EXHIBIT A

Expert Report of

Kristopher Kaliebe, MD

DeGross v. Senn

United States District Court
Western District of Washington

TABLE OF CONTENTS

LIST OF ACRONYMS

- AACAP – American Academy of Child and Adolescent Psychiatry
- APA – American Psychiatric Association
- ASPS – The American Society for Plastic Surgeons
- BMJ – British Medical Journal
- CBT – Cognitive Behavioral Therapy
- DSD – Disorders of Sexual Development
- DSM-5 – The Diagnostic and Statistical Manual of Mental Disorders, fifth edition
- FP – Fertility Preservation
- GIDS – The United Kingdom National Health Service's Gender Identity Development Service
- NIH – National Institutes of Health (US)
- NHS – National Health Service (UK)
- ROGD – Rapid Onset Gender Dysphoria
- TYRN – Trans Youth Research Network
- WPATH – World Professional Association for Transgender Health

I. Background and Professional Qualifications

1. I have been retained by Plaintiffs in the above-captioned lawsuit to provide an expert opinion concerning evidence-based care for children and adolescents experiencing gender dysphoria. My opinions are based primarily on my own experience as a physician, psychiatrist, and professor in the field of psychiatry, as well as the relevant literature in this area. I have also reviewed documents and court filings in this case. I may wish to supplement my opinions or the basis for them as new evidence emerges or new research is published. I cite to the materials I considered in forming the opinions in this report throughout the report itself and have included a complete reference list at the conclusion of this report.

2. I am over the age of 18, am qualified to give this declaration, and have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion. I am being compensated at a rate of $450 per hour. Testimony and depositions are billed in 4-hour increments. Any compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony that I provide.

3. I am Board Certified in Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry. My clinical work has been primarily in university-based clinics, community clinics, and correctional facilities.

4. I am a professor at the University of South Florida in Tampa, Florida, United States. I was promoted to the position on August 1, 2023. From 2016 to August 2023, I served as an Associate Professor at the University of South Florida, where my clinical roles included working in university clinics, providing consultative services at Tampa General Hospital, assessing and treating juveniles within correctional facilities, and supporting primary care physicians through the Florida Medicaid Psychiatric Medication hotline. From 2005 to 2016, I served as an Assistant Professor at the Louisiana State University Health Science Center – New

Orleans. I served as the training director of the LSU Child Psychiatry Fellowship for two years.

5. I received my medical degree in 1999 and subsequently completed general psychiatry, child and adolescent psychiatry, and forensic psychiatry training. This training included education in human biology, human sexuality, development, brain functioning, normal development, and psychopathology. Gender dysphoria (then labeled "gender identity disorder") and gender dysphoria treatment were part of my professional training.

6. I have extensive teaching experience, including teaching medical students, general psychiatry residents, child and adolescent psychiatry fellows, and forensic psychiatry fellows. I have had years of extensive positive feedback from medical students and psychiatric residents. I have been awarded four teaching awards, including from the general University of South Florida residents in June 2023 and as the Forensic Psychiatry Fellowship Educator of the Year in June 2025.

7. I practice forensic psychiatry, working on both child and adult cases in both criminal and civil courts. I teach forensic psychiatry, and I lecture child and adolescent psychiatry fellows on a biannual basis on forensic psychiatry.

8. I volunteer with direct patient care and resident supervision at the University of South Florida's refugee clinic. I am also on call for nights, holidays, and weekends at Tampa General Hospital's consult service.

9. I work in two university-based training clinics. As a supervising physician at the University of South Florida's Silver Child Development Center, my role is to function as a clinical supervisor and instructor. Psychiatry residents and child psychiatry residents serve as primary patient evaluators and clinicians. I also evaluate new patients directly and then see patients as needed. I oversee the residents' work product and function as the physician of record. In this clinic, I evaluate and treat pediatric patients with gender dysphoria. In addition to these

direct clinical experiences, my duties at the Silver Child Development Center include training residents regarding the treatment of patients, including those with gender dysphoria.

10. Additionally, I am a supervising physician at the University of South Florida's general (adult) psychiatry clinic, the Outpatient Psychiatry Center. My duties at the Outpatient Psychiatry Center include supervising and instructing psychiatry residents. At this clinic, general psychiatry residents serve as primary patient evaluators and clinicians. I evaluate new patients directly and see them as needed afterward. I oversee the residents' work product and function as the physician of record. As part of my role in this clinic, I evaluate and treat adult patients with gender dysphoria.

11. I have worked juvenile corrections at various facilities since I graduated from the Forensics Fellowship in 2005. I also treat patients with gender dysphoria at seven juvenile correctional centers I actively cover in the vicinity of Tampa, Florida. I have also been consulted to provide a second opinion and coordinate care regarding a patient with gender dysphoria in the Louisiana juvenile correctional system.

12. I have advocated for the expansion of Federally Qualified Health Centers, along with improved mental health collaboration within primary care settings (Kaliebe, 2016, 2017). I have presented at the Preventing Overdiagnosis conference in Oxford, England, in 2014, and at the National Institutes of Health (NIH) in Bethesda, Maryland, in 2015. The Preventing Overdiagnosis conferences examine how physicians, researchers, and patients can implement solutions to the problems of overdiagnosis and overuse in the healthcare system.

13. I am a member of the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Psychiatry and the Law, and the American Psychiatric Association. I am also a member of the Open Therapy

Institute, Therapy First, and Heterodox Academy. I co-chair the Heterodox Academy Campus Community at the University of South Florida.

14. I have been very active in the AACAP since I joined in 2000 and have presented at its annual conference 26 times. I was awarded the status of a Distinguished Fellow at AACAP in 2016. I served as co-chair of AACAP Media Committee from 2013 to 2021 and was an author on AACAP's clinical practice guidelines for telepsychiatry. In addition, I served as the liaison between AACAP and the American Academy of Pediatrics from 2016 to 2022. I have also served AACAP through its state affiliates, acting as secretary-treasurer of the Louisiana Council for Child Psychiatry for four years and as president for two years. I was also a member of the Association for Behavioral and Cognitive Therapies from 2004 to 2016.

15. I have extensive experience in psychotherapy and have received additional training in cognitive behavioral therapy and trauma-focused therapies. Throughout my career, I have provided psychotherapy and taught psychotherapy to psychiatry trainees. I currently routinely supervise psychiatry residents at the University of South Florida regarding psychotherapy. From 2007 to 2016, I created and taught a cognitive behavioral therapy practicum for LSU residents.

16. I routinely present and speak on the topic of gender dysphoria at prominent academic conferences both nationally and internationally. Recent presentations of mine include "The recommendations of the Cass Review: What clinicians need to know" at the 2025 AACAP annual meeting in Chicago and "Comparison of Clinical Guidelines for Pediatric Gender Dysphoria: What is the Role of Systematic Reviews" at the 2025 American Psychiatric Association (APA) annual meeting in Los Angeles. And I have published or co-authored 4 peer-reviewed articles on the topic of gender dysphoria, the latest being "Obstacles to progress in paediatric gender medicine" (Kozlowska et al., 2025). I was a coauthor

on the U.S. Department of Health and Human Services Report, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (HHS, 2025a). A complete account of my professional experience and publications is provided in my curriculum vitae, which is attached as Exhibit A.

II. **Summary**

- Biological sex is binary and immutable, while a person's self-perceived gender is a subjective and unfalsifiable.
- Gender dysphoria in children and adolescents involves diverse etiologies and demographics.
- Children with gender dysphoria are the most studied population. They are mostly male and the majority of them will naturally grow out of their discomfort by puberty.
- Adolescents with gender dysphoria (who generally did not experience it as children) are a novel population, exploding since the mid-to-late 2000s. They are mostly female and often exhibit psychiatric comorbidities, trauma, neurodivergence, and transgender identification. A large proportion, likely a majority, of this population will naturally desist from a transgender identification.
- The differences between these populations caution against extrapolating from one to the other. Further, both children and adolescents are very different from adult transsexuals. Grouping children, adolescents, and adults together under the "transgender" umbrella masks that they are distinct populations.
- There are three competing models for treating gender dysphoria in young people: exploratory psychotherapy, watchful waiting, and the "affirming" model of care.
- Evidence-based medicine relies on systematic reviews to synthesize the highest quality evidence and the *GRADE* framework to evaluate whether a body of evidence supports clinical guidelines. Low-quality evidence cannot justify interventions with unproven benefits and possible harms.
- While many medical institutions promote the "affirming" model of care, it is not evidence-based.
- Social transitioning for children is a potent psychiatric intervention without proven benefits. It strongly predisposes a child to continue in a transgender identification that would otherwise resolve itself while increasing the likelihood that the child embarks upon medical interventions.

- Endocrine and surgical interventions to treat gender dysphoria are not evidence-based, have no proven benefits, and lead to many possible harms.
- The state of Washington is going to extraordinary lengths to promote policies for foster families that are aligned with strident ideological views toward how to support and care for gender nonconforming children. To justify these policies, the state must morally elevate questionable parenting approaches such as social transition and misrepresent the clinical research regarding child development and outcomes for gender nonconforming children.

III. The etiology of gender dysphoria.

A. Sex is binary and biological while gender is subjective.

17. The basic biology of human beings is as a sexually dimorphic species. Sex is binary and determined at conception (Dougan, 2025). Sex is well-defined in all biological sciences, including medicine, and is programmed into every cell in the human body (Bhargava et al., 2021). Sex is important in human development and throughout the lifecycle and influences many aspects of human behavior (Bhargava et al., 2021; Archer, 2019).

18. While gender and sex were long used interchangeably in medical writing, they are no longer synonyms in the medical literature. As noted by Bhargava et al. (2021), "The terms sex and gender should not be used interchangeably. Sex is dichotomous, with sex determination in the fertilized zygote stemming from unequal expression of sex chromosomal genes. By contrast, gender includes perception of the individual as male, female, or other, both by the individual and by society; both humans and animals have sex, but only humans have gender" (p. 220). "Sex often influences gender, but gender cannot influence sex" (Bhargava et al., 2021, p. 228).

19. The term "gender non-conforming" refers to individuals whose behavior, interests or sexual orientation does not align with the traditional sex

stereotypes. Being gender non-conforming is not pathological nor does it induce the need for any psychological or medical intervention.

20. The term "gender identity" was introduced in the 1960s and originally meant a person's knowledge that they belong to a particular sex—the awareness of being male or female (Byrne, 2023). Originally, it did not encompass any conception of sex beyond male or female (i.e., non-binary, two-spirit, asexual, etc.), nor any subjective sense of self as transgender. Rather, it referred to the typical awareness developed in infancy that a person is a member of one of the two sexes. As Archer & Lloyd (2002) note, the term really meant a person's "sex identity" (p. 67, fn. 1).

21. In the last decades, gender identity has developed new meanings with novel, unclear, and more mysterious connotations. As the gender identity concept became intertwined with postmodern theories, both gender and gender identity became dissociated from biological sex. As noted by Joyce (2021), "gender is no longer even something that is performed. It is innate and ineffable: something like a sexed soul" (p. 2)

22. "Gender identity" now commonly refers to a person's internal sense of being a man, a woman, or something else. The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) 8 define gender identity as a "person's deeply felt, internal, intrinsic sense of their own gender." Hence, the term "transgender" is typically explained in terms of gender identity: a transgender person's gender identity does not align with the person's sex.

23. The core issue with this definition of gender identity is that it is circular (Byrne, 2025). Gender identity refers to a person's subjective sense of self as man or woman, and a man or woman is whatever a person perceives themselves to be. The terms "deeply felt," "internal" and "intrinsic," do little to characterize this amorphous construct.

24. So while these terms are commonly used in literature, they are ill-defined (Byrne, 2023). Many outside of medicine assume gender identity is a coherent and well-grounded concept. In fact, it remains controversial. As the DSM-5-TR recognizes, "[t]he area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines" (American Psychiatric Association [APA], 2022, p. 511).

25. Importantly, gender identity has no objective aspect, such as an identifiable biological underpinning. Rather, it is a subjective, unverifiable, and unfalsifiable concept dependent entirely on a person's self-report. "Gender identity is a psychological concept that refers to an individual's self-perception; while associations between gender identity, neuroanatomic, genetic, and hormone levels exist, a clear causative biological underpinning of gender identity remains to be demonstrated" (Bhargava et al., 2021, p. 226).

26. While there are different uses of the term "gender" (Byrne, 2025), in this report, I will not use "gender" to refer to the biological distinction between men and women but will use the terms sex, biological sex, or natal sex for clarity.

B. Intersex conditions or DSDs do not negate the sex binary.

27. Some advocates and authors have used disorders of sexual development (DSDs), sometimes also known as intersex conditions, to suggest that the biological sex binary is false, thereby lending support to the idea that transgender identities and gender dysphoria are a natural (and therefore healthy) biological phenomenon. This conflates two distinct phenomena.

28. Intersex conditions are rare biological and developmental disorders, not psychiatric disorders. They are objective physical conditions in which treatment does not depend on the person's internal sense of identity or future goals of embodiment.

29. Some activists have falsely claimed that intersex conditions prove that sex is a spectrum. The presence of intersex conditions does not negate the sex binary, nor do DSDs "constitute a third sex" or a sex somewhere in between male and female (Dougan, 2025). Rather, they all involve atypical variations of the male and female sexes.

30. Indeed, intersex conditions can be thought of as the exceptions that prove the rule. For example, some females are born with Mayer-von Rokitansky-Küster-Hauser syndrome, which is characterized by a lack of menstruation after puberty. These women are generally born without a uterus or womb and cannot carry a child. No one would suggest that this congenital condition means these women are not women. Similarly, some males are born with Klinefelter syndrome, characterized by karyotype 47 XXY. They may suffer from fatigue, infertility, and other symptoms from their unique genetic trait. Again, no one would suggest that these men are not men because of their syndrome.

31. In other words, the ways in which intersex conditions diverge from typical male and female characteristics reveals that sex is binary. To make further ontological claims about the nature of sex and the human body is both reductive and misleading. The vast majority, somewhere around 99%, of persons with DSDs are and identify as either male or female (Kreukels et al., 2019).

32. Further, the overwhelming majority of children and adults who identify as transgender are biologically typical males or females, meaning they have standard XX chromosomes and female anatomy (for females who later identify as "transgender men") or XY chromosomes and male anatomy (for males who later identify as "transgender women"), with typical gonadal and hormonal development consistent with their biological sex (Pang et al., 2018; Cankaya et al., 2021). In fact, the ICD-10 (the International Classification of Diseases, 10th revision — the World Health Organization's medical classification system), and previous iterations of the

DSM specifically excluded the transsexualism diagnosis under conditions of chromosomal abnormalities (Meyer-Bahlburg, 1994).

C. Gender dysphoria is a psychiatric condition involving distress because of a felt incongruence between a person's body and self-perception.

33. Gender dysphoria is like depression, anxiety, and other mental disorders and is not among the most severe and persistent illnesses such as schizophrenia, Level 3 autism, or bipolar disorder. That is, gender dysphoria shares more phenomenological and clinical similarities with depression and anxiety disorders than with severe persistent mental illnesses like schizophrenia or severe autism. Like depression and anxiety, gender dysphoria is primarily characterized by subjective emotional distress and psychological discomfort. Gender dysphoria can arise at any age and can spontaneously remit.

34. In contrast, severe persistent conditions like schizophrenia or severe autism involve fundamentally different core features, such as schizophrenia's features psychotic symptoms including hallucinations, disorganized thinking, and negative symptoms. These are chronic, biologically driven illnesses with marked reality-testing and global impairment across functional domains.

35. The DSM-5 provides that the diagnostic criteria for gender dysphoria in adolescents are:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least six months, as manifested by at least two of the following symptoms:

- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender

- A strong desire to be of the other gender (or some alternative gender different from one's sex).
- A strong desire to be treated as the other gender (or some alternative gender different from one's sex).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's sex).

- The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(APA, 2022, p. 512).

36. The criteria for gender dysphoria in children (prepubertal, typically under age 12–13) are similar:

A. **A marked incongruence** between one's experienced/expressed gender and assigned gender, lasting **at least 6 months**, as manifested by **at least 6** of the following criteria (and **at least one** must be the first criterion):

- A strong desire to be of the other gender (or some alternative gender different from one's sex) **or** an insistence that one is the other gender (or some alternative gender) *(this criteria must be present).*
- In males, a strong preference for cross-dressing or simulating female attire; or in females, a strong preference for wearing only typical masculine clothing and a strong resistance to wearing typical feminine clothing.
- A strong preference for cross-gender roles in make-believe or fantasy play.
- A strong preference for the toys, games, or activities stereotypically used by the other gender.
- A strong preference for playmates of the other gender.
- A strong rejection of toys, games, and activities typical of one's assigned gender.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match the experienced gender.

B. Additionally, the condition must be associated with **clinically significant distress** or **impairment** in social, school, or other important areas of functioning.

(APA, 2022, pp. 512–23)

37. While gender dysphoria is viewed by some as a serious medical or psychiatric illness, others have also viewed it as a developmental adaptation to psychological problems, or an issue of sexual minority rights (Levine, 2016). These beliefs about the nature of gender dysphoria will affect clinicians' treatment approach and the expectations of individuals experiencing gender dysphoria.

D. The "transgender" umbrella masks distinct populations and conditions.

38. The increasingly broad label of transgender, or even LGBTQ+, often referred to as "umbrella" terms, has led a diverse group of gender non-conforming patient populations to be labeled by one name. This one designation (transgender) and one diagnosis (gender dysphoria) hide the diversity of these populations.

1. Gender non-conformity is not pathological or unhealthy.

39. Throughout human history there have always been children and adolescents who don't act like "typical" boys or girls (i.e. tomboys). Both children and adult humans naturally display a spectrum of what is considered typically masculine and feminine behaviors. Gender norms also continue to evolve and differ across societies (Diekman & Eagly, 2000).

40. Labeling young people, particularly children, as gender "diverse" or "transgender" because of atypical gendered behavior is inappropriate. While a gender nonconforming child or adolescent *might* also experience gender dysphoria, there is nothing pathological or unhealthy for a male to be feminine or for a female to be masculine (American Psychological Association, 2015).

41. The DSM-5-TR notes that gender non-conformity alone (e.g., gender-atypical behaviors or preferences without marked distress or the core

incongruence/insistence) does not meet criteria for gender dysphoria (APA, 2022, p. 512–23). And for each iteration of what is now gender dysphoria in the DSM-5 (previously transsexualism and then gender-identity disorder), studies have identified populations of children who experienced some level of gender non-conformance but were "subthreshold" for the DSM diagnosis (Zucker 2010, Wallien & Cohen-Kettenis, 2008). This reinforces that behaviors outside typical sex stereotypes do not call for interventions.

2. Children with early onset gender dysphoria are a unique group whose distress will naturally resolve itself.

42. Literature has long been aware of children who, before puberty, express a transgender identity or a distress related to their body and atypical traits not fitting the sex stereotypes (Green, 1976; Zucker et al., 1997). Green (1987) conducted a landmark 15-year prospective follow-up study of 66 "feminine" boys (often exhibiting cross-gender behaviors and preferences, termed the "sissy boy syndrome") compared to masculine controls, finding that approximately three-quarters of the feminine boys grew up to identify as homosexual or bisexual in adolescence or adulthood, while nearly all controls remained heterosexual. The work suggested early gender-atypical behavior as a strong predictor of later same-sex orientation.

43. This group of children with gender dysphoria have historically been disproportionately male (Wood et al., 2013). When they grow up, they will mostly end up being same-sex attracted adults although many will grow up to be bisexual or heterosexual also (Singh et al., 2021; Drummond et al., 2008). These outcome are substantially more likely than having an enduring transgender identity as an adult *absent* interventions like social transition or endocrine supplements (Singh et al., 2021)

44. These young people may intrinsically have higher risks of psychiatric disorders. They may also experience hostility and social stigma in some settings. But the important part is that they will generally grow up to be same-sex attracted adults.

45. Children experiencing distress over their gender incongruence should be made to feel comfortable with themselves and be provided space to develop their interests within a safe and nurturing environment. They should not be told they are the other sex or "transgender," that they need to change their body parts, or that they may have a brain of the other sex. This is inappropriate and can be harmful because this distress will naturally resolve itself in the majority of children who will reconcile their thoughts and feelings with their natural bodies and/or naturally desist from a transgender identity (Zucker, 2018; Cantor, 2019; Singh et al., 2021). As Cantor (2019) explains, this claim is well-grounded in the literature (citing Lebovitz, 1972; Zuger, 1978; Money & Russo, 1979; Zuger, 1984; Davenport, 1986; Green, 1987; Kosky, 1987; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Singh, 2012; Steensma et al., 2013).

46. The 2018 article by Julia Temple Newhook and colleagues, titled "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children," critiques four key longitudinal studies (from clinics in Toronto and the Netherlands) that reported high "desistance" rates (73–88%) among gender-nonconforming children. Temple Newhook et al. (2018) argue that these rates are inflated and misused to discourage early social transitions. The authors assert methodological weaknesses, such as including subthreshold cases (up to 40% not fully meeting DSM criteria for gender identity disorder), assuming lost-to-follow-up participants (22–32%) desisted without evidence, conducting follow-ups at relatively young ages (16–23 years mean), and limiting samples to clinic-referred children without considering

affirming environments or cultural contexts, which undermines generalizability and overestimates desistance.

47. The expert report of Matt Goldenberg (disclosed to Plaintiffs during the discovery process) also critiques the studies showing high desistance rates and seems to mirror Temple Newhook's criticism specific to two studies by Steensma et al. (2011, 2013) (Goldenberg, pp. 31–33). According to Goldenberg, the 2011 article in particular contains "a serious methodological flaw" and cannot be "utilized in any serious discussion of how to best care for gender diverse youth" (p. 32).

48. These criticisms lack merit for at least two reasons. First, Temple Newhook et al. (2018) and Goldenberg criticize the Steensma studies for failing to accomplish something they never attempted to do. "[B]oth studies did not aim to report on the prevalence of desistence or persistence of GD" (Steensma & Cohen-Kettenis, 2018, p. 225). As noted by Zucker (2018), the sub-threshold participants were transparently included based on the broader (DSM-III/IV) gender identity disorder criteria at the time, and the follow up underscores that many such cases involve transient gender nonconformity, not inflating desistance but highlighting natural variability in outcomes. Excluding this large population, many of which today in certain communities may be put under the "transgender" child umbrella, would distort understanding of the full range of developmental trajectories. Furthermore, Steensma and Cohen-Kettenis (2018) note that "[t]he first comprehensive and inclusive summary of historical follow-up studies on the psychosexual outcome in gender variant children was provided by Zucker and Bradley (1995). Later, these numbers were updated in Steensma et al. (2011) and updated again and further discussed in Ristori and Steensma (2016)" (p. 225), reinforcing that research literature had already provided data to calculate the overall persistence rate prior to the four studies examined by Temple Newhook et al. As such, Temple Newhook et al. (and Goldenberg) functionally ignore a

"comprehensive and inclusive summary of historical follow-up studies" (Steensma & Cohen-Kettenis, 2018, p. 225) that document the temporary nature of childhood gender-related distress and support the over 80% rates of desistance.

49. Second, the criticism about inclusion criteria and children lost to follow up also misses the mark. As Steensma and Cohen-Kettenis (2018) explain:

> the suggested reasons why nonresponders may actually be persisters are unlikely and farfetched. For instance, the authors suggested that children were lost at follow-up because they moved out of the country, were being treated elsewhere in the Netherlands, or institutionalized. The chance that one of these situations occurred is, however, very low. The few families that had to go abroad for some time usually stayed in touch with the clinic, because in those days there were hardly any gender identity clinics for children and it was extremely difficult to get a prescription of puberty-blocking hormones. Besides language barriers and insurance problems, this would have been a major reason why going to clinics abroad out of dissatisfaction with the Dutch clinic would have been hard. Going to another Dutch clinic was not an option either (pp. 226–27).

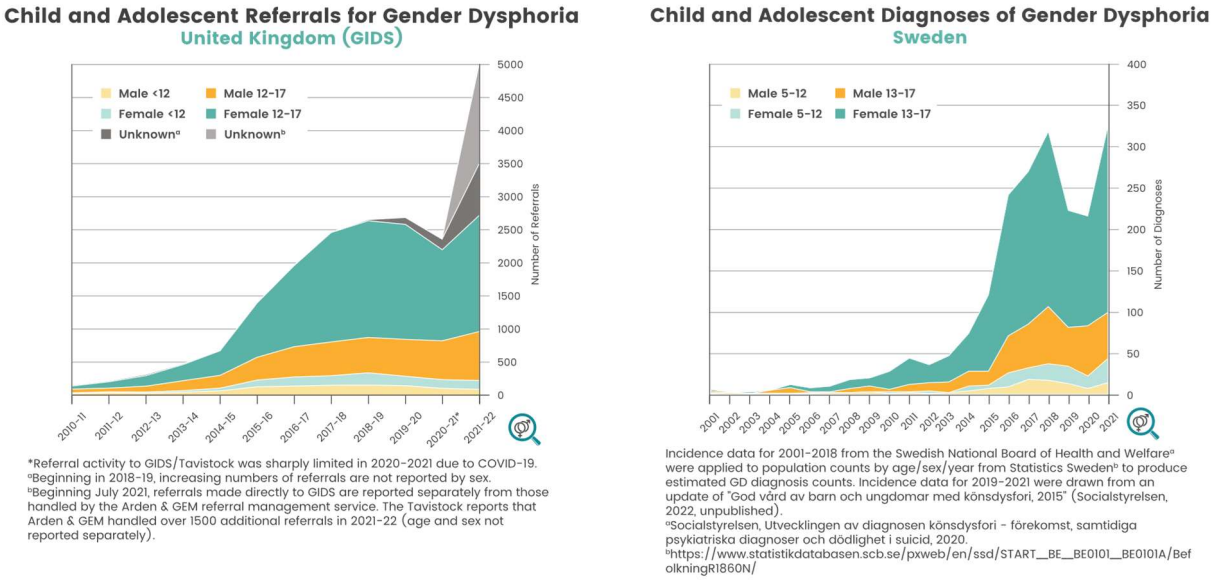
50. Children will naturally display a spectrum of stereotypically girlish or boyish behavior. And most children who experience distress because they don't "feel" like they are a boy or a girl will naturally grow out of it. Labeling these children "transgender" seems more of a politically expedient term than typical medical or mental health nosology.

3. The recent explosion of gender dysphoria among adolescents points to sociological phenomenon.

51. As the number of young people expressing gender dysphoria has increased, the largest increase has occurred among a novel cohort of preadolescent and adolescent females, who typically exhibit minimal or no prior history of gender non-conformity or gender-related distress (Aitken et al., 2015; de Graaf et al., 2018; Littman, 2018; Zucker, 2019).

52. This population has skyrocketed in recent years. For example, in England, a study analyzing primary care data from 2011 to 2021 found the

incidence rate of gender dysphoria in minors rose from 0.14 to 4.4 per 10,000 person years, a 50-fold increase (Jarvis et al., 2025). This was most marked in 17–18-year-olds (Jarvis et al., 2025). Similar increases are found especially in industrialized Western countries, many showing over 1000% rises in gender dysphoria over the last decades (Marianowicz-Szczygiel, 2022).



The graphs above were created by the Society for Evidence Based Gender Medicine (https://segm.org/) and were drawn from data from the Tavistock clinic and the Swedish National Board of Health and Welfare, respectively.

53. The same phenomenon has occurred in the United States. An investigative report of U.S. clinical data on gender dysphoria diagnoses among youth (ages 6–17) between 2017 and 2021, using counts reported in a large-scale analysis of insurance claims and healthcare records, shows that diagnoses nearly tripled over five years, rising from 15,172 in 2017 to 42,167 in 2021. The sharpest increase occurred between 2020 and 2021, suggesting accelerating dysphoria during the Covid-19 pandemic (Respaut & Terhune, 2022). This trend reflects diagnosed gender dysphoria, not general transgender identification, and is based on clinical data.

54. “A rise of this magnitude suggests that what is being measured is not merely an increase in a previously understood clinical condition but the emergence of a new sociocultural phenomenon.” (Schwartz & Lal, 2025, p. 1001, citing Jarvis et al., 2025).

55. This large increase has been termed Rapid Onset Gender Dysphoria (ROGD) as detailed in Dr. Lisa Littman’s 2018 landmark paper (Littman, 2018), and elsewhere (Kaltiala et al., 2015; Hutchinson et al., 2020). As these papers explore, adolescent onset gender dysphoria appears to relate to social and online factors because the marked increase in cases coincides with the first generation of young people prolifically accessing the internet and encountering slogans and memes like: some people are “born in the wrong body”; sex change is possible; and transitioning may be a solution to bodily discomfort. It also appears to be a consequence of the push to indoctrinate young people into a system of thought which prioritizes gender identity and devalues biological sex.

56. The traditionally seen and described population with early onset gender dysphoria differs markedly from the recent cohort of adolescent-onset cohort in several key ways: the childhood-onset group is predominantly male, with symptoms often emerging in early childhood, and has remained relatively stable in numbers and presentation over decades (Wood et al., 2013). This group typically shows lower rates of severe psychiatric comorbidities beyond the gender distress itself. As noted previously, they will most likely grow into adults with same sex attraction without a persistent transgender identity.

57. In sharp contrast, the adolescent-onset group is predominantly female (assigned female at birth, often 70-80% in recent clinic data) and experiences onset around puberty without prior childhood signs. This population was effectively non-existent in gender clinics before ~2010 but has exploded dramatically since then (Aitken et al, 2015; de Graf et al, 2018). These adolescents also present with

substantially more comorbidities such as anxiety, depression, autism, trauma history, self-harm, and other psychiatric disorders that often predate the gender dysphoria (Kennedy et al., 2025; Marconi et al., 2023; Thompson et al., 2022).

58. Because of the differences between these groups, it is scientifically and medically inappropriate to assume that what we know about the longstanding and better characterized childhood-onset gender dysphoria population applies to the adolescent-onset population. The two groups differ in demographics (sex ratio reversal), timing/onset, prevalence trends, and comorbidity burden, all of which suggests a new phenomenon is at play and that direct extrapolations from one group to the other are invalid and potentially harmful without separate, rigorous research on this newer cohort (Zucker, 2019).

59. Some have disputed that the surge in adolescent onset gender dysphoria reflects a new phenomenon and instead claim that it simply reflects previously hidden cases coming to light (Goldenberg, pp. 12–14). This claim is not consistent with the data. In the 1990s and early 2000s, gender clinics in the Netherlands, UK, and North America saw only a handful of referrals per year who were overwhelmingly prepubertal boys with classic early onset gender dysphoria that had been evident since toddlerhood (Wood et al., 2013; Marianowicz-Szczygiel, 2022). By contrast, referrals exploded after 2014—rising 4,000% or more in many Western clinics (Marianowicz-Szczygiel, 2022). And whereas children presenting to gender clinics were disproportionately male, now there has been a complete reversal of the sex ratio with ~70% or more of referrals being female (Aitken et al., 2015, de Graaf, 2018; Zucker, 2019). Such an abrupt, multi-thousand-fold increase occurring in just 5–10 years, concentrated in a narrow adolescent window and reversing the historic sex ratio, is implausible for a condition that has supposedly always existed at similar prevalence but was simply "undiagnosed" (Schwartz & Lal, 2025). No other psychiatric or medical condition has ever been hidden so effectively across

entire generations, then revealed almost overnight. Instead, the timing and pattern closely track the well-documented, real epidemic of adolescent mental health deterioration since ~2010 (sharp rises in depression, anxiety, self-harm, and suicidality, especially among girls), which broader epidemiological literature universally accepts as genuine and not merely the result of increased awareness (Twenge, 2020; Keyes, 2019).

60. Goldenberg further argues that "cisgender" identities should be evaluated the same way for desistance or persistence rates:

> Note that researchers do not seem to be concerned that cisgender youth may identify as cisgender due to social influence, although there are clear social and economic benefits to identifying as cisgender. Additionally, cisgender people appear to outnumber gender diverse people, and so if social contagion was the cause of gender identity, it would be unlikely that many individuals would identify as gender diverse because most people are likely to know and associate with more cisgender people than gender diverse people (p. 12).

61. This ignores fundamental unknowns regarding whether transgender identities are, in fact, psychologically healthy, normal variants. Furthermore, social contagion theories (well-established for phenomena like eating disorders, self-harm, or internet acquired tic disorders) predict spread within susceptible networks or vulnerable subcultures, not uniform population-wide adoption (Alho et al., 2024). Contagion operates selectively among distressed or impressionable young people facing mental health crises (Twenge, 2020), not as a broad societal force overriding biology or norms for everyone.

62. Positing "clear social and economic benefits" to having a gender identity which matches your biology while implying the reverse for transgender-identifying youth ignores many contemporary progressive contexts in which friends, counselors, or partners may encourage or pressure a person to adopt a transgender identity, or other contexts in which identifying as sexual minority can confer social approval, community belonging, accommodations, or moral status within certain

circles (Littman, 2021). Indeed, even WPATH has recognized that "[f]or a select subgroup of young people, susceptibility to social influence impacting gender may be an important differential to consider" (Coleman et al., 2022, p. 545). This reinforcement could amplify spread in those environments.

63. As the concepts of gender dysphoria and transgender identity became increasingly visible, discussed, and normalized within childhood and adolescent culture—through media, schools, online communities, and clinical frameworks—they entered the shared lexicon of young people as legitimate ways to name and explain their personal experience and suffering. For many young people already grappling with intense distress from a wide array of sources—such as depression, anxiety, trauma, family conflict, bullying, social rejection, autism-related challenges, emerging same-sex attraction, academic pressure, body-image issues, or the broader adolescent mental health crisis—this new language provided a ready-made, socially recognized framework to articulate feelings of alienation, disconnection from one's body, or a desire to escape current circumstances. In this way, identifying as transgender or experiencing gender dysphoria sometimes functioned less as a fixed, innate orientation and more as an expressive outlet or coping narrative for complex, multifaceted pain that might otherwise have been labeled differently in earlier eras, illustrating how cultural availability of diagnostic and identity categories can shape how young people interpret and communicate their internal turmoil. The history of psychosomatic illness is full of examples of this cultural interplay (Shorter, 1994).

64. For example, trauma may be another contributing factor. It has long been known that cross-sex identification can arise after trauma (Cosentino et al., 1993; Withers, 2020). Transgender-identifying people have experienced a higher incidence of trauma than the general population (Brewerton et al., 2022; Gehring &

Knudsen, 2005, Biedermann et al., 2021), raising the possibility that trauma exposure can lead to a transgender identity and gender dysphoria.

65. Attachment theory, which emphasizes the importance of a secure emotional bond between a child and their primary caregiver (Bowlby, 1969; Ainsworth, 1978), supports this possibility. When caregivers are consistently responsive and attuned to a child's needs, the child is more likely to develop a secure attachment, which fosters resilience, self-worth, and a coherent sense of identity. Conversely, insecure or disrupted attachments can lead to difficulties in emotional regulation, relationship building, and self-concept. Ultimately, the quality of early attachment relationships shapes not only how children see themselves but also how they relate to others throughout life.

66. Research indicates a significant association between insecure attachment styles and elevated rates of gender dysphoria or transgender identification, often intertwined with adverse childhood experiences and trauma. In a study of children and adolescents with gender dysphoria, participants predominantly exhibited high-risk attachment patterns and unresolved loss/trauma, comparable to those in mixed psychiatric groups but markedly higher than non-clinical controls, with factors like maltreatment and family disruption exacerbating these risks (Kozlowska et al., 2021).

67. Similarly, among adults diagnosed with gender dysphoria, insecure attachment representations—particularly preoccupied and fearful styles—correlate with complex trauma histories (Giovanardi et al., 2018), suggesting early relational disruptions may contribute to gender-related distress via maladaptive self-protective strategies (Withers, 2020).

68. Another exploration found that attachment insecurity influenced psychotherapeutic engagement in gender dysphoric patients, with internal working models shaping identity formation and treatment outcomes (Lingiardi et al., 2017;

Vitelli & Riccardi, 2011). These patterns highlight how attachment disturbances may amplify the likelihood of transgender identification and gender dysphoria and can worsen outcomes. For the dependency care system, this underscores the need for a focus finding parents that can form strong attachment bond with the children they foster and encouraging the use of attachment-informed interventions.

69. Studies suggest that children in foster care have disproportionate rates of gender dysphoria or transgender identification. For example, a key UK study found that looked-after children (akin to children in foster care) were overrepresented among those referred to the Gender Identity Development Service (GIDS), comprising 4.9% of GIDS referrals, despite representing only about 0.58% of England's general child population. Adopted children accounted for an additional 3.8% of referrals. These were substantially higher rates of transgender identification or gender dysphoria compared to the broader population (Matthews et al., 2019). Some American studies have also suggested overrepresentation in the U.S. foster-care system (Baams et al., 2019; Fish et al., 2019). This also supports the thesis that trauma is a common contributing factor to bodily discomfort and gender dysphoria (Cass, 2024) (noting overrepresentation of looked after children along with higher rates of adverse childhood experiences, autism, and mental health difficulties).

70. To be clear, these studies do not purport to show that LGBT identification *causes* overrepresentation in foster care, nor do they establish whether a child's pre-existing mental health issues, trauma, or family dysfunction may have contributed to their gender dysphoria. The point here is merely that, to the extent that children identifying as transgender or non-binary are overrepresented in the foster-care system, it would support the observation that trauma contributes to gender dysphoria diagnoses and/or a person's discomfort with their body.

71. Further, as I discussed earlier with respect to adolescent-onset gender dysphoria, research shows higher rates of transgender identification among populations with psychiatric and neurodevelopmental conditions, like autism, as well as ADHD (Warrier et al., 2020; Hisle-Gorman et al., 2019; Kahn et al., 2023; Thrower et al., 2020).

4. There is no reliable method to determine whether gender dysphoria will persist in children or adolescents.

72. As noted in the United Kingdom's Cass Review, "[c]linicians are unable to determine with any certainty which children and young people will go on to have an enduring trans identity." (Cass, 2024, p. 22).

73. Although children with gender dysphoria are the most extensively studied cohort, there remains no reliable method to predict whether any specific child's gender dysphoria will persist into adulthood due to the probabilistic nature of identified factors, methodological limitations in longitudinal studies, and the influence of variable social and environmental factors (Zucker, 2018). Promoters of pediatric medical interventions, such as the Endocrine society, acknowledge that "we cannot predict the psychosexual outcome for any specific child" and that "the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence" (Hembree et al., 2017, p. 3876).

74. There is even less data and more reasons to be concerned about long term persistence for the new cohort of adolescents or children with near-pubertal onset of gender dysphoria, which is now the largest cohort. This group seem particularly unstable in their gender dysphoria. For example, Bachmann et al.'s (2024) review of German insurance data revealed "diagnosis persistence was below 50% in all age groups," with only 27.3% persistence for the cohort of 15–19-year-old females (p. 370). This is consistent with a Dutch study on "gender non-contentedness" showing that 19% of adolescents expressed unhappiness with their

gender in adolescence but no longer did so in adulthood compared to only 2% of adolescents who had an increasing discontentedness (Rawee et al., 2024). A non-academic review of US insurance data showed the same downward-sloping trend (Sapir, 2024). There has been no developed instrument or clinical approach to ascertain which adolescents will have a persisting transgender identity.

75. Furthermore, there has been increased visibility and discussion regarding the desistance and detransitioning of those who have expressed a transgender identity and even undergone an endocrine or surgical intervention. It is still difficult to determine exact numbers, but detransitioners are emerging at increasing rates (Littman, 2021; Vandenbussche, 2022). The amount of desistance and detransitioning is far more than the extremely low rates proposed in some of the literature (Bustos et al., 2021) (suggesting less than 1% regret surgical procedures). The low quality of studies on this topic obscures the true number (Cohn, 2023). What is clear is that some unknown percentage will reassume a gender identity consistent with their natal sex, even after irreversible procedures (Jorgensen, 2023; Steensma et al., 2011).

76. Further, detransitioning rates do not fully capture the prevalence of regret. "For example, there are those who both regret and detransition, those who regret medical intervention but feel detransition is impractical given their physical changes, those who do not report regret but would have preferred, in retrospect, to not have medicalized, and those who think that their medical intervention was inappropriate; all of these outcomes provide important information." (Cohn, 2023, p. 1937).

77. The upshot is that labeling a child or an adolescent "transgender" masks distinct populations exhibiting different demographics (male-heavy early-onset vs. female-heavy adolescent-onset), different comorbidity profiles, and

different etiological factors. And for most of these young people across age groups and sexes, gender-related distress is fleeting.

5. Children and adolescents are distinct from adult transsexuals.

78. Children and adolescents experiencing gender dysphoria are distinct from later onset adult transsexualism, a group that medical literature has been aware of for some time.

79. We have known for decades that, among males, there are two developmental pathways leading to gender dysphoria in adulthood: early-onset (the focus here) and late-onset. Further, Blanchard (1989) divided male adults into homosexual and autogynephilic transsexuals. The motivations and psychological profiles of these two sub-types are quite different in and of themselves, and both profoundly different from those experiencing early onset or adolescent onset gender dysphoria.

80. The adult onset gender dysphoria typically appears after puberty, with less childhood femininity, non-homosexual orientations (gynephilic, bisexual, or asexual), and often with a history of autogynephilia—erotic arousal at the thought of oneself as female, sometimes linked to transvestic fetishism. These individuals tend to transition later in life, often in their 40s or beyond, and represent a fundamentally different clinical presentation driven by paraphilic motivations rather than innate cross-gender identity from childhood (Blanchard, 1989, 1991; Blanchard et al., 1987; Lawrence, 2010, 2017).

81. For females, adult onset gender dysphoria also represents a distinct clinical population that differs markedly from the childhood-onset group. Adult-onset females often present in their 20s, 30s, or later with no significant gender nonconformity or dysphoria in childhood. The condition frequently emerges alongside high rates of pre-existing mental health challenges. These differences in

onset timing, comorbidity burden, demographic, and etiological factors make it inappropriate to make generalizations about the adult-onset female cohort based on the better-studied childhood-onset population. Invoking late-onset patients to suggest that early-onset patients might only come out or transition in adulthood is not compelling because it ignores the profound etiological and demographic distinctions between these groups.

82. Referring to all of these groups as "transgender," let alone applying a single treatment model (i.e. the same approach for adult transsexuals and gender-nonconforming children), is contrary to the usual course of medicine, no different from applying different treatments to Type 1 and Type 2 diabetes, or rheumatoid arthritis and osteoarthritis. The early onset boyish girls, depressed teenage girls, same-sex attracted young adults, and middle-aged men with autogynephilia, are extremely different patient populations that require completely different, individualized treatment approaches.

83. The takeaway is that evaluating what the literature says and how treatment models apply to children and adolescents requires careful thought and precision in language. The childhood-onset, adolescent-onset, and adult-onset cohorts (to say nothing about the demographic differences withing these cohorts) represent separate clinical populations, making it inappropriate to conflate them or use one to infer about the other. Unfortunately, even prestigious medical institutions and practitioners in this field eschew this nuance by lumping all of these groups together to promote far-reaching and unsubstantiated claims that the "affirming" model of care is the best and only way to treat young people with gender-related distress.

IV. **Competing models of treatment.**

84. There are at least three different treatment models for gender dysphoria and bodily discomfort in children and adolescents: 1) watchful waiting, 2) psychotherapeutic, and 3) affirming (Zucker, 2020). I will briefly describe them here.

85. The watchful waiting approach is supportive and directly treats psychiatric comorbidities, such as depression and anxiety that frequently co-occur with gender dysphoria. This is a cautious approach based on the principle that there is not a need to interfere with child development without a firm understanding of the potential consequences and that gender dysphoria in children is mostly likely a transitory phenomenon. Not all human suffering should be a target of psychological or medical intervention. With any treatment, there is a potential for medical and psychological harm, wasted resources, and undermining patient independence and self-sufficiency. As gender non-conformity is not pathological, it may be beyond the capacity and understanding of professionals to create interventions that are clearly beneficial and a reasonable use of resources for gender non-conforming individuals.

86. Watchful waiting is a medically valid approach to caring for a child or adolescent with feelings or gender non-conformity or with gender dysphoria. As detailed more fully below, the available literature does not establish that this approach is harmful, nor does it establish that an alternative approach is superior. To the contrary, the high desistance rates among untreated children are encouraging, and treating a young person's comorbidities with approaches that are better-established than any treatment for gender dysphoria follows the "do not harm" principle that is foundational to modern medicine.

87. The second clinical approach is psychotherapeutic, aimed at alleviating distress by applying longstanding and evidence-informed tools of psychotherapy for

patients suffering from gender dysphoria. Proper psychotherapy for gender distress does not impose the ideas of the clinician but can empower patients "to develop creative solutions to their difficulties and promotes agency and autonomy" (D'Angelo, 2023, p. 3).

88. Non-affirming, exploratory psychotherapy is also a medically valid approach to caring for a child or adolescent with gender non-conformity or gender dysphoria (Elkadi et al., 2023). While the available evidence on this approach is thin, it draws upon the traditional skills of the therapist, the longstanding evidence base of psychotherapy in general (Wuthrich et al., 2023), and de-exceptionalizes patients with gender dysphoria. As noted by Hutchinson (2025) "Psychotherapists should therefore approach this group in the same way that they would any other, utilizing their full training and expertise to inform standard clinical best practice. This process should involve thorough biopsychosocial assessment and the development of individualized clinical formulations to guide interventions that aim to alleviate distress and enhance functioning" (pp. 14–15).

89. The traditional approach does not directly challenge a claimed transgender identity, nor do they affirm the patient's narrative or theories. Instead, they permit the patient to continue to express a transgender identity (Hakeem, 2012; D'Angelo et al., 2021), while engaging in a dialogue with the patient regarding these matters without providing the answer. Therapists are aware that an individual is shaped by his or her upbringing, socialization, and life events. Therapists and patients work together to help the patient identify and address why the patient is uncomfortable with his or her sense of self, just as the therapist can help put the patient's other identities (such as racial and ethnic backgrounds, religious or spiritual affiliations, or professions) in perspective. The dialogue in psychotherapy would look for adversity, abuse, and other traumas as potential contributors (Hutchinson, 2025;; Withers, 2020; Gehring & Knudson, 2005).

Therapy explores the influence of exposure to images, ideologies, and modeling, including online. This paradigm also considers fantasy, parental attachment, and psychosexual influences. Therapists who do not use affirming approaches are often forced to hide their viewpoint and therapeutic approach because of both hostile work environments and, in states with vaguely worded "conversion therapy" laws, threats to their license for providing standard ethical psychotherapy (Jenkins & Panozzo, 2024).

90. The third treatment approach is the affirmation model (American Academy of Pediatrics, 2018; Coleman et al., 2022), which promotes affirmation of the transgender identity immediately and decisively. This approach contrasts with the traditional psychotherapeutic approach of exploring potential causative factors, enhancing self-awareness and self-efficacy, and facilitating the patients' ability to cope with comorbidities.

91. Social transition, i.e., living as the opposite sex, includes changing the individual's name, preferred pronouns, and appearance, and is encouraged. This approach considers the body parts and physical features that are associated with dysphoria as targets for treatment. Pursuant to this model, social transition, hormones, and surgeries would be provided without regard, or with minimal regard, toward factors associated with transgender identities, such as trauma, disorders of personality development, internalized or externalized homophobia, and neurocognitive disorders (e.g., autism).

92. Medical transition is the provision of endocrine and surgical interventions to change the body to fit the vision of the young person. This can include puberty blockers, cross-sex hormones, or, less often, surgeries in minors.

V. The entrenchment of the "affirming" model of care.

93. What began as a novel treatment for adults in the mid-20th century has, in the last 40 years, grown to include children and adolescents. These interventions started with something called the Dutch Protocol. Now, many medical organizations, like the World Professional Association for Transgender Health (WPATH) and the Endocrine Society promote the "affirming" model of care as the *only* effective and ethical approach to treating gender dysphoria.

A. Gender "transitioning" began as a treatment for adult transsexuals.

94. Medical and surgical gender transition for adults first gained traction in the mid-20th century, with early hormone therapy and surgeries performed in Europe during the 1920s–1930s (e.g., at Magnus Hirschfeld's Institute for Sexual Science in Berlin). U.S. endocrinologist Harry Benjamin published The Transsexual Phenomenon in 1966, helping to legitimize the approach as medical treatment for severe gender dysphoria.

95. University-based clinics like Johns Hopkins' Gender Identity Clinic (opened 1966) formalized adult care with hormones, surgeries, and protocols, while the Harry Benjamin International Gender Dysphoria Association (later WPATH) issued its first Standards of Care in 1979, solidifying hormones (e.g., estrogen/testosterone) and procedures (e.g., vaginoplasty, phalloplasty) as standard for adults after a safeguarding and vetting process that included living for a year as the other sex. Over subsequent decades, refinements in techniques, media coverage, cultural changes, and policy changes (e.g., allowing Medicare coverage in 2014) led to increased adult medical transitions.

96. In the last two decades, society has increasingly acquiesced to treating the adult-onset gender dysphoric population as "transgender," including via a more liberal provision of hormonal and surgical interventions. In many communities of

adults, it is seen as respectful or kind for others to also go along with a person's claimed gender identity, making the "social transition" more pleasant for the individual. As noted by Stock (2021), "For many people with misaligned gender identities, immersing the self in a fiction of sex change is a way of managing the intense feelings of dysphoria this produces" (p. 190).

97. Even for the adult population, these interventions have known harms, opaque risk-to-benefit ratios, and low quality, uncertain research support. Longitudinal studies on outcomes following gender-affirming hormone therapy and surgeries reveal persistent uncertainties and a history of concerning results, with elevated risks for adverse events remaining in many cohorts despite interventions.

98. The landmark Swedish cohort study (Dhejne et al., 2011) followed 324 individuals post-sex reassignment surgery over a median of more than 10 years and found substantially higher overall mortality (adjusted hazard ratio [aHR] 2.8), suicide mortality (aHR 19.1), suicide attempts (aHR 4.9), and psychiatric inpatient care (aHR 2.8) compared to matched controls of the same birth sex, even after adjusting for prior psychiatric morbidity. Recent population-based studies, such as those in Denmark (Erlangsen et al., 2023) and England (Jackson et al., 2023), similarly report elevated all-cause mortality (aIRR 2.0), suicide attempts (aIRR 7.7), and suicide deaths (aIRR 3.5) among transgender individuals compared to controls (Erlangsen et al., 2023), with risks from external causes (including suicide) remaining high. Other analyses highlight increased suicide attempt risks post-surgery (Straub et al., 2024), and ongoing questions about whether these disparities improve meaningfully long-term, underscoring the need for more robust, prospective research amid methodological debates and mixed findings in the literature (Dhejne et al., 2011).

B. The Dutch Protocol popularized social transitioning and medical interventions for minors.

99. The affirmative approach—the one endorsed by Washington state—has its roots in something called the Dutch Protocol.

100. In the 1990s, a Dutch clinical team noted the poor outcomes in adult gender transitions and sought to attempt earlier interventions (Biggs, 2023a). They applied this approach to a highly selective population of psychologically healthy early onset gender dysphoric youth (de Vries & Cohen-Kettenis, 2012). This protocol offered puberty blockers around age 12, cross-sex hormones at age 16, and cross-sex surgeries at around 18. Two initial reviews of this protocol noted positive outcomes in early adulthood (de Vries et al., 2011, 2014), though, as noted below, the results were neither as positive nor as generalizable as is often thought.

101. The Dutch Protocol can be thought of as an innovative practice when it was first introduced—a novel intervention with some promise but unproven benefits. The Dutch Protocol also began when "it was not uncommon for medical professionals to practice medicine based on 'empirical evidence,' relying on expert opinion and often backed by only minimal research" (Abbruzzese et al., 2023, p. 674). That contrasts with evidence-based medicine (EBM), which prioritizes high-quality clinical research over expert opinions or consensus.

102. Innovative clinical practice can rapidly progress scientific knowledge but also requires early and high-quality clinical research to establish the intervention's benefits and risk-reward ratio. Early research is also important to prevent "runaway diffusion," or the spread of a new or untested intervention that may in fact prove harmful or not beneficial (Earl, 2019).

103. Yet "'[r]unaway diffusion' is exactly what has happened in pediatric gender medicine" (Abbruzzese et al., 2023, p. 675). Without rigorous analysis of existing data and before long-term data became available, this mode of treatment,

including the use of puberty blockers and cross-sex hormones in adolescents, spread worldwide. (Abbruzzese et al., 2023).

104. WPATH first published what they called "Standards of Care" in 1979, and have published updated versions since then in 1980, 1981, 1990, 1998, 2001, 2012 [SOC-7], and 2022 [SOC-8]). SOC-7 explicitly incorporated and endorsed the Dutch Protocol for managing gender dysphoria in adolescents, including the use of puberty suppression followed by cross-sex hormones and eventually surgeries. Clinicians and pioneers of the Dutch Protocol, including Peggy T. Cohen-Kettenis and Annelou L. C. de Vries, contributed to SOC-7 and SOC-8 (Coleman et al., 2012, 2022), placing their Dutch early-intervention model into a document that is often cited as an international guideline.

105. As described further below in § VII.C, the WPATH standards do not satisfy the criteria for clinical guidelines, were infected by conflicts of interests, contain many methodological flaws, and overstate the evidence for social, endocrine, and surgical interventions to promote the "gender-affirming" model as the default and ethically preferred approach.

106. These flaws did not stop other medical organizations from relying on WPATH's guidelines as the authoritative standard. One systematic review of the clinical guidelines published by professional organizations noted that most guidance documents used "a consensus or expert-led approach" that led them to adopt recommendations by WPATH or the Endocrine Society (Taylor et al., 2024c, p. s71). "This relationship may explain why there has until recently been an apparent consensus on key areas of practice for which evidence remains lacking" (Taylor at al., 2024c, p. s71).

107. In short, WPATH "has been highly influential in directing international practice, although its guidelines … lack developmental rigour" (Cass, 2024, p. 28). "This process failure has wide-ranging implications since many

countries, professional organizations, and clinicians have considered WPATH guidelines to be evidence-based and a rock-solid foundation for designing their own guidelines" (Kozlowska et al., 2025, p. 7).

C. No studies have been able to replicate the Dutch Protocol's results.

108. The Dutch Protocol showed modest but statistically significant improvements in some mental health metrics over the course of treating gender dysphoric youth with puberty blockers (de Vries et al., 2011). But as Abbruzzese et al. (2023) explain, there were many problems with taking these results at face value and the rapid spread and institutional entrenchment of the gender-affirming care model far exceed what the Dutch Protocol's design and acknowledged limitations can support. Some of its flaws include:

- A cohort of only 70.
- No follow-up data for 15 patients. In a sample of that size and in a nationalized healthcare system with no other treatment options, this loss to follow-up is significant and could skew the results.
- Selectively chosen patients from a much larger pool, which screened out children with meaningful psychological comorbidities—the bulk of the population currently presenting to gender clinics.
- Limited to childhood onset gender dysphoria, which renders the results not generalizable to the bulk of the patients currently presenting to gender clinics.
- 69 out of 70 patients had same-sex attraction or bisexual orientation, which suggests a narrow, unrepresentative subset of the gender non-conforming population.
- One death from surgical complications, which is an extraordinarily high death rate in a small sample.
- Limited discussion or data regarding potential harms.
- Psychosocial improvements were statistically *but not clinically*, or only marginally clinically significant. The baseline scores were already psychologically healthy, and the improvements were minimal.

(Levine et al., 2022; Biggs, 2023a; Abbruzzese et al., 2023).

109. No study has replicated the Dutch Protocol's initial success despite at least two significant attempts. The Tavistock Clinic in England failed to replicate the results and showed no change in psychosocial metrics (Carmichael et al., 2021). More recently, the Trans Youth Care study in the United States reported no change in psychosocial metrics over the course of treatment with puberty blockers (Olson-Kennedy et al., 2025).

110. To be sure, Olson-Kennedy et al. (2025) speculate that mental health would have declined *without* puberty blockers, but the study did not attempt to prove that, and there are good reasons to doubt this claim. First, in the Tavistock studies, the children who were not initially given puberty blockers but instead were treated with therapy only experienced improvements in mental health (Costa et al., 2015). Second, the authors' reference to older adolescents with greater psychological concerns improperly extrapolates from adolescent-onset to childhood-onset populations. Third, the authors themselves predicted mental health improvements in their publicly disclosed hypothesis (Chen et al., 2023 [Protocol], p. 32). So claiming now that stasis is a positive result is engaging in revisionist history. As explained further below when I review the systematic reviews, the evidence fails to show any association between puberty blockers and mental health.

VI. **Principles of evidence-based medicine.**

111. To establish the groundwork for our discussion of the literature, I will briefly review the principles of EBM. EBM emerged in the early 1990s and represented a foundational shift in standard medical practice. It involves "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996, p. 71).

112. At its core, EBM relies on the principles of the scientific method, including empiricism (objective observations), falsifiability, and repeatability, to

test whether a course of treatment accomplishes what it is intended to do and to continually improve upon the practice of medicine (Popper, 1959; Sestini, 2010). "External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer" (Sackett, 1996, p. 72).

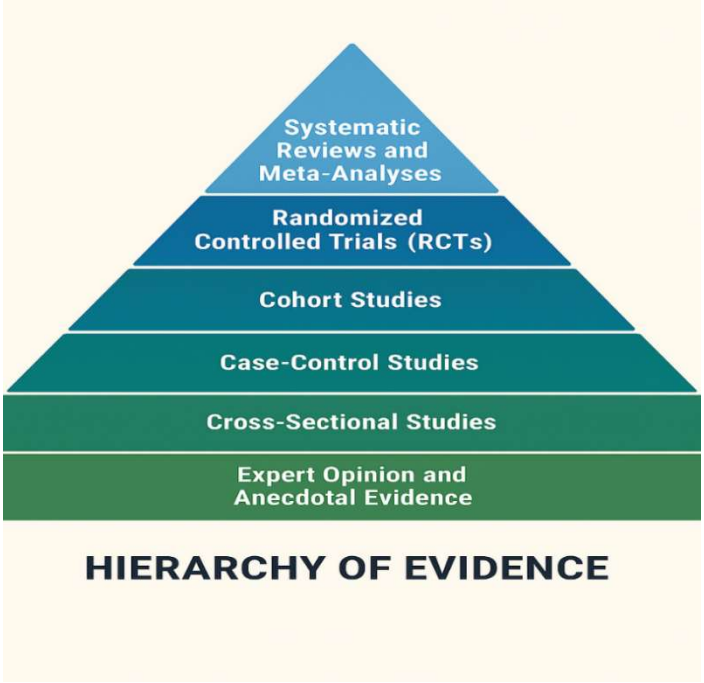
113. Before EBM, "clinical decisions were based largely on experience and skill (the 'art' of medicine); medical teaching and practice were dominated by knowledge delivered by medical leaders" (Institute of Medicine, 2011, p. 30). As mentioned above, this was still common practice when the Dutch Protocol first emerged. EBM, by contrast, relies on high-quality clinical research, along with clinical expertise and patient values, to guide clinical decision-making. EBM "de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making" in favor of rigorous and systematic evaluations of research (Evidence-Based Medicine Working Group [EBM Group], 1992, p. 2421).

114. Two frameworks in particular help point to evidence-based practices: the hierarchy of evidence and the GRADE system.

115. *The hierarchy of evidence.* In medicine, hierarchies of evidence are structured frameworks used to rank the reliability and validity of different types of research studies, guiding clinical decision-making and evidence-based practice (Guyatt et al., 1995; Evans, D., 2003). Typically depicted as a pyramid, the hierarchy places **systematic reviews and meta-analyses of randomized controlled trials (RCTs)** at the top, as they synthesize high-quality data across multiple studies. Just below are **RCTs**, valued for their ability to minimize bias

through randomization and control groups. Further down are **cohort studies**, **case-control studies**, and **cross-sectional studies**, which offer observational insights but are more susceptible to confounding factors and other forms of bias. At the base lie **expert opinions** and **anecdotal evidence**, which, while sometimes useful, lack the rigorous methodology needed for strong clinical recommendations.

116. While the various pyramids "should not be taken too seriously … the basic point these pyramids make is sound: some ways of gathering evidence about



the effects of a treatment are better than others" (U.S. Department of Health and Human Services [HHS], 2025a, p. 285–86). The hierarchy helps clinicians prioritize the most trustworthy studies and evidence when evaluating treatments, diagnostics, or prognostic tools.

117. Importantly, "optimal clinical decision making requires systematic summaries of the best available evidence" (Guyatt et al., 2015, p. xxvi). Systematic reviews are a rigorous form of evidence synthesis in which researchers formulate a clearly defined question, establish explicit inclusion and exclusion criteria, comprehensively search for all relevant studies using reported and thus replicable

search methods, and appraise and summarize the findings using transparent, reproducible methods designed to minimize bias and error (Brignardello-Petersen & Guyatt, 2025). Systematic reviews are foundational to evidence-based medicine because they provide the most reliable assessment of the totality of evidence, allowing clinicians and policymakers to make decisions grounded in comprehensive, unbiased, and methodologically appraised research rather than isolated or lower-quality studies.

118. After multiple systematic reviews are available, umbrella reviews (overviews of reviews or meta-reviews) are possible. An umbrella reviews sits alongside or above systematic reviews by synthesizing the highest level of evidence. The two most prominent umbrella reviews on pediatric gender medicine are the Cass Review and the U.S. Department of Health and Human Services Treatment of Pediatric Gender Dysphoria Review of Best Evidence and Best Practices.

119. *The GRADE System and systematic reviews*. The GRADE (Grading of Recommendations, Assessment, Development, and Evaluation) system provides a systematic and transparent framework for rating the quality of evidence. While the hierarchy of evidence provides general principles for evaluating a study, the GRADE system evaluates a *body of evidence* based on factors such as study design, risk of bias, consistency of results, directness of evidence, and precision of estimates (Balshem et al., 2011).

120. Under the GRADE approach, "quality of evidence" refers to how confident we can be that the research finding reflects the true effect of an intervention in the context of a systematic review. There are four GRADE ratings: high, moderate, low, and very low (Balshem et al., 2011).

Quality level	Definition
High	We are very confident that the true effect lies close to that of the estimate of the effect
Moderate	We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very Low	We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

(Balshem et al., 2011, p. 404)

121. High-quality evidence typically comes from well-conducted RCTs and suggests that further research is unlikely to change our confidence in the results. In contrast, low-quality evidence—often from observational studies or flawed trials—means that future studies may significantly alter our understanding of the effect. These ratings help clinicians and policymakers make informed decisions by weighing the strength and reliability of the available data (Balshem et al., 2011).

122. While the design (RCT vs. observational) determines the default quality rating, reviewers consider a number of factors—such as risk of bias—to upgrade or downgrade the rating. It is therefore possible for RCTs to be rated low or very low quality based on downgrades, and for observational studies—particularly well-controlled and conducted cohort studies—to be rated moderate or high quality based on upgrades (Balshem et al., 2011).

123. *The GRADE system and clinical guidelines.* GRADE distinguishes between the quality of evidence in the context of systematic reviews and the strength of a recommendation in the context of clinical guideline development. In the latter, GRADE evaluates "our confidence that the estimates are adequate to support a particular decision or recommendation" (Balshem et al., 2011, p. 403).

124. There are two categories of recommendations: strong and weak. And these recommendations can be *for* or *against* particular interventions. A strong recommendation for a treatment reflects confidence that the benefits outweigh the risks. A weak recommendation for a treatment reflects less confidence and that the benefits *probably* outweigh the risks (Guyatt et al., 2008). As a general rule, there should be "concordance between the quality (certainty) of the evidence and the strength of the recommendations" (Chong et al., 2023, p. 2).

125. There are four key factors for determining the direction and strength of recommendations: the tradeoffs or risk-to-benefit ratio involving alternative treatments (or no treatment), the quality of the evidence, the estimates of the typical patient's values and preferences, and costs (Guyatt et al., 2008; Andrews et al., 2013).

126. Clinical decision-making requires an evaluation of the risk-to-benefit ratio taking alternatives into consideration. And evaluating these tradeoffs is closely related to the quality of the evidence base. This involves two related questions: what is our best estimate for the benefits and risks of a treatment, and what is our confidence in these estimates. We can, for example, estimate that a treatment is highly effective based on a single cross-sectional or observational study, but still have much uncertainty/not much confidence in this estimate because of the limitations of cross-sectional study designs or the lack of other studies reproducing the results.

127. A guideline will ideally reference systematic reviews of studies on patient values and preferences to determine how the typical patient will value the tradeoffs involved in a course of treatment (Andrews et al., 2013, p. 727). A *strong* recommendation reflects that most patients in the relevant situation would opt for and should receive the recommended treatment. A weak recommendation reflects greater variability but that most patients would still opt for the treatment. Of

course, the patient's individual preferences and values necessarily inform how to balance the tradeoffs.

128. Finally, costs necessarily factor into clinical decision-making, but involve much variability. As a general rule of thumb, greater costs weigh against a strong recommendation (Guyatt et al., 2008).

129. Consistent with the concordance principle, greater uncertainty/low-quality evidence/or low estimates of benefits will weigh against a strong recommendation for (or potentially against) a treatment (Guyatt et al., 2008, 2015). Uncertainty can arise from imprecision of estimates, inconsistency of results across studies, indirectness of evidence to the question at hand, risk of bias in the body of evidence, or publication bias (Guyatt et al., 2015).

130. High quality evidence does not necessarily translate to a strong recommendation, nor does low-quality evidence require a weak recommendation (Balshem et al., 2011). There are "five paradigmatic situations … in which a strong recommendation could be made based on low or very low certainty of evidence," three of which require moderate or high-quality evidence of benefit or harm but allow for low-quality evidence of the other (Chong et al., 2023, p. 2). The only situation in which strong recommendations are permitted when evidence of benefit and harm are both low quality is when a treatment has a low estimate of benefits in a life-threatening situation (strong recommendation in favor) or when there is low-quality evidence of benefit and harm, but the harm is potentially catastrophic (strong recommendation against) (Andrews et al., 2013). As a real-world example of the former, clinical practice guidelines recommend that lay rescuers initiate CPR on infants or children with no signs of life without checking first for a pulse, despite limited evidence addressing manual pulse checks vs. simply looking for signs of life. This makes sense given the imminent risk of death (Joyner et al., 2025).

Paradigmatic situations in which low certainty evidence may justify a strong recommendation

Paradigmatic situation	Explanation	Recommendation
Potential equivalence, one option clearly less risky or costly	When low quality evidence suggests equivalence of two alternatives, but high-quality evidence of less harm for one of the competing alternatives	Strong recommendation **against** the more harmful/more expensive alternative (**or for** the less harmful/less expensive alternative)
Uncertain benefit, certain harm	When very low/ low quality evidence suggests modest benefits and moderate/high quality evidence suggests possibility of harm	Strong recommendation **against** intervention with potentially more harm or more cost (**or for** the less harmful/less expensive alternative)
High certainty in similar benefits, one option potentially more risky or costly	When high quality evidence suggests equivalence of two alternatives and low or very-low quality evidence suggests harm in one alternative	Strong recommendation **against** the intervention with possibly greater harm
Potential catastrophic harm	When low or high quality evidence suggests modest benefits and low-quality evidence suggests possible catastrophic harm	Strong recommendation **against** the intervention (or **for** the less harmful/less expensive alternative when two are compared)
Life-threatening situation	When low quality evidence suggests some benefit in a life-threatening or similarly catastrophic situation	Strong recommendation **for** intervention

(Chart from Chong et al. 2023, p. 3, table 1).

131. Finally, when offering treatments for minors, there is an added complication of considering the minor's maturity and capacity for decision-making and providing informed consent. Informed consent generally requires a patient able to understand and voluntarily decide upon a proposed course of action (Varkey, 2021). But an adult patient's autonomy to embark upon an experimental treatment with uncertain or even unfavorable balance or risks-to-rewards, as an example, does not necessarily mean that a practitioner should provide the same experimental treatment to a minor.

132. Applying GRADE in the context of pediatric gender medicine, clinicians, guideline panels, and policymakers must consider the benefit, risks, and

evidence base for the available alternatives, including social and medical interventions, watchful waiting, exploratory psychotherapy, or no intervention at all, taking into account what a typical patient would value and prefer among different outcomes.

133. However, systematic reviews and umbrella reviews reveal that social transitioning and medical interventions for minors suffering from gender dysphoria are based on low-quality evidence, involve disproportionate risks, low certainty evidence of sustained benefits, and at least modest confidence about the harms of endocrine and surgical procedures in particular, in addition to the heightened ethical concerns of deploying potentially life-altering treatments on minors who lack full decision-making capacity.

134. These interventions invoke one or more "paradigmatic" situations that justify strong recommendations *against* the interventions, and against endocrine and surgical procedures in particular because they involve uncertain benefits but certain harms, with some of these harms being potentially catastrophic (e.g., lifelong infertility) (Andrews et al., 2013, pp. 731–32).

135. They do *not* involve a life-threatening condition thereby justifying a strong recommendation in favor of the interventions despite low-quality evidence. Indeed, there is an absence even of low-quality evidence suggesting that hormonal interventions prevent or reduce suicide (Baker et al., 2021) and the risk of completed suicide is extremely low (Biggs, 2022).

136. In this case, standard ethical principles of nonmaleficence and beneficence demand rigorous demonstrations that the benefits outweigh the harms before proceeding. Proponents must provide high-quality, prospective data showing clear net improvement in mental health, quality of life, and regret/detransition rates, rather than relying on consensus guidelines or observational studies with serious methodological flaws.

137. As noted in the HHS report:

> The unfavorable risk/benefit profile distinguishes PMT [puberty blockers and cross sex hormones and surgeries] from many other off-label uses of drugs and medical devices. Advocates for PMT point to the prevalence of off-label prescribing in pediatrics, but the legitimacy of some off-label uses does not license the prescription of any pharmaceutical to any patient for any reason. The favorable risk/benefit threshold, or, more minimally, the precautionary threshold, must be met irrespective of whether the intervention is approved by FDA. Off-label use of an intervention is sometimes justifiable based on studies of the intervention in a different patient population or for a different indication. Such use may be warranted when there is a reasonable expectation of benefit, when there are no superior alternatives, and when the prognosis, absent medical intervention, is predicted to be worse for the patient than the negative effects of the off-label drug.
>
> This is decidedly not the situation with PMT. The natural history of pediatric GD is poorly understood and decades of research has shown that early-onset GD usually resolves without medical intervention. There is no compelling evidence that the same will not prove true in the case of adolescent-onset symptoms, and limited evidence suggesting it will.

(HHS, 2025a, p. 231).

138. In short, the promoters of pediatric social and medical interventions bear the burden of proof and these interventions cannot be justified based solely on expert opinions or a perceived consensus: "Guideline developers should always engage experts to help understand the evidence; they must also uncover and make clear the evidence that underlies the experts' opinions and rate the quality of that evidence, not the opinions that follow from the evidence and its interpretation." (Balshem et al., 2011, p. 402).

VII. **The false promises of affirmation and social transitioning.**

139. A common refrain in this field is that the science is settled when it comes to pediatric gender medicine and that the "gender-affirming" model of care is the best, most effective, and most ethical approach (Abbruzzese et al, 2023, p. 673).

In fact, studies have shown that its promises are largely illusory and that the affirmative-care model is not evidence based (McDeavitt, Cohn, & Kulatunga-Moruzi, 2025).

A. Social transitioning is a life-altering psychiatric intervention without proven benefits.

1. Social transitioning is a potent psychiatric intervention without proven benefits.

140. Social transitioning involves immersing a person in the idea that they embody a sex different from their natal sex. It typically involves adopting a different name, going by different pronouns, and adopting superficial attributes associated with the opposite sex like clothes, hairstyles, makeup, etc. Although most commonly this encompasses a binary social transition (identifying and living as the opposite sex), it may also encompass adopting a non-binary identity.

141. There is a dearth of studies on social transitioning and what studies do exist largely rely on low-quality studies and come to contradictory results. Overall, these studies fail to show that social transitioning is beneficial.

142. The 2023 study by James S. Morandini et al. examined whether social transition and name change was associated with mental health outcomes in a study of 645 children and adolescents (aged 4–17) referred to the UK's GIDS with gender dysphoria. Using clinician-rated measures of mood/anxiety difficulties and past suicide attempts, the researchers found overall, "no significant effects of social transition or name change on mental health status." (p. 1045).

143. Morandini's study is consistent with Sievert et al.'s (2021) study—"the only other study that directly compared clinic-referred youth experiencing gender dysphoria who had socially transitioned with those who had not" (Morandini, 2023, p. 1058). Sievert et al. examined the psychological functioning in a clinical sample of 54 German children (aged 5–11) diagnosed with gender dysphoria and found that

the degree of social transition (e.g., changes in name, pronouns, clothing) did not significantly predict better outcomes on the Child Behavior Checklist, whereas poor peer relations and worse family functioning were strong predictors of impaired psychological health.

144. Similarly, Wong et al. (2019) compared psychosocial wellbeing (using the Child Behavior Checklist) between socially transitioned transgender children and gender-variant children with similar levels of gender variance (who identified with their natal sex). They found little evidence that social transition status was associated with differences in internalizing or externalizing problems, with peer relations emerging as a more relevant factor for psychological challenges in the non-transitioned group. Wong et al. found that psychosocial challenges for socially transitioned youth were similar to those of their peers.

145. England's National Health Service commissioned a systematic review (Hall et al., 2024) on the social transitioning of children and adolescents by the University of York as part of the Cass Review. This is, to date, the most comprehensive review of the evidence on this topic. This systematic review revealed an "absence of robust evidence of the benefits or harms of social transition for children and adolescents" (Hall et al., 2024, p. 1). The evidence is "limited, [and] low quality" because most studies were "cross-sectional with non-representative samples and lack an appropriate comparator group" (Hall et al., 2024, p. 6).

146. To be sure, some studies have suggested that social transitioning has positive effects (Durwood et al., 2017; Olson et al., 2016). These were covered in Hall et al. (2024). Without diving into the flaws in these studies, they highlight contradictory results that at the very least weigh against a strong or even weak recommendation in favor of social transitioning.

147. Also important is the lack of evidence "that *not* allowing a child to socially transition may in itself be harmful." This is "not supported from the findings of [the Hall et al.] systematic review" (Hall et al., 2024, p. 6).

148. Other studies similarly support this conclusion. A related scoping review by Conabere et al. (2025) examined how social transition is defined and measured in studies of transgender youth under 18, finding significant variability, oversimplification, and inconsistency in definitions/measures, limiting comparability and understanding of its impacts.

149. In short, there is no high-quality evidence that social transition improves psychosocial functioning, and the *body of evidence* suggests there is no benefit.

2. Social transition reduces rates of desistance while widening the pathway to medicalization.

150. There are also many reasons to believe social transitioning is harmful or iatrogenic (where medical treatment causes the disease or illness) (Zucker, 2020).

151. As previously discussed, most instances of gender dysphoria in young people will naturally resolve itself (Zucker, 2018; Cantor, 2019; Singh et al., 2021). Yet social transition in children and adolescents appears to prolong transgender identification and continue gender dysphoria (Zucker, 2020; Olson et al., 2022). Because social transition involves the idea that a biological male or female internally embody the opposite sex, there is a plausible risk that it reduces a person's capacity to recognize or admit the factual nature of their biological sex. In other words, socially transitioning a young person may alter their psychosexual and personal development and engrain continued body-related distress. Their identity becomes "locked in" (Zucker, 2020; Olson et al., 2022). "Gender-affirmative psychotherapy seems to collude with primitive defences that keep the individual in a frozen psychological state" (van Zyl, 2024, p. 172). Resolution of gender-related

distress is aided when it is not affirmed, and when the individual is not enveloped in ideologies that normalize or encourage gender-related distress (van Zyl, 2024; Hutchinson, 2025).

152. Even Dutch researchers, who pioneered pediatric interventions for gender-related distress, recommend against ("a cautious attitude") early social transition because of how difficult it can be for those who would like to "return" to their natal sex and "the unpredictability of their child's psychosexual outcome" (Steensma et al., 2011, p. 16). In particular, some girls who desisted experienced "great trouble when they wanted to return to the female gender role," making "social steps long before puberty … hard to reverse" (Steensma et al., 2011, p. 16).

153. There is strong evidence that this altered trajectory and prolonged transgender-identification widens the pathway to medicalization involving puberty blockers, hormones, and eventually surgery (Zucker, 2020). A quantitative follow-up by Steensma et al. (2013) of 127 Dutch youth found that childhood social transition was a strong predictor of persistence into adolescence, directly linking it to a greater likelihood of seeking medical transition. Similarly, Olson et al., (2022) tracked 317 socially transitioned U.S. youth (ages 3–12 at transition) over 5 years, reporting 94% persistence in transgender identity, with the majority advancing to puberty blockers or hormones as they reached adolescence.

154. Hall et al., (2024) synthesized these and other studies, concluding that earlier social transition is associated with higher persistence rates and a greater tendency to proceed to medical pathways, emphasizing that prolonged transgender identification (often entrenched by social transition) shifts trajectories away from natural desistance (historically 60–90% without intervention) toward endocrine and even surgical interventions. The Endocrine Society guidelines have similarly noted that social transition contributes to persistence, increasing risks of medical escalation without robust predictors for individual outcomes (Hembree et al., 2017).

155. Thus, social transition could be thought of as a possible initiation into the medicalized pathway, a pathway that the majority of children will otherwise avoid. This means that social transitioning increases the likelihood of prolonged gender dysphoria and later sex trait modification via pharmaceuticals or surgery with all of the attendant risks of harm and lifelong medical dependency, and unknown psychological, functional, and psychosexual outcomes (discussed further below).

156. As noted by Zucker regarding social transition in children, "if one conceptualizes gender social transition as a type of psychosocial treatment, it should come as no surprise that the rate of gender dysphoria persistence will be much higher as these children are followed into their adolescence and young adulthood …. If this is, in fact, the case, one might ask why would one recommend a first-line treatment that is, in effect, iatrogenic [illness cause by treatment]" (Zucker, 2020 p. 37).

157. As noted in the Cass Review, social transition is described as a significant psychosocial intervention that requires caution. This caution is all the more acute considering the high rates of children whose gender-related distress naturally resolves alongside with the lack of evidence that transitioning in any form (social, pharmaceutical, or surgical) leads to any discernible benefits.

158. This is not to say that gender non-conformity or sexual orientation can be changed. Sexual orientation and sex-trait expression (such as more masculine females, and more feminine males) is likely to persist in many individuals. Yet distress regarding sex traits or sexual orientation can, and does, resolve. Not fitting sex stereotypes can be difficult for young people. Part of personal growth and identity development during adolescence is learning to accept yourself. This natural process is being distorted by the rush to label young people transgender before they have even finished their process of psychosexual development.

B. Medicalized transition has unproven benefits and likely harms.

159. While this report cannot exhaustively review the evidence on medical interventions, I will provide (1) an overview of the systematic reviews of the evidence, which overwhelmingly demonstrate a lack of reliable evidence that these interventions are safe or effective; (2) a discussion of whether there is reliable evidence that medical interventions prevent suicide, and (3) a review of select potential harms that are particularly serious.

1. Systematic reviews show that the evidence base for endocrine and medical interventions is low to very low.

160. As noted above, systematic reviews sit atop the pyramid of evidence because, when conducted well, they pull together all the relevant available evidence on a particular question, assess the strength of the available evidence, and provide a comprehensive understanding of the state of the science.

161. There have been several systematic reviews assessing the safety or efficacy (or both) of various forms of medicalized transitioning of minors. While the HHS review (discussed below) went through each systematic review that met its inclusion criteria, below I highlight several that show the evolution of attempts to review the evidence and the continued lack of high-quality evidence. Taken together, they show that there is widespread and longstanding agreement among systematic reviewers that the evidence base here is low or very low quality.

162. *Chew et al. (2018).* One of the earliest systematic reviews found "[l]ow-quality evidence" that "hormonal treatment ... achieve their intended physical effects" (e.g., testosterone masculinizes appearance) but a lack of evidence on the psychosocial and cognitive effects of these interventions (p. 1).

163. *National Institute for Health Care (NICE) (2020).* As part of the Cass Review, the British National Health Service commissioned two systematic reviews performed by the British National Institute for Health Care Excellence, one on

puberty blockers (NICE, 2020a) and one on cross-sex hormones (NICE, 2020b). Both used the GRADE system for rating the quality of evidence, and both found the quality to be "very low." Under the GRADE system, it means the reviewers have "very little confidence in the effect estimate," and the real effects of the intervention are "likely to be substantially different" from the hypothesized effects or reported effects (Balshem et al., 2011, p. 404). Summing up, the authors of the puberty-blockers review found "little change … from baseline to follow-up" in mental health metrics for children given puberty blockers (NICE, 2020a, p. 13). And the authors of the cross-sex hormone review noted that the evidence of efficacy was "very low certainty" and "must be weighed against the largely unknown long-term safety profile of these treatments" (NICE, 2020b, p. 14).

164. *NICE Update (2024).* A group of German researchers updated the NICE reviews by re-upping the literature search through August 2023. They found nothing suggesting a change in the original authors' conclusions (Zepf et al., 2024).

165. *Ludvigsson (2023).* A group of Swedish researchers conducted a systematic review in which they screened almost 10,000 abstracts. Based on the included studies, they concluded that, "long-term effects of hormone therapy on psychosocial and somatic health are unknown, except that GnRHa [puberty-blocking] treatment seems to delay bone maturation and gain in bone mineral density" (p. 2290).

166. *First McMaster University Review (2022).* A team from Canada's prestigious McMaster University conducted a systematic review and found "great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria" (Brignardello-Peterson et al., 2022).

167. *Thompson (2023).* A team of British and Swedish researchers conducted a systematic review of adolescent gender dysphoria treatment and found "a lack of quality evidence in relation to adolescent GD in general: epidemiology,

comorbidity, and treatment impact is difficult to robustly assess" (p. 43). They concluded that "[w]ithout an improvement in the scientific field, clinicians, parents, and young people are left ill-equipped to make safe and appropriate decisions." (Thompson et al., 2023, p. 43).

168. *New Zealand Ministry of Health (2024)*. The New Zealand Ministry of Health conducted its own literature review regarding puberty blockers and found that the evidence was low quality. They found "[e]vidence about the impact of GnRHa on clinical and mental health and wellbeing outcomes is scarce, with available evidence largely of poor quality" (New Zealand Ministry of Health, 2024, p. 3). Based on this review, in November 2025, New Zealand banned the use of puberty blockers to treat "gender incongruence" or "gender dysphoria" (New Zealand Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations, 2025)).

169. *The Cass Review (2024)*. The Cass Review (2024), commissioned by England's NHS, delivered a highly critical assessment of the use of puberty blockers (also known as puberty suppressing hormones) in children and adolescents. The review and the associated systematic reviews by the University of York concluded that the evidence supporting the safety, effectiveness, and long-term outcomes of these drugs is extremely limited and uncertain. As a result, the UK government has indefinitely banned the use of puberty blockers to treat gender dysphoria (UK Government, 2024), and NHS England has paused the use of cross-sex hormones (Wise, 2026). Any access to these treatments is available only to participants in carefully controlled research programs, reflecting the need for a stronger evidence base before such interventions can be considered appropriate for widespread use. And the clinical trial for puberty blockers that was planned has itself been paused due to safety and ethical concerns (Walker et al., 2026).

170. The Cass Review emphasized that puberty is a critical developmental window, not just for physical changes, but also for psychological and neurological maturation. Halting this process with puberty blockers may have unintended and potentially harmful consequences. The Cass Review reflects a deep skepticism about the benefits of puberty blockers and a commitment to caution, research, and individualized care moving forward.

171. The Cass Review was based on a series of systematic reviews, including one addressing puberty blockers (Taylor et al., 2024a) and one addressing cross-sex hormones (Taylor et al., 2024b). The puberty-blocker review found that while "[b]one health and height may be compromised during treatment," no other conclusions could be drawn because of the lack of "high-quality studies using an appropriate study design" (Taylor et al., 2024a, p. s45). The cross-sex hormones review found "a lack of high-quality research assessing the outcomes of hormone interventions in adolescents experiencing gender dysphoria/incongruence" (Taylor et al., 2024b, p. s54). It determined that, "No conclusions can be drawn about the effect on gender-related outcomes, body satisfaction, psychosocial health, cognitive development or fertility" (Taylor et al., 2024b, p. s54).

172. *Second McMaster University Reviews (2025).* Teams at McMaster University recently published three systematic reviews: one on puberty blockers (Miroshnychenko et al., 2025a), cross-sex hormones (Miroshnychenko et al., 2025b), and mastectomy (Miroshnychenko et al., 2025c). The review on cross-sex hormones reported "(e)vidence about the effects of GAHT in individuals aged <26 years with GD is predominantly of very low certainty, with lack of moderate and high certainty evidence about the effects of this intervention. This information is crucial for patients, caregivers, clinicians, guideline developers, and policy makers involved in treatment decisions" (Miroshnychencko, 2025b, p. 443). This review concluded that, "The best available evidence reporting on the effects of GAHT in individuals with

GD ranged from moderate to high certainty for cardiovascular events and low to very low certainty for the outcomes of GD, global function, depression, sexual dysfunction, BMD and death by suicide. ... The evidence in this SR and meta-analysis does not exclude the possibility of benefit or harm upon receipt of GAHT" (Miroshnychencko, 2025b, p. 444).

173. The puberty-blocker review found that the available evidence was "very low certainty," meaning that the researchers could not "exclude the possibility of benefit or harm." (Mirosnychenko, 2025a, p. 435). This systematic review used the GRADE methodology, which I consider the gold-standard in evaluating the quality of scientific evidence.

174. The mastectomy review was notable in that there are few attempts to systematically review the evidence on using mastectomy to treat gender dysphoria in young people. The only high-certainty evidence was for surgical complications like necrosis and scarring, neither of which was particularly rare. The evidence regarding any beneficial outcomes was all low or very low certainty (Miroshnychenko, 2025c).

175. *Cochrane Library (2020).* While not limited to young people, the prestigious Cochrane Library conducted a systematic review on cross-sex hormones to transition males to female (Haupt et al., 2020). It did not find a single study with sufficient rigor and reliability to analyze and thus concluded that there was "insufficient evidence to determine the efficacy or safety" of these interventions (p. 2).

176. Endocrine Society Guidelines. The Endocrine Society's 2017 clinical practice guidelines commissioned two systematic reviews: one on the effect of sex steroid use on lipids and cardiovascular outcomes, and one on the effects on bone health. The evidence quality for both was low, and one found adverse results for some cardiovascular risk factors for both sexes (Hembree et al., 2017). Evaluating

the literature as a whole, the guidelines rated the evidence regarding the use of puberty blockers as low.

177. *HHS Report on Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices (2025).* I was one of the coauthors on an umbrella review published by the U.S. Department of Health and Human Services in November 2025 titled: *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (HHS, 2025a). This version was peer-reviewed and synthesizes the 17 high-quality systematic reviews on interventions for children and adolescents with gender dysphoria, including puberty blockers, cross-sex hormones, and surgeries. It concludes that the overall quality of evidence for the effects of any intervention on psychological outcomes, quality of life, regret, or long-term health is very low, with sparse data on harms and insufficient high-certainty proof of sustained benefits. The review highlights methodological weaknesses across the literature (e.g., small samples, short follow-ups, and lack of robust controls), notes serious concerns about risks like infertility, bone density impairment, cardiovascular issues, and psychiatric complications, and emphasizes that the evidence base does not support claims of net benefit for pediatric medical transition.

178. As shown above, systematic review after systematic review confirms that the evidence concerning the safety and efficacy of medically transitioning young people is poor. Any assertion that medical transition is "safe," "effective," "medically necessary," or "life-saving" is not supported by the available evidence. Responsible parents should feel no pressure whatsoever to shepherd their children down this unproven path, nor should governments or medical authorities use their considerable power and influence to coerce or pressure parents or children toward it.

2. There is no evidence that medical interventions reduce rates of either suicide or suicidality.

179. Studies do not show that medicalized transition reduces rates either of suicide or of suicidality. A common claim is that medical interventions are necessary to prevent suicide or, more conservatively, that these interventions reduce the risk of suicide among youth who identify as transgender. Given the ubiquity and moral force of this claim, it bears a closer inspection.

180. To begin, suicidality, suicide attempts, and completed suicide are distinct yet interconnected phenomena that require differentiated responses from health and mental health professionals. Suicidality refers broadly to thoughts and feelings about suicide, including suicidal ideation, which may range from fleeting thoughts to persistent desires to die. Suicide attempts involve engaging in potentially self-injurious behavior with at least some intent to die, but which does not result in death. In contrast, completed suicide refers to death resulting from intentional self-harm. Each of these phenomena reflects varying degrees of risk for self-harm and clinical severity, necessitating tailored interventions (Franklin et al., 2017; Goñi-Sarriés et al., 2018; Rogers et al., 2020).

181. Understanding these distinctions is critical for clinicians, as the presence of suicidal ideation does not always predict behavior, and many individuals who die by suicide may not have previously expressed suicidal thoughts (Pappas, 2021). Moreover, research shows that individuals with a history of actual suicide attempts tend to exhibit more severe clinical symptoms than those with aborted or interrupted attempts, suggesting a need for nuanced risk assessments and personalized care strategies (Rogers et al., 2020). Health professionals must be equipped to recognize the unique psychological, social, and biological factors influencing each stage of suicidality to implement effective prevention and treatment strategies.

182. With this backdrop, there is no evidence supporting the common assertion that medical interventions are necessary to avoid self-harm. WPATH's own commissioned systematic review reveals a high risk of bias in the available studies, and it appears to have been manipulated to frame the unimpressive results as supporting affirmative treatments. Even so, this systematic review explicitly indicates that it was "impossible to draw conclusions about the effects of hormone therapy on death by suicide" (Baker et al., 2021, p.12).

183. The Trans Youth Research Network (TYRN) is a multi-site, longitudinal study funded by the NIH (Olson-Kennedy et al., 2019). Its primary aim was to investigate the physical and mental health outcomes of transgender-identifying youth who are undergoing pediatric medical transition treatments, including puberty blockers and cross-sex hormones. The study involves several leading pediatric gender clinics across the United States and follows participants over time to assess the effects of medical transition during adolescence. Despite funding starting in 2015, there has been a lack of publicly available data, particularly regarding outcomes related to self-harm, suicidality, and completed suicides.

184. According to the study's registration in the study's protocol paper, the researchers outlined a large number of domains and metrics they intended to measure, including: (1) mental health, (2) suicidality, (3) substance use, (4) sexual health, (5) cognitive development, (6) physical health, (7) social functioning, and (8) quality of life. (Chen et al., 2023, supplementary material). These factors were selected to provide a comprehensive understanding of the biopsychosocial impacts of gender-affirming treatments in youth. However, despite multiple conference presentations and some published papers, full results across these domains, especially regarding suicidality and self-harm, have not yet been released. This has

led to growing calls for transparency, particularly given public funding and the importance of these findings for clinical decision-making and policy development.

185. Regardless, the evidence that exists does not suggest that puberty blockers or cross-sex hormones reduce suicide risk. Short-term studies often cited to support that conclusion are methodologically weak and cannot imply a causal connection. Examples include the following.

186. Kuper et al. (2020) surveyed patients receiving hormonal interventions on a variety of mental health measures at baseline and approximately one year after beginning the interventions. Notably, rates of passive suicidal ideation, suicide attempts, and non-suicidal self-injury all *increased* from 1–3 months before the initial assessment (25%, 2%, and 10%, respectively) to the one-year follow-up period (38%, 5%, and 17%, respectively.) While the authors did not test for statistical significance, these data suggest that hormonal interventions did not *reduce* suicidality.

187. Similarly, the van der Miesen et al. (2020) study investigated mental health outcomes, including self-harm, among transgender-identifying youth and found that transgender adolescents reported significantly higher levels of psychological distress, including elevated rates of self-harm and suicidal ideation. However, the limitations include that first, the study relied on self-reported data, which can be subject to bias and inaccuracies. Second, the study design was cross-sectional, meaning it captured a snapshot in time and could not establish causality between gender identity, medical interventions, and mental health outcomes. Third, the sample size was relatively small and drawn from clinical settings, which may not be representative of the broader transgender-identifying youth population. Additionally, the study did not fully account for confounding variables such as pre-existing psychiatric conditions, family support, or socioeconomic status, which could influence both gender identity development and self-harm behaviors.

188. When we move to longer-term data, we find that the picture is mixed, with some of the most powerful data being unfavorable (Anckarsäter & Gillberg, 2020; Dhejne et al., 2011). Based on long-term data in Sweden, cross-sex interventions have not been shown to reduce self-harm or suicide (Bränström et al., 2020). The Dhejne et al. review of the long-term follow-up of medical transition surgeries in Sweden "found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalisations in sex-reassigned transsexual individuals compared to a healthy control population" (p. 7).

189. These concerns are echoed in the results of multiple other reviews (Wiepjes et al., 2020; McNeil et al., 2017; Asscheman et al., 2011).

190. Recent reviews related to younger cohorts raise serious concerns that hormonal treatment and affirmative protocols may increase suicide. Concerningly, 2 deaths from suicide in the TYRN cohort occurred in 2 years and among just 315 patients in active treatment (Chen et al., 2023). Biggs (2023b) noted, "[t]he relatively high rate of suicide among the participants in the study by Chen et al. is remarkable given that the authors had excluded anyone presenting serious psychiatric symptoms or manifesting suicidal distress. Aside from the two deaths, 11 other participants reported suicidal ideation during a study visit. It is imperative for Chen et al. to report outcomes for their own scale of suicidal ideation, as described in the study protocol … and how these changed over the 2 years" (Biggs, 2023b, p. 1537). As stated previously, to this day this self-harm data from TYRN has not been provided.

191. Furthermore, after the NHS restricted puberty blockers and cross-sex hormones, despite claims otherwise, there has been no known rise in self-harm (Appleby, 2024).

3. Endocrine interventions are associated with harm, including with potentially catastrophic harms.

192. While the evidence is generally poor, the literature suggests there are substantial short- and long-term risks associated with the use of puberty blockers and cross-sex hormones. These include:

- Declines in bone density (Klink et al., 2015; Vlot et al., 2017; Joseph et al., 2019; Biggs, 2021)
- Disruptions of normal psychosocial and psychosexual development (Hughes, 2022, [Transcript of Identity Evolution Workship] pp. 192, 212; Biggs, 2023b; Levine, 2022, 2023).
- Sexual dysfunction (Shrier, 2021).
- Increased risk of cardiovascular disease (Getahun et al., 2018; Aranda et al., 2021; van Zijverden et al., 2024)
- Pelvic floor dysfunction (da Silva et al., 2024)
- Hair loss (Marks et al., 2019; Gao et al., 2023).
- Psychiatric disorders; worsening psychiatric symptoms, and increased need for psychiatric help or medication (Glintborg, 2023, p. 341; Hisle-Gorman et al., 2021; Kaltiala et al., 2023)
- Other adverse reactions, including organ poisoning, nervous system disorders, and death, including suicide (Gomez-Lumbreras & Villa-Zapata, 2024; Chen et al., 2023; Biggs, 2023b).

193. Further, there is troubling data suggesting that no improvement to mental health outcomes, or even worsening mental health outcomes, after surgical interventions:

- No improvement in or worse mental health outcomes after surgery (Lewis et al., 2025; Bränström & Pachankis, 2020; Ring & Malone, 2020).
- Elevated risk of suicide after surgery (Straub et al., 2024; Wold, 2020).

194. Until recently, medical interventions for gender dysphoria have been rare with little tracking of long-term outcomes. What long-term data does exist is

mixed, with some of the most powerful data being unfavorable (Anckarsäter & Gillberg, 2020; Dhejne et al., 2011).

195. This presents a troubling risk-benefit calculus that warrants great caution and a recommendation *against* these interventions, at least outside of clinical trials.

196. For this report I will delve further into two associated harms that I find potentially be catastrophic given the relative risks: impaired neurological development and infertility.

197. *Impaired neurological function and development.* Puberty is a critical period for neurological development. It is an open question whether disrupting that development via puberty blockers causes long-term harm, or whether neurological development simply occurs as it would have when cross-sex hormones commence. The Endocrine Society's 2017 clinical practice guidelines recognized this concern, noting "unknown effects on brain development" and calling for "more rigorous evaluations" of these effects (Hembree et al., 2017).

198. In 2020, a large group of scientists published a "consensus parameter" outlining the need for additional research to assess "neurodevelopmental effects" of "pubertal suppression in transgender youth" (Chen et al., 2020, p. 246–47). They stated, "[t]o the extent that pubertal suppression may also put some features of brain development on hold, it is critical to know whether these features 'catch up' (either once GAH treatment is initiated or if the adolescent elects to stop GnRHa and resume endogenous puberty), or whether a sensitive window for hormone-dependent brain development has closed" (Chen et al., p. 252). In other words, it is unknown whether puberty suppression permanently impeded some features of brain development.

199. In 2024, Dr. Sally Baxendale published a review of the literature on the effects of puberty suppression on neurological function (Baxendale, 2024). The

review synthesizes animal data showing complex, sometimes detrimental effects on brain structure, social behavior and cognitive development. It revealed limited human evidence, while noting no robust, systematic studies tracking neurocognitive outcomes in youth taking puberty blockers. It calls urgently for better research, especially on domains like executive function, intelligence, memory, and emotional processing. Baxendale (2024) notes that "[c]ritical questions remain unanswered regarding the nature, extent and permanence of any arrested development of cognitive function associated with puberty blockers" (p. 1). She also states that "studies examining the impact of puberty suppression in young people indicate a possible detrimental impact on IQ" (Baxendale, 2024, p. 9).

200. In sum, there are good reasons to think puberty suppression may damage brain development, and the available evidence fails to refute that legitimate concern. Accordingly, claims that puberty blockers are a benign "pause" or "fully reversible" are unscientific and not supported by the available evidence.

201. *Infertility*. Both puberty blockers and cross-sex hormones, particularly the use of supraphysiologic doses of testosterone in females identifying as males, pose potential risks to future fertility that are not yet fully understood. What is clear (since this is their explicit purpose) is that these endocrine interventions interfere with normal reproductive development.

202. High doses of testosterone in females, often far exceeding natural hormone levels, can lead to significant histological changes in the ovaries and uterus, including polycystic-appearing ovaries, endometrial atrophy, and stromal fibrosis (Maiorano et al., 2025). While some individuals have conceived after discontinuing testosterone, there is no reliable data on fertility outcomes for those who began treatment before completing puberty. The long-term effects of testosterone on immature ovarian tissue remain largely unknown, especially in

youth who begin treatment before reaching reproductive maturity (Nahata et al., 2020).

203. Risks related to infertility for those prescribed cross-sex hormones are significant (De Roo et al., 2025). For males taking estrogen, some patients only retain limited sperm production, while many no longer have sperm production and exhibit testicular atrophy, hyalinization, and fibrosis. These histological changes may lead to an elevated risk of cancer. Taking estrogen alongside testosterone blockers was linked to sperm abnormalities and azoospermia (complete loss of sperm). These effects may or may not be reversible, and tissue studies following surgical removal of the testis show widespread damage (Schwartz & Moravek, 2021).

204. Some posit that fertility preservation (FP) is the answer. But ovarian tissue cryopreservation in prepubertal patients is still considered experimental (Nahata et al., 2020). And these procedures are often not feasible for adolescents who begin medical transition before reaching reproductive maturity. For example, spermatogenesis typically begins in Tanner Stage 4, meaning early use of puberty blockers may prevent sperm production entirely (Laidlaw et al., 2025).

205. Moreover, the success of assisted reproductive technologies remains limited. According to the CDC, in 2021, 413,776 assisted reproductive technology cycles were performed in the U.S., resulting in only 91,906 live births, a success rate of approximately 22% per cycle (Jewett et al., 2024). These outcomes are influenced by factors such as age, health status, and whether fresh or frozen gametes are used. Ethical concerns also arise regarding the disposition of preserved gametes or embryos in cases where the patient does not survive or changes their reproductive intentions.

206. FP is costly, invasive, and effectively impossible in prepubertal patients without the patient experiencing endogenous puberty. A study conducted

at the Stanford Pediatric & Adolescent Gender Clinic found that although 24% of adolescents accepted referrals for FP consultation, only 6.8% ultimately underwent FP procedures (Cooper et al., 2022). Males with a transfeminine identity were more likely to pursue FP than transmasculine or non-binary peers, but overall uptake remained low. This aligns with broader findings that, despite interest in biological children among transgender adults, adolescents rarely pursue FP due to minimal interest in parenting at that stage of life, uncertain efficacy of FP, cost, and lack of provider expertise (Maiorano et al., 2025).

207. The risk of infertility is particularly acute for minors who are not developmentally ready to consider their potential future desire for offspring. This potential for regret can be profound and, in my opinion, potentially catastrophic.

C. There are no authoritative standards of care for gender dysphoria.

208. Advocates for the "affirmative" care model claim that there is a consensus within the medical community that this model represents the standard of care (Singal, 2026) (quoting advocacy groups claiming "the science is settled").

209. As the previous discussion reveals, this is demonstrably false. Here, I will examine the shortcomings of internationally cited guidelines such as the WPATH standards of care.

1. The WPATH standards of care are flawed.

210. As previously discussed, WPATH has had an outsized influence in entrenching the gender-affirming care model through its different standards of care. But WPATH's standards are not authoritative. This was recently confirmed by courtroom testimony in a malpractice lawsuit by Randy Schechter, president-elect of WPATH. Journalist Benjamin Ryan noted that "the most astonishing assertion Dr. Schechter made on the stand is that WPATH's trans-care guidelines, which are

rather boldly entitled The Standards of Care, are not, in fact, considered the standard of care" (Ryan, 2026).

211. WPATH has mismanaged conflicts of interest, committed research malfeasance, systematically misrepresents evidence to make recommendations based on low-quality supporting evidence, and has redefined medical necessity to include experimental procedures with life-altering consequences.

212. *Conflicts of interest.* The authors of SOC-8 had conflicts of interest that violated guidelines with which WPATH claimed to comply. Managing both financial and intellectual conflicts of interests is particularly important "when guidelines rely heavily on expert consensus" (HHS, 2025a, p. 167). Further, the chair for guideline panels and other panel members should be "free of significant conflicts and neutral between differing perspectives," and "conflicted members should constitute no more than a minority of any [guideline development group]" (HHS, 2025a, p.167).

213. It appears that virtually all authors of SOC-8 had both financial and intellectual conflicts of interest because they made part of their living off of providing pediatric medical transition and they had already publicly advocated for pediatric medical transition.

214. "When the principal investigator of the JHU EPC team became involved in the SOC-8 process, she observed that they 'would expect many, if not most, SOC8 members to have competing interests.' SOC-8's final COI statement reads as follows: 'Conflict of interests [sic] were reviewed as part of the selection process for committee members and at the end of the process before publication. No conflicts of interest were deemed significant or consequential.' Based in part on correspondence between WPATH and the EPC team during the development of SOC-8, there are serious questions regarding the accuracy of this statement" (HHS, 2025a, p. 167). While there were conflicts throughout the SOC-8 authorship, the conflicts were most glaring at the top, where Eli Coleman, the chair of the SOC-8

committee and first author of SOC-8 was employed by the University of Minnesota, which received substantial financial commitments from the Tawani Foundation directly supporting his work (*Boe v. Marshall,* No. 2:22-cv-00184: Dkt. 700-3, 2024, pp. 239–44[1]; HHS, 2025a, p. 168). The Tawani Foundation is chaired by Jennifer Pritzker, a philanthropist and advocate for transgender issues. The Tawani Foundation was also the primary funder for SOC-8. Coleman admitted under deposition that there was essentially no screening of authors regarding conflicts of interest and conflicts of interest were an afterthought, as they were not presented until at least six months after members had already been selected (*Boe v. Marshall*, Dkt. 700-3, 2024, pp. 219–224)).

215. *Lack of developmental rigor*. SOC-7 and -8 fail on key metrics for establishing standards of care. Dahlen et al. (2021) reviewed SOC-7 as part of a systematic review and quality assessment of international clinical practice guidelines for gender minority/trans people. They noted that SOC-7 "contains no list of key recommendations nor auditable quality standards" (Dahlen et al., 2021, p. 6). Among the principal findings was that SOC-7 "cannot be considered 'gold standard" (Dhalen et al., 2021, p. 8). The WPATH review scored poorly on editorial independence, applicability, and rigor of development. The reviewers noted that WPATH and other international clinical practice guidelines tended to prioritize stakeholder involvement rather than methodological rigor.

216. Among the implications were that "[c]linicians should be made aware that gender minority/trans health [clinical practice guidelines] outside of HIV-related topics are linked to a weak evidence base" and that "[o]rganizations producing guidelines and aspiring to higher-level quality could use more robust

[1] Cited documents from the *Boe v. Marshall* case are publicly available at https://www.alabamaag.gov/boe-v-marshall/.

methods, handling of competing interests and quality assessment" (Dahlen et al., p. 9).

217. Despite the well-known methodological weakness to SOC-7, WPATH created SOC-8 in a similar manner, only selectively using the conventions expected to create a trustworthy clinical practice guideline.

218. The Cass Review similarly found "serious questions about the reliability of [WPATH's] current guidelines" (Cass, 2024, p. 130). Taylor et al. (2024c) found they "lack[ed] developmental rigour and are linked through cosponsorship" with the Endocrine Society's similarly flawed guidelines (p. s65). "Most guidelines have not followed the international standards for guideline development, and because of this the [Cass Review] could only recommend two guidelines for practice - the Finnish guideline published in 2020 and the Swedish guideline published in 2022" (Cass, 2024, p. 27).

219. "Previous guidelines relied much more heavily on expert opinion rather than on systematic reviews of the evidence" (Cass, 2024, p. 132). "[I]nstead of stating that some of its recommendations are based on clinical consensus, WPATH 8 overstates the strength of the evidence in making these recommendations" (Cass, 2024, p. 132). "However, none of the WPATH 8 statements in favour of social transition in childhood are supported by the findings of the University of York's systematic review" (Cass, 2024, p. 163).

220. *Efforts to suppress evidence*. "It has recently become clear …that WPATH speaks of evidence-based medicine but does not practice it" (Kozlowska et al., 2025, p. 6). "The organization's efforts to suppress evidence – dating back to 2018 – were revealed via WPATH internal documents." (Kozlowska, 2025, p. 6).

221. WPATH's SOC-8 did not clearly document what reviews were attempted, and it was later discovered that WPATH started, but then stopped and buried unfavorable results of reviews they commissioned.

222. After a court in Alabama unsealed court documents, it came to light that SOC-8 submitted for likely more than a dozen systematic reviews of evidence, but once WPATH realized the data was unfavorable, it interfered with the researchers conducting the reviews, disallowed publication of most reviews, and undermined the publication of the available data (Kozlowska et al., 2025; Economist, 2024). WPATH did what should be unthinkable; it hid, to this day, what systematic reviews were attempted, then buried them to hide unfavorable results.

223. The systematic reviews were supposed to be performed by the evidence-based medicine center at Johns Hopkins University. However, once the results of the systemic reviews began to come in, they began to place restrictions on Johns Hopkins to sway the results and later forced the university to withhold publication of the rest.

224. For an example of how they pressured the researchers, WPATH introduced a policy that permitted the use/publication of data only if "the intention [is] to use the Data for the benefit of advancing transgender health in a positive manner" (*Boe v. Marshall*, Dkt. 560-17, p. 76). This policy sought to "spin" the data in a manner favorable toward the positive aspects (while downplaying the negative aspects) of gender medicine by preventing unfavorable data from coming to light.

225. WPATH required the researchers both (a) submit the prospective publication to WPATH for its review and approval and then, in direct contradiction, (b) assert that the researchers are "solely responsible for the content of the manuscript, and the manuscript does not necessarily reflect the view of WPATH" (*Boe v. Marshall*, Dkt. 560-17, p. 78–79).

226. "This dual, mutually inconsistent requirement inescapably compromises the integrity of the researchers and also violates the conditions for the development of clinical practice guidelines" (Kozlowska et al., 2025, p. 7). At its core, WPATH's deception involved pressuring the Johns Hopkins researchers to

emphasize positive data and downplay negative data. Results of this distortion of research occurred in the abstract of the Baker (2021) systematic review, which contains narrative elements that overstate the strength of evidence. Abstracts are extremely important because that is the only part most readers will read and they trust that the abstract narrative reflects the data in the paper.

227. WPATH further prevented the publication of the vast majority of systematic reviews it commissioned. By burying these reviews, WPATH chose to hide the weakness of the evidence rather than be honest with professionals, the public, and worst of all, patients with gender dysphoria considering medical treatments with lifelong bodily changes and potentially severe side effects.

228. My analysis is supported by the British Medical Journal (BMJ) Investigations Unit's review of the evidence for transgender treatments, including SOC-8 (Block, 2023). BMJ investigators interviewed Gordan Guyatt, M.D., an internationally recognized leader on systematic reviews and also the co-developer and first author of the original GRADE guidelines. BMJ also interviewed expert Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University. The investigation highlighted transparency issues with the guidelines: "Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and what the results were." (Block, 2023, p.3). But whereas SOC-8 claimed that the evidence was so limited regarding transitioning treatments for gender dysphoric youth that "a systematic review regarding outcomes of treatment in adolescents is not possible," as Guyatt pointed out, "systematic reviews are always possible, even if few or no studies meet the eligibility criteria" (Block, 2023, p.3.).

229. Journalists have similarly documented WPATH's deviation from ethical and clinical standards.

230. Benjamin Ryan, '*Damning' Information About Trans Medical Group Expected to Reach Supreme Court, as Justices Consider Challenge to Ban on Gender Treatments for Minors*, NY Sun (July 10, 2024):

- "The unsealed documents indicate Wpath leadership caved to political pressure from outside groups and quietly crafted its pediatric guidelines with the intent of influencing public policy. Wpath leadership also balked at the potential publication of research findings the organization had commissioned that its leadership believed might negatively impact access to gender-transition treatment."

- "According to unsealed internal communications, WPATH also wielded a heavy hand after it in 2018 commissioned from evidence-based medicine experts at Johns Hopkins University a series of systematic literature reviews—the gold standard of scientific evidence—regarding various facets of trans medical care. After some of the Hopkins teams' findings raised concerns among WPATH leadership that they might 'negatively affect the provision of transgender health care,' WPATH compromised the independence of the Hopkins researchers. This included asserting the final say on the publication of any systematic reviews. To date, just two reviews have been published."

231. The Economist, *Marking their own homework* (June 29, 2024):

- "Court documents recently released as part of the discovery process in a case involving youth gender medicine in Alabama reveal that wpath's claim was built on shaky foundations. The documents show that the organisation's leaders interfered with the production of systematic reviews that it had commissioned from the Johns Hopkins University Evidence-Based Practice Centre (EPC) in 2018."

- "Among the recently released court documents is a wpath checklist confirming that an individual from WPATH was involved 'in the design, drafting of the article and final approval of [that] article'. (The article itself explicitly claims the opposite.) Now, more than six years after signing the agreement, the EPC team does not appear to have published anything else, despite having provided WPATH with the material for six systematic reviews, according to the documents."

232. WPATH's SOC-8 intentionally obscured the most important element required for a trustworthy clinical practice guideline: the assessment of the strength of the evidence used to make recommendations. Hiding the strength of evidence hides critical data from readers trying to evaluate the evidence base for an organization's recommendations (Murad et al., 2017). This is especially concerning

due to the lifelong implication and irreversible nature of the treatments WPATH advocates.

233. *Foundational Problems with SOC-8.* While SOC-8 is beyond the scope of this report to review completely, I must note four major concerns as a mental health professional.

234. SOC-8 makes no analysis for why it prioritizes affirmation of gender identity over affirmation and acceptance of the physical sexed body. For clinicians and psychotherapists, these trade-offs are complex matters and fundamental to treatment, yet SOC-8 treats the question as though it had a clear answer supported by the evidence: affirmation always. In fact, gender dysphoria is the only psychiatric disorder where affirmation is recommended as part of a treatment approach, raising questions whether this exceptionalism arose from considered clinical reasoning, outcome data, or was primarily the result of the advocacy campaign the WPATH itself had led.

235. SOC-8 suggests consumer-driven medical and surgical interventions and deems these medically necessary without adequate supporting evidence. In medicine, life-altering interventions do not become medically necessary based on the desire of the patient. This is a profound ethical lapse, as noted in the Finnish review of Pediatric Medical Transition (roughly translated as follows:

- "In healthcare, self-determination is realized primarily as the right to refuse treatments within the available service spectrum. This principle must be balanced against the freedom of individuals to express their own gender identity. Nevertheless, autonomy in healthcare does not imply unrestricted freedom to select treatments based purely on personal preference; rather, the patient exercises his autonomy among treatments that are medically justified and included within the recognized service options."

(Council for Choices in Health Care in Finland [COHERE], 2020b, p. 59).

236. SOC-8 normalizes self-mutilation via inclusion of "eunuchs" as just another non-binary category without any suggestion that these individuals require

mental health assessment prior to any consideration of chemical or surgical procedures. This addition to SOC-8 displays how WPATH's allegiance to the concept of self-identified gender identities collapses clinical safeguarding and puts vulnerable patients at risk.

237. SOC-8 downplays concerns related to detransitioning and regret and devotes minimal exploration of these topics. SOC-8 repeatedly claims detransition is rare, but neither defined rare, nor explored the recent literature on detransition. In fact, the detransition rate is unknown (Jorgensen, 2023; Cohn, 2023). As noted by a recent systematic review "[t]aken together, the results of the present analysis indicate that detransition in persons undergoing gender-affirming treatment has been insufficiently investigated. Quality measurement tools are needed, as are long-term follow-up and monitoring standards" (Feigerlova, 2025, p. 1). These failures relate directly to WPATH's oversized influence and push to remove safeguard or track harms.

238. For an even more detailed description of the corruption and ideological influence at WPATH, see pages 159–187 of the HHS Review (2025a). For further analysis of SOC-8's lack of rigor and deviation from standards, see the February 2026 appraisal in Archives of Sexual Behavior by Zhang et al., which evaluated six key SOC-8 chapters, finding low scores in rigor of development (39–47%), applicability (28–40%), and editorial independence (43–44%), with a median overall quality rating of 3.5–4 out of 7. The children's and adolescent's chapters each rated poorly with a mean AGREE score of 3.8 out of 7. The authors specifically noted that "SOC-8 received low scores not due to the limitations of the evidence itself, but because of how the recommendations were formulated" (Zhang et al., 2026, p. 6). SOC-8 deficiencies are manifest in both a lack of supporting evidence and inappropriate guideline construction. They concluded, "[o]ur assessment revealed that WPATH's SOC-8 guidelines have limitations in scientific and methodological

rigor, applicability, and transparency in managing competing interests. Evidence-based guidelines addressing the needs of transidentified children and adolescents are urgently needed, but the uncritical adoption or endorsement of WPATH's guidelines may result in a disservice or even harm to this vulnerable population" (Zhang et al., 2026, p. 12).

2. The Endocrine Society guidelines are limited in scope and do not establish standards of care

239. The Endocrine Society also publishes clinical practice guidelines for treating gender dysphoria (Hembree et al., 2017). I will briefly discuss the flaws in their most recent guidelines published in 2017.

240. First, the 2017 guidelines were developed by a small group interconnected with WPATH (9/10 authors are WPATH members), highlighting that these guidelines cannot be viewed as an independent assessment of the evidence base and are at high risk of bias. "The two guidelines … have close links, with WPATH adopting Endocrine Society recommendations in its own guideline and acting as a cosponsor for and providing input on drafts of the Endocrine Society guideline" (Taylor, 2024c, p. s70).

241. Further, umbrella reviews, including the Cass Review and the HHS Review have found that WPATH's and the Endocrine Society's "guidelines lack a robust and transparent approach to their development" (Taylor, 2024c, p. s70). "The WPATH and Endocrine Society international guidelines … lack developmental rigour and transparency [and] have, until recently, dominated the development of other guidelines. Healthcare professionals should consider the lack of quality and independence of available guidance when utilising this for practice" (Taylor, 2024c, p. s71).

242. The systematic appraisals applying AGREE II rated it (and several other clinical guidelines) poorly in rigor of development, editorial independence, and

stakeholder involvement, noting a lack of transparent systematic evidence reviews, failure to balance benefits/harms, and omission of non-medical options such as watchful waiting, exploratory psychotherapy, or addressing comorbidities (e.g., autism, mental health issues) before medicalization (Dahlen et al., 2021).

243. In short, the 2017 guidelines are discordant because they used low- or very-low-quality evidence (e.g., observational studies with methodological flaws like small samples, short follow-ups, and confounding factors) to issue strong recommendations for medical interventions. And the Endocrine Society did not try to justify this discord based on one of the recognized exceptional justifications for doing so. Instead, it justified endocrine interventions based only on patient values and preferences, thereby prioritizing theorized mental health benefits, which have never been shown to materialize, to justify the recommendation.

244. Additionally, the guidelines overlook the high historical desistance rates and did not adequately discuss ethical concerns implicated when minors are seeking these interventions. Rather, it downplayed alternative options despite acknowledging there is no way to predict which young people will go on to have a persistent transgender identity.

245. Here too, the BMJ investigation supports my conclusions. Both Guyatt and Helfand noted "serious problems" with the WPATH and Endocrine Society guidelines, including a lack of transparency, absence of proper grading of evidence, and "several instances in which the strength of evidence presented to justify a recommendation was 'at odds with what their own systematic reviewers found'" (Block, 2023).

3. Other medical organizations have promoted the gender-affirming care model without critically examining the evidence base.

246. Taylor et al. (2024c) found "that early versions of … the Endocrine Society and World Professional Association for Transgender Health (WPATH) guidelines (specifically the 2009 Endocrine Society guideline and WPATH V.7 published in 2012) have influenced nearly all the national and regional guidelines identified" in their systematic review of clinical guidelines for treating gender dysphoria (p. s69). But as just explained, this "considerable influence" outstrips the quality and rigor of the guideline development process (Taylor et al., 2024c, p. s69)

247. Yet "[m]any professional organizations and government health authorities that published position statements or guidelines in support of GAT have not amended their positions or guidelines even though systematic reviews and population-based studies have yielded evidence that undercuts earlier, pro-GAT claims" (Kozlowska et al., 2025, p. 10).

248. Further, when a medical organization adopts a consensus-based, i.e. not evidence-based, official position on pediatric transitions, it is not surprising that their associated journals have championed the same approach. Medical journals are often closely intertwined with the professional medical organizations that own, fund, or oversee them, creating structural conditions in which editorial priorities may be influenced by the advocacy positions of the parent organization. Because these organizations frequently have policy agendas, reputational interests, and financial relationships with industry or specialty groups, their control over journal governance can introduce institutional conflicts of interest, shaping what research is prioritized, how controversies are framed, and which perspectives receive editorial amplification (World Association of Medical Editors, 2009).

249. Further, journal editors have wide discretion to filter topics that are covered in their journals through the selection of articles sent for review,

commentaries, clinical perspective, and Letters to the Editor; guiding what is included in the book review column; and setting editorial policies.

250. Editorial leaders have long acknowledged that such organizational entanglements can compromise scientific neutrality, noting that journals must actively guard against pressures that could distort peer review, suppress dissenting evidence, or selectively promote research aligned with organizational advocacy (Bauchner et al., 2018).

251. I will discuss my own experience at the American Academy of Child & Adolescent Psychiatry, and I believe it mirrors issues in other medical organizations including the Endocrine Society, American Academy of Pediatrics, and the American Psychiatric Association. I have been intimately involved with AACAP for over twenty years and believe its integrity and trustworthiness have been severely compromised over the last decade by its activism, especially on the issues of youth gender medicine.

252. For example, I routinely attend the meetings of their Sexual Orientation and Gender Identity (SOGI) committee and have heard the stigmatizing language and authoritarian perspectives of gender medicine enthusiasts. I have repeatedly attempted to introduce views urging caution and emphasizing alternatives to pediatric medical transition yet have been blocked by the committee membership from created any presentations with standard scholarly dialogue on the fundamental issues major issues. Conference submissions have been repeatedly rejected, despite the inclusion of prominent gender-dysphoria researchers and clinicians on panels discussing this topic, including Riittakerttu Kaltiala-Heino, MD, Ph.D; Lisa Littman, MD; and Ken Zucker, Ph.D; Stephen Levine, MD; and Erica Anderson, Ph.D. (Sibarium, 2023). AACAP leadership has similarly called those with contrary viewpoints unconscionable or implied that they are acting out of hate or with malicious intent (AACAP, 2022).

253. I have personally spoken to a range of child psychiatrists, from very senior AACAP "life members" to residents in training, who have told me that they are unwilling to openly express their viewpoint on this issue, but they do not see data or logic supporting "gender-affirming" treatments. This reinforces my belief that the politicization has helped manufacture a perceived "consensus" because researchers and clinicians are afraid to express their views (Noelle-Neumann, 1974).

254. The AACAP has also taken contradictory positions on the capacity of adolescents to give informed consent. The organization has supported the idea that minors have the emotional and cognitive development to consent to the consequential psychiatric and medical interventions involved in pediatric transitions. Yet in other contexts, the AACAP has taken a different position. In *Miller v. Alabama*, the Supreme Court considered whether it was constitutional to sentence minors to mandatory life in prison. The AACAP (with the American Medical Association) submitted an amicus brief stating that "[s]cientists have found that adolescents as a group, even at later stages of adolescence, are more likely than adults to engage in risky, impulsive, and sensation-seeking behavior. This is, in part, because they overvalue short-term benefits and rewards, and are less capable of controlling their impulses making them susceptible to acting in a reflexive rather than a planned voluntary manner. Adolescents are also more emotionally volatile and susceptible to stress and peer influences. In short, the average adolescent cannot be expected to act with the same control or foresight as a mature adult."[2] This contradicts the organization's position on pediatric transitions.

[2] Amicus Brief of the American Academcy of Child and Adolescent Psychiatry, *Miller v. Alabama,* 567 U.S. 460 (2012), available here: https://www.aacap.org/App_Themes/AACAP/docs/Advocacy/amicus_curiae/miller_v_alabama.pdf

255. I have found the Journal of the AACAP to exhibit the same hostility to a diversity of viewpoints. For example, in 2022, the Journal of the American Academy of Child and Adolescent Psychiatry published a Commentary that pressured researchers to adopt progressive gender theories to "become allies" (Dixon et al., 2022). I, along with two child and adolescent psychiatric colleagues, wrote a Letter to the Editor in response to Dixon et al. discussing the problems with the article cited above, but the journal editor refused to even send this letter out for review.

256. Lisa Littman's saga provides another example. As previously discussed, in 2018, Lisa Littman published her article on the rapid spread of gender dysphoria in adolescents (Littman, 2018). After this research was peer reviewed and published, the journal PLOS ONE had a reediting of the publication with a commentary added (Littman, 2019). This showed a disregard for the typical rules of scientific discourse because, importantly, this was not a correction; there was no finding of error, misconduct, or faulty methods with Littman's original paper. As confirmed by the PLOS ONE re-review, Dr. Littman's research methods were unremarkable and comparable to other mental health research.

257. Precisely because of the data supporting Littman's theories of Rapid Onset Gender Dysphoria, many advocates of the medicalized treatment of youth with gender dysphoria have attempted to suppress scientific exploration rather than reformulate their own deeply held beliefs. This antagonism of Dr. Littman was not about her methods, but rather that her data indicated that gender dysphoria was spreading in a pattern consistent with social influence. Clinicians at the Tavistock center, which before its closure was the world's biggest gender identity service, documented their own experience with similarly-named "adolescent onset" gender dysphoria, how clinicians around the world are witnessing the same phenomenon, and how unhelpful it is to suppress research or malign scholars who

bring uncomfortable facts to light: "Unless we are free to discuss, explore, and research differential presentations of gender dysphoria, the range of interventions which might best serve each young person may not be available to them. We do not think that this is good enough for our patients" (Hutchinson, 2020, p. 1 of online version).

258. A similar controversy occurred with another paper that provides data behind the ROGD concept, titled "Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases" which was eventually retracted and then published in a different journal (Diaz & Bailey, 2023a, 2023b).

259. These are just a couple of examples among many showing that research that runs counter to the prevailing orthodoxy causes panic among gender ideologues and activist scholars. There are many more examples of politicization squelching scholarly research (Dreger, 2008; Stevenson et al., 2023; Kozlowksa et al., 2025; Suissa & Sullivan, 2021; Meyer-Bahlburg et al., 2023; Hooven, 2023). Open inquiry is the ability to ask questions and share ideas without risk of censure. It is fundamental to medical research and scientific progress. Within medicine, the ability for constructive disagreement and the expression of divergent opinions has withered with regards to questions of biological sex, gender, and gender medicine.

260. Yet pressures to accept "affirmative" treatment as being the most virtuous and only effective approach discourages good faith scholarly dialogue. Furthermore, the characterization of those who oppose gender affirming care as transphobic or hateful has been used to justify silencing scholars whose data or logic does not support the gender-affirming approach. Former sex researchers have left the field due to the harassment and intellectual bullying they received (Soh, 2020).

261. Medicine must adapt as constructive disagreement and scholarly exchange expose the inappropriate care. For years, many assumed that the Dutch research was a firm evidence base, but now systematic reviews and critiques have

displayed the weak underpinnings of pediatric medical transition. When the new information becomes available, medicine must adapt. But as demonstrated by WPATH's suppression of evidence, proponents have instead responded "by dismissing negative research results and insisting that the available evidence continues to support GAT [gender-affirming treatment]; by seeing the rights of patients as overriding questions concerning the reliability of the evidence; and by establishing different goals for GAT and dismissing the goal of patient 'improvement' as the product of a misconceived narrative about GAT" (Kozlowska et al., 2025, p. 11)."This process of doubling down by 'trusted' organizations – and failing to offer guidelines in line with existing research – undercuts the foundation for gender medicine's chain of trust. Clinicians can no longer blindly trust either the position statements put out by their organizations or the clinical guidelines published by WPATH. Likewise, patients and their families can no longer remain confident that the GAT offered by their clinicians reflects current medical standards" (Kozlowska, 2025, p. 11).

VIII. Ethical concerns with pediatric interventions.

262. Social and medical transition—to the extent a healthcare professional influences the former—raise two types of ethical concerns. First, there are concerns about informed consent. Second, there are concerns about recommending a course of treatment with little reliable information or a disfavorable risk-benefit profile. Assisting a young person with gender-related confusion is a sensitive and difficult endeavor.

A. Ethics requires giving the patient sufficient information to make an informed decision.

263. Informed consent is a bedrock ethical principle of clinical practice. The touchstones of informed consent are information, comprehension, and voluntariness (U.S. Department of Health, Education, and Welfare & National Commission for

the Protection of Human Subjects of Biomedical and Behavioral Research [DHEW], 2014). While these touchstones were originally developed in the context of participation in clinical research, they are applicable to clinical practice generally—especially when a healthcare professional is recommending or presenting an intervention with the complex risk-benefit profile.

264. **Information**. The healthcare professional must provide sufficient information for a patient to "understand clearly the range of risks" (DHEW, 2014, p. 11). When the risks are poorly understood, it is difficult to convey the risks. It is not meaningfully helpful to patients—even well-educated adult patients—for a healthcare professional to simply say, "we don't know" when explaining the risks and benefits of treatment.

265. **Comprehension**. Professionals must evaluate the patient's and caregiver's actual understanding of the information provided, ensuring they possess the mental and emotional capacity to make a medical decision.

266. **Voluntariness**. Voluntariness requires that the decision be free from controlling internal and external forces.

B. Social transitioning's weak evidence base makes it ethically fraught.

267. While social transition is not typically a medical intervention "prescribed" by a doctor, it is a powerful social intervention that appears to change the life-course and promote persistence of a transgender identity. So it is my opinion that healthcare professionals asked for advice on social transition should treat it like a medical intervention.

268. Here, the knowledge base is so low and the effects on a young person's life-course so poorly understood, that counseling a young person on this intervention becomes ethically fraught because of the unknown risk-to-benefit profile of social transitions.

269. That's particularly problematic for adolescents given the known effects of social influences on their decision-making (Grootens-Weigers et al., 2017). And it's particularly acute in the world of gender dysphoria when there appears to be an element of social contagion in its spread, particularly among adolescent females (Diaz & Bailey, 2023; Littman, 2018). It's equally problematic when we know that adolescents with gender dysphoria suffer disproportionately from psychiatric co-morbidities that could influence their judgment. The same is true for social transition. A child or adolescent could easily be susceptible to pressure to socially transition from a peer group or simply from a desire to make the psychological pain go away without fully grasping the consequences. As such, informed consent for social transition would require a thorough process and include psychological exploration.

C. Medical transitioning is even more ethically fraught.

270. The knowledge base for medicalized transitions is so low that the practice is effectively experimental, which I do not think meets the standard for providing sufficient information in a clinical context.

271. With respect to medical transition, young people are not cognitively and psychologically equipped to understand and assess the risks. The risk of sterilization is a prime example. As clinicians associated with WPATH fully admit, young people are not able to adequately understand or predict their future desire for children and thus cannot fully comprehend the risk of giving that up (Hughes, 2024). This tracks with research demonstrating that adolescents struggle with decision-making in emotionally fraught situations, during which they are more likely to engage in undue risk-taking, and prioritize short-term benefits over long-term consequences (Grootens-Weigers et al., 2017). These concerns are amplified for puberty blockers since the entire purpose of the intervention is to stop a process—puberty—that contributes to neurological and psychological development. As Dr.

Cass noted, "We do not fully understand the role of adolescent sex hormones in driving the development of both sexuality and gender identity through the early teen years, so by extension we cannot be sure about the impact of stopping these hormone surges on psychosexual and gender maturation. We therefore have no way of knowing whether, rather than buying time to make a decision, puberty blockers may disrupt that decision-making process" (Cass, 2024, [Appendix 6] p. 5).

272. Both social and medical transitions for minors are ethically fraught. At a minimum, a bright-line rule pushing young people toward either is inappropriate, as it is unclear that any young person—much less every young person—can properly consent to these interventions.

IX. The growing retreat from the affirming-care model.

A. European countries have sharply limited medical interventions for minors based on independent reviews of the evidence.

1. Finland

273. The first review of youth gender medicine was started in Finland in 2018. It was completed in 2020, leading to the first country to turn away. Finland is another Nordic country with an organized medical system and longstanding availability of care for gender dysphoria. The recommendation from the Finland Council for Choices in Health Care (COHERE) on the Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors concluded: "The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders." (COHERE, 2020a, p. 5). The authors further report cross-sex identification "even in extreme cases, generally disappears during puberty. However, in some cases it persists or intensifies" (COHERE, 2020a, p.5).

274. The authors state, "[a] lack of recognition of comorbid psychiatric disorders common among gender-dysphoric adolescents can also be detrimental.

Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment. A young person's identity and personality development must be stable so that they can genuinely face and discuss their gender dysphoria, the significance of their own feelings, and the need for various treatment options" (COHERE, 2020s, p.7). They conclude: "In light of available evidence, gender reassignment of minors is an experimental practice. Based on studies examining gender identity in minors, hormonal interventions may be considered before reaching adulthood in those with firmly established transgender identities, but it must be done with a great deal of caution, and no irreversible treatment should be initiated. Information about the potential harms of hormone therapies is accumulating slowly and is not systematically reported" (COHERE, 2020a, p. 8).

2. Sweden

275. The Swedish National Board of Health and Welfare was commissioned by the Swedish government to updated the country's guidance on "Care of Children and Adolescents with Gender Dysphoria." (Socialstyrelsen, 2022). The Swedish systematic review by Ludvigsson et al. (2023), published in Acta Paediatrica, evaluated the evidence for hormonal treatment in minors (<18 years) with gender dysphoria, drawing on a comprehensive screening of nearly 10,000 abstracts. The review found that data on psychosocial outcomes are largely absent, with no reliable evidence demonstrating improvements in mental-health or quality-of-life measures following puberty blockers or cross-sex hormones. Instead, the strongest available findings relate to negative somatic effects, particularly that puberty blockers may influence bone maturation, though long-term consequences remain unclear. Given the overall low certainty of evidence, the authors concluded that hormonal treatment for adolescents with gender dysphoria should be regarded as

experimental rather than established clinical practice, and emphasized the need for rigorous, long-term research to clarify both benefits and risks.

276. After this systematic review was published in 2022, the National Board of Health and Welfare recommended a move away from cross-sex hormones (Socialstyrelsen, 2022). The authors conclude that risks currently outweigh the possible benefits and most patients will need psychotherapy and support rather than medical care. The National Board of Health and Welfare reported the three main factors:

- A lack of reliable scientific evidence concerning the safety and efficacy of treatments.
- Increasing concerns about detransitions.
- Uncertainty brought about by the extreme rise in those seeking care, especially females.

277. The guidelines further reported that "[g]ender dysphoria rather than gender identity should guide access to care and treatment." (Socialstyrelsen, 2022, p. 4). The report concludes that, for adolescents as a whole, "the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments," and therefore the report gave a "weak" and "negative recommendation[]" for treatment with puberty blockers, hormones, or mastectomies to "be administered in exceptional cases" only (Socialstyrelsen, 2022, p.3).

3. England and The Cass Review

278. England has recently sharply limited the use of endocrine and surgical interventions on minors outside of clinical trials owing to the scandal at the Tavistock clinic.

279. The Tavistock clinic was the National Health Service's central gender clinic and at the time the largest gender clinic in the world. Whistleblowers exposed unethical practices beginning in 2005, when psychiatric nurse Susan Evans raised

concerns about rushed treatments. More scandals followed (Barnes, 2023), including Governor David Bell's 2018 report highlighting inadequate assessments, failures in child safeguarding, pressure to adopt an unquestioning affirmative approach, and risks to vulnerable youth with comorbidities like autism or trauma. This led to a 2020 Care Quality Commission inspection rating the service "inadequate" for poor risk management and consent practices.

280. These revelations prompted NHS to commission the independent Cass Review in 2020, led by Dr. Hilary Cass, whose 2022 interim report criticized the clinic's single-provider model as unsafe and unsustainable amid surging referrals (over 5,000 in 2021–22, as reported in Cass (2024)), insufficient evidence for interventions like puberty blockers, and an ideological bias overriding holistic care, recommending immediate closure and replacement with regional hubs focused on multidisciplinary support. The Cass Review led to the clinic's closure in 2024, marking a shift toward evidence-based, cautious approaches in youth gender services.

281. As previously discussed, the Cass Review conducted a systematic review of available clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence. Dr. Hillary Cass reviewed 23 guidelines published from 1998 to 2022. "The findings from this review . . . raise questions about the credibility of currently available guidance, despite the majority being published in the last 5 years. Most guidelines have not followed international standards for guideline development set out by the [Appraisal of Guidelines for Research and Evaluation II] initiative and/or provide insufficient information about their development. Because of this, the review team only recommended two guidelines for practice—the Finnish guideline published in 2020 and the Swedish guideline published in 2022." (Taylor et al., 2024c, p. s70). As described above, these

two guidelines—the only guidelines recommended by Dr. Cass—both recommend psychotherapy and psychosocial supports as first-line treatment.

282. The Cass Review commissioned eight independent systematic reviews (and one practice review) from the University of York evidence synthesis team that form the evidentiary backbone of its conclusions. They are:

1. **Psychological and psychosocial outcomes of gender-affirming medical treatment in adolescents with gender dysphoria:** The review found very low-quality evidence that gender-affirming medical treatments may improve short-term psychological functioning, with no reliable evidence for long-term mental health benefits.
2. **Physical health outcomes of gender-affirming medical treatment in adolescents with gender dysphoria:** The review concluded that evidence on physical outcomes of adolescent medical transition is extremely limited, with insufficient data to determine long-term safety or risk profiles.
3. **Puberty suppression for children and adolescents with gender dysphoria: a systematic review:** The review found no convincing evidence that puberty blockers improve mental health or psychosocial functioning, and highlighted significant uncertainty about long term effects on bone health, neurocognition, and fertility.
4. **Cross-sex hormone treatment for adolescents with gender dysphoria: a systematic review:** The review determined that evidence for benefits of adolescent cross-sex hormones is low quality and largely observational, with unknown long term outcomes and uncertain risk–benefit balance.
5. **Surgical interventions for adolescents with gender dysphoria: a systematic review:** The review found almost no evidence on surgical outcomes in adolescents, with data too sparse and methodologically weak to support conclusions about safety, efficacy, or regret.
6. **Detransition and discontinuation of gender-affirming treatment: a systematic review** The review identified major gaps in evidence, noting that detransition is poorly studied, definitions are inconsistent, and existing research is insufficient to estimate prevalence or predictors.
7. **Diagnostic and prognostic factors for gender dysphoria in children and adolescents:** The review found no validated diagnostic or prognostic tools capable of predicting which youth will persist in gender dysphoria or benefit from medical transition.
8. **Service models and pathways for children and adolescents with gender dysphoria:** The review concluded that no service model (affirmative, exploratory, or hybrid) has been evaluated with sufficient methodological rigor to determine comparative effectiveness or safety.
9. **International clinical guidelines for gender-affirming care in children and adolescents: a systematic review:** The review found that major guidelines — including WPATH SOC — do not meet accepted standards for evidence based guideline development, rely on low quality evidence, and lack transparent, systematic methods.

283. England effectively banned new prescriptions for puberty blockers outside of clinical trials in 2024 (National Health Services, 2024), and just recently paused all new prescriptions for cross-sex hormones for minors (Wise, 2026)

284. There have been some criticisms of the Cass Review in the academic and grey literature, including most prominently Meredith McNamara's paper, which is part of the Yale Integrity Project (McNamara et al., 2024; Noone et al., 2025; Grijseels, 2024; Horton, 2024). These criticisms have largely been debunked (Cheung et al., 2025; McDeavitt, Cohn, & Levine, 2025).

285. The McNamara critique is not a peer-reviewed article and its explicit purpose as part of the Yale Integrity Project is to inform litigation. Two of its authors were also authors of WPATH's flawed guidelines. As Cheung points out, "the way in which the authors highlight their perceived authority, with an emphasis on their '86 years collectively caring for 4800 transgender youth,'" along with their "'shotgun' argumentation approach" reveal a paper that elevates appeals to authority over substantive critiques. (Cheung et al., 2025, p. 253). "Although McNamara et al resembles an academic critique, its primary purpose is to support litigation." (Cheung et al., 2025, p. 252).

286. One of McNamara's critiques of the Cass Review is that it failed to employ the appropriate standards for formulating clinical practice guidelines (McNamara et al., 2024). But that was not the Cass Review's purpose. This is "a category error that invalidates many of the paper's arguments …." (Cheung et al., 2025, p. 253). For example, McNamara claims that because "many of the Review's authors' identities are unknown," the Review lacks credibility (McNamara et al., p. 3). But "[t]he sole author of the Review is Dr Cass, and the over 1000 individuals the Review met with did not function as a guideline development group. Disclosure of the identities of individuals providing evidence or input to the Review is neither an expectation of independent reviews, nor would it be appropriate in this case,

given the extreme politicisation of the topic and not infrequent threats to personal safety" (Cheung et al., 2025, p. 253). Indeed, "Given the increasingly evident polarization among clinical professionals, Dr. Cass was asked to chair the group as a senior clinician *with no prior involvement or fixed views in this area*. [emphasis added]" (Cass, 2024, p. 75). This adds to the Cass Review's credibility rather than detracting from it.

287. In her critique of the Cass Review, McNamara et al. (2024) attempted to refute the observation that the exponential rise in referrals to UK gender clinics signals potential overtreatment by arguing that the increase reflects greater awareness, reduced stigma, improved access to care, and greater social acceptance of gender diversity, rather than a novel surge warranting caution. However, this response reveals a common methodological conflation in gender medicine: it equates self-reported transgender identification (e.g., ~0.5–0.6% from census data) with the much lower clinical prevalence of gender dysphoria requiring specialist referral, which established estimates well under 0.1% of the population (Collin et al., 2016). By using broader identity figures as a benchmark for "underserved" youth, such arguments inflate perceived need and downplay the unprecedented scale of the rise (thousands-fold in some clinics over a decade), which far exceeds typical patterns of minority acceptance and suggests social/cultural/ideological influences on child/identity development and possibly also diagnostic expansion rather than simple unmasking of a stable, hidden population.

4. Norway

288. Over the past several years, Norway has undergone a significant reassessment of medical interventions for adolescents with gender incongruence, driven by growing concerns about patient safety, evidence quality, and rising referral rates. In 2023, the Norwegian Healthcare Investigation Board (UKOM)

issued a landmark report concluding that puberty blockers, cross-sex hormones, and surgeries for minors should be considered "experimental" due to insufficient evidence for efficacy and safety and recommended restricting their use to formal research settings until stronger data are available. Norway has seen a sharp rise in youth referrals, particularly among adolescent females, many of whom present with complex psychiatric histories, self-harm, or prior suicidality, prompting further scrutiny of assessment pathways and support services. Norwegian health authorities have tightened access to puberty blockers, citing insufficient documentation of mental health benefits and unresolved concerns about long-term outcomes. Overall, Norway is moving toward a more cautious, research-based model of care, emphasizing comprehensive mental health evaluation, evidence-graded decision-making, and the need for robust long-term studies before widespread adoption of medical interventions for youth.

5. The European Society for Child and Adolescent Psychiatry

289. The European Society for Child and Adolescent Psychiatry stated in 2024 that "[m]ore recently, clinicians, scientists, and the general public have been increasingly questioning some of the existing practices and standards of care for children and adolescents presenting with gender dysphoria" (Radobuljac et al., 2024, p.2). This article calls for caution, rather than following WPATH guidelines: "ESCAP calls for healthcare providers not to promote experimental and unnecessarily invasive treatments with unproven psychosocial effects and, therefore, to adhere to the 'primum-nil-nocere' (first, do no harm) principle" (Radobuljac et al., 2024, p. 4).

B. American institutions have started to shift against social transitioning and medical interventions for minors.

1. HHS Review

290. The HHS Review raises concerns about medical interventions and advocates for psychotherapy over medical treatments. The key findings of the report include the following:

291. *Umbrella Review*: The Review conducted an overview of systematic reviews—also known as an "umbrella review"—to evaluate the direct evidence regarding the benefits and harms of treatment for children and adolescents with gender dysphoria. This reviewed 17 high-quality existing systematic reviews of evidence, including several that have informed health authorities in Europe, for methodological quality. The umbrella review found that the overall quality of evidence concerning the effects of any intervention on psychological outcomes, quality of life, regret, or long-term health, is very low. This indicates that the beneficial effects reported in the literature are likely to differ substantially from the true effects of the interventions. It currently serves as the most complete and broad assessment of the evidence in youth gender medicine.

292. *Concerns About Medical Interventions*: The report expresses serious concerns regarding medical interventions for children and adolescents with gender dysphoria, such as puberty blockers, cross-sex hormones, and surgeries. It highlights potential risks, including irreversible harms like infertility, while finding weak evidence supporting the benefits of these treatments. It raises ethical concerns regarding the use of these treatments considering known harms and unclear benefits. It raises ethical concerns about communicating overly-positive statements regarding pediatric medical transition and social transition. It also revealed numerous examples of the dysfunctional nature of the practice of pediatric medical transition in the United States.

293. *Advocacy for Psychotherapy*: The HHS report recommends broader use of psychotherapy as a primary treatment for young people with gender dysphoria because it is a safer alternative to medical interventions and possibly more effective. The authors note that a lack of data precludes drawing conclusions regarding the best psychotherapy approach.

294. A psychotherapy protocol specifically for gender dysphoria has never been studied. But for an example of the strength of research supporting the general effectiveness of psychotherapy, note that the review of meta-analysis of cognitive behavior therapy (CBT) yielded a final sample consisting of 269 meta-analyses that showed broad and deep efficacy of CBT (Hofman et al., 2012). The breadth and depth of this research is impressive: not 269 original studies, 269 meta-analyses of CBT. This review examined CBT for: substance use disorder, schizophrenia and other psychotic disorders, depression and dysthymia, bipolar disorder, anxiety disorders, somatoform disorders, eating disorders, insomnia, personality disorders, anger and aggression, criminal behaviors, general stress, distress due to general medical conditions, chronic pain and fatigue, distress related to pregnancy complications and female hormonal conditions. While variation of effectiveness exists across conditions, CBT consistently proves its effectiveness (David et al., 2018). Yet proponents of gender affirming treatments claim no therapy, CBT or otherwise, would work for gender dysphoria. The breadth of evidence supporting CBT's effectiveness belies this extreme position.

295. *Criticism of Medical Organizations and WPATH guidelines*: The HHS report details the history of pediatric medicine, and the clinical realities in the United States where affirmative approaches very quickly came to dominate care. Even WPATH guidelines are often not followed in clinical practice, and many that have raised concerns have been stigmatized and harassed.

a. Critiques of the HHS Report fall short.

296. The HHS report has received some criticism. I was one of the authors that drafted a detailed response to each of these critiques (HHS, 2025b). Rather than reproduce all of it here, I will highlight the most salient points from one unsolicited peer review that we responded to (Dowshen et al., 2025). It exemplifies why these critiques miss the mark.

297. Dowshen et al. (2025) published a commentary alleging the HHS Review engages in "numerous violations of scientific norms, misrepresentation of scientific evidence, and mischaracterizations of both gender identity in youth and the standard of care" (p. 342). Because these criticisms draw from the bottom of the evidence (and disagreement) pyramids, they fail to substantively rebut the HHS report.

298. *Scientific Norms*. Dowshen et al. (2025) claim the Review violates scientific norms because it failed to name its authors, cited non-peer-reviewed articles for over 20% of references, and the results were "predetermined" by the Trump Administration's Executive Order on gender-dysphoric care. Goldenberg relies on Dowshen to make the same points (Goldenberg, p. 10). Like some of the criticisms of the Cass Review, these criticisms have superficial appeal but lack substance. The anonymous nature of the report stemmed from the politicization of this issue and, besides, the authors (including myself) are now known. Further, the ratio of scientific to non-scientific citations has no bearing on its trustworthiness of the Report (or any document) so long as the document does not misrepresent what a source says or the strength of its findings. For example, McNamara et al. (2024) is not a peer-reviewed article, so as discussed above, it does not receive the same weight as a peer-reviewed article (and Dr. Meredithe McNamara, lead author of that essay, was a senior author of Dowshen et al. (2025)). Moreover, the Review used transparent methodology, followed scholarly citation norms, and the report

was created without interference from the commissioning administration. The central conclusions underwent independent peer review by subject-matter experts from across the ideological spectrum who found the analyses robust. These critiques are classic misdirection because they fail to substantively critique the Report's findings. As one peer reviewer noted, if bias existed, "it should be possible to point out where the report engages in motivated reasoning," which Dowshen et al. fail to do (HHS, 2025b, p. 97). Importantly, Dowshen et al. do not dispute the veracity of the Report's findings casting considerable doubt on WPATH's credibility.

299. *Misrepresentation of Evidence*. Dowshen et al. (2025) claim the Review "misrepresents" studies, citing Chen et al. (2023) as an example and alleging the Review "ignores" positive findings. This is false. The Review extensively discusses Chen et al. but notes critical qualifications: males showed no improvement in any outcome except "appearance congruence" (measured on a scale never validated in minors), and the improvements in depression and anxiety scores were too small to meet the threshold for clinical significance. Dowshen et al. cite additional studies, but these illustrate inconsistencies rather than robust evidence: Achille et al. (2020) found depression improved only in males (opposite of Chen et al.); Kuper et al. (2020) showed improvement in self-reported but not clinician-reported depression. One citation derives from the same patient cohort as Chen et al., which inflates perceptions of evidence. This exemplifies how the authors rely on an inverted hierarchy of evidence, privileging weak observational studies over systematic reviews. Dowshen et al. also claim the Review "provides no evidence" of harms (p. 343), but Chapter 7 presents detailed indirect evidence from basic science and developmental physiology demonstrating plausible harms, which one peer-reviewer, who was the former president of the Endocrine Society, found "scientifically valid" (HHS, 2025b, p. 104). This claim of no evidence of harms is an especially dubious

claim, because pediatric medical transition targets physiologically healthy tissue via hormones and surgeries, making harm inevitable and a part of every treatment.

300. *Safety Claims*. Dowshen et al. (2025) claim puberty blockers are safe for gender-dysphoric youth because they are "used for decades to treat cisgender youth" with precocious puberty (p. 343). As the Review explains, these are two distinct patient populations. In precocious puberty, blockers stop abnormally timed puberty and puberty later resumes; for gender dysphoria, blockers stop normally timed puberty and over 90% proceed to cross-sex hormones in which puberty does not resume. Senior author Dr. McNamara has acknowledged blockers should be assessed as a single treatment modality with cross-sex hormones, presenting a fundamentally different risk profile.[3] Dowshen et al. also cite the "Utah Review" to show these treatments are safe (p. 343). But the Utah Review does not qualify as a systematic review and is at high risk of bias in all domains (HHS, 2025c, pp. 21–26).

301. *"Conversion Therapy" claims*. Dowshen et al. (2025) allege the Review recommends "conversion therapy" by discussing psychotherapy (p. 343). This is false. The Review describes psychotherapy modalities—including CBT, DBT, and family therapy—aimed at support, distress mitigation, and self-understanding. Notably, Dr. Jack Turban who promotes the "affirming" care model has stated that "conversion efforts and exploratory psychotherapy are distinct, mutually exclusive practices."[4] Even WPATH has stated it "unequivocally oppose[s]" "equating conversion therapy with psychotherapy" for "youth who are exploring gender identity" (WPATH, 2025).

---

[3] *U.S. v. Skrmetti* 605 U.S. 495, (2025) (No. 23-477), Expert Researchers and Physicians, Amicus Curiae brief (2024, pp. 16–17), perma.cc/CSV2-SG7H.

[4] *Chiles v. Salazar*, (No. 24-539), Dr. Jack L. Turban and Dr. Lisa R. Fortuna, Amicus Curiae brief (2025, p. 4),

302. *Guidelines and Clinical Practice.* Dowshen et al. (2025) claim the WPATH guidelines, which the HHS report critiqued, are evidence-based, represent "consensus," took over ten years to develop, and exemplify "the existing standard of care" (pp. 343–44). In fact, there is no accepted standard of care for treating gender dysphoria in minors. As discussed above, guidelines in parts of Europe differ markedly from the WPATH guidelines. Further, none of these attributes establish trustworthiness under AGREE II. Systematic reviews, for example, are much more important than a supposed expert consensus. "Medicine should be evidence-based, not eminence-based" (HHS, 2025b, p. 111). And as already explained, WPATH suppressed systematic reviews it had commissioned that contradicted its pro-interventionist approach. This casts serious doubt on WPATH's credibility and Dowshen never engages with these revelations.

303. In conclusion, Dowshen et al.'s objections are characterized by mischaracterizations, selective quotation, reliance on flawed studies, and an inverted hierarchy of evidence. The commentary fails to identify any actual errors or motivated reasoning; rhetorical criticisms are not a substitute for substantive engagement with the science.

2. The American Society for Plastic Surgeons' Position Statement

304. The American Society for Plastic Surgeons (ASPS) issued a position statement on February 3, 2026, recommending that surgeons delay gender-related breast/chest, genital, and facial surgeries for patients until at least age 19, citing insufficient evidence of a favorable risk-benefit ratio for gender-affirming endocrine and surgical interventions in children and adolescents. The statement emphasizes the low-certainty evidence base (drawing from sources like the Cass Review and the 2025 HHS report), the irreversible nature of procedures in a developmentally vulnerable population, potential long-term harms (e.g., fertility, sexual function),

and the need to balance compassion with scientific rigor and ethical considerations. It distinguishes gender-related surgeries from other adolescent plastic procedures (e.g., breast reduction for physical issues) while also critiquing the entire range of treatment in pediatric medical transition. This marks a shift toward caution and did not focus solely on surgical interventions.

3. The American Medical Association

305. The American Medical Association (AMA) responded to ASPS's February 2026 position statement recommending that gender-related surgeries for minors be delayed until at least age 19 by stating that due to insufficient evidence for surgical interventions in minors, such procedures should generally be deferred to adulthood.

4. State Restrictions

306. 27 states have passed laws or policies limiting youths' access to medical interventions like hormones and surgery. These laws reflect a commitment to safeguarding children during a formative and vulnerable stage of life. By limiting access to irreversible medical interventions such as hormone therapy and surgery, these policies prioritize caution and concerns about these treatments on long-term well-being. Such measures allow more time for youth to explore their identities without pressure, ensuring that any decisions about medical transition are made with maturity, informed consent, and comprehensive psychological support. These restrictions uphold ethical standards in medicine and protect children from regret or harm, which would fall disproportionately on same-sex attracted and bisexual people, who are overrepresented in childhood onset gender dysphoria. It also protects autistic, traumatized, and socially struggling youth who are vastly over-represented in adolescent onset gender dysphoria. At the very least, these laws

reflect a profound disagreement with Washington's position about the acceptable standard of care for these vulnerable children.

X. Concerns with Washington's policy

307. I have reviewed the pleadings in this case, including the licensing waiver issued to the DeGrosses (Am. Compl., Ex. C at 2), and the report of Matt Goldberg, which it appears that Washington relied on to implement its policies and issue the waiver. I have been asked to provide an opinion on the waiver conditions, including those requiring the child-placing agency to:

- "Certify the [DeGrosses'] home for respite of children or youth ages 2–18 years OR placement of children ages 2–5."
- "Not place in this home on an emergent basis, to include receiving care, to have time to thoroughly review the needs of each individual child or youth."
- "Inform the potential child or youth's caseworker/social worker that this family has a waiver on the home for WAC 1520(9) prior to placement to verify there is no known gender diverse identity considerations."
- "Ensure caregivers complete LGBTQIA+ Basics for Supporting Youth within the first year of their license." See Am. Compl. Ex. C at 2.

308. My understanding is that the age restriction requires the child-placing agency to not place children over five with the DeGrosses (or to allow a child placed with the DeGrosses to remain in their home once the child turns six), unless the DeGrosses obtain a license modification from DCYF/Licensing Division allowing an older child to be placed/remain in their care. That modification would be assessed by DCYF based on the needs and best interests of that specific child.

309. Further, my understanding is that these conditions are premised on DCYF's determination that "there is less likelihood for children up through the age of five to identify and articulate a variant gender expression," thereby reducing the chances that a child who identifies as transgender or non-binary will be placed in

the DeGrosses' home. Pls.' Third Set of Interrogatories and Defs.' Objs. and Answers Thereto at 9.

310. Building on the previous sections in this report, I make four observations: 1) Washington's policy assumes that "affirmation" is the correct response to a gender-dysphoric child when there is little evidence showing that the affirmative-care model leads to any discernible health benefits; 2) there is similarly little evidence that failing to affirm a child's gender identity leads to negative health effects; 3) there are good reasons to believe that social transitioning young people is harmful; 4) Washington's specific waiver conditions do not have a basis in science and even seem to contradict the State's position that children can develop a transgender or non-binary identity at any age.

311. *First*, and as I previously explained, the body of evidence on social transitioning and name changes does not show that this model leads to better mental health outcomes. *See* § VII.A (Morandini et al., 2023; Hall et al., 2024).

312. *Second*, there is little evidence that failing to affirm a child's gender identity in this way leads to any negative impacts on a child's mental health. It is easy to support, care for, and raise children of any kind without ever having to affirm a gender identity. For gender non-conforming children who have a gender expression outside of stereotypes, they can be accepted and loved for who they are.

313. Furthermore, children lack the cognitive development necessary to even understand the concept of gender identity, revealing that this label is placed on children by adults. In a commentary on Potter et al.'s (2021) findings from the Adolescent Brain Cognitive Development study, Burke et al. (2021) noted that more than one-third (39.5%) of children aged approximately 9–10 reported not understanding the term "transgender." It's reasonable to believe that proportion rises substantially in younger children. All of which raises concerns about the validity and developmental appropriateness of using this label in surveys or clinical

assessments at such young ages. They suggested that questions about simpler, more concrete concepts—such as "felt-gender" congruence or alignment with assigned sex—would likely be more accurate and suitable for pre-adolescents, whose cognitive grasp of abstract identity terms remains limited.

314. As a child ages into adolescence, they mature into holding more complex beliefs about their inner sense of self. Many articles stress the importance of adolescence to identity formation. These children do not need to be affirmed as anything and regarding their sense of self, it is still in development.

315. *Third*, social transitioning increases the chances that a child's gender dysphoria will persist, diverting a child from the healthy process of reconciliation with their body, toward the path of medicalization and all of the attendant complications and risks. *See above* § VII.A, B.

316. *Fourth*, as noted above, even at age nine, many children do not even understand the concept of transgender identity. Two to five-year-olds lack the cognitive ability to grasps these adult concepts and merely display behaviors which may or may not fit sex stereotypes. There would be no reason to place labels on these children, nor would they have the intellectual capacity to voice the criteria if a clinician attempted to diagnoses the disorder. The eminent psychiatrist Allen Francis wrote that "[f]or kids, the diagnosis should always be written in pencil," recognizing how premature labels can harm development, self-efficacy, and sense of self (Francis, 2016).

317. Further, because Washington posits that children can develop a gender identity at any age, the waiver conditions seem to contradict the State's own position that it must minimize any chance of a child's chosen identity not being affirmed. In response to Plaintiffs' discovery requests, Washington posits that children can "develop gender identity and expression at any age," including as young as two, and that failing to accept this identity can be "traumatic," and cause

trauma “no matter the age of the child” (Goldenberg, p. 17). These overstatements are inaccurate and lack any basis in the literature. Further, these contradictions show the restriction related to children ages 2 to 5 are arbitrary.

I declare under 28 U.S.C. § 1746 and under penalty of perjury under the laws of the United States of America that this declaration is true and correct.

Executed this 20th day of March, 2026, at Tampa Florida, USA.

Kristopher Kaliebe, M.D.

REFERENCE LIST

Abbruzzese, E., Levine, S. B., & Mason, J. W. (2023). The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies-and research that has followed. *Journal of Sex & Marital Therapy*, *49*(6), 673–699. https://doi.org/10.1080/0092623X.2022.2150346

Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *International Journal of Pediatric Endocrinology*, *2020*(1), 8. https://doi.org/10.1186/s13633-020-00078-2

Ainsworth, M. D. S. (1978). The Bowlby-Ainsworth attachment theory. *Behavioral and Brain Sciences, 1*(3), 436–438. https://doi.org/10.1017/S0140525X00075828

Aitken, M., Steensma, T. D., Blanchard, R., VanderLaan, D. P., Wood, H., Fuentes, A., Spegg, C., Wasserman, L., Ames, M., Fitzsimmons, C. L., Leef, J. H., Lishak, V., Reim, E., Takagi, A., Vinik, J., Wreford, J., Cohen-Kettenis, P. T., de Vries, A. L., Kreukels, B. P., & Zucker, K. J. (2015). Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. *The Journal of Sexual Medicine, 12*(3), 756–763. https://doi.org/10.1111/jsm.12817

Alho, J., Gutvilig, M., Niemi, R., Komulainen, K., Böckerman, P., Webb, R. T., Elovainio, M., & Hakulinen, C. (2024). Transmission of Mental Disorders in Adolescent Peer Networks. *Journal of the American Medical Association Psychiatry*, *81*(9), 882–888. https://doi.org/10.1001/jamapsychiatry.2024.1126

American Academy of Child & Adolescent Psychiatry (AACAP) (2022). Florida's "Don't Say Gay or Trans" Law Stigmatizes LGBTQ+ Youth and Families.https://www.aacap.org/AACAP/zLatest_News/Floridas_Dont_Say_Gay_or_Trans_Law_Stigmatizes_LGBTQ_Youth_Families.aspx

American Academy of Pediatrics (2018). Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*, *142*(4), e20182162. https://doi.org/10.1542/peds.2018-2162

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychological Association (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832–864. https://doi.org/10.1037/a0039906

Anckarsäter H, & Gillberg C. (2020) Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery. *The American Journal of Psychiatry. 177*(8), 764-765. https://doi.org/10.1176/appi.ajp.2020.19111117

Andrews, J. C., Schünemann, H. J., Oxman, A. D., Pottie, K., Meerpohl, J. J., Coello, P. A., Rind, D., Montori, V. M., Brito, J. P., Norris, S., Elbarbary, M., Post, P., Nasser, M., Shukla, V., Jaeschke, R., Brozek, J., Djulbegovic, B., & Guyatt, G. (2013). GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *Journal of Clinical Epidemiology, 66*(7), 726–735. https://doi.org/10.1016/j.jclinepi.2013.02.003

Appleby, L. (2024). *Review of suicides and gender dysphoria at the Tavistock and Portman NHS Foundation Trust: independent report.* Department of Health and Social Care. https://www.gov.uk/government/publications/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust-independent-report

Aranda, G., Halperin, I., Gomez-Gil, E., Hanzu, F. A., Seguí, N., Guillamon, A., & Mora, M. (2021). Cardiovascular Risk Associated With Gender Affirming Hormone Therapy in Transgender Population. *Frontiers in Endocrinology*, *12*, Article 718200. https://doi.org/10.3389/fendo.2021.718200

Archer J. (2019). The reality and evolutionary significance of human psychological sex differences. *Biological Reviews of the Cambridge Philosophical Society*, *94*(4), 1381–1415. https://doi.org/10.1111/brv.12507

Archer, J., & Lloyd, B. (2002). *Sex and gender* (2nd ed.). Cambridge University Press. https://doi.org/10.1017/CBO9781139051910

Asscheman, H., Giltay, E. J., Megens, J. A., de Ronde, W. P., van Trotsenburg, M. A., & Gooren, L. J. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology, 164*(4), 635-642. https://doi.org/10.1530/EJE-10-1038

Baams, L., Wilson, B. D. M., & Russell, S. T. (2019). LGBTQ Youth in Unstable Housing and Foster Care. *American Academy of Pediatrics, 143*(3), Article e20174211. https://doi.org/10.1542/peds.2017-4211

Bachmann, C. J., Golub, Y., Holstiege, J., & Hoffmann, F. (2024). Gender Identity Disorders Among Young People in Germany: Prevalence and Trends, 2013-2022. *Deutsches Arzteblatt International*, *121*(11), 370–371. https://doi.org/10.3238/arztebl.m2024.0098

Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. *Journal of the Endocrine Society, 5*(4). https://doi.org/10.1210/jendso/bvab011

Balshem, H., Helfand, M., Schünemann, H. J., Oxman, A. D., Kunz, R., Brozek, J., Vist, G. E., Falck-Ytter, Y., Meerpohl, J., Norris, S., & Guyatt, G. H. (2011). GRADE guidelines: 3. Rating the quality of evidence. *Journal of Clinical Epidemiology*, *64*(4), 401–406. https://doi.org/10.1016/j.jclinepi.2010.07.015

Barnes, H. (2023). *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children.* Pitchstone Publishing.

Bauchner, H., Fontanarosa, P. B., Flanagin, A., & Thornton, J. (2018). Scientific Misconduct and Medical Journals. *Journal of the American Medical Association*, *320*(19), 1985–1987. https://doi.org/10.1001/jama.2018.14350

Baxendale S. (2024). The impact of suppressing puberty on neuropsychological function: A review. *Acta Paediatrica (Oslo, Norway : 1992), 113*(6), 1156–1167. https://doi.org/10.1111/apa.17150

Bhargava, A., Arnold, A. P., Bangasser, D. A., Denton, K. M., Gupta, A., Hilliard Krause, L. M., Mayer, E. A., McCarthy, M., Miller, W. L., Raznahan, A., & Verma, R. (2021). Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement. *Endocrine reviews, 42*(3), 219–258. https://doi.org/10.1210/endrev/bnaa034

Biedermann, S. V., Asmuth, J., Schröder, J., Briken, P., Auer, M. K., & Fuss, J. (2021). Childhood adversities are common among trans people and associated with adult depression and suicidality. *Journal of Psychiatric Research*, *141*, 318–324. https://doi.org/10.1016/j.jpsychires.2021.07.016

Biggs, M. (2021). Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *Journal of Pediatric Endocrinology & Metabolism, 34*(7), 937–939. https://doi.org/10.1515/jpem-2021-0180

Biggs, M. (2022). Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom. *Archives of Sexual Behavior*, *51*(2), 685–690. https://doi.org/10.1007/s10508-022-02287-7

Biggs, M. (2023a). The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence. *Journal of Sex & Marital Therapy*, *49*(4), 348–368. https://doi.org/10.1080/0092623X.2022.2121238

Biggs, M. (2023b). Psychosocial Functioning in Transgender Youth after Hormones. *The New England Journal of Medicine*, *389*(16), 1536–1537. https://doi.org/10.1056/NEJMc2302030

Blanchard, R., Clemmensen, L. H., & Steiner, B. W. (1987). Heterosexual and homosexual gender dysphoria. *Archives of Sexual Behavior*, *16*(2), 139–152. https://doi.org/10.1007/BF01542067

Blanchard, R. (1989). The concept of autogynephilia and the typology of male gender dysphoria. *The Journal of Nervous and Mental Disease*, *177*(10), 616–623. https://doi.org/10.1097/00005053-198910000-00004

Blanchard, R. (1991). Clinical observations and systematic studies of autogynephilia. *Journal of Sex & Marital Therapy*, *17*(4), 235–251. https://doi.org/10.1080/00926239108404348

Block, J. (2023). Gender dysphoria in young people is rising-and so is professional disagreement. *BMJ (Clinical research ed.), 380*, 382. https://doi.org/10.1136/bmj.p382

Block J. (2024). Dispute arises over World Professional Association for Transgender Health's involvement in WHO's trans health guideline. *BMJ (Clinical research ed.), 387*, Article q2227. https://doi.org/10.1136/bmj.q2227

Bowlby, J. (1969). *Attachment and Loss*. Tavistock Institute of Human Relations.

Bränström, R., & Pachankis, J. E. (2020). Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *The American Journal of Psychiatry, 177*(8), 727–734. https://doi.org/10.1176/appi.ajp.2019.19010080

Brewerton, T. D., Suro, G., Gavidia, I., & Perlman, M. M. (2022). Sexual and gender minority individuals report higher rates of lifetime traumas and current PTSD than cisgender heterosexual individuals admitted to residential eating disorder treatment. *Eating and Weight Disorders, 27*(2), 813–820. https://doi.org/10.1007/s40519-021-01222-4

Brignardello-Petersen, R., & Wiercioch, W. (2022, May 16). *Effects of gender affirming therapies in people with gender dysphoria: Evaluation of the best available evidence.* Florida Agency for Health Care Administration.

Brignardello-Petersen, R., & Guyatt, G. H. (2025). Assessing the certainty of the evidence in systematic reviews: importance, process, and use. *American Journal of Epidemiology*, *194*(6), 1681–1686. https://doi.org/10.1093/aje/kwae332

Burke, S. M., Manzouri, A. H., & Savic, I. (2021). Commentary on Potter et al.: Gender diversity and mental health in the Adolescent Brain Cognitive Development study. *Journal of Child Psychology and Psychiatry, 62*(2), 180–181. https://doi.org/10.1111/jcpp.13389

Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and Reconstructive Surgery. Global Open*, *9*(3), Article e3477. https://doi.org/10.1097/GOX.0000000000003477

Byrne A. (2023). The Origin of "Gender Identity". *Archives of Sexual Behavior*, *52*(7), 2709–2711. https://doi.org/10.1007/s10508-023-02628-0

Byrne, A. (2025). How Many Sexes? How Many Genders? *Archives of Sexual Behavior, 54*(10), 3803–3804 (2025). https://doi.org/10.1007/s10508-025-03209-z

Byrne, A. (2023). *Trouble with Gender: Sex Facts, Gender Fictions.* Polity Press.

Çankaya, T., Onur Cura, D., Özkalaycı, H., & Ulgenalp, A. (2021). Chromosomal Evaluation Results for Transgender Individuals and Questioning the Necessity of Karyotyping. *Journal of Clinical Practice and Research, 43*(2), 166-169. https://doi.org/10.14744/etd.2020.67915

Cantor J. M. (2019). Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *Journal of sex & marital therapy, 46*(4), 307–313. https://doi.org/10.1080/0092623X.2019.1698481

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PloS one, 16*(2), Article e0243894. https://doi.org/10.1371/journal.pone.0243894

Cass, H. (2022a). *The Cass Review: Independent review of gender identity services for children and young people Interim report.* National Health Service (NHS), UK. https://cass.independent-review.uk/publications/interim-report/

Cass, H. (2022b). *Independent Review of Gender Identity Services for Children and Young People – Further Advice.* National Health Services (NHS), UK.

Cass, H. (2024). *The Cass Review: Independent review of gender identity services for children and young people: Final Report.* National Health Service (NHS), UK.https://cass.independentreview.uk/home/publications/final-report/

Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *The New England Journal of Medicine*, *388*(3), 240–250. https://doi.org/10.1056/NEJMoa2206297

Chen, D., Strang, J. F., Kolbuck, V. D., Rosenthal, S. M., Wallen, K., Waber, D. P., Steinberg, L., Sisk, C. L., Ross, J., Paus, T., Mueller, S. C., McCarthy, M. M., Micevych, P. E., Martin, C. L., Kreukels, B. P. C., Kenworthy, L., Herting, M. M., Herlitz, A., Haraldsen, I. R. J. H., Dahl, R., … Garofalo, R. (2020). Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth. *Transgender Health, 5*(4), 246–257. https://doi.org/10.1089/trgh.2020.0006

Chew, D., Anderson, J., Williams, K., May, T., & Pang, K. (2018). Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics, 141*(4), Article e20173742. https://doi.org/10.1542/peds.2017-3742

Cheung, C. R., Abbruzzese, E., Lockhart, E., Maconochie, I. K., & Kingdon, C. C. (2025). Gender medicine and the Cass Review: why medicine and the law make poor bedfellows. *Archives of Disease in Childhood, 110*(4), 251–255. https://doi.org/10.1136/archdischild-2024-327994

Chong, M. C., Sharp, M. K., Smith, S. M., O'Neill, M., Ryan, M., Lynch, R., Mahtani, K. R., Clyne, B. (2023). Strong recommendations from low certainty evidence: A cross-sectional analysis of a suite of national guidelines. *BMC Medical Research Methodology, 23*(1), 68. https://doi.org/10.1186/s12874-023-01895-8

Cohn J. (2023). The Detransition Rate Is Unknown. *Archives of Sexual Behavior*, *52*(5), 1937–1952. https://doi.org/10.1007/s10508-023-02623-5

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J.,Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., … Zucker, K. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism*, *13*(4), 165–232. https://doi.org/10.1080/15532739.2011.700873

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., Nieder, T. O., … Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, *23*(Suppl 1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

Collin, L., Reisner, S. L., Tangpricha, V., & Goodman, M. (2016). Prevalence of Transgender Depends on the "Case" Definition: A Systematic Review. *The Journal of Sexual Medicine*, *13*(4), 613–626. https://doi.org/10.1016/j.jsxm.2016.02.001

Conabere, W., Lami, F., Andrews, H., Skarlatos, M., Pace, C. C., Buckingham, P., Hay, S., De Ieso, T., Pang, K. C., & Tollit, M. A. (2025). Operationalising social transition in trans and gender diverse youth: a scoping review of definitions and measures. *EClinicalMedicine, 91*, Article 103720. https://doi.org/10.1016/j.eclinm.2025.103720

Cooper, H. C., Long, J., & Aye, T. (2022). Fertility preservation in transgender and non-binary adolescents and young adults. *PloS one, 17*(3), Article e0265043. https://doi.org/10.1371/journal.pone.0265043

Cosentino, C. E., Meyer-Bahlburg, H. F., Alpert, J. L., & Gaines, R. (1993). Cross-gender behavior and gender conflict in sexually abused girls. *Journal of the American Academy of Child and Adolescent Psychiatry*, *32*(5), 940–947. https://doi.org/10.1097/00004583-199309000-00008

Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *The Journal of Sexual Medicine*, *12*(11), 2206–2214. https://doi.org/10.1111/jsm.13034

Dahlen, S., Connolly, D., Arif, I., Junejo, M. H., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. *BMJ open, 11*(4), Article e048943. https://doi.org/10.1136/bmjopen-2021-048943

da Silva, L. M. B., Freire, S. N. D., Moretti, E., & Barbosa, L. (2024). Pelvic Floor Dysfunction in Transgender Men on Gender-affirming Hormone Therapy: A Descriptive Cross-sectional Study. *International Urogynecology Journal, 35*(5), 1077–1084. https://doi.org/10.1007/s00192-024-05779-3

David, D., Cristea, I., & Hofmann, S. G. (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. *Frontiers in Psychiatry, 9*, 4. https://doi.org/10.3389/fpsyt.2018.00004

D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria. *Archives of Sexual Behavior*, *50*(1), 7–16. https://doi.org/10.1007/s10508-020-01844-2

D'Angelo R. (2023). Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy. *Journal of Medical Ethics*, *51*(1), 3–9. https://doi.org/10.1136/jme-2023-109282

Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15*, 511–517. https://doi.org/10.1007/BF01542316

de Graaf, N. M., Giovanardi, G., Zitz, C., & Carmichael, P. (2018). Sex ratio in children and adolescents referred to the Gender Identity Development Service in the UK (2009–2016). *Archives of Sexual Behavior, 47*(5), 1301–1304. https://doi.org/10.1007/s10508-018-1204-9

De Roo, C., Schneider, F., Stolk, T. H. R., van Vugt, W. L. J., Stoop, D., & van Mello, N. M. (2025). Fertility in transgender and gender diverse people: systematic review of the effects of gender-affirming hormones on reproductive organs and fertility. *Human Reproduction Update, 31*(3), 183–217. https://doi.org/10.1093/humupd/dmae036

de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *The Journal of Sexual Medicine*, *8*(8), 2276–2283. https://doi.org/10.1111/j.1743-6109.2010.01943.x

de Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*(4), 696–704. https://doi.org/10.1542/peds.2013-2958

de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality, 59*(3), 301–320. https://doi.org/10.1080/00918369.2012.653300

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE, 6*(2), Article e16885. https://doi.org/10.1371/journal.pone.0016885

Diaz, S., & Bailey, J. M. (2023). Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Archives of Sexual Behavior*, *52*(3), 1031–1043. https://doi.org/10.1007/s10508-023-02576-9 (Retraction published *Archives of Sexual Behavior*. 2023 Nov;52(8):3577. doi: 10.1007/s10508-023-02635-1.)

Diaz, S., & Bailey, J. M. (2023b). Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Journal of Open Inquiry in the Behavioral Sciences*, *3*(4). https:/doi.org/10.58408/issn.2992-9253.2023.01.01.00000012.

Diekman, A. B., & Eagly, A. H. (2000). Stereotypes as Dynamic Constructs: Women and Men of the Past, Present, and Future. *Personality and Social Psychology Bulletin*, *26*(10), 1171-1188, https://doi.org/10.1177/0146167200262001

Dixon, M., Hawke, L. D., Relihan, J., Darnay, K., & Henderson, J. L. (2022). Let's Talk Gender: Ten Things Transgender and Nonbinary Youth Want All Researchers to Know. *Journal of the American Academy of Child and Adolescent Psychiatry*, *61*(8), 960–964. https://doi.org/10.1016/j.jaac.2021.12.010

Dougan, F.S. There Are Only Two Sexes and There Can Never Be More. *Archives of Sexual Behavior, 54*, 3815-3820 (2025). https://doi.org/10.1007/s10508-025-03311-2

Dowshen, N., Baker, K., Garofalo, R., Chen, D., Inwards-Breland, D. J., Sequeira, G., Mehringer, J. E., & McNamara, M. (2025). A Critical Scientific Appraisal of the Health and Human Services Report on Pediatric Gender Dysphoria. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine, 77*(3), 342–345. https://doi.org/10.1016/j.jadohealth.2025.06.002

Dreger, A. D. (2008). The controversy surrounding *The man who would be Queen*: A case history of the politics of science, identity, and sex in the Internet age. *Archives of Sexual Behavior, 37*(3), 366–421. https://doi.org/10.1007/s10508-007-9301-1

Drobnič Radobuljac, M., Grošelj, U., Kaltiala, R., ESCAP Policy Division, ESCAP Board, Vermeiren, R., Crommen, S., Kotsis, K., Danese, A., Hoekstra, P. J., & Fegert, J. M. (2024). ESCAP statement on the care for children and adolescents with gender dysphoria: an urgent need for safeguarding clinical, scientific, and ethical standards. *European Child & Adolescent Psychiatry, 33*(6), 2011–2016. https://doi.org/10.1007/s00787-024-02440-8

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*(1), 34–45. https://doi.org/10.1037/0012-1649.44.1.34

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental Health and Self-Worth in Socially Transitioned Transgender Youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, *56*(2), 116–123.e2. https://doi.org/10.1016/j.jaac.2016.10.016

Earl, J. (2019). Innovative Practice, Clinical Research, and the Ethical Advancement of Medicine. *The American Journal of Bioethics, 19*(6), 7-18. https://doi.org/10.1080/15265161.2019.1602175

Economist (Jun. 29, 2024). *Marking their own homework: court documents show how research into trans medicine has been manipulated.* https://www.economist.com/united-states/2024/06/27/research-into-trans-medicine-has-been-manipulated.

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

Elkadi, J., Chudleigh, C., Maguire, A. M., Ambler, G. R., Scher, S., & Kozlowska, K. (2023). Developmental Pathway Choices of Young People Presenting to a Gender Service with Gender Distress: A Prospective Follow-Up Study. *Children (Basel, Switzerland)*, *10*(2), 314. https://doi.org/10.3390/children10020314

Erlangsen, A., Jacobsen, A. L., Ranning, A., Delahaut, C., Andersen, P. K., & Nordentoft, M. (2023). Transgender identity and suicide attempts and mortality in Denmark. *Journal of the American Medical Association, 329*(23), 2059–2068. doi.org/10.1001/jama.2023.8627

Evans, D. (2003). Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing*, *12*(1), 77–84. doi.org/10.1046/j.1365-2702.2003.00662.x

Evans, M. (2023). Assessment and treatment of a gender-dysphoric person with a traumatic history. *Journal of Child Psychotherapy, 49*(1), 60–75. doi.org/10.1080/0075417X.2023.2172741

Evidence-Based Medicine Working Group (1992). Evidence-based medicine. A new approach to teaching the practice of medicine. *Journal of the American Medical Association, 268*(17), 2420–2425. https://doi.org/10.1001/jama.1992.03490170092032

Feigerlova E. (2025). Prevalence of detransition in persons seeking gender-affirming hormonal treatments: a systematic review. *The Journal of Sexual Medicine, 22*(2), 356–368. https://doi.org/10.1093/jsxmed/qdae186

Figliola, J. (2025, October 16). *The anatomy of institutional capture: Gender medicine policy and the Texas Medical Association.* Manhattan Institute.

https://manhattan.institute/article/the-anatomy-of-institutional-capture-gender-medicine-policy-and-the-texas-medical-association

Finland Council for Choices in Health Care (COHERE) (2020a). Recommendation of the Council for Choices in Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. https://palveluvalikoima.fi/documents/1237350/22895008/Alaik%C3%A4iset_suositus.pdf/c987a74c-dfac-d82f-2142-684f8ddead64. A translation is available here: https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

Finland Council for Choices in Health Care (COHERE) (2020b). Preparation memorandum of the Service Selection Council. https://palveluvalikoima.fi/documents/1237350/22895008/Valmistelumuistio_sukupuoliidentiteetin+variaatiot.pdf/991c7413-3bd5-3e9d-52c4-24c4e2a7a9e5/Valmistelumuistio_sukupuoliidentiteetin+variaatiot.pdf?t=1592317702000

Fish, J. N., Baams, L., Wojciak, A. S., & Russell, S. T. (2019). Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data. *Child Abuse & Neglect, 89*, 203–211. https://doi.org/10.1016/j.chiabu.2019.01.005

Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin, 143*(2), 187-232. doi.org/10.1037/bul0000084 [apa.org]

Francis, A.J. (2016, October 31). DSM-5 Diagnoses in Kids Should Always Be Written in Pencil. *Psychology Today*. www.psychologytoday.com/us/blog/saving-normal/201610/dsm-5-diagnoses-in-kids-should-always-be-written-in-pencil.

Gao, J. L., Sanz, J., Tan, N., King, D. S., Modest, A. M., & Dommasch, E. D. (2023). Androgenetic alopecia incidence in transgender and gender diverse populations: A retrospective comparative cohort study. *Journal of the American Academy of Dermatology, 89*(3), 504–510. https://doi.org/10.1016/j.jaad.2023.01.037

Gehring, D., & Knudson, G. (2005). Prevalence of Childhood Trauma in a Clinical Population of Transsexual People. *International Journal of Transgenderism, 8*(1), 23–30. doi.org/10.1300/J485v08n01_03

Getahun, D., Nash, R., Flanders, W. D., Baird, T. C., Becerra-Culqui, T. A., Cromwell, L., Hunkeler, E., Lash, T. L., Millman, A., Quinn, V. P., Robinson, B., Roblin, D., Silverberg, M. J., Safer, J., Slovis, J., Tangpricha, V., & Goodman, M. (2018). Cross-sex Hormones and Acute Cardiovascular Events

in Transgender Persons: A Cohort Study. *Annals of Internal Medicine, 169*(4), 205–213. https://doi.org/10.7326/M17-2785

Giovanardi, G., Vitelli, R., Maggiora Vergano, C., Fortunato, A., Chianura, L., Lingiardi, V., & Speranza, A. M. (2018). Attachment Patterns and Complex Trauma in a Sample of Adults Diagnosed with Gender Dysphoria. *Frontiers in Psychology*, *9*, 60. https://doi.org/10.3389/fpsyg.2018.00060

Glintborg, D., Kjer Møller, J.-J., Hass Rubin, K., Lidegaard, Ø., T'Sjoen, G., Ørsted Larsen, M.-L. J., Hilden, M., & Skovsager Andersen, M. (2023). Gender-affirming treatment and mental health diagnoses in Danish transgender persons: A nationwide register-based cohort study. *European Journal of Endocrinology, 189*(3), 336–345. https://doi.org/10.1093/ejendo/lvad119

Gomez-Lumbreras, A., & Villa-Zapata, L. (2024). Exploring Safety in Gender-Affirming Hormonal Treatments: An Observational Study on Adverse Drug Events Using the Food and Drug Administration Adverse Event Reporting System Database. *The Annals of pharmacotherapy, 58*(11), 1089–1098. https://doi.org/10.1177/10600280241231612

Goñi-Sarriés, A., Blanco, M., Azcárate, L., Peinado, R., & López-Goñi, J. J. (2018). Are previous suicide attempts a risk factor for completed suicide? *Psicothema, 30*(1), 33-38. https://psycnet.apa.org/record/2018-24695-006 [psycnet.apa.org]

Graham, C. (2019, September 12). *An open letter to Prof. Alice Roberts on the subject of DSDs and kindness.* MRKH Voice. perma.cc/BK6V-PUTA.

Green, R. (1976). One hundred ten feminine and masculine boys: behavioral contrasts and demographic similarities. *Archives of Sexual Behavior, 5*:425–446. doi.org/10.1007/BF01541335

Green, R. (1987). The "sissy boy syndrome" and the development of homosexuality. New Haven, CT: Yale University Press.

Grijseels, D. M. (2024). Biological and psychosocial evidence in the Cass Review: A critical commentary. International Journal of Transgender Health, 27(1), 278–288. https://doi.org/10.1080/26895269.2024.2362304

Grootens-Wiegers, P., Hein, I. M., van den Broek, J. M., & de Vries, M. C. (2017). Medical decision-making in children and adolescents: developmental and neuroscientific aspects. *BMC pediatrics*, 17(1), 120. https://doi.org/10.1186/s12887-017-0869-x

Guyatt, G. H., Sackett, D. L., Sinclair, J. C., Hayward, R., Cook, D. J., & Cook, R. J. (1995). Users' guides to the medical literature. IX. A method for grading health care recommendations. Evidence-Based Medicine Working Group. *JAMA*, *274*(22), 1800–1804. doi.org/10.1001/jama.274.22.1800

Guyatt, G. H., Oxman, A. D., Kunz, R., Falck-Ytter, Y., Vist, G. E., Liberati, A., Schünemann, H. J., & GRADE Working Group (2008). Going from evidence to

recommendations. *BMJ (Clinical research ed.)*, *336*(7652), 1049–1051. doi.org/10.1136/bmj.39493.646875.AE

Guyatt, G. H., Rennie, D., Meade, M., & Cook, D. (Eds.) (2015). Users' guide to the medical literature: Essentials of evidence-based clinical practice, 3rd edition. McGraw-Hill Education. https://jamaevidence.mhmedical.com/content.aspx?bookid=847&sectionid=69030714

Hakeem, A. (2012). Psychotherapy for gender identity disorders. *Advances in Psychiatric Treatment*, *18*(1), 17–24. https://doi.org/10.1192/apt.bp.111.009431

Hall, R., Taylor, J., Hewitt, C. E., Heathcote, C., Jarvis, S. W., Langton, T., & Fraser, L. (2024). Impact of social transition in relation to gender for children and adolescents: a systematic review. *Archives of disease in childhood*, *109*(Suppl 2), s12–s18. https://doi.org/10.1136/archdischild-2023-326112

Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane Database of Systematic Reviews, 11,* Art. No.: CD013138.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, T. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/ gender-incongruent persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 102,* 3869–3903.

Hisle-Gorman, E., Landis, C. A., Susi, A., Schvey, N. A., Gorman, G. H., Nylund, C. M., & Klein, D. A. (2019). Gender Dysphoria in Children with Autism Spectrum Disorder. *LGBT health*, *6*(3), 95–100. https://doi.org/10.1089/lgbt.2018.0252

Hisle-Gorman, E., Schvey, N. A., Adirim, T. A., Rayne, A. K., Susi, A., Roberts, T. A., & Klein, D. A. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *The Journal of Sexual Medicine, 18,* 1444–1454

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognitive therapy and research, 36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Horton C. (2024). The Cass Review: Cis-supremacy in the UK's approach to healthcare for trans children. International journal of transgender health, 26(4), 1120–1144. https://doi.org/10.1080/26895269.2024.2328249

Hughes, M. (2024). The WPATH Files: Pseudoscientific Surgical and Hormonal Experiments on Children, Adolescents, and Vulnerable Adults. *Environmental Progress*. https://perma.cc/U27U-VS5J

Hooven C. K. (2023). Academic Freedom Is Social Justice: Sex, Gender, and Cancel Culture on Campus. *Archives of Sexual Behavior, 52*(1), 35–41. https://doi.org/10.1007/s10508-022-02467-5

Hutchinson, A., Midgen, M., & Spiliadis, A. (2020). In Support of Research Into Rapid-Onset Gender Dysphoria. *Archives of Sexual Behavior*, *49*(1), 79–80. https://doi.org/10.1007/s10508-019-01517-9

Hutchinson, A. (2025). Cass informed psychotherapy for gender distressed youth. *European Journal of Developmental Psychology*, 1–19. https://doi.org/10.1080/17405629.2025.2540809. Epub 2025 Jul 30

Institute of Medicine. (2011). Clinical practice guidelines we can trust. Washington, DC: National Academies Press. Available from perma.cc/7N6Q-59EJ.

Irvine, Angela, and Canfield, Aisha. The Overrepresentation of Lesbian, Gay, Bisexual, Questioning, Gender Nonconforming and Transgender Youth within the Child Welfare to Juvenile Justice Crossover Population, 24.2 A.m. U. J. Gender Soc. Pol'y & L., 243-261 (2016), https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1679&context=jgspl.

Jackson, S. S., Sun, Y., Hughes, L. D., Gootee, E., Chan, L., & Getahun, D. (2023). Analysis of mortality among transgender and gender diverse adults in England. *JAMA Network Open, 6*(1), Article e2252569. https://doi.org/10.1001/jamanetworkopen.2022.52569

Jarvis SW, Fraser LK, Langton T*, et al* (2025). Epidemiology of gender dysphoria and gender incongruence in children and young people attending primary care practices in England: retrospective cohort study. *Archives of Disease in Childhood 110:*612-621. https://doi.org/10.1136/archdischild-2024-327992

Jenkins, P., & Panozzo, D. (2024). "Ethical Care in Secret": Qualitative Data from an International Survey of Exploratory Therapists Working with Gender-Questioning Clients. *Journal of Sex & Marital Therapy*, *50*(5), 557–582. https://doi.org/10.1080/0092623X.2024.2329761

Jewett, A., Zhang, Y., Sunderam, M., Buxton, C., & Kissin, D. M. (2024, January 10). *2021 assisted reproductive technology fertility clinic and national summary report.* Centers for Disease Control and Prevention. https://stacks.cdc.gov/view/cdc/154438.

Jorgensen, S.C.J. (2023). Transition Regret and Detransition: Meanings and Uncertainties. *Archives of Sexual Behavior, 52*(5), 2173–2184. https://doi.org/10.1007/s10508-023-02626-2

Joseph, T., Ting, J., & Butler, G. (2019). The effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria: Findings from a large national cohort. *Journal of Pediatric Endocrinology and Metabolism, 32,* 1077–1081. https://doi.org/10.1515/jpem-2019-0046

Joyce, H.. (2021). *Trans: When Ideology Meets Reality.* Simon & Schuster.

Joyner, B. L., Jr, Dewan, M., Bavare, A., de Caen, A., DiMaria, K., Donofrio-Odmann, J., Fosse, G., Haskell, S., Mahgoub, M., Meckler, G., Requist, J., Schexnayder, S. M., Olech Smith, M., Werho, D., & Raymond, T. T. (2025). Part 6: Pediatric Basic Life Support: 2025 American Heart Association and American Academy of Pediatrics Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*, *152*(16_suppl_2), S424–S447. https://doi.org/10.1161/CIR.0000000000001370

Kahn, N. F., Sequeira, G. M., Garrison, M. M., Orlich, F., Christakis, D. A., Aye, T., Conard, L. A. E., Dowshen, N., Kazak, A. E., Nahata, L., Nokoff, N. J., Voss, R. V., & Richardson, L. P. (2023). Co-occurring Autism Spectrum Disorder and Gender Dysphoria in Adolescents. *Pediatrics*, *152*(2), Article e2023061363. https://doi.org/10.1542/peds.2023-061363

Kaliebe K. E. (2016). The Future of Psychiatric Collaboration in Federally Qualified Health Centers. *Psychiatric Services (Washington, D.C.), 67*(8), 827–829. https://doi.org/10.1176/appi.ps.201500419

Kaliebe K. E. (2017). Expanding Our Reach: Integrating Child and Adolescent Psychiatry Into Primary Care at Federally Qualified Health Centers. *Journal of the American Academy of Child and Adolescent Psychiatry, 56*(11), 907–909. https://doi.org/10.1016/j.jaac.2017.08.010

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

Kaltiala-Heino, R., Bergman, H., Työläjärvi, M., & Frisén, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics, 9*, 31–41. https:// doi.org/10.2147/AHMT.S135432

Kaltiala, R., Bergman, H., Carmichael, P., de Graaf, N. M., Egebjerg Rischel, K., Frisén, L., Schorkopf, M., Suomalainen, L., & Waehre, A. (2020). Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK. *Nordic Journal of Psychiatry, 74*(1), 40–44. https://doi.org/10.1080/08039488.2019.1667429

Kaltiala, R., Holttinen, T., & Tuisku, K. (2023). Have the psychiatric needs of people seeking gender reassignment changed as their numbers increase? A register study in Finland. *European Psychiatry, 66,* e93, 1–8. https://doi.org/10.1192/j.eurpsy.2023.2471

Kennedy, E., Fysh, M. C., Vickerstaff, V., Gronostaj-Miara, A., Hanson, C., McKay, K., Lane, C., Senior, R., Carmichael, P., Allison, C., Wright, T., Butler, G., Baron-Cohen, S., Hunter, R. M., & Omar, R. (2025). Baseline findings from the Longitudinal Outcomes of Gender Identity in Children (LOGIC) study. *The British Journal of Psychiatry: The Journal of Mental Science*, 1–9. Advance online publication. https://doi.org/10.1192/bjp.2025.10451

Keyes, K. M., Gary, D., O'Malley, P. M., Hamilton, A., & Schulenberg, J. (2019). Recent increases in depressive symptoms among US adolescents: trends from 1991 to 2018. *Social Psychiatry and Psychiatric Epidemiology*, *54*(8), 987–996. https://doi.org/10.1007/s00127-019-01697-8

Klink, D., Caris, M., Heijboer, A., van Trotsenburg, M., & Rotteveel, J. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *Journal of Clinical Endocrinology & Metabolism, 100,* E270–E275. https://doi.org/10.1210/jc.2014-2439

Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146*, 565–569. https://doi.org/10.5694/j.1326-5377.1987.tb120415.x

Kozlowska, K., Hunter, P., Clayton, A., Kaliebe, K., & Scher, S. (2025). Obstacles to progress in paediatric gender medicine. *European Journal of Developmental Psychology*, 1-31. https://doi.org/10.1080/17405629.2025.2546574

Kozlowska, Kasia & Chudleigh, Catherine & McClure, Georgia & Maguire, Ann & Ambler, Geoffrey. (2021). Attachment Patterns in Children and Adolescents With Gender Dysphoria. Frontiers in Psychology. 11. 582688. 10.3389/fpsyg.2020.582688.

Kreukels, B. P. C., Köhler, B., Nordenström, A., Roehle, R., Thyen, U., Bouvattier, C., de Vries, A. L. C., Cohen-Kettenis, P. T., & dsd-LIFE group (2018). Gender Dysphoria and Gender Change in Disorders of Sex Development/Intersex Conditions: Results From the dsd-LIFE Study. *The Journal of Sexual Medicine*, *15*(5), 777–785. https://doi.org/10.1016/j.jsxm.2018.02.021

Kreukels, B. P. C., Cohen-Kettenis, P. T., Roehle, R., van de Grift, T. C., Slowikowska-Hilczer, J., Claahsen-van der Grinten, H., Lindén Hirschberg, A., de Vries, A. L. C., Reisch, N., Bouvattier, C., Nordenström, A., Thyen, U., Köhler, B., & Group, O. B. O. T. D. (2019). Sexuality in Adults with Differences/Disorders of Sex Development (DSD): Findings from the dsd-LIFE Study. *Journal of Sex & Marital Therapy, 45*(8), 688–705. https://doi.org/10.1080/0092623X.2019.1610123

Kuper, L. E., Adams, N., & Mustanski, B. S. (2018). Exploring cross-sectional predictors of suicide ideation, attempt, and risk in a large online sample of

transgender and gender nonconforming youth and young adults. *LGBT Health, 5*(7), 391–400. https://doi.org/10.1089/lgbt.2017.0259

Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics*, *145*(4), Article e20193006. https://doi.org/10.1542/peds.2019-3006

Kuvalanka, K. A., Weiner, J. L., Munroe, C., Goldberg, A. E., & Gardner, M. (2017). Trans and gender-nonconforming children and their caregivers: Gender presentations, peer relations, and well-being at baseline. *Journal of Family Psychology*, *31*(7), 889–899. https://doi.org/10.1037/fam0000338

Laidlaw, M. K., Lahl, J., & Thompson, A. (2025). Fertility preservation: is there a model for gender-dysphoric youth?. *Frontiers in Endocrinology, 16*, 1386716. https://doi.org/10.3389/fendo.2025.1386716

Lawrence A. A. (2010). Sexual orientation versus age of onset as bases for typologies (subtypes) for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior*, *39*(2), 514–545. https://doi.org/10.1007/s10508-009-9594-3

Lawrence, A. A. (2017). Autogynephilia and the typology of male-to-female transsexualism: Concepts and controversies. *European Psychologist, 22*(1), 39–54. https://doi.org/10.1027/1016-9040/a000276

Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128*, 1283–1289. https://doi.org/10.1176/ajp.128.10.1283

Levine S. B. (2021). Reflections on the Clinician's Role with Individuals Who Self-identify as Transgender. *Archives of Sexual bBehavior*, *50*(8), 3527–3536. https://doi.org/10.1007/s10508-021-02142-1

Levine, S. B., Abbruzzese, E., & Mason, J. W. (2022). Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults. *Journal of Sex & Marital Therapy*, *48*(7), 706–727. https://doi.org/10.1080/0092623X.2022.2046221

Levine, S.B., Abbruzzese, E. (2023). Current Concerns About Gender-Affirming Therapy in Adolescents. *Current Sexual Health Reports 15*, 113–123. https://doi.org/10.1007/s11930-023-00358-x

Lewis, J. E., Patterson, A. R., Effirim, M. A., Patel, M. M., Lim, S. E., Cuello, V. A., Phan, M. H., & Lee, W. C. (2025). Examining gender-specific mental health risks after gender-affirming surgery: a national database study. *The Journal of Sexual Medicine, 22*(4), 645–651. https://doi.org/10.1093/jsxmed/qdaf026

Lingiardi, V., Giovanardi, G., Fortunato, A., Nassisi, V., & Speranza, A. M. (2017). Personality and Attachment in Transsexual Adults. *Archives of Sexual Behavior*, *46*(5), 1313–1323. https://doi.org/10.1007/s10508-017-0946-0

Littman, L. (2018). Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. / Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE, 13*(8), Article e0202330. https://doi.org/10.1371/journal.pone.0202330

Littman, L. (2019). "Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria": Correction. *PLoS ONE, 14*(3), Article e0214157. https://doi.org/10.1371/journal.pone.0214157

Littman, L. (2021). Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*, *50*(8), 3353–3369. https://doi.org/10.1007/s10508-021-02163-w

Ludvigsson, J. F., Adolfsson, J., Höistad, M., Rydelius, P.-A., Kriström, B., & Landén, M. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica (Oslo, Norway : 1992), 112*(11), 2279–2292. https://doi.org/10.1111/apa.16791

Maiorano, M. F. P., Cormio, G., Loizzi, V., Maiorano, B. A., Arezzo, F., & Silvestris, E. (2025). Fertility preservation for transgender and non-binary individuals: a systematic review and thematic synthesis of clinical, psychosocial, and structural challenges. *Human Fertility (Cambridge, England), 28*(1), 2527383. https://doi.org/10.1080/14647273.2025.2527383

Marconi, E., Monti, L., Marfoli, A., Kotzalidis, G. D., Janiri, D., Cianfriglia, C., Moriconi, F., Costa, S., Veredice, C., Sani, G., & Chieffo, D. P. R. (2023). A systematic review on gender dysphoria in adolescents and young adults: focus on suicidal and self-harming ideation and behaviours. *Child and Adolescent Psychiatry and Mental Health*, *17*(1), 110. https://doi.org/10.1186/s13034-023-00654-3

Marianowicz-Szczygiel, A. (2022). Rise of gender identity disorders among children and adolescents- data from 10 countries: Possible explanations, conclusions for parents. *Kwartalnik Naukowy Fides Et Ratio, 49*(1), 122-141. https://doi.org/10.34766/fetr.v49i1.1060

Marks, D. H., Hagigeorges, D., Manatis-Lornell, A. J., Dommasch, E., & Senna, M. M. (2019). Hair loss among transgender and gender-nonbinary patients: a cross-sectional study. *The British Journal of Dermatology, 181*(5), 1082–1083. https://doi.org/10.1111/bjd.18099

Matthews, T., Holt, V., Sahin, S., Taylor, A., & Griksaitis, D. (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. *Clinical Child Psychology and Psychiatry*, *24*(1), 112–128. https://doi.org/10.1177/1359104518791657

McDeavitt, K., Cohn, J., & Levine, S. B. (2025). Critiques of the Cass Review: Fact-Checking the Peer-Reviewed and Grey Literature. *Journal of Sex & Marital Therapy, 51*(2), 175–199. https://doi.org/10.1080/0092623X.2025.2455133

McDeavitt, K., Cohn, J. & Kulatunga-Moruzi, C. (2025). Pediatric Gender Affirming Care is Not Evidence-based. *Current Sexual Health Reports, 17*(12). https://doi.org/10.1007/s11930-025-00404-w

McNamara, M., Baker, K., Connelly, K., Janssen, A., Olson-Kennedy, J., Pang, K. C., Scheim, A., Turban, J., Alstott, A. (2024). An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria. https://web.archive.org/web/20240702100251/https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf

McNeil, J., Ellis, S. J., & Eccles, F. J. R. (2017). Suicide in trans populations: A systematic review of prevalence and correlates. *Psychology of Sexual Orientation and Gender Diversity, 4*(3), 341–353. https://doi.org/10.1037/sgd0000235

Meyer-Bahlburg, H. F. L. (1994). Intersexuality and the diagnosis of gender identity disorder. *Archives of Sexual Behavior, 23*, 21–40. https://doi.org/10.1007/BF01541616

Meyer-Bahlburg, H.F.L., Lowrey, K., Hooven, C. K., & Pfaus, J. G. (2023). A Response to the Commentary by Sterling et al. (2023): "Political Views, Not Science: A Response to the Recent 'Cancel Culture' Special Section". *Archives of Sexual Behavior, 52*(8), 3189–3191. https://doi.org/10.1007/s10508-023-02705-4

Miroshnychenko, A., Roldan, Y., Ibrahim, S., Kulatunga-Moruzi, C., Montante, S., Couban, R., Guyatt, G., & Brignardello-Petersen, R. (2025a). Puberty blockers for gender dysphoria in youth: A systematic review and meta-analysis. *Archives of Disease in Childhood, 110*(6), 429–436. https://doi.org/10.1136/archdischild-2024-327909

Miroshnychenko, A., Ibrahim, S., Roldan, Y., Kulatunga-Moruzi, C., Montante, S., Couban, R., Guyatt, G., & Brignardello-Petersen, R. (2025). Gender affirming hormone therapy for individuals with gender dysphoria aged <26 years: a systematic review and meta-analysis. *Archives of Disease in Childhood, 110*(6), 437–445. https://doi.org/10.1136/archdischild-2024-327921

Miroshnychenko, A., Roldan, Y. M., Ibrahim, S., Kulatunga-Moruzi, C., Dahlin, K., Montante, S., Couban, R., Guyatt, G., & Brignardello-Petersen, R. (2025). Mastectomy for Individuals with Gender Dysphoria Younger Than 26 Years: A Systematic Review and Meta-Analysis. *Plastic and Reconstructive Surgery, 155*(6), 915–923. https://doi.org/10.1097/PRS.0000000000011734

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*(1), 29–41. https://doi.org/10.1093/jpepsy/4.1.29

Morandini, J. S., Kelly, A., de Graaf, N. M., Malouf, P., Guerin, E., Dar-Nimrod, I., & Carmichael, P. (2023). Is social gender transition associated with mental

health status in children and adolescents with Gender Dysphoria? *Archives of Sexual Behavior, 52*, 1045–1060. https://doi.org/10.1007/s10508-023-02588-5

Murad, M. H., Mustafa, R. A., Schünemann, H. J., Sultan, S., & Santesso, N. (2017). Rating the certainty in evidence in the absence of a single estimate of effect. *Evidence-based Medicine, 22*(3), 85–87. https://doi.org/10.1136/ebmed-2017-110668

Nahata, L., Valentine, A., & Tishelman, A. C. (2020). Fertility considerations for gender diverse youth. In M. Forcier, G. Van Schalkwyk, & J. L. Turban (Eds.), *Pediatric gender identity: Gender-affirming care for transgender & gender diverse youth* (pp. 203–217). Springer Nature Switzerland AG. https://doi.org/10.1007/978-3-030-38909-3_15

National Health Services (2024). Clinical Policy: Puberty suppressing hormones (PSH) for children and young people who have gender incongruence / gender dysphoria. https://www.england.nhs.uk/wp-content/uploads/2024/03/clinical-commissioning-policy-gender-affirming-hormones-v2.pdf

Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M., Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, *19*(2), 212–224. https://doi.org/10.1080/15532739.2018.1456390

New Zealand Medicines (Restriction on Prescribing Gonadotropin-releasing Hormone Analogues) Amendment Regulations 2025 (Nov. 17, 2025). SL 2025/256. https://www.legislation.govt.nz/secondary-legislation/pco-drafted/2025/256/en/latest/#LMS1542785.

New Zealand Ministry of Health (2024). Impact of Puberty Blockers in Gender-Dysphoric Adolescents: An evidence brief. Wellington: Ministry of Health. https://www.health.govt.nz/system/files/2024-11/Impact-of-Puberty-Blockers-in-Gender-Dysphoric-Adolescents-evidence-brief.pdf.

National Institute for Health and Care Excellence (NICE) (2020a). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310144323mp_/https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf

National Institute for Health and Care Excellence (NICE) (2020b). Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310144323mp_/https://cass.independent-review.uk/wp-

content/uploads/2022/09/20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf

Noelle-Neumann, E. (1974). The Spiral of Silence A Theory of Public Opinion. *Journal of Communication, 24*: 43-51. https://doi.org/10.1111/j.1460-2466.1974.tb00367.x

Noone, C., Southgate, A., Ashman, A., Quinn, É., Comer, D., Shrewsbury, D., Ashley, F., Hartland, J., Paschedag, J., Gilmore, J., Kennedy, N., Woolley, T. E., Heath, R., Biskupovic Goulding, R., Simpson, V., Kiely, E., Coll, S., White, M., Grijseels, D. M., Ouafik, M., … McLamore, Q. (2025). Critically appraising the cass report: methodological flaws and unsupported claims. *BMC medical research methodology, 25*(1), 128. https://doi.org/10.1186/s12874-025-02581-7

Norwegian Healthcare Investigation Board (UKOM) (2023). Pasientsikkerhet for barn og unge med kjønnsinkongruens. https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag/_/service/no.seeds.ukom/download-pdf?id=0b7ef34d-f1c0-4ba0-b2b9-c9252270e05d

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*, *137*(3), Article e20153223. https://doi.org/10.1542/peds.2015-3223

Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender Identity 5 Years After Social Transition. *Pediatrics*, *150*(2), Article e2021056082. https://doi.org/10.1542/peds.2021-056082

Olson-Kennedy, J., Chan, Y. M., Rosenthal, S., Hidalgo, M. A., Chen, D., Clark, L., Ehrensaft, D., Tishelman, A., & Garofalo, R. (2019). Creating the Trans Youth Research Network: A Collaborative Research Endeavor. *Transgender Health*, *4*(1), 304–312. https://doi.org/10.1089/trgh.2019.0024

Olson-Kennedy, J., Durazo-Arvizu, R., Wang, L., Wong, C. F., Chen, D., Ehrensaft, D., Hidalgo, M. A., Chan, Y. M., Garofalo, R., Radix, A. E., & Rosenthal, S. M. (2025). Mental and Emotional Health of Youth after 24 months of Gender-Affirming Medical Care Initiated with Pubertal Suppression. *MedRxiv: The Preprint Server for Health Sciences*. https://doi.org/10.1101/2025.05.14.25327614

Pang, K. C., Feldman, D., Oertel, R., & Telfer, M. (2018). Molecular Karyotyping in Children and Adolescents with Gender Dysphoria. *Transgender health*, *3*(1), 147–153. https://doi.org/10.1089/trgh.2017.0051

Pappas, S. (2021, August 25). New research in suicide prevention. *Monitor on Psychology, 52*(6). American Psychological Association. https://www.apa.org/monitor/2021/09/news-suicide-prevention

Popper, K. R. (1959). *The Logic of Scientific Discovery*. London: Hutchinson.

Potter, A., Dube, S., Allgaier, N., Loso, H., Ivanova, M., Barrios, L. C., Bookheimer, S., Chaarani, B., Dumas, J., Feldstein-Ewing, S., Freedman, E. G., Garavan, H., Hoffman, E., McGlade, E., Robin, L., & Johns, M. M. (2021). Early adolescent gender diversity and mental health in the Adolescent Brain Cognitive Development study. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 62*(2), 171–179. https://doi.org/10.1111/jcpp.13248

Rawee, P., Rosmalen, J. G. M., Kalverdijk, L., & Burke, S. M. (2024). Development of Gender Non-Contentedness During Adolescence and Early Adulthood. *Archives of sexual behavior, 53*(5), 1813–1825. https://doi.org/10.1007/s10508-024-02817-5

Respaut, R., & Terhune, C. (2022, October 6). Number of transgender children seeking treatment surges in U.S. *Reuters*. https://www.reuters.com/investigates/special-report/usa-transyouth-data/

Ring, A., & Malone, W. J. (2020). Confounding Effects on Mental Health Observations After Sex Reassignment Surgery. *The American Journal of Psychiatry, 177*(8), 768–769. https://doi.org/10.1176/appi.ajp.2020.19111169

Rogers, M. L., Hom, M. A., Dougherty, S. P., Gallyer, A. J., & Joiner, T. E. (2020). Comparing suicide risk factors among individuals with a history of aborted, interrupted, and actual suicide attempts. *Archives of Suicide Research, 24*(Suppl 1), S57-S74. https://doi.org/10.1080/13811118.2018.1522283

Ryan, B. (2026). Unheard Testimony From WPATH's President Elect In the Historic Detransitioner Lawsuit: "A reasonable surgeon would have put on the brakes." *Hazard Ratio: Benjamin Ryan.* https://benryan.substack.com/p/unheard-testimony-from-wpaths-president

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. *BMJ (Clinical Research ed.), 312*(7023), 71–72. https://doi.org/10.1136/bmj.312.7023.71

Sapir, L. (2024, August 8). Adolescent Gender Dysphoria Is a Temporary Diagnosis for Most Teens. *City Journal*. https://www.city-journal.org/article/adolescent-gender-dysphoria-is-a-temporary-diagnosis-for-most-teens

Schwartz, L., & Lal, M. (2025). Order of Magnitude: On the Critical Distinction Between Self-Reported Identity and Clinical Prevalence in Adolescent Gender Dysphoria: A Methodological Commentary. *Journal of Sex & Marital Therapy, 51*(8), 998–1003. https://doi.org/10.1080/0092623X.2025.2566764

Schwartz, A. R., & Moravek, M. B. (2021). Reproductive potential and fertility preservation in transgender and nonbinary individuals. *Current Opinion in Obstetrics & Gynecology, 33*(4), 327–334. https://doi.org/10.1097/GCO.0000000000000729

Sestini P. (2010). Epistemology and ethics of evidence-based medicine: putting goal-setting in the right place. *Journal of Evaluation in Clinical Practice*, *16*(2), 301–305. https://doi.org/10.1111/j.1365-2753.2009.01327.x

Shrier, A. (2021). Top trans doctors blow the whistle on 'sloppy' care. *The Free Press.* https://www.thefp.com/p/top-trans-doctors-blow-the-whistle

Sibarium, Aaron (2023). They Support Sex Changes for Children, with Safeguards. A Top Child Psychiatry Group Won't Let Them Speak as Its Annual Conference. *The Washington Free Beacon.* https://freebeacon.com/campus/they-support-sex-changes-for-children-with-safeguards-a-top-child-psychiatry-group-wont-let-them-speak-at-its-annual-conference/

Sievert, E. D., Schweizer, K., Barkmann, C., Fahrenkrug, S., & Becker-Hebly, I. (2021). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with gender dysphoria. *Clinical Child Psychology and Psychiatry, 26*(1), 79–95. https://doi.org/10.1177/1359104520964530

Simonsen, R. K., Giraldi, A., Kristensen, E., & Hald, G. M. (2016). Long-term follow-up of individuals undergoing sex reassignment surgery: Psychiatric morbidity and mortality. *Nordic Journal of Psychiatry, 70*(4), 241–247. https://doi.org/10.3109/08039488.2015.1081405

Singal, J. (2026, February 24). Medical associations trusted belief over science on youth gender care. *The New York Times.* https://www.nytimes.com/2026/02/24/opinion/medical-associations-youth-gender-care.html

Singh, D. (2012). *A follow-up study of boys with gender identity disorder* (Unpublished doctoral dissertation). University of Toronto.

Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder. *Frontiers in Psychiatry*, *12*, Article 632784. https://doi.org/10.3389/fpsyt.2021.632784

Shorter, E. (1994). *From the Mind into the Body*. The Free Press.

Shumer, D. E., Nokoff, N. J., & Spack, N. P. (2016). Advances in the Care of Transgender Children and Adolescents. *Advances in Pediatrics, 63*(1), 79–102. https://doi.org/10.1016/j.yapd.2016.04.018

Soh, D. (2020). *The End of Gender: Debunking the Myths about Sex and Identity in Our Society*. Threshold Editions.

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clinical child Psychology and Psychiatry, 16*(4), 499–516. https://doi.org/10.1177/1359104510378303

Steensma, T. D., Kreukels, B. P., de Vries, A. L., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. *Hormones and Behavior, 64*(2), 288–297. https://doi.org/10.1016/j.yhbeh.2013.02.020

Steensma, T. D., & Cohen-Kettenis, P. T. (2018). A critical commentary on "A critical commentary on follow-up studies and 'desistence' theories about transgender and gender non-conforming children." *International Journal of Transgenderism, 19*(2), 225–230. https://doi.org/10.1080/15532739.2018.1468292

Stevenson, D. K., Murray, J. C., Muglia, L. J., Wong, R. J., & Katz, M. (2023). Challenges to the study of gender dysphoria. *Acta Paediatrica, 112*(11), 2273–2275. https://doi.org/10.1111/apa.16975

Stock, K. (2021). *Material Girls: Why Reality Matters for Feminism*. Fleet.

Straub, J. J., Paul, P., Khera, R., & Gulati, M. (2024). Risk of suicide and self-harm following gender-affirmation surgery. *Cureus, 16*(4), Article e57886. https://doi.org/10.7759/cureus.57886

Suissa, J. & Sullivan, A., The Gender Wars, Academic Freedom and Education, *Journal of Philosophy of Education*, *55*(1): 55–82, https://doi.org/10.1111/1467-9752.12549

Sullivan, A., et al. (2025). Review of data, statistics and research on sex and gender: Report 2: Barriers to research on sex and gender. *UK Government Department for Science, Innovation, and Technology*. https://sullivanreview.uk/barriers.pdf.

Sweden National Board of Health and Welfare (Socialstyrelsen) (2022). Care of children and adolescents with gender dysphoria: Summary of national guidelines. https://www.socialstyrelsen.se/contentassets/444af6c0a5fb429c9b56fd51b931a816/2023-1-8330.pdf.

Taylor, J., Mitchell, A., Hall, R., Heathcote, C., Langton, T., Fraser, L., & Hewitt, C. E. (2024a). Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: a systematic review. *Archives of Disease in Childhood, 109*(Suppl 2), s33–s47. https://doi.org/10.1136/archdischild-2023-326669

Taylor, J., Mitchell, A., Hall, R., Langton, T., Fraser, L., & Hewitt, C. E. (2024b). Masculinising and feminising hormone interventions for adolescents experiencing gender dysphoria or incongruence: a systematic review. *Archives of Disease in Childhood, 109*(Suppl 2), s48–s56. https://doi.org/10.1136/archdischild-2023-326670.

Taylor, J., Hall, R., Heathcote, C., Hewitt, C. E., Langton, T., & Fraser, L. (2024c). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part

1). *Archives of Disease in Childhood*, *109*(Suppl 2), s65–s72. https://doi.org/10.1136/archdischild-2023-326499

Taylor, J., Hall, R., Heathcote, C., Hewitt, C. E., Langton, T., & Fraser, L. (2024d). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of recommendations (part 2). *Archives of Disease in Childhood, 109*(Suppl 2), s73–s82. https://doi.org/10.1136/archdischild-2023-326500

Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M. L., Jamieson, A., & Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, *19*(2), 212–224. https://doi.org/10.1080/15532739.2018.1456390

Thompson, L., Sarovic, D., Wilson, P., Sämfjord, A., & Gillberg, C. (2022). A PRISMA systematic review of adolescent gender dysphoria literature: 2) mental health. *PLOS Global Public Health*, *2*(5), Article e0000426. https://doi.org/10.1371/journal.pgph.0000426

Thompson, L., Sarovic, D., Wilson, P., Irwin, L., Visnitchi, D., Sämfjord, A., & Gillberg, C. (2023). A PRISMA systematic review of adolescent gender dysphoria literature: 3) treatment. *PLOS Global Public Health*, *3*(8), Article e0001478. https://doi.org/10.1371/journal.pgph.0001478

Thrower, E., Bretherton, I., Pang, K. C., Zajac, J. D., & Cheung, A. S. (2020). Prevalence of Autism Spectrum Disorder and Attention-Deficit Hyperactivity Disorder Amongst Individuals with Gender Dysphoria: A Systematic Review. *Journal of Autism and Developmental Disorders*, *50*(3), 695–706. https://doi.org/10.1007/s10803-019-04298-1

Twenge, J. M. (2020). Increases in Depression, Self-Harm, and Suicide Among U.S. Adolescents After 2012 and Links to Technology Use: Possible Mechanisms. *Psychiatric Research and Clinical Practice*, *2*(1), 19–25. https://doi.org/10.1176/appi.prcp.20190015

UK Department of Education (2023). Gender Questioning Children, Non-statutory guidance for schools and colleges in England. Draft for consultation. https://consult.education.gov.uk/equalities-political-impartiality-anti-bullying-team/gender-questioning-children-proposed-guidance/supporting_documents/Gender%20Questioning%20Children%20%20nonstatutory%20guidance.pdf

UK Government (2024, December 11). Ban on puberty blockers to be made indefinite on experts' advice. https://www.gov.uk/government/news/ban-on-puberty-blockers-to-be-made-indefinite-on-experts-advice.

U.S. Department of Health, Education, and Welfare (DHEW), & National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (NCPHSBBR) (2014). The Belmont Report. Ethical

principles and guidelines for the protection of human subjects of research. *The Journal of the American College of Dentists*, 81(3), 4–13. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

U.S. Department of Health and Human Services (HHS) (2025a). Treatment for pediatric gender dysphoria: Review of evidence and best practices. https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf

U.S. Department of Health and Human Services (HHS) (2025b). Supplement to Treatment for Pediatric Gender Dysphoria Review of Evidence and Best Practices. https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-supplement.pdf

U.S. Department of Health and Human Services (HHS) (2025c). Appendix 4: Overview of Systematic Reviews. https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-appendix.pdf

Vandenbussche, E. (2022). Detransition-Related Needs and Support: A Cross-Sectional Online Survey. *Journal of Homosexuality*, *69*(9), 1602–1620. https://doi.org/10.1080/00918369.2021.1919479

van der Miesen, A. I., Steensma, T. D., de Vries, A. L., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health, 66*(6), 699-704. https://doi.org/10.1016/j.jadohealth.2019.12.018

van Zijverden, L. M., Wiepjes, C. M., van Diemen, J. J. K., Thijs, A., & den Heijer, M. (2024). Cardiovascular disease in transgender people: a systematic review and meta-analysis. *European Journal of Endocrinology, 190*(2), S13–S24. https://doi.org/10.1093/ejendo/lvad170

van Zyl, J. (2024). Formulating gender dysphoria as an affective-perceptual disturbance involving the body. *Psychodynamic Practice, 31*(2), 160-176. https://doi.org/10.1080/14753634.2024.2371655

Varkey, B. (2021). Principles of Clinical Ethics and Their Application to Practice. *Medical Principles and Practice: International Journal of the Kuwait University, Health Science Centre*, *30*(1), 17–28. https://doi.org/10.1159/000509119

Vitelli, R., & Riccardi, E. (2011). Gender identity disorder and attachment theory: The influence of the patient's internal working models on psychotherapeutic engagement and objective. A study undertaken using the Adult Attachment Interview. *International Journal of Transgenderism, 12*(4), 241–253. https://doi.org/10.1080/15532739.2010.551485

Vlot, M., Klink, D. T., den Heijer, M., Blankenstein, M. A., Rotteveel, J., & Heijboer, A. C. (2017). Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in

transgender adolescents. *Bone, 95,* 11–19. https://doi.org/10.1016/j.bone.2016.11.008

Walker, A., & Holt, A. (2026, February 21). Puberty blockers trial paused over concerns from medicines watchdog. *BBC News.* https://www.bbc.com/news/articles/cjd9z0p27k5o

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual Outcome of Gender-Dysphoric Children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(12), 1413–1423. https://doi.org/10.1097/CHI.0b013e31818956b9

Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M. C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications*, *11*(1), 3959. https://doi.org/10.1038/s41467-020-17794-1

Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Block, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). *Acta Psychiatrica Scandinavica, 141*, 486-491. https://doi.org/10.1111/acps.13164

Wise, J. (2026). NHS halts cross-sex hormone treatment for under 18s. *BMJ, 392*, s461. https://doi.org/10.1136/bmj.s461

Withers, R. (2020), Transgender medicalization and the attempt to evade psychological distress. *Journal of Analytical Psychology, 65*(5): 865–889. https://doi.org/10.1111/1468-5922.12641.

Wold, A. (2020). Gender-Corrective Surgery Promoting Mental Health in Persons With Gender Dysphoria Not Supported by Data Presented in Article. *American Journal of Psychiatry, 177*(8), 768-768. https://doi.org/10.1176/appi.ajp.2020.19111170

Wong W. I., van der Miesen A. I. R., Li T. G. F., MacMullin L. N., VanderLaan D. P. (2019). Childhood Social Gender Transition and Psychosocial Well-Being: A Comparison to Cisgender Gender-Variant Children. *Clinical Practice in Pediatric Psychology, 7*(3):241–253. https://doi.org/10.1037/cpp0000295

Wood, H., et al. (2013). Patterns of referral to a Gender Identity Service for Children and Adolescents (1976–2011). *Journal of Sex and Marital Therapy, 39*(1), 1–6. https://doi.org/10.1080/0092623X.2012.675022

World Association of Medical Editors. (2009). Conflict of interest in peer-reviewed medical journals: a policy statement of the World Association of Medical Editors (WAME). *Journal of Child Neurology, 24*(10), 1321–1323. https://doi.org/10.1177/0883073809345928

World Professional Association for Transgender Health (WPATH) & United States Professional Association for Transgender Health. (2025). WPATH and USPATH Response to the HHS Report on Gender Dysphoria. https://wpath.org/wp-content/uploads/2025/05/WPATH-USPATH-Response-to-HHS-Report-02May2025-3.pdf

Wuthrich, V. M., Zagic, D., Dickson, S. J., McLellan, L. F., Chen, J. T., Jones, M. P., & Rapee, R. M. (2023). Effectiveness of Psychotherapy for Internalising Symptoms in Children and Adolescents When Delivered in Routine Settings: A Systematic Review and Meta-analysis. *Clinical Child and Family Psychology Review*, *26*(3), 824–848. https://doi.org/10.1007/s10567-023-00433-8

Zepf, F. D., König, L., Kaiser, A., Ligges, C., Ligges, M., Roessner, V., Banaschewski, T., Holtmann, M. (2024). Beyond NICE: Updated systematic review on the current evidence for using puberty blockers and cross-sex hormones in minors with gender dysphoria: Electronic supplementary online materials I: adapted abbreviated English version. *Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie*, 1422-4917/a000972, https://econtent.hogrefe.com/doi/suppl/10.1024/1422-4917/a000972/suppl_file/1422-4917_a000972_esm1.pdf

Zhang, Y., Januś, D., Kaltiala, R., Karvonen, M., Ptak, J. J., & Yepes-Nuñez, J. J. (2026). Quality of the World Professional Association for Transgender Health Guideline Standards of Care 8: An Appraisal Using the AGREE II Instrument. *Archives of Sexual Behavior*, Advance online publication. https://doi.org/10.1007/s10508-025-03399-6

Zucker, K.J., Bradley, S.J., & Sanikhani, M. (1997). Sex differences in referral rates of children with gender identity disorder: some hypotheses. *Journal of Abnormal Child Psychology*, 25, 217–227. https://doi.org/10.1023/a:1025748032640

Zucker, K.J. (2010). The DSM Diagnostic Criteria for Gender Identity Disorder in Children. *Archives of Sexual Behavior*, *39*(2), 477–498. https://doi.org/10.1007/s10508-009-9540-4

Zucker, K. J. (2018). The myth of persistence: Response to "a critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018). *International Journal of Transgenderism, 19*(2), 231–245. https://doi.org/10.1080/15532739.2018.1468293

Zucker, K. J. (2019). Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues. *Archives of Sexual Behavior, 48*(7), 1983–1992. https://doi.org/10.1007/s10508-019-01518-8

Zucker K. J. (2020). Debate: Different strokes for different folks. *Child and Adolescent Mental Health, 25*(1), 36–37. https://doi.org/10.1111/camh.12330

Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 9*(4), 363–369. https://doi.org/10.1016/0010-440x(78)90019-6

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*(2), 90–97. https://doi.org/10.1097/00005053-198402000-00005