bioethicists generally do not afford the ability of giving informed consent to children who lack the competence to make decisions that pose permanent consequences (Varkey, 2021). Laidlaw, Cretella, and Donovan reinforce this point regarding sex reassignment treatment when they state that “children and adolescents have neither the cognitive nor the emotional maturity to comprehend the consequences of receiving a treatment for which the end result is sterility and organs devoid of sexual function” (Laidlaw et al, 2019). This further raises the question whether clinicians who make such treatment recommendations are providing full disclosure about the irreversible effects and truly obtaining informed consent.

Another issue is the conflict between consumerism and the practitioner's ability to provide appropriate care. Consumerism refers to patients learning about treatments through media/marketing and requesting their health care provider to prescribe it, regardless of medical necessity. Considering that social media is rife with individuals promoting "gender affirmative" drugs and surgeries, children are making self-assessments based on feelings they may not understand and that can lead to deep regret in the future (Littman, 2018). This can contribute to patients applying pressure on their doctors to prescribe medications not proven safe or effective for the condition. Consumerism can also affect bioethical compliance because it constrains clinicians from using their full "knowledge and skills to benefit the patient," which is "tantamount to a form of patient abandonment and therefore is ethically indefensible" (Varkey, 2021).

In his assessment, G. Kevin Donovan explains the bioethical challenges related to sex reassignment treatment, emphasizing the lack of informed consent when administering these services. He asserts that gender dysphoria is largely a self-diagnosis practitioners cannot verify with empirical tests (e.g., labs and imaging) and that providing such treatments is experimental. Because of the lack of consent and off-label use of puberty blockers and cross-sex hormones, Donovan raises the question as to how "experienced and ethical physicians so mislead others or be so misled themselves?" He further attributes this phenomenon to societal and peer pressures that influence self-diagnosis and confirm decisions to transition. As a result, these pressures lead to individuals wanting puberty blockers, cross-sex hormones, and surgery. Donovan goes on to identify several news stories where embracing sex reassignment treatment is a "cult-like" behavior. To conclude, he links these factors back to the failure to obtain informed consent from transgender patients and how that violates basic bioethical principles (Donovan, 2022).

Coverage Policies of the U.S. and Western Europe

U.S. Federal Level Coverage Policies

Medicare: In 2016, the Centers for Medicare and Medicaid Services (CMS) published a decision memo announcing that Medicare Administrative Contractors (MACs) can evaluate sex reassignment surgery coverage on a “case-by-case” basis.¹⁰ CMS specifically noted that the decision memo is not a National Coverage Determination and that “no national policy will be put in place for the Medicare program” (CMS, 2016). This memo was the result of CMS reviewing over 500 studies, reports, and articles to the validity of the procedures. Following its evaluation, CMS determined that “the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . small sample sizes, lack of validated assessment tools, and considerable (number of participants in the studies) lost to follow up.” In 2017, CMS reinforced this position with a policy transmittal that repeated the 2016 memo’s criteria (CMS, 2017).

The basis for Medicare’s decision is that the “clinical evidence is inconclusive” and that “robust” studies are “needed to ensure that patients achieve improved health outcomes.” In its review of available literature, CMS sought to answer whether there is “sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria.” After evaluating 33 studies that met inclusion criteria, CMS’s review concludes that “not enough high-quality evidence” is available “to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively.” Additionally, out of the 33 studies, just 6 provided “useful information” on the procedures’ effectiveness, revealing that their authors “assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies” that “did not demonstrate clinically significant changes or differences in psychometric test results” following sex reassignment surgery (CMS, 2016).

U.S. Department of Defense – Tricare: Tricare does not cover sex reassignment surgery, but it will cover psychological services such as counseling for individuals diagnosed with gender dysphoria and cross-sex hormones when medically necessary (Tricare, 2022).¹¹

U.S. Department of Veterans Affairs: The U.S. Department of Veterans Affairs (VA) does not cover sex reassignment surgery, although it will reimburse for cross-sex hormones and pre- and post-operative care related to transitioning. Because the VA only provides services to veterans of the U.S. armed forces, it cannot offer sex reassignment treatment to children (VA, 2020).¹²

¹⁰ The Centers for Medicare and Medicaid Services is part of the U.S. Department of Health and Human Services. Its primary functions are to administer the entire Medicare system and oversee federal compliance of state Medicaid programs. In addition, CMS sets reimbursement rates and coverage criteria for the Medicare program.

¹¹ Tricare is the insurance program that covers members of the U.S. armed forces and their families. This includes children of all ages.

¹² The U.S. Department of Veterans Affairs oversees the Veterans Health Administration (VHA), which consists of over 1,000 hospitals, clinics, and long-term care facilities. As the largest health care network in the U.S., the VHA provides services to veterans of the U.S. armed forces.

State-Level Coverage Policies

Florida: In April 2022, DOH issued guidance for the treatment of gender dysphoria, recommending that minors not receive puberty blockers, cross-sex hormones, or sex reassignment surgery.¹³ The justification offered for recommending against these treatments is that available evidence is low-quality and that European countries also have similar guidelines. Accordingly, DOH provided the following guidelines:

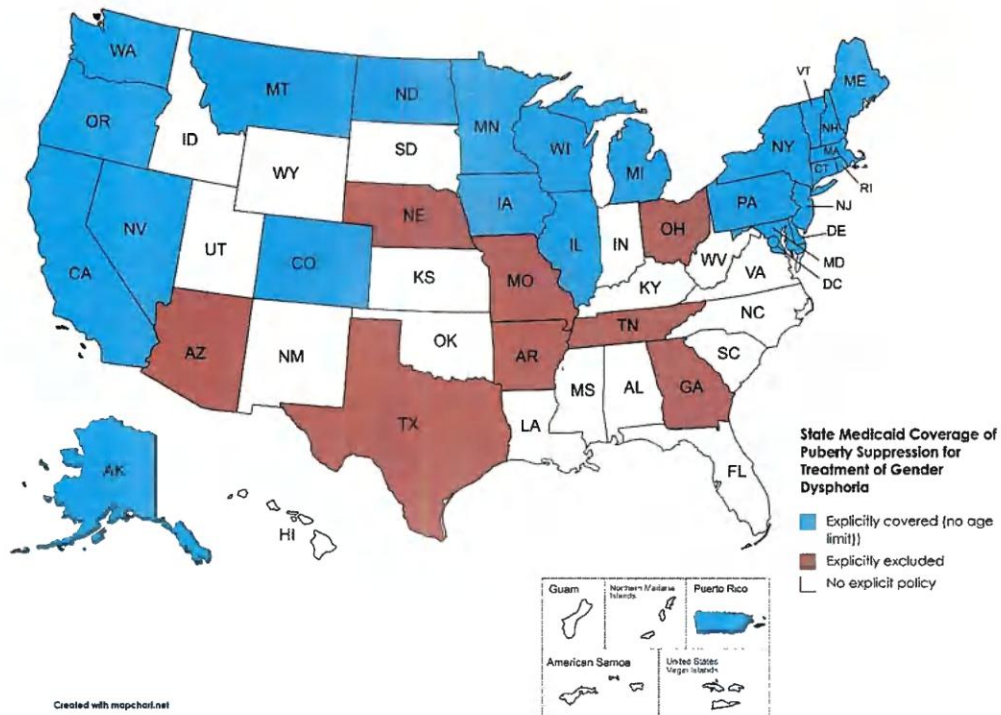
- “Social gender transition should not be a treatment option for children or adolescents.”
- “Anyone under 18 should not be prescribed puberty blockers or hormone therapy.”
- “Gender reassignment surgery should not be a treatment option for children or adolescents.”
- “Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider.”

In a separate fact sheet released simultaneously with the guidance, DOH further asserts that the evidence cited by the federal government cannot establish sex reassignment treatment’s ability to improve mental health (DOH, 2022).

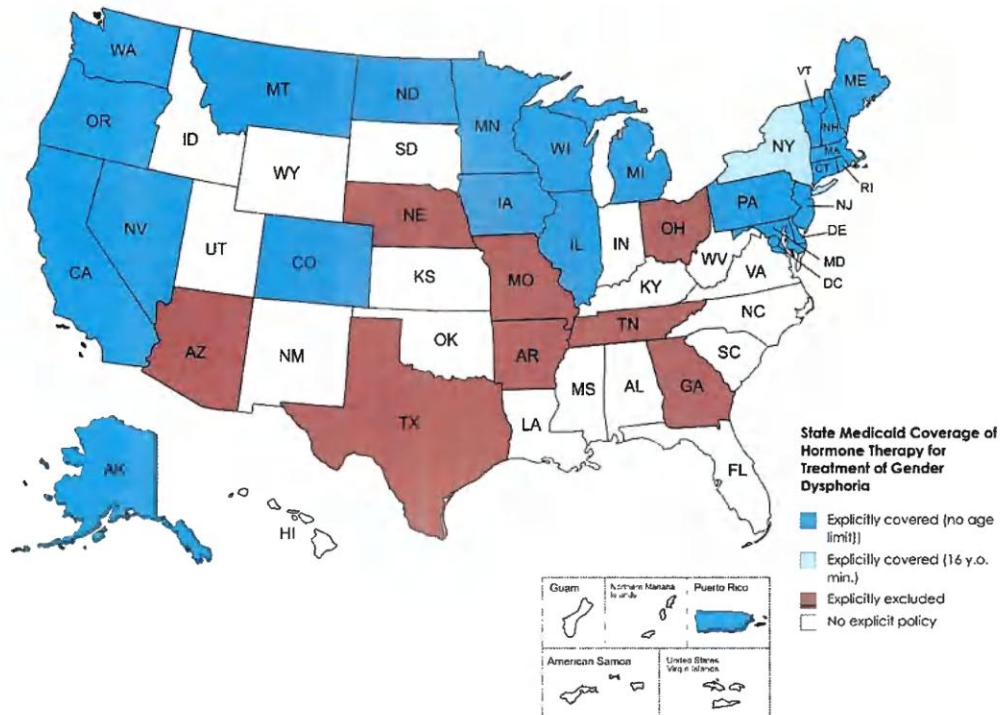
State Medicaid Programs: Because individual states differ in health services offered, Medicaid programs vary in their coverage of sex reassignment treatments. The following maps identify states that cover sex reassignment treatments, states that have no policy, and states that do not cover such treatments.

¹³ Unlike the federal government, the State of Florida delegates responsibilities for Medicaid and health care services to five separate agencies (Agency for Health Care Administration, Department of Health, Department of Children and Families, Department of Elder Affairs, and Agency for Persons with Disabilities). Each agency has its own separate head (secretary or surgeon general), which reports directly to the Executive Office of the Governor. As Florida’s public health agency, DOH oversees all county health departments, medical professional boards, and numerous health and welfare programs (e.g., Early Steps and Women, Infants, and Children). Because it oversees the boards, DOH has authority to release practice guidelines.

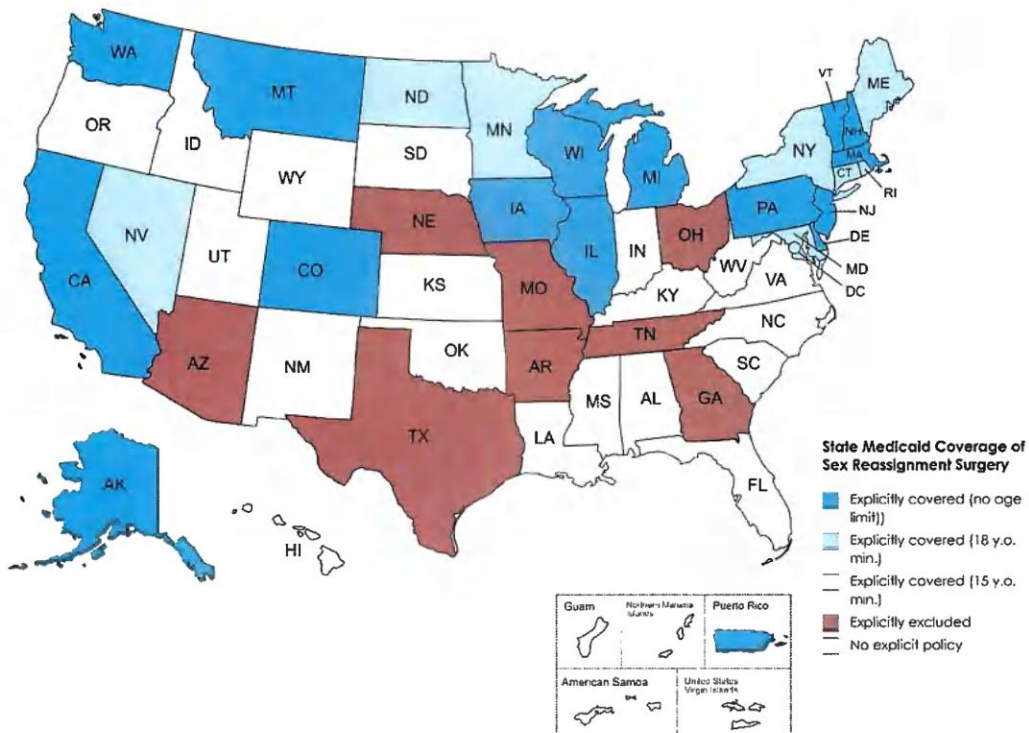
State Medicaid programs with coverage decisions regarding puberty blockers:



State Medicaid programs with coverage decisions regarding cross-sex hormones:



State Medicaid programs with coverage decisions regarding sex reassignment surgery:



Western Europe

Scandinavian countries such as Sweden and Finland have released new guidelines on sex reassignment treatment for children. In 2022, the Swedish National Board of Health stated that “the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits.” With the exception of youths who exhibited “classic” signs of gender identity issues, adolescents who present with the condition will receive behavioral health services and gender-exploratory therapy (Society for Evidence Based Gender Medicine, 2022).

In Finland, the Palveluvalikoima issued guidelines in 2020 stating that sex reassignment in minors “is an experimental practice” and that “no irreversible treatment should be initiated.” The guidelines further assert that youths diagnosed with gender dysphoria often have co-occurring psychiatric disorders that must be stabilized prior to prescribing any cross-sex hormones or undergoing sex reassignment surgery (Palveluvalikoima, 2020).

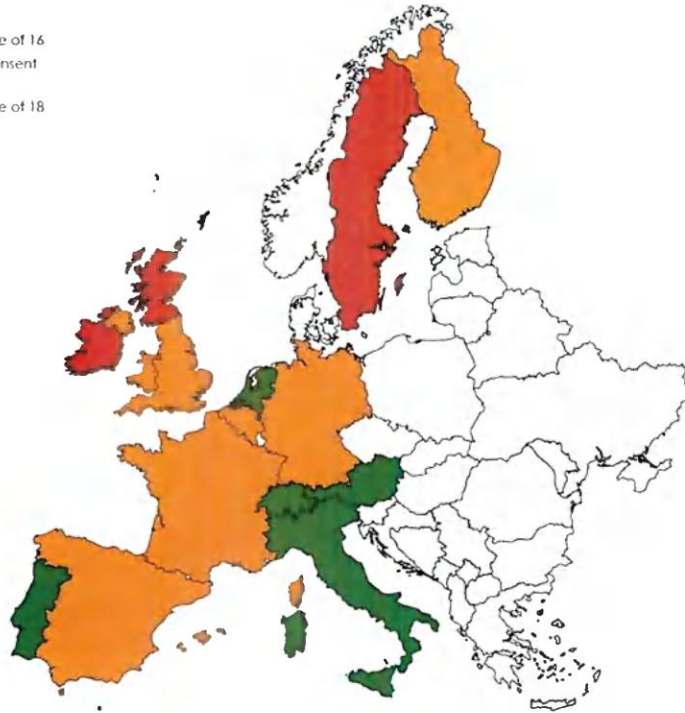
The United Kingdom (U.K.) is also reassessing the use of irreversible treatments for gender dysphoria due the long-term effects on mental and physical health. In 2022, an independent interim report commissioned by the U.K.’s National Health Service (NHS) indicates that additional research and systematic changes are necessary to ensure the safe treatment of gender dysphoric youths. These include reinforcing the diagnosis process to assess all areas of physical and behavioral health, additional training for pediatric endocrinologists, and informing parents about the uncertainties regarding puberty blockers. The interim report is serving as a benchmark until the research is completed for final guidelines (The Cass Report, 2022).

Like state Medicaid programs, health systems across Western Europe also vary in their coverage of sex reassignment treatment.

Western European nations' requirements for cross-sex hormones:

**The Age of Consent for
Hormonal Treatments in
Western Europe**

- Prohibited Under Age of 16
- General Medical Consent
Rules Apply*
- Prohibited Under Age of 18

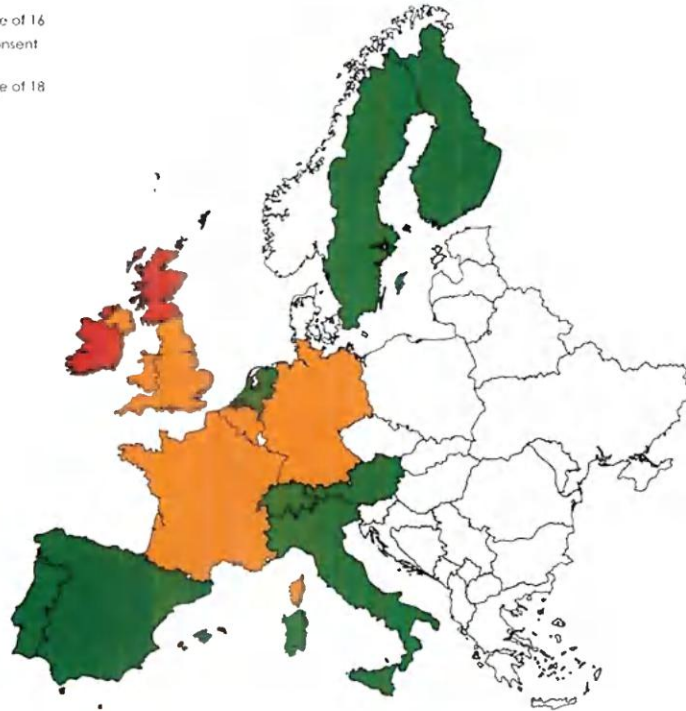


In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Western European nations' requirements for sex reassignment surgery:

The Age of Consent for Surgery in Western Europe

- Prohibited Under Age of 16
- General Medical Consent Rules Apply*
- Prohibited Under Age of 18



In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Generally Accepted Professional Medical Standards Recommendation

This report does not recommend sex reassignment treatment as a health service that is consistent with generally accepted professional medical standards. Available evidence indicates that the services are not proven safe or effective treatments for gender dysphoria.

Rationale

The available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. As this report demonstrates, the evidence favoring "gender affirming" treatments, including evidence regarding suicidality, is either low or very low quality:

- **Puberty Blockers:** Evidence does not prove that puberty blockers are safe for treatment of gender dysphoria. Evidence that they improve mental health and reduce suicidality is low or very low quality.
- **Cross-Sex Hormones:** Evidence suggesting that cross-sex hormones provide benefits to mental health and prevents suicidality is low or very low quality. Rather, evidence shows that cross-sex hormones cause multiple irreversible physical consequences as well as infertility.
- **Sex Reassignment Surgery:** Evidence of improvement in mental health and reduction in suicidality is low or very low quality. Sex reassignment surgery results in irreversible physical changes, including sterility.

While clinical organizations like the AAP endorse the above treatments, none of those organizations relies on high quality evidence. Their eminence in the medical community alone does not validate their views in the absence of quality, supporting evidence. To the contrary, the evidence shows that the above treatments pose irreversible consequences, exacerbate or fail to alleviate existing mental health conditions, and cause infertility or sterility. Given the current state of the evidence, the above treatments do not conform to GAPMS and are experimental and investigational.

☒ Concur

☐ Do not Concur

Comments:


Deputy Secretary for Medicaid (or designee)

6/2/22
Date

Works Cited

- Almost Half of LGBTQ Youths 'Seriously Considered' Suicide in Past Year, Survey Says. *NBC News*. 4 May 2022.
- American Academy of Pediatrics. Policy Statement: Off-Label Use of Drugs in Children. *Pediatrics*. 2014. 133(3).
- American Psychiatric Association. *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders*. 2013.
- American Psychiatric Association. *Gender Dysphoria Diagnosis*. 2017.
- American Psychiatric Association. *What Is Depression*. 2020.
- American Psychological Association. *APA Resolution on Gender Identity Change Efforts*. 2021.
- Baker GM, Guzman-Arocho YD, Bret-Mounet VC, Torous VF, Schnitt SJ, Tobias AM, Bartlett RA, Fein-Zachary VJ, Collins LC, Wulf GM, Heng YJ. Testosterone Therapy and Breast Histopathological Features in Transgender Individuals. *Mod Pathol*. 2021. 34(1).
- Blake K, Cangelosi S, Johnson-Brooks S, Belcher HME. Reliability of the GAF and CGAS with Children Exposed to Trauma. *Child Abuse and Neglect*. 2007. 31: 909-915.
- Bizic MR, Jevtovic M, Pusica S, Stojanovic B, Duisin D, Vujovic S, Rakic V, Djordjevic ML. Gender Dysphoria: Bioethical Aspects of Medical Treatment. *BioMed Research International*. 2018: 9652305.
- Bizic M, Kojovic V, Duisin D, Stanojevic D, Vujovic S, Milosevic A, Korac G, Djordjevic ML. An Overview of Neovaginal Reconstruction Options in Male to Female Transsexuals. *The Scientific World Journal*. 2014. 638919.
- Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *American Journal of Psychiatry*. 2020. 177(8).
- Brignardello-Petersen R, Wiercioch W. Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. Unpublished: Commissioned by the Florida Agency for Health Care Administration. 2022.
- Bruggeman BS, Dayton K, Diaz A, Evans J, Haller MJ, Hudak ML, Mathews CA, Shapiro M. We 300 Florida Health Care Professionals Say the State Gets Transgender Guidance Wrong. *Tampa Bay Times*. 27 April 2022.
- Cantor J. Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *Journal of Sex and Marital Therapy*. 46(4).
- Cantor J. *Science of Gender Dysphoria and Transsexualism*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.
- Cass H. *The Cass Review: Independent Review of Gender Identity Services for Children and Young People, Interim Report*. 2022.

The Centers for Medicare and Medicaid Services. Decision Memo: Gender Dysphoria and Gender Reassignment Surgery. 30 August 2016.

The Centers for Medicare and Medicaid Services. Pub 100-03 Medicare National Coverage Determinations. 3 March 2017.

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, Steinberg L, Sisk CL, Roth J, Paus T, Mueller SC, McCarthy MM, Micevych PE, Martin CL, Kreukels BPC, Kenworthy L, Herting MM, Herlitz A, Haraldsen RJH, Dahl R, Crone EA, Chelune GJ, Burke SM, Berenbaum SA, Beltz AM, Bakker J, Eliot L, Vilain E, Wallace GL, Nelson EE, Garofalo R. Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth. *Transgender Health*. 2020. 5(4).

Claahsen-van der Grinten H, Verhaak C, Steensma T, Middelberg T, Roeffen J, Klink D. Gender Incongruence and Gender Dysphoria in Childhood and Adolescence – Current Insights in Diagnostics, Management, and Follow-Up. *European Journal of Pediatrics*. 2020. 180: 1349-1357.

Costa R, Colizzi M. The Effect of Cross-Sex Hormonal Treatment on Gender Dysphoria Individuals' Mental Health: A Systematic Review. *Neuropsychiatric Disease and Treatment*. 2016. 12: 1953-1966.

Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*. 2015. 12(11).

Davy Z, Toze M. What Is Gender Dysphoria? A Critical Systematic Narrative Review. *Transgender Health*. 2018. 3(1).

De Sanctis V, Soliman AT, Di Maio S, Soliman N, Elsedfy H. Long-Term Effects and Significant Adverse Drug Reactions (ADRs) Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: A Brief Review of Literature. *Acta Biomed*. 2019. 90(3).

De Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment. *Pediatrics*. 2014. 134(4).

Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Langstrom N, Landen M. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS One*. 6(2).

Donovan GK. *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Dutra E, Lee J, Torbati T, Garcia M, Merz CNB, Shufelt C. Cardiovascular Implications of Gender-Affirming Hormone Treatment in the Transgender Population. *Maturitas*. 2019. 129: 45-49.

Few Transgender Children Change Their Minds After 5 Years, Study Finds. *New York Times*. 4 May 2022.

Gaetano P. David Reimer and John Money Gender Reassignment Controversy: The John/Joan Case. *The Embryo Project Encyclopedia*. 2017.

Geffen S, Horn T, Smith KJ, Cahill S. Advocacy for Gender Affirming Care: Learning from the Injectable Estrogen Shortage. *Transgender Health*. 2018. 3(1).

- Go JJ. Should Gender Reassignment Surgery Be Publicly Funded? *Bioethical Inquiry*. 2018. 15: 527-534.
- Gu J, Kanai, R. What contributes to individual differences in brain structure. *Front Hum Neurosci*. 2014. 8:262.
- Hariton E, Locascio JJ. Randomised Controlled Trials – The Gold Standard for Effectiveness Research. *BJOG: An International Journal of Obstetrics and Gynecology*. 2018. 125(13).
- Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinological Metabolism*. 2017. 102(11).
- Herman JL, Brown TNT, Haas AP. *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. University of California at Los Angeles School of Law Williams Institute. 2019.
- Hess J, Neto RR, Panic L, Rubben H, Senf W. Satisfaction with Male-to-Female Gender Reassignment Surgery. *Deutsches Arzteblatt International*. 2014. 111: 795-801.
- Hruz PW. Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *Catholic Medical Association*. 2020. 87(1).
- James HA, Chang AY, Imhof RL, Sahoo A, Montenegro MM, Imhof NR, Gonzalez CA, Lteif AN, Nippoldt TB, Davidge-Pitts CJ. A Community-Bases Study of Demographics, Medical and Psychiatric Conditions, and Gender Dysphoria/Incongruence Treatment in Transgender/Gender Diverse Individuals. *Biology of Sex Differences*. 2020. 11(55).
- Jensen RK, Jensen JK, Simons LK, Chen D, Rosoklija I, Finlayson C. Effect of Concurrent Gonadotropin-Releasing Hormone Against Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients. *Transgender Health*. 2019. 4(1).
- Joel D., Berman Z., Tavor L. Sex beyond the Genitalia: The Human Brain Mosaic. *Proceedings of the National Academy of Sciences of the United States of America*. 2015. 112(50).
- Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals after Gender-Affirming Surgeries: A Comment by the Editor on the Process (Letter). *American Journal of Psychiatry*. 2020. 177:765.
- Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*. 2015. 9(9).
- Kozłowska K, Chudleigh C, McClure G, Maguire AM, Ambler GR. Attachment Patterns in Children and Adolescents with Gender Dysphoria. *Frontiers in Psychology*. 2021. 11: 582688.
- Kuper LE, Mathews S, Lau M. Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy. *Journal of Developmental Behavior Pediatrics*. 2019. 40(8).

Kyriakou A, Nicolaides NC, Skordis N. Current Approach to the Clinical Care of Adolescents with Gender Dysphoria. *Acta Biomed*. 2020. 91(1).

Laidlaw M, Cretella M, Donovan K. The Right to Best Care for Children Does Not Include the Right to Medical Transition. *The American Journal of Bioethics*. 2019. 19(2).

Laidlaw M, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: Endocrine Treatment of Gender-Dysphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *Journal of Clinical Endocrinological Metabolism*. 2018.

Lappert P. *Surgical Procedures and Gender Dysphoria*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Lee JY, Finlayson C, Olson-Kennedy J, Garofalo R, Chan YM, Glidden DV, Rosenthal SM. Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study. *Journal of the Endocrine Society*. 2020. 4(9).

Levine SB. Informed Consent for Transgendered Patients. *Journal of Sex & Marital Therapy*. 2018. 10:1080.

Littman L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*. 2021. 50: 3353-3369.

Littman L. Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports. *PLOS One*. 2018. 13(8).

Mayer L, McHugh PR. Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *The New Atlantis*. 2016. Fall Edition. 103.

McHugh PR. *The Mind Has Mountains: Reflections on Society and Psychiatry*. The Johns Hopkins University Press. 2006.

Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida. *Fox News*. 8 May 2022.

Merck Pharmaceuticals. *Merck Manual: Professional Version*. 2021.

Monstrey SJ, Ceulemans P, Hoebeke P. Sex Reassignment Surgery in the Female-to-Male Transsexual. *Seminars in Plastic Surgery*. 2011. 25(3).

Nguyen HB, Chavez AM, Lipner E, Hantsoo L, Kornfield SL, Davies RD, Epperson CN. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. *Curr Psychiatry Rep*. 2019. 20(12).

Nhi Le HP. *Eminence-Based Medicine vs. Evidence-Based Medicine*. Students 4 Best Evidence. 12 January 2016. <https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine,appraisal%20of%20scientific%20evidence%20available>

- Olson KR, Durwood L, DeMeules M, McLaughlin KL. Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*. 2015. 137(3).
- Olson KR, Durwood L, Horton R, Gallagher NM, Devor A. Gender Identity 5 Years After Social Transition. *Pediatrics*. 2022; doi: 10.1542/peds.2021-056082.
- Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*. 2018. 172(5).
- Palveluvalikoima of Finland. Recommendation of the Council for Choices in Health Care in Finland (Palko/Cohere Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. 2020.
- Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018. 142(4).
- Sadr M, Korashad BS, Talaei A, Fazeli N, Honekopp J. 2D:4D Suggests a Role of Prenatal Testosterone in Gender Dysphoria. *Archives of Sexual Behavior*. 2020. 49: 421-432.
- Saleem F, Rizvi SW. Transgender Associations and Possible Etiology: A Literature Review. *Cureus*. 9(12).
- Shumer DE, Reisner SL, Edwards-Leeper L, Tishelman A. Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic. *LGBT Health*. 2016. 3(5).
- Society for Evidence Based Gender Medicine. Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW). 2022.
- Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2013. 52(6).
- Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Open Network*. 2022; 59(2).
- Trum H, Hoebeke P, Gooren L. Sex Reassignment of Transsexual People from a Gynecologist's and Urologist's Perspective. *Acta Obstetrica et Gynecologica*. 2016. 94: 563-567.
- Turban JL, Loo SS, Almazan AN, Keuroghlian AS. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Method Analysis *LGBT Health*. 2021. 8(4).
- UF Doctor Says Gender-Affirming Care Works for Kids Who Need It, and Can Even Save Lives. *Health News Florida*. 26 April 2022.
- Unger CA. Hormone Therapy for Transgender Patients. *Translational Andrology and Urology*. 2016. 5(6).
- University of California at San Francisco Health System. *Overview of Feminizing Hormone Therapy*. 2020.

University of California at San Francisco Health System. *Overview of Masculinizing Hormone Therapy*. 2020.

U.S. Department of Defense, Tricare. *Gender Dysphoria Services*. 2022.

U.S. Department of Health and Human Services: Office for Civil Rights. HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy. 2 March 2022.

U.S. Drug Enforcement Administration. *Drug Fact Sheet: Steroids*. 2020.

A Review of the President's FY 2023 Funding Request and Budget Justification for the National Institutes of Health. U.S. Senate Committee on Appropriations. Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. 17 May 2022.

<https://www.appropriations.senate.gov/hearings/a-review-of-the-presidents-fy-2023-funding-request-and-budget-justification-for-the-national-institutes-of-health>

Van Meter QL. Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Van der Miesen AIR, Hurley H, Bal AM, de Vries ALC. Prevalence of the Wish to Be of the Opposite Gender in Adolescents and Adults with Autism Spectrum Disorder. *Archives of Sexual Behavior*. 2018. 47: 2307-2317.

Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence. *American Journal of Psychiatry*. 2020. 177:765.

Varkey B. Principles of Clinical Ethics and Their Application to Practice. *Medical Principles and Practice*. 2021. 30: 17-28.

World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 2012.

Zhao JJ, Marchaim D, Palla MB, Bogan CW, Hayakawa K, Tansek R, Moshos J, Muthusamy A, Kotra H, Lephart PR, Wilson AN, Kaye KS. Surgical Site Infections in Genital Reconstruction Surgery for Gender Reassignment, Detroit: 1984-2008. *Surgical Infections*. 2014. 15(2).

Zucker K. Debate: Different strokes for different folks. *Child and Adolescent Mental Health*. 2019. doi.org/10.1111/camh.12330.

Attachments

Attachment A: Secretary for the Florida Agency for Health Care Administration's Letter to Deputy Secretary Thomas Wallace. 20 April 2022.

Attachment B: Complete text of Rule 59G-1.035, F.A.C.

Attachment C: Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.

Attachment D: James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.

Attachment E: Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.

Attachment F: Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.

Attachment G: G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

ATTACHMENT A



RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

April 20, 2022

Tom Wallace
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Deputy Secretary Wallace:

On April 20, 2022, the Florida Department of Health released guidance on the treatment of gender dysphoria for children and adolescents.¹ The Florida Medicaid program does not have a policy on whether to cover such treatments for Medicaid recipients diagnosed with gender dysphoria. Please determine, under the process described in Florida Administrative Code Rule 59G-1035, whether such treatments are consistent with generally accepted professional medical standards and not experimental or investigational. Pursuant to Rule 59G-1035(5), I look forward to receiving your final determination.

Sincerely,

Simone Marstiller
Secretary

¹ See <https://www.floridahealth.gov/newsroom/2022/04/20220420-gender-dysphoria-press-release.pr.html> (last visited Apr. 20, 2022).



ATTACHMENT B

59G-1.035 Determining Generally Accepted Professional Medical Standards.

(1) Definitions.

(a) Generally accepted professional medical standards – Standards based on reliable scientific evidence published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations' recommendations.

(b) Health service(s) – Diagnostic tests, therapeutic procedures, or medical devices or technologies.

(c) Relevant – Having a significant and demonstrable bearing on the matter at hand.

(2) Pursuant to the criteria set forth in subparagraph 59G-1.010(166)(a)3., Florida Administrative Code (F.A.C.), the Agency for Health Care Administration (hereafter referred to as Agency) will determine when health services are consistent with generally accepted professional medical standards and are not experimental or investigational.

(3) Health services that are covered under the Florida Medicaid program are described in the respective coverage and limitations handbooks, policies, and fee schedules, which are incorporated by reference in the F.A.C. The public may request a health service be considered for coverage under the Florida Medicaid program by submitting a written request via e-mail to HealthServiceResearch@ahca.myflorida.com. The request must include the name, a brief description, and any additional information that supports coverage of the health service, including sources of reliable evidence as defined in paragraph 59G-1.010(84)(b), F.A.C.

(4) To determine whether the health service is consistent with generally accepted medical standards, the Agency shall consider the following factors:

(a) Evidence-based clinical practice guidelines.

(b) Published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations).

(c) Effectiveness of the health service in improving the individual's prognosis or health outcomes.

(d) Utilization trends.

(e) Coverage policies by other creditable insurance payor sources.

(f) Recommendations or assessments by clinical or technical experts on the subject or field.

(5) Based upon the information collected, a report with recommendations will be submitted to the Deputy Secretary for Medicaid (or designee) for review. The Deputy Secretary for Medicaid (or designee) will make a final determination as to whether the health service is consistent with generally accepted professional medical standards and not experimental or investigational.

(6) In order for the health service to be covered under the Florida Medicaid program, it must also meet all other medical necessity criteria as defined in subsection 59G-1.010(166), F.A.C., and funded through the General Appropriations Act or Chapter 216, F.S.

Rulemaking Authority 409.919 FS. Law Implemented 409.902, 409.906, 409.912, 409.913 FS. History—New 2-26-14, Amended 9-28-15.

ATTACHMENT C

Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence

Romina Brignardello-Petersen, DDS, MSc, PhD
Wojtek Wiercioch, MSc, PhD

1. Introduction

We prepared this report to fulfill a request from the Florida Agency for Health Care Administration. This report contains three documents: 1. Main document (this document) summarizing the methodology used and the findings, 2. Methods document, which provides a detailed description of the systematic methodology used to find, prioritize, appraise, and synthesize the evidence, and 3. Results document, which describes the evidence available, the estimates of the effects of gender affirming therapies, and the certainty (also known as quality) of the evidence.

This document is organized in four parts. First, we describe the credentials and expertise of the health research methodologists conducting this evidence evaluation. Second, we summarize the methodology used. Third, we summarize the main findings. Finally, we briefly discuss strengths and limitations of our process and of the evidence.

2. Credentials and expertise

Two experts in health research methodology, who specialize in evidence synthesis to support decision making, prepared this report. Their relevant credentials and expertise are described below.

Dr. Romina Brignardello-Petersen: Assistant Professor at the Department of Health Research Methods, Evidence, and Impact, at McMaster University. Dr. Brignardello-Petersen obtained a DDS degree (University of Chile) in 2007, an MSc degree in Clinical Epidemiology and Health Care Research (University of Toronto) in 2012, and MSc in Biostatistics (University of Chile) in 2015, and a PhD in Clinical Epidemiology and Health Care Research (University of Toronto) in 2016. Dr. Brignardello-Petersen has worked in evidence synthesis projects since 2010, and her research has focused on the methodology for the development of Systematic Reviews and Clinical Practice Guidelines since 2012. Through January 2022, she has published 122 peer reviewed scientific articles (24 as a first author and 9 as a senior author). Dr. Brignardello-Petersen has acted as a research methodologist for several groups and organizations, including the World Health Organization, the Pan-American Health Organization, the American Society of Hematologists, the American College of Rheumatology, and the Society for Evidence Based Gender Medicine, among others. Her research program has been awarded over \$2M CAD from the Canadian Institutes for Health Research. Dr. Brignardello-Petersen has no lived experience as a person or family member of a person with gender dysphoria, and her research interests are not in this area.

Dr. Wojtek Wiercioch: Postdoctoral Research Fellow at the Department of Health Research Methods, Evidence, and Impact, at McMaster University. Dr. Wiercioch obtained an MSc degree (2014, McMaster University) and a PhD degree (2020, McMaster University) in Health Research Methodology. Dr. Wiercioch has worked in evidence syntheses projects since 2011, and his research focuses on evidence synthesis, guideline development methodology, and the guideline development process. Through April

Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Main report; May 16, 2022

2022, he has published 86 peer-reviewed scientific articles. Dr. Wiercioch has acted as a guideline methodologist for several groups and organizations, including the World Health Organization, the American Society of Hematologists, the Endocrine Society (of America), and the American Association for Thoracic Surgeons, among others. Dr. Wiercioch has no lived experience as a person or family member of a person with gender dysphoria, and his research interests are not in this area.

3. Methods

We conducted an overview of systematic reviews. We used a reproducible approach to search, select, prioritize, appraise, and synthesize the available evidence, following high methodological standards. We describe full details of the methodology in an accompanying document.

In brief, we searched for systematic reviews published in English language in Epistemonikos, OVID Medline, and grey literature sources, through April 30, 2022. We selected systematic reviews which included studies on young individuals with a diagnosis of gender dysphoria, who received puberty blockers, cross-sex hormones, or surgeries; and in which authors reported data regarding outcomes important to patients: gender dysphoria, depression, anxiety, quality of life, suicidal ideation, suicide, adverse effects, and complications. Systematic reviews could have included any type of primary study design.

The two reviewers screened all titles and abstracts, followed by full text of potentially relevant systematic reviews. We then prioritized the most useful systematic review providing evidence for each of the outcomes, using pre-established criteria that considered date of publication, applicability, availability of outcome data, methodological quality of the systematic review, and usefulness of the data synthesis conducted in the systematic review (see methods document for details).

After abstracting data from the systematic reviews, we synthesized the best available evidence for each of the outcomes, and assessed the certainty (also known as quality) of the evidence using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. We conducted GRADE assessments using the information provided by the systematic review authors (risk of bias of primary studies, characteristics of included studies, results reported by the studies). We present the all the information about outcomes in GRADE summary of findings tables.

In addition, to evaluate the robustness of our conclusions, we systematically searched for and evaluated primary studies answering the questions of interest published after the authors of the included systematic reviews conducted their searches.

4. Results

We included 61 systematic reviews, from which 3 addressed the effects of puberty blockers, 22 addressed the effects of cross-sex hormones, 30 addressed the effects of surgeries, and 6 addressed the effects of more than one of these interventions. After our prioritization exercise, we included information from 2 systematic reviews on puberty blockers, 4 on cross-sex hormones, and 8 on surgeries.

4.1 Puberty blockers

For most outcomes (except suicidality), there is no evidence about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. There is very low certainty about the effects of puberty blockers on suicidal ideation.

The studies included in the systematic review reported outcomes among a group of people with gender dysphoria after receiving puberty blockers. Low certainty evidence suggests that after treatment with puberty blockers, people with gender dysphoria experience a slight increase in gender dysphoria, and an improvement in depression, and anxiety. Low certainty evidence also suggests that a moderate percentage of patients experience adverse effects. The findings must be interpreted considering that these studies did not have a comparison group, and that it is unknown if people with gender dysphoria that do not use puberty blockers experience similar or different outcomes.

4.2 Cross sex hormones

For almost all outcomes (except breast cancer) there is no evidence about the effect of cross sex hormones compared to not using cross sex hormones. In other words, no studies compared the outcomes between a group of people with gender dysphoria using cross sex hormones and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use cross-sex hormones experience more improvement in gender dysphoria, depression, anxiety, quality of life, and suicidality than those with gender dysphoria who do not use cross-sex hormones. There is low certainty evidence suggesting that cross-sex hormones may not increase the risk of breast cancer.

The studies included in the systematic reviews reported changes in the outcomes among a group of patients with gender dysphoria after the use of cross-sex hormones. Low certainty evidence suggests that after treatment with cross-sex hormones, people with gender dysphoria experience an improvement in gender dysphoria, depression, anxiety, and suicidality. There is very low certainty evidence about the changes in quality of life. There is moderate certainty evidence suggesting a low prevalence of venous thromboembolism after treatment with cross-sex hormones. The findings must be interpreted considering that these studies did not have a comparison group, and that it is unknown if people with gender dysphoria that do not use cross-sex hormones experience similar or different outcomes.

4.3 Surgeries

There were no systematic reviews and studies reporting on gender dysphoria, depression, anxiety, and suicidality. Therefore, the effects of surgeries on these outcomes (when compared to a group of patients with gender dysphoria who do not undergo surgery), or the changes in these outcomes (improvements or deterioration) among patients who undergo any gender-affirming surgery is unknown. Because of the lack of comparative studies, it is also unknown whether people with gender dysphoria who undergo surgeries experience more improvement in quality of life or less regret than those with gender dysphoria who do not undergo any surgeries. There is low certainty evidence suggesting that a low percentage of participants experience regret, and very low certainty evidence about changes in quality of life after surgery.

In assigned females at birth, low certainty evidence suggests that a high percentage of people are satisfied after chest surgery. There is very low certainty evidence, however, about satisfaction after bottom surgery, and about complications after both chest and bottom surgery. In assigned males at birth, low certainty evidence suggests a high percentage of people satisfied and a low percentage of people experiencing regret after vaginoplasty. There is very low certainty, however, about satisfaction with chest surgery and complications and reoperations after bottom surgery.

4.4 Evidence published after the systematic reviews selected

We found 10 relevant studies that were published after the systematic reviews were conducted. This evidence was not sufficient to importantly change the conclusions previously made.

5. Discussion

5.1 Summary of the evidence

In this report, we systematically summarized the best available evidence regarding the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria. We did not find evidence about the effect of these interventions on outcomes important to patients when compared to not receiving the intervention. We found low and very low certainty evidence suggesting improvements in gender dysphoria, depression, anxiety, and quality of life, as well as low rates of adverse events, after treatment with puberty blockers and cross-sex hormones.

5.2 Completeness and applicability

There are several gaps in the evidence regarding the effects of puberty blockers, cross-sex hormones, and surgeries in patients with gender dysphoria. Although we found some evidence for all the outcomes of interest, the evidence is suboptimal: several limitations included the lack of studies with a comparison group, and the risk of bias and imprecision, resulting in low or very low certainty evidence for all outcomes.

The applicability of the evidence may also be limited. Although we only rated down for indirectness when it was considered a serious problem (i.e., in evidence about the effects of surgeries, which was collected from people who were importantly older than the target population in this report), there are also potential applicability issues to consider in the evidence regarding the effects of puberty blockers and cross-sex hormones. It is not clear to what extent the people included in the studies were similar enough to the people seeking these treatment options today. For example, some of the included studies were conducted in people who had a diagnosis of gender dysphoria confirmed with strict criteria, as well as a supportive environment. It is important to take into account to what extent this may compromise the applicability of the results to people who are not in the same situation.

5.3 Strengths and limitations of the process for developing this report

We followed a reproducible process for developing this report. We used the highest methodological standards and the approach to evidence synthesis we generally use when supporting organizations in the development of their guidelines. This approach is based on prioritizing the sources of evidence most likely to be informative (i.e., to identify and use the evidence with the highest certainty level).

To follow the principles for evidence-based decision making, which require using the best available evidence to inform decisions, we summarized the best available evidence. Because knowing the best

available evidence necessitates being aware of all the available evidence, we based this report on systematic reviews of the literature. We chose the most trustworthy and relevant systematic reviews among many published reviews.

One potential limitation of the process is that, due to feasibility concerns, we relied on the information reported by the systematic reviewers. Most of the systematic reviews we used, unfortunately, were judged at moderate or low methodological quality, which may raise concerns about the trustworthiness of the evidence presented in this report. We believe, however, that the results and conclusions of this report would not be importantly different had the systematic reviews been conducted following higher methodological standards. Because there are no randomized controlled trials, well-conducted comparative observational studies, or very large case series (which include a large sample of consecutive patients who are representative of the whole population) addressing the effects of puberty blockers, cross-sex hormones, and surgeries; the certainty of the evidence about the effects of these interventions is likely to continue being low or very low, even if a few more studies are included (as observed after searching for primary studies published after the reviews were conducted) or some data points were reported inaccurately in the systematic reviews.

Also due to feasibility concerns, the scope of this report was limited to outcomes that are important to patients. Although some may question the decision of not including surrogate outcomes for which there is evidence available (e.g. bone density, blood pressure), decision makers should rarely consider these outcomes and should instead focus on outcomes that do matter to people and stakeholders (e.g., fractures, cardiovascular events).

5.4 Implications

The evidence evaluating the effects of puberty blockers, cross-sex hormones, and surgeries in people with gender dysphoria has important limitations. Therefore, decisions regarding their use should carefully consider other relevant factors. At a patient level, these factors include patients' values and preferences (how patients trade off the potential benefit and harms - what outcomes are more important to them), and resources needed to provide the interventions (and the availability of such resources). At a population level, in addition to these factors, it would be important to consider resources needed to implement the interventions, feasibility, acceptability by relevant stakeholders, and equity.

It is important to note that when there is low or very low certainty evidence, it is rarely appropriate to make decisions that will be applied to the majority of the patients (equivalent to strong recommendations). This implies, at the patient level, that shared decision making is a key part of the decision-making process. At a policy level, extensive debate may be needed.

6. Conclusions

Due to the important limitations in the body of evidence, there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria. This evidence alone is not sufficient to support whether using or not using these treatments. We encourage decision makers to be explicit and transparent about which factors play an important role in their decision, and how they are weighed and traded off.

Methods

To ensure completeness and feasibility of the evidence review, we used an approach in which we prioritized the types of studies according to the design that was more likely to provide the best available evidence. First, we searched for systematic reviews of the literature. Second, we appraised all existing systematic reviews to select the most trustworthy (highest methodological quality, most up-to-date, most applicable) from which to draw conclusions. Third, we used the information presented in the systematic reviews to abstract information regarding the effects of the interventions of interest. Fourth, we assessed the certainty of the evidence (also known as quality of the evidence) abstracted from the selected systematic reviews. We planned to search for primary studies if systematic reviews were not found.

Information sources: We searched for existing systematic reviews in:

1. Epistemonikos (<https://www.epistemonikos.org>), an electronic database that focuses on systematic reviews. We used a comprehensive search strategy based on the population, using the terms “gender dysphoria”, “gender identity disorder” and “transgender”. We conducted this search on April 23, 2022.
2. OVID Medline. We used a search strategy based on the population and the interventions of interest, as well as an adaptation of a filter for systematic reviews from the Health Information Research Unit at McMaster University. We conducted this search on April 23, 2022.
3. Grey literature: we conducted a manual search in the websites of specific health agencies: National Institutes for Health and Care Excellence (NICE), Agency for Healthcare Research and Quality (AHRQ), Canada’s Drug and Health Technology Agency (CADTH), and the website from the Society for Evidence-Based Gender Medicine (SEGM). We conducted these searches between April 27-30, 2022.

We used no date limits for the searches, but we did limit to systematic reviews published in English. Search strategies are available in Appendix 1.

Eligibility criteria: We included systematic reviews, which we defined as:

1. Reviews in which the authors searched for studies to include in at least one electronic database, and in which there were eligibility criteria for including studies and a methodology for assessing and synthesizing the evidence, or
2. Reviews in which the authors searched for studies to include in at least one electronic database, and although there was no description of eligibility criteria or methodology, the presentation of the results strongly suggested that the authors used systematic methods (e.g. flow chart depicting study selection, tables with the same information from all included studies, synthesis of data at the outcome level).

We screened systematic reviews using the following criteria for inclusion:

- **Type of participants:** Young individuals (< 25 years old) with a diagnosis of gender dysphoria/gender identity disorder. We included reviews in which authors used any label and diagnostic criteria for this condition. We included reviews in which the participants in the reported studies were older if it was the only evidence available for a specific question. We excluded reviews with mixed populations (i.e. with and without gender dysphoria) in which people without gender dysphoria constituted more than 20% of the total sample.
- **Type of Interventions:** Puberty blockers, cross-sex hormones, gender affirming surgeries. We included any type of puberty blockers and cross-sex hormones, provided with any regimen. We included the following surgeries: phalloplasty, vaginoplasty, and chest surgery (mastectomy or breast implants/augmentation). We only included these when they were performed for the first time (i.e., not revision surgeries).
- **Type of comparison:** When the systematic reviews included comparative studies, the comparator of interest was no intervention. Participants could have received psychotherapy or counselling as a cointervention (in both groups).
- **Type of outcomes:** Gender dysphoria, mental health outcomes (depression and anxiety), quality of life, suicidal ideation, suicide, adverse effects (for puberty blockers and cross-sex hormones only), and satisfaction, complications, reoperation, and regret (for surgeries only). We included any length of follow-up. We excluded surrogate outcomes such as blood pressure, bone mineral density, kidney or liver function test values, etc.
- **Type of studies included in the systematic reviews:** Any clinical study (studies in which the researchers recruited and measured outcomes in humans) regardless of study design. This included randomized clinical trials, comparative observational studies, and case series. Because we could not quantify effect measures, incidence, or prevalence, we excluded case reports.

We excluded systematic reviews published only in abstract format, and those that we could not retrieve in full text (no access through the McMaster University library, or open access online).

Selection process: The two reviewers screened all titles and abstracts independently and in duplicate, followed by screening of full texts of potentially eligible systematic reviews independently and in duplicate, using the systematic review online application Covidence (<https://www.covidence.org>). We solved disagreements by consensus.

To select the most useful systematic reviews among all of those that met the eligibility criteria, we used the following prioritization criteria:

1. Date of publication: we prioritized systematic reviews published within the last 3 years (2020-2022)

2. Match between eligibility criteria of the review and the question of interest: we prioritized reviews in which the authors specifically included the population, intervention, comparison, and outcomes of interest for this evidence review
3. Outcome data available: we prioritized systematic reviews in which the authors report outcome data
4. Methodological quality: we used a modified version of the items in AMSTAR 2.¹ We modified the items to ensure assessment of methodological rather than reporting quality (Table 1). We rated each systematic review as having high, moderate, low, or critically low methodological quality, according to the guidance from the developers of the tool.¹ We reached consensus on critical items that determined this rating (Table 1). We prioritized selection of systematic reviews with highest methodological quality.

For surgical interventions, in addition, we prioritized systematic reviews that covered all gender affirming surgeries (instead of focusing on a specific type of surgery).

We selected a systematic review specifically for each of the outcomes of interest. In other words, we chose the best systematic review to inform each outcome. Each systematic review, however, could inform more than one outcome.

Table 1: Items used to rate the methodological quality of the eligible systematic reviews

AMSTAR Item	Modification to measure methodological quality
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Does the review have a clear question and are the eligibility criteria for studies consistent with the question?
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	No modification needed
3. Did the review authors explain their selection of the study designs for inclusion in the review?	No modification needed
4. Did the review authors use a comprehensive literature search strategy?	Did the authors search in at least 2 electronic databases, using a reproducible search strategy?
5. Did the review authors perform study selection in duplicate?	No modification needed
6. Did the review authors perform data extraction in duplicate?	No modification needed
7. Did the review authors provide a list of excluded studies and justify the exclusions?	No modification needed
8. Did the review authors describe the included studies in adequate detail?	No modification needed
9. Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?	No modification needed

10. Did the review authors report on the sources of funding for the studies included in the review?	Did the review authors consider conflicts of interest and how they may have affected the results of the primary studies?
11. If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results?	Was the synthesis of evidence done appropriately? (outcome level, appropriate meta analysis or narrative synthesis)
12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	Did authors use subgroup or sensitivity analysis to assess the effect of risk of bias in meta-analytic results? Likely not applicable to most cases
13. Did the review authors account for RoB in primary studies when interpreting/discussing the results of the review?	Did the review authors incorporate an assessment of risk of bias at the outcome level when drawing conclusions?
14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?	Did the review authors incorporate an assessment of heterogeneity at the outcome level when drawing conclusions?
15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?	Did the authors address publication bias? (regardless of whether synthesis was using a meta-analysis or narrative)
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Did the authors report conflicts of interest and did they manage any existing conflict of interest appropriately?

Shaded items were items considered critical.

Data abstraction: We abstracted outcome data from each of the systematic reviews. To ensure feasibility, we used the data as reported by the authors of the review and did not re-abtract data from the primary studies. One reviewer abstracted the data and a second reviewer checked the data for accuracy.

Data synthesis: Using the systematic reviews prioritized, we synthesized the evidence at the outcome level. Because of the higher likelihood of it resulting in higher certainty of evidence (details below) for each outcome, when there was comparative data (i.e. comparison of outcomes between an untreated and a treated group) and non-comparative data (i.e. changes from before to after treatment in one group, or only outcomes after treatment), we prioritized comparative data.

We prioritized numerical results (i.e. magnitudes of effect) and reported estimates and their 95% confidence intervals (CIs). When results were not reported in that way, we calculated the estimates and CIs when systematic review authors provided sufficient information. When necessary, we assumed moderate correlation coefficients for the changes between baseline and follow up (coefficient= 0.4). When this information was not available we reported narratively the effect estimates and ranges.

When a specific study reported the same outcome measured by more than one scale, we chose the scale presented first. We highlighted situations when the results obtained with other scales were importantly different.

When the same outcome was reported by more than one study but we could not pool the results, we created narrative syntheses.

Certainty of evidence: For each outcome, we assessed the certainty of the evidence (also known as quality of the evidence) using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach.² The certainty of evidence can be rated as high, moderate, low, or very low (Table 2). For effects of interventions, the certainty of the evidence started as high and could be rated down due to serious concerns about risk of bias, inconsistency, indirectness, imprecision, and publication bias. For inferences about the effect of using a treatment versus no treatment, when there was no comparison group, we assessed risk of bias as very serious and rated down the certainty of the evidence 2 levels by default. We used the same principles when assessing the certainty of the evidence in estimates of prevalence or rates, but did not judge risk of bias as resulting in very serious concerns due to lack of a comparison group. For all assessments, we used the information presented by the authors of the systematic review (e.g. assessments of risk of bias of the included studies, effect estimates from studies).

Table 2: GRADE levels of certainty of the evidence

Certainty level	Definition
High ⊕⊕⊕⊕	We are very confident that the true result (effect estimate/ prevalence/ mean, etc.) lies close to that of the estimate of the result
Moderate ⊕⊕⊕○	We are moderately confident in the result: the true result is likely to be close to the estimate of the result, but there is a possibility that it is substantially different
Low ⊕⊕○○	Our confidence in the result is limited: the true result may be substantially different from the estimate of the result
Very low ⊕○○○	We have very little confidence in the result: the true result is likely to be substantially different from the estimate of the result

Presentation of results: We created GRADE Summary of Findings tables in which we describe the evidence available for each of the outcomes, and the certainty of the evidence. These tables contain the following information:

- Outcomes: measurement method (including scales, if applicable) and follow-up
- Estimates of effect: absolute and relative estimates of effect, and their corresponding 95% CIs.
- Number of studies and participants providing evidence for the outcome
- GRADE certainty of the evidence, with a link to detailed explanations (provided at the bottom of the table) of why the certainty of the evidence was rated at a specific level
- A narrative statement about what happens with the outcome, based on the estimate of effect and certainty of evidence.

Searching for new evidence not included in the systematic reviews: To assess if newer evidence not included in the included systematic reviews would change the conclusions importantly, we searched for and assessed primary studies answering the questions of interest that were published after the authors of such systematic reviews conducted their searches. We defined an important change in conclusions as a change in the certainty of the evidence (from low/ very low/ not available to high/ moderate).

We searched OVID Medline from January 1, 2019 through May 12, 2022, for studies published in English. We included studies if they enrolled young individuals (< 25 years old, with at least 20% of the people being this age) with a diagnosis of gender dysphoria/gender identity disorder, who received puberty blockers, cross-sex hormones, or surgeries; and measured any of the outcomes of interest.

For outcomes that should be evaluated in a comparative manner (e.g., depression, anxiety, etc.), because they are the only type of study design that would change the conclusions importantly, we selected comparative clinical studies (studies in which the researchers recruited and measured outcomes in humans, and compared a group of people who received the intervention with another one who did not receive the intervention). This included randomized clinical trials, and comparative observational studies. For outcomes that can only occur when the treatment is administered, we included non-comparative observational studies (case series). For these to change conclusions, they should have a sufficiently large sample size, and therefore we excluded case series in which the researchers reported information from <100 people.

Two reviewers screened the potentially relevant articles at title and abstract and full text screening stage. We abstracted relevant study characteristics and outcome data, and assessed risk of bias of comparative studies using the most relevant domains of the Risk of Bias for non-Randomized studies of Interventions (ROBINS-I) tool³ (table 3). For non-comparative studies, we used a list of custom items that captured the most important potential risk of bias concerns of case series (table 4). We judged the risk of bias of each study as the highest risk of bias of any of the domains assessed (e.g., one domain judged at critical risk of bias resulted in the study judged at critical risk of bias). We summarized this information at the study and judged whether it would have changed the conclusions importantly if added to the body of evidence from the systematic reviews.

Table 3: Domains used to assess risk of bias of comparative studies

Domain	Low	Critical
Confounding	Adjusted for all relevant confounding factors	No adjustment
Classification of intervention	Intervention recorded prospectively or from medical records	Asked patients to recall whether they received the intervention
Deviation from intended interventions	No cointerventions or cointerventions balanced between the groups	Cointerventions unbalanced between the groups

Missing data	More than 90% of patients who started the study provided outcome data	Less than 50% of patients who started the study provided outcome data
Measurement of outcome	All outcomes measured in the same way in both groups	Outcomes measured differently in both groups

Each domain could be judged at low, moderate, serious, or critical risk of bias. In addition, information could be insufficient to make a judgment. The table describes the criteria used to judge a domain in the extreme categories.

Table 4: Domains used to assess risk of bias of non-comparative studies

Domain	Low	High
Representativeness of the sample	Included all consecutive patients	Highly selected sample based on specific characteristics related with the prognosis after treatment
Classification of the intervention	Intervention recorded prospectively or from medical records	Asked patients to recall whether they received the intervention
Deviation from intended interventions	No cointerventions outside what would be observed in practice (or in a small proportion of patients)	Most patients received co-interventions that could influence the outcomes
Missing data	More than 90% of patients who started the study provided outcome data	Less than 50% of patients who started the study provided outcome data
Measurement of outcome	Outcomes measured prospectively or from medical records	Outcomes reported by the patients and/or needed to recall what happened a long time ago

Each domain could be judged at low, moderate, or high risk of bias. In addition, information could be insufficient to make a judgment. The table describes the criteria used to judge a domain in the extreme categories.

References

1. Shea BJ, Reeves BC, Wells G, et al. AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *Bmj* 2017;358:j4008. doi: 10.1136/bmj.j4008 [published Online First: 2017/09/25]
2. Blashem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of the evidence. *Journal of clinical epidemiology* 2011;64:401-06.
3. Sterne JA, Hernan MA, Reeves BC, et al. ROBINS-I: a tool for assessing risk of bias in non-randomised studies of interventions. *BMJ (Clinical research ed)* 2016;355:i4919. doi: 10.1136/bmj.i4919 [published Online First: 2016/10/14]

Search Strategies

Questions Covered:

PICO questions:

1. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **puberty blockers (gonadotrophin releasing hormone (GnRH) analogues)** compared to no puberty blockers?
2. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **cross-sex hormones** compared to no cross-sex hormones?
3. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of **gender-affirming surgeries** compared to no surgery?

Search Strategies:

Note: Population, puberty blocker, cross-sex hormones search blocks adapted from NICE (2020) evidence reviews. Gender-affirming search block adapted from Wernick *et al.* 2019. Systematic reviews filter adapted from McMaster University Health Information Research Unit (HIRU).

Databases: Medline, Epistemonikos

Grey Literature: CADTH, AHRQ, SEGM, NICE

Medline

OVERVIEW		
Interface:	Ovid	
Databases:	OVID Medline Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present	
Study Types:	Systematic Reviews	
Search Run:	April 23, 2022	
Search Strategy: search terms [number of results]		
<i>Population</i>		
1	exp "Sexual and Gender Minorities"/	12385
2	Gender Dysphoria/	774
3	Gender Identity/	20481
4	Gender Role/	197
5	"Sexual and Gender Disorders"/	81
6	Transsexualism/	4236
7	Transgender Persons/	5303
8	Health Services for Transgender Persons/	186

- 9 exp Sex Reassignment Procedures/ 1208
- 10 gender identity disorder.mp. 492
- 11 non-binary.mp. 566
- 12 transgender.mp. 9989
- 13 (gender* adj3 (dysphori* or disorder* or distress or nonconform* or non-conform* or atypical or incongru* or identi* or disorder* or confus* or minorit* or queer* or variant or diverse or creative or explor* or question* or expan* or fluid)).tw. 16428
- 14 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition* or expression*)).tw. 13749
- 15 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. 19665
- 16 (genderfluid or genderqueer or agender).mp. 130
- 17 ((correct or chosen) adj3 name).mp. 591
- 18 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. 135313
- 19 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition* or expression*)).tw. 13749
- 20 (male-to-female or m2f or female-to-male or f2m).tw. 148579
- 21 or/1-20 342948

Cross-Sex Hormones

- 22 Hormones/ad, tu, th 4676
- 23 exp Progesterone/ad, tu, th 11265
- 24 exp Estrogens/ad, tu, th 29635
- 25 exp Gonadal Steroid Hormones/ad, tu, th 35375
- 26 (progesteron* or oestrogen* or estrogen*).tw. 223307
- 27 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medic* or drug* or intervention* or care)).tw. 1488
- 28 exp Estradiol/ad, tu, th 11197
- 29 exp Testosterone/ad, tu, th 8710
- 30 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).tw. 86509
- 31 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinyloestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle).tw. 100252
- 32 or/22-31 345895

Puberty Blockers

- 33 Gonadotropin-Releasing Hormone/ 28809
- 34 (pubert* adj3 block*).ti,ab. 141
- 35 ((gonadotrophin or gonadotropin) and releasing).ti,ab. 20121
- 36 (GnRH adj2 analog*).ti,ab. 2878
- 37 GnRH*.ti,ab. 24390
- 38 "GnRH agonist*".ti,ab. 4749
- 39 Triptorelin Pamoate/ 1981
- 40 triptorelin.ti,ab. 821
- 41 arvekap.ti,ab. 1

42	("AY 25650" or AY25650).ti,ab.	1	
43	("BIM 21003" or BIM21003).ti,ab.	0	
44	("BN 52014" or BN52014).ti,ab.	0	
45	("CL 118532" or CL118532).ti,ab.	0	
46	Debio.ti,ab.	119	
47	diphereline.ti,ab.	28	
48	moapar.ti,ab.	0	
49	pamorelin.ti,ab.	1	
50	trelstar.ti,ab.	3	
51	triptodur.ti,ab.	1	
52	("WY 42422" or WY42422).ti,ab.	0	
53	("WY 42462" or WY42462).ti,ab.	0	
54	gonapeptyl.ti,ab.	0	
55	decapeptyl.ti,ab.	225	
56	salvacyl.ti,ab.	0	
57	Buserelin/	2137	
58	buserelin.ti,ab.	1395	
59	onist.ti,ab.	0	
60	("hoe 766" or hoe-766 or hoe766).ti,ab.	72	
61	profact.ti,ab.	2	
62	receptal.ti,ab.	31	
63	suprecur.ti,ab.	5	
64	suprefact.ti,ab.	25	
65	tiloryth.ti,ab.	0	
66	histrelin.ti,ab.	78	
67	"LHRH-hydrogel implant".ti,ab.	1	
68	("RL 0903" or RL0903).ti,ab.	1	
69	("SPD 424" or SPD424).ti,ab.	1	
70	goserelin.ti,ab.	1016	
71	Goserelin/	1643	
72	("ici 118630" or ici118630).ti,ab.	51	
73	("ZD-9393" or ZD9393).ti,ab.	0	
74	zoladex.ti,ab.	388	
75	leuprorelin.ti,ab.	525	
76	carcinil.ti,ab.	0	
77	enanton*.ti,ab.	26	
78	ginecrin.ti,ab.	0	
79	leuplin.ti,ab.	15	
80	Leuprolide/	3018	
81	leuprolide.ti,ab.	2004	
82	lucrin.ti,ab.	16	
83	lupron.ti,ab.	183	
84	provren.ti,ab.	0	
85	procrin.ti,ab.	3	
86	("tap 144" or tap144).ti,ab.	41	
87	(a-43818 or a43818).ti,ab.	3	
88	Trenantone.ti,ab.	2	
89	staladex.ti,ab.	0	

90	prostag.	ti,ab.	6	
91	Nafarelin/		327	
92	nafarelin.	ti,ab.	263	
93	("76932-56-4" or "76932564").	ti,ab.	0	
94	("76932-60-0" or "76932600").	ti,ab.	0	
95	("86220-42-0" or "86220420").	ti,ab.	0	
96	("rs 94991 298" or rs94991298).	ti,ab.	0	
97	synarel.	ti,ab.	13	
98	deslorelin.	ti,ab.	306	
99	gonadorelin.	ti,ab.	237	
100	("33515-09-2" or "33515092").	ti,ab.	0	
101	("51952-41-1" or "51952411").	ti,ab.	0	
102	("52699-48-6" or "52699486").	ti,ab.	0	
103	cetorelix.	ti,ab.	520	
104	cetrotide.	ti,ab.	52	
105	("NS 75A" or NS75A).	ti,ab.	0	
106	("NS 75B" or NS75B).	ti,ab.	0	
107	("SB 075" or SB075).	ti,ab.	1	
108	("SB 75" or SB75).	ti,ab.	67	
109	gonadoliberin.	ti,ab.	151	
110	kryptocur.	ti,ab.	7	
111	cetorelix.	ti,ab.	520	
112	cetrotide.	ti,ab.	52	
113	antagon.	ti,ab.	18	
114	ganirelix.	ti,ab.	160	
115	("ORG 37462" or ORG37462).	ti,ab.	3	
116	orgalutran.	ti,ab.	26	
117	("RS 26306" or RS26306).	ti,ab.	5	
118	("AY 24031" or AY24031).	ti,ab.	0	
119	factrel.	ti,ab.	13	
120	fertagyl.	ti,ab.	12	
121	lutrelif.	ti,ab.	5	
122	lutrepulse.	ti,ab.	3	
123	relefact.	ti,ab.	10	
124	fertiral.	ti,ab.	0	
125	(hoe471 or "hoe 471").	ti,ab.	6	
126	relisorm.	ti,ab.	4	
127	cystorelin.	ti,ab.	19	
128	dirigestran.	ti,ab.	5	
129	or/33-128		47108	

Gender-affirming Surgeries

130	virilization/		2309	
131	(virilism or virili?ation or masculini?ation).	mp.	5657	
132	feminization/		797	
133	femini?ation.	mp.	3420	
134	(vaginoplasty or vaginoplasties).	mp.	1022	

135 exp Vagina/ or *Reconstructive Surgical Procedures/ 78841
 136 (vaginoplasty or vaginoplasties).mp. 1022
 137 (phalloplasty or phalloplasties).mp. 561
 138 exp Penile Prosthesis/ 1636
 139 "penile reconstruction".mp. 292
 140 (vagina reconstruction or vaginal reconstruction).mp. 549
 141 (genitoplasty or genitoplasties).mp. 263
 142 transsexualism/su [Surgery] 1007
 143 sex reassignment.mp. 1668
 144 sex transformation.mp. 42
 145 or/130-144 91560

Systematic Review Filter

147 meta-analysis/ 158633
 148 (meta anal* or meta-anal* or metaanal*).ti,ab. 231876
 149 ((systematic or evidence) adj2 (review* or overview*)).ti,ab. 279806
 150 ((pool* or combined) adj2 (data or trials or studies or results)).ab. 65411
 151 (search strategy or search criteria or systematic search or study selection or data extraction).ab. 70886
 152 (search* adj4 literature).ab. 84593
 153 or/146-152 521554

Combine Interventions and Population

154 32 or 129 or 145 459771
 155 21 and 154 17838

Limit to Systematic Reviews in English Language

156 153 and 155 295
 157 limit 156 to english language 288

OVERVIEW	
Interface:	https://www.epistemonikos.org/
Database:	Epistemonikos
Study Types:	Systematic Reviews
Search Run:	April 23, 2022
Search Strategy: search terms [number of results]	
<p><i>Population</i></p> <p>(title:((title:(gender dysphoria) OR abstract:(gender dysphoria)) OR (title:(gender identity disorder) OR abstract:(gender identity disorder)) OR (title:(transgender) OR abstract:(transgender))) OR abstract:((title:(gender dysphoria) OR abstract:(gender dysphoria)) OR (title:(gender identity disorder) OR abstract:(gender identity disorder)) OR (title:(transgender) OR abstract:(transgender))))</p> <p><i>Limit to Systematic Reviews</i></p> <p>*Limited by publication type "systematic review" [425]</p>	

Canadian Agency for Drugs and Technologies in Health (CADTH)

OVERVIEW	
Interface:	https://www.cadth.ca/
Database:	CADTH
Study Types:	Systematic Reviews, Health Technology Reviews
Search Run:	April 27, 2022
Search Strategy: search terms [number of results]	
<p>"gender dysphoria" [10] <i>Limit to Health Technology Review</i> [2]</p> <p>"transgender" [9] <i>Limit to Health Technology Review</i> [5]</p> <p>"gender identity disorder" [1]</p>	

Agency for Healthcare Research and Quality (AHRQ)

OVERVIEW	
Interface:	https://search.ahrq.gov/
Database:	AHRQ
Study Types:	Evidence Based Practice (EPC) Centre Reports, Full Research Reports, Health Technology Assessments
Search Run:	April 29, 2022
Search Strategy: search terms [number of results]	
<i>Search titles only: "gender identity disorder" "gender dysphoria" "transgender" [7]</i>	

Society for Evidence-based Gender Medicine (SEGM)

OVERVIEW	
Interface:	https://segm.org/news
Database:	SEGM News
Study Types:	Systematic Reviews
Search Run:	April 30, 2022
Search Strategy: search terms [number of results]	
<i>Find in page: "systematic" [5]</i>	

National Institute for Health and Care Excellence (NICE)

OVERVIEW	
Interface:	https://www.nice.org.uk/
Database:	NICE
Study Types:	Systematic Reviews, Guidelines with Systematic Reviews
Search Run:	April 30, 2022
Search Strategy: search terms [number of results]	
gender dysphoria [1] <i>Limit to Guidance</i> [1]	
transgender [10] <i>Limit to Guidance</i> [7]	

gender identity disorder [9]
Limit to Guidance [8]

Search Strategies – Individual Studies

Questions Covered:

PICO questions:

1. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **puberty blockers (gonadotrophin releasing hormone (GnRH) analogues)** compared to no puberty blockers?
2. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **cross-sex hormones** compared to no cross-sex hormones?
3. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of **gender-affirming surgeries** compared to no surgery?

Search Strategies:

Note: Population, puberty blocker, cross-sex hormones search blocks adapted from NICE (2020) evidence reviews. Gender-affirming search block adapted from Wernick *et al.* 2019.

Databases: Medline

Medline

OVERVIEW		
Interface:	Ovid	
Databases:	OVID Medline Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present	
Study Types:	Any	
Search Run:	May 12, 2022	
Search Strategy: search terms [number of results]		
<i>Population</i>		
1	exp "Sexual and Gender Minorities"/	12631
2	Gender Dysphoria/	781
3	Gender Identity/	20586
4	Gender Role/	204
5	"Sexual and Gender Disorders"/	81
6	Transsexualism/	4259
7	Transgender Persons/	5371
8	Health Services for Transgender Persons/	187
9	exp Sex Reassignment Procedures/	1211
10	gender identity disorder.mp.	492

- 11 non-binary.mp. 574
- 12 transgender.mp. 10079
- 13 (gender* adj3 (dysphori* or disorder* or distress or nonconform* or non-conform* or atypical or incongru* or identi* or disorder* or confus* or minorit* or queer* or variant or diverse or creative or explor* or question* or expan* or fluid)).ti,ab. 16546
- 14 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).ti,ab. 9375
- 15 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).ti,ab. 19788
- 16 (genderfluid or genderqueer or agender).mp. 132
- 17 ((correct or chosen) adj3 name).mp. 591
- 18 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).ti,ab. 135744
- 19 (male-to-female or m2f or female-to-male or f2m).ti,ab. 149067
- 20 or/1-19 341083

Cross-sex Hormones

- 21 Hormones/ad, tu, th 4690
- 22 exp Progesterone/ad, tu, th 11270
- 23 exp Estrogens/ad, tu, th 29646
- 24 exp Gonadal Steroid Hormones/ad, tu, th 35401
- 25 (progesteron* or oestrogen* or estrogen*).ti,ab. 223689
- 26 ((cross-sex or crossex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medici* or drug* or intervention* or care)).ti,ab. 1507
- 27 exp Estradiol/ad, tu, th 11200
- 28 exp Testosterone/ad, tu, th 8722
- 29 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).ti,ab. 86670
- 30 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinyloestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle).ti,ab. 100411
- 31 or/21-30 346508

Puberty Blockers

- 32 Gonadotropin-Releasing Hormone/ 28845
- 33 (pubert* adj3 block*).ti,ab. 142
- 34 ((gonadotrophin or gonadotropin) and releasing).ti,ab. 20158
- 35 (GnRH adj2 analog*).ti,ab. 2879
- 36 GnRH*.ti,ab. 24437
- 37 "GnRH agonist*".ti,ab. 4763
- 38 Triptorelin Pamoate/ 1983
- 39 triptorelin.ti,ab. 822
- 40 arvekap.ti,ab. 1
- 41 ("AY 25650" or AY25650).ti,ab. 1
- 42 ("BIM 21003" or BIM21003).ti,ab. 0
- 43 ("BN 52014" or BN52014).ti,ab. 0
- 44 ("CL 118532" or CL118532).ti,ab. 0

45	Debio.ti,ab.	119	
46	diphereline.ti,ab.	28	
47	moapar.ti,ab.	0	
48	pamorelin.ti,ab.	1	
49	trelstar.ti,ab.	3	
50	triptodur.ti,ab.	1	
51	("WY 42422" or WY42422).ti,ab.	0	
52	("WY 42462" or WY42462).ti,ab.	0	
53	gonapeptyl.ti,ab.	0	
54	decapeptyl.ti,ab.	225	
55	salvacyl.ti,ab.	0	
56	Buserelin/	2137	
57	buserelin.ti,ab.	1396	
58	onist.ti,ab.	0	
59	("hoe 766" or hoe-766 or hoe766).ti,ab.	72	
60	profact.ti,ab.	2	
61	receptal.ti,ab.	31	
62	suprecur.ti,ab.	5	
63	suprefact.ti,ab.	25	
64	tiloryth.ti,ab.	0	
65	histrelin.ti,ab.	78	
66	"LHRH-hydrogel implant".ti,ab.	1	
67	("RL 0903" or RL0903).ti,ab.	1	
68	("SPD 424" or SPD424).ti,ab.	1	
69	goserelin.ti,ab.	1017	
70	Goserelin/	1644	
71	("ici 118630" or ici118630).ti,ab.	51	
72	("ZD-9393" or ZD9393).ti,ab.	0	
73	zoladex.ti,ab.	388	
74	leuprorelin.ti,ab.	529	
75	carcinil.ti,ab.	0	
76	enanton*.ti,ab.	26	
77	ginecrin.ti,ab.	0	
78	leuplin.ti,ab.	15	
79	Leuprolide/	3018	
80	leuprolide.ti,ab.	2003	
81	lucrin.ti,ab.	16	
82	lupron.ti,ab.	183	
83	provren.ti,ab.	0	
84	procrin.ti,ab.	3	
85	("tap 144" or tap144).ti,ab.	41	
86	(a-43818 or a43818).ti,ab.	3	
87	Trenantone.ti,ab.	2	
88	staladex.ti,ab.	0	
89	prostap.ti,ab.	6	
90	Nafarelin/	327	
91	nafarelin.ti,ab.	263	
92	("76932-56-4" or "76932564").ti,ab.	0	

93 ("76932-60-0" or "76932600").ti,ab.	0
94 ("86220-42-0" or "86220420").ti,ab.	0
95 ("rs 94991 298" or rs94991298).ti,ab.	0
96 synarel.ti,ab.	13
97 deslorelin.ti,ab.	310
98 gonadorelin.ti,ab.	238
99 ("33515-09-2" or "33515092").ti,ab.	0
100 ("51952-41-1" or "51952411").ti,ab.	0
101 ("52699-48-6" or "52699486").ti,ab.	0
102 cetorelix.ti,ab.	520
103 cetrotide.ti,ab.	52
104 ("NS 75A" or NS75A).ti,ab.	0
105 ("NS 75B" or NS75B).ti,ab.	0
106 ("SB 075" or SB075).ti,ab.	1
107 ("SB 75" or SB75).ti,ab.	67
108 gonadoliberin.ti,ab.	152
109 kryptocur.ti,ab.	7
110 cetorelix.ti,ab.	520
111 cetrotide.ti,ab.	52
112 antagon.ti,ab.	18
113 ganirelix.ti,ab.	161
114 ("ORG 37462" or ORG37462).ti,ab.	3
115 orgalutran.ti,ab.	26
116 ("RS 26306" or RS26306).ti,ab.	5
117 ("AY 24031" or AY24031).ti,ab.	0
118 factrel.ti,ab.	13
119 fertagyl.ti,ab.	12
120 lutrelef.ti,ab.	5
121 lutrepulse.ti,ab.	3
122 relefact.ti,ab.	10
123 fertiral.ti,ab.	0
124 (hoe471 or "hoe 471").ti,ab.	6
125 relisorm.ti,ab.	4
126 cystorelin.ti,ab.	19
127 dirigestran.ti,ab.	5
128 or/32-127	47179

Surgery

129 virilization/	2309
130 (virilism or virili?ation or masculini?ation).mp.	5664
131 feminization/	798
132 femini?ation.mp.	3425
133 (vaginoplasty or vaginoplasties).mp.	1032
134 (vaginoplasty or vaginoplasties).mp.	1032
135 (phalloplasty or phalloplasties).mp.	561
136 exp Penile Prosthesis/	1642
137 "penile reconstruction".mp.	292

138 (vagina reconstruction or vaginal reconstruction).mp. 550
139 (genitoplasty or genitoplasties).mp. 263
140 transsexualism/su [Surgery] 1007
141 sex reassignment.mp. 1674
142 sex transformation.mp. 42
143 or/129-142 14290

Any intervention AND population

144 31 or 128 or 143 386835
145 20 and 144 16516

Limit to Humans

146 animals/ not humans/ 4972586
147 145 not 146 9281
148 limit 147 to humans 7901

Limit to Publication Year 2019 to Current

149 limit 148 to yr="2019 -Current" 1859

Results

Search results and eligible reviews: After screening 647 records found through our searches, we found 61 eligible systematic reviews. From these, 27 were published between 2020 and 2022 (Figure 1). Overall, 4% (1/27) of the reviews were judged to be of high methodological quality, 15% (4/27) were moderate methodological quality, 37% (10/27) were low methodological quality, and 44% (12/27) were critically low methodological quality.

We provide reasons for excluding systematic reviews in appendix 1.

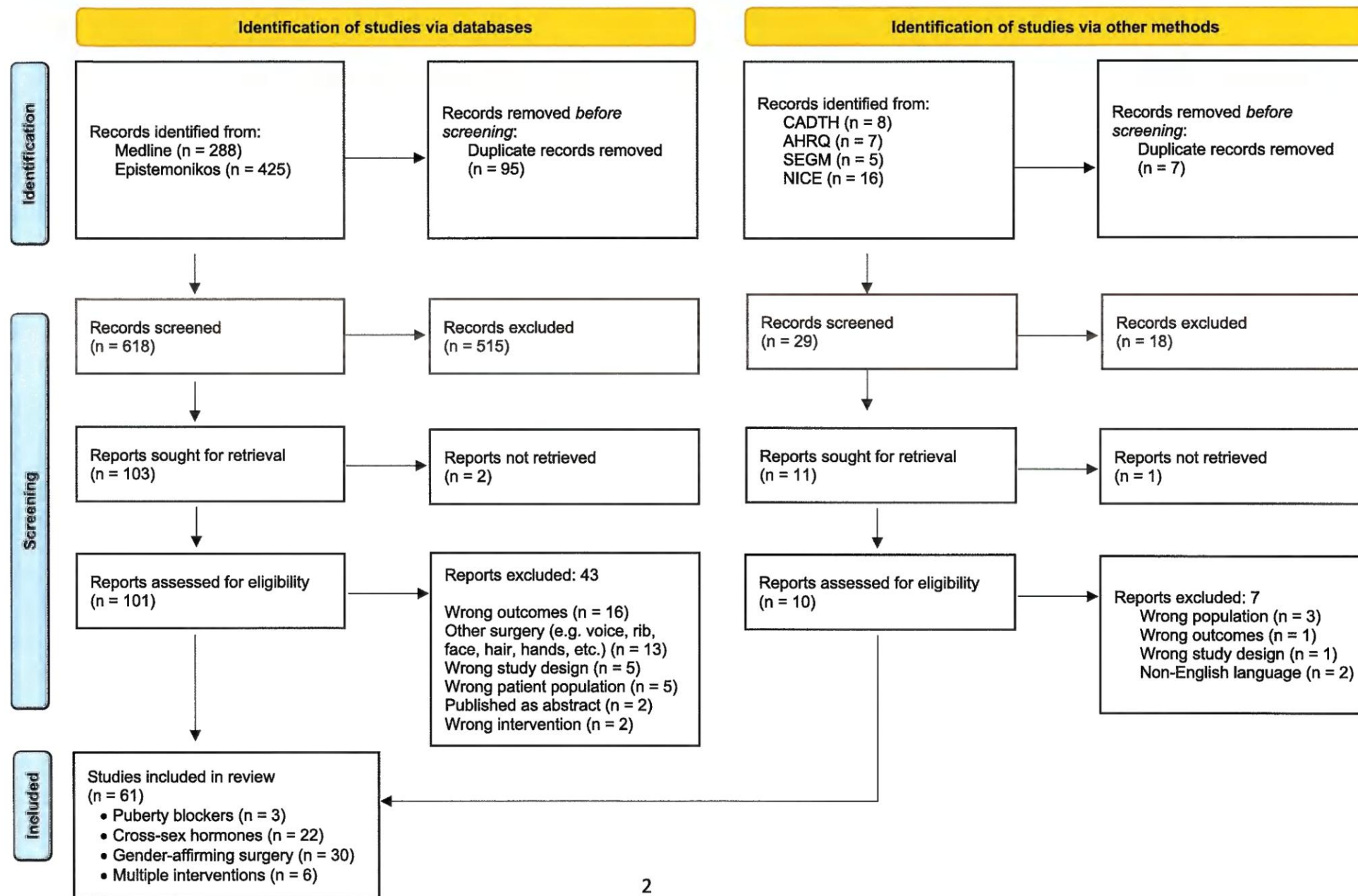


Figure 1: PRISMA flow diagram for the selection of systematic reviews. *From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71. *For more information, visit:* <http://www.prisma-statement.org/>

Outcomes:

- 1. Puberty blockers:** We found 4 systematic reviews assessing the effects of puberty blockers published between 2020 and 2022.¹⁻⁴ From these, we judged 2 as having moderate methodological quality, and 2 as having critically low methodological quality. Details of the assessment are provided in Figure 2.

Table 1 summarizes the evidence about the effects of puberty blockers on the outcomes of interest. We used information from 2 systematic reviews.^{2,3} For most outcomes (except suicidality), there is no evidence about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. There is very low certainty about the effects of puberty blockers on suicidal ideation (see details in Table 1).

Studies, however, reported outcomes among a group of people with gender dysphoria after receiving puberty blockers. The findings are:

- There is low certainty evidence suggesting that treatment with puberty hormones may slightly increase gender dysphoria severity (mean change score in the Utrecht Gender Dysphoria scale, 0.7 points [95% CI, -4.2 to 5.6], range 12-60, with higher scores reflecting more severe gender dysphoria)
- There is low certainty evidence suggesting that treatment with puberty blockers may decrease depression (mean change score in the Beck Depression Inventory, -3.4 [95% CI, -5.7 to -1.0], range 0-63, with higher scores reflecting more severe depression)
- There is low certainty evidence suggesting that treatment with puberty blockers may decrease anxiety (mean change score in the Trait Anxiety Scale, trait subscale, -1.5 [95% CI, -4.7 to -1.8], range 0-80, with higher scores reflecting more severe anxiety)
- There is low certainty evidence suggesting a moderate percentage of patients reporting adverse events after treatment with puberty blockers (see Table 1 for details)
- There is very low certainty evidence about how puberty blockers affect suicidality

Figure 2: AMSTAR assessment judgements for systematic reviews addressing puberty blockers

Review ID	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12	Item 13	Item 14	Item 15	Item 16	Methodological quality
AHRQ 2021	Yes	Probably yes	No	Yes	Probably yes	Probably yes	Yes	Probably yes	Probably yes	Probably yes	Probably yes	Probably yes	Probably yes	Probably yes	Probably yes	Yes	MODERATE
NICE 2020a	Yes	Probably yes	Yes	Yes	Probably yes	Probably yes	Yes	Yes	Probably yes	Yes	Probably yes	Probably yes	Yes	Yes	No	No	MODERATE
Ramos 2020	Yes	No	No	Probably yes	Probably yes	Yes	No	Probably yes	No	No	No	Probably yes	No	No	No	Yes	CRITICALLY LOW
Rew 2020	Yes	No	No	Yes	No	Probably yes	No	Yes	Yes	No	No	Probably yes	No	No	No	Yes	CRITICALLY LOW

Figure legend:

Yes

Probably yes

Probably no

No

Not applicable



Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: puberty blockers (gonadotrophin releasing hormone analogues)

Comparison: no puberty blockers


Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	Risk / mean with puberty blockers				
Gender dysphoria assessed with: difference (effect) in gender dysphoria proportion or severity			Not reported			The effects of puberty blockers on gender dysphoria are unknown
Gender dysphoria assessed with: mean change score in the Utrecht Gender Dysphoria Scale (12-60, higher scores reflect more gender dysphoria, 40 points or more indicate a diagnosis of gender dysphoria) (NICE, 2020a) Follow up: mean 1.9 years (range 0.4 to 5.1 years)	NA	0.7 (-4.2 to 5.6)	NA	41 (1 study)	 LOW ¹	The mean gender dysphoria score may increase by 0.7 points after puberty blockers
Depression assessed with: difference (effect) in depression proportion or severity			Not reported			The effects of puberty blockers on depression are unknown

Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: puberty blockers (gonadotrophin releasing hormone analogues)
Comparison: no puberty blockers



Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	Risk / mean with puberty blockers				
Depression assessed with: mean change score in Beck Depression Inventory-II scale (0-63, higher scores represent more severe depression) (NICE, 2020a) Follow up: mean 1.9 years (range 0.4 to 5.1 years)	NA	-3.4 (-5.7 to -1.0)	NA	41 (1 study)	 LOW ¹	The mean depression score may decrease by 3.4 points after puberty blockers
Anxiety assessed with: difference (effect) in anxiety proportion or severity			Not reported			The effects of puberty blockers on anxiety are unknown
Anxiety assessed with: mean change score in STAI-Trait scale (0-80, higher scores represent more severe anxiety) (NICE, 2020a) Follow up: mean 1.9 years (range 0.4 to 5.1 years)	NA	-1.5 (-4.7 to 1.8)	NA	41 (1 study)	 LOW ¹	The mean anxiety score may decrease by 1.5 points after puberty blockers

Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: puberty blockers (gonadotrophin releasing hormone analogues)
Comparison: no puberty blockers



Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	Risk / mean with puberty blockers				
Quality of life assessed with: any measure			Not reported			The effects of puberty blockers on quality of life are unknown
Suicidal ideation difference (effect) in suicidal ideation (Rew, 2020) Follow-up: cross-sectional survey	The authors report that "compared to youth who did not receive pubertal suppression, those who did showed lower lifetime rates of suicidal ideation".			89 (1 study)	 VERY LOW ²	We are very uncertain about the effect of puberty blockers on suicidal ideation
Adverse effects assessed with: proportion of patients reporting adverse effects (NICE, 2020a) Follow up: mean 2.3 years (range 0.0 to 11.3 years)	NA	11% ³ (2% to 29%)	NA	27 (1 study)	 LOW ⁴	The proportion of patients reporting adverse effects after treatment with puberty blockers may be 11%
STAI-Trait: Trait Anxiety Scale. Range: 0-80 CI: Confidence interval NA: Not applicable						

Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: puberty blockers (gonadotrophin releasing hormone analogues)
Comparison: no puberty blockers

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	Risk / mean with puberty blockers				

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Mean change rated down due to risk of bias and imprecision. According to the systematic review authors, the study had poor methodological quality. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size).
2. The authors of Rew 2020 narratively summarized the outcome of Turban *et al.* 2020; a cross-sectional online survey study. According to the systematic review authors, Turban *et al.* did not describe the study participants and the setting in detail and it was unclear whether outcomes were measured in a valid and reliable way. We therefore, downgraded the certainty of evidence by one level from low to very low due to high risk of bias.
3. The authors reported 3/27 (11%) participants treated with GnRHa developed side effects: 1 participant developed sterile abscesses; they were switched from leuprolide acetate to triptorelin, 1 participant developed leg pains and headaches, which eventually resolved without treatment, 1 participant gained 19 kg within 9 months of initiating GnRH analogues.
4. Proportion of adverse effects rated down due to risk of bias and imprecision. According to the systematic review authors, the cohort study Khatchadourian *et al.* 2014 was assessed at high risk of bias due to incomplete reporting of its cohort. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size).

- 2. Cross-sex hormones:** We found 9 systematic reviews assessing the effects of cross-sex hormones published between 2020 and 2022.⁴⁻¹² One of these, however, included both puberty blockers and cross-sex hormones combined in their evidence synthesis as was not prioritized.⁵ From the 8 remaining reviews, we judged 1 as having high methodological quality, 2 as having moderate methodological quality, 2 as having low methodological quality, and 3 as having critically low methodological quality. Details of the assessment are provided in Figure 3. Because of its eligibility criteria related to study design, the systematic review judged at high methodological quality⁷ did not include any studies and therefore we could not use it to inform any outcome.

Table 2 summarizes the evidence about the effects of cross-sex hormones on the outcomes of interest. We used information from 4 systematic reviews.^{6,9,11,12} For most outcomes (all except risk of breast cancer), there is no evidence about the effect of cross-sex hormones compared to not using cross-sex hormones. In other words, no studies compared the outcomes between a group of people with gender dysphoria using cross-sex hormones and another not using it. Therefore, it is unknown whether people with gender dysphoria who use cross-sex hormones experience more improvement in gender dysphoria, depression, anxiety, quality of life, and suicidality than those with gender dysphoria who do not use them. There is low certainty evidence suggesting that cross-sex hormones may not increase or decrease the risk of breast cancer (see details in Table 2).

Studies, however, reported outcomes among a group of people with gender dysphoria after receiving cross-sex hormones. The findings are:

- There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease gender dysphoria severity (mean change score in the Utrecht Gender Dysphoria scale, -42.4 points [95% CI, -44.1 to -40.1], range 12-60, with higher scores reflecting more severe gender dysphoria)
- There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease depression (measured with different scales, see Table 4 for details) and the need for treatment for depression (change in percentage, -39%)
- There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease anxiety (measured with different scales, see Table 4 for details) and the need for treatment for anxiety (change in percentage, -32%)
- There is very low certainty about the change in quality of life after treatment with cross-sex hormones.
- There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease suicidality degree (mean change score in the Ask Suicide-Screening questions scale, -0.84 points [95% CI, -1.30 to -0.44], range 0-4, with higher scores reflecting more severe suicidality) and the percentage of patients with need for treatment due to suicidality/self-harm (change in percentage, -31%). There is very low certainty evidence about the percentage of people with suicidal ideation and suicide attempts after treatment with cross-sex hormones.

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Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Results; May 16, 2022

- There is low certainty evidence suggesting a low prevalence of venous thromboembolism after treatment with cross-sex hormones (see Table 2 for details)

Figure 3: AMSTAR assessment judgements for systematic reviews addressing cross-sex hormones

Review ID	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12	Item 13	Item 14	Item 15	Item 16	Methodological quality
AHRQ 2021	Yes	Probably no	No	Yes	Probably yes	Not applicable	Yes	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Yes	MODERATE
Baker 2021	Yes	Yes	Yes	Probably yes	Yes	Probably yes	Probably yes	Yes	Probably no	No	Yes	Not applicable	Yes	Probably no	No	Probably no	MODERATE
Fledderus 2020	Probably yes	No	No	Probably yes	Probably yes	Yes	No	Yes	Yes	No	No	No	No	No	No	Yes	CRITICALLY LOW
Haupt 2020	Yes	Yes	Yes	Yes	Yes	Not applicable	Yes	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	HIGH
Karalexi 2020	Yes	Yes	Probably yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	Probably yes	Yes	LOW
Kotamarti 2021	Probably yes	No	No	Probably yes	Probably no	Probably no	Probably yes	Yes	Yes	No	Yes	No	Probably yes	Probably yes	No	Yes	CRITICALLY LOW
Mattawanon 2021	Probably yes	No	Probably yes	Probably yes	Probably yes	Probably no	No	Probably yes	No	No	Probably yes	Not applicable	No	Probably no	No	Yes	CRITICALLY LOW
NICE 2021b	Yes	Probably no	Yes	Yes	Probably yes	Probably yes	Yes	Yes	Yes	Probably yes	Yes	Not applicable	Yes	Yes	No	No	MODERATE
Totaro 2021	Yes	Yes	No	Probably yes	Probably yes	Probably yes	Probably yes	Yes	Yes	No	Yes	No	No	Probably yes	Yes	Yes	LOW

Figure legend:

Yes

Probably yes

Probably no

No

Not applicable



Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: cross-sex hormones

Comparison: no cross-sex hormones


Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones				
Gender dysphoria assessed with: difference (effect) in gender dysphoria percentage or severity			Not reported			The effects of cross-sex hormones on gender dysphoria are unknown
Gender dysphoria assessed with: mean change score in the Utrecht Gender Dysphoria Scale (12-60, higher scores reflect more gender dysphoria, 40 points or more indicate a diagnosis of gender dysphoria) (NICE, 2020b) Follow up: 1 year	NA	-42.4 (-44.1 to -40.1)	NA	23 (1 study)	 LOW ¹	The mean gender dysphoria score may decrease by 42 points after cross-sex hormones
Depression assessed with: difference (effect) in depression percentage or severity			Not reported			The effects of cross-sex hormones on depression are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: cross-sex hormones

Comparison: no cross-sex hormones



Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones				
Depression assessed with: mean change score in depression scales (higher scores represent more severe depression) (NICE, 2020b) Follow up: 1 year	NA	The mean depression score reduction was 9.6 points when using the BDI-II scale (n=23) and 7.5 when using the CESD-R scale (n=50). The authors report that both reductions were statistically significant ²	NA	73 (2 studies)	 LOW ¹	The mean depression score may decrease after cross-sex hormones
Depression assessed with: change in percentage of patients with need for treatment (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants requiring treatment was reduced by 39% (from 54% at baseline), which was statistically significant	NA	52 (1 study)	 LOW ¹	The percentage of participants requiring treatment may be reduced by 39% after cross-sex hormones
Anxiety assessed with: difference (effect) in anxiety percentage or severity			Not reported			The effects of cross-sex hormones on anxiety are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: cross-sex hormones

Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones				
Anxiety assessed with: mean change score in anxiety scales (higher scores represent more severe anxiety) (NICE, 2020b) Follow up: 1 year	NA	The mean anxiety score reduction was 16.5 points when using the STAI-State scale and 14.5 when using the STAI-Trait scale. The authors report that both reductions were statistically significant	NA	23 (1 study)	⊕⊕○○ LOW ¹	The mean anxiety score may decrease after cross-sex hormones
Anxiety assessed with: change in percentage of patients with need for treatment (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants requiring treatment was reduced by 32% (from 48% at baseline), which was statistically significant	NA	52 (1 study)	⊕⊕○○ LOW ¹	The percentage of participants requiring treatment may be reduced by 32% after cross-sex hormones
Quality of life assessed with: difference (effect) in quality of life improvement	Not reported					The effects of cross-sex hormones on quality of life are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: cross-sex hormones

Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones				
Quality of life assessed with: mean change score in QLES-Q-SF score (higher scores represent better quality of life) (NICE, 2020b) Follow up: 1 year	NA	The mean quality of life score improved, but the differences were not statistically significant. The magnitudes were not reported	NA	50 (1 study)	⊕○○○ VERY LOW ³	We are very uncertain about the quality of life change after cross-sex hormones
Suicide/ suicidal ideation assessed with: difference (effect) in suicide or suicidal ideation	Not reported					The effects of cross-sex hormones on suicide/ suicidal ideation are unknown
Suicidality assessed with: change in score from ASQ instrument (higher scores represent greater degree of suicidality) (NICE, 2020b) Mean follow up: 1 year	NA	-0.84 (-1.30 to -0.44)	NA	39 (1 study)	⊕⊕○○ LOW ¹	Suicidality scores may decrease by 0.84 points after cross-sex hormones

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: cross-sex hormones

Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones					
Suicidal ideation assessed with: percentage of participants with suicidal ideation measured with PHQ-9 (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants with suicidal ideation decreased by 6% (from 10% at baseline). The authors did not conduct a statistical analysis	NA	50 (1 study)	⊕○○○ VERY LOW ³	We are very uncertain about the change in percentage of patients in suicidal ideation after cross-sex hormones
Suicide attempts assessed with: not reported (NICE, 2020b) Follow up: not reported	NA	The percentage of people with lifetime suicide attempts was 15%, those with attempts 3 months before treatment was 2%, and those with attempts at follow up was 5%	NA	130 (1 study)	⊕○○○ VERY LOW ³	We are very uncertain about the percentage of people with suicide attempts after cross-sex hormones
Suicidality/ self-harm assessed with: change in percentage of patients with need for treatment (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants requiring treatment was reduced by 31% (from 35% at baseline), which was statistically significant	NA	52 (1 study)	⊕⊕○○ LOW ¹	The percentage of participants requiring treatment may be reduced by 31% after cross-sex hormones
Venous thromboembolism assessed with: Risk of VTE	Not reported					The effects of cross-sex hormones on the risk of VTE are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: cross-sex hormones

Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones					
Venous thromboembolism assessed with: Prevalence among assigned males at birth (Totaro, 2021) Mean follow up: 4.1 years	NA	20 per 1,000 (10 to 30)	NA	11,542 (18 studies)	⊕⊕⊕⊙ MODERATE ⁴	The prevalence of VTE among assigned males at birth is probably 2% after cross-sex hormones
Venous thromboembolism assessed with: Prevalence among assigned females at birth (Kotamarti, 2021) Mean follow up: 5.7 years	NA	6 per 1,000 (CI not reported) ⁵	NA	4,218 (8 studies)	⊕⊕⊕⊙ MODERATE ⁶	The prevalence of VTE among assigned females at birth is probably 0.6% after cross-sex hormones
Breast cancer assessed with: Risk of breast cancer (Fledderus, 2020) Follow up: not reported	Two studies compare the risk of breast cancer between assigned females at birth using versus not using testosterone, and found no differences (0 vs 1 case [total n= 130], and 1 vs 6 [total n=1579]). A third study compared assigned females at birth with non transgender women and found a lower risk in the former (magnitude not reported)		NA	2,938 (3 studies)	⊕⊕⊕⊙ LOW ⁷	The risk of breast cancer may not increase or decrease due to the use of cross-sex hormones

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria

Intervention: cross-sex hormones

Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones				

ASQ: Ask Suicide-Screening Questions. Range 0-4

BDI-II: Beck Depression Inventory. Range: 0-63

CESD-R: Center for Epidemiological Studies Depression Scale. Range: 0-60

CI: Confidence interval

NA: Not applicable

PHQ-9: Patient Health Questionnaire (PHQ) Modified for Teens. For suicidal ideation, it is a single question (yes/no)

QLES-Q-SF: Quality of Life Enjoyment and Satisfaction Questionnaire. Range: 15-75

STAI: State-Trait Anxiety Inventory. Range: 0-80

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Mean change rated down due to risk of bias and imprecision. According to the systematic review authors, the studies had poor methodological quality. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size)
2. Similar results when this outcome was measured using the Patient Health Questionnaire (PHQ) Modified for Teens in one of the same studies
3. Rated down due to risk of bias, imprecision, and indirectness. According to the systematic review authors, the studies had poor methodological quality. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size). Finally, 30% of the participants did not have a diagnosis of gender dysphoria.
4. Prevalence rated down due to risk of bias. According to the systematic review authors, only 6 out of the 18 studies (representing 16.5% of the weight of the studies) were at low risk of bias.

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5. A meta-analysis of independent studies reported in this systematic review suggested that the prevalence of VTE in non-transgender females at birth was 1.7% (based on 7 studies and 18,748 persons)
6. Prevalence rated down due to risk of bias. According to the systematic review authors, all studies had at least one domain judged as problematic.
7. Risk rated down 2 levels because of risk of bias. The researchers did not account for confounding in any of the studies.

3. Surgeries: We found 15 systematic reviews assessing the effects of gender-affirming surgeries published between 2020 and 2022. We judged 8 as having low methodological quality and 7 as having critically low methodological quality. Details of the assessment are provided in Figure 4. We present the results regarding the effects of surgeries in three parts. First, we describe the effects of all surgeries on mental health outcomes in all patients. Second, we describe the effects of all surgeries on surgical outcomes in assigned females at birth (transgender males). Finally, we describe the effects of all surgeries on surgical outcomes in assigned males at birth (transgender females).

3.1 Effects of surgeries on mental health outcomes: Table 3 summarizes the evidence about the effects of all surgeries on mental health outcomes in all patients. We used information from 2 systematic reviews.^{13 14} There were no systematic reviews and studies reporting on gender dysphoria, depression, anxiety, and suicidality. Therefore, the effects of surgeries on these outcomes (when compared to a group of patients with gender dysphoria who do not undergo surgery), or the changes in these outcomes (improvements or deterioration) among patients who undergo surgeries is unknown.

The systematic reviews addressed quality of life and depression, but none of the included studies included a comparison group. Thus, it is unknown whether people with gender dysphoria who undergo surgeries experience more improvement in quality of life or less regret than those with gender dysphoria who do not undergo surgeries.

Studies, however, reported the following outcomes among a group of people with gender dysphoria after undergoing surgeries. The findings are:

- There is low certainty evidence suggesting that the percentage of people who experience regret after surgery is low (1%)
- There is very low certainty evidence about how surgeries affect quality of life (see Table 3 for details)

Figure 4: AMSTAR assessment judgements for systematic reviews addressing gender-affirming surgery

Review ID	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12	Item 13	Item 14	Item 15	Item 16	Methodological quality
Bustos SS 2021	Yes	No	No	Yes	Yes	Probably no	Probably no	Probably no	Yes	No	Yes	No	Probably no	Yes	No	Yes	LOW
Bustos VP 2021	Yes	No	No	Yes	Yes	Probably no	Probably no	Probably no	Yes	No	Yes	Yes	Yes	Probably no	Yes	No	LOW
Bustos VP 2021b	Yes	No	No	Yes	Yes	Probably no	Probably no	Probably no	Probably no	No	Yes	No	Yes	Yes	Yes	No	LOW
Dunford 2021	Yes	No	No	Yes	Yes	Yes	Probably no	Probably no	Probably no	No	Probably no	Not applicable	Probably no	No	Probably no	Yes	LOW
Eftekhari, 2020	Probably no	No	No	Probably no	Yes	Yes	Probably no	Probably no	Yes	No	Probably no	No	No	Probably no	Probably no	Probably no	LOW
Falcone 2021	Probably no	No	No	Probably no	Yes	Probably no	No	Probably no	No	No	Probably no	No	No	No	No	No	CRITICALLY LOW
Hu, 2022	Probably no	No	No	Yes	Yes	Probably no	Probably no	Probably no	No	No	Yes	No	No	No	No	Yes	CRITICALLY LOW
Huayllani 2021	Probably no	No	No	Yes	Yes	Probably no	Probably no	Yes	Yes	No	No	No	No	No	Probably no	Yes	CRITICALLY LOW
Jolly 2021	Yes	Yes	No	Yes	Yes	Yes	Probably no	Yes	Yes	No	Yes	No	No	Probably no	No	Yes	LOW
Nassiri 2020	Probably no	No	No	Probably no	Yes	Probably no	No	Probably no	Probably no	No	Yes	No	No	Probably no	No	Yes	CRITICALLY LOW
Oles 2022	Yes	No	No	Yes	Yes	Yes	Probably no	Probably no	No	No	Probably no	No	Probably no	No	Probably no	No	LOW
Oles 2022b	Yes	No	No	Yes	Yes	Yes	Probably no	Probably no	No	No	Probably no	No	Probably no	No	Probably no	No	LOW
Salibian 2021	Probably no	No	Yes	Yes	Probably no	Probably no	Probably no	Probably no	No	No	Probably no	Not applicable	No	No	No	Yes	CRITICALLY LOW
Sijben 2021	Probably no	No	No	No	Probably no	Probably no	No	Probably no	No	No	Probably no	Not applicable	No	No	No	Yes	CRITICALLY LOW
Tay 2021	Yes	Yes	No	Yes	Yes	Probably no	Probably no	Probably no	No	No	No	Not applicable	No	No	No	Yes	CRITICALLY LOW

Figure legend:

Yes

Probably yes

Probably no

No

Not applicable



Table 3: All surgeries compared to no surgeries in young people (<21 years old) with gender dysphoria



Patient or population: young people (<21 years old) with gender dysphoria

Intervention: surgeries

Comparison: no surgeries

Outcomes: Mental health and regret

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Gender dysphoria assessed with: any measure			Not reported			The effects of surgery on gender dysphoria, the changes in gender dysphoria severity after surgery, and the prevalence of gender dysphoria after surgery are unknown
Depression assessed with: any measure			Not reported			The effects of surgery on depression, the changes in depression severity after surgery, and the prevalence of depression after surgery are unknown
Anxiety assessed with: any measure			Not reported			The effects of surgery on anxiety, the changes in anxiety severity after surgery, and the prevalence of anxiety after surgery are unknown
Suicidality assessed with: any measure			Not reported			The effects of surgery on suicidality, the changes in anxiety severity after surgery, and the prevalence of anxiety after surgery are unknown
Quality of life assessed with: difference (effect) in quality of life			Not reported			The effects of surgery on quality of life are unknown
Quality of life assessed with: change in quality of life			Not reported			The change in quality of life after surgery is unknown

Quality of life assessed with: mean score in the Short Form-36 Scale (0-100, higher scores reflect better quality of life) (Eftekhar Ardebili, 2020) Follow up: cross-sectional	NA	59.17 (48.59 to 69.74) ¹	NA	633 (5 studies)	 VERY LOW²	We are very uncertain about the quality of life after surgeries
Regret assessed with: difference (effect) in percentage of people with regret			Not reported			The effects of surgery on regret are unknown
Regret assessed with: percentage of people with regret (Bustos, 2021) Mean follow up: 4 years	NA	1% (0 to 2%) ³	NA	7928 (27 studies)	 LOW⁴	The percentage of people who experience regret is low
CI: Confidence interval NA: Not applicable						
GRADE Working Group grades of evidence High certainty: We are very confident that the true effect lies close to that of the estimate of the effect Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect						

Explanations

1. Similar scores for assigned males at birth and assigned females at birth.
2. Mean score rated down for risk of bias and inconsistency. According to the systematic review authors, all studies had concerns related to risk of bias. In addition, the smaller studies showed better quality of life than the larger study.
3. Similar percentage for assigned males at birth and assigned females at birth, and for different types of surgeries (all pooled percentages below 2%).
4. Percentage rated down due to risk of bias and indirectness. According to the authors, many of the studies had moderate or high risk of bias. The mean age of the participants at the time of surgery was higher than the target population. Because it was considered to not have an important effect on the pooled estimate, we did not rate down for statistical heterogeneity

3.2 Effects of surgeries on assigned females at birth: Table 4 summarizes the evidence about the effects of all surgeries on surgical outcomes among assigned at birth females. We used information from 3 systematic reviews.¹³⁻¹⁷ Due to the nature of the outcomes (i.e. they can only be experienced by people who undergo surgeries), there cannot be studies comparing the outcomes between a group of people with gender dysphoria who undergo surgeries and another who does not.

Studies, therefore, assessed the outcomes among a group of people with gender dysphoria after surgery. The findings are:

- There is low certainty evidence suggesting that the percentage of people who are satisfied after chest surgery is high (92%)
- There is very low certainty evidence about the rate of surgical complications after chest surgery
- There is very low certainty evidence about the percentage of people who are satisfied, and the rate of surgical complications after bottom surgeries (see Table 4 for details)

Table 4: All surgeries compared to no surgeries in assigned females at birth (<21 years old) with gender dysphoria

Patient or population: assigned females at birth (<21 years old) with gender dysphoria

Intervention: surgeries

Comparison: no surgeries




Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Chest surgery						
Satisfaction assessed with: percentage of people who reported being satisfied (Bustos VP, 2020b) Range of follow up: 6 weeks to 46 months ¹	NA	92% (88% to 96%) ²	NA	733 (14 studies)	 LOW ³	The percentage of people who reports being satisfied may be 92%
Surgical complications assessed with: rate of complications across patients (Oles, 2022) Range of follow up: 8 weeks to 1 year	NA	16.8% Range (5.5% to 80.0%)	NA	1255 (7 studies)	 VERY LOW ⁴	We are very uncertain about the rate of surgical complications
Reoperation assessed with: rate of reoperation across patients (Oles, 2022) Range of follow up: 8 weeks to 1 year	NA	6.2% Range (0.7% to 11.2%)	NA	1214 (6 studies)	 VERY LOW ⁴	We are very uncertain about the rate of reoperation
Bottom surgery						

Table 4: All surgeries compared to no surgeries in assigned females at birth (<21 years old) with gender dysphoria

Patient or population: assigned females at birth (<21 years old) with gender dysphoria

Intervention: surgeries

Comparison: no surgeries


Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Satisfaction assessed with: percentage of people who reported being satisfied (Oles, 2022b) Range of follow up: 6 weeks to 46 months	NA	89.6% (45% to 100%) ⁵	NA	1458 (27 studies)	⊕○○○ VERY LOW ⁴	We are very uncertain about the percentage of people who reports being satisfied
Surgical complications-Major assessed with: percentage of people experiencing major complications (Oles, 2022b) follow up: not reported	NA	The percentage was - 2.3% (range 0 to 20%) experiencing total flap loss - 19.5% (range 0 to 72%) experiencing prosthesis issues - 24.5% (range 0 to 86%) experiencing urethral issues	NA	3177 (42 studies) ⁶	⊕○○○ VERY LOW ⁴	We are very uncertain about the percentage of people who experience major surgical complications
Surgical complications-Minor assessed with: percentage of people experiencing major complications (Oles, 2022b) follow up: not reported	NA	The percentage varied from 9.3% (range 0% to 45.5%) experiencing donor site issues, to 24% (range 10 to 93%) experiencing urethral issues ⁷	NA	4466 (52 studies) ⁸	⊕○○○ VERY LOW ⁴	We are very uncertain about the percentage of people who experience minor surgical complications

Table 4: All surgeries compared to no surgeries in assigned females at birth (<21 years old) with gender dysphoria

Patient or population: assigned females at birth (<21 years old) with gender dysphoria

Intervention: surgeries

Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Reoperation assessed with: rate of reoperation across patients (Oles, 2022b) follow up: not reported	NA	27.6% Range (2.5% to 40%)	NA	1624 (15 studies)	 VERY LOW⁴	We are very uncertain about the percentage of people who undergo reoperations

CI: Confidence interval

NA: Not applicable

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Studies used different scales to assess satisfaction
2. The percentage was similar when the analysis was done by type of surgery and by follow up time (< 1 year vs 1 year or more). Another systematic review (Oles, 2022) also investigated this outcome, and reported a very similar percentage of satisfaction (91.8%, range 73% to 100%)
3. Percentage of patients satisfied rated down due to risk of bias and indirectness. According to the systematic review authors, several studies were judged at moderate and high risk of bias. In addition, the median of the mean age of patients included in the studies was 28 years
4. Rated down due to risk of bias, inconsistency/ imprecision, and indirectness. Even though the review authors did not assess risk of bias, these studies were included in other systematic reviews in which the authors judged several of them at high risk of bias. The studies report inconsistent results (some high and other low rates). The patients are older than the target population.
5. Results for phalloplasty. Similar results for metoidioplasty (91.3%).

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6. People and studies for urethral complications. 2671 people (37 studies) for prosthesis issues, and 1548 people (22 studies) for total flap loss.
7. Percentage of wound dehiscence 9.8% (range, 2.9% to 75%), percentage of infection/ partial necrosis 10.3% (range, 0 to 45.8%), percentage of prosthesis issues 14.2% (range, 1.6 to 41.9%), percentage of incontinence 15.3% (range, 5.4% to 59.1%)
8. People and studies for infection/ partial necrosis. 2389 people (31 studies) for urethral issues, 1736 people (17 studies) for wound dehiscence, 1080 (10 studies) for prosthesis issues, 1053 people (8 studies) for donor site issues, 131 people (3 studies) for incontinence

3.3 Effects of surgeries on assigned males at birth: Table 5 summarizes the evidence about the effects of all surgeries on surgical outcomes among assigned at birth males. We used information from 3 systematic reviews.^{16 18 19} Due to the nature of the outcomes (i.e. they can only be experienced by people who undergo surgeries), there cannot be studies comparing the outcomes between a group of people with gender dysphoria who undergo surgeries and another who does not.

Studies, therefore, assessed the outcomes among a group of people with gender dysphoria after surgery. The findings are:

- There is low certainty evidence suggesting that the percentage of people who are satisfied after vaginoplasty is high (91%)
- There is very low certainty evidence about the percentage of people who are satisfied, the rate of complications, and the rate of reoperations after chest surgery (see Table 5 for details)
- There is low certainty evidence suggesting that the percentage of people who have regret after vaginoplasty is low (2%)
- There is very low certainty evidence about the rate of complications and the rate of reoperations after vaginoplasty (see Table 5 for details)

Table 5: All surgeries compared to no surgeries in assigned males at birth (<21 years old) with gender dysphoria

Patient or population: assigned males at birth (<21 years old) with gender dysphoria

Intervention: surgeries

Comparison: no surgeries




Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Chest surgery						
Satisfaction assessed with: percentage of people who reported being satisfied (Oles 2022) Range of follow up: 12 months to 17 years	NA	Range 75% (80/107) to 95% (33/35) ¹	NA	142 (2 studies)	 VERY LOW ²	We are very uncertain about the percentage of people who report being satisfied
Surgical complications assessed with: rate of complications across patients (Oles 2022) Range of follow up: 2 weeks to 16 years	NA	The complication rates were: - 3.8% (range 0% to 5.5%) of capsular contracture - 2.2% of major hematoma - 2.2% of implant extrusion ³	NA	432 (5 studies)	 VERY LOW ²	We are very uncertain about the rate of surgical complications
Reoperation assessed with: rate of reoperation across patients (Oles 2022) Range of follow up: Not reported	NA	8.6% Range (4.4% to 10.4%)	NA	291 (2 studies)	 VERY LOW ²	We are very uncertain about the rate of reoperation
Bottom surgery						

Table 5: All surgeries compared to no surgeries in assigned males at birth (<21 years old) with gender dysphoria

Patient or population: assigned males at birth (<21 years old) with gender dysphoria

Intervention: surgeries

Comparison: no surgeries


Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Satisfaction assessed with: percentage of people who reported being satisfied for overall outcomes (Bustos SS, 2021) Range of follow up: 1 week to 11.3 years	NA	91% (81% to 98%) ⁴	NA	1230 (12 studies)	⊕⊕○○ LOW ⁵	The percentage of people who report being satisfied with overall outcomes may be 91%
Regret assessed with: percentage of people who reported regret (Bustos SS, 2021) Range of follow up: 2 months to 24.1 years	NA	2% (1% to 3%)	NA	1137 (15 studies)	⊕⊕○○ LOW ⁶	The percentage of people who report regret may be 2%
Surgical complications assessed with: rate of complications across patients (Bustos SS, 2021) Range of follow up: 3 weeks to 24.1 years	NA	The complication rates were: - 1% (95% CI, <0.1% to 2%) of fistula - 11% (95% CI, 8% to 14%) of stenosis and/or strictures - 4% (95% CI, 1% to 9%) of tissue necrosis - 3% (95% CI, 1% to 4%) of prolapse ⁷	NA	4196 (42 studies) ³	⊕○○○ VERY LOW ⁸	We are very uncertain about the rate of surgical complications

Table 5: All surgeries compared to no surgeries in assigned males at birth (<21 years old) with gender dysphoria

Patient or population: assigned males at birth (<21 years old) with gender dysphoria

Intervention: surgeries

Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Reoperation assessed with: rate of reoperation across patients (Tay, 2021) Range of follow up: 6 weeks to 14.8 months	NA	One study reported a surgical revision rate of 9% (1/11 patients), and a second study reported that 13% (19/145) patients required repeat surgery due to complications.	NA	156 (2 studies)	 VERY LOW ^a	We are very uncertain about the percentage of people who undergo reoperations

CI: Confidence interval

NA: Not applicable

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Another systematic review, Sijben 2021, reported satisfaction from 3 additional studies: 82% (113/138) were satisfied or very satisfied, 93% (32/34) were happier and more satisfied with their chest, and 79% (28/36) were very satisfied with the overall cosmetic result (very low certainty of evidence due to risk of bias, imprecision, and indirectness).
2. Rated down due to risk of bias, indirectness (the included studies were not restricted to youth or young adults), and imprecision (too few participants included, not meeting optimal information size).

3. Another systematic review, Sijben 2021, reported similar ranges for rates of complication requiring reoperation from 7 studies (835 patients): capsular contraction (range 0.0-5.6%), asymmetry (3.6%), hematoma (range 0.0-2.9%), infection (range 0.0-0.9%), striae distensae (0.7%), implant rupture (0.7%), abscess (0.4%), scarring (0.0%), hypersensitivity (0.0%), and numbness (0.0%) (very low certainty of evidence due to risk of bias, imprecision, and indirectness).
4. Bustos SS *et al.* 2021 additionally reported on satisfaction for functional (87%, 95% CI 77% to 94%) and aesthetic (90%, 95% CI 84% to 94%) outcomes. Another systematic review and meta-analysis, Oles 2022b, similarly reported that 92.3% (range 23.1% to 100%) of patients (2410/2601) were satisfied after vaginoplasty (very low certainty of evidence due to risk of bias, imprecision, and indirectness).
5. Rated down due to risk of bias (the systematic review authors reported the quality of the included studies to be low to moderate using the New Castle Ottawa scale), and indirectness as the included studies were not restricted to youth or young adults. We did not rate down for imprecision or inconsistency despite high I^2 values as a satisfaction rate of 80% or above was deemed as a minimum threshold for clinical importance.
6. Rated down due to risk of bias (the systematic review authors reported the quality of the included studies to be low to moderate using the New Castle Ottawa scale), and indirectness as the included studies were not restricted to youth or young adults.
7. Another systematic review, Oles 2022b, similarly reported the percentage of patients experiencing complications from 51 studies, ranging from 2.4% to 12.0% (range 0% to 88%) for minor complications (intraoperative injury, wound dehiscence, superficial necrosis, infection, urinary issues, vaginal prolapse, stenosis, and bleeding) and 1.6% to 2.1% (range 0% to 31%) for major complications (flap/graft necrosis and infection) after genitoplasty (very low certainty of evidence due to risk of bias, imprecision, and indirectness).
8. Rated down due to risk of bias (the systematic review authors reported the quality of the included studies to be low to moderate using the New Castle Ottawa scale), imprecision and inconsistency, with wide confidence intervals and I^2 values ranging from 65.8% to 94.3%, and indirectness as the included studies were not restricted to youth or young adults.
9. Rated down due to risk of bias, indirectness (the age range of patients in the included studies was 24 to 39 years; the studies included were restricted to those that investigated the use of peritoneum in neovagina construction), and imprecision (too few participants included, not meeting optimal information size).

Results from search for studies not included in the systematic reviews: After screening 1854 records found through our searches, we found 10 eligible studies (figure 5). From these, 8 were comparative observational studies²⁰⁻²⁷ and 2 were non-comparative^{28 29}. We provide reasons for excluding studies in appendix 2.

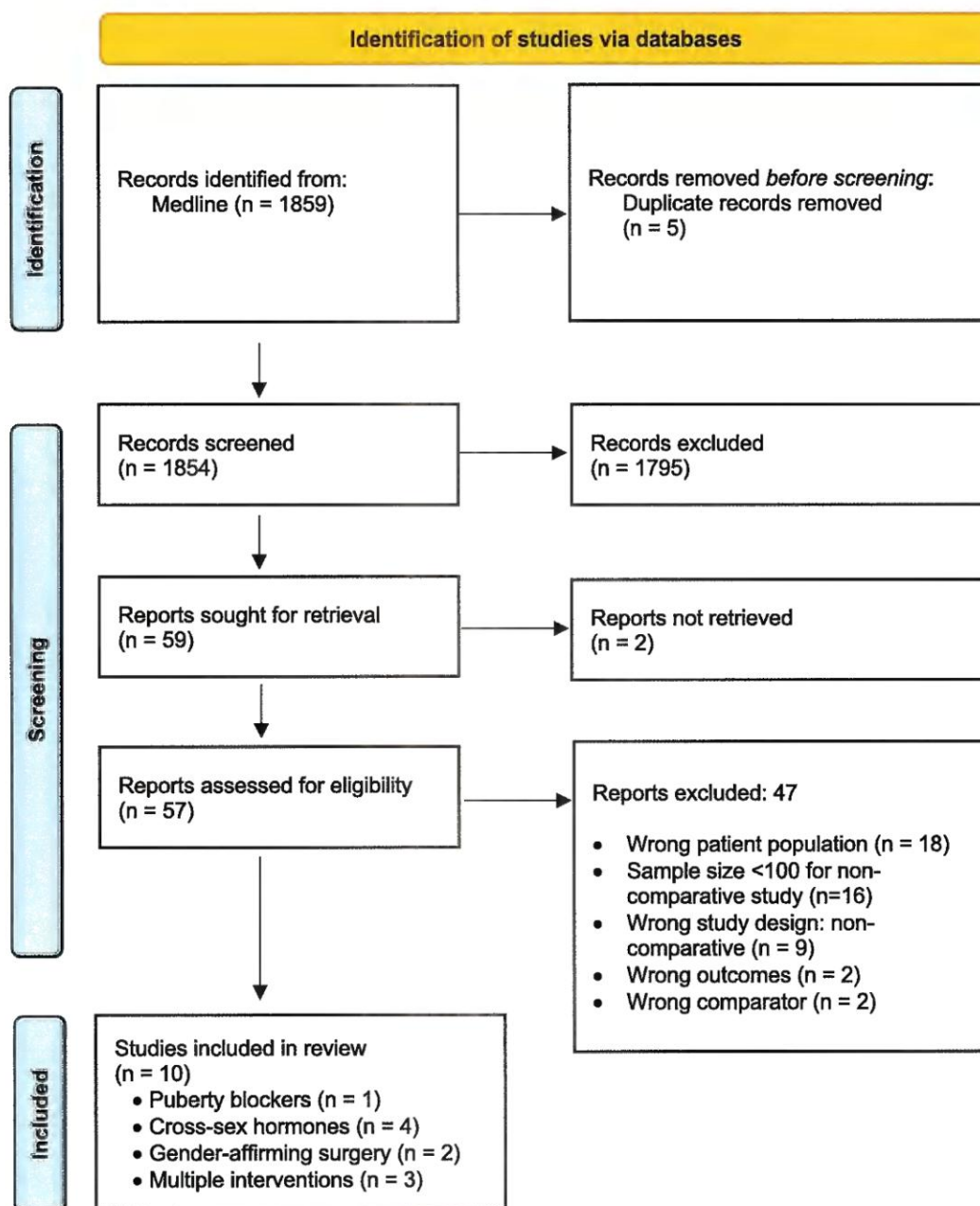


Figure 5: PRISMA flow diagram for the selection of primary studies. *From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: <http://www.prisma-statement.org/>

None of the studies were judged as likely to importantly change the conclusions obtained from the systematic reviews (Tables 6 and 7). The main limitations of the comparative studies were risk of bias concerns (Figures 6 and 7) due to confounding, classification of intervention, and missing data; as well as small sample sizes. Although non-comparative studies were at lower risk of bias, because their results were consistent with those of the included evidence, they were also judged as unlikely to change the conclusions importantly.

Table 6: Characteristics of eligible comparative observational studies

Study ID	Sample size*	Study design	Intervention	Comparator	Outcomes measured	Likely to change conclusions	Reasons
VanDerMiesen, 2020	450	Retrospective cohort study	Puberty blockers	Waiting for puberty blockers	Self-harm/ suicidality, internalizing behaviors	No	Reports a small benefit on suicidality and moderate on internalizing behaviours, but high risk of bias
Becker-Hebly, 2021	75	Prospective cohort study	1. Puberty blockers 2. Cross-sex hormones 3. Surgery	No medical intervention yet; psychosocial intervention only	Health-related quality of life	No	Critical risk of bias (missing data due to low response rate, and confounding). Reports small benefit in mean change score for mental and physical dimension QoL as compared to no medical treatment. Imprecision; the 95% CIs for mean change scores are wide.
Green, 2021	3235	Cross-sectional study	Cross-sex hormones	Would like to take cross-sex hormones	Depression, suicidality	No	Critical risk of bias, no follow up of patients (measurement of current outcomes and not adjusting for baseline)
Tordoff, 2022	84	Prospective cohort study	1. Puberty blockers 2. Cross-sex hormones	No intervention	Depression, anxiety, suicidal thoughts	No	Moderate risk of bias, small sample size
Turban, 2022	9341	Cross-sectional study	Cross-sex hormones	Desired but never accessed gender affirming hormones	Suicidal ideation, suicidal attempt	No	Critical risk of bias, no follow up of patients (measurement of current outcomes and not adjusting for baseline)
Grannis, 2021	47	Cross-sectional study	Cross-sex hormones	No intervention yet	Anxiety, depression	No	Critical risk of bias, no follow up of patients, small sample size
Fontanari, 2020	350	Cross-sectional study	1. Cross-sex hormones 2. Cross-sex hormones or surgery	1. Waiting for cross-sex hormones 2. No intervention	Anxiety, depression, gender distress	No	Critical risk of bias (confounding, self-reported classification of interventions). Online cross-sectional survey reported small benefit in anxiety and depression mean scores, and little to no effect on gender distress with cross-sex hormones and/or surgery. Non-randomized comparative study provides very low certainty evidence due to

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Castelo-Branco, 2021	205	Cross-sectional study	Cross-sex hormones	No intervention	Anxiety, depression	No	very serious risk of bias and serious imprecision (95% CIs include little to no effect) Critical risk of bias due to confounding (non-adjusted analysis). Reported no difference observed in anxiety and depression mean scores (Symptom Checklist-90-Revised scale) between groups. Non-randomized comparative study provides low certainty evidence.
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*Considered the number of participants relevant to the questions of this report, not all people included in the studies

Table 7: Characteristics of eligible non- comparative observational studies

Study ID	Sample size	Intervention	Outcomes measured	Likely to change conclusions	Reasons
Bordas, 2021	813	FtM bottom surgery	Surgical complications, satisfaction	No	Reports rate of complications (10.5%) and satisfaction (79% totally satisfied, 20% mainly satisfied) within range of effects reported by studies already included in systematic reviews. Unlikely to reduce imprecision and inconsistency within body of evidence (3177 and 1458 people, respectively) of non-comparative studies (42 and 27, respectively) to increase certainty of evidence
Elias, 2022	110	FtM top surgery	Complications	No	Reports rate of complications (16%) and revision surgery (5%), which is consistent with the rates reported in the studies included. Unlikely to increase the certainty of evidence

Figure 6: Risk of bias judgements for comparative studies

Study ID	Intervention	Confounding	Classification of the intervention	Deviations from intended interventions	Missing data	Measurement of outcome	Overall
Becker-Hebly, 2021	Puberty blockers, cross-sex hormones, or surgery	Critical	Low	Moderate	Critical	Low	CRITICAL
Castelo-Branco, 2021	Cross-sex hormones	Critical	Low	Unclear	Low	Low	CRITICAL
Fontanari, 2020	Cross-sex hormones, cross-sex hormones or surgery	Critical	Serious	Unclear	Low	Low	CRITICAL
Grannis, 2021	Cross-sex hormones	Critical	Moderate	Unclear	Low	Low	CRITICAL
Green, 2021	Cross-sex hormones	Critical	Critical	Unclear	Moderate	Low	CRITICAL
Tordoff, 2022	Puberty blockers, cross-sex hormones	Moderate	Moderate	Unclear	Moderate	Low	MODERATE
Turban, 2022	Cross-sex hormones	Critical	Critical	Unclear	Low	Low	CRITICAL
Van Der Miesen, 2020	Puberty blockers	Serious	Low	Unclear	Low	Moderate	SERIOUS

Figure legend:

Low

Moderate

Serious

Critical

Unclear



Figure 7: Risk of bias judgements for non-comparative studies

Study ID	Intervention	Representativeness of sample	Classification of intervention	Deviation from intended interventions	Missing data	Measurement of outcome	Overall
Bordas, 2021	FtM bottom surgery						LOW
Elias, 2022	FtM top surgery						MODERATE

Figure legend:

Low

Moderate

High



References

1. Ramos GGF, Mengai ACS, Daltro CAT, et al. Systematic Review: Puberty suppression with GnRH analogues in adolescents with gender incongruity. *Journal of endocrinological investigation* 2021;44(6):1151-58. doi: <https://dx.doi.org/10.1007/s40618-020-01449-5>
2. Rew L, Young CC, Monge M, et al. Review: Puberty blockers for transgender and gender diverse youth-a critical review of the literature. *Child and adolescent mental health* 2021;26(1):3-14. doi: <https://dx.doi.org/10.1111/camh.12437>
3. Excellence NfHaC. Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria, 2020.
4. Quality AfHRA. Topic Brief: Treatments for Gender Dysphoria in Transgender Youth, 2021.
5. Baker KE, Wilson LM, Sharma R, et al. Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. *Journal of the Endocrine Society* 2021;5(4):bvab011. doi: 10.1210/jendso/bvab011
6. Fledderus AC, Gout HA, Ogilvie AC, et al. Breast malignancy in female-to-male transsexuals: systematic review, case report, and recommendations for screening. *Breast (Edinburgh, Scotland)* 2020;53(9213011):92-100. doi: <https://dx.doi.org/10.1016/j.breast.2020.06.008>
7. Haupt C, Henke M, Kutschmar A, et al. Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *The Cochrane database of systematic reviews* 2020;11:CD013138. doi: 10.1002/14651858.CD013138.pub2
8. Karalexi MA, Georgakis MK, Dimitriou NG, et al. Gender-affirming hormone treatment and cognitive function in transgender young adults: a systematic review and meta-analysis. *Psychoneuroendocrinology* 2020;119:104721. doi: 10.1016/j.psyneuen.2020.104721
9. Kotamarti VS, Greige N, Heiman AJ, et al. Risk for Venous Thromboembolism in Transgender Patients Undergoing Cross-Sex Hormone Treatment: A Systematic Review. *The journal of sexual medicine* 2021 doi: 10.1016/j.jsxm.2021.04.006
10. Mattawanon N, Charoenkwan K, Tangpricha V. Sexual Dysfunction in Transgender People: A Systematic Review. *The Urologic clinics of North America* 2021;48(4):437-60. doi: 10.1016/j.ucl.2021.06.004
11. Totaro M, Palazzi S, Castellini C, et al. Risk of Venous Thromboembolism in Transgender People Undergoing Hormone Feminizing Therapy: A Prevalence Meta-Analysis and Meta-Regression Study. *Frontiers in endocrinology* 2021;12:741866. doi: 10.3389/fendo.2021.741866
12. Excellence NfHaC. Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria., 2020.
13. Eftekhari Ardebili M, Janani L, Khazaei Z, et al. Quality of life in people with transsexuality after surgery: a systematic review and meta-analysis. *Health and quality of life outcomes* 2020;18(1):264. doi: 10.1186/s12955-020-01510-0
14. Bustos VP, Bustos SS, Mascaro A, et al. Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and reconstructive surgery Global open* 2021;9(3):e3477. doi: 10.1097/GOX.00000000000003477
15. Oles N, Darrach H, Landford W, et al. Gender Affirming Surgery: A Comprehensive, Systematic Review of All Peer-reviewed Literature and Methods of Assessing Patient-centered Outcomes (Part 2: Genital Reconstruction). *Annals of surgery* 2022;275(1):e67-e74. doi: 10.1097/SLA.00000000000004717
16. Oles N, Darrach H, Landford W, et al. Gender Affirming Surgery: A Comprehensive, Systematic Review of All Peer-Reviewed Literature and Methods of Assessing Patient-Centered Outcomes (Part 1: Breast/Chest, Face, and Voice). *Annals of surgery* 2022 doi: 10.1097/SLA.00000000000004728
17. Bustos VP, Bustos SS, Mascaro A, et al. Transgender and Gender-nonbinary Patient Satisfaction after Transmasculine Chest Surgery. *Plastic and reconstructive surgery Global open* 2021;9(3):e3479. doi: 10.1097/GOX.00000000000003479
18. Bustos SS, Bustos VP, Mascaro A, et al. Complications and Patient-reported Outcomes in Transfemale Vaginoplasty: An Updated Systematic Review and Meta-analysis. *Plastic and reconstructive surgery Global open* 2021;9(3):e3510. doi: 10.1097/GOX.00000000000003510
19. Tay YT, Lo CH. Use of peritoneum in neovagina construction in gender-affirming surgery: A systematic review. *ANZ journal of surgery* 2021 doi: 10.1111/ans.17147

Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Results; May 16, 2022

20. Becker-Hebly I, Fahrenkrug S, Campion F, et al. Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: a descriptive study from the Hamburg Gender Identity Service. *European child & adolescent psychiatry* 2021;30(11):1755-67. doi: <https://dx.doi.org/10.1007/s00787-020-01640-2>
21. Castelo-Branco C, RiberaTorres L, Gomez-Gil E, et al. Psychopathological symptoms in Spanish subjects with gender dysphoria. A cross-sectional study. *Gynecological endocrinology : the official journal of the International Society of Gynecological Endocrinology* 2021;37(6):534-40. doi: <https://dx.doi.org/10.1080/09513590.2021.1913113>
22. Fontanari AMV, Vilanova F, Schneider MA, et al. Gender Affirmation Is Associated with Transgender and Gender Nonbinary Youth Mental Health Improvement. *LGBT health* 2020;7(5):237-47. doi: <https://dx.doi.org/10.1089/lgbt.2019.0046>
23. Grannis C, Leibowitz SF, Gahn S, et al. Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys. *Psychoneuroendocrinology* 2021;132(7612148, qgc):105358. doi: <https://dx.doi.org/10.1016/j.psytneuen.2021.105358>
24. Green AE, DeChants JP, Price MN, et al. Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine* 2022;70(4):643-49. doi: <https://dx.doi.org/10.1016/j.jadohealth.2021.10.036>
25. Tordoff DM, Wanta JW, Collin A, et al. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA network open* 2022;5(2):e220978. doi: <https://dx.doi.org/10.1001/jamanetworkopen.2022.0978>
26. Turban JL, King D, Kobe J, et al. Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PloS one* 2022;17(1):e0261039. doi: <https://dx.doi.org/10.1371/journal.pone.0261039>
27. van der Miesen AIR, Steensma TD, de Vries ALC, et al. Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine* 2020;66(6):699-704. doi: <https://dx.doi.org/10.1016/j.jadohealth.2019.12.018>
28. Bordas N, Stojanovic B, Bizic M, et al. Metoidioplasty: Surgical Options and Outcomes in 813 Cases. *Frontiers in endocrinology* 2021;12(101555782):760284. doi: <https://dx.doi.org/10.3389/fendo.2021.760284>
29. Elias N, Rysin R, Kwartin S, et al. Breaking the Binary: The Approach to Chest Masculinizing Gender-Affirming Surgery in Transgender Men. *The Israel Medical Association journal : IMAJ* 2022;24(1):20-24.

ID	Study	Reason
#534	Abu-Ghname 2020	Wrong population: non transgender men
#434	Aires 2022	Wrong interventions: Other type of surgery: glottoplasty Wrong outcomes: It does not include any outcome of interest. Includes: serum total testosterone concentration, body fat redistribution, breast development, and facial/body hair reduction
#514	Angus 2021	Wrong intervention. Continuing vs stopping estrogen during perioperative period of vaginoplasty
#318	Baddredine 2022	Wrong outcomes: only clinical outcomes are sperm count, testicular histology, hormone levels, etc.
#40	Baram 2019	Wrong outcomes: sexual satisfaction, desire, and function outcomes only
#145	Barcelos 2022	No outcome data
#60	Boczar 2021	Wrong population: unclear that more than 80% are transgender
#386	Bouman 2014	Wrong intervention: nipple areola reconstruction
#208	Bustos 2021	Wrong outcomes: Blood pressure
#54	Connelly 2021	Wrong intervention: facial gender surgery
#43	Coon 2022	Wrong design: narrative review
#34	D'Angelo 2018	Wrong outcomes: bone density
#165	Delgado-Ruiz 2019	Other type of surgery: facial surgery
#355	Escandon 2022	Wrong outcomes: bone mass
#129	Fighera 2019	Practice guideline, does not report the methods/ results of the systematic review in details
#597	Hembree 2017	Wrong outcomes: histological findings
#120	Kakadekar 2021	Wrong intervention: self administered hormones
#451	Kennedy 2021	Wrong outcomes: sexual health and satisfaction outcomes only
#375	Kloer 2021	More than 20% participants did not have gender dysphoria
#439	Kovar 2019	Wrong outcomes: aggression and hostility
#297	Kristensen 2021	Wrong design: commentary of a systematic review
#637	Leclerc 2015	Published in abstract format only
#293	Miranda 2021	Wrong intervention: facial feminization surgery
#624	Morrison 2016	Wrong design: narrative review
#270	Narayan 2021	Wrong intervention: phonosurgery
#119	Nolan 2019	Wrong intervention: facial hair transplantation
#167	Patel 2021	Wrong population: cisgender is the population of interest, transgender included as indirect evidence and not in a systematic manner
#287	Ray 2020	Published in abstract format only
#518	Rozga 2020	Wrong population: More than 20% participants did not have gender dysphoria
#265	Sariyaka 2017	Wrong intervention: facial masculinization surgery
#35	Sayegh 2019	Wrong intervention: laryngeal surgery
#124	Schwarz 2017	

#97	Siringo 2021	Wrong intervention: facial feminization surgery
#253	Song 2016	Wrong intervention: phonosurgery
#250	Song 2017	Wrong intervention: phonosurgery
#104	Spanos 2020	Wrong outcomes: lean mass, fat mass or insulin resistance
#257	Therattil 2017	Wrong intervention: thyroid cartilage reduction surgery
#328	Tirrell 2022	Wrong intervention: facial feminization surgery
#676	Traish 2010	Wrong design: narrative review
#279	VanDamme 2017	Wrong intervention: voice pitch raising surgery
#171	Vellho 2017	Wrong outcomes: BMI, blood pressure, hematocrit, hemoglobin, lipid profile, and liver enzymes
		Wrong outcomes: prolactin related outcomes (levels, hyperprolactinemia, prolactinoma)
#112	Wilson 2020	hyperprolactinemia, prolactinoma)
#245	Worth 2018	Unable to access full text
#122	Ziegler 2018	Wrong outcomes: voice parameters and satisfaction with voice
#499	Zucker 2021	Unable to access full text

ID	Study	Reason
#1458	Al-Tamimi 2019	Wrong patient population
#287	Al-Tamimi 2020	Wrong study design: non comparative
#403	Alcon 2021	Wrong study design: non comparative
#214	Aldridge 2021	Wrong study design: non comparative
#54	Almazan 2021	Wrong patient population
#1387	Boas 2019	Wrong patient population
#1323	Branstrom 2020	Wrong patient population
#1447	Breidenstein 2019	Wrong study design: non comparative
#114	Briles 2022	Insufficient Sample Size <100
#1804	Butler 2019	Wrong patient population
#716	Carmichael 2021	Wrong study design: non comparative
#622	Cocchetti 2021	Wrong outcomes
#1067	Coon 2020	Wrong patient population
#1835	Cristofari 2019	Wrong patient population
#1486	Cuccolo 2019	Wrong patient population
#1276	deBlok 2020	Wrong patient population
#577	deRooij 2021	Wrong patient population
#1625	DeWolf 2019	Wrong patient population
#1759	Djordjevic 2019	Wrong patient population
#244	Falcone 2020	Insufficient Sample Size <100
#258	FosterSkewis 2021	Wrong comparator
#1583	Gallagher 2019	Wrong patient population
#139	Gumussoy 2022	Wrong study design: non comparative
#515	Hisle-Gorman 2021	Wrong study design: non comparative
#350	Hougen 2021	Insufficient Sample Size <100
#1007	Meyer 2020	Wrong study design: non comparative
#499	Miller 2021	Wrong patient population
#621	Mullins 2021	Wrong study design: non comparative
#1653	Naeimi 2019	Insufficient Sample Size <100
#1691	Namba 2019	Insufficient Sample Size <100
#1770	Neuville 2019	Insufficient Sample Size <100
#623	Neuville 2021	Insufficient Sample Size <100
#644	Nieder 2021	Insufficient Sample Size <100
#1624	Nikkels 2019	Wrong patient population
#353	Opsomer 2021	Wrong patient population
#1306	Papadopoulos 2020	Wrong comparator
#640	Papadopoulos 2021	Insufficient Sample Size <100
#1472	Pigot 2019	Wrong patient population
#899	Pigot 2020	Insufficient Sample Size <100
#1212	Segev-Becker 2020	Insufficient Sample Size <100
#1351	Staples 2020	Wrong outcomes
#645	Staud 2021	Insufficient Sample Size <100
#864	Terrier 2020	Insufficient Sample Size <100
#1083	vanderSluis 2020	Insufficient Sample Size <100

#1204	Veerman 2020	Insufficient Sample Size <100
#1409	Watanabe 2019	Wrong patient population
#512	Waterschoot 2021	Insufficient Sample Size <100

ATTACHMENT D

THE SCIENCE OF GENDER DYSPHORIA AND TRANSSEXUALISM

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

JAMES M. CANTOR, PHD

17 MAY 2022

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I. Background & Credentials

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

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

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

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

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

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

II. Summary of Conclusions

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

III. Science of Gender Dysphoria and Transsexualism

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

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

A. Adult-Onset Gender Dysphoria

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

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

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

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

¹ Blanchard, 1985.

² Blanchard, 1990, 1991.

³ Blanchard, 1988.

⁴ Blanchard 1989a, 1989b, 1991.

⁵ Blanchard, *et al.*, 1989.

⁶ Dhejneberg, *et al.*, 2014.

⁷ Wiepjes, *et al.*, 2018.

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

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

2. Mental Health Issues in Adult-Onset Gender Dysphoria

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

⁸ See, e.g., Hepp, *et al.*, 2005.

⁹ Dhejne, *et al.*, 2016.

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

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

B. Childhood Onset (Pre-Puberty) Gender Dysphoria

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

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

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

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

¹⁰ Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.*, 2018; Wood, *et al.*, 2013.

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

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

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

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

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

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

20. In contrast, one research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children’s “peer preference, toy preference, clothing preference, gender similarity, and gender identity.”¹² They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, “Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability.”¹³ Although the Olson team declared that “social transitions may be predictable from gender identification and preferences,”¹⁴ their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.¹⁵ Both of those are lower than the value of .75, so both of those would be more likely than not

¹¹ Singh, *et al.* (2021); Steensma *et al.*, 2013.

¹² Rae, *et al.*, 2019, at 671.

¹³ Rae, *et al.*, 2019, at 673.

¹⁴ Rae, *et al.*, 2019, at 669.

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

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

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

2. "Watchful Waiting" and "The Dutch Protocol"

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

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

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

¹⁶ Delemarre-van de Waal & Cohen-Kettenis (2006).

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

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

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

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

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

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

¹⁷ de Vries & Cohen-Kettenis, 2012

¹⁸ de Vries & Cohen-Kettenis, 2012, at 301.

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

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

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

a. Four studies found no mental health improvement

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

¹⁹ de Vries, *et al.*, 2011, at 2280-2281.

²⁰ Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020; Kuper, *et al.*, 2020.

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

²² Achille, *et al.*, 2020; Costa, *et al.*, 2015.

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

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

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

²³ Carmichael, *et al.*, 2021.

²⁴ Kuper, *et al.*, 2020, at 5.

²⁵ Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.

²⁶ Kuper, *et al.*, 2020, at Table 2.

²⁷ Kuper, *et al.*, 2020, at 4.

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

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

b. Five studies confounded psychotherapy and medical treatment

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

35. The Dutch clinical research team followed up a cohort of youth at their clinic undergoing puberty suppression³³ and later cross-hormone treatment and surgical sex reassignment.³⁴ The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and

²⁸ Hisle-Gorman, et al., 2021, at 1448.

²⁹ Hisle-Gorman, et al., 2021, at 1448, emphasis added.

³⁰ Kaltiala et al., 2020, at 213.

³¹ Kaltiala et al., 2020, at 213.

³² de Vries, *et al.*, 2011; de Vries, *et al.*, 2014

³³ de Vries, *et al.*, 2011.

³⁴ de Vries, *et al.*, 2014.

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

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

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

³⁵ Biggs, 2020.

³⁶ de Vries, *et al.* 2011, at 2281.

³⁷ van der Miesen, *et al.*, 2020, at 699.

term mental health outcomes.”³⁸

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

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

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

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

³⁸ van der Miesen, *et al.*, 2020, at 703.

³⁹ Allen, *et al.*, 2019.

⁴⁰ Tordoff, *et al.*, 2022, Table 1.

⁴¹ Costa, *et al.*, at 2212 Table 2.

⁴² Costa, *et al.*, at 2206.

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

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

d. Conclusions

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

⁴³ Carmichael, *et al.*, 2021.

⁴⁴ Achille, *et al.*, 2020, at 2.

⁴⁵ Achille, *et al.*, 2020, at 2.

⁴⁶ Achille, *et al.*, 2020, at 3 (*italics added*).

⁴⁷ de Vries, *et al.* 2011, at 2282, *italics added*.

led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, 1 to 2 years⁴⁸) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

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

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

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

⁴⁸ de Vries, *et al.*, 2011.

⁴⁹ Tetelepta, 2021.

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

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

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

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

⁵⁰ Wallien, *et al.*, 2007.

⁵¹ Cohen-Kettenis, *et al.*, 2003, at 46.

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

C. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

48. In the social media age, a third profile has recently begun to present clinically or socially, characteristically distinct from the two previously identified profiles.⁵⁶ Unlike adult-onset or childhood-onset gender dysphoria, this group is predominately biologically female. This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD).⁵⁷ The majority of cases appear to occur within clusters of peers and in association with increased social media use⁵⁸ and especially among people with autism or other neurodevelopmental or mental health issues.⁵⁹

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

⁵² Thrower, *et al.*, 2020.

⁵³ Thrower, *et al.*, 2020, at 703.

⁵⁴ Cohen-Kettenis *et al.*, 2003, at 51; Skelly *et al.*, 2012.

⁵⁵ Janssen, *et al.*, 2016.

⁵⁶ Kaltiala-Heino, *et al.*, 2015; Littman, 2018.

⁵⁷ Littman, 2018.

⁵⁸ Littman, 2018.

⁵⁹ Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.

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

2. Social Transition and Puberty Blockers with Adolescent Onset

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

⁶⁰ Boivin, *et al.*, 2020.

⁶¹ Biggs, 2020; Littman, 2018.

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

3. Mental Illness in Adolescent-Onset Gender Dysphoria

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

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

⁶² Janssen, *et al.*, 2019.

⁶³ Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.

⁶⁴ Reisner, *et al.*, 2015.

⁶⁵ Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.

⁶⁶ de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.

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

⁶⁸ *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

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

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

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

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

(Italics added.)

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

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

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

IV. Other Scientific Claims Assessed

A. Suicide and Suicidality

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

behavior they encourage.⁶⁹

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

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

⁶⁹ Gould & Lake, 2013.

⁷⁰ Freeman, *et al.*, 2017.

⁷¹ Turecki & Brent, 2016

⁷² Klonsky *et al.*, 2016; Turecki & Brent, 2016

⁷³ Borges *et al.*, 2010; Nock *et al.*, 2008

⁷⁴ Klonsky, *et al.*, 2016.

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

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

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

⁷⁵ Bachman, 2018.

⁷⁶ World Health Organization, 2022.

⁷⁷ Samaritans, 2020.

⁷⁸ E.g., MSNBC, 2015, *Trans youth and suicide: An epidemic*.

⁷⁹ Haas, *et al.*, 2011.

⁸⁰ McNeil, *et al.* (2017)

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

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

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

⁸¹ Wiepjes, *et al.*, 2020.

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

⁸³ Bauer, *et al.*, 2015; Canetto, *et al.*, 2021.

⁸⁴ Marshall, *et al.*, 2016.

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

64. The scientific study of suicide is inextricably linked to that of mental illness, and Borderline Personality Disorder is repeatedly documented to be greatly elevated among sexual minorities⁸⁶.

B. Conversion Therapy

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

⁸⁵ McNeil, *et al.*, 2017.

⁸⁶ Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.

⁸⁷ D’Angelo, *et al.*, 2021.

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

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

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

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

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

69. Formal clinical approaches to helping children expressing gender dysphoria

⁸⁸ Turban, 2021, March 16.

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

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

D. Assessing the “Minority Stress Hypothesis”

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

⁸⁹ Meyer, 2003.

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

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

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

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

⁹⁰ Meyer, 2003.

upon transition and integration into an affirming environment.

V. Assessing Statements from Professional Associations

A. Understanding the Value of Statements from Professional Associations

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

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

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

B. Misrepresentations of statements of professional associations.

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

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

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

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

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

1. World Professional Association for Transgender Health (WPATH)

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

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

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

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

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

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

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

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

⁹¹ Coleman, *et al.*, 2012, at 172.

⁹² Coleman, *et al.*, 2012, at 173.

⁹³ Coleman, *et al.*, 2012, at 173.

⁹⁴ Coleman, *et al.*, 2012, at 176.

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

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

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

2. Endocrine Society (ES)

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

88. The document acknowledged the frequency of desistance among gender

⁹⁶ Dahlen, *et al.*, 2021.

⁹⁷ Dahlen, *et al.*, 2021, at 6.

⁹⁸ Dahlen, *et al.*, 2021, at 7.

dysphoric children:

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

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

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

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

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

⁹⁹ Hembree, *et al.*, 2017, at 3876.

¹⁰⁰ Hembree, *et al.*, 2017, at 3876.

¹⁰¹ Hembree, *et al.*, 2017, at 3877.

¹⁰² Hembree, *et al.*, 2017, at 3872.

psychological and social outcomes.”¹⁰³

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

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

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

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

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

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

¹⁰³ Hembree, *et al.*, 2017, at 3877.

¹⁰⁴ PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.

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

¹⁰⁶ Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

¹⁰⁷ Hembree, *et al.* 2017, at 3883.

¹⁰⁸ Hembree, *et al.*, 2017 at 3872, 3894.

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

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

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

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

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

¹⁰⁹ Adelson & AACAP, 2012, at 969.

¹¹⁰ Adelson & AACAP, 2012, at 969 (*italics added*).

¹¹¹ Adelson & AACAP, 2012, at 963.

¹¹² Adelson & AACAP, 2012, at 968.

¹¹³ Adelson & AACAP, 2012, at 970 (*italics added*).

¹¹⁴ Adelson & AACAP, 2012, at 969.

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

5. American College of Obstetricians & Gynecologists (ACOG)

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

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

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

¹¹⁵ Adelson & AACAP, 2012, at 969.

¹¹⁶ ACOG, 2017, at 1.

¹¹⁷ ACOG, 2017, at 1.

¹¹⁸ ACOG, 2017, at 1, 3.

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

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

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

6. American College of Physicians (ACP)

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

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

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

¹²⁰ ACOG, 2017, at 3 Table 1.

¹²¹ Daniel & Butkus, 2015a, 2015b.

¹²² Daniel & Butkus, 2015b, at 2.

¹²³ Daniel & Butkus, 2015b, at 8 (italics added).

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

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

7. American Academy of Pediatrics (AAP)

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

¹²⁴ APA, 2009 (*italics added*).

¹²⁵ Daniel & Butkus, 2015b, at 8 (*italics added*).

¹²⁶ Safer & Tangpricha, 2019.

¹²⁷ Safer & Tangpricha, 2019, at ITC1.

¹²⁸ Safer & Tangpricha, 2019, at ITC9.

¹²⁹ Safer & Tangpricha, 2019, at ITC9.

¹³⁰ Safer & Tangpricha, 2019, at ITC9.

¹³¹ Cantor, 2020.

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

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

8. The ESPE-LWPES GnRH Analogs Consensus Conference Group

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

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

¹³² Cantor, 2020, at 1.

¹³³ Carel et al., 2009.

¹³⁴ Carel et al. 2009, at 752.

VI. International Health Care Consensus

1. United Kingdom

112. The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes¹³⁵. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019¹³⁶.

113. The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review¹³⁷. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the “cherry-picking” or selective citation favouring or down-playing any one conclusion¹³⁸. The review’s results were unambiguous: “The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low”¹³⁹, again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as “very low” the quality of evidence regarding “body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment”¹⁴⁰. The report concluded that of the existing research, “The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding....They suggest little change with GnRH analogues [puberty

¹³⁵ Marsh, 2020; Rayner, 2018.

¹³⁶ BBC, 2021; Donnelly, 2019.

¹³⁷ National Health Service, 2020, Sept. 22.

¹³⁸ National Institute for Health and Care Excellence, 2020.

¹³⁹ National Institute for Health and Care Excellence, 2020, p. 4.

¹⁴⁰ National Institute for Health and Care Excellence, 2020, p. 5.

blockers] from baseline to follow-up”¹⁴¹.

2. Finland

114. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment¹⁴². That study showed that despite the purpose of medical transition to improve mental health: “Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development”¹⁴³. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

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

¹⁴¹ National Institute for Health and Care Excellence, 2020, p. 13.

¹⁴² Kaltiala et al., 2020.

¹⁴³ Kaltiala et al., 2020, p. 213.

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

3. Sweden

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

117. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research¹⁴⁶. Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence¹⁴⁷.

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

¹⁴⁴ Council for Choices in Health Care in Finland, 2020; italics added.

¹⁴⁵ Council for Choices in Health Care in Finland, 2020; italics added.

¹⁴⁶ Orange, 2020, Feb 22.

¹⁴⁷ Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

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

4. France

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

¹⁴⁸ Swedish National Board of Health and Welfare, 2022.

¹⁴⁹ Académie Nationale de Médecine, 2022, Feb. 25.

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

REFERENCES

- Académie Nationale de Médecine. (2022, Feb. 25). Medicine and gender transidentity in children and adolescents. Retrieved from <https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en>
- Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. *International Journal of Pediatric Endocrinology*. doi: 10.1186/s13633-020-00078-2
- Adams, N. J., & Vincent, B. (2019). Suicidal thoughts and behaviors among transgender adults in relation to education, ethnicity, and income: A systematic review. *Transgender Health*, 4, 226–246.
- Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues. (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51, 957–974.
- Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, 7, 302–311.
- American College of Obstetricians and Gynecologists. (2017). Care for transgender Adolescents. Committee Opinion No. 685. Retrieved from www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/care-for-transgender-adolescents
- American Psychiatric Association. (2022). Diagnostic and statistical manual for mental disorders, fifth edition, text revision (DSM-5-TR). Washington, DC: Author.
- American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Retrieved from <http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html>
- Anzani, A., De Panfilis, C., Scandurra, C., & Prunas, A. (2020). Personality disorders and personality profiles in a sample of transgender individuals requesting gender-affirming treatments. *International Journal of Environmental Research and Public Health*, 17, 1521. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7084367/>
- Bachmann, S. (2018). Epidemiology of suicide and the psychiatric perspective. *International Journal of Environmental Research and Public Health*, 15, 1425.
- Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15,

- BBC News. (2021, Sept. 5). NHS child gender identity clinic whistleblower wins tribunal. *British Broadcasting Company*. Retrieved from <https://www.bbc.com/news/uk-58453250>
- Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 16, 2043.
- Biggs, M. (2020). Gender dysphoria and psychological functioning in adolescents treated with GnRHa: Comparing Dutch and English prospective studies. *Archives of Sexual Behavior*, 49, 2231–2236.
- Blanchard, R. (1985). Typology of male-to-female transsexualism. *Archives of Sexual Behavior*, 14, 247–261.
- Blanchard, R. (1988). Nonhomosexual gender dysphoria. *The Journal of Sex Research*, 24, 188–193.
- Blanchard, R. (1989a). The classification and labeling of nonhomosexual gender dysphorias. *Archives of Sexual Behavior*, 18, 315–334.
- Blanchard, R. (1989b). The concept of autogynephilia and the typology of male gender dysphoria. *Journal of Nervous and Mental Disease*, 177, 616–623.
- Blanchard, R. (1990). Gender identity disorders in adult women. In R. Blanchard & B. W. Steiner (Eds.), *Clinical management of gender identity disorders in children and adults* (pp. 77–91). Washington, DC: American Psychiatric Press.
- Blanchard, R. (1991). Clinical observations and systematic studies of autogynephilia. *Journal of Sex and Marital Therapy*, 17, 235–251.
- Blanchard, R., Steiner, B. W., Clemmensen, L. H., & Dickey, R. (1989). Prediction of regrets in postoperative transsexuals. *Canadian Journal of Psychiatry*, 34, 43–45.
- Boivin, L., Notredame, C.-E., Jardri, R., & Medjkane, F. (2020). Supporting parents of transgender adolescents: Yes, but how? *Archives of Sexual Behavior*, 49, 81–83.
- Borges, G., Nock, M. K., Haro Abad, J. M., Hwang, I., Sampson, N. A., Alonso, J., Helena Andrade, L., Kessler, R. C. (2010) Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization World Mental Health Surveys. *Journal of Clinical Psychiatry*, 71, 1617–1628.
- Bränström, R., & Pachankis, J. E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: A total population study. *American Journal of Psychiatry*, 177, 727–734.
- Canetto, S. S., Antonelli, P., Ciccotti, A., Dettore, D., & Lamis, D. A. (2021). Suicidal as normal: A lesbian, gay, and bisexual youth script? *Crisis*, 42, 292–300.
- Cantor, J. M. (2020). Transgender and gender diverse children and adolescents:

- Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, 46, 307–313.
- Carel, J. C., Eugster, E. A., Rogol, A., Ghizzoni, L., Palmert, M. R.; ESPE-LWPES GnRH Analogs Consensus Conference Group, Antoniazzi, F., Berenbaum, S., Bourguignon, J. P., Chrousos, G. P., Coste, J., Deal, S., de Vries, L., Foster, C., Heger, S., Holland, J., Jahnukainen, K., Juul, A., Kaplowitz, P., Lahlou, N., Lee, M. M., Lee, P., Merke, D. P., Neely, E. K., Oostdijk, W., Phillip, M., Rosenfield, R. L., Shulman, D., Styne, D., Tauber, M., Wit, J. M. (2009). Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*, 123(4), e752–e762.
- Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., Viner, R. M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS ONE*, 16(2): e0243894.
- Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 391–391.
- Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, 31, 41–53.
- Cohen, J., Cohen, P., West, S. G. Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., Lev, A. I., Mayer, G., Meyer-Bahlburg, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L. S., Tangpricha, V., van Trotsenburg, M., Vitale, A., Winter, S., Whittle, S., Wylie, K. R., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13, 165–232.
- Costa, R., Dunsford, M., Skagerberg, E., Holt V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 12, 2206–2214.
- Council for Choices in Health Care in Finland (COHERE). (2020, June 16). Medical treatment methods for dysphoria associated with variations in gender identity in minors—Recommendation. [Translated] Retrieved from [https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+\(1\).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+\(1\).pdf?t=1631773838474](https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474)
- Dahlen, S., Connolly, D., Arif, I., Hyder Junejo, M., Bewley, S., & Meads, C. (2021). *International clinical practice guidelines for gender minority/trans people: Systematic review and quality assessment*. *BMJ Open*, 11, e048943.

- D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50, 7–16.
- Daniel, H., & Butkus, R. (2015a). Lesbian, gay, bisexual, and transgender health disparities: Executive summary of a policy position paper from the American College of Physicians. *Annals of Internal Medicine*, 163, 135–137.
- Daniel, H., & Butkus, R. (2015b). Appendix: Lesbian, gay, bisexual, and transgender health disparities: A policy position paper from the American College of Physicians. *Annals of Internal Medicine*, 163(2), [unpaginated].
- de Vries, A. L. C. & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch Approach. *Journal of Homosexuality*, 59, 301–320.
- de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134, 1–9.
- de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine*, 8, 2276–2283.
- de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*, 52, 1195–1202.
- de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, 40, 930–936.
- Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155 (suppl 1), S131–S137.
- Dhejne, C., Van Vlerken, R., Geylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, 28, 44–57.
- Dhejneberg, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43, 1535–1545.
- Donnelly, L. (2019, Dec. 12). Children's transgender clinic hit by 35 resignations in three years as psychologists warn of gender dysphoria 'over-diagnoses'. *The Telegraph*. Retrieved from https://www.telegraph.co.uk/news/2019/12/12/childrens-transgender-clinic-hit-35-resignations-three-years/?WT.mc_id=tmg_share_em
- Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow up study of girls with gender identity disorder. *Developmental Psychology*, 44, 34–

- Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56, 116–123.
- Finland Ministry of Social Affairs and Health, Council for Choices in Health Care. (2020, June 11). *Medical treatment methods for dysphoria associated with variations in gender identity in minors—Recommendation*. Retrieved from [https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+\(1\).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+\(1\).pdf?t=1631773838474](https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474)
- Finland Ministry of Social Affairs and Health, Council for Choices in Health Care. (2020, June 16). *Medical treatments for gender dysphoria that reduces functional capacity in transgender people—Recommendation*. Retrieved from <https://palveluvalikoima.fi/documents/1237350/22895838/Summary+transgender.pdf/2cc3f053-2e34-39ce-4e21-becd685b3044/Summary+transgender.pdf?t=1592318543000>
- Freeman, A., Mergl, R., Kohls, E., Székely, A., Gusmao, R., Arensman, E., Koburger, N., Hegerl, U., & Rummel-Kluge, C. (2017). A cross-national study on gender differences in suicide intent. *BMC Psychiatry*, 17, 234.
- Gould, M. S., & Lake, A. M. (2013, Feb. 6). II.4 *The contagion of suicidal behavior*. Forum on Global Violence Prevention, Board on Global Health; Institute of Medicine; National Research Council. Contagion of Violence: Workshop Summary. National Academies Press: Washington, DC. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK207262/>
- Green, R. (1987). *The “sissy boy syndrome” and the development of homosexuality*. New Haven, CT: Yale University Press.
- Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D’Augelli, A. R., Silverman, M. M., Fisher, P. W., Hughes, T., Rosario, M., Russell, S. T., Malley, E., Reed, J., Litts, D. A., Haller, E., Sell, R. L., Remafedi, G., Bradford, J., Beautrais, A. L., Brown, G. K., ... Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of homosexuality*, 58, 10–51.
- Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, T. D., Tangpricha, V., & T’Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/ gender-incongruent persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism*, 102, 3869–3903.
- Hepp, U., Kraemer, B., Schnyder, U., Miller, N., & Delsignore, A. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research*, 58, 259–261.
- Hisle-Gorman, E., Schvey, N. A., Adirim, T. A., Rayne, A. K., Susi, A., Roberts, T. A., & Klein, D. A. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *The Journal of Sexual Medicine*, 18, 1444–1454.

- Holt, V., Skagerberg, E., & Dunsford, M. (2016). Young people with features of gender dysphoria: Demographics and associated difficulties. *Clinical Child Psychology and Psychiatry*, 21, 108–118.
- Jacobs, L. A., Rachlin, K., Erickson-Schroth, L., & Janssen, A. (2014). Gender dysphoria and co-occurring autism spectrum disorders: Review, case examples, and treatment considerations. *LGBT Health*, 1, 277–282.
- Janssen, A., Busa, S., Wernick, J. (2019). The complexities of treatment planning for transgender youth with co-occurring severe mental illness: A literature review and case study. *Archives of Sexual Behavior*, 48, 2003–2009.
- Janssen, A., Huang, H., & Duncan, C. (2016). Gender variance among youth with autism spectrum disorders: A retrospective chart review. *Transgender Health*, 1, 63–68.
- Kalin, N. H. (2020). Reassessing mental health treatment utilization reduction in transgender individuals after gender-affirming surgeries: A comment by the Editor on the process. *American Journal of Psychiatry*, 177, 765.
- Kaltiala-Heino, R., Sumia, M., Työläjärvä, M., & Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, 9, 9.
- Kaltiala, R., Heino, E., Työläjärvä, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*, 74, 213–219.
- Kaltiala, R., Heino, E., Työläjärvä, & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*, 74, 213–219.
- Klonsky, E. D., May, A. M., Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual Review of Clinical Psychology*, 12, 307–330.
- Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, 145, e20193006.
- Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE*, 13(8), e0202330.
- Marsh, S. (2020, Sept. 20). NHS to hold review into gender identity services for children and young people. *The Guardian*. Retrieved from <https://www.theguardian.com/society/2020/sep/22/nhs-to-hold-review-into-gender-identity-services-for-children-and-young-people>
- Marshall, E., Claes, L. L., Bouman, W. P., Witcomb, G. L., & Arcelus, J. (2016). Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. *International Review of Psychiatry*, 28, 58–69.
- May, T., Pang, K., & Williams, K. J. (2016). Gender variance in children and adolescents with autism spectrum disorder from the National Database for

- Autism Research. *International Journal of Transgenderism*, 18, 7–15.
- McCall, B. (2021, October 7). Psychiatrists shift stance on gender dysphoria, recommend therapy. *Medscape Psychiatry*. Retrieved from www.medscape.com/viewarticle/960390?src=soc_tw_share
- McNeil, J., Ellis, S. J., & Eccles, F. J. R. (2017). Suicide in trans populations: A systematic review of prevalence and correlates. *Psychology of Sexual Orientation and Gender Diversity*, 4, 341–353.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674–697.
- Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology*, 4, 29–41.
- MSNBC. (2015, Jan. 5). *Trans youth and suicide: An epidemic*. Retrieved from <https://www.msnbc.com/ronan-farrow/watch/trans-youth-and-suicide-an-epidemic-380294211712>
- Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health*, 100, 2426–2432.
- Nainggolan, L. (2021, May 12). Hormonal Tx of youth with gender dysphoria stops in Sweden. *Medscape Psychiatry*. Retrieved from www.medscape.com/viewarticle/950964?src=soc_tw_share
- National Health Service (NHS). (2020, Sept. 22). NHS announces independent review into gender identity services for children and young people. United Kingdom. Retrieved from <https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/>
- National Institute for Health and Care Excellence (NICE). (2020, Oct. 14). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Retrieved from <https://arms.nice.org.uk/resources/hub/1070905/attachment>
- Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A....Williams, D. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *British Journal of Psychiatry*, 192, 98–105.
- Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, 137, e20153223.
- Orange, R. (2020, Feb 22). Teenage transgender row splits Sweden as dysphoria diagnoses soar by 1,500%: New health report and TV debates highlight backlash against gender reassignment. *The Guardian*. Retrieved from <https://www.theguardian.com/society/2020/feb/22/ssweden-teenage-transgender-row-dysphoria-diagnoses-soar>

- Pediatric Endocrine Society & Endocrine Society. (2020, December 15). *Transgender health*. Retrieved from www.endocrine.org/advocacy/position-statements/transgender-health.
- Pediatric Endocrine Society. (Online). About PES. Retrieved from <https://pedsendo.org/about-pes/>
- Rae, J. R., Gülgoz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, 30, 669–681.
- Rafferty, J., AAP Committee on psychosocial aspects of child and family health, AAP Committee on adolescence, AAP Section on lesbian, gay, bisexual, and transgender health and wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, 142(4), e20182162
- Rayner, G. (2018, Sept. 16). Minister orders inquiry into 4000 percent rise in children wanting to change sex. *The Telegraph*. Retrieved from <https://www.telegraph.co.uk/politics/2018/09/16/minister-orders-inquiry-4000-per-cent-rise-children-wanting/>
- Reisner, S. L., Veters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health*, 56(3), 274–279.
- Reuter, T. R., Sharp, C., Kalpakci, A. H., Choi, H. J., & Temple, J. R. (2016). Sexual orientation and Borderline Personality Disorder features in a community sample of adolescents. *Journal of Personality Disorders*, 30, 694–707.
- Rodriguez-Seiljas, C., Morgan, T. A., & Zimmerman, M. (2021). A population-based examination of criterion-level disparities in the diagnosis of Borderline Personality Disorder among sexual minority adults. *Assessment*, 28, 1097–1109.
- Safer, J. D., Tangpricha, V. (2019). In the clinic: Care of the transgender patient. *Annals of Internal Medicine*, 171(1), ITC1–ITC6.
- Samaritans. (2020). *Media guidelines for reporting suicide*. Ewell, Surrey, UK. Retrieved from https://media.samaritans.org/documents/Media_Guidelines_FINAL_v2_TABa8C6.pdf
- Schumm, W. R., & Crawford, D. W. (2020). Is research on transgender children what it seems? Comments on recent research on transgender children with high levels of parental support. *The Linacre Quarterly*, 87, 9–24.
- Schumm, W. R., Crawford, D. W., Fawver, M. M., Gray, N. K., Niess, Z. M., & Wagner, A. D. (2019). Statistical errors in major journals: Two case studies used in a basic statistics class to assess understanding of applied statistics. *Psychology and Education—An Interdisciplinary Journal*, 56, 35–42.
- Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry*, 12, 632784.

- Skagerberg, E., Parkinson, R., & Carmichael, P. (2013). Self-harming thoughts and behaviors in a group of children and adolescents with gender dysphoria. *International Journal of Transgenderism*, 14, 86–92.
- Skelly, A. C., Dettori, J. R., & Brodt, E. D. (2012). Assessing bias: The importance of considering confounding. *Evidence-based Spine-Care Journal*, 3, 9–12.
- Steensma, T. D., Cohen-Kettenis, P. T., & Zucker, K. J. (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988–2016). *Journal of Sex & Marital Therapy*, 44, 713–715.
- Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 582–590.
- Strang, J. F., Kenworthy, L., Dominska, A., Sokoloff, J., Kenealy, L. E., Berl, M., ... Wallace, G. L. (2014). Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior*, 43, 1525–1533.
- Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., ... Anthony, L. G. (2016). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child and Adolescent Psychology*, 47, 105–115.
- Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU). (2019, Sept. 6). Gender dysphoria in children and adolescents: An inventory of the literature. A systematic scoping review. Retrieved from <https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/>
- Swedish Agency of Health Technology Assessment and Assessment of Social Services. (2019). *Gender dysphoria in children and adolescents: An inventory of the literature*. Retrieved from: www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/
- Swedish National Board of Health and Welfare (NBHW). (2020, Feb. 22). Uppdaterade rekommendationer för hormonbehandling vid könsdysfori hos unga. [*Updated recommendations for hormone therapy for gender dysphoria in young people*.] Author: Socialstyrelsen. Retrieved from <https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/>
- Tetelepta, B. (2021, Feb 27). More research is urgently needed into transgender care for young people: 'Where does the large flow of children come from?' [translated]. *Algemeen Dagblad*. Retrieved from www.ad.nl/nijmegen/dringend-meer-onderzoek-nodig-naar-transgenderzorg-aan-jongeren-waar-komt-de-grote-stroom-kinderen-vandaan~aec79d00/?referrer=https%3A%2F%2Ft.co%2F
- Thrower, E., Bretherton, I., Pang, K. C., Zajac, J. D., & Cheung, A. S. (2020). Prevalence of Autism Spectrum Disorder and Attention-Deficit Hyperactivity Disorder amongst individuals with Gender Dysphoria: A systematic review.

- Journal of Autism and Developmental Disorders*, 50, 695–706.
- Turban, J. (2021, March 16). Trans girls belong on girls' sports teams. *Scientific American*. www.scientificamerican.com/article/trans-girls-belong-on-girls-sports-teams/
- Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behavior. *Lancet*, 387, 1227–1239.
- United Kingdom National Health Service (NHS), National Institute for Health and Care Excellence, (2021, March 11). *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria*. Retrieved from www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3ffrom%3d2020-01-01%26q%3dgender%2bdysphoria%26sp%3don%26to%3d2021-03-31
- van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., Popma, A. (2020). Psychological functioning in transgender adolescence before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, 66, 699–704.
- Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47, 1413–1423.
- Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1307–1314.
- Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M.-C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications*, 11, 3959.
- Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Block, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica*, 141, 486–491.
- Wiepjes, C. M., Nota, N. M., de Bok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M.-B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels B. P. C., & den Heijer, M. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, 15, 582–590.
- World Health Organization (2022). *Age standardized suicide rates (per 100 000 population)*. Retrieved from <https://www.who.int/data/gho/data/themes/mental-health/suicide-rates>
- Wood, H., Sasaki, S., Bradley, S. J., Singh, D., Fantus, S., Own-Anderson, A., Di Giacomo, A., Bain, J., & Zucker, K. J. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): Age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy*, 39, 1–6.

- Zanarini, M. C., Magni, L. R., Temes, C. M., Hein, K. E., Aguirre, B. A., & Goodman, M. (2021). Sexual orientation and gender of intimate relationship partners among adolescents with BPD and psychiatrically healthy adolescents. *Journal of Personality Disorders, 35* (Suppl. B), 1–7.
- Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior, 48*, 1983–1992.
- Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.
- Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy, 38*, 151–189.
- Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*, 90–97.

APPENDICES

Appendix 1

The Outcomes Studies of Childhood-Onset Gender Dysphoria

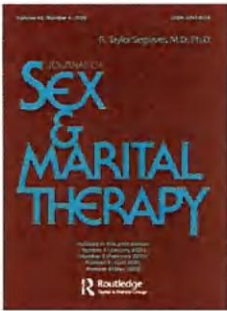
Appendix 2

Peer-reviewed article:

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

Prospective Outcomes Studies of Gender Dysphoric Children

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



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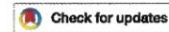
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Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

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ABSTRACT

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

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

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

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

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

“[C]onversion” or “reparative” treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. ... Reparative approaches have been proven to be not only unsuccessful³⁸ but also deleterious and are considered outside the mainstream of traditional medical practice.^{29,39–42}

The citations were:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The citations from AAP’s reference list are:

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

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

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

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

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

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

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

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

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

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

Disclosure statement

No potential conflict of interest was reported by the author.

References

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

Appendix

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

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

ATTACHMENT E

Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent

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May 17, 2022

Qualifications

I received my B.A. in Science at the College of William and Mary and my M.D. from the Medical College of Virginia, Virginia Commonwealth University. I am currently a pediatric endocrinologist in private practice in Atlanta, Georgia. I am the President of Van Meter Pediatric Endocrinology, P.C. I am on the clinical faculties of Emory University School of Medicine and Morehouse College of Medicine, in the role of adjunct Associate Professor of Pediatrics. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Georgia since 1991. I have been previously licensed to practice medicine in California, Louisiana, and Maryland.

I did my Pediatric Endocrine fellowship at Johns Hopkins Hospital from 1978-1980. The faculty present at that time had carried on the tradition of excellence established by Lawson Wilkins, M.D. Because of the reputation of the endocrine program as a center for exceptional care for children with disorders of sexual differentiation, I had well-above average exposure to such patients. As a Pediatric Fellow, I was also exposed to adults with Gender Identity Disorder, then called Trans-Sexuality, and received training from John Money, Ph.D., in his Psycho-hormonal Division. Over the past 44 years, I have closely followed the topic of incongruent gender in children adolescents and adults, but I am focusing in this document on working with children and adolescents. To get a more solid understanding of how male and female human beings develop in utero, it is important to start at the point when a sperm meets an egg.

Differentiation in the Fetus

From the moment of conception, a fetus is determined to be either a male (XY), female (XX), or in rare cases, to have a combination of sex-determining chromosomes, many of which are not compatible with life, and some of which are the cause of identifiable clinical syndromes. The presence of a Y chromosome in the developing fetus directs the developing gonadal tissue to develop as a testicle. The absence of a functional Y chromosome allows the gonadal tissue to develop as an ovary. Under the influence of the mother's placental hormones, the testicle will produce testosterone which directs the genital tissue to form a penis and a scrotum. Simultaneously, the testicle produces anti-Müllerian Hormone (AMH) which regresses development of the tissue that would otherwise develop into the uterus, fallopian tubes, and upper third of the vagina. This combination of actions in early fetal development is responsible for what we subsequently see on fetal sonograms, and what we observe at birth as male or female genitalia. It is only when the genital structures are ambiguous in appearance that sex determination is withheld until a thorough expert team evaluation has occurred.

For reasons most often occurring as random events, there are malfunctions of the normal differentiation. These aberrations of normal development are responsible for what we classify as Disorders of Sexual Differentiation (DSD), and they represent a very small fraction of the human population. The incidence of such circumstances occurs in 1:4500 to 1:5500 births.¹ Sex is binary, male or female, and is determined by chromosomal complement and corresponding reproductive role. The exceedingly rare DSDs are all medically identifiable deviations from this sexual binary norm. The 2006 consensus statement of the Intersex Society of North America and the 2015 revision of the Statement do not endorse DSD as a third sex.² DSD outcomes range from appearance of female external genitalia in an XY male (complete androgen insensitivity syndrome) to appearance of male external genitalia in an XX female (severe congenital adrenal hyperplasia).

As one would expect, there are variations of the degree of hormonally driven changes that create ambiguous genital development that prevent assigning of a specific classification as either male or female at birth. DSD patients are not “transgender”; they have an objective, physical, medically verifiable, physiologic condition. Transgender people generally do not have intersex conditions or any other verifiable physical anomaly. People who identify as “feeling like the opposite sex” or “somewhere in between” do not comprise a third sex. They remain biological men or biological women.

In some DSDs there exist more than one set of chromosomes. When there is a divergence of the appearance of the external genitalia from the chromosomally determined sex due to the presence of both an ovarian and testicular cell lines in a patient simultaneously, the patient is classified as having ovo-testicular DSD (formerly termed a true hermaphrodite). When there is a disruption in the development of genital structures but there is solely testicular tissue present in the chromosomal male or solely ovarian tissue in the chromosomal female, the term 46 XY DSD or 46 XX DSD is used instead respectively (formerly termed male pseudohermaphrodite or female pseudohermaphrodite).

The decision to assign a sex of rearing is complex and is specific to the diagnosis. Patients with complete androgen insensitivity (CAIS) are XY DSD but are never reared as a male. Because testosterone never influences development, they become happy, functional female adults with infertility. Females with severe congenital adrenal hyperplasia (CAH) are XX DSD but are not reared as males despite the male appearance of the genitalia at birth. Although these girls may show a tendency for male play behaviors as children, they generally assume a female sexual identity. Therapeutic interventions in the DSD individuals from infancy onward are aimed at what function can be expected from their disordered sexual anatomy in terms of function and fertility. Most often, the chromosomal sex aligns with the sex of rearing.

Gender Identity

“Gender” is a term that refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one. The term gender possessed solely a linguistic meaning prior to the 1950s. This changed when sexologists of the 1950s and 1960s co-opted the term to conceptualize cross-dressing and transsexualism in their psychological practice. “Gender identity” is a term coined by my former endocrine faculty member John Money in the 1970s and has come to refer to an individual’s mental and emotional sense of being male or female. The norm is for individuals to have a gender identity that aligns with one’s biological sex.

Gender discordance (formerly Gender Identity Disorder) is used to describe a psychological condition in which a person experiences marked incongruence between his experienced gender and the gender associated with his biological sex. He will often express the belief that he is the opposite sex. Up until 2010, gender discordance occurred in 0.001% of biological females and in 0.0033% of biological males.³ Exact numbers are hard to document since reporting is often anecdotal. Gender discordance is not considered a normal developmental variation.

“Gender Dysphoria” is a diagnostic term to describe the emotional distress caused by gender incongruity.⁴ John Money played a prominent role in the early development of gender theory and transgenderism. He understood gender to be “the social performance indicative of an internal sexed identity.”⁵ He joined the Johns Hopkins faculty in 1951 specifically to have access to children diagnosed with DSD, hoping to prove his theory that gender was arbitrary and fluid. Money experimented with DSD infants by assigning them to the opposite biological sex through surgical revision, counseling, and hormonal manipulation during puberty. His mode of operation was to have a theory and then experiment with patients to see how his theory worked.

Ethics in Clinical Research on Human Subjects

It is important to discuss the need for ethics to play a role in the design of clinical studies involving human patients. To have a hypothesis, as did John Money, is not at issue. However, to clearly elucidate the potential for harm and balance that knowledge with the potential benefits is key and essential. After the travesties of open-ended experimentation in the Nazi concentration camps, international guidelines were established to protect human subjects from just such experimentation.⁶ John Money ignored these guidelines as he assigned genders to infants and toddlers with ambiguous genitalia. There was no informed consent of the patients, who were infants and toddlers, and their parents were just told to follow the advice of Dr. Money and to trust that he had the correct information. There was no standardized protocol to follow, and no known outcome that could be guaranteed. This kind of endeavor did not anticipate or prevent adverse outcomes and was the antithesis of ethical science. Money never submitted his research proposals for review by an independent external review board. This left the patients unprotected and vulnerable to harm, and, indeed, in the case of the Reimer twins, to death due to drug addiction/overdose in one brother to and suicide in the other.⁷

Near the end of my fellowship training at Johns Hopkins, a male infant was sent to our clinic to assess the cause of his very small penis and testicles. My attending physician and I laid out a diagnostic work-up based on the known science which would help us understand whether the problem was due to a pituitary deficiency or an inability of tissue response to hormones. We purposely left John Money off the care "team," having some serious concerns about his tendency to dismiss science and to experiment. We sent the family home with their son and were quite surprised when the mother returned six weeks later with a baby wearing a pink dress and an eyelet bonnet. Without our knowledge, Dr. Money had intervened and told the family that our protocol was nonsense and the baby needed to be reared as female. On physical exam, there was clear evidence that not only was the baby able to produce testosterone, but his penis responded well, as expected, to the hormone production by his own body. The family was relieved but had not been spared suffering under the experimentation by Dr. Money. They had suffered deeply when they divulged to their extended family that their baby boy was actually a baby girl, and then they suffered even more when they recanted and resumed calling him a boy.

Because of his experience with infants, Money initially garnered support from endocrine colleagues and surgical colleagues, and Johns Hopkins became a renowned center for care of patients with DSD in the 1970s, receiving referrals from around the world. Follow-up studies on these infants later showed, however, that altering their natal sexual identity via social intervention could lead to severe psychological harm. Clinical case reports of children with DSD have revealed that gender identity is indeed not immune to environmental input.⁸

Meanwhile, Money had expanded into the field of adult patients with persistent gender identity disorder. This very small group of patients chose voluntarily, as adults, to enter a very precise protocol which began with living socially as the opposite sex for a year, eventually receiving hormonal therapy to change their physical appearance to some extent. The final step was surgical revision of the body structures that would otherwise be at odds with their desired gender identity. This small group of patients was followed for a number of years past their final surgical procedures and required continuous counseling. These patients expressed some degree of subjective satisfaction but showed no objective improvement in overall wellbeing.⁹ The legacy of John Money fell into disrepute and the transsexual treatment program at Johns Hopkin was closed in the 1980s based on the lack of evidence that this protocol produced an effective cure.

Etiology of Gender Disorders

Transgender affirming professionals claim transgender individuals have a "feminized brain" trapped in a male body at birth and vice versa based upon various brain studies. Diffusion-weighted MRI scans have demonstrated that the pubertal testosterone surge in boys increases white matter volume. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.¹⁰ Other

diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.¹¹ These studies, however, are of limited clinical significance due to the small number of subjects and failure to account for neuroplasticity.

Neuroplasticity is the well-established phenomenon in which long-term behavior alters brain microstructure. For example, the MRI scans of experienced cab drivers in London are distinctly different from those of non-cab drivers, and the changes noted are dependent on the years of experience.¹² There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.^{13,14} Therefore, any transgender brain differences would more likely be the result of transgender behavior than its cause.

Furthermore, infants' brains are imprinted prenatally by their own endogenous sex hormones, which are secreted from their gonads beginning at approximately eight weeks' gestation.^{15,16,17} There are no published studies documenting MRI-verified differences in the brains of gender-disordered children or adolescents. The DSD guidelines also specifically state that current MRI technology cannot be used to identify those patients who should be raised as males or raised as females.¹⁸ Behavior geneticists have known for decades that while genes and hormones influence behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid "blueprints" for behavior. Rather, humans "develop traits through the dynamic process of gene-environment interaction. ... [genes alone] don't determine who we are."¹⁹

Regarding transgenderism, twin studies of adults prove definitively that prenatal genetic and hormone influence is minimal. The largest twin study of transgender adults found that only 20 percent of identical twins were both transgender-identified.²⁰ Since identical twins contain 100 percent of the same DNA from conception and develop in exactly the same prenatal environment exposed to the same prenatal hormones, if genes and/or prenatal hormones contributed to a significant degree to transgenderism, the concordance rates would be close to 100 percent. Instead, 80 percent of identical twin pairs were discordant. This difference would indicate that at least 80 percent of what contributes to transgenderism as an adult in one co-twin consists of one or more non-shared post-natal experiences including but not limited to non-shared family experiences. These findings also mean that persistent GD is due predominately to the impact of nonshared environmental influences. These studies provide compelling evidence that discordant gender is not hard-wired genetically.

Gender Dysphoria vs. Gender Identity Disorder

Up until the recent revision of the DSM-IV criteria, the American Psychological Association (APA) held that Gender Identity Disorder (GID) was the mental disorder described as a discordance between the natal sex and the gender identity of the patient. Dr. Kenneth Zucker, who is a highly respected clinician and researcher from Toronto, carried on evaluation and

treatment of GID patients for forty years. His works, widely published, found that the vast majority of boys and girls with GID identify with their biological sex by the time they emerge from puberty to adulthood, through either watchful waiting or family and individual counseling.²¹ His results were mirrored in studies from Europe.^{22,23}

When the DSM-V revision of the diagnosis of GID was proposed by the APA committee responsible for revision, Dr. Zucker strongly opposed the change to the term Gender Dysphoria, which purposefully removed gender discordance as a mental disorder apart from the presence of significant emotional distress. With this revision, Gender Dysphoria describes the mental anguish which is experienced by the gender discordant patient. The theory that societal rejection is the root cause of Gender Dysphoria was validly questioned by a study from Sweden which showed that the dysphoria was not eliminated by hormones and sex reassignment surgery even with widespread societal acceptance.²⁴

Treatment of Gender Dysphoria

The treatment of children and adolescents with gender discordance and accompanying gender dysphoria should include an in-depth evaluation of the child and family dynamics. This evaluation provides a basis on which to proceed with psychologic therapy. The entire biologic and social family should be involved in psychological therapy designed to assist the patient, if at all possible, to align gender identity with natal sex. Psychological support by competent counselors with an intent of resolving the gender conflict should be provided as long as the patient continues to suffer emotionally. Given the high degree of eventual desistance of gender discordance/dysphoria by the end of puberty, it would be ethical and logical to counsel the patient and family to rear the child in conformity with natal sex.

There should be no interruption of natural puberty. Natural pubertal maturation in accordance with one's natal sex is not a disease. It is designed to carry malleable, immature children forward to be healthy adults capable of conceiving their own progeny by providing either a sperm or an egg. Puberty affects physical changes, some of them painful, unique to the natal sex to reflect the laws of nature. Interruption of puberty has been reserved for children who begin puberty at an age much younger than normal in an effort to preserve final height potential and avoid the social consequences of precocious maturation.²⁵

There are a number of physical changes that are a consequence of normally timed puberty that could be classified as disadvantageous: changes in body proportions can alter success with dance and gymnastics; acne can be severe and disfiguring; a boy soprano can suddenly hardly carry a tune. It has not been the ethical standard of care to stop puberty so that these changes can be circumvented. Erikson described the stage of adolescence as "Identity versus Role Confusion" during which the teen works at developing a sense of self by testing roles then integrating them into a single identity.²⁶ This process is often unpleasant regardless of the presence or absence of gender identity conflicts. The major benefit of enduring puberty in a GD patient is that it provides a strong likelihood of alignment of his gender identity with his

natal sex. There is no doubt that these patients need compassionate care to get them through their innate pubertal changes.

The light at the end of the tunnel is the proven scientific evidence that 80%- 95% of pre-pubertal children with GD will come to identify with their biological sex by late adolescence. Some will require lifelong supportive counseling while others will not.²⁷ Intervention at a young age with gonadotropin releasing hormone analogs (often referred to as puberty blockers) to either stop puberty early on or prevent it from starting before it naturally occurs is suggested by guidelines developed by WPATH without scientific basis. These guidelines are essentially nothing more than an open-ended experiment in the manner of John Money. They represent the ideas of their authors with clear admission that there is no long-term evidence that harm will exceed benefits as these patients grow to old age. There is evidence that bone mineral density is irreversibly decreased if puberty blockers are used during the years of adolescence.²⁸ To treat puberty as a pathologic state of health that should be avoided by using puberty blockers (GnRH analogs) is to interrupt a major necessary physiologic transformation at a critical age when such changes can effectively happen. We have definite evidence of the need for estrogen in females to store calcium in their skeleton in their teen years. That physiologic event can't be put off successfully to a later date. It is very difficult to imagine ethical controlled clinical trials that could elucidate the effects of delaying puberty until the age of consent.

The use of cross-sex hormones during this same time frame has no basis of safety and efficacy. The use of such treatment in adults raises scientifically valid concerns that were amply expressed in the 2009 Endocrine Society Guidelines on Transgender treatment. The next step in WPATH-recommended intervention is to use cross-sex hormone therapy during the time when the patient would naturally be experiencing endogenous pubertal changes. This too is not based on scientifically proven theories. The use of cross-sex hormones can cause permanent infertility.²⁹

The final recommended step is so-called "sex reassignment surgery," which can include surgical removal of the breasts in natal females, or removal of the penis and scrotum in natal males. Each of these steps has adverse outcomes, some reversible and others not. Mastectomies leave scars, and there is great difficulty in creating a functional vaginal-like orifice, and certainly no success in creating an innervated erectile penis where none existed previously. Sex reassignment surgery is, by nature, permanent.

Recurrent Themes that Are Repeatedly Published

Puberty blockers are stated to be completely reversible in their effects on the adolescent who has entered puberty based on clinical studies in young children with precocious puberty who have been treated with these drugs. This is comparing apples to oranges. Precocious puberty, by definition, is defined as puberty which starts before the 8th birthday for a female child or the before the 9th birthday in a male child. The end of treatment is carefully timed so that resumption of puberty occurs at the average age for females (10.5 years) and males (11.5

years). This allows the necessary functions of puberty to prepare the body for reproduction and affects the bones, gonads, and brain, among other body systems. On the other hand, blocking puberty at the age of normal puberty prevents the needed accretion of calcium into the skeleton and prevents the maturation of the gonads. There is no long-term data that compares bone, gonad, and brain health in pubertal-aged patients who have had puberty interrupted and those who have not, as was noted as a concern in the Endocrine Society Guidelines. There are no such ongoing studies completed that guarantee the full reversibility of blocking puberty in this age group, but there is evidence that normal bone density can't be fully reestablished. Without any verifiable safety data, using the puberty blockers for interrupting normal puberty is not a sanctionable off-label use of these drugs and is therefore to be considered uncontrolled, non-consentable experimentation on children.

Advocates for the social, medical and surgical affirmation of gender incongruent children insist that they are only following established standards of care. There are no standards of care for transgender health. Standards of care established by broad consensus are reached by inclusion of the whole spectrum of opinions, clinical experience and published science in the formation thereof. The guidelines published by WPATH³⁰, the Endocrine Society,^{29,31} the American Academy of Pediatrics³², and the Pediatric Endocrine Society³³ are solely the opinions of like-minded practitioners who excluded any contrary opinion. The Endocrine Society Guidelines, as mentioned before, clearly stated that they are not to be considered standards of care. Before true consensus-driven standards of care are established for the treatment of transgender patients of all ages, following the current guidelines is risky experimentation in a manner reminiscent of John Money's tactics.

What We Do Know and Do Not Know

We do know that social affirmation of an incongruent gender tears the fabric of the patient's life into pieces- pitting family members against each other, ruining child friendships and it introduces the child to a fantasy world, much of it on the internet. Kenneth Zucker aptly documented the detrimental effects of such affirmation and the immense amount of work it takes to undo these effects when the child does come to realize they can't change their sex and wants to go back to identifying with their sex³⁴. We do not know that social affirmation does anything other than push the child away from the proven, 80-90% effective, so-called watch-and wait treatment option. Embarrassingly unscientific short term convenience sample studies purport to show that all gender incongruent children who are socially affirmed have improved mental health and are therefore better off than those children who are not allowed to socially transition.³⁵

We do know that blocking puberty during the age when puberty naturally happens lessens accretion of calcium into the skeleton and that this can't be regained by allowing puberty to resume or by using cross sex hormones. We do know that the ovary and testicle cease to mature with treatment. What we do not know is whether allowing puberty to resume will allow the ovary and testicle to fully mature and have full function in terms of fertility. We do

not know if brain development that is halted with puberty blockers can return to full function once puberty is allowed to resume.

We do know that elevated levels of testosterone in females and of estrogen in males create significant medical morbidity. This knowledge comes from the evaluation and treatment of naturally occurring disease states in children and adults. Treatment of these conditions is aimed at returning hormone levels to normal, thereby avoiding cancers, heart disease, and stroke. We do not know that elevating testosterone in females and estrogen in males to levels ten-fold higher than these known disease states is safe, but common sense would say it can't possibly be safe.

The Myth of Increased Suicide

The affirmation advocates repeatedly refer to the established increased risk of suicide if any of the affirmation strategies are not followed to completion. They point to their own published studies touting dramatic improvement in mental health status of patients who are affirmed in all three ways, but they cite data from convenience sampling, which never should be used to prove anything other than association, at best. Such studies can never prove causation. There are only two total population studies in the peer-reviewed medical literature.^{24,36,37} They show that when every recorded case in the population of Sweden was analyzed, neither medical affirmation nor medical affirmation followed by surgical affirmation improved the mental health of the patients in the long run.

What of the Nearly Logarithmic Increase in Incidence of Gender Incongruence?

Data collection in this regard is subject to estimates based on surveys, which can easily alter the numbers upward or downward, depending on who designed the survey and to whom it was presented. Fear, self-loathing or suicide will necessarily lower the numbers of survey participants whose lives are made miserable by the choice to affirm an incongruent gender. Instant gratification, payback to strict parents, and current celebrity will draw survey participants to express euphoric satisfaction with their decision to affirm their incongruent gender, especially when the surveys are circulated by trans-activist organizations, such as the Trevor Project. What had been in 2010 a nearly invisible fraction of adults who admitted to living with an incongruent gender has exponentially increased in frequency to as many as one out of five students in a suburban Pittsburgh school district in 2021. After I completed my fellowship at Johns Hopkins in 1980, it was not until 1993 that a biologic male presented to my private practice office with a desire to be treated with estrogen to feminize his body so that he could appear to be a female and identify as such. There was nothing in published medical literature that I could find to guide my treatment options. I canvassed my broad contact pediatric endocrinology network across the United States, and nobody had heard of such a clinical case, and none had any suggestions about what I should do. In the ensuing 19 years, the number of transgender treatment centers have burgeoned from zero to several hundred between university-based centers and Planned Parenthood. Minority stress theory is frequently used to cover this explosion in numbers, but that is utterly impossible. What does

explain this increase is online recruiting and grooming of vulnerable children and adolescents by a generously funded political movement aimed at dissolving the reality and birthright of biologic sex. This will not end well. By the time a plethora of legal action against those who promoted and engineered the social, medical, and surgical affirmation of incongruent gender knocks down this house of cards, millions of children and adolescents will have been medically, surgically, and mentally maimed as well sterilized.

Endnotes

- ¹ Lee PA et al, Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care, 2016 *Horm Res Paediatr*.
- ² Lee PA et al, Consensus Statement on Management of Intersex Disorders, *Pediatrics* 2006; 118 e488-e500.
- ³ Seaborg E, About Face, *Endocrine News* 2014 (May) 16-19.
- ⁴ American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed; 2013:451-459.
- ⁵ Jeffreys, S. *Gender Hurts: A feminist analysis of the politics of transgenderism*. Routledge. 2014 (p. 27).
- ⁶ Annas GJ and Grodin MA, Reflections on the 70th Anniversary of the Nuremberg Doctor's Trial, *AM J Pub Health* 2018;108:10-12
- ⁷ <https://www.baltimoresun.com/news/bs-xpm-2000-02-10-0002100278-story.html>
- ⁸ Whitehead, N. *My Genes Made Me Do It*. Chapter 5.
- ⁹ Meyer J.K. and Reter D. Sex Reassignment Follow-up. *Arch. Gen. Psychiatry* 36:1010-1015, 1979.
- ¹⁰ Rametti G, Carrillo B, Gomez-Gil E, et al. White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study. *J Psychiatr Res* 2011; 45:199-204.
- ¹¹ Kranz GS, Hahn A, Kaufmann U, et al. White matter microstructure in transsexuals and controls.
- ¹² Maguire EA et al, Navigation-related structural change in the hippocampi of taxi drivers, *PNAS* 2000; 97:4398- 4403.
- ¹³ Gu J, Kanai R. What contributes to individual differences in brain structure? *Front Hum Neurosci* 2014; 8:262.
- ¹⁴ Sale A, Berardi N, Maffei L, Environment and Brain Plasticity: Towards an Endogenous Pharmacotherapy, *Physiol Rev* 2014; 94: 189 –234.
- ¹⁵ Reyes FI, Winter JS, Faiman C. Studies on human sexual development fetal gonadal and adrenal sex steroids. *J Clin Endocrinol Metab* 1973; 37(1):74-78.
- ¹⁶ Lombardo M. Fetal testosterone influences sexually dimorphic gray matter in the human brain. *J Neurosci* 2012; 32:674-680.
- ¹⁷ Campano A. [ed]. Geneva Foundation for Medical Education and Research. *Human Sexual Differentiation*; 2016. Available at ww.gfmer.ch/Books/Reproductive_health/Human_sexual_differentiation.html. Accessed May 11, 2016.

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- ¹⁸ Lee PA et al, Consensus Statement on Management of Intersex Disorders, *Pediatrics* 2006; 118 e488-e500.
- ¹⁹ Shenk, D. *The Genius in All of Us: Why everything you've been told about genetics, talent, and IQ is wrong.* (2010) New York, NY: Doubleday; p. 18.
- ²⁰ Diamond, M. "Transsexuality Among Twins: identity concordance, transition, rearing, and orientation." *International Journal of Transgenderism*, 14(1), 24-38.
- ²¹ Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. *Child and Adolescent psychiatry*, 4th ed, Malden Mass: Blackwell, 2006: 737-753.
- ²² Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J AM Academy Child Adolescent Psychiatry* 2008; 47:1413-1423.
- ²³ Schechner T. Gender Identity Disorder: A Literature Review from a Developmental Perspective. *Isr J Psychiatry Related Sci* 2010; 47:42-48.
- ²⁴ Dhejne C, et al. Long-term Follow-up of transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden *PLoS One* February 2011 Vol 6 Issue 2, e16885.
- ²⁵ Carel JC, Eugster EA, Rogol A, et al. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009 Apr. 123(4):e752-62.
- ²⁶ Erikson EH (1993). *Childhood and society*. WW Norton & Company.
- ²⁷ Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. *Child and Adolescent psychiatry*, 4th ed, Malden Mass: Blackwell, 2006: 737-753.
- ²⁸ *J Clin Endo Metab* 2008; 93:190-195.
- ²⁹ Hembree WC et al, Endocrine Treatment of Transsexual Persons: and Endocrine Society Clinical Practice Guideline, *J Clin Endo Metab* 2009; 94:3132-3154.
- ³⁰ Coleman E, Bockting W, Botzer M et al, Standards of Care for the Health of Transsexual, Transgender, and Gender-Non-conforming People, version 7, *International Journal of Transgenderism* 2012;13(4): 165-232
- ³¹ Wylie W et al, "Endocrine Treatment of Gender-dysphoric/Gender-incongruent Persons: An Endocrine Society Clinical Practice Guideline, *JCEM* 2017; 102:3869-3903
- ³² Rafferty J, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, *Pediatrics*, 2018;142:e20182162
- ³³ Lopez X et al, Pediatric Endocrine Society Transgender Health Special Interest Group statement on gender-affirmative approach to care the Pediatric Endocrine Society, 2017 *Curr Opin Pediatr*;29:475-480.
- ³⁴ Zucker K. J. (2019), Debate: Different strokes for different folks. *Child Adolesc Ment Health*. doi:[10.1111/camh.12330](https://doi.org/10.1111/camh.12330)
- ³⁵ Olson KR et al, Mental Health of Transgender Children Who are Supported in Their Identities, *Pediatrics* 2016;137 e20153223

³⁶ Bränström R and Pachankis JE Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study, *Am J Psychiatry* 2020; 177:727-734

³⁷ Bränström R and Pachankis JE. Toward Rigorous Methodologies for Strengthening Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals' Mental Health: Response to Letters. *American Journal of Psychiatry* 2020 177:8, 769-772 doi: 10.1176/appi.ajp.2020.20050599.

ATTACHMENT F

Florida Medicaid Project: Surgical Procedures and Gender Dysphoria

Patrick Lappert, M.D.

May 17, 2022

Florida Medicaid Project: Surgical Procedures and Gender Dysphoria

Patrick Lappert, M.D.

Overview

The “Gender Affirmation” care model for children who suffer from gender identity issues is experimental in nature because it is based in low to very low-quality scientific evidence. There is no body of quality scientific evidence to support the hypothesis that gender dysphoria with its associated problems of self-harm and suicide, is improved long-term by gender affirmation surgical procedures.

The best evidence available today demonstrates that transgender is not a single condition that can be explained by any single factor. There are vast differences in age of presentation, predominant sex, persistence into adulthood, and resolution during adolescent development. Moreover, there are numerous and common co-morbid conditions such as autism-spectrum disorder, major anxiety disorders, and clinical depression that severely affect any sense of certainty about the true cause of the child’s dysphoria, as well as their capacity to understand and give assent to irreversible medical and surgical procedures that lead to permanent sterility, sexual impotence, and a lifetime of medical problems associated with affirmation care.

The process of obtaining medical informed consent as part of gender affirming surgery is morally indefensible, and likely legally indefensible as well. Parents of suffering children are led by medical professionals to believe that there is only one valid option of care (affirmation medicine and surgery), utterly concealing the historic reality that greater than 92% of children desist in their cross-sex self-identification when treated using the “watchful waiting” therapeutic strategy. Parents are told that if they do not consent to affirmation care, there is a high likelihood that their child will die from suicide. This is not informed consent, but rather consent under duress.

Gender identity is being presented as a fixed and unchanging, biologically determined, personal characteristic. It is not. The medical literature has consistently shown over many years that the vast majority of children with cross-sex gender identity resolve the issue during adolescence and adopt a gender identity that is congruent with their biological sex.

Because surgeons who perform gender affirmation surgeries have no diagnostic test to predict who among the self-identified transgender minors would have persisted in their cross-sex self-identification into adulthood, and who among those children would have desisted, they have no way to know, in any particular case if the irreversible surgery is being performed on a person who would have continued to self-identify in the cross-sex persona into adulthood. Given the historically well-known desistance rate, it is possible that as many as 90% of children are undergoing surgery based upon an incorrect diagnosis.

“Gender Affirming” breast surgery for self-identifying transgender minors is not medically and ethically equivalent to similar procedures performed for objectively identifiable medical conditions. Transgender breast surgery is always cosmetic (aesthetic) in nature because the indication is a hoped-for improvement in the interior emotional life of the patient. Transgender surgery is not based in any medical diagnosis and does not seek to restore any form or function that may have been lost due to trauma, disease, or developmental accident. It begins with normal structures and changes their appearance in order to achieve a subjective improvement and is therefore cosmetic surgery.

Because gender affirming surgery is cosmetic (aesthetic) in nature, such surgeries must never be offered if they are known to predictably produce an irreversible loss of function. To knowingly sacrifice a human capacity (breast feeding, capacity for sexual intimacy, fertility) in the pursuit of a cosmetic result in a minor who is incapable of giving informed consent, is morally indefensible. The hoped-for subjective improvement that is sought in transgender surgery is a short-lived improvement and is only supported by low to very low-quality scientific evidence. Long term longitudinal cohort studies that are based in level III evidence show that affirmation surgical care is of no benefit in reducing self-harm including suicide.

Problems with Informed Consent

The protection of children in situations requiring informed consent is a crucial problem that the state has a historic and abiding interest in. In the particular situation of self-identified transgender children, it becomes a most significant problem, given that they are being submitted for permanently life-altering interventions. In my opinion as a plastic and reconstructive surgeon, the life-altering nature of hormonal and surgical interventions needs to be addressed from the moment of the child’s entry into the gender-transition system, given the fact that the overwhelming majority of children who first begin puberty blockade, go onto the physically altering and permanent changes produced by cross sex hormones, and many ultimately also pursue surgery, as is attested to by multiple papers, the content of which is examined below. Informed consent has several requirements that need to be met if such consent is to be deemed valid. These requirements include a thorough discussion of the details of the proposed procedure including risks, known complications, and some measure of the likelihood of a favorable outcome. The discussion must include alternative treatments, and their risks, known complications and their likelihood of a favorable outcome. In the case of the interventions associated with gender-transition medicine and surgery, the favorable outcomes should be evident over the lifetime of the patient, given that they are permanently sacrificing structures and capacities (breasts and breast-feeding, or genitals and fertility).

Because the commonly cited medical literature used in support of these surgeries is of low to very low quality, it must be recognized that such surgeries must be considered experimental in nature given the unknown long-term effects of treatment, and the vast uncertainty in the patient selection and diagnostic processes. Yet the experts who provide opinion in support of these surgeries speak with absolute certainty of their efficacy, and the absence of any alternative treatment. Considering these factors severally and together it becomes difficult to imagine a

more flawed consent process. It also becomes understandable how parents can be drawn into uninformed participation given the simultaneous presentation of dire consequences if gender dysphoria is left untreated, and the insistence that affirmation care including surgery is the only way to bring lasting happiness to the child.

Chest Masculinization” in Natal Females is Not Ethically Equivalent to Mastectomies for Breast Cancer

When mastectomy is performed for the management of breast cancer, or to mitigate the proven risk of developing breast cancer in women, it is done on the basis of objective diagnoses either by pathological examination of biopsy tissue, or as in the case of prophylactic mastectomy, on the basis of genetic analysis that shows known markers of increased risk of developing breast cancer. These tests (microscopic examination of tissue specimens, detection of cell surface markers with proven association with malignancy, and genetic screening of at-risk patients) have known positive predictive value for the diagnosis of breast cancer, and these tests have known error rates that can be used when obtaining informed consent for mastectomy. The validity of these tests has been proven using scientific methodologies that produce high quality evidence in longitudinal population studies with control populations, and very long follow up. As the result, when a woman gives consent for mastectomy to control or prevent the potentially lethal disease, it is with a clear and proven evaluation of the risks and benefits that consent is obtained. Mastectomy is being performed based upon an objective diagnosis of a potentially lethal condition, and the surgical procedure has proven benefit in management of that condition.

In stark contrast, this is not the case when mastectomy is performed to “masculinize” the chest of girls and women who self-identify as transgender or who self-report symptoms of dysphoria. In the self-identified transgender adolescent, breasts are being removed on the basis of a diagnosis that is made by the patient since there are no tests with known error rates that can be used to predict who will benefit from this disfiguring and irreversible surgery. The claim is made that chest masculinization has proven benefit in reducing dysphoria and the associated risk of suicide. But published studies that make this claim of benefit offer evidence that is low to very low quality, typically small case collections with self-selection bias, very short follow up, and no case controls.

The best data presently available on the long-term effects of medical and surgical transitioning are long-term, longitudinal, population-based studies. For example, Dehjne, et al., examined the putative long-term benefit of full transitioning (including hormonal and surgical treatments) found in the Swedish medical database. (See Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden; Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Långström, Mikael Landén; PLOSOne February 22, 2011 <https://doi.org/10.1371/journal.pone.0016885>). That database includes all persons in the Swedish medical system, from pre-natal to death. It reports all episodes of care and all demographic information in a uniform vocabulary. Furthermore, Sweden has been on the forefront of “gender affirmation” long before the American medical

system seriously considered its claims. Because of the nature of Sweden's database, it is possible to study a cohort of patients that very closely matches the inquiry group with regards to age, sex, economic status, etc. It is possible to ask with great precision such questions as, "What is the likelihood that a fully transitioned transgender male will be hospitalized for psychiatric illness when compared to the age/sex matched control group?" Even more, one could urgently ask, "What is the relative risk of suicide in transgender persons, when compared to age/sex matched controls?"

Why are such longitudinal, population-based studies superior to the case-collection/case series methodology? Because confounding variables such as age, sex, and self-selection biases are removed. In the flawed case-collection methodology, the reported cases are typically only those who return for follow up. You have no way of knowing if the patient had a good outcome or didn't return for follow up because they were in a psychiatric hospital, were incarcerated, or committed suicide. In the Swedish longitudinal study, the suicide is in the same database, as are the other issues of hospitalization, incarceration, and addiction treatment, among other rates of comorbidity. Thus the longitudinal population study can give us what is called a "hazard ratio" for a particular study population (patients who have completed transgender transition in this case).

What this Swedish study shows us that the risk of completed suicide in all transgender persons is 19.1 times higher than in the control cohort. If you look only at patients who have transitioned — patients after "treatment" — from female to "male presentation," the risk of completed suicide is 40 times higher than in the general population. (Note: this finding is consistent with the historic Bränström 10-year follow up study, which found no benefits to "transitioning treatments" but did note an increased risk of serious suicide attempts and anxiety disorders AFTER "treatment.") (Correction to Bränström and Pachankis, *Am J Psychiatry* 177:8, August 2020; see detailed citations in the "Notes" section of this report below).

Another cautionary note was added to the literature by the reputed Cochrane Review, a UK based international association of researchers who examine the quality of scientific evidence used in medical decision making. The Cochrane Review recently published findings concerning the medical evidence used to support the decision to give young women cross sex hormones as part of the transition process. The authors summarize the world literature review thus: "We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition. This lack of studies shows a gap between current clinical practice and clinical research." (Does hormone therapy help transgender women undergoing gender reassignment to transition? See, Haupt C, Henke M, Kutschmar A, Hauser B, Baldinger S, Saenz SR, Schreiber G., *Cochrane Review*, 28 Nov 2020).

Similar issues of very poor, low quality scientific support for chest masculinization surgery can be seen in a recent article by Tolstrup et al. published in the journal *Aesthetic Plastic Surgery* (See Anders Tolstrup, Dennis Zetner, Jacob Rosenberg, Outcome Measures in Gender-Confirming Chest Surgery: A Systematic Scoping Review, *Aesthetic Plast Surg* 2020 Feb;44(1):219-228. doi: 10.1007/s00266-019-01523-1. Epub 2019 Oct 29). The article reports a

comprehensive review of the world literature concerning the efficacy of “gender confirming” chest surgery in transgender patients. The authors found 849 articles on the subject, published in peer reviewed medical journals. Of these 849 articles, only 47 could be included in the review. This means that only 5.5% of all the published, peer-reviewed transgender surgery articles demonstrated even rudimentary scientific rigor. Of those 47 articles, the authors report that only 29 of the articles addressed mental health outcomes (3.4% of all the articles). What is startling is that the mental health outcomes were judged only on the basis of uncorroborated, untested, and unassessed patient subjective reporting with descriptors that varied so widely from article to article that results could not even be compared. The authors summarize by saying, “Evaluation of outcomes in gender-confirming chest surgery showed large variations in reporting, and further streamlining of reporting is therefore required to be able to compare surgical outcomes between studies.” None of these negligent articles even bothered to examine rates of psychiatric hospitalization, substance abuse, self-harm behaviors, and suicide. This tells us that the main reason for performing these surgeries (psychological distress and suicide risk) isn’t even evaluated with regard to efficacy.

An example of an article with very low-quality data, reckless (now banned practices), and methodology, published in a “leading journal,” and promoted as evidence for the efficacy of “chest masculinization” surgery makes this fact very clear. The lead author (Olson-Kennedy, a leading national advocate for the transgender treatment enterprise) is a board-certified pediatrician who leads the gender clinic for the Los Angeles Children’s Hospital. The article appeared in 2018 (See J. Olson-Kennedy, J. Warus, MD1, et al., Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults; Comparisons of Nonsurgical and Postsurgical Cohorts., *JAMA Pediatr.* 2018;172(5):431-436. doi:10.1001/jamapediatrics.2017.5440. In their summary of findings, the authors reported that “chest dysphoria” is common among “trans males” (natal females seeking to present as males) and claimed that dysphoria is “decreased by surgery.” They claim that regret for surgery is “rare.” The article reports breast removal surgery on at least one girl aged 13 years. (Note that this reckless, experimental practice has now apparently been abandoned as unethical/experimentation on children by England, Sweden, and Finland. The average age of patients in the study was 19. Children were entered into the study through recruitment from among patients visiting the clinic and by telephone over a six-month period. The authors found that, of the patients recruited from among visitors to the clinic (convenience sampling), there was an over-representation of non-operated patients, so the authors were forced to reach out to all the post-surgical patients by phone. Twenty-six percent of the clinic’s post-surgical patients could not be reached for various reasons including no working phone, or failure to respond to multiple messages. The 26% drop-out rate is never even questioned by these authors. Were surgical patients lost to follow up because of dissatisfaction, psychiatric hospitalization, or suicide? This problem is called “self-selection bias,” and it is evidence of careless study design. Of the remaining 74% of patients, only 72% completed the survey. This is a second example of self-selection bias. Why would some post-surgical patients who had been successfully contacted, not complete the survey? The authors — demonstrating multiple levels of confirmation bias — do not even ask such essential questions. (See detailed citations in the “Notes” section of this report below).

In the study, dysphoria was evaluated using what the author called “a novel measure,” which amounted to a series of subjective questions about happiness that was in part designed by the adolescent test subjects themselves. Essentially, the methodology used an entirely unvalidated (“junk science”) test instrument, with no known error rates and no proven predictive power. Furthermore, the post-surgical patients were administered the survey at widely varying time intervals post-surgery. The longest interval between surgery and the satisfaction survey was 5 years, but children less than a year post-surgery were included in this obviously flawed sample, and yet the authors claim evidence of “negligible regret.” This is a remarkable, misleading, and deceptive claim given that long-term, longitudinal population studies show that there is a dramatic rise in post-surgical problems such as depression, hospitalization, substance abuse, and suicide beginning at around seven years post-surgery (Ibid). Surely the authors are familiar with the world literature on transgender outcomes?

Having deceptively or negligently promised in the introduction to their paper that “chest dysphoria” is reduced by surgery, at the conclusion the authors confessed to the fact that the study design and execution produced very low-quality data that is not useful for patient selection, or prediction of outcomes. They even confessed that the study does not address the efficacy of surgery in improving outcomes regarding the single most compelling reason for performing the operation: mitigation of depression and suicide. The authors write, “An additional limitation of the study was the small sample size. The nonsurgical cohort was a convenience sample, recruited from those with appointments during the data collection period. There could be unknown imbalances between the nonsurgical and postsurgical cohorts that could have confounded the study findings.”

Finally, the authors did not even bother to validate their “Chest Dysphoria Scale.” Such a “made-up” scale is unlikely to accurately represent distress or correlate with properly validated measures of quality of life, depression, anxiety, or functioning. Their own analysis at the conclusion of the paper directly contradicts the deceptive claim made in their introduction.

This is the kind of “junk science” that is used to support transgender medicine and surgery. The paper is only a few years old. It was written by board certified physicians who practice in one of the nation’s largest pediatric gender clinics and was published in a peer-reviewed medical journal. It is essentially useless in making any clinical decisions regarding who should be offered surgery, what is the likelihood they will benefit from it, and what is the likelihood they will regret their decision. Most importantly, it does not even measure the effect of therapy on suicide risk. The very morbidity (the risk of suicide) that they claim is improved by surgery is not even measured in their low-quality study.

Because of the very low-quality scientific support for mastectomy in the management of gender dysphoria, valid consent would demand that these procedures be described as experimental, would need the approval of ethics panels to monitor human experimentation, and would require the use of valid controls found in long-term, longitudinal population-based study models. These are the kinds of patient protections now endorsed in England, Sweden and Finland but still

ignored in the US environment where proper scientific critiques of such studies can get faculty “cancelled.”

Even though the transgender treatment industry has been performing these surgeries for over 50 years, gender treatment centers continue to publish the same low quality, methodologically defective studies based upon collected cases that are degraded in value by self-selection bias, confirmation bias, and short-term follow-up, while continuing to deceptively claim that such defective research provides a sufficient scientific basis for performing irreversible, disfiguring, and ultimately sterilizing hormonal treatments and surgeries on children.

“Chest Masculinization” in Natal Females is Not Ethically Equivalent to Gynecomastectomy

Gynecomastectomy is the surgical treatment of gynecomastia, a fairly common condition in which males develop female-type breast gland tissue. Proponents of “masculinization” mastectomy in natal females erroneously equate the ethics of removing healthy breast tissue from gender dysphoric children with the removal of abnormal breast tissue in men (gynecomastia). In the case of gynecomastectomy in male patients, the operation is performed to remove the objectively diagnosed presence of female type glandular breast tissue present in a male patient. Physical examination demonstrates the presence of a dense retro-areolar mass which is tender and sometimes disfiguring. Pathological examination of the removed tissue will demonstrate the presence of female-type fibroglandular tissue in a male patient. This is an objectively abnormal condition. It should further be noted that the absence of such abnormal, female-type fibroglandular tissue in the submitted surgical specimen places the chest recontouring in the category of cosmetic surgery and is therefore not typically paid for by third-party payors.

A comprehensive literature review on the subject of gynecomastectomy and suicidal behavior conducted by Sollie in 2018 (Management of gynecomastia—changes in psychological aspects after surgery—a systematic review: *Gland Surg.* 2018 Aug; 7(Suppl 1): S70–76.doi: 10.21037/gs.2018.03.09) did not produce a single paper claiming improvement in suicide rate in patients who underwent this surgery. There were many reports concerning improvement in the pain that men with this objective condition suffer with. The remainder of the reported data was in the category of subjective “satisfaction survey”. This tells us that the author did not distinguish between medically indicated and aesthetic surgeries. Nonetheless, no claim is made of decreased suicide rates in a suicidal population of male patients. This is because any male patient seeking removal of abnormal, female-type, breast tissue who reported suicidal ideation would be considered incompetent to give consent and would require a psychiatric evaluation and treatment to manage suicidal thinking before being considered for surgery. This kind of decision in favor of psychiatric support does not appear to be at work in the transgender affirmation world. There, and there alone, is suicidal thinking considered a qualification for a surgery.

“Chest Masculinization” in Natal Females is Not Ethically Equivalent to Breast Reduction

It should be obvious that “Chest Masculinization” surgery in natal females is not ethically equivalent to breast reduction surgery in non-transgender females. In the case of breast reduction for females with excessively large breasts (macromastia, or gigantomastia), the operation is performed to relieve a debilitating orthopedic complaint of neck, back, and shoulder pain associated with the postural/mechanical effects of the weight of the breasts. These patients experience significant activity restriction and chronic pain that is not relieved by medical management or physical therapy. Furthermore, there is voluminous actuarial data, based upon many years of longitudinal population-based study by medical insurance agencies that is used to predict who will benefit from surgery, and who will not. These physical, objective tests, based upon the actual measurement of the breasts, and the patient’s overall body habitus, have known error rates that can be used to predict the likelihood that a breast reduction will relieve the orthopedic complaints of neck, back, and shoulder pain. When the tissue specimens are submitted to pathology, they are weighed in order to ensure that enough tissue has been removed so that there will be a very high likelihood that the surgery will relieve the orthopedic condition of neck, back, and shoulder pain (Accuracy of Predicted Resection Weights in Breast Reduction Surgery, Theodore A. Kung, MD, Raouf Ahmed, MBBS1 Christine O. Kang, MPH,1 Paul S. Cederna, MD, and Jeffrey H. Kozlow, MD; *Plast Reconstr Surg Glob Open*. 2018 Jun; 6(6): e1830.

Based upon that, adequate pre-operative consent can be obtained. The supporting data is based in very high-quality methodology. There is no quality research data, no pre-operative test or study, and no known error rates that can be used to predict the likelihood that any child suffering from gender dysphoria will benefit from the experimental procedures of mastectomy and chest “masculinization.” As noted above, because of the very low quality data, transgender chest masculinization is at best experimental and at worst, should be viewed as a form of medical child abuse — it is important to note that Finland, Sweden, and the UK apparently now all agree with this analysis, as they have all retreated from such reckless surgical procedures for (See detailed citations in the “Notes” section of this report below).

It is crucial to remember that “chest masculinization-affirmation surgery” of healthy breast tissue results in a complete loss of function, that this loss is two-fold (breast feeding and erotic sensibility), and the cause of the loss is two-fold (gland removal and severing of the intercostal nerve). (See Breast Reduction with Use of the Free Nipple Graft Technique; Stephen R. Colen, MD; *Aesthetic Surgery Journal*, (Breast Reduction with Use of the Free Nipple Graft Technique; Stephen R. Colen, MD; *Aesthetic Surgery Journal*, Volume 21, Issue 3, May 2001, Pages 261–271, <https://doi.org/10.1067/maj.2001.116439>).

If a patient who undergoes “chest masculinization” should regret the surgery, they do have the option of breast reconstruction. However, all that will be produced is a counterfeit of a breast. The patient will have lost the function of breast feeding. Additionally, the most commonly performed “masculinization” surgery involves the removal of the nipples, and subsequent re-

attachment in the form of a nipple graft. Those nipples will have lost their native nerve connections that provoke erotic sensibility. All that can be hoped for is the eventual random ingrowth of local skin sensation, but there will never be erotic sensation because the particular branch of the fourth intercostal nerve which communicates with particular centers in the brain responsible for oxytocin release and erotic provocation will have been permanently severed. This means that breast function has been completely and irreversibly sacrificed for the sake of producing a cosmetic result (a masculine appearing chest). This is the exact opposite of the goals of any reconstructive surgery. It must therefore be understood that “chest masculinization” is a cosmetic procedure that has violated the most essential principle of cosmetic surgery: never sacrifice function for the sake of a cosmetic result.

Erroneous use of the word “Reconstructive” to describe Gender Affirmation Surgeries

The transgender treatment enterprise uses the word “reconstructive” to characterize a group of surgical treatments that seek to alter the sexed appearance of the person. It is important to understand that these procedures, because of the indications for surgery, the motivations for surgery, and the outcomes of surgery, are not reconstructive, but are to be properly understood to be cosmetic in nature.

Reconstructive surgeries are procedures that seek to establish or restore structures and their functioning that have been lost due to trauma, disease, in-utero developmental abnormalities, or surgical treatment for disease. Such reconstructive surgeries must begin with the objective characterization of the defect, including abnormalities of form, and associated loss of function. This process of defining the defect begins with a thorough understanding of normal human form and function and seeks to select, develop, and execute procedures that will restore both. In some cases function may be emphasized more than form, as when the mangled hand of a man is reconstructed. In other cases, reconstruction of form is all that is possible because as yet there are no techniques to restore function. An example of this is seen in the reconstruction of a woman’s breast following cancer care. All that can be offered is the appearance of a breast; she will never be able to feed an infant through the reconstructed part.

This is to be contrasted with cosmetic, or aesthetic surgery in which the appearance of a structure is modified in order to produce a subjective (aesthetic) result for the patient. No functional restoration is addressed because no functional or structural loss exists. The object of the surgery is aesthetic. There is no lost form or function that needs to be reconstructed. It is aesthetic surgery because the motivation is aesthetic (subjective feelings about appearance). Further evidence for this is the fact that nearly the entirety of the outcome studies cited in support of these surgeries use subjective questionnaires which the patient fills out. The questions used are typical of those used to evaluate any aesthetic surgery. They are called “satisfaction surveys”. Such surveys are prone to suffer from self-selection bias, confirmation bias, and high drop-out rates.

One of the key problems that the transgender treatment enterprise faces on a daily basis is the issue of third-party payment for services. No health insurance provider, including federal and state agencies will pay for cosmetic surgery. For this reason, it is necessary, in order for the business model to succeed, that providers characterize their services as reconstructive. This is doubly difficult given the intense political pressure that has been exerted upon the medical community to “de-pathologize” the condition of transgender. This is seen in the abandoning of the diagnostic nomenclature of “body dysmorphic disorder”, and “gender identity disorder” in favor of the more recent DSM manual using the term “gender dysphoria”. This leads transgender treatment providers into the difficult situation of claiming that transgender is not a pathology, while at the same time insisting that the services are medically necessary and describing the procedures as reconstructive without characterizing any physical/ functional defect.

As we consider the specific “gender affirming” surgical procedures we will see that comparison to medically indicated surgeries on both men and women actually serves to reinforce the evidence that these surgeries are essentially and fundamentally cosmetic.

Masculinizing and Feminizing Chest Surgeries are Not “Medically Necessary”

Supporters of “transitioning” treatments justify surgical treatment based upon “medical necessity.” They claim that gender dysphoria can lead to debilitating anxiety and depression, as well as serious incidents of self-harm, including self-mutilation, suicide attempts, and suicide. Yet with only a single exception, in the studies they cite no measures are made of the effects of surgery on what is claimed to constitute the “medical necessity” for these procedures. In contrast, the Branstrom study¹ documented no reliable benefits for transgender surgery/hormonal treatments and no reduction in suicide and even an increase in serious suicide attempts requiring hospitalization in patients receiving surgery. These recent, long-term, published, peer reviewed, credible research findings are quite contrary to the claims of supporters of “transitioning treatments” — as are the National Science Reviews in this area from England-NICE, Sweden, and Finland. (See detailed citations in the Notes section in this declaration).

Scientific rigor would demand an examination of objective outcomes such as: rates of substance abuse, psychiatric hospitalization, self-harm, or suicide, and how they were changed by surgery. One paper does ask these crucial questions concerning efficacy in a very comprehensive, long term, longitudinal population cohort study which actually shows the opposite of what experts claim for these patient outcomes. When followed beyond eight years post operatively, this paper shows that patients receiving these treatments have the same alarmingly high rates of hospitalization, substance abuse, self-harm, and completed suicide as persons who have had no medical or surgical intervention.

¹*Correction of a key study: No evidence of “gender-affirming” surgeries improving mental health.* Home. (2020, August 30). Retrieved May 17, 2022, from https://segm.org/ajp_correction_2020

In summary, on the issue of the efficacy of these surgeries, the scientific support is very weak, while the scientific evidence rejecting the hypothesis of efficacy is remarkably strong (See Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden; Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Långström, Mikael Landén; PLOS One February 22, 2011 <https://doi.org/10.1371/journal.pone.0016885>).

The surgical removal of the breasts, and the re-contouring of the chest through liposuction is a common procedure for women who seek to present as men. These operations are performed in both men and women, for a variety of reasons. They are generally very safe, and typically performed in the outpatient setting. It is important to understand that the only way of distinguishing cosmetic breast surgery from “medically necessary” surgery is based upon the diagnosis of underlying pathology. For example, breast reduction may be cosmetic, or it may be medically indicated. In both cases, the patient presents with a complaint that her breasts are too big. The distinction between cosmetic breast reduction and medically indicated breast reduction is based upon the presenting symptoms of orthopedic problems when working, such as chronic neck back and shoulder pain caused by the weight of the breasts. But even then, the weight of the removed tissue is factored into the objective verification that the surgery was “medically necessary.” There is a vast body of medical and actuarial data that demonstrates the relationship between the weight of the breast tissue removed and the probability that back pain will be cured by performing a breast reduction.

The same issues are at stake in breast enhancement for men seeking to present as women. Cross-sex hormones will have caused varying degrees of gynecomastia (breast enlargement in men). Surgical enhancement procedures are exactly the same in both men and women.

Medically necessary surgery in women is based upon the diagnosis of an objective medical condition, such as Poland’s syndrome (congenital absence of a breast), surgical absence of the breast following cancer care. In men, the objective diagnosis of gynecomastia might warrant surgery based upon medical necessity, but it would be the removal of tissue that has objective pathological features (breast gland proliferation in a man). A rare diagnosis of breast cancer in a man might warrant chest wall reconstruction after cancer care. On the other hand, cosmetic surgery of the breast is entirely about the subjective feelings of the patient, and that is all that we find in the case of the self-identified transgender patient.

In the case of transgender chest surgery, the diagnosis is based on the patient’s subjective report of dysphoria, but the medical necessity is based on the expectation that surgery will relieve the patient of the risk of, among other things, major depression, self-harm behaviors, and suicide. None among the many papers typically cited by supporters of “transitioning treatments” address themselves to the question of medical necessity for either masculinizing surgery, or feminizing surgery. They only address technical issues, management of complications, and subjective outcomes that employ precisely the same language that is used to assess every

other cosmetic surgery of the breast. Such papers often begin with standard language about the suffering of self-identified transgender adolescents, and their risk of self-harm. They will claim that the reported surgeries somehow reduce the risk of suicide, or the frequency or severity of self-harm, but they never report actual results of improvement in the risk of suicide, or substance abuse, or cutting, or sexual risk taking. The claim of benefit is unsupported in the scientific literature.

In summary, the medical necessity of transgender chest surgery is not supported by scientific evidence and appears to be firmly in the category of cosmetic surgery. What is more, the surgeries when performed on natal females causes a life-long loss of function, placing those surgeries in the category of malpractice. No other cosmetic procedure is expected to produce major functional loss. Such a result would only be the result of a complication, or other surgical misadventure. To actually have a 100% certainty of loss when surgical consent is being obtained constitutes a complete neglect of one of the foundational principles in plastic surgery: Never sacrifice function for the sake of a cosmetic result.

About the Author

Education and Training: I received my Bachelor of Arts in Biological Sciences at the University of California, Santa Barbara, 1979. There I was engaged in research in cell membrane physiology with Dr. Philip C. Laris, studying stoichiometry of the sodium: potassium ATPase pump. I received my M.D., Doctor of Medicine degree at the Uniformed Services University of the Health Sciences, 1983 at Bethesda, Md. I served my General Surgery Residency at the Naval Hospital Oakland/UC Davis East Bay Consortium, 1987-1991 and served as Chief Resident, Department of Surgery, Naval Hospital Oakland, 1990-1991. I also served a Plastic Surgery Residency at the University of Tennessee-Memphis, 1992-1994. My professional background, experience, and publications are described in more detail in my curriculum vitae, which is attached as Exhibit A to this declaration.

Board Certifications in Medicine: I have been Board Certified in Surgery (American Board of Surgery, 1992), in Plastic Surgery (American Board of Plastic Surgery, 1997; American Board of Plastic Surgery, 2008).

Medical Staff Appointments: I served as the Staff General Surgeon at the Naval Hospital Oakland, CA 1991-1992 and as Associate Professor of Surgery, UC Davis-East Bay, 1991-1992. I also served as a Plastic and Reconstructive Surgeon, Naval Medical Center, Portsmouth, Virginia, 1994-2002 and as Chairman, Department of Plastic and Reconstructive Surgery, Naval Hospital Portsmouth, Virginia, 1996-2002. I later served as Clinical Assistant Professor, Department of Surgery, Uniformed Services University of the Health Sciences, 1995-2002 and as Founding Director, Pediatric Cleft Palate and Craniofacial Deformities Clinic, Naval Hospital Portsmouth, Virginia, 1996-2002 also as the Founding Director, Wound Care Center, Naval Hospital Portsmouth, Virginia, 1995-2002. I have also served as a Staff Plastic Surgeon in Nebraska and Alabama.

U.S. Surgeon General Service: I served as a Specialty Leader, Plastic and Reconstructive Surgery, Office of the Surgeon General-USN, 1997-2002.

Faculty Appointments: I served as Teaching Faculty at Eastern Virginia Medical School, Division of Plastic Surgery, 1995-2002. I also served on the teaching faculty of the Via College of Osteopathic Medicine, 2017-2020.

Military Service: I served as an Aviation Officer Candidate, Naval Aviation Schools Command, NAS Pensacola, 1978 and was Commissioned an Ensign, MC, USNR 1979 and Commissioned as a Lieutenant, MC, USN 1983. I served as a Designated Naval Flight Surgeon, Naval Aerospace Medical Institute, 1985, and I was Assigned Marine Fighter/Attack Squadron-451, serving as Flight Surgeon, and serving as Radar Intercept Officer in the Marine F4S Phantom, accumulating 235 flight hours, and trained for qualification as an Air Combat Tactics Instructor. I was deployed to the Western Pacific as UDP forward deployed fighter squadron in Korea, Japan, and the Philippines. I served in the US Navy for 24 years, and I served in the USMC for 3 years. I retired with the rank of Captain, USN in 2002.

Publications - Peer Reviewed Medical Journals: Lappert PW. Peritoneal Fluid in Human Acute Pancreatitis. Surgery. 1987 Sep; 102(3):553-4; Toth B, Lappert P. Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning. J Plastic and Reconstructive Surgery. 1991; 87 (6): 1048-53; Lappert P. Patch Esophagoplasty. J Plastic and Reconstructive Surgery. 1993; 91 (5): 967-8; Smoot E C III, Bowen D G, Lappert P, Ruiz J A. Delayed development of an ectopic frontal sinus mucocele after pediatric cranial trauma. J Craniofacial Surg. 1995;6(4):327-331; Lappert PW. Scarless Fetal Skin Repair: "Unborn Patients" and "Fetal Material". J Plastic and Reconstructive Surgery. 1996 Nov; 98(6): 1125; Lappert PW, Lee JW. Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation. Plastic and Reconstructive Surgery 1998; 102(5): 1642-5.

Publications - Medical Textbooks: Wound Management in the Military. Lappert PW, Weiss DD, Eriksson E. Plastic Surgery: Indications, Operations, and Outcomes, Vol. 1; 53-63. Mosby. St. Louis, MO 2000.

Operations and Clinical Experience: Consultations and Discussions: As a physician and surgeon, I have treated many thousands of patients in 7 states and 4 foreign nations. My practice has included Primary Care, Family Medicine, Aerospace Medicine, General Surgery, Reconstructive Surgery for combat injured, cancer reconstructive surgeries including extensive experience with microvascular surgery, Pediatric Congenital Deformity, and the care of chronic wounds. I have practiced in rural medicine, urban trauma centers, military field hospitals, university teaching hospitals, and as a solo private practitioner. In my private practice I have had occasion to treat many self-identified transgender patients for skin pathologies related to their use of high dose sex steroids, laser therapies for management of facial hair both in transitioners and detransitioners. I have performed breast reversal surgeries for detransitioning patients. My practice is rated as "LGBTQ friendly" on social media. I have consulted with families with children who are experiencing gender discordance. I have given many presentations to professional meetings of educators and counselors on the subject of transgender, and the present state of the science and treatment. I have discussed the scientific issues relevant to the case with many physicians and experts over a number of years and also discussed related issues with parents and others.

ATTACHMENT G

Florida Medicaid Project: Treatment for Transgender Children
Medical Experimentation without Informed Consent:
An Ethicist's View of Transgender Treatment for Children

G. Kevin Donovan, MD, MA
5-12-2022

Florida Medicaid Project: Treatment for Transgender Children

Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children

I. The Issue

Growing controversy attends the diagnosis and treatment of individuals identifying as transgender, particularly those who are still children or adolescents. As was recently pointed out, leading medical, mental health, and public health organizations support understanding gender-diverse youth and providing gender-affirming medical (hormonal) and other(surgical) care as the standard of care, including the American Academy of Pediatrics, American Psychological Association, Centers for Disease Control and Prevention, Society for Adolescent Health and Medicine, and the American Medical Association. Major nursing organizations—the American Nurses Association and the American Academy of Nursing—have made statements that young people's access to inclusive, safe, and competent health care is a human rights issue. (Wolfe, I., & Goepferd, A. "Child Abuse in Texas." *The Hastings Center*. 14 Mar. 2022) However, this widespread support is not going unchallenged, even by those who have been providing medical interventions for these children and adolescents.

Recently, questions have arisen about the appropriateness of both the diagnosis, and the safety and efficacy of these interventions that have been strongly encouraged up until now. Currently, less than half of state Medicaid programs provide gender affirming care. (Mallory, C., & Tentindo, W. "Medicaid coverage of gender-affirming care." Williams Institute, UCLA School of Law. Oct 2019). The Florida Surgeon General has said that minors should not undergo gender transition procedures, puberty blockers and hormone treatments. "[Florida Department of Health Releases Guidance on Treatment of Gender Dysphoria for Children and Adolescents](#)." 20220420-Gender-Dysphoria-Press-Release | Florida Department of Health.) In Texas, the state attorney general issued a decision that gender-affirming medical treatments such as puberty-suppressing hormones fall under the definition of child abuse in Texas state law. In fact, 34 states have introduced legislation to limit hormonal and surgical interventions for such transgender patients. This aligns with similar reassessments and limitations in the United Kingdom, Sweden, Finland, and France. A new position statement from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) stresses the importance of a mental health evaluation for people with gender dysphoria — in particular for children and adolescents — before any firm decisions are made on whether to prescribe hormonal treatments to transition or to perform surgeries, often referred to as "gender-affirming care." "There is a paucity of quality evidence on the outcomes of those presenting with gender dysphoria. In particular, there is a need for better evidence in relation to outcomes for children and young people," the guidance states.

Given the legitimate concerns about the diagnosis, treatment, and the paucity of supportive, scientific studies in regard to the interventions being offered to minors who identify as transgender, I will offer a view of these from the perspective of an ethicist and pediatrician. This will be done in the face of strong and sometimes heated opposition to any variance from the currently prevailing recommendations. Each category of currently recommended or potential treatments will be briefly considered within this framework. The evidence base for these will be reviewed, and an overall argument made that such interventions must be considered as medical experimentation, subject to the requirements of research in childhood with informed consent. Finally, I will conclude with an examination of the fundamental flaw of the transgender project in childhood, and how it is leading to inevitable and controversial challenges.

In order to do this, we must review the ethical requirements for medical research in childhood and the elements of **informed consent**. Because of numerous abuses in the past, a strong system of regulations and oversight has been developed for the protection of human subjects in the United States. This began with the Belmont Report: (<https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html>) The report not only described the ethical principles listed below, but led to guidelines for research protections that are now codified in Federal regulations (Code of Federal Regulations, or 'CFR') and monitored by the U.S. Department of Health and Human Services (DHHS). These led to the establishment of IRBs (Institutional Review Boards) which are responsible for the protection of human subjects in federally funded research—IRBs are the Federally mandated committees that review research activities for the protection of human subjects. The Office for Human Research Protections (OHRP) provides leadership in the protection of the rights, welfare, and wellbeing of subjects involved in research conducted or supported by the DHHS. The OHRP helps ensure this by providing clarification and guidance, developing educational programs and materials, maintaining regulatory oversight, and providing advice on ethical and regulatory issues in biomedical and social-behavioral research. These measures have laid the ground rules for human research, in adults and children including the need for informed consent.

Although adults may be included in research, this should only be done with *fully informed consent*, and the requirements will differ for children and other vulnerable subjects. The bedrock of these protections lies in obtaining the informed consent from the participant. Informed consent to medical treatment and research involvement is fundamental to both ethics and law. The process requires that a *fully autonomous patient* have the ability to *understand relevant medical information* about the proposed interventions, including the *risks, benefits if any, and alternatives* (including doing nothing/non-participation). and consent *voluntarily* without *coercion*. This is rooted in respect for the **ethical principles of autonomy, beneficence, and justice**.

Autonomy is derived from respect for persons, which requires that we not only respect those who are fully autonomous but protect those individuals that are not fully autonomous. Vulnerable subjects such as children cannot legally or ethically participate in the consent process due to their age and maturity level. The rules for their involvement are set out by the Code of Federal Regulations (46 CFR 401-409). While consent cannot be given for another person, parents or guardians can give "permission" and children can give assent to the extent that they are able. The process of obtaining assent should be appropriate to the age, maturity, and psychological development of the child. The consent process must contain three ethically required components: *information, comprehension, and voluntariness*. Deficiencies in any of these categories would invalidate the process. The main contention here is that deficiencies in *all* these categories can be found in the current approach to minors who identify as transgender, and current attempts at treatment should not proceed as they are now practiced.

Beneficence is reflected in the complementary expressions of (1) do no harm and (2) maximize possible benefits and minimize possible harms. An assessment of risks and benefits will depend heavily on the delivery of accurate and complete information as described above. An assessment of risk will include both the probability and the severity of envisioned harms, both physical and psychological.

Finally, **justice** requires fairness in distribution of risks and benefits. It suggests that not only should like cases be treated alike, but different approaches are appropriate for different circumstances. This is highly relevant in the selection process for those being subjected to the various interventions while still minors.

Thus the process of informed consent must proceed with a correct diagnosis, the nature and purpose of recommended interventions, the known burdens and benefits of all options, including doing nothing or forgoing the intervention. While not able to do an exhaustive review of these elements as they apply to the main treatment approaches recommended for transgender minors, we can briefly examine each category to assess for obvious deficiencies. The issue of deficient information will be significant in each category, and questions of comprehension and voluntariness will be addressed at the end.

II. The Interventions

Surgery

A variety of surgeries have been performed on transgender adults. These range from removal of both breasts (bilateral mastectomy) and associated chest reconstruction, nipple repositioning, dermal implant and tattooing, to gender surgery for trans men which includes construction of a penis (phalloplasty or metoidioplasty), construction of a scrotum (scrotoplasty) and testicular implants, or a penile implant. Removal of the womb (hysterectomy) and the ovaries and fallopian tubes (salpingo-oophorectomy) may also be considered. Surgery for trans women includes removal of the testes (orchidectomy), removal of the penis (penectomy), construction of a vagina (vaginoplasty), construction of a vulva (vulvoplasty), construction of a clitoris (clitoroplasty), as well as breast implants for trans women, facial feminisation surgery and hair transplants. Certainly there are multiple known risks to this long list of surgeries. These used to be described as “sex-change” operations: they are now termed “gender affirming surgeries.” The semantic shift is important, as we will see.

Most, but not all, practitioners would delay undertaking these permanent alterations in minor children and adolescents. This may be as much for legal reasons as for medical considerations. However, the lack of sexual maturity in younger patients, especially if previously delayed by puberty blocking agents, makes the sparse tissue more difficult to work with and outcomes less favorable, with problems such as wound rupture more likely. These are not challenges that are routinely described to minors at the beginning of their treatment progression with puberty blocking agents or hormones. This deficit of information would be a major failing.

Hormonal Treatment

Treatment with cross-sex hormones is a mainstay of gender affirming care. These result in the changes in body habitus, facies, voice tone, and hair development that transgender patients seek. They are described as “gender affirming”, “life-saving” and “a human right” by their proponents. They have been prescribed by Planned Parenthood clinics and others after a first visit for gender dysphoria (<https://www.plannedparenthood.org/planned-parenthood-greater-texas/patient-resources/transgender-healthcare>). Surely no one would argue that such a precipitous practice has been accompanied by a full psychological evaluation, or disclosure of medical risks. Chief among these is the fact that the resulting bodily changes will not disappear, even if the initial desire for them changes. And this change is no unlikely development – upwards of 80% of minors who identify as transgender will reverse this identity by the time they reach their mid-20’s if left untreated, and revert to their previous identification, albeit possibly with a same-sex attraction. It is more than simply changes in one’s body that are at risk; sex hormones have an important and lasting effect on brain development and adolescent psychology. To not fully appreciate this fact, or to not have it delineated in the first place, is an egregious failure of informed consent.

Puberty Blockers

Perhaps the greatest failure of informed consent, and non-disclosure of human experimentation outcomes, is found in the supposedly benign use of puberty blocking agents in minors. They are routinely and widely prescribed with the thought that this will “buy time” for those questioning their gender as minors. Children and their supportive parents are assured that they are a benign intervention whose effects are easily reversible, just in case the child decides not to transition. Some potential effect on the development of bone density may be mentioned. The extent of this danger is just now being appreciated, with severe and disabling osteoporosis described in at least one child in Sweden. This led to new guidelines for gender-affirming care issued in February by the National Board of Health and Welfare. It stated that, based on current knowledge: “the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases.” However, the effect of puberty blocking agents (started in early adolescent development) on long-term sexual function seems to be largely unstudied. Current guidelines recommend starting puberty blockers at the earliest stage of sexual maturation in children (Tanner two). These will not only prevent the enlargement of penile tissue, it will desensitize the orgasmic potential for tissues later exposed to cross-sex hormones. Simply put, transgender adults treated in early adolescence with puberty blockers may never experience orgasm. When children with gender dysphoria are given these powerful hormones (around age 11) they are too young to appreciate the implications of what will happen.

It is not simply a matter of chronology. As children mature into adolescents and adults, their brains are also being formed and reformed under the influence of sex hormones. There is evidence for structural changes, and these are likely to be demonstrated in cognitive and behavioral changes. In fact, the development of the adolescent brain and the maturation of its rational and executive functions does not typically complete until one’s early 20s. Although the deleterious effects on sexual development and function in adulthood from puberty blockers may be predicted, no one is entirely certain of the effects on other critical areas such as brain development and bone density. Carefully constructed and monitored studies have not been done. *Until they are, these off-label treatments with puberty blockers and cross sex hormones can only be considered experimental.* Experimental interventions should be done as carefully as any other research, and fully informed consent is the only ethical way to enter into such studies. Clearly, this is not the current practice.

III. The Fundamental Flaw

There appears to have been a headlong rush in the past decade towards the process of gender affirming care described above. After close scrutiny, it can only be seen as off label experimentation, despite the fact that informed consent practices do not conform to this reality. Given this, we must ask ourselves: how can experienced and ethical physicians so mislead others or be so misled themselves? In 2013, the American Psychiatric Association published their update of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5. In it the diagnosis of “gender identity disorder” was replaced with “gender dysphoria.” This was done to “avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender” other than the one to which they were born. The APA stated that “it is important to note the gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.” Dysphoria is a state of uneasiness, unhappiness, or dissatisfaction. With this change in terminology there was also a shift from seeking or correcting the underlying cause of the dysphoria, and a focus on transitioning to the preferred gender.

This revision has probably done more harm than good by accepting a self-diagnosis characterized by the belief that the patient (or their essence) is “trapped in the wrong body.” This concept relies on the Cartesian duality, a body-self dichotomy. It reverts to the fallacious “ghost in the machine” concept. In reality, we cannot be trapped in the wrong body; we are our bodies, which are an integral and inseparable part of ourselves. To assert that there is a female self inside a male body (or the reverse), is to fail to achieve a full understanding that we are embodied persons, unified body and mind, if you will. A generation ago, sex and gender were taken to be synonyms for the same phenomena. Even now, a transgender female, no matter how much or how long of a hormonal therapeutic regimen they undergo, is still genetically male. Ignoring this fact has led to a contradiction, where sympathetic practitioners recommend “holistic care” while insisting on a fragmented concept of the self. This approach has been warmly embraced, even insisted upon, by many practitioners while viewed as nonsensical and even ludicrous by many laypersons.

Inevitably this has led to added difficulties. Even young patients are encouraged to begin puberty blockers and then hormones based on a self-diagnosis. Self-diagnosing psychiatric conditions is always fraught with the possibility of error. In this case, there can be no confirmatory lab tests, radiologic exams, or genetic findings. Moreover, the dysphoria can only be diagnosed and opened to treatment if it is causing significant trauma to the individual. The clinically significant distress manifests itself in underlying psychiatric diagnoses such as depression and suicidality. It is argued that embarking on affirmative treatment as early as possible is urgently needed to prevent further psychiatric complications, a contested assertion. Studies have shown that adult transgender persons continue to have evidence of depression and suicidality following treatment. The rate of suicide among post-operative transgender adults in a study from Sweden found an incidence 20 times greater than that of the general population. Such treatment may not be urgently needed to protect adolescents; it may not even be effective protection for their adult counterparts.

The claim of urgency coupled with an impulse toward nonjudgmental empathy for the disturbed patients has led to a frantic insistence on a single approach that may seem almost cult like in its insularity and opposition to outside challenges. Both parents (Trinko, K. (Nov. 19, 2018 “What It’s Like to Lose Your Children to the ‘Transgender Cult,’ From a Mom Who Knows.” *The Daily Signal*, 30 Oct. 2019) and teachers (Manning, M. for The Mail on Sunday. “Whistleblower Teacher Makes Shocking Claim That ‘Most Are Autistic.’” *Daily Mail Online*, Associated Newspapers, 19 Nov. 2018, <https://www.dailymail.co.uk/news/article-6401593/Whistleblower-teacher-makes-shocking-claim-autistic.html>.) report that their children or students are being wrongly encouraged at school to think of themselves as transgender. Sometimes this is the result of overenthusiastic acceptance or “love bombing”. Sometimes it appears to influence the susceptible, as in autistic children. Sometimes transgender counseling is taking place even without the parents’ knowledge, and this troubling approach has been supported in the literature with statements that adolescents should be legally empowered to obtain puberty-blocking without parental consent (Priest, M. Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm. *Am J Bioeth.* 2019 Feb;19(2):45-59).

Inevitably, this has resulted in complications and conflicts. The media have been replete with reports of such things as contested accessibility of transgender females to such things as domestic abuse shelters, female prisons, and female sports competitions. Similar issues regarding bathroom accessibility in schools recently came to a boil in Virginia, when it came to light that a sexual assault by a self-described trans- female (with a penis) was repeated in another school after the perpetrator was transferred. (Poff, J. “Loudoun superintendent failed to inform state of school sexual assault.” *Washington Examiner*, 4 May 2022.) These issues are far from any resolution by debate, discussion, or legislation. In fact, both sides of the debate have doubled down with insistence that the opposing viewpoint must not only be rejected but considered unethical and made illegal.

Some disturbing trends have developed resulting not only from this dichotomy of opinion about the proper treatment approach, but ultimately based in the acceptance of the mind-body dichotomy. There has been a change in the diagnosed population. As Abigail Schrier pointed out:

For the nearly 100-year diagnostic history of gender dysphoria, it overwhelmingly afflicted boys and men, and it began in early childhood (ages two to four). According to the DSM-V, the latest edition of the historical rate of incidence was 0.01 percent of males (roughly one in 10,000).

For decades, psychologists treated it with “watchful waiting” — that is, a method of psychotherapy that seeks to understand the source of a child’s gender dysphoria, lessen its intensity, and ultimately help a child grow more comfortable in her own body. Now such an approach is disdained by the term “conversion therapy”, and labelled as unethical, and even made illegal.

She continues:

Since nearly seven in 10 children initially diagnosed with gender dysphoria eventually outgrew it, the conventional wisdom held that, with a little patience, most kids would come to accept their bodies. The underlying assumption was children didn’t always know best. But in the last decade, watchful waiting has been supplanted by “affirmative care,” which assumes children do know what’s best. Affirmative care proponents urge doctors to corroborate their patients’ belief that they are trapped in the wrong body. The family is pressured to help the child transition to a new gender identity — sometimes having been told by doctors or activists that, if they don’t, their child may eventually commit suicide. From there, pressures build on parents to begin concrete medical steps to help children on their path to transitioning to the “right” body. That includes puberty blockers as a preliminary step. Typically, cross-sex hormones follow and then, if desired, gender surgery. (Shrier, A. “Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care.” Emmaus Road Ministries, 5 Oct. 2021)

These pressures apply not only to parents, but to the children themselves because of the strong emphasis on affirmative support for anyone declaring themselves transgender. As one mother described: “A lot of these kids have concurrent mental health issues, and they find a place to fit in because as soon as you say that you’re trans, you get love-bombed,” she reflects. “You get love-bombed online, you get love-bombed on at school ... As soon as you say you’re trans, you turn into a star. And kids are thirsty for that kind of affirmation.” (Trinko, 2019)

Two phenomena may be associated with this. Strong affirmation for the diagnosis and hormonal treatment may be altering the natural course of the phenomenon in childhood. It may not only be easier to identify as transgender in today’s environment; it may be more difficult to turn ones back on the diagnosis. This may help explain a recent report that found that an average of 5 years after their initial social transition, 7.3% of youth had retransitioned (changed gender identity) at least once. At the end of this period, most youth identified as binary transgender youth (94%), including 1.3% who retransitioned to another identity before returning to their binary transgender identity. 2.5% of youth identified as cisgender and 3.5% as nonbinary. Later cisgender identities were more common amongst youth whose initial social transition occurred before age 6 years; the retransition often occurred before age 10. Unlike previous studies of transgender youth, males were not predominant, but were outnumbered by 2 to 1. Moreover, this is a direct contradiction of previous data showing a high rate of reversion towards a sex/gender coherence in children as they mature. (Olson, Kristina R., Durwood, Lily, Horton, Rachel, Gallagher, Natalie M., & Devor, Aaron; Gender Identity 5 Years

After Social Transition. *Pediatrics* 2022; 10.1542/peds.2021-056082) We must ask if this represents a shift towards being trapped in a wrong diagnosis, rather than a child being trapped in a wrong body.

In fact, there has been another shift. Unlike in the past, we now see increased numbers of females identifying as transgender, and later in their adolescence. Sometimes this occurs in large cohorts within a single school or peer group, a phenomenon labelled “rapid onset gender dysphoria.” Both these phenomena call into question the underlying cause for the concept of gender dysphoria. Rather than approaching it as an accurate self-diagnosis that must be affirmed and treated to change the outward sexual appearance, isn’t there a better model? We may be making a fundamental mistake in approaching transgender phenomena, not as a disease or disorder, but at most a dysphoria that is a cause for affirmation. This contrasts with our approach to similar conditions claiming a mind- body divergence, such as anorexia nervosa or body integrity identity disorder. The former is familiar to most Americans. The latter is a rare mental disorder characterized by a desire to have a physical disability, claiming discomfort with being able-bodied and often resulting in a request for amputation of the body part that makes them uncomfortable. People with this condition may refer to themselves as “trans abled.”

In all three of these conditions there is a claim for a mismatch between one’s mental bodily image and physical body. All tend to find an onset in prepubescence and are frequently associated with other mental disturbances. “Affirmative care” is the only recommended standard for transgender patients. It is horribly disturbing to contemplate amputation of a healthy limb because of a mental disorder (although this has been done). No one would seriously consider surgery to limit caloric intake or weight gain for a patient with anorexia nervosa, in order to support and affirm her distorted body image. Nevertheless, sex change operations have been recast as “gender affirming surgeries”. The change in language reflects the change in attitude that distorts the approach to treatment for a psychiatric, not medical/surgical, disorder.

Finally, what are we to make of this situation, as a medical profession, and as a society? This question cannot be answered until both the affected people and profession can overcome our collective hubris. It is not enough to admit we don’t know all the answers. We must see that we are not yet certain of all the questions that must be answered. In such a situation, competing interests must not pretend to take the moral high ground when no one can be certain where it will be located. First and foremost, we must back off from our current approaches until questions can be answered with proper studies, done with sufficient patients, and sufficient controls, over a sufficient period of time. Any insistence on a single course of therapy without this information could prove to be the same type of morally unacceptable interventions that caused formal research protections to be created in the first place.

In the meantime, we must adopt a more respectful tone with those whom we disagree. As John Milton said, “Where there is much desire to learn, there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making.” Most important of all, in order to protect the current and future well-being of these affected children, we must rely on the ancient principal of medical ethics “In the first place, do no harm.” Until we can demonstrate the efficacy and safety of any proposed treatment or intervention, its usage must properly be considered a medical experimentation and require fully informed consent. Anything less is a betrayal of both our principles and our progeny.

About the author: *Dr. Donovan’s observations flow from his professional experience. He has been a Board-certified pediatrician for over 40 years, as an academic physician who rose to Vice-chair of the Department of Pediatrics and ultimately interim Chair at the University of Oklahoma in Tulsa. His professional role and interests expanded in the 1990’s after he took a sabbatical in medical ethics at*

Georgetown University under the world-famous Dr. Edmund Pellegrino, a founding father of modern bioethics. He subsequently went on to earn a master's degree in Bioethics and founded the first bioethics center in his home university, where he was responsible for ethics training and education for students and physicians. He also served as clinical ethics consultant for three teaching hospitals. He was chair of the Section on Bioethics for the American Academy of Pediatrics (AAP) for three years and then their first liaison member of the AAP Committee on Bioethics. He has also served as the chair for a hospital Institutional Review Board for 17 years. Finally, he was asked to become Director for the Center for Clinical Bioethics at Georgetown University School of Medicine, where he served from 2012-2020. His duties included teaching, consultation, publishing papers and speaking on bioethics extensively at the local, national, and international level on four continents. He has been interviewed and quoted on National Broadcasting Company (NBC), National Public Radio (NPR), Eternal Word Television Network (EWTN), and Al Jazeera, as well as the New York Times and the Washington Post, among others. He was awarded the Humanism in Medicine award from the Gold Foundation, which recognizes physicians to have successfully integrated humanism into the delivery of care to their patients and families. He has also offered formal testimony on bioethical issues before state legislatures and the U.S. Congress.

July 14, 2022

Dr. David Diamond, Chair
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Re: Ladapo letter dated June 2, 2022 on medical care for gender dysphoria

Dear Dr. Diamond and members of the Florida Board of Medicine:

We are writing in regard to the June 2 letter that Florida Surgeon General, Dr. Joseph Ladapo, sent the Florida Board of Medicine (the “Board”).¹ In his letter, Dr. Ladapo requested that the Board review the Agency for Health Care Administration’s June 2 report, *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria* (the “June 2 AHCA report”).² He further requested that the Board establish a standard of care for medical treatment for gender dysphoria.

Dr. Ladapo’s letter requests that the Board move to ban or disfavor standard medical care for transgender patients. Such an action would violate federal and Florida constitutional and statutory protections against discrimination and would harm tens of thousands of Floridians. Such action by the Board would interfere with the doctor-patient relationship by outlawing medical care that is expressly approved by the World Professional Association for Transgender Health, the Endocrine Society, and every major medical association in the United States, including the American Medical Association and the American Academy of Pediatrics.³

The June 2 AHCA report provides no scientific foundation for the recommendation to restrict standard medical care for gender dysphoria. After reviewing the report carefully, we are distressed as scientists and stewards of public health by the quality of the document, which disregards scientific knowledge and clinical practice guidelines developed by authoritative bodies of medical experts. Contrary to the June 2 AHCA report’s conclusion, standard medical treatments for gender dysphoria meet accepted professional medical standards and are not experimental or investigational.

We are a group of physicians, psychologists, and a law professor. We hold academic appointments at the University of Alabama, the University of Texas Southwestern, and Yale

¹ Letter from Dr. Joseph Ladapo to Florida Board of Medicine, June 2, 2022, accessed July 12, 2022, at <https://www.documentcloud.org/documents/22050967-board-letter>

² Division of Florida Medicaid, Agency for Health Care Administration, *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria*, June 2022, at https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf. Our comments reflect our views and not those of the University of Alabama, the University of Texas, or Yale University. We received no funding for this letter or for the enclosed report, and we have no conflicts of interest.

³ [Brief of Amicus Curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations in Support of Plaintiffs’ Motion for Temporary Restraining Order and Preliminary Injunction, Eknes-Tucker v. Ivey \(later redesignated Eknes-Tucker v. Abbott\), May 5, 2022, at https://www.aamc.org/media/60556/download.](https://www.aamc.org/media/60556/download)

University. Our scientists include three Ph.D. child and adolescent psychologists and four M.D. physicians with specialties in pediatric endocrinology, child and adolescent psychiatry, and adolescent medicine. The seven clinicians treat transgender youth on a daily basis. Among us, we have accumulated more than 57 years of clinical practice and have treated more than 2,100 transgender youth.

We are concerned that any action by the Board to ban or curtail standard medical care in Florida for individuals with gender dysphoria would set a troubling national precedent. We are also alarmed that Florida's health care agency has adopted a purported scientific report that is full of errors. Ignoring established science, the June 2 AHCA report instead relies on biased and discredited sources, journalism, blog entries, and letters to the editor. Of note, the "experts" commissioned by the AHCA have undisclosed conflicts of interest, and some have been disqualified as experts in litigation.

We have reviewed the published science that addresses each of the specific areas of concern raised by the June 2 AHCA report. We hope our analysis, attached to this letter, is useful in your deliberations.

Feel free to reach out to any of us. We are happy to discuss this further.

Very truly yours,

Anne L. Alstott

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Attachment: *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria.*⁴

⁴ McNamara M, Abdul-Latif H, Boulware, SD, Kamody R, Kuper L, Olezeski C, Szilagyi N, and Alstott A. A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria. July 8, 2022. Accessed July 12, 2022. https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20final%20july%208%202022%20accessible_443048_284_55174_v3.pdf

July 8, 2022

A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria

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Introduction

On June 2, 2022, the Florida Agency for Health Care Administration (“AHCA”) issued a purported scientific report (hereinafter, “June 2 Report”) concluding that standard medical care for gender dysphoria does not meet generally accepted medical standards and is experimental and investigational.¹

* The authors have received no funding for this report or for our public comments on Florida's proposed Medicaid rule. We have no conflicts of interest to declare. Dr. Olezeski prepared paid expert testimony in a case for the Federal Public Defender for the District of Connecticut. We thank Melisa Olgun for excellent research assistance.

¹ Division of Florida Medicaid, Agency for Health Care Administration, Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria, June 2022, at https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf (“June 2 Report”).

We are a group of seven scientists and a law professor, and we have concluded, after a careful examination of the June 2 Report, that its conclusions are incorrect and scientifically unfounded. The June 2 Report purports to be a review of the scientific and medical evidence but is, in fact, fundamentally unscientific.

We are alarmed that Florida's health care agency has adopted a purportedly scientific report that so blatantly violates the basic tenets of scientific inquiry. The report makes false statements and contains glaring errors regarding science, statistical methods, and medicine. Ignoring established science and longstanding, authoritative clinical guidance, the report instead relies on biased and discredited sources, including purported "expert" reports that carry no scientific weight due to lack of expertise and bias.

So repeated and fundamental are the errors in the June 2 Report that it seems clear that the report is not a serious scientific analysis but, rather, a document crafted to serve a political agenda.

The AHCA has offered the June 2 Report as justification for a proposed rule that would deny Florida Medicaid coverage for gender dysphoria to people of all ages (the "Proposed Rule").² We strongly oppose the Proposed Rule and have documented our reasons in public comments submitted to the AHCA on July 8, 2022. This report provides our detailed reasons for concluding that the June 2 Report provides no scientific support for Florida's proposed action.

Executive Summary

As we note in our comments on the Proposed Rule, we strongly oppose Florida's proposal to deny Medicaid coverage to standard medical care for gender dysphoria. In this report, we show that the June 2 Report is so thoroughly flawed and biased that it deserves no scientific weight. Although our focus is on the science, we also note that the Proposed Rule would violate the sex discrimination protections provided by the U.S. and Florida Constitutions and the federal statute that governs Medicaid by discriminating against transgender people on the basis of their sex, transgender status, and gender identity.³

In this report, we examine closely the "scientific" claims made in the June 2 Report, and we show that its basic conclusion is incorrect. Medical treatment for gender dysphoria does meet generally accepted professional medical standards and is not experimental or investigational. We also show that the June 2 report reflects a faulty understanding of statistics, medical regulation, and scientific research. The report ignores solid scientific evidence and instead repeats discredited claims, cites to sources with no scientific merit, and engages in unfounded speculation based on stereotypes rather than science.

Specifically, we show that:

² 48 Fl. Admin. Reg. 2461 (June 17, 2022).

³ See *Bostock v. Clayton County*, 590 U.S. ____ (2020); *Kadel v. Folwell, M.D. N.C.*, Mem. Op. 6-10-22 (applying *Bostock* to public health plan coverage); 42 U.S.C. 18116 (requiring nondiscrimination in Medicaid plans).

- Contrary to the June 2 Report’s repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported “expert” reports that are biased, inexpert, and full of errors. The claimed “expert” reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
- The linchpin of the June 2 Report is an analysis by two epidemiologists that claims to undermine the scientific evidence supporting medical care for gender dysphoria. Their analysis is extremely narrow in scope, inexpert, and so flawed that it merits no scientific weight at all.
- The June 2 Report repeatedly and erroneously dismisses solid studies as “low quality.” If Florida’s Medicaid program applied the June 2 Report’s approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.

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III. The June 2 Report reflects a faulty understanding of statistics, medical regulation, and scientific research, and it repeats discredited claims and engages in speculation and stereotyping without scientific evidence. _____ 15

A. The June 2 Report repeatedly and erroneously dismisses solid studies as “low quality.” If Florida’s Medicaid program applied the June 2 Report’s approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries. _____ 15

B. The June 2 Report disregards robust clinical research studies and instead relies on letters to the editor and opinion pieces. The report’s analysis fails to satisfy Florida’s own regulatory standards for Medicaid coverage decisions and does not undermine the scientific research that supports medical treatment for gender dysphoria. _____ 16

C. The June 2 Report mistakenly claims that puberty blockers and hormones are experimental because they are used “off-label” and not approved by the FDA. In fact, off-label use, when supported by scientific evidence, as is the case here, is extremely common in medical practice and especially in pediatrics. _____ 19

D. The June 2 Report falsely claims that medical care for gender dysphoria is provided to a large percentage of children who will come to regret their treatment. In fact, patients with gender dysphoria have vanishingly low rates of regret regarding their medical treatment. ____ 21

The June 2 Report attempts to cast doubt on medical treatment for gender dysphoria by repeating the debunked claim that most transgender teens ultimately reject their transgender identity. Below, we analyze two related claims made in the report and show why both are refuted by sound evidence. _____ 21

E. The June 2 Report repeats discredited claims that “social contagion” is leading teens to become transgender. The issue, although sensationalized in the June 2 Report, is ultimately irrelevant to medical treatment, which is provided only after a multidisciplinary assessment and after a finding that gender dysphoria is persistent and medical treatment is warranted. _ 23

F. The June 2 Report claims that inappropriate medical care is provided to adolescents with gender dysphoria who also have anxiety, depression, and other mental health conditions. These assertions are unsupported by scientific evidence and disregard evidence-based clinical practice guidelines that provide sound guidance for treating complex cases. _____ 25

G. The June 2 Report speculates, without evidence, that psychotherapy alone is as effective as medical treatment for gender dysphoria. This claim contradicts the findings of solid scientific studies, which show that medical care is more effective than psychotherapy alone. _____ 27

Analysis

I. Contrary to the June 2 Report’s repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.

The conclusion of the June 2 report – that medical treatments for gender dysphoria “do not conform to [generally accepted professional medical standards] and are experimental and investigational”⁴ – is demonstrably false.

Medical care for the treatment of gender dysphoria, which for youth under the age of majority can include gonadotropin releasing hormone agonists (“GnRHa” or puberty blockers) and hormone therapy, has been vetted and approved by international bodies of experts based on the scientific evidence. Two authoritative bodies of scientists, the World Professional Association for Transgender Health (WPATH) and The Endocrine Society, have published extensive clinical practice guidelines for treating gender dysphoria.⁵ These clinical guidelines are based on rigorous, structured processes that include a committee of scientific experts and peer review by additional experts. The guidelines are based on careful reviews of the scientific literature and are revised periodically to reflect scientific developments.

These longstanding clinical practice guidelines have been used by clinicians for decades. WPATH issued its initial guidelines in 1979 and updated them in 1980, 1981, 1990, 1998, 2001, and 2012. The eighth version remains in process, and it incorporates systematic literature reviews and ample opportunities for peer review and revision.⁶ The original Endocrine Society guidelines were published in 2009 and updated in 2017.⁷

Reflecting this scientific and medical consensus, medical care for gender dysphoria has been confirmed as standard care by every relevant medical organization in the United States, including the American Academy of Pediatrics, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry.⁸ In 2022, these organizations united with the American Medical Association, the American College of Obstetricians and Gynecologists, and other groups to file an amicus brief representing a total of 20 major medical

⁴ June 2 Report, p. 2.

⁵ See Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, World Professional Association for Transgender Health (7th version, 2012), at <https://www.wpath.org/publications/soc> (“WPATH (2012)”); Wylie C. Hembree, et al., Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102(11) J. Clin. Endocrinol. Metab. 3869-3903 (2017) (“Endocrine Society (2017)”).

⁶ See World Professional Association for Transgender Health (WPATH), Methodology for the Development of Standards of Care 8 (Soc 8), at <https://www.wpath.org/soc8/Methodology>.

⁷ Endocrine Society (2017), supra note 5.

⁸ Jason Rafferty, Committee on Psychosocial Aspects of Child and Family Health; Committee on Adolescence; Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, 142(4) Pediatrics E20182162 (2018); American Psychological Association, Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, 70(9) American Psychologist 832-64 (2015); Stewart L. Adelson, Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents, 51(9) J. Am. Acad. Child & Adolescent Psychiatry, 957-974 (2012).

societies. The brief reaffirms that puberty blockers and hormone treatments for gender dysphoria are standard medical care and opposes legal measures that would limit patient access to this standard care.⁹

The weight and volume of these endorsements, across diverse medical specialties, sharply contradicts the June 2 Report's conclusions.

II. The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science. The report heavily relies on five purported "expert" documents that are biased, inexperienced, and full of errors.

The Florida report dismisses or ignores the WPATH and Endocrine Society clinical practice guidelines and the science that underlies them and instead relies on five attached documents that, the report claims, constitute "clinical and technical expert assessments."¹⁰

Despite their billing as "expert" reports, the attachments to the June 2 report are unpublished, non-peer-reviewed documents written by authors with questionable claims to expertise and with red flags for undisclosed author bias. These documents should be given no weight in a serious scientific process.

A. The purported "expert" documents attached to the June 2 Report carry no scientific weight. They are unpublished and not peer-reviewed, and they are written by authors whose expertise has been successfully challenged in legal proceedings and whose backgrounds raise red flags for bias.

None of the documents attached to the June 2 Report meet standard criteria for expert scientific investigations, because none is published or peer reviewed. Publication and peer review are fundamental to science, as they ensure that a scientist's data and conclusions are open to scrutiny from scientific experts.

Florida's own standards for the determination of medical necessity recognize this point when they state that determinations of Medicaid coverage must consult "*published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations).*"¹¹ It is thus both unscientific and a violation of the regulations for the June 2 Report to rely on the unpublished documents as its principal evidence base.

Further, the attachments all raise red flags for author bias. The June 2 Report does not disclose how these "experts" were identified or by what criteria their expertise was assessed. The opacity

⁹ Brief of Amicus Curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction, *Eknes-Tucker v. Ivey* (later redesignated *Eknes-Tucker v. Abbott*), May 5, 2022, at <https://www.aamc.org/media/60556/download>.

¹⁰ June 2 Report, p. 2.

¹¹ Fl. Admin. Code Section 59G-1.035(4).

of the Florida AHCA process for identifying experts is particularly troubling because at least four of the experts have strong indications of bias. Further, the qualifications and credibility of two of the experts have been successfully challenged in litigation.¹² Two of the expert reports duplicate, word-for-word (or with very slight edits) testimony that was offered, apparently for pay, in litigation. Both have connections to advocacy organizations that oppose LGBTQ rights across the board. The endorsement of these individuals as Florida's banner "experts" raises the appearance of bias – that the AHCA sought a pre-ordained outcome, not a true scientific perspective.

Adding to these red flags for bias, none of the authors of the attachments provide a statement of funding and conflicts of interest. This omission violates a strong norm in scientific writing, which requires authors to declare any conflicts of interest; these include any professional or financial arrangements that could call into question their independence of judgment.¹³ That strong norm also requires authors to disclose whether projects have been funded and if so, by whom and whether the authors have engaged in expert testimony. Without these statements, the Florida AHCA and the public cannot detect biases that could affect the integrity of these written products.

These are more than theoretical concerns: at least four of the attachments have notable indicators of conflicts of interest and bias. (Note that these are the only four we examined in detail, and so we do not imply that the other one is free from such bias.)

The author of the document provided as Attachment E is Quentin van Meter, whose history indicates bias and lack of expertise. Although the AHCA presents van Meter as an expert in medical treatment for gender dysphoria, at least one court barred him from providing expert testimony on the issue.¹⁴ Van Meter is the president of the American College of Pediatricians (the "ACP"), which presents itself as a scientific group (and might be confused, by a non-expert, with the authoritative American Academy of Pediatrics). The ACP is, in fact, a political group that opposes same-sex marriage,¹⁵ supports mental health providers practicing conversion therapy,¹⁶ and describes childhood gender dysphoria as "confusion."¹⁷ Troublingly, the van

¹² See Stephen Caruso, A Texas Judge Ruled That This Doctor Was Not an Expert, *Pennsylvania Capital-Star*, Sept. 15, 2020 (reporting that van Meter was disqualified as an expert in a Texas divorce case, now sealed).

¹³ For example, the conflict of interest rules for JAMA, one of the premier medical journals in the United States and the world state that "[a]uthors are expected to provide detailed information about all relevant financial interests, activities, relationships, and affiliations (other than those affiliations listed in the title page of the manuscript) including, but not limited to, employment, affiliation, funding and grants received or pending, consultancies, honoraria or payment, speakers' bureaus, stock ownership or options, expert testimony, royalties, donation of medical equipment, or patents planned, pending, or issued." JAMA Network, Instructions for Authors, visited June 22, 2022, at <https://jamanetwork.com/journals/jama/pages/instructions-for-authors#SecConflictsofInterestandFinancialDisclosures>

¹⁴ Caruso, *supra* note 12.

¹⁵ Den Trumbull, *Defending Traditional Marriage*, American College of Pediatricians (2013), <https://acpeds.org/position-statements/defending-traditional-marriage>. **Error! Hyperlink reference not valid.** See Jack Turban, *The American College of Pediatricians is an Anti-LGBTQ Group*, *Psychology Today*, May 8, 2017.

¹⁶ Christopher Rosik and Michelle Cretella, *Psychotherapy for Unwanted Homosexual Attraction Among Youth*, American College of Pediatricians (2016), <https://acpeds.org/position-statements/psychotherapy-for-unwanted-homosexual-attraction-among-youth>.

¹⁷ Michelle Cretella, *Gender Dysphoria in Children*, American College of Pediatricians (2018), <https://acpeds.org/position-statements/gender-dysphoria-in-children> (site visited June 22, 2022).. The author of the

Meter attachment, proffered by the AHCA as a scientific report, contains several passages of uncredited, verbatim language that appears in a “position statement” published by the ACP.¹⁸ The van Meter attachment appears to be a re-use of paid testimony rather than an original product.¹⁹

James Cantor’s document, presented as Attachment D to the June 2 Report, also faces serious questions about bias and lack of expertise. In a 2022 case, a federal court took a skeptical view of Cantor’s purported expertise, noting that “the Court gave [Cantor’s] testimony little weight because he admitted, *inter alia*, to having no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria.”²⁰ Cantor’s document is nearly identical to what appears to be paid testimony in another case, where Cantor’s declaration was used to support legislation barring transgender athletes from sports teams,²¹ Troublingly, Cantor’s appearance in that case seems to have been funded by the Alliance Defending Freedom (“ADF”),²² a religious and political organization that opposes legal protections for transgender people and same-sex marriage²³ and defends the criminalization of sexual activity between partners of the same sex.²⁴ Because Cantor provides no conflicts of interest disclosure, readers cannot ascertain whether Florida AHCA also paid for Cantor’s report and whether Florida officials were aware that the Cantor report reused his work for (apparently) the ADF.

Romina Brignardello-Petersen is one of two authors of the document provided as Attachment C to the June 2 Report. Although Brignardello-Petersen claims to have no research interests in medical care for transgender youth,²⁵ she has conducted research for the Society for Evidence-

ACP position paper is Michelle Cretella, who was publicly rebuked by the Society for Adolescent Health and Medicine, the leading society for adolescent medicine in the United States, for “pushing political and ideological agendas not based on science and facts.” [https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2017-Activity/Senate-Bill-439-\(2\).aspx](https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2017-Activity/Senate-Bill-439-(2).aspx)

¹⁸ The similarity was shown by a Word comparison of the van Meter report provided as Attachment E to the June 2 Report with a “position statement” published on the ACP website, with authorship credit given on the website to Michelle Cretella. See Michelle Cretella, Gender Dysphoria in Children, *supra* note 17.

¹⁹ The van Meter document attached to the June 2 Report is substantially identical to his expert declaration in *Adams v. School Board of St. Johns County, Florida*. <https://files.eqcf.org/wp-content/uploads/2017/12/41-D-AMENDED-Notice-Documents-iso-Response-to-PI.pdf>.

²⁰ Opinion and Order, *Eknes-Tucker v. Marshall*, 2:22-CV-184-LCB, M.D. Alabama, May 13, 2022.

²¹ The case is *BPJ v. West Virginia State Board of Education*, and the Alliance Defending Freedom takes credit for it here: <https://adfmedia.org/case/bpj-v-west-virginia-state-board-education>. Cantor’s declaration appears here: <https://adfmedialegalfiles.blob.core.windows.net/files/BPJ-CantorDeclaration.pdf>

²² The ADF seems to take credit for the case in this press conference notice: <https://adfmedia.org/case/bpj-v-west-virginia-state-board-education>

²³ Marriage is the Future, American College of Pediatricians, <https://adflegal.org/issues/marriage/overview> (site visited July 2, 2022). Content on the page includes this statement: “Marriage is about equality and diversity. It’s about joining the two equally important and diverse halves of humanity represented in men and women.”

²⁴ Southern Poverty Law Center, *Dangerous Liaisons*, July 10, 2013, <https://www.splcenter.org/20130709/dangerous-liaisons> [visited July 2, 2022].

²⁵ Like the van Meter and Cantor attachments, the BPW document provides no express statement of conflicts of interest. The BPW document does offer a statement of “credentials and expertise,” in which she declares that “her research interests are not in this area,” meaning apparently research on medical care for gender dysphoria. BPW Document, p. 1.

Based Gender Medicine (“SEGM”).²⁶ Although SEGM claims to be an international medical society, it is actually an activist group that opposes standard medical care for gender dysphoria. The SEGM has no publications or conferences and seems to consist solely of a website created by a small group of people with limited or no scientific credentials or clinical experience. The site presents a cherry-picked collection of studies and narrative content that is full of scientific errors.²⁷

Patrick Lappert, whose document is attached to the June 2 Report as Attachment F, has been disqualified as an expert in a recent federal court decision in North Carolina.²⁸ The judge found that evidence “calls Lappert’s bias and reliability into serious question” and noted that Lappert has worked closely with ADF and has actively lobbied for legal bans on medical care for transgender youth.²⁹ The judge gave no weight to Lappert’s testimony about informed consent in that case, finding that it was unsupported by scientific evidence.³⁰ The judge also found that “Lappert has provided the Court with no data or methodology used to draw his conclusion that surgical treatment for gender dysphoria has “never been generally accepted by the relevant scientific community.”³¹

B. The linchpin of the June 2 Report is the analysis by Brignardello-Petersen and Wiercioch (the “BPW document”), provided as Attachment C, which purports to be a comprehensive review of the scientific literature on medical treatment for gender dysphoria but, in fact, is extremely narrow in scope and so flawed in its analysis that it merits no scientific weight.

The BPW document, like the other attachments to the June 2 Report, is an unpublished, non-peer-reviewed document. It claims to conduct a systematic review of the relevant scientific literature, but in fact, it is written by inexpert authors who construct an arbitrarily truncated sample and adopt a method that violates scientific guidelines and produces a biased result. The authors describe their findings in deceptive language and jargon predictably mislead the reader. Our review shows that *nothing in the BPW document calls into question the scientific foundations of the WPATH and the Endocrine Society clinical practice guidelines.*

²⁶ BPW document, p. 1. For one example of the purported research that Brignardello-Petersen apparently assisted in, see Alison Clayton et al., Commentary: the Signal and the Noise – Questioning the Benefits of Puberty Blockers for Youth with Gender Dysphoria – A Commentary on Rew et al. (2021), *Child and Adolescent Mental Health*, Dec. 22, 2021, at <https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12533>. In the “Acknowledgements” section, the authors state, “We would also like to thank the Society for Evidence-based Gender Medicine (SEGM) for providing access to several experts who helped shape this commentary and ensure its accuracy. Specifically, we would like to thank Dr. Romina Brignardello Petersen [sic] for contributing her methodological expertise.”

²⁷ Susan Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims* (April 28, 2022), at 28-29 (Appendix A) available at <https://medicine.yale.edu/childstudy/policy-and-social-innovation/lgbtq-youth/>.

²⁸ *Kadel v. Folwell*, 1:19CV272, M.D. N.C. June 10, 2022. The judge ruled that Lappert was not qualified to “render opinions about the diagnosis of gender dysphoria, its possible causes, the efficacy of the DSM, the efficacy of puberty blocking medication or hormone treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists, or any opinion on the non-surgical treatments.” Lappert was also disqualified from opining on “the efficacy of randomized clinical trials, cohort studies, or other longitudinal, epidemiological, or statistical studies of gender dysphoria.” *Id.*

²⁹ *Id.*

³⁰ *Id.*, pp. 29-30.

³¹ *Id.*, p. 31.

The BPW document seems scientific on its face, and it may be impressive to non-experts, because it uses technical jargon and includes numerous tables and charts. But a closer examination shows that it violates established standards for medical research and shows signs of being engineered to produce a pre-ordained and inaccurate result: the false claim that there is no scientific evidence base for medical treatment for gender dysphoria. Contrary to the authors' claims, there is a large body of reliable scientific literature that supports standard medical treatment for gender dysphoria and spans decades.

The bottom line is that, contrary to the BPW document's claims, there is a large body of reliable scientific literature that supports standard medical treatment for gender dysphoria.

(1) The BPW document lacks scientific credibility due to the authors' lack of relevant qualifications and their ties to an activist group.

The BPW document purports to be a systematic review of the scientific literature on medical treatment for gender dysphoria. But the document, like the other attachments to the June 2 Report, is not published or peer-reviewed, and its design and execution raise numerous red flags for bias. Here, we describe just four of the notable defects that undercut entirely the document's claim to objectivity and sound method.

First, neither of the BPW authors are experts in medical care for gender dysphoria, either as researchers or clinicians. One author (Brignardello-Petersen) has not previously studied the subject, except in her work for the ideological organization SEGM.org, noted just above. Her only clinical experience appears to be in dentistry.³² The other author (Wiercioch) is a junior researcher (a postdoctoral fellow) with no prior research or clinical experience in this field.³³

The authors' lack of interest and experience renders the BPW work inexpert rather than objective, and it violates the National Academy of Medicine (formerly, Institute of Medicine) standards for systematic reviews.³⁴ By analogy, one would not rely on, say, two dermatologists to conduct a review of the scientific literature on neurosurgery and to make recommendations for clinical practice.

³² Romina Brignardello bio, at <https://experts.mcmaster.ca/display/brignarr> [visited July 2, 2022]

³³ Google Scholar, Wojtek Wiercioch, visited June 22, 2022, https://scholar.google.com/citations?user=vdi3r_AAAAAJ&hl=en

³⁴ Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Institute of Medicine, Finding What Works in Health Care: Standards for Systematic Reviews, National Academies (Jill Eden et al., eds 2011), p. 48 (Standard 2.1.1 states that teams for systematic reviews should include expertise in pertinent clinical content areas). Background: The Institute of Medicine, now called the National Academy of Medicine, is one of three branches of the National Academies of Science, Engineering, and Medicine. The National Academy of Science dates to 1963 and was established by Congress; the Institute of Medicine was established as a separate entity in 1970 and serves as the nation's leading authority on scientific research and knowledge. National Academy of Medicine, About the National Academy of Medicine, website visited June 22, 2022, <https://nam.edu/about-the-nam/> The standards for systematic reviews were published in 2011, responding to a Congressional request to set benchmarks for high-quality systematic reviews that could reliably guide physicians and health-care providers in making informed, scientific judgments about health care.

Second, not only is the study not formally peer-reviewed, the BPW authors violate scientific norms and standards by *failing to engage at all with their peers or with actual experts in the subject matter*. As experts in research methodology should know, any sound systematic review should propose explicit and reproducible methods to methodically summarize the existing literature; the protocol (i.e., the research design) is then published to solicit input and criticisms from potential users of the review and experts in the field.³⁵ Peer review of the literature review and publication of the protocol are not optional or merely window-dressing; they reflect bedrock commitments of the scientific method. These processes help ensure that the authors of any review understand the existing research and craft a research design that will usefully build on and add to prior work.

The BPW document violates these standards, raising questions about whether this was a rushed study designed to serve a political agenda – rather than a considered, comprehensive, scientific enterprise. The BPW document does not contain a review of the existing literature, and it does not acknowledge the WPATH and Endocrine clinical practice guidelines, which are themselves based on careful systematic reviews. The BPW authors appear not to have published their protocol in advance or otherwise to have submitted their protocol for peer review. That is, there is no indication that they vetted their research design in consultation with subject-matter experts.

Third, the BPW document raises red flags for opinion bias. Buried in the methodology pages of the BPW document is the fact that the authors uncritically include politically biased “grey literature” sources, giving them equal weight to peer-reviewed, published literature. Specifically, the authors include in their search the fringe website SEGM.org.³⁶ As noted above, the group’s website posts are not peer-reviewed or published, and its content is assembled by a small group of activists with few or no expert credentials and is often full of errors.³⁷ Troublingly, this is the group to which one of the authors, Brignardello-Petersen, has ties, as noted above.

(2) The BPW document examines a truncated sample of the literature and adopts a methodology that violates scientific standards for evaluating medical evidence. The authors compound this bias by describing their results using overstated and deceptive language. The picture that emerges is of a rushed and inexperienced report with indications of bias.

The BPW document has a patina of scientific expertise. It invokes the respected GRADE standards for rating the quality of studies, and it occupies many pages with tables and technical specifications. When a reader looks past the jargon, however, the BPW authors adopt a method that actually violates GRADE standards and appears to be jury-rigged to reach a foregone conclusion. The authors then convey their conclusions in misleading language. *Contrary to the BPW authors’ claims, their study does not call into question the scientific and clinical importance of the established science that supports medical care for gender dysphoria.*

³⁵ Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Institute of Medicine, *supra* note 34, at pp. 72-75.

³⁶ BPW document, Methods section, p. 2.

³⁷ See Boulware et al., *supra* note 27 pp. 28-29 (Appendix A).

The BPW analysis incorporates numerous decisions that bias their results, and they make numerous misleading statements. First, the BPW document reviewed only a small sample of the relevant scientific literature. In the introduction, the BPW authors initially claim to have reviewed 61 systematic reviews of medical treatment for gender dysphoria.³⁸ But buried in the middle of the document is the admission that the analysis is based on a sample of 27 systematic reviews, not 61 as claimed.³⁹ The result is that the BPW analysis excludes a great deal of relevant evidence, and the authors provide no rationale for this “prioritization,” as they call it. Troublingly, although the BPW document claims to be conducting a review of the literature that analyzes existing systematic reviews, the 27 studies they analyze are not all systematic reviews. Three of the 27 are mislabeled as systematic reviews but are actually practice bulletins, unpublished protocols or unlocatable.

Troublingly, the authors also embed in the middle of their document an *unjustified decision to limit their analysis to studies published from 2020 to the present, and their project has strong indications that it was rushed work*. The authors disclose that they “prioritized” studies from the last 30 months (two full years plus four months in 2022), but they do not defend that priority. The reader is left to wonder whether this truncation served only to help the authors produce their analysis in what was apparently a very short time frame.⁴⁰

The truncation of the literature sample to the period from 2020 to early 2022 is worrisome because that period coincides with the worst global public health emergency in generations. The pandemic disrupted many institutions, straining the health care system and putting immense pressure on clinicians. It is likely that the pandemic stalled the production and publication of non-COVID research during this period, calling into sharp question the BPW authors’ sampling strategy.

The BPW sample is also questionable because the authors choose, without justification, a small subsection of databases to search and have likely missed important literature as a result. Specifically, they chose not to source from other important databases such as Embase, PsycInfo, Web of Science, Scopus, or Cochrane. They also limited their scope to works published in English only, an exclusion that can introduce bias.

Second, the BPW authors misused and mechanically applied a well-regarded rating system known as AMSTAR, which is intended to evaluate the methodological strength of systematic reviews. They misused this rating system because their so-called group of systematic reviews included documents that cannot correctly be included (practice bulletins, unpublished protocols, and unlocatable documents) and thus led to a negative bias. The BPW error is further amplified because the authors used the flawed results of the AMSTAR phase to inform their next level of analysis, the GRADE system (which assesses the quality of medical evidence of pooled systematic reviews). Based on this flawed and purely mechanical review of truncated sources,

³⁸ BPW document, Introduction Section, p. 2.

³⁹ BPW document, Results Section, p. 1.

⁴⁰ The authors disclose that they conducted their initial literature searches – the first step in the review process – at the end of April 2022. BPW document, Methods section, p. 2.

the BPW analysis reaches the conclusion that there is little or no evidence for the benefits of medical care for gender dysphoria.⁴¹

The BPW analysis is highly deceptive, because it dismisses nearly all existing studies of medical treatment for gender dysphoria as “low quality,” without explaining that this is a highly technical term and not a natural-language condemnation of the studies. By contrast, the GRADE system, which the authors purport to use, is quite clear about its quality rating systems and its limitations.⁴² In general, only randomized controlled trials (RCTs) are coded as “high” quality evidence in the GRADE system. A randomized controlled trial is a study that divides patients randomly into a control group (no treatment) and a treatment group. In contrast, an observational study records information about patients in a real-world setting that is more reliably generalizable, e.g., a cohort of patients seen at a clinic. Under the GRADE guidelines, observational studies are coded as “low” in quality.

The key point is that “low quality” in this context is a technical term and not a condemnation of the evidence, because “low quality” studies regularly guide important aspects of clinical practice. Indeed, the GRADE system, which the BPW document claims to use, specifically notes that GRADE should *not* be used to dismiss observational studies or to give absolute priority to RCTs:

Although higher quality evidence is more likely to be associated with strong recommendations than lower quality evidence, a particular level of quality does not imply a particular strength of recommendation. *Sometimes, low or very low quality evidence can lead to a strong recommendation.*⁴³

The methodology adopted by the BPW document will thus, predictably, conclude that any body of scientific literature that does not contain RCTs is “low” in quality. Had BPW begun, as they should have, with a literature review of the evidence on puberty blockers and hormones, they would have seen that the evidence consists primarily of observational studies (for the good reasons discussed below). Thus, the 30 pages that it takes the authors to lay out their methodology is misleading: a knowledgeable reader would know that if there are few or no RCTs in the literature, then the BPW technical conclusion is foregone and, as importantly, is not a sound guide for clinical recommendations.

Put in simpler terms, if we coded apples as “high quality fruit” and bananas as “low quality fruit,” then any fruit bowl that has only bananas would predictably be technically coded as “low quality.” But that technical conclusion conveys very little information without context. For example, if no apples exist, then bananas may be a nutritious choice.

⁴¹ For example, the BPW document states that there is *no evidence* about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. BPW document, Results section, p. 4.

⁴² See Howard Balshem et al., GRADE Guideline: 3. Rating the Quality, 64 J. Clinical Epidemiology P401-406 (2011), Table 3, p. 404

⁴³ Balshem et al., *supra* note 42, at 402 (emphasis added).

The drafters of the GRADE system emphasize that technically “low quality” evidence can support a strong clinical treatment recommendation. For example, pediatricians now agree that children should not be given aspirin for fevers. This recommendation is based on observational studies that showed an association between aspirin treatment during viral illnesses and the development of Reyes syndrome (a rapid and progressive disease of neurological dysfunction that can be fatal). Based on those studies, it would be unethical to conduct an RCT giving some children aspirin, and so the strong, consensus treatment recommendation is based entirely on “low quality” studies.⁴⁴

The critical fact is that RCTs are not, and cannot be, the gold standard for medical research on gender dysphoria. In the context of treatments for gender dysphoria, randomized controlled trials would often be inappropriate for ethical reasons. Medical care has long been shown, by reliable scientific methods, to address gender dysphoria and improve mental health: as we have repeatedly noted, these treatments have been recommended by rigorous clinical practice guidelines issued by WPATH and the Endocrine Society and endorsed by every major medical organization. Given this medical consensus, which is based on solid scientific evidence, it would be unethical to conduct an RCT that involved denying standard medical care to a control group of individuals.

Similar ethical issues, along with practical barriers, leave many areas of consensus medicine supported by observational studies and not RCTs. Many surgical procedures, for example, are not supported by RCTs.⁴⁵ Nor are standard protocols for lowering cholesterol using statins, one of the most widely-prescribed drugs in the United States. (See Section III.A of this report.)

It is thus simply a mistake – and a mischaracterization of medical research across fields of medicine – to conclude that the absence of RCTs means that there is “no evidence” for the efficacy of medical treatment for gender dysphoria. Medical research requires, instead, that researchers evaluate the design and conduct of specific observational studies and do so with an awareness of clinical context.⁴⁶

In sharp contrast to BPW, this is precisely what the authors of the Endocrine Society did in their 2017 clinical guidelines, which use the GRADE system but, in addition, carefully discuss the characteristics of the studies supporting each treatment guideline.⁴⁷ The Endocrine Society discloses the GRADE rankings for each treatment recommendation in order to be transparent about the evidence base for each of its recommendations. Then, following National Academy of

⁴⁴ Id.

⁴⁵ See, e.g., Peter McCulloch, et al., Randomised Trials in Surgery: Problems and Possible Solutions, 324 (7351) BMJ 1448-1451 (2002).

⁴⁶ See Balshem et al., supra note 42 at 405 (“[W]e caution against a mechanistic approach toward the application of the criteria for rating the quality of the evidence up or down.... Fundamentally, the assessment of evidence quality is a subjective process, and GRADE should not be seen as obviating the need for or minimizing the importance of judgment or as suggesting that quality can be objectively determined”). See also the National Institute of Medicine (Institute of Medicine) Standards, supra note 34, at 176: (“We are disappointed when a systematic review simply lists the characteristics and findings of a series of single studies without attempting, in a sophisticated and clinically meaningful manner, to discover the pattern in a body of evidence. Although we greatly value meta-analyses, we look askance if they seem to be mechanistically produced without careful consideration of the appropriateness of pooling results or little attempt to integrate the finds into the contextual background.”)

⁴⁷ Endocrine Society (2017), supra note 5.

Medicine (formerly, Institute of Medicine) standards for clinical practice guidelines, they proceed to a qualitative review of the evidence, place the evidence in clinical context, and discuss openly the values at stake in making a clinical practice recommendation.⁴⁸

III. The June 2 Report reflects a faulty understanding of statistics, medical regulation, and scientific research, and it repeats discredited claims and engages in speculation and stereotyping without scientific evidence.

The June 2 Report is full of errors and misstatements. Disregarding solid scientific evidence, the report relies on debunked studies and sheer speculation, and it levels criticisms at solid evidence that betray a poor understanding of medical research and statistics.

A. The June 2 Report repeatedly and erroneously dismisses solid studies as “low quality.” If Florida’s Medicaid program applied the June 2 Report’s approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.

In its opening words, the June 2 Report makes an error that is repeated throughout the document: “Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased.”

As we document in Section II.B., above, it is an outright mistake to conclude that a study in the technical category of “low quality” is unreliable or poor evidence for clinical practice.⁴⁹ Thus, it is frank error for the June 2 Report to dismiss well-done, scientifically important studies because they rank as “low quality” using specialized, technical terms.

Like the BPW document, the June 2 Report thus relies on a deceptive use of technical terminology that is at odds with the standards used in medical research. It simply is not – and cannot be – the case that all clinical recommendations must be based on RCTs. Many areas of medicine do not lend themselves to ethical and practical RCTs. It is unethical to conduct an RCT when randomizing a patient to a control group would cause harm by denying treatments of known efficacy. For example, it would be unethical to conduct an RCT on the treatment of juvenile diabetes by randomizing some participants to receive insulin and others to receive no treatment.⁵⁰

It is quite common for the medical community to adopt important, consensus clinical practices supported by observational studies alone. For example, observational studies, notably the famous Framingham Heart Study, provided the framework for clinical practice guidelines in

⁴⁸ Id.

⁴⁹ Balshem et al., *supra* note 42, at 404 (“Well-conducted studies may be part of a body of evidence rated low quality because they only provide indirect or imprecise evidence for the question of interest.”)

⁵⁰ RCTs have other limitations as well. For example, RCTs often have strict exclusionary criteria that recruit healthier and more homogenous study populations than observational studies. Thus, this can lead to results that are not easily generalizable in real-world settings.

prevention and treatment of cardiovascular disease. In 2013, the American College of Cardiology and the American Heart Association issued updated clinical practice guidelines on the treatment of cholesterol to reduce heart disease risk in adults (the “Cholesterol Guidelines”).⁵¹ These authoritative guidelines have been widely used in clinical practice but are based not only on RCTs but on a great deal of observational evidence, including studies technically ranked as “low quality.”⁵² Concretely, many of the original treatment recommendations regarding statins are based on observational studies, not RCTs.⁵³ The authors of the Cholesterol Guidelines, very much like the Endocrine Society authors, are quite careful to grade their evidence. But they do not rest their treatment guidelines on a mechanical assessment of technical quality. Instead, they (like the Endocrine Society) carefully explain why particular bodies of evidence should be given weight in clinical decisionmaking.

The cholesterol example shows that the June 2 Report rests on a fundamental misunderstanding of medical research and clinical practice. If the Florida Medicaid program actually adopted the standard of evidence urged by the June 2 report, the program would not cover statins (drugs to lower cholesterol) for many patients, which are prescribed to 28% of adults over the age of 40 and are one of the most effective ways to prevent cardiovascular death.⁵⁴ Other common practices that would have to be reconsidered under this logic include: post-menopausal hormone replacement therapy (which reduces lifetime risk of heart attacks and stroke) and mammography screening for breast cancer.

The same point is true of the technically “low quality” evidence base for many surgical procedures, including minimally invasive gall bladder surgery, which have long since had a foundational grounding in observational studies. We think it unlikely that Florida’s Medicaid program will begin to refuse to pay for statins, mammograms, and routine surgeries. If not, then the June 2 Report reflects an untenable and discriminatory double standard.

Thus, the June 2 Report not only relies on the biased and methodologically flawed evidence in the BPW document, as documented in Section II above; it also misuses scientific terminology in an effort to mislead readers and to support the unwarranted conclusion that medical treatment for gender dysphoria is “experimental.”

B. The June 2 Report disregards robust clinical research studies and instead relies on letters to the editor and opinion pieces. The report’s analysis fails to satisfy Florida’s own regulatory standards for Medicaid coverage decisions and does not undermine the scientific research that supports medical treatment for gender dysphoria.

The June 2 Report repeatedly cites sources with little or no scientific credibility – including journalism, a student blog, a website, and letters to the editor – rather than peer-reviewed

⁵¹ Neil J. Stone, et al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, 129(25) *Circulation* S1-S45 (2014).

⁵² Id., Tables 3 and 4.

⁵³ Syed S. Mahmood, et al., The Framingham Heart Study and the Epidemiology of Cardiovascular Disease: a Historical Perspective, 383 *Lancet* 999-1008 (2014).

⁵⁴ Joseph A. Salami et al., National Trends in Statin Use and Expenditures in the U.S. Adult Population From 2002 to 2013, 2(1) *JAMA Cardiology* 56-65 (2017).

empirical research.⁵⁵ At the same time, the report makes baseless or exaggerated criticisms of solid studies. The report's objections to these studies incorporate mistakes about basic statistics and often misrepresent the aims and findings of studies. Here, we offer several examples, but the problem of selective and ungrounded criticism permeates the June 2 Report and further undermines its scientific credibility.

For example, the June 2 report attacks a 2015 study by Costa et al., claiming that the study design is flawed because it did not include a control group of adolescents without gender dysphoria.⁵⁶ This point is simply incorrect. The Costa study was designed to measure the impact of puberty blockers on gender dysphoria. To do so, the authors validly compared outcomes in teens with dysphoria who received treatment with blockers and those who did not. They were able to do this ethically because the control group of teens (who received psychotherapy but not puberty blockers) were not yet eligible for blockers or were eligible but chose to delay or forgo blockers. The study found that puberty suppression was associated with improvements in psychosocial functioning.

The Costa study is, despite the June 2 Report's claims, a solid methodology. In the context of this study, adding a third "control group" of teens without gender dysphoria would serve no scientific purpose. Further, the June 2 Report also criticizes Costa for "rel[ying] heavily on self-assessments."⁵⁷ But this is a wildly off-base criticism. Costa et al. measure psychosocial functioning using a widely-used and accepted instrument, the Children's Global Assessment Scale. Psychological research typically relies on such assessments, which are carefully constructed and psychometrically validated. This is one example of the June 2 Report's poor understanding of research in psychology and medicine.

In addition to these glaring errors, the June 2 Report's criticism of Costa makes an even more fundamental error: the June 2 report levels baseless criticisms at a single study *and fails to acknowledge that the weight of the literature as a whole strongly supports the same results that*

⁵⁵ Sources from journalism include Jon Brown, Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida, Fox News, May 8, 2022, at 8 <https://www.foxnews.com/politics/textbook-strips-gender-dysphoria-definition-cited-florida> [visited July 3, 2022]; Lawrence S. Mayer and Paul McHugh, Sexuality and Gender: Finding from the Biological, Psychological, and Social Science, The New Atlantis (Fall 2016), https://www.thenewatlantis.com/wp-content/uploads/legacy-pdfs/20160819_TNA50SexualityandGender.pdf [visited July 3, 2022]. The citation to the student blog is Hong Phuong Nhi Le, Eminence-Based Medicine vs. Evidence-Based Medicine, Students 4 Best Evidence [blog], <https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine> [visited July 3, 2022]. The website is SEGM.org, which we discuss in the text in Section II.B and Section III.A. Citations to letters and opinion pieces include, inter alia, Andre van Mol, et al., Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765-766 (2020); Michael Laidlaw, et al., The Right to Best Care for Children Does Not Include the Right to Medical Transition, 19(2) Am. J. Bioethics 75-77 (2019); Michael Laidlaw, et al., Letter to the Editor: "Endocrine Treatment of Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," 104(3) J. Clinical Endocrinology and Metabolism 686-687 (2018); Andre van Mol, et al., Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765-766 (2020).

⁵⁶ June 2 Report, p. 15 ("Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control"). The Costa study is Rosalia Costa et al., Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria, 12 (11) J. Sexual Medicine P2206-2214 (2015) (hereinafter, "Costa et al. (2015)").

⁵⁷ Id.

Costa et al. report. Scientific knowledge is, importantly, cumulative. It is thus entirely misleading – and unscientific – to dismiss the effectiveness of puberty blockers by criticizing studies in isolation. Put simply, the June 2 Report fails to acknowledge the number of solid studies that all find that puberty blockers are effective.⁵⁸ Indeed, at least 16 studies show that puberty blockers and hormones benefit patients with gender dysphoria, and the benefits have been documented across study designs, including retrospective report, cross sectional, longitudinal, and qualitative studies.⁵⁹

To take another example, the June 2 Report grossly misleads the reader in its discussion of a study by Chen et al. in 2020.⁶⁰ The report cherry-picks quotes from Chen et al. to the effect that "the effects of pubertal suppression warrant further study" and the "full consequences of suppressing endogenous puberty are not yet understood."⁶¹

These criticisms are misapplied, because the Chen article is not a substantive study of the effects of puberty blockers. It is, instead, a consensus parameter, which is an article that uses a structured methodology to consult experts to develop a research agenda for future studies. It is expected that the Chen piece would focus on what is not yet known, or what is not completely known, because it is attempting to identify research topics and approaches. Notably, and contrary to the June 2 Report's claims, Chen et al. recognize that existing evidence suggests that puberty blockers improve mental health functioning.

More generally, the June 2 Report's misleading characterization of Chen et al. reflects a basic lack of knowledge about scientific research. All research is flawed, including all RCTs: there simply is no perfect study in any area of medicine. The task of the scientist is to be rigorous in assessing what we know and to work to improve knowledge, incrementally, by conducting additional studies that build on earlier work. Thus, it is commonplace for authors to conclude medical research studies by calling for further research. Chen et al.'s statements are not indictments of puberty blockers – they are conventional acknowledgments of the value of further study that drives scientific inquiry and innovation.

The June 2 Report also contains a misleading account of the study by DeSanctis et al. The DeSanctis article reviews the literature on the use of puberty blockers (GnRHa's) for children diagnosed with central precocious puberty. De Sanctis finds that blockers are generally "safe

⁵⁸ See Luke R. Allen, et al., Well-Being and Suicidality Among Transgender Youth after Gender-Affirming Hormones, 7(3) *Clinical Practice in Pediatric Psychology* 302-11 (2019); Amy E. Green, et al., Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth, 70(4) *J. Adolescent Health* 643-649 (2022); Jack L. Turban, et al., Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation, 145(2) *Pediatrics* e20191725 (2020); Maureen D. Connolly, et al., The Mental Health of Transgender Youth: Advances in Understanding, 59(5) *J. Adolescent Health* 489-95 (2016); Gemma L. Witcomb et al., Levels of Depression in Transgender People and its Predictors: Results of a Large Matched Control Study with Transgender People Accessing Clinical Services, *J. Affective Disorders* (2018).

⁵⁹ For citations, see Boulware et al., *supra* note 27, at n. 43.

⁶⁰ Diane Chen, et al., Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Puberty Suppression in Transgender Youth, *Transgender Health* 246-257 (2020).

⁶¹ June 2 Report, p. 15.

and well-tolerated in children and adolescents” and that most drug reactions were mild.⁶² The June 2 Report misleadingly and without foundation cites the De Sanctis piece as “[raising] questions about whether off-label use to treat a psychological condition [gender dysphoria] is worth the risks.”⁶³ This attribution is bizarre, because De Sanctis et al. actually *support* the use of puberty blockers (by finding them safe and with only rare side effects) and do not offer any evidence at all to suggest that the risks are higher in the treatment of gender dysphoria.

As a final example, the June 2 Report criticizes a 2019 preliminary study by Kuper et al. without acknowledging the existence of a 2020 study by Kuper et al.⁶⁴ The earlier study presented data on the mental health of adolescents when initially presenting for care; only the later study presented full data that demonstrated the benefit of treatment.

C. The June 2 Report mistakenly claims that puberty blockers and hormones are experimental because they are used “off-label” and not approved by the FDA. In fact, off-label use, when supported by scientific evidence, as is the case here, is extremely common in medical practice and especially in pediatrics.

The June 2 Report repeatedly notes that the FDA has not approved the use of puberty blockers and hormones for the treatment of gender dysphoria in minors.⁶⁵ The report infers that lack of FDA approval renders a treatment unauthorized and experimental, but this is false.

Once again, the June 2 Report is (mis)using technical language in a way that is likely confusing to non-experts. The term “off-label” has a very specific meaning: a drug is off-label if the FDA has not specifically approved a particular medication for a particular use in a specific population. The off-label use of medications for children is quite common and often necessary, because an “overwhelming number of drugs” have no FDA-approved instructions for use in pediatric patients.⁶⁶

The lack of FDA approval does not imply that the use of medications should be restricted. There is a consensus in the medical community that off-label use reflects a product of burdensome and expensive regulatory processes. Pharmaceutical companies often lack financial incentives to support research required for FDA approval for specific use in children.⁶⁷

⁶² Vincenzo De Sanctis, et al., Long-Term Effects and Significant Adverse Drug Reactions (ADRs) Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: a Brief Review of Literature, 90(3) Acta Biomed. 345-359 (2019).

⁶³ June 2 Report, p. 16.

⁶⁴ June 2 Report, p. 16. The earlier Kuper et al. study is Laura E. Kuper et al., Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy, 40(8) J. Dev. Behav. Pediatr. 589-596 (2019). The later study is Laura E. Kuper et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) Pediatrics e20193006 (2020).

⁶⁵ June 2 Report, pp. 8, 14, 15, 19.

⁶⁶ Boulware et al, supra note 27, quoting Kathleen A. Neville, et al., American Academy of Pediatrics Committee on Drugs, Off-label use of drugs in children, 133(3) Pediatrics 563-7 (2014) (“AAP Committee on Drugs”).

⁶⁷ AAP Committee on Drugs (2014), supra note 66.

The American Academy of Pediatrics, recognizing these facts, specifically authorizes the off-label use of drugs:

The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, *the term “off-label” does not imply an improper, illegal, contraindicated, or investigational use.* Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.⁶⁸

Off-label use is so common in pediatrics that off-label drugs are prescribed in 20% of patient visits.⁶⁹ Combined hormonal contraceptives or progesterone-only contraceptive methods, which are approved on-label for contraception, are also used off-label to treat heavy menstrual bleeding, which could be due to a bleeding disorder, a delay in normal pubertal maturity or variety of other conditions; they are also used off-label for premenstrual dysphoria disorder and polycystic ovarian syndrome.

A host of familiar examples provide illustrations of day-to-day, off-label use in pediatrics.⁷⁰ The use of steroids for croup is a life-saving treatment that is off-label. The medication helps toddlers get through severe, potentially airway-obstructing illnesses safely. Ondansetron (Zofran) is used off-label for nausea and vomiting to prevent fluid loss, as children are particularly vulnerable to severe dehydration.

Off-label use is also common in pediatric compassionate care, and frequently the on-label use is very different from the off-label use. Gabapentin, for example, is used on-label for the treatment of seizures but used off-label for neuropathic or mixed pain. Ketamine and fentanyl are used on-label in anesthesia but off-label for pain relief, for example, to manage chronic pain in palliative care and in patients with cancer.

In neonatal medicine, off-label medications are routinely used to treat the smallest and most fragile babies. Caffeine is used off-label to treat apnea (i.e., idiopathic respiratory arrest) of prematurity and phenobarbital is used off-label to treat neonatal seizures. More routinely, in general pediatric care, pantoprazole is a proton pump inhibitor (PPI) used to treat acid reflux. It is used off-label in neonates with gastroesophageal reflux disease who do not respond to traditional first-line treatments. It is used successfully to help infants gain adequate weight in the first four to six months of life if they do not respond to using different types of bottles, slow flow nipples, or more frequent and lower volume feedings.

In addiction medicine, routine medications like supplemental nicotine patches are off-label; they are not approved for use in those younger than 18 but are used successfully in vaping/smoking cessation, so much so that the AAP has issued guidelines on how to use and dose them.

⁶⁸ Id. (emphasis added). See also Lenneke Schrier, et al., Off-label Use of Medicines in Neonates, Infants, Children, and Adolescents: a Joint Policy Statement by the European Academy of Paediatrics and the European Society for Developmental Perinatal and Pediatric Pharmacology, 179(5) Eur. J. Pediatr 839-845 (2020).

⁶⁹ Diya Hoon, et al., Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015, 144(4) Pediatrics 1-10 (2019) (emphasis added).

⁷⁰ These examples are drawn from the list of off-label uses in AAP Committee on Drugs (2014) and reflect our clinical experience in major hospitals and clinics.

Bupropion is used on-label as an antidepressant and off-label for smoking cessation. Buprenorphine (suboxone) is used on-label in those 16 or older with opioid use disorder but used off-label in those who are younger; this medication prevents overdose death and allows those struggling with addiction to safely recover.

In psychiatry, some of the most commonly-prescribed medications for youth are off label. For example, selective serotonin reuptake inhibitors (SSRIs) are used to treat major depressive disorder and generalized anxiety in adolescents and have been shown to be effective, even though several of these including sertraline and escitalopram) are off-label.⁷¹ Other common examples include clonidine, which is FDA-approved for attention deficit hyperactivity disorder (ADHD) but is also used off-label for anxiety, insomnia, and post-traumatic stress disorder (PTSD).⁷²

Finally, the June 2 Report also notes that testosterone is a controlled substance and is subject to risk of abuse, but, once again, this is misleading. The inclusion of testosterone on the schedule of controlled substances reflects the misuse of the drug by some individuals and communities (e.g., weight lifters and athletes who may use the drug to build muscle). The classification does not in any way imply that physicians should not dispense the drug if medically necessary. No special license is necessary for prescribing the medication, which is routinely prescribed to cisgender men with testosterone deficiency as well as to transmasculine patients.

D. The June 2 Report falsely claims that medical care for gender dysphoria is provided to a large percentage of children who will come to regret their treatment. In fact, patients with gender dysphoria have vanishingly low rates of regret regarding their medical treatment.

The June 2 Report attempts to cast doubt on medical treatment for gender dysphoria by repeating the debunked claim that most transgender teens ultimately reject their transgender identity. Below, we analyze two related claims made in the report and show why both are refuted by sound evidence.

First, the report claims that “the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex.”⁷³ This is false. We have refuted this claim in detail in prior work (addressing similar claims made to support medical treatment bans in Texas and Alabama). The key point is that *adolescents with gender dysphoria rarely find that their dysphoria resolves without treatment*.⁷⁴ Because medical treatment for gender dysphoria begins only in adolescence, and only if medically necessary for gender dysphoria, medical treatment is thus provided only to a group known to be quite stable in their gender identity.

⁷¹ For AACAP guidelines, see Boris Birmaher and David Brent, Practice Parameter for the Assessment and treatment of Children and Adolescents with Depressive Disorders, 46(10 J. Am. Acad. Child and Adolescent Psychiatry P1503-1526 (2007).

⁷² Rama Yasaei and Abdolreza Saadabadi, Clonidine, National Library of Medicine (2022), at <https://www.ncbi.nlm.nih.gov/books/NBK459124/> [visited July 4, 2022].

⁷³ June 2 Report, p. 14.

⁷⁴ Boulware et al., *supra* note 27, at 17-19.

The authoritative WPATH and Endocrine Society clinical practice guidelines contain measures to ensure that medical treatment is administered only when medically necessary.⁷⁵ As part of the process of diagnosis and treatment, clinicians take care to explain to the youth and their parents the risks and the benefits of medical treatment as well as the risks and benefits of no medical interventions.

Second, the June 2 report claims, without citation, that “roughly 8% [of transgender people] decide to return to their natal sex” for reasons ranging “from treatment side effects to more self-exploration that provided insight on individuals' gender dysphoria.”⁷⁶ The 8% figure is not large, but it is nevertheless an overstatement of the percentages found in the scientific literature: solid studies show very low percentages of regret (typically under 1%) among transgender people who receive medical treatment for gender dysphoria.

The June 2 report offers as general evidence for its claims about regret only a 2021 study by Littman.⁷⁷ But the Littman study cannot establish how prevalent it is for transgender individuals to reject their transgender identity. Indeed, the Littman study does not even purport to show the percentage of transgender people who “detransition.” Instead, it simply asked 100 people who self-identified as “detransitioners” about their reasons. Using Littman’s study as evidence of widespread regret is akin to saying that giant pandas (an endangered species) are common because, if we search, we can find 100 of them.

Furthermore, the Littman study used a biased sampling and survey methodology: survey was anonymous; its participants were solicited from (among other venues) anti-transgender social media groups.

Finally, the June 2 Report makes a flagrant error in conflating “detransition” with “regret.”⁷⁸ In addition, the Littman study is unscientific in describing a likely very diverse group of people as “detransitioners.” She defines detransition as “discontinuing medications, having surgery to reverse the effects of transition, or both.” Littman’s definition is highly misleading, because transgender people may have many reasons to discontinue medication. One might continue to live socially in a gender role that is not the one assigned at birth and yet, by Littman’s criteria, be counted as a “detransitioner.” In our clinical practice, we have seen youth who discontinued hormone therapy because the effects had addressed their dysphoria; these patients were nonbinary, but Littman’s method would mistakenly count them as “detransitioners.”

By contrast, the June 2 report disregards a very large and far more nuanced and important 2021 study by Turban et al., which shows that transgender people who do return to live as the sex assigned at birth may not permanently do so and are, by their own report, influenced largely by “external factors, such as pressure from family, nonaffirming school environments, and sexual

⁷⁵ WPATH (2012) and Endocrine Society (2017), *supra* note 5.

⁷⁶ *Id.*

⁷⁷ Lisa Littman, Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners, 50 *Archives of Sexual Behavior* 3353-3369 (2021).

⁷⁸ See generally Jack L. Turban, et al., Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis, 8(4) *LGBT Health* 273-280 (2021) (noting that “the term ‘detransition’ has at times been conflated with regret, particularly with regard to medical and surgical affirmation”).

assault.”⁷⁹ The study found that only a minority of survey participants “reported that detransition was due to internal factors, including psychological reasons, uncertainty about gender identity, and fluctuations in gender identity.” Indeed, as the authors note, these psychological experiences “*did not necessarily reflect regret* regarding past gender affirmation, and were presumably temporary, as all of these respondents subsequently identified as transgender/gender diverse, an eligibility requirement for study participation.”⁸⁰

The June 2 Report also ignores a recent study, Olson et al. (2022), who find that after an average of 5 years of social transition, only 2.5% of youth identified as cisgender.⁸¹

Studies that actually focus on regret consistently find that transgender people only rarely regret their medical treatments.⁸² For example, Bustos et al. (2021) found regret expressed by one percent or fewer of transgender patients who underwent gender-affirming surgery, and Danker et al. (2018) report a rate of far less than 1%, as do Wiepjes et al. (2015).⁸³

E. The June 2 Report repeats discredited claims that “social contagion” is leading teens to become transgender. The issue, although sensationalized in the June 2 Report, is ultimately irrelevant to medical treatment, which is provided only after a multidisciplinary assessment and after a finding that gender dysphoria is persistent and medical treatment is warranted.

The June 2 Report claims that “social factors (e.g., peer influences and media) may be contributing factors to gender dysphoria,”⁸⁴ citing as evidence a single, discredited study by Littman. We have addressed this study at length in other work and note that

WPATH, among other authorities, has taken a skeptical view of Littman’s claim, and the study has been criticized for serious methodological errors, including the use of parent reports instead of clinical data and the recruitment of its sample of parents from anti-transgender websites. The journal of publication required an extensive correction of the original Littman article because of its misstatements. Such a correction in reputable, peer-reviewed academic journals is taken only when a panel of experts, in retrospect, came to recognize the methodological flaws of the original study and concluded that it would be unscientific to allow the originally published findings to stand.”⁸⁵

⁷⁹ Id.

⁸⁰ Id.

⁸¹ Kristina R. Olson, et al., Gender Identity Five Years After Social Transition, Pediatrics (preprint, May 2022).

⁸² Valeria P. Bustos, et al., Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence, 9(3) Plastic and Reconstructive Surgery - Global Open e3477 (2021); Sara Danker, et al., Abstract: A Survey Study of Surgeons’ Experience with Regret and/or Reversal of Gender-Confirmation Surgeries, 6(9 Supp.) Plastic and Reconstructive Surgery 189 (2018); Chantal M. Wiepjes, et al., The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets, 15(4) J. Sex Med. 582-590 (2018); see also Yolanda L.S. Smith, et al., Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals, 35(1) Psychological Medicine 89-199 (2005).

⁸³ Id.

⁸⁴ June 2 Report, p. 12.

⁸⁵ Boulware et al., supra note 27, at 20-21 (internal citations omitted).

Littman's sensationalist hypothesis has been widely covered in the press, but no clinical studies have found that rapid-onset gender dysphoria exists. Further, no professional organization has recognized "rapid-onset gender dysphoria" as a distinct clinical condition or diagnosis.

Most recently, an April 2022 study of 173 youth presenting at Canadian gender clinics *found no evidence of rapid-onset dysphoria or social contagion*. The researchers posited that if "rapid onset" gender dysphoria were a real phenomenon, then teens who had more recently begun identifying as transgender would (per the Littman hypothesis) also be more likely to report online support and engagement in their gender identity. They might also (per Littman's hypothesis) be more likely to struggle with mental health concerns.

An April 2022 study of 173 youth found no such correlations, strongly undercutting the "rapid-onset" hypothesis endorsed by the June 2 report. The researchers controlled for age and sex assigned at birth and looked for correlations with recent gender knowledge (defined as less than one to two years having passed since "you realized your gender was different from what other people called you"). Recent gender knowledge was *not* significantly associated with depressive symptoms, psychological distress, past diagnoses with mental health issues or neurodevelopmental disorders, or self-harm. Nor was it associated with having gender-supportive online friends, general support from online friends or transgender friends, or gender support from parents.⁸⁶

Data do substantiate that younger people today are more likely to identify as transgender than are older people, but this does not substantiate the idea of social contagion. The increase may be due to the increasing social acceptance of gender diversity (i.e., older people grew up in a more transphobic social environment). In fact, adolescent presentation of transgender identity is often observed and should not be pathologized. In the largest U.S. sample of transgender adults, over half reported first starting to realize that they were transgender in adolescence (57% ages 11-20) and roughly half (47%) started to disclose their identity during this time frame.⁸⁷

Further, the data do not show a massive wave of transgender identity even among teens. A 2022 study by the Williams Institute found that, using an expansive definition of "transgender," about 0.5% of adults now identify as transgender, while 1.4% of youth aged 13-17 do, or about 300,000 young people.⁸⁸ This is not a large percentage or a large absolute number.

Underlying the June 2 Report's claim about social contagion is a set of imagined stereotypes – that teenagers do not know their own gender identity and readily change their gender identity based on peer influence and social media. But these stereotypes contradict the scientific understanding of gender identity formation. Studies of so-called "conversion" or "reparative" therapy, for example, finds that transgender identity is highly resistant to change even in the face

⁸⁶ Greta R. Bauer, et al., 243 J. Pediatrics 224-227 (2022).

⁸⁷ Sandy E. James, et al., The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2015).

⁸⁸ Jody L. Herman, et al., How Many Adults and Youth Identify as Transgender in the United States?, U.C.L.A. School of Law, Williams Institute (2022).

of concerted efforts by medical authorities versed in psychological methods. Studies find that conversion therapy is ineffective in altering gender identity and is psychologically damaging.⁸⁹

F. The June 2 Report claims that inappropriate medical care is provided to adolescents with gender dysphoria who also have anxiety, depression, and other mental health conditions. These assertions are unsupported by scientific evidence and disregard evidence-based clinical practice guidelines that provide sound guidance for treating complex cases.

The June 2 Report speculates that because “a high proportion” of youth receiving medical care for gender dysphoria also have a behavioral health disorder, “available research raises questions as to whether the [individuals’] distress is secondary to pre-existing behavioral health disorders and not gender dysphoria.”⁹⁰ In simpler terms, *the June 2 Report speculates that perhaps gender dysphoria is not real but is, rather, an imagined by-product of underlying mental illness.* A close examination shows that this claim has no foundation in science; it rests on unexamined and harmful stereotypes and unaccountably dismisses the scientific knowledge and clinical skill of child and adolescent psychologists and psychiatrists.

First, the June 2 Report implicitly posits a causal hypothesis that behavioral health disorders cause gender dysphoria. This hypothesis is entirely devoid of scientific evidence. Indeed, the scientific evidence strongly suggests that the direction of causation runs the other way. It is well-established that being transgender leads to mental health concerns because of the social stress and discrimination of being transgender in a society that is strongly oriented to cisgender identity and disapproving of transgender identity.⁹¹ In our society, transgender individuals experience a great deal of discrimination, hostility, and physical violence. Quite simply, it is unsafe to be transgender in this current hostile climate.⁹² Accumulation of existential fear and threatening experiences can manifest as physical and mental conditions. Thus, one would expect – and studies confirm – that transgender people, on average, have worse physical and mental health than cisgender people.

Although the effects of gender minority stress are well-known, the June 2 Report makes no mention of the literature. Instead, it indulges in speculation based, apparently, on the

⁸⁹ A survey of the scientific literature by the U.S. Department of Health and Human Services finds that “none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.” Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, U.S. Department of Health and Human Services, HHS Publication No. (SMA) 15-4928 (2015), p. 1.

⁹⁰ June 2 Report, p. 6.

⁹¹ Rylan J. Testa, et al., Development of the Gender Minority Stress and Resilience Measure, 2(1) *Psychology of Sexual Orientation and Gender Diversity* 65-77 (2015); Rylan J. Testa, et al., Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors, 126(1) *J. Abnormal Psychology* 125-36 (2017); Alexandrai M. Delozier, et al., Health Disparities in Transgender and Gender Expansive Adolescents: A Topical Review from a Minority Stress Framework, 45(8) *J. Pediatric Psychology* 842-847 (2020); Jessica Hunter, et al., Gender Minority Stress in Trans and Gender Diverse Adolescents and Young People, 26(4) *Clinical Child Psychology and Psychiatry* 1182-1195 (2021).

⁹² See, e.g., Rebecca L. Stotzer, *Violence Against Transgender People: A Review of United States Data*, 14(3) *Aggression and Violent Behavior* 170-179 (2009).

stereotyping of transgender people as confused and dysfunctional. The June 2 Report posits that individuals with mental health concerns cannot be trusted to understand their own gender identity. This is a highly prejudicial stance and one that disregards the key role of psychologists and psychiatrists, who have developed sensitive and effective approaches to treating adolescents with gender dysphoria and mental health concerns.⁹³

Second, the co-occurrence of psychological distress among individuals with gender dysphoria provides no reason for denying care. Any population of individuals – cisgender or transgender – will include some with mental health concerns, and the WPATH and Endocrine Society guidelines recognize that there is a higher prevalence of anxiety, depression and post-traumatic stress disorder among transgender youth than among cisgender youth. In response, the guidelines set out practices that include a careful psychological assessment of each adolescent as part of the process for determining whether medical treatment for gender dysphoria is appropriate and likely to have benefits that outweigh risks.

The Endocrine Society guidelines specifically recommend that mental health professionals should be able to diagnose gender dysphoria and distinguish it from other “conditions that have similar features (*e.g.*, body dysmorphic disorder).” In addition, the mental health provider should be prepared to diagnose psychiatric conditions, provide or refer for treatment, and to “psychosocially assess the person’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy.”⁹⁴ In our clinical practice, we also ensure that youth and their caregivers have the information and support necessary to fully understand the risks, benefits, and outcomes of treatment. That is, we not only provide assessment but also fill in any gaps in understanding and support the decision-making process.

Our experience in clinical practice reflects these guidelines. Any consultation for medical treatment for gender dysphoria includes a mental health assessment. Further, the treatment plan for each adolescent is then individualized to reflect the risks and benefits of treatment and the risks and benefits of no treatment. Consistent with the WPATH guidelines, as clinicians, we ensure that the mental health concerns are not interfering with our ability to assess gender dysphoria and youth assent to treatment.

Third, the June 2 Report implicitly claims that any mental health disorder impairs a minor’s ability to provide informed assent and, somehow, also invalidates the informed consent of their guardian. Experts in child and adolescent psychiatry, child psychology, and adolescent medicine have established that youth can make complex medical decisions. Further, the literature specifically demonstrates that transgender youth with co-occurring mental health conditions can competently participate in decision-making.⁹⁵ With guidance from mental health providers, parents, and physicians, teens can be part of a decision process that helps them explore their identity and make nuanced decisions about the benefits and risks of medical treatment.⁹⁶ Indeed,

⁹³ See John F. Strang, et al., Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents, 47(1) *J. Clinical Child & Adolescent Psychology* 105-115 (2016).

⁹⁴ Endocrine Society (2017), *supra* note 5.

⁹⁵ Lieke J. Vrouenraets, et al., Assessing Medical Decision-Making Competence in Transgender Youth, 148(6) *Pediatrics* e2020049643 (2021).

⁹⁶ Beth A. Clark and Alice Virani, “This wasn’t a Split-Second Decision”: An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy, 18 *J. Bioethical Inquiry* 151-

these processes of exploration and decision-making are central goals of, and central tasks for, trained mental health providers who work with teens.

G. The June 2 Report speculates, without evidence, that psychotherapy alone is as effective as medical treatment for gender dysphoria. This claim contradicts the findings of solid scientific studies, which show that medical care is more effective than psychotherapy alone.

The June 2 Report argues, without scientific evidence, that youth with gender dysphoria should not be offered medical treatment but instead should only receive psychotherapy, an approach that it mistakenly terms “watchful waiting.”⁹⁷

The report offers no actual evidence for this denial of standard medical care. Its recommendation rests, instead, on an unfounded and mistaken criticism of the existing literature. The Cantor document, attached to the AHCA report as Appendix C, states that several studies “successfully identified evidence of [mental health] improvement [due to medical treatment for gender dysphoria], *but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.*”⁹⁸

This statement is false. Medical treatment for gender dysphoria has been shown to lead to positive effects on mental health that are not associated with psychotherapy alone. Costa et al. in 2015 found that puberty blockers improve psychosocial functioning in teens with gender dysphoria, compared to teens who receive psychotherapy but not blockers.⁹⁹ Costa’s study was designed to include a control group of teens with gender dysphoria who did not receive blockers.

In a 2022 study, Tordoff et al find that puberty blockers and hormone therapy are associated with significant improvements in depression and suicidality in a population of transgender and nonbinary youths aged 13 to 20.¹⁰⁰ The authors showed the independent effects of medications such as puberty blockers and hormones on depression, anxiety, and gender dysphoria. They controlled for temporal trends and other confounding factors, expressly including whether the teen received “ongoing mental health therapy other than for the purpose of a mental health assessment to receive a gender dysphoria diagnosis.”¹⁰¹ Put simply, Tordoff et al. clearly found

164(2021); Vrouenrats, et al., supra note 95; Megan S. O'Brien, Critical Issues for Psychiatric Medication Shared Decision Making with Youth and Families, 92(3) Families in Society 310-316 (2011); Mary Ann McCabe, Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations 21(4) J. Pediatric Psychology 505-516 (1996).

⁹⁷ For example, at p. 12, the June 2 Report asks, “[S]hould conventional behavioral health services be utilized without proposing treatments that pose irreversible effects [i.e., drug therapies]? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects {i.e., the watchful waiting approach}?” At p. 20, the June 2 Report misuses the term “watchful waiting” to describe the denial of medical care to adolescents with gender dysphoria, and the report miscites its own purported expert report. The Cantor document discusses “watchful waiting” meaning the denial of social transition to prepubertal children, not the denial of medical treatment to adolescents. Cantor document, p. 10-11.

⁹⁸ Cantor document, p. 13.

⁹⁹ Costa et al., supra note 56.

¹⁰⁰ Diana M. Tordoff et al., Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care, 5(2) JAMA Network Open e220978 (2022).

¹⁰¹ Id.

that youth with gender dysphoria reported better outcomes if they received puberty blockers, even after controlling for the effects of psychotherapy.

Similarly, in a 2020 study, Laura Kuper et al. found that gender-affirming hormone therapy made a large improvement in adolescents' body-related distress and led to small to moderate improvement in symptoms of depression and anxiety.¹⁰² Kuper et al. specifically collected data on psychotherapy and the use of psychiatric medications and expressly controlled for both. Thus, Kuper et al.'s study shows that hormone treatment for gender dysphoria is effective above and beyond the benefits of psychotherapy and psychiatric medications.

¹⁰² Laura E. Kuper, et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) *Pediatrics* e20193006 (2020).



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July 29, 2022

Dr. David Diamond, Chair
Florida Board of Medicine
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Dear Dr Diamond,

The American Academy of Pediatrics (AAP), a nonprofit organization representing 67,000 pediatricians dedicated to the health, safety and well-being of all children and the Florida Chapter of American Academy of Pediatrics, Inc (FCAAP), a nonprofit organization representing more than 2,600 pediatricians committed to serving all children across the state, writes to express our concern regarding the request from the Florida Surgeon General for the Florida Board of Medicine to develop new standards of care for the treatment of gender dysphoria.

Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics;ⁱ the Florida Chapter of the American Academy of Pediatrics, Inc;ⁱⁱ the American Medical Association;ⁱⁱⁱ the American College of Obstetricians and Gynecologists;^{iv} the American College of Physicians;^v the American Psychiatric Association;^{vi} the American Psychological Association;^{vii} the American Academy of Family Physicians;^{viii} the American Academy of Child and Adolescent Psychiatry;^{ix} the Endocrine Society;^x the Society for Adolescent Health and Medicine;^{xi} the Pediatric Endocrine Society;^{xii} the World Professional Association for Transgender Health (WPATH);^{xiii} and many more medical organizations committed to providing the best evidence-based care.^{xiv}

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7^{xv} and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline^{xvi} (both are herein referenced as "standards of care") are well recognized and accepted among the medical community as the gold standard for treating gender dysphoria.

Included in the Board's meeting agenda to discuss the development of new standards of care for the treatment of gender dysphoria is the June 2, 2022 Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report (GAPMS)^{xvii}. The AAP and FCAAP provided in-depth comments in opposition of both the GAPMS report and the proposed Medicaid rule to ban coverage of gender-affirming care. Our joint comments are included in our communication to the Florida Board of Medicine and we encourage you to review them. The GAPMS report, which serves as the evidentiary basis for the attempt to develop new standards of care, fails to satisfy even the basic tenets of scientific

inquiry and research.^{xviii} Experts from Yale University recently released a critical review of the GAPMS report and found:

- Contrary to the June 2 Report's repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported "expert" reports that are biased, inexperienced, and full of errors. The claimed "expert" reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
- The linchpin of the June 2 Report is an analysis by two epidemiologists that claims to undermine the scientific evidence supporting medical care for gender dysphoria. Their analysis is extremely narrow in scope, inexperienced, and so flawed that it merits no scientific weight at all.
- The June 2 Report repeatedly and erroneously dismisses solid studies as "low quality." If Florida's Medicaid program applied the June 2 Report's approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.^{xix}

Adolescents with gender dysphoria face increased challenges in life compared to their cisgender peers. Bullying, discrimination, harassment, and a lack of social acceptance are issues adolescents with gender dysphoria deal with on a daily basis and all these issues lead to increased risks of suicide and other mental health conditions.^{xx} In a study of more than 1,000 transgender adolescents, transgender adolescents had higher odds of all suicide outcomes compared to cisgender adolescents, and were at greater risk for suicidal ideations and attempts compared to their cisgender peers.^{xxi} Additionally, in the first large scale (N = 120,670) study examining the relationship between transgender adolescents and suicide, the authors found that between 30-51% of transgender adolescents reported engaging in suicidal behavior, compared to between 10-18% of their cisgender peers.^{xxii}

By proposing an alternative standard of care, Florida is ignoring the broad consensus among the medical community and the weight of peer reviewed medical literature. We call on the Florida Board of Medicine to reject the call for the development of new standards of care and ensure that the existing evidence-based standards of care are allowed to be used to care for children and adolescents with gender dysphoria. Only by doing so will the health and well-being of children and adolescents with gender dysphoria in Florida be preserved.

Thank you for your consideration of our comments.

Sincerely,

A handwritten signature in cursive script that reads "Moira Szilaygi".

Moira Szilaygi, MD, PhD, FAAP
President, American Academy of Pediatrics



Lisa Gwynn, DO, MBA, MSPH, FAAP

President, Florida Chapter of the American Academy of Pediatrics, Inc

ⁱ Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Gay, Lesbian, Bisexual and Transgender Health and Wellness. *Pediatrics*. Oct 2018; 142 (4) e20182162

ⁱⁱ Florida Chapter of the American Academy of Pediatrics, Inc. FCAAP Rejects New Florida Department of Health Guidelines on Gender-Affirming Care for Youth. 2022. Accessed on June 23, 2022. <https://www.fcaap.org/posts/news/press-releases/florida-chapter-of-the-american-academy-of-pediatrics-rejects-new-florida-department-of-health-guidelines-on-gender-affirming-care-for-youth/>

ⁱⁱⁱ American Medical Association. Health insurance coverage for gender-affirming care of transgender patients. 2019. Accessed on June 23, 2022. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>

^{iv} American College of Obstetricians and Gynecologists. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. 2021. Accessed on June 23, 2022. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>

^v Safer J, Tangpricha V. Care of the Transgender Patient. *Annals of Internal Medicine*. 2019 Jul 2;171(1):ITC1-ITC16.

^{vi} American Psychiatric Association. Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. 2020. Accessed on June 23, 2022. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>

^{vii} American Psychological Association. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, December 2015. Vol. 70, No. 9, 832–864

^{viii} American Academy of Family Physicians. Care for the Transgender and Gender Nonbinary Patient. 2020. Accessed on June 23, 2022. <https://www.aafp.org/about/policies/all/transgender-nonbinary.html>

^{ix} Adelson SL. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. *Jrnl of the American Academy of Child & Adolescent Psychiatry*. 2020; 957-974

^x Hembree W, Cohen-Kettenis P, Gooren L, Hannema S, Meyer W, Murad M, Rosenthal S, Safer J, Tangpricha V, T'Sjoen T. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2017; 102(11): 3869–3903

^{xi} Barkley L, Kodjo C, West KJ, et al. Promoting Health Equality and Nondiscrimination for Transgender and Gender-Diverse Youth. *Jrnl of Adolescent Health*. 2020; 66 (6): 804-807

^{xii} Lopez X, Marinkovic M, Rosenthal SM, et al. Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health. *Current Opinion in Pediatric*. 2017; 29(4). 475-480.

^{xiii} The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People 2011. Accessed on June 25, 2022. https://www.wpath.org/media/cms/Documents/SOC_v7/SOC_V7_English2012.pdf

^{xiv} Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>

^{xv} WPATH

^{xvi} Hembree et al

^{xvii} Florida Agency for Health Care Administration (ACHA), Division of Florida Medicaid. *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria (GAPMS)*. 2022. Accessed on June 22, 2022. https://ahca.myflorida.com/LetKidsBeKids/docs/AHCA_GAPMS_June_2022_Report.pdf

^{xviii} Alstott A, Boulware SD, Kamody R, Kuper L, Abdul-Latif H, McNamara M, Olezeski C, and Szilaygi N. Biased Science: A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria. July 8, 2022. Accessed on July 21, 2022. https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20ofinal%20july%208%202022%20accessible_443048_284_55174_v3.pdf

^{xix} Alstott et al

^{xx} Rafferty

^{xxi}Thoma BC, Salk RH, Choukas-Bradley , et al. Suicidality Disparities Between Transgender and Cisgender Adolescents. *Pediatrics*. 2019; 144(5)

^{xxii} Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 2018; 142(4)

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July 7, 2022

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Tom Wallace
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive
Mail Stop #8
Tallahassee, FL 32308

Dear Director Wallace,

The American Academy of Pediatrics (AAP), a nonprofit organization representing 67,000 pediatricians dedicated to the health, safety and well-being of all children and the Florida Chapter of American Academy of Pediatrics, Inc (FCAAP), a nonprofit organization representing more than 2,600 pediatricians committed to serving all children across the state, thank you for the opportunity to provide comments on the Florida Agency for Health Care Administration's proposed rule to prohibit gender-affirming care in the state's Medicaid program.

We write to express our grave concerns with the proposed rule. Denying evidence-based, medically necessary standards of care to transgender adolescents constitutes a broad and sweeping discriminatory action by the State of Florida and its Medicaid program.

Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics;¹ the Florida Chapter of the American Academy of Pediatrics, Inc;² the American Medical Association;³ the American College of Obstetricians and Gynecologists;⁴ the American College of Physicians;⁵ the American Psychiatric Association;⁶ the American Psychological Association;⁷ the American Academy of Family Physicians;⁸ the American Academy of Child and Adolescent Psychiatry;⁹ the Endocrine Society;¹⁰ the Society for Adolescent Health and Medicine;¹¹ the Pediatric Endocrine Society;¹² the World Professional Association for Transgender Health (WPATH);¹³ and many more members of the medical community.¹⁴

Gender-Affirming Care is the Standard of Care

Gender-affirming care is developmentally appropriate care that seeks to understand and appreciate a child's or adolescent's gender identity and experience through a safe and nonjudgmental partnership that includes general pediatricians, pediatric specialists, mental health providers, children and adolescents and their families.¹⁵ While gender-affirming care is irrefutably the standard of care, it must, like all other areas of medicine, be individualized to meet the needs of each and every unique patient.

¹ Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Gay, Lesbian, Bisexual and Transgender Health and Wellness. *Pediatrics*. Oct 2018; 142 (4) e20182162

² Florida Chapter of the American Academy of Pediatrics, Inc. FCAAP Rejects New Florida Department of Health Guidelines on Gender-Affirming Care for Youth. 2022. Accessed on June 23, 2022. <https://www.fcaap.org/posts/news/press-releases/florida-chapter-of-the-american-academy-of-pediatrics-rejects-new-florida-department-of-health-guidelines-on-gender-affirming-care-for-youth/>

³ American Medical Association. Health insurance coverage for gender-affirming care of transgender patients. 2019. Accessed on June 23, 2022. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>

⁴ American College of Obstetricians and Gynecologists. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. 2021. Accessed on June 23, 2022. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>

⁵ Safer J, Tangpricha V. Care of the Transgender Patient. *Annals of Internal Medicine*. 2019 Jul 2;171(1):ITC1-ITC16.

⁶ American Psychiatric Association. Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. 2020. Accessed on June 23, 2022. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>

⁷ American Psychological Association. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, December 2015. Vol. 70, No. 9, 832–864

⁸ American Academy of Family Physicians. Care for the Transgender and Gender Nonbinary Patient. 2020. Accessed on June 23, 2022. <https://www.aafp.org/about/policies/all/transgender-nonbinary.html>

⁹ Adelson SL. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents. *Jrnl of the American Academy of Child & Adolescent Psychiatry*. 2020; 957-974

¹⁰ Hembree W, Cohen-Kettenis P, Gooren L, Hannema S, Meyer W, Murad M, Rosenthal S, Safer J, Tangpricha V, T'Sjoen T. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2017; 102(11): 3869–3903

¹¹ Barkley L, Kodjo C, West KJ, et al. Promoting Health Equality and Nondiscrimination for Transgender and Gender-Diverse Youth. *Jrnl of Adolescent Health*. 2020; 66 (6): 804-807

¹² Lopez X, Marinkovic M, Rosenthal SM, et al. Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health. *Current Opinion in Pediatric*. 2017; 29(4). 475-480.

¹³ The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People 2011. Accessed on June 25, 2022. https://www.wpath.org/media/cms/Documents/SOC_v7/SOC_V7_English2012.pdf

¹⁴ Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>

¹⁵ Rafferty

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7¹⁶ and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline¹⁷ (both are herein referenced as "standards of care") are in fact the gold standard, contrary to the State of Florida's assertion, among the medical community for caring for children and adolescents with gender dysphoria.

For a model of care to be considered the standard of care for a specific diagnosis, the care must be "treatment that is accepted by medical experts as a proper treatment for a certain type of disease and that is widely used by healthcare professionals."¹⁸ The State of Florida's attempt to argue that gender-affirming care is not the standard of care, as referenced in its Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report¹⁹ and its "Florida Fact-Checked" version of the²⁰ HHS Office of Population Affairs Guidance on gender-affirming care, is entirely inconsistent with the well-recognized and established definition of standard of care, and represents a purposeful mischaracterization of available evidence as well as the position of the medical community.

Instead of supporting the standard of care for transgender adolescents, the state is seeking to rely only on "watchful waiting." This outdated model is based on long-refuted binary notions of gender and assumes without evidence that gender identity becomes fixed at a certain age²¹ and will result in direct harm to gender dysphoric children and adolescents who are denied access to well-evidenced multidisciplinary care.²² Notably, "watchful waiting" is based on studies with flawed methodology, validity concerns, and limited follow-up of transgender adolescents.²³ Thus, "watchful waiting" is not recommended by any major medical association in the United States.

Gender Dysphoria

Gender dysphoria is a formal diagnosis under *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) in which there is a pronounced incongruence between someone's gender identity or expression and sex assigned at birth.²⁴ For the diagnosis, the patient must exhibit 2 of the following for at least 6 months:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)

¹⁶ WPATH

¹⁷ Hembree et al

¹⁸ National Institute for Health, National Cancer Institute. Definition of Standard of Care. Accessed June 21, 2022.

<https://www.cancer.gov/publications/dictionaries/cancer-terms/def/standard-of-care>

¹⁹ Florida Agency for Health Care Administration (ACHA), Division of Florida Medicaid. *Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria* (GAPMS). 2022. Accessed on June 22, 2022.

https://ahca.myflorida.com/LetKidsBeKids/docs/AHCA_GAPMS_June_2022_Report.pdf

²⁰ Florida Agency for Health Care Administration (ACHA). *Florida Fact-Checked*. 2022. Accessed on June 22, 2022.

<https://ahca.myflorida.com/LetKidsBeKids/docs/FLFactCheck.pdf>

²¹ Ibid

²² Rafferty

²³ Ibid

²⁴ American Psychiatric Association. A Guide for Working with Transgender and Gender Nonconforming Patients, Gender Dysphoria Diagnosis. Accessed on June 26, 2022. <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis>

- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)²⁵

In an apparent attempt to undermine the validity of the diagnosis of gender dysphoria, the state, under "Etiology of Gender Dysphoria,"²⁶ implies that mental and physical health conditions are the primary cause of gender dysphoria and that psychological support is all that is needed to provide care for gender dysphoric youth. However, the preponderance of the evidence indicates that gender dysphoria is indeed a primary diagnosis in which mental health issues are often exacerbated by lack of access to appropriate gender affirming care.²⁷ The state disqualifies its own arguments by stating: "At the moment, none of these studies provides a definitive cause and offer only correlations and weakly supported hypotheses. In addition, evidence favoring a biological explanation is highly speculative."²⁸ To be clear, there is no evidence that mental or physical health conditions cause gender dysphoria. As such, mischaracterizing the diagnosis in an effort to prohibit gender-affirming care is disingenuous at best and would result in direct harm to transgender children and adolescents.

Included in the state's document is the suggestion that mental health care should be the first line of care for youth diagnosed with gender dysphoria. On this, we agree. In fact, the evidence-based standards of care for gender-dysphoria, as referenced above, recommend mental health evaluation and care as the first step for affected children and adolescents.²⁹ Indeed, research demonstrates that transgender children and adolescents experience stigma and discrimination, which adversely affects their mental health.³⁰ Children and adolescents diagnosed with gender dysphoria often have to hide their gender identities to avoid bullying and harassment and face greater risks of homelessness, physical violence in the home and in the community, and substance use.³¹ However, the state conflates the association of mental health diagnoses, trauma, and attachment issues with causality for gender dysphoria in an effort to discredit the primary diagnosis. In reality, the mental health issues faced by those with gender dysphoria are often the *direct result of* a lack of access to care or not being supported in their gender identity.³²

²⁵ Ibid

²⁶ Florida ACHA GAPMS

²⁷ Rafferty

²⁸ Florida ACHA GAPMS

²⁹ WPATH; Hembree et al

³⁰ Rafferty

³¹ Ibid

³² Ibid

In further attempting to undermine the well-established diagnosis of gender dysphoria, the state seeks to incorporate the concept of “rapid onset gender dysphoria.”³³ The manuscript from which the term “rapid onset gender dysphoria” originates has been widely criticized.³⁴ An expert review emphasized the following issues:

- “This study of parent observations and interpretations serves to develop the hypotheses that rapid-onset gender dysphoria is a phenomenon and that social influences, parent-child conflict, and maladaptive coping mechanisms may be contributing factors for some individuals. Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon. Additional research that includes AYAs, along with consensus among experts in the field, will be needed to determine if what is described here as rapid-onset gender dysphoria (ROGD) will become a formal diagnosis. Furthermore, the use of the term, rapid-onset gender dysphoria should be used cautiously by clinicians and parents to describe youth who appear to fall into this category. The term should not be used in a way to imply that it explains the experiences of all gender dysphoric youth nor should it be used to stigmatize vulnerable individuals.”³⁵
- “...the study design of this research falls under descriptive research: as such, it did not assign an exposure, there were no comparison groups, and the study’s output was hypothesis-generating rather than hypothesis-testing.”³⁶

The Coalition for the Advancement & Application of Psychological Science, which includes the American Psychiatric Association, the American Psychological Association, the Society for a Science of Clinical Psychology, the Society of Clinical Child and Adolescent Psychology, the Society of Pediatric Psychology, and many more international, national, and state psychological and psychiatric associations, published a position statement on the concept of rapid onset gender dysphoria, stating:

- ...it has not been subjected to rigorous peer-review processes that are standard for clinical science. Further, there is no evidence that ROGD aligns with the lived experiences of transgender children and adolescents.
- Research on gender identity development in children and adolescents continues to evolve and these advances will likely influence diagnosis and empirically-based standards of care, as well as the legislative landscape impacting trans people’s access to care and legal protections. The available research is clear that transgender people are subjected to marginalization, stigmatization, and minority stress, which have significant detrimental effects on health and well-being. Terms, such as ROGD, that further stigmatize and limit access to gender-affirming and evidence-based care violate the principles upon which CAAPS was founded and public trust in clinical science.³⁷

Mental Health Care

Under the evidence-based standards of care, mental health care is indeed the first step in the care of children and adolescents diagnosed with gender dysphoria. The evidence-based standards of care recommend that a child or adolescent diagnosed with gender dysphoria be seen and evaluated by a qualified mental health professional trained in child and adolescent developmental psychopathology, competent in diagnosing and

³³ ACHA GAPMS

³⁴ Littman L. Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE* 2019; 14(3): e0214157

³⁵ Ibid

³⁶ Ibid

³⁷ Coalition for the Advancement and Application of Psychological Science (CAAPS). CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD). Accessed June 24, 2022. <https://www.caaps.co/rogd-statement>

treating the ordinary problems of children and adolescents and meeting the same competency requirements as mental health professionals working with adults.³⁸ Under the evidence-based standards of care, a qualified mental health professional has a responsibility to:³⁹

- Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).
- Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.
- Assess and treat any coexisting mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.
- Refer adolescents for additional physical interventions (such as puberty-suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.
- Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).
- Provide children, youth, and their families with information and referral for peer support such as support groups for parents of gender-nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).⁴⁰

The evidence-based standards of care clearly recommend that mental health providers who care for children and adolescents with gender dysphoria diagnose and treat any other mental health conditions the child or adolescent is experiencing. Thus, the state's implication that mental health providers are not addressing existing mental health concerns prior to beginning gender-affirming medical care is wholly inaccurate. Prior to puberty, mental health professionals, pediatricians, and other health care providers "work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender" without medical interventions.⁴¹

Medical Care

The state begins its literature review on gender dysphoria and puberty suppression by attempting to argue that a majority of children and adolescents will cease showing signs of gender dysphoria and conform to their sex assigned at birth. Herein lies a distinction between prepubertal children and adolescents that the state fails to consider, or outright ignores.

³⁸ WPATH

³⁹ Ibid

⁴⁰ WPATH

⁴¹ Rafferty

In its “Florida Fact-Checked” version of the HHS Gender Affirming Care document, the state notes that “most *children* identifying as transgender will detransition following the onset of puberty.”⁴² Additionally, in the ACHA GAPMS report, the state makes a similar argument, including “neither organization explains that a majority of young *adolescents* who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that puberty suppression can have side effects.”⁴³ By definition, a child is defined as “a young person especially between infancy and puberty,”⁴⁴ while adolescence is defined as “the period of life when a child develops into an adult: the period from puberty to maturity terminating legally at the age of majority.”⁴⁵ The key difference between children and adolescents being the onset of puberty. By referencing “children” it is “Florida Fact-Checked” document⁴⁶ and “young adolescents”⁴⁷ in the ACHA GAPMS report, the state erroneously conflates the 2 terms. However, the definitions of these terms are different and cannot be used interchangeably.

Furthermore, the state relies on a study that “offers data on the percentage of children who opt not to transition after experiencing gender dysphoria.”⁴⁸ Similar claims made in other states that have attempted to ban gender-affirming care have been thoroughly debunked by a recent expert review from faculty from Yale University and the University of Texas Southwestern. The report from Yale examined in detail the misrepresentation of the Steensma et al study, explaining that:

- “...the Steensma study was not designed to (and the lead author has acknowledged) does not provide a basis for calculating what percentage of prepubertal children diagnosed with gender dysphoria persist with that diagnosis into adolescence. Rather, the Steensma study was designed only to study the characteristics of those who persisted.”⁴⁹ Among other limitations, in Steensma (2013), former patients who opted to not participate in the study (either refused to participate or did not respond to an offer to participate) were categorized as “desisters,” i.e., patients whose gender dysphoria resolved without transition or treatment. Patients can fail to respond to a study request for many reasons, including having moved away, receiving treatment elsewhere, or being uninterested in participating in a study. Thus, SEGM misuses the Steensma data by counting nonresponding patients as having “desisted” in experiencing gender dysphoria.⁶⁰ Indeed, in published correspondence, Steensma emphasizes that the 2013 study should not be used to calculate the percentages of “persisters” and “desisters.”⁶² The misrepresentation of Steensma on the SEGM website constitutes a major violation of the scientific method and the accepted conventions of research.⁴⁹

Some prepubertal children's diagnosis of gender dysphoria will indeed not continue in adolescence, and as such, **there are no recommended medical interventions for prepubertal children.** For prepubertal children,

⁴² ACHA GAPMS; Florida Fact-Checked

⁴³ Florida ACHA GAPMS

⁴⁴ Merriam-Webster. Definition of child, 2022. Accessed on June 25, 2022. <https://www.merriam-webster.com/dictionary/child>

⁴⁵ Merriam-Webster. Definition of adolescence, 2022. Accessed on June 25, 2022. <https://www.merriam-webster.com/dictionary/adolescence>

⁴⁶ Florida Fact-Checked

⁴⁷ Florida ACHA GAPMS

⁴⁸ Ibid

⁴⁹ Boulware SD, Kamody R, Kuper L, McNamara M, Olezeski C, Szilaygi N, and Alstott A. Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims. April 28, 2022. Accessed on June 27, 2022. https://medicine.yale.edu/childstudy/policy-and-social-innovation/lgbtq-youth/report%20on%20the%20science%20of%20gender-affirming%20care%20final%20april%2028%202022_437080_54636_v2.pdf

gender exploration is a natural part of child development.⁵⁰ However, for children diagnosed with gender dysphoria persisting at the onset of puberty (adolescence), research demonstrates that gender dysphoria will continue.^{51,52} Under gender-affirming care, adolescents diagnosed with gender dysphoria, after careful and exhaustive mental health evaluation and care⁵³, may progress to gender-affirming medical care under the evidence-based standards of care.

Pubertal Blockers

Under the evidence-based standards of care, gender-affirming medical care is a highly individualized model of care. Prior to beginning gonadotrophin-releasing hormone agonists (GnRH, herein referred to as puberty blockers) as a component of a multidisciplinary approach to caring for adolescents diagnosed with gender dysphoria, adolescents must meet stringent criteria under the evidence-based standards of care from WPATH, including:

- The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
- Gender dysphoria emerged or worsened with the onset of puberty;
- Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment.
- The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment.”⁵⁴

The Endocrine Society lays out additional criteria that must be met prior to undergoing puberty blockers as a component of gender-affirming medical care:

- (the adolescent) has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- (the adolescent) has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment
 - agrees with the indication for GnRH agonist treatment,
 - has confirmed that puberty has started in the adolescent (Tanner stage \geq G2/B2),
 - has confirmed that there are no medical contraindications to GnRH agonist treatment.⁵⁵

⁵⁰ Rafferty

⁵¹ WPATH

⁵² Boulware et al

⁵³ WPATH

⁵⁴ Ibid

⁵⁵ Hembree et al

In the ACHA GAPMS report and the “Florida Fact-Checked” document, the state asserts that there is no credible evidence demonstrating puberty blockers benefit adolescents diagnosed with gender dysphoria. However, the state either unknowingly or willingly ignores the body of evidence that supports this practice.⁵⁶ Medication to suppress puberty has been used to treat precocious puberty for decades.⁵⁷ The identical therapeutics are also used in adolescents diagnosed with gender-dysphoria and perhaps more importantly represent a very reasonable balance of risk and benefit when considering the totality of the available data and clinical experience. The pubertal blocker phase of gender-affirming care importantly allows the patient to delay the development of secondary sex characteristics.⁵⁸ By pausing the progression of secondary sex characteristics, adolescents are provided time to explore their gender identity, access and/or continue mental health support, and assess and define their treatment goals, in conjunction with their families.⁵⁹

Contrary to the state’s assertion that the evidence supporting use of puberty blockers is “weak,” a large body of evidence supports their use in adolescents diagnosed with gender dysphoria.⁶⁰ For example, recent research examined 272 adolescents who were referred to a gender clinic, but had not yet begun undergoing gender-affirming medical care, including puberty blockers, and 178 adolescents who had already begun receiving gender-affirming care using puberty blockers with 651 cisgender adolescents.⁶¹ The researchers found that adolescents with gender dysphoria had worse psychological health compared with their cisgender adolescent peers and that after receiving puberty blockers as part of gender-affirming care, the adolescents with gender dysphoria had similar or better psychological health than their cisgender peers.⁶² Another recent study found that transgender adults who wanted and were able to access puberty blockers as adolescents were less likely to have lifetime suicidal ideation compared to transgender adults who were not able to access puberty suppression medication as adolescents.⁶³ In a 2-year follow-up study, researchers found that the use of puberty blockers led to improvements in overall functioning and decreased instances of depression.⁶⁴

The state further asserts that “puberty suppression causes side effects, some of which have the potential to be permanent.”⁶⁵ However, experts point out that “recent studies suggest that puberty-blocking medication has negligible or small effects on bone development in adolescents, and any negative effects are temporary and reversible. The most recent studies show that puberty-blocking drug therapy either has no effect on bone mineral density (BMD), a proxy measure of bone strength, or is associated with a very small decrease.”⁶⁶

⁵⁶ Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>; Rafferty; Boulware et al

⁵⁷ Guaraldi F, Beccuti G, Gori D, and Ghizzoni L. MANAGEMENT OF ENDOCRINE DISEASE: Long-term outcomes of the treatment of central precocious puberty. *European Journal of Endocrinology*. 174(3); 79-87

⁵⁸ Rafferty

⁵⁹ Rafferty

⁶⁰ Eknes-Tucker et al v Ivey et al. Brief amicus curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations. 4 May 2022. <https://downloads.aap.org/DOFA/%5b%5bAs-Filed%5d%5d2022.05.04EknesTuckerv.IveyMedicalOrgAmicusBrief.pdf>; Rafferty; Boulware et al

⁶¹ van der Miesen, AI, Steensma, TD, de Vries, AL, Bos, H, & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*. 66(6), 699-704

⁶² Ibid

⁶³ Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. Feb 2020;145(2) doi:10.1542/peds.2019-1725

⁶⁴ De Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis, PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011 Aug;8(8):2276-83

⁶⁵ Florida ACHA GAPMS

⁶⁶ Boulware et al

Overall, the studies that have examined the use of puberty blockers, as a component of gender-affirming care, demonstrate that the use of these medications is evidence-based and provides for an appropriate risk/benefit ratio for adolescents diagnosed with gender dysphoria.⁶⁷

In addition, the state fixates on the argument that puberty blockers are used off-label, not approved by the Federal Drug Administration (FDA), and that no randomized clinical trials (RCT) have been completed on the use of puberty blockers to treat gender dysphoria. These arguments lack any basis. First, in pediatric medicine, “the purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, the term “off-label” does not imply an improper, illegal, contraindicated, or investigational use. Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.”⁶⁸ The use of off-label medication in pediatric medicine is supported by clinical evidence and data.⁶⁹ In suggesting that puberty blockers cannot be used to treat gender dysphoria simply because they have not been approved by the FDA for such purposes, the state fails to understand the relationship between the FDA and the practice of medicine:

- Good medical practice and the best interests of the patient require that physicians use legally available drugs, biologics and devices according to their best knowledge and judgment. If physicians use a product for an indication not in the approved labeling, they have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain records of the product's use and effects. Use of a marketed product in this manner when the intent is the “practice of medicine” does not require the submission of an Investigational New Drug Application (IND), Investigational Device Exemption (IDE) or review by an Institutional Review Board (IRB). However, the institution at which the product will be used may, under its own authority, require IRB review or other institutional oversight.⁷⁰

The use of off-label medication in pediatric medicine is not experimental, nor does it constitute anything other than the practice of evidence-based medicine. Off-label medication use for pediatric patients is commonplace and there is no basis to prohibit puberty blockers because of their off-label use in pediatrics.⁷¹

The state’s argument that puberty blockers have not undergone RCTs and therefore should be disqualified for use treating adolescents diagnosed with gender dysphoria is also severely flawed. As explained by Armand H. Antommara, MD, PhD, FAAP, HEC-C, Director of the Ethics Center, the Lee Ault Carter Chair of Pediatric Ethics, and an Attending Physician in the Division of Hospital Medicine at Cincinnati Children’s Hospital Medical Center:

- ...it may, at times, be unethical to conduct randomized trials. For randomized trials to be ethical, clinical equipoise must exist; there must be uncertainty about whether the efficacy of the intervention or the control is greater. Otherwise, it would be unethical to knowingly expose trial participants to an inferior intervention or control. Trials must also be feasible; it would also be unethical to expose

⁶⁷ Ibid

⁶⁸ Neville, KA, Frattarelli DAC, Galinkin JL, Green TP, et al; American Academy of Pediatrics Committee on Drugs. Off-Label Use of Drugs in Children. *Pediatrics*. 2014; 133(3):563-567

⁶⁹ Ibid

⁷⁰ US Food and Drug Administration. “Off-Label” and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices. 2020. Accessed on June 27, 2022. <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/label-and-investigational-use-marketed-drugs-biologics-and-medical-devices>

⁷¹ Allen HC, Garbe CM, Lees J, et al. Off-Label Medication use in Children, More Common than We Think: A Systematic Review of the Literature. *J Okla State Med Assoc*. 2018 Oct; 111(8): 776–783

individuals to the risks of trial participation without the benefit of the trial generating generalizable knowledge. A randomized trial that is unlikely to find enough people to participate because they believe they might be randomized to an inferior intervention would be unethical because it could not produce generalizable knowledge due to an inadequate sample size.⁷²

Furthermore, a group of leading bioethicists echo Dr Antommaria's explanation: "Randomized control trials also are only ethical when there is clinical " equipoise," which means they are only appropriate when there is genuine uncertainty about whether the intervention will be more effective than the control."⁷³ There is no uncertainty about the use of puberty blockers to treat adolescents diagnosed with gender dysphoria -- the evidence fully supports this intervention as a component of gender-affirming care. Studies other than RCTs are, in fact, utilized regularly in the practice of medicine and are preferable in some instances.⁷⁴

Gender-Affirming Hormone Therapy

As a component of gender-affirming care, adolescents who have received extensive mental health care and puberty blockers may progress to hormone therapy. As with every component of gender-affirming care, the use of hormone therapy is a highly individualized decision, and any decisions are made in concert with the adolescent, their family, and mental health and medical care providers. Under the evidence-based standards of care for receiving hormone therapy, the following criteria must be met:

- A qualified MHP (mental health professional) has confirmed:
 - the persistence of gender dysphoria,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
 - the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
- And the adolescent:
 - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
 - agrees with the indication for sex hormone treatment,
 - has confirmed that there are no medical contraindications to sex hormone treatment.⁷⁵

The state remarks in its Fact-Checked document that it is "misleading" to state that hormone therapy is partially reversible.⁷⁶ This is purposefully misleading. The evidence-based standards of care acknowledge that

⁷² Eknes-Tucker et al v Ivey et al. Declaration of Dr Armand H. Matheny Antommaria. 15 June 2021
<https://www.aclu.org/legal-document/brandt-et-al-v-rutledge-et-al-declaration-dr-armand-h-matheny-antommaria>.

⁷³ Eknes-Tucker et al v Ivey et al. Brief amicus curiae Biomedical Ethics and Public Health Scholars. 19 January 2022
<https://www.aclu.org/legal-document/brandt-et-al-v-rutledge-et-al-amicus-brief-bioethicists>

⁷⁴ Eknes-Tucker et al v Ivey et al. Declaration of Dr Armand H. Matheny Antommaria

⁷⁵ Hembree et al

⁷⁶ Florida Fact-Checked

some forms of hormone therapy are reversible and that some are not reversible.⁷⁷ Initiating hormone therapy is not a decision that is made lightly and there are stringent criteria that must be met, as referenced above. Furthermore, experts at Yale University explain that hormone therapy has a wide range of uses in adolescents:

- Estrogen and testosterone are often used off-label to treat adolescents with intersex conditions. Common hormonal medications used off-label include norethindrone, a progesterone analogue used off-label for the treatment of heavy menstrual bleeding in those with polycystic ovarian syndrome, bleeding disorder, and anovulatory bleeding of early puberty. It is also used to treat endometriosis, which is a painful inflammatory condition. Many forms of combined hormonal contraception, as well as a testosterone-blocking medication (spironolactone), are used off-label to treat acne. Other examples include clonidine, a blood pressure medication used off-label for the treatment of ADHD, migraine headaches, disorders of behavioral regulation, and insomnia; and propranolol, a blood pressure medication used off-label for the treatment of performance anxiety.⁷⁸

As referenced in the preceding paragraph, the off-label use of hormone therapy for adolescents diagnosed with gender dysphoria “does not imply an improper, illegal, contraindicated, or investigational use. Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.”⁷⁹ Decision-making to initiate this form of gender-affirming care takes place at the clinical level, using the evidence-based standards of care and the best available evidence. By attempting to argue that hormone therapy is somehow more dangerous to adolescents with gender dysphoria than to cisgender adolescents undergoing to same treatment for a different medical condition, the state makes it abundantly clear that this is not about the health and well-being of adolescents; it is rather a misguided attempt to discriminate against adolescents with gender dysphoria.

In the GAPMS report, the state cites a study by Dutra et al that “examined the results of over 50 studies evaluating the effects of cross-sex hormones on not only transgender individuals but those with menopause and other endocrine disorders, all of which indicate that the use of estrogen or testosterone can increase risks for cardiovascular disease.”⁸⁰ To use this as a basis for the state’s argument to prohibit gender-affirming care for adolescents diagnosed with gender dysphoria would mean that the state would need to prohibit the use of hormone therapy in Florida’s population at large. Additionally, in making this argument the state fails to consider the intent of hormone therapy -- to align one’s body with one’s gender identity. The experts at Yale University also clarify this misrepresentation or misunderstanding:

- The medical result is that transgender individuals move toward the typical medical profile of their identified gender. And so transgender women, like cisgender women, have lower risks of cardiovascular disease than cisgender men.¹¹¹ Transgender women, like cisgender women, have a slightly higher risk of venous thromboembolism than cisgender men. In fact, transgender women have a lower risk of venous thromboembolism than cisgender women, and the overall risk is extremely low (less than 1%) for all transgender individuals, both women and men.¹¹² The risk of venous thromboembolism in transgender women and non-pregnant cisgender women is less than the risk in pregnancy, which is the highest estrogenic physiologic state known.
- It is also critical to note that the medical impact of gender-affirming treatment is generally the same in transgender people as in cisgender people who take the same hormone medications. For example, physicians commonly prescribe hormonal contraceptives containing ethinyl estradiol (a synthetic

⁷⁷ WPATH

⁷⁸ Boulware et al

⁷⁹ Neville et al

⁸⁰ Florida ACHA GAPMS

estrogen) to adolescents for reasons including birth control, management of irregular or painful menstrual periods, and acne. In other words, similar doses of exogenous sex hormones are commonly administered to cisgender individuals for a host of reasons and are well tolerated.⁸¹

Research shows that hormone therapy, as a component of gender-affirming care, is beneficial to caring for adolescents diagnosed with gender dysphoria. A recent study in the *Journal of Adolescent Health* examined data from transgender or nonbinary adolescents and young adults between 13-24 and found that the provision of hormone therapy in those under 18 resulted in lower levels of depression and suicide attempts compared to adolescents who were unable to access hormone therapy.⁸² Another recent study demonstrated that the provision of puberty blockers and hormone therapy reduced depression and suicidality over the course of 1 year.⁸³

Additionally, the evidence cited in the evidence-based standards of care reinforces the sound basis for the provision of hormone therapy in adolescents diagnosed with gender dysphoria. Under the evidence-based standards of care, there are specific criteria for gender-affirming surgical interventions.⁸⁴ The state's focus on gender-affirming surgery and its attempt to classify it as common is a blatant misrepresentation intended to politicize the issue and cast doubt on the evidence-based standards of care.

Risks

Unlike the state's assertion on its "Florida Fact-Checked" document that "no reliable evidence shows that gender dysphoria significantly increases the risk of suicide," there is in fact evidence to support this.⁸⁵ In a study of more than 1,000 transgender adolescents, transgender adolescents had higher odds of all suicide outcomes compared to cisgender adolescents, and were at greater risk for suicidal ideations and attempts compared to their cisgender peers.⁸⁶ Additionally, in the first large scale (N = 120,670) study examining the relationship between transgender adolescents and suicide, the authors found that between 30-51% of transgender adolescents reported engaging in suicidal behavior, compared to between 10-18% of their cisgender peers.⁸⁷

As noted in the earlier section on mental health, adolescents with gender dysphoria face increased bullying, discrimination, harassment, and a lack of social acceptance.⁸⁸ To add to these daily, ongoing issues, adolescents with gender dysphoria are at greater risk for suicide and other mental health conditions. Curiously, the State of Florida appears to agree that transgender adolescents (and other LGBTQ adolescents) face more serious mental health concerns than their cisgender peers, as it maintains a web site, Youth Suicide Prevention under the FL Department of Health, explaining the protective factors and risks associated with suicide in

⁸¹ Boulware et al

⁸² Green AE, DeChants JP, Price MN, Davis, CK. Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Jrnl of Adol Health*. 2021; 70(4) P643-649

⁸³ Tordoff, DM, Wanta, JW, Collin, A, Stephney, C, Inwards-Breland, DJ, Ahrens, K. (2022) Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open*, 5(2), e220978

⁸⁴ WPATH, Hembree et al

⁸⁵ Turban J. The Evidence for Trans Youth Gender-Affirming Medical care. *Psychology Today*. January 24, 2022. Accessed on June 27, 2022. <https://www.psychologytoday.com/us/blog/political-minds/202201/the-evidence-trans-youth-gender-affirming-medical-care>

⁸⁶ Thoma BC, Salk RH, Choukas-Bradley, et al. Suicidality Disparities Between Transgender and Cisgender Adolescents. *Pediatrics*. 2019; 144(5)

⁸⁷ Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 2018; 142(4)

⁸⁸ Rafferty

adolescents (the state refers to this population as teens).⁸⁹ In identifying these protective factors and risks associated with suicide in adolescents, the state readily admits that “It is important to know that some youths experience an increased amount of risk. Youths are those who identify as LGBTQ, American Indian/Alaska Native, youth in the child welfare and juvenile justice systems or military service members can have higher incidence of suicidal behavior.”⁹⁰ The state cannot have it both ways; it cannot argue that gender dysphoria doesn’t increase the risk of suicide, as noted in its “Florida Fact-Checked” document⁹¹ (ignoring the evidence that patently refutes this argument), and then readily acknowledge via its youth suicide prevention web site that transgender adolescents are at increased risk of suicide.

As referenced in an earlier section of this comment letter, access to and the provision of puberty blockers and hormone therapy as part of gender-affirming care works and is the gold standard according to the medical community to alleviate mental health conditions and risks associated with gender dysphoria in adolescents.⁹²

Medicaid is a Critical Source of Health Care for Children, including Transgender Adolescents

Medicaid is a vital source of health insurance for children (for data reporting purposes below, the term “children” is inclusive of “adolescents”) in Florida and across the United States. Nationally, children make up the single largest group of enrollees in Medicaid and the Children’s Health Insurance Program (CHIP); more than 40 million—or 53% of all US children—rely on Medicaid and CHIP coverage, including with special health care needs and those from low-income families.⁹³ In Florida, over 2.8 million children were enrolled in Medicaid or CHIP as of February 2022.⁹⁴ Medicaid also provides comprehensive prenatal care, enabling millions of healthy pregnancies and births, thereby helping millions of children obtain a healthy start. In states that have expanded Medicaid coverage to low-income adults, this coverage not only provides many documented benefits to those adults,⁹⁵ but also has added benefits for children and adolescents, including an increased likelihood that they are covered, improved access to needed care, improved financial security for the family, higher preventive care use, and other benefits.^{96; 97}

The direct benefits of Medicaid coverage for children and adolescents are many. In addition to improved access to care and health outcomes, those with Medicaid coverage miss less school, do better in school, are more likely to graduate and attend college, become healthier adults, earn higher wages, and pay more in taxes.⁹⁸

⁸⁹ Florida Department of Health. Youth Suicide Prevention. June 16, 2022. Accessed on June 28, 2022.

<https://www.floridahealth.gov/programs-and-services/prevention/suicide-prevention/youth.html>

⁹⁰ Florida Department of Health. Youth Suicide Prevention

⁹¹ Florida Fact-Checked

⁹² Tordoff et al

⁹³ AAP analysis of data submitted by states to CMS released through the Medicaid and the Children’s Health Insurance Program (CHIP) Performance Indicator Projects

⁹⁴ The Centers for Medicare and Medicaid Services (CMS). February 2022 Medicaid & CHIP Enrollment Data Highlights. Accessed June 29, 2022. <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

⁹⁵ Guth M, Garfield R, Rudowitz R. The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020. March 17, 2020. Accessed June 28, 2022. <https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>

⁹⁶ Searing A, Corcoran A, Alker J. Report Finds Medicaid Expansion Associated with Lower Child Uninsured Rates.

Georgetown Center for Children and Families. February 17, 2021. Accessed June 27, 2022.

<https://ccf.georgetown.edu/2021/02/17/report-finds-medicaid-expansion-associated-with-lower-child-uninsured-rates/>

⁹⁷ Schubel J. Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children. Center for Budget and Policy Priorities. June 14, 2021. Accessed June 27, 2022. <https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and>

⁹⁸ Wagnerman, K, Chester A, Alker J. Medicaid Is a Smart Investment

Together with CHIP, Medicaid has been instrumental in driving down the rate of uninsurance among children, which stands at 5.7% nationally and 7.6% in Florida (2019).⁹⁹

Medicaid is not a benefit exclusive to cisgendered individuals. Indeed, Medicaid is of vital importance to transgender individuals, as it is estimated that almost 1/3 of all transgender persons will fall below the poverty line, more than twice the rate of the general population.¹⁰⁰ Both cisgender and transgender individuals enrolled in Medicaid rely on the program to cover their necessary medical care. However, the State of Florida, in promulgating this rule, is discriminating against Medicaid's transgender enrollees by seeking to arbitrarily ban a whole category of treatments which is exclusively utilized by transgender individuals.

Unlike many private health insurance plans, Medicaid guarantees that benefits for children are designed specifically for them. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision of federal Medicaid law is a cornerstone Medicaid protection and the definitive gold standard of pediatric health care benefits. EPSDT guarantees that all Medicaid-eligible children are screened to assess and identify health issues early and ensures the provision of medically necessary health services to address those identified health conditions.¹⁰¹ EPSDT is designed to attend to a broad range of child health needs, including preventive care; physical and mental health; oral, hearing and vision care; habilitative care; and social and emotional development. EPSDT ensures that the medically necessary health care needs of the individual child determine what services and treatments Medicaid ultimately covers for that child. Such decisions of medical necessity are based on the expertise of the pediatrician or other treating clinician, who, through years of education, clinical training, and practice, takes into consideration the widely accepted evidence-based standards of care for the condition being treated.

This regulation as proposed would usurp this process of expert clinical decision-making made in the context of the physician-patient relationship; instead, it seeks to codify a discriminatory ban on widely accepted evidence-based standards of care for transgender adolescents and other individuals. As described in detail above, these standards of care are evidence-based and recommended by the medical community. Presented under the guise of an alternative care standard, this proposed prohibition on specific treatments for gender dysphoria not only ignores the prevailing consensus of numerous medical organizations, but also seeks to jettison the role of the treating clinician in determining medically necessary care for an individual. In every way, this proposed ban is a discriminatory gutting of the practice of medicine for transgender adolescents and other individuals, seeking to stifle the physician-patient relationship and replace it with the state's entirely ideological interest in ending gender affirming care in Florida's Medicaid program. In so doing, this proposed rule ignores the health and well-being of children, adolescents, and other individuals in Florida, both now and in the future, who could benefit from these treatments, and places their health interests as secondary to that of the state. This proposed rule counters medical consensus, discriminates against transgender adolescents, obstructs the physician-patient relationship, subverts Medicaid's EPSDT protection that places medical judgment central to coverage determinations, and, if finalized as proposed, would leave transgender adolescents and other individuals enrolled in Florida Medicaid with nowhere to turn for their much-needed health care.

in Children. Georgetown Center for Children and Families. March 2017. Accessed June 27, 2022.

<https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>

⁹⁹ US Census Bureau. American Community Survey. Accessed June 27, 2022. <https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html>

¹⁰⁰ National Center for Transgender Equality. The Report of the 2015 Transgender Survey. December 2016. Accessed June 27, 2022. <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>

¹⁰¹ The Centers for Medicare and Medicaid Services (CMS). Early and Periodic Screening, Diagnostic and Treatment. Accessed June 27, 2022. <https://www.medicare.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>

The consequences of such actions are likely to be many. As detailed throughout this letter, the mental and physical health and well-being of transgender children and adolescents often rely on their abilities to access much needed mental and physical health care—care that is in keeping with the widely recognized evidence-based standards of care for gender dysphoria. In proposing this rule, Florida ignores broad consensus among the medical community as to what those evidence-based standards of care are, and instead seeks, for its own discriminatory reasons, to impose alternate standards and an outright ban of specific treatments for transgender adolescents in the state's Medicaid program. As pediatricians who care for the health and well-being of all children in Florida and across the United States, we call for the Florida Medicaid program to return to the evidence-based standards of care widely accepted among the medical community, and for this discriminatory ban to be rescinded. Only by doing so will the health and well-being of transgender children and adolescents in Florida be preserved.

Sincerely,

A handwritten signature in cursive script that reads "Moira Szilaygi MD".

Moira Szilaygi, MD, PhD, FAAP
President, American Academy of Pediatrics

A handwritten signature in cursive script that reads "Lisa Gwynn".

Lisa Gwynn, DO, MBA, MSPH, FAAP
President, Florida Chapter of the American Academy of Pediatrics, Inc

July 8, 2022

A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria

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Introduction

On June 2, 2022, the Florida Agency for Health Care Administration (“AHCA”) issued a purported scientific report (hereinafter, “June 2 Report”) concluding that standard medical care for gender dysphoria does not meet generally accepted medical standards and is experimental and investigational.¹

* The authors have received no funding for this report or for our public comments on Florida's proposed Medicaid rule. We have no conflicts of interest to declare. Dr. Olezeski prepared paid expert testimony in a case for the Federal Public Defender for the District of Connecticut. We thank Melisa Olgun for excellent research assistance.

¹ Division of Florida Medicaid, Agency for Health Care Administration, Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria, June 2022, at https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf (“June 2 Report”).

We are a group of seven scientists and a law professor, and we have concluded, after a careful examination of the June 2 Report, that its conclusions are incorrect and scientifically unfounded. The June 2 Report purports to be a review of the scientific and medical evidence but is, in fact, fundamentally unscientific.

We are alarmed that Florida's health care agency has adopted a purportedly scientific report that so blatantly violates the basic tenets of scientific inquiry. The report makes false statements and contains glaring errors regarding science, statistical methods, and medicine. Ignoring established science and longstanding, authoritative clinical guidance, the report instead relies on biased and discredited sources, including purported "expert" reports that carry no scientific weight due to lack of expertise and bias.

So repeated and fundamental are the errors in the June 2 Report that it seems clear that the report is not a serious scientific analysis but, rather, a document crafted to serve a political agenda.

The AHCA has offered the June 2 Report as justification for a proposed rule that would deny Florida Medicaid coverage for gender dysphoria to people of all ages (the "Proposed Rule").² We strongly oppose the Proposed Rule and have documented our reasons in public comments submitted to the AHCA on July 8, 2022. This report provides our detailed reasons for concluding that the June 2 Report provides no scientific support for Florida's proposed action.

Executive Summary

As we note in our comments on the Proposed Rule, we strongly oppose Florida's proposal to deny Medicaid coverage to standard medical care for gender dysphoria. In this report, we show that the June 2 Report is so thoroughly flawed and biased that it deserves no scientific weight. Although our focus is on the science, we also note that the Proposed Rule would violate the sex discrimination protections provided by the U.S. and Florida Constitutions and the federal statute that governs Medicaid by discriminating against transgender people on the basis of their sex, transgender status, and gender identity.³

In this report, we examine closely the "scientific" claims made in the June 2 Report, and we show that its basic conclusion is incorrect. Medical treatment for gender dysphoria does meet generally accepted professional medical standards and is not experimental or investigational. We also show that the June 2 report reflects a faulty understanding of statistics, medical regulation, and scientific research. The report ignores solid scientific evidence and instead repeats discredited claims, cites to sources with no scientific merit, and engages in unfounded speculation based on stereotypes rather than science.

Specifically, we show that:

² 48 Fl. Admin. Reg. 2461 (June 17, 2022).

³ See *Bostock v. Clayton County*, 590 U.S. ____ (2020); *Kadel v. Folwell, M.D. N.C.*, Mem. Op. 6-10-22 (applying *Bostock* to public health plan coverage); 42 U.S.C. 18116 (requiring nondiscrimination in Medicaid plans).

- Contrary to the June 2 Report’s repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported “expert” reports that are biased, inexperienced, and full of errors. The claimed “expert” reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
- The linchpin of the June 2 Report is an analysis by two epidemiologists that claims to undermine the scientific evidence supporting medical care for gender dysphoria. Their analysis is extremely narrow in scope, inexperienced, and so flawed that it merits no scientific weight at all.
- The June 2 Report repeatedly and erroneously dismisses solid studies as “low quality.” If Florida’s Medicaid program applied the June 2 Report’s approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.

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III. The June 2 Report reflects a faulty understanding of statistics, medical regulation, and scientific research, and it repeats discredited claims and engages in speculation and stereotyping without scientific evidence. _____ 15

A. The June 2 Report repeatedly and erroneously dismisses solid studies as “low quality.” If Florida’s Medicaid program applied the June 2 Report’s approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries. _____ 15

B. The June 2 Report disregards robust clinical research studies and instead relies on letters to the editor and opinion pieces. The report’s analysis fails to satisfy Florida’s own regulatory standards for Medicaid coverage decisions and does not undermine the scientific research that supports medical treatment for gender dysphoria. _____ 16

C. The June 2 Report mistakenly claims that puberty blockers and hormones are experimental because they are used “off-label” and not approved by the FDA. In fact, off-label use, when supported by scientific evidence, as is the case here, is extremely common in medical practice and especially in pediatrics. _____ 19

D. The June 2 Report falsely claims that medical care for gender dysphoria is provided to a large percentage of children who will come to regret their treatment. In fact, patients with gender dysphoria have vanishingly low rates of regret regarding their medical treatment. ____ 21

The June 2 Report attempts to cast doubt on medical treatment for gender dysphoria by repeating the debunked claim that most transgender teens ultimately reject their transgender identity. Below, we analyze two related claims made in the report and show why both are refuted by sound evidence. _____ 21

E. The June 2 Report repeats discredited claims that “social contagion” is leading teens to become transgender. The issue, although sensationalized in the June 2 Report, is ultimately irrelevant to medical treatment, which is provided only after a multidisciplinary assessment and after a finding that gender dysphoria is persistent and medical treatment is warranted. _ 23

F. The June 2 Report claims that inappropriate medical care is provided to adolescents with gender dysphoria who also have anxiety, depression, and other mental health conditions. These assertions are unsupported by scientific evidence and disregard evidence-based clinical practice guidelines that provide sound guidance for treating complex cases. _____ 25

G. The June 2 Report speculates, without evidence, that psychotherapy alone is as effective as medical treatment for gender dysphoria. This claim contradicts the findings of solid scientific studies, which show that medical care is more effective than psychotherapy alone. _____ 27

Analysis

I. Contrary to the June 2 Report’s repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.

The conclusion of the June 2 report – that medical treatments for gender dysphoria “do not conform to [generally accepted professional medical standards] and are experimental and investigational”⁴ – is demonstrably false.

Medical care for the treatment of gender dysphoria, which for youth under the age of majority can include gonadotropin releasing hormone agonists (“GnRHa” or puberty blockers) and hormone therapy, has been vetted and approved by international bodies of experts based on the scientific evidence. Two authoritative bodies of scientists, the World Professional Association for Transgender Health (WPATH) and The Endocrine Society, have published extensive clinical practice guidelines for treating gender dysphoria.⁵ These clinical guidelines are based on rigorous, structured processes that include a committee of scientific experts and peer review by additional experts. The guidelines are based on careful reviews of the scientific literature and are revised periodically to reflect scientific developments.

These longstanding clinical practice guidelines have been used by clinicians for decades. WPATH issued its initial guidelines in 1979 and updated them in 1980, 1981, 1990, 1998, 2001, and 2012. The eighth version remains in process, and it incorporates systematic literature reviews and ample opportunities for peer review and revision.⁶ The original Endocrine Society guidelines were published in 2009 and updated in 2017.⁷

Reflecting this scientific and medical consensus, medical care for gender dysphoria has been confirmed as standard care by every relevant medical organization in the United States, including the American Academy of Pediatrics, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry.⁸ In 2022, these organizations united with the American Medical Association, the American College of Obstetricians and Gynecologists, and other groups to file an amicus brief representing a total of 20 major medical

⁴ June 2 Report, p. 2.

⁵ See Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, World Professional Association for Transgender Health (7th version, 2012), at <https://www.wpath.org/publications/soc> (“WPATH (2012)”); Wylie C. Hembree, et al., Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102(11) J. Clin. Endocrinol. Metab. 3869-3903 (2017) (“Endocrine Society (2017)”).

⁶ See World Professional Association for Transgender Health (WPATH), Methodology for the Development of Standards of Care 8 (Soc 8), at <https://www.wpath.org/soc8/Methodology>.

⁷ Endocrine Society (2017), supra note 5.

⁸ Jason Rafferty, Committee on Psychosocial Aspects of Child and Family Health; Committee on Adolescence; Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, 142(4) Pediatrics E20182162 (2018); American Psychological Association, Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, 70(9) American Psychologist 832-64 (2015); Stewart L. Adelson, Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents, 51(9) J. Am. Acad. Child & Adolescent Psychiatry, 957-974 (2012).

societies. The brief reaffirms that puberty blockers and hormone treatments for gender dysphoria are standard medical care and opposes legal measures that would limit patient access to this standard care.⁹

The weight and volume of these endorsements, across diverse medical specialties, sharply contradicts the June 2 Report's conclusions.

II. The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science. The report heavily relies on five purported "expert" documents that are biased, inexperienced, and full of errors.

The Florida report dismisses or ignores the WPATH and Endocrine Society clinical practice guidelines and the science that underlies them and instead relies on five attached documents that, the report claims, constitute "clinical and technical expert assessments."¹⁰

Despite their billing as "expert" reports, the attachments to the June 2 report are unpublished, non-peer-reviewed documents written by authors with questionable claims to expertise and with red flags for undisclosed author bias. These documents should be given no weight in a serious scientific process.

A. The purported "expert" documents attached to the June 2 Report carry no scientific weight. They are unpublished and not peer-reviewed, and they are written by authors whose expertise has been successfully challenged in legal proceedings and whose backgrounds raise red flags for bias.

None of the documents attached to the June 2 Report meet standard criteria for expert scientific investigations, because none is published or peer reviewed. Publication and peer review are fundamental to science, as they ensure that a scientist's data and conclusions are open to scrutiny from scientific experts.

Florida's own standards for the determination of medical necessity recognize this point when they state that determinations of Medicaid coverage must consult "*published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations).*"¹¹ It is thus both unscientific and a violation of the regulations for the June 2 Report to rely on the unpublished documents as its principal evidence base.

Further, the attachments all raise red flags for author bias. The June 2 Report does not disclose how these "experts" were identified or by what criteria their expertise was assessed. The opacity

⁹ Brief of Amicus Curiae American Academy of Pediatrics and Additional National and State Medical and Mental Health Organizations in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction, *Eknes-Tucker v. Ivey* (later redesignated *Eknes-Tucker v. Abbott*), May 5, 2022, at <https://www.aamc.org/media/60556/download>.

¹⁰ June 2 Report, p. 2.

¹¹ Fl. Admin. Code Section 59G-1.035(4).

of the Florida AHCA process for identifying experts is particularly troubling because at least four of the experts have strong indications of bias. Further, the qualifications and credibility of two of the experts have been successfully challenged in litigation.¹² Two of the expert reports duplicate, word-for-word (or with very slight edits) testimony that was offered, apparently for pay, in litigation. Both have connections to advocacy organizations that oppose LGBTQ rights across the board. The endorsement of these individuals as Florida's banner "experts" raises the appearance of bias – that the AHCA sought a pre-ordained outcome, not a true scientific perspective.

Adding to these red flags for bias, none of the authors of the attachments provide a statement of funding and conflicts of interest. This omission violates a strong norm in scientific writing, which requires authors to declare any conflicts of interest; these include any professional or financial arrangements that could call into question their independence of judgment.¹³ That strong norm also requires authors to disclose whether projects have been funded and if so, by whom and whether the authors have engaged in expert testimony. Without these statements, the Florida AHCA and the public cannot detect biases that could affect the integrity of these written products.

These are more than theoretical concerns: at least four of the attachments have notable indicators of conflicts of interest and bias. (Note that these are the only four we examined in detail, and so we do not imply that the other one is free from such bias.)

The author of the document provided as Attachment E is Quentin van Meter, whose history indicates bias and lack of expertise. Although the AHCA presents van Meter as an expert in medical treatment for gender dysphoria, at least one court barred him from providing expert testimony on the issue.¹⁴ Van Meter is the president of the American College of Pediatricians (the "ACP"), which presents itself as a scientific group (and might be confused, by a non-expert, with the authoritative American Academy of Pediatrics). The ACP is, in fact, a political group that opposes same-sex marriage,¹⁵ supports mental health providers practicing conversion therapy,¹⁶ and describes childhood gender dysphoria as "confusion."¹⁷ Troublingly, the van

¹² See Stephen Caruso, A Texas Judge Ruled That This Doctor Was Not an Expert, *Pennsylvania Capital-Star*, Sept. 15, 2020 (reporting that van Meter was disqualified as an expert in a Texas divorce case, now sealed).

¹³ For example, the conflict of interest rules for JAMA, one of the premier medical journals in the United States and the world state that "[a]uthors are expected to provide detailed information about all relevant financial interests, activities, relationships, and affiliations (other than those affiliations listed in the title page of the manuscript) including, but not limited to, employment, affiliation, funding and grants received or pending, consultancies, honoraria or payment, speakers' bureaus, stock ownership or options, expert testimony, royalties, donation of medical equipment, or patents planned, pending, or issued." JAMA Network, Instructions for Authors, visited June 22, 2022, at <https://jamanetwork.com/journals/jama/pages/instructions-for-authors#SecConflictsofInterestandFinancialDisclosures>

¹⁴ Caruso, *supra* note 12.

¹⁵ Den Trumbull, *Defending Traditional Marriage*, American College of Pediatricians (2013), <https://acpeds.org/position-statements/defending-traditional-marriage>. **Error! Hyperlink reference not valid.** See Jack Turban, *The American College of Pediatricians is an Anti-LGBTQ Group*, *Psychology Today*, May 8, 2017.

¹⁶ Christopher Rosik and Michelle Cretella, *Psychotherapy for Unwanted Homosexual Attraction Among Youth*, American College of Pediatricians (2016), <https://acpeds.org/position-statements/psychotherapy-for-unwanted-homosexual-attraction-among-youth>.

¹⁷ Michelle Cretella, *Gender Dysphoria in Children*, American College of Pediatricians (2018), <https://acpeds.org/position-statements/gender-dysphoria-in-children> (site visited June 22, 2022).. The author of the

Meter attachment, proffered by the AHCA as a scientific report, contains several passages of uncredited, verbatim language that appears in a “position statement” published by the ACP.¹⁸ The van Meter attachment appears to be a re-use of paid testimony rather than an original product.¹⁹

James Cantor’s document, presented as Attachment D to the June 2 Report, also faces serious questions about bias and lack of expertise. In a 2022 case, a federal court took a skeptical view of Cantor’s purported expertise, noting that “the Court gave [Cantor’s] testimony little weight because he admitted, *inter alia*, to having no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria.”²⁰ Cantor’s document is nearly identical to what appears to be paid testimony in another case, where Cantor’s declaration was used to support legislation barring transgender athletes from sports teams,²¹ Troublingly, Cantor’s appearance in that case seems to have been funded by the Alliance Defending Freedom (“ADF”),²² a religious and political organization that opposes legal protections for transgender people and same-sex marriage²³ and defends the criminalization of sexual activity between partners of the same sex.²⁴ Because Cantor provides no conflicts of interest disclosure, readers cannot ascertain whether Florida AHCA also paid for Cantor’s report and whether Florida officials were aware that the Cantor report reused his work for (apparently) the ADF.

Romina Brignardello-Petersen is one of two authors of the document provided as Attachment C to the June 2 Report. Although Brignardello-Petersen claims to have no research interests in medical care for transgender youth,²⁵ she has conducted research for the Society for Evidence-

ACP position paper is Michelle Cretella, who was publicly rebuked by the Society for Adolescent Health and Medicine, the leading society for adolescent medicine in the United States, for “pushing political and ideological agendas not based on science and facts.” [https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2017-Activity/Senate-Bill-439-\(2\).aspx](https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2017-Activity/Senate-Bill-439-(2).aspx)

¹⁸ The similarity was shown by a Word comparison of the van Meter report provided as Attachment E to the June 2 Report with a “position statement” published on the ACP website, with authorship credit given on the website to Michelle Cretella. See Michelle Cretella, Gender Dysphoria in Children, *supra* note 17.

¹⁹ The van Meter document attached to the June 2 Report is substantially identical to his expert declaration in *Adams v. School Board of St. Johns County, Florida*. <https://files.eqcf.org/wp-content/uploads/2017/12/41-D-AMENDED-Notice-Documents-iso-Response-to-PI.pdf>.

²⁰ Opinion and Order, *Eknes-Tucker v. Marshall*, 2:22-CV-184-LCB, M.D. Alabama, May 13, 2022.

²¹ The case is *BPJ v. West Virginia State Board of Education*, and the Alliance Defending Freedom takes credit for it here: <https://adfmedia.org/case/bpj-v-west-virginia-state-board-education>. Cantor’s declaration appears here: <https://adfmedialegalfiles.blob.core.windows.net/files/BPJ-CantorDeclaration.pdf>

²² The ADF seems to take credit for the case in this press conference notice: <https://adfmedia.org/case/bpj-v-west-virginia-state-board-education>

²³ Marriage is the Future, American College of Pediatricians, <https://adflegal.org/issues/marriage/overview> (site visited July 2, 2022). Content on the page includes this statement: “Marriage is about equality and diversity. It’s about joining the two equally important and diverse halves of humanity represented in men and women.”

²⁴ Southern Poverty Law Center, *Dangerous Liaisons*, July 10, 2013, <https://www.splcenter.org/20130709/dangerous-liaisons> [visited July 2, 2022].

²⁵ Like the van Meter and Cantor attachments, the BPW document provides no express statement of conflicts of interest. The BPW document does offer a statement of “credentials and expertise,” in which she declares that “her research interests are not in this area,” meaning apparently research on medical care for gender dysphoria. BPW Document, p. 1.

Based Gender Medicine (“SEGM”).²⁶ Although SEGM claims to be an international medical society, it is actually an activist group that opposes standard medical care for gender dysphoria. The SEGM has no publications or conferences and seems to consist solely of a website created by a small group of people with limited or no scientific credentials or clinical experience. The site presents a cherry-picked collection of studies and narrative content that is full of scientific errors.²⁷

Patrick Lappert, whose document is attached to the June 2 Report as Attachment F, has been disqualified as an expert in a recent federal court decision in North Carolina.²⁸ The judge found that evidence “calls Lappert’s bias and reliability into serious question” and noted that Lappert has worked closely with ADF and has actively lobbied for legal bans on medical care for transgender youth.²⁹ The judge gave no weight to Lappert’s testimony about informed consent in that case, finding that it was unsupported by scientific evidence.³⁰ The judge also found that “Lappert has provided the Court with no data or methodology used to draw his conclusion that surgical treatment for gender dysphoria has “never been generally accepted by the relevant scientific community.”³¹

B. The linchpin of the June 2 Report is the analysis by Brignardello-Petersen and Wiercioch (the “BPW document”), provided as Attachment C, which purports to be a comprehensive review of the scientific literature on medical treatment for gender dysphoria but, in fact, is extremely narrow in scope and so flawed in its analysis that it merits no scientific weight.

The BPW document, like the other attachments to the June 2 Report, is an unpublished, non-peer-reviewed document. It claims to conduct a systematic review of the relevant scientific literature, but in fact, it is written by inexpert authors who construct an arbitrarily truncated sample and adopt a method that violates scientific guidelines and produces a biased result. The authors describe their findings in deceptive language and jargon predictably mislead the reader. Our review shows that *nothing in the BPW document calls into question the scientific foundations of the WPATH and the Endocrine Society clinical practice guidelines.*

²⁶ BPW document, p. 1. For one example of the purported research that Brignardello-Petersen apparently assisted in, see Alison Clayton et al., Commentary: the Signal and the Noise – Questioning the Benefits of Puberty Blockers for Youth with Gender Dysphoria – A Commentary on Rew et al. (2021), *Child and Adolescent Mental Health*, Dec. 22, 2021, at <https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12533>. In the “Acknowledgements” section, the authors state, “We would also like to thank the Society for Evidence-based Gender Medicine (SEGM) for providing access to several experts who helped shape this commentary and ensure its accuracy. Specifically, we would like to thank Dr. Romina Brignardello Petersen [sic] for contributing her methodological expertise.”

²⁷ Susan Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims* (April 28, 2022), at 28-29 (Appendix A) available at <https://medicine.yale.edu/childstudy/policy-and-social-innovation/lgbtq-youth/>.

²⁸ *Kadel v. Folwell*, 1:19CV272, M.D. N.C. June 10, 2022. The judge ruled that Lappert was not qualified to “render opinions about the diagnosis of gender dysphoria, its possible causes, the efficacy of the DSM, the efficacy of puberty blocking medication or hormone treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists, or any opinion on the non-surgical treatments.” Lappert was also disqualified from opining on “the efficacy of randomized clinical trials, cohort studies, or other longitudinal, epidemiological, or statistical studies of gender dysphoria.” *Id.*

²⁹ *Id.*

³⁰ *Id.*, pp. 29-30.

³¹ *Id.*, p. 31.

The BPW document seems scientific on its face, and it may be impressive to non-experts, because it uses technical jargon and includes numerous tables and charts. But a closer examination shows that it violates established standards for medical research and shows signs of being engineered to produce a pre-ordained and inaccurate result: the false claim that there is no scientific evidence base for medical treatment for gender dysphoria. Contrary to the authors' claims, there is a large body of reliable scientific literature that supports standard medical treatment for gender dysphoria and spans decades.

The bottom line is that, contrary to the BPW document's claims, there is a large body of reliable scientific literature that supports standard medical treatment for gender dysphoria.

(1) The BPW document lacks scientific credibility due to the authors' lack of relevant qualifications and their ties to an activist group.

The BPW document purports to be a systematic review of the scientific literature on medical treatment for gender dysphoria. But the document, like the other attachments to the June 2 Report, is not published or peer-reviewed, and its design and execution raise numerous red flags for bias. Here, we describe just four of the notable defects that undercut entirely the document's claim to objectivity and sound method.

First, neither of the BPW authors are experts in medical care for gender dysphoria, either as researchers or clinicians. One author (Brignardello-Petersen) has not previously studied the subject, except in her work for the ideological organization SEGM.org, noted just above. Her only clinical experience appears to be in dentistry.³² The other author (Wiercioch) is a junior researcher (a postdoctoral fellow) with no prior research or clinical experience in this field.³³

The authors' lack of interest and experience renders the BPW work inexpert rather than objective, and it violates the National Academy of Medicine (formerly, Institute of Medicine) standards for systematic reviews.³⁴ By analogy, one would not rely on, say, two dermatologists to conduct a review of the scientific literature on neurosurgery and to make recommendations for clinical practice.

³² Romina Brignardello bio, at <https://experts.mcmaster.ca/display/brignarr> [visited July 2, 2022]

³³ Google Scholar, Wojtek Wiercioch, visited June 22, 2022, https://scholar.google.com/citations?user=vdi3r_AAAAAJ&hl=en

³⁴ Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Institute of Medicine, Finding What Works in Health Care: Standards for Systematic Reviews, National Academies (Jill Eden et al., eds 2011), p. 48 (Standard 2.1.1 states that teams for systematic reviews should include expertise in pertinent clinical content areas). Background: The Institute of Medicine, now called the National Academy of Medicine, is one of three branches of the National Academies of Science, Engineering, and Medicine. The National Academy of Science dates to 1963 and was established by Congress; the Institute of Medicine was established as a separate entity in 1970 and serves as the nation's leading authority on scientific research and knowledge. National Academy of Medicine, About the National Academy of Medicine, website visited June 22, 2022, <https://nam.edu/about-the-nam/> The standards for systematic reviews were published in 2011, responding to a Congressional request to set benchmarks for high-quality systematic reviews that could reliably guide physicians and health-care providers in making informed, scientific judgments about health care.

Second, not only is the study not formally peer-reviewed, the BPW authors violate scientific norms and standards by *failing to engage at all with their peers or with actual experts in the subject matter*. As experts in research methodology should know, any sound systematic review should propose explicit and reproducible methods to methodically summarize the existing literature; the protocol (i.e., the research design) is then published to solicit input and criticisms from potential users of the review and experts in the field.³⁵ Peer review of the literature review and publication of the protocol are not optional or merely window-dressing; they reflect bedrock commitments of the scientific method. These processes help ensure that the authors of any review understand the existing research and craft a research design that will usefully build on and add to prior work.

The BPW document violates these standards, raising questions about whether this was a rushed study designed to serve a political agenda – rather than a considered, comprehensive, scientific enterprise. The BPW document does not contain a review of the existing literature, and it does not acknowledge the WPATH and Endocrine clinical practice guidelines, which are themselves based on careful systematic reviews. The BPW authors appear not to have published their protocol in advance or otherwise to have submitted their protocol for peer review. That is, there is no indication that they vetted their research design in consultation with subject-matter experts.

Third, the BPW document raises red flags for opinion bias. Buried in the methodology pages of the BPW document is the fact that the authors uncritically include politically biased “grey literature” sources, giving them equal weight to peer-reviewed, published literature. Specifically, the authors include in their search the fringe website SEGM.org.³⁶ As noted above, the group’s website posts are not peer-reviewed or published, and its content is assembled by a small group of activists with few or no expert credentials and is often full of errors.³⁷ Troublingly, this is the group to which one of the authors, Brignardello-Petersen, has ties, as noted above.

(2) The BPW document examines a truncated sample of the literature and adopts a methodology that violates scientific standards for evaluating medical evidence. The authors compound this bias by describing their results using overstated and deceptive language. The picture that emerges is of a rushed and inexperienced report with indications of bias.

The BPW document has a patina of scientific expertise. It invokes the respected GRADE standards for rating the quality of studies, and it occupies many pages with tables and technical specifications. When a reader looks past the jargon, however, the BPW authors adopt a method that actually violates GRADE standards and appears to be jury-rigged to reach a foregone conclusion. The authors then convey their conclusions in misleading language. *Contrary to the BPW authors’ claims, their study does not call into question the scientific and clinical importance of the established science that supports medical care for gender dysphoria.*

³⁵ Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Institute of Medicine, *supra* note 34, at pp. 72-75.

³⁶ BPW document, Methods section, p. 2.

³⁷ See Boulware et al., *supra* note 27 pp. 28-29 (Appendix A).

The BPW analysis incorporates numerous decisions that bias their results, and they make numerous misleading statements. First, the BPW document reviewed only a small sample of the relevant scientific literature. In the introduction, the BPW authors initially claim to have reviewed 61 systematic reviews of medical treatment for gender dysphoria.³⁸ But buried in the middle of the document is the admission that the analysis is based on a sample of 27 systematic reviews, not 61 as claimed.³⁹ The result is that the BPW analysis excludes a great deal of relevant evidence, and the authors provide no rationale for this “prioritization,” as they call it. Troublingly, although the BPW document claims to be conducting a review of the literature that analyzes existing systematic reviews, the 27 studies they analyze are not all systematic reviews. Three of the 27 are mislabeled as systematic reviews but are actually practice bulletins, unpublished protocols or unlocatable.

Troublingly, the authors also embed in the middle of their document an *unjustified decision to limit their analysis to studies published from 2020 to the present, and their project has strong indications that it was rushed work*. The authors disclose that they “prioritized” studies from the last 30 months (two full years plus four months in 2022), but they do not defend that priority. The reader is left to wonder whether this truncation served only to help the authors produce their analysis in what was apparently a very short time frame.⁴⁰

The truncation of the literature sample to the period from 2020 to early 2022 is worrisome because that period coincides with the worst global public health emergency in generations. The pandemic disrupted many institutions, straining the health care system and putting immense pressure on clinicians. It is likely that the pandemic stalled the production and publication of non-COVID research during this period, calling into sharp question the BPW authors’ sampling strategy.

The BPW sample is also questionable because the authors choose, without justification, a small subsection of databases to search and have likely missed important literature as a result. Specifically, they chose not to source from other important databases such as Embase, PsycInfo, Web of Science, Scopus, or Cochrane. They also limited their scope to works published in English only, an exclusion that can introduce bias.

Second, the BPW authors misused and mechanically applied a well-regarded rating system known as AMSTAR, which is intended to evaluate the methodological strength of systematic reviews. They misused this rating system because their so-called group of systematic reviews included documents that cannot correctly be included (practice bulletins, unpublished protocols, and unlocatable documents) and thus led to a negative bias. The BPW error is further amplified because the authors used the flawed results of the AMSTAR phase to inform their next level of analysis, the GRADE system (which assesses the quality of medical evidence of pooled systematic reviews). Based on this flawed and purely mechanical review of truncated sources,

³⁸ BPW document, Introduction Section, p. 2.

³⁹ BPW document, Results Section, p. 1.

⁴⁰ The authors disclose that they conducted their initial literature searches – the first step in the review process – at the end of April 2022. BPW document, Methods section, p. 2.

the BPW analysis reaches the conclusion that there is little or no evidence for the benefits of medical care for gender dysphoria.⁴¹

The BPW analysis is highly deceptive, because it dismisses nearly all existing studies of medical treatment for gender dysphoria as “low quality,” without explaining that this is a highly technical term and not a natural-language condemnation of the studies. By contrast, the GRADE system, which the authors purport to use, is quite clear about its quality rating systems and its limitations.⁴² In general, only randomized controlled trials (RCTs) are coded as “high” quality evidence in the GRADE system. A randomized controlled trial is a study that divides patients randomly into a control group (no treatment) and a treatment group. In contrast, an observational study records information about patients in a real-world setting that is more reliably generalizable, e.g., a cohort of patients seen at a clinic. Under the GRADE guidelines, observational studies are coded as “low” in quality.

The key point is that “low quality” in this context is a technical term and not a condemnation of the evidence, because “low quality” studies regularly guide important aspects of clinical practice. Indeed, the GRADE system, which the BPW document claims to use, specifically notes that GRADE should *not* be used to dismiss observational studies or to give absolute priority to RCTs:

Although higher quality evidence is more likely to be associated with strong recommendations than lower quality evidence, a particular level of quality does not imply a particular strength of recommendation. *Sometimes, low or very low quality evidence can lead to a strong recommendation.*⁴³

The methodology adopted by the BPW document will thus, predictably, conclude that any body of scientific literature that does not contain RCTs is “low” in quality. Had BPW begun, as they should have, with a literature review of the evidence on puberty blockers and hormones, they would have seen that the evidence consists primarily of observational studies (for the good reasons discussed below). Thus, the 30 pages that it takes the authors to lay out their methodology is misleading: a knowledgeable reader would know that if there are few or no RCTs in the literature, then the BPW technical conclusion is foregone and, as importantly, is not a sound guide for clinical recommendations.

Put in simpler terms, if we coded apples as “high quality fruit” and bananas as “low quality fruit,” then any fruit bowl that has only bananas would predictably be technically coded as “low quality.” But that technical conclusion conveys very little information without context. For example, if no apples exist, then bananas may be a nutritious choice.

⁴¹ For example, the BPW document states that there is *no evidence* about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. BPW document, Results section, p. 4.

⁴² See Howard Balshem et al., GRADE Guideline: 3. Rating the Quality, 64 J. Clinical Epidemiology P401-406 (2011), Table 3, p. 404

⁴³ Balshem et al., *supra* note 42, at 402 (emphasis added).

The drafters of the GRADE system emphasize that technically “low quality” evidence can support a strong clinical treatment recommendation. For example, pediatricians now agree that children should not be given aspirin for fevers. This recommendation is based on observational studies that showed an association between aspirin treatment during viral illnesses and the development of Reyes syndrome (a rapid and progressive disease of neurological dysfunction that can be fatal). Based on those studies, it would be unethical to conduct an RCT giving some children aspirin, and so the strong, consensus treatment recommendation is based entirely on “low quality” studies.⁴⁴

The critical fact is that RCTs are not, and cannot be, the gold standard for medical research on gender dysphoria. In the context of treatments for gender dysphoria, randomized controlled trials would often be inappropriate for ethical reasons. Medical care has long been shown, by reliable scientific methods, to address gender dysphoria and improve mental health: as we have repeatedly noted, these treatments have been recommended by rigorous clinical practice guidelines issued by WPATH and the Endocrine Society and endorsed by every major medical organization. Given this medical consensus, which is based on solid scientific evidence, it would be unethical to conduct an RCT that involved denying standard medical care to a control group of individuals.

Similar ethical issues, along with practical barriers, leave many areas of consensus medicine supported by observational studies and not RCTs. Many surgical procedures, for example, are not supported by RCTs.⁴⁵ Nor are standard protocols for lowering cholesterol using statins, one of the most widely-prescribed drugs in the United States. (See Section III.A of this report.)

It is thus simply a mistake – and a mischaracterization of medical research across fields of medicine – to conclude that the absence of RCTs means that there is “no evidence” for the efficacy of medical treatment for gender dysphoria. Medical research requires, instead, that researchers evaluate the design and conduct of specific observational studies and do so with an awareness of clinical context.⁴⁶

In sharp contrast to BPW, this is precisely what the authors of the Endocrine Society did in their 2017 clinical guidelines, which use the GRADE system but, in addition, carefully discuss the characteristics of the studies supporting each treatment guideline.⁴⁷ The Endocrine Society discloses the GRADE rankings for each treatment recommendation in order to be transparent about the evidence base for each of its recommendations. Then, following National Academy of

⁴⁴ Id.

⁴⁵ See, e.g., Peter McCulloch, et al., Randomised Trials in Surgery: Problems and Possible Solutions, 324 (7351) BMJ 1448-1451 (2002).

⁴⁶ See Balshem et al., supra note 42 at 405 (“[W]e caution against a mechanistic approach toward the application of the criteria for rating the quality of the evidence up or down.... Fundamentally, the assessment of evidence quality is a subjective process, and GRADE should not be seen as obviating the need for or minimizing the importance of judgment or as suggesting that quality can be objectively determined”). See also the National Institute of Medicine (Institute of Medicine) Standards, supra note 34, at 176: (“We are disappointed when a systematic review simply lists the characteristics and findings of a series of single studies without attempting, in a sophisticated and clinically meaningful manner, to discover the pattern in a body of evidence. Although we greatly value meta-analyses, we look askance if they seem to be mechanistically produced without careful consideration of the appropriateness of pooling results or little attempt to integrate the finds into the contextual background.”)

⁴⁷ Endocrine Society (2017), supra note 5.

Medicine (formerly, Institute of Medicine) standards for clinical practice guidelines, they proceed to a qualitative review of the evidence, place the evidence in clinical context, and discuss openly the values at stake in making a clinical practice recommendation.⁴⁸

III. The June 2 Report reflects a faulty understanding of statistics, medical regulation, and scientific research, and it repeats discredited claims and engages in speculation and stereotyping without scientific evidence.

The June 2 Report is full of errors and misstatements. Disregarding solid scientific evidence, the report relies on debunked studies and sheer speculation, and it levels criticisms at solid evidence that betray a poor understanding of medical research and statistics.

A. The June 2 Report repeatedly and erroneously dismisses solid studies as “low quality.” If Florida’s Medicaid program applied the June 2 Report’s approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.

In its opening words, the June 2 Report makes an error that is repeated throughout the document: “Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased.”

As we document in Section II.B., above, it is an outright mistake to conclude that a study in the technical category of “low quality” is unreliable or poor evidence for clinical practice.⁴⁹ Thus, it is frank error for the June 2 Report to dismiss well-done, scientifically important studies because they rank as “low quality” using specialized, technical terms.

Like the BPW document, the June 2 Report thus relies on a deceptive use of technical terminology that is at odds with the standards used in medical research. It simply is not – and cannot be – the case that all clinical recommendations must be based on RCTs. Many areas of medicine do not lend themselves to ethical and practical RCTs. It is unethical to conduct an RCT when randomizing a patient to a control group would cause harm by denying treatments of known efficacy. For example, it would be unethical to conduct an RCT on the treatment of juvenile diabetes by randomizing some participants to receive insulin and others to receive no treatment.⁵⁰

It is quite common for the medical community to adopt important, consensus clinical practices supported by observational studies alone. For example, observational studies, notably the famous Framingham Heart Study, provided the framework for clinical practice guidelines in

⁴⁸ Id.

⁴⁹ Balshem et al., *supra* note 42, at 404 (“Well-conducted studies may be part of a body of evidence rated low quality because they only provide indirect or imprecise evidence for the question of interest.”)

⁵⁰ RCTs have other limitations as well. For example, RCTs often have strict exclusionary criteria that recruit healthier and more homogenous study populations than observational studies. Thus, this can lead to results that are not easily generalizable in real-world settings.

prevention and treatment of cardiovascular disease. In 2013, the American College of Cardiology and the American Heart Association issued updated clinical practice guidelines on the treatment of cholesterol to reduce heart disease risk in adults (the “Cholesterol Guidelines”).⁵¹ These authoritative guidelines have been widely used in clinical practice but are based not only on RCTs but on a great deal of observational evidence, including studies technically ranked as “low quality.”⁵² Concretely, many of the original treatment recommendations regarding statins are based on observational studies, not RCTs.⁵³ The authors of the Cholesterol Guidelines, very much like the Endocrine Society authors, are quite careful to grade their evidence. But they do not rest their treatment guidelines on a mechanical assessment of technical quality. Instead, they (like the Endocrine Society) carefully explain why particular bodies of evidence should be given weight in clinical decisionmaking.

The cholesterol example shows that the June 2 Report rests on a fundamental misunderstanding of medical research and clinical practice. If the Florida Medicaid program actually adopted the standard of evidence urged by the June 2 report, the program would not cover statins (drugs to lower cholesterol) for many patients, which are prescribed to 28% of adults over the age of 40 and are one of the most effective ways to prevent cardiovascular death.⁵⁴ Other common practices that would have to be reconsidered under this logic include: post-menopausal hormone replacement therapy (which reduces lifetime risk of heart attacks and stroke) and mammography screening for breast cancer.

The same point is true of the technically “low quality” evidence base for many surgical procedures, including minimally invasive gall bladder surgery, which have long since had a foundational grounding in observational studies. We think it unlikely that Florida’s Medicaid program will begin to refuse to pay for statins, mammograms, and routine surgeries. If not, then the June 2 Report reflects an untenable and discriminatory double standard.

Thus, the June 2 Report not only relies on the biased and methodologically flawed evidence in the BPW document, as documented in Section II above; it also misuses scientific terminology in an effort to mislead readers and to support the unwarranted conclusion that medical treatment for gender dysphoria is “experimental.”

B. The June 2 Report disregards robust clinical research studies and instead relies on letters to the editor and opinion pieces. The report’s analysis fails to satisfy Florida’s own regulatory standards for Medicaid coverage decisions and does not undermine the scientific research that supports medical treatment for gender dysphoria.

The June 2 Report repeatedly cites sources with little or no scientific credibility – including journalism, a student blog, a website, and letters to the editor – rather than peer-reviewed

⁵¹ Neil J. Stone, et al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, 129(25) *Circulation* S1-S45 (2014).

⁵² Id., Tables 3 and 4.

⁵³ Syed S. Mahmood, et al., The Framingham Heart Study and the Epidemiology of Cardiovascular Disease: a Historical Perspective, 383 *Lancet* 999-1008 (2014).

⁵⁴ Joseph A. Salami et al., National Trends in Statin Use and Expenditures in the U.S. Adult Population From 2002 to 2013, 2(1) *JAMA Cardiology* 56-65 (2017).

empirical research.⁵⁵ At the same time, the report makes baseless or exaggerated criticisms of solid studies. The report's objections to these studies incorporate mistakes about basic statistics and often misrepresent the aims and findings of studies. Here, we offer several examples, but the problem of selective and ungrounded criticism permeates the June 2 Report and further undermines its scientific credibility.

For example, the June 2 report attacks a 2015 study by Costa et al., claiming that the study design is flawed because it did not include a control group of adolescents without gender dysphoria.⁵⁶ This point is simply incorrect. The Costa study was designed to measure the impact of puberty blockers on gender dysphoria. To do so, the authors validly compared outcomes in teens with dysphoria who received treatment with blockers and those who did not. They were able to do this ethically because the control group of teens (who received psychotherapy but not puberty blockers) were not yet eligible for blockers or were eligible but chose to delay or forgo blockers. The study found that puberty suppression was associated with improvements in psychosocial functioning.

The Costa study is, despite the June 2 Report's claims, a solid methodology. In the context of this study, adding a third "control group" of teens without gender dysphoria would serve no scientific purpose. Further, the June 2 Report also criticizes Costa for "rel[ying] heavily on self-assessments."⁵⁷ But this is a wildly off-base criticism. Costa et al. measure psychosocial functioning using a widely-used and accepted instrument, the Children's Global Assessment Scale. Psychological research typically relies on such assessments, which are carefully constructed and psychometrically validated. This is one example of the June 2 Report's poor understanding of research in psychology and medicine.

In addition to these glaring errors, the June 2 Report's criticism of Costa makes an even more fundamental error: the June 2 report levels baseless criticisms at a single study *and fails to acknowledge that the weight of the literature as a whole strongly supports the same results that*

⁵⁵ Sources from journalism include Jon Brown, Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida, Fox News, May 8, 2022, at 8 <https://www.foxnews.com/politics/textbook-strips-gender-dysphoria-definition-cited-florida> [visited July 3, 2022]; Lawrence S. Mayer and Paul McHugh, Sexuality and Gender: Finding from the Biological, Psychological, and Social Science, The New Atlantis (Fall 2016), https://www.thenewatlantis.com/wp-content/uploads/legacy-pdfs/20160819_TNA50SexualityandGender.pdf [visited July 3, 2022]. The citation to the student blog is Hong Phuong Nhi Le, Eminence-Based Medicine vs. Evidence-Based Medicine, Students 4 Best Evidence [blog], <https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine> [visited July 3, 2022]. The website is SEGM.org, which we discuss in the text in Section II.B and Section III.A. Citations to letters and opinion pieces include, inter alia, Andre van Mol, et al., Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765-766 (2020); Michael Laidlaw, et al., The Right to Best Care for Children Does Not Include the Right to Medical Transition, 19(2) Am. J. Bioethics 75-77 (2019); Michael Laidlaw, et al., Letter to the Editor: "Endocrine Treatment of Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," 104(3) J. Clinical Endocrinology and Metabolism 686-687 (2018); Andre van Mol, et al., Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765-766 (2020).

⁵⁶ June 2 Report, p. 15 ("Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control"). The Costa study is Rosalia Costa et al., Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria, 12 (11) J. Sexual Medicine P2206-2214 (2015) (hereinafter, "Costa et al. (2015)").

⁵⁷ Id.

Costa et al. report. Scientific knowledge is, importantly, cumulative. It is thus entirely misleading – and unscientific – to dismiss the effectiveness of puberty blockers by criticizing studies in isolation. Put simply, the June 2 Report fails to acknowledge the number of solid studies that all find that puberty blockers are effective.⁵⁸ Indeed, at least 16 studies show that puberty blockers and hormones benefit patients with gender dysphoria, and the benefits have been documented across study designs, including retrospective report, cross sectional, longitudinal, and qualitative studies.⁵⁹

To take another example, the June 2 Report grossly misleads the reader in its discussion of a study by Chen et al. in 2020.⁶⁰ The report cherry-picks quotes from Chen et al. to the effect that "the effects of pubertal suppression warrant further study" and the "full consequences of suppressing endogenous puberty are not yet understood."⁶¹

These criticisms are misapplied, because the Chen article is not a substantive study of the effects of puberty blockers. It is, instead, a consensus parameter, which is an article that uses a structured methodology to consult experts to develop a research agenda for future studies. It is expected that the Chen piece would focus on what is not yet known, or what is not completely known, because it is attempting to identify research topics and approaches. Notably, and contrary to the June 2 Report's claims, Chen et al. recognize that existing evidence suggests that puberty blockers improve mental health functioning.

More generally, the June 2 Report's misleading characterization of Chen et al. reflects a basic lack of knowledge about scientific research. All research is flawed, including all RCTs: there simply is no perfect study in any area of medicine. The task of the scientist is to be rigorous in assessing what we know and to work to improve knowledge, incrementally, by conducting additional studies that build on earlier work. Thus, it is commonplace for authors to conclude medical research studies by calling for further research. Chen et al.'s statements are not indictments of puberty blockers – they are conventional acknowledgments of the value of further study that drives scientific inquiry and innovation.

The June 2 Report also contains a misleading account of the study by DeSanctis et al. The DeSanctis article reviews the literature on the use of puberty blockers (GnRHa's) for children diagnosed with central precocious puberty. De Sanctis finds that blockers are generally "safe

⁵⁸ See Luke R. Allen, et al., Well-Being and Suicidality Among Transgender Youth after Gender-Affirming Hormones, 7(3) *Clinical Practice in Pediatric Psychology* 302-11 (2019); Amy E. Green, et al., Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth, 70(4) *J. Adolescent Health* 643-649 (2022); Jack L. Turban, et al., Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation, 145(2) *Pediatrics* e20191725 (2020); Maureen D. Connolly, et al., The Mental Health of Transgender Youth: Advances in Understanding, 59(5) *J. Adolescent Health* 489-95 (2016); Gemma L. Witcomb et al., Levels of Depression in Transgender People and its Predictors: Results of a Large Matched Control Study with Transgender People Accessing Clinical Services, *J. Affective Disorders* (2018).

⁵⁹ For citations, see Boulware et al., *supra* note 27, at n. 43.

⁶⁰ Diane Chen, et al., Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Puberty Suppression in Transgender Youth, *Transgender Health* 246-257 (2020).

⁶¹ June 2 Report, p. 15.

and well-tolerated in children and adolescents” and that most drug reactions were mild.⁶² The June 2 Report misleadingly and without foundation cites the De Sanctis piece as “[raising] questions about whether off-label use to treat a psychological condition [gender dysphoria] is worth the risks.”⁶³ This attribution is bizarre, because De Sanctis et al. actually *support* the use of puberty blockers (by finding them safe and with only rare side effects) and do not offer any evidence at all to suggest that the risks are higher in the treatment of gender dysphoria.

As a final example, the June 2 Report criticizes a 2019 preliminary study by Kuper et al. without acknowledging the existence of a 2020 study by Kuper et al.⁶⁴ The earlier study presented data on the mental health of adolescents when initially presenting for care; only the later study presented full data that demonstrated the benefit of treatment.

C. The June 2 Report mistakenly claims that puberty blockers and hormones are experimental because they are used “off-label” and not approved by the FDA. In fact, off-label use, when supported by scientific evidence, as is the case here, is extremely common in medical practice and especially in pediatrics.

The June 2 Report repeatedly notes that the FDA has not approved the use of puberty blockers and hormones for the treatment of gender dysphoria in minors.⁶⁵ The report infers that lack of FDA approval renders a treatment unauthorized and experimental, but this is false.

Once again, the June 2 Report is (mis)using technical language in a way that is likely confusing to non-experts. The term “off-label” has a very specific meaning: a drug is off-label if the FDA has not specifically approved a particular medication for a particular use in a specific population. The off-label use of medications for children is quite common and often necessary, because an “overwhelming number of drugs” have no FDA-approved instructions for use in pediatric patients.⁶⁶

The lack of FDA approval does not imply that the use of medications should be restricted. There is a consensus in the medical community that off-label use reflects a product of burdensome and expensive regulatory processes. Pharmaceutical companies often lack financial incentives to support research required for FDA approval for specific use in children.⁶⁷

⁶² Vincenzo De Sanctis, et al., Long-Term Effects and Significant Adverse Drug Reactions (ADRs) Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: a Brief Review of Literature, 90(3) Acta Biomed. 345-359 (2019).

⁶³ June 2 Report, p. 16.

⁶⁴ June 2 Report, p. 16. The earlier Kuper et al. study is Laura E. Kuper et al., Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy, 40(8) J. Dev. Behav. Pediatr. 589-596 (2019). The later study is Laura E. Kuper et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) Pediatrics e20193006 (2020).

⁶⁵ June 2 Report, pp. 8, 14, 15, 19.

⁶⁶ Boulware et al, supra note 27, quoting Kathleen A. Neville, et al., American Academy of Pediatrics Committee on Drugs, Off-label use of drugs in children, 133(3) Pediatrics 563-7 (2014) (“AAP Committee on Drugs”).

⁶⁷ AAP Committee on Drugs (2014), supra note 66.

The American Academy of Pediatrics, recognizing these facts, specifically authorizes the off-label use of drugs:

The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, *the term “off-label” does not imply an improper, illegal, contraindicated, or investigational use.* Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.⁶⁸

Off-label use is so common in pediatrics that off-label drugs are prescribed in 20% of patient visits.⁶⁹ Combined hormonal contraceptives or progesterone-only contraceptive methods, which are approved on-label for contraception, are also used off-label to treat heavy menstrual bleeding, which could be due to a bleeding disorder, a delay in normal pubertal maturity or variety of other conditions; they are also used off-label for premenstrual dysphoria disorder and polycystic ovarian syndrome.

A host of familiar examples provide illustrations of day-to-day, off-label use in pediatrics.⁷⁰ The use of steroids for croup is a life-saving treatment that is off-label. The medication helps toddlers get through severe, potentially airway-obstructing illnesses safely. Ondansetron (Zofran) is used off-label for nausea and vomiting to prevent fluid loss, as children are particularly vulnerable to severe dehydration.

Off-label use is also common in pediatric compassionate care, and frequently the on-label use is very different from the off-label use. Gabapentin, for example, is used on-label for the treatment of seizures but used off-label for neuropathic or mixed pain. Ketamine and fentanyl are used on-label in anesthesia but off-label for pain relief, for example, to manage chronic pain in palliative care and in patients with cancer.

In neonatal medicine, off-label medications are routinely used to treat the smallest and most fragile babies. Caffeine is used off-label to treat apnea (i.e., idiopathic respiratory arrest) of prematurity and phenobarbital is used off-label to treat neonatal seizures. More routinely, in general pediatric care, pantoprazole is a proton pump inhibitor (PPI) used to treat acid reflux. It is used off-label in neonates with gastroesophageal reflux disease who do not respond to traditional first-line treatments. It is used successfully to help infants gain adequate weight in the first four to six months of life if they do not respond to using different types of bottles, slow flow nipples, or more frequent and lower volume feedings.

In addiction medicine, routine medications like supplemental nicotine patches are off-label; they are not approved for use in those younger than 18 but are used successfully in vaping/smoking cessation, so much so that the AAP has issued guidelines on how to use and dose them.

⁶⁸ Id. (emphasis added). See also Lenneke Schrier, et al., Off-label Use of Medicines in Neonates, Infants, Children, and Adolescents: a Joint Policy Statement by the European Academy of Paediatrics and the European Society for Developmental Perinatal and Pediatric Pharmacology, 179(5) Eur. J. Pediatr 839-845 (2020).

⁶⁹ Diya Hoon, et al., Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015, 144(4) Pediatrics 1-10 (2019) (emphasis added).

⁷⁰ These examples are drawn from the list of off-label uses in AAP Committee on Drugs (2014) and reflect our clinical experience in major hospitals and clinics.

Bupropion is used on-label as an antidepressant and off-label for smoking cessation. Buprenorphine (suboxone) is used on-label in those 16 or older with opioid use disorder but used off-label in those who are younger; this medication prevents overdose death and allows those struggling with addiction to safely recover.

In psychiatry, some of the most commonly-prescribed medications for youth are off label. For example, selective serotonin reuptake inhibitors (SSRIs) are used to treat major depressive disorder and generalized anxiety in adolescents and have been shown to be effective, even though several of these including sertraline and escitalopram) are off-label.⁷¹ Other common examples include clonidine, which is FDA-approved for attention deficit hyperactivity disorder (ADHD) but is also used off-label for anxiety, insomnia, and post-traumatic stress disorder (PTSD).⁷²

Finally, the June 2 Report also notes that testosterone is a controlled substance and is subject to risk of abuse, but, once again, this is misleading. The inclusion of testosterone on the schedule of controlled substances reflects the misuse of the drug by some individuals and communities (e.g., weight lifters and athletes who may use the drug to build muscle). The classification does not in any way imply that physicians should not dispense the drug if medically necessary. No special license is necessary for prescribing the medication, which is routinely prescribed to cisgender men with testosterone deficiency as well as to transmasculine patients.

D. The June 2 Report falsely claims that medical care for gender dysphoria is provided to a large percentage of children who will come to regret their treatment. In fact, patients with gender dysphoria have vanishingly low rates of regret regarding their medical treatment.

The June 2 Report attempts to cast doubt on medical treatment for gender dysphoria by repeating the debunked claim that most transgender teens ultimately reject their transgender identity. Below, we analyze two related claims made in the report and show why both are refuted by sound evidence.

First, the report claims that “the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex.”⁷³ This is false. We have refuted this claim in detail in prior work (addressing similar claims made to support medical treatment bans in Texas and Alabama). The key point is that *adolescents with gender dysphoria rarely find that their dysphoria resolves without treatment*.⁷⁴ Because medical treatment for gender dysphoria begins only in adolescence, and only if medically necessary for gender dysphoria, medical treatment is thus provided only to a group known to be quite stable in their gender identity.

⁷¹ For AACAP guidelines, see Boris Birmaher and David Brent, Practice Parameter for the Assessment and treatment of Children and Adolescents with Depressive Disorders, 46(10 J. Am. Acad. Child and Adolescent Psychiatry P1503-1526 (2007).

⁷² Rama Yasaei and Abdolreza Saadabadi, Clonidine, National Library of Medicine (2022), at <https://www.ncbi.nlm.nih.gov/books/NBK459124/> [visited July 4, 2022].

⁷³ June 2 Report, p. 14.

⁷⁴ Boulware et al., *supra* note 27, at 17-19.

The authoritative WPATH and Endocrine Society clinical practice guidelines contain measures to ensure that medical treatment is administered only when medically necessary.⁷⁵ As part of the process of diagnosis and treatment, clinicians take care to explain to the youth and their parents the risks and the benefits of medical treatment as well as the risks and benefits of no medical interventions.

Second, the June 2 report claims, without citation, that “roughly 8% [of transgender people] decide to return to their natal sex” for reasons ranging “from treatment side effects to more self-exploration that provided insight on individuals' gender dysphoria.”⁷⁶ The 8% figure is not large, but it is nevertheless an overstatement of the percentages found in the scientific literature: solid studies show very low percentages of regret (typically under 1%) among transgender people who receive medical treatment for gender dysphoria.

The June 2 report offers as general evidence for its claims about regret only a 2021 study by Littman.⁷⁷ But the Littman study cannot establish how prevalent it is for transgender individuals to reject their transgender identity. Indeed, the Littman study does not even purport to show the percentage of transgender people who “detransition.” Instead, it simply asked 100 people who self-identified as “detransitioners” about their reasons. Using Littman’s study as evidence of widespread regret is akin to saying that giant pandas (an endangered species) are common because, if we search, we can find 100 of them.

Furthermore, the Littman study used a biased sampling and survey methodology: survey was anonymous; its participants were solicited from (among other venues) anti-transgender social media groups.

Finally, the June 2 Report makes a flagrant error in conflating “detransition” with “regret.”⁷⁸ In addition, the Littman study is unscientific in describing a likely very diverse group of people as “detransitioners.” She defines detransition as “discontinuing medications, having surgery to reverse the effects of transition, or both.” Littman’s definition is highly misleading, because transgender people may have many reasons to discontinue medication. One might continue to live socially in a gender role that is not the one assigned at birth and yet, by Littman’s criteria, be counted as a “detransitioner.” In our clinical practice, we have seen youth who discontinued hormone therapy because the effects had addressed their dysphoria; these patients were nonbinary, but Littman’s method would mistakenly count them as “detransitioners.”

By contrast, the June 2 report disregards a very large and far more nuanced and important 2021 study by Turban et al., which shows that transgender people who do return to live as the sex assigned at birth may not permanently do so and are, by their own report, influenced largely by “external factors, such as pressure from family, nonaffirming school environments, and sexual

⁷⁵ WPATH (2012) and Endocrine Society (2017), *supra* note 5.

⁷⁶ *Id.*

⁷⁷ Lisa Littman, Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners, 50 *Archives of Sexual Behavior* 3353-3369 (2021).

⁷⁸ See generally Jack L. Turban, et al., Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis, 8(4) *LGBT Health* 273-280 (2021) (noting that “the term ‘detransition’ has at times been conflated with regret, particularly with regard to medical and surgical affirmation”).

assault.”⁷⁹ The study found that only a minority of survey participants “reported that detransition was due to internal factors, including psychological reasons, uncertainty about gender identity, and fluctuations in gender identity.” Indeed, as the authors note, these psychological experiences “*did not necessarily reflect regret* regarding past gender affirmation, and were presumably temporary, as all of these respondents subsequently identified as transgender/gender diverse, an eligibility requirement for study participation.”⁸⁰

The June 2 Report also ignores a recent study, Olson et al. (2022), who find that after an average of 5 years of social transition, only 2.5% of youth identified as cisgender.⁸¹

Studies that actually focus on regret consistently find that transgender people only rarely regret their medical treatments.⁸² For example, Bustos et al. (2021) found regret expressed by one percent or fewer of transgender patients who underwent gender-affirming surgery, and Danker et al. (2018) report a rate of far less than 1%, as do Wiepjes et al. (2015).⁸³

E. The June 2 Report repeats discredited claims that “social contagion” is leading teens to become transgender. The issue, although sensationalized in the June 2 Report, is ultimately irrelevant to medical treatment, which is provided only after a multidisciplinary assessment and after a finding that gender dysphoria is persistent and medical treatment is warranted.

The June 2 Report claims that “social factors (e.g., peer influences and media) may be contributing factors to gender dysphoria,”⁸⁴ citing as evidence a single, discredited study by Littman. We have addressed this study at length in other work and note that

WPATH, among other authorities, has taken a skeptical view of Littman’s claim, and the study has been criticized for serious methodological errors, including the use of parent reports instead of clinical data and the recruitment of its sample of parents from anti-transgender websites. The journal of publication required an extensive correction of the original Littman article because of its misstatements. Such a correction in reputable, peer-reviewed academic journals is taken only when a panel of experts, in retrospect, came to recognize the methodological flaws of the original study and concluded that it would be unscientific to allow the originally published findings to stand.”⁸⁵

⁷⁹ Id.

⁸⁰ Id.

⁸¹ Kristina R. Olson, et al., Gender Identity Five Years After Social Transition, Pediatrics (preprint, May 2022).

⁸² Valeria P. Bustos, et al., Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence, 9(3) Plastic and Reconstructive Surgery - Global Open e3477 (2021); Sara Danker, et al., Abstract: A Survey Study of Surgeons’ Experience with Regret and/or Reversal of Gender-Confirmation Surgeries, 6(9 Supp.) Plastic and Reconstructive Surgery 189 (2018); Chantal M. Wiepjes, et al., The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets, 15(4) J. Sex Med. 582-590 (2018); see also Yolanda L.S. Smith, et al., Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals, 35(1) Psychological Medicine 89-199 (2005).

⁸³ Id.

⁸⁴ June 2 Report, p. 12.

⁸⁵ Boulware et al., supra note 27, at 20-21 (internal citations omitted).

Littman's sensationalist hypothesis has been widely covered in the press, but no clinical studies have found that rapid-onset gender dysphoria exists. Further, no professional organization has recognized "rapid-onset gender dysphoria" as a distinct clinical condition or diagnosis.

Most recently, an April 2022 study of 173 youth presenting at Canadian gender clinics *found no evidence of rapid-onset dysphoria or social contagion*. The researchers posited that if "rapid onset" gender dysphoria were a real phenomenon, then teens who had more recently begun identifying as transgender would (per the Littman hypothesis) also be more likely to report online support and engagement in their gender identity. They might also (per Littman's hypothesis) be more likely to struggle with mental health concerns.

An April 2022 study of 173 youth found no such correlations, strongly undercutting the "rapid-onset" hypothesis endorsed by the June 2 report. The researchers controlled for age and sex assigned at birth and looked for correlations with recent gender knowledge (defined as less than one to two years having passed since "you realized your gender was different from what other people called you"). Recent gender knowledge was *not* significantly associated with depressive symptoms, psychological distress, past diagnoses with mental health issues or neurodevelopmental disorders, or self-harm. Nor was it associated with having gender-supportive online friends, general support from online friends or transgender friends, or gender support from parents.⁸⁶

Data do substantiate that younger people today are more likely to identify as transgender than are older people, but this does not substantiate the idea of social contagion. The increase may be due to the increasing social acceptance of gender diversity (i.e., older people grew up in a more transphobic social environment). In fact, adolescent presentation of transgender identity is often observed and should not be pathologized. In the largest U.S. sample of transgender adults, over half reported first starting to realize that they were transgender in adolescence (57% ages 11-20) and roughly half (47%) started to disclose their identity during this time frame.⁸⁷

Further, the data do not show a massive wave of transgender identity even among teens. A 2022 study by the Williams Institute found that, using an expansive definition of "transgender," about 0.5% of adults now identify as transgender, while 1.4% of youth aged 13-17 do, or about 300,000 young people.⁸⁸ This is not a large percentage or a large absolute number.

Underlying the June 2 Report's claim about social contagion is a set of imagined stereotypes – that teenagers do not know their own gender identity and readily change their gender identity based on peer influence and social media. But these stereotypes contradict the scientific understanding of gender identity formation. Studies of so-called "conversion" or "reparative" therapy, for example, finds that transgender identity is highly resistant to change even in the face

⁸⁶ Greta R. Bauer, et al., 243 J. Pediatrics 224-227 (2022).

⁸⁷ Sandy E. James, et al., The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2015).

⁸⁸ Jody L. Herman, et al., How Many Adults and Youth Identify as Transgender in the United States?, U.C.L.A. School of Law, Williams Institute (2022).

of concerted efforts by medical authorities versed in psychological methods. Studies find that conversion therapy is ineffective in altering gender identity and is psychologically damaging.⁸⁹

F. The June 2 Report claims that inappropriate medical care is provided to adolescents with gender dysphoria who also have anxiety, depression, and other mental health conditions. These assertions are unsupported by scientific evidence and disregard evidence-based clinical practice guidelines that provide sound guidance for treating complex cases.

The June 2 Report speculates that because “a high proportion” of youth receiving medical care for gender dysphoria also have a behavioral health disorder, “available research raises questions as to whether the [individuals’] distress is secondary to pre-existing behavioral health disorders and not gender dysphoria.”⁹⁰ In simpler terms, *the June 2 Report speculates that perhaps gender dysphoria is not real but is, rather, an imagined by-product of underlying mental illness.* A close examination shows that this claim has no foundation in science; it rests on unexamined and harmful stereotypes and unaccountably dismisses the scientific knowledge and clinical skill of child and adolescent psychologists and psychiatrists.

First, the June 2 Report implicitly posits a causal hypothesis that behavioral health disorders cause gender dysphoria. This hypothesis is entirely devoid of scientific evidence. Indeed, the scientific evidence strongly suggests that the direction of causation runs the other way. It is well-established that being transgender leads to mental health concerns because of the social stress and discrimination of being transgender in a society that is strongly oriented to cisgender identity and disapproving of transgender identity.⁹¹ In our society, transgender individuals experience a great deal of discrimination, hostility, and physical violence. Quite simply, it is unsafe to be transgender in this current hostile climate.⁹² Accumulation of existential fear and threatening experiences can manifest as physical and mental conditions. Thus, one would expect – and studies confirm – that transgender people, on average, have worse physical and mental health than cisgender people.

Although the effects of gender minority stress are well-known, the June 2 Report makes no mention of the literature. Instead, it indulges in speculation based, apparently, on the

⁸⁹ A survey of the scientific literature by the U.S. Department of Health and Human Services finds that “none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.” Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, U.S. Department of Health and Human Services, HHS Publication No. (SMA) 15-4928 (2015), p. 1.

⁹⁰ June 2 Report, p. 6.

⁹¹ Rylan J. Testa, et al., Development of the Gender Minority Stress and Resilience Measure, 2(1) *Psychology of Sexual Orientation and Gender Diversity* 65-77 (2015); Rylan J. Testa, et al., Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors, 126(1) *J. Abnormal Psychology* 125-36 (2017); Alexandrai M. Delozier, et al., Health Disparities in Transgender and Gender Expansive Adolescents: A Topical Review from a Minority Stress Framework, 45(8) *J. Pediatric Psychology* 842-847 (2020); Jessica Hunter, et al., Gender Minority Stress in Trans and Gender Diverse Adolescents and Young People, 26(4) *Clinical Child Psychology and Psychiatry* 1182-1195 (2021).

⁹² See, e.g., Rebecca L. Stotzer, Violence Against Transgender People: A Review of United States Data, 14(3) *Aggression and Violent Behavior* 170-179 (2009).

stereotyping of transgender people as confused and dysfunctional. The June 2 Report posits that individuals with mental health concerns cannot be trusted to understand their own gender identity. This is a highly prejudicial stance and one that disregards the key role of psychologists and psychiatrists, who have developed sensitive and effective approaches to treating adolescents with gender dysphoria and mental health concerns.⁹³

Second, the co-occurrence of psychological distress among individuals with gender dysphoria provides no reason for denying care. Any population of individuals – cisgender or transgender – will include some with mental health concerns, and the WPATH and Endocrine Society guidelines recognize that there is a higher prevalence of anxiety, depression and post-traumatic stress disorder among transgender youth than among cisgender youth. In response, the guidelines set out practices that include a careful psychological assessment of each adolescent as part of the process for determining whether medical treatment for gender dysphoria is appropriate and likely to have benefits that outweigh risks.

The Endocrine Society guidelines specifically recommend that mental health professionals should be able to diagnose gender dysphoria and distinguish it from other “conditions that have similar features (*e.g.*, body dysmorphic disorder).” In addition, the mental health provider should be prepared to diagnose psychiatric conditions, provide or refer for treatment, and to “psychosocially assess the person’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy.”⁹⁴ In our clinical practice, we also ensure that youth and their caregivers have the information and support necessary to fully understand the risks, benefits, and outcomes of treatment. That is, we not only provide assessment but also fill in any gaps in understanding and support the decision-making process.

Our experience in clinical practice reflects these guidelines. Any consultation for medical treatment for gender dysphoria includes a mental health assessment. Further, the treatment plan for each adolescent is then individualized to reflect the risks and benefits of treatment and the risks and benefits of no treatment. Consistent with the WPATH guidelines, as clinicians, we ensure that the mental health concerns are not interfering with our ability to assess gender dysphoria and youth assent to treatment.

Third, the June 2 Report implicitly claims that any mental health disorder impairs a minor’s ability to provide informed assent and, somehow, also invalidates the informed consent of their guardian. Experts in child and adolescent psychiatry, child psychology, and adolescent medicine have established that youth can make complex medical decisions. Further, the literature specifically demonstrates that transgender youth with co-occurring mental health conditions can competently participate in decision-making.⁹⁵ With guidance from mental health providers, parents, and physicians, teens can be part of a decision process that helps them explore their identity and make nuanced decisions about the benefits and risks of medical treatment.⁹⁶ Indeed,

⁹³ See John F. Strang, et al., Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents, 47(1) *J. Clinical Child & Adolescent Psychology* 105-115 (2016).

⁹⁴ Endocrine Society (2017), *supra* note 5.

⁹⁵ Lieke J. Vrouenraets, et al., Assessing Medical Decision-Making Competence in Transgender Youth, 148(6) *Pediatrics* e2020049643 (2021).

⁹⁶ Beth A. Clark and Alice Virani, “This wasn’t a Split-Second Decision”: An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy, 18 *J. Bioethical Inquiry* 151-

these processes of exploration and decision-making are central goals of, and central tasks for, trained mental health providers who work with teens.

G. The June 2 Report speculates, without evidence, that psychotherapy alone is as effective as medical treatment for gender dysphoria. This claim contradicts the findings of solid scientific studies, which show that medical care is more effective than psychotherapy alone.

The June 2 Report argues, without scientific evidence, that youth with gender dysphoria should not be offered medical treatment but instead should only receive psychotherapy, an approach that it mistakenly terms “watchful waiting.”⁹⁷

The report offers no actual evidence for this denial of standard medical care. Its recommendation rests, instead, on an unfounded and mistaken criticism of the existing literature. The Cantor document, attached to the AHCA report as Appendix C, states that several studies “successfully identified evidence of [mental health] improvement [due to medical treatment for gender dysphoria], *but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.*”⁹⁸

This statement is false. Medical treatment for gender dysphoria has been shown to lead to positive effects on mental health that are not associated with psychotherapy alone. Costa et al. in 2015 found that puberty blockers improve psychosocial functioning in teens with gender dysphoria, compared to teens who receive psychotherapy but not blockers.⁹⁹ Costa’s study was designed to include a control group of teens with gender dysphoria who did not receive blockers.

In a 2022 study, Tordoff et al find that puberty blockers and hormone therapy are associated with significant improvements in depression and suicidality in a population of transgender and nonbinary youths aged 13 to 20.¹⁰⁰ The authors showed the independent effects of medications such as puberty blockers and hormones on depression, anxiety, and gender dysphoria. They controlled for temporal trends and other confounding factors, expressly including whether the teen received “ongoing mental health therapy other than for the purpose of a mental health assessment to receive a gender dysphoria diagnosis.”¹⁰¹ Put simply, Tordoff et al. clearly found

164(2021); Vrouenrats, et al., supra note 95; Megan S. O'Brien, Critical Issues for Psychiatric Medication Shared Decision Making with Youth and Families, 92(3) Families in Society 310-316 (2011); Mary Ann McCabe, Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations 21(4) J. Pediatric Psychology 505-516 (1996).

⁹⁷ For example, at p. 12, the June 2 Report asks, “[S]hould conventional behavioral health services be utilized without proposing treatments that pose irreversible effects [i.e., drug therapies]? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects {i.e., the watchful waiting approach}?” At p. 20, the June 2 Report misuses the term “watchful waiting” to describe the denial of medical care to adolescents with gender dysphoria, and the report miscites its own purported expert report. The Cantor document discusses “watchful waiting” meaning the denial of social transition to prepubertal children, not the denial of medical treatment to adolescents. Cantor document, p. 10-11.

⁹⁸ Cantor document, p. 13.

⁹⁹ Costa et al., supra note 56.

¹⁰⁰ Diana M. Tordoff et al., Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care, 5(2) JAMA Network Open e220978 (2022).

¹⁰¹ Id.

that youth with gender dysphoria reported better outcomes if they received puberty blockers, even after controlling for the effects of psychotherapy.

Similarly, in a 2020 study, Laura Kuper et al. found that gender-affirming hormone therapy made a large improvement in adolescents' body-related distress and led to small to moderate improvement in symptoms of depression and anxiety.¹⁰² Kuper et al. specifically collected data on psychotherapy and the use of psychiatric medications and expressly controlled for both. Thus, Kuper et al.'s study shows that hormone treatment for gender dysphoria is effective above and beyond the benefits of psychotherapy and psychiatric medications.

¹⁰² Laura E. Kuper, et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) *Pediatrics* e20193006 (2020).

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Patricia Schicchi
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patschicchi@email.toast.net

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Matthew Inman
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From: charlie.behrens@everyactioncustom.com on behalf of Charles Behrens
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Dear Florida Board of Medicine,

As physicians – it is your responsibility to do no harm. It is therefore your duty to reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The Dept of Health and the studies being referenced by this board are inaccurate and dangerous. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk the politically and religiously motivated publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including:

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There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

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The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Reject this proposal and keep Florida safe for all.

Sincerely,
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Please reject this proposal and keep Florida safe for all.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Phil Moore
PO Box 120502 Melbourne, FL 32912-0502
philforFL@gmail.com

From: aaalc20@everyactioncustom.com on behalf of Anne Anderson
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 10:47:02 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Anne Anderson
5951 Center St Mentor, OH 44060-2273
aaalc20@yahoo.com

From: ginnycozy@everyactioncustom.com on behalf of virginia cozy
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 10:44:31 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
virginia cozy
5642 Rockfield Loop Valrico, FL 33596-9236
ginnycozy@gmail.com

From: sjenik@everyactioncustom.com on behalf of Susan Jenik
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 10:40:16 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Susan Jenik
1223 Quintuplet Ct Casselberry, FL 32707-3509
sjenik@gmail.com

From: enarra99@everyactioncustom.com on behalf of Evalyn Narramore
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 10:09:46 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Evalyn Narramore
2088 Downing Dr Pensacola, FL 32505-1860
enarra99@gmail.com

From: yamilethmedina1@everyactioncustom.com on behalf of Yamileth Medina
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 10:08:34 AM

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I want to be proud of my state and be happy to welcome people here, but it's hard to do that in good conscience with policies like this. In addition to all of the other problems, this is a clear example of government overreach--this process should be between a child, parents, and their doctors.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Yamileth Medina
3630 N 56th Ave Hollywood, FL 33021-2252
yamilethmedina1@gmail.com

From: jdm9161@everyactioncustom.com on behalf of Jeff Myers
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 9:31:15 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jeff Myers
10003 Celtic Ash Dr Ruskin, FL 33573-6730
jdm9161@gmail.com

From: dlebedeff@everyactioncustom.com on behalf of Diane Lebedeff
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 9:18:31 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Diane Lebedeff
101 S Bayshore Blvd Safety Harbor, FL 34695-4024
dlebedeff@gmail.com

From: sandratversky@everyactioncustom.com on behalf of Alexandrina Tversky
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 9:06:41 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Alexandrina Tversky
9209 Seminole Blvd Seminole, FL 33772-3143
sandratversky@gmail.com

From: Istol10403@everyactioncustom.com on behalf of Linda Stoller
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 9:03:50 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Linda Stoller
701 Mirror Lake Dr N St Petersburg, FL 33701-3266
Istol10403@aol.com

From: clcross34698@everyactioncustom.com on behalf of Carol Cross
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 8:23:45 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Carol Cross
1987 Golf View Dr Dunedin, FL 34698-3239
clcross34698@gmail.com

From: marleensalogm@everyactioncustom.com on behalf of Marleen Salo
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 8:16:10 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Marleen Salo
223 Island Way Apt 2E Clearwater Beach, FL 33767-2252
marleensalogm@gmail.com

From: tiffanyschrist@everyactioncustom.com on behalf of Tiffany Kelly
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 8:10:34 AM

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Dear Florida Board of Medicine,

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Tiffany Kelly
406 Country Ln NE Winter Haven, FL 33881-2676
tiffanyschrist@yahoo.com

From: szinkerman@everyactioncustom.com on behalf of Sheila Zinkerman
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 8:09:13 AM

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Sincerely,
Sheila Zinkerman
125 John Anderson Dr Ormond Beach, FL 32176-5703
szinkerman@gmail.com

From: tcehren@everyactioncustom.com on behalf of Tom Ehren
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 8:08:58 AM

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Sincerely,
Tom Ehren
521 N Bay Blvd Fl 34216 Anna Maria, FL 34216
tcehren@gmail.com

From: macrdh12@everyactioncustom.com on behalf of Melanie Daily
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 7:28:47 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Melanie Daily
1904 Page Ave Orlando, FL 32806-4953
macrdh12@gmail.com

From: ergann@everyactioncustom.com on behalf of Roxanne Gann
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 6:51:40 AM

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Sincerely,
Roxanne Gann
987 Livingston Loop The Villages, FL 32162-2631
ergann@icloud.com

From: adamocatg@everyactioncustom.com on behalf of Adam Miller
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 6:47:08 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Adam Miller
1384 Lake Baldwin Ln Apt B Orlando, FL 32814-6667
adamocatg@gmail.com

From: spyfvandana@everyactioncustom.com on behalf of Vandana Dillon
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 5:47:23 AM

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Sincerely,
Vandana Dillon
2160 62nd Ave S Apt 24 Saint Petersburg, FL 33712-5741
spyfvandana@gmail.com

From: branscomes@everyactioncustom.com on behalf of Sara Branscome
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 4:01:03 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sara Branscome
3165 Abana Path The Villages, FL 32163-2366
branscomes@aol.com

From: querido@everyactioncustom.com on behalf of Tito Galdo
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Tuesday, August 2, 2022 1:46:32 AM

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Sincerely,
Tito Galdo
3105 Riverdale Rd The Villages, FL 32162-7606
querido@queridomundo.com

From: disalvodmd@everyactioncustom.com on behalf of Denise Di Salvo
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 11:34:32 PM

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Sincerely,
Denise Di Salvo
1616 Trinidad Dr Key West, FL 33040-5220
disalvodmd@gmail.com

From: 32goaz@everyactioncustom.com on behalf of Carman.Kazanzas
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:50:33 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Carman. Kazanzas
4390 La Mirage Pensacola, FL 32504-7866
32goaz@gmail.com

From: foxology@everyactioncustom.com on behalf of Craig Fox
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:40:36 PM

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Dear Florida Board of Medicine,

The end of gender affirming care is a political game that WILL DO HARM. Please I beg you to follow the science and not the evil politics.

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Craig Fox
1223 E Osborne Ave Tampa, FL 33603-4233
foxology@gmail.com

From: howboutthatthomasfam@everyactioncustom.com on behalf of Jennifer Thomas
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:38:55 PM

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Dear Florida Board of Medicine,

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jennifer Thomas
5527 Corot Ct Fairfax, VA 22032-3828
howboutthatthomasfam@gmail.com

From: biogeek91@everyactioncustom.com on behalf of Carolyn Burns
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:25:01 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Carolyn Burns
1600 Pullen Rd Apt 16A Tallahassee, FL 32303-1604
biogeek91@gmail.com

From: nick.m.perretta@everyactioncustom.com on behalf of Nick Perretta
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:12:22 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Nick Perretta
241 Erie Dr Naples, FL 34110-1341
nick.m.perretta@gmail.com

From: Jdoman974@everyactioncustom.com on behalf of Jordan Doman
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:12:21 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jordan Doman
10403 Regent Square Dr Orlando, FL 32825-4523
Jdoman974@gmail.com

From: danspafford@everyactioncustom.com on behalf of Dan Spafford
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:11:23 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Dan Spafford
97652 Overseas Hwy Apt HH46 Key Largo, FL 33037-2220
danspafford@gmail.com

From: summer.decker@everyactioncustom.com on behalf of Summer Decker
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:06:07 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Summer Decker
521 Winterside Dr Apollo Beach, FL 33572-3425
summer.decker@me.com

From: swadle@everyactioncustom.com on behalf of Stacey Wadle
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:50:30 PM

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Dear Florida Board of Medicine,

I am the parent of a trans person. Reject this proposed guidance because it will harm many Floridians. I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Stacey Wadle
10650 SW 77th Ct Pinecrest, FL 33156-3726
swadle@hotmail.com

From: mloneill168@everyactioncustom.com on behalf of Mary O'Neill
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:43:05 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Mary O'Neill
170 Sand Hill St Marco Island, FL 34145-4615
mloneill168@att.net

From: edit4food@everyactioncustom.com on behalf of Nancy Armitage
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:14:16 PM

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Dear Florida Board of Medicine,

I am writing to demand that you REJECT the proposed guidance by Surgeon General Ladapo's Dept of Health on Gender Dysphoria in Children and Adolescents and on state interference (again!) in private adult healthcare decisions!

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please provide truthful information based on SCIENCE and DATA, not false statements based on PREJUDICE and POLITICS. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please REJECT this proposal and keep Florida safe for all.

Sincerely,
Nancy Armitage
308 Lake Placid Ct Oldsmar, FL 34677-4537
edit4food@verizon.net

From: stephaniehall106@everyactioncustom.com on behalf of Stephanie Hall
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:02:47 PM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Stephanie Hall
202 SE Gilliland Rd Pensacola, FL 32507-3116
stephaniehall106@gmail.com

From: johnshelbyreader@everyactioncustom.com on behalf of Shelby Norris
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:42:27 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

I was a therapist for children and teens so I know the harm that comes when they don't get the help they need.

Sincerely,
Shelby Norris
1064 Florence Rd Lantana, FL 33462-5339
johnshelbyreader@att.net

From: hannadownsoth@everyactioncustom.com on behalf of Whitney Hanna
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:39:00 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Whitney Hanna
8609 E Glasgow Pl Inverness, FL 34450-1717
hannadownsoth@gmail.com

From: crysalis1@everyactioncustom.com on behalf of Bridget Welch
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:37:41 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Bridget Welch
626 E 9th Ave Apt 2 Tallahassee, FL 32303-5784
crysalis1@juno.com

From: tenisgal4@everyactioncustom.com on behalf of Lindsay McClelland
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:35:38 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Lindsay McClelland
728 Westwood Dr Brandon, FL 33511-5820
tenisgal4@yahoo.com

From: donnalynn@everyactioncustom.com on behalf of Donna Minton
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:15:36 PM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Donna Minton
150 Bent Arrow Dr Unit 38 Destin, FL 32541-2586
donnalynn@gnt.net

From: racknrollp@everyactioncustom.com on behalf of Patty Simonetta
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 7:26:42 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. First and foremost, people are people no matter what gender they are.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda. It is ill informed and dishonest.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening. In keeping with faith, God loves everyone and in the end he will make judgement. It is not yours to make.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Patty Simonetta
134 Azalea St Tavernier, FL 33070-2201
racknrollp@aol.com

From: bonnie.jarvis11@everyactioncustom.com on behalf of Bonnie Clay
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 7:17:35 PM

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I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Bonnie Clay
5914 Wishing Well Dr Port Orange, FL 32127-7577
bonnie.jarvis11@gmail.com

From: dannersc@everyactioncustom.com on behalf of Sarah Danner
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 7:13:40 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sarah Danner
6661 Fairmont St Navarre, FL 32566-8135
dannersc@bellsouth.net

From: kgross@everyactioncustom.com on behalf of Kara Gross
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 6:58:48 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Kara Gross
4242 W Flagler St Coral Gables, FL 33134-1606
kgross@aclufl.org

From: saracast7@everyactioncustom.com on behalf of Sara Castro
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 6:30:11 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sara Castro
140 Lakebreeze Cir Lake Mary, FL 32746-6037
saracast7@gmail.com

From: barbranmanning@everyactioncustom.com on behalf of Barbara Manning
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 6:24:16 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Barbara Manning
15666 Aurora Lake Cir Wimauma, FL 33598-4059
barbranmanning@yahoo.com

From: jiljeanwalther@everyactioncustom.com on behalf of Jiljean Walther
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 6:06:52 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jiljean Walther
10503 Sevilla Dr Apt 102 Fort Myers, FL 33913-7032
jiljeanwalther@gmail.com

From: vickicarlie7@everyactioncustom.com on behalf of Victoria Carlie
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 6:06:41 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Victoria Carlie
1430 50th St N St Petersburg, FL 33710-6000
vickicarlie7@gmail.com

From: lorig1943@everyactioncustom.com on behalf of Loretta Gordon
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:47:18 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Loretta Gordon
3468 Marcus Pointe Blvd Pensacola, FL 32505-1892
lorig1943@gmail.com

From: helendixon9@everyactioncustom.com on behalf of Helen Dixon
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:44:15 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Helen Dixon
5702 Foxlake Dr Apt 3 North Fort Myers, FL 33917-8615
helendixon9@gmail.com

From: jess@everyactioncustom.com on behalf of Jessica Girven
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:43:14 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. We are a military family with a transgender child. We run the risk of being stationed in Florida. In addition our oldest son (23) is also active duty and IS stationed in Florida currently. These proposed changes would be devastating to my family. If we are stationed in Florida our 16 year old transgender child would suffer. We also can not run the risk of even visiting her brother.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jessica Girven
8418 Allsworth Ct Fort George G Meade, MD 20755-1500
jess@girven.org

From: andrea@everyactioncustom.com on behalf of Andrea Ancha
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:42:29 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Andrea Ancha
701 W Azeele St Tampa, FL 33606-2337
andrea@drancha.com

From: suzy.reingold@everyactioncustom.com on behalf of Suzy Reingold
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:26:56 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all. As a parent it isy decision to allow my child the benefits of health care under Medicare. It is not Governor DiSantis's right to interfere in my families decision regarding health care.

Sincerely,
Suzy Reingold
4953 Marble Springs Cir Wimauma, FL 33598-4094
suzy.reingold@yahoo.com

From: sabrinajave@everyactioncustom.com on behalf of Sabrina Javellana
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:22:22 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sabrina Javellana
810 NE 27th Ave Hallandale Beach, FL 33009-2946
sabrinajave@gmail.com

From: mlue32504@everyactioncustom.com on behalf of Melanie Luedeke
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:21:44 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Melanie Luedeke
3870 Summer Dr Pensacola, FL 32504-7539
mlue32504@hotmail.com

From: RH20Bug@everyactioncustom.com on behalf of Robin Carroll
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:21:33 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Robin Carroll
9575 Fleming Grant Rd Micco, FL 32976-3025
RH20Bug@aol.com

From: COSALANA@everyactioncustom.com on behalf of Alana Costello
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 4:00:28 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Alana Costello
2834 Calumet Cir Jacksonville Beach, FL 32250-1608
COSALANA@GMAIL.COM

From: rdaily09@everyactioncustom.com on behalf of [Robin Daily](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 6:37:18 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Robin Daily
1904 Page Ave Orlando, FL 32806-4953
rdaily09@gmail.com

From: julieruns82@everyactioncustom.com on behalf of [Julie Shatto](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:07:16 PM

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Dear Florida Board of Medicine,

As a teacher, I have seen the need for gender-affirming care for adolescents. ALL children deserve the treatments and medical care that allow them to be healthy and live a full life.

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Julie Shatto
1301 CALUMET Dr Orlando, FL 32810
julieruns82@gmail.com

From: sabeau22@everyactioncustom.com on behalf of [Savannah Beaulieu](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 5:01:05 PM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Savannah Beaulieu
33 Marlborough Rd Shalimar, FL 32579-1038
sabeau22@gmail.com

From: anewlon@everyactioncustom.com on behalf of [Nancy Newlon](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 4:56:58 PM

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Dear Florida Board of Medicine,

The proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents is wrong. Do not adopt.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Nancy Newlon
7524 3rd Ave W Bradenton, FL 34209-3234
anewlon@yahoo.com

From: marilyn21@everyactioncustom.com on behalf of [Marilyn Brown](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 4:37:10 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Marilyn Brown
4609 Pebble Creek Ct Pensacola, FL 32526-4380
marilyn21@yahoo.com

Washington, Shaila

From: carolyn@everyactioncustom.com on behalf of Carolyn Stimel
<carolyn@everyactioncustom.com>
Sent: Monday, August 1, 2022 4:17 PM
To: zzzz Feedback, BOM_MeetingMaterials
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents

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Dear Florida Board of Medicine,

As Executive Director of the Florida Psychological Association, I would appreciate your consideration of the following statement our association has recently approved.

FLORIDA PSYCHOLOGICAL ASSOCIATION OPPOSES BLOCK ON SEXUAL ORIENTATION & GENDER IDENTITY CHANGE EFFORTS July 22, 2022 The 11th U.S. Circuit Court of Appeals rejected a rehearing request, which upholds the decision of a three-judge panel of the court in 2020 that ruled bans on sexual orientation and gender identity change efforts (SOGICE) violated the First Amendment. The use of SOGICE are more than controversial, they are dangerous, abusive, and psychologically harmful. These efforts are not therapeutic and should not be referred to as "conversion or reparative therapy." The American Psychological Association (APA) issued two separate resolutions for sexual orientation change efforts (SOCE) and gender identity change efforts (GICE) in February 2021. The resolutions addressed the harm in these practices and indicate the APA opposes SOGICE because such efforts create vulnerability for significant risk of harm to sexual and gender minorities and encourages clinicians, organizations and families to avoid practicing SOCE/GICE (APA, 2021). According to the Williams Institute (2021), 58.8% of the 1,747 participants in a study from 2016-2018 were under the age of 18 when they were subjected to SOGICE. Another study estimates nearly 700,000 LGBTQ adults were subjected to SOGICE in their lifetime (Williams Institute, 2019).

The Florida Psychological Association stands united with the APA, American Academy of Pediatrics, American Association of Sexuality Educators, Counselors and Therapists, American College of Physicians, American Counseling Association, American Medical Association, American Psychiatric Association, American School Counselor Association, National Association of Social Workers, World Professional Association for Transgender Health, American Academy of Family Physicians, American Academy of Nursing, American Medical Student Association, American Psychoanalytic Association, Association of LGBTQ Psychiatrists, Society for Affectional, Intersex and Gender Expansive Identified, GLMA: Health Professionals Advancing LGBTQ Equality, and many other organizations to express grave concerns about the risk of long-lasting and irreparable harm from SOGICE.

References

American Psychological Association. (2021). APA resolution on gender identity change efforts. <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.apa.org%2Fabout%2Fpolicy%2Fresolution-gender-identity-change-efforts.pdf&data=05%7C01%7CBOM.MeetingMaterials%40flhealth.gov%7C3563bbd1477a4db5d8d208da73fac0ec%7C28cd8f803c444b2781a0cd2b03a31b8d%7C0%7C0%7C637949818347850423%7CUnknown%7CTWFpbGZsb3d8eyJWlloiMC4wLjAwMDAiLCJQIjoiV2luMzliLCJBTiI6Ikl1aWwWLCJXVCi6Mn0%3D%7C3000%7C%7C%7C&sdata=VCro74BuDDeohlzqJlfYz2yqRIYrJ2zqSyb3mTuKBvk%3D&reserved=0>

American Psychological Association. (2021). APA resolution on sexual orientation change efforts.
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.apa.org%2Fabout%2Fpolicy%2Fresolution-sexual-orientation-change-efforts.pdf&data=05%7C01%7CBOM.MeetingMaterials%40flhealth.gov%7C3563bbd1477a4db5d8d208da73fac0ec%7C28cd8f803c444b2781a0cd2b03a31b8d%7C0%7C0%7C637949818347850423%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzliLCJBTiI6IklhaWwiLCJXVCi6Mn0%3D%7C3000%7C%7C%7C&sdata=%2BRN%2BRe8h64sXSTbZtdM1KsXM5QoE9zkshhuoKRCG1%2BM%3D&reserved=0>

Williams Institute. (2021). LGBTQ people in the US: Select findings from the Generations and TransPop Studies.
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwilliamsinstitute.law.ucla.edu%2Fwp-content%2Fuploads%2FGenerations-TransPop-Toplines-Jun-2021.pdf&data=05%7C01%7CBOM.MeetingMaterials%40flhealth.gov%7C3563bbd1477a4db5d8d208da73fac0ec%7C28cd8f803c444b2781a0cd2b03a31b8d%7C0%7C0%7C637949818347850423%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzliLCJBTiI6IklhaWwiLCJXVCi6Mn0%3D%7C3000%7C%7C%7C&sdata=QVK8z81yuC%2FhTkfQBQITvTAD0eVlzSHZJ30WSWQWvnl%3D&reserved=0>

Williams Institute (2019). Conversion therapy and LGBT youth update.
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwilliamsinstitute.law.ucla.edu%2Fwp-content%2Fuploads%2FConversion-Therapy-Update-Jun-2019.pdf&data=05%7C01%7CBOM.MeetingMaterials%40flhealth.gov%7C3563bbd1477a4db5d8d208da73fac0ec%7C28cd8f803c444b2781a0cd2b03a31b8d%7C0%7C0%7C637949818347850423%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzliLCJBTiI6IklhaWwiLCJXVCi6Mn0%3D%7C3000%7C%7C%7C&sdata=%2F7Gj%2BD3k%2FB3ow1wUqszyYwqqRyHyK4GdbDYEM4WYWds%3D&reserved=0>

Sincerely,
Carolyn Stimmel
408 Office Plaza Dr Tallahassee, FL 32301-2757 carolyn@flapsych.com

From: Jenniferderycker@everyactioncustom.com on behalf of [Jennifer De Rycker](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 4:11:52 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jennifer De Rycker
52 Turtleback Trl Ponte Vedra Beach, FL 32082-2565
Jenniferderycker@mac.com

From: loisfries@everyactioncustom.com on behalf of [Lois Fries](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 4:04:48 PM

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No one would choose to have this problem --- do you doubt that? The least we can do is give these unfortunate individuals medical care. Can you really say that ALL the experts cited above are wrong, and you are right? Where is your humanity or your humility?

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lois Fries
13300 Indian Rocks Rd Apt 404 Largo, FL 33774-2008
loisfries@gmail.com

From: COSALANA@everyactioncustom.com on behalf of Alana Costello
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 4:00:28 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Alana Costello
2834 Calumet Cir Jacksonville Beach, FL 32250-1608
COSALANA@GMAIL.COM

From: idamnissen@everyactioncustom.com on behalf of Ida Nissen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 3:51:15 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ida Nissen
300 Pensacola, FL 32503
idadamnissen@gmail.com

From: kgumph@everyactioncustom.com on behalf of Kathleen Gumph
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 3:41:38 PM

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Base your decisions on science, not political leanings. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening. Please reject this proposal and keep Florida safe for all.

Sincerely,
Kathleen Gumph
8126 Valiant Dr Naples, FL 34104-6669
kgumph@gmail.com

From: rescuejenny2020@everyactioncustom.com on behalf of Jennifer Johnson-Chunka
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 3:18:56 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jennifer Johnson-Chunka
5588 S HIGHWAY A1A Melbourne Beach, FL 32951
rescuejenny2020@gmail.com

From: m4hedrich@everyactioncustom.com on behalf of Maura Hedrich
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 3:16:55 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Maura Hedrich
2260 Habersham Dr Clearwater, FL 33764-3725
m4hedrich@yahoo.com

From: thesadsoprano@everyactioncustom.com on behalf of Sarah Patrick
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 3:03:15 PM

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Sincerely,
Sarah Patrick
95 Dorell Ct Oviedo, FL 32765-9043
thesadsoprano@yahoo.com

From: alexandra.mcclay15@everyactioncustom.com on behalf of aleaxandra mcclay
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:48:00 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
aleaxandra mcclay
15106 Canoe Pl Winter Garden, FL 34787-4558
alexandra.mcclay15@gmail.com

From: emily.everetts@everyactioncustom.com on behalf of Emily Everetts
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:46:13 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Emily Everetts
650 Kenwick Cir Apt 104 Casselberry, FL 32707-4268
emily.everetts@gmail.com

From: scpt1@everyactioncustom.com on behalf of Teller Sandra
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:46:10 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Teller Sandra
1426 NW 178th Ter Pembroke Pines, FL 33029-3155
scpt1@aol.com

From: susangirl1@everyactioncustom.com on behalf of Susan Anderson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:44:27 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Susan Anderson
3926 Valrico Grove Dr Valrico, FL 33594-4825
susangirl1@outlook.com

From: rachshein@everyactioncustom.com on behalf of Rachel Sheinbart
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:43:09 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Rachel Sheinbart
3814 Simms St Hollywood, FL 33021-3028
rachshein@gmail.com

From: thompssk2003@everyactioncustom.com on behalf of Sherry Thompson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:41:18 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sherry Thompson
56 Beechwood Dr Ormond Beach, FL 32176-3510
thompssk2003@yahoo.com

From: kellumt3@everyactioncustom.com on behalf of Tanya Kellum
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:39:26 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Tanya Kellum
2209 Krista Ln Brandon, FL 33511-7217
kellumt3@gmail.com

From: thebarksdales@everyactioncustom.com on behalf of Brandyn Barksdale
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:31:34 PM

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Dear Florida Board of Medicine,

I am writing to you today to respectfully demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Brandyn Barksdale
378 E Mimosa St Starke, FL 32091-3504
thebarksdales@gmail.com

From: kraushouse5@everyactioncustom.com on behalf of Polly Kraus
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:30:27 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Polly Kraus
1654 Sheffield Dr Clearwater, FL 33764-6544
kraushouse5@gmail.com

From: DandWH@everyactioncustom.com on behalf of Darlene Henderson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:21:28 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Darlene Henderson
10254 N Palafox St Pensacola, FL 32534-1233
DandWH@aol.com

From: pasiliao@everyactioncustom.com on behalf of C Pasiliao
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:21:08 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
C Pasiliao
529 Pocahontas Dr Fort Walton Beach, FL 32547-3220
pasiliao@yahoo.com

From: battled@everyactioncustom.com on behalf of Dianne Battle
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:12:41 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. THIS PROPOSAL TAKES OUR MEDICAL SYSTEM BACK TO THE DAYS WHEN LEECHES WERE APPLIED TO CURE "ILLNESSES". YES, THERE IS DISFUNCTION HERE AND IT'S COMING FROM THE DEPT OF HEALTH.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Dianne Battle
631 Sweetwater Branch Ln Saint Johns, FL 32259-5491
battled@gmail.com

From: vofxiii@everyactioncustom.com on behalf of Alex C
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 2:02:03 PM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Alex C
PO Box 27 Auburn, KS 66402-0027
vofxiii@gmail.com

From: dfcatlover@everyactioncustom.com on behalf of Donna Minasian-Friedman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:56:05 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Donna Minasian-Friedman
203 Somerset Ln Palm Harbor, FL 34684-3326
dfcatlover@gmail.com

From: kbdavey70@everyactioncustom.com on behalf of Kathleen Davey
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:42:51 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely, Kathleen B. Davey, a Florida resident since 1994

Sincerely,
Kathleen Davey
2881 Coral Way Punta Gorda, FL 33950-5032
kbdavey70@gmail.com

From: anne2021russell@everyactioncustom.com on behalf of Anne Russell
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:42:05 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate AND DANGEROUS. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. This initiative and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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This rule will deny them this life-saving treatment. REJECT THIS PROPOSAL.

I call on this Board to provide medically informed information as opposed to false statements based on prejudice driven by anti LGBTQ+ agendas. Denying transgender youth the ability to transition is abusive, and life-threatening. Decisions like these reach well beyond the care for transgender youth and show the lack of concern for the health of all citizens that this country is becoming well known for. Please show your support for the well-being of ALL citizens.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Anne Russell
68 Ash Breeze Cv Saint Augustine, FL 32095-0041
anne2021russell@gmail.com

From: allison.lang75@everyactioncustom.com on behalf of Allison Lang
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:37:58 PM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Allison Lang
1740 E Jersey Ave Orlando, FL 32806-4921
allison.lang75@gmail.com

From: sheree.rust@everyactioncustom.com on behalf of Sheree Rust
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:23:59 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sheree Rust
4809 Hawkshead Park Sarasota, FL 34241-6214
sheree.rust@gmail.com

From: jschreiner51@everyactioncustom.com on behalf of John Schreiner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:22:32 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
John Schreiner
250 58th St N St Petersburg, FL 33710-7904
jschreiner51@gmail.com

From: skankainen@everyactioncustom.com on behalf of Sandra Kankainen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:20:59 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sandra Kankainen
683 Aberdeen Run The Villages, FL 32162-4400
skankainen@gmail.com

From: yerblues73@everyactioncustom.com on behalf of Bruce Costella
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:01:16 PM

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I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Bruce Costella
7427 Lakewood Ranch, FL 34202
yerblues73@hotmail.com

From: progressivesrock@everyactioncustom.com on behalf of Mikki Royce
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 12:55:45 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Mikki Royce
569 Laconia Cir Lake Worth, FL 33467-2668
progressivesrock@pobox.com

From: kklausser@everyactioncustom.com on behalf of Kristina Klausser
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 12:51:31 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Kristina Klausser
12800 Vonn Rd Apt 9604 Largo, FL 33774-6505
kklausser@gmail.com

From: danielle.s.fanara@everyactioncustom.com on behalf of Danielle Fanara
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 12:26:27 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Danielle Fanara
6856 Moorhen Cir Orlando, FL 32810-6073
danielle.s.fanara@gmail.com

From: tskirkland@everyactioncustom.com on behalf of Travis Kirkland
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 12:23:35 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Travis Kirkland
216 B Longview Ave Kissimmee, FL 34747-5040
tskirkland@gmail.com

From: leslielongenbaugh@everyactioncustom.com on behalf of Leslie Longenbaugh
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 12:23:15 PM

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Dear Florida Board of Medicine,

I write in opposition to Surgeon General Ladapo's proposed guidance to the Department of Health on Gender Dysphoria in Children and Adolescents.

The proposed rule is based on studies that are both inaccurate and dangerous. I know you have access, in your roles as physicians and as government officials, to peer-reviewed studies that put the lie to the junk science the Surgeon General has employed in publishing bigoted propaganda. You have a duty to all residents of Florida to do your homework and base your decisions on real data.

As you may know, the nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others. These organizations do not have a political ax to grind; they exist to support their members in providing science-based good care to patients.

Transgender youth are at tremendous risk for mental health-related injury and even death. A state that does not support them in their private health care decisions, that intrudes upon their and their physicians' careful considerations, can only contribute to a mental health crisis.

This Board's mission is to ensure that physicians licensed in Florida meet minimum requirements for safe practice. I ask that this Board use facts, not bigotry, in reaching this crucial decision. In rejecting the proposed guidance, the Board will show its support for safe medical practice for all Floridians, including our vulnerable youth.

Thank you for your attention to this matter.

Sincerely,
Leslie Longenbaugh
97 Meigs Dr Shalimar, FL 32579-2145
leslielongenbaugh@yahoo.com

From: cheilsberg@everyactioncustom.com on behalf of Carol Heilsberg
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 12:21:07 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Carol Heilsberg
1849 Maravilla Ave Apt D8 Fort Myers, FL 33901-7141
cheilsberg@gmail.com

From: tera.webb1979@everyactioncustom.com on behalf of Tera Webb
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 12:12:59 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Tera Webb
19 Seminole Dr Debary, FL 32713-3209
tera.webb1979@gmail.com

From: fencer-talc.0e@everyactioncustom.com on behalf of Dawn Messing
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 11:57:21 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Dawn Messing
1209 Margaret St Key West, FL 33040-3213
fencer-talc.0e@icloud.com

From: drstephany@everyactioncustom.com on behalf of Stephany Mahaffey
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 11:54:50 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Stephany Mahaffey
10220 Water Hyacinth Dr Orlando, FL 32825-8817
drstephany@authenticlifetransitions.com

From: sharon@everyactioncustom.com on behalf of Sharon McAuliffe
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 11:22:59 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. This guidance is yet another attempt to strip citizens of control over our own healthcare decisions. While it focuses on youths, it also threatens adults already receiving gender-affirming care.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sharon McAuliffe
311 Meggs Dr NE Fort Walton Beach, FL 32548-6413
sharon@nextstopparadise.com

From: charityrose80@everyactioncustom.com on behalf of Charity Henesy-Brooks
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 11:18:30 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Charity Henesy-Brooks
31244 Wrencrest Dr Wesley Chapel, FL 33543-7884
charityrose80@yahoo.com

From: donnawindle1@everyactioncustom.com on behalf of Donna Windle
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 11:04:31 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Donna Windle
126 Peary Ct Unit C Key West, FL 33040-7723
donnawindle1@gmail.com

From: ajsiegel00@everyactioncustom.com on behalf of Adam Siegel
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 11:02:52 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Adam Siegel
5036 Blue Major Dr Windermere, FL 34786-3107
ajsiegel00@yahoo.com

From: laurahenry2@everyactioncustom.com on behalf of Laura Henry
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:38:38 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Laura Henry
4466 Marlin Ct Spring Hill, FL 34606-1669
laurahenry2@hotmail.com

From: keyboard7788@everyactioncustom.com on behalf of Cheryl Huber
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:35:02 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

I have 2 trans friends who are under 40 and loving their lives. I can't imagine how awful their lives would be if they hadn't been able to transition, or had to stop treatments. If you knew them, you could see that they are now where they belong. Please allow people to make their own decisions with their doctor's help.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Cheryl Huber
24332 Westgate Blvd Port Charlotte, FL 33980-5585
keyboard7788@comcast.net

From: wahooqueen@everyactioncustom.com on behalf of Darice Horachek
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:28:41 AM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Darice Horachek
31139 Avenue H Big Pine Key, FL 33043-4642
wahooqueen@gmail.com

From: jessica@everyactioncustom.com on behalf of Jessica Alexander
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:27:42 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jessica Alexander
134 Registry Blvd Saint Augustine, FL 32092-3651
jessica@alexanderdental.com

From: smgee@everyactioncustom.com on behalf of Sophie McGee
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:22:25 AM

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PLEASE REJECT THIS CRUEL PROPOSAL!

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sophie McGee
102 Southard St Apt 1 Key West, FL 33040-8337
smgee@emeritus.wccnet.edu

From: jajara19@everyactioncustom.com on behalf of Jaime Jara
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:18:39 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jaime Jara
1638 Marina Lake Dr Kissimmee, FL 34744-6460
jajara19@gmail.com

From: sbollag@everyactioncustom.com on behalf of Sascha Bollag
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:11:31 AM

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SUICIDE--SUICIDE--SUICIDE--That's what this dangerous new guidance means for children and adults who find their bodies are not the gender assigned at birth. Can you imagine how difficult it is to try to grow up in a body that feels foreign to you? We need to help these children and adults make peace with who they are. Gender dysphoria is not a made up or imposed condition--it is a natural phenomenon assigned by our creator if you will. Denying children and adolescents their natural states of being is to cause depression, discontent, and dissonance with living in this world. Yes, the natural outcome is suicide.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,

Sascha Bollag
515 Short St New Orleans, LA 70118-2722
sbollag@gmail.com

From: egmerkel.egm@everyactioncustom.com on behalf of Eva Merkel
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 10:03:19 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Eva Merkel
104500 Overseas Hwy Apt A203 Key Largo, FL 33037-2953
egmerkel.egm@gmail.com

From: imade.borha@everyactioncustom.com on behalf of Imadé Borha
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:57:14 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Imadé Borha
522 Kipling Way Durham, NC 27713-2173
imade.borha@gmail.com

From: fslack@everyactioncustom.com on behalf of Francine.Slack
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:50:18 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Francine. Slack
226 Lakewood Dr Bradenton, FL 34210-4605
fslack@tampabay.rr.com

From: jcosier@everyactioncustom.com on behalf of James Cosier
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:49:18 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
James Cosier
6606 Abeydon Ct Orlando, FL 32818-8865
jcosier@cfl.rr.com

From: chrisjmcDonald042186@everyactioncustom.com on behalf of Christopher McDonald
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:43:39 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Christopher McDonald
5740 Westmont Rd Milton, FL 32583-2333
chrisjmcDonald042186@yahoo.com

From: gardengroupie2@everyactioncustom.com on behalf of Elaine Lontz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:41:53 AM

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Dear Florida Board of Medicine,

This is wrong on so many levels, not the least of which is discrimination, LGBT youth already have a higher suicide rate. These discriminatory policies have to stop. No one should be denied healthcare.

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Elaine Lontz
5827 Tennessee Ave New Port Richey, FL 34652-2850
gardengroupie2@gmail.com

From: mcmduda@everyactioncustom.com on behalf of Mary Duda
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:31:51 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Mary Duda
13511 4th Plz E Bradenton, FL 34212-9682
mcmduda@aol.com

From: Floridapedsdoc@everyactioncustom.com on behalf of STANLEY m zuba
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:25:55 AM

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Dear Florida Board of Medicine,

As a Pediatrician,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
STANLEY m zuba
151 Lake Rd Tavernier, FL 33070-2220
Floridapedsdoc@gmail.com

From: kroniger@everyactioncustom.com on behalf of Kathy Roniger
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:18:50 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Kathy Roniger
63 7th Ave Shalimar, FL 32579-1812
kroniger@cox.net

From: gggreer4@everyactioncustom.com on behalf of Greer Griffirh
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:17:18 AM

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Sincerely,
Greer Griffirh
103 Golf Club Dr Key West, FL 33040-7917
gggreer4@mac.com

From: 4shaver@everyactioncustom.com on behalf of Anne Shaver
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:15:57 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Anne Shaver
17273 La Brisa Ln Summerland Key, FL 33042-3654
4shaver@gmail.com

From: hrauen@everyactioncustom.com on behalf of Holley Rauen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 9:05:44 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Holley Rauen
1305 Rio Vista Ave Fort Myers, FL 33901-8822
hrauen@mac.com

From: nicolecoasca@everyactioncustom.com on behalf of Nicole Ciasca
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:29:15 AM

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Sincerely,
Nicole Ciasca
1518 Whitehall Dr Davie, FL 33324-6674
nicolecoasca@gmail.com

From: bfieldman3@everyactioncustom.com on behalf of BARBARA FIELDMAN
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:28:29 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
BARBARA FIELDMAN
810 Maybank Loop The Villages, FL 32162-8782
bfieldman3@comcast.net

From: ednabms@everyactioncustom.com on behalf of Edna Sinnott
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:24:25 AM

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Please reject this proposal and keep Florida safe for all. This is not a political issue. It's humanity at stake

Sincerely,
Edna Sinnott
6614 12th Ave W Bradenton, FL 34209-4573
ednabms@msn.com

From: jlwb523@everyactioncustom.com on behalf of Joyce Burd
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:20:10 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Joyce Burd
1118 Curry Ln Unit 102 Key West, FL 33040-7276
jlwb523@gmail.com

From: kblue7@everyactioncustom.com on behalf of Kay Blue
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:17:49 AM

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Please reject this proposal and keep Florida safe for all by protecting the freedom to make private health care decisions.

Sincerely,
Kay Blue
2760 W Marion Ave Punta Gorda, FL 33950-5041
kblue7@hotmail.com

From: jcamp1408@everyactioncustom.com on behalf of Julie Camp
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:16:31 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Julie Camp
1408 Merelyn Ln Big Pine Key, FL 33043-5139
jcamp1408@comcast.net

From: keywestsuzie@everyactioncustom.com on behalf of Suzanne Sullivan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:12:23 AM

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Please reject this proposal and keep Florida safe for all.
Sincerely, Suzanne Sullivan

Sincerely,
Suzanne Sullivan
1210 Watson St Key West, FL 33040-3322
keywestsuzie@gmail.com

From: rissich@everyactioncustom.com on behalf of Morrisa Cherie
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:07:43 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Morrisa Cherie
517 S Francis St Interlachen, FL 32148-5485
rissich@gmail.com

From: conchdoc@everyactioncustom.com on behalf of Elliott Goldner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:07:39 AM

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all. e wm goldner, dds key west fl

Sincerely,
Elliott Goldner
1500 Atlantic Blvd Key West, FL 33040-5000
conchdoc@bellsouth.net

From: rfdavis001@everyactioncustom.com on behalf of Rebecca Davis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:04:26 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

My daughter is transgender and depends on this care for her life. Prior to transitioning, she struggled with severe depression and we were constantly afraid she would practice self-harm. Despite being a straight "A" student, she had significant behavior issues due to this depression that negatively impacted her school life everyday. The school implemented a behavior plan, but we still had four significant incidents with the crisis team being called to the school to screen for suicide: 1st, 2nd, 5th and 6th grade. This was terrifying to me as a parent. Since transitioning, she has blossomed into a happy child. She is outgoing and has as a great group of friends. I no longer have to worry about suicide or self harm. If you take away her healthcare, you are basically telling her you don't care about her life.

My home town is Saint Augustine, Florida. My entire extended family, including my 81 year old mother live in my neighborhood. If you take away my child's healthcare, I will be forced to move away from my hometown, my entire family and out of my home state just to make sure my child is able to keep this life saving healthcare. Please do not make me choose between staying near my elderly mother and healthcare for my child.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based

on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Rebecca Davis
701 Saint Augustine South Dr Saint Augustine, FL 32086-6213
rfdavis001@comcast.net

From: tgriffo@everyactioncustom.com on behalf of Terry Griffo
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:03:58 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Terry Griffo
27 Snapper Ave Key Largo, FL 33037-4755
tgriffo@yahoo.com

From: in1era@everyactioncustom.com on behalf of Leda Andrews
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 8:03:09 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Leda Andrews
2110 Staples Ave Key West, FL 33040-3738
in1era@aol.com

From: kim_bo_wie@everyactioncustom.com on behalf of Kimberly Honnell
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 7:51:54 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kimberly Honnell
6511 Matchett Rd Belle Isle, FL 32809-5153
kim_bo_wie@yahoo.com

From: kathyvill@everyactioncustom.com on behalf of Kathy Vill
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 7:49:08 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kathy Vill
129 Martin St Indian Harbour Beach, FL 32937-2728
kathyvill@gmail.com

From: hukajigger11@everyactioncustom.com on behalf of Patricia Rowe
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 7:33:56 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Patricia Rowe
481 Andrew Dr Valparaiso, FL 32580-1104
hukajigger11@gmail.com

From: linda.bigelow@everyactioncustom.com on behalf of Linda Bigelow
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 6:45:14 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all. Please speak strongly to support this type of treatment for adults as well as young people. Linda Bigelow

Sincerely,
Linda Bigelow
1471 Ricardo Ave Fort Myers, FL 33901-6842
linda.bigelow@juno.com

From: melanie.baldi@everyactioncustom.com on behalf of Melanie Baldi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 4:09:36 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Melanie Baldi
200 Derrs Chapel Rd Italy, TX 76651-3900
melanie.baldi@yahoo.com

From: amplify11@everyactioncustom.com on behalf of Adriana Parrino
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:51:28 AM

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Sincerely,
Adriana Parrino
30308 Emerson Ln Menifee, CA 92584-6454
amplify11@yahoo.com

From: terrorgoddesss@everyactioncustom.com on behalf of Faith Walston
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Monday, August 1, 2022 1:38:19 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Faith Walston
6806 Yocona Dr Colorado Springs, CO 80925-9663
terrorgoddesss@gmail.com

From: scookfl@everyactioncustom.com on behalf of Sandra Cook
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:21:32 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sandra Cook
1031 1st St S Apt 706 Jacksonville Beach, FL 32250-6555
scookfl@outlook.com

From: iporze@everyactioncustom.com on behalf of Ilana Porzecanski
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:59:09 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Ilana Porzecanski
4909 Soundside Dr Gulf Breeze, FL 32563-8919
iporze@yahoo.com

From: darthprolix@everyactioncustom.com on behalf of James Black
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:48:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. It's bad guidance based on outdated and/or junk science and it runs counter to all other research from the nation's leading health organization. It will cause misery and, quite literally, death.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As government officials, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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If that's not enough - if science, empathy, and compassion are not enough for you - then please consider this: Nazi Germany didn't only kill Jews. The Romani, the disabled, homosexuals and, yes, transgender people were all on their list of undesirables. And they did this "for the good of the children," "to keep our society pure." This is how creeping fascism works. Minority outgroups are canaries in the coal mine. You've all read the poem - this doesn't stop here and you know it.

Please reject this proposal and keep Florida safe for all.

Sincerely,

James Black
22 Luella St Rochester, NY 14609-7202
darthprolix@gmail.com

From: afmarena@everyactioncustom.com on behalf of Mauricioarena
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:43:52 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Mauricioarena
10800 Jason Rd Port Richey, FL 34668-2632
afmarena@hotmail.com

From: ckulk44@everyactioncustom.com on behalf of Claudette Kulkarni
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:25:27 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Claudette Kulkarni
1133 N Saint Clair St Pittsburgh, PA 15206-1625
ckulk44@aol.com

From: sreederphd@everyactioncustom.com on behalf of Susan Reeder
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:21:23 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Susan Reeder
480 Pleasant Grove Rd Inverness, FL 34452-5746
sreederphd@embarqmail.com

From: kwilkin425@everyactioncustom.com on behalf of Kathryn Wilkin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:16:42 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Kathryn Wilkin
1190 E Washington St Ph 13 Tampa, FL 33602-3706
kwilkin425@yahoo.com

From: alixg1@everyactioncustom.com on behalf of Alexandra Gordon
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:05:18 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Alexandra Gordon
11701 SW 80th Rd Pinecrest, FL 33156-4408
alixg1@aol.com

From: tristanpun14@everyactioncustom.com on behalf of Tristan Pun
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:59:36 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Tristan Pun
732 Eastlawn Dr Kissimmee, FL 34747-4213
tristanpun14@gmail.com

From: geologyisverygneiss@everyactioncustom.com on behalf of Cassie Geraghty
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:54:17 PM

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Sincerely,
Cassie Geraghty
148 SW 332nd Pl Apt 2906 Federal Way, WA 98023-6243
geologyisverygneiss@gmail.com

From: pepe8chiquita@everyactioncustom.com on behalf of WILLIAM PRITCHARD
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:47:36 PM

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Sincerely,
WILLIAM PRITCHARD
13511 Woodcrest Blvd Panama City, FL 32409-3565
pepe8chiquita@gmail.com

From: sharidworkinsmith@everyactioncustom.com on behalf of Shari Dworkin-Smith
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:47:22 PM

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Sincerely,
Shari Dworkin-Smith
8007 Old Town Dr Orlando, FL 32819-3919
sharidworkinsmith@gmail.com

From: alta101@everyactioncustom.com on behalf of Barbara Drake
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:47:00 PM

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Sincerely,
Barbara Drake
4149 66Th Street Cir W Bradenton, FL 34209-7604
alta101@hotmail.com

From: mlbohlmann@everyactioncustom.com on behalf of Michele Bohlmann
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:38:04 PM

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Dear Florida Board of Medicine,

I am writing to you today as a physician to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Michele Bohlmann
10800 Brighton Bay Blvd NE St Petersburg, FL 33716-3478
mlbohlmann@gmail.com

From: Boskibs@everyactioncustom.com on behalf of Judy Abbinante
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:26:40 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Judy Abbinante
1641 N Shadowview Path Hernando, FL 34442-6184
Boskibs@embarqmail.com

From: sdubman@everyactioncustom.com on behalf of Irene Dubman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:01:34 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Irene Dubman
1313 Landeros Ln Lady Lake, FL 32159-8592
sdubman@gmail.com

From: Georgiajoneslcsw@everyactioncustom.com on behalf of Georgia Jones
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:40:33 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents, and now Adults.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Georgia Jones
3063 Bay St Gulf Breeze, FL 32563-3105
Georgiajoneslcsw@gmail.com

From: tlcarrroll@everyactioncustom.com on behalf of Tiffany French
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:00:55 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Tiffany French
3121 W Jackson St Pensacola, FL 32505-7651
tlcarrroll@gmail.com

From: janedstory@everyactioncustom.com on behalf of Jane Story
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:58:04 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jane Story
2004 Skyland Glen Dr Snellville, GA 30078-3864
janedstory@gmail.com

From: destinydimattei@everyactioncustom.com on behalf of Destiny DiMattei
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:53:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Destiny DiMattei
7912 Saint Claire Ln Dundalk, MD 21222-3531
destinydimattei@gmail.com

From: Llseriguchi@everyactioncustom.com on behalf of Laura Seriguchi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:48:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Laura Seriguchi
8443 Benelli Ct Naples, FL 34114-2754
Llseriguchi@gmail.com

From: hyvette21@everyactioncustom.com on behalf of Yvette Herrera
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:43:24 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. My daughter is transgender and I am outraged that you could be careless about these children!! The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida
Sincerely
Yvette Herrera

Sincerely,
Yvette Herrera
78 Stowe Rd Mary Esther, FL 32569-2158
hyvette21@gmail.com

From: wmfurlow@everyactioncustom.com on behalf of Anne Furlow
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:42:27 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Department of Health is wrong and dangerous. The guidance and the standards of care it sets are not based upon scientific fact, but unproven and unscientific ideas and opinions. Do not allow the Board's power and authority to be manipulated by political or religious views. Patients who are transgender and their physicians must have the freedom to make decisions that are in accordance with scientifically based standards of care, and are best for each patient's health and well-being.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. Denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Anne Furlow

Sincerely,
Anne Furlow
2036 Angus St Tallahassee, FL 32317-9500
wmfurlow@aol.com

From: whitney.paige2@everyactioncustom.com on behalf of Whitney Strohmayr
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:36:03 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Whitney Strohmayr
700 L'Ambiance Cir # 102 Naples, FL 34108
whitney.paige2@gmail.com

From: sbpm57@everyactioncustom.com on behalf of Sally Miller
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:29:32 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sally Miller
917 Loyalty Ave Marco Island, FL 34145-4430
sbpm57@gmail.com

From: lindseyhein@everyactioncustom.com on behalf of Lindsey Hein
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:22:45 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lindsey Hein
107 Sandpoint Ct Sanford, FL 32773-5997
lindseyhein@gmail.com

From: stampintree@everyactioncustom.com on behalf of Theresa Crawford
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:16:42 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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If parents have a say in their child's education, they most assuredly have a say in their medical care.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Theresa Crawford
121 E Pace Dr Perry, FL 32347-1415
stampintree@hotmail.com

From: dmandch@everyactioncustom.com on behalf of Drew Martin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:13:26 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Drew Martin
1015 N M St Lake Worth Beach, FL 33460-2245
dmandch@aol.com

From: cabett69@everyactioncustom.com on behalf of Annie Corbett
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:06:53 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Annie Corbett
131 Mississippi Ave NW Fort Walton Beach, FL 32548-4337
cabett69@yahoo.com

From: amyw1219@everyactioncustom.com on behalf of Amy Pearson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:54:22 PM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Amy Pearson
1852 Sea Pines Ln Fleming Island, FL 32003-8362
amyw1219@gmail.com

From: vrath@everyactioncustom.com on behalf of Viv Gunnip
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:49:13 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Viv Gunnip
280 Anderson Dr Mary Esther, FL 32569-1804
vrath@readokaloosa.org

From: kchernecky@everyactioncustom.com on behalf of Kim Chernecky
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:47:29 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Cutting off life-saving gender-affirming healthcare is dangerous and incredibly cruel. Taking away access to gender-affirming care will result in more suicides and will put trans youth in particular, in great danger.

The fact that these "guidelines" primarily target young people is beyond cruel but to then move on to require adults to register, ask for permission, or any other political hurdles to obtain necessary healthcare is in direct violation of our rights as American citizens.

The issued "guidance" by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kim Chernecky

9530 Royal Vista Ave Clermont, FL 34711-8649
kchernecky@hotmail.com

From: pastormattw@everyactioncustom.com on behalf of Matthew Wallis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:41:45 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Matthew Wallis
2625 Burntfork Dr Clearwater, FL 33761-4008
pastormattw@gmail.com

From: js363@everyactioncustom.com on behalf of Jane Schlechtweg
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:40:11 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jane Schlechtweg
1618 Briarwood Ct Marco Island, FL 34145-4008
js363@me.com

From: Catherine8627@everyactioncustom.com on behalf of Catherine Gaffney
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:39:44 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Catherine Gaffney
4602 Abdella Ln Holiday, FL 34690-3831
Catherine8627@protonmail.com

From: l.bradbury314@everyactioncustom.com on behalf of Luke Bradbury
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:24:05 PM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Luke Bradbury
6860 Moorhen Cir Orlando, FL 32810-6075
l.bradbury314@gmail.com

From: Laura-Keith-King@everyactioncustom.com on behalf of Laura King
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:23:25 PM

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I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Laura King
5889 Ashton Woods Cir Milton, FL 32570-1569
Laura-Keith-King@hotmail.com

From: dancingotter13@everyactioncustom.com on behalf of E Thomas
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:14:50 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
E Thomas
5043 Tan St Jacksonville, FL 32258-2254
dancingotter13@gmail.com

From: adanto@everyactioncustom.com on behalf of Croitiene ganMoryn
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:07:36 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Croitiene ganMoryn
6211 SE 24th Ave Ocala, FL 34480-8122
adanto@jps.net

From: shellyandjoel18@everyactioncustom.com on behalf of Michelle and Joey Newman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:04:09 PM

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Please reject this proposal and keep Florida safe for all. As retired educators, we must protect the rights and health of all of our students, following our oath we took when becoming licensed teachers in the State of Michigan. Why is Dr. Ladipo doing less than his sworn oath of "do no harm?" Democratically yours, Michelle Sher Newman and Joel Newman

Sincerely,
Michelle and Joey Newman
3212 Killington Loop The Villages, FL 32163-2259
shellyandjoel18@gmail.com

From: knocky93@everyactioncustom.com on behalf of Joyce Lahna
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:58:11 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Joyce Lahna
119 George Miller Rd Hastings, FL 32145-4414
knocky93@aol.com

From: Lks11645@everyactioncustom.com on behalf of Lawrence Schlatter
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:56:34 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Lawrence Schlatter
PO Box 567 Gambier, OH 43022-0567
Lks11645@aol.com

From: narno004@everyactioncustom.com on behalf of Natasha Arnold
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:55:37 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Natasha Arnold
5681 Tyburn Ct Virginia Beach, VA 23462-1029
narno004@odu.edu

From: svosburg@everyactioncustom.com on behalf of Stephanie Vosburg
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:49:28 PM

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Sincerely,
Stephanie Vosburg
792 Whooping Crane Ct Sanford, FL 32771-5410
svosburg@mail.bradley.edu

From: samantha.wisniewski@everyactioncustom.com on behalf of Samantha Carter
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:43:13 PM

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Sincerely,
Samantha Carter
204 E Vine St Inverness, FL 34450-4302
samantha.wisniewski@gmail.com

From: thalia989231@everyactioncustom.com on behalf of Thalia Su
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:36:30 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Thalia Su
1626 Corner Meadow Cir Orlando, FL 32820-1943
thalia989231@knights.ucf.edu

From: jarefr@everyactioncustom.com on behalf of Janet Frank
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:34:57 PM

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Dear Florida Board of Medicine,

Dear Chair Diamond, Vice-Chair Cairns, and members of the Florida Board of Medicine,

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What makes our governor so willing to disregard the recommendations of so many professional organizations?

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I can count three people I know personally who have dealt or are dealing with children who have come out as trans just in the last year. It's always existed, and always will. What Gov. DeSantis and Dr. Ladapo are trying to do is misguided, cruel, and overreaching for their roles.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Janet Frank

Sincerely,
Janet Frank
4830 NW 16th Pl Gainesville, FL 32605-3412
jarefr@cox.net

From: penelben@everyactioncustom.com on behalf of penelope benson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:23:55 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
penelope benson
3081 Riverdale Rd The Villages, FL 32162-7606
penelben@yahoo.com

From: sssnurse1829@everyactioncustom.com on behalf of Shirley Schantz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:18:26 PM

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Please reject this proposal and keep Florida safe for all.

Tell them to stay out of your lane.

Sincerely,
Shirley Schantz
730 Bradford Loop The Villages, FL 32163-6037
sssnurse1829@yahooo.com

From: hollisbeth@everyactioncustom.com on behalf of Beth Hollis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:12:49 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Beth Hollis
428 Aldrich Ave The Villages, FL 32162-4339
hollisbeth@comcast.net

From: jamie@everyactioncustom.com on behalf of Jamie Greenebaum
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:07:17 PM

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Sincerely,
Jamie Greenebaum
15000 W Highway 318 Williston, FL 32696-4313
jamie@g2partners.com

From: dgar1776@everyactioncustom.com on behalf of Mary Kay Lantz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:06:54 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Mary Kay Lantz
14350 97th St Fellsmere, FL 32948-7622
dgar1776@gmail.com

From: carolingschroeder@everyactioncustom.com on behalf of Carol Schroeder
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:05:37 PM

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Please reject this proposal and keep Florida safe for ALL!

Sincerely,
Carol Schroeder
8008 SE Little Harbor Dr Hobe Sound, FL 33455-3827
carolingschroeder@gmail.com

From: palexander@everyactioncustom.com on behalf of MARGARET ALEXANDER
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:02:50 PM

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Please reject this proposal and keep Florida safe for all. Equality for ALL!

Sincerely,
MARGARET ALEXANDER
101 Lakeview Dr Defuniak Springs, FL 32433-4050
palexander@panhandle.rr.com

From: boodog301@everyactioncustom.com on behalf of Ellen Siegel
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:01:56 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ellen Siegel
4046 NW 59th Ave Gainesville, FL 32653-8360
boodog301@bellsouth.net

From: ldberms@everyactioncustom.com on behalf of Lawrence Berman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:56:38 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Lawrence Berman
992 Winnsboro Dr The Villages, FL 32162-4044
ldberms@gmail.com

From: judyrognli@everyactioncustom.com on behalf of Judy Rognli
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:52:40 PM

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Please reject this proposal and keep Florida safe for all.

I am a pediatric nurse practitioner and have had transgender patients, coworkers and colleagues. You need to stop and reject this proposal. I would also encourage you to find a transgender adolescent or adult and listen to their story. Otherwise you will continue to be ignorant of transgender folks and their need to be their authentic selves. Your proposal will only lead to more suicides within the transgender population, or is that your ultimate goal? Shame on you for not following your medical oath if “first do no harm”.

Sincerely,
Judy Rognli
1081 Smith Ave S Saint Paul, MN 55118-1106

judyrognli@comcast.net

From: pgranerku@everyactioncustom.com on behalf of Pat Graner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:51:54 PM

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Sincerely,
Pat Graner
1920 S Ocean Blvd Apt G Delray Beach, FL 33483-6437
pgranerku@gmail.com

From: mariah.barber@everyactioncustom.com on behalf of Mariah Reynolds
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:49:42 PM

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Sincerely,
Mariah Reynolds
202 Hawthorne Cir Fort Walton Beach, FL 32547-3708
mariah.barber@gmail.com

From: elizabethfsu@everyactioncustom.com on behalf of Elizabeth Class
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:44:52 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Elizabeth Class
3118 W Wallcraft Ave Tampa, FL 33611-1943
elizabethfsu@yahoo.com

From: pperry54@everyactioncustom.com on behalf of Pamela Perry
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:41:50 PM

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Sincerely,
Pamela Perry
675 SE 44th St Keystone Heights, FL 32656-6259
pperry54@gmail.com

From: slkoudsi@everyactioncustom.com on behalf of Suzanne Koudsi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:41:25 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Suzanne Koudsi
3270 Oakshire Dr Los Angeles, CA 90068-1762
slkoudsi@hotmail.com

From: saraibowden@everyactioncustom.com on behalf of Saraia Bowden
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:41:14 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Saraia Bowden
376 S Military Hwy Apt G Norfolk, VA 23502-5269
saraibowden@gmail.com

From: bobandpaulette@everyactioncustom.com on behalf of Paulette Estok
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:41:00 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents, as well adults in the midst of receiving treatment or considering treatment.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Paulette Estok
831 Tamarind Cir Barefoot Bay, FL 32976-2410
bobandpaulette@gmail.com

From: alysonbecker@everyactioncustom.com on behalf of ALYSON BECKER
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:40:09 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
ALYSON BECKER
54 Nowell Farme Rd Carlisle, MA 01741-1831
alysonbecker@hotmail.com

From: dakaplan@everyactioncustom.com on behalf of Debra Kaplan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:36:52 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Debra Kaplan
706 Kenmoore Ct Eustis, FL 32726-7813
dakaplan@aol.com

From: stevendnorton@everyactioncustom.com on behalf of Steven Norton
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:33:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

As a Psychologist, I am very familiar with the issue of gender-affirming care. Decisions regarding such care should be left to parents and children, with the support of health care and mental health professionals. Politics should have no role to play in such decisions. Or, the next time you or a family member need surgery, go to a politician with a scalpel!

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

Sincerely,

Steven D. Norton, Ph.D.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Steven Norton
625 Amber Jack Ct Barefoot Bay, FL 32976-2554
stevendnorton@gmail.com

From: dakerner@everyactioncustom.com on behalf of Donna Kerner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:33:38 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Donna Kerner
1012 N J St Lake Worth, FL 33460-2228
dakerner@hotmail.com

From: jacquelinearndt62@everyactioncustom.com on behalf of Jacquelin Arndt
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:27:57 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jacquelin Arndt
2300 Palmetto Rd Mount Dora, FL 32757-2418
jacquelinearndt62@gmail.com

From: skye.matth@everyactioncustom.com on behalf of Skye Matthews
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:27:35 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Skye Matthews
12869 Pumpkin Hill Rd Jacksonville, FL 32226-1415
skye.matth@gmail.com

From: lamberth@everyactioncustom.com on behalf of Cathy Lamberth
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:26:42 PM

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Dear Florida Board of Medicine,

I am writing to you today to implore you to reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Department of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that clearly debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Cathy Lamberth
907 Judson St Fort Walton Beach, FL 32547-1416
lamberth@yahoo.com

From: dtheronwilliams@everyactioncustom.com on behalf of Theron Williams
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:23:24 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the poorly researched and misleading proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all and protect the Right of an Individual's Self Determination for All.

Sincerely,
Theron Williams
2006 S Countryside Cir Orlando, FL 32804-6923
dtheronwilliams@gmail.com

From: morgantmclaughlin@everyactioncustom.com on behalf of Morgan McLaughlin
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:23:22 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Morgan McLaughlin
376 S Mill View Way Ponte Vedra Beach, FL 32082-4393
morgantmclaughlin@gmail.com

From: ali1mac@everyactioncustom.com on behalf of Alison Smith
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:22:39 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Alison Smith
4524 Woodlands Dr Niceville, FL 32578-4093
ali1mac@yahoo.com

From: adrianamontroy@everyactioncustom.com on behalf of Adriana Dixon
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:19:48 PM

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Sincerely,
Adriana Dixon
1803 Cotton Tree Ct Fort Walton Beach, FL 32547-4970
adrianamontroy@yahoo.com

From: mitsy2doni@everyactioncustom.com on behalf of Maryanne McGrath
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:11:14 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Maryanne McGrath
813 Silverthorn Ct Sebastian, FL 32976-7691
mitsy2doni@gmail.com

From: laura.deveny@everyactioncustom.com on behalf of Laura Deveny
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:09:52 PM

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I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Laura Deveny
145 Parkwood Dr Niceville, FL 32578-9769
laura.deveny@yahoo.com

From: karapoquette@everyactioncustom.com on behalf of Karalynn Poquette
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:09:25 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. If you truly care about the well-being of children and adolescents within our society, then listen to them now.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda. The wording of the proposed guidance would disallow consenting adults from controlling their body. Not to mention the banning of hormone pills and similar treatment for those under 18, which has little to no long-lasting effect on your body, would cause pain and suffering. If you are to accept this, you will carry the burden of all the innocent lives lost to suicide, the rise of depression within adolescents, and the gradual decline of mental health that is assured to happen.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all. Your people demand it.

Sincerely,
Karalynn Poquette
E MACARTHUR Eau Claire, WI 54701
karapoquette@gmail.com

From: jssyllyn94@everyactioncustom.com on behalf of Jessica Wardlaw
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:05:41 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jessica Wardlaw
115 Palm St Melrose, MN 32609
jssyllyn94@msn.com

From: bridgetcw30@everyactioncustom.com on behalf of Bridget Kennedy
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:02:03 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

I would challenge that none of you have met raised or cared for transgender youth. I have. I do. The misconceptions about this group of individuals is largely not accepted nor understood. And no one tries. The surgeon General had cherry picked portions of studies to make his ridiculous claims. Factual evidenced medicine tells you differently. Talk to the endocrine experts. Talk to parents. Talk to the individuals for which rights you again are taking away. What about HIPAA???? NONE OF YOU WILL even read this. Just proving moreso that you care about election agenda and power.

I am a Pediatric Nurse Practioner. I HAVE A Trans child who receives care.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Bridget Kennedy
6108 Pasadena Point Blvd Gulfport, FL 33707-3875
bridgetcw30@hotmail.com

From: storchmarcia1965@everyactioncustom.com on behalf of Marcia Storch
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:56:25 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Marcia Storch
10310 SW 51st Ln Gainesville, FL 32608-4378
storchmarcia1965@gmail.com

From: hkpicardi@everyactioncustom.com on behalf of Holly Picardi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:52:24 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Holly Picardi
5740 E Bay Blvd Gulf Breeze, FL 32563-9664
hkpicardi@gmail.com

From: sewerdanielle@everyactioncustom.com on behalf of Danielle Sewer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:50:23 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Danielle Sewer
5916 Golden Eagle Cir Palm Beach Gardens, FL 33418-1529
sewerdanielle@yahoo.com

From: valeriedelvalle77@everyactioncustom.com on behalf of Valerie Delvalle
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:39:40 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Valerie Delvalle
14311 SW 286th St Homestead, FL 33033-1750
valeriedelvalle77@gmail.com

From: g8rkate@everyactioncustom.com on behalf of Sarah Marr
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:39:01 PM

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Dear Florida Board of Medicine,

I oppose the guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in children and adolescents. It is inaccurate and does great harm to the children of Florida who are currently receiving or seeking gender affirming care. I support the rights of trans kids to receive gender affirming care and reject this proposed guidance that would end this medically sound option for the youth of Florida.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sarah Marr
3222 Bollard Rd West Palm Beach, FL 33411-6474
g8rkate@comcast.net

From: lovejoey@everyactioncustom.com on behalf of Pamela and Walle Bergsma
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:36:50 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

We know what we are talking about as we have a happy, healthy trans grandchild. What is being proposed is absolutely dangerous! and scaring the hell out of us in our old age. Could the state we live in really be this uninformed and backward?!

My husband and I are counting on you to protect our grandchild and all citizens of Florida.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Pamela and Walle Bergsma
619 S K St Lake Worth, FL 33460-4908
lovejoey@bellsouth.net

From: jarruda1@everyactioncustom.com on behalf of Julio Arruda
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:36:30 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Julio Arruda
5164 NW 121st Dr Coral Springs, FL 33076-3507
jarruda1@gmail.com

From: eveningglass@everyactioncustom.com on behalf of Allison Cohen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:36:22 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Allison Cohen
501 S K St Lake Worth Beach, FL 33460-4511
eveningglass@gmail.com

From: sarjfitz@everyactioncustom.com on behalf of Sarah Fitzgerald
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:33:49 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sarah Fitzgerald
3 Quail Run Holliston, MA 01746-1385
sarjfitz@gmail.com

From: annfonfa@everyactioncustom.com on behalf of Ann Fonfa
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:32:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. It's abuse to deny care.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ann Fonfa
7319 Serrano Ter Delray Beach, FL 33446-2215
annfonfa@aol.com

From: yuritversky@everyactioncustom.com on behalf of Yuri Tversky
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:31:58 PM

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Dear Florida Board of Medicine,

I am 15 years old. I knew with certainty that I am trans when I was 10 years old. When I first came out, everyone rejected me and told me it was a phase. 5 years later, it is not a phase.

When I was 10 years old, I was suicidal, and would self harm because nobody believed me and I knew I couldn't keep going through the wrong puberty and wait 8 years before I could transition.

I became secretive, and would lie to my parents about anything related to my trans identity as to hide it from them. Because when I had told them at age 10, they didn't believe me.

Last year, right before I turned 15, I came out to them again. And they were more accepting.

At that point, I had wanted to start transitioning for 5 years. After telling them I want to try and start, they hesitantly accepted it and we tried to start the process of getting testosterone.

IT TOOK ME 6 MONTHS TO GET TESTOSTERONE. It is not easy. No matter what your propaganda says, I had to fight every step of the way and be denied every step of the way until finally, after 4 different professionals, I was given my prescription.

Going on testosterone is the single best decision I have ever made in my life and that is not an exaggeration.

I am no longer suicidal. I can finally acknowledge and embrace the fact that I have a future, and a family that loves and accepts me for who I am. I don't have to pretend to be someone else anymore.

Until now. Until you.

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Yuri Tversky
11028 63rd Ave Seminole, FL 33772-6879
yuritversky@gmail.com

From: dawn.saunders1@everyactioncustom.com on behalf of Gwendolyn Saunders
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:31:00 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Gwendolyn Saunders
5312 36Th Avenue Cir W Bradenton, FL 34209-6034
dawn.saunders1@icloud.com

From: barbarazdravecky@everyactioncustom.com on behalf of Barbara Zdravecky
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:24:02 PM

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I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all. As a psychiatric nurse it is immoral to deny care for any Floridian, especially young people. Who are diagnosed with gender dysphoria. Do not interject politics into medical decisions.

Sincerely,
Barbara Zdravecky
707 Fern St Anna Maria, FL 34216
barbarazdravecky@yahoo.com

From: swansonfj@everyactioncustom.com on behalf of Laurie Swanson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:22:42 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

SUICIDE--SUICIDE--SUICIDE--That's what this dangerous new guidance means for children and adults who find their bodies are not the gender assigned at birth. Can you imagine how difficult it is to try to grow up in a body that feels foreign to you? We need to help these children and adults make peace with who they are. Gender dysphoria is not a made up or imposed condition--it is a natural phenomenon assigned by our creator if you will. Denying children and adolescents their natural states of being is to cause depression, discontent, and dissonance with living in this world. Yes, the natural outcome is suicide.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians -- it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Laurie Swanson

PO Box 511277 Key Colony Beach, FL 33051-1277
swansonfj@yahoo.com

From: lpglenn@everyactioncustom.com on behalf of Laura Glenn
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:22:06 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Gov. DeSantis is so quick to rally around parents' rights when it comes the mask-wearing and what books can sit on the shelves of the children's school libraries. But let a parent support their child by seeking care with a doctor on the most sensitive issue of their child's gender dysphoria, this requires governmental intervention and oversight. Parental rights disappear.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Laura Glenn
2230 Monaghan Dr Tallahassee, FL 32309-3125
lpglenn@comcast.net

From: rmkilmer22@everyactioncustom.com on behalf of Riley Kilmer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:10:33 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Riley Kilmer
25459 Hawks Run Ln Sorrento, FL 32776-7736
rmkilmer22@gmail.com

From: pattybeenutty@everyactioncustom.com on behalf of Patricia Benson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 3:07:15 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Patricia Benson
1406 90th Ct NW Bradenton, FL 34209-3500
pattybeenutty@gmail.com

From: ben_strom@everyactioncustom.com on behalf of Benjamin Strom
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:45:55 PM

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Sincerely,
Benjamin Strom
5708 31st Ct E Ellenton, FL 34222-4370
ben_strom@yahoo.com

From: ralvarez81@everyactioncustom.com on behalf of Rebecca Alvarez
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:45:29 PM

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Sincerely,
Rebecca Alvarez
1020 S Atlantic Ave Cocoa Beach, FL 32931-2419
ralvarez81@gmail.com

From: quinten.ershock@everyactioncustom.com on behalf of Quinten Ershock
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:44:19 PM

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Sincerely,
Quinten Ershock
1902 NW 7th Pl Gainesville, FL 32603-1111
quinten.ershock@gmail.com

From: nicholcollector@everyactioncustom.com on behalf of Eran Barner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:43:24 PM

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Sincerely,
Eran Barner
7657 NW 182nd Ter Hialeah, FL 33015-2942
nicholcollector@gmail.com

From: sapassehl13@everyactioncustom.com on behalf of Sheila Passehl
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:43:17 PM

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Sincerely,
Sheila Passehl
838 Navin St The Villages, FL 32163-2338
sapassehl13@gmail.com

From: zoniacarolynn@everyactioncustom.com on behalf of Carolynn Zonia
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:28:02 PM

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Sincerely,
Carolynn Zonia
620 Flatwoods Forest Loop Santa Rosa Beach, FL 32459-8848
zoniacarolynn@gmail.com

From: krisknisely@everyactioncustom.com on behalf of Kris Knisely
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:22:34 PM

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Sincerely,
Kris Knisely
7547 W Phobos Dr Tucson, AZ 85743-7463
krisknisely@gmail.com

From: NINABAIO11@everyactioncustom.com on behalf of NINA KILMER
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:18:46 PM

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Sincerely,
NINA KILMER
25459 Hawks Run Ln Sorrento, FL 32776-7736
NINABAIO11@GMAIL.COM

From: rozflorida28@everyactioncustom.com on behalf of Rosalyn Grossman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:14:25 PM

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Sincerely,
Rosalyn Grossman
2412 24th Ct Jupiter, FL 33477-9329
rozflorida28@gmail.com

From: bowwhitesman@everyactioncustom.com on behalf of Bo Whitesman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:10:57 PM

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Sincerely,
Bo Whitesman
1236 SE 8th St Cape Coral, FL 33990-2913
bowwhitesman@gmail.com

From: gregelger@everyactioncustom.com on behalf of Greg Elger
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:10:38 PM

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Sincerely,
Greg Elger
11451 NE 93rd Ter Bronson, FL 32621-3223
gregelger@att.net

From: breed863@everyactioncustom.com on behalf of Elizabeth Reed
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:06:37 PM

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Elizabeth Reed
432 Glen Arbor Ln Leesburg, FL 34748-9687
breed863@gmail.com

From: trishalane@everyactioncustom.com on behalf of Trisha Lane
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:01:59 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Trisha Lane
5975 Ibis Ct North Port, FL 34287-6158
trishalane@comcast.net

From: leddib@everyactioncustom.com on behalf of Lisa Eddib
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:54:05 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

My 18 year old is alive and thriving as are many others due to gender affirming care. Being transgender is not a choice and as such these patients need and deserve care that helps them cope.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lisa Eddib
2030 Bridgeport Cir Rockledge, FL 32955-4336
leddib@gmail.com

From: s.b.lapierre@everyactioncustom.com on behalf of Sarah LaPierre
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:54:04 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sarah LaPierre
4245 Willow Pond Cir West Palm Beach, FL 33417-8246
s.b.lapierre@gmail.com

From: bongo1285@everyactioncustom.com on behalf of john vaughn
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:51:29 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
john vaughn
16000 NW 208th St Okeechobee, FL 34972-0441
bongo1285@hotmail.com

From: gaugs03@everyactioncustom.com on behalf of Gail Augustine
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:51:05 PM

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Dear Florida Board of Medicine,

I am writing to you today to insist that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful, accurate information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal as a representative for all the people of this great state and keep Florida safe for all our diverse citizens.

Regards,

Gail Augustine
mother, sister, Florida voter, wife, teacher and community volunteer

Sincerely,
Gail Augustine
2716 Herndon St Valrico, FL 33596-5909

gaugs03@gmail.com

From: clieblich@everyactioncustom.com on behalf of Cathy Liebllich
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:50:08 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Cathy Liebllich
1832 Meeting Pl Orlando, FL 32814-6364
clieblich@me.com

From: mariatnryan@everyactioncustom.com on behalf of Maria Ryan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:49:02 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Maria Ryan
2007 E Dellview Dr Tallahassee, FL 32303-4807
mariatnryan@gmail.com

From: kaijeon6@everyactioncustom.com on behalf of Kora Sen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:36:05 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kora Sen
296 6th St Brooklyn, NY 11215-3676
kaijeon6@gmail.com

From: jjames3000@everyactioncustom.com on behalf of Jay James
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:31:16 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jay James
2420 Melrose Ave S St Petersburg, FL 33712-2166
jjames3000@gmail.com

From: bagdadcreel@everyactioncustom.com on behalf of Susan Creel
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:27:38 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Susan Creel
PO Box 353 Bagdad, FL 32530-0353
bagdadcreel@gmail.com

From: pbeerhalter@everyactioncustom.com on behalf of Pat Beerhalter
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:26:59 PM

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Dear Florida Board of Medicine,

I am writing to you today to urge you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children studies used by this board are notably inaccurate and dangerous.

As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject Dr. Ladapo's proposal for "non-care" and keep Florida safe for all.

Sincerely,
Patricia Beerhalter

Sincerely,
Pat Beerhalter
2104 Welcome Way The Villages, FL 32162-1245
pbeerhalter@gmail.com

From: marcaimac@everyactioncustom.com on behalf of Caitlin MacLaren
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:26:00 PM

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There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Caitlin MacLaren
7716 SW 56th Ave Apt 1 Miami, FL 33143-5636
marcaimac@gmail.com

From: obiesotheadgreat@everyactioncustom.com on behalf of Rayne Knowles
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:22:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Please. Losing access to care will kill so many of us. Please help.

Sincerely,
Rayne Knowles
11645 Grand Bay Blvd Clermont, FL 34711-7855
obiesotheadgreat@hotmail.com

From: caracschmidt@everyactioncustom.com on behalf of Cara Schmidt
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:19:42 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

As a transgender woman, who transitioned 9 years ago, but wished she had the opportunity and knowledge to medically transition before the irreversible damage of childhood puberty. Being transgender is not a phase or defect. We just want to be able to live our lives peacefully and respectfully without fear and persecution.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Cara Schmidt
19204 Dove Rd Land O Lakes, FL 34638-2584
caracschmidt@gmail.com

From: amardsen@everyactioncustom.com on behalf of Amar Sen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:12:40 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Amar Sen
296 6th St Brooklyn, NY 11215-3676
amardsen@gmail.com

From: jihanbazile93@everyactioncustom.com on behalf of Jihan Bazile
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:04:56 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jihan Bazile
1700 NW 8th St Boca Raton, FL 33486-2004
jihanbazile93@gmail.com

From: sarahstokes813@everyactioncustom.com on behalf of Sarah Stokes
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:57:36 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sarah Stokes
2308 S Bumby Ave Orlando, FL 32806-3233
sarahstokes813@gmail.com

From: Ischwartz.fl@everyactioncustom.com on behalf of Lauren Schwartz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:55:50 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lauren Schwartz
18078 Clear Brook Cir Boca Raton, FL 33498-1942
lschwartz.fl@gmail.com

From: smomargolies@everyactioncustom.com on behalf of Margolies Family
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:51:06 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Margolies Family
2807 Winningham Rd Chapel Hill, NC 27516-0524
smomargolies@gmail.com

From: mary7ferg@everyactioncustom.com on behalf of Mary Ferguson
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:47:32 PM

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Dear Florida Board of Medicine,

Please reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. The guidance is not based on accurate information, and it is certainly dangerous for many people. There is so much information available which rebukes the "facts" used to create the guidance.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Mary Ferguson
1840 Bamberg Ave The Villages, FL 32162-6788
mary7ferg@yahoo.com

From: sarah.rottenberg@everyactioncustom.com on behalf of Sarah Rottenberg
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:47:32 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sarah Rottenberg
744 Fitzwater St Philadelphia, PA 19147-2815
sarah.rottenberg@gmail.com

From: nancyf431@everyactioncustom.com on behalf of Nancy Farmer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:45:36 PM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Nancy Farmer
118 Lake Pine Cir Greenacres, FL 33463-5511
nancyf431@gmail.com

From: linamendt@everyactioncustom.com on behalf of Lin Amendt
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:44:29 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Lin Amendt
2125 NW 18th St Delray Beach, FL 33445-2622
linamendt@gmail.com

From: marbert@everyactioncustom.com on behalf of Marbert SISE
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:42:41 PM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Marbert SISE
1614 Trinidad Dr Key West, FL 33040-5220
marbert@bellsouth.net

From: bhkowalski@everyactioncustom.com on behalf of Barbara Kowalski
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:41:27 PM

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Sincerely,
Barbara Kowalski
22319 General St Boca Raton, FL 33428-4062
bhkowalski@yahoo.com

From: molliemaccormack@everyactioncustom.com on behalf of Mollie MacCormack
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:37:39 PM

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Sincerely,
Mollie MacCormack
131 Cross St Carlisle, MA 01741-1568
molliemaccormack@gmail.com

From: nopenothappening.ew@everyactioncustom.com on behalf of Erin Ward
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:36:50 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Erin Ward
4075 43rd Ave W Apt 16 Bradenton, FL 34205-2372
nopenothappening.ew@gmail.com

From: kaelger@everyactioncustom.com on behalf of Karen Elger
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:35:07 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Karen Elger
11451 NE 93rd Ter Bronson, FL 32621-3223
kaelger@gmail.com

From: kkysen@everyactioncustom.com on behalf of Khyber Sen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:30:02 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Khyber Sen
296 6th St Brooklyn, NY 11215-3676
kkysen@gmail.com

From: mortenbc58@everyactioncustom.com on behalf of Morten Christoffersen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:27:03 PM

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Sincerely,
Morten Christoffersen
61 W Klosterman Rd Apt C Tarpon Springs, FL 34689-2074
mortenbc58@gmail.com

From: eastratton08@everyactioncustom.com on behalf of Beth Stratton
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:26:18 PM

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Sincerely,
Beth Stratton
4213 Lake Haven Blvd Sebring, FL 33875-5221
eastratton08@gmail.com

From: seefeldt1987@everyactioncustom.com on behalf of Leslie Seefeldt
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:17:52 PM

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Sincerely,
Leslie Seefeldt
10901 Vista Del Sol Cir Clermont, FL 34711-7275
seefeldt1987@gmail.com

From: deemelvin1@everyactioncustom.com on behalf of Mamie Melvin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:10:44 PM

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The issued guidance by the Department of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. There is no doubt that this guidance will cause harm to many. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Sincerely,
Mamie A. Melvin
The Villages FL 32163

Sincerely,
Mamie Melvin
5859 Tupper Ct The Villages, FL 32163-5756
deemelvin1@gmail.com

From: teresamancuso4@everyactioncustom.com on behalf of Teresa Mancuso
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:00:17 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Teresa Mancuso
12201 NW 18th St Plantation, FL 33323-2133
teresamancuso4@icloud.com

From: bevjsaul@everyactioncustom.com on behalf of Beverly Saul
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:50:17 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Beverly Saul
7833 Rustling Pines Dr Milton, FL 32583-3414
bevjsaul@gmail.com

From: cashinkat@everyactioncustom.com on behalf of Katy Cashin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:43:58 AM

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Dear Florida Board of Medicine,

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Katy Cashin
41 Woodbine St Apt 2 Brooklyn, NY 11221-4301
cashinkat@gmail.com

From: sten27@everyactioncustom.com on behalf of Kristen McElveen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:39:28 AM

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Please reject this proposal and keep Florida safe for all. No one should be able to rule a state with uneducated opinion. This is why we go to licensed medical professionals for our medical care, not politicians.

Sincerely,
Kristen McElveen
621 House Wren Cir Palm Harbor, FL 34683-6264
sten27@icloud.com

From: epicindiewreck@everyactioncustom.com on behalf of Salena Kay
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:29:30 AM

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Sincerely,
Salena Kay
1867 7th St S St Petersburg, FL 33705-2782
epicindiewreck@gmail.com

From: eliz_maj@everyactioncustom.com on behalf of elizabeth major
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:28:38 AM

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Sincerely,
elizabeth major
1900 Reserve Blvd Gulf Breeze, FL 32563-7088
eliz_maj@yahoo.com

From: ""robuz3@everyactioncustom.com on behalf of rhoda zweigbaum
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:13:50 AM

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Please reject this proposal and keep Florida safe for all.

Remember that doctors take an oath to serve patients, not politicians with an agenda.

Sincerely,
rhoda zweigbaum
2940 Hidden Bay Blvd Navarre, FL 32566-9032
"robuz3@yahoo.com

From: janet_28484@everyactioncustom.com on behalf of Janet Mays
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:11:08 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Janet Mays
5474 Dallas Ct Gulf Breeze, FL 32563-9646
janet_28484@msn.com

From: chessdaddycat@everyactioncustom.com on behalf of Ray Gullett
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 11:02:47 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ray Gullett
2305 Gilmerton Rd Chesapeake, VA 23323-4901
chessdaddycat@gmail.com

From: scholle-loehne@everyactioncustom.com on behalf of Herbert Scholle
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:54:13 AM

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Dear Florida Board of Medicine,

Ihre Nachricht Ich schreibe Ihnen heute, um Sie aufzufordern, die vorgeschlagenen Leitlinien des Gesundheitsministeriums von Surgeon General Ladapo zur Gender-Dysphorie bei Kindern und Jugendlichen abzulehnen. Die vom Gesundheitsministerium herausgegebenen Leitlinien und die von diesem Gremium verwendeten Studien sind bemerkenswert ungenau und gefährlich. Als Ärzte – es liegt in Ihrer Verantwortung, keinen Schaden anzurichten. Als Regierungsbeamter liegt es in Ihrer Verantwortung, wahrheitsgemäße Informationen bereitzustellen, um eine besser informierte Bevölkerung zu schaffen. Es gibt zahlreiche Peer-Review-Artikel, die politisch und religiös motivierte wissenschaftliche Publikationen, die im Bericht des Boards über geschlechtsspezifische Pflege enthalten sind, leicht entlarven. Leider sind diese Leitlinien und die Rosinenpickerei-Studien dieses Gremiums nichts anderes als Anti-Transgender-Propaganda. Die führenden Gesundheitsorganisationen des Landes unterstützen die geschlechtsspezifische Versorgung von Transgender- und gender-nonkonformen Menschen - einschließlich der American Academy of Pediatrics; die American Medical Association; Das American College of Obstetricians and Gynecologists; Das American College of Physicians; Die American Psychiatric Association; Die American Psychological Association; Die American Academy of Family Physicians; Die Endokrine Gesellschaft; Die Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; Nationaler Verband der Sozialarbeiter; Weltärzteverband; und die World Professional Association for Transgender Health, unter anderem. Es gibt in der Tat überwältigende Beweise für die positiven Auswirkungen der geschlechtsspezifischen medizinischen Versorgung von Trans-Jugendlichen auf die psychische Gesundheit - einschließlich einiger der vom DOH und dem Board of Medicine zitierten Studien. Das Verbot des sozialen Übergangs ist ein klarer Eingriff der Regierung in die persönliche und elterliche Entscheidungsfindung. Zahlreiche Studien haben ergeben, dass Transgender-Jugendliche nach dem sozialen Übergang ein ähnliches psychisches Gesundheitsniveau wie die allgemeine Jugendbevölkerung aufweisen, wodurch die typischerweise auftretenden psychischen Ungleichheiten beseitigt werden. Wenn Transgender-Jugendliche von Menschen um sie herum bestätigt werden, sinken die gemeldeten Raten von Depressionen und Suizidalität signifikant. Diese Regel wird ihnen diese lebensrettende Behandlung verweigern. Ich fordere diesen Vorstand auf, wahrheitsgemäße Informationen auf der Grundlage von Wissenschaft und Daten bereitzustellen, im Gegensatz zu falschen Aussagen, die auf Vorurteilen und politischen Agenden basieren. Die Wahrheit ist immer noch wichtig und die Beweise sind klar: Transgender-Jugendlichen die Fähigkeit zum Übergang zu verweigern, ist gefährlich, missbräuchlich und lebensbedrohlich. Bitte lehnen Sie diesen Vorschlag ab und halten Sie Florida für alle sicher.

Sincerely,
Herbert Scholle
Loehner 346 Daytona Beach, FL 32120
scholle-loehne@t-online.de

From: romoarts.com@everyactioncustom.com on behalf of Robin Morgan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:53:48 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Robin Morgan
2511 Parma St Sarasota, FL 34231-5127
romoarts.com@gmail.com

From: dahego@everyactioncustom.com on behalf of Helaine Gottschalk
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:52:48 AM

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This is THE MOST CRUEL legislation

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Sincerely,
Helaine Gottschalk
3483 Edinburgh Dr Pace, FL 32571-8660
dahego@aol.com

From: larryjacas@everyactioncustom.com on behalf of larry jacas
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:45:04 AM

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Sincerely,
larry jacas
2048 Hammock Moss Dr Orlando, FL 32820-2231
larryjacas@gmail.com

From: swiftsmith4@everyactioncustom.com on behalf of Tammy Smith
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:39:53 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Tammy Smith
GRANDVIEW Way Casselberry, FL 32707
swiftsmith4@gmail.com

From: nwouk@everyactioncustom.com on behalf of Nina Wouk
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:27:50 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Nina Wouk
1259 El Camino Real # 215 Menlo Park, CA 94025-4208
nwouk@ix.netcom.com

From: toji369@everyactioncustom.com on behalf of Troy Ferrill-Espin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:27:42 AM

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Sincerely,
Troy Ferrill-Espin
5229 Hoof Print Dr N Jacksonville, FL 32257-3343
toji369@gmail.com

From: jpjules101@everyactioncustom.com on behalf of Julie Palmer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:25:51 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Julie Palmer
8641 Olivera St Navarre, FL 32566-2146
jpjules101@gmail.com

From: mcmduda@everyactioncustom.com on behalf of Mary Duda
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:24:55 AM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Mary Duda
13511 4th Plz E Bradenton, FL 34212-9682
mcmduda@aol.com

From: dawnantonis@everyactioncustom.com on behalf of Dawn Antonis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:14:05 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Dawn Antonis
1479 Selbydon Way Winter Garden, FL 34787-4654
dawnantonis@gmail.com

From: avianamae11@everyactioncustom.com on behalf of aviana reyes
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:11:29 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
aviana reyes
AVIANAMAE1 Gmailcom Fort Lee, VA 23801
avianamae11@gmail.com

From: acreeangela@everyactioncustom.com on behalf of Angela Acree
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:04:32 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Angela Acree
4646 Mystic Blue Way Fort Myers, FL 33966-8148
acreeangela@gmail.com

From: pamela753@everyactioncustom.com on behalf of Pamela Stewart
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:03:06 AM

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Please reject this proposal and keep Florida safe for all. For my much. Loved Granddaughter and the children searching for their true selves...don't persecute them but show Love and Acceptance...Do No Harm ... Pamela

Sincerely,
Pamela Stewart
5470 Collins Mill Creek Dr Milton, FL 32570-8236
pamela753@hotmail.com

From: whitezwza@everyactioncustom.com on behalf of Wendy White
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 10:00:31 AM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Wendy White
815 65th Ave E Bradenton, FL 34203-7635
whitezwza@gmail.com

From: pa_padilla1@everyactioncustom.com on behalf of Patricia Padilla
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:47:14 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

I cannot believe anyone in their right mind would consider making this medical decision and harming these youth. God is watching you!

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Patricia Padilla
1925 North St Longwood, FL 32750-6184
pa_padilla1@yahoo.com

From: egbraverman@everyactioncustom.com on behalf of Ellen Braverman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:35:25 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ellen Braverman
7 Alexander Ln Short Hills, NJ 07078-1172
egbraverman@verizon.net

From: waxyq@everyactioncustom.com on behalf of Ashley Redondo
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:23:23 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ashley Redondo
15704 Almondwood Dr Tampa, FL 33613-1004
waxyq@yahoo.com

From: stacif1995@everyactioncustom.com on behalf of staci frederiksen
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:19:39 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
staci frederiksen
5118 Magnolia Ter Fruitland Park, FL 34731-6019
stacif1995@gmail.com

From: loisbehr@everyactioncustom.com on behalf of Lois Behr
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 9:07:36 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Lois Behr
224 W Cherry Pl Deland, FL 32724-8822
loisbehr@gmail.com

From: jpgorlando@everyactioncustom.com on behalf of John Paul Stolt
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:58:15 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
John Paul Stolt
737 Park Lake Cir Orlando, FL 32803-3926
jpgorlando@gmail.com

From: Gnetluvsgreg@everyactioncustom.com on behalf of Jeanette Jeanette
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:56:14 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jeanette Jeanette
4550 NW 85th Ave Coral Springs, FL 33065-1322
Gnetluvsgreg@yahoo.com

From: fiveftnone@everyactioncustom.com on behalf of Karissa Wright
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:48:27 AM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Karissa Wright
5632 25th Ave S Gulfport, FL 33707-5014
fiveftnone@gmail.com

From: jaxriley99@everyactioncustom.com on behalf of Jax Sprague
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:46:41 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jax Sprague
16095 Cleveland St Redmond, WA 98052-1548
jaxriley99@gmail.com

From: j.siebenaler@everyactioncustom.com on behalf of Jean Siebenaler
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:45:40 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jean Siebenaler
7502 Old Bay Pointe Rd Milton, FL 32583-2968
j.siebenaler@gmail.com

From: jml@everyactioncustom.com on behalf of Joann Lipman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:44:31 AM

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I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Joann Lipman
31530 Marchester Dr Wesley Chapel, FL 33543-5113
jml@moneval.com

From: graceellenhanna@everyactioncustom.com on behalf of Grace Hanna
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:38:53 AM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

I have personally seen the benefits on gender affirming care in the lives of dozens of patients, friends, and colleagues, and my heart breaks to know that medical professionals could reject the extensive evidence of its benefits to support a political talking point.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Grace Hanna
2055 Thomasville Rd Apt E302 Tallahassee, FL 32308-0799
graceellenhanna@gmail.com

From: bulaas@everyactioncustom.com on behalf of Arthur Schurr
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:37:43 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Arthur Schurr
100 W 94th St New York, NY 10025-7041
bulaas@aol.com

From: ejemminger@everyactioncustom.com on behalf of Elizabeth Emminger
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:36:46 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Elizabeth Emminger
11519 Ivy Flower Loop Riverview, FL 33578-9476
ejemminger@gmail.com

From: robbcheryl@everyactioncustom.com on behalf of Cheryl Robb
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:30:44 AM

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Dear Florida Board of Medicine,

As a parent of an LGBTQ+ I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. I don't agree with many of the Surgeon General's statements and he seems bent on doing more harm than good for the people of Florida and their children.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Cheryl Robb
1011 McKean Cir Winter Park, FL 32789-2618
robbcheryl@gmail.com

From: robynluck22@everyactioncustom.com on behalf of Robyn Luck
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:20:41 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Robyn Luck
12085 Hudson Ridge Dr Apt Port Richey, FL 34668-1977
robynluck22@gmail.com

From: allisondemott@everyactioncustom.com on behalf of Allison Hancock
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:14:54 AM

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Sincerely,
Allison Hancock
283 SE Anastasia St Lake City, FL 32025-1731
allisondemott@gmail.com

From: Patrickkimball@everyactioncustom.com on behalf of Patrick Kimball
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:12:31 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Patrick Kimball
2358 Riverside Ave Apt 504 Jacksonville, FL 32204-4636
Patrickkimball@yahoo.com

From: barrhousehold@everyactioncustom.com on behalf of Debbie Evans
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:04:14 AM

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Sincerely,
Debbie Evans
910 N Shine Ave Orlando, FL 32803-3330
barrhousehold@yahoo.com

From: cjwojcek@everyactioncustom.com on behalf of Chris Wojcek
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 8:02:23 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Chris Wojcek
2215 Camden Park Ave Davenport, FL 33837-1798
cjwojcek@gmail.com

From: wnordbruch@everyactioncustom.com on behalf of Wil Nordbruch
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 7:16:33 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Wil Nordbruch
4627 6th Ave N St Petersburg, FL 33713-7219
wnordbruch@gmail.com

From: j_rosenfeld@everyactioncustom.com on behalf of Jennifer Rosenfeld
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:52:32 AM

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Sincerely,
Jennifer Rosenfeld
1813 Fayetteville Ave Deltona, FL 32725-3605
j_rosenfeld@cfl.rr.com

From: karen.binns@everyactioncustom.com on behalf of Karen S Binns
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 6:05:38 AM

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Please reject this proposal and keep Florida safe for all. All children transgender or otherwise have the right to have medical care, no matter what it is for!

Sincerely,
Karen S Binns
4910 N Monroe St Apt A107 Tallahassee, FL 32303-7027
karen.binns@comcast.net

From: silvk9@everyactioncustom.com on behalf of Kim Silvia
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 5:14:30 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kim Silvia
12308 NW 11th Ct Pembroke Pines, FL 33026-3805
silvk9@aol.com

From: portered2010@everyactioncustom.com on behalf of Edward porter
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:53:39 AM

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Sincerely,
Edward porter
2493 Amber Orchard Ct E Odenton, MD 21113-3672
portered2010@gmail.com

From: debi.kaur@everyactioncustom.com on behalf of Debi Kaur
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 4:00:15 AM

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Sincerely,
Debi Kaur
6604 Cherry Laurel Dr Liberty Township, OH 45044-8371
debi.kaur@gmail.com

From: noname1479@everyactioncustom.com on behalf of Delores Dickerson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:34:31 AM

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Dear Florida Board of Medicine,

Please reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. Please set back Florida's medical access for trans children.

Sincerely,
Delores Dickerson
14745 Merriltown Rd Apt 4921 Austin, TX 78728-4103
noname1479@gmail.com

From: simmygirl34@everyactioncustom.com on behalf of Elizabeth Kelly
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:20:41 AM

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Sincerely,
Elizabeth Kelly
900 W Tyler St Dalton, GA 30720-8777
simmygirl34@gmail.com

From: dbech@everyactioncustom.com on behalf of lynette bech
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:18:30 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
lynette bech
23588 Highway 430 Franklinton, LA 70438-2602
dbech@bellsouth.net

From: samanthan.garcia1998@everyactioncustom.com on behalf of Samantha Garcia
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 2:14:20 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Samantha Garcia
11181 Rankin Dr El Paso, TX 79927-3539
samanthan.garcia1998@gmail.com

From: boobalina@everyactioncustom.com on behalf of John Rokas
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 1:38:06 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
John Rokas
22168 Schroeder Ave Eastpointe, MI 48021-4008
boobalina@yahoo.com

From: huangwm1977@everyactioncustom.com on behalf of Winston Huang
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:50:39 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Winston Huang
220 Valley West Ct West Des Moines, IA 50265-3927
huangwm1977@yahoo.com

From: richardghennig@everyactioncustom.com on behalf of Richard Hennig
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:40:48 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Richard Hennig
14218 NW 31st Ave Gainesville, FL 32606-4701
richardghennig@gmail.com

From: leahhnah@everyactioncustom.com on behalf of Eleana Manousiouthakis
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:37:49 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Eleana Manousiouthakis
230 SW 2nd Ave Gainesville, FL 32601-6266
leahhnah@gmail.com

From: heatherlynnbogart87@everyactioncustom.com on behalf of Heather Bogart
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:23:44 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Heather Bogart
1317 Flaxwood Ave Brandon, FL 33511-8810
heatherlynnbogart87@gmail.com

From: jenna@everyactioncustom.com on behalf of Jenna Carter
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:16:19 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jenna Carter
1201 Beier Dr Apt B Fostoria, OH 44830-3536
jenna@jmc-infotech.com

From: susan.chakmakian@everyactioncustom.com on behalf of Susan Chakmakian
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Sunday, July 31, 2022 12:00:48 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Susan Chakmakian
38 Susan Dr Cranston, RI 02920-5525
susan.chakmakian@gmail.com

From: darrenhayessavagegarden@everyactioncustom.com on behalf of Darren Lazor
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:52:04 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Darren Lazor
1108 Glencove Cmns Brunswick, OH 44212-2591
darrenhayessavagegarden@gmail.com

From: wacky_tangerine@everyactioncustom.com on behalf of Stephanie Moynihan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:50:25 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Stephanie Moynihan
605 S Miramar Ave Indialantic, FL 32903-3297
wacky_tangerine@hotmail.com

From: multtudeofcheerfulfires@everyactioncustom.com on behalf of Dezeray Lyn
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:48:18 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. AS A NURSE THIS PROPOSAL HORRIFIES ME.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Sincerely,
Dezeray Lyn
4210 W Granada St Tampa, FL 33629-6617
multtudeofcheerfulfires@gmail.com

From: guillane@everyactioncustom.com on behalf of Kathleen Guilmette
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:43:34 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Kathleen Guilmette
5951 Ibis Ct North Port, FL 34287-6158
guillane@comcast.net

From: kmdorn@everyactioncustom.com on behalf of Kathryn Dorn
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:43:23 PM

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Dear Florida Board of Medicine,

I am writing to you as a near-lifelong Floridian (recently moved away to Arizona), concerned citizen, and responsible adult (defined here as "adult who does not viciously attack children for political gain") to ask you to please immediately reject the dangerous, dehumanizing, and scientifically nonsensical proposed "guidance" by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents!

Gender-affirming healthcare - including puberty-blocking medication - is often lifesaving for transgender children, who, when they are deprived of proper medical care and societal support, are at much greater risk of suicide (and homicide, for that matter) than cisgender children. Mr. Lapado's proposed "guidance" to deprive trans children of vital gender-affirming healthcare has absolutely no basis in science, nor in any honest concern for the welfare of Florida's children; instead, the "guidance" cites discredited and cherry-picked studies, ignoring the wide body of peer-reviewed evidence and myriad medical associations (listed below) which support the safety and necessity of gender-affirming healthcare, and the only apparent motivations behind the proposed "guidance" are political gamesmanship and vile malice against Florida's trans children, who are currently the targets of a bigoted and thoroughly one-sided war being waged against them by many of Florida's elected officials.

Here's a partial list of the medical organizations which support the need for and medical safety of gender-affirming healthcare for people of *all* ages, children most definitely included:

- American Academy of Pediatrics
- American Medical Association
- American College of Obstetricians and Gynecologists
- American College of Physicians
- American Psychiatric Association
- American Psychological Association
- American Academy of Family Physicians
- Endocrine Society
- Pediatric Endocrine Society
- American Nurses Association
- American Public Health Association
- American Heart Association
- National Association of Social Workers
- World Medical Association
- World Professional Association for Transgender Health.

This is your choice - you can swallow the lethal proposed "guidance" from Mr. Lapado, becoming a weapon in certain politicians' war on Florida's transgender children, and know that some children will suffer and very likely die by suicide as a direct result of your actions; or you can fulfill your fundamental medical duty to protect all patients' health and stand alongside the most respected organizations in your field by rejecting this child-attacking "guidance." Please choose the latter option. The health, happiness, and survival of Florida's children depend on their access to *all* of the medical care that they need, and for many children, that includes gender-affirming care.

Sincerely,
Kathryn Dorn
1059 W Myrna Ln Tempe, AZ 85284-2837
kmdorn@usf.edu

From: jenna5993@everyactioncustom.com on behalf of Jenna Kunz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:38:39 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jenna Kunz
650 Spring St Unit 2205 Sun Prairie, WI 53590-9328
jenna5993@gmail.com

From: shakydog808@everyactioncustom.com on behalf of Michael Sarabia
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:36:05 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Michael Sarabia
407 W Longview Ave Stockton, CA 95207-5147
shakydog808@sbcglobal.net

From: hvalesti@everyactioncustom.com on behalf of Hayley Valestin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:28:52 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Hayley Valestin
555 Glendale Blvd Valparaiso, IN 46385-2917
hvalesti@gmail.com

From: rnovkov@everyactioncustom.com on behalf of Russell Novkov
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:15:34 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Russell Novkov
602 Sawyer Ter Apt 308 Madison, WI 53705-3253
rnovkov@gmail.com

From: figmentbear62@everyactioncustom.com on behalf of Paul Saint
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:04:28 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Paul Saint
PO Box 520552 Longwood, FL 32752-0552
figmentbear62@aol.com

From: marianryan@everyactioncustom.com on behalf of Marian Ryan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:02:55 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Marian Ryan
2215 Avenue A NW Winter Haven, FL 33880-2430
marianryan@gmail.com

From: lree2101@everyactioncustom.com on behalf of Aaron Reep
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 10:16:39 PM

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Sincerely,
Aaron Reep
1030 26th Ave SE Minneapolis, MN 55414-2642
lree2101@gmail.com

From: wendica_b@everyactioncustom.com on behalf of Wendy Bailey
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 10:01:33 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Wendy Bailey
3119 Riders Pass Odessa, FL 33556-3101
wendica_b@hotmail.com

From: danafarmer@everyactioncustom.com on behalf of Dana Farmer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:56:35 PM

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Sincerely,
Dana Farmer
1990 Mallory Sq Tallahassee, FL 32308-4891
danafarmer@comcast.net

From: sedond@everyactioncustom.com on behalf of Douglas Sedon
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:50:24 PM

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Sincerely,
Douglas Sedon
2815 Fry Rd Jefferson, MD 21755-7424
sedond@yahoo.com

From: jitzelyr@everyactioncustom.com on behalf of Jitzely Rodriguez
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:44:29 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jitzely Rodriguez
8290 Gate Pkwy W Unit 506 Jacksonville, FL 32216-3640
jitzelyr@gmail.com

From: wingatehse@everyactioncustom.com on behalf of Wingate Steitz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:29:10 PM

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Sincerely,
Wingate Steitz
6151 N Winthrop Ave Chicago, IL 60660-2695
wingatehse@comcast.net

From: agebox@everyactioncustom.com on behalf of Adriane Esteban
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:15:47 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Adriane Esteban
1021 W Smith St Orlando, FL 32804-5231
agebox@aol.com

From: karenjwiner@everyactioncustom.com on behalf of Karen Winer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:15:28 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Karen Winer
32 Laguna Ter Palm Beach Gardens, FL 33418-5771
karenjwiner@yahoo.com

From: dfinn@everyactioncustom.com on behalf of Deborah Finn
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:14:06 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Deborah Finn
750 Weaver Dairy Rd Apt 229 Chapel Hill, NC 27514-1468
dfinn@earthlink.net

From: brittanyalexix@everyactioncustom.com on behalf of Brittany Williams
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:10:03 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Brittany Williams
10181 SW 1st St Plantation, FL 33324-2223
brittanyalexix@gmail.com

From: elisande215@everyactioncustom.com on behalf of Clyde Holman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:06:17 PM

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Sincerely,
Clyde Holman
2822 NW 40th Pl Gainesville, FL 32605-1502
elisande215@gmail.com

From: lilivaughan@everyactioncustom.com on behalf of Lili Vaughan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:05:47 PM

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Sincerely,
Lili Vaughan
1358 Henry Ave Des Plaines, IL 60016-6530
lilivaughan@gmail.com

From: dwstranger@everyactioncustom.com on behalf of Diana Wallace MD
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 9:01:03 PM

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Sincerely,
Diana Wallace MD
16 Emma St Apt 433 Binghamton, NY 13905-2793
dwstranger@yahoo.com

From: JudeSpeegle@everyactioncustom.com on behalf of Jude Speegle
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:58:03 PM

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Sincerely,
Jude Speegle
1221 S Beach St Apt 1041 Daytona Beach, FL 32114-6313
JudeSpeegle@gmail.com

From: shariknechel@everyactioncustom.com on behalf of Shari Knechel-Jones
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:57:49 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Shari Knechel-Jones
3372 Ramblewood Pl Sarasota, FL 34237-3835
shariknechel@gmail.com

From: mharkey@everyactioncustom.com on behalf of Marie Alford-Harkey
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:49:09 PM

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As pastor of a mostly LGBTQ+ congregation, I know firsthand the damage that is done to transgender youth when they cannot receive proper medical care. I also know the culture of fear and isolation that is being created by the DeSantis administration's senseless attacks on transgender people.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Marie Alford-Harkey
4859 Northlake Blvd Palm Beach Gardens, FL 33418-5726
mharkey@gmail.com

From: jennifer.b.leon@everyactioncustom.com on behalf of Jennifer Leon
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:42:07 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jennifer Leon
5602 N Branch Ave Tampa, FL 33604-7006
jennifer.b.leon@gmail.com

From: mcm11012003@everyactioncustom.com on behalf of MARIA MANDRY
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:30:51 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
MARIA MANDRY
307 Shelby Brooke Dr Plant City, FL 33563-8536
mcm11012003@yahoo.com

From: herrero_caro@everyactioncustom.com on behalf of Carolina Herrero
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:22:39 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Carolina Herrero
11520 SW 183rd St Miami, FL 33157-4963
herrero_caro@hotmail.com

From: angola84@everyactioncustom.com on behalf of Angie Glegola
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:16:01 PM

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Dear Florida Board of Medicine,

This is needed healthcare and I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Angie Glegola
17047 Kinloch Redford, MI 48240-2431
angola84@att.net

From: pglaufer@everyactioncustom.com on behalf of Paul Laufer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:15:21 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Paul Laufer
923 Dogwood Dr Sebastian, FL 32976-7123
pglaufer@gmail.com

From: photojack53@everyactioncustom.com on behalf of Jack Schlotte
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:14:05 PM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all and honor the 14th Amendment.

Sincerely,
Jack Schlotte
PO Box 635188 San Diego, CA 92163-5188
photojack53@yahoo.com

From: Sternsl@everyactioncustom.com on behalf of Sharon Stern
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:10:13 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sharon Stern
9854 Indian Key Trl Fl 33776 Seminole, FL 33776-1073
Sternsl@hotmail.com

From: sjstew@everyactioncustom.com on behalf of John and Sheila Stewart
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 8:06:26 PM

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Dear Florida Board of Medicine,

We are retired schoolteachers who had transgender students. We are writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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We call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
John and Sheila Stewart
2130 Burlington Ave N St Petersburg, FL 33713-8035
sjstew@gte.net

From: kcoots89@everyactioncustom.com on behalf of Katrina Coots
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:57:50 PM

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Sincerely,
Katrina Coots
2604 Iroquois Ave Jacksonville, FL 32210-5952
kcoots89@gmail.com

From: phoenixgiffen@everyactioncustom.com on behalf of Phoenix Giffen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:56:50 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Phoenix Giffen
115 Bodega Ave Petaluma, CA 94952-2654
phoenixgiffen@gmail.com

From: kelseytressler@everyactioncustom.com on behalf of Kelsey Tressler
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:55:06 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kelsey Tressler
904 E Chelsea St Tampa, FL 33603-4137
kelseytressler@gmail.com

From: wolflowlmama@everyactioncustom.com on behalf of Lydia Garvey
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:51:56 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Lydia Garvey
429 S 24th St Clinton, OK 73601-3713
wolflowlmama@yahoo.com

From: clareann.despain@everyactioncustom.com on behalf of Clareann Despain
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:49:18 PM

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Clareann Despain
15111 Shaw Rd Tampa, FL 33625-5530
clareann.despain@gmail.com

From: Chauncey6336@everyactioncustom.com on behalf of Olivia Brake
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:42:41 PM

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Please reject this proposal and keep Florida safe for all.

Thank you For listening

Sincerely,
Olivia Brake
20699 Coleman Brake Rd Milford Center, OH 43045-9773
Chauncey6336@gmail.com

From: eturn14@everyactioncustom.com on behalf of Erin Turner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:16:25 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Erin Turner
963 Stowell Dr Rochester, NY 14616-1852
eturn14@gmail.com

From: linuxman@everyactioncustom.com on behalf of Mark Anderson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:14:00 PM

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Our "surgeon general" already risks the lives of Floridians by ignoring the advise of experts because it does not align with his (and DeSantis's) political beliefs. Enough is enough!

Please reject this proposal and keep Florida safe for all.

Sincerely,
Mark Anderson
18835 Monroe Ave Orlando, FL 32820-2620
linuxman@prodigy.net

From: bdeleon0@everyactioncustom.com on behalf of Bianca deLeon
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:07:09 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Bianca deLeon
3343 Liberty Square Way Fort Pierce, FL 34982-8456
bdeleon0@aol.com

From: andrea.wolfson@everyactioncustom.com on behalf of Andrea Wolfson
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:06:59 PM

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Dear Florida Board of Medicine,

Please consider the grave harm that denying care will cause transgender youth and reject Surgeon General Ladapo's heinous call to strip medical licenses from doctors who abide by this proposed guidance.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population.

There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Andrea Wolfson
13356 88th Ave Seminole, FL 33776-2415
andrea.wolfson@gmail.com

From: zygopetalum2020@everyactioncustom.com on behalf of BP GEORGE
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:06:25 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
BP GEORGE
350 Venice Ave W Unit 20 Venice, FL 34284-7002
zygopetalum2020@gmail.com

From: catrules618@everyactioncustom.com on behalf of Catherine England
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:05:58 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Catherine England
700 Maple St Meadville, PA 16335-2328
catrules618@gmail.com

From: rnerwick@everyactioncustom.com on behalf of Randall Nerwick
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:04:35 PM

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Sincerely,
Randall Nerwick
3438 SE Mary Ct Milwaukie, OR 97222-5540
rnerwick@gmail.com

From: futureairbuspilot@everyactioncustom.com on behalf of Bryce Cantrell
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 7:02:59 PM

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Sincerely,
Bryce Cantrell
4156 Aqua Vista Dr Pensacola, FL 32504-7604
futureairbuspilot@gmail.com

From: BTucker506@everyactioncustom.com on behalf of Barbara Tucker
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:58:50 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Barbara Tucker
1312 Essex Dr Wellington, FL 33414-5610
BTucker506@aol.com

From: floraeloisemerigold@everyactioncustom.com on behalf of Flora Guthrie
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:53:38 PM

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Sincerely,
Flora Guthrie
519 Aquatic Dr Atlantic Beach, FL 32233-3840
floraeloisemerigold@gmail.com

From: lindsdavis@everyactioncustom.com on behalf of Lindsay Davis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:49:40 PM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lindsay Davis
1394 W Lakeshore Dr Clermont, FL 34711-2940
lindsdavis@yahoo.com

From: klinahoyer@everyactioncustom.com on behalf of Kristin Hoyer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:46:52 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Kristin Hoyer
911 Warehouse Rd Orlando, FL 32803-3561
klinahoyer@gmail.com

From: cstottler@everyactioncustom.com on behalf of Cindy Stottler
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:26:38 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Cindy Stottler
3909 Reserve Dr Tallahassee, FL 32311-8200
cstottler@comcast.net

From: Archangeladvocacy@everyactioncustom.com on behalf of Angel D'Angelo
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:24:35 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Please do not turn back the clock on trans care!

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Angel D'Angelo
9660 Kona Village Dr Apt 110 Riverview, FL 33578-5216
Archangeladvocacy@gmail.com

From: conbro.32578@everyactioncustom.com on behalf of Deidre and Ronald Brown
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:23:33 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Deidre and Ronald Brown
214 4th Ave Longmont, CO 80501-5504
conbro.32578@gmail.com

From: michael.breinlinger@everyactioncustom.com on behalf of Mike Breinlinger
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:15:28 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Mike Breinlinger
2788 Maderia Cir Melbourne, FL 32935-5599
michael.breinlinger@gmail.com

From: leexanthippe@everyactioncustom.com on behalf of Le Ami
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:13:31 PM

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Dear Florida Board of Medicine,

I am writing to you today to strongly encourage you to reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Le Ami
5416 Home Ct Carmichael, CA 95608-5004
leexanthippe@yahoo.com

From: cmetz711@everyactioncustom.com on behalf of Constance Metzler
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:12:14 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Constance Metzler
3392 NE Skyline Dr Jensen Beach, FL 34957-3985
cmetz711@gmail.com

From: kbrown023@everyactioncustom.com on behalf of Kristen Braun
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:05:10 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kristen Braun
721 Putnam Ave Orlando, FL 32804-7326
kbrown023@gmail.com

From: broadwaybrandon88@everyactioncustom.com on behalf of Brandon Singer
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 6:02:20 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Brandon Singer
648 Kismet Rd Philadelphia, PA 19115-1121
broadwaybrandon88@gmail.com

From: fyziksgirl@everyactioncustom.com on behalf of Eileen Murphy
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:59:17 PM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Eileen Murphy
15713 Starling Dale Ln Lithia, FL 33547-3920
fyziksgirl@yahoo.com

From: merissa.carlisle@everyactioncustom.com on behalf of Merissa Carlisle
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:58:27 PM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Merissa Carlisle
4805 Alt 19 Palm Harbor, FL 34683-1244
merissa.carlisle@gmail.com

From: ROMERXVI@everyactioncustom.com on behalf of Frank Roder
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:57:13 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Frank Roder
908 E Louisiana Ave Tampa, FL 33603-4043
ROMERXVI@aol.com

From: jaymerw@everyactioncustom.com on behalf of Jayme Calhoun
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:55:53 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jayme Calhoun
3476 Babiche St Jacksonville, FL 32259-2196
jaymerw@yahoo.com

From: EWasfi@everyactioncustom.com on behalf of Ellen Wasfi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:50:38 PM

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Please reject this proposal and keep Florida safe for all. Thank you.

Sincerely,
Ellen Wasfi
286 Pine Valley Rd Dover, DE 19904-7111
EWasfi@aol.com

From: vituspr@everyactioncustom.com on behalf of Karen Howard
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:44:58 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Karen Howard
1019 SW Estaugh Ave Port St Lucie, FL 34953-1808
ventuspr@aol.com

From: amazingrace32117@everyactioncustom.com on behalf of Grace White
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:32:43 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Grace White
1240 W Hubbard Ave Deland, FL 32720-9554
amazingrace32117@gmail.com

From: rwjb4446@everyactioncustom.com on behalf of Jane Wiley
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:29:50 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jane Wiley
16233 Pebblebrook Dr Tampa, FL 33624-1074
rwjb4446@aol.com

From: abrein58@everyactioncustom.com on behalf of Adele Breinlinger
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:29:23 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Adele Breinlinger
954 Fostoria Dr Melbourne, FL 32940-1512
abrein58@gmail.com

From: garyhowellpsyd@everyactioncustom.com on behalf of Gary Howell
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:18:45 PM

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Dear Florida Board of Medicine,

As a psychologist, I can tell you that trans teens will die and suicide attempts will increase. I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Gary Howell
4400 W Spruce St Apt 489 Tampa, FL 33607-4244
garyhowellpsyd@gmail.com

From: lazybumhealer@everyactioncustom.com on behalf of Susan Zecchini
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:18:33 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Susan Zecchini
933 Spring Ave Panama City, FL 32401-4540
lazybumhealer@gmail.com

From: breinwi57@everyactioncustom.com on behalf of William Breinlinger
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:18:27 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
William Breinlinger
954 Fostoria Dr Melbourne, FL 32940-1512
breinwi57@gmail.com

From: jkracoff@everyactioncustom.com on behalf of Jen Kracoff
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:16:49 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jen Kracoff
66 Rathbun Rd Natick, MA 01760-1025
jkracoff@gmail.com

From: bhadrayut@everyactioncustom.com on behalf of BJ Trivedi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:14:18 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
BJ Trivedi
5146 NW 22nd Dr Gainesville, FL 32605-5480
bhadrayut@yahoo.com

From: lanerichards7@everyactioncustom.com on behalf of Richard Ryan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:11:48 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Richard Ryan
3730 Cadbury Cir Apt 530 Venice, FL 34293-2214
lanerichards7@gmail.com

From: kemccldain@everyactioncustom.com on behalf of Karen McClain
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:10:01 PM

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Sincerely,
Karen McClain
32341 Groat Blvd Brownstown, MI 48173-8635
kemccldain@gmail.com

From: Kaynet98@everyactioncustom.com on behalf of Kaylin Guy
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:06:40 PM

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Sincerely,
Kaylin Guy
1212 SW Mayo Rd Lake City, FL 32024-2942
Kaynet98@yahoo.com

From: dieter@everyactioncustom.com on behalf of Dieter Randolph
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:05:05 PM

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Sincerely,
Dieter Randolph
3529 Haines Rd N Saint Petersburg, FL 33704-1103
dieter@waypastokay.com

From: margeaster@everyactioncustom.com on behalf of Margaret Easter
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:03:33 PM

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Sincerely,
Margaret Easter
17330 Quaker Ln Apt 316 Sandy Spring, MD 20860-1220
margeaster@aol.com

From: dbdolphin50@everyactioncustom.com on behalf of Denise Barber
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 5:00:04 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Denise Barber
501 S Blair Stone Rd Apt 2923 Tallahassee, FL 32301-3043
dbdolphin50@yahoo.com

From: gbsho1@everyactioncustom.com on behalf of Graciela Sholander
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:59:27 PM

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Sincerely,
Graciela Sholander
3362 Wagon Trail Rd Fort Collins, CO 80524-1270
gbsho1@yahoo.com

From: reelfish5354@everyactioncustom.com on behalf of Diane Cell
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:57:28 PM

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Sincerely,
Diane Cell
420 N Range Rd Cocoa, FL 32926-5352
reelfish5354@gmail.com

From: yinyangtwins@everyactioncustom.com on behalf of Audra Bowling
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:56:24 PM

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Sincerely,
Audra Bowling
247 Davis Ave SW Leesburg, VA 20175-3400
yinyangtwins@gmail.com

From: ravanderveer@everyactioncustom.com on behalf of Richard Van Derveer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:56:13 PM

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Sincerely,
Richard Van Derveer
1212 Newton St Key West, FL 33040-7024
ravanderveer@icloud.com

From: vonwellon@everyactioncustom.com on behalf of DUANE TASH
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:55:29 PM

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Sincerely,
DUANE TASH
3730 Cadbury Cir Apt 530 Venice, FL 34293-2214
vonwellon@gmail.com

From: michaellaffitte321@everyactioncustom.com on behalf of Michael Laffitte
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:52:58 PM

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Sincerely,
Michael Laffitte
8401 Admiral Pt Winter Park, FL 32792-9385
michaellaffitte321@gmail.com

From: nathankehoe98@everyactioncustom.com on behalf of Nathan K.
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:52:53 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Nathan K.
10210 Whitewood Rd Brecksville, OH 44141-1652
nathankehoe98@gmail.com

From: gail_allan8@everyactioncustom.com on behalf of Abigail Laffitte
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:49:55 PM

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Sincerely,
Abigail Laffitte
8401 Admiral Pt Winter Park, FL 32792-9385
gail_allan8@yahoo.com

From: KEELMORE5@everyactioncustom.com on behalf of Kirby Elmore
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:49:21 PM

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Sincerely,
Kirby Elmore
2204 MO Ho Dr Orlando, FL 32839-8739
KEELMORE5@GMAIL.COM

From: rtaylorbriggs@everyactioncustom.com on behalf of Ruth Briggs
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:46:50 PM

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Sincerely,
Ruth Briggs
13708 8th Ave E Tacoma, WA 98445-1457
rtaylorbriggs@gmail.com

From: aeritter12@everyactioncustom.com on behalf of Adelaide Ritter
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:43:25 PM

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Sincerely,
Adelaide Ritter
4008 Maguire Blvd Apt 5209 Orlando, FL 32803-7207
aeritter12@gmail.com

From: eagleyachts@everyactioncustom.com on behalf of Eric West
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:40:27 PM

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Sincerely,
Eric West
3943 S Peninsula Dr Port Orange, FL 32127-6515
eagleyachts@gmail.com

From: rdszarenski@everyactioncustom.com on behalf of ronald szarenski
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:39:50 PM

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Sincerely,
ronald szarenski
8460 Arborfield Ct Fort Myers, FL 33912-4675
rdszarenski@gmail.com

From: 2kbeach@everyactioncustom.com on behalf of Kathi Olson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:38:00 PM

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Sincerely,
Kathi Olson
370 Bayland Rd Fort Myers Beach, FL 33931-3904
2kbeach@comcast.net

From: mary.eaton61@everyactioncustom.com on behalf of Mary Eaton
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:36:27 PM

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Sincerely,
Mary Eaton
2343 SE Seafury Ln Port St Lucie, FL 34952-4844
mary.eaton61@gmail.com

From: nealdeschain@everyactioncustom.com on behalf of Neal Deschain
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:36:15 PM

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Sincerely,
Neal Deschain
440 Cambridge Blvd Winter Park, FL 32789-3410
nealdeschain@gmail.com

From: yassirc23@everyactioncustom.com on behalf of Yassir Cruz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:34:14 PM

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Sincerely,
Yassir Cruz
9848 N Kendall Dr Apt B201 Miami, FL 33176-1890
yassirc23@gmail.com

From: rachel.c.fitzpatrick@everyactioncustom.com on behalf of RACHEL FITZPATRICK
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:33:46 PM

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Sincerely,
RACHEL FITZPATRICK
715 Garden Rd Glenside, PA 19038-5111
rachel.c.fitzpatrick@gmail.com

From: Slevyr26@everyactioncustom.com on behalf of Sara Levy
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:31:26 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sara Levy
2929 Arch St Philadelphia, PA 19104-2857
Slevyr26@gmail.com

From: kklcac@everyactioncustom.com on behalf of Kevin Lindemann
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:27:41 PM

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Sincerely,
Kevin Lindemann
27 W403 Providence Ln Winfield, IL 60190-1881
kklcac@earthlink.net

From: hillaryostrow@everyactioncustom.com on behalf of Hillary Ostrow
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:22:32 PM

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Sincerely,
Hillary Ostrow
5835 Hesperia Ave Encino, CA 91316-1013
hillaryostrow@yahoo.com

From: Bohemian_tchick@everyactioncustom.com on behalf of Jessica Whittington
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:22:00 PM

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Sincerely,
Jessica Whittington
2322 Riverview Ter Alexandria, VA 22303-1911
Bohemian_tchick@yahoo.com

From: mikamcbain@everyactioncustom.com on behalf of Myka McBain
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:20:40 PM

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Dear Florida Board of Medicine,

It was 1963 when I needed transgender care and help. Now at age 67 I am transitioning to be the best version of myself in spite of the misplaced hate and discrimination proposals like these encourage. Please don't try to dictate our life's !

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Myka McBain
372 Cedar Creek Rd Palatka, FL 32177-6915
mikamcbain@gmail.com

From: eeunice@everyactioncustom.com on behalf of Elissa Eunice
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:20:18 PM

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Sincerely,
Elissa Eunice
1511 Hibiscus Ave Winter Park, FL 32789-1615
eeunice@cfl.rr.com

From: jimloveland52@everyactioncustom.com on behalf of Jim Loveland
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:17:39 PM

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Sincerely,
Jim Loveland
2500 54th Ave N Lot 100 St Petersburg, FL 33714-1970
jimloveland52@yahoo.com

From: harpy.vixen@everyactioncustom.com on behalf of Darby Atwood
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:17:31 PM

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Sincerely,
Darby Atwood
1106 Norman St Anchorage, AK 99504-2338
harpy.vixen@gmail.com

From: ceg72005@everyactioncustom.com on behalf of Christine Grossman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:15:49 PM

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Please reject this proposal and keep Florida safe for all.

This will kill folks and already high suicide rates will skyrocket among trans and non-binary youth and adults.

Sincerely,
Christine Grossman
2528 18th Ave N Saint Petersburg, FL 33713-4932
ceg72005@gmail.com

From: vpetta@everyactioncustom.com on behalf of Vincent Petta
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:14:46 PM

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Sincerely,
Vincent Petta
308 Oak Track Crse Ocala, FL 34472-9310
vpetta@aol.com

From: agk20centuryculture@everyactioncustom.com on behalf of Abby Kocher
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:10:19 PM

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Sincerely,
Abby Kocher
1410 Favonius Way West Chester, PA 19382-7824
agk20centuryculture@yahoo.com

From: dnsurf@everyactioncustom.com on behalf of Douglas Nightengale
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 4:08:11 PM

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Sincerely,
Douglas Nightengale
9351 Nile Dr New Port Richey, FL 34655-1664
dnsurf@comcast.net

From: t.mcgoo@everyactioncustom.com on behalf of Teresa McGaughey
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:53:35 PM

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Teresa McGaughey
15308 Alsask Cir Port Charlotte, FL 33981-3180
t.mcgoo@yahoo.com

From: Licy75@everyactioncustom.com on behalf of Felicity Hohenshelt
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:52:44 PM

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Sincerely,
Felicity Hohenshelt
4321 Sunbeam Lake Dr Jacksonville, FL 32257-8118
Licy75@aol.com

From: erieknight@everyactioncustom.com on behalf of David Iosue
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:41:34 PM

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Sincerely,
David Iosue
4672 Morningside Dr Cleveland, OH 44109-4558
erieknight@sbcglobal.net

From: wyrmfire3@everyactioncustom.com on behalf of David Dougherty
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:38:14 PM

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Sincerely,
David Dougherty
282 Pershing Ave New Britain, CT 06053-2750
wyrmfire3@gmail.com

From: hawkwhale@everyactioncustom.com on behalf of Laura Sachs
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:36:51 PM

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Sincerely,

Laura L. Sachs

Sincerely,
Laura Sachs
13837 Via Flora Apt G Delray Beach, FL 33484-1901
hawkwhale@aol.com

From: hawkwhale@everyactioncustom.com on behalf of Laura Sachs
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:34:21 PM

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Sincerely,
Laura Sachs
13837 Via Flora Apt G Delray Beach, FL 33484-1901
hawkwhale@aol.com

From: ddjewett711@everyactioncustom.com on behalf of Donna Jewett
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:30:08 PM

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Sincerely,
Donna Jewett
756 White Pine Tree Rd Apt 112 Venice, FL 34285-4229
ddjewett711@comcast.net

From: spygirl726@everyactioncustom.com on behalf of Margaret Cobb
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:26:38 PM

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Sincerely,
Margaret Cobb
8017 SW 135th Ter Archer, FL 32618-3237
spygirl726@yahoo.com

From: yolandaberumen12@everyactioncustom.com on behalf of Yolanda Berumen
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:26:02 PM

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Sincerely,
Yolanda Berumen
3505 Mangum St Baldwin Park Baldwin Park, CA 91706
yolandaberumen12@gmail.com

From: cncmykids@everyactioncustom.com on behalf of Faith Shafman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:21:48 PM

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Sincerely,
Faith Shafman
22120 Laramore Ave Port Charlotte, FL 33952-4502
cncmykids@yahoo.com

From: tomdeligio@everyactioncustom.com on behalf of Thomas DeLigio
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:18:28 PM

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Sincerely,
Thomas DeLigio
2440 Potter St Eugene, OR 97405-3068
tomdeligio@gmail.com

From: violet.hirst76@everyactioncustom.com on behalf of Violet Hirst
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:16:48 PM

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Sincerely,
Violet Hirst
1764 S Anderson Rd Exeter, CA 93221-9631
violet.hirst76@gmail.com

From: charlesdaniel1@everyactioncustom.com on behalf of charles daniel
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:10:33 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
charles daniel
725 Holly Rd Anna Maria, FL 34216
charlesdaniel1@mac.com

From: wrangler649@everyactioncustom.com on behalf of Ian Vargas
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 3:01:00 PM

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Sincerely,
Ian Vargas
11896 Sturbridge Ln Wellington, FL 33414-5714
wrangler649@gmail.com

From: kendra85210@everyactioncustom.com on behalf of Kendra Moore
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:58:21 PM

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Sincerely,
Kendra Moore
58 E Millett Ave Mesa, AZ 85210-3724
kendra85210@q.com

From: latinleo@everyactioncustom.com on behalf of Hank Ramírez
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:57:34 PM

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Sincerely,
Hank Ramírez
4823 Mansfield St San Diego, CA 92116-1979
latinleo@sbcglobal.net

From: debwile@everyactioncustom.com on behalf of Debra Wile
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:53:27 PM

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Sincerely,
Debra Wile
1757 Kingfisher Ct The Villages, FL 32162-3174
debwile@gmail.com

From: judepatton@everyactioncustom.com on behalf of Jude Patton
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:51:39 PM

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Sincerely,
Jude Patton
1149 Marina Dr Yuba City, CA 95993-8108
judepatton@aol.com

From: sarahmurphree@everyactioncustom.com on behalf of Sarah Meek
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:48:13 PM

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Sincerely,
Sarah Meek
200 Herons Run Dr Sarasota, FL 34232-1756
sarahmurphree@yahoo.com

From: samal0006@everyactioncustom.com on behalf of Samantha Loper
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:42:30 PM

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Sincerely,
Samantha Loper
1009 Shallow Water Way Murfreesboro, TN 37127-2501
samal0006@gmail.com

From: aprilgirl1951@everyactioncustom.com on behalf of HARRIET HAMMELL
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:41:47 PM

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Sincerely,
HARRIET HAMMELL
1713 Bulavista Ave Lot 282 Jacksonville, FL 32221-1401
aprilgirl1951@yahoo.com

From: lzchin@everyactioncustom.com on behalf of Laura Chinofsky
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:40:14 PM

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Sincerely,
Laura Chinofsky
422 Wendy Rd Southampton, PA 18966-3521
lzchin@hotmail.com

From: k8tealexandra@everyactioncustom.com on behalf of Kate Lynch
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:37:22 PM

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Sincerely,
Kate Lynch
300 Beach Rd Belvedere Tiburon, CA 94920-2409
k8tealexandra@gmail.com

From: ddbtrnjyr59@everyactioncustom.com on behalf of Daryl W. De Boer
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:29:28 PM

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Sincerely,
Daryl W. De Boer
20 Westbrook Dr Toms River, NJ 08757-4416
ddbtrnjyr59@yahoo.com

From: ddbtrnjyr59@everyactioncustom.com on behalf of Daryl W. De Boer
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:29:00 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Daryl W. De Boer
20 Westbrook Dr Toms River, NJ 08757-4416
ddbtrnjyr59@yahoo.com

From: cbg1027@everyactioncustom.com on behalf of Abby Derby
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:28:32 PM

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Sincerely,
Abby Derby
353 Gathering Oaks Dr Tallahassee, FL 32308-5694
cbg1027@gmail.com

From: Kristinejohnson456@everyactioncustom.com on behalf of Kristine Johnson
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:28:00 PM

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Sincerely,
Kristine Johnson
411 Walnut St # 15825 Green Cove Springs, FL 32043-3443
Kristinejohnson456@gmail.com

From: nmorelou@everyactioncustom.com on behalf of Nanci Moore
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:26:00 PM

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Do you really value politics over people's lives. As a clinical psychologist I saw patient's who were suicidal due to their gender dysphoria.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Nanci Moore
8090 S Woods Cir Unit 12 Fort Myers, FL 33919-6872
nmorelou@bellsouth.net

From: steven.yacovelli@everyactioncustom.com on behalf of Steven Yacovelli
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:25:56 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Steven Yacovelli
823 Mayfair Cir Orlando, FL 32803-6523
steven.yacovelli@gmail.com

From: mandybuffington@everyactioncustom.com on behalf of Mandy Buffington
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:25:00 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Mandy Buffington
2999 NE Brogden St Hillsboro, OR 97124-6707
mandybuffington@gmail.com

From: macy.geiger@everyactioncustom.com on behalf of Macy Geiger
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:24:47 PM

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Sincerely,
Macy Geiger
2926 SW 38th Pl Gainesville, FL 32608-6704
macy.geiger@gmail.com

From: bwoodard44@everyactioncustom.com on behalf of Bennie Woodard
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:14:46 PM

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Dear Florida Board of Medicine,

My family has lived in Florida since 1853!

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Bennie Woodard
3645 7th Ave N Saint Petersburg, FL 33713-9022
bwoodard44@yahoo.com

From: beralmu@everyactioncustom.com on behalf of bernardo alayza mujica
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:14:37 PM

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Sincerely,
bernardo alayza mujica
133 Sioux St Sioux City, IA 51103-4950
beralmu@hotmail.com

From: sl1239n@everyactioncustom.com on behalf of Solon Liberman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:13:25 PM

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Sincerely,
Solon Liberman
6843 Lake Island Dr Lake Worth, FL 33467-7911
sl1239n@yahoo.com

From: ltmulhern@everyactioncustom.com on behalf of Lauren Tavares Mulhern
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:11:57 PM

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Sincerely,
Lauren Tavares Mulhern
1522 High St Bridgewater, MA 02324-1971
ltmulhern@gmail.com

From: fisher.eunice13@everyactioncustom.com on behalf of Eunice Fisher
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:09:58 PM

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AS PERSONS GIVEN THE AUTHORITY TO MAKE DECISIONS THAT WILL AFFECT THE PEACE AND PROGRESS OF OUR COMMUNITIES AND STATE, YOU HAVE A RESPONSIBILITY TO FACILITATE THE WELL BEING OF ALL (YES ALL!) OF OUR CITIZENS, REGARDLESS OF SEXUAL ORIENTATION OR GENDER IDENTITY. Personal prejudice and/or ignorance has no place in decisions that affect any citizen's right to joy or fulfillment of potential achievement.

Sincerely,
Eunice Fisher

430 Bay St NE Saint Petersburg, FL 33701-3053
fisher.eunice13@gmail.com

From: lynotto@everyactioncustom.com on behalf of Lynne Otto
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:08:33 PM

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Dear Florida Board of Medicine,

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The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lynne Otto
1510 Ariana St Lot 85 Lakeland, FL 33803-6911
lynotto@yahoo.com

From: adknick@everyactioncustom.com on behalf of Deanna Knickerbocker
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:07:50 PM

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Sincerely,
Deanna Knickerbocker
2421 Michele Jean Way Santa Clara, CA 95050-5572
adknick@comcast.net

From: jordan.stanly@everyactioncustom.com on behalf of Jordan Stanly
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:07:34 PM

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Sincerely,
Jordan Stanly
12749 Central Ave Crestwood, IL 60418-5101
jordan.stanly@yahoo.com

From: chelliek68@everyactioncustom.com on behalf of Michelle Korob-Kurtiak
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
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Sincerely,
Michelle Korob-Kurtiak
1141 Dot Dr Altamonte Springs, FL 32714-2730
chelliek68@gmail.com

From: michaelfosbakk@everyactioncustom.com on behalf of Michael Fosbakk
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:06:37 PM

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Sincerely,
Michael Fosbakk
603 W Maplehurst St Ferndale, MI 48220-1290
michaelfosbakk@gmail.com

From: beralmu@everyactioncustom.com on behalf of bernardo alayza mujica
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:04:55 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
bernardo alayza mujica
133 Sioux St Sioux City, IA 51103-4950
beralmu@hotmail.com

From: mylesarobertson@everyactioncustom.com on behalf of Myles Robertson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:01:35 PM

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Sincerely,
Myles Robertson
2024 Ted Hines Dr Tallahassee, FL 32308-4828
mylesarobertson@yahoo.com

From: scott_w_barlow@everyactioncustom.com on behalf of Scott Barlow
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 2:00:16 PM

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Sincerely,
Scott Barlow
1533 Orillia Ct Sunnyvale, CA 94087-4456
scott_w_barlow@yahoo.com

From: musiczak@everyactioncustom.com on behalf of Adabeth Lawniczak
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:53:30 PM

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Sincerely,
Adabeth Lawniczak
5491 Greyston St Palm Harbor, FL 34685-1149
musiczak@hotmail.com

From: julieskelton@everyactioncustom.com on behalf of Julie Skelton
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:52:42 PM

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Sincerely,
Julie Skelton
40900 Bemis Rd Van Buren Twp, MI 48111-9159
julieskelton@msn.com

From: muff.inman@everyactioncustom.com on behalf of Greg Ash
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:52:42 PM

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Sincerely,
Greg Ash
1370 4th Ct Vero Beach, FL 32960-5816
muff.inman@yahoo.com

From: jenniferrobbins29@everyactioncustom.com on behalf of Jennifer Robbins
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:51:32 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jennifer Robbins
21 Eleuthera Dr Ocean Ridge, FL 33435-3331
jenniferrobbins29@hotmail.com

From: annfonfa@everyactioncustom.com on behalf of Ann Fonfa
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:51:22 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. I feel this attack on the MOST VULNERABLE among us, is unconscionable. It's like a Nazi move (a la WWII).

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Ann Fonfa
7319 Serrano Ter Delray Beach, FL 33446-2215
annfonfa@aol.com

From: ithrowbarrelsatplumbers@everyactioncustom.com on behalf of Grady Parrott
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:49:57 PM

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Sincerely,
Grady Parrott
4140 Dogwood Dr Jackson, MS 39211-6520
ithrowbarrelsatplumbers@gmail.com

From: elena@everyactioncustom.com on behalf of Elena Sledge
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:48:48 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Elena Sledge
1935 Azalea Ave Winter Park, FL 32792-1008
elena@awakentherapyco.com

From: sophiestanzo@everyactioncustom.com on behalf of Sophia Stanzo
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:47:28 PM

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Dear Florida Board of Medicine,

What you do as physicians and government officials should protect the health of Floridians. However, this proposed guidance is not meant to protect the health of transgender youths or anyone in Florida but rather to fuel DeSantis's political ambitions. His administration is trying to score political points with primary Republican voters who hate the very existence of transgender people because they complicate their worldviews. First, they banned transgender youths from competing in sports that matched their gender identities. Then, they passed the "Don't Say Gay" law to discourage discussion of LGBTQ people in schools. Surely you can see that this is a pattern of blatantly anti-LGBTQ attacks.

Anyone who has ever known a transgender person knows that their identities are not by any means superficial or temporary, and transgender children are highly unlikely to "grow out of" gender dysphoria if they are not allowed to transition. Most of my transgender friends, in fact, reported that their gender dysphoria got worse as they hit puberty and went through traumatizing changes in their bodies. Some spent their teenage years seriously considering suicide. I have never met a transgender person who said that they regretted transitioning, which is the supposed concern behind attempts to ban gender-affirming care. Accessing gender-affirming care is already a lengthy process for minors that involves parents, children, doctors, and therapists working together. If gender-affirming care is banned or even made harder to access in Florida, then transgender Floridian youths will suffer lifelong negative consequences from allowing their bodies to take on distressing changes during puberty, and sadly, some will not even survive to adulthood.

If you truly care about health in Florida, you will ignore the Department of Health's politically-motivated report and reject guidance that would harm and stigmatize vulnerable transgender youths. Please show courage and protect transgender people.

Sincerely,
Sophia Stanzo
28022401 E Hall Gainesville, FL 32612-2801
sophiestanzo@yahoo.com

From: meaghan1031@everyactioncustom.com on behalf of Meaghan Barakett
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:46:29 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Meaghan Barakett
245 Ridgeview Dr Palm Beach, FL 33480-3305
meaghan1031@yahoo.com

From: jwlewis4040@everyactioncustom.com on behalf of Jeff Lewis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:45:48 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jeff Lewis
134 W College St Henry, TN 38231-3741
jwlewis4040@gmail.com

From: kstoner@everyactioncustom.com on behalf of Kristen Stoner
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:44:03 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

As the mother of two transgender children, I can assure you from personal experience that without gender affirming care (medically and socially transitioning), my children would not have survived their childhoods. If you pass this legislation, the effect, intended or not, is that children across our state will end their lives by suicide - not being allowed to just be themselves. You will have their blood on your hands.

By legislating against the LGBTQ community, you will not erase them, you cannot "legislate the gay away." LGBTQ people exist whether you like it or not - and the majority of Americans support their right to exist and have rights. If you support this hateful and dangerous legislation, you will be on the wrong side of history, and the people WILL vote you out.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians - it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Sincerely,
Kristen Stoner
2626 NW 18th Way Gainesville, FL 32605-3806
kstoner@arts.ufl.edu

From: curtis.rome@everyactioncustom.com on behalf of Curtis Romey
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:42:08 PM

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Sincerely,
Curtis Romey
680 E Stanford St Bartow, FL 33830-4853
curtis.rome@gmail.com

From: DJJAZYJESS85@everyactioncustom.com on behalf of JESSE MUCHMORE
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:40:36 PM

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Sincerely,
JESSE MUCHMORE
1507 Chandler Ave Clearwater, FL 33755-2808
DJJAZYJESS85@YAHOO.COM

From: angel6wit9horns@everyactioncustom.com on behalf of Angel Hess
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:37:46 PM

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Sincerely,
Angel Hess
8256 Garden St Jacksonville, FL 32219-2910
angel6wit9horns@yahoo.com

From: patsie11@everyactioncustom.com on behalf of Patricia Dysart
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:35:26 PM

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Sincerely,
Patricia Dysart
5722 Newton Ave S Gulfport, FL 33707-3442
patsie11@msn.com

From: steven.j.vogel@everyactioncustom.com on behalf of Steven Vogel
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:34:17 PM

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"Big Brother" GQP "government" has NO BUSINESS intruding in our doctor's offices with us about our care-- BUTT OUT NOW!

Please reject this proposal and keep Florida safe for all.

Sincerely,
Steven Vogel
449 Hampton Ct Falls Church, VA 22046-4121
steven.j.vogel@earthlink.net

From: lucas.hess6@everyactioncustom.com on behalf of Lucas Hess
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:34:16 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lucas Hess
8256 Garden St Jacksonville, FL 32219-2910
lucas.hess6@gmail.com

From: martin7ahorwitz@everyactioncustom.com on behalf of Martin Horwitz
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:33:52 PM

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Sincerely,
Martin Horwitz
1326 23rd Ave San Francisco, CA 94122-1608
martin7ahorwitz@yahoo.com

From: khayb55@everyactioncustom.com on behalf of Kathy Bradley
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:31:30 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kathy Bradley
1220 Fredericksburg Dr S Lugoff, SC 29078-9626
khayb55@aol.com

From: sks4224@everyactioncustom.com on behalf of Keith Stockwell
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:29:49 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Keith Stockwell
770 S Palm Ave Sarasota, FL 34236-7769
sks4224@aol.com

From: cdaymaines@everyactioncustom.com on behalf of Csthy Day
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:29:44 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Csthy Day
8200 Tarsier Ave New Port Richey, FL 34653-6559
cdaymaines@gmail.com

From: roses41usa@everyactioncustom.com on behalf of Howard Jaffe
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:28:03 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Howard Jaffe
370 White Oak Cir Maitland, FL 32751-4831
roses41usa@gmail.com

From: Runbunny1961@everyactioncustom.com on behalf of Christine Gasco
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:28:02 PM

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Sincerely,
Christine Gasco
1615 Stonehaven Way Tarpon Springs, FL 34689-3059
Runbunny1961@Yahoo.com

From: dontbenosy@everyactioncustom.com on behalf of Aaron Alton
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:26:43 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

Plus, why are you gonna bother what someone else does with their life? Leave them alone, and mind your own damn business.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Aaron Alton
123 Fake San Marcos, TX 78666
dontbenosy@hotmail.com

From: davidnthg@everyactioncustom.com on behalf of David Larson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:26:16 PM

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Sincerely,
David Larson
17631 Nathans Dr Tampa, FL 33647-2273
davidnthg@gmail.com

From: richan@everyactioncustom.com on behalf of Richard Han
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:26:04 PM

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Sincerely,
Richard Han
16 Eastbury Ct Ann Arbor, MI 48105-1403
richan@umich.edu

From: chunt_mata@everyactioncustom.com on behalf of Cyndi Hunt
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:23:48 PM

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Sincerely,
Cyndi Hunt
960 Towhee Rd Tallahassee, FL 32305-8404
chunt_mata@comcast.net

From: brianmstill@everyactioncustom.com on behalf of Brian Still
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:23:16 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Brian Still
4077 3rd Ave Apt 307 San Diego, CA 92103-2127
brianmstill@gmail.com

From: daniel.shirley@everyactioncustom.com on behalf of Daniel Shirley
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:22:58 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

On behalf of my trans daughter, please do the right thing and don't put politics or religion ahead of science-based medical care.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

Please reject this proposal.

Sincerely,
Daniel Shirley
17987 Turning Leaf Cir Land O Lakes, FL 34638-3821
daniel.shirley@gmail.com

From: foley16731@everyactioncustom.com on behalf of Amy Foley
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:22:49 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Amy Foley
1298 W Gleneagles Rd Ocala, FL 34472-3356
foley16731@yahoo.com

From: mgmohr1@everyactioncustom.com on behalf of Myron Mohr PhD
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:22:15 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Myron Mohr PhD
408 1/2 W Main St Van Wert, OH 45891-1641
mgmohr1@yahoo.com

From: battypiper@everyactioncustom.com on behalf of Brian Batty
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:20:38 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Brian Batty
2725 Dover Glen Cir Orlando, FL 32828-7525
battypiper@gmail.com

From: beconstant@everyactioncustom.com on behalf of Pam Costantini
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:17:30 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Pam Costantini
424 Beltrees St Dunedin, FL 34698-7903
beconstant@yahoo.com

From: mrawlinj@everyactioncustom.com on behalf of Rawlin Julius
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:16:07 PM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Rawlin Julius
939 N Shine Ave Orlando, FL 32803-3329
mrawlinj@yahoo.com

From: jmlil78b@everyactioncustom.com on behalf of Joannah Lillian
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:14:41 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Joannah Lillian
2424 50th Ave N Saint Petersburg, FL 33714-2449
jmlil78b@yahoo.com

From: thorfranlmt@everyactioncustom.com on behalf of Thor Siegfried
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:12:24 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Thor Siegfried
18337 SW 102Nd Street Rd Dunnellon, FL 34432-4460
thorfranlmt@yahoo.com

From: aalbino502@everyactioncustom.com on behalf of Alnardo Albino
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:09:30 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Alnardo Albino
1179 W Minneola Ave Clermont, FL 34711-2053
aalbino502@gmail.com

From: ant_215@everyactioncustom.com on behalf of Anthony Hernandez
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:07:47 PM

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Sincerely,
Anthony Hernandez
1179 W Minneola Ave Clermont, FL 34711-2053
ant_215@yahoo.com

From: brittanigadway@everyactioncustom.com on behalf of Brittani Gadway
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:03:30 PM

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Sincerely,
Brittani Gadway
44 4th St Unit 121 Shalimar, FL 32579-1759
brittanigadway@yahoo.com

From: ariselliotmusic@everyactioncustom.com on behalf of Victor Sperling
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:02:05 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Victor Sperling
3637 Woodhill Dr Brandon, FL 33511-7815
ariselliotmusic@gmail.com

From: ricciard8@everyactioncustom.com on behalf of Anthony Ricciardi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 1:00:59 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Anthony Ricciardi
783 Harold Ave SE Atlanta, GA 30316-1217
ricciard8@aol.com

From: kelsy.wickham@everyactioncustom.com on behalf of Kelsy Wickham
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:57:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Kelsy Wickham
4854 Aguila Pl Orlando, FL 32826-6513
kelsy.wickham@ymail.com

From: julia.deters@everyactioncustom.com on behalf of Julia Deters
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:57:40 PM

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Sincerely,
Julia Deters
252 Greenshire Ln O Fallon, MO 63368-8363
julia.deters@yahoo.com

From: dorameza16@everyactioncustom.com on behalf of Dora Meza
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:57:31 PM

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Sincerely,
Dora Meza
2744 N Hampden Ct Chicago, IL 60614-6147
dorameza16@gmail.com

From: owenkrissy@everyactioncustom.com on behalf of Krissy Moses
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:52:16 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Krissy Moses
200 Saint Andrews Blvd Winter Park, FL 32792-4267
owenkrissy@hotmail.com

From: benmike12@everyactioncustom.com on behalf of Patti Schultze
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:50:46 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Patti Schultze
17811 Lake Carlton Dr Lutz, FL 33558-6315
benmike12@yahoo.com

From: Dondarminio@everyactioncustom.com on behalf of don darminio
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:50:18 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
don darminio
328 NE 20th St Wilton Manors, FL 33305-2050
Dondarminio@yahoo.com

From: clundoff@everyactioncustom.com on behalf of Catherine Lundoff
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:50:00 PM

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Dear Florida Board of Medicine,

I am writing to you today to insist that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Catherine Lundoff
3816 13th Ave S Minneapolis, MN 55407-2734
clundoff@gmail.com

From: jebains@everyactioncustom.com on behalf of Jeffrey Bains
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:49:59 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jeffrey Bains
1721 Myrtle Beach Dr The Villages, FL 32159-6210
jebains@gmail.com

From: tallyanna@everyactioncustom.com on behalf of Anna Easton
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:47:56 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Anna Easton
203 Ridgeland Rd Tallahassee, FL 32312-1916
tallyanna@yahoo.com

From: justintash@everyactioncustom.com on behalf of Justin Tash
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:46:40 PM

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Sincerely,
Justin Tash
10012 Tuller Loop Winter Garden, FL 34787-4051
justintash@gmail.com

From: dean.heaton.ii@everyactioncustom.com on behalf of Dean Heaton II
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:45:39 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Dean Heaton II
1901 Ryan Rd Saint Augustine, FL 32092-9226
dean.heaton.ii@gmail.com

From: jjgls@everyactioncustom.com on behalf of John Gallagher
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:45:31 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
John Gallagher
2 Academy Ct Patchogue, NY 11772-3828
jjgls@optonline.net

From: elvier.yemaya16@everyactioncustom.com on behalf of Elvier Yemaya
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:44:12 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Elvier Yemaya
3979 35th Way S Saint Petersburg, FL 33711-4382
elvier.yemaya16@gmail.com

From: kaspurchase@everyactioncustom.com on behalf of Karen Stanford
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:43:23 PM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Karen Stanford
1990 Mallory Sq Tallahassee, FL 32308-4891
kaspurchase@comcast.net

From: tgiovannelli9@everyactioncustom.com on behalf of thorayya said giovannelli
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:42:46 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
thorayya said giovannelli
16465 Enclave Village Dr Tampa, FL 33647-5107
tgiovannelli9@gmail.com

From: jlshadrake@everyactioncustom.com on behalf of Jackie Shadrake
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:39:09 PM

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Dear Florida Board of Medicine,

I am writing to you today to as a mother of a transgender son.

I demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all including my son.

Sincerely,
Jackie Shadrake
3321 Royal Tern Dr Winter Haven, FL 33881-7301
jlshadrake@yahoo.com

From: thedivinelondon@everyactioncustom.com on behalf of London VanHoose
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:38:48 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
London VanHoose
8501 N 50th St Tampa, FL 33617-6100
thedivinelondon@yahoo.com

From: justintruong56@everyactioncustom.com on behalf of Justin Truong
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:37:13 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Justin Truong
33 Junior Ter San Francisco, CA 94112-3245
justintruong56@gmail.com

From: edjp822@everyactioncustom.com on behalf of Edward Hartnett
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:37:11 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Edward Hartnett
3959 Spyglass Hill Rd Sarasota, FL 34238-2826
edjp822@gmail.com

From: rajema07@everyactioncustom.com on behalf of Rachel Mathis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:35:03 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Rachel Mathis
2312 Napoleon Bonaparte Dr Tallahassee, FL 32308-5919
rajema07@gmail.com

From: jvan56cfc@everyactioncustom.com on behalf of James van Koolbergen
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:33:27 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
James van Koolbergen
8429 Silver Way Apt C Tampa, FL 33615-6010
jvan56cfc@yahoo.com

From: bamarmb68@everyactioncustom.com on behalf of Renee Burk
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:31:13 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Renee Burk
1133 16th Ave N Saint Petersburg, FL 33704-4127
bamarmb68@aol.com

From: bob532@everyactioncustom.com on behalf of Robert Lombardi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:28:18 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Robert Lombardi
1465 E 64th St Brooklyn, NY 11234-5612
bob532@aol.com

From: t.prandini@everyactioncustom.com on behalf of Taylor Weiss
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:26:59 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Taylor Weiss
5870 Wind Drift Ln Boca Raton, FL 33433-5426
t.prandini@yahoo.com

From: touchthefloor@everyactioncustom.com on behalf of Leann St Clair
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:26:21 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Leann St Clair
3360 W Wyoming Cir Tampa, FL 33611-4341
touchthefloor@gmail.com

From: cghappel2001@everyactioncustom.com on behalf of Charles Happel
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:25:56 PM

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Sincerely,
Charles Happel
2034 Allison Ave Speedway, IN 46224-5608
cghappel2001@yahoo.com

From: acalfee7@everyactioncustom.com on behalf of Amanda Calfee
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:25:44 PM

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Sincerely,
Amanda Calfee
389 Scrub Jay Dr Saint Augustine, FL 32092-1708
acalfee7@gmail.com

From: ltstylist@everyactioncustom.com on behalf of Lindsay Ingeneri
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:25:44 PM

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Sincerely,
Lindsay Ingeneri
9464 Loretto St Spring Hill, FL 34608-1735
ltstylist@yahoo.com

From: h_5h3i1ah@everyactioncustom.com on behalf of Sheilah Hall
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:25:40 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sheilah Hall
115 John Glenn Dr Rincon, GA 31326-5008
h_5h3i1ah@outlook.com

From: engstromgr@everyactioncustom.com on behalf of Lee Engstrom
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:25:26 PM

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Sincerely,
Lee Engstrom
1021 Iroquois Dr SE Grand Rapids, MI 49506-6512
engstromgr@aol.com

From: Virginia_tee@everyactioncustom.com on behalf of Virginia Tee
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:21:56 PM

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Sincerely,
Virginia Tee
9551 Pinetree Dr Lake Wales, FL 33898-7209
Virginia_tee@yahoo.com

From: jt1262@everyactioncustom.com on behalf of Jessica Tomlinson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:21:33 PM

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Sincerely,
Jessica Tomlinson

Saint Petersburg, FL 33704
jt1262@yahoo.com

From: dtandedna@everyactioncustom.com on behalf of Darby Tatsak
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:21:12 PM

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Sincerely,
Darby Tatsak
6351 Dartmouth Ave N Saint Petersburg, FL 33710-7747
dtandedna@gmail.com

From: alicia122181@everyactioncustom.com on behalf of Alicia Mercer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:20:27 PM

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Sincerely,
Alicia Mercer
837 Haulover Dr Altamonte Springs, FL 32714-7539
alicia122181@gmail.com

From: burtbinner@everyactioncustom.com on behalf of Burt Binner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:20:07 PM

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Sincerely,
Burt Binner
14810 Rue De Bayonne Apt 4F Clearwater, FL 33762-3032
burtbinner@gmail.com

From: ldkrick418@everyactioncustom.com on behalf of Leah Krick
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:19:41 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Leah Krick
8840 Autumn Winds Dr Raleigh, NC 27615-1992
ldkrick418@gmail.com

From: christopherwhuck@everyactioncustom.com on behalf of Christopher Huck
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:19:01 PM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Christopher Huck
347 Cooper Rd Rochester, NY 14617-3037
christopherwhuck@yahoo.com

From: gbtrigeek@everyactioncustom.com on behalf of Greg Brown
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:18:50 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Greg Brown
109 N Golfview Rd Lake Worth Beach, FL 33460-3526
gbtrigeek@aol.com

From: jaime.gummere@everyactioncustom.com on behalf of Jaime Gummere
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:17:06 PM

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Dear Florida Board of Medicine,

This may be a bit boilerplate and I'm sure you'll be seeing several identical or nearly identical messages from people like me all over the state. The below statements can be summed up to say: the government should not dictate how families choose what medical treatments are right for them. To remove options is to remove rights. Regardless of all the correct information provided below, America was founded on the principle of representation in direct opposition to a government which gave its people no choice. America is about having choices and making your own choices. Government should remain small and not interfere with those choices except in the case of national security. I have a difficult time believing trans people are a threat to National security.

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,

Jaime Gummere
551 SW Glen Crest Way Stuart, FL 34997-7253
jaime.gummere@gmail.com

From: liannadchen@everyactioncustom.com on behalf of Lianna C
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:15:57 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Lianna C
1405 Caladesi Dr Wesley Chapel, FL 33544-6663
liannadchen@gmail.com

From: monifita@everyactioncustom.com on behalf of Lupe Torre
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:14:31 PM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lupe Torre
440 4th Ave N Saint Petersburg, FL 33701-2832
monifita@gmail.com

From: lromer62@everyactioncustom.com on behalf of Lynor Romer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:14:16 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Lynor Romer
1380 Gulf Blvd Unit 706 Clearwater, FL 33767-2820
lromer62@gmail.com

From: jessicapecota@everyactioncustom.com on behalf of Jessica Pecota
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:13:14 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jessica Pecota
26 Northway Ct Saratoga Springs, NY 12866-5107
jessicapecota@gmail.com

From: mbecker042@everyactioncustom.com on behalf of Mackenzie Becker
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:12:48 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Mackenzie Becker
2939 Audubon St New Orleans, LA 70125-2611
mbecker042@gmail.com

From: cvmmcleskey@everyactioncustom.com on behalf of Caryn McCleskey
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:12:37 PM

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Dear Florida Board of Medicine,

I am writing to you today to strongly urge you to reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Caryn McCleskey
408 Summit Ridge Pl Longwood, FL 32779-6243
cvmmcleskey@gmail.com

From: guy1970g@everyactioncustom.com on behalf of William Guy
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:11:28 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
William Guy
1212 SW Mayo Rd Lake City, FL 32024-2942
guy1970g@gmail.com

From: sarahlleer1@everyactioncustom.com on behalf of Sarah Leer
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:10:47 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sarah Leer
2822 Rand Ln Anderson, IN 46013-9538
sarahlleer1@gmail.com

From: ezeikiels1986@everyactioncustom.com on behalf of Ezekiel Beal
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:09:29 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ezekiel Beal
2477 Atlantis Ave Fort Pierce, FL 34981-5551
ezeikiels1986@yahoo.com

From: milomorai01@everyactioncustom.com on behalf of Gavi Stevens
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:09:13 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Gavi Stevens
460 Deville Dr E Largo, FL 33771-1113
milomorai01@yahoo.com

From: trp9007@everyactioncustom.com on behalf of Tricia Pockey
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:09:04 PM

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Sincerely,
Tricia Pockey
12643 Banting Ter Orlando, FL 32827-7646
trp9007@gmail.com

From: amelia.lynch196@everyactioncustom.com on behalf of Amelia Lynch
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:08:58 PM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

As an RN and a parent I have first hand experience with multiple trans kids and allowing them to transition socially makes a huge impact on their self esteem and mental well being. It's easy to see how much more comfortable they are in their own skin with just a few changes to their pronouns and appearance. Transitioning medically with the use of HRT and puberty blockers is also low risk, especially when you take into account the greatly increased risk of self harm and suicide among trans kids who are not accepted and supported.

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I also suggest that in order to make informed decisions on these issues one should have first hand experience, so my recommendation is that each and every member of this board go to a center like Also Youth in Sarasota and volunteer. See the people that your decision would impact and observe the importance that the freedom to transition

into who they are provides.

Sincerely,
Amelia Lynch
4181 Taggart Cay S Sarasota, FL 34233-4831
amelia.lynch196@gmail.com

From: erica.dominguez13@everyactioncustom.com on behalf of Erica Dominguez
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:06:40 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Erica Dominguez
3230 Whitefield Dr Kissimmee, FL 34747-2082
erica.dominguez13@gmail.com

From: emilyegemo321@everyactioncustom.com on behalf of Emily Egemo
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:04:25 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Emily Egemo
1341 Pohl Rd Mankato, MN 56001-5815
emilyegemo321@gmail.com

From: Shannaminshew@everyactioncustom.com on behalf of Shanna Minshew
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:03:43 PM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Shanna Minshew
411 9th St Pacific Grove, CA 93950-4509
Shannaminshew@gmail.com

From: ezrawils0n@everyactioncustom.com on behalf of Ezra Wilson
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:03:12 PM

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There are numerous peer-reviewed articles that easily debunk the politically and religiously motivated academic publications found in the Board's report on gender-affirming care: a report that consists of guidance founded on the misrepresentation of legitimate studies and, more maliciously, the cherry-picking of studies based in anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people, including—but not limited to—the American Academy of Pediatrics, the American Medical Association, The American College of Obstetricians and Gynecologists, The American College of Physicians, The American Psychiatric Association, The American Psychological Association, The American Academy of Family Physicians, The Endocrine Society, The Pediatric Endocrine Society, American Nurses Association, American Public Health Association, American Heart Association, National Association of Social Workers, World Medical Association, and The World Professional Association for Transgender Health.

There is OVERWHELMING evidence to support the positive mental health impacts of gender-affirming medical care for trans youth, some of which appears in the very studies cited by the DOH and Board of Medicine.

You NEED to understand: On top of their empirical benefit when medically indicated for a particular patient, puberty blockers ARE the neutral option that allows youth to avoid permanent bodily changes until they're old enough to decide which puberty they should undergo. Banning puberty blockers for gender-affirming care is NOT a moderate decision. Removing the option to delay puberty ensures that trans youth will be forced to undergo permanent changes from their endogenous hormones. Not only is this devastating for their mental health, but it causes longterm issues for surgery outcomes & the ability to "pass" as their gender, opening them up to harassment and the threat of violence. Denying trans youth & their doctors the ability to determine which direction is best for their psyche and health is a flagrant human rights violation.

Moreover, prohibiting SOCIAL transition—which solely consists of youth having the choice of what clothing to wear and what pronouns/name/haircut they would like to have—is clear government intrusion on personal and parental decision making. There is nothing medical about this proposed rule. It is merely treating trans youth as a subordinate class of people, subject to more government control over choices as small as what clothes they are permitted to wear. If this is not transparently horrifying to you, I don't know what to say.

Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When trans youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this

life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please, I am begging you to reject this proposal and keep Florida safe for ALL.

Sincerely,

Ezra Wilson

1875 Florida Club Dr Apt 7305 Naples, FL 34112-8739

ezrawils0n@aol.com

From: caronyna@everyactioncustom.com on behalf of Caroline Sévilla
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 12:02:14 PM

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Sincerely,
Caroline Sévilla
4 Allée Marc Chagall Boling, TX 77420
caronyna@msn.com

From: rgmittan@everyactioncustom.com on behalf of Ron Mittan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:59:54 AM

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Sincerely,
Ron Mittan
5024 Sevilla Ave NW Albuquerque, NM 87120-1832
rgmittan@gmail.com

From: yankee209@everyactioncustom.com on behalf of gloria muszynski
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:59:11 AM

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Sincerely,
gloria muszynski
PO Box 2100 Flagler Beach, FL 32136-2100
yankee209@yahoo.com

From: jcarnal@everyactioncustom.com on behalf of Jim Carnal
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:58:17 AM

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Sincerely,
Jim Carnal
6101 Hartman Ave Bakersfield, CA 93309-1927
jcarnal@aol.com

From: jpcam1@everyactioncustom.com on behalf of Jean Cameron
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:57:31 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Jean Cameron
5717 NW 43rd Rd Gainesville, FL 32606-4380
jpcam1@cox.net

From: raych91777@everyactioncustom.com on behalf of Rachael Yanvary
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:56:44 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Rachael Yanvary
200 Palisade Dr Saint Augustine, FL 32092-1134
raych91777@yahoo.com

From: felixgriffinquinn@everyactioncustom.com on behalf of James Webster
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:56:42 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
James Webster
12 Chimney St Orange Park, FL 32067
felixgriffinquinn@gmail.com

From: jancsalas4@everyactioncustom.com on behalf of Jan Salas
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:56:18 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jan Salas
610 14th Ave Santa Cruz, CA 95062-4069
jancsalas4@att.net

From: pmbp145@everyactioncustom.com on behalf of Robert Kershaw
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:55:40 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Robert Kershaw
7023 Lincoln Dr Philadelphia, PA 19119-2541
pmbp145@yahoo.com

From: mdtearle@everyactioncustom.com on behalf of Maryann D'Aquino-Tearle
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:55:31 AM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Maryann D'Aquino-Tearle
3344 Hadfield Greene Sarasota, FL 34235-5136
mdtearle@gmail.com

From: shaunmarie171@everyactioncustom.com on behalf of Shaun Levin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:55:16 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Shaun Levin
1436 SW 25th Ave Boynton Beach, FL 33426-7431
shaunmarie171@gmail.com

From: katiekoehler88@everyactioncustom.com on behalf of Katie Koehler
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:54:43 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Katie Koehler
1960 Durham Ln The Villages, FL 32162-6302
katiekoehler88@gmail.com

From: sbfarcas@everyactioncustom.com on behalf of Stephanie Barton-Farcas
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:54:25 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. What is next? Concentration camps and the gas chambers?

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all. This will cost lives, money and will send this country down a road of Nazism.

Sincerely,
Stephanie Barton-Farcas
130 Acklins Cir Daytona Beach, FL 32119-9763
sbfarcas@gmail.com

From: chrisguyart@everyactioncustom.com on behalf of Christopher Guy
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:53:23 AM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Christopher Guy
1212 SW Mayo Rd Lake City, FL 32024-2942
chrisguyart@yahoo.com

From: mike2299@everyactioncustom.com on behalf of Michael Crider
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:52:37 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Michael Crider
11204 Princessa Ln Jacksonville, FL 32218-4148
mike2299@icloud.com

From: mattebejar@everyactioncustom.com on behalf of Matthew Bejar
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:52:02 AM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Matthew Bejar
3376 7th St Sarasota, FL 34237-4704
mattebejar@gmail.com

From: bonnie.knapp@everyactioncustom.com on behalf of Bonita Knapp
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:52:00 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. Whether we agree with or understand the needs of these individuals, their lives & rights must be protected at all costs and are must legally be provided. A fascist state government should not be allowed to deny care.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Bonita Knapp
2488 Breakwater Way Naples, FL 34112-5993
bonnie.knapp@yahoo.com

From: skitty0706@everyactioncustom.com on behalf of Jay Moore
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:51:09 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jay Moore
44 Porcupine Dr Palm Coast, FL 32164-6736
skitty0706@gmail.com

From: emily.schanker@everyactioncustom.com on behalf of Emily Schanker
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:48:31 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Emily Schanker
209 Jackson Loop Deland, FL 32724-3253
emily.schanker@yahoo.com

From: bargnesijacob@everyactioncustom.com on behalf of Jacob Bargnesi
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:48:23 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jacob Bargnesi
2039 NW 16th Ter Cape Coral, FL 33993-5840
bargnesijacob@gmail.com

From: pizzog@everyactioncustom.com on behalf of Eugene Pizzo
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:47:21 AM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Eugene Pizzo
3006 W Clinton St Tampa, FL 33614-3439
pizzog@gmail.com

From: lckhrt3@everyactioncustom.com on behalf of Christi Lockhart
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:46:33 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Christi Lockhart
3547 Ponce De Leon Blvd North Port, FL 34291-5308
lckhrt3@yahoo.com

From: robasmith1@everyactioncustom.com on behalf of Bob Smith
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:46:09 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Bob Smith
445 Quaker Dr East York, PA 17402-4139
robasmith1@comcast.net

From: tdinuuccidayton@everyactioncustom.com on behalf of Tracy Dayton
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:45:31 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Tracy Dayton
5522 Winhawk Way Lutz, FL 33558-8042
tdinuuccidayton@gmail.com

From: perkyperko@everyactioncustom.com on behalf of Connie Perko
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:45:16 AM

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Dear Florida Board of Medicine,

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Connie Perko
3910 Valencia Grove Ln Orlando, FL 32817-1729
perkyperko@yahoo.com

From: stormcrow60@everyactioncustom.com on behalf of Jon Hager
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:44:01 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jon Hager
11760 S 1300 W Riverton, UT 84065-7843
stormcrow60@Xmission.com

From: michaelhorner99@everyactioncustom.com on behalf of Michael R.Horner
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:43:07 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Michael R. Horner
30518 Southfield Rd Apt 115 Southfield, MI 48076-1234
michaelhorner99@icloud.com

From: nicole_fl2003@everyactioncustom.com on behalf of Nicole Horenstein
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:43:05 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Nicole Horenstein
25528 NW 62nd Ave High Springs, FL 32643-9837
nicole_fl2003@yahoo.com

From: lynnemartin823@everyactioncustom.com on behalf of Maggie Martin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:42:47 AM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Maggie Martin
618 90th Ave N Saint Petersburg, FL 33702-3020
lynnemartin823@gmail.com

From: octbabe28@everyactioncustom.com on behalf of Heather Martin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:42:07 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Heather Martin
1099 Crescent Pkwy Deland, FL 32724-3711
octbabe28@yahoo.com

From: ginnpr1@everyactioncustom.com on behalf of Ginnie Preuss
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:40:53 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Ginnie Preuss
405 Ruth St Bridgeport, CT 06606-3362
ginnpr1@aol.com

From: tatlock@everyactioncustom.com on behalf of Nina Tatlock
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:40:38 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Nina Tatlock
1413 Beach Club Ln Apollo Beach, FL 33572-3063
tatlock@verizon.net

From: bkrashpad@everyactioncustom.com on behalf of Brian Kruger
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:40:35 AM

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Dear Florida Board of Medicine,

I demand that you reject the proposed "guidance" by Surgeon General Ladapo's Department of Health, on Gender Dysphoria in Children and Adolescents. Lapado's an unqualified clown and a political hack with no credentials for the job, skating purely on his allegiance to his gubernatorial fuhrer. An embarrassing laughingstock.

The issued "guidance" by the Dept of Health and the studies used by this board are notably inaccurate and dangerous pseudo-science. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk the politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Brian Kruger
10210 SW 38th Pl Gainesville, FL 32608-9048
bkrashpad@yahoo.com

From: cjmansfield76@everyactioncustom.com on behalf of cameron mansfield
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:40:17 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
cameron mansfield
PO Box 181615 Casselberry, FL 32718-1615
cjmansfield76@gmail.com

From: mhartley412@everyactioncustom.com on behalf of Marissa Hartley
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:39:50 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Marissa Hartley
6110 Marta Dr Tampa, FL 33617-1337
mhartley412@gmail.com

From: ethanwejslcsw@everyactioncustom.com on behalf of Ethan Weiss
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:39:35 AM

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Dear Florida Board of Medicine,

I am writing to you today as both a parent and a child and adolescent mental health professional to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Ethan Weiss
5158 Asher Ct Sarasota, FL 34232-3641
ethanwejslcsw@gmail.com

From: bluetoothfairy18@everyactioncustom.com on behalf of Sharon Paltin
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:39:14 AM

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Sharon Paltin
PO Box 18 Laytonville, CA 95454-0018
bluetoothfairy18@gmail.com

From: ajlindell@everyactioncustom.com on behalf of Amanda Lindell
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:39:12 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Amanda Lindell
1509 Tera Ct Capitola, CA 95010-2566
ajlindell@ucdavis.edu

From: mmontes813@everyactioncustom.com on behalf of Max Montes
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:38:35 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Max Montes
505 N Lincoln Ave Tampa, FL 33609-1439
mmontes813@gmail.com

From: jeremysass238@everyactioncustom.com on behalf of Jeremy Sass
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:38:31 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Jeremy Sass
1282 Hazel St North Bellmore, NY 11710-2402
jeremysass238@gmail.com

From: cgracet@everyactioncustom.com on behalf of Charlotte Thompson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:38:02 AM

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Dear Florida Board of Medicine,

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Charlotte Thompson
131 Calyer St Brooklyn, NY 11222-2509
cgracet@gmail.com

From: rgtg@everyactioncustom.com on behalf of Richard Gouttiere
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:38:00 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Richard Gouttiere
13200 SE 93rd Cir Summerfield, FL 34491-9336
rgtg@att.net

From: vj6522@everyactioncustom.com on behalf of Vicki Joseph
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:37:50 AM

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Sincerely,
Vicki Joseph
6522 N Glenwood Ave Chicago, IL 60626-7600
vj6522@yahoo.com

From: rsmrclsn@everyactioncustom.com on behalf of Rosemary Colson
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:35:15 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Rosemary Colson
4436 Meandering Way Tallahassee, FL 32308-8705
rsmrclsn@aol.com

From: michael1603@everyactioncustom.com on behalf of Michael Lieberman
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:34:05 AM

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Sincerely,
Michael Lieberman
8609 Via Rapallo Dr Estero, FL 33928-8312
michael1603@sbcglobal.net

From: amassidas@everyactioncustom.com on behalf of Amanda Massidas
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:33:36 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Amanda Massidas
3154 Lenwood Dr New Port Richey, FL 34655-3317
amassidas@gmail.com

From: jillianbrugal@everyactioncustom.com on behalf of Jillian Abby
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:32:31 AM

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Sincerely,
Jillian Abby
8709 Imperial Ct Tampa, FL 33635-1513
jillianbrugal@gmail.com

From: DUNCANS@everyactioncustom.com on behalf of Sue Duncan
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:31:10 AM

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Sincerely,
Sue Duncan
1312 Essex Dr Wellington, FL 33414-5610
DUNCANS@aol.com

From: mike2299@everyactioncustom.com on behalf of Tracy Crider
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:30:58 AM

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Sincerely,
Tracy Crider
11204 Princessa Ln Jacksonville, FL 32218-4148
mike2299@att.net

From: aletan416@everyactioncustom.com on behalf of Aleta Norris
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:30:57 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Aleta Norris
2488 N Reddington Way Post Falls, ID 83854-6828
aletan416@gmail.com

From: lbkadams@everyactioncustom.com on behalf of Linda Adams
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:30:29 AM

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The government has no business intruding on decisions that should be between a patient and his/her doctor.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Linda Adams
1705 Santa Maria Pl # 1LACE Orlando, FL 32806-1445
lbkadams@aol.com

From: MONYBOB@everyactioncustom.com on behalf of ROBERT TRAUM
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:30:05 AM

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Dear Florida Board of Medicine,

A DOCTORS DUTY IS TO HELP AND HEAL not TO DENY ANY ASPECT OF HEALTHCARE.

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Please reject this proposal and keep Florida safe for all.

Sincerely,
ROBERT TRAUM
7053 Castlemaine Ave Boynton Beach, FL 33437-6435
MONYBOB@AOL.COM

From: dtbsmb94@everyactioncustom.com on behalf of Dena Berthelette
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:29:49 AM

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The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

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I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Dena Berthelette
25360 Celmar St Brooksville, FL 34601-4752
dtbsmb94@aol.com

From: wafisk61@everyactioncustom.com on behalf of William Fisk
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:29:40 AM

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Sincerely,
William Fisk
2105 Redwood Cir NE Palm Bay, FL 32905-4001
wafisk61@gmail.com

From: michael-stella@everyactioncustom.com on behalf of Michael Stella
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:29:29 AM

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Sincerely,
Michael Stella
11 Nassau Ln Key West, FL 33040-7135
michael-stella@comcast.net

From: amaris_diana@everyactioncustom.com on behalf of Diana Amaris
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:29:03 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Diana Amaris
2920 Network Pl Lutz, FL 33559-3197
amaris_diana@yahoo.com

From: spiralwoman@everyactioncustom.com on behalf of Sandi Lodge
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:28:49 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sandi Lodge
217 Meridianna Dr Tallahassee, FL 32312-2716
spiralwoman@hotmail.com

From: seabaillet@everyactioncustom.com on behalf of Sebastien Baillet
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:28:40 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sebastien Baillet
2220 Hargill Dr Orlando, FL 32806-1501
seabaillet@gmail.com

From: bq45@everyactioncustom.com on behalf of Debora OQuinn
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:27:30 AM

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Sincerely,
Debora OQuinn
2579 Coco Palm Cir Wesley Chapel, FL 33543-4002
bq45@aol.com

From: mjstalter@everyactioncustom.com on behalf of MARLENE STALTER
To: [BOM PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:26:17 AM

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Dear Florida Board of Medicine,

I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents. Ladapo & his quack science are doing Gov DeSantis' bidding, putting lives in danger!

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Please reject this proposal and keep Florida safe for all.

Sincerely,
MARLENE STALTER
3419 Annette Ct # 68 Clearwater, FL 33761-1301
mjstalter@yahoo.com

From: jocienjim@everyactioncustom.com on behalf of Jocelyn Green
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:26:16 AM

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Sincerely,
Jocelyn Green
6 Acadia St Kenner, LA 70065-1073
jocienjim@aol.com

From: aunastewart@everyactioncustom.com on behalf of Auna Stewart
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:24:15 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Auna Stewart
10306 Midvale Ave N Seattle, WA 98133-9416
aunastewart@gmail.com

From: carrieweaverwhatley@everyactioncustom.com on behalf of Carrie Whatley
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:24:04 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Carrie Whatley
1001 E 62nd Ave Unit 79 Denver, CO 80216-1115
carrieweaverwhatley@yahoo.com

From: cheetahsprinter@everyactioncustom.com on behalf of Sofia Montemayor-Thomas
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:24:03 AM

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Please reject this proposal and keep Florida safe for all.

Sincerely,
Sofia Montemayor-Thomas
3912 Alabaster Cv Round Rock, TX 78681-2462
cheetahsprinter@gmail.com

From: ltlewis10@everyactioncustom.com on behalf of Larry Lewis
To: [BOM_PostLicensure](#)
Subject: Reject the Proposed Guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents
Date: Saturday, July 30, 2022 11:23:29 AM

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I am writing to you today to demand that you reject the proposed guidance by Surgeon General Ladapo's Department of Health on Gender Dysphoria in Children and Adolescents.

The issued guidance by the Dept of Health and the studies used by this board are notably inaccurate and dangerous. As physicians – it is your responsibility to do no harm. As a government official, it is your responsibility to provide truthful information to create a more informed population. There are numerous peer reviewed articles that easily debunk politically and religiously motivated academic publications found in the Board's report on gender-affirming care. Unfortunately, this guidance and the cherry-picked studies by this board are nothing more than anti-transgender propaganda.

The nation's leading health organizations support gender-affirming care for transgender and gender non-conforming people -- including the American Academy of Pediatrics; the American Medical Association; The American College of Obstetricians and Gynecologists; The American College of Physicians; The American Psychiatric Association; The American Psychological Association; The American Academy of Family Physicians; The Endocrine Society; The Pediatric Endocrine Society; American Nurses Association; American Public Health Association; American Heart Association; National Association of Social Workers; World Medical Association; and The World Professional Association for Transgender Health, among others.

There is, in fact, overwhelming evidence to support the positive mental health impacts of gender-affirming medical care for trans youth - including in some of the very studies cited by the DOH and Board of Medicine. Prohibiting social transition is clear government intrusion on personal and parental decision making. Numerous studies have found that after social transition, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. When transgender youth are affirmed by people around them, reported rates of depression and suicidality drop significantly. This rule will deny them this life-saving treatment.

I call on this Board to provide truthful information based on science and data as opposed to false statements based on prejudice and political agendas. The truth still matters and the evidence is clear: denying transgender youth the ability to transition is dangerous, abusive, and life-threatening.

Please reject this proposal and keep Florida safe for all.

Sincerely,
Larry Lewis
2404 Panoramic Cir Apopka, FL 32703-9245
ltlewis10@yahoo.com

From: [Vazquez, Paul](#)
To: [Washington, Shaila](#)
Cc: [Strickland, Bettye C](#)
Subject: FW: Florida Surgeon General's June 2, 2022 letter to the Board of Medicine
Date: Monday, August 1, 2022 4:37:11 PM
Attachments: [Outlook-2vznda3g.jpg](#)
[image001.jpg](#)
[FLORIDA DOH Trans Care of Children and Adolescents Guidelines.pdf](#)
[image002.jpg](#)



Paul A. Vazquez, J.D.
Executive Director
Florida Board of Medicine
Florida Department of Health
Phone: 850-245-4130

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: Tony Lima <tlima@sunserve.org>
Sent: Monday, August 1, 2022 4:20 PM
To: Vazquez, Paul <Paul.Vazquez@flhealth.gov>
Cc: Jim Lopresti <jlopresti@sunserve.org>; Dr. Susan Gritz <sgritz@sunserve.org>
Subject: Florida Surgeon General's June 2, 2022 letter to the Board of Medicine

You don't often get email from tlima@sunserve.org. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Paul Vazquez, JD
Executive Director
Board of Medicine
Florida Department of Health
597 W 11th St, 1
Panama City, FL, 32401,
Mr. Vazquez:

I want to inform the Board of Medicine that we have communicated with an author of the research article used by the Florida Surgeon General to justify the following guidance:

- **Social gender transition should not be a treatment option for children or adolescents.**

In clear contradiction to the Surgeon General's universalizing guidance, the research study comes to a very different conclusion. In fact, the findings agree with the current Standards of Care issued by the World Professional Association for Transgender Health.

"The present study highlights the importance of considering every case individually, as well as making decisions about a gender transition together with the whole family, as currently suggested by the SoC 7 of the WPATH"

I have copied the text of the message sent to Dr. Katinka Schweizer, Hamburg Medical School. We informed Dr. Schweitzer that the Surgeon General cited her and her colleagues research to justify that directive, even though the research does not support such an action. We invited her to communicate with the Board as you will see in the email message sent from our founder, Dr.

James Lopresti. It is his continuing 20-year guidance in using best practices of care for the needs of the LGBTQ community that informs the day-to-day work of SunServe.

Our agency will be at the meeting in Dania Beach, FL.

Sincerely,

Tony Lima



From: Jim Lopresti

Sent: Sunday, July 31, 2022 7:48 AM

To: katinka.schweizer@medicalschooll-hamburg.de <katinka.schweizer@medicalschooll-hamburg.de>

Subject: Florida Surgeon General directly quotes your research to justify banning social transitioning
Dr. Schweitzer:

I write to you as the founder of the premier social service agency in Florida serving the needs of LGBTQ+ children, youth, and their families. Approximately 70% of the adolescents [about 400 per year] who access our services are gender diverse, i.e. either self-identified transgender, or gender non-binary, or gender questioning. Our program engages the young person and the family to help them understand their child's questions and proceed to help them connect with their child in a way that would engender self-esteem, a secure identity, and an emerging self-confidence. That frequently leads to careful exploration of experiences of social transitioning if, as and when it seems advisable

On Friday, Aug. 5th the Florida Board of Medicine is meeting to hear a request from the state's Surgeon General that the Board of Medicine regulate the practice of medicine to restrict options for care. That includes not only matters of medical interventions, but also matters related to psycho-social care

The Guidelines sent to the Board for their consideration are attached. The guidelines include the following

"Due to the lack of conclusive evidence, and the potential for long-term, irreversible effects, the Department's guidelines are as follows:"

- **"Social gender transition should not be a treatment option for children or adolescents."**

That directive includes a direct hyperlink to your 2020 study in Hamburg as you will see in the attached document

It is our understanding that such an extreme directive goes far beyond the findings of your research. We believe that you should be informed that your research has been specifically referenced to justify that directive, so that you may consider whether to communicate with the Board. See the contact information below

[Department of Health](#)

[Board of Medicine](#)

4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253
Paul Vazquez, JD,
Executive Director
paul.vazquez@flhealth.gov



James Lopresti, PhD, LMHC

He, Him, His
Senior Clinical Supervisor

Clinical Education

SunServe

2312 Wilton Dr.

Wilton Manors, FL 33309

954-560-1564



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Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

Treatment of Gender Dysphoria for Children and Adolescents

April 20, 2022

The Florida Department of Health wants to clarify evidence recently cited on a [fact sheet](#) released by the US Department of Health and Human Services and provide guidance on treating gender dysphoria for children and adolescents.

Systematic reviews on hormonal treatment for young people show a trend of [low-quality evidence](#), small sample sizes, and medium to high risk of bias. A paper published in the [International Review of Psychiatry](#) states that 80% of those seeking clinical care will lose their desire to identify with the non-birth sex. [One review concludes](#) that "hormonal treatments for transgender adolescents can achieve their intended physical effects, but **evidence regarding their psychosocial and cognitive impact is generally lacking.**"

According to the [Merck Manual](#), "gender dysphoria is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the sex assigned at birth."

Due to the lack of conclusive evidence, and the potential for long-term, irreversible effects, the Department's guidelines are as follows:

- [Social gender transition](#) should not be a treatment option for children or adolescents.
- Anyone under 18 should not be [prescribed puberty blockers](#) or [hormone therapy](#).
- [Gender reassignment surgery](#) should [not be a treatment option](#) for children or adolescents.
 - Based on the [currently available evidence](#), "encouraging mastectomy, ovariectomy, uterine extirpation, penile disablement, tracheal shave, the prescription of hormones which are out of line with the genetic make-up of the child, or puberty blockers, are all clinical practices which run an **unacceptably high risk of doing harm.**"
- Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider.

These guidelines do not apply to procedures or treatments for children or adolescents born with a genetically or biochemically verifiable [disorder of sex development](#) (DSD). These disorders include, but are not limited to, 46, XX DSD; 46, XY DSD; sex chromosome DSDs; XX or XY sex reversal; and ovotesticular disorder.

The Department's guidelines are consistent with the federal Centers for Medicare and Medicaid Services [age requirement for surgical and non-surgical treatment](#). These guidelines are also in line with the guidance, reviews, and [recommendations](#) from [Sweden](#), [Finland](#), the [United Kingdom](#), and [France](#).

Parents are encouraged to reach out to their child's health care provider for more information.

Florida Department of Health**Office of the State Surgeon General**

4052 Bald Cypress Way, Bin A-00 • Tallahassee, FL 32399-1701
PHONE: 850/245-4210 • FAX: 850/922-9453

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Public Health Accreditation Board

Mission:

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Ron DeSantis
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Parents are encouraged to reach out to their child's health care provider for more information.

August 1, 2022

BOM.MeetingMaterials@flhealth.gov

Department of Health, Board of Medicine,
4052 Bald Cypress Way, Bin C03,
Tallahassee, FL 32399

Re: Florida State Medical Board Meeting About the Non-binding AHCA Report

After the state's move to ban coverage for all transgender medical treatments for Medicaid became inconclusive (no vote), they struck again. Now, they seek to directly attack doctors via the state medical board for providing gender-affirming care.¹ By doing so, they (again) put that care within the grasp "of ... [state] officials"—not "withdraw[n] ... from the vicissitudes of political controversy[.]" *West Virginia Bd. of Ed. v. Barnette*, 319 U. S. 624, 638 (1943). Like with the Medicaid policy proposal, they use the same report, which has been rebutted by experts. Scientific standing is not the only problem here. I wrote in July that the proposed Medicaid "policy ... 'raise[s] the inevitable inference that the disadvantage imposed is born of animosity toward the class of persons affected.'" Response to Gen. Medicaid Pol. Propos. (quoting *Romer v. Evans*, 517 U.S. 620, 634 (1996)). That quote still holds water; it is not frivolous nor redundant. Indeed, state actions tell you everything you need to know: they only restrict the minority. It is illogical and perverse—it makes no sense to fulminate against transgender treatments while they could be equally applied to non-transgender individuals. And while the state is playing with the law, they are playing with trans people's lives and their liberty. This mistake should not be repeated by the Florida Medical Board. Accordingly, the medical board should not make any new rules or adjustments vis-à-vis transgender healthcare.

Absent any hiatus, the state is moving quickly to push flagrantly undermining rules to restrict (in all ways possible) transgender healthcare. To be clear, this is not the only state action in this area. On April 20, 2022, the Department of Health announced its new (non-binding) guidance opposing everything from "[s]ocial gender transition" to "puberty blockers or hormone therapy[]" for adolescents. Fla. Dept. of H. 2022. *Treatment of Gender Dysphoria for Children & Adolescents*. *Contra* Human Rights Campaign Rebuttal 2022, 1 (the guidance "dangerously cherry-pick[s] select research to assert their claims" while simultaneously "ignor[ing] the vast majority of the literature" supporting such treatments). And in June, the state's Health Care Administrative Agency sent a 46-letter claiming that "gender affirming" treatments are not safe or effective in the

¹ The meeting is set for August 5, 2022. See Florida Board of Medicine. n.d. "Meeting Information." Florida - Board of Medicine. <https://flboardofmedicine.gov/meeting-information/>

absence of “available medical literature[.]” DeSantis, Ron, and Simone Marsteller. 2022. *Fla. Medicaid-Gen. Acpted. Pro. Med. Std. Determ. on the Treatment of Gender Dysphoria* (hereinafter “AHCA Report”); see Florida Administrative Register 2022, pg. 2462 (a proposed medicaid rule barring Medicaid coverage for all medical treatments corresponding to “Gender Dysphoria[.]”) (unpub. rule).² Although the meeting has already finished (July 8), there still has not been a final decision. In its most recent move—and not even a month later—it seeks to have a new meeting with the medical board, consistent with the request by the surgeon general. This is particularly chilling given the statutory authority the Florida Medical Board possesses, and now it’s not just Medicaid—it’s every trans person at risk. Today, the medical board is at the center of the stage in the middle of a scientific and constitutional calamity.

Under Florida law, the Florida Medical Board has substantial power, including “disciplinary action” against physicians. Fla. Stat. § 458.331. Below are a few reasons for disciplinary action, clearly applying to gender-affirming treatments in the state’s dogma of them being, *inter alia*, “experimental” and not safe. AHCA Report, 38.

(q) it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs ... *inappropriately* or in excessive or inappropriate quantities *is not in the best interest of the patient* and is not in the course of the physician’s professional practice, without regard to his or her intent

(ee) prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs ...

Id., at 458.331 (1) (q)(ee) (emphasis added).³

If a physician violates those statutes above, the punishment could be, for example, “[r]estriction of practice or license,” “[s]uspension or permanent revocation of a license[.]” or even “an

² <https://www.flrules.org/notice/Proposedinfo.asp?id=25979915>

³ Surgeries for transgender individuals (more modest in usage than hormones or hormone blockers) may be also found within chapter 458. See Fla. Stat. § 458.328 (1) (h) (“...The board shall impose a fine of \$5,000 per day on a physician who performs a procedure or surgery in an office *that is not registered with the department*”) (emphasis added). Since the state is seeking to outlaw all transgender treatments, see *supra* ¶2, it is unlikely that it would be registered with the department. Even if we could surpass all of these statutes, “[t]he board has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it.” Fla. Stat. § 458.309 (1)

administrative fine[.]” Fla. Stat. § 456.072 (2) (b)(c)(d).⁴ The effect on the physicians is self-evident: many will be injured beyond just economic impairment. So too is the effect on transgender patients receiving (and needing) care. When treatment is diminished or stopped, the increase in the rates of suicide, suffering, and depression is not a mere question—it is a statement.⁵

The state’s actions today should not survive in the United States. When looking at the state’s actions relative to the AHCA Report, there’s no sheer concern about the “irreversible physical changes and side effects that can affect long-term health” related to treatments for gender dysphoria. 2. Nor could they: to this day, they have consistently failed to equally apply it to cisgender individuals, even when many treatments (as applied to cisgenders) are just as dangerous. *Compare* Fla. Dept. of Health guidance (opposing specifically gender-affirming care) *and* Florida Administrative Register 2022, 2462 (similar) *with* AHCA Report, 2–38 (similar). Indeed, “[i]f there is need to have [a] physician prescribe (and a pharmacist dispense) contraceptives, that need is as great for unmarried persons as for married persons.” *Eisenstadt v. Baird*, 405 U.S. 438, 450 (1972). Or, said another way, “[i]f there is a need to protect transgender youth from the purported risks of the banned treatments (there is not), then that need is as great for cisgender and/or intersex youth who receive the same medical treatments.” *Walker v. Marshall*, 2:22-cv-00167 (N.D. Ala. 2022), ECF 10, pg. 38 (hereinafter “*Walker*”). I will name a few examples. The state is fine with “chest surgery for [the] treatment of gynecomastia” as well as “chest-feminizing surgery” for non-transgenders. *Id.*, at 40. Similarly, gender dysphoria treatments, such as puberty blockers, “are also used to delay puberty in children with central precocious puberty[.]” *Id.*, at 39. The state says nothing about that. The same issue applies to hormone therapy: as for “nontransgender girls with primary ovarian insufficiency,” “hypogonadism,” and “Turner’s Syndrome,” for example, the state does not say anything about hormone treatment for those either. *Id.*, at 39–40. “[P]olycystic ovarian syndrome” may require testosterone blockers. *Id.*, at 40. Yet, the state bats no eye on blockers for that (nor any of the examples above)—even though apparently *all* medical treatments for gender dysphoria can cause “side effects that can affect long-term health[.]” AHCA Report, 2.

⁴ The medical board’s mission statement is far more candid: “The Florida Board of Medicine ... will license, monitor, discipline, educate, and when appropriate, rehabilitate physicians and other practitioners[.]” Florida Board of Medicine. n.d. Florida Board of Medicine - Healthcare Practitioner Licensing and Regulation. Accessed July 30, 2022. <https://flboardofmedicine.gov/>

⁵ See, e.g., Human Rights Campaign Rebuttal, *supra*, at 4–5 (listing six studies that demonstrate this); Olson, Kristina R. 2016. “Mental Health of Transgender Children Who Are Supported in Their Identities.” *Pediatrics* 137, no. 3 (March): 2015–3223 (stating that “[s]ocially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety”—albeit better than not getting treatment or being “supported.”); *infra* ¶7 (*Amicus Curiae* brief)

There's no legitimate concern by the state about the quality of evidence either—and it would be almost impossible for the state to carry their burden of making an “exceedingly persuasive” justification. *United States v. Virginia*, 518 U.S. 515, 524 (1996). Beyond the purported concern about “side effects,” the report also claims there is “weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures[.]” AHCA Report, 3. Thus, such treatments “are experimental and investigational.” *Id.* The public record demonstrates, however, that the state “tethers [transgender individuals] to sex stereotypes which, as a matter of medical necessity, they seek to reject.” *Kadel v. Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020). As a threshold matter, “the State cannot carry its burden to justify the[ir] [state actions] based on purported concerns about the quality of the evidence concerning the treatment for two reasons: (1) the consensus within the mainstream medical community is that the treatment is effective, and (2) even if there were limitations in the data supporting efficacy of the care, that would not explain why only this medical care—when provided to transgender [individuals]—is singled out for a uniquely high standard of evidence.” *Walker*, 44. All mainstream medical organizations, such as “the American Medical Association, the American Academy of Pediatrics, and the Endocrine Society,” have deduced and affirmed that gender-affirming treatment “is safe and effective.” *Id.* Even experts from Yale are on the same train: “If Florida[] ... applied the June 2 Report’s [low-quality concern] approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.”⁶ McNamara, Meredith et al. 2022. *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria*, pg. 3 (hereinafter “AHCA Review Report”); *see id.*, at 16; *see also id.*, at 5 (gender-affirming care “has been vetted and approved by international bodies of experts based on the scientific evidence.”) The state has failed to do so and subjects transgender individuals to an unusual standard of evidence vis-à-vis their non-transgender counterparts. Therefore, there are no legitimate state interests.

⁶ To continue with the “low quality” concern, the state mentions it many times—even at the start. *See, e.g.*, AHCA Report, 2 (“Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality”). When readers surpass this deceptive language, however, they see that under the GRADE rating standards, even “low quality” studies “support a strong clinical treatment recommendation.” AHCA Review Report, 14; *see* Balshem, Howard, et al. 2011. “GRADE guidelines: 3. Rating the quality of evidence.” *J Clin. Epidemiol.* 64, no. 4 (Jan): 401-6. Randomized control trials would be considered “high quality” (AHCA Review Report, 13) while, conversely, observational proof, such as “studies [are] technically ranked as ‘low quality,’” *id.*, at 16 (citing Stone, Neil J. 2014. “2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults.” *Circulation* 129, no. 25 (June): S1-S45.) As stated above, medications, including statins and “common medical procedures like mammograms and routine surgeries,” rely on observational studies. AHCA Review Report, 3, 16 & n53. Thus, those studies are “low quality”—yet we don’t see the state sending a 46-page letter opposing any of those treatments, nor the other actions it has taken over the past couple of months. Either the state is hypocritical or it is discriminatory. It seems to be one or the other.

The state's dependence on faulty scientific findings does not rescue their claims. The state has sanctioned a reputedly "scientific report that so blatantly violates the basic tenets of scientific inquiry." *Id.*, at 2. It is "a document crafted to serve a political agenda." *Id.* In form and in effect, it endangers "adolescents with gender dysphoria access to medical interventions that alleviate suffering" by creating an unscientific report that spreads like a wildfire. Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, p. 19, *Eknes-Tucker v. Ivey*, 2:22-cv-184-LCB-SRW (M.D. Ala. 2022). And when "research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation," the state merely ducks. *Id.*⁷ Hereunder, I will go over the major findings in the AHCA Review Report.

First, five attachments (by "experts") to the AHCA Report disregard medical guidelines for the treatment of gender dysphoria and instead "recommend against the use of such interventions to treat what is categorized as a mental health disorder[.]" 2. *Contra* Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, 7–14 (20 major medical organizations listing the guidelines and affirming their effectiveness). However, the attachments could not be further afield. Not only do they go against the 20 major organizations listed above, but they also have underlying questions of bias and expertise. See AHCA Review Report, 6. Most notably, *none* are "peer-reviewed or published," a vital criterion by which scientific pieces may be publicly scrutinized. Nor do any of "the attachments provide a statement of funding and conflicts of interest." *Id.*, at 7. And *all* raise "flags" of bias. *Id.*, at 6. But first, turn to attachment E, which is by Quentin van Meter. He is the president of the American College of Pediatricians (ACP), a "political" organization "that opposes same-sex marriage, supports mental health providers practicing conversion therapy, and describes childhood gender dysphoria as 'confusion.'" *Id.*, at 7 (citations omitted); see *id.*, at n15, n16, n17. Meter has also been disqualified by a judge for being incapable of giving expert testimony about "the legal question of whether an adolescent transgender child should be administered puberty blockers and whether affirmation of an incongruent gender in a child is harmful or not[.]"⁸ Similarly, James Cantor (attachment D) in the report fares no better. There, "the Court gave

⁷ While "Cantor specifically notes that actual suicides are highly unlikely among gender dysphoric individuals, particularly trans-males[.]" the wall of medical experts (20 to be exact) seem to say otherwise. AHCA Report, 28. To be clear, "*more than one in three* transgender adolescents reported having attempted suicide in the preceding 12 months." Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, 6 (emphasis added); see *id.*, at n15. And even if Cantor and the state are true, they miss the point: Suicide attempts are a risk factor for completing suicide. Bostwick, Michael. 2016. "Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew." *Am J Psychiatry* 173, no. 11 (Nov): 1094–1100.

⁸ Caruso, Stephen. 2020. "A Texas judge ruled this doctor was not an expert. A Pennsylvania Republican invited him to testify on trans health care." *Pennsylvania Capital-Star*, September 15, 2020. <https://www.penncapital-star.com/government-politics/a-texas-judge-ruled-this-doctor-was-not-an-expert-a-pennsylvania-republican-invited-him-to-testify-on-trans-health-care/>

[Cantor’s] testimony little weight because he admitted, *inter alia*, to having no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria.” *Id.*, at 8 (quoting Opinion and Order, *Eknes-Tucker v. Marshall*, 2:22-CV-184-LCB-SRW (M.D. Ala. 2022)). He could have been on the case because his “appearance in that case seems to have been funded by the Alliance Defending Freedom (‘ADF’), a religious and political organization that opposes legal protections for transgender people and same-sex marriage and defends the criminalization of sexual activity between partners of the same sex.” *Id.* (citations omitted); *see id.*, at n22, n23, n24. As for Attachment C (Romina Brignardello-Petersen & Wojtek Wiercioch), issues run the gamut, including inexpertise. The first problem is quite simple—Brignardello-Petersen’s “only clinical experience appears to be in dentistry.” *Id.*, at 10.⁹ Apparently, we live in an alternate universe (“Florida”) where “dentistry” in lieu of endocrinology and mental health as applied to transgender care somehow passes as “expert.” Wiercioch, the other author, is a “postdoctoral fellow” who has “no prior research or clinical experience in” transgender care. *Id.* Indeed, the foregoing issues go against relevant guidelines; they require “expertise in the pertinent clinical content areas.”¹⁰ The study that the authors provide (Attachment C) is not peer-reviewed, nor are any of the studies in the attachments for that matter. As stated above, peer review is very important—it is not “merely window-dressing; they reflect bedrock commitments of the scientific method.” *Id.*, at 11. By failing to undertake basic peer-review, the authors (and most of the authors from the attachments) truncated ordinary procedures of scientific review. Furthermore, the authors include in their study a website called SEGM.org. *See id.* That citation crumbles upon examination; “the group’s website posts are not peer-reviewed or published, and its content is assembled by a small group of activists with few or no expert credentials[.]” *Id.* (quoting Boulware 2022).¹¹ Most notably, Brignardello-Petersen is connected to the group, having “conducted research” for them. *Id.*, at 8. The study provided by the authors suffers even more losses by further review. *See id.*, at 11–14 (evaluating the authors’ usage of certain rating systems and the absence of sufficient literature). Now, we turn to Patrick Lappert (Attachment F). Like Meter and Cantor, “evidence ... calls Lappert’s bias and reliability into serious question.” Memorandum Opinion and Order, *Kadel v. Folwell*, 1:19CV272 (M.D.N.C 2022), pg.

⁹ Brignardello-Petersen’s profile also states that she is a “Assistant Professor[of] Health Research Methods, Evidence, and Impact[.]” Brignardello, Romina. n.d. “Romina Brignardello Assistant Professor, Health Research Methods, Evidence, and Impact.” McMaster Experts. Accessed July 30, 2022. <https://experts.mcmaster.ca/display/brignarr>. But, as of July 30, 2022, her only contributions are in, *inter alia*, virology and epidemiology—both, again, inexpert for transgender care. *See id.*

¹⁰ Institute of Medicine, Board on Health Care Services, and Committee on Standards for Systematic Reviews of Comparative Effectiveness Research. 2011. *Finding What Works in Health Care: Standards for Systematic Reviews*. Edited by Alfred Berg, et al. N.p.: National Academies Press.

¹¹ Boulware, Susan D. 2022. “Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims.”

27. The court order also observed that “Lappert has worked closely with ADF” and had been to conferences that “asked whether they would be willing to participate as expert witnesses.” *id.* (quoting ECF No. 209-2 at 90:13–91:13).¹² The issues listed above are not mere hypothetical concerns; they are serious barriers posed, such as conflicts of interest and biases. Worse, the authors as listed in the attachments never address or mention them—or list them as every “scientific” report is supposed to do. *See* AHCA Review Report, 7 & n13.

Second, the AHCA Report attempts to dismiss various studies. However, by doing so, they trip over their own feet in the process—another fatal mistake. Below is a non-exhaustive list of those failed attempts. To begin, turn to page 15 of the report. There, the Costa study “relies heavily on self-assessments” so apparently the results “are likely biased and invalid.” AHCA Report, 15. The report also claims that the “short-term period of the study” warrants condemnation. *Id.* These points lack merit for two reasons. First, the “self-assessments” are from a test called the Children’s Global Assessment Scale. It is well-documented, well-regarded, and accepted, and is relied upon for psychological research. AHCA Review Report, 17. The scale is thus “carefully constructed and psychometrically validated.” *Id.* Lastly, one cannot solely criticize a medical study—that is, in this study, about the efficacy of puberty blockers—without looking into the vast array of other studies because “[s]cientific knowledge is ... cumulative.” *Id.*, at 18. The AHCA Report blindly attacks “a single study and fails to acknowledge that the weight of the literature as a whole strongly supports the same results that Costa et al. report.” *Id.*, at 17–18 (emphasis deleted). Continuing on to the other studies, the AHCA Report on the Chen article deludes the reader by misrepresenting the article’s contents. *See* AHCA Report 15–16 (stating, by use of the article, that the “the effects of pubertal suppression warrant further study”).¹³ *But see* AHCA Review Report, 18 (The article “is not a substantive study of the effects of puberty blockers”). The article is “a consensus parameter[]”—a type of “structured methodology” that enables experts to create a “research agenda for future studies.” *Id.* Thus, those types of opportunities are simply to pick out ways to research subjects and techniques—not to be cited in such a narrow manner by the state. The review report says it perfectly: the article’s “statements are not indictments of puberty blockers—they are conventional acknowledgments of the value of further study that drives scientific inquiry and innovation.” *Id.* The AHCA Report separately cites a case in which they say “puberty suppression causes side effects, some of which have the potential to be permanent.” 16. Interestingly, the report says that these “indicate that Gn-RH is safe” and that the majority of the “side effects associated

¹² He has also stated that physicians “should be ‘criminally prosecute[d]’ for giving gender-affirming care. *Kadel*, at 27 (quoting ECF No. 209-2 at 52:4-18, 54:7–55:2, 57:8-15, 61:16–64:20).

¹³ (quoting Chen, Diane. 2020. “Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth.” *Transgender Health* 5 (4): 246-257) (hereinafter “Chen et al”)

with Gn-RH are mild[.]” *Id.* One of the side effects the report digs into is “osteonecrosis.” *Id.* However, even it states that this side effect “is rare[.]” *Id.* From the state’s perspective, minor or moderate side effects (in its view, more solid than others) cause burdens—burdens that could be circumvented in toto if we strip away the right (and only the right) to gender-affirming care even though every medical organization opposes it. This is a strange way of looking at rights, and there is a good reason courts have not adopted this thinking. Further, it’s clear that gender-affirming care is not atypical for having specific side effects, so it makes no sense to only try to restrict and demean that care to a sole minority group. *See Walker*, 41–42 (rejecting the state’s concern of “risks” to justify banning gender-affirming care because there was nothing special tailored to those treatments).¹⁴

Third, the state again tries to negate the applicability of gender-affirming treatments to other treatments. Now, they try to assert that the “FDA did not approve [puberty blockers and hormone therapy] for treating gender dysphoria” and, as a result, it is classified as “off-label[.]” AHCA Report, 8. But the fact is, many drugs are used “off-label.” *See, e.g.*, AHCA Review Report, 20–21 (gabapentin is used off-label “for neuropathic or mixed pain”); (ketamine and fentanyl is used “off-label for pain relief”); (“[c]affeine is used off-label to treat apnea” including “phenobarbital is used off-label to treat neonatal seizures” in the NICU); (“pantoprazole is a proton pump inhibitor” and is also “used off-label in neonates with gastroesophageal reflux disease”); (“[o]ndansetron (Zofran) is used off-label for nausea and vomiting to prevent fluid loss”). As mentioned above, the state subjects transgender individuals to different standards of care in relation to their non-transgender counterparts. *See supra* ¶6.

Fourth, the AHCA Report claims that “the *majority* of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex[.]” 14 (emphasis added). Similar to Texas Attorney General Ken Paxton’s interpretations, the report uses the term “children” *Id.* “Actual scientific evidence on the course of gender dysphoria emphasizes the importance of distinguishing between prepubertal children and adolescents.”¹⁵ When the AHCA Report uses that

¹⁴ Also troubling, the letter cites studies that contradict its previous assertions, “in what looks like a circular firing squad.” *Equality Florida v. DeSantis*, 4:22-cv-0134-AW-MJ (N.D. Fla. 2022), ECF 81, pp. 13–14. *Compare* AHCA Report, 17 (“Prescribers ... de-emphasize that these drugs cause permanent physical changes and side effects that can lead to premature death”) with AHCA Report, 17 (the risk of long term effects are small, “most side effects associated ... are mild,” and “the authors indicate that Gn-RH is safe”) and Chen et al, 249 (“[s]uppressing puberty may reduce dysphoria and diminish risks for poor mental health in this population, thereby exerting *neuroprotective* effects.”) (emphasis added).

¹⁵ Boulware, Susan D. 2022. “Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims,” p. 18 (hereinafter “Texas and Alabama Report”).

terminology, it gives a false sense “that most or all children *and* teens diagnosed with dysphoria will cease identifying with the gender not assigned at birth.” Texas and Alabama Report, 18. Of course, that is wrong. Rather, studies paint a different picture: “[A]dolescents who are diagnosed with gender dysphoria will persist in their gender identity[.]” *Id.*; *see id.*, n63, n64, n65. Although the resolving rate *is* higher in prepubescent children suffering from gender dysphoria, “standard medical protocols do not treat prepubertal children with drug therapy or ... surgery.” *Id.*, at 18; *see* Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, 9. To defend its position, the state generally cites a study by Littman, but that goes awry.¹⁶ In the study, Littman “defines detransition as ‘discontinuing medications, having surgery to reverse the effects of transition, or both.’” AHCA Review Report, 22. This is obviously confusing because there are many reasons why people might want to stop medications. Applying her logic, her definition of a transgender individual could continue to be socially transitioned but be counted as a “detransition[er].” *Id.* Conversely, the state disregards important studies showing, *inter alia*, low regret and a detransition rate (findings were around $\leq 1\%$).¹⁷

Fifth (and lastly), the AHCA Report’s groundless statements about gender dysphoria being caused by “social and peer contagion.” 12. This so-called “peer contagion” in gender dysphoria may be caused by “rapid onset gender dysphoria[.]” *Id.* What is the pathology, or even the citations to back up this extraordinary claim? The former is not supported by any studies while the latter, is *her* study only. “Neither the American Psychiatric Association nor any other reputable professional organization” has actually validated ROGD. Texas and Alabama Report, 21. It could be because the study itself did not receive adequate feedback for it to be sufficient in the eyes of major organizations. The Texas and Alabama Report said

WPATH, among other authorities, has taken a skeptical view of Littman’s claim, and the study has been criticized for serious methodological errors, including the use of parent reports instead of clinical data and the recruitment of its sample of parents from anti-transgender websites. The journal of publication required an extensive correction of

¹⁶ Littman, Lisa. 2021. “Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners.” *Arch Sex Behav.* 50, no. 8 (Nov): 3353–69.

¹⁷ Bustos, Valeria et al P. 2021. “Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence.” *Plast Reconstr Surg Glob Open.* 9, no. 3 (Mar); Danker, Sara et al. 2018. “Abstract: A Survey Study of Surgeons’ Experience with Regret and/or Reversal of Gender-Confirmation Surgeries.” *Plastic and Reconstructive Surgery* 6, no. 9S (Sept); Wiepjes, Chantal M., et al. 2018. “The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets.” *J Sex Med.* 15, no. 4 (Apr): 582–90; *see also* Smith, Yolanda L. 2005. “Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals.” *Psychol Med.* 35, no. 1 (Jan): 89-99; Olson, Kristina R. 2022. “Gender Identity 5 Years After Social Transition.” *Pediatrics* 150, no. 2 (Aug).

the original Littman article because of its misstatements. Such a correction in reputable, peer reviewed academic journals is taken only when a panel of experts, in retrospect, came to recognize the methodological flaws of the original study and concluded that it would be unscientific to allow the originally published findings to stand.

Id., at 20–21.

Moreover, studies have rejected these notions of ROGD. When 173 youth arrived at Canadian gender clinics in 2022, they “found no evidence of rapid-onset dysphoria or social contagion” even when considering Littman’s hypothesis. AHCA Review Report, 24. And when another 173 youths were studied, they were also stumped with the same result: “no such correlations[]” materialized. *Id.*¹⁸ Data from the Williams Institute also supports those studies. The data simply “do[es] not show a massive wave of transgender identity even among teens.” *Id.* As of 2022, a study shows that 0.5% of adults and 1.4% of youth aged 13-17 identify as transgender (equivalent to 300,000 young individuals). *Id.*¹⁹ Collectively, the foregoing studies and resources join together to demonstrate the opposite of what the AHCA Report claims: there is no evidence of “rapid onset gender dysphoria” nor “social and peer contagion.” 12. Instead, it shows something else hidden under the cracked surface—stereotypes that transgender individuals “do not know[] their own gender identity and readily change their gender identity based on peer influence and social media.” AHCA Review Report, 24.

“[W]e are beyond the day when an [individual or] employer could evaluate [others] by assuming or insisting that they matched the stereotype associated with their group[.]” *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) (plurality op.). The state collapses under its own feet. “Nor is there an adequate remedy for preventable ‘life-long diminished well-being and life-functioning.’” *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1042 (7th Cir. 2017). When the state could eliminate discrimination, it chooses not to. The detrimental and irreparable effect is on the minority whom they have a compelling interest in protecting. *See Bd. of Dirs. of Rotary Int. v. Rotary Club of Duarte*, 481 U.S. 537, 549 (1987) (declaring the “State’s compelling interest in eliminating discrimination”); *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 252–53 (1964) (observing the systemic effects of discrimination); *id.*, at 274 (similar) (Black, J. concurring).

¹⁸ Bauer, Greta R., et al. 2022. “Do Clinical Data from Transgender Adolescents Support the Phenomenon of “Rapid Onset Gender Dysphoria?”” *J Pediatr.* (Apr), 224–27.

¹⁹ Herman, Jody L. 2022. “How Many Adults and Youth Identify as Transgender in the United States?” The Williams Institute.

Respectfully,

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References:

1. Balshem, Howard. 2011. "GRADE guidelines: 3. Rating the quality of evidence." *J Clin. Epidemiol.* 64, no. 4 (Jan): 401–6. 10.1016.
2. Bauer, Greta R. 2022. "Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?" *J Pediatr.*, (Apr), 224–27. 10.1016.
3. Bostwick, Michael. 2016. "Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew." *Am J Psychiatry* 173, no. 11 (Nov): 1094–1100. 10.1176.
4. Boulware, Susan D. 2022. "Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims."
5. Brignardello, Romina. n.d. "Romina Brignardello Assistant Professor, Health Research Methods, Evidence, and Impact." McMaster Experts. Accessed July 30, 2022.
<https://experts.mcmaster.ca/display/brignarr>.
6. Bustos, Valeria P. 2021. "Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence." *Plast Reconstr Surg Glob Open.* 9, no. 3 (Mar). 10.1097.
7. Caruso, Stephen. 2020. "A Texas judge ruled this doctor was not an expert. A Pennsylvania Republican invited him to testify on trans

health care.” *Pennsylvania Capital-Star*, September 15, 2020.

<https://www.penncapital-star.com/government-politics/a-texas-judge-ruled-this-doctor-was-not-an-expert-a-pennsylvania-republican-invited-him-to-testify-on-trans-health-care/>.

8. Florida Administrative Register. 2022. “Florida Administrative Register.” 48, no. 118 (June): 2459–74.
9. Florida Department of Health. 2022. *Treatment of Gender Dysphoria for Children and Adolescents*.
10. Human Rights Campaign. 2022. *Florida Department of Health Memo Misleading the Public on the Science Behind Gender-Affirming Care*.
11. DeSantis, Ron, and Simone Marstiller. 2022. *Florida Medicaid - Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria*.
12. Chen, Diane. 2020. “Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth.” *Transgender Health* 5 (4): 246–57.
13. Danker, Sara. 2018. “Abstract: A Survey Study of Surgeons’ Experience with Regret and/or Reversal of Gender-Confirmation Surgeries.” *Plastic and Reconstructive Surgery* 6, no. 9S (Sept). 10.1097.
14. DeSanctis, Vincenzo. 2019. “Long-term effects and significant Adverse Drug Reactions (ADRs) associated with the use of Gonadotropin-Releasing Hormone analogs (GnRHa) for central precocious puberty: a brief review of literature.” *Acta Biomed*. 90, no. 3 (Sep): 345–59. 10.23750.

15. Florida Board of Medicine. n.d. Florida Board of Medicine - Healthcare Practitioner Licensing and Regulation. Accessed July 30, 2022. <https://flboardofmedicine.gov/>
16. Florida Board of Medicine. n.d. "Meeting Information." Florida - Board of Medicine. <https://flboardofmedicine.gov/meeting-information/>
17. Herman, Jody L. 2022. "How Many Adults and Youth Identify as Transgender in the United States?" The Williams Institute.
18. Institute of Medicine, Board on Health Care Services, and Committee on Standards for Systematic Reviews of Comparative Effectiveness Research. 2011. *Finding What Works in Health Care: Standards for Systematic Reviews*. Edited by Alfred Berg, Sally Morton, Laura Levit, and Jill Eden. N.p.: National Academies Press.
19. Littman, Lisa. 2021. "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners." *Arch Sex Behav*. 50, no. 8 (Nov): 3353–69. 10.1007.
20. McNamara, Meredith. 2022. *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria*.
21. Olson, Kristina R. 2016. "Mental Health of Transgender Children Who Are Supported in Their Identities." *Pediatrics* 137, no. 3 (March): 2015–3223.
22. Olson, Kristina R. 2022. "Gender Identity 5 Years After Social Transition." *Pediatrics* 150, no. 2 (Aug). 10.1542.

23. Smith, Yolanda L. 2005. "Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals." *Psychol Med.* 35, no. 1 (Jan): 89–99. 10.1017.
24. Stone, Neil J. 2014. "2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults." *Circulation* 129, no. 25 (June): S1–S45.
25. Wiepjes, Chantal M. Apr. "The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets." *J Sex Med.* 15, no. 4 (2018): 582–90. 10.1016.

Other References:

Cases:

1. *West Virginia Bd. of Ed. v. Barnette*, 319 U. S. 624 (1943)
2. *Romer v. Evans*, 517 U.S. 620 (1996)
3. *Eisenstadt v. Baird*, 405 U.S. 438 (1972)
4. *Walker v. Marshall*, 2:22-cv-00167 (N.D. Ala. 2022)
5. *United States v. Virginia*, 518 U.S. 515 (1996)
6. *Kadel v. Folwell*, 446 F. Supp. 3d 1 (M.D.N.C. 2020)
7. *Eknes-Tucker v. Marshall*, 2:22-CV-184-LCB-SRW (M.D. Ala. 2022)
8. Brief for the Am. Acad. Pediatr. as *Amicus Curiae*, *Eknes-Tucker v. Ivey*, 2:22-cv-184-LCB-SRW (M.D. Ala. 2022)
9. *Equality Florida v. DeSantis*, 4:22-cv-0134-AW-MJ (N.D. Fla. 2022)
10. *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)
11. *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034 (7th Cir. 2017).
12. *Bd. of Dirs. of Rotary Int. v. Rotary Club of Duarte*, 481 U.S. 537 (1987)
13. *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964)

Statutes:

1. Fla. Stat. § 458.331
2. Fla. Stat. § 456.072
3. Fla. Stat. § 458.328
4. Fla. Stat. § 458.309



July 28, 2022

Dr. David Diamond, Chairperson
Florida Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

**Re: Human Rights Campaign Comments on the Surgeon General's July 2,
2022 Letter concerning gender affirming medical care**

Dear Dr. Diamond and Members of the Florida Board of Medicine:

On behalf of the Human Rights Campaign's more than three million members and supporters nationwide, we submit this comment in response to the letter from the Surgeon General of Florida recommending the creation of a standard of care that would ban or significantly curtail the ability of medical practitioners to provide standard and medically necessary gender affirming health care to minors.¹ As the nation's largest organization working on behalf of lesbian, gay, bisexual, transgender, and queer people, we are deeply troubled by this letter in which the Surgeon General disregards scientifically based standards set by numerous medical professional organizations including the American Academy of Pediatrics, the American Medical Association, and the Endocrine Society.² The creation of a standard of care in line with the Surgeon General's recommendations would cause confusion and chaos among medical professionals in the State as they attempt to comply with standards that contravene the majority scientific consensus. It would also potentially force many vulnerable young patients to either delay the start of treatment or suspend medically necessary care during the course of treatment. We implore the Board to disregard the unfounded recommendation by the Surgeon General of Florida or to ensure that any creation of a standard of care includes gender affirming healthcare as a viable treatment for medical practitioners to recommend and dispense in consultation with their patients and their families.

¹ Joseph A. Lapado, Letter to the Florida Board of Medicine, July 2, 2022, accessed July 28, 2022, at <https://www.documentcloud.org/documents/22050967-board-letter>.

² *Id.*

Denying access to safe, affirming, and age-appropriate medical care such as gender-affirming hormones or puberty-delaying medication is dangerous and can be life-threatening. There is a clear correlation between youth receiving gender-affirming care and a decrease in anxiety, depression, self harm, and suicidal ideation. A blanket denial of care by preventing medical practitioners from engaging in the practice would increase rates of adverse mental health outcomes among transgender young adults.³

Gender-affirming care for transgender youth and adolescents largely involves social transitioning – whereby a person adopts a name, pronouns, and gender expressions that are consistent with their gender identity. Additionally, youth are often supported by a host of medical practitioners in their social transition through therapy and later consultation regarding medical transition if the patient so desires it.⁴ Numerous studies have found that, after social transitioning, transgender youth report similar mental health levels to the general youth population, eliminating mental health disparities typically seen. “Transitioning socially should not only be viewed as a form of treatment, but can be understood as a possibility for children to explore their own individual developmental pathways.”⁵ It is clear that these non-medical elements of transitioning help increase positive health outcomes. As stated, healthcare supporting social transitioning is sometimes only one part of a transgender individual’s healthcare plan to live fully as their whole selves.

For some people, medical transition is necessary. Gender-affirming medical care encompasses hormone therapy, puberty blockers or other medical procedures. And to be done properly and safely, there must be close consultation with medical practitioners. According to Williams Institute, there are approximately 16,200 transgender youth (ages 13-17) throughout the state of Florida.⁶ A standard banning or severely restricting gender affirming care would outright prevent these individuals from receiving care for gender affirming procedures within the State of Florida. For example, many transgender individuals report having to leave their home state (Florida included) in order to receive gender affirming care as the closest provider of such care resides outside of state lines.⁷ A new standard of care banning or severely restricting gender affirming care would push transgender youth across the State to either: 1) leave to a different, more welcoming state, to receive gender affirming care as there would remain no practitioner within the state that could provide them with said care, 2) suffer the mental health consequences as described above due to an inability to transition (due to financial, employment, familial, or other

³ “Use of GAHT [gender affirming health treatments] was associated with lower odds of recent depression and seriously considering suicide compared to those who wanted GAHT but did not receive it.” Amy E. Green, *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, Journal of Adolescent Health, (2021) <https://doi.org/10.1016/j.jadohealth.2021.10.036>.

⁴ American Psychiatric Association, *Gender Affirming Therapy, A Guide for Working With Transgender and Gender Nonconforming Patients* (accessed July 28, 2022), <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-affirming-therapy>.

⁵ Elisabeth DC Sievert and Katinka Schweizer, *Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria*, Clin Child Psychol Psychiatry (Oct. 19, 2020). P.92. <https://doi.org/10.1177/1359104520964530>.

⁶ Jody Herman, Andrew Flores, and Kathryn O’Neill, *How Many Adults and Youth Identify as Transgender in the United States*, UCLA School of Law Williams Institute (June 2022), <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>.

⁷ Puckett, J., Cleary, P., Rossman, K., Newcomb, M., and Mustanski, B., *Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals*, National Library of Medicine, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5842950/>.

restriction preventing them from crossing state lines), or 3) leave the state permanently with (or potentially without) their families to a state that is more welcoming and able to provide them with the standard and medically necessary treatments they need. Additionally, a new standard of care may lead to either the de-licensing of medical professionals throughout the state for having provided such care or the moving of medical professionals throughout the state because of a desire to provide such care. This could leave the State with a shortage of licensed medical professionals.

A new standard to prevent medical professionals from providing gender affirming care not only restricts access to necessary medical care, it also prevents parents from making decisions in the best interest of their children. This new standard would also prevent doctors from making medically sound determinations based on widely accepted and vetted standards of care and from working with their patients on how to provide the best care possible tailored to the individual for fear of losing their job and their license to practice medicine in the State. In a study of over 160 medical doctors, “[o]verall, 85.7 percent of clinicians were willing to provide routine care to transgender patients.”⁸ Although this number is encouraging, “willingness is not necessarily equivalent to competence or the ability to provide high-quality, sensitive care.”⁹ It is imperative to ensure that medical practitioners are able to provide gender affirming care not only for the benefit of youth throughout the State, but also to ensure that those same practitioners are keeping up to date with the latest in treatments made available by the scientific community.

A new standard also ignores the fact that the medical establishment has already spoken on this matter. The American Medical Association, representing millions of doctors across the United States, points out that the majority of medical associations throughout the nation include gender affirming care as part of their own treatment standards noting that:

The AMA opposes any discrimination based on an individual’s sex, sexual orientation or gender identity, opposes the denial of health insurance on the basis of sexual orientation or gender identity, and supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient’s physician....In addition, other medical associations, including the American Academy of Family Physicians, American College of Obstetricians and Gynecologists and American Psychiatric Association have stated that medically necessary transition-related care should be covered by insurance.¹⁰

Numerous fallacies underlie the Surgeon General’s letter recommending a new standard of care. The theory of rapid onset gender dysphoria has been debunked throughout the scientific and medical literature, and met with significant and substantial methodological critiques.¹¹ In fact, determining

⁸ Deirdre A. Shires, Daphna Stroumsa, Kim D. Jaffee and Michael R. Woodford, *Primary Care Clinicians’ Willingness to Care for Transgender Patients*, *The Annals of Family Medicine* (Nov. 2018) <https://doi.org/10.1370/afm.2298>.

⁹ *Id.*

¹⁰ American Medical Association and GLMA: Health Professionals Advancing LGBTQ Equality, *Health Insurance Coverage for gender-affirming care of transgender patients*, Issue Brief, <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>.

¹¹ Arjee Javellana Restar, *Methodological Critique of Littman’s (2018) Parental-Respondents Accounts of “Rapid-Onset Gender Dysphoria*, *National Library of Medicine* (Apr. 22, 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7012957/>; see also Greta R. Bauer, Margaret L. Lawson, and Daniel

treatment approaches (or, in this case, lack thereof) based on so-called rapid onset gender dysphoria would not meet the generally accepted professional medical standards determination, due to the lack of empirical support for this theory. This would make a new standard of care an outlier nationally. Indeed, in 2021, the American Psychological Association, the American Psychiatric Association, the Florida Psychological Association, and over 120 other medical associations issued a position statement calling for “eliminating the use of Rapid-Onset Gender Dysphoria and similar concepts for clinical and diagnostic application given the lack of rigorous empirical support for its existence and its likelihood of contributing to harm and mental health burden.”¹²

In addition, the overwhelming evidence supports the ability of medical professionals to provide gender affirming care due to the positive mental health impacts of treatments such as puberty blockers on transgender youth.¹³ For example, a systematic review of 13 studies found that receipt of puberty blockers had numerous positive psychosocial impacts, including “significant improvements in multiple psychological measures, including global functioning, depression, and overall behavioral and/or emotional problems.”¹⁴ Puberty blockers are both safe and fully reversible.¹⁵ According to the Endocrine Society, “Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD [gender dysphoric]/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/ gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains.”¹⁶

L. Metzger, *Do Clinical Data from Transgender Adolescents Support the Phenomenon of “Rapid Onset Gender Dysphoria”?*, *The Journal of Pediatrics* (Apr. 1, 2022), <https://www.jpeds.com/article/S0022-34762101085-4/fulltext>.

¹² Coalition for the Advancement & Application of Psychological Science, *CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD)*, Coalition for the Advancement & Application of Psychological Science (July 8, 2022), <https://www.caaps.co/rogd-statement>.

¹³ Denise Chew, *Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review*, *American Academy of Pediatrics*, (Apr. 1, 2018) <https://publications.aap.org/pediatrics/article/141/4/e20173742/37799/Hormonal-Treatment-in-Young-People-With-Gender?autologincheck=redirected>; see also Diana M. Tordoff, MPH, Jonathon W. Wanta, Arin Collin, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, *JAMA*, (Feb. 25, 2022) <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423>; see also Jack Turban, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, *American Academy of Pediatrics*, (Feb. 01, 2020), <https://publications.aap.org/pediatrics/article/145/2/e20191725/68259/Pubertal-Suppression-for-Transgender-Youth-and>

[and](https://publications.aap.org/pediatrics/article/141/4/e20173742/37799/Hormonal-Treatment-in-Young-People-With-Gender)

¹⁴ Denise Chew, *Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review*, *American Academy of Pediatrics* at 14. (Apr. 1, 2018). <https://publications.aap.org/pediatrics/article/141/4/e20173742/37799/Hormonal-Treatment-in-Young-People-With-Gender>

¹⁵ Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, *American Academy of Pediatrics*, (Oct. 1, 2018), <https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for> or; Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha, and Guy G T’Sjoen, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, *The Journal of Clinical Endocrinology & Metabolism* (July 13, 2018), <https://academic.oup.com/jcem/article/102/11/3869/4157558?login=false>

¹⁶ Hembree, Cohen-Kettenis, Gooren, Hannema, Meyer, Murad, Rosenthal, Safer, Tanpricha, T’Sjoen, *supra*.

‘Off label’ use does not mean experimental, illegal, or unsafe. Puberty blockers have been used safely and effectively with cisgender youth for decades under FDA approval, with minimal side effects.¹⁷ They have been used safely and effectively with transgender youth since the 1990s.¹⁸ As with puberty blockers, there is substantial evidence demonstrating positive mental health benefits associated with gender-affirming hormones, including lower rates of depression, anxiety, and suicidality.¹⁹ Any form of gender affirming care received by transgender youth is administered in consultation with medical and mental health professionals and their parents. The vast majority of transgender youth and adults remain consistent in their transgender identity.²⁰ Doctors must have the ability to choose safe and effective medical treatments for actual patients with actual health needs.

HRC reiterates our strong opposition to the Surgeon General of Florida’s letter recommending the creation of a standard of care banning or severely restricting the use of gender affirming care by medical practitioners. We urge the Board of Medicine to recognize the positive health benefits that gender-affirming care has on transgender individuals and the necessity of medical practitioners in that care. It is important to recognize that denial of transition-related care is damaging and has effects beyond access to gender-affirming medical procedures and medication, including resulting in a chilling effect on support for social transition and culturally sensitive healthcare for a person’s full range of medical needs. Medical professionals must be able to care for their patients using the full swath of care paths possible, not just those deemed politically acceptable by the government.

¹⁷ FDA Guidance for Administering Puberty Blockers https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020263s042lbl.pdf; see also Jason Lambrese, *Suppression of Puberty in Transgender Children*, AMA Journal of Ethics (Aug. 2010).

¹⁸ Jason Lambrese, *Suppression of Puberty in Transgender Children*, AMA Journal of Ethics (Aug. 2010). <https://journalofethics.ama-assn.org/article/suppression-puberty-transgender-children/2010-08>

¹⁹ Luke R. Allen, *Well-being and Suicidality Among Transgender Youth After Gender-affirming Hormones*, Clinical Practice in Pediatric Psychology (2019), <https://psycnet.apa.org/record/2019-52280-009>; see also Jack L. Turban, *Access to Gender-Affirming Hormones During Adolescents and Mental Health Outcomes Among Transgender Adults*, (Jan. 12, 2022), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039>; see also Amy E. Green, *Association of Gender-affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, Journal of Adolescent Health (2021), <https://www.jahonline.org/action/showPdf?pii=S1054-139X%2821%2900568-1>.

²⁰ Chantel M Wiepjes, *The Amsterdam Cohort of Gender Dysphoria Studies (1972-2015): Trends in Prevalence, Treatment, and Regrets*, J Sex Med (Apr. 15, 2018), <https://pubmed.ncbi.nlm.nih.gov/29463477/>; see also Valeria P. Bustos, *Regrets After Gender-affirming Surgery: A Systematic Review and Meta-analysis of Prevalence*, (Mar. 19, 2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8099405/>; see also Christina M. Roberts, *Continuation of Gender-affirming Hormones Among Transgender Adolescents and Adults*, The Journal of Clinical Endocrinology & Metabolism (Apr. 22, 2022), <https://doi.org/10.1210/clinem/dgac251>.

From: [Kelly Windsor](#)
To: [zzzz Feedback, BOM MeetingMaterials](#)
Subject: Conversion Theory
Date: Thursday, July 28, 2022 3:52:52 PM

You don't often get email from kelly.s.windsor@gmail.com. [Learn why this is important](#)

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To Whom It May Concern:

I have recently been given to understand that there is a proposal before the board for emphasizing conversion therapy rather than current standard care for transgender individuals. I am writing to implore you to reject standards of care for transgender people that emphasize conversion therapy. This "therapy" has long since been debunked as not only ineffective but harmful. The hippocratic oath requires a vow to "first, do no harm" . To replace transgender care with conversion therapy would in fact be harmful for transgender individuals of all ages. No matter how you or, more importantly, a political base feel about their existence, they have a right to exist as they are. No individual regardless of your opinion of their identity should have to be diminished or told that their existence is not real or valid-or that a political party or a single religion knows their identity better than they and their medical providers do. The consequences for the mental health and suicidal rates amongst teenagers alone could be disastrous. Here a couple of recent references:

Journal of Forensic and Legal Medicine statement on conversion therapy:
<https://doi.org/10.1016/j.jflm.2020.101930>

Forsythe A, Pick C, Tremblay G, Malaviya S, Green A, Sandman K. Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States. *JAMA Pediatr.* 2022;176(5):493–501. doi:10.1001/jamapediatrics.2022.0042

Sincerely,

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