

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

NICHOLAS W. BROWN, in his official
capacity as Attorney General for the State
of Washington; DENNIS WORSHAM, in
his official capacity as Secretary of Health
for the State of Washington; and SHAWNA
FOX, in her official capacity as Assistant
Secretary of the Health Systems Quality
Assurance division of the Washington State
Department of Health,

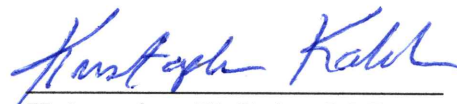
Defendants.

Case No. 3:21-cv-05359

DECLARATION OF
KRISTOPHER KALIEBE

I, Kristopher Kaliebe, M.D., hereby declare under penalty of perjury of the
laws of the United States that the statements in my expert report attached hereto
are true and accurate to the best of my knowledge and represent my professional
opinions.

DATED this 17th day of June, 2026, at Hillsborough County, Florida.

 M.D.
Kristopher Kaliebe, M.D.

Expert Report of
Kristopher Kaliebe, MD

Tingley v. Ferguson

United States District Court
Western District of Washington

TABLE OF CONTENTS

Table of Contents	ii
List of Acronyms	iv
I. Background and Professional Qualifications	1
II. Summary	5
III. Principles of evidence-based medicine.	6
IV. The etiology of gender dysphoria.....	14
A. Sex is binary and biological while gender is subjective.....	14
B. Intersex conditions or DSDs do not negate the sex binary.....	16
C. Gender dysphoria is a psychiatric condition involving distress because of a felt incongruence between a person’s body and self-perception.	18
D. The “transgender” umbrella masks distinct populations and conditions.	20
1. Gender non-conformity is not pathological or unhealthy.....	20
2. Children with early onset gender dysphoria are a unique group whose distress will naturally resolve itself.....	21
3. The recent explosion of gender dysphoria among adolescents points to sociological phenomenon.	25
4. Children and adolescents are distinct from adult transsexuals.	30
5. There is no reliable method to determine whether gender dysphoria will persist in children or adolescents.....	31
V. The origins of the “affirming” model of care.	34
A. There are at least three methods for treating gender dysphoria.	34
B. “Transitioning” or “affirming” a person’s transgender identity began as a treatment for adult transsexuals.....	36
C. The Dutch Protocol popularized social transitioning and medical interventions for minors.....	38
D. The growing retreat from the affirming-care model.....	41
1. European countries have sharply limited medical interventions for minors based on independent reviews of the evidence.....	41
2. American institutions have started to shift against social transitioning and medical interventions for minors.....	46
VI. The false promises of affirmation and social transitioning.....	48
A. Social transitioning is a life-altering psychosocial intervention without proven benefits.	49
1. Social transitioning is a potent psychiatric intervention without proven benefits.	49
2. Social transition reduces rates of desistance while widening the pathway to medicalization.....	51
B. Medicalized transition has unproven benefits and likely harms.	54
1. Systematic reviews show that the evidence base for endocrine and medical interventions is low to very low.	54

2.	Umbrella reviews have similarly graded the evidence-base for PMT as low-quality.	58
3.	There is no evidence that medical interventions reduce rates of either suicide or suicidality.	66
4.	Endocrine interventions are associated with harm, including with potentially catastrophic harms.....	71
C.	WPATH and Endocrine Society guidelines are not authoritative standards of care.	75
1.	The paucity of evidence precludes recommendations for “affirming” a young person’s claimed gender identity.....	75
2.	The WPATH standards of care are flawed.	77
3.	The Endocrine Society guidelines are limited in scope and do not establish standards of care.....	86
4.	Other medical organizations have promoted the gender-affirming care model without critically examining the evidence base.....	87
VII.	Ethical concerns with pediatric interventions.....	93
A.	Ethics requires giving the patient sufficient information to make an informed decision.....	94
B.	Social transitioning’s weak evidence base makes it ethically fraught.	95
C.	Medical transitioning is even more ethically fraught.....	95
VIII.	Psychotherapy and Washington’s “conversion therapy” ban.	96
A.	Psychotherapy is a valid treatment for gender dysphoria.....	97
B.	Talk therapy is not “conversion therapy.”.....	103
	Reference list.....	113

LIST OF ACRONYMS

- AACAP – American Academy of Child and Adolescent Psychiatry
- AGREE – Appraisal of Guidelines for Research & Evaluation
- APA – American Psychological Association
- 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
- EBM – Evidence-based medicine
- FP – Fertility preservation
- GICE – Gender identity change efforts
- GRADE – Grading of Recommendations, Assessment, Development and Evaluation
- HHS – United States Department of Health and Human Services
- NIH – National Institutes of Health (US)
- NHS – National Health Service (UK)
- PMT – Pediatric medical transition
- RCT – Randomized controlled trial
- SOCE – Sexual-orientation change efforts
- ROGD – Rapid onset gender dysphoria
- USTS – United States Transgender Survey
- WPATH – World Professional Association for Transgender Health

I. Background and Professional Qualifications

1. I have been retained by Plaintiff 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 materials I considered in forming the opinions in this report throughout the report itself and have included a complete reference list at the conclusion.

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. 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 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 in 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 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 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 pediatric gender medicine" (Kozłowska et al., 2025). I was a co-author 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.

17. I have reviewed pleadings in this case, including the complaint and Brian Tingley's declarations, and have been asked to provide an expert opinion on Washington's law prohibiting so-called "conversion therapy." Specifically, I have been asked to opine on the evidence base for available treatments for gender dysphoria in children and adolescents, and the clinical and ethical implications of restricting the therapeutic options available to practitioners and their patients.

II. Summary

- Evidence-based medicine evaluates competing treatments through systematic reviews of the evidence. The GRADE framework is also helpful to evaluate the body of evidence and whether it justifies recommendations for treatment. Low quality evidence rarely justifies interventions with unproven benefits, particularly when those interventions carry real risks of harm.
- Gender dysphoria is a psychiatric disorder characterized by psychological distress arising from a persistent belief that there is an incongruence between a person's biological sex and their subjective sense of a "gender identity."
- Gender identity is amorphous and poorly defined construct which started as the sense of knowing to which sex you belong, but now has become theorized to include a "inner sense" that can be either sex or other options.
- While a person's self-conceived "gender identity" is an imprecise, subjective, unfalsifiable concept, biological sex is binary and immutable.
- Gender dysphoria manifests itself differently in children versus adolescents versus adults. These are distinct populations with different demographics, causes, and likely trajectories.
- 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 the end of puberty. There is no reliable method for predicting who falls into the small category of children who may not grow out of it.

- 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.
- There are at least three competing models for treating gender dysphoria in young people: exploratory psychotherapy, watchful waiting, and the “affirming” model of care.
- The “affirming” model of care (which Washington mandates) is not evidence-based. Encouraging children or adolescents to socially “transition” involves a potent psychosocial intervention without proven benefits. It strongly predisposes children, and potentially adolescents, to continue in a transgender identification that would otherwise resolve itself while increasing the likelihood that the young person embarks upon medical interventions.
- Medical interventions to treat gender dysphoria, including puberty blockers, hormone supplements, and surgery, have even less evidence of benefits and often involve certain or high possibilities of harms.
- Psychotherapies aimed at reducing gender dysphoria by helping a child develop comfort with his or her natural body are valid treatment options because the dysphoria is rooted in beliefs about the self and negative appraisals of one’s body.
- As such, psychotherapy to help patients with gender dysphoria must allow the therapist to discuss with patients the full range of possible impacts of negative body-related self-narratives, just as therapists do for other psychiatric disorders, such as health-related anxieties, anorexia, body dysmorphic disorder, OCD, and other somatic syndromes.
- Helping children and adolescents understand themselves better and reducing their distress is not “conversion therapy.” Labeling all efforts to reduce gender-related distress or to encourage alignment between feelings and the child’s body as “conversion therapy” is scientifically unsupported.

III. Principles of evidence-based medicine.

18. To establish the groundwork for our discussion of the literature on therapy for gender dysphoria, I will briefly review the principles of evidence-based medicine (EBM).

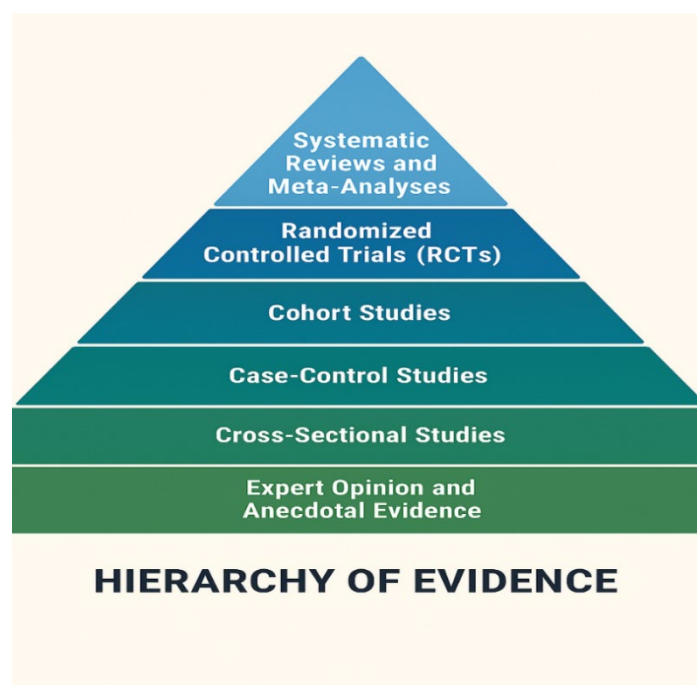
19. EBM emerged in the early 1990s and represented a foundational shift in medicine from an era in which “clinical decisions were based largely on experience and skill (the ‘art’ of medicine)” (Institute of Medicine, 2011, p. 30) to “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett et al., 1996, p. 71). At its core, EBM utilizes 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). 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, 1992, p. 2421).

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

21. *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, 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.

22. 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” (HHS, 2025a, p. 285–86). The hierarchy helps clinicians prioritize the most trustworthy studies and evidence when evaluating treatments, diagnostics, or prognostic tools.

23. 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.

24. After multiple systematic reviews are available, umbrella reviews (overviews of reviews or meta-reviews) are possible. An umbrella review 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.

25. *GRADE 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.¹ 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).

26. Under the GRADE approach, “quality of evidence” refers to how confident we can be that the research finding reflects the true effect of an

¹ While GRADE is not the only well-regarded framework for systematically evaluating evidence quality in an area, it was developed by the founders of EBM and is often regarded as a gold-standard tool. AGREE II (Appraisal of Guidelines for Research & Evaluation) is another well-regarded framework for evaluating the methodological rigor and transparency of clinical guidelines.

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)

27. 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).

28. 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).

29. *GRADE 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).

30. 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).

31. 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).

32. 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.

33. 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.

34. 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).

35. 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).

36. High-quality evidence does not necessarily translate to a strong recommendation, nor does low-quality evidence require a weak recommendation (Balslem 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).

37. 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.

38. Applying GRADE in the context of pediatric gender medicine, clinicians, guideline panels, and policymakers must consider the evidence base, benefits, and risks of the available alternatives (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.

IV. The etiology of gender dysphoria.

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

39. 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).

40. 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).

41. 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.

42. 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., nonbinary, 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).

43. In the last decades, gender identity has developed new meanings that are vague and ambiguous. “Gender identity” 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 defines 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.

44. The first problem 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. What is clear is that gender identity is no longer tied to biological sex.

45. A second problem is that, while gender identity often appears in literature and popular media, the term is ill-defined (Byrne, 2023, 2025). 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” (DSM-5, 2022, p. 511).

46. 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).

47. 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.

48. 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.

49. 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.

50. 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, p. 3815). Rather, they all involve atypical variations of the male and

female sexes. The suggestion that intersex conditions reveal a sex spectrum “conflate[s] sex with secondary traits, developmental anomalies, or mating systems that do not involve gamete dimorphism” (Dougan, 2025, p. 3816). “Given the complexities of the biology of sexual determination and differentiation, it is not surprising that there are dozens of examples of variations or errors in these pathways associated with genetic mutations that are now well known to endocrinologists and geneticists” (Bhargava et al., 2021, p. 225).

51. 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.

52. 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).

53. 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; Çankaya 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.

54. 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.

55. In contrast, severe persistent conditions like schizophrenia or severe autism involve fundamentally different core features, such as schizophrenia’s 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.

56. 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).

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

(DMS-5, 2022, p. 512).

57. 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 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.

(DSM-5, 2022, pp. 512–23)

58. While gender dysphoria is viewed by some as a serious medical or psychiatric illness, others have viewed it as a developmental adaptation to psychological problems (Withers, 2020), 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.

59. 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.

60. 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).

61. 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.

62. Children often 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 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.

63. 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 (DSM-5, 2022, pp. 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 intervention.

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

64. 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 “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.

65. 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 (Singh et al., 2021; Drummond et al., 2008). These outcomes 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)

66. 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.

67. Children experiencing distress over their gender incongruence 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).

68. Julia Temple Newhook’s 2018 article 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. 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 on average); and
- limiting samples to clinic-referred children without considering affirming environments or cultural contexts, which undermines generalizability and overestimates desistance.

69. These criticisms lack merit for at least two reasons. First, Temple Newhook et al. (2018) criticize the Steensma et al. (2011, 2013) studies for failing to accomplish something they never attempted to do. “[B]oth studies did not aim to report on the prevalence of desistance 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. 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 desistance rates north of 80%.

70. Second, the criticism that labeling children lost-to-follow-up inflates the desistance percentage also misses the mark. In the Dutch system at the time, there was only one gender clinic in the entire country, so children who did not receive gender-transition treatment there almost certainly didn’t receive it anywhere. As Steensma and Cohen-Kettenis (2018) explain:

[T]he 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).

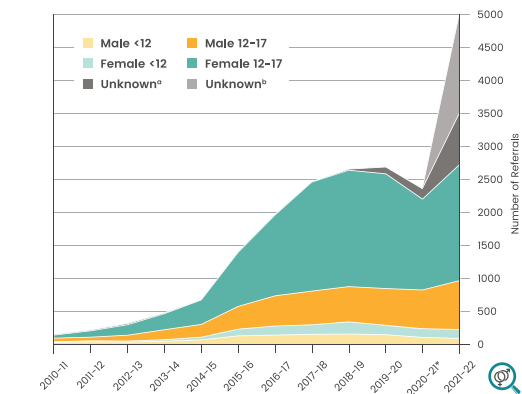
71. To summarize, children will naturally display a spectrum of stereotypically girlish or boyish behavior. And most children who experience distress because they don’t “feel” like they are a boy or a girl will naturally grow out of it. Labeling these children “transgender” seems more of a politically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

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

72. 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).

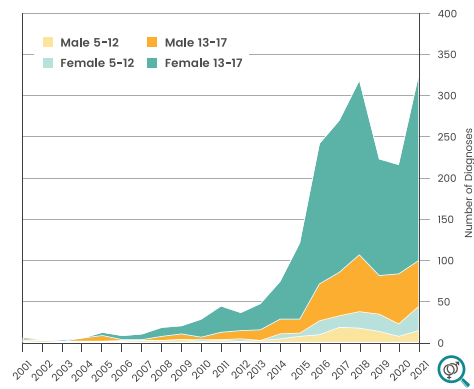
73. This population has skyrocketed in recent years. For example, in England, a study analyzing primary care data from 2011 to 2021 found the incidence rate of gender dysphoria in minors rose from 0.14 to 4.4 per 10,000 person years, a 50-fold increase (Jarvis et al., 2025). This was most marked in 17–18 year olds (Jarvis et al., 2025). Similar increases are found especially in industrialized Western countries (Kaltiala et al., 2020), many showing over 1000% rises in gender dysphoria over the last decades (Marianowicz-Szczygiel, 2022).

**Child and Adolescent Referrals for Gender Dysphoria
United Kingdom (GIDS)**



*Referral activity to GIDS/Tavistock was sharply limited in 2020–2021 due to COVID-19.
 *Beginning in 2018–19, increasing numbers of referrals are not reported by sex.
 *Beginning July 2021, referrals made directly to GIDS are reported separately from those handled by the Arden & GEM referral management service. The Tavistock reports that Arden & GEM handled over 1500 additional referrals in 2021–22 (age and sex not reported separately).

**Child and Adolescent Diagnoses of Gender Dysphoria
Sweden**



Incidence data for 2001–2018 from the Swedish National Board of Health and Welfare* were applied to population counts by age/sex/year from Statistics Sweden* to produce estimated GD diagnosis counts. Incidence data for 2019–2021 were drawn from an update of "God vård av barn och ungdomar med könsdysfori, 2015" (Socialstyrelsen, 2022, unpublished).
 *Socialstyrelsen, Utvecklingen av diagnosen könsdysfori - förekomst, samtliga psykiatriska diagnoser och dödlighet i suicid, 2020.
 *https://www.statistikdatabasen.scb.se/pxweb/en/ssd/START_BE_BE0101_BE0101A/BefolkningR1860N/

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.

74. 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 accelerated 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.

75. 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.

76. 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).

77. 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).

78. The natural question then is: what is the explanation for the recent surge of gender dysphoria in adolescents?

79. Dr. Lisa Littman (2018) coined the term “Rapid Onset Gender Dysphoria” (ROGD) to describe the phenomenon. Others have described the same observed rapid appearance of gender-related distress (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 that some people are “born in the wrong body.” 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 likely 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 may sometimes function 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).

80. Further, Littman (2021) describes accounts of friends, counselors, or partners encouraging or pressuring a person to adopt a transgender identity, revealing how sexual minority status can confer social approval, community belonging, accommodations, or moral status within certain circles. 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.

81. The timing and pattern of diagnoses also closely tracks the well-documented epidemic of adolescent mental health deterioration since ~2010 characterized by 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). 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 (Alho et al., 2024). Contagion operates selectively among distressed or impressionable young people facing mental health crises (Twenge, 2020). For example, 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).

82. While beyond the scope of this report, Dr. Littman’s account is consistent with studies also pointing to trauma as a potential contributing factor (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). This is further consistent with research indicating a significant association between insecure or disorganized attachment styles and elevated rates of gender dysphoria or transgender identification, often intertwined with adverse childhood experiences and trauma. (Kozłowska et al., 2021; Giovanardi et al., 2018). This suggests early relational disruptions may contribute to gender-related distress via maladaptive self-protective strategies (Withers, 2020).

83. An alternative theory posits that this novel cohort of adolescents experiencing gender-related distress simply reflects previously hidden cases of transgender identities coming to light (*e.g.*, McNamara et al., 2024; Coleman et al., 2022). 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 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). “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).

4. Children and adolescents are distinct from adult transsexuals.

84. While not at issue in this case, it is important to note that children and adolescents experiencing gender dysphoria are distinct from late-onset adult transsexualism, a group that medical literature has been aware of for some time. Further, invoking the late-onset population to suggest that transgender identities are “hidden” in young people is not compelling because it ignores the profound etiological and demographic distinctions between these groups.

85. 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.

86. 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).

87. 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.

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

88. The central premise of “conversion therapy” laws, seems to be that a young person’s asserted transgender identity is always normal, developmentally healthy, and enduring, and it is therefore harmful to seek to change it (*e.g.*, APA, 2021). This conception of gender identity is not supported by the literature.

89. To begin, there are fundamental unknowns regarding whether transgender identities are, in fact, psychologically healthy, normal variants. As previously explained, whether a person embodies a gender different from their sex is not something we can test or verify empirically.

90. We also cannot predict whose gender dysphoria will persist into adolescence or adulthood. As the United Kingdom’s Cass Review explained: “[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).

91. 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).

92. Rae et al. (2019) is a prominent example of scholarship suggesting that “social transitions may be predictable from gender identification and preferences,”

when the data shows the opposite (p. 669). Rae et al. measured gender identity and gender-role preferences in a group of gender-nonconforming children before any of them had socially transitioned and found that children with more extreme cross-gender identification and preferences at baseline were more likely to have socially transitioned approximately two years later. Specifically, a child with a gender-nonconformity score of 0.50 had about a 30% probability of transitioning, while a child scoring 0.75 had roughly a 48% probability. However, even among the most gender-nonconforming children, social transition remained essentially a coin flip as less than half were predicted to transition. This demonstrates that baseline gender nonconformity was a relatively weak predictor of which children would go on to adopt and persist in a transgender identity, even with a time frame as short as two years.

93. 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 U.S. 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.

94. There has been increased visibility and discussion about 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; Vandebussche, 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).

95. Importantly, 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).

96. The upshot is that labeling a child or an adolescent “transgender” is a simple label for a complex issue that masks distinct populations exhibiting different demographics (male-heavy early-onset vs. female-heavy adolescent-onset), different comorbidity profiles, and different etiological factors. This is unfortunately the starting point for applying a single treatment model (i.e., the same approach for adult transsexuals and gender-nonconforming children), which 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 childhood-onset, adolescent-onset, and adult-onset cohorts (to say nothing about the demographic differences within these cohorts) represent separate clinical

populations, making it inappropriate to conflate them or use one to infer about the other.

97. Unfortunately, even prestigious medical institutions and practitioners in this field eschew 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. In fact, for most of these young people across age groups and sexes, gender-related distress is fleeting.

V. The origins of the “affirming” model of care.

A. There are at least three methods for treating gender dysphoria.

98. 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) affirmation (Zucker, 2020). I will briefly describe them here.

99. 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.

100. Watchful waiting is a medically valid approach to caring for a child or adolescent with feelings of 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.

101. 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, 2025, p. 3). I will discuss this approach more in § VIII, below.

102. The third treatment approach is the affirmation model (American Academy of Pediatrics, 2018; Coleman et al., 2022), which promotes affirming 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. It generally involves two steps:

- Encouraging or "affirming" social transition, i.e., living as the opposite sex. This may include changing the individual's name, preferred pronouns, and appearance in terms of clothes, makeup, or binders.
- Followed by medical transition, including the provision of endocrine and surgical interventions that consider the body parts and physical features associated with the dysphoria as targets for treatment. This can include puberty blockers, cross-sex hormones, or, less often, surgeries in minors.

103. Under the affirmation model, social and medical interventions do not depend on resolving, or sometimes even meaningfully addressing, trauma, disorders of personality development, internalized or externalized homophobia, neurocognitive disorders (e.g., autism), or other comorbidities often associated with transgender identities and gender dysphoria.

B. “Transitioning” or “affirming” a person’s transgender identity began as a treatment for adult transsexuals.

104. 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 WPATH and the Endocrine Society, promote the “affirming” model of care as the *only* effective and ethical approach to treating gender dysphoria.

105. 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.

106. 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.

107. 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).

108. 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.

109. 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).

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

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

111. 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 age 18.

112. Two foundational studies (the “Dutch Studies”) 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, de Vries et al., 2014). 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 Studies’ design and acknowledged limitations can support. Some of the flaws include:

- A cohort of only 70 (de Vries et al., 2011), which shrank to 55 (de Vries et al., 2014).
- No follow-up data for 15 patients. In a sample of that size, and in a nationalized healthcare system with no other gender clinics providing endocrine treatment, 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, including adolescent-onset 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 clinical population today.
- One death from surgical complications, which is an extraordinarily high death rate in a small sample. And this participant was excluded from the 2014 study.
- Limited discussion or data regarding potential harm.
- 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).

113. Importantly, 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).

114. 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 only treated with therapy 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.

115. 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 EBM, which prioritizes high-quality clinical research over expert opinions or consensus.

116. 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).

117. 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).

118. WPATH first published what they called “Standards of Care” in 1979, and have published updated versions since then, including most recently in 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.

119. As described further below in § VI.C, the WPATH standards are deeply flawed and do not establish evidence-based standards of care for treating gender dysphoria. But these flaws did not stop other medical organizations from relying on the guidelines as an authoritative standard.

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

120. Clinicians worldwide are turning against routine gender-affirming care for minors. Landmark reports like the United Kingdom’s Cass Review (2024) and Nordic systematic evidence reviews have prompted countries including Sweden, Finland, Norway, and the UK to sharply restrict puberty blockers and cross-sex hormones for youth, citing weak evidence and significant risks, with a shift toward psychotherapy-first approaches. In the US, this approach to care is also being reconsidered. The HHS review highlighted the low-quality evidence, and there is growing caution from medical groups like the American Society of Plastic Surgeons. Overall, there is an increasing emphasis on evidence-based care, comprehensive mental health evaluation, and recognition of biological sex over affirmation-only models.

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

121. *Finland.* Finland began the first review of youth gender medicine in 2018 and completed in 2020, leading to the first country to turn away from the affirming-care model. Finland is another Nordic country with an organized medical system and longstanding availability of care for gender dysphoria. Consistent with other European nations and my opinion here, Finland’s Council for Choices in Health Care (COHERE) recognized that “[s]ince reduction of psychiatric symptoms

cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment” (COHERE, 2020s, p.7). Rather, “[t]he first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders” (COHERE, 2020a, p. 5). “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).

122. *Sweden.* Sweden commissioned its National Board of Health and Welfare to update the country’s guidance on “Care of Children and Adolescents with Gender Dysphoria” (Socialstyrelsen, 2022). After Ludvigsson et al.’s (2023) systematic review of endocrine treatments for gender dysphoria, the National Board of Health and Welfare recommended a move away from cross-sex hormones (Socialstyrelsen, 2022). The authors concluded that the 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.

123. 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).

124. *England.* 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, the National Health Service’s (NHS) 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.

125. These revelations prompted the 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.

126. As I will discuss more below, 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 support as first-line treatment.

127. The Cass Review commissioned eight independent systematic reviews (and one practice review) from the University of York's 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’s SOC—do not meet accepted standards for evidence-based guideline development, rely on low-quality evidence, and lack transparent, systematic methods.

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

129. *Norway.* 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.

130. *The European Society for Child and Adolescent Psychiatry*. 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’s 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).

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

131. *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 (an overview of systematic reviews) 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 synthesized 17 high-quality systematic reviews on interventions for children and adolescents with gender dysphoria, including psychotherapy, puberty blockers, cross-sex hormones, and surgeries.

132. The HHS review concludes that the overall quality of evidence for the effects of “affirming” interventions 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. This indicates that the beneficial effects reported in the literature are likely to differ substantially from the true effects of the interventions. 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. The review advocates for psychotherapy over medicalized transition and currently serves as the most complete and broad assessment of the evidence in youth gender medicine.

133. *The American Society for Plastic Surgeons.* The American Society for Plastic Surgeons 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.

134. *The American Medical Association.* The American Medical Association responded to the plastic surgeon's position statement by stating that due to insufficient evidence for surgical interventions in minors, such procedures should generally be deferred to adulthood.

135. *State Restrictions.* 27 U.S. 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 the 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 vulnerable children.

VI. The false promises of affirmation and social transitioning.

136. 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). This is also the premise of “conversion therapy” laws like Washington's that require therapists to encourage a child's social transition and preclude them from helping a child who wants to develop comfort with his or her natural body. In fact, studies have shown that the promises of “affirmation” are largely illusory and not evidence based (McDeavitt, Cohn, & Kulatunga-Moruzi, 2025).

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

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

137. 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 nonbinary identity.

138. 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.

139. The 2023 study by James S. Morandini et al. examined whether social transition and name change were associated with mental health outcomes in a study of 645 children and adolescents (aged 4–17) referred to the NHS Gender Identity Development Service because of 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).

140. 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.

141. 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.

142. England's NHS 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).

143. To be sure, some studies have suggested that social transitioning has positive effects (Durwood et al., 2017; Olson et al., 2016; 2022). This lab's work suffers from serious methodological weaknesses, including small, highly self-selected, extremely affluent, convenience samples recruited through transgender-affirming networks. There was an absence of appropriate control groups of gender-dysphoric children who did not socially transition, and heavy reliance on reports from highly motivated, affirming parents. These design limitations, particularly the lack of pre-transition baseline data, the failure to account for strong selection effects, the presence of highly affluent and possibly ideologically driven families,

and the persistent use of the same biased cohort, render the reported benefits unreliable and likely inflated.

144. 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).

145. 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.

146. In short, there is no high-quality evidence that social transition improves psychosocial functioning, and the *body of evidence* suggests there is no benefit. As the data available is sparse and short-term, there may be long-term psychological harms with social transition that are not captured in the available research.

147. What that means in practice is that the very first step of the affirmative model—adults, including counselors, accepting the young person’s self-identified gender and treating the young person accordingly—is not supported by the available evidence. Yet that is what “conversion therapy” laws like Washington’s dictate for the counseling profession.

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

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

149. 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).

150. 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).

151. 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 transition pharmaceuticals (puberty blockers or hormones) as they reached adolescence.

152. 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).

153. 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).

154. 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).

155. The Cass Review similarly describes social transition 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.

156. Not fitting sex stereotypes can certainly be difficult for young people. However, this distress is often temporary and does not require social transition, which is not a reliable way to resolve it. A normal part of adolescent development is learning to accept yourself—whether as a more masculine woman or a more feminine man. The current rush to label young people as transgender interferes with this natural process of identity and psychosexual development. Furthermore, and as mentioned previously, the identity label of transgender reifies a category of person that Byrne and Gorin (2026) note are a socially created construct: “transgender children are brought into existence by a social process that involves (in part) naming or classifying children as transgender.” The distress and feelings of incongruence are real, but further ontological claims remain up for debate.

B. Medicalized transition has unproven benefits and likely harms.

157. 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. This is important because the counseling approach that Washington mandates sets young people down this path. As noted above, the vast majority of young people who socially transition go on to receive some form of medicalized transition.

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

158. 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.

159. 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, I will 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.

160. *Chew et al. (2018)*. One of the earliest systematic reviews found “[l]ow-quality evidence” that “hormonal treatment[s] ... 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).

161. *National Institute for Health Care (NICE) (2020)*. As part of the Cass Review, the NHS 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).

162. *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).

163. *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.

164. *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).

165. *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).

166. *Ludvigsson (2023)*. 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 the 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. The “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). 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.

167. *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).

168. *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 [a] 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” (Miroshnychenko, 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” (Miroshnychenko, 2025b, p. 444).

169. 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.” (Miroshnychenko, 2025a, p. 435). This systematic review used the GRADE methodology, which I consider the gold-standard in evaluating the quality of scientific evidence.

170. The mastectomy review was notable in that there are few attempts to systematically review the evidence on performing a 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).

171. 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 “lifesaving” 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, nor prohibit parents or youths who seek out alternative options.

2. Umbrella reviews have similarly graded the evidence-base for PMT as low-quality.

a. The Cass Review

172. 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).

173. 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.

174. 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).

175. There have been some criticisms of the Cass Review in 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).

176. 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).

177. 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.*” (Cass, 2024, p. 75, emphasis added). This adds to the Cass Review’s credibility rather than detracting from it.

178. 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 a simple unmasking of a stable, hidden population.

b. HHS review

179. As previously discussed, the HHS review of treatment for pediatric gender dysphoria reviewed 17 systematic reviews and concluded that the overall quality of evidence for social and medical transitioning remains low. 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 U.S.

180. 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.

181. The HHS report has received some criticism. I was one of the authors that drafted a detailed response to each of these critiques, which represents my opinion on the critiques' flaws (HHS, 2025b). 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.

182. Dowshen et al. (2025) published a commentary alleging that 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.

183. *Scientific Norms.* Dowshen et al. (2025) claim the HHS review violates scientific norms because it failed to name its authors, cited non-peer-reviewed articles for over 20% of its references, and the results were “predetermined” by the Trump Administration’s Executive Order on gender-dysphoric care. 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 the report's (or any document's) trustworthiness 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. Meredith McNamara, lead author of that essay, was a senior author of Dowshen et al. (2025)). Moreover, the HHS review used transparent methodology, followed scholarly citation norms, and was created without interference from the commissioning administration.

184. The HHS review was simply an evidence synthesis that systematically evaluated 17 existing peer-reviewed systematic reviews on pediatric gender dysphoria treatments (puberty blockers, cross-sex hormones, and surgeries). It used rigorous methods to assess these reviews, including those from the UK, Sweden, and Finland. And the Review relied on the GRADE approach, which systematically rates the certainty of evidence for each outcome as high, moderate, low, or very low by evaluating key domains including risk of bias, inconsistency, imprecision, indirectness, and publication bias. This rigorous method produces more accurate and transparent conclusions (Brignardello-Petersen & Guyatt, 2025). The central conclusions further underwent independent peer review by subject-matter experts from across the ideological spectrum who found the analyses robust.

185. Critiques like Dowshen et al. are classic misdirection because they fail to substantively critique the Review'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.

186. *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 HHS 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 harm 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.

187. *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.² 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).

188. *“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 cognitive behavior therapy (CBT), dialectical behavior therapy, and family therapy—aimed at support, distress mitigation, and self-understanding. And as described further below in section VIII, talk therapy should not be conflated with “conversion therapy,” even if lawmakers call them the same thing.

189. *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 et al. never engage with these revelations.

190. Critics such as Dowshen et al. have offered no substantive critiques that undermine the primary conclusions of the HHS review. These objections are

² *U.S. v. Skrametti*, 605 U.S. 495 (2025) (No. 23-477), Expert Researchers and Physicians, Amicus Curiae brief (2024, pp. 16–17), perma.cc/CSV2-SG7H.

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.

c. Other Umbrella Reviews

191. Other umbrella reviews have similarly noted the weak evidence base for the affirming model of care.

192. *New Zealand Ministry of Health (2024)*. The New Zealand Ministry of Health conducted its own literature review regarding puberty blockers and found that the “[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).

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

193. Studies do not show that medicalized transition reduces rates of either suicide or 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.

194. 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).

195. 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.

196. 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).

197. The Trans Youth Research Network 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.

198. 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.

199. 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:

200. 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.

201. 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.

202. 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).

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

204. Recent reviews related to younger cohorts raise serious concerns that hormonal treatment and affirmative protocols may worsen mental health and even increase suicidality. Concerningly, 2 deaths from suicide in the Trans Youth

Research Network 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 the Trans Youth Research Network has not been provided.

205. A new review, Ruuska et al. (2026), is the most comprehensive study to date on real-world outcomes to PMT, using objective national health registry data rather than self-reports or convenience samples. Ruuska et al. is a nationwide Finnish register study that followed all 2,083 adolescents and young adults (under age 23) who contacted Finland’s specialized gender identity services between 1996 and 2019, with a mean follow-up of 5.5 years. The key findings include that gender-referred youth had dramatically higher psychiatric morbidity than matched controls both before referral (45.7% vs. 15.0%) and ≥ 2 years after (61.7% vs. 14.6%). The psychiatric needs increased rather than decreased after medical gender reassignment: In the feminizing (male-to-female) pathway: 9.8% $\rightarrow$ 60.7% and in the masculinizing (female-to-male) pathway: 21.6% $\rightarrow$ 54.5%. The more recent cohorts (post-2010) showed even higher psychiatric burden and the authors conclude that medical gender reassignment does not reduce and may be associated with worsening psychiatric morbidity in this population.

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

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

207. 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 Workshop] 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).

208. Further, there is troubling data suggesting 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).

209. 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).

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

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

212. *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).

213. 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., 2020, p. 252). In other words, it is unknown whether puberty suppression permanently impedes some features of brain development.

214. 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).

215. 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.

216. *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.

217. 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).

218. 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).

219. 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).

220. 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.

221. 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 nonbinary 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).

222. 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. WPATH and Endocrine Society guidelines are not authoritative standards of care.

223. 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”). 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 under the GRADE framework.

1. The paucity of evidence precludes recommendations for “affirming” a young person’s claimed gender identity.

224. As previously explained, systematic reviews and umbrella reviews reveal that social transitioning and medical interventions for minors suffering from gender dysphoria are based on low-quality evidence and involve disproportionate risks and low-certainty evidence of sustained benefits. There is also 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.

225. 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).

226. 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).

227. 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.

228. As noted in the HHS report:

- The unfavorable risk/benefit profile distinguishes PMT 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 [the] 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).

229. 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.” (Balslem et al., 2011, p. 402).

2. The WPATH standards of care are flawed.

230. 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, 2026a).

231. 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.

232. *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).

233. 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 transitions and they had already publicly advocated for pediatric medical transitions.

234. “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, SOC-8 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 (Tr. of Eli Coleman at 239–44, *Boe v. Marshall*, No. 2:22-cv-00184 (M.D. Ala., Mar. 31, 2026), Dkt. No. 700-3³, 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

³ Cited documents from the *Boe v. Marshall* case are publicly available at www.alabamaag.gov/boe-v-marshall/.

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 (Tr. of Eli Coleman at 219–224, *Boe v. Marshall*, No. 2:22-cv-00184 (M.D. Ala., Mar. 31, 2026), Dkt. No. 700-3).

235. *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’” (Dahlen 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.

236. 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 methods, handling of competing interests and quality assessment” (Dahlen et al., 2021, p. 9).

237. Despite the well-known methodological weakness of SOC-7, WPATH created SOC-8 in a similar manner, only selectively using the expected conventions for creating a trustworthy clinical practice guideline.

238. 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).

239. “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 [SOC] 8 overstates the strength of the evidence in making these recommendations” (Cass, 2024, p. 132). “However, none of the WPATH [SOC] 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).

240. *Efforts to suppress evidence.* “It has recently become clear ... that WPATH speaks of evidence-based medicine but does not practice it” (Kozłowska et al., 2025, p. 6). “The organization’s efforts to suppress evidence—dating back to 2018—were revealed via WPATH internal documents.” (Kozłowska, 2025, p. 6).

241. 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 the unfavorable results of reviews they commissioned.

242. 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 (Kozłowska 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.

243. The systematic reviews were supposed to be performed by the evidence-based medicine center at Johns Hopkins University. However, once the

results of the systematic 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.

244. 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.” Notice of Evidentiary Submission in Support of Summ. J., Ex. 167 at 76, *Boe v. Marshall*, No. 2:22-cv-00184 (M.D. Ala., Mar. 31, 2026), Dkt. No. 560-17. 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.

245. WPATH required the researchers to both (a) submit the prospective publication to WPATH for its review and approval and then, in direct contradiction, to (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.” Notice of Evidentiary Submission in Support of Summ. J., Ex. 167 at 78–79, *Boe v. Marshall*, No. 2:22-cv-00184 (M.D. Ala., Mar. 31, 2026), Dkt. No. 560-17 (*Boe v. Marshall*, Dkt. No. 560-17).

246. “This dual, mutually inconsistent requirement inescapably compromises the integrity of the researchers and also violates the conditions for the development of clinical practice guidelines” (Kozłowska 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. The 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.

247. 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.

248. 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.).

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

250. 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.”

251. 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.”

252. 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.

253. *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.

254. 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 WPATH itself led.

255. 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 PMT (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).

256. SOC-8 normalizes self-mutilation via inclusion of “eunuchs” as just another nonbinary 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.

257. SOC-8 downplays concerns related to detransitioning and regret and devotes minimal exploration to these topics. SOC-8 repeatedly claims detransitioning is rare, but doesn't define rare, nor explores the recent literature on detransitioning. 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 safeguards or track harms.

258. 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).

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

259. 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.

260. 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).

261. 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).

262. 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).

263. 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.

264. Additionally, the guidelines overlook the high historical desistance rates and do 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 person will go on to have a persistent transgender identity.

265. 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).

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

266. A systematic review of clinical guidelines for treating gender dysphoria found that most 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).

In fact, “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 Taylor et al.’s systematic review (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). “This relationship may explain why there has until recently been an apparent consensus on key areas of practice for which evidence remains lacking” (Taylor et al., 2024c, p. s71).

267. “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” (Kozłowska et al., 2025, p. 7). 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” (Kozłowska et al., 2025, p. 10).

268. 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).

269. 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 perspectives, and letters to the editor; guiding what is included in the book review column; and setting editorial policies.

270. 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).

271. 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, the 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.

272. For example, I routinely attend 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 creating any presentations with standard scholarly dialogue on the fundamental 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, 2022a).

273. 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. I have received many spontaneous calls, texts, and emails from AACAP colleagues, encouraging me to continue to raise questions and call for open dialogue. 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).

274. 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, 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. 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.”⁴

This contradicts the organization’s position on pediatric transitions.

275. I have found the Journal of the American Academy of Child and Adolescent Psychiatry 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. Over the last decade, the same journal has continually refused to foster active debate, constructive disagreement, or alternative opinions.

276. 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 re-edited 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.

277. Precisely because of the data supporting Littman’s theories of Rapid Onset Gender Dysphoria, many advocates of the medicalized treatment of youth

⁴ Brief for the American Academy of Child and Adolescent Psychiatry as Amici Curiae Supporting Neither Party, *Miller v. Alabama*, 567 U.S. 460 (2012), available here: www.aacap.org/App_Themes/AACAP/docs/Advocacy/amicus_curiae/miller_v_alabama.pdf

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 clinic, which before its closure was the world's biggest gender-identity clinic, documented their own experience with similarly-named "adolescent onset" gender dysphoria, how clinicians around the world were witnessing the same phenomenon, and how unhelpful it was 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 the online version).

278. 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).

279. 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 regard to questions of biological sex, gender, and gender medicine.

280. 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).

281. 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; 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” (Kozłowska 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” (Kozłowska, 2025, p. 11).

VII. **Ethical concerns with pediatric interventions.**

282. 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.

283. 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, 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.

284. **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.

285. **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.

286. **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.

287. 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 the persistence of a transgender identity. So it is my opinion that healthcare professionals asked for advice on social transition should treat it like medical intervention.

288. 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.

289. 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 comorbidities 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.

290. 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.

291. 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, [App’x 6] p. 5).

292. 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.

VIII. **Psychotherapy and Washington’s “conversion therapy” ban.**

293. I understand that Washington’s law classifies the performance of so-called conversion therapy on a minor (under age 18) as unprofessional conduct for licensed health care providers (RCW § 18.130.180(26)). “Conversion therapy” is defined as any “regime that seeks to change an individual’s sexual orientation or

gender identity,” including “efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex” (RCW § 18.130.020(4)). The law explicitly exempts counseling or psychotherapies that provide acceptance, support, or understanding, provided they do not seek to change sexual orientation or gender identity.

A. Psychotherapy is a valid treatment for gender dysphoria.

294. Non-affirming, exploratory psychotherapy is a medically valid approach to caring for a child or adolescent with gender dysphoria or other gender-related distress (Elkadi et al., 2023). In fact, it should be the first-line treatment for young persons struggling with gender dysphoria.

295. The traditional approach does not directly challenge a claimed transgender identity, nor does the practitioner affirm the patient’s narrative or theories (contrary to Washington’s mandate). Instead, they permit the patient to continue to express a transgender identity, while engaging in a dialogue with the patient regarding these matters and without providing the answer (Hakeem, 2012; D’Angelo et al., 2021). 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) into perspective.

296. Starting with psychotherapy is beneficial to help uncover and address potential comorbidities. 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. That makes

psychotherapy appropriate for young persons struggling with gender dysphoria and presenting with high rates of mental illness (D'Angelo, 2025; Becerra-Culqui et al., 2018). “[P]sychotherapy can be considered ‘transdiagnostic’ rather than diagnosis specific, making it applicable to a range of emotional disorders” (D'Angelo, 2025, p. 4).

297. To be sure, the precise etiological relationship between gender dysphoria and these co-occurring conditions remains unclear. As Zucker (2019) explains, gender dysphoria may emerge secondary to another mental illness or traumatic event, like sexual abuse (Evans 2023). Alternatively, gender dysphoria may be the distress that generates symptoms such as anxiety or depression. These uncertainties about causal interplay do not diminish the appropriateness of psychotherapy as an intervention. “If we accept that some people will be helped by transition and some will not, then the most important ethical responsibility for clinicians is to explore whether gender dysphoria is a manifestation of another problem” (D'Angelo, 2025, p. 6).

298. A clinical approach centered on psychotherapy de-exceptionalizes patients with gender dysphoria, treating it as a form of psychological distress similar to other mental health conditions, rather than a unique, special category. Psychotherapy allows time for the therapist to get to know the patient and to understand their history, temperament, stressors, and life situation.

299. Similarly, the U.K.’s Cass Review (2024) warns strongly against the related problem of “diagnostic overshadowing”—the risk that a focus on gender dysphoria becomes the dominant or overriding explanation, causing clinicians to overlook or fail to address co-occurring mental health conditions, neurodiversity, trauma, family issues, or other sources of distress (p. 17). This can and has led to insufficient safeguarding of vulnerable young people. As noted by Hutchinson (2025), “[p]sychotherapists 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).

300. One critique of this approach is that a psychotherapy protocol specifically for gender dysphoria has never been studied. But that does not mean psychotherapy is an invalid approach, much less harmful. Psychotherapy draws upon the traditional skills of the therapist and the longstanding evidence base of psychotherapy in general (Wuthrich et al., 2023). So while the evidence specific to gender dysphoria is “low quality and inadequate ... [m]ost analyses of mental health, psychological and/or psychosocial outcomes showed either benefit or no change, with none indicating any negative/adverse effects of the interventions offered” (Heathcote et al., 2024, p. s31).

301. This lack of a specific program or protocol for psychotherapy is common across clinical dilemmas. Therapists often encounter situations without a precise treatment protocol, and in these situations, they lean on their skills and training.

302. Similarly, physicians often evaluate a range of treatment options, and weigh costs, risks, benefits, and practical considerations. Eminent child psychiatrist Eugene Arnold presented a practical SECS–RUDE framework to guide clinicians in choosing among dietary and nutritional interventions for ADHD when the evidence base is mixed and uncertain (Hurt & Arnold, 2014). Hurt and Arnold defined SECS interventions (Safe, Easy, Cheap, and Sensible in light of other knowledge)—such as moderate-dose Omega-3 essential fatty acids or standard RDA/RDI multivitamin/mineral supplements—as requiring relatively modest evidence of efficacy to justify an individual patient trial, because they carry low risk and minimal burden. In contrast, RUDE interventions (Risky, Unrealistic, Difficult, or Expensive)—such as a full restricted elimination diet—demand stronger evidence

and closer monitoring, given their higher potential for nutritional imbalance, family stress, cost, and organizational demands. This common-sense paradigm helps clinicians weigh practicality, safety, and family resources against the available data before recommending any specific nutritional approach.

303. For an example of the strength of research supporting the general effectiveness of psychotherapy, one 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 (Hofmann 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 variations of effectiveness exist 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.

304. As noted by Bailey and Zucker (2026): “With its emphasis on identifying negative and irrational thought patterns and behaviors and learning better ways of coping, cognitive-behavioral therapy is a promising treatment for gender dysphoria. Furthermore, CBT is effective at treating depression and anxiety, both of which are common among gender dysphoric youth” (p. 3).

305. As further support for this approach, European countries that conducted systematic reviews of the evidence have recommended psychotherapy as the first line of treatment for gender dysphoria (HHS, 2025a, pp. 255–56).

306. Per the NHS:

- Medical intervention is not the standard approach. The primary intervention for children and young people ... is biopsychosocial and psychological support and intervention; the main objective is to alleviate distress associated with gender incongruence and promote the individual's global functioning and wellbeing (NHS, 2026, p. 2).

307. Per Finland's Council for Choices in Health Care in Finland:

- The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders. (COHERE, 2020b, p. 5).

308. Per Sweden's National Guidelines:

- In accordance with child psychiatric practice, the psychosocial care of young people with gender dysphoria needs to be adapted to the needs of the individual adolescent. Psychosocial support that helps adolescents deal with natal puberty without medication needs to be the first option when choosing care measures. For those suffering from mental health problems, measures such as supportive counseling, psychotherapy, child psychiatric treatment, and suicide prevention need to be offered and adapted to the nature and severity of the mental health problem and the young person's overall situation. (Socialstyrelsen, 2022b, p. 45).

309. Based on my personal experience, and the reported patients from Brian Tingley, this composite could be a patient example: Alex, a 15-year-old natal female, presents for therapy reporting several months of intense gender dysphoria: distress about developing breasts, hatred of menstruation, and a strong desire to be perceived as male. Alex has socially transitioned at school (using he/him pronouns and a male name) and is researching puberty blockers online. However, after reading about desistance rates and long-term outcomes, Alex now says, "I don't want hormones or surgery. I want to feel comfortable in my female body and stop feeling like I need to escape it." Alex's goals are explicit: explore the roots of the dysphoria (including possible social contagion from friends, anxiety, and discomfort with puberty), reduce body distress, improve self-acceptance as a girl who may be

more masculine-presenting, and develop coping skills without medical transition. Alex is open to therapy that supports this desistance-oriented objective and specifically requests a counselor who will not automatically affirm a transgender identity or push toward medicalization.

310. An exploratory, psychotherapy-centered approach is a high-quality clinical option for a young person like Alex who experiences genuine gender dysphoria yet explicitly wants to develop comfort with their biological sex and natural body. Rather than exceptionalizing gender dysphoria as a unique condition requiring immediate social or medical transition, the therapist conducts a comprehensive assessment and applies well-established evidence-based techniques used successfully with analogous disorders involving distorted body perception or overvalued ideas. For example, cognitive behavioral therapy for body dysmorphic disorder helps patients reduce distress and accept their actual appearance instead of acquiescing to the patient's desire to pursue cosmetic interventions highly unlikely to resolve the body-related distress (Wilhelm et al., 2011; Miroshnychenko et al., 2025c). Cognitive approaches in anorexia nervosa use restructuring and exposure to challenge distorted beliefs about body size and weight, restoring healthy self-acceptance without affirming the patient's maladaptive conviction that they are "too fat" (Steinglass et al., 2011). Exposure-and-response-prevention for OCD with overvalued beliefs reduces fixation on intrusive ideas by testing them against reality (Gillihan et al., 2012). Management of somatic symptom disorders addresses health-related distress without reinforcing unfounded beliefs about the body (Henningsen, 2018). In each case, positive long-term outcomes—reduced distress, improved functioning, and desistance from the maladaptive belief—demonstrate that carefully exploring and resolving the underlying psychological drivers is both ethical and effective, exactly as it would be for any other adolescent with body-image or identity-related distress.

311. There is no compelling evidence that non-affirmative, exploratory psychotherapy for gender dysphoria is harmful. “[W]hile numerous potential harms of gender-affirming interventions have been established, there is no evidence that appropriate, non-pathologising psychotherapy causes harm to trans-identified youth” (D’Angelo, 2025, p. 4). On the contrary, there are strong clinical and theoretical reasons to believe such therapy is helpful: it applies the same well-established, evidence-based techniques proven effective for body dysmorphic disorder, anorexia nervosa, OCD with overvalued ideas, and somatic symptom disorders, while respecting the patient’s own goals and promoting long-term psychological resilience and seeking to reduce distress.

B. Talk therapy is not “conversion therapy.”

312. I understand Washington’s law to prohibit most forms of exploratory psychotherapy under the banner of “conversion therapy” unless the therapist encourages or affirms a claimed transgender identity. In other words, the law forbids the therapist from discussing the client’s desire to desist from a transgender identity or gently exploring whether gender-related distress stems from a traumatic experience to help the client resolve their distress and reconcile their feelings with their biological bodies. To my understanding, discussions such as these would “seek[] to change an individual’s sexual orientation or gender identity,” or “change behaviors or gender expressions” (RCW § 18.130.020(4)(a)). And the law exempts only “counseling ... that provide[s] acceptance, support, and understanding of clients or the facilitation of clients’ coping, social support, and identity exploration and development that do[es] not seek to change sexual orientation or gender identity” (RCW § 18.130.020(4)(b)).

313. This misleadingly prohibits a broad array of standard talk therapy under charged terms like “conversion” or “reparative” therapy that conjure up images of aversive techniques like electroshock therapy. Psychotherapy brings

professional expertise into the young person's life to build skills, gain perspective, and help manage symptoms. Psychotherapy works with the values and goals of the patient to increase functioning and help prepare for the stressors and challenges that life will bring. It is not coercive. Rather, it builds autonomy.

314. As noted by D'Angelo (2025): "To suggest that psychotherapy is a form of conversion therapy betrays a fundamental misunderstanding of psychotherapy. Psychotherapy *resides outside the affirmation-conversion binary* and aims to address the *distress* of gender-dysphoric youth *rather than to correct a sense of misalignment*. Psychotherapy does not attempt to force change or impose any predetermined notion of 'cure' or preferred gender or sexual orientation on the patient. A core ethical principle of psychotherapy is that therapists must respect patient autonomy and self-determination" (p. 5).

315. Psychotherapy was an essential component of the Dutch Protocol, as noted in the HHS report: "In the Dutch research that underpins the contemporary pediatric medical transition (PMT) approach, the psychotherapist occupied an essential role. The original Dutch approach involved an intensive assessment process. Adolescents who began medical transition were required by the protocol to continue to receive regular mental health care" (HHS, 2025a, p. 253).

316. Studies suggesting that exploratory psychotherapy is harmful in this context have many flaws because they conflate talk therapy with aversive techniques. This association with electroshocks and unwilling participants creates visions of coercive punishment far removed from the Socratic questioning, exploration, and building of emotional vocabulary characteristic of therapy with children and adolescents. The studies also rely on retrospective surveys that introduce a significant risk of recall bias.

317. I will discuss two prominent examples of this flawed reasoning: the American Psychological Association's Resolution on Gender Identity Change Efforts

(APA, 2021) and Turban et al.'s 2020 study on the association between gender-identity change efforts (GICE) and mental health in adults identifying as transgender.

318. The APA's policy statement condemns therapeutic approaches seeking to align a person's gender identity or expression with their biological sex (APA, 2021). While the Resolution purports to rest on scientific evidence and clinical expertise, a careful examination reveals it to be a poorly reasoned, ideologically driven document with significant evidentiary shortcomings. It should not be afforded substantial weight in clinical guidelines or policymaking, especially when it is used to stigmatize ethical psychotherapy for children and adolescents or to justify vaguely worded "conversion therapy" bans.

319. *Ideological framing.* The Resolution frames ideological statements as established facts. It declares that "gender is a nonbinary construct," that transgender and gender nonbinary identities represent "normal variations in human expression of gender," and that incongruence between sex and gender "in and of itself is not a mental disorder" (APA, 2021, pp. 1, 4). These assertions are stated without qualification or robust engagement with contrary clinical perspectives, historical desistance data (particularly for pre-pubertal children), or the role of comorbidities such as autism, trauma, or social influences.

320. *Conflation with sexual-orientation change efforts.* Similar to Washington's law, the Resolution analogizes *gender-identity* change efforts to *sexual-orientation* change efforts (SOCE) (APA, 2021, p. 1), importing moral and evidentiary arguments from the SOCE debate to bolster its GICE position. This rhetorical linkage is imprecise: sexual orientation concerns patterns of attraction, whereas gender identity involves a subjective sense of self. Nowhere in the efforts to pass broad laws banning SOCE and GICE have I seen analysis or research with data showing why these separate constructs should be placed together. This

conflation weakens the logical foundation and imports contested assumptions from one domain into another. Definitions of prohibited “GICE” are expansive and vague, potentially encompassing non-coercive practices and standard exploratory psychotherapy, parental guidance, or discussion of desistance rates and medical risks.

321. *Weak evidence base and misleading citations.* One of the Resolution’s core defects is that it relies on selective, often low-quality citations that do not adequately substantiate the sweeping claim that “GICE put individuals at significant risk of harm” (APA, 2021, p. 3). For example, the Resolution cites its own previous statements and the statements from other ideological organizations, in addition to citing reports like SAMHSA (2015), which was not a study but a list of “recommendations ... based on consensus statements developed by experts in the field” (p. 1). The Resolution also cites studies such as Brinkman et al. (2014) and Gagné & Tewksbury (1998), which were qualitative studies seeking to theorize how we think about gender identity. Research studies aimed at measuring outcomes such as Green et al. (2020) and Turban et al. (2020) have several shortcomings because they rely on retrospective self-reports from convenience sample surveys that cannot reliably establish causation. They fail to isolate specific therapeutic techniques, control for pre-existing mental health issues, or distinguish between coercive and non-coercive approaches. The Resolution itself also conflates correlation with causation and omits studies showing neutral or positive outcomes in certain non-affirming contexts. In short, the Resolution relies on evidence from advocacy-aligned organizations or methodologically flawed studies that do not directly test the specific claims for which they are invoked.

322. Troublingly, the Resolution asserts that GICE lacks empirical support while implying strong support for affirmation. This fundamental assumption, that affirmation is empirically supported, virtuous, and the only type of care that should

be offered, seems to be the motivation for this document. As I have documented in this report, the limited evidence base for the affirmative-care model and the reasonable support for other approaches undermine the Resolution’s position.

323. *Political advocacy.* The Resolution prioritizes policy advocacy—endorsing legal bans on practices with minors, opposing dissemination of “inaccurate information” (which in fact includes accurate information skeptical of the immutability of gender identity in youth), and aligning with activist organizations—over dispassionate clinical analysis (APA, 2021, p. 4). It frames disagreement as discrimination rather than legitimate scientific debate. This orientation is consistent with other advocacy by the APA, but inconsistent with the APA’s own definition of evidence-based practice, which requires integration of the best research, clinical expertise, and patient values.

324. Turban et al. (2020), which the Resolution cites, justifies a separate discussion because of its outsized influence. Turban et al. is a cross-sectional study, based on the 2015 U.S. Transgender Survey (USTS) that analyzed self-reported data from over 27,000 transgender adults. It found that recalled exposure to GICE by professionals was associated with higher odds of severe psychological distress in the past month, lifetime suicide attempts, and even higher odds when exposure occurred before age 10. While the paper acknowledges limitations from its cross-sectional design, it has been widely cited to support bans on “conversion therapy” for gender identity. “Rather than appropriately acknowledging the significant study limitations and calling for more research, Turban et al. (2020) used their flawed findings to engage in a media campaign promoting legislative bans of GICE. Two of the study authors penned an op-ed in which they state, ‘It’s time for conversion efforts to be illegal in every state, before more people die’” (D’Angelo et al., 2021, p. 11).

325. *Inability to show causation.* First, Turban et al. cannot establish causation. The study relies on retrospective self-reporting from a highly selected sample. Individuals with worse pre-existing mental health may have been more likely to seek (or receive) non-affirming therapy, or therapists may have attempted exploratory approaches with more distressed patients. Therapists may be reasonably less likely to affirm the most mentally ill patients, deferring clinical questions about affirmation and social transition until after using evidence-based treatments for comorbid disorders. The authors note this possibility but downplay it in their conclusions and public communications. Reverse causation or confounding by severity of underlying psychopathology remains a critical unaddressed issue.

326. The fallibility of human memory is well documented; this is especially true for retrospective recall on an event strongly connected with personal identity. Problems with memory include the ability to form firm beliefs in false memories and to alter memories to justify current mental states (Loftus & Hoffman, 1989; Loftus, 1997; Tavris & Aronson, 2020). Unfortunately, mental health professionals discussing the USTS have failed to caution the public regarding the weaknesses and suggestibility of autobiographical memory. It could be that the more psychologically impaired individual remembers, or misremembers, these potential events. These types of problems and relationships in memory are well documented inside and outside of gender medicine (Kulatunga Moruzi & Lawler, 2025; Otgaar et al., 2022; Mazzoni & Memon, 2003). And typically, retrospective survey data are met with skepticism (Bradburn et al., 1987; Coughlin, 1990).

327. *Biased and non-representative sample.* The USTS was a convenience sample recruited primarily through transgender advocacy organizations and online communities. It overrepresents individuals who are politically engaged, white, and urban, while underrepresenting desisters, those with religious backgrounds, or

those who resolved their dysphoria without transition. This limits generalizability and introduces selection bias.

328. *Vague and overly broad definition of “GICE”.* The key survey question asked if any professional “tr[ied] to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?” (Turban et al., 2020, p. 69). This could encompass coercive practices (widely rejected) as well as standard exploratory psychotherapy, watchful waiting, discussion of desistance data, or cautionary counseling about medical interventions. The study does not distinguish between abusive conversion attempts and ethical, non-directive therapy. Indeed, Dr. Jack Turban has acknowledged that “conversion efforts and exploratory psychotherapy are distinct, mutually exclusive practices.”⁵ WPATH has similarly stated it “unequivocally oppose[s]” “equat[ing] conversion therapy with psychotherapy” for “youth who are exploring gender identity” (WPATH, 2025).

329. *Failure to control for baseline mental health.* Another critical omission is that the study’s analysis did not adequately adjust for pre-existing or co-occurring mental illness. Those recalling GICE showed markedly higher rates of serious psychopathology. This suggests selection effects rather than clear evidence of harm from therapy itself.

330. *Selective interpretation and overreach.* The paper concludes that GICE should be avoided, supporting professional statements against them. However, the data only shows an *association* in a specific population, *not causation* or applicability to all clinical scenarios—especially with children or adolescents, where desistance is well-documented.

331. It must be noted that the same professional mental health and medical organizations arguing for restrictions on what psychotherapy can be practiced in

⁵ Br. of Dr. Jack L. Turban and Dr. Lisa R. Fortuna as Amici Curiae at 4, *Chiles v. Salazar*, 146 S.Ct. 1010 (2026) (No. 24-539).

this context have asserted that the government must not interfere in clinical decision-making. The American Academy of Pediatrics, as an example, has emphasized that “[p]atients, their families, and their physicians—not politicians or government officials—should be the ones to make decisions together about what care is best” (Jenco, 2025). It has also advocated that pediatricians should be able to continue providing “gender-affirming care” “without political interference” (Jenco, 2025). The AACAP has stated that it “vehemently opposes efforts to block access to care,” warning that such actions “endanger the physician-patient-caregiver relationship, which is the foundation of pediatric healthcare” (AACAP, 2022b). In short, organizations that supported government bans on “conversion therapy” were quick to argue that politics should not interfere with clinical practice when the legislation aligned with their goals.

332. As noted in the HHS report: “Critics of exploratory psychotherapy for GD claim that therapists are trying to ‘promote gender identities that are aligned with the person’s sex assigned at birth.’ A less theoretically-laden description would be that some therapists are trying to help children and adolescents come to terms with their bodies. Discomfort with the sexed body or with societal sex-based expectations is common during puberty and adolescence” (2025a, p. 262).

333. The unfortunate reality is that the campaign to stigmatize psychotherapy has real potential to do harm, and I believe this has already occurred at scale. First, because it will cause young people to avoid psychotherapy, believing it to be potentially harmful. Second, even if young persons do engage with therapy, these politically motivated criticisms create the false binary of “affirming” and “conversion” therapy, with the potential to cause serious nocebo effects (Clayton, 2023).

334. “Placebo and nocebo effects refer to the beneficial or adverse effects that occur in clinical or laboratory medical contexts, respectively, after

administration of an inert treatment or as part of active treatments, due to mechanisms such as expectancies of the patient” (Evers et al., 2018, p. 205). Placebo effects are routinely calculated and openly discussed regarding other disorders (Oronowicz-Jaśkowiak & Babel, 2019), and are routinely seen/quite strong in the context of internalizing disorders, such as depression and anxiety (Bschor et al., 2024). Gender dysphoria is among the internalizing disorders and shares features with anxiety and depressive disorders. As such, it should show large placebo effects, but this has not generally been explored.

335. What is equally concerning but even less discussed are nocebo effects, which are negative treatment outcomes often caused by negative expectations of the treatment. Just the concept alone that children should be affirmed in their stated gender identity can affect a significant nocebo effect from ethical psychotherapy. Traditional psychotherapists, no matter what approach they espouse, share a commitment to the uniqueness of the individual and the healing ethos of therapy. Their practices are designed to increase the client’s insight, agency, coping skills, and grasp on reality. “Stigmatizing non-‘affirmative’ psychotherapy for GD as ‘conversion’ will reduce access to treatment alternatives for patients seeking non-biomedical solutions to their distress” (D’Angelo et al., 2021, p. 7).

336. Further, psychotherapeutic attempts to “change” a person’s gender identity face a foundational conceptual challenge because “gender identity” itself is not a well-defined, stable, or empirically robust construct. As previously explained, it is a subjective and often circular concept whose coherence and clinical utility remain actively debated within psychology and psychiatry. This is especially true in minors still undergoing identity development, and with a need to accept their developing sexed human bodies.

337. “Unquestioning affirmation is in itself a form of influence that forecloses a thoroughgoing exploration and potentially compromises autonomy”

(D'Angelo, 2025, p. 6). Discouraging talk therapy may steer distressed young people toward medicalization and irreversible interventions with unclear benefits and known harms. Indeed, it remains unclear whether affirmation is psychologically beneficial in the long term, while it has not been demonstrated that non-affirming, exploratory approaches are inherently harmful. There are sound clinical reasons to refrain from affirmation in favor of individualized, evidence-based care.

338. Recent legal developments highlight the risks of affirmation and rushing distressed minors toward medicalization without adequately addressing psychiatric comorbidities. In a landmark 2026 case, a New York jury awarded \$2 million to detransitioner Fox Varian after finding that psychologist Kenneth Einhorn and plastic surgeon Simon Chin failed to meet the standard of care before approving and performing a double mastectomy on her at age 16 (Ryan, 2026b). Detransitioner Camille Kiefel recently settled a lawsuit against Oregon mental health providers who approved her for chest surgery after brief sessions despite a documented history of trauma, depression, and other comorbidities (Parks, 2026). These cases underscore how the affirmative model's emphasis on rapid validation can overlook serious psychiatric comorbidities, contributing to preventable detransition and long-term harm.



Kristopher Kaliebe, M.D.

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