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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. A series of cases with a control group;

d. A cohort study;

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

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