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Gender Dysphoria in Children

American College of Pediatricians – November 2018

ABSTRACT: Gender dysphoria (GD) of childhood describes a psychological condition in which children experience a marked incongruence between their experienced gender and the gender associated with their biological sex. When this occurs in the pre-pubertal child, GD resolves in the vast majority of patients by late adolescence. Currently there is a vigorous, albeit suppressed, debate among physicians, therapists, and academics regarding what is fast becoming the new treatment standard for GD in children. This new paradigm is rooted in the assumption that GD is innate, and involves pubertal suppression with gonadotropin releasing hormone (GnRH) agonists followed by the use of cross-sex hormones—a combination that results in the sterility of minors. A review of the current literature suggests that this protocol is founded upon an unscientific gender ideology, lacks an evidence base, and violates the long-standing ethical principle of "First do no harm."

Gender Dysphoria in Children: This Debate Concerns More than Science

Gender is a term that refers to the psychological and cultural characteristics associated with biological sex.[1] It is a psychological concept and sociological term, not a biological one. Gender identity refers to an individual's awareness of being male or female and is sometimes referred to as an individual's "experienced gender." Gender dysphoria (GD) in children describes a psychological condition in which they experience marked incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the opposite sex.[2] The prevalence rates of GD among children has been estimated to be less than 1%.[3] Sex differences in rate of referrals to specialty clinics vary by age. In pre-pubertal children, the ratio of boys to girls ranges from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the ratio of males to females range from 1:1 to 6.1:1.2

The debate over how to treat children with GD is primarily an ethical dispute; one that concerns physician worldview as much as science. Medicine does not occur in a moral vacuum; every therapeutic action or inaction is the result of a moral judgment of some kind that arises from the physician's philosophical worldview.

Medicine also does not occur in a political vacuum and being on the wrong side of sexual politics can have severe consequences for individuals who hold the politically incorrect view.

As an example, Dr. Kenneth Zucker, long acknowledged as a foremost authority on gender identity issues in children, has also been a lifelong advocate for gay and transgender rights. However, much to the consternation of adult transgender activists, Zucker believes that gender-dysphoric pre-pubertal children are best served by helping them align their gender identity with their anatomic sex. This view ultimately cost him his 30-year directorship of the Child Youth and Family Gender Identity Clinic (GIC) at the Center for Addiction and Mental Health in Toronto.[4,5]

Many critics of pubertal suppression hold a modernist teleological worldview. They find it self-evident that there is a purposeful design to human nature, and that cooperation with this design leads to human flourishing. Others, however, identify as post-modernists who reject teleology. What unites the two groups is a traditional interpretation of "First do no harm." For example, there is a growing online community of gay-affirming physicians, mental health professionals, and academics with a webpage entitled "First, do no harm: youth trans critical professionals." They write:

We are concerned about the current trend to quickly diagnose and affirm young people as transgender, often setting them down a path toward medical transition.... We feel that unnecessary surgeries and/or hormonal treatments which have not been proven safe in the long-term represent significant risks for young people. Policies that encourage—either directly or indirectly—such medical treatment for young people who may not be able to evaluate the risks and benefits are highly suspect, in our opinion.[6]

Advocates of the medical interventionist paradigm, in contrast, are also post-modernists but hold a subjective view of "First do no harm." Dr. Johanna Olson-Kennedy, an adolescent medicine specialist at Children's Hospital Los Angeles, and leader in pediatric gender transitioning, has stated that "[First do no harm] is really subjective. [H]istorically we come from a very paternalistic perspective... [in which] doctors are really given the purview of deciding what is going to be harmful and what isn't. And that, in the world of gender, is really problematic."[7] Not only does she claim that "First do no harm" is subjective, but she later also states that it should be left to the child decide what constitutes harm based upon their own subjective thoughts and feelings.[7] Given the cognitive and experiential immaturity of the child and adolescent, the American College of Pediatricians (ACPeds) finds this highly problematic and unethical.

Gender dysphoria as the result of an innate internal sexed identity

Professor of social work, Dr. William Brennan, has written that "[t]he power of language to color one's view of reality is profound."[8] It is for this reason that linguistic engineering always precedes social engineering — even in medicine. Many hold the mistaken belief that gender once meant biological sex. Though the terms are often used interchangeably they were never truly synonymous.[9,10] Feminists of the late 1960's and 1970's used gender to refer to a "social sex" that could differ from one's "biological sex" in order to overcome unjust discrimination against women rooted in sex stereotypes. These feminists are largely responsible for mainstreaming the use of the word gender in place of sex. More recently, in an attempt to eliminate heteronormativity, queer theorists have expanded gender into an excess of 50 categories by merging the concept of a social sex with sexual attractions.[9] However, neither usage reflects the original meaning of the term.

Prior to the 1950s, gender meant male or female, but applied only to grammar not persons.[9,10] Latin based languages categorize nouns and their modifiers as masculine or feminine and for this reason are still referred to as having a gender. This changed during the 1950s and 1960s as sexologists realized that their sex reassignment agenda could not be sufficiently defended using the words sex and transsexual. From a purely scientific standpoint, human beings possess a biologically determined sex and innate sex differences. No sexologist could actually change a person's genes through hormones and surgery. Sex change is objectively impossible. Their solution was to hijack the word gender and infuse it with a new meaning that applied to persons.

John Money, PhD was among the most prominent of these sexologists who redefined gender to mean "the social performance indicative of an internal sexed identity".[10] In essence, these sexologists invented the ideological foundation necessary to justify their treatment of transsexualism with sex reassignment surgery and called it gender. It is this man-made ideology of an innate and immutable "internal sexed identity" that now dominates mainstream medicine, psychiatry and academia. This linguistic history makes it clear that gender is not and never has been a biological or scientific entity. Rather, gender is a socially and politically constructed concept.

In their "Overview of Gender Development and Gender Nonconformity in Children and Adolescents," Forcier and Olson-Kennedy dismiss the binary model of human sexuality as "ideology" and present an "alternate perspective" of "innate gender identity" that presents along a "gender continuum." They recommend that pediatricians tell parents that a child's "real gender" is what he or she feels it to be because "a child's brain and body may not be on the same page."[11]

Forcier and Olson-Kennedy's claim of an innate discordance between a child's brain and the rest of the body derives from diffusion-weighted MRI scans that demonstrate the pubertal testosterone surge in boys increases white matter volume, as well as from brain studies of adults who identify as transgender. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.[12] Other diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.[13] These and more recent studies, however, fail to prove causation due to several design flaws. A properly designed brain difference study needs to be prospective and longitudinal; it would require a large randomly selected population based sample of a fixed set of individuals, would follow them with serial brain imaging from infancy through adulthood, and would have to be replicated. Not one brain study to date meets a single one of these requirements to be considered rigorous research design. Even if they did, causation would not be certain due to neuroplasticity.

Neuroplasticity

Neuroplasticity is the well-established phenomenon in which thinking and behavior alters brain microstructure. There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.[14] Therefore, if scientifically rigorous studies ever do identify transgender brain differences, these differences will still more likely be the result of transgender behavior rather than its cause.

More importantly, however, is the fact that the brains of all male infants are masculinized prenatally by their own endogenous testosterone, which is secreted from their testes beginning at approximately eight weeks' gestation. Female infants, of course, lack testes, and therefore, do not have their brains masculinized by endogenous testosterone.[15,16,17] For this reason, barring maternal exposure to androgens or one of the rare disorders of sex development (DSDs), boys are not born with feminized brains, and girls are not born with masculinized brains.

Genetic Determinism

Might gender identity be genetically determined? Behavior geneticists have known for decades that while genes *influence* behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid "blueprints" for behavior. Rather, humans "develop traits through the dynamic process of gene-environment interaction… [genes alone] don't determine who we are."[18] Regarding the etiology of transgenderism, twin studies of adult transsexuals prove definitively that genetic influence is far less than that of environmental factors.

Twin studies are instrumental in elucidating whether genes or environmental factors contribute more significantly to a particular trait. Since monozygotic twins are conceived with exactly the same DNA, and spontaneous mutations before birth are rare, traits that are solely determined by genes, will manifest in both

identical twins close to if not exactly 100 percent of the time. Skin color is an example of a trait that identical twins share virtually 100 percent of the time because it is solely determined by genes.

The largest transsexual twin study to date examines 110 twin pairs and was published by Dr. Milton Diamond in the May 2013 issue of the International Journal of Transgenderism.[19] Table 5 documents that the number of monozygotic twin pairs concordant for transsexualism is greater than that of dizygotic twin pairs. This suggests a possible biological predisposition for gender dysphoria. The most significant data entry, however, is the low number of concordant monozygotic twin pairs. Only 21 monozygotic twin pairs out of a total of 74 monozygotic pairs, or 28 percent, were concordant for transsexualism; the remaining 72 percent of identical twins were discordant for transsexualism.

This means that environmental factors trump any biological predisposition. Environmental factors account for nearly 75 percent of what causes transsexualism in one twin and not in the other; and since identical twins develop in the same uterus, non-shared post-birth experiences are likely to have a greater influence than the prenatal environment. A high 72 percent discordance rate among identical twins proves that no one is born pre-determined to have gender dysphoria let alone pre-determined to identify as transgender or transsexual.

This is what would be expected given the dramatic rates of resolution of gender dysphoria documented among children when they are not encouraged to impersonate the opposite sex. The low concordance rate also supports the theory that persistent GD is due predominantly to the impact of non-shared environmental influences upon certain biologically vulnerable children. To be clear, twin studies alone establish that the "alternative perspective" of an "innate gender identity" trapped in the wrong body is in fact an ideological belief that has no basis in rigorous science.

A teleological binary view of human sexuality, in contrast, is compatible with biological reality. The norm for human design is to be conceived either male or female. Sex chromosome pairs "XY" and "XX" are genetic determinants of sex, male and female, respectively. They are not genetic markers of a disordered body or birth defect. Human sexuality is binary by design with the purpose being the reproduction of our species. This principle is self-evident. Barring one of the rare disorders of sex development (DSD), no infant is "assigned" a sex or a gender at birth. Sex declares itself anatomically in utero and is clearly evident and acknowledged at birth.

Disorders of sex development (DSDs), including but not limited to androgen insensitivity syndrome and congenital adrenal hyperplasia, affect less than 0.02 percent of the population.[20] These disorders are all medically identifiable deviations from the human binary sexual norm. Unlike individuals with a normal genotype and hormonal axis who identify as "transgender," those with DSDs have an innate biological condition. Sex assignment in individuals with DSDs can be complex and depends on a variety of genetic, hormonal, and physical factors. Nevertheless, the 2006 consensus statement of the Intersex Society of North America did not endorse DSD as a third sex.[21]

Post-natal Factors Predominate in the Development and Persistence of GD

Identical twin studies demonstrate that environmental factors, especially post-natal non-shared events, predominate in the development and persistence of gender dysphoria. This is not surprising since it is well accepted that a child's emotional and psychological development is impacted by positive and negative experiences from infancy forward. Family and peer relationships, one's school and neighborhood, the experience of any form of abuse, media exposure, chronic illness, war, and natural disasters are all examples of environmental factors that impact an individual's emotional, social, and psychological development. *There is no single family dynamic, social situation, adverse event, or combination thereof that has been found to destine any child to develop GD.* This fact, together with twin studies, suggests that there are many paths that may lead to GD in certain predisposed children.

The literature regarding the etiology and psychotherapeutic treatment of childhood GD is heavily based upon clinical case studies. These studies suggest that social reinforcement, parental psychopathology, family

dynamics, and social contagion -facilitated by mainstream and social media, all contribute to the development and/or persistence of GD in some vulnerable children. There may be other as yet unrecognized contributing factors as well.

Most parents of children with GD recall their initial reactions to their child's cross-sex dressing and other cross-sex behaviors to have been tolerance and/or encouragement. Sometimes parental psychopathology is at the root of the social reinforcement. For example, among mothers of boys with GD who had desired daughters, a small subgroup experienced what has been termed "pathologic gender mourning." Within this subgroup the mother's desire for a daughter was acted out by the mother actively cross-dressing her son as a girl. These mothers typically suffered from severe depression that was relieved when their sons dressed and acted in a feminine manner.[22]

A large body of clinical literature documents that fathers of feminine boys report spending less time with their sons between the ages of two and five as compared with fathers of control boys. This is consistent with data that shows feminine boys feel closer to their mothers than to their fathers. In his clinical studies of boys with GD, Stoller observed that most had an overly close relationship with their mother and a distant, peripheral relationship with their father. He postulated that GD in boys was a "developmental arrest … in which an excessively close and gratifying mother-infant symbiosis, undisturbed by father's presence, prevents a boy from adequately separating himself from his mother's female body and feminine behavior."[22]

It has also been found that among children with GD, the rate of maternal psychopathology, particularly depression and bipolar disorder is "high by any standard." Additionally, a majority of the fathers of GD boys are easily threatened, exhibit difficulty with affect regulation, and possess an inner sense of inadequacy. These fathers typically deal with their conflicts by overwork or otherwise distance themselves from their families. Most often, the parents fail to support one another, and have difficulty resolving marital conflicts. This produces an intensified air of conflict and hostility. In this situation, the boy becomes increasingly unsure about his own self-value because of the mother's withdrawal or anger and the father's failure to intercede. The boy's anxiety and insecurity intensify, as does his anger, which may all result in his inability to identify with his biological sex.[23]

Systematic studies regarding girls with GD and the parent-child relationship have not been conducted. However, clinical observations suggest that the relationship between mother and daughter is most often distant and marked by conflict, which may lead the daughter to disidentify from the mother. In other cases, masculinity is praised while femininity is devalued by the parents. Furthermore, there have been cases in which girls are afraid of their fathers who may exhibit volatile anger up to and including abuse toward the mother. A girl may perceive being female as unsafe, and psychologically defend against this by feeling that she is really a boy; subconsciously believing that if she were a boy she would be safe from and loved by her father.[22]

There is evidence that psychopathology and/or developmental diversity may precipitate GD in adolescents, particularly among young women. Recent research has documented increasing numbers of adolescents who present to adolescent gender identity clinics and request sex reassignment (SR). Kaltiala-Heino and colleagues sought to describe the adolescent applicants for legal and medical sex reassignment during the first two years of an adolescent gender identity clinic in Finland, in terms of sociodemographic, psychiatric, and gender identity related factors and adolescent development. They conducted a structured quantitative retrospective chart review and qualitative analysis of case files of all adolescent SR applicants who entered the assessment by the end of 2013. They found that the number of referrals exceeded expectations in light of epidemiological knowledge. Natal girls were markedly overrepresented among applicants. Severe psychopathology preceding the onset of GD was common. Many youth were on the autism spectrum. These findings do not fit the commonly accepted image of a gender dysphoric child. The researchers conclude that treatment guidelines need to consider GD in minors in the context of severe psychopathology and developmental difficulties.[24]

A recent study has documented an increasing trend among adolescents to self-diagnose as transgender after binges on social media sites such as Tumblr, Reddit, and YouTube.25 This suggests that social contagion may be

at play. In many schools and communities, there are entire peer groups "coming out" as trans at the same time.[25] Finally, strong consideration should be given to investigating a causal association between adverse childhood events, including sexual abuse, and transgenderism. The overlap between childhood gender discordance and an adult homosexual orientation has long been acknowledged.[26] There is also a large body of literature documenting a significantly greater prevalence of childhood adverse events and sexual abuse among homosexual adults as compared to heterosexual adults. Andrea Roberts and colleagues' published a study in 2013 that found "half to all of the elevated risk of childhood abuse among persons with same-sex sexuality compared to heterosexuals was due to the effects of abuse on sexuality."[27] It is therefore possible that some individuals develop GD and later claim a transgender identity as a result of childhood maltreatment and/or sexual abuse. This is an area in need of research.

GD as an Objective Mental Disorder

Psychology has increasingly rejected the concept of norms for mental health, focusing instead on emotional distress. The American Psychiatric Association (APA), for example, explains in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) that GD is listed therein not due to the discrepancy between the individual's thoughts and physical reality, but due to the presence of emotional distress that hampers social functioning. The DSM-5 also notes that a diagnosis is required for insurance companies to pay for cross-sex hormones and sex reassignment surgery (SRS) to alleviate the emotional distress of GD. Once the distress is relieved, GD is no longer considered a disorder.[2]

There are problems with this reasoning. Consider the following examples: a girl with anorexia nervosa has the persistent mistaken belief that she is obese; a person with body dysmorphic disorder (BDD) harbors the erroneous conviction that she is ugly; a person with body integrity identity disorder (BIID) identifies as a disabled person and feels trapped in a fully functional body. Individuals with BIID are often so distressed by their fully capable bodies that they seek surgical amputation of healthy limbs or the surgical severing of their spinal cord.[28] Dr. Anne Lawrence, who is transgender, has argued that BIID has many parallels with GD.[29] The aforementioned false beliefs, like GD, are not merely emotionally distressing for the individuals but also life-threatening. In each case, surgery to "affirm" the false assumption (liposuction for anorexia, cosmetic surgery for BDD, amputation or surgically induced paraplegia for BIID, sex reassignment surgery for GD) may very well alleviate the patient's emotional distress, but will do nothing to address the underlying psychological problem, and may result in the patient's death. Completely removed from physical reality, the art of psychotherapy will diminish as the field of psychology increasingly devolves into a medical interventionist specialty, with devastating results for patients.

Alternatively, a minimal standard could be sought. Normality has been defined as "that which functions according to its design."[30] One of the chief functions of the brain is to perceive physical reality. Thoughts that are in accordance with physical reality are normal. Thoughts that deviate from physical reality are abnormal—as well as potentially harmful to the individual or to others. This is true whether or not the individual who possesses the abnormal thoughts feels distress. A person's belief that he is something or someone he is not is, at best, a sign of confused thinking; at worst, it is a delusion. Just because a person thinks or feels something does not make it so. This would be true even if abnormal thoughts were biologically "hardwired."

The norm for human development is for an individual's thoughts to align with physical reality; for an individual's gender identity to align with biologic sex. People who identify as "feeling like the opposite sex" or "somewhere in between" or some other category do not comprise a third sex. They remain biological men or biological women. GD is a problem that resides in the mind not in the body. Children with GD do not have a disordered body—even though they feel as if they do. Similarly, a child's distress over developing secondary sex characteristics does not mean that puberty should be treated as a disease to be halted, because puberty is not, in fact, a disease. Likewise, although many men with GD express the belief that they are a "feminine essence" trapped in a male body, this belief has no scientific basis.

Until recently, the prevailing worldview with respect to childhood GD was that it reflected abnormal thinking or confusion on the part of the child that may or may not be transient. Consequently, the standard approach was either watchful waiting or pursuit of family and individual psychotherapy.[1,2] The goals of therapy were to address familial pathology if it was present, treat any psychosocial morbidities in the child, and aid the child in aligning gender identity with biological sex.[22,23] Experts on both sides of the pubertal suppression debate agree that within this context, 80 percent to 95 percent of children with GD accepted their biological sex by late adolescence.[31] This worldview began to shift, however, as adult transgender activists increasingly promoted the "feminine essence" narrative to secure social acceptance.[10] In 2007, the same year that Boston Children's Hospital opened the nation's first pediatric gender clinic, Dr. J. Michael Bailey wrote:

Currently the predominant cultural understanding of male-to-female transsexualism is that all male-to-female (MtF) transsexuals are, essentially, women trapped in men's bodies. This understanding has little scientific basis, however, and is inconsistent with clinical observations. Ray Blanchard has shown that there are two distinct subtypes of MtF transsexuals. Members of one subtype, homosexual transsexuals, are best understood as a type of homosexual male. The other subtype, autogynephilic transsexuals, are (sic) motivated by the erotic desire to become women. The persistence of the predominant cultural understanding, while explicable, is damaging to science and to many transsexuals.[32]

As the "feminine essence" view persisted, the suffering of transgender adults was invoked to argue for the urgent rescue of children from the same fate by early identification, affirmation, and pubertal suppression. It is now alleged that discrimination, violence, psychopathology, and suicide are the direct and inevitable consequences of withholding social affirmation and puberty blockers or cross-sex hormones from a gender dysphoric child.[33] Yet, the fact that 80 percent to 95 percent of gender-dysphoric youth emerge physically and psychologically intact after passing through puberty without social affirmation refutes this claim.[31] Furthermore, over 90 percent of people who die of suicide have a diagnosed mental disorder.[34] There is no evidence that gender-dysphoric children who commit suicide are any different. Therefore, the cornerstone for suicide prevention should be the same for them as for all children: early identification and treatment of psychological co-morbidities.

Nevertheless, there are now 40 gender clinics across the United States that promote the use of pubertal suppression and cross-sex hormones in children. The rationale for suppression is to allow the gender-dysphoric child time to explore gender identity free from the emotional distress triggered by the onset of secondary sex characteristics. The standards followed in these clinics are based on "expert opinion." There is not a single large, randomized, controlled study that documents the alleged benefits and potential harms to gender-dysphoric children from pubertal suppression and decades of cross-sex hormone use. Nor is there a single long-term, large, randomized, controlled study that compares the outcomes of various psychotherapeutic interventions for childhood GD with those of pubertal suppression followed by decades of toxic synthetic steroids. In today's age of "evidence-based medicine," this should give everyone pause. Of greater concern is that pubertal suppression at Tanner Stage 2 (usually 11 years of age) followed by the use of cross-sex hormones will leave these children sterile and without gonadal tissue or gametes available for cryo-preservation.[35,36,37]

Neuroscience clearly documents that the adolescent brain is cognitively immature and lacks the adult capacity needed for risk assessment prior to the early to mid-twenties.[38] There is a serious ethical problem with allowing irreversible, life-changing procedures to be performed on minors who are too young to give valid consent themselves. This ethical requirement of informed consent is fundamental to the practice of medicine, as emphasized by the U.S. Department of Health & Human Services website: "The voluntary consent of the human subject is absolutely essential."[39] Moreover, when an individual is sterilized, even as a secondary outcome of therapy, lacking full, free, and informed consent, it is a violation of international law.[40]

Transgender-Affirming Protocol: What Is the Evidence Base?

Over the past two decades, Hayes, Inc. has grown to become an internationally recognized research and consulting firm that evaluates a wide range of medical technologies to determine the impact on patient safety,

health outcomes, and resource utilization. This corporation conducted a comprehensive review and evaluation of the scientific literature regarding the treatment of GD in adults and children in 2014. It concluded that although "evidence suggests positive benefits" to the practice of using sex reassignment surgery in gender dysphoric adults, "serious limitations [inherent to the research] permit only weak conclusions."[41] Similarly, Hayes, Inc. found the practice of using cross-sex hormones for gender dysphoric adults to be based on "very low" quality of evidence:

Statistically significant improvements have not been consistently demonstrated by multiple studies for most outcomes. Evidence regarding quality of life and function in male-to-female (MtF) adults was very sparse. Evidence for less comprehensive measures of well-being in adult recipients of cross-sex hormone therapy was directly applicable to GD patients but was sparse and/or conflicting. The study designs do not permit conclusions of causality and studies generally had weaknesses associated with study execution as well. There are potentially long-term safety risks associated with hormone therapy but none have been proven or conclusively ruled out.[42]

Regarding treatment of children with GD using gonadotropin releasing hormone (GnRH) agonists and cross-sex hormones, Hayes, Inc. awarded its lowest rating indicating that the literature is "too sparse and the studies [that exist are] too limited to suggest conclusions."[42]

Gender Clinics Proliferate Across United States Despite Lack of Medical Evidence

In 2007 Dr. Norman Spack, a pediatric endocrinologist and founder of the nation's first gender clinic at Boston Children's Hospital, launched the pubertal suppression paradigm in the United States.[43] It consists of first affirming the child's false self-concept by instituting name and pronoun changes, and facilitating the impersonation of the opposite sex within and outside of the home. Next, puberty is suppressed via GnRH agonists as early as age 11 years, and then finally, patients may graduate to cross-sex hormones at age 16 in preparation for sex-reassignment surgery as an older adolescent or adult.[44] Endocrine Society guidelines currently prohibit the use of cross-sex hormones before age 16 but this prohibition is being reconsidered.[45] Some gender specialists are already bypassing pubertal suppression and instead putting children as young as 11 years old directly onto cross-sex hormones.[46] The rationale is that the child will experience the pubertal development of the desired sex and thereby avoid the iatrogenic emotional distress from maintaining a pre-pubertal appearance as peers progress along their natural pubertal trajectory.

In 2014 there were 24 gender clinics clustered chiefly along the East Coast and in California; one year later there were 40 across the nation. Dr. Ximena Lopez, a pediatric endocrinologist at Children's Medical Center Dallas, and a member of that program's GENder Education and Care, Interdisciplinary Support program (Genecis) stated, "[Use of this protocol is] growing really fast. And the main reason is [that] parents are demanding it and bringing patients to the door of pediatric endocrinologists because they know this is available."[47] Notice, the *main* reason for the protocol's increased use is parent demand; not evidence-based medicine.

Risks of GnRH Agonists

The GnRH agonists used for pubertal suppression in gender dysphoric children include two that are approved for the treatment of precocious puberty: leuprolide by intramuscular injection with monthly or once every three month dosing formulations, and histrelin, a subcutaneous implant with yearly dosing.[36] In addition to preventing the development of secondary sex characteristics, GnRH agonists arrest bone growth, decrease bone accretion, prevent the sex-steroid dependent organization and maturation of the adolescent brain, and inhibit fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment. If the child discontinues the GnRH agonists, puberty will ensue.[36,44] Consequently, the Endocrine Society maintains that GnRH agonists, as well as living socially as the opposite sex, are fully reversible interventions that carry no risk of permanent harm to children.[44] However, social learning theory, neuroscience, and the single long-term follow-up study of adolescents who have received pubertal suppression described below challenge this claim.

In a follow-up study of their first 70 pre-pubertal candidates to receive puberty suppression, de Vries and colleagues documented that all subjects eventually embraced a transgender identity and requested cross-sex hormones.[48] This is cause for concern. Normally, 80 percent to 95 percent of pre-pubertal youth with GD do not persist in their GD. To have 100 percent of pre-pubertal children choose cross-sex hormones suggests that the protocol itself inevitably leads the individual to identify as transgender.

There is an obvious self-fulfilling nature to encouraging a young child with GD to socially impersonate the opposite sex and then institute pubertal suppression. Purely from a social learning point of view, the repeated behavior of impersonating and being treated as the opposite sex will make identity alignment with the child's biologic sex less likely. This, together with the suppression of puberty that prevents further endogenous masculinization or feminization of the entire body and brain, causes the child to remain either a gender non-conforming pre-pubertal boy disguised as a pre-pubertal girl, or the reverse. Since their peers develop normally into young men or young women, these children are left psychosocially isolated. They will be less able to identify as being the biological male or female they actually are. A protocol of impersonation and pubertal suppression that sets into motion a single inevitable outcome (transgender identification) that requires lifelong use of toxic synthetic hormones, resulting in infertility, is neither fully reversible nor harmless.

GnRH Agonists, Cross-sex Hormones, and Infertility

Since GnRH agonists prevent the maturation of gonadal tissue and gametes in both sexes, youth who graduate from pubertal suppression at Tanner Stage 2 to cross-sex hormones will be rendered infertile without any possibility of having genetic offspring in the future because they will lack gonadal tissue and gametes for cryo-preservation. The same outcome will occur if pre-pubertal children are placed directly upon cross-sex hormones. Older adolescents who declined pubertal suppression are advised to consider cryo-preservation of gametes prior to beginning cross-sex hormones. This will allow them to conceive genetic offspring in the future via artificial reproductive technology. While there are documented cases of transgendered adults who stopped their cross-sex hormones in order to allow their bodies to produce gametes, conceive, and have a child, there is no absolute guarantee that this is a viable option in the long term. Moreover, transgendered individuals who undergo sex reassignment surgery and have their reproductive organs removed are rendered permanently infertile.[36,37,38]

Additional Health Risks Associated with Cross-sex Hormones

Potential risks from cross-sex hormones to children with GD are based on the adult literature. Recall that regarding the adult literature, the Hayes report states: "There are potentially long-term safety risks associated with hormone therapy but none have been proven or conclusively ruled out."[42] For example, most experts agree that there is an increased risk of coronary artery disease among MtF adults when placed on oral ethinyl estradiol; therefore, alternative estrogen formulations are recommended. However, there is one study of MtF adults using alternative preparations that found a similar increased risk. Therefore, this risk is neither established nor ruled out.[49,50,51] Children who transition will require these hormones for a significantly greater length of time than their adult counterparts. Consequently, they may be more likely to experience physiologically theoretical though rarely observed morbidities in adults. With these caveats, it is most accurate to say that oral estrogen administration to boys *may* place them at risk for experiencing: thrombosis/thromboembolism; cardiovascular disease; weight gain; hypertrigyceridemia; elevated blood pressure; decreased glucose tolerance; gallbladder disease; prolactinoma; and breast cancer.[49,50,51] Similarly, girls who receive testosterone *may* experience an elevated risk for: low HDL and elevated triglycerides; increased homocysteine levels; hepatotoxicity; polycythemia; increased risk of sleep apnea; insulin resistance; and unknown effects on breast, endometrial and ovarian tissues.[49,50,51] In addition, girls may legally obtain a mastectomy as early as 16 years of age after receiving testosterone therapy for at least one year; this surgery carries its own set of irreversible risks.[36]

The Post-Pubertal Adolescent with GD

As previously noted, 80 percent to 95 percent of pre-pubertal children with GD will experience resolution by late adolescence if not exposed to social affirmation and medical intervention. This means that 5 percent to 20

percent will persist in their GD as young adults. Currently, there is no medical or psychological test to determine which children will persist in their GD as young adults. Pre-pubertal children with GD who persist in their GD beyond puberty are more likely to also persist into adulthood. The Endocrine Society and others, including Dr. Zucker, therefore regard it reasonable to affirm children who persist in their GD beyond puberty, as well as those who present after puberty, and to proceed with cross-sex hormones at age 16 years.[44]

ACPeds disagrees for the following reasons. First, not all adolescents with GD inevitably go on to trans-identification, but cross-sex hormones inevitably result in irreversible changes for all patients. Second, adolescents are not sufficiently mature to make significant irreversible medical decisions. The adolescent brain does not achieve the capacity for full risk assessment until the early to mid-twenties. There is a serious ethical problem with allowing minors to receive life-altering medical interventions including cross-sex hormones and, in the case of natal girls, bilateral mastectomy, when they are incapable of providing informed consent for themselves.

As stated earlier, ACPeds is also concerned about an increasing trend among adolescents to self-diagnose as transgender after binges on social media sites. While many of these adolescents will seek out a therapist after self-identifying, many states have been forced by non-scientific political pressure to ban therapists from asking why an adolescent believes he or she is transgender. In these states therapists may not explore underlying mental health issues; cannot consider the symbolic nature of the gender dysphoria; and may not look at possible confounding issues such as social media use or social contagion.[6]

Impact of sex reassignment in adults as it relates to risk in children

Surveys suggest that transgender adults initially express a sense of "relief" and "satisfaction" following the use of hormones and sex reassignment surgery (SRS). In the long term, however, SRS does not result in a level of health equivalent to that of the general population.[52] For example, a 2001 study of 392 male-to-female and 123 female-to-male transgender persons found that 62 percent of the male-to-female (MtF) and 55 percent of the female-to-male (FtM) transgender persons were depressed. Nearly one third (32 percent) of each population had attempted suicide.[53] Similarly, in 2009, Kuhn and colleagues found considerably lower general health and general life satisfaction among 52 MtF and 3 FtM transsexuals fifteen years after SRS when compared with controls.54 Finally, a thirty-year follow-up study of post-operative transgender patients from Sweden found that thirty years out from surgery, the rate of suicide among post-operative transgender adults was nearly twenty times greater than that of the general population.

To be clear, this does not prove that sex reassignment causes an increased risk of suicide or other psychological morbidities. Rather, it indicates that sex reassignment alone does not provide the individual with a level of mental health on par with the general population. The authors of the Swedish study summarized their findings as follows:

Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, though alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group.[52]

It is noteworthy that these mental health disparities are observed in one of the most lesbian, gay, bisexual and transgender (LGBT) affirming nations of the world. It suggests that these health differences are not due primarily to social prejudice, but rather due to underlying trauma that also induced transgender belief, and/or the adult transgender condition or lifestyle. This is also consistent with an American study published in the *Journal of LGBT Health* in 2008 that found discrimination did not account for the mental health discrepancies between LGBT-identified individuals and the heterosexual population.[55]

Absent hormonal and surgical intervention, only 5-20 percent of pre-pubertal children with GD will face a transgender adulthood which seems to predispose them to certain morbidities and an increased risk of early

death. In contrast, the single study of pre-pubertal children with GD who received pubertal suppression makes clear that as many as 100 percent of these children will face a transgender adulthood. Therefore, the current transgender affirming interventions at pediatric gender clinics will statistically yield this outcome for the remaining 80 to 95 percent of pre-pubertal children with GD who otherwise would have identified with their biological sex by adulthood.

Recommendations for research

Identical twin studies establish that post-natal environmental factors exert a significant influence over the development of GD and transgenderism. Data also reflects a greater than 80% resolution rate among pre-pubertal children with GD. Consequently, identification of the various environmental factors and pathways that trigger GD in biologically vulnerable children should be one focus of research. Particular attention should be given to the impact of childhood adverse events and social contagion. Another area of much needed research is within psychotherapy. Large long term longitudinal studies in which children with GD and their families are randomized to treatment with various therapeutic modalities and assessed across multiple measures of physical and social emotional health are desperately needed and should have been launched long ago. In addition, long term follow-up studies that assess objective measures of physical and mental health of post-surgical transsexual adults must include a matched control group consisting of transgender individuals who do not undergo SRS. This is the only way to test the hypothesis that SRS itself may cause more harm to individuals than they otherwise would experience with psychotherapy alone.

Conclusion

Gender dysphoria (GD) in children is a term used to describe a psychological condition in which a child experiences marked incongruence between his or her experienced gender and the gender associated with the child's biological sex. Twin studies demonstrate that GD is not an innate trait. Moreover, barring pre-pubertal affirmation and hormone intervention for GD, 80 percent to 95 percent of children with GD will accept the reality of their biological sex by late adolescence.

The treatment of GD in childhood with hormones effectively amounts to mass experimentation on, and sterilization of, youth who are cognitively incapable of providing informed consent. There is a serious ethical problem with allowing irreversible, life-changing procedures to be performed on minors who are too young to give valid consent themselves; adolescents cannot understand the magnitude of such decisions.

Ethics alone demands an end to the use of pubertal suppression with GnRH agonists, cross-sex hormones, and sex reassignment surgeries in children and adolescents. The American College of Pediatricians recommends an immediate cessation of these interventions, as well as an end to promoting gender ideology via school curricula and legislative policies. Healthcare, school curricula and legislation must remain anchored to physical reality. Scientific research should focus upon better understanding the psychological underpinnings of this disorder, optimal family and individual therapies, as well as delineating the differences among children who resolve with watchful waiting versus those who resolve with therapy and those who persist despite therapy.

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The American College of Pediatricians is a national medical association of licensed physicians and healthcare professionals who specialize in the care of infants, children, and adolescents. The mission of the College is to enable all children to reach their optimal, physical and emotional health and well-being.

A printable Adobe Acrobat (pdf) copy of this position is available by clicking here: Gender Dysphoria in Children

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POINT-OF-CARE QUICK REFERENCE | AUGUST 20 2021

Gender Identity

Amy Weimer, MD

Quick References (2021)
https://doi.org/10.1542/aap.ppcqr.396041

Key Points

- The prevalence of gender dysphoria is increasing, and all providers should be prepared to interact with transgender patients.
- Gender-affirming care has been shown to improve health outcomes. The specific treatments recommended vary depending on age and developmental stage.
- Pubertal suppression may be used for children at Tanner stages 2 to 4 to prevent unwanted pubertal changes and allow more time to evaluate goals.
- Hormone therapy is partially irreversible and may be considered for teenagers with stable gender identity.
- Surgery is typically deferred until adulthood, although masculinizing chest reconstruction may be pursued in adolescence.
- Care through a multidisciplinary program may be optimal, but pediatricians have an important role in providing resources and psychosocial support and navigating family discussions.

Topics: gender, gender dysphoria, gender identity, transgender persons, endocrine therapy, hormone replacement therapy, puberty, signs and symptoms

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Jamie Reed at home in Missouri. (Theo R. Welling.)

I Thought I Was Saving Trans Kids. Now I'm Blowing the Whistle.

There are more than 100 pediatric gender clinics across the U.S. I worked at one. What's happening to children is morally and medically appalling.

By Jamie Reed
February 9, 2023

I am a 42-year-old St. Louis native, a queer woman, and politically to the left of Bernie Sanders. My worldview has deeply shaped my career. I have spent my professional life providing counseling to vulnerable populations: children in foster care, sexual minorities, the poor.

For almost four years, I worked at The Washington University School of Medicine Division of Infectious Diseases with teens and young adults who were HIV positive. Many of them were trans or otherwise gender [illegible]

Other girls were disturbed by the effects of testosterone on their clitoris, which enlarges and grows into what looks like a microphallus, or a tiny penis. I counseled one patient whose enlarged clitoris now extended below her vulva, and it chafed and rubbed painfully in her jeans. I advised her to get the kind of compression undergarments worn by biological men who dress to pass as female. At the end of the call I thought to myself, "Wow, we hurt this kid."

There are rare conditions in which babies are born with atypical genitalia—cases that call for sophisticated care and compassion. But clinics like the one where I worked are *creating* a whole cohort of kids with atypical genitals—and most of these teens haven't even had sex yet. They had no idea who they were going to be as adults. Yet all it took for them to permanently transform themselves was one or two short conversations with a therapist.

Being put on powerful doses of testosterone or estrogen—enough to try to trick your body into mimicking the opposite sex—affects the rest of the body. I doubt that any parent who's ever consented to give their kid testosterone (a lifelong treatment) knows that they're also possibly signing their kid up for blood pressure medication, cholesterol medication, and perhaps sleep apnea and diabetes.

But sometimes the parents' understanding of what they had agreed to do to their children came forcefully:

Neglected and Mentally Ill Patients

Besides teenage girls, another new group was referred to us: young people from the inpatient psychiatric unit, or the emergency department, of St. Louis Children's Hospital. The mental health of these kids was deeply concerning—there were diagnoses like schizophrenia, PTSD, bipolar disorder, and more. Often they were already on a fistful of pharmaceuticals.

This was tragic, but unsurprising given the profound trauma some had been through. Yet no matter how much suffering or pain a child had endured, or how little treatment and love they had received, our doctors viewed gender transition—even with all the expense and hardship it entailed—as the solution.

Some weeks it felt as though almost our entire caseload was nothing but disturbed young people.

For example, one teenager came to us in the summer of 2022 when he was 17 years old and living in a lockdown facility because he had been sexually abusing dogs. He'd had an awful childhood: His mother was a drug addict, his father was imprisoned, and he grew up in foster care. Whatever treatment he may have been getting, it wasn't working.

During our intake I learned from another caseworker that when he got out, he planned to reoffend because he believed the dogs had willingly submitted.

Somewhere along the way, he expressed a desire to become female, so he ended up being seen at our center. From there, he went to a psychologist at the hospital who was known to approve virtually everyone seeking transition. Then our doctor recommended feminizing hormones. At the time, I wondered if this was being done as a form of chemical castration.

That same thought came up again with another case. This one was in spring of 2022 and concerned a young man who had intense obsessive-compulsive disorder that manifested as a desire to cut off his penis after he masturbated. This patient expressed no gender dysphoria, but he got hormones, too. I asked the doctor what protocol he was following, but I never got a straight answer.

In Loco Parentis

Another disturbing aspect of the center was its lack of regard for the rights of parents—and the extent to which doctors saw themselves as more informed decision-makers over the fate of these children.

In Missouri, only one parent's consent is required for treatment of their child. But when there was a dispute between the parents, it seemed the center always took the side of the affirming parent.

My concerns about this approach to dissenting parents grew in 2019 when one of our doctors actually testified in a custody hearing against a father who opposed a mother's wish to start their *11-year-old daughter* on puberty blockers.

I had done the original intake call, and I found the mother quite disturbing. She and the father were getting divorced, and the mother described the daughter as "kind of a tomboy." So now the mother was convinced her child was trans. But when I asked if her daughter had adopted a boy's name, if she was distressed about her body, if she was saying she felt like a boy, the mother said no. I explained the girl just didn't meet the criteria for an evaluation.

Then a month later, the mother called back and said her daughter now used a boy's name, was in distress over her body, and wanted to transition. This time the mom and daughter were given an appointment. Our providers decided the girl was trans and prescribed a puberty blocker to prevent her normal development.

The father adamantly disagreed, said this was all coming from the mother, and a custody battle ensued. After the hearing where our doctor testified in favor of transition, the judge sided with the mother.

'I Want My Breasts Back'

Because I was the main intake person, I had the broadest perspective on our existing and prospective patients. In 2019, a new group of people appeared on my radar: desisters and detransitioners. Desisters choose not to go through with a transition. Detransitioners are transgender people who decide to return to their birth gender.

The one colleague with whom I was able to share my concerns agreed with me that we should be tracking desistance and detransition. We thought the doctors would want to collect and understand this data in order to figure out what they had missed.

We were wrong. One doctor wondered aloud why he would spend time on someone who was no longer his patient.

But we created a document anyway and called it the Red Flag list. It was an Excel spreadsheet that tracked the kind of patients that kept my colleague and me up at night.

One of the saddest cases of detransition I witnessed was a teenage girl, who, like so many of our patients, came from an unstable family, was in an uncertain living situation, and had a history of drug use. The overwhelming majority of our patients are white, but this girl was black. She was put on hormones at the center when she was around 16. When she was 18, she went in for a double mastectomy, what's known as "top surgery."

Three months later she called the surgeon's office to say she was going back to her birth name and that her pronouns were "she" and "her." Heartbreakingly, she told the nurse, "I want my breasts back." The surgeon's office contacted our office because they didn't know what to say to this girl.

My colleague and I said that we would reach out. It took a while to track her down, and when we did we made sure that she was in decent mental health, that she was not actively suicidal, that she was not using substances. The last I heard, she was pregnant. Of course, she'll never be able to breastfeed her child.

'Get On Board, Or Get Out'

My concerns about what was going on at the center started to overtake my life. By spring 2020, I felt a medical and moral obligation to do something. So I spoke up in the office, and sent plenty of emails.

Here's just one example: On January 6, 2022, I received an email from a staff therapist asking me for help with a case of a 16-year-old transgender male living in another state. "Parents are open to having patient see a therapist but are not supportive of gender and patient does not want parents to be aware of gender identity. I am having a challenging time finding a gender affirming therapist."

I replied:

"I do not ethically agree with linking a minor patient to a therapist who would be gender affirming with gender as a focus of their work without that being discussed with the parents and the parent agreeing to that kind of care."

In all my years at the Washington University School of Medicine, I had received solidly positive performance reviews. But in 2021, that changed. I got a below-average mark for my "Judgment" and "Working Relationships/Cooperative Spirit." Although I was described as "responsible, conscientious, hard-working and productive" the evaluation also noted: "At times Jamie responds poorly to direction from management with defensiveness and hostility."

Things came to a head at a half-day retreat in summer of 2022. In front of the team, the doctors said that my colleague and I had to stop questioning the "medicine and the science" as well as their authority. Then an administrator told us we had to "Get on board, or get out." It became clear that the purpose of the retreat was to deliver these messages to us.

The Washington University system provides a generous college tuition payment program for long-standing employees. I live by my paycheck and have no money to put aside for five college tuitions for my kids. I had to keep my job. I also feel a lot of loyalty to Washington University.

But I decided then and there that I had to get out of the Transgender Center, and to do so, I had to keep my head down and improve my next performance review.

I managed to get a decent evaluation, and I landed a job conducting research in another part of The Washington University School of Medicine. I gave my notice and left the Transgender Center in November of 2022.

(Theo R. Welling)

What I Want to See Happen

For a couple of weeks, I tried to put everything behind me and settled into my new job as a clinical research coordinator, managing studies regarding children undergoing bone marrow transplants.

Then I came across comments from Dr. Rachel Levine, a transgender woman who is a high official at the federal Department of Health and Human Services. The article read: "Levine, the U.S. assistant secretary for health, said that clinics are proceeding carefully and that no American children are receiving drugs or hormones for gender dysphoria who shouldn't."

I felt stunned and sickened. It wasn't true. And I know that from deep first-hand experience.

So I started writing down everything I could about my experience at the Transgender Center. Two weeks ago, I brought my concerns and documents to the attention of Missouri's attorney general. He is a Republican. I am a progressive. But the safety of children should not be a matter for our culture wars.

Click here to read Jamie Reed's letter to the Missouri AG.

Given the secrecy and lack of rigorous standards that characterize youth gender transition across the country, I believe that to ensure the safety of American children, we need a moratorium on the hormonal and surgical treatment of young people with gender dysphoria.

In the past 15 years, according to Reuters, the U.S. has gone from having no pediatric gender clinics to more than 100. A thorough analysis should be undertaken to find out what has been done to their patients and why—and what the long-term consequences are.

There is a clear path for us to follow. Just last year England announced that it would close the Tavistock's youth gender clinic, then the NHS's only such clinic in the country, after an investigation revealed shoddy practices and poor patient treatment. Sweden and Finland, too, have investigated pediatric transition and greatly curbed the practice, finding there is insufficient evidence of help, and danger of great harm.

Some critics describe the kind of treatment offered at places like the Transgender Center where I worked as a kind of national experiment. But that's wrong.

Experiments are supposed to be carefully designed. Hypotheses are supposed to be tested ethically. The doctors I worked alongside at the Transgender Center said frequently about the treatment of our patients: "We are building the plane while we are flying it." No one should be a passenger on that kind of aircraft.

Listen to our conversation with Jamie Reed here. And if you have a tip or a story for us, please write to tips@thefp.com

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The Unhedged Capitalist Writes The Unhedged Capitalist Feb 9 Liked by Suzy Weiss

You wrote, "Today I am speaking out. I am doing so knowing how toxic the public conversation is around this highly contentious issue—and the ways that my testimony might be misused. I am doing so knowing that I am putting myself at serious personal and professional risk."

From the bottom of our hearts, thank you. Thank you for taking the risk to write this. What's happening now is insane and surely one of the lowest points our culture has ever stooped to.

I think that what you've just said will make a difference.

LIKE (866) REPLY

235 replies

tugordie Feb 9

What's so insane about this is the harm it does is OBVIOUS, yet most nice white liberals have their minds so open they've fallen out.

All it takes is a 15 min segment by John Oliver based on a couple shoddy studies (seriously, read Jesse Singal on them) and their minds are made up and arguing against this becomes not only difficult but borderline impossible. When acceptance of youth transition becomes coded strongly blue no one in the progressive tribe wants to step away from the give mind.

Thanks for sharing the personal experience here, I hope it makes an impact

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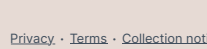

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Affidavit of Jamie Reed

Jamie Reed, being sworn, states:

1. I am an adult, I am under no mental incapacity or disability, and I know that the facts set forth in this affidavit are true because I have personal knowledge of them.

2. I hold a Bachelors of Arts in Cultural Anthropology from the University of Missouri St. Louis and a Master's of Science in Clinical Research Management from Washington University.

3. I have been working at Washington University for seven years. Initially at Washington University, I worked with HIV-positive patients, caring for many transgender individuals.

4. From 2018 until November 2022, I worked as a case manager at the Washington University Pediatric Transgender Center ("the Center") at St. Louis Children's Hospital. My duties included meeting with patients two to three days a week and completing the screening triage intake of patients who were referred to the Center.

5. I was offered and accepted the job as case manager for the Center because I had experience and expertise in working with transgender individuals and pediatric populations.

6. I took the job because I support trans rights and firmly believed I would be able to provide good care for children at the Center who are appropriate candidates to be receiving medical transition. Instead, I witnessed the Center cause permanent harm to many of the patients.

7. During my time at the Center, I personally witnessed Center healthcare providers lie to the public and to parents of patients about the treatment, or lack of treatment, and the effects of treatment provided to children at the Center. I witnessed staff at the Center provide puberty blockers and cross-sex hormones to children without complete informed parental consent and without an appropriate or accurate assessment of the needs of the child. I witnessed children experience shocking injuries from the medication the Center prescribed. And I saw the Center make no attempt or effort to track adverse outcomes of patients after they left the Center.

8. I raised concerns internally for years. But the doctors at the Center told me to stop raising these concerns. Last fall, the Center and the University Administration told me to "get with the program or get out." Because the Center was unwilling to make any changes in response to my concerns, I left the Center in November 2022 and accepted employment elsewhere within Washington University.

The Center Misleads the Public and Parents About What Care it Provides

9. The Center tells the public and parents that it provides multidisciplinary care. The Center says that you can come to the clinic and get transition hormones, if that is needed, but you can also get psychological and psychiatric care.

10. That is not true. The Center says that it has four practice areas: Endocrinology, Adolescent Medicine, Psychiatry, and Psychology. But the Center placed such strict limits on Psychiatry and Psychology that I was almost never allowed to schedule patients for those practices. Those practices were advertised as available, but most of the time they were not in fact available. Even when psychology was available, it was only to write

a letter of support for the medical transition treatments and never for ongoing therapy. And psychiatry was allowed, but only on an extremely limited basis.

11. Instead, I was required to schedule children for Endocrinology or Adolescent Medicine. Rather than provide psychiatric or psychological therapy, these practices (Endocrinology and Adolescent Medicine) would medically transition patients' gender. Endocrinology would prescribe puberty blockers and cross-sex hormones. Adolescent Medicine, which was for children after puberty, prescribed cross-sex hormones. Children were sent to one practice or the other based on their age and stage of puberty or prepuberty. There was no continuing or ongoing mental health evaluation or treatment required or provided by the Center for patients.

12. The Center also claims that it is a multidisciplinary team approach. The benefit of that approach is supposed to be that patients and their parents can feel more confident that all aspects of their care options have been considered and that their treatment plan has the input of all of the team. This Center did have members who would advocate for different options for the patients with concerning gender histories, concerning comorbidities, and attempt to raise the serious concerns regarding patient care. Patients and their parents, however, were never informed that the team did not have consensus on the treatment. The staff members on the team that were not universally in support of immediate cross sex hormones were not supported and were told to stop questioning the prevailing narrative of immediate cross sex hormones for all by the prescribing physicians. The administration at the university did not actively support the multidisciplinary model of care and did not provide any oversight, and instead the administration told those raising

concerns and questions to stop raising them. The public has been led to believe that a 'team' has considered their child's care and that the 'team' had ruled it best for the cross sex hormones to be initiated, but the public was not told the truth.

13. Medical transition practice for children and adolescents is based on a study from the Netherlands. That study, the "Dutch study," excluded participants who presented underlying mental health issues.

14. But nearly all children who came to the Center here presented with very serious mental health problems. Despite claiming to be a place where children could receive multidisciplinary care, the Center would not treat these mental health issues. Instead, children were automatically given puberty blockers or cross-sex hormones even though the Dutch study excluded persons experiencing mental health issues.

15. One patient came to the Center identifying as a "communist, attack helicopter, human, female, maybe non binary." The child was in very poor mental health and early on reported that they had no idea their gender identity. Rather than treat the child for their serious mental health problems, the Center put the child on cross-sex hormones and ignored the child's obvious mental health problems. The child subsequently reported that their mental health actually was worsening once they started the cross-sex hormones.

16. Most children who come into the Center were assigned female at birth. Nearly all of them have serious comorbidities including, autism, ADHD, depression, anxiety, PTSD, trauma histories, OCD, and serious eating disorders. Rather than treat these conditions, the doctors prescribe puberty blockers or cross-sex hormones. Some examples include:

a. Patient was in a residential sex offender treatment facility in state custody. Patient had previously sexually abused animals and had stated when they were released that they would do so again. There were questions about consistency of gender history. The Center did not treat this underlying condition, but instead started the patient on hormones.

b. Patient who has severe Obsessive Compulsive Disorder and had threatened to self-harm their genitals. The Patient did not have a trans or other incongruent gender identity. The patient was placed on hormones not even to treat any gender dysphoria but to chemically reduce libido and sexual arousal.

c. Patient had history of sexual abuse and notified the psychologist of this. It was even documented in the letter of support that the patient had concerns about the changes that testosterone would cause to their genitals. Instead of treating the underlying trauma the patient was started on testosterone.

d. Patient had serious mental health concerns and was prescribed mental health medications directly before being prescribed hormones, yet didn't take the mental health medications. Nevertheless, the patient was placed on hormones.

e. Patient had significant autism with unrealistic expectations, struggled to answer questions, and wanted questions to be provided ahead of time. Yet the patient was started on feminizing hormones.

f. Patient had a mental health history that included being violent. In addition, the parent was forcing the patient to cross dress. The patient was put on feminizing hormones.

17. These serious comorbidities were not treated by the Center, and doctors would prescribe puberty blockers or cross-sex hormones while patients were struggling with these comorbidities.

18. The psychiatry services were limited and could only serve patients who were 'not too severe,' which meant that many patients were being sent to the already overburdened emergency rooms for suicidal ideations, for self-harm, and for inpatient eating disorder treatment.

19. Many patients had depression and anxiety symptoms before starting cross sex hormones but it was only after starting these medications that they became more severe and required starting mental health medications. Many patients were also suspected of having autism and were not even required to be formally assessed for this condition before starting cross sex hormones.

20. Toward the end of my time at the Center, it became clear that many children coming to the Center had gender identities that were likely the result of social contagion. When I first started in 2018, the Center would receive between 5 and 10 calls a month. By the time I left, that number was more than 40 calls a month.

21. Social media is at least partly responsible for this large increase in children seeking gender transition treatment from the Center. Many children themselves would say that

they learned of their gender identities from TikTok. Children would arrive at the Center identifying not only as transgender, but also as having tic disorders (Tourette Syndrome) or multiple personality disorders (dissociative identity disorder). Doctors at the Center would ignore and dismiss as social contagion the claims about the tics and multiple personalities; but then those doctors would uncritically accept the children's statements about gender identity and place these children on puberty blockers and cross-sex hormones.

22. In one case, a child came into the Center identifying as "blind," even though the child could in fact see (after vision tests were performed). The child also identified as transgender. The Center dismissed the child's assertion about blindness as a somatization disorder but uncritically accepted the child's statement about gender and prescribed that child with drugs for medical transition without confirming the length or persistence of the condition. No concurrent mental health care was provided.

23. The Center tells the public and parents of patients that the point of puberty blockers is to give children time to figure out their gender identity. But the Center does not use puberty blockers for this purpose. Instead, the Center uses puberty blockers just until children are old enough to be put on cross-sex hormones. Doctors at the Center *always* prescribe cross-sex hormones for children who have been taking puberty blockers.

24. The Center also tells parents, children, and the public that puberty blockers are fully reversible. They are not. In children going through normal puberty, puberty blockers do

lasting damage. They cause children to go through menopause early, they reduce bone density, and they worsen mental health.

25. Doctors at the Center also have publicly claimed that they do not do any gender transition surgeries on minors. For example, last year Dr. Lewis and Dr. Garwood told the Missouri legislature, "at no point are surgeries on the table for anyone under 18" and also, "surgeries are not an option for anyone under 18 years of age." This was a lie. The Center regularly refers minors for gender transition surgery. The Center routinely gives out the names and contact information of surgeons to those under the age of 18. At least one gender transition surgery was performed by Dr. Allison Snyder-Warwick at St. Louis Children's Hospital in the last few years.

26. During medical visits with patients, I have personally heard providers report that they examined results of gender transition surgeries on minors. This includes examining the scar tissue and healing of sutures of breast surgeries.

27. At one point, Dr Chris Lewis and Dr Sarah Garwood reported that the Endocrine division leadership didn't want us referring minors for surgery. Yet, the Center continued referring minors for surgery. We claimed that the referrals were only "for educational purposes" for when children turned 18. But these referrals were in fact referrals. And patients we referred did in fact obtain transition surgeries as minors.

The Center Does Not Assess Children or Obtain Consent Before Placing them on Puberty Blockers and Hormones

28. The Center has four criteria that must be met before a child is placed on puberty blockers or cross-sex hormones. Although these criteria are supposed to enable the doctors to make case-by-case decisions, in practice everybody who meets these minimum criteria are prescribed cross-sex hormones or puberty blockers.

(1) Age

29. First, the child must be at a certain age or stage of puberty. Puberty stages are measured according to the Tanner Stage system.

30. The World Professional Association for Transgender Health ("WPATH") is an organization that drafts what it believes to be the best medical standard of care. WPATH is controversial. It is considered an activist organization, and its standards of care (or "guidelines") are much more lenient than the standards of care created by other organizations.

31. During the time, I was at the clinic, the WPATH Standard of Care Version 7 stated that children be at least 16 years old to start using cross-sex hormones. The Center deviated even from this most lenient standard and routinely prescribed cross-sex hormones to children as young as 13.

(2) Therapist Letter

32. The second criteria for a person to receive puberty blockers or cross-sex hormones is that the child have a letter of referral from a therapist. This requirement is supposed to ensure that two independent professional clinicians agree that medical transition is appropriate

before a child is given medication that causes irreversible change. But nothing about this process at the Center involved independent judgment.

33. The Center steered children toward therapists that the Center knew would refer these children back to the Center with a letter supporting medical transition. The Center had a list of therapists we would send children to, and a therapist could be on that list only if the Center "knew they would say yes" to medical transition. The Center had two in-house psychologists. They were Dr. Alex Maixner and Dr. Sarah Girresch-Ward as well as several outside therapists. Nobody on our list was required to be licensed in psychology or psychiatry.

34. If we did not receive a letter from an outside therapist that would let us prescribe puberty blockers or cross-sex hormones, we would then just send the patient to the in-house therapists: Dr. Alex Maixner and Dr. Sarah Girresch-Ward.

35. We also instructed the therapists what to say in their letters to us. I was instructed to draft and send language to the therapists for them to use in letters they then sent to us, and most therapists on the list had a template letter drafted by the Center that they could fill out to return to the Center.

36. The WPATH guidelines require a full psychological assessment of the child before recommending puberty blockers or cross-sex hormones. A full assessment typically requires 10 to 12 hours of time with the child. Therapists on the Center's list would send us letters after just 1-2 hours with a patient.

(3) Consent

37. The third criteria was parental consent. The Center routinely issued puberty blockers or cross-sex hormones without parental consent.

38. Doctors at the Center routinely pressured parents into "consenting" by pushing those parents, threatening them, and bullying them.

39. A common tactic was for doctors to tell the parent of a child assigned female at birth, "You can either have a living son or a dead daughter." The clinicians would tell parents of a child assigned male at birth, "You can either have a living daughter or dead son." The clinicians would say this to parents in front of their children. That introduced the idea of suicide to the children. The suicide assertion was also based on false statistics. The clinicians would also malign any parent that was not on board with medicalizing their children. They would speak disparaging of those parents.

40. I was present during the visits with many parents when this happened.

41. Parents would come into the Center wanting to discuss research and ask questions. The clinicians would dismiss the research that the parents had found and speak down to the parents.

42. When parents suggested that they wanted only therapy treatment, not cross-sex hormones or puberty blockers, doctors treated those parents as if the parents were abusive, uneducated, and willing to harm their own children.

43. These assertions about abuse and suicide were used as tools to stop parents from asking questions and to pressure parents into consenting.

44. The Center has a team culture of supporting the affirming parent and maligning the non-affirming parent.

45. Parents routinely said they felt they were being pressured to consent. Often parents would give "consent" but say they were only doing so because "you guys are going to do this anyway."

46. The Center was also intentionally blind about who had legal authority to consent. I wanted the Center to ask parents before the first visits about and request copies of custody agreements because custody agreements often spell out who among divorced parents must consent to medical procedures. I was told not to ask for custody agreements because "if we have the custody agreement, we have to follow it."

47. At one point, a child's father said no to cross-sex hormones. The child later arrived with an adult male (step parent) who said the child could receive cross-sex hormones. The Center did not check to see if this adult male was a legal parent or guardian who had any legal right to consent to treatment.

48. Other centers who prescribe cross-sex hormones and puberty blockers require parents to issue written consent. Several times, I asked the doctors to require written consent. They repeatedly refused. The entire time I worked there the Center had no written informed consent, and none that was provided to or signed by patients.

49. On several occasions, the doctors have continued prescribing medical transition even when a parent stated that they were revoking consent.

50. Before placing children on cross-sex hormones or puberty blockers, the Center also did not inform parents or children of the very serious side effects.

51. Doctors know that cross-sex hormones (immediately after puberty blockers) make children permanently sterile. The doctors did not share this information with parents or children.

52. For example, the Center nurse and I expressed concerns about a patient's intellectual function and ability to provide informed consent. The patient had a history of attending a school district for special education needs, couldn't identify where they lived, and couldn't explain what kind of legal documents (ID) they had. Our concerns were dismissed by the provider, and hormones were given. Patient then stated in a follow up appointment that they wanted to potentially have biological children and had not been seen by the fertility department. When the nurse and I asked the Center provider if they had covered the fertility questions, the Center provider became livid and adamantly disagreed that treatment could "potentially render the patient sterile."

53. Doctors knew that many of our former patients had stopped taking cross-sex hormones and were detransitioning. Doctors did not share this information with parents or children.

(4) Clinical Visit

54. The fourth criteria for prescribing cross-sex hormones or puberty blockers is that the child must have a one-hour consultation with Endocrinology or Adolescent Medicine.

55. This is little more than a box-checking exercise. One hour is not sufficient time to fully assess these children. I witnessed doctors on several occasions' mention that they did not have time in the meeting to discuss everything they wanted to discuss. The Center decided to give these children cross-sex hormones and puberty blockers anyway.

56. The WPATH standard of care in effect when I was at the Center required a full assessment of a child's situation. That typically cannot be done in less than 10 or 12 hours. The Center ignored this standard and gave children puberty blockers and cross-sex hormones after just two 1-hour visits (one with a therapist and one with a doctor at the Center).

Cross-Sex Hormones and Puberty Blockers Are Automatic

57. The Center tells the public and parents that it makes individualized decisions. That is not true. Doctors at the Center believe that every child who meets four basic criteria—age or puberty stage, therapist letter, parental consent, and a one-hour visit with a doctor—is a good candidate for irreversible medical intervention. When a child meets these four simple criteria, the doctors always decide to move forward with puberty blockers or cross-sex hormones. There were no objective medical test or criteria or individualized assessments.

58. The doctors do this even though many children coming to the Center are either experiencing social contagion or have very serious mental health issues that should be addressed first. The standard of care in studies says a center should resolve mental health

issues before sending children through medical transition. The Center is not following that standard.

59. Children come into the clinic using pronouns of inanimate objects like “mushroom,” “rock,” or “helicopter.” Children come into the clinic saying they want hormones because they do not want to be gay. Children come in changing their identities on a day-to-day basis. Children come in under clear pressure by a parent to identify in a way inconsistent with the child’s actual identity. In all these cases, the doctors decide to issue puberty blockers or cross-sex hormones.

60. In one case where a girl was placed on cross-sex hormones, I found out later that the girl desired cross-sex hormones only because she wanted to avoid becoming pregnant. There was no need for this girl to be prescribed cross-sex hormones. What she needed was basic sex education and maybe contraception. An adequate assessment before prescribing hormones would have revealed this fact. But because the doctors automatically prescribe cross-sex hormones or puberty blockers for children meeting the bare minimum criteria, this girl was unnecessarily placed on drugs that cause irreversible change to the body.

61. On another occasion, a patient had their breasts removed. Although the patient had turned 18, this surgery was performed at St. Louis Children’s Hospital. Three months later, the patient contacted the surgeon and asked for their breasts to be “put back on.” Had a requisite and adequate assessment been performed before the procedure, the doctors could have prevented this patient from undergoing irreversible surgical change.

62. In July 2022, the FDA issued a "black box warning" for puberty blockers, the strictest kind of warning the FDA can give a medication. It issued the warning following evidence in patients of brain swelling and loss of vision. Despite this warning, doctors at the Center continued their automatic practice of giving kids these drugs.

63. In more than four years working at the clinic, I witnessed only two examples of the doctors deciding not to prescribe cross-sex hormones or puberty blockers for a child who met the four basic criteria. Both cases involved patients with severe developmental delays. And in one of those cases, the doctors in fact said that they would prescribe cross-sex hormones or puberty blockers. The only reason the doctor did not prescribe those medications was that the parents would not agree to monitor administration of the medication.

64. In hundreds of other cases, Center doctors automatically issued puberty blockers or cross-sex hormones without considering the child's individual circumstances or mental health.

65. In one case, a psychiatrist called the Center's endocrinologist and explained that a child, who had already tried to commit suicide by threatening to jump off a roof, should not be given cross-sex hormones because the child was struggling with serious mental health issues. I witnessed the endocrinologist yell at the psychiatrist on the phone and speak down to this provider.

66. Because I was concerned that the doctors were giving cross-sex hormones and puberty blockers to children who should not be on them, I created a "red flag" list of children

where other staff and I had concerns. The doctors told me I had to stop raising these concerns. I was not allowed to maintain the red flag list after that.

67. During the time I was creating the red flag list, noting my concern that these children were not good candidates for permanent, irreversible medication treatment, the doctors would simply send these children to our in-house therapists. Those therapists would inevitably provide letters to the doctors, and then the doctors would say there can't be any concern over these children because another therapist was fine with prescribing puberty blockers or cross-sex hormones.

Children Are Experiencing Serious Harm, and the Center Will Not Do Any Follow Up

68. It is my professional opinion that cross-sex hormones and puberty blockers should only be used where the benefits outweigh the harms. These drugs have imposed and are imposing serious harms on the children who have been patients at the Center.

69. The doctors at the Center tell the public and tell parents of patients that puberty blockers are fully reversible. They really are not. They do lasting damage to the body.

70. I have seen puberty blockers worsen the mental health outcomes of children. Children who have not contemplated suicide before being put on puberty blockers have attempted suicide after. Puberty blockers force children to go through premature menopause. Puberty blockers decrease bone density.

71. Cross-sex hormones (after puberty blockers) in almost all cases will permanently sterilize children. Children on cross-sex hormones also experience substantial gain in blood

pressure, cholesterol, and weight. All of these have significant negative health effects. One patient started hormones and took one dose and then started having symptoms that they believed was indicative of a blood clot.

72. Children who take testosterone as a cross-sex hormone experience severe atrophy of vaginal tissue. One patient on cross-sex hormones called the Center after having sexual intercourse. The patient experienced vaginal lacerations so severe that the patient bled through a pad, through pants, and through a towel wrapped around their waist, and had to have the vaginal lacerations surgically treated in St. Louis Children's Hospital emergency room.

73. Most patients who have taken cross-sex hormones have experienced near-constant abdominal pain.

74. One doctor at the Center, Dr. Chris Lewis, is giving patients a drug called Bicalutamide. The drug has a legitimate use for treating pancreatic cancer, but it has a side effect of causing breasts to grow, and it can poison the liver. There are no clinical studies for using this drug for gender transitions, and there are no established standards of care for using this drug.

75. Because of these risks and the lack of scientific studies, other centers that do gender transitions will not use Bicalutamide. The adult center affiliated with Washington University will not use this medication for this reason. But the Center treating children does.

76. I know of at least one patient at the Center who was advised by the renal department to stop taking Bicalutamide because the child was experiencing liver damage. The child's parent reported this to the Center through the patient's online self-reporting medical chart (MyChart). The parent said they were not the type to sue, but "this could be a huge PR problem for you."

77. I have heard from patients given testosterone that their clitorises have grown so large that they now constantly chafe against the child's pants, causing them pain when they walk.

78. Despite telling the public and parents that the Center offers multidisciplinary, complete care, the Center makes no attempt to provide care after prescribing cross-sex hormones or puberty blockers. The Center does not provide mental health care or refer children for mental health care even though nearly all children who come to the Center are experiencing serious mental health issues. The Center does not require children to continue with mental health care after they prescribe cross-sex hormones or puberty blockers and even continues those medications when the patients directly report worsening mental health after initiating those medications. Some additional examples to those discussed above include:

a. Patient was on hormones and had decompensating mental health, outlandish name changes, self-diagnosis of multiple personalities (DID). The patient was continued on hormones.

b. Patient believed that they were being poisoned by the testosterone and stopped for a period. They had significant serious mental health issues, but were put back on testosterone.

c. Patient was brought to the Center at the age of 17 by a man who was not related to them yet with whom the patient had been living. They were started on hormones as soon as they turned 18. Patient's mental health subsequently got worse and it was disclosed in an Emergency Department visit that the man that had brought them to the clinic had been sexually and physically abusing them. The medical transition treatment was not stopped and the Center provider did not require trauma therapy, mental health care or an assessment.

d. Patient was in residential facility, in foster care. We convinced the staff that it was ok for patient to start testosterone. Patient ran away numerous times from facility and was having unprotected intercourse while on testosterone (which causes birth defects). The patient was continued on the testosterone.

e. Patient admits that they were started on testosterone when they were very young- age 11- and only because they were moving to a state (Florida) that the parent was concerned wouldn't prescribe later. Patient has desisted in male identity to a vague non binary with their own self-diagnosis of autism. Patient has changed their name numerous times and is clearly struggling with thoughts about desistence, even saying they wanted breast development. The Center continued the testosterone.

f. Patient who was on hormones was being evaluated for OCD and having somatization disorder with 'seizure' activity. Patient was kept on hormones.

g. Patient who was on hormones stopped taking their schizophrenia medications without consulting a doctor. Patient was continued on hormones.

h. Patient changed to non-binary identity, then changed preferred name and stated that their identity was shifting day to day. Patient was continued on hormones.

79. The Center also refuses to track complications and adverse events among its patients. There is no standard protocol for tracking patients who have received treatment. And the Center actively avoids trying to learn about these adverse events.

80. On my own initiative, I have tracked some patients on a case-by-case basis, but the Center discouraged me from doing so. I wanted to track the number of our patients who detransition. I wanted to track the number of our patients who have attempted suicide or committed suicide. The Center would not make either of these tracking systems a priority.

81. It is my belief that the Center does not track these outcomes because they do not want to have to report them to new patients and because they do not want to discontinue cross-sex hormone prescriptions. The Center never discontinues cross-sex hormones, no matter the outcome.

82. In just a two-year period from 2020 to 2022, the Center initiated medical transition for more than 600 children. About 74% of these children were assigned female at birth. These procedures were paid for mostly by private insurance, but during this time, it is my understanding that the Center also billed the cost for these procedures to state and federal publicly funded insurance programs.

83. I have personally witnessed staff say they were uncomfortable with how the Center has told them they have to code bills sent to publicly funded insurance programs. I have witnessed staff directly ask the providers for clarification on billing questions and have providers dismiss the concerns and work to have the patients have this care covered as the priority.

84. I have personally witnessed staff report that they were aware that patients had been coded incorrectly (coding for precocious puberty for puberty blockers when the child does not in fact have that condition).

85. Based on my observation that the Center has prescribed puberty blockers or cross-sex hormones hundreds of times where they should not have, the Center is billing private and public insurance for unnecessary procedures.

86. Even when it is clear that the cross-sex hormones or puberty blockers are harming the child, the Center continues that treatment and continues billing public and private insurance.