

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, *et al.*,

Plaintiffs,

v.

JASON WEIDA, *et al.*,

Defendants.

Case No. 4:22-cv-00325-RH-MAF

**PLAINTIFFS' MOTION TO PARTIALLY EXCLUDE EXPERT
TESTIMONY OF DR. PATRICK W. LAPPERT AND INCORPORATED
MEMORANDUM OF LAW**

Pursuant to Federal Rules of Civil Procedure 26 and 37, and Federal Rules of Evidence 104, 403, and Rule 702, Plaintiffs move to partially exclude certain testimony of Defendants' expert Dr. Patrick W. Lappert, M.D., on the grounds that he fails to meet the qualification, reliability, and helpfulness requirements imposed by Fed. R. Evid. 702 and *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993). Specifically, Dr. Lappert's testimony should be limited to his area of expertise: the field of plastic surgery. To the extent that any of Dr. Lappert's purported opinions beyond plastic surgery hold any probative value (they do not), it is far outweighed by unfair prejudice and confusion of the issues and therefore the testimony should

be excluded pursuant to Fed. R. Evid 403. In support of this motion, Plaintiffs state as follows:

FACTUAL BACKGROUND

On February 17, 2023, Defendants served their expert witness disclosures for Dr. Lappert and thereafter provided his rebuttal opinions.¹ His rebuttal opinions were primarily directed to the reports of Dr. Loren S. Schechter, M.D., and Dr. Johanna Olson-Kennedy, M.D., M.S. Lappert Rebuttal ¶ 1.

In his reports, Dr. Lappert opines on numerous subjects that fall well outside the scope of his experience in plastic surgery, including the nature, causes, and diagnosis of gender dysphoria, non-surgical treatments for gender dysphoria, the quality of the evidence supporting medical treatments for gender dysphoria, and the development of clinical practice guidelines by professional medical associations of which he is not even a member. *See generally*, Lappert Rep.; Lappert Rebuttal.

However, as a retired plastic surgeon, Dr. Lappert is not qualified to offer expert testimony on these matters. Indeed, in a prior case in the Middle District of North Carolina involving a challenge to a categorical exclusion of gender-affirming health services from coverage through a state-sponsored health plan, the District Court precluded the vast majority of Dr. Lappert's proffered opinions based on his

¹ *See* Declaration of William Miller ("Miller Dec.") ¶¶ 4-5; Ex. A, Expert Declaration of Patrick W. Lappert, M.D. ("Lappert Rep."); Ex. B, Rebuttal Expert Report of Patrick W. Lappert, M.D. ("Lappert Rebuttal").

lack qualifications and the unreliability of his testimony, limiting his testimony solely to those opinions related to the field of plastic surgery. *Kadel v. Folwell*, Case No. 1:19CV272, 2022 WL 3226731, *13-14 (M.D.N.C. Aug. 10, 2022).² Notably, the Court also found that the available evidence “call[ed] Lappert’s bias and reliability *into serious question*.” *Id.* at *12 (emphasis added).

Similarly, in *Brandt v. Rutledge*, the court curtailed Dr. Lappert’s testimony even further, limiting Dr. Lappert to offering opinions solely “to his practice,” “to what he has personally done in his practice,” and “his actual interaction with patients and what the outcomes were.” Miller Dec. ¶ 6; Ex. C, Excerpts of *Brandt v. Rutledge* Trial Transcript (“*Brandt Tr.*”), at 1058:25, 1059:11-15. Indeed, the court sustained objections that sought to elicit Dr. Lappert’s testimony about what the clinical practice guidelines pertaining to gender-affirming medical treatment entail and any specific risks for transgender individuals because Dr. Lappert “is not an expert in gender-affirming care” and such testimony “is outside the scope of the doctor’s practice.” *Brandt Tr.* 1058:4-10, 1067:10-14.

This Court should do the same. Dr. Lappert lacks the necessary qualifications to so testify regarding any subject matter beyond the field of plastic surgery,

² Specifically, the court in *Kadel* held that Dr. Lappert was “limited to testifying to (1) the risks associated with the surgeries at issue in this case; (2) his anecdotal experience treating patients seeking to “de-transition”; and (3) the WPATH recommended role of the surgeon in treating gender dysphoria as compared to the role of the surgeon in other surgical contexts.” 2022 WL 3226731, at *15.

including as to the nature, causes, or diagnosis of gender dysphoria, non-surgical treatments for gender dysphoria, the quality of evidence supporting medical treatments for gender dysphoria, and the development of clinical practice guidelines for the treatment of gender dysphoria, and any such testimony is otherwise unreliable, unhelpful, or its probative value is outweighed by potential prejudice.

LEGAL STANDARD

Federal Rule of Evidence 702 places “a special gatekeeping obligation” on the trial court to ensure that an expert’s testimony is “relevant to the task at hand” and “rests on a reliable foundation.” *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 597 (1993). As articulated by the Eleventh Circuit, “[t]he importance of Daubert's gatekeeping requirement cannot be overstated.” *United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004).

In determining admissibility under Rule 702, courts must engage in a “rigorous” inquiry to determine whether (1) the expert is qualified to testify regarding the matters they intend to address; (2) the methodology employed by the expert to reach their conclusions is sufficiently reliable, as determined by the inquiry mandated under *Daubert*; and (3) the testimony assists the trier of fact to understand the evidence or determine a fact at issue. *Id.*, at 1260; *see also City of Tuscaloosa v. Harcros Chems., Inc.*, 158 F.3d 548, 562 (11th Cir. 1998), *cert. denied*, 528 U.S. 812 (1999). These considerations of “qualification,” “reliability,” and “helpfulness”

are “distinct concepts that courts and litigants must take care not to conflate.” *Quiet Tech. DC-8, Inc. v. Hurel-Dubois UK Ltd.*, 326 F.3d 1333, 1341 (11th Cir. 2003). Crucially, the party offering the expert testimony has the “burden of establishing qualification, reliability, and helpfulness.” *Frazier*, 387 F.3d at 1260.

ARGUMENT

I. Dr. Lappert Is Not Qualified to Offer a Significant Portion of His Purported Opinions

“A witness may be qualified as an expert by virtue of his ‘knowledge, skill, experience, training, or education.’” *Quiet Technology DC-8, Inc.*, 326 F.3d at 1342. But “expertise in one field does not qualify a witness to testify about others.” *Lebron v. Sec’y of Fla. Dep’t of Children & Families*, 772 F.3d 1352, 1368 (11th Cir. 2014) (holding that a psychiatrist was properly prevented from opining on rates of drug use in an economically vulnerable population because he had never conducted research on the subject and instead relied on studies to form his opinion). “A scientist, however well credentialed he may be, is not permitted to be the mouthpiece of a scientist in a different specialty.” *Id.* (quoting *Dura Automotive Systems of Indiana, Inc. v. CTS Corp.*, 285 F.3d 609, 614 (7th Cir. 2002)). Indeed, even “a supremely qualified expert cannot waltz into the courtroom and render opinions unless those opinions are based upon some recognized scientific method and are reliable and relevant.” *Clark v. Takata Corp.*, 192 F.3d 750, 759 n.5 (7th Cir. 1999).

If a designated expert witness does not “propose to testify about matters growing naturally and directly out of research he had conducted independent of the litigation,” the expert should be disqualified. *Lebron*, 772 F.3d at 1369 (quoting Fed. R. Evid. 702 (cleaned up)). Simply put, “an expert’s qualifications must be within the same technical area as the subject matter of the expert’s testimony; in other words, a person with expertise may only testify as to matters within that person’s expertise.” *Martinez v. Sakurai Graphic Sys. Corp.*, 2007 WL 2570362, at *2 (N.D. Ill. Aug. 30, 2007).

Indeed, the qualification inquiry is subject-specific because “[g]eneralized knowledge of a particular subject will not necessarily enable an expert to testify as to a specific subset of the general field of the expert’s knowledge.” *Id.*, at *2. “For example, no medical doctor is automatically an expert in every medical issue merely because he or she has graduated from medical school or has achieved certification in a medical specialty.” *O’Conner v. Commonwealth Edison Co.*, 807 F. Supp. 1376, 1390 (C.D. Ill. 1992), *aff’d*, 13 F.3d 1090 (7th Cir. 1994). Here, Dr. Lappert’s opinions topics relating to plastic surgery fail to meet the most basic standard for admissibility and must be excluded.

A. Dr. Lappert is Not Qualified to Offer Opinions on Topics Other Than Plastic Surgery

Dr. Lappert offers a clutter of opinions far afield from his experience as a plastic surgeon, including regarding the fields of endocrinology, psychology,

psychiatry, and treatment guidelines issued within those specialties. But Dr. Lappert lacks the necessary qualifications, or any other basis, to offer an expert opinion in these areas.³ To be clear, Dr. Lappert has previously testified he “do[es] not claim to be an expert in the treatment of gender dysphoria.” *Brandt* Tr. 1042:13-15.

Recognizing Dr. Lappert’s lack of expertise on precisely the same subjects on which he purports to opine in this case, the court in *Kadel* precluded Dr. Lappert from providing expert testimony on matters outside the realm of plastic surgery and his anecdotal experiences as a surgeon. *See* 2022 WL 3226731 at *12-15. Similarly, at trial, the Court in *Brandt* limited his testimony solely “to his practice,” “to what he has personally done in his practice,” and “his actual interaction with patients and what the outcomes were.” *Brandt* Tr. 1058:25, 1059:11-15. The Court should adopt the same approach here.

For example, Dr. Lappert proselytizes on the efficacy of hormone therapy as a treatment for gender dysphoria, and on the reliability of peer-reviewed medical

³ Although Plaintiffs do not move to exclude Dr. Lappert’s opinions, however fringe, within his own field, it must be noted that he has conceded that he has “never performed any kind of gender-affirming surgery in transgender patients.” Miller Dec. ¶ 7; Ex. D, Excerpts of Sept. 30, 2021 Deposition Transcript (“Lappert Tr.”), at 168; *id.* at 151 (“I have never treated a patient with gender dysphoria surgically.”). He has also emphatically stated that he would never perform such surgeries, because in his personal view he does not “see them as beneficial” and thinks they are “incorrect treatments.” *Id.* at 150. Indeed, Dr. Lappert believes that “in all instances” gender-affirming genital surgery is “an irreversible mutilation[.]” Lappert Rep. ¶ 42.

publications, and in particular clinical practice guidelines issued by the Endocrine Society (the nationally recognized professional society for endocrinologists), cited as support for the use of such treatments. *See* Lappert Rep. ¶¶ 33, 38-42. Dr. Lappert further purports to opine on the nature of, and differences between, gender and sex. *Id.* ¶¶ 31-32. But Dr. Lappert has previously conceded that he is “not an endocrinologist” and has “no specialized training or expertise in endocrinology.” Lappert Tr., at 153, 204; *see also* Brandt Tr. 1040:22-25 (“Q And you're not an endocrinologist? A I am not. Q You're not an expert in endocrinology? A I am not.”).

Dr. Lappert likewise admitted that he has “never prescribed cross-sex hormones for treatment of gender dysphoria,” and that he has “no firsthand experience with advising [his] patients about potential risks and benefits” of such treatment. Lappert Tr., at 214. He has acknowledged that he does not “hold [himself] out as an expert in endocrinology,” and indicated in a prior case that he did not plan to offer “any expert opinions in endocrinology . . . because that’s outside [his] scope of expertise.” Lappert Tr., at 204. Accordingly, as previously held in *Kadel*, all of Dr. Lappert’s purported opinions relating to endocrinology should be excluded. *Kadel*, 2022 WL 3226731 at *13.

Dr. Lappert likewise is not qualified to opine regarding the development or efficacy of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (“DSM-V”), the diagnosis of gender dysphoria, or the treatment of gender dysphoria

by a mental health provider. *See, e.g.*, Lapper Rep. ¶¶ 46, 74-76, 93-94. The reasoning in *Kadel* applies equally here. Dr. Lappert “is not a psychiatrist, psychologist, or mental health professional, nor has he ever diagnosed a patient with gender dysphoria,” but he nonetheless provides opinions in these areas. *Kadel*, 2022 WL 3226731 at *13. Dr. Lappert himself has acknowledged that he “do[es] not hold [himself] out as an expert in diagnosing mental health conditions[,]” and that he also does “not have special[ized] training or expertise in treating mental health conditions.” Lappert Tr., at 75; *see also Brandt* Tr. 1041:6-8 (“Q You don't claim to be an expert in the diagnosis of gender dysphoria? A Expertise, no.”). He further admitted that he has never been involved in the development of the DSM-V, and does not know “what kind of scientific literature review was done” during that development or what went on during “different meetings or conferences” to “discuss that development[;]” thus, Dr. Lappert “do[es] ***not have expert firsthand knowledge*** of how the DSM-V was developed.” Lappert Tr., at 190-93 (emphasis added).

In sum, Dr. Lappert’s ability to read and regurgitate information pertaining to the treatment of gender dysphoria does not qualify him as an expert. Because Dr. Lappert’s purported opinions about matters within the fields of psychology, psychiatry, and endocrinology are outside of his training and expertise, such opinions should be precluded, as they were in *Kadel* and *Brandt*. *See Kadel*, 2022 WL 3226731 at *12-15; *see also, e.g., Lebron*, 772 F.3d at 1368-69.

B. Dr. Lappert is Not Qualified to Opine on the Quality of the Studies Supporting Gender-Affirming Care

Aware that his views on gender dysphoria and gender-affirming care are contradicted by the position of every major medical society and professional organization in the country, Dr. Lappert goes to great lengths to attempt to undermine the validity and basis of a select few of the multitude of medical studies that support the safety and efficacy of gender-affirming care by pointing out what he perceives as methodological flaws. *See, e.g.*, Lappert Rep ¶¶ 38-41, 58-67, 85-87; Lappert Rebuttal ¶¶ 8, 11-12, 16-22. He repeatedly contends that the existing studies do not constitute “quality evidence,” and as a result, gender-affirming care is experimental or unsupported by reliable science. *See* Lappert Rep. ¶¶ 24-25, 57, 59, 106; Lappert Rebuttal ¶ 25. But once again, such opinions are far afield from Dr. Lappert’s professional experience.

As the court in *Kadel* noted, Dr. Lappert is “not a statistician or epidemiologist, and there is no evidence . . . that he has any experience, specialized training, or knowledge about crafting a research study, analyzing data, or conducting a clinical trial.” *Kadel*, 2022 WL 3226731 at *13. Given his lack of personal experience with the study of gender-affirming care, the court in *Brandt* similarly limited his testimony to “to what he has personally done in his practice, not what the evidence shows.” *Brandt* Tr. 1059:9-13. Indeed, Dr. Lappert’s prior publications (seven in total) include case reports and opinion essays, and he has not published in

a peer-reviewed journal in over *twenty-five years*. See Lappert Rep., at 69 (curriculum vitae). His curriculum vitae notes a brief academic career, but that role appears limited to overseeing clinical practitioners and did not involve conducting research or clinical trials of any kind. See *id.*, at 68; see also *Kadel*, 2022 WL 3226731 at *13.

In sum, as the court in *Kadel* noted, “[j]ust as an epidemiologist or statistician would not be qualified to perform surgery, a surgeon with little to no research experience is not qualified to opine of the veracity of statistical studies.” *Kadel*, 2022 WL 3226731 at *13. Accordingly, Dr. Lappert’s proffered opinions regarding the validity or veracity of studies pertaining to gender-affirming care or gender dysphoria should be excluded.

II. Dr. Lappert’s Opinions on Topics Other than Plastic Surgery are Also Either Unreliable, Unhelpful, or Both

As a rule, an expert’s testimony should only be admitted if it is sufficiently reliable. “To meet the reliability requirement, an expert’s opinion must be based on scientifically valid principles, reasoning, and methodology that are properly applied to the facts at issue.” *In re 3M Combat Arms Earplug Products Liab. Litig.*, 3:19MD2885, 2022 WL 1262203, at *1 (N.D. Fla. Apr. 28, 2022). The reliability requirement in Rule 702 is “the centerpiece of any determination of admissibility.” *Rider v. Sandoz Pharm. Corp.*, 295 F.3d 1194, 1197 (11th Cir. 2002). “At this stage, the court must undertake an independent analysis of each step in the logic leading to

the expert's conclusions; if the analysis is deemed unreliable at any step the expert's entire opinion must be excluded.” *Hendrix v. Evenflo Co., Inc.*, 255 F.R.D. 568, 578 (N.D. Fla. 2009), *aff'd sub nom. Hendrix ex rel. G.P. v. Evenflo Co., Inc.*, 609 F.3d 1183 (11th Cir. 2010).

To satisfy the helpfulness requirement, the proffered testimony must have a justified scientific relationship to the facts at issue. *Daubert*, 509 U.S. at 591. Thus, helpfulness, “goes primarily to relevance.” *Daubert*, 509 U.S. at 580. Relevant expert testimony “logically advances a material aspect of the proposing party's case” and “fits” the disputed facts. *McDowell v. Brown*, 392 F.3d 1283, 1298-99 (11th Cir. 2004). “The relationship must be an appropriate ‘fit’ with respect to the offered opinion and the facts of the case.” *Id.* Where the court determines that proffered expert testimony does not “fit” the facts of the case, it is properly excluded. *See id.*, at 1301.

Here, Plaintiffs’ case turns primarily on two issues, among others, (1) whether the Agency employed a process that was reasonable and (2) whether gender-affirming medical care is experimental or investigational. Many of Dr. Lappert’s opinions are both unreliable and unhelpful to the issues before this Court, as detailed below.

A. Dr. Lappert's Opinions are Rejected by the Vast Majority of the Scientific and Medical Community and Lack Credible Support

General acceptance in the relevant scientific community is an important element to the reliability inquiry. *Allison v. McGhan Medical Corp.*, 184 F.3d 1300, 1313 (11th Cir. 1999). Moreover, the fact that a known theory “has been able to attract only minimal support within the community may properly be viewed with skepticism.” *Daubert*, 509 U.S. at 594. Here, Dr. Lappert’s opinions about the effectiveness and propriety of gender-affirming care, which he is not qualified to present, are far outside the mainstream of medical and scientific opinion and have been explicitly rejected by every relevant scientific and medical community. While undoubtedly Dr. Lappert “has strong beliefs,” the fact that his opinions are “not generally accepted by the scientific community, and [are] unsupported by other studies” means that “his testimony is based more on personal opinion than on scientific knowledge,” making it unreliable. *Allison*, 184 F.3d at 1319.

Dr. Lappert cites virtually no evidentiary support for his critiques of medical studies substantiating the need for gender-affirming care. *See generally*, Lappert Rep.; Lappert Rebuttal. And to the contrary, the evidence shows that Dr. Lappert’s opinions regarding the supposedly “experimental” nature of gender-affirming care are on the scientific fringe. *See, e.g.*, Lappert Rep. ¶¶ 23, 97-98; Lappert Rebuttal ¶¶ 21-22, 25 n. 3. For example, in a recent case addressing a challenge to Arkansas’ state-law ban on gender-affirming treatment for minors, Dr. Lappert offered

substantially similar opinions in support of the ban, contending that “[g]ender affirming’ treatments are experimental[.]” *See Brandt v. Rutledge*, 551 F.Supp.3d 882 (E.D. Ark. 2021); Lappert Tr., at 33-35; Miller Dec. ¶ 8; Ex. E, Declaration of Dr. Lappert in *Brandt v. Rutledge*.

Nevertheless, the *Brandt* court preliminarily enjoined the ban, recognizing that “the consensus recommendation of medical organizations is that the only effective treatment for . . . gender dysphoria is to provide gender-affirming care,” citing briefs from organizations like the American Medical Association, American Academy of Pediatrics, and many more. *Brandt*, 551 F.Supp.3d at 890 n.3. *Brandt* also found that “gender-affirming treatment is supported by medical evidence that has been subject to rigorous study,” and that “every major expert medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary to improve the physical and mental health of transgender people.” *Id.*, at 891; *see also Fain v. Crouch*, Case No. 3:20-0740, 2022 WL 3051015, *10 (“[m]any of the major medical organizations have opposed the blanket denial of this medically necessary [gender-affirming] care.”).

Dr. Lappert himself has previously acknowledged that “every major expert medical association disagrees with [him] because they’ve all taken [the] position that this treatment is in fact medically necessary.” Lappert Tr., at 40. Dr. Lappert’s own

former association, the American Society of Plastic Surgeons⁴ (“ASPS”) (whose categorizations of evidence for prognostic and therapeutic studies Dr. Lappert repeatedly relies upon in critiquing the studies and evidence in support of gender-affirming care) issued a statement in February 2021 stating that it “firmly believes that plastic surgery services can help gender dysphoria patients align their bodies with whom they know themselves to be,” and promising to “continue its efforts to advocate across state legislatures for full access to medically necessary transition care.” Miller Dec. ¶ 9; Ex. F, Feb. 25, 2021 ASPS Statement. So as Dr. Lappert has admitted, the ASPS also “does not agree with [his] opinions that gender affirming surgery is experimental.” Lappert Tr., at 112-13. In short, the overwhelming consensus confirms that, far from being generally accepted, Dr. Lappert’s opinions regarding gender-affirming care are unsupported and unreliable.

B. Dr. Lappert’s Critiques of the WPATH Standards of Care, the Endocrine Society Guidelines, and Other Organizations’ Positions Are Unreliable

Given that his views are unsupported by any reliable scientific evidence, and indeed run contrary to the position of every major medical society and professional organization, Dr. Lappert attempts to discredit the clinical guidelines and standards of care espoused by these respected organizations, including the World Professional

⁴ Dr. Lappert’s report misidentifies his own former professional organization as the “American Society of Plastic Surgery.” *E.g.*, Lappert Rep. ¶ 24.

Association for Transgender Health (“WPATH”) and the Endocrine Society. For example, Dr. Lappert asserts that “the WPATH standard of medical necessity is not supported in reliable scientific evidence” and he purports to “examine how such guidelines are developed.” Lappert Rep. ¶¶ 36, 51; *see also, e.g.*, Lappert Rebuttal ¶ 8 (contending that the “evidence cited in support of the WPATH Standard reveals a lack of evidence even to support a weak recommendation in a treatment guideline.”).

But Dr. Lappert has previously conceded that he was “not involved with the development” of WPATH guidelines, he did not “know what kind of scientific literature [review] the WPATH conducted as part of drafting” the guidelines, or what other forms of “peer review,” “outside experts,” or “public comments” the WPATH may have relied on in developing their guidelines. Lappert Tr., at 184-87. To the point, Dr. Lappert admitted that he is “*not an expert*” in the development of either versions 7 or 8 of the WPATH standards of care. *Id.*, at 188-89. The court in *Kadel* agreed, precluding Dr. Lappert’s views on the WPATH standards as “unscientific opinion and speculation.” *Kadel*, 2022 WL 3226731 at *14. So did the court in *Brandt*, which sustained an objection to an attempt to elicit testimony from Dr. Lappert as to what the WPATH guidelines mean. *Brandt* Tr. 1058:4-10.

Dr. Lappert similarly opines that the “scientific evidence used to support the Endocrine Society’s special treatment guidelines for gender dysphoric/gender

incongruent persons appears to be of low to very low quality[.]” Lappert Rep. ¶ 38. Yet Dr. Lappert has admitted that he does not know when these guidelines “were initially published” or “last revised;” he was “not involved with the[ir] development;” he does not know “what kind of scientific literature review” went into that development; thus, he agreed he is “not an expert in how the Endocrine Society developed the original 2009 guidelines” or “the 2017 updates.” Lappert Tr., at 195-200.

At bottom, Dr. Lappert has no expertise or understanding of the development of the WPATH or Endocrine Society guidelines, and therefore his criticism of the evidence in support of these standards is unreliable. *See Kadel*, 2022 WL 3226731 at *14. Consequently, he should not be permitted to mislead a factfinder with his baseless *ipse dixit* critiques. *See Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997).

C. Dr. Lappert’s Opinions Regarding Informed Consent, “Desistance,” and Changes in Demographics are Unreliable, Unhelpful, and Irrelevant.

Dr. Lappert dedicates a portion of his report to his opinions on whether patients diagnosed with gender dysphoria can provide “meaningful consent” to gender-affirming treatment, and he makes a number of claims regarding statistics pertaining to the supposed “resolution” of the condition of “transgenderism” absent gender-affirming care, and changes in the rates of diagnosis and makeup of the population of individuals diagnosed with gender dysphoria. *E.g.*, Lappert Rep. ¶¶

69-70, 73. But these purported opinions are unreliable, unhelpful, and irrelevant to the issues before the Court.

First, Dr. Lappert has failed to support his opinions regarding “informed consent” with any credible evidence or data. *See generally*, Lappert Rep. Accordingly, his conclusions regarding informed or meaningful consent are speculative and unreliable and should be excluded. *See Jones v. Otis Elevator Co.*, 861 F.2d 655, 662 (11th Cir. 1988) (“relevant testimony from a qualified expert is admissible only if the expert knows of facts which enable him to express a reasonably accurate conclusion as opposed to conjecture or speculation.”); *see also Hendrix*, 255 F.R.D. at 578; *Kadel*, 2022 WL 3226731, at *14 (concluding that Dr. Lappert’s opinions regarding informed consent to gender-affirming care were “irrelevant” and “not admissible.”).

Second, Dr. Lappert’s opinions that gender dysphoria may resolve on its through his mischaracterizing description of “watchful waiting” (e.g., Lappert Rep. ¶¶ 93, 94, 98) are based on a severely flawed reading of the literature, which renders his opinions unreliable, and regardless, such opinions are also irrelevant. Specifically, Dr. Lappert cites a single article by Zucker et al. in support of this proposition. But that study pertains to (1) *preadolescent/prepubertal* youth not *adolescents after the onset of puberty* and (2) who were diagnosed with *gender identity disorder* under the DSM-III or the DSM-IV not *gender dysphoria* under the

DSM-V. It is therefore inapplicable and irrelevant in this context, where the changes from the DSM-IV diagnosis of gender identity disorder to the DSM-V diagnosis of gender dysphoria in 2013 made “the diagnosis more restrictive and conservative” to reduce “false positives.” *See* Miller Dec. ¶ 10; Ex. G, Memo Outlining Evidence for Change for Gender Identity Disorder, at 904-05.

Dr. Lappert’s assertions are also flawed because they misrepresent Dr. Zucker’s work. Indeed, Dr. Zucker authored the chapter in “Gender Dysphoria and Gender Incongruence” in the medical textbook *Lewis’s Child and Adolescent Psychiatry, Fifth Edition*, published in 2018. *See* Miller Dec. ¶ 11, Ex. H, Excerpt of *Lewis’s Child and Adolescent Psychiatry, Fifth Edition*. That chapter states that: (1) “it appears that the vast majority of transgender adolescents persist in their transgender identity,” *id.* at 638; and (2) “Once children have reached puberty, transgender identity persists in the vast majority of cases, and medical intervention is often considered[.]” *Id.* at 640. Given that this case pertains to gender-affirming medical treatments which are not provided until after the *onset of puberty*, Dr. Lappert’s opinions, premised on his flawed reading and understanding of the “desistance” literature, are irrelevant and unreliable.

Third, Dr. Lappert’s opinions regarding a change of demographics are wholly unreliable and irrelevant. Lappert Rep. ¶ 73. He cites no scientific or peer-reviewed literature. To the contrary, he cites solely to a non-medical, non-scientific book by

an anti-transgender activist.⁵ But Rule 703 requires that “[t]he facts or data ... upon which an expert bases an opinion or inference” must be “of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject,” Fed. R. Evid. 703, and the book upon which Dr. Lappert relies is *not* the type of material reasonably relied upon by experts in any field of medicine. Moreover, Dr. Lappert’s opinion is irrelevant. Gender dysphoria is a real and recognized condition that requires treatment – whether the demographics have changed has no bearing on that or the questions before the Court.

D. Dr. Lappert’s Commentary on Gender-Affirming Care Provided in Other Countries is Unreliable and Unhelpful

Dr. Lappert also offers opinion regarding the treatment of gender dysphoria and the provision of gender-affirming care in certain European countries, including the United Kingdom, Sweden, Finland, France, and Italy, and cites developments in those countries as evidence in support of his opinions proffered in this case. *See* Lappert Rep. ¶¶ 104-05; Lappert Rebuttal ¶ 24. But, according to the curriculum vitae he supplied, Dr. Lappert is not licensed to practice in any of those countries. *See* Lappert Rep., at 67-69. His report and rebuttal report likewise offer no

⁵ Abigail Shrier is not a doctor but an anti-transgender activist and opinion columnist. She has described transgender rights as a “war on women” and has advocated against what she considers to be a “transgender craze.” GLAAD, GLAAD Accountability Project: Abigail Shrier, <https://www.glaad.org/gap/abigail-shrier> (accessed Apr. 6, 2023).

indication that Dr. Lappert has personal knowledge regarding the policies regarding gender-affirming care issued in those countries or how those policies were developed. *See generally*, Lappert Rep.; Lappert Rebuttal. Dr. Lappert also either wholly fails to cite any facts or data in support of his opinions regarding developments in these countries, or the data he cites is insufficient to support those opinions. *See* Lappert Rep. ¶¶ 104-05; Lappert Rebuttal ¶¶ 24-25. Consequently, the Court should exclude Dr. Lappert’s testimony regarding such opinions. *See Jones*, 861 F.2d at 662.

III. Dr. Lappert’s Opinions are Based on His Personal Beliefs and Not Science

Reliability is a flexible inquiry, under which “courts must ensure that an expert’s opinion is based on scientific, technical, or other specialized knowledge and not on belief or speculation.” *Sardis v. Overhead Door Corp.*, 10 F.4th 268, 281 (4th Cir. 2021); *see also Jones*, 861 F.2d at 662 (“relevant testimony from a qualified expert is admissible only if the expert knows of facts which enable him to express a reasonably accurate conclusion as opposed to conjecture or speculation.”). Here, there is abundant evidence that Dr. Lappert’s opinions are so tainted by his strong personal views against gender-affirming care as to render those opinions unreliable. Although Plaintiffs of course do not seek to impugn any moral or religious views that Dr. Lappert may hold, those views plainly inform the opinions he proffers in this case (and indeed appear to be the primary motivation for those opinions), and

therefore the Court must consider those views in assessing the reliability of Dr. Lappert's conclusions.

Dr. Lappert has previously testified that he has "strong personal opinions on whether doctors should be providing gender-affirming treatment to minors." Lappert Tr., at 78. That is an understatement. He has previously lobbied state legislatures in, at a minimum, Utah, Arkansas, Alabama, Texas to pass laws or regulations that would ban doctors from providing gender-affirming medical care to adolescents. *See id.*, at 57, 61-62; *id.* at 54-55 (agreeing he has "actively lobbied to get these kinds of bans passed"). In Alabama he spoke in favor of a ban on gender-affirming care for adolescents, and "publish[ed] an op-ed" that urged the legislature to protect what he called "gender-confused children." *Id.*, at 76, 63-64. He argued to the Utah legislature that "you can't change a person's sex," and that "all that is happening is that the patient is undergoing an intentional mutilation in order to create a counterfeit appearance of the other sex." *Id.*, at 57-60.

Dr. Lappert also affirmed in deposition testimony that he "absolutely" considers "gender reassignment surgery to be an intentional mutilation." *Id.*, at 60. He further testified that he would like to see doctors who perform these gender-affirming surgeries to be "criminally prosecute[d] – confirming that he thinks "that's a good idea." *Id.*, at 52. Dr. Lappert went so far as to confirm in his report in this

case that “in all instances” gender-affirming genital surgery is “an irreversible mutilation[.]” Lappert Rep. ¶ 42.

Dr. Lappert has also worked hand in hand with the Alliance Defending Freedom (“ADF”), an organization he agrees has “moral objections” to gender-affirming healthcare. Lappert Tr., at 81. Among other things, he attended an ADF conference that discussed the “poverty of [experts] who are willing to testify” about these anti-gender-affirming treatments. *Id.*, at 90-91. Attendees at that conference “were asked whether they would be willing as participate as expert witnesses[;]” not coincidentally, Dr. Lappert became an expert witness for the first time after attending that conference. *Id.*, at 91; *see also Brandt* Tr. 1080:5-1081:11. In this sense, Dr. Lappert is the definition of a manufactured “expert witness” who “developed his opinions expressly for purposes of testifying” in an area that he did not otherwise specialize in. *Lebron*, 772 F.3d at 1369.

Dr. Lappert’s public interviews and presentations reinforce his vehement opposition to any form of gender-affirming care. These include, for example, his views that the religious conception of “the human person” “defines the ‘end’ of medical and surgical care.” Lappert Tr., at 459. They also include his opinions that “changing a person’s sex is a lie and also a moral violation for a physician,” and that gender-affirming surgery is “diabolical in every sense of the word.” *Id.*, at 464-65; *see also Miller* Dec. ¶ 12; Ex. I, Article titled *Plastic surgeon: Sex-change operation*

‘utterly unacceptable’ and a form of ‘child abuse’ (“LifeSite Article”), at 1, 7; Lappert Tr., at 465 (agreeing that he “hold[s] those views”). And finally, these also include his inflammatory views that parents who “discuss[] gender identity issues with children” are “sexualizing them” (Lappert Tr., at 462), and that these conversations are “grooming a generation” for abuse. *Id.* at 461; Miller Dec. ¶ 13; Ex. J, Presentation by Dr. Lappert titled “Transgender Surgery & Christian Anthropology,” at 24; *see also* LifeSite Article, at 1, 2 (reporting that “regarding children, Lappert said, sexualizing them at a young age with these ideas is grooming them for later abuse.”).

As the court in *Kadel* found, these positions call “Lappert’s bias and credibility into serious question.” *Kadel*, 2022 WL 3226731, at *12.

IV. Dr. Lappert’s Opinions Lack Probative Value and are Therefore Neither Helpful to the Fact-Finder Nor Admissible Under Fed. R. Evid. 403

Finally, the Court should exclude the opinions and testimony of Dr. Lappert outside the field of plastic surgery because introduction of those opinions will result in unfair prejudice, confusion of the issues, or in misleading testimony. Fed. R. Evid. 403. As articulated above, Dr. Lappert’s non-surgical opinions are irrelevant to the issues in this case, and are otherwise speculative, unhelpful, and unreliable. His testimony outside of his discipline would also result in prejudice, as it would sow confusion about the propriety of gender-confirming care based on speculation and irrelevant, misleading, and biased opinions. Accordingly, to the extent not

excluded for the reasons detailed above, Dr. Lappert's opinions outside of plastic surgery should be precluded under Rule 403.

CONCLUSION

For the foregoing reasons, the Court should exclude any opinion proffered by Dr. Lappert outside the field of plastic surgery and limit his testimony to the provision of surgical care generally.

Dated: April 7, 2023

Respectfully Submitted,

**PILLSBURY WINTHROP SHAW
PITTMAN, LLP**

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CERTIFICATE OF WORD COUNT

As required by Local Rule 7.1(F), I certify that this Motion and Incorporated Memorandum of Law contains 5,753 words.

/s/ William C. Miller
Attorney for Plaintiffs

**CERTIFICATE OF SATISFACTION OF
ATTORNEY-CONFERENCE REQUIREMENT**

Pursuant to Local Rule 7.1(B), counsel for Plaintiffs and counsel for Defendants conferred regarding the instant motion during a Zoom conference on April 6, 2023. Defendants indicated they do not consent to the relief requested herein.

CERTIFICATE OF SERVICE

I hereby certify that on this 7th day of April, 2023, a true copy of the foregoing has been filed with the Court utilizing its CM/ECF system, which will transmit a notice of electronic filing to counsel of record for all parties in this matter registered with the Court for this purpose.

/s/ William C. Miller
Attorney for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, *et al.*,

Plaintiffs,

v.

JASON WEIDA, *et al.*,

Defendants.

Case No. 4:22-cv-00325-RH-MAF

DECLARATION OF WILLIAM C. MILLER

I, William C. Miller, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am over the age of eighteen and make this declaration from my own personal knowledge. If called as a witness, I could and would testify competently to the matters stated herein.
2. I am an attorney with Pillsbury Winthrop Shaw Pittman in Washington, D.C., and I have been retained by Plaintiffs as co-counsel in the above-captioned matter.
3. I make this Declaration in support of Plaintiffs' Motion to Partially Exclude Expert Testimony of Dr. Patrick W. Lappert.
4. Attached as **Exhibit A** is a true and correct copy of the expert witness report of Dr. Patrick W. Lappert, M.D. (including a copy of his curriculum vitae) in

the above-captioned matter, which is dated February 16, 2023, and was served upon Plaintiffs on February 17, 2023.

5. Attached as **Exhibit B** is a true and correct copy of the expert witness rebuttal report of Dr. Patrick W. Lappert, M.D. in the above-captioned matter, which is dated March 10, 2023, and was served upon Plaintiffs on that date.

6. Attached as **Exhibit C** is what I understand, upon information and belief, to be true and correct excerpts from the transcript of trial testimony offered in *Brandt v. Rutledge*, 4:21-CV-00450-JM (E.D. Ark.).

7. Attached as **Exhibit D** is what I understand, upon information and belief, to be true and correct excerpts from the transcript of the deposition of Dr. Patrick W. Lappert on September 30, 2021 taken in relation to *Kadel v. Falwell*, No. 1:19-CV-00272-LCB-LPA (M.D.N.C.).

8. Attached as **Exhibit E** is a true and correct copy of a declaration by Dr. Lappert that was filed in *Brandt v. Rutledge*, No. 4:21-CV-00450-JM (E.D. Ark.), which I downloaded from the case docket through the CM/ECF system for the United States District Court for the Eastern District of Arkansas on April 5, 2023.

9. Attached as **Exhibit F** is a true and correct copy of a statement issued by the American Society of Plastic Surgeons titled *State Focus on Gender Affirmation Intensifies* (Feb. 25, 2021), available at <https://www.plasticsurgery.org/for-medical-professionals/advocacy/advocacy->

[news/state-focus-on-gender-affirmation-intensifies.](#)

10. Attached as **Exhibit G** is what I understand, upon information and belief, to be a true and correct copy of a report titled *Memo Outlining Evidence for Change for Gender Identity Disorder in the DSM-5* (July 19, 2013), co-authored by Dr. Kenneth J. Zucker.

11. Attached as **Exhibit H** is what I understand, upon information and belief, to be a true and correct copy of an excerpt from a medical textbook titled *Lewis's Child and Adolescent Psychiatry, Fifth Edition*, published in 2018.

12. Attached as **Exhibit I** is a true and correct copy of an article titled *Plastic surgeon: Sex-change operation 'utterly unacceptable' and a form of 'child abuse'* (Sept. 9, 2019), available at <https://www.lifesitenews.com/news/plastic-surgeon-sex-change-operation-utterly-unacceptable-and-a-form-of-child-abuse/>.

13. Attached as **Exhibit J** is what I understand, upon information and belief, to be a true and correct copy of Dr. Lappert's presentation titled *Transgender Surgery & Christian Anthropology* that was filed as an exhibit in *Kadel v. Falwell*, No. 1:19-CV-00272-LCB-LPA (M.D.N.C.), which I downloaded from the case docket through the CM/ECF system for the United States District Court for the Middle District of North Carolina on April 5, 2023.

I declare under penalty of perjury that the foregoing is true and correct.

Dated this 7th day of April, 2023.

/s/ William C. Miller
William C. Miller

EXHIBIT A

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

AUGUST DEKKER, et al.,

Plaintiffs,

v.

JASON WEIDA, et al.,

Defendants.

Case No. 4:22-cv-00325-RH-MAF

EXPERT DECLARATION OF
PATRICK W. LAPPERT, M.D.

I, Patrick Lappert, M.D., pursuant to 28 USC 1746, declare as follows:

1. I am over the age of eighteen and submit this expert declaration based on my personal knowledge.

2. I have been retained by counsel for the defendants in the above captioned lawsuit to provide an expert opinion concerning the nature of gender surgery. That opinion will be based primarily in my own experience as a physician and surgeon. It will also be based in an evaluation of the scientific publications that Plaintiffs have provided to the court in support of their complaint. It will additionally include an examination the world literature on the subject, as well as an examination of the massive public controversies that have led to near complete reversal of public health policy in multiple European states who have turned away from the social, medical, and surgical transitioning of minors.

3. I am a retired plastic surgeon, as well as a retired senior medical officer in the United States Navy. I have been a physician for 40 years. I completed my undergraduate education at the University of California, Santa Barbara. While there I had significant experience in university level research having been invited to be an undergraduate research assistant, working in the laboratory of Dr. Philip C. Laris. It gave me experience in the evaluation of research publications. We were involved in the collaborative work of elucidating the electrodynamic and stoichiometric quantification of the sodium and potassium pump, located in every living cell. I

completed my undergraduate degree in four years, and went directly to medical school.

4. I completed my preliminary medical training while on active duty in the US Navy. I attended the Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine, graduating as Doctor of Medicine in 1983.

5. I completed a surgical internship at the Oakland Naval Hospital, followed by Aerospace Medicine/ Flight Surgeon Training at the Naval Aerospace Medical Institute, Naval Air Station Pensacola.

6. I then served for 2 1/2 years with a deploying, front-line Marine Corps fighter squadron, serving in the dual functions of medical department head, and squadron Radar Intercept Officer flying in the F-4 Phantom. I was deployed to Asia and the Western Pacific. I provided medical care to squadron personnel while deployed in Japan, Korea, and the Philippines.

7. I completed my General Surgery residency at the Oakland Naval Hospital- University of California, Davis/ East Bay Consortium. Following residency, I was retained there as a staff surgeon, and was responsible for the training of surgical residents. I was awarded the inaugural “Resident’s Choice” award given to the attending surgeon deemed most effective by the residents in training, and presented by Claude Organ, MD, past President, American College of Surgeons.

8. I trained in Plastic and Reconstructive Surgery at the University of Tennessee, Memphis, graduating in 1994. During that training I traveled to Peru and provided craniofacial surgical care for indigent Peruvian children. This included the publication of a case report of surgical management of a very late post traumatic ectopic frontal sinus mucocele.

9. I received Board Certification in General Surgery from the American Board of Surgery in 1992. I received Board Certification in Plastic and Reconstructive Surgery in 1997 from the American Board of Plastic Surgery. I re-certified in Plastic and Reconstructive Surgery in 2008.

10. I served as a staff plastic surgeon at Naval Hospital Portsmouth, Virginia. 1994-2002. I became Department Chairman in 1998, and served in that office until my retirement. We had 5 staff plastic surgeons, and 10 Enlisted and civilian members. I established the Wound Care Center, providing specialized wound care services to a global catchment area. For example, our department was responsible for the limb and pelvic reconstruction of some of the sailors wounded when the USS Cole was attacked while at anchor at Aden in Yemen. I also established and chaired the multi-disciplinary Cleft Palate, Craniofacial Board. We provided comprehensive services for congenital pediatric deformities to a global catchment area.

11. Following selection to the rank of Captain, USN, I was selected to serve as Specialty Leader, Plastic and Reconstructive Surgery for the office of the Surgeon General, USN. In addition to being responsible for the selection and training of surgical residents, I was also responsible for Navy Medical Department policy concerning coverage for services, and medical evaluation and evacuation policy. I was responsible for the resolution of issues concerning what conditions constitute a requirement for immediate care in military hospitals, what may be purchased from civilian medical organizations and provided to eligible members on a delayed (elective) basis, and what is to be considered cosmetic surgery and therefore not an obligation of the government. I served in that position until my retirement. While serving as Department Chairman, I co-authored a textbook chapter on the management of combat injuries with the Chairman of Plastic Surgery at Harvard University, Dr. Elof Erickson. During that time I also published the first case report in the world literature detailing the use of endoscopic technique for reduction and plate fixation of a fronto-facial fracture.

12. I retired from the Navy after 24 years of continuous active duty. I was invited to join a surgical group in Scottsbluff Nebraska, primarily to provide comprehensive reconstructive surgery for women suffering breast cancer. I also provided reconstructive services to a very large regional catchment served by the Level II trauma center at Regional West Medical Center (RWMC). I established and

chaired the Cleft Palate/ Craniofacial multi-specialty clinic at RWMC. I also established comprehensive wound care services for the many rural community hospitals in the western prairie including Nebraska, Eastern Wyoming, southwest South Dakota and northeast Colorado.

13. For reasons pertaining to the education of our six children, I moved my practice to Northern Alabama in 2005. I have been a solo practitioner here for the last 17 years. I was brought here by a local hospital that wanted to offer comprehensive breast reconstruction to women affected by breast cancer. I also started a comprehensive wound care center. I have also had a very active practice in aesthetic/ cosmetic surgery. I maintained my own surgical suite for in-office facial rejuvenation procedures as well as minimally invasive body contouring procedures. I was an early adopter of advanced techniques in autologous fat grafting for facial re-contouring as well as for the resolution of radiation burn wounds of the skin. I continued to serve in the training of medical students in my office practice.

14. Although I maintain a practice in wound consultation, skin care, and laser services, I retired from my surgical practice in 2020, after having practiced as a plastic and reconstructive surgeon for 30 years. I was an Active Member in good standing of the American Society of Plastic Surgery for all but the last two years in practice. With only two years remaining in my practice, I elected to forgo a third certification by the American Board of Plastic Surgery. The certification was no

longer necessary for maintaining my hospital credentials, and I saw it as an unjustifiable expense for a solo practitioner planning retirement. When my board certification lapsed, my membership in the American Society of Plastic Surgery lapsed as a result.

15. As can be gleaned from this summary, I have a meaningful breadth of experience, not only in the advanced surgical care of trauma, cancer, head/ neck disease, as well as cranial and facial birth defects. Many of those procedures require the use of the most advanced sensate, microvascular flaps, including composite and pre-fabricated flaps. These are all the same techniques employed by today's gender surgeons. As regards surgery of the breast, I co-authored a ground-breaking article regarding pre-operative plastic surgical planning in the care of women suffering from breast cancer. It is among the most frequently cited papers in the field of breast reconstruction.¹

16. Since 2014 I have made a concerted effort to examine the medical literature as it pertains to the care of self-identified transgender persons including children and adults. I have had an eight year long running discussion on these issues with Family Practitioners, Pediatricians, Pediatric and Adult Psychologists and

¹ Toth, B.A. and Lappert, P. (1991) Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Pre-Operative Planning. Plastic and Reconstructive Surgery, 87, 1048-1053. <http://dx.doi.org/10.1097/00006534-199106000-00006>

Psychiatrists, Pediatric Endocrinologists, as well as PhDs who specialize in the evaluation of the validity of scientific publications. During that time I have made many public presentations to teachers, counselors, pastors, and administrators on the subject of transgender, and the medical-scientific evidence that informs that care.

17. I have offered testimony, both written and in person on this issue to state legislators, state health benefits management agencies, as well as to State Attorneys General.

18. I have also had experience in making judgments concerning distinctions between reconstructive surgery and cosmetic surgery. I gained this experience while serving in senior leadership for a government medical care system in which I had no financial stake. I have no financial interests in the matter in question, and the professional opinion that I offer is not influenced by my sources of income nor by my position in any organization that financially benefits from medical services that are discussed in this opinion.

19. My peer-reviewed publications include: Lappert PW. Peritoneal Fluid in Human Acute Pancreatitis. Surgery. 1987 Sep; 102(3):553-4; Toth B, Lappert P. Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning. J Plastic and Reconstructive Surgery. 1991; 87 (6): 1048-53; Lappert P. Patch Esophagoplasty. J Plastic and Reconstructive Surgery. 1993; 91 (5): 967-8; Smoot E C III, Bowen D G, Lappert P, Ruiz J A. Delayed development

of an ectopic frontal sinus mucocele after pediatric cranial trauma. J Craniofacial Surg. 1995;6(4):327–331; Lappert PW. Scarless Fetal Skin Repair: “Unborn Patients” and “Fetal Material”. J Plastic and Reconstructive Surgery. 1996 Nov; 98(6): 1125; Lappert PW, Lee JW. Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation. Plastic and Reconstructive Surgery 1998; 102(5): 1642-5. I have also published the following medical textbooks: Wound Management in the Military. Lappert PW, Weiss DD, Eriksson E. Plastic Surgery: Indications, Operations, and Outcomes, Vol. 1; 53-63. Mosby. St. Louis, MO 2000.

20. Over the past four years, I have testified at trial and/or deposition in the following cases: *Brandt v. Rutlege*, Case No. 4:21-CV-00450-JM (E.D. Ark.) and *Kadel v. Folwell*, Case No. 1:19CV272 (M.D.N.C.). I have also submitted an expert report in *Siefert v. Hamilton County Job and Family Services*, Case No. 1:17-CV-511 (S.D.Ohio).

21. For my services as an expert witness, I am being compensated at an hourly rate of \$400 for preparation of my written testimony as well for deposition and hearing. Additionally my travel expenses will be reimbursed. My compensation is not dependent upon the substance of my opinion nor upon the outcome of the litigation.

22. If called to testify in this matter I will do so truthfully, and to the best of my ability.

23. The Plaintiffs make the claim that “gender affirmation care” including “gender affirming (or confirming) surgery” should be paid for by the State of Florida because such care has scientifically proven efficacy, and safety. Furthermore they claim that there is such an abundance of scientific support for these treatments that they must be understood to be the standard of care, and that there is no controversy in the matter. As shall be seen in this report, the claims made by the plaintiffs are not supported in the science. This will be seen in the examination of those scientific documents which they cite in support of what will be seen to be experimental treatments on children.

24. In recent years professional medical societies have been making a concerted effort to strengthen the scientific basis upon which their particular specialties stand. This effort is commonly given the name “evidence based medicine”. It is a systematic effort to categorize the quality of prognostic and therapeutic studies so that physicians reading these publications can distinguish what is vague and speculative from what is a matter of high likelihood, or grave certainty. Tools for making such distinctions have been developed that categorize clinical or experimental findings on the basis of how that data was obtained, the reliability of the test instruments used, the variability of the results, the sample size, and the

likelihood of bias among other factors. For the purposes of this response, I will use the tool developed by the American Society of Plastic Surgery². For prognostic studies, the categorization of evidence is divided into Levels I- V, with Level I being the most rigorous and having the highest likelihood of scientific certainty, and Level V having the least rigor, and having very little certainty. Here are the definitions of those levels according to the American Society of Plastic Surgery:

Level I: High quality prospective cohorts study with adequate power or systematic review of these studies.

Level II: Lesser quality prospective cohort, retrospective cohort study, untreated controls from an RCT (randomized control study), or systematic review of these studies.

Level III: Case- control study or systematic review of these studies.

Level IV: Case series

Level V: Expert opinion; case report or clinical example; or evidence based on physiology, bench research or “first principles”.

25. For therapeutic studies, the ASPS categorization is similar, but with a few helpful distinctions:

² The Levels of Evidence and their role in Evidence-Based Medicine

[Patricia B. Burns](#), MPH,¹ [Rod J. Rohrich](#), MD,² and [Kevin C. Chung](#), MD, MS³
[Plast Reconstr Surg. 2011 Jul; 128\(1\): 305–310.](#)

http://www.plasticsurgery.org/Medical_Professionals/Health_Policy_and_Advocacy/Health_Policy_Resources/Evidence-based_GuidelinesPractice_Parameters/Description_and_Development_of_Evidence-based_Practice_Guidelines/ASPS_Evidence_Rating_Scales.html.

Level	Type of Evidence
1A	Systematic review (with homogeneity) of RCTs
1B	Individual RCT (with narrow confidence intervals)
1C	All or none study
2A	Systematic review (with homogeneity) of cohort studies
2B	Individual Cohort study (including low quality RCT, e.g. <80% follow-up)
2C	“Outcomes” research; Ecological studies
3A	Systematic review (with homogeneity) of case-control studies
3B	Individual Case-control study
4	Case series (and poor quality cohort and case-control study)
5	Expert opinion without explicit critical appraisal or based on physiology bench research or “first principles”

26. These distinctions are very important to physicians who seek to understand the weight of the evidence presented in support of a change in therapeutic care. Sometimes such scientific findings can be so compelling regarding an issue, that professional societies will publish clinical guidelines that strongly suggest conformity to a new treatment plan based in that evidence. Occasionally the evidence will be of such certainty, on a matter that is so grave, that professional

societies and even public law will assert that there exists a standard of care based in this evidence that if ignored has a high probability of injury or harm to the patient. That is what is implied when the phrase “standard of care” is used.

27. To that end, the ASPS document provides a grading system for Practice Recommendations that helps in the decision making. It is a synthesis of the breadth of scientific data that addresses the issue in question. In the case of Grade A there is an accompanying “Strong recommendation”, versus Grade D where the evidence is so lacking in empirical value that the proposed treatment can only be offered as an option if at all, depending upon the strength of existing or alternative treatments, and the particular issues of a particular patient.

28. To summarize, it can be said that Level-V evidence is anecdotal, and in the world of surgery it is typified by the phrase “expert opinion”. Such evidence is not to be dismissed since it is the known starting point for much meaningful research and discovery. A surgeon with great experience and unassailable credentials will observe something peculiar. He will form a hypothesis about its cause or treatment. Hopefully he will publish his single case report, and share his thoughts with the wider surgical community. Perhaps one of his residents will start a hunt for other cases. Perhaps surgeons who read his paper will report similar cases. Eventually it might lead the surgeon to apply his new principal to a series of cases. The series may already be there in his own case files. If he publishes his series of cases, that would

constitute an improvement to Level-IV evidence. Even then, it would be considered “poor” evidence because it suffers from the fact that it is a small collection of cases, from a single surgeon, and perhaps no one has yet replicated his observations. Additionally it may suffer from “selection bias” (as when the patient decides if he will receive long term follow up), lack of proper controls (which help us to separate out what is the result of our treatment, and what is within the range of normal variation in the population), inadequate study duration (if you claim a long term improvement in survival, you have to follow the patients long-term).

29. An example from the history of surgery will serve to illustrate how Level-IV and V evidence, when widely encouraged and applied through expert opinion, can result in grave missteps. For over 100 years, ulcer disease of the stomach was considered a surgical problem. This very debilitating disease did not appear to be manageable through medical means. Laboratory study of the stomach had already demonstrated that acid production in the stomach is regulated by particular nerves. That finding suggested that if those nerves are cut, acid production will decline, and the ulcer will heal. It was also determined that the surgery must include some form of “drainage procedure” because cutting the nerves would also impair the muscular contracture of the stomach. Through the course of the decades many of the greatest surgeons gave their names to the elegant techniques for selectively cutting the nerves, or draining the stomach in ways that hopefully would

not result in a “gastric cripple” (an all too common outcome). Long hospitalizations, and many months spent accommodating to the reordering of their digestive tract was expected. There is a syndrome of bad effects from these surgeries that most people adapt to but some never do. Nonetheless, untreated peptic ulcer disease was often deadly, either from peritoneal sepsis, or bleeding to death. Because of the gravity of ulcer disease, it was ethically sound to risk “post gastrectomy syndrome” if it meant saving a life.³ By the 1980s, level II and I studies had demonstrated that peptic ulcer disease is actually a bacterial infection that can be treated with antibiotics and an acid-reducing medication. This had been very seriously suspected for at least 30 years. However, poorly designed studies published by the greatest academic surgeons of the day had utterly suppressed the bacterial explanation in favor of the surgical solution. A very well-reasoned 2014 paper by Seselja and Strasser⁴ shows the heuristic pitfalls that can result in unintended harms to patients when surgical decision making is driven by expert opinions that aren’t well supported by quality scientific evidence.

30. Generations of surgeons will follow what is taught to them by the academic surgeons. These are esteemed mentors who are responsible for training the

³ History and evolution of peptic ulcer surgery; John B. Blalock Jr. MD1; The American Journal of Surgery Volume 141, Issue 3, March 1981, Pages 317-322

⁴ Dunja Šešelja 1, Christian Straßer; Heuristic reevaluation of the bacterial hypothesis of peptic ulcer disease in the 1950s; *Acta Biotheor* 2014 Dec;62(4):429-54.

next generation of surgeons. That is how it has always been. However today, medical science has advanced in crucial ways through the application of the “science of science”. We understand better now how to examine the evidence. We are less likely to make needless errors of judgement because we are better able to analyze the data particularly with regard to its reliability. This is indispensable when studying biological systems that, in every measurable trait, demonstrate great variability. It is particularly essential when examining and caring for the human person, because you have the added dimension of their subjective interior life.

31. In the professional literature that supports gender-affirmation care, the word “transgender” is defined on the basis of a subjective conflict within the patient’s internal sense of themselves. It affirms this interior subjective division on the basis of an idea that sex is somehow “assigned” at birth, rather than scientifically discovered through tissue sampling, in utero ultrasound, or simple inspection at birth. In 99.98% of cases, simple inspection correctly detects the sex of the subject. Furthermore, this test can be administered by untrained personnel. His use of the term “assigned” implies that there can be errors of “assignment”. Such an assertion demands not only that we examine the result, but we must also look at the consistency of the data. It is well understood that consistency of the data is one of the hallmarks of good evidence. Any test that can be correct 99.98% of the time regardless of who administers the test is perhaps unequaled in scientific medicine.

32. Gender, on the other hand, as it relates to sex, is a very different matter. While there are some aspects of gender that are more fixedly related to the sex, there are large areas of gender that are learned within the milieu of the local culture, and find their origins in family life. There is no objective, repeatable test, with known error rates, that can be used to detect “gender”. Gender, as the term is used in the world of medicine and surgery is not objectively measurable. Such traits as hair length, occupation, preference for violent sport, clothing selection, among others, may have vague gender associations, but are so variable from culture to culture as to be useless for our purposes. This is because “gender” is one of the many expressions of the interior life of the person. It is a mercurial thing because it is not entirely fixed to that part of the patient that is a reliable object for examination and treatment. That difficulty with diagnosis and prognosis is further complicated by the fact that variability in gender presentation doesn’t just occur within any particular human grouping, it is also known to vary within the span of the life of a single patient.((Zucker, K. J. (2018). The myth of persistence: response to “A critical commentary on follow-up studies and ‘desistance’ theories about transgender and gender nonconforming children” by Temple Newhook et al. *International Journal of Transgenderism*, 19(2), 231–245. Published online May 29, 2018. <http://doi.org/10.1080/15532739.2018.1468293>)

33. The claim is made that hormone therapy and gender confirmation surgeries can help alleviate gender dysphoria, and that these treatments have been shown to be an effective treatment for gender dysphoria. In support of this claim, a further claim will be made that there is a prevailing consensus of the medical community that these treatments are medically necessary, and are safe and effective treatments for gender dysphoria. We will examine the efficacy, and safety by examining the papers offered in support of these claims. We will examine the world literature more broadly in order to evaluate the claim of a “prevailing consensus”. The claim of consensus insists on an absence of important controversy surrounding the use of social, medical, and surgical gender affirmation, particularly with regard to the young. That examination will show that there are startling and permanent differences in outcomes between “affirmation-care” as proposed by the plaintiffs, and the historically proven approach that begins in proven psychological care, and results in resolution nearly 90% of the time.

34. In virtually every instant when the claim of the efficacy and safety of gender-affirmation is made, the WPATH “Standards of Care” will be cited in support. This document is the product of the World Professional Association of Transgender Health. It has had 8 iterations. This document has been, and continues to be produced through a process of consensus-seeking within working committees of experts. As we have seen in our discussion about the grading of scientific

evidence, expert opinion is the most rudimentary level of evidence. It is the starting point of scientific investigation, not the end. As any medical subject is investigated over time, the expert opinion becomes better supported by well developed and monitored scientific processes. In short, expert consensus is only as valuable as the scientific evidence that can be reviewed and evaluated which supports the opinion. If the evidence hasn't progressed very far beyond the category of expert opinion, then we are speaking about evidence that is neither sufficiently developed so as to drive either clinical decision making, nor fiduciary decision making when public or invested resources are involved.

35. It will be recalled that the use of the words "standards of care" imply that a particular treatment or clinical principle, if not employed, would have an unacceptable probability of harm to the patient. The term "standard of care" addresses issues of duty, negligence, harm, and causation. It is a legal term that is applied when evaluating the malpractice of medicine. In its Introduction to the WPATH standards, the authors acknowledge that their document is meant to be a guideline only, and subject to individual and local adaptation, and that it is not binding in any way. On page 2 of v.7 in bold face it states "The Standards of Care are flexible clinical guidelines". This calls into question the motivation for the use of the phrase "standards of care" in all of its publications and statements.

36. If the WPATH document is actually a collection of clinical guidelines, then we must examine how such guidelines are developed. In the International Journal of Quality in Healthcare (2016) Kredo et al.⁵ offer a helpful examination of that process. They point out that in the past they were just consensus statements offered by experts in the field. They were ““systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” With the push toward evidence based medicine, it was realized that guidelines required more scientific rigor, so in 2011 the definition was changed to, “statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options””. In order to have real value, clinical practice guidelines must therefore do two things: Use high quality scientific data to evaluate risks, and beneficial results while presenting alternative approaches for the practitioner and patient to consider.

37. With respect to the particular questions at issue in this case, “high quality scientific data to evaluate risks, and results while presenting alternative approaches for the practitioner and patient to consider”, should be evidenced in the complaint, and its supporting documents.

⁵ Guide to clinical practice guidelines: the current state of play; Kredo et al. [Int J Qual Health Care](#). 2016 Feb; 28(1): 122–128. Published online 2016 Jan 21. doi: [10.1093/intqhc/mzv115](https://doi.org/10.1093/intqhc/mzv115)

38. Among the scientific publications frequently cited in support of the efficacy and safety of hormonal treatment of transgender persons is a paper by Hembree et al.⁶ which is itself a clinical practice guideline promulgated by the Endocrine Society (hereafter ES). Since this paper is a product of the Endocrine Society, it must be understood by reconstructive surgeons given that the referral path of children into the surgical treatment arm is universally through the prior evaluation by an endocrinologist. This guideline was produced in order to update an earlier guideline from 2009. It was produced using GRADE consensus methodology, and is the product of 9 experts who formed the committee. The GRADE methodology cautions its users that “inconsistency of result across multiple studies”, “indirectness of evidence”, “imprecision in measurement”, and “publication bias” are to be watched for in its application; essentially that doctors must watch out for sloppy measurement, and bias in the working group. The scientific evidence used to support the Endocrine Society’s special treatment guidelines for gender dysphoric/ gender incongruent persons appears to be of low to very low quality, since the clinical recommendations were so equivocal. It was published in 2017 and includes the statement:

⁶ Wylie C Hembree, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, <https://doi.org/10.1210/jc.2017-01658>

“guidelines cannot guarantee any specific outcome, nor do they establish a standard of care”: “The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The guidelines are not intended to dictate the treatment of a particular patient.” P. 3895.

39. As was discussed earlier, this language of uncertainty when included in a clinical practice guideline is what we would expect with low quality evidence. This is what the ASPS would call a Grade D result that rests on level IV-V evidence, and is therefore not useful in directing clinical decision making. This consensus process described by Hembree et al. would likely appear very similar to the decision making that drove peptic ulcer surgery in opposition to evidence that it is a bacterial disease. Academic physicians of the highest calibre were making recommendations to their fellow practitioners, as they are now, based upon anecdotal experience and low level evidence.

40. Just 2 years later, in 2019, the ES , along with an international panel of endocrinology societies, concluded **“the only evidence-based indication for testosterone therapy for women is for the treatment of HSDD [Hypoactive sexual desire disorder],”** and that **“There are insufficient data to support the use of testosterone for the treatment of any other symptom or clinical condition, or**

for disease prevention.” Also, “The **safety of long-term testosterone therapy has not been established.**”⁷

41. It is somewhat alarming to note that these findings are entirely consistent with a consensus statement from 5 years earlier in 2014 (8). In the span of just 5 years, the Endocrine Society consensus has swung from “no other indication for androgen in women” to something akin to, “it is crucial that androgens be given to women who are gender dysphoric”, and then back to “no other indication for androgen”. This kind of consensus oscillation is what you would expect when there is such scant scientific basis for the decision making.

42. Leading experts in the nascent field of “gender-affirmation surgery” will cite the ES guidelines as the “criteria for initiation of surgical treatment”, and that such surgery is “often necessary and effective”. Additional citation of other specialty consensus statements, developed by similar methodology, includes the American Pediatric Society, and the American Psychiatric Association. These

⁷ Endocrine Society Susan R Davis, et al, Global Consensus Position Statement on the Use of Testosterone Therapy for Women, *The Journal of Clinical Endocrinology & Metabolism*, Volume 104, Issue 10, October 2019, Pages 4660–4666, <https://doi.org/10.1210/jc.2019-01603>.

(8)- Margaret E. Wierman, et al. Androgen Therapy in Women: A Reappraisal: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 99, Issue 10, 1 October 2014, Pages 3489–3510, <https://doi.org/10.1210/jc.2014-2260>

consensus statements are also important for reconstructive surgeons to be familiar with since it is in these areas of practice that the initial diagnosis of gender dysphoria is made, a diagnosis which constitutes the foundation for referral to surgery. The surgeon must understand the strength of the scientific support of the diagnosis given that in some instances breast surgery, and in all instances genital surgery is an irreversible mutilation of the child resulting in permanent losses to essential human functions.

43. Surgeries that are used in gender-affirmation care are described by plaintiffs experts as being “reconstructive”. They include surgeries of the face, the chest, and the genitals. It is crucial to understand the meaning of the term reconstructive surgery, and contrast it with the term “aesthetic surgery”. It is precisely this distinction that distinguishes medical necessity, which in turn is the basis for evaluating claims of obligation on the part of the State or any other 3rd party payor, to pay for these procedures. This is an area where I have some experience, having served the office of the Surgeon General, USN as specialty leader for reconstructive surgery. Making determinations of coverage for any agency is essentially about rightly answering this as the first question: “Is this reconstructive, or is this cosmetic?”

44. Reconstructive surgery is the restoration of form and function for a person who has suffered a loss through genetic, in utero developmental accident,

trauma, infection, or surgery for infectious events or cancer. It begins with the most comprehensive knowledge available concerning the nature and function of the injured part, and seeks to optimize function as the primary goal, while seeking to restore the natural form. Both form and function are understood objectively, and both have subjective effects. Restoration of form and function in a combat injured leg has measurable effects on mobility, range of motion, strength, and capacity for work. Subjectively, the impact is profound as well, but it is not the central purpose of the operation.

45. In contrast, aesthetic surgery begins in the subjective life of the patient. The patient presents seeking an opinion concerning the aesthetics of a particular feature, such as the nose. They will express a dislike of the feature. Their hope is that by modifying its appearance, they will improve their interior subjective life. What the patient is seeking is a normal human objective: to improve the aesthetics of things, for ourselves and for the people around us. When the surgeon is planning and performing the operation on the nose, there is great objective precision; however, all of it is placed in the service of the subjective life of the patient. It is of no use for the surgeon to impress himself with a technically perfect result if the patient loathes it. The surgeon additionally has the grave duty of managing the risk for the patient and weighing it against the potential benefit. The patient must not be submitted for a surgery which entails a significant risk of loss if the surgery is being

performed only to achieve an aesthetic outcome. If there is a certainty of loss, then there is a certainty of error. To give a young woman a perfect nose, and in the process destroy her ability to breath through it would be a terrible error of surgical decision making. It is axiomatic in plastic surgery that we are to avoid a predictable sacrificing of function in the pursuit of cosmetic improvement.

46. All of the world's literature in the area of gender affirmation medicine and surgery begins in the subjective life of the patient. In the past the associated diagnostic terms directed us to consider the subtle processes at work in the mind of the patient that cause obsessive thinking, and compulsive behaviors that center on how the world views their sexed appearance. More recently the condition has been "de-pathologised" and now the preferred term of "gender dysphoria" has come into use. This new language has hidden away virtually all of the issues of the interior emotional life of the patient, and left us only with the vaguest descriptions of the patient's condition: "dysphoria", "unhappy". Simple though the term is, it is still entirely in the subjective life of the patient. There is nothing found in the term "gender dysphoria" that points to a lost or otherwise damaged body structure in need of reconstruction. No functional or physical loss is described or even suggested by the term "gender dysphoria". It is a fundamental characteristic of a cosmetic surgery patient that the presenting complaints are only subjective, and in the course of the complete evaluation of the patient, no functional or structural defect is found.

47. A further reason for the crucial importance of clarity in separating what is reconstructive from what is cosmetic is the part that this distinction plays in surgical planning, and informed consent processes. Planning for a reconstructive operation includes an assessment of the size and severity of the wound, or the dimensions and tissue types of the missing part. This determination guides the selection of tissue from other body areas that can be employed in the reconstruction. At the same time the surgeon must understand the scope of the harm that will be caused by harvesting that tissue to complete the reconstruction. That harm is given the name “donor defect”, and it forms an important part in the risk/ benefit calculation. For example if I were to reconstruct a man’s jaw that was shot away in combat, one of my first options would be to use a portion of bone from the leg. I can transpose that bone to the face, attach the blood supply, then cut and form the bone segment to replace what was lost. One of the important considerations is to prevent loss of function of the leg (donor defect). The operation is in part designed around that consideration because we seek to limit (entirely if possible) the magnitude of the functional loss caused by the donor defect. The only reason that we accept any loss at all is because of the grave nature of the original wound. We accept some small degree of loss if by doing the operation we restore the functions lost in the wounding event. Furthermore, whatever function is lost because of the donor defect is considered a complication had there been any way to avoid it.

48. In contrast cosmetic surgeries, because they begin with an otherwise fully intact person, they do not begin with any assessment of any loss from any of the wounding processes described above. The only measurable findings in cosmetic surgery are those of aesthetic proportion, and which being aesthetic find their importance in the subjective life of the observer. In the case of the cosmetic operation, any functional loss caused by surgery is considered an avoidable complication since the surgery neither anticipates nor yields any functional improvement except in the subjective life of the patient. This is why measures of success in cosmetic surgery are always made using subjective “quality of life” questionnaires.

49. As we examine the particular surgeries used in gender affirmation we will see that there is a very troubling abandonment of these first principles of reconstructive surgery. The first troubling example is “chest masculinization” surgery in female to male presentation patients. This surgery actually begins with the known expectation that the surgery will produce a loss of two essential human functions, namely: sexual arousal, and breast feeding. Both functions are permanently and irretrievably lost, and that loss is one of the expected results of the surgery. This step is then followed by the cosmetic shaping of the chest through the use of liposuctioning in an effort to further masculinize the appearance of the chest. This surgery is now being routinely performed on minor girls, and version 8 of the

WPATH “standards of care”, which is presented as authoritative by proponents of gender affirmation, actually recommends mastectomy in girls as young as 15 years of age. This surgery does not involve the restoration of form and function, and is therefore not reconstructive. It is an operation that begins in the subjective life of the patient and aims at a result that also resides entirely within the subjective life of the patient. It is thus by definition an aesthetic (cosmetic) surgery. Because it includes the 100% likelihood of a massive functional loss, it must be considered unsupportable as a matter of policy.

50. Similarly, genital surgery procedures cannot be considered reconstructive because they do not meet the definition of reconstructive surgery. They begin with an obsessive concern or anxiety in the subjective life of an otherwise normal, healthy person. They involve the planned destruction of an essential human function, and they are not restoring a form that is missing due to trauma, genetic accident, in utero event, or disease. The surgery seeks to create counterfeit structures that never could have existed in the patient, except as an artifact of surgery. I have done many reconstructive surgeries involving the entire genital area in patients with military injuries and infectious illnesses. If the injury is so devastating as to require a counterfeit structure, and that is all that can be offered, then there is no question as to how the surgeon must proceed. In contrast, gender affirmation surgery only produces counterfeit structures that are created to serve the

subjective life of the patient. Because these surgeries are cosmetic, and because they are 100% certain to produce grave functional losses, they must not be supported as a matter of public policy, and never be paid for using public funds.

51. In spite of these clear distinctions between reconstructive and cosmetic surgery, proponents of gender affirmation surgery will claim that such procedures are medically necessary. This language of medical necessity is found in the WPATH “standards of care”. It should be remembered that the WPATH standard of medical necessity is not supported in reliable scientific evidence, but only on rudimentary, low level, expert opinion/ consensus statement data, which is no support at all. The use of the term “medical necessity” is language that is used by medical insurance programs, both private and public to establish insurance coverage in the case of particular procedures. Benefits of insurance programs can vary from policy to policy, but when the term “medically necessary” is used, it implies that failure to cover the care is likely to cause harm to the beneficiary. For this reason, insurance programs, including state Medicaid programs routinely examine the efficacy of treatments in the management of medical conditions, and develop policies of coverage or exclusion if benefit has not been demonstrated, or if a less hazardous or less expensive process of care can be offered to the beneficiary.

52. There are circumstances in which the exact same surgery may be considered reconstructive in one patient, but cosmetic in another. It is important to

be familiar with this problem since advocates of gender affirmation surgery will use the similarity as the basis for claiming that it should be a covered benefit, and that failure to include surgery in the insurance coverage is evidence of legal prejudice against a particular class of patients. For example, the claim will be made that removal of breast tissue from a female seeking to present as a male is the same as removing breast tissue from a male who suffers from the condition of gynecomastia (female breast tissue on a male chest). Or they will offer the analogy that mastectomy (complete removal of the breast) in a healthy female who seeks to present as male is the same as prophylactic mastectomy in a female who has inherited a high lifetime risk of breast cancer. Both females are at present healthy, both females get mastectomy. Gender affirmation advocates will ask, why one is a covered benefit, and the other excluded?

53. One of the essential mechanisms that third-party payors (including state Medicaid agencies) have for distinguishing reconstructive surgery from cosmetic surgery is found in the laboratory examination of tissue removed during surgery. This tissue examination by the pathology department is required by insurance programs in order to confirm that the operation performed was reconstructive (covered benefit) and not cosmetic (excluded from coverage). Two operations may be outwardly identical even while one is reconstructive and the other cosmetic. An excellent example is breast reduction surgery. This surgery may be reconstructive

if it is performed on patients who suffer from chronic neck, back, and shoulder pain caused by the orthopedic effects of their heavy breasts. The same, technically identical operation, might be done for purely cosmetic reasons. In the case of reconstruction, the patient has an objectively diagnosable condition that causes lost time from work, frequent covered visits to physical therapy, or to pain clinics, chiropractors and radiologists. There is abundant actuarial data, based upon the highest levels of scientific support, that a breast reduction of sufficient weight (based upon the anthropometric measurement of the patient) has a very high probability of resolving the chronic pain. High quality medical literature that addresses this issue, and its importance to insurance plans, is typically very precise in its data gathering and actuarial interpretation.⁸ However, pain cannot really be measured. Pain is reported by the patient. Nonetheless, health insurance plans are able to distinguish cosmetic breast lift from reconstructive breast reduction based upon the measured and reported weights of the breast tissue that is submitted to pathology during surgery. An objective, repeatable medical test, with known error rates is used to confirm the diagnosis, ensure correct care for the patient, and separate cosmetic

⁸ Accuracy of Predicted Resection Weights in Breast Reduction Surgery: Kung, Theodore A. MD;
Plastic and Reconstructive Surgery - Global Open: [June 2018 - Volume 6 - Issue 6](#)
[- p e1830](#)

surgery from reconstructive surgery in the interest of preserving medical resources and preventing fraud.

54. No such process exists in the case of mastectomy for chest masculinization of self-identified transgender females seeking to present as males. There is no physical, biochemical, hormonal or tissue pathology, that can be demonstrated to localize the patient's condition in her healthy breasts. It is the young woman's subjective sense of revulsion when she looks at herself that has caused her to believe that mastectomy might make her feel better.

55. In spite of this glaring lack of objective, scientifically validated methodologies for making the diagnosis, or for proving benefit of care, advocates for gender affirmation care will cite many papers, published in peer reviewed professional journals, that claim sufficient improvement in the subjective life of the patient that lifelong morbidity and suicide are avoided. Close examination of this literature will show the very low quality of evidence that is offered, even after many years of affirmation care. Before reviewing the literature supporting gender affirmation, we must understand what it means when an article is reported as "peer reviewed".

56. Peer review is the very important process by which highly educated and trained experts review scientific medical papers for publication. They are examined in order to ensure that the corpus of medical literature is protected from imprecise,

substantively erroneous, or conceptually flawed publications. It is an essential part of the historic, magisterial process in medicine. In fact, it is so much a part of the life-long learning process of doctors that any reputable training program will have a robust “journal club” in which doctors at every level of training take turns at publicly “peer reviewing” an article and leading a lively discussion of its value. A good doctor is constantly peer reviewing. It is an essential element of good medical care because it keeps the doctor in contact with the finest practitioner in their particular field, and thus improving care.

57. Establishing that an article is peer-reviewed is a basic and essential practice. You might read a medical paper with level-III evidence of high quality, or a paper that is level-V evidence of low or questionable quality, both of which undergo peer review, and are published. The level-III will likely drive decision making, and possibly a recommendation as high as “standard of care”, while the poor-evidence paper suggests research, or perhaps the consideration of an alternative approach, if that approach does not put the patient in any significant risk. Papers that have very low-quality evidence, such as single case reports, or case collections by a single practitioner, or collected from several practitioners at a single medical center, will be published by peer reviewed medical journals. These papers are not offered to guide clinical decision making. They are offered in the service of advancing the understand of complex problems, and suggesting areas of research

that might lead to higher quality evidence, and thus to future improvements in the quality of care. So, the label “peer reviewed” says absolutely nothing about the value of the evidence for either clinical decision making, or larger issues of practice guidelines, and policies of medical coverage or exclusion by healthcare agencies like state Medicaid programs.

58. A 2019 publication by Miller et al.⁹ is typical of a single-surgeon, case collection paper published in a peer reviewed medical journal. It reports a collection of cases that claims to show complete satisfaction on the part of the patients (that 100% would do it again). Upon examination of Dr. Miller’s paper we see that it is a report of a single surgeon, and is a retrospective review of his cases. It begins with a chart review of only 34 patients, only 12 of whom responded to the quality-of-life questionnaire. This means 74% of the study patients dropped out (patient self-selection bias, with dropout rate greater than 20% being unacceptably high for publication in most journals). All of the data is based in subjective reporting by the patients, rather than objective findings such as substance abuse rates, psychiatric hospitalization rates, suicide attempt etc.. Published reports which use purely subjective evaluations such as satisfaction surveys, or quality of life surveys etc. are characteristic of the cosmetic surgery literature, not the reconstructive surgery

⁹ Miller, TJ, et al. Breast Augmentation in Male-to-Female Transgender Patients: Technical Considerations and Outcomes, 21 JPRAS Open 63-74 (2019)

literature. He reports that “every patient surveyed at 1 year” reported that “their life had changed for the better”. This statement is again reporting only subjective data, this time following a meaninglessly short follow-up of a very small group that has been biased by self-selection. The overall study is little better from the standpoint of the duration of the study because the final follow-up was only 4 to 7 years. This paper presents level-IV and level-V (low to very low quality) evidence, and is possibly useful in suggesting further research, particularly since the author is a subject matter expert. It is not useful for clinical decision making. Neither can it be presented as evidence for anything more than a cautiously worded practice guideline (as in the ES guideline concerning the use of cross-sex hormones presented above), and certainly can never be used in support of a “standard of care”.

59. A 2006 paper by Newfield et al.¹⁰ is an example of a paper that was published in a peer reviewed journal, and perhaps ought not to have been. This paper asserts that mastectomy and chest masculinization in transgender biological females “increases self-esteem and improves body image” while providing the patient with “some security and safety for those who remove their shirts in public areas such as gyms or beaches”. This assertion is made by the authors in the paper’s preamble, and is an assertion frequently quoted when the paper is cited in evidence to support

¹⁰ Newfield, N, et al., Female to-Male Transgender Quality of Life, 15 Quality of Life Research 1447- 1457 (2006)

gender affirmation surgery. In reading the entirety of the paper one finds that it does not demonstrate this claim at all. The assertion is a personal editorial opinion expressed by the authors in support of transgender surgery. The assertion is never verified in the objective data on post-surgical patients.

60. The paper is a report of an anonymous survey. It claims to provide meaningful information about the effect of female to male transitioning medicine and surgery without even verifying that the subjects who responded to the survey have in fact undergone medical and surgical gender transition. Subjects were recruited **“via online promotion and printed materials, including flyers and postcards that were distributed to San Francisco Bay Area community centers, cafes, stores, and health clinics that serve the transgender community.”** In terms of self-selection bias (patient determines who is followed by the study) it is hard to imagine a more problematic patient selection process. The researchers even admit that they were unable to determine how many surveys may have been submitted multiple times by the same study respondent. They write: “Although this procedure *helped* (italics mine) prevent duplicate submissions by the same participant, we could not employ more sophisticated computerized systems due to administrative and financial constraints”.

61. All of the demographic information contained in the study was self-reported but not verified, including age, sex, health status, history of hormonal

therapy, and history of gender surgery. The study uses a quality-of-life survey with 36 questions in 8 areas of interest, producing only self-reported subjective information. Even the claim of simple benefit is poorly support, as is reflected in the conclusion to the paper. The authors write, **“The 376 US FTM transgender participants analyzed in this sample had diminished mental-health related QOL compared with the general US population, as measured by the SF36v2. These findings are consistent when compared against specific age and sex norms.”** This statement demonstrates the lack of value in the study. The study participants demonstrated a quality of life that is statistically significantly lower than the age/ sex comparison cohort, and the authors can only speculate as to the cause. There is no way to tell if treatment helped, had no effect, or harmed the patients because there was no information available about the anonymous subjects. This is because the anonymous test subjects hadn’t received pre-treatment evaluation using the same or comparable test instrument. This study which is frequently offered in support of the claim of efficacy is of the lowest evidentiary value, may be useful for suggesting future research, but is of no value in directing clinical decision making, or meaningful allocation of public resources in the service of public health.

62. Another peer reviewed article, presently cited in filings by advocates in cases pending before federal courts, is from 2013 by Weigert et al.¹¹ which makes the claim that there is a statistically significant improvement in “psychosocial well-being” following cosmetic breast augmentation in biological males who are presenting as women. This paper is very simple to analyze and classify as not helpful in clinical-therapeutic decision making, or for establishing coverage/ exclusion criteria for public health agencies. At the bottom of the published article is written, “Clinical question/level of evidence: Therapeutic, IV.” As was discussed above, this paper is at the same alarmingly low level, because it is a single-center sampling of a small cohort of patients, and relies on subjective, self-reporting through questionnaire, over a short study duration. Patient collection was made between 2008- 2012. The paper was published in 2013. If the peer review process followed the usual timeline, it is likely that there are a significant number of patients in the study who were followed for less than a year. The authors, in the abstract are only able to report the pre-surgery, and the 4th month post-surgery as assured time points. This is remarkably short follow up even for a cosmetic breast augmentation study group. The article is perhaps useful in suggesting inquiry into why their cohort

¹¹ Weiger, R, Frison,E., Sessiecq, Q., et al.; Patient Satisfaction with Breasts and Psychosocial, Sexual, and Physical Well-Being after Breast Augmentation in Male to Female Transsexuals. *Plastic and Reoncstructive Surgery*, 132(6), 1421-1429. doi:10.1097/01.prs.0000434415.70711.49 (2013)

reported no improvement in physical well-being, given the known association between emotional health and physical health. There is nothing in the article to support even a guardedly worded clinical guideline suggestion.

63. Another citation in legal claims presently before federal courts and offered in support of gender surgery is another peer-reviewed study by Horbach et al. published in 2015.¹² This is a review of transgender surgical literature published between 1995 and encompassing nearly 20 years. It yielded 26 papers that satisfied the search criteria, and includes 1,461 patients. The paper claims that “transgender women (biological males presenting as women) who had vaginoplasty found that study participants’ mean improvement in quality of life after surgery was 7.9 on a scale of one to ten”. In the conclusion of the paper the authors write, “

“Sexual function and patient satisfaction were overall acceptable, but many different outcome measures were used. QoL was only reported in one study. Comparison between techniques was difficult due to the lack of standardization.”

64. Of the merely 26 studies out of a sampling that spanned 20 years, only one paper was found to have used a standardized metric, one that only measures subjective, patient reported information, and the rest could not even be compared to each other. The authors write,

¹² Horbach, SER, Bouman, M, Smit, JM et al. Outcome of Vaginoplasty in Male-to-Female Transgenders: A Systematic Review of Surgical Techniques ; J Sex Med 2015 Jun;12(6):1499-512. doi: 10.1111/jsm.12868.55.

“The available literature is heterogeneous in patient groups, surgical procedure, outcome measurement tools, and follow-up. Standardized protocols and prospective study designs are mandatory for correct interpretation and comparability of data.”

65. This result is startlingly reminiscent of a paper offered by Tolstrup et al. published in 2020 (&&). It is a comprehensive literature review on the subject of breast surgery in transgender patients, including both male to female, and female to male presentation. It is a scoping review that yielded 849 papers of which 47 papers met the inclusion criteria based upon title, abstract, and full text. In the study results, the authors report that,

“The summary of outcome domains and classifications showed that there are large variations in outcome evaluation between studies. Although several studies reported on similar outcome categories, there was a high level of heterogeneity of domains and classifications of outcomes.” The authors then conclude by explaining that **“Evaluation of outcomes in gender-confirming chest surgery showed large variations in reporting, and further streamlining of reporting is therefore required to be able to compare surgical outcomes between studies.”**

66. Tolstrup’s review of the literature¹³ show us that the general level of evidence for the efficacy of gender affirmation breast surgery is in the category of **“early experimental” evidence**. None of the articles examined rates of psychiatric hospitalization, substance abuse, self-harm behaviors, or suicide. This tells us that the most compelling reason offered for performing these surgeries

¹³ Tolstrup A¹, Zetner D¹, Rosenberg J¹ Measures in Gender-Confirming Chest Surgery: A Systematic Scoping Review. **Aesthetic Plastic Surgery**, 29 Oct 2019, 44(1):219-228 DOI: [10.1007/s00266-019-01523-1](https://doi.org/10.1007/s00266-019-01523-1)

(psychological distress and suicide risk) isn't even evaluated by the researchers, and can support no claims of efficacy in the world transgender surgery literature.

67. Professionally speaking, these are very disappointing findings from the comprehensive examination of the transgender surgery literature. To have a surgical sub-specialty working diligently, and guided by professionals at the highest levels of academic expertise, that has only produced case-series reports, retrospective case collections, and fruitless 20 year literature reviews, and still only have level-IV and V evidence to show for its work is alarming. It shows that the sub-specialty has not developed uniform descriptive language, standardized reporting nor test instruments that might raise the value of expert opinion to a level that could make reliable recommendations that might help in surgical decision making, rightly inform the consent process, or guide decision making by officials entrusted with the care of public and private medical resources. It would cause me to make a sober review of the medical and surgical principles that are guiding this work.

The Question of Consent in Gender-Affirmation

68. It is firmly established in high quality research¹⁴ (that persons with gender dysphoria have a greater than 30% likelihood of being on the autism

¹⁴ Kaltiala-Heino R, Sumia M, Työläjäarvi M, Lindberg N. Two Years of Gender identity service for Minors: overrepresentation of natal girls with severe problems in adolescent development.

spectrum, and a nearly 40% probability of a diagnosis of depression or major anxiety disorder. The proponents of gender surgery will rightly point to the high probability of self-harming behavior, including suicide attempts and completed suicide among self-identified transgender persons.

69. However, as is known by all surgeons, it is considered imprudent to obtain consent from patients suffering from psychological conditions that provoke the patient to acts of self-harm, or to suicidal ideation. These psychological disturbances are known to impair the patient's capacity for understanding the information they are hearing from the surgeon, interpreting that information, and reasoning from that information. If those capacities are impaired by psychological disturbances sufficient to consider suicide, then meaningful consent is not actually possible. Certainly in the case of conditions that constitute a threat to life and limb in a patient with decreased competence, consent may be obtained with the assistance of family, guardian, or in particularly urgent cases a group of professionals who agree on the grave necessity to proceed with surgery.

70. The problem however is that none of the surgeries, on the list of commonly performed gender affirmation surgeries, can be described as emergency operations performed to save the life of the patient. They are all elective because

Child and Adolescent Psychiatry and Mental Health (2015) 9:9.)

they are scheduled when convenient and after the patient is deemed fully ready. Furthermore, an ever-growing percentage of patients submitted for gender surgeries are minors who by definition are not competent to consent. The claim is made that these surgeries are in fact “lifesaving”. This is a claim that is not supported in high quality scientific evidence. In fact, high quality evidence, which I will present below, shows that while self-harm and suicide rates are improved in the very short term for some sub-groupings of patients, in the long-term these problems remain if not worsen.

71. Documents like the WPATH v.8 speak of the need to have these psychological disturbances “well-controlled” prior to surgery. This must be taken to mean that self-harming or suicidal thoughts must be well controlled before one can proceed with surgery. If that is the case, then the main reason for the consenting the child for surgery has been successfully treated medically, and the patient no longer requires the surgery. That would be very felicitous news to the child’s parents.

72. What is more troubling is that the co-morbid conditions of autism spectrum disorder, clinical depression, and major anxiety disorder are never examined as the possible causes of the gender identity disturbance. These are conditions that, if treated, might improve or even resolve the gender problem. To the contrary, these serious problems are viewed as mere impediments to gender surgery that must be “reasonably well-controlled” so that surgery may proceed. This is

consistent with the regnant WPATH model that there is a single explanation that the child's condition is caused by a disconnection between biological reality and subjective identity which has an as-yet undiscovered cause, and has only a single solution: the social, medical, and surgical affirmation of the child's gender discordance.

73. Such a single cause/ single solution assumption would seem to be unlikely, given the massive range and the recent complete reversal in the demographics of transgenderism. What used to be a condition that was nearly exclusively found in little boys, and resolved nearly 90% of the time¹⁵, is now predominantly a condition affecting young women, and at a rate that has risen between 4000 and 5000% in the course of the last decade.

74. The claim is often made that gender affirmation surgery is not cosmetic, because it is based in a "medical diagnosis" that can be found listed in the Diagnostic and Statistical Manual. This is a document produced by the American Psychiatric Association. It is essentially a dictionary of terminologies recommended in descriptions of psychiatric conditions. This publication used to include the terms "body dysmorphic disorder", and "gender identity disorder" among others used to describe self-identified transgender person. Changes to the language found in the

¹⁵ Irreversible Damage: The Transgender Craze Seducing Our Daughters; Abigail Shreier, (2020)

DSM are based upon expert consensus methodologies described above, which are the lowest form of scientific evidence. The consensus is not obtained by polling the membership of the Society, but within a small group of provider- advocates. Conditions that were once in the category of paraphillias are now considered normal and not listed. It is in this committee that the decision was made to “depathologize” gender discordance. The difficulty is that without a medical diagnosis, you cannot generate billing for medical services. This is why the term “gender dysphoria” was chosen. No high quality scientific evidence was presented and reviewed by the committee in making the changes.

75. This methodology by the DSM committee has made the document essentially useless in making either a diagnosis, establishing principles of care, or estimating likely resolution of psychiatric medical problems. This appears to be why the National Institute of Mental Health, which has been the original source of funding for the DSM publicly its support for the DSM project just weeks before the present iteration was published in 2013. The fact that gender affirmation physicians and surgeons cite the DSM as a source document for diagnostic criteria is further proof that the condition exists in the subjective life of the patient, and therefore surgery performed to address the subjective condition is by definition cosmetic surgery.

76. Diagnostic and pre-operative selection for of patients for surgery is through a process that begins in psychology, continues with psychological support, and concludes with certification by psychological services that the patient is ready for surgical modification. At no point is there described any medical diagnostic process of history-taking, physical examination, laboratory evaluation, or radiographic examination that is used to confirm a surgical diagnosis. The entire process is in psychological services which is operating on the premise that the anxious child has made a correct diagnosis. The indication for surgery begins in the subjective life of the patient. Surgery is offered to the patient with the assurance that it is likely to improve the subjective life of the patient, and is therefore by definition cosmetic surgery.

On the Safety of Gender Affirmation Surgery

77. A discussion of surgical safety must include anticipated losses which are either expected, or even remotely possible. In order to examine the comparable issues in transgender versus reconstructive surgery our effort is simplified by comparing identical operations. I will describe two operations which use the identical techniques, and even the same tissue source so that we can better compare gender affirmation surgery, with actual reconstructive surgery.

78. On several occasions I have performed the reconstructive operation called “Sensate radial-forearm microvascular free flap hypopharyngeal

reconstruction”. I performed this surgery in order to reconstruct the tongue and throat of patients who had suffered a grievous wound of the mouth and throat when he underwent removal of an aggressive cancer. The defects caused by that wounding needed to be replaced with thin, pliant, abrasion and fluid resistant tissue. It needed to provide the patient with sensation in the reconstructed area so that they can feel the food and liquids in their mouth, and manipulate the food so as to swallow it. We selected an area of skin on the inside of the forearm that has regular and robust blood flow, is thin and durable, and has an easily dissected sensory nerve that can be attached to the nerves in the wound. The forearm flap satisfied all the requirements. An operation of this complexity, duration, and technical requirements has many issues, big and small, that can diminish or destroy the result.

79. The throat reconstruction operation is in almost every way identical to the second most commonly performed female to male (FtM) gender affirmation surgery of the genital. It is called the “Sensate radial forearm microvascular free flap phalloplasty”. In that operation, the identical flap is raised and transferred. It too must be resistant to abrasion, be water tight, pliant, sensate, and of correct volume. Through a process of incision, plication and suturing, a tubular phallus is constructed within which is a skin lined tube which will serve as the urethra. The suture closures in both flaps is where most things go wrong because the skin edges that define the suture line can lose their blood supply to varying degrees. In the phalloplasty, when

this happens, the patient suffers from delayed healing, urine leakage, varying degrees tissue death, and scarring. All of those problems can happen with either the throat flap, or the phallus flap. When the phallus flap fails, the patient suffers due to varying degrees of tissue loss, chronic urinary leakage, or urinary obstruction due to scarring that can cause kidney injury if left un-treated. When the throat flap fails, bacteria laden saliva will leak into the neck where it can cause fulminant infections, or erode into a major artery and cause the patient to bleed to death in a matter of moments. A singularly terrible event.

80. In the case of the throat operation, if the removal of the cancer had not been performed, there was a known and significant probability that the cancer would have eroded into the tissues of the neck and caused a fulminant infection, or eroded into a large blood vessel, as described above. In contrast, if the phallus flap operation, had not been performed, the patient would have remained fully functional in every human capacity, though suffering from an inner subjective disturbance called gender dysphoria, which has not yet been adequately treated.

81. Both operations involve the use of a highly complex surgical techniques to remedy a wound. In the case of the cancer operation the wound was the result of a cancer that would have ended in a terrible death. In the case of the phallus operation the surgeon is creating multiple physical wounds in a healthy child (castration, loss of pelvic organs of reproduction, de-gloving injury of the forearm, skin graft donor

site injury), with their associated risks of complications. The surgery is performed in attempt to remedy a subjective, patient-reported sense of their identity.

82. Clearly the pre-operative condition of the cancer patient is far more grievous than the condition of the young person who is suffering from gender dysphoria. The cancer patient would likely be more than willing to endure significant loss, such as voice, or teeth, or the sense of smell. And yet, if I were discussing surgical risk pre-operatively with my patient who has the throat cancer, and told him that there was a certainty that in the course of the operation he would lose all of his reproductive organs, he would be justified in asking why he was being subjected to such an unsafe operation. The patient wouldn't be even slightly interested in any further discussion of operative risks. The question of safety addresses itself to the question of potential losses caused by surgery. Transgender surgery of the genital apparatus predictably causes grievous loss that dwarfs such complications as infection, local tissue loss, urinary leakage or scarring. Such surgery can justly be considered universally unsafe in all cases, and particularly grievous when visited upon the young.

83. One of the peer reviewed article presented in support of masculinizing chest surgery, and found in numerous expert opinions submitted in pending federal

cases. It is a 2017 paper, published in the peer reviewed journal JAMA Pediatrics¹⁶. it claims to support the conclusion that “surgical intervention (mastectomy, or chest masculinization) positively affected both minors and adults”. This paper is perhaps the most alarming of all the citations presently offered and deserves a detailed examination.

84. The principle author, Dr. Olson-Kennedy is also an academic expert in her capacity as Associate Professor of Clinical Pediatrics, Keck School of Medicine of USC, and Medical Director of The Center for Transyouth Health and Development in Los Angeles. She holds professional membership in The Society for Pediatric Research, the World Professional Association for Transgender Health(WPATH), and the Society for Adolescent Health and Medicine. If any gender affirmation expert would be in a position to offer high quality, evidence-based publications, it would certainly be Dr. Olson -Kennedy.

85. In their summary of findings, the authors report that “chest dysphoria” is common among “trans males” (natal females seeking to present as males), and that the dysphoria is decreased by surgery. They claim that regret for surgery is “rare”. It is a retrospective review of children treated at a single center. The article

¹⁶ Olson-Kennedy,J., Warus, . et al. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts; JAMA Pediatr2018 May 1;172(5):431-436. doi: 10.1001/jamapediatrics.2017.5440.

reports breast removal surgery on at least one girl aged 13 years. The average age was 19. Children were entered into the study through recruitment from among patients visiting the clinic, and by telephone over a six-month period. The authors found that patients recruited from among visitors to the clinic (convenience sampling) yielded an abundance of non-operated patients, so they were forced to reach out to all the known post-surgical patients by phone. 26% of the clinic's post-surgical patients could not be reached for various reasons including no working phone, or failure to respond to multiple messages. A 26% drop-out rate is never questioned by the authors. Were they lost to follow up because of dissatisfaction, psychiatric hospitalization, or suicide? This problem is called "self-selection bias", and is evidence of careless study design. Of the remaining 74% of patients, only 72% of them (only 53% of the study patients) completed the survey. This is a second example of self-selection bias. Why would some post-surgical patients who had been successfully contacted, not complete the survey? The authors do not ask the question.

86. In the study, dysphoria was measured using "a novel measure" (an unproven test instrument) which was a series of subjective questions about happiness. Among the designers of this novel test instrument were some of the adolescent patients themselves. Their flawed methodology included the use of an entirely unvalidated test instrument, with no known error rates, or proven predictive

power, **that was in part designed by the minors and young adults who were the subject of the study.** Furthermore, the post-surgical patients were given the survey at varying time intervals post-surgery. The longest interval between surgery and the satisfaction survey was 5 years, but children less than a year post surgery were included in their flawed sample, and yet the authors claim evidence of “negligible regret.” This is a remarkable claim given that long term, longitudinal population studies show that there is a dramatic rise in post-surgical problems such as depression, hospitalization, substance abuse, and suicide beginning at around year 7 post surgery (Dhejne cited below). Surely Dr. Olson-Kennedy is familiar with the international literature on transgender outcomes?

87. Having promised in the introduction to her paper that “chest dysphoria” is reduced by surgery, at the conclusion they confess the fact that the study design and execution produced very low-quality data that is not useful for patient selection, or prediction of outcomes. They even confess that the study does not address the efficacy of surgery in improving outcomes regarding the single most compelling reason for performing the operation: mitigation of depression and suicide. The authors write:

“An additional limitation of the study was the small sample size. The nonsurgical cohort was a convenience sample, recruited from those with appointments during the data collection period. There could be unknown imbalances between the nonsurgical and postsurgical cohorts that could have confounded the study findings.

Finally, the Chest Dysphoria Scale is not yet validated, and may not represent distress or correlate with validated measures of quality of life, depression, anxiety, or functioning.”

88. This paper is a typical example of a publications which are used to support transgender medicine and surgery, written by board certified transgender expert physicians who practice in our nation’s largest pediatric gender clinics, and was published in peer-reviewed medical journals. The article is essentially useless in making any clinical decisions regarding who should be offered surgery, what the likelihood is that they will benefit from it, or the likelihood that they will regret their decision. Most importantly, it cannot even vaguely estimate if the risk of hospitalization, incarceration, or suicide will be reduced. For the same reason that the paper is not useful in clinical decision making, it is likewise not meaningful in decision-making by persons responsible the just management of public and private medical resources.

On the Experimental Nature of Transgender Surgery

89. One of the important usages of the term “experimental” in the world of medical care is in the domain of insurance services, both public and private. Leadership in these agencies is charged with the responsibility of managing medical resources in a way that both preserves resources, while at the same time applying those resources to the patient as correctly as medical science and their own actuarial information will allow. Whenever a novel therapy is proposed for a given condition,

insurance services will examine the medical and actuarial data to see if the proposed therapy is likely to yield a result that serves those two purposes (health of the patient, and financial soundness of the insurance process). Typically, in the early years of a new treatment there is resistance on the part of the payors because early on (as discussed in detail above) all that the proponents are able to present is low-level scientific papers that present anecdotal case collections without controls, or multiple studies that can not be compared due to methodological variation or are methodologically questionable due to unvalidated test instruments. History has shown, and the fact remains, that good surgery demands good evidence, particularly when permanent damage to the client is a possible result.

90. Nonetheless, if the insurance agency reviewer see evidence that a new approach may be helpful, they prudently insist that therapies of known value be tried to their reasonable limit first , and that they be found to have failed in solving the patient's condition. Only then will consideration be given to the new treatment.

91. This dynamic process between the patient, the physicians, and the insurance industry has many problems, but good, well validated scientific evidence is not one of those problems. In fact well validated science is typically the best remedy for those problems. Sometime the good science is from the doctors, and sometimes the good science comes from the actuaries. In both cases the patient benefits.

92. From the perspective of the case in question, this sense of the term “experimental surgery” may be the most important. How did the affirmation care scientific model and its associated social, medical and surgical treatments enter into the mainstream of the medical community? Did it follow this same process of gradual acceptance in both the medical and insurance communities through a process of steadily improving evidence levels? Was it used on a careful trial basis after having exhausted treatment by established methods? The answer is that it did so, but only in part.

93. The historically validated treatment model for what is today called gender dysphoria is what is called “watchful waiting”. On hearing the name one is tempted to think of this as a resignation to inaction. It is not. It is a psychotherapeutic process that is rooted first in an examination of the cognitive processes of the child, and seeing how the child has responded to the reality of their life. For this reason, in order to be effective, it must include family therapy. The goal is to keep the anxious and confused child in loving contact with reality, while seeking to understand and remedy the subjective dynamic that is provoking the condition of distress. It is essentially the same process used in helping persons who suffer other obsessive-compulsive issues, like eating disorders. Psychological research, having high level evidence, has shown that over the course of time this approach results in over 80%

resolution of the cross-sex self-identification during adolescence, and nearly 92% by young adulthood.(Zucker et al.).

94. This watchful-waiting approach is likely the reason why gender discordance used to be a rare diagnosis. The vast majority of people with the condition resolved the issues, and went on to live their lives without the need for life-long medications, without destructive surgeries, without the loss of their sexual faculties, and without the loss of fertility. What has happened, however, is that the dynamic between patient, physician, and insurance services has been severely disrupted.

95. The science based medical and actuarial management of this condition has been separated from the evidence, and now rests entirely on the opinions of academic experts who have managed to influence the decision makers in their favor. In large part, they have accomplished this by never speaking about watchful waiting except to dismiss it as folly. This process of silence and dismissal is exactly what ulcer surgeons did to the proponents of the scientifically correct infection model of ulcer disease.

96. Silence and dismissal about watchful waiting is not the only reason for the 5,000% increase in the diagnosis of transgender over the past decade. Surgeons who were seeking to achieve the best results for their transgender patients came to realize that most of the difficulty with good cosmetic results was that young men

seeking to present as women tend to appear too masculine, and young women seeking to present as men tend to appear too feminine. They reasoned that if their masculine or feminine development had been arrested early, they would achieve better results. It was reasonable, in light of their treatment model, to think that a better cosmetic result would mean a better resolution of the gender incongruence. Thus the idea was born that the earlier the child was transitioned, the better the cosmetic surgical result, and thus the better psychological result, which is the goal.

97. This theoretical improvement in outcomes for transgender persons through early transition was certainly an idea worth investigating. Because the lifelong effects of the approach might include some really bad outcomes for the children, and because the actual outcomes were unknown at the time, it would have been prudent, and scientifically consistent to categorize this from the above described insurance industry perspective, as experimental. It would have required that the patients exhaust the fully established and proven treatment model of watchful waiting. If that treatment failed to resolve the issue, then on a trial basis, and supervised under very strenuous human experimentation oversight, the affirmation model could be tried.

98. In order for any highly supervised experimental approach to pass ethical standards in human experimentation there would have to have been a previously established diagnostic and patient selection process of very high

specificity. If the proven and established method of watchful waiting is yielding 92% resolution, then what the ethically minded surgeon is really supposed to be doing is trying to find that 8% of children who would have failed watchful waiting, and select them out for surgery earlier in their life. Then studying the result on a very long-term and comprehensive basis, he would have been able to provide high-value evidence that his hypothesis about the successful early management of transgenderism is a safe and valid option for his patient. This was not done. Instead, the routine social and medical transitioning of children began, which includes puberty blockade, and cross-sex hormones in children and youth.

99. Instead of seeking the historically small cohort of children who would have carried the condition into adulthood and treating them, physicians and surgeons are treating all of those children now. Instead of seeking the scientific methodology with which to make a correct diagnosis so as to increase the likelihood that you are operating on the right person, the transgender treatment model is essentially turning all affected children into “the right person”. By the time the youth or young adult person arrives in the surgeon’s office the process has been locked into place.

100. It would seem that the best course of action for those who serve the insurance industry, including state Medicaid, is to return this process to the time tested dynamic model of patient, physician, and insurance plan discussed above.

Because the affirmation model rests upon such low-quality evidence, it seems justifiable to suspend financial support until such time as testing and patient selection processes are improved to acceptable levels of reliability. Given the serious, lifelong consequences of mis-diagnosis, and the misapplication of surgery, levels of patient selection reliability would have to be quite high.

101. A review of the European literature on this topic is instructful. The American literature used in support of the claim of benefit is of low reliability. We make this assertion based on the fact that to date all scientific citations offered in support of gender affirmation medicine and surgery is that they report studies of short duration. Follow up durations of less than 3 years are common. Some, as we have seen are as short as 4 months. This fact helps us to understand why proponents of the affirmation model are enthusiastic. Medical services in a number of European countries utilize centralized medical databases which employ uniform language, and report care over the life of the citizen.

102. The Swedish medical establishment maintains an excellent and centralized data base of all episodes of care for beneficiaries. It uses uniform language, and captures treatment events at all levels, from school clinics, to psychiatric hospitals, to prison infirmaries, to public clinics. The database can be analyzed for such things as emergency room visits, drug addiction treatment, hospitalization for suicide, psychiatric admissions for self-harming event etc.

103. In 2011, Dhejne et al.¹⁷ published a population based, longitudinal cohort study of that database that sought to examine the lifetime hazard ratio of such things as substance abuse, incarceration for violent behavior, psychiatric hospitalization, and completed suicide. This is level-III evidence of high order given the methodology employed and the proven reliability of the database. It examined persons who have fully completed the gender affirmation process and compares them to age and sex matched controls in the Swedish population. It did not use anonymous surveys, or other faulty convenience sampling. It found the post-transition patients by finding the associated episodes of care, such as when hormone therapy prescriptions began, or admission for gender surgery occurred. The data set spans 30 years. What it shows is that fully transitioned subjects showed a relative risk of suicide roughly equal to the age/ sex matched controls, but the effect appears to last for just a few years. The trend line for death from any cause begins a sharp drop at approximately 10 years and continues to drop massively over the subsequent 15 years. When the researchers looked at the aggregate life-time relative risk of suicide, persons who fully transitioned were over 19 times more likely to have killed themselves when compared to age and sex matched controls. If you only look at the subgroup of biological females who transitioned to male-presentation, the risk of

¹⁷ Dhejne, C., Lichtenstein, P., et al. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden; PLoS One 2011 Feb 22;6(2):e16885. doi: 10.1371/journal.pone.0016885.

suicide is 40 times higher than the control group. Results such as these, because they are obtained using tested and reliable methodology, are able to help meaningfully in clinical and administrative decision making, and in several European countries it has.

104. Over the past several years, the medical systems in Great Britain, Sweden, Finland, and France¹⁸¹⁹²⁰ have stepped away from early medical and surgical transitioning of the young. The Tavistock-Portman Institute in London, which was the sole provider of these services to children in Great Britain was closed

¹⁸ **NHS Amendments to service specifications for Gender Identity Development Service (GIDS) for children and adolescents, effective 01 Dec 2020.**

<https://www.england.nhs.uk/wp-content/uploads/2020/12/Amendment-to-Gender-Identity-Development-Service-Specification-for-Children-and-Adolescents.pdf>

¹⁹ **Sweden’s Karolinska Hospital** (affecting Astrid Lindgren Children’s Hospital’s pediatric gender services) issues a **policy change effective April 1, 2021:**

- “...hormonal treatments (*i.e.*, *puberty blocking and cross-sex hormones*, see above) will not be initiated in gender dysphoric patients under the age of 16.”
- “For patients between ages 16 and 18, it is hereby decided that treatment may only occur within the clinical trial settings approved by the EPM (*Ethical Review Agency/Swedish Institutional Review Board*).”
- “These changes shall not affect the continued psychological and psychiatric care within BUP (*Public Child and Adolescent Psychiatry*) for patients under 18 years of age.” “The patient must receive comprehensive information about potential risks of the treatment...”
- Cited UK High Court Decision, NHS policy change in light of it, and that in “2019, the SBU (*Swedish Agency for Health Technology Assessment and Assessment of Social Services*) published an overview of the knowledge base which showed a lack of evidence for both the long-term consequences of the treatments, and the reasons for the large influx of patients in recent years.”¹⁹
- “These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis.”

[Karolinska Policyförändring K2021-3343 March 2021 \(Swedish\).pdf](#)

[Karolinska Policy Change K2021-3343 March 2021 \(English, unofficial translation\).pdf](#)

²⁰ **Finland rejects routine “affirmation” pathway for minors with GD. From Finnish Health Authority, *Council for Choices in Health Care in Finland (COHERE Finland)* 2020:**

recently following the public declaration by a review committee that the Institute was “unsafe for children”. Similarly, the Karolinska Institute in Stockholm reversed its policy by suspending the medical and surgical transitioning of the young in favor of psychological support and treatment. Similar changes in treatment guidelines for self-identified transgender youth have been published in Finland, and are currently being developed in Italy.

105. Based upon these developments in Europe, it is very troubling to read assessments or declarations by leaders in the field of transgender surgery which assert that these treatments are mainstream and beyond controversy, or that they are part of a core curriculum of surgical training, or that an oral board examiner might fail a candidate surgeon if their answers reveal a reticence to join the mainstream as defined by gender affirmation advocates. The world literature demonstrates emphatically that early medical and surgical transitioning is in fact so controversial that medical leadership in multiple countries has put a stop to it.

106. In summary, transgender surgery is based in a treatment model of affirmation that lacks scientific support based in quality evidence. The scientific support offered by the leaders in the field is entirely composed of small studies, single provider /single center studies that are lacking in control cohorts, and are often rendered uninterpretable due to haphazard case-collections such as the solicitation of study participants without methodology to confirm that the patient is a treatment

subject. All of the studies cited in expert filings by gender affirmation practitioners have short follow-up, and most studies suffer from massive self-selection bias and high drop-out rates. The studies often employ untested assessment methodologies, and all of the literature cited by experts report only subjective data, which is typical of papers that address outcomes in cosmetic surgery.

107. Transgender surgery is, by definition, cosmetic surgery. The move towards surgery begins in the subjective life of the patient, is conducted with the aim of improving the subjective life of the patient, and outcomes are measured in subjective terms based in satisfaction surveys. Transgender surgery violates fundamental principle of cosmetic surgery, because it predictably destroys essential functions of the human person. It is not reconstructive surgery because the patient is physically healthy before the surgery, and has no definable deficit that can be objectively characterized to be the cause of the presenting complaint. There is no objective test to confirm the diagnosis of transgender, and no way to correctly select patients for surgery from among the young. The enterprise of gender affirmation medicine and surgery is based entirely in a consensus of expert opinion of low reliability because it is supported by unreliable scientific evidence.

I declare, pursuant to 28 USC § 1746, under penalty of perjury that the foregoing is true and correct. Executed this 16th day of February, 2023.

/s/ Patrick W. Lappert
Dr. Patrick W. Lappert, M.D.

Curriculum Vitae- Patrick W. Lappert, MD

Education and Training :

— Bachelor of Arts in Biological Sciences at the University of California, Santa Barbara, 1979. Research in cell membrane physiology with Dr. Philip C. Laris, studying stoichiometry of the sodium: potassium ATPase pump.

— M.D., Doctor of Medicine degree at the Uniformed Services University of the Health Sciences, 1983 at Bethesda, Md.

— General Surgery Residency at the Naval Hospital Oakland/ UC Davis East Bay Consortium, 1987-1991

— Chief Resident, Department of Surgery, Naval Hospital Oakland, 1990-1991.

— Plastic Surgery Residency at the University of Tennessee- Memphis, 1992-1994.

Board Certifications in Medicine :

— Board Certified in Surgery — American Board of Surgery, 1992-2002

— Board Certified in Plastic Surgery — American Board of Plastic Surgery, 1997-2018

Medical Staff Appointments :

— Staff General Surgeon at the Naval Hospital Oakland, CA 1991-1992

— Associate Professor of Surgery, UC Davis-East Bay, 1991-1992.

— Plastic and Reconstructive Surgeon, Naval Medical Center, Portsmouth, VA 1994-2002

— Chairman, Department of Plastic and Reconstructive Surgery, Naval Hospital Portsmouth, VA 1996-2002.

— Clinical Assistant Professor, Department of Surgery, Uniformed Services University of the Health Sciences, 1995-2002

— Founding Director, Pediatric Cleft Palate and Craniofacial Deformities Clinic, Naval Hospital Portsmouth, VA 1996-20002

— Founding Director, Wound Care Center, Naval Hospital Portsmouth, VA 1995-2002.

— Staff Plastic Surgeon in Nebraska, and Alabama.

U.S.N. Surgeon General Service:

— Specialty Leader, Plastic and Reconstructive Surgery, Office of the Surgeon General-USN, 1997-2002

Faculty Appointments:

— Teaching Faculty at Eastern Virginia Medical School, Division of Plastic Surgery, 1995-2002

Military Service :

— Aviation Officer Candidate, Naval Aviation Schools Command, NAS Pensacola, 1978

— Commissioned an Ensign, MC, USNR 1979 and Commissioned as a Lieutenant, MC, USN 1983 .

— Designated Naval Flight Surgeon, Naval Aerospace Medical Institute, 1985

— Flight Surgeon, Marine Fighter/ Attack Squadron-451

— Radar Intercept Officer in the Marine F-4S Phantom, accumulating 235 flight hours, and trained for qualification as an Air Combat Tactics Instructor.

— Deployed to the Western Pacific as UDP forward deployed fighter squadron in Korea, Japan, and the Philippines.

— Service in the US Navy for 24 years

— Service in the US Marine Corp. for 3 years.

— Retired with the rank of Captain, USN in 2002

Military Awards:

— Navy Commendation Medal - For service with Marine Fighter/Attack Squadron - 451

— Meritorious Unit Citation- 3rd award

— Humanitarian Service Medal - For service in the aftermath of the Loma Prieta earthquake.

Publications - Peer Reviewed Medical Journals :

— Lappert PW. Peritoneal Fluid in Human Acute Pancreatitis. Surgery. 1987 Sep;102(3):553-4

— Toth B, Lappert P. Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning. J Plastic and Reconstructive Surgery. 1991; 87: 1048-53

— Lappert P. Patch Esophagoplasty. J Plastic and Reconstructive Surgery. 1993; 91 (5): 967-8

— Smoot E C III, Bowen D G, Lappert P, Ruiz J A. Delayed development of an ectopic frontal sinus mucocele after pediatric cranial trauma. *J Craniofacial Surg.* 1995;6(4):327–331.

— Lappert PW. Scarless Fetal Skin Repair: “Unborn Patients” and “Fetal Material”. J Plastic and Reconstructive Surgery. 1996 Nov;98(6):1125

— Lappert PW, Lee JW. Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation. Plastic and Reconstructive Surgery 1998;102(5):1642-5.

Publications - Medical Textbooks:

— Wound Management in the Military. Lappert PW, Weiss DD, Eriksson E. Plastic Surgery: Indications, Operations, and Outcomes, Vol. 1; 53-63. Mosby. St. Louis, MO 2000

Operations and Clinical Experience - Consultations and Discussions : As a physician and surgeon, I have treated many thousands of patients in 7 states and 4 foreign nations. My practice has included Primary Care, Family Medicine, Aerospace Medicine, General Surgery, Reconstructive Surgery for combat injured, cancer reconstructive surgeries including extensive experience with microvascular surgery, Pediatric Congenital Deformity, and the care of chronic wounds. I have practiced in rural medicine, urban trauma centers, military field hospitals, university teaching hospitals, and as a solo private practitioner. In my private practice I have had occasion to treat many self-identified transgender patients for skin pathologies related to their use of high dose sex steroids, laser therapies for management of facial hair both in transitioners and detransitioners. I have performed breast reversal surgeries for detransitioning patients. My practice is rated as "LGBTQ friendly" on social media. I have consulted with families with children who are experiencing gender discordance. I have given many presentations to professional meetings of educators and counselors on the subject of transgender, and the present state of the science and treatment. I have discussed the scientific issues relevant to the case with many physicians and experts over a number of years and also discussed related issues with parents and others.

EXHIBIT B

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

AUGUST DEKKER, et al.,

Plaintiffs,

v.

JASON WEIDA, et al.,

Defendants.

Case No. 4:22-cv-00325-RH-MAF

**REBUTTAL EXPERT REPORT OF
PATRICK W. LAPPERT, M.D.**

I, Patrick W. Lappert, M.D., declare that the facts contained herein are true and correct to the best of my knowledge and belief, and that the opinions expressed herein represent my own.

1. I have been asked by counsel for the Defendants to respond to the expert reports of Loren S. Schechter, M.D., and Johanna Olson-Kennedy, M.D., M.S. My qualifications, publications, prior expert testimony, and compensation are discussed in my prior expert declaration served on February 17, 2023.

2. I have been a physician for 40 years. For 30 of those years, I practiced as a plastic and reconstructive surgeon. Details of my multiple board certifications in plastic surgery and general surgery are contained in the narrative of my earlier declaration, as are my surgical experience in all forms of reconstructive surgery including pediatric, congenital, cancer, and trauma reconstruction, most of it gained during my 24 years of service in the United States Navy. I served in teaching positions for plastic surgery training programs, ran multidisciplinary teams for the management of congenital deformities in children, was a department head in a tertiary referral center, and specialty leader to the Office of the Surgeon General (USN).

3. The opinions I offer here are based in that body of experience, my knowledge of the medical and scientific literature that is offered by Drs. Schechter and Olson-Kennedy and those cited in the footnotes of this report, as well as on the

clear methods used to evaluate the quality of that same evidence in making clinical decisions.

4. In order to simplify my rebuttal to declarations of Drs. Schechter and Olson-Kennedy, it is useful to define and clarify the following terms frequently used by experts that often lead to misunderstanding about the value of scientific evidence.

Peer reviewed publications: When scientific papers are presented as having been published in peer reviewed journals, this is merely a statement about the process by which a paper is examined for possible publication. It says absolutely nothing about the evidentiary value of the paper. A paper may be published that shows high-quality, irrefutable evidence that a treatment method is curative in virtually all cases. Another paper may offer a single case report of a surprising cure that resulted serendipitously under unusual circumstances. The first paper has very high value evidence that is powerful in establishing a standard of care. The other paper is interesting, well reported, and documented, but is useful only in formulating a research project, and utterly useless in guiding the prudent care of patients. Both were published in the same “peer reviewed” journal, but only one is helpful in clinical decision making. The difference is based in how we grade evidence, and this distinction is crucial in evaluating the claims of plaintiffs’ experts.

The Standard of Care: This is a phrase that must be used with the greatest caution because it suggests that any deviation from the ‘standard’ is likely to result in significant objective harms to the patient. It is a phrase that assures the reader that there exists a considerable body of research and high-quality outcomes data to support the particular treatment. It declares that a particular

treatment is so superior to any other known treatment that to choose otherwise is to risk significant harm to the patient. It is not based in professional opinion, no matter how esteemed the doctor may be. It is based in the reliable observation of objective facts. This understanding of the phrase “standard of care” is crucial in evaluating the claims made by Drs. Schechter and Olson-Kennedy in their respective declarations, particularly since their most frequent citation is the WPATH Standards of Care v.8, a document that in its first pages cautions that it is not a “standard of care” (see citation in my original declaration).

Treatment Guidelines: These are formulated by select experts from a medical specialty and compares treatment options, using those comparisons to help practitioners make clinical decisions in particular cases. These guidelines, if properly developed, typically include distinctions about particular patient characteristics that may influence treatment decisions. For example it may exclude certain patients from a particular treatment plan because of other health conditions. Such guidelines should offer a careful examination of the risks and benefits of all treatment options so that these can be discussed with the patient in the process of obtaining informed consent. Treatment guidelines are not promulgated to bind a physician to a particular course of treatment. They are there to assist the doctor and protect the patient from imprudent decision making.

This is particularly important when examining this case because new forms of care, when first introduced, must be compared to existing modalities which have known benefits and risks. The process of developing treatment guidelines is never a sudden, radical course change informed by a novel and unproven treatment method. It is a careful comparison, and thus the quality

of care advances while it protects the patient from incautious physicians. The complete absence of such comparison between the “affirmation care” model offered by plaintiffs’ experts, and any other treatment model is startling, and bears consideration when evaluating their claims of efficacy, safety, and long-term outcome. It also greatly bears upon the processes of informed consent used by physicians and surgeons who practice gender affirmation.

Reconstructive Surgery: This term describes those surgeries that aim at the restoration of form and function that may have been lost due to trauma, cancer care, or congenital abnormalities. Such surgeries begin with the objective definition of the defect including its composition and functional loss. The success of such surgeries can be objectively measured, typically including the restoration of function. For example, if I reconstruct the thumb of a farmer, I can measure his grip strength and dexterity with objects like keys both before and after surgery. Sometimes the result may only be cosmetic such as with breast reconstruction, but there is still a defined diagnosable objective loss that precedes surgery, and seeks remedy in surgery. Virtually all reconstructive operations have aesthetic (subjective) consequences, but the subjective improvement is not the first aim of the surgery, only one of the happy results.

Cosmetic Surgery: These are surgeries that are performed only to improve the subjective life of the patient. They begin in the subjective life of the patient when the patient identifies a personal physical attribute (such as shape of nose) as a source of annoyance, insecurity, emotional discomfort, or even profound fear and grief. The goal of the surgery is resolution of the subjective disturbance. There is no antecedent functional defect. There is no

objectively discoverable defect, only common variations in form seen in the general population. Likewise, the results of surgery are measured in the subjective life of the patient, using such instruments as Quality of Life tests. It is crucial to understand these clear distinctions between cosmetic and reconstructive surgery in order to evaluate the claims made by plaintiffs' experts.

Measures of Scientific Evidence: Beginning in paragraph 22 of my prior report, I presented the test instruments used by the American Society of Plastic Surgery (ASPS) when evaluating the quality of scientific studies, and how to apply that evidence in patient care. I will here offer the simple table that can be referred to when considering the publications offered by plaintiffs' experts:

- Level I: High quality prospective cohorts study with adequate power or systematic review of these studies.
- Level II: Lesser quality prospective cohort, retrospective cohort study, untreated controls from an RCT (randomized control study), or systematic review of these studies.
- Level III: Case-control study or systematic review of these studies.
- Level IV: Case series
- Level V: Expert opinion; case report or clinical example; or evidence based on physiology, bench research or "first principles".¹

¹ The Levels of Evidence and their role in Evidence-Based Medicine Patricia B. Burns, MPH,¹ Rod J. Rohrich, MD,² and Kevin C. Chung, MD, MS³ *Plast Reconstr Surg.* 2011 Jul; 128(1): 305–310.
http://www.plasticsurgery.org/Medical_Professionals/Health_Policy_and_Advocacy/Health_Policy_Resources/Evidence-

The same ASPS document provides a grading system for Practice Recommendations that helps in the decision making. It is a synthesis of the breadth of scientific data that addresses the issue in question. In the case of Grade A there is an accompanying “Strong recommendation”, versus Grade D where the evidence is so lacking in empirical value that the proposed treatment can only be offered as an option if at all, depending upon the strength of existing or alternative treatments, and the particular issues of a particular patient.

“Prevailing consensus of the medical community”: This is a phrase without scientific merit. It is an allegation of broad agreement among doctors, but does not explain how that consensus was obtained. They do not describe to what extent that opinion prevails nor who was asked to agree or disagree with the opinion. This is discussed in greater detail in my original report, and is a misrepresentation. As we will see, there are many physicians, and even national healthcare systems that disagree with the therapeutic model of “gender affirmation” as is evidenced in the world literature, where whole nations are retreating from the affirmation model in the care of minors based upon a large body of high quality, long-term data. A claim of consensus demands an examination of the scientific data used to develop the opinion. Expert consensus has been shown to be a flawed methodology and is precisely the reason that modern medicine abandoned it in favor of “evidence-based medicine” (see my discussion in paragraph 27 of my earlier report). The failures of expert consensus methodology is why the American Society of Plastic Surgery, among other professional organizations,

based_GuidelinesPractice_Parameters/Description_and_Development_of_Evidence-based_Practice_Guidelines/ASPS_Evidence_Rating_Scales.html.

developed the orderly means for evaluating scientific information, such as the method described above, which we will use here.

5. In their respective declarations, Dr. Schechter and Dr. Olson-Kennedy have offered no scientific evidence that can be used to support any clinical decision making in the care of self-identified transgender minors. We will examine the papers cited in their declarations, evaluating the objective level of evidence, using the test instrument developed by the American Society of Plastic Surgery.

6. Dr. Schechter begins his report with a discussion of the WPATH Standards of Care, citing it as the primary reference document for decision making in the care of self-identified transgender minors. As discussed previously, the WPATH document is not a standard of care. It makes no scientific comparisons between the “affirmation care” model and any other established method for treating the condition. Within the document itself, under the discussion of the methodology which produced the document, it clearly states that the product of its consensus deliberations is either “recommend” or “suggest” (S247). As discussed above, the phrase “standard of care” is reserved for methods of care that must be followed because failing to do so has a high likelihood of harm to the patient. “Recommendations” and “suggestions” are what is found in treatment guidelines, and always include a discussion of alternative treatment modalities, and a comparison of objectively measured results.

7. Even if we accept the WPATH document as a treatment guideline, rather than a standard of care, such guidelines must stand or fall based upon the quality of scientific evidence presented in those papers cited by the authors. Given that Drs. Schechter and Olson-Kennedy are among the authors of the WPATH document, it may be expected that the scientific papers that they cite in support of their expert opinions will be of the highest evidentiary value. That, however, is not the case.

8. In support of his opinion that gender confirmation surgeries are “medically necessary”, the only citation Dr. Schechter offers is a series of page references from the WPATH document. In paragraph 32 of his report, he states that “the medical community generally considers those surgeries to be medically necessary”. He offers no evidence in support of that statement. He does not discuss how this consensus was obtained, who was asked, how they were asked, or how consistent the data has been over time. It is a statement without scientific merit, and is characteristic of historically flawed consensus methodology that has been replaced by evidence-based medicine. We will see below that a careful examination of the evidence cited in support of the WPATH Standard reveals a lack of evidence even to support a weak recommendation in a treatment guideline.

9. Also in paragraph 32 of his declaration, Dr. Schechter declares that “Gender confirming surgeries are not cosmetic”. To support this opinion, he again

quotes the Standard of Care, and makes a claim of efficacy without citing the scientific evidence that one would expect to see when proposing radical and irreversible surgery in minors. His declaration rests upon his own opinion which also informed his writing of the Standard of Care.

10. In paragraph 33, Dr. Schechter contradicts the well-established principles that distinguish cosmetic surgery from reconstructive surgery by claiming that breast surgery in self-identified transgender minors “may be medically indicated for the treatment of gender dysphoria”. Here he has confessed the fact that breast surgery conversely “might not” be indicated for treating minors who self-identify as transgender. This is exactly the problem which he fails to address. Dr. Schechter, and WPATH have no method for determining which minor “may benefit” and which minor “likely might not benefit” from irreversible breast amputation. Dr. Schechter offers no pre-operative test, with any degree of repeatable, verifiable accuracy that can be used to establish risk vs. benefit, and that can be presented to the parents of the minor to help them with the consent process. There is no such test. This startling shortcoming in the “gender affirmation” model of care is among the reasons why laws and professional sanctions are being used to stop these treatments in minors.

11. In paragraph 34, another claim of medical efficacy is made, and the additional claims of safety is added, both supported by Dr. Schechter’s opinion and his own anecdotal reporting of his experience with certain patients and their post-

surgical subjective reporting. He cites the 2018 article by Agarwal et al. This article is a prospective case series by a single provider. The selection period extended over a period of 14 months. For each patient only two time points are examined: pre-operatively, and 6 months post operatively. There were 87 patients treated by the single surgeon who performed “chest masculinization” surgery on natal males seeking to present as female. Of those 87 patients, only 42 patients were present for the evaluation of results at the 6-month time point. The test instrument used at both time points was a quality-of-life measure, which gathers only subjective data.

12. Using the American Society of Plastic Surgery tool for the evaluation of the scientific basis of any opinion based upon the methodology (presented above), we see that this is a **Level IV** study which suffers from several critical problems. The first is that it is a single provider study. The second is that 52% of the patients fell out of the study, and no explanation is offered for their absence. Are they already disappointed with the result and chose not to come back? Are they hospitalized for an attempt at self-harm? Third, there is no comparison to established treatment methods, or comparison to no treatment at all. Fourth, all of the measures of outcome are in the area of subjective patient reporting (characteristic of cosmetic surgery). Lastly, the post operative follow-up interval is unsupportably brief. Since this study is at best barely **Level IV evidence**, it cannot be used to inform surgical decision-

making. Nor can it be used to inform parents or other legal custodians of minors concerning surgical risk or benefit.

13. In paragraph 35 of his report, Dr. Schechter proposes that there is no difference between the loss of function (breast feeding), and the loss of sensitivity in a woman undergoing mastectomy for breast cancer, versus a minor female undergoing mastectomy for gender dysphoria. He seems to suggest that the two are ethically equivalent because they are technically the same operation. Clearly the surgical management of a potentially lethal cancer often results in considerable wound and a functional loss to the patient. It is in the objective nature of the disease, and the objective limits of our therapeutic skills that brings about the loss. On the other hand, the dysphoric young woman has no objectively determined disease, only subjective complaints of anxiety, sorrow, and self-loathing. The surgical wound that she sustains is caused by the scientifically unsupported claim that the child is suffering due to the mere presence of her breasts. The surgeon has no means of measuring the likelihood of benefit pre-operatively, and no long-term follow-up data to prove that such surgery can prevent self-harm including suicide.

14. When I performed mastectomies for breast cancer, I was able to show the patient long-term evidence of benefit for mastectomy when applied to her particular cancer, based on the extent of spread, tumor type etc. She could understand the direct relationship between the disfiguring effects of the surgery, and the

likelihood that she would be cured of her cancer. With these objective truths she is then better able to make her choice. To expect that by irreversibly sacrificing a human function and producing two grievous wounds you will cure the emotional despair of an anxious minor is highly problematic. In no way can the two operations be equated from an ethical perspective. It would be exactly like comparing a leg amputation in a diabetic with gangrene, to the amputation of a leg from a healthy patient who is suffering from body dysmorphic disorder. It is morally unsupportable precisely because it is not supported by good science.

15. Dr. Schechter's discussion of safety in paragraph 37 does not offer any response to the issues of safety raised in my report. Surgical safety discussions must include all of the losses, including functional losses. Before the gender affirmation cosmetic operation called "chest masculinization" occurs, the patient is perfectly healthy, and has no physical or functional losses. Before the reconstructive operation called "breast reconstruction" begins, the patient has cancer, and the breast is missing due to cancer care. Before the breast removal in that case, the patient had a potentially lethal disease. Safety of mastectomy is considered (among other reasons) in light of the safety risk of not adequately treating breast cancer. Dr. Schechter claims that gender affirmation surgery is life-saving. He has yet to prove that point.

16. The first scientific article offered to support efficacy of affirmation surgery in self-identified transgender minors (Weigert et al. 2013) is a 10-year-old

article that declares in the abstract itself that it only offers **Level-IV evidence**. Such evidence is insufficient to inform clinical decision making. The treatment group was not minors, and the study duration was variable in length, but not more than 4 years. This is typical of the literature cited in support of affirmation surgery in minors. The fact that one of the leading surgeons in this field cites a 10-year-old, **Level-IV evidence** paper shows the utter poverty of quality scientific evidence in this area.

17. The next paper cited (Miller 2019) is a retrospective review of a single surgeon's experience with adult patients undergoing breast enhancement with implants over a 2 1/2 year study period. Average follow up interval was about 16 months. Efficacy of surgery was measured using a subjective test instrument that had 19 questions (typical of cosmetic surgery evaluations). The study does not involve any test of efficacy on self-identified transgender minors. Taken together this is **Level-V evidence** (single physician, small case collection, short follow-up, lack of comparison cohort, self-selection bias). Level-V evidence is not sufficient to inform clinical decision making, nor is it sufficient for consideration in obtaining consent for surgical care. Between the paper cited in paragraph 13, and this paper, ten years of affirmation surgery had elapsed, and the specialty could not yet produce scientific evidence to inform therapeutic decision making. The fact that a further 3 years of affirmation surgery has since passed, and papers such as this are cited as decisive by experts in the field of gender surgery, is alarming. This is not "standard

of care”. It isn’t even helpful for inclusion in a treatment guideline. This level of evidence is only useful for suggesting areas of future experimental research.

18. The next paper offered is a 2015 paper by Horbach et al. It is a retrospective review of the gender affirmation surgical literature published over a 20-year period, looking specifically at male-to-female genital surgery. It examined technical surgical outcomes and complications. It did not examine issues of self-harm or suicide. In the introduction the authors describe that quality of life was one of the surgical outcomes examined. Within the paper, however, we see that out of the 26 papers, published over a 20-year period, only one paper examined quality of life. All of the papers were retrospective case collections without a comparison cohort. None of the papers examined outcomes in minors. Taken in summary, this paper is an examination of papers that present **Level-IV (or lower)** evidence. Such evidence is not sufficient for informing therapeutic decision making, particularly where irreversible harms are certain to occur. What is particularly startling here is that the authors conclude by saying, “The available literature is heterogeneous in patient groups, surgical procedure, outcome measurement tools, and follow-up. Standardized protocols and prospective study designs are mandatory for correct interpretation and comparability of data.” So the very paper cited by Dr. Schechter to demonstrate a “standard of care” that he would have us apply to the care of minors actually points out the fact that the specialty hasn’t even developed a standard

language for describing either the condition or its care over the course of the 20 years examined by the paper.

19. The next paper offered is by Hess et al. from 2014. It is single center, retrospective review of outcomes in 254 consecutive patients that had undergone male-to-female genital surgery. Patients were asked to fill out a questionnaire that asked questions about subjective satisfaction. There is no comparison cohort. The average post operative follow-up interval was 5 years. The authors report that less than half of the patients completed the survey. Such a single-center retrospective case collection, with such a massive drop-out rate (>50%), places this paper in the ‘very low quality’ category, **Level-V evidence**, which cannot be used to inform clinical decision making.

20. The next paper is by Hadj-Moussa published in 2018. This is actually the publication which formed part of the WPATH Standard of Care. Its title is “Feminizing Genital Gender-Confirmation Surgery,” and its aim is **“To summarize the World Professional Association for Transgender Health’s (WPATH) surgical eligibility criteria and describe how patients with gender dysphoria benefit from GCS, provide an overview of genital and non-genital feminizing gender-confirmation procedures, and review vaginoplasty techniques, preoperative considerations, complications, and outcomes.”** Examination of this document is critical because it gives us insight into the working process that

produced the WPATH standard. That standard is cited as a being definitive and sufficient for making clinical/therapeutic decisions for irreversible surgical interventions in minors. If this paper is not sufficient, then it is safe to say that sufficient evidence to support gender affirmation surgery in minors does not yet exist.

21. Hadj-Moussa et al. cite a list of scientific publications all of which are either retrospective literature reviews, single surgeon retrospective reviews, or simple reviews of techniques and their complications. There is even one actual experimental study examining post operative sensation that was unable to reach any conclusions because no measurement standard had yet been established. This is experimental work of the most rudimentary kind, and taken in sum only constitutes **Level-IV evidence**. Even within the substance of the WPATH Standard itself, which is understood and promoted as the best summary of gender affirmation surgical care, there is no scientific evidence sufficient to guide clinical decision making. It cannot even be called a clinical guideline because it does not compare affirmation care with any other treatment strategies, and it offers no consistent measurable benefits.

22. If Level-IV evidence is all that informs the WPATH Standard, then any claims of necessity, efficacy, or safety can declared as unsupported, and cannot be understood to represent evidence-based medicine. The entirety of the document rests upon “expert opinion” which medical history has repeatedly shown to be unreliable

(as I discussed at length in paragraph 27 of my original report). Such evidence therefore is at best sufficient to support experimental work. At present any such treatment of minors would require strenuous oversight. Such oversight would require a consistent descriptive language, reliable and repeatable methods of measurement including long-term value in preventing suicide among other adverse outcomes, a comprehensive and shared database, and a centralized and monitored reporting system. None of those requirements have yet been met by gender affirmation surgeons in the US.

23. The remaining discussions of evidence by Drs. Schechter and Olson-Kennedy present the same poor level of evidence which I reviewed in my original report. None of the evidence is sufficient to inform clinical decision making, or to assist in pre-operative consent consultation with parents of minor children.

24. In paragraph 53, Dr. Schechter declares that higher quality evidence is unavailable because double-blinded placebo control studies are not ethically acceptable. This presumes that there is no level of evidence between Level-II and Level-IV. This is a misrepresentation of the world literature. An examination of the ASPS instrument we have been using here to evaluate scientific evidence shows us that Level-III evidence is defined as “Case-control study or systematic review of these studies.” This kind of evidence has been in the world literature at least since 2011, and is the reason why European gender clinics are all abandoning the social,

medical, and surgical transitioning of minors. (See footnote below re: Dhejne, Cass Review, Karolinska Policy, etc.). The discussions of that literature which Dr. Schechter includes in his report only discuss the rewriting of a conclusion in a single paper. Nothing in that rewrite changed any of the comprehensive Level-III data, which shows that long-term risk of suicide is not improved, nor is substance abuse, incarceration for violence, or any other objective measure. The study clearly shows that the morbidity and mortality of fully transitioned transgender persons climbs precipitously after 8 to 10 years. Since the American publications never follow patients beyond 3 to 5 years, and only rely on evidence plagued by self-selection bias, it is easy to understand why American physicians and surgeons might have a high opinion of the treatment model. The Swedish database tracks patients lifelong, and can compare transitioned patients to the general population in many ways, over a long interval. That Level-III evidence (longitudinal, cohort study) tells us there is no long-term benefit from the gender affirmation care model.

25. It is impossible to accept the position that affirmation care is the only model of care, when England, Sweden, and Finland have abandoned this approach and are returning to the proven psychological approaches of family therapy,

cognitive-behavioral care, and the care of co-morbid conditions that may be at play in the distress that the minor is experiencing.^{2 3 4}

26. In their expert reports, Drs. Schechter, and Olson-Kennedy have presented only low-quality scientific information, none of it above Level-IV. For this reason, none of it can be used to inform clinical decision making in the care of self-identified transgender minors. Their position in support of gender affirmation medicine and surgery is based in low quality, expert consensus-seeking methodologies which professional organizations have abandoned in favor of evidence-based methodologies, as illustrated by the ASPS tool which we have used

² The Tavistock-Portman Institute in London was the sole provider of gender affirmation services to minors in England. In the wake of a very public personal injury case against Tavistock, Dr. Hillary Cass, past president of the Royal College of Paediatrics undertook a comprehensive review of those affirmation services. The result was the immediate process of closure, and a return to the proven methods which are now elaborated in Public Consultation: Interim service specification for specialist gender dysphoria services for children and young people, dated 20 October 2022. That service specification details many substantive changes, and begins by emphasizing that there is very poor evidence in support of hormonal manipulation, that care must turn in the direction of psychology/ neurology, and account for the many co-morbid conditions including Autism. https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria-services-for-children-and-young-people-22.pdf

³ In April 2021, the Karolinska Institute in Sweden formally, and publicly abandoned medical gender affirmation in minors below age 16, and allows it for 16-18yo minors, but only under highly supervised experimental protocols. This speaks clearly to the experimental nature of affirmation care in the treatment of minors.
https://segm.org/Sweden_ends_use_of_Dutch_protocol

⁴ “The Finnish Health Authority (PALKO/COHERE) deviated from WPATH’s ‘Standards of Care 7,’ by issuing new guidelines that state that psychotherapy, rather than puberty blockers and cross-sex hormones, should be the first-line treatment for gender-dysphoric youth. This change occurred following a systematic evidence review, which found the body of evidence for pediatric transition inconclusive.”
https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors

in this response. Given this absence of compelling evidence to support the efficacy of gender affirmation medicine and surgery, and given the known harms that such interventions cause to minors, it is reasonable that children should be protected from this form of care.

I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct.

Executed this 10th day of March 2023.

/s/ Patrick W. Lappert

Patrick W. Lappert, M.D.

EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

DYLAN BRANDT, et al.,

Plaintiffs,

v.

No. 4:21CV00450 JM

November 29, 2022
Little Rock, Arkansas
8:03 AM

LESLIE RUTLEDGE, et al.,

Defendants.

TRANSCRIPT OF BENCH TRIAL - VOLUME 6
BEFORE THE HONORABLE JAMES M. MOODY, JR.,
UNITED STATES DISTRICT JUDGE

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1
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18 MR. MICHAEL CANTRELL, Attorney at Law
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24 *prepared utilizing computer-aided transcription.*
25

INDEX - VOLUME 6 (11/29/22)**WITNESSES FOR THE DEFENDANTS: Direct Cross Redirect Recross**

DANIEL REGNERUS	970,979	1025	1033

PATRICK LAPPERT	1037,1043	1080	1081

VOIR DIRE BY PLAINTIFFS:

DANIEL REGNERUS	972

PATRICK LAPPERT	1040

1 people didn't really have a problem with the data.

2 MR. JACOBS: No further questions, Your Honor.

3 MR. RICHARDSON: Nothing more from us, Your Honor.

4 THE COURT: Thank you, Doctor. We'll let you
5 disconnect and be about your business.

6 THE WITNESS: All right. Thank you, Your Honor.

7 MR. JACOBS: We've got another witness if the
8 Court's ready for it or I don't know what time you were
9 planning to break for lunch today.

10 THE COURT: Probably 1:00, so let's get an hour into
11 it and we'll proceed from there.

12 MR. JACOBS: Defense will call Dr. Patrick Lappert.

13 **PATRICK LAPPERT, DEFENDANTS' WITNESS, DULY SWORN**

14 DIRECT EXAMINATION

15 BY MS. TEMPLIN:

16 Q Good morning, Dr. Lappert. Could you state your name and
17 spell it for the court reporter?

18 A Patrick Walter Lappert. L-a-p-p-e-r-t.

19 Q Dr. Lappert, what is your profession?

20 A I'm a physician surgeon.

21 Q What type of surgeon?

22 A Plastic and reconstructive surgery.

23 Q How long have you been a plastic surgeon?

24 A I did my training in 1992, so 30 years.

25 Q What do plastic surgeons do?

1 A It is.

2 MS. TEMPLIN: Your Honor, depending on whether the
3 plaintiffs wish to voir dire the witness, otherwise we would
4 seize questioning on his qualifications and rest on the CV.

5 MS. OSWELL: Your Honor, we do have voir dire
6 questions for this witness. As the Court knows, we have moved
7 to exclude this witness on testifying beyond the scope of his
8 expertise as a plastic surgeon. With the Court's permission,
9 we do have a few questions to establish the basis of our
10 objections.

11 THE COURT: Briefly.

12 VOIR DIRE EXAMINATION

13 BY MS. OSWELL:

14 Q Good morning, Dr. Lappert. My name is Laura Oswell. I'm
15 an attorney for the plaintiffs in this case.

16 Doctor, you're not a psychiatrist, correct?

17 A That's correct.

18 Q You're not a psychologist either, are you?

19 A That's correct.

20 Q You do not claim to be an expert in mental health?

21 A No, I don't.

22 Q And you're not an endocrinologist?

23 A I am not.

24 Q You're not an expert in endocrinology?

25 A I am not.

1 Q You don't claim to be an expert in pediatrics?

2 A I do not.

3 Q You don't hold yourself out to others as an expert in
4 medical ethics or bioethics, do you?

5 A I do not.

6 Q You don't claim to be an expert in the diagnosis of
7 gender dysphoria?

8 A Expertise, no. I'm familiar with the process of
9 diagnosis, but I'm not an expert.

10 Q You have never diagnosed any person with gender
11 dysphoria, have you?

12 A I have, but in the course of my practice, persons come to
13 me with issues relating to their appearance, but they ascribe
14 to their gender presentation so I have made that diagnosis and
15 excluded them from surgical intervention.

16 Q Could we quickly just take a look at your testimony in
17 this matter? You were deposed, Dr. Lappert, in this case on
18 May 6th of this year; is that correct?

19 A Correct.

20 Q We're going to take a quick look at your testimony. It
21 will be up on the screen just a moment here. Here we go.
22 Direct you to page 150, line 18. Question here is: "Have you
23 ever diagnosed someone of gender dysphoria? Answer: Are you
24 talking about like making a formal diagnosis and sending an
25 insurance document? Answer: No."

1 Did I read that correctly?

2 A You read it correctly, yes.

3 Q Thank you. You have not conducted or published research
4 on gender dysphoria or transgender people. Is that correct?

5 A That's correct.

6 Q You agree that gender dysphoria is not your area of care,
7 correct?

8 A Correct.

9 Q Your only education or training in gender dysphoria was
10 one weekend class at the California Society for Plastic
11 Surgery, wasn't it?

12 A Correct.

13 Q You do not claim to be an expert in the treatment of
14 gender dysphoria, do you?

15 A I do not.

16 Q And you only hold yourself out as an expert in plastic
17 and reconstructive surgery, correct?

18 A Correct.

19 Q Thank you.

20 Your Honor, I know in your order on our motion to
21 exclude, you asked us to take our objections question by
22 question. We would plan to do so in accordance with the
23 Court's instruction.

24 THE COURT: Thank you.

25 BY MS. TEMPLIN:

1 A Well, for example, the risk of pinning someone's ears
2 back because their ears are prominent, that's about as low risk
3 surgery as I could imagine. There's no risk of function lost,
4 there's little or no risk of local problems even. So that
5 would be a very low risk procedure. On the other hand, doing
6 an operation that involves the transfer of large flaps of
7 tissue and the removal of natal tissues, there's a lot at risk
8 there. For example, in the case of transgender surgery, you're
9 talking about hazarding a fundamental human function, which is
10 capacity for sexual embrace and reproduction. That's a huge
11 thing to put in jeopardy compared to a cosmetic ear surgery.

12 Q You're not a psychiatrist, but as a plastic surgeon, are
13 you familiar with what gender dysphoria is?

14 A Yes, I am.

15 Q How are you familiar with that?

16 A I follow the literature. I've reviewed the DSM.

17 Q Are you familiar with the WPATH guidelines on treating
18 patients who are seeking gender reassignment surgery?

19 A I am.

20 Q What do those guidelines recommend?

21 A Well, first of all, they recommend affirmation. The
22 basic position of the WPATH documents is affirmation. They
23 have portions of their what they call the WPATH Standards of
24 Care that discuss psychological, psychiatric support, but
25 there's little to nothing in there about the process of

1 diagnosis, which is a very troubling thing. The diagnosis is
2 what the patient presents with. So the recommendation, the
3 default position of the WPATH documents is affirmation.

4 Q For specifically in the surgical context, what would that
5 mean?

6 MS. OSWELL: Your Honor, we object to this line of
7 questioning on the grounds that the witness is not an expert in
8 gender-affirming care and was not included in his expert
9 report.

10 THE COURT: Sustained.

11 BY MS. TEMPLIN:

12 Q Dr. Lappert, can you predict whether a transgender
13 patient would be satisfied with the outcome of cosmetic
14 surgery?

15 A I cannot.

16 Q Is there evidence on this?

17 MS. OSWELL: Objection, Your Honor. Again, outside
18 the scope of the testimony. The doctor has testified that he
19 has not performed any sort of gender-affirming care surgery.

20 MS. TEMPLIN: Your Honor, Dr. Lappert has also
21 testified that as a plastic surgeon, he has to take into
22 account his patient's goals and whether it would be effective
23 and whether that expertise -- we believe he has the expertise
24 to discuss that.

25 THE COURT: I'm going to limit it to his practice.

1 THE WITNESS: Could you repeat the question?

2 BY MS. TEMPLIN:

3 Q Yes. In your practice, can you predict whether a
4 transgender person who comes to you -- have you been able to
5 predict whether that person would be satisfied with --

6 THE COURT: He's already answered that question.

7 MS. TEMPLIN: Apologies.

8 BY MS. TEMPLIN:

9 Q In your review of the evidence as part of your practice,
10 what does the evidence show?

11 THE COURT: No, ma'am. I just said that he can
12 testify to what he has personally done in his practice, not
13 what the evidence shows. So he can testify to his actual
14 interaction with patients and what the outcomes were, but I'm
15 going to limit it to that.

16 MS. TEMPLIN: Can I ask him about certain studies
17 that may have been referred to in his expert report or is that
18 also outside the scope of permissible testimony, Your Honor?

19 THE COURT: I don't know what your question is so I
20 can't answer that question. I can tell you what I'm limiting
21 to you the question that's before the witness now. He can
22 answer to the extent that he has hands-on experience with that,
23 but your next question I'll just have to field as it comes.

24 BY MS. TEMPLIN:

25 Q Okay. I'll try that question then. Dr. Lappert, are you

1 observation and then it can get to the point of pain. So
2 capsular contracture is the most common thing and it most
3 likely results from incidental infection with bacteria, maybe a
4 failure of technique during surgery, maybe a failure of
5 manufacture of the implant. Sometimes it can become so severe
6 that the implant has to be removed because of peri-implant
7 infections. So those are the two most common complications.
8 And then you have less common things like failure of the wound
9 closure. Typically not a problem.

10 Q Are there any special difficulties with performing breast
11 augmentation on a transgender individual?

12 MS. OSWELL: Objection, Your Honor. This is outside
13 the scope of the doctor's practice.

14 THE COURT: Sustained.

15 BY MS. TEMPLIN:

16 Q Have you ever performed a vaginoplasty?

17 A No.

18 Q Are there similar procedures you've performed on
19 nontransgender individuals that would utilize these techniques?

20 A Yes.

21 Q Can you explain?

22 A Perineal reconstruction and vaginal reconstruction
23 following cancer care and trauma. For example, in the
24 reconstruction, I had a patient who was one of the victims of
25 the bombing of the USS Cole when I was on active duty in the

LAPPERT - CROSS

1 (Proceedings commenced in open court at 12:50 p.m.)

2 THE COURT: Ready when you're ready.

3 CROSS-EXAMINATION

4 BY MS. OSWELL:

5 Q. Dr. Lappert, just a few questions for you.

6 The American Society of Plastic Surgeons considers
7 gender-affirming surgeries to be reconstructive not
8 cosmetic, correct?

9 A. Right.

10 Q. And changing topics, you attended two meetings in
11 Arizona on the subject of transgender organized by the
12 Alliance Defending Freedom. Is that correct?

13 A. That's correct.

14 Q. It's an organization otherwise known as ADF for
15 short.

16 A. I'm sorry?

17 Q. Refer to that organization as ADF for short.

18 A. That's correct.

19 Q. The first meeting you attended took place in 2017.

20 A. I think that's correct, yes.

21 Q. And ADF is not a professional scientific
22 organization, is it?

23 A. Not to my understanding. I don't know them real
24 well, but my understanding is they're advocacy --
25 Christian-based advocacy legal organization.

LAPPERT - REDIRECT

1 Q. Okay. And at that meeting in 2017, there was a
2 fairly long discussion about the lack of people who are
3 willing to testify and the difficulty of finding expert
4 witnesses on transgender issues, wasn't there?

5 A. I believe there was.

6 Q. And people at that meeting were asked whether they
7 would be willing to participate as expert witnesses,
8 weren't they?

9 A. Yes.

10 Q. Both you and Dr. Hruz attended that meeting, correct?

11 A. That's correct.

12 MS. OSWELL: Pass the witness, thank you.

13 REDIRECT EXAMINATION

14 BY MS. TEMPLIN:

15 Q. Just a couple follow-up questions, Dr. Lappert.

16 As you were just asked about, the association of
17 plastic surgeons classifies gender-transition surgery as
18 reconstructive.

19 Do you agree with that classification?

20 A. I do not. It's contrary to every other case that we
21 work on. It's an exceptional case, I should say.

22 Q. And is it common for you to attend professional
23 conferences with other people, other doctors, medical
24 professionals, to discuss medical issues?

25 A. Yes, it is.

EXHIBIT D



Deposition of:
Patrick Lappert, M.D.

September 30, 2021

In the Matter of:
Kadel, et al vs. Folwell

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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

3
4
5
6
7 CIVIL ACTION NO.: 1:19-cv-272-LCB-LPA

8
9 MAXWELL KADEL, et al.
10 Plaintiffs

11
12 v .

13
14 DALE FOLWELL, et al.
15 Defendants

16
17
18 REMOTE VIDEOTAPED VIDEOCONFERENCE
19 DEPOSITION TESTIMONY OF:
20 PATRICK LAPPERT, M.D.
21 September 30, 2021
22
23

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16

17 ALSO PRESENT (via remote
18 videoconference):

19
20 Andrew Baker, Videographer
21
22
23

1 I, Lane C. Butler, a Court
2 Reporter and Notary Public, State of
3 Alabama at Large, acting as Notary,
4 certify that on this date, pursuant to
5 the Federal Rules of Civil Procedure,
6 there came before me via remote
7 videoconference from Decatur, Alabama,
8 commencing at approximately 8:30 a.m.
9 Central, on the 30th day of September,
10 2021, PATRICK LAPPER, M.D., witness in
11 the above cause, for oral examination,
12 whereupon the following proceedings were
13 had:

14
15 THE VIDEOGRAPHER: Good morning.
16 We are going on the record at 8:31 a.m.,
17 Thursday, September 30th, 2021. This is
18 Media Unit 1 of the videorecorded
19 deposition of Dr. Patrick Lappert as
20 taken by counsel for plaintiff in the
21 matter of Kadel, et al. v. Folwell, et
22 al., filed in the United States District
23 Court for the Middle District of North

1 Carolina, Civil Action No.

2 1:19-cv-272-LCB-LPA.

3 This deposition is being
4 recorded remote via Zoom located in
5 Decatur, Alabama. My name is Andrew
6 Baker from the firm Veritext Legal
7 Solutions. I am the videographer. The
8 court reporter is Lane Butler, also from
9 Veritext Legal Solutions.

10 Will counsel now state their
11 appearance and affiliations for the
12 record. The court reporter will swear in
13 the witness. Thank you. We may proceed.

14 MR. TISHYEVICH: This is Dmitriy
15 Tishyevich from McDermott, Will & Emery,
16 LLP, for plaintiffs.

17 MR. KNEPPER: My name is John
18 Knepper. I represent three of the
19 defendants in this matter: the North
20 Carolina State Health Plan for Teachers
21 and State Employees; Dale Folwell, the
22 treasurer for the State of North
23 Carolina; and Dee Jones, the executive

1 administrator of the North Carolina State
2 Health Plan. I'll be defending Dr.
3 Lappert's deposition.

4
5 PATRICK LAPPERT, M.D.,
6 having first been duly sworn,
7 was examined and testified as follows:

8
9 EXAMINATION BY MR. TISHYEVICH:

10 Q. Good morning, Doctor.

11 A. Good morning, sir.

12 Q. State your full name for the
13 record.

14 A. Patrick Walter Lappert.

15 Q. Any reason you're not able to
16 give complete and truthful testimony
17 today?

18 A. There is no reason.

19 Q. You've been retained as an
20 expert by defendants in this case;
21 correct?

22 A. I have.

23 Q. You've prepared an expert

1 serving as an expert in another case,
2 Brandt v. Rutledge. B-R-A-N-D-T.
3 Correct?

4 A. Yes.

5 Q. That's a case pending in federal
6 court in Arkansas; right?

7 A. Correct.

8 Q. In that case, you were retained
9 by the defendants, by the State of
10 Arkansas; right?

11 A. Yes.

12 Q. Dr. Hruz, who is one of the
13 defendants -- strike that. Dr. Hruz, who
14 is one of the experts in this case, is
15 also serving as an expert for defendants
16 in that Brandt case; right?

17 A. That's my understanding, yes.

18 Q. And the same is true for Dr.
19 Levine; right?

20 A. I didn't know about Dr. Levine,
21 but.

22 Q. And you submitted an expert
23 declaration in that Brandt case in July

1 of this year; correct?

2 A. I believe that was when I
3 submitted it, yes.

4 Q. All right. Let's look at it.
5 And let me know when you get the exhibit,
6 Doctor.
7 (Exhibit 3 was marked for identification
8 and is attached.)

9 A. Here it is. Let's see. All
10 right.

11 Q. All right. Page 1 says,
12 "Declaration of Dr. Patrick Lappert."
13 That's you; right?

14 A. Yes.

15 Q. Fair to say that there is at
16 least some overlap between the opinions
17 that you're offering in this case and the
18 opinions that you're offering in that
19 Brandt case; right?

20 MR. KNEPPER: Form.

21 A. Well, given that the subject
22 matter is the same, I would expect some
23 overlap, yes, sir.

1 Q. Go to page 5 of that
2 declaration.

3 A. All right. I'm there.

4 Q. You say under Section II,
5 "'Gender affirming' treatments are
6 experimental." Right?

7 A. Yes.

8 Q. It's basically the same opinion
9 that you offered in this case; right?

10 A. Yes, sir.

11 Q. Go to page 29 of your
12 declaration. See there's a paragraph 63?

13 A. Yes, sir.

14 Q. And toward the end of that
15 paragraph, you talk about the national
16 reviews in England, Sweden, and Finland
17 and other reviews like Cochrane, Griffin,
18 and Carmichael. You see that?

19 A. Yes, sir.

20 Q. You relied -- you relied on all
21 those studies for your opinions in this
22 case as well; right?

23 A. I did.

1 Q. Look at the next sentence. It
2 says, "Every major expert medical
3 association recognizes that
4 gender-affirming care for transgender
5 minors may be medically appropriate and
6 necessary to improve the physical and
7 mental health of transgender people."

8 That's what it says; right?

9 A. That's what it says, yes, sir.

10 Q. That's also contrary to the
11 opinions that you and Dr. Hruz and Dr.
12 Levine are offering in both these cases;
13 right?

14 A. Yes, it certainly is.

15 Q. In fact, according to this
16 order, every major expert medical
17 association disagrees with you because
18 they've all taken a position that this
19 treatment is in fact medically necessary;
20 right?

21 MR. KNEPPER: Objection to form.

22 A. Apparently so, yes.

23 Q. All right. Look at page 6.

1 medical treatment to anyone under
2 eighteen; correct?

3 A. Yes.

4 Q. You yourself support these kind
5 of state law bans; right?

6 MR. KNEPPER: Objection, form,
7 scope.

8 A. I do support a control over
9 these kinds of therapies, yes, I do.

10 Q. Well, not -- not just control,
11 because Arkansas says it will criminally
12 prosecute doctors that do it; right?

13 A. Right.

14 MR. KNEPPER: Objection to form,
15 scope.

16 Q. And you think that's a good
17 idea; right?

18 A. I do.

19 MR. KNEPPER: Objection to form,
20 scope.

21 Q. You think that other states
22 outside of Arkansas should be passing
23 similar bans; right?

1 Q. Go to page 17.

2 A. Okay.

3 Q. The bottom of the page says,
4 "Patrick Lappert, M.D."

5 A. Yes.

6 Q. That's you; right?

7 A. Yes.

8 Q. So at some point earlier this
9 year, you were providing information to
10 the Utah State Legislature to support the
11 potential enactment of a ban on
12 gender-affirming healthcare for minors;
13 right?

14 MR. KNEPPER: Objection, form.

15 A. Yes.

16 Q. Look at the fourth name from the
17 bottom on page 17.

18 A. Fourth name -- I'm sorry?

19 Q. Fourth name from the bottom.

20 A. Paul Hruz. Yes.

21 Q. That's the same Dr. Hruz who's
22 an expert in this case; right?

23 A. Yes.

1 Q. Go to page 18. The second name
2 from the top is Stephen B. Levine M.D.;
3 right?

4 A. Yes.

5 Q. Same Dr. Levine who is an expert
6 in this case; right?

7 A. Yes. I think so, yes.

8 Q. And the next name is Paul
9 McHugh, M.D.; right?

10 A. Yes.

11 Q. The same Dr. McHugh who is an
12 expert in this case; right?

13 A. Yes.

14 Q. All four of you were providing
15 information to the Utah State Legislature
16 to support this potential ban; right?

17 MR. KNEPPER: Objection to form.

18 A. Yes.

19 Q. How did you get involved with
20 providing this information to the Utah
21 State Legislature?

22 A. I don't recall. My -- my
23 suspicion is I may have been contacted by

1 e-mail or some other such thing. In
2 fact, I'm fairly confident it was an
3 e-mail request for assistance, probably.

4 Q. Do you remember who the e-mail
5 was from?

6 A. I do not.

7 Q. Do you remember who at the Utah
8 State Legislature or anyone affiliated
9 with them you were communicating with in
10 this respect?

11 A. I don't remember, no.

12 Q. All right. Let's see what you
13 were telling the state legislature in
14 this report. Go to page 5. See there's
15 a section near the top titled "Sex
16 reassignment surgeries"?

17 A. Yes.

18 Q. There's some language in quotes
19 -- in quotes and italicized. Do you see
20 that?

21 A. I do.

22 Q. And the first portion of the
23 paragraph says: "Sex reassignment

1 surgery' is a massive misrepresentation
2 of what these operations actually do.

3 You can't change a person's sex. All
4 that is happening is that the patient is
5 undergoing an intentional mutilation in
6 order to create a counterfeit appearance
7 of the other sex."

8 Do you see that?

9 A. I do.

10 Q. And underneath, it says,
11 "Patrick Lappert, M.D." Right?

12 A. Yes.

13 Q. These are your words, Dr.
14 Lappert; right?

15 A. Yes.

16 Q. You consider gender reassignment
17 surgery to be an intentional mutilation;
18 right?

19 A. I do. Absolutely.

20 MR. KNEPPER: Form.

21 Q. And calling gender reassignment
22 surgery, quote, intentional mutilation,
23 is that commonly accepted terminology in

1 this field, Doctor?

2 A. I expect not.

3 Q. And then you say that when a
4 patient undergoes gender reassignment
5 surgery, all that is happening is, quote,
6 a counterfeit appearance of the other
7 sex; right?

8 A. Yes.

9 Q. This phrase, "counterfeit
10 appearance," do you think that's an
11 appropriate term for a doctor to use?

12 A. Absolutely.

13 Q. And you stand by these words;
14 right?

15 A. I do.

16 Q. All right. So, we've talked
17 about Arkansas, we've talked about Utah.
18 Now, I know there is currently a number
19 of other states that are considering
20 passing similar bans. Outside of Utah,
21 have you done any work whatsoever in
22 connection with these potential bans in
23 other states?

1 MR. KNEPPER: Objection, form,
2 scope.

3 A. I have.

4 Q. Which states?

5 A. Alabama, Texas.

6 Q. What else?

7 A. Texas. I don't know if there
8 were any in the Northwest or not. I
9 think that's all of them. I may be
10 wrong, but I think that's all. Alabama
11 and Texas I would just add to your list.

12 Q. Okay.

13 A. There may been something in
14 Arizona. I'm not certain about Arizona
15 as well, but --

16 Q. Now let me introduce another
17 exhibit. Okay. Let me know when you get
18 this one.

19 (Exhibit 6 was marked for identification
20 and is attached.)

21 A. I've got it.

22 Q. All right. This article is
23 titled, "Alabama bill that would

1 criminalize treatment for transgender
2 minors headed to full Alabama Senate."

3 You see that?

4 A. I do.

5 Q. Alabama, your home state, was
6 considering a ban very similar to
7 Arkansas just this year; correct?

8 A. Actually over the last couple of
9 years.

10 Q. Okay. The first paragraph says,
11 "The Alabama Senate Health Committee on
12 Wednesday approved a bill that would
13 outlaw puberty-blocking medications and
14 gender-affirming care for minors,
15 giving" -- "giving it a favorable report
16 in an 11-2 vote." You see that?

17 A. I do.

18 Q. Then it says, "An Alabama House
19 committee heard testimony in a public
20 hearing on a companion bill, but the
21 committee did not vote on the" -- "on the
22 measure." You see that?

23 A. I do.

1 Q. You testified in support of this
2 bill; right?

3 A. Yes, sir.

4 Q. Go to page 2.

5 A. Okay.

6 Q. Look at the second paragraph
7 from the bottom.

8 A. Second from the bottom. Yes.

9 Q. It says, "Dr. Patrick Lappert, a
10 Decatur plastic surgeon, spoke in favor
11 of the bill."

12 That's you; right?

13 A. That's right.

14 Q. Go to page 3.

15 A. Okay.

16 Q. And look at the third paragraph.
17 It says that you've "spoken against the
18 use of medicine and surgery for
19 transgender people as a Catholic deacon
20 in his local diocese." See that?

21 A. Yes.

22 Q. You don't deny that you've
23 spoken against the use of medical and

1 of, psychologically, the -- the quality
2 of the -- sort of a transformative power
3 of cosmetic surgery.

4 And then the third criteria
5 would be that they -- they see something
6 that you don't see. They see a defect
7 that you don't see. And that's probably
8 the key diagnostic criteria. For
9 example, a man who presents seeking a
10 modification to his nose who has evidence
11 of living a life of social isolation who
12 is adamant that by changing his -- the
13 appearance of his nose, he will -- he
14 will have a much better life. And
15 hearing that, of course, the alarm bells
16 go off and then examining the patient and
17 seeing that there's no objectively
18 definable deformity, only a normal
19 variation that one would expect to see on
20 a man's face.

21 Those are all red flags. And --
22 and based upon that, it is -- it
23 is definitely the -- has been

1 historically the recommendation of the
2 likes of Dr. Mark Gorney and other
3 leaders in the American Society of
4 Plastic Surgery to not offer surgery, but
5 rather to offer referral for
6 psychiatric/psychological support and
7 evaluation.

8 Q. These diag- -- these diagnostic
9 criteria that you mentioned, where do
10 they come from?

11 A. They -- I think you can find
12 much of that in the DSM book, if -- if --
13 if that's the route you want to go. You
14 find it in the literature. There are --
15 there are references in the scientific
16 literature about it dating back to I
17 think the 1920s. I included some of
18 those, I think, in my discussion, if not
19 on this one, in the Arkansas case.

20 But -- but there have been
21 papers published through the years that
22 describe the condition and make
23 recommendations about care, and again,

1 course, who presents for body
2 modification. That -- that's a fairly
3 readily and obvious one.

4 But no, I'm not a -- I'm not
5 formally trained in psychiatry or
6 psychology.

7 Q. You do not have -- you do not
8 hold yourself out as an expert in
9 diagnosing mental health conditions
10 outside, potentially, of body dysmorphic
11 disorder; right?

12 A. Correct.

13 Q. You do not have specialist
14 training or expertise in treating mental
15 health conditions; right?

16 A. No.

17 Q. You would refer that person to a
18 qualified mental health professional;
19 right?

20 A. I would. I would.

21 Q. Because you yourself are not a
22 qualified mental health professional;
23 correct?

1 A. Correct.

2 Q. All right. You've also
3 published an op-ed in May of this year
4 supporting this Alabama ban; correct?

5 A. Yes.

6 Q. And you said that Alabama
7 legislators should enact this ban because
8 they have a duty to protect the
9 vulnerable population of gender-confused
10 children. Does that sound familiar?

11 A. Yes.

12 Q. So again, earlier you said you
13 had a preference for professional
14 societies dealing with this, but you're
15 out there publishing op-eds calling on
16 state legislatures to pass these bans;
17 right?

18 MR. KNEPPER: Objection, form.

19 A. Right. Yes, sir.

20 Q. All right. How about Texas?
21 Tell me what work you've done supporting
22 this kind of a ban in Texas?

23 A. It's been similar. I've been in

1 because it's the same problem, the same
2 science, the same language. All of it's
3 the same.

4 Q. So earlier, we saw that in
5 addition to you, Dr. Hruz and Dr. Levine
6 and Dr. McHugh were also involved with
7 those Utah legislative efforts; right?

8 MR. KNEPPER: Objection, form.

9 A. I -- I don't know their
10 involvement in -- in Texas. I'm -- I'm
11 not aware.

12 Q. Yeah. Do you know whether any
13 of them have been involved with any of
14 these efforts in any other state?

15 A. I don't. I don't know.

16 Q. Okay. Fair to say that you have
17 some strong personal opinions on whether
18 doctors should be providing
19 gender-affirming treatment to minors?

20 MR. KNEPPER: Objection to form.

21 A. Very fair to -- very fair to
22 say, yes.

23 MR. TISHYEVICH: Let's go off

1 a -- the opinion that the present state
2 of transgender medicine and surgery is
3 not in the interest of the patients or
4 the families.

5 Q. The ADF has moral objections to
6 doctors performing this kind of surgery
7 and treatment; right?

8 MR. KNEPPER: Objection, form,
9 scope.

10 A. I would -- I would characterize
11 the ADF's position as more than just a
12 moral objection. It's both moral and
13 objective scientific objections.

14 So the -- the -- the sense I got
15 from that conference was that most of the
16 invited speakers came to speak about --
17 for example, Dr. Hruz was there, and he
18 spoke about endocrinology and the
19 endocrinol- -- endocrinologic basis for
20 sex/gender. And he spoke about the
21 effects of -- the endocrinological
22 effects, the objective changes that are
23 caused by, for example, puberty-blocking

1 heart of the presentation was what's the
2 state of the science and where is the
3 reliable science coming from and what is
4 it -- what is it showing us, so. But
5 they also -- the audience wanted to have
6 an understanding of what these plastic
7 surgery interventions were. So there was
8 an extensive discussion of the
9 particulars of the surgeries, the details
10 about the surgeries, the typical outcomes
11 of the surgeries, so.

12 Q. I want to -- strike that.

13 One of the topics of discussion
14 at that meeting was about the need to
15 have expert witnesses for litigation;
16 right?

17 MR. KNEPPER: Objection, form,
18 scope.

19 A. I remember -- I remember a
20 fairly long discussion about the poverty
21 of people who are willing to testify
22 because of the risk that they take in
23 testifying. That was a -- that was a

1 fairly long discussion. And the
2 difficulty that that -- that people have
3 in finding expert witnesses because of
4 the risks they place themselves in, in
5 testifying.

6 Q. And people at that meeting were
7 asked whether they would be willing to
8 participate as expert witnesses; right?

9 A. Yes.

10 Q. Before that meeting, you had
11 never testified as an expert witness?

12 A. Before this moment, I never
13 testified as an expert witness.

14 Q. Who made the introductory
15 remarks at the beginning of this meeting?

16 MR. KNEPPER: Objection, form,
17 scope.

18 A. I'm trying to remember. It was
19 a -- it was an attorney whose first name
20 is Jeff, and I'm trying to remember what
21 his last name was. But he seemed to be
22 the -- the -- kind of the emcee, if you
23 will. Yeah, Jeff. I'll see if, in the

1 language used by the other professional
2 organizations, and essentially, the
3 language takes the position that surgical
4 intervention for a subjective problem is
5 medically indicated. And that's the
6 difficulty that I'm having here, is that
7 in this document the ASPS does not --
8 does not provide medical scientific
9 support. They essentially admit that the
10 surgery is for help with a psychological
11 problem of perception on the part of the
12 patient. So essentially what -- what the
13 ASPS firmly believes in is the use of
14 surgery to manage a psychological
15 problem. And -- and this is -- this is
16 consonant with the -- with the -- the
17 consensus opinions that were offered by
18 the other professional organizations that
19 you listed earlier.

20 Q. The AS- -- ASPS does not agree
21 with your opinions that gender-affirming
22 surgery is experimental; correct?

23 MR. KNEPPER: Objection, form.

1 A. They don't -- let's see, do they
2 say anything about experimental in here?
3 No, they don't. So yeah, I would agree.

4 Q. Do you agree? Yeah.

5 A. I would agree, yeah, sure.

6 Q. Look at the last sentence. It
7 says, "ASPS will continue its efforts to
8 advocate across state legislatures for
9 full access to medically necessary
10 transition care." Do you see that?

11 A. Yeah. I don't find that
12 statement at all surprising. No.

13 Q. Yeah.

14 A. I do see that, yeah. Not
15 surprising. This is legislative --

16 Q. The ASPS --

17 A. -- legislative advocacy by the
18 ASPS.

19 Q. The ASPS considers transition
20 care to be medically necessary; right?

21 MR. KNEPPER: Objection, form.

22 A. Again, that returns -- returns
23 to that -- that inherent and

1 A. Right. That's -- that's my
2 understanding, yes.

3 Q. You personally have never been
4 part of this kind of a multidisciplinary
5 team for any patient with gender
6 dysphoria; correct?

7 A. No. I have always -- I have
8 always turned away personal -- for per-
9 -- well, my understanding of those
10 procedures has caused me to reject
11 offering them to my patients because I
12 don't see them as beneficial. So
13 clearly, I wouldn't want to participate
14 in a multidisciplinary team that's
15 offering therapies that I consider to be
16 incorrect treatments for a condition that
17 deserves our care, so.

18 Q. All right.

19 A. If you want, I can give you a
20 shorter answer. No.

21 Q. Yeah, let's -- you personally
22 have never treated a single patient for
23 gender dysphoria; correct?

1 A. I have never treated a patient
2 with gender dysphoria surgically.

3 Q. Okay.

4 A. Other than the detransitioner.
5 I -- I suspect they were still suffering
6 from dysphoria even though they were
7 detransitioning, but I didn't treat them
8 with surgery to -- per se for that
9 condition the way the transgender teams
10 do. Yeah.

11 Q. When you were providing laser
12 hair removal to trans women, is that
13 providing gender-affirming care?

14 MR. KNEPPER: Objection, form.

15 A. I don't get into the affirmation
16 side of the treatment. I'm simply
17 providing a service to -- to people who
18 -- who I want to have as friends.
19 Believe it or not, it's true. I -- I
20 don't turn anyone away whose -- whose
21 request is -- is within the scope of what
22 I consider moral practice of medicine and
23 surgery, so.

1 transition, acne doesn't enter into it.
2 But certainly laser hair removal, yeah.

3 Q. You personally have never sat in
4 any meetings between a provider and a
5 patient where the doctor was trying to
6 diagnose whether the patient has gender
7 dysphoria; correct?

8 A. Correct.

9 Q. You have never sat in any
10 meetings between a provider and a patient
11 discussing their potential treatment
12 options for gender dysphoria; correct?

13 A. No.

14 Q. All right. You're not an
15 endocrinologist; right?

16 A. Correct.

17 Q. You're not a psychiatrist;
18 right?

19 A. Correct.

20 Q. You're not a licensed mental
21 healthcare provider of any kind; right?

22 A. Correct.

23 Q. In your professional day-to-day

1 vaginoplasty for a transgender patient?

2 A. No.

3 Q. You have never performed a
4 metoidioplasty for any transgender
5 patient?

6 A. No.

7 Q. You've never performed what's
8 colloquially known as bottom surgery for
9 any transgender patient; correct?

10 A. Correct.

11 Q. Fair to say you've never
12 performed any kind of gender-affirming
13 surgery in transgender patients; right?

14 A. Correct.

15 Q. And fair to say you don't have
16 recent and substantive experience in
17 performing gender-affirming -- -affirming
18 surgery for transgender patients;
19 correct?

20 MR. KNEPPER: Form.

21 A. I have -- I have substantive
22 experience with all the actual -- the
23 nature of the particular operations but

1 Q. The latest publicly available
2 standard of care is Version 7; correct?

3 A. Correct.

4 Q. And that was published in 2012;
5 right?

6 A. That's right.

7 Q. All right. Before you wrote
8 your report, did you sit down and review
9 the Standards of Care, Version 7 that
10 you're criticizing?

11 A. Yes, I did.

12 Q. All right. You yourself are not
13 part of the WPATH; correct?

14 A. No, I am not.

15 Q. You've never been part of the
16 WPATH; right?

17 A. I would never be part of the
18 WPATH.

19 Q. You've never advised the WPATH
20 in any capacity; right?

21 A. They've never asked my opinion.
22 No.

23 Q. You've never advised the WPATH

1 in any capacity; correct?

2 A. I have not.

3 Q. You personally have not been
4 involved with the development of WPATH's
5 Standards of Care, Version 7; correct?

6 A. Correct.

7 Q. You don't know what year the
8 WPATH started working on Version 7;
9 right?

10 A. My understanding was it was in
11 2007, but I could be wrong. I think it
12 was 2007. I think it was a five-year
13 process, but I could be wrong on that.

14 Q. You don't know for sure?

15 A. I don't know for sure.

16 Q. You don't know how many
17 different work groups at the WPATH were
18 involved with working on Version 7;
19 correct?

20 MR. KNEPPER: Objection, form.

21 A. In reading the -- the
22 introduction to the document, the number
23 nine pops into my mind, but I can't swear

1 to that.

2 Q. Okay. You don't know what kind
3 of scientific literature the WPATH
4 conducted as part of drafting Version 7;
5 right?

6 A. As far as naming the particular
7 papers that they may have reviewed, I
8 can't do that for you because those
9 are -- that happens in closed committee.
10 I -- all I can say to you is my -- based
11 upon my reading of the product and the
12 verbiage that it's used, my suspicion is
13 that it's pretty heavily weighted towards
14 the American literature and -- and does
15 not bring in particular document -- well,
16 being that it was published in 2012, the
17 big inflection point in 2011 probably
18 wasn't available to the committee when
19 they were writing that document.

20 So given that the document is
21 already out of date and it's -- and the
22 subsequent WPATH 8, no one knows when
23 it's going to come out, yeah, it's --

1 it's almost -- it's almost irrelevant
2 because of the change in the literature
3 that happened since it was published, so.
4 In particular, the 2011 article by
5 Dhejne, Cecilia Dhejne, and -- and others
6 that kind of changed the view of the
7 scientific evidence.

8 So yeah, it's an out-of-date
9 document by the standards of what are
10 called standards of care. It's not a
11 standards of care document. It's a --
12 it's a treatment guideline document is
13 really what it is, and it's a poorly
14 supported treatment guideline at that,
15 so -- gosh, I wandered off.

16 Did I -- did I answer your
17 question?

18 Q. Yeah, you anticipated my
19 objection.

20 MR. TISHYEVICH: Which, again,
21 I'll move to strike most of that as
22 nonresponsive.

23 Q. Because here's my question. You

1 don't personally know what kind of
2 scientific literature the WPATH conducted
3 as part of drafting Version 7; correct?

4 MR. KNEPPER: Objection, form.

5 A. No. Again, a closed session, so
6 I don't know what documents they used.

7 Q. You don't know what kind of
8 outside experts the WPATH may have
9 consulted in drafting Version 7; right?

10 A. No.

11 Q. You don't know what kind of peer
12 review the WPATH may have conducted as
13 part of developing Version 7; right?

14 MR. KNEPPER: Objection, form.

15 A. No.

16 Q. You don't know what kind of
17 public comments the WPATH may have
18 solicited as part of developing Version
19 7.

20 MR. KNEPPER: Objection, form.

21 Q. Right?

22 A. No.

23 Q. You don't know how many

1 different drafts the Version 7 went
2 through before it was finalized; right?

3 A. No.

4 Q. You don't know how many
5 different meetings or conferences the
6 WPATH had to discuss the development of
7 Version 7; right?

8 A. Correct.

9 Q. You have no idea what may have
10 gone on during those meetings or
11 conferences; correct?

12 MR. KNEPPER: Objection, form.

13 A. No. I was not a part of the
14 conferences that produced the product.

15 Q. Yeah, you are not an expert in
16 how Version 7 of the WPATH was developed;
17 right?

18 A. Correct.

19 Q. And we can go through all these
20 questions again individually for Version
21 8, but maybe we can shortcut this.

22 A. Well, no one knows what's in
23 Version 8 except the people who are in

1 the committee. It's a -- it's a
2 privileged document. There's no one in
3 plastic surgery who knows it apart from
4 the people who serve as members of the
5 WPATH, so that would be the case.

6 Q. Okay.

7 A. It's a -- it -- yeah.

8 Q. So just so we have it on the
9 record, you don't hold yourself out as an
10 expert on how Version 8 of the WPATH
11 Standards of Care are currently being
12 developed; fair?

13 A. Fair.

14 Q. Okay. We talked earlier about
15 the DSM; right?

16 A. Yes.

17 Q. In your day-to-day practice, you
18 don't use the DSM-5; correct?

19 A. No.

20 Q. But you do know the DSM-5 is
21 widely used by psychiatrists; correct?

22 A. Yes.

23 Q. The DSM-5 was published in 2013;

1 correct?

2 A. I don't know the publication
3 date, but it sounds about right.

4 Q. Do you know that it was
5 developed by the American Psychiatric
6 Association?

7 A. Yes.

8 Q. You're not a member of the APA;
9 right?

10 A. Correct.

11 Q. You personally have not been
12 involved with the development of DSM-5;
13 right?

14 A. No.

15 Q. You don't know how many
16 different working groups were involved
17 with developing the DSM-5; right?

18 MR. KNEPPER: Objection, form.

19 A. Correct.

20 Q. You don't know how many
21 different members those working groups
22 had; right?

23 MR. KNEPPER: Objection, form.

1 A. No.

2 Q. Or how they were selected;
3 right?

4 MR. KNEPPER: Objection, form.

5 A. Correct.

6 Q. You don't know how many
7 different authors contributed to the
8 development of DSM-5; correct?

9 A. Correct.

10 MR. KNEPPER: Objection, form.

11 Q. You don't know what kind of
12 scientific literature review was done by
13 different work groups as part of
14 developing the DSM-5; correct?

15 MR. KNEPPER: Objection, form.

16 A. Correct.

17 Q. You don't know what kind of
18 public comments the APA may have
19 solicited in developing the DSM-5;
20 correct?

21 MR. KNEPPER: Objection, form.

22 A. Correct.

23 Q. You don't know how many

1 different drafts the DSM-5 went through
2 before it was finalized; correct?

3 MR. KNEPPER: Objection, form.

4 A. Correct.

5 Q. You don't know how many
6 different meetings or conferences or
7 telephonic conferences the working groups
8 had to discuss the development of the
9 DSM-5; right?

10 MR. KNEPPER: Objection, form.

11 A. Right.

12 Q. You have no idea what was
13 discussed during any of those meetings;
14 right?

15 A. Right.

16 Q. Let me ask you specifically
17 about the Sexual and Gender Identity
18 Disorders Work Group. First of all,
19 before today, did you know that the APA
20 had a Sexual and Gender Identity
21 Disorders Work Group as part of the
22 development of the DSM-5?

23 MR. KNEPPER: Objection, form.

1 A. Yes.

2 Q. Do you know how many members
3 were in that work group?

4 A. No.

5 Q. You don't know --

6 MR. KNEPPER: Objection.

7 Q. -- how those members were
8 selected; right?

9 MR. KNEPPER: Objection to form.

10 A. Correct.

11 Q. You don't know their expertise;
12 right?

13 A. Correct.

14 Q. You do not have expert firsthand
15 knowledge of how the DSM-5 was developed;
16 fair?

17 MR. KNEPPER: Objection, form.

18 A. Fair.

19 Q. Are you aware that the DSM-4
20 used the term "gender identity disorder"
21 instead of "gender dysphoria"?

22 A. Yes.

23 Q. Do you know the reason for that

1 faces is that having done that, there's
2 no mechanism for providing the services
3 that they felt that the patients needed,
4 so there had to be a diagnose -- a
5 diagnostic code in order to get
6 thirty-part -- third-party payers to pay.
7 So it's a de-pathologize but maintain a
8 diagnostic -- diagnostic code. That's my
9 understanding of it.

10 Again, I wasn't there. But
11 again, reading the writings of people who
12 could only have gleaned it from having
13 been present because it's closed session,
14 that's my understanding.

15 Q. Understood. All right. Do you
16 know what the Endo- -- Endocrine Society
17 guidelines for treatment of
18 gender-dysphoric or gender-incongruent
19 persons are?

20 A. Do I know what they are?

21 Q. Yeah.

22 A. Yes.

23 Q. Do you know when they were

1 initially published?

2 A. No.

3 Q. Do you know when they were last
4 revised?

5 A. I think it was just a couple of
6 years ago, but I don't know the exact
7 date.

8 Q. If I tell you it's 2017, does
9 that sound right?

10 A. That wouldn't -- it wouldn't
11 surprise me if that were true. I -- just
12 within the last couple of years. I think
13 theirs are current, and the expectation
14 is that these standards of care or
15 treatment guidelines will have a
16 five-year revision. So given that
17 they're current, they couldn't be any
18 older than, say, 2017. So I suspect that
19 -- yeah.

20 Q. All right. Did you review the
21 latest available version of those
22 Endocrine Society guidelines before
23 forming your opinions in this case?

1 A. Yes. I have read them, yes.

2 Q. Okay. You yourself are not part
3 of the Endocrine Society; right?

4 A. Correct.

5 Q. Have never been part of that
6 society; right?

7 A. Correct.

8 Q. You've never advised the
9 Endocrine Society in any capacity;
10 correct?

11 A. Correct.

12 Q. You personally were not involved
13 with the development of these original
14 guidelines; correct?

15 A. That's correct.

16 Q. Not personally involved with the
17 development of the updated guidelines in
18 2017; right?

19 A. Correct.

20 Q. Do you know how many people at
21 the Endocrine Society were involved with
22 those 2017 updates?

23 A. I do not know that number.

1 Q. And you don't know how they were
2 selected to work on the 2017 updates;
3 correct?

4 A. Correct.

5 Q. You personally don't know what
6 kind of scientific literature review the
7 Endocrine Society conducted in developing
8 those updates; correct?

9 MR. KNEPPER: Objection to form.

10 A. Correct.

11 Q. You don't know what kind of
12 outside experts they may have used;
13 right?

14 A. What kind of outside experts? I
15 would imagine they were all
16 endocrinologists. Or are you asking did
17 they have plastic surgeon input or --

18 Q. Do you know specifically whether
19 the Endocrine Society used any outside
20 experts in updating the -- in
21 implementing the 2017 updates?

22 A. Well --

23 MR. KNEPPER: Objection, form.

1 A. I can only infer that they
2 would, because such -- such statements,
3 in order to be valid, demand review by
4 outside parties to -- to obviate
5 conflicts of interest, whether financial
6 or professional. Those are all issues
7 when generating standards of care, so of
8 necessity, they would have had to have
9 had outside experts to come in, yes.

10 Q. Okay. Do you know what kind of
11 public comments the Endocrine Society may
12 have solicited as part of developing the
13 2017 updates?

14 A. I don't.

15 MR. KNEPPER: Objection to form.

16 Q. You don't know how many
17 different drafts there were of those 2017
18 updates before they were finalized;
19 right?

20 A. No.

21 MR. KNEPPER: Objection to form.

22 A. No, I don't.

23 Q. Again, you haven't been to any

1 meetings or conferences or telephonic
2 conferences where those 2017 updates were
3 discussed, where the development of those
4 2017 updates was discussed; correct?

5 MR. KNEPPER: Objection to form.

6 A. Correct.

7 Q. You don't know what went on
8 during those meetings or conferences;
9 right?

10 MR. KNEPPER: Objection, form.

11 A. I do not.

12 Q. You -- you're not an expert in
13 how the Endocrine Society developed the
14 original 2009 guidelines for treating
15 gender dysphoria; correct?

16 MR. KNEPPER: Objection to form.

17 A. That's not -- that's not my area
18 of expertise. That's correct.

19 Q. Right. And you're also not an
20 expert in how the Endocrine Society then
21 developed the 2017 updates back to those
22 guidelines; correct?

23 A. Correct.

1 endocrinologists, yes.

2 Q. Right. You have no specialized
3 training or expertise in endocrinology;
4 correct?

5 A. Correct.

6 Q. You don't hold yourself out as
7 an expert in endocrinology; correct?

8 A. No, I do not.

9 Q. You're not planning on offering
10 any expert opinions in endocrinology in
11 this case because that's outside your
12 scope of expertise; right?

13 A. Yes.

14 MR. KNEPPER: Objection to form.

15 Q. All right. Earlier, you said
16 you have never prescribed
17 puberty-blocking agents to anyone, so I
18 take it you have no experience, no
19 firsthand experience with advising your
20 patients about potential risks and
21 benefits of puberty blockers; right?

22 MR. KNEPPER: Objection, form.

23 A. Well, I have talked to patients

1 A. Yes.

2 Q. For transgender women, estrogen
3 is a hormone that's typically prescribed;
4 right?

5 A. Yes.

6 Q. For transgender men,
7 testosterone is the hormone that's
8 typically prescribed; right?

9 A. Right.

10 Q. You've never prescribed
11 cross-sex hormones for treatment of
12 gender dysphoria to anyone; correct?

13 A. Correct.

14 Q. You have no firsthand experience
15 with advising your patients about
16 potential risks and benefits of cross-sex
17 hormones when used for treatment of
18 gender dysphoria; correct?

19 A. Correct.

20 Q. You personally don't know what
21 doctors who do prescribe estrogen or
22 testosterone to their patients for gender
23 dysphoria tell those patients about the

1 Okay.

2 Q. So the first two bullets say,
3 "Why must we consider first the nature of
4 the human person?" Then it says,
5 "Defines the 'end' of medical and
6 surgical care."

7 A. Yes.

8 Q. What does it mean that it
9 "defines the 'end' of medical and
10 surgical care"?

11 MR. KNEPPER: Objection, form,
12 scope.

13 A. Okay. So that's a -- that's a
14 term that dates back to Aristotelian
15 philosophy. And what it has to do is
16 what is the purpose or what is the
17 ultimate arc of a particular thing. So
18 the "end" meaning what are you seeking to
19 accomplish, what is the final goal of
20 that -- of that medical or surgical
21 treatment.

22 So -- and the examples I use are
23 you have to have an understanding, for

1 Q. The top left says, "Shaping the
2 Conversation, & Grooming a Generation."

3 A. Right.

4 Q. You see that?

5 A. Right.

6 Q. What do you mean by "grooming a
7 generation"?

8 A. Grooming is a -- is a process by
9 which ideas are introduced that make
10 subsequent actions possible, so that's
11 what -- that's what grooming is, yeah.

12 Q. Grooming is sometimes used to
13 refer to preparing to -- strike that.

14 Grooming is sometimes used as
15 preparing children for sexual abuse.
16 Isn't that true?

17 A. That's one of the --

18 MR. KNEPPER: Objection, form,
19 scope.

20 A. That's one of the uses of
21 grooming, yeah, but it's not exclusive
22 use of grooming. Yeah. And I discuss
23 this in this -- in this slide. Yes, I

1 do.

2 Q. And you think that discussing
3 gender identity issues with children
4 means sexualizing them; right?

5 A. Yes, I do. Absolutely, I do.

6 MR. KNEPPER: Objection, form,
7 scope.

8 Q. And you think that discussing
9 gender identity issues with children
10 means grooming them for potential later
11 sexual abuse; right?

12 MR. KNEPPER: Objection, form,
13 scope.

14 A. No. No. What we're talking
15 about here is grooming them for -- for
16 future -- what's the word I would want to
17 choose carefully? It's preparing them
18 for these interventions is what it does.
19 It lays the groundwork for it by
20 sexualizing their thoughts in a way
21 that's -- is not consonant with their
22 best interest. That's what this slide is
23 about, so --

1 may be sexual but not necessarily sexual.
2 And so this is -- one of the things I
3 talk about in that slide is -- is for the
4 people who are care providers,
5 counselors, school administrators, to be
6 alert to that possibility.

7 So I'm sorry, we were going to
8 move on to the next one.

9 Q. Do you have the next exhibit?

10 A. And that is Exhibit 34?

11 Q. Yeah.

12 A. Okay.

13 Q. All right. This is a printout
14 from LifeSite, and the title is "Plastic
15 surgeon: Sex-change operation 'utterly
16 unacceptable' and a form of 'child
17 abuse.'" Right?

18 A. Yes.

19 Q. And it says, "Dr. Patrick
20 Lappert, a Catholic deacon in Alabama,
21 says changing a person's sex is a lie and
22 also a moral violation for a physician."
23 Right?

1 A. Yes.

2 Q. And you hold those views --

3 A. I do.

4 Q. -- correct?

5 A. I do.

6 MR. KNEPPER: Objection, form,
7 scope.

8 Q. Go to page 2.

9 A. Okay.

10 Q. This was published in September
11 2019; right?

12 A. Yes.

13 Q. This is reporting on you
14 appearing on a broadcast of something
15 called the "Relevant Radio's Trending
16 With Timmerie."

17 A. Yes.

18 Q. Right?

19 A. Yes.

20 Q. You made that appearance; right?

21 A. On the radio, yes.

22 Q. Okay. Look -- look to the fifth
23 paragraph on page 2.

1 C E R T I F I C A T E

2 STATE OF ALABAMA)

3 COUNTY OF JEFFERSON)

4 I hereby certify that the above
5 and foregoing proceeding was taken down
6 by me by stenographic means, and that the
7 content herein was produced in transcript
8 form by computer aid under my
9 supervision, and that the foregoing
10 represents, to the best of my ability, a
11 true and correct transcript of the
12 proceedings occurring on said date at
13 said time.

14 I further certify that I am
15 neither of counsel nor of kin to the
16 parties to the action; nor am I in
17 anywise interested in the result of said
18 case.

19 /s/ Lane C. Butler

20 LANE C. BUTLER, RPR, CRR, CCR

21 CCR# 418 -- Expires 9/30/22

22 Commissioner, State of Alabama

23 My Commission Expires: 2/11/25

1 John G. Knepper, Esquire

2 john@knepperllc.com

3 October 13, 2021

4 RE: Kadel, Et Al v. Folwell

5 9/30/2021, Patrick Lappert, M.D. (#4814384)

6 The above-referenced transcript is available for
7 review.

8 Within the applicable timeframe, the witness should
9 read the testimony to verify its accuracy. If there are
10 any changes, the witness should note those with the
11 reason, on the attached Errata Sheet.

12 The witness should sign the Acknowledgment of
13 Deponent and Errata and return to the deposing attorney.
14 Copies should be sent to all counsel, and to Veritext at
15 erratas-cs@veritext.com

16
17 Return completed errata within 30 days from
18 receipt of transcript.

19 If the witness fails to do so within the time
20 allotted, the transcript may be used as if signed.

21
22 Yours,

23 Veritext Legal Solutions
24
25

Kadel, Et Al v. Folwell

Patrick Lappert, M.D. (#4814384)

E R R A T A S H E E T

PAGE_____ LINE_____ CHANGE_____

REASON_____

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REASON_____

Patrick Lappert, M.D.

Date

1 Kadel, Et Al v. Folwell

2 Patrick Lappert, M.D. (#4814384)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Patrick Lappert, M.D., do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Patrick Lappert, M.D.

_____ Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

16
17
18 _____
19 NOTARY PUBLIC
20
21
22
23
24
25

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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EXHIBIT E

**IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION**

DYLAN BRANDT, et al.,

PLAINTIFFS,

v.

No. 4:21-CV-00450-JM

LESLIE RUTLEDGE, et al.,

DEFENDANTS.

DECLARATION OF DR. PATRICK W. LAPPERT

Pursuant to 28 U.S.C. 1746, I declare:

I. KNOWLEDGE, TRAINING, AND EXPERIENCE

1. **Education and Training:** I received my Bachelor of Arts in Biological Sciences at the University of California, Santa Barbara, 1979. There I was engaged in research in cell membrane physiology with Dr. Philip C. Laris, studying stoichiometry of the sodium: potassium ATPase pump. I received my M.D., Doctor of Medicine degree at the Uniformed Services University of the Health Sciences, 1983 at Bethesda, Md. I served my General Surgery Residency at the Naval Hospital Oakland/UC Davis East Bay Consortium, 1987-1991 and served as Chief Resident, Department of Surgery, Naval Hospital Oakland, 1990-1991. I also served a Plastic Surgery Residency at the University of Tennessee-Memphis, 1992-1994. My professional background, experience, and publications are described in more detail in my curriculum vitae, which is attached as Exhibit A to this declaration.

2. **Board Certifications in Medicine:** I have been Board Certified in Surgery (American Board of Surgery, 1992), in Plastic Surgery (American Board of Plastic Surgery, 1997; American Board of Plastic Surgery, 2008).

3. **Medical Staff Appointments:** I served as the Staff General Surgeon at the Naval Hospital Oakland, CA 1991-1992 and as Associate Professor of Surgery, UC Davis-East Bay,



1991-1992. I also served as a Plastic and Reconstructive Surgeon, Naval Medical Center, Portsmouth, Virginia, 1994-2002 and as Chairman, Department of Plastic and Reconstructive Surgery, Naval Hospital Portsmouth, Virginia, 1996-2002. I later served as Clinical Assistant Professor, Department of Surgery, Uniformed Services University of the Health Sciences, 1995-2002 and as Founding Director, Pediatric Cleft Palate and Craniofacial Deformities Clinic, Naval Hospital Portsmouth, Virginia, 1996-2002 also as the Founding Director, Wound Care Center, Naval Hospital Portsmouth, Virginia, 1995-2002. I have also served as a Staff Plastic Surgeon in Nebraska and Alabama.

4. **U.S. Surgeon General Service:** I served as a Specialty Leader, Plastic and Reconstructive Surgery, Office of the Surgeon General-USN, 1997-2002.

5. **Faculty Appointments:** I served as Teaching Faculty at Eastern Virginia Medical School, Division of Plastic Surgery, 1995-2002. I also served on the teaching faculty of the Via College of Osteopathic Medicine, 2017-2020.

6. **Military Service:** I served as an Aviation Officer Candidate, Naval Aviation Schools Command, NAS Pensacola, 1978 and was Commissioned an Ensign, MC, USNR 1979 and Commissioned as a Lieutenant, MC, USN 1983. I served as a Designated Naval Flight Surgeon, Naval Aerospace Medical Institute, 1985, and I was Assigned Marine Fighter/Attack Squadron-451, serving as Flight Surgeon, and serving as Radar Intercept Officer in the Marine F-4S Phantom, accumulating 235 flight hours, and trained for qualification as an Air Combat Tactics Instructor. I was deployed to the Western Pacific as UDP forward deployed fighter squadron in Korea, Japan, and the Philippines. I served in the US Navy for 24 years, and I served in the USMC for 3 years. I retired with the rank of Captain, USN in 2002.

7. **Publications - Peer Reviewed Medical Journals:** Lappert PW. Peritoneal Fluid in Human Acute Pancreatitis. *Surgery*. 1987 Sep; 102(3):553-4; Toth B, Lappert P. Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning. *J Plastic and Reconstructive Surgery*. 1991; 87 (6): 1048-53; Lappert P. Patch Esophagoplasty. *J Plastic and Reconstructive Surgery*. 1993; 91 (5): 967-8; Smoot E C III, Bowen D G, Lappert P, Ruiz J A. Delayed development of an ectopic frontal sinus mucocoele after pediatric cranial trauma. *J Craniofacial Surg*. 1995;6(4):327–331; Lappert PW. Scarless Fetal Skin Repair: “Unborn Patients” and “Fetal Material”. *J Plastic and Reconstructive Surgery*. 1996 Nov; 98(6): 1125; Lappert PW, Lee JW. Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation. *Plastic and Reconstructive Surgery* 1998; 102(5): 1642-5.

8. **Publications - Medical Textbooks:** Wound Management in the Military. Lappert PW, Weiss DD, Eriksson E. *Plastic Surgery: Indications, Operations, and Outcomes*, Vol. 1; 53-63. Mosby. St. Louis, MO 2000.

9. **Operations and Clinical Experience - Consultations and Discussions:** As a physician and surgeon, I have treated many thousands of patients in 7 states and 4 foreign nations. My practice has included Primary Care, Family Medicine, Aerospace Medicine, General Surgery, Reconstructive Surgery for combat injured, cancer reconstructive surgeries including extensive experience with microvascular surgery, Pediatric Congenital Deformity, and the care of chronic wounds. I have practiced in rural medicine, urban trauma centers, military field hospitals, university teaching hospitals, and as a solo private practitioner. In my private practice I have had occasion to treat many self-identified transgender patients for skin pathologies related to their use of high dose sex steroids, laser therapies for management of facial hair both in transi-

tioners and detransitioners. I have performed breast reversal surgeries for detransitioning patients. My practice is rated as “LGBTQ friendly” on social media. I have consulted with families with children who are experiencing gender discordance. I have given many presentations to professional meetings of educators and counselors on the subject of transgender, and the present state of the science and treatment. I have discussed the scientific issues relevant to the case with many physicians and experts over a number of years and also discussed related issues with parents and others.

10. **Retained as an Expert Witness - Compensation - Bases for Opinions:** I have been retained as an expert witness by the State of Arkansas for the defense in connection with this litigation. I have actual knowledge of the matters stated in this declaration. I am being compensated at an hourly rate for actual time devoted, at the rate of \$400 per hour including report drafting, travel, testimony, and consultation. My compensation does not depend on the outcome of this litigation. To formulate opinions in this case I have reviewed many scientific publications, case filings, and the plaintiffs’ witness declarations.

11. **Expert Report Limitations:** My opinions and hypotheses in this matter are — as in all expert witness reports — subject to the limitations of documentary and related evidence, the impossibility of absolute predictions, as well as the limitations of social, biological, and medical science. All opinions are offered to a reasonable degree of medical certainty. I have not met with, nor personally interviewed, anyone in this case. As always, I have no expert opinions regarding the veracity of witnesses in this case. I have not yet reviewed all of the evidence in this case and my opinions are subject to change at any time as new information becomes available to me. Only the trier of fact can determine the credibility of witnesses and how scientific research may or may not be related to the specific facts of any particular case. In my opinion, a key role

of an expert witness is to help the court, lawyers, parties, and the public understand and apply reliable scientific, technical, and investigative principles, hypotheses, methods, and information.

II. GENDER AFFIRMING TREATMENTS ARE EXPERIMENTAL.

12. “Gender affirming” treatments remain experimental as the historic Branstrom study and National Reviews in England, Sweden, and Finland indicate. “Gender affirming” treatments (i.e., hormones and surgery) have not been proven effective, or even competently tested. Such “treatments” are not generally accepted by the relevant scientific community and have no documented error rates (See, Daubert/Kumho). Patients who experience a gender identity that is discordant with biological sex have an alarmingly high incidence of serious psychosocial morbidity including depression, anxiety, eating disorders, substance abuse, HIV infection, suicidality, and homelessness. Connolly, M. D., M. J. Zervos, C. J. Barone, C. C. Johnson, and 2nd C. L. Joseph. 2016. “*The Mental Health of Transgender Youth: Advances in Understanding.*” *Journal of Adolescent Health* 59:489–95. :10.1016/j.jadohealth.2016.06.012. While a need for effective treatment modalities is clear, there are currently significant deficiencies in our understanding of the etiology of this condition, of the risks and benefits of the current experimental (unproven, untested) medical interventions, and of the long-term success of various “affirmation” treatments in achieving the primary desired goal of reducing mental illness including reductions in suicide risk.

13. Multiple recent studies and reviews including the recent national science summaries and guidelines from England-NICE, Sweden, Finland, the Cochrane Review, the British Royal College of Psychiatrists and others all document significant deficits in our current understanding of these complex disorders and significant defects in the “low quality,” contradictory, and controversial existing evidence. As we strive to provide real, effective, and sustained treat-

ment to patients who experience gender dysphoria within established ethical boundaries, it is essential that we properly and scientifically research the causes of gender dysphoria as well as conduct competent, properly conducted randomized clinical trials and long-term treatment outcome studies. These basic, foundational tasks — the tasks that make experimental procedures actual, proven treatments worthy of trust — have *never been accomplished in the highly controversial field of the transgender treatment industry*. Why? Suffering and vulnerable patients and their families continue to wait for this basic, foundational scientific work to be completed. Meanwhile, affirmation “treatments” are properly viewed as experimental. (See detailed citations in the “Notes” section of this report below).

14. The science and medical world have — in just the past few years — become increasingly aware of and deeply concerned about the glaring science and ethical defects of the transgender treatment industry. For example, the very recently released 2020 Finland national science review and guidelines documented “a lack of quality evidence to support the use of hormonal interventions in adolescents with gender dysphoria.” The new strict Finnish guidance prioritizes psychological therapy over treatment with hormones or surgery, thus directly contradicting the non-science-based association protocols of WPATH. The 2020 Finland national science review and guidelines also document the ongoing lack of scientific basis for the transgender treatment industry, stating “Only limited research has been conducted on transgender identity and other gender identity conflicts, and comparative studies are very rare.” In sum, the Finland National Science Review and Guidelines, like the new Sweden Review and Guidelines, the Cochrane Review, and other reviews, and the collapse and recantation of the 2020 Branstrom long-term treatment outcome study (which proved *no benefits* to these “treatments”) claims, all

appear contrary to the opinions of plaintiffs’ experts, WPATH, and the endorsements of professional associations. (See detailed citations in the “Notes” section of this report below).

15. Meanwhile, practitioners in this troubled field continue to offer defective research and politicized endorsements from politicized, union-like associations (WPATH, APA, ACP, etc.) rather than competent, credible, valid, and reliable peer-reviewed and published scientific evidence. The plaintiffs’ experts failed to even discuss the serious defects and methodological limits of transgender medicine data and experimental practices. Fifty years of experimenting is enough. It is time for the transgender treatment industry to come up with real, competently constructed scientific evidence that they help more people than they hurt. As the recent national science reviews from England, Sweden, the Cochrane Review, and Finland have all noted, it is time to step back, slow down, and prudently investigate a range of approaches — including years of careful psychotherapy prior to experimental sterilizing “treatments” — to vulnerable patients struggling with gender discordance issues. (See detailed citations in the “Notes” section of this report below).

III. THE ETHICS OF PLASTIC SURGERY

A. “Chest Masculinization” in Natal Females is Not Ethically Equivalent to Mastectomies for Breast Cancer.

16. When mastectomy is performed for the management of breast cancer, or to mitigate the proven risk of developing breast cancer in women, it is done on the basis of objective diagnoses either by pathological examination of biopsy tissue, or as in the case of prophylactic mastectomy, on the basis of genetic analysis that shows known markers of increased risk of developing breast cancer. These tests (microscopic examination of tissue specimens, detection of cell surface markers with proven association with malignancy, and genetic screening of at-risk patients) have known positive predictive value for the diagnosis of breast cancer, and these tests

have known error rates that can be used when obtaining informed consent for mastectomy. The validity of these tests has been proven using scientific methodologies that produce high quality evidence in longitudinal population studies with control populations, and very long follow up. As the result, when a woman gives consent for mastectomy to control or prevent the potentially lethal disease, it is with a clear and proven evaluation of the risks and benefits that consent is obtained. Mastectomy is being performed based upon an objective diagnosis of a potentially lethal condition, and the surgical procedure has proven benefit in management of that condition.

17. In stark contrast, this is not the case when mastectomy is performed to “masculinize” the chest of girls and women who self-identify as transgender or who self-report symptoms of dysphoria. Otherwise healthy breasts are being removed on the basis of a diagnosis that is made by the patient since there are no tests with known error rates that can be used to predict who will benefit from this disfiguring and irreversible surgery. The claim is made that chest masculinization has proven benefit in reducing dysphoria and the associated risk of suicide. But published studies that make this claim of benefit offer evidence that is low to very low quality, typically small case collections with self-selection bias, very short follow up, and no case controls.

18. The best data presently available on the long-term effects of medical and surgical transitioning are long-term, longitudinal, population based studies. For example, Dehjne, et al., examined the putative long-term benefit of full transitioning (including hormonal and surgical treatments) found in the Swedish medical database. (See Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden; Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Långström, Mikael Landén; PLOS One February 22, 2011 <https://doi.org/10.1371/journal.pone.0016885>). That database includes

all persons in the Swedish medical system, from pre-natal to death. It reports all episodes of care and all demographic information in a uniform vocabulary. Furthermore, Sweden has been on the forefront of “gender affirmation” long before the American medical system seriously considered its claims. Because of the nature of Sweden’s database, it is possible to study a cohort of patients that exactly matches the inquiry group with regards to age, sex, economic status, etc. It is possible to ask precisely such questions as, “What is the likelihood that a fully transitioned transgender male will be hospitalized for psychiatric illness when compared to the age/sex matched control group?” or “What is the relative risk of suicide in transgender persons, when compared to age/sex matched controls?”

19. Why are such longitudinal, population based studies superior to the case-collection/case series methodology? Because confounding variables such as age, sex, and self-selection biases are removed. In the flawed case-collection methodology, the reported cases are typically only those who return for follow up. You have no way of knowing if the patient had a good outcome or didn’t return for follow up because they were in a psychiatric hospital, were incarcerated, or committed suicide. In the Swedish longitudinal study, the suicide is in the same database, as are the other issues of hospitalization, incarceration, and addiction treatment, among other rates of comorbidity. Thus the longitudinal population study can give us what is called a “hazard ratio” for a particular study population (patients who have completed transgender transition).

20. What did this Swedish study show us? It showed us that the risk of completed suicide in all transgender persons is *19.1 times higher* than in the control cohort. If you look only at patients who have transitioned — patients after “treatment” — from female to “male presentation,” the risk of completed suicide is *40 times higher* than in the general population.

(Note: this finding is consistent with the historic Bränström 10yr follow up study, which found no benefits to “transitioning treatments” but did note an increased risk of serious suicide attempts and anxiety disorders AFTER “treatment.” (Correction to Bränström and Pachankis, Am J Psychiatry 177:8, August 2020; see detailed citations in the “Notes” section of this report below).

21. Another cautionary note was added to the literature review by the reputed Cochrane Review, a UK based international association of researchers who examine the quality of scientific evidence used in medical decision making. The Cochrane Review recently published findings concerning the medical evidence used to support the decision to give young women cross sex hormones as part of the transition process. The authors summarize the world literature review thus: “We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition. This lack of studies shows a gap between current clinical practice and clinical research.” (Does hormone therapy help transgender women undergoing gender reassignment to transition? See, Haupt C, Henke M, Kutschmar A, Hauser B, Baldinger S, Saenz SR, Schreiber G., Cochrane Review, 28 Nov 2020).

22. Similar issues of very poor, low quality scientific support for chest masculinization surgery can be seen in a recent article by Tolstrup et al. published in the journal Aesthetic Plastic Surgery (See Anders Tolstrup, Dennis Zetner, Jacob Rosenberg, Outcome Measures in Gender-Confirming Chest Surgery: A Systematic Scoping Review, Aesthetic Plast Surg 2020 Feb;44(1):219-228. doi: 10.1007/s00266-019-01523-1. Epub 2019 Oct 29). The article reports a comprehensive review of the world literature concerning the efficacy of “gender confirming” chest surgery in transgender patients. The authors found 849 articles on the subject, published in peer reviewed medical journals. Of these 849 articles, only 47 could be included in the review. This means that only 5.5% of all the published, peer-reviewed transgender surgery articles

demonstrated even rudimentary scientific rigor. Of those 47 articles, the authors report that only 29 of the articles addressed mental health outcomes (3.4% of all the articles). What is startling is that the mental health outcomes were judged only on the basis of uncorroborated, untested, and unassessed patient subjective reporting with descriptors that varied so widely from article to article that results could not even be compared. The authors summarize by saying, “Evaluation of outcomes in gender-confirming chest surgery showed large variations in reporting, and further streamlining of reporting is therefore required to be able to compare surgical outcomes between studies.” None of these negligent articles even bothered to examine rates of psychiatric hospitalization, substance abuse, self-harm behaviors, and suicide. This tells us that the main reason for performing these surgeries (psychological distress and suicide risk) isn’t even evaluated with regard to efficacy.

23. An example of an article with very low quality data, reckless (now banned practices), and methodology, published in a “leading journal,” and promoted as evidence for the efficacy of “chest masculinization” surgery makes this fact very clear. The lead author (Olson-Kennedy, a leading national advocate for the transgender treatment industry) is a board certified pediatrician who leads the gender clinic for the Los Angeles Children’s Hospital. The article appeared in 2018 (See J. Olson-Kennedy, J. Warus, MD1, et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults; Comparisons of Nonsurgical and Postsurgical Cohorts.*, JAMA Pediatr. 2018;172(5):431-436. doi:10.1001/jamapediatrics.2017.5440). In their summary of findings, the authors reported that “chest dysphoria” is common among “trans males” (natal females seeking to present as males), and claimed that dysphoria is “decreased by surgery.” They claim that regret for surgery is “rare.” The article reports breast removal surgery on at least one girl aged 13 years. (Note that this reckless, experimental

practice has now apparently been abandoned as unethical/experimentation on children by England, Sweden, and Finland). The average age of patients in the study was 19. Children were entered into the study through recruitment from among patients visiting the clinic and by telephone over a six month period. The authors found that of the patients recruited from among visitors to the clinic (convenience sampling) there was an abundance of non-operated patients, so they were forced to reach out to all the post-surgical patients by phone. Twenty-six percent of the clinic's post-surgical patients could not be reached for various reasons including no working phone, or failure to respond to multiple messages. The 26% drop-out rate is never even questioned by these authors. Were surgical patients lost to follow up because of dissatisfaction, psychiatric hospitalization, or *suicide*? This problem is called "self-selection bias," and it is evidence of careless study design. Of the remaining 74% of patients, only 72% completed the survey. This is a second example of self-selection bias. Why would some post-surgical patients who had been successfully contacted, not complete the survey? The authors — demonstrating multiple levels of confirmation bias — do not even ask such essential questions. (See detailed citations in the "Notes" section of this report below).

24. In the study, dysphoria was evaluated using what the author called "a novel measure," which amounted to a series of subjective questions about happiness that was in part designed by the adolescent test subjects themselves. Essentially, the methodology used an entirely unvalidated ("junk science") test instrument, with no known error rates and no proven predictive power. Furthermore, the post-surgical patients were administered the survey at widely varying time intervals post-surgery. The longest interval between surgery and the satisfaction survey was 5 years, but children less than a year post-surgery were included in this obviously flawed sample, and yet the authors claim evidence of "negligible regret." This is a remarkable, misleading, and

deceptive claim given that long-term, longitudinal population studies show that there is a dramatic rise in post-surgical problems such as depression, hospitalization, substance abuse, and suicide beginning at around 7 years post-surgery (Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden; Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Långström, Mikael Landén; PLOS One February 22, 2011 <https://doi.org/10.1371/journal.pone.0016885>). Surely the authors are familiar with the world literature on transgender outcomes?

25. Having deceptively or negligently promised in the introduction to their paper that “chest dysphoria” is reduced by surgery, at the conclusion the authors confessed to the fact that the study design and execution produced very low quality data that is not useful for patient selection, or prediction of outcomes. They even confessed that the study does not address the efficacy of surgery in improving outcomes regarding the single most compelling reason for performing the operation: mitigation of depression and suicide. The authors write: “An additional limitation of the study was the small sample size. The nonsurgical cohort was a convenience sample, recruited from those with appointments during the data collection period. There could be unknown imbalances between the nonsurgical and postsurgical cohorts that could have confounded the study findings.”

26. Finally, the authors did not even bother to validate their “Chest Dysphoria Scale.” Such a “made-up” scale is unlikely to accurately represent distress or correlate with properly validated measures of quality of life, depression, anxiety, or functioning.” Their own analysis at the conclusion of the paper directly contradicts their own deceptive claim made in their introduction.

27. This is the kind of “junk science” that is used to support transgender medicine and surgery. It was written by board certified physicians who practice in one of the nation’s largest pediatric gender clinics and published in a peer-reviewed medical journal. It is essentially useless in making any clinical decisions regarding who should be offered surgery, what is the likelihood they will benefit from it, what is the likelihood they will regret their decision, and most importantly, whether their risk of suicide would be reduced.

28. Because of the very low quality scientific support for mastectomy in the management of gender dysphoria, valid consent would require that these procedures be described as experimental, would need the approval of ethics panels to monitor human experimentation, and would require the use of valid controls found in long-term, longitudinal population based study models. These are the kinds of patient protections now endorsed in England, Sweden and Finland but still ignored in the US environment where proper scientific critiques of such studies can get faculty “cancelled.” (See detailed citations in the “Notes” section of this report below).

29. Even though the transgender treatment industry has been performing these surgeries for over 50 years, gender treatment centers continue to publish the same low quality, methodologically defective studies based upon collected cases that are degraded in value by self-selection bias, confirmation bias, and short-term follow-up, while continuing to deceptively claim that such defective research provides a sufficient scientific basis for performing irreversible, disfiguring, and ultimately sterilizing hormonal treatments and surgeries. (See detailed citations in the “Notes” section of this report below).

B. “Chest Masculinization” in Natal Females is Not Ethically Equivalent to Gynecomastectomy.

30. Gynecomastectomy is the surgical treatment of gynecomastia, a fairly common condition in which males develop female-type breast gland tissue. Proponents of “masculinization” mastectomy in natal females erroneously equate the ethics of removing healthy breast tissue from these patients with the removal of abnormal breast tissue in men (gynecomastia). In the case of gynecomastectomy in male patients, the operation is performed to remove the objectively diagnosed presence of female type glandular breast tissue present in a male patient. Physical examination demonstrates the presence of a dense retro-areolar mass which is tender and sometimes disfiguring. Pathological examination of the removed tissue will demonstrate the presence of female-type fibroglandular tissue in a male patient. This is an objectively abnormal condition. It should further be noted that in the absence of such abnormal, female-type fibroglandular tissue, chest recontouring is considered to be cosmetic, and is typically not paid for by third-party payors.

31. I have never read a peer reviewed journal article which discusses the indications for gynecomastectomy that included any claim to reduce major depression and suicide. This is because any male patient seeking removal of abnormal, female-type, breast tissue who reported suicidal ideation would be considered incompetent to give consent, and would require a psychiatric evaluation and treatment to manage suicidal thinking before being considered for surgery.

C. “Chest Masculinization” in Natal Females is Not Ethically Equivalent to Breast Reduction.

32. It should be obvious that “Chest Masculinization” surgery in natal females is not ethically equivalent to breast reduction surgery in non-transgender females. In the case of breast reduction for females with excessively large breasts (macromastia, or gigantomastia), the operation is performed to relieve a debilitating orthopedic complaint of neck, back, and shoulder pain

associated with the postural/mechanical effects of the weight of the breasts. These patients experience significant activity restriction and chronic pain that is not relieved by medical management or physical therapy. Furthermore, there is voluminous actuarial data, based upon many years of longitudinal population based study by medical insurance agencies that is used to predict who will benefit from surgery, and who will not. These physical, objective tests, based upon the actual measurement of the breasts, and the patient's overall body habitus, have known error rates that can be used to predict the likelihood that a breast reduction will relieve the orthopedic complaints of neck, back, and shoulder pain. When the tissue specimens are submitted to pathology, they are weighed in order to ensure that enough tissue has been removed so that there will be a very high likelihood that the surgery will relieve the orthopedic condition of neck, back, and shoulder pain (Accuracy of Predicted Resection Weights in Breast Reduction Surgery, Theodore A. Kung, MD, Raouf Ahmed, MBBS¹ Christine O. Kang, MPH,¹ Paul S. Cederna, MD, and Jeffrey H. Kozlow, MD; *Plast Reconstr Surg Glob Open*. 2018 Jun; 6(6): e1830.

33. Based upon that, adequate pre-operative consent can be obtained. The supporting data is based in very high quality methodology. There is no quality research data, no pre-operative test or study, and no known error rates, that can be used to predict the likelihood that any child suffering from gender dysphoria will benefit from the experimental procedures of mastectomy and chest "masculinization." As noted above, because of the very low quality data, transgender chest masculinization is at best experimental and at worst, should be viewed as a form of medical child abuse — it is important to note that Finland, Sweden, and the UK appar-

ently now all agree with this analysis, as they have all retreated from such reckless surgical procedures for minors — similar to what Arkansas’s science-informed, responsible legislature has now done. (See detailed citations in the “Notes” section of this report below).

34. It is crucial to remember that “chest masculinization” of healthy breast tissue results in a complete loss of function, that this loss is two-fold (breast feeding and erotic sensibility), and the cause of the loss is two-fold (gland removal and severing of the intercostal nerve). (See Breast Reduction with Use of the Free Nipple Graft Technique; Stephen R. Colen, MD; Aesthetic Surgery Journal, (Breast Reduction with Use of the Free Nipple Graft Technique; Stephen R. Colen, MD; Aesthetic Surgery Journal, Volume 21, Issue 3, May 2001, Pages 261–271, <https://doi.org/10.1067/maj.2001.116439>).

35. If a patient who undergoes “chest masculinization” should regret the surgery, they do have the option of breast reconstruction. But all that will be produced is the appearance of a breast. The patient will have lost the function of breast feeding. Additionally, the most commonly performed “masculinization” surgery involves the removal of the nipples, and subsequent re-attachment in the form of a nipple graft. Those nipples will have lost their native nerve connections that provoke erotic sensibility. All that can be hoped for is the eventual random ingrowth of local skin sensation, but there will never be erotic sensation because the particular branch of the fourth intercostal nerve which communicates with particular centers in the brain responsible for oxytocin release and erotic provocation will have been permanently severed. This means that breast function has been completely and irreversibly sacrificed for the sake of producing a cosmetic result (a masculine appearing chest). This is the exact opposite of the goals of any reconstructive surgery. It must therefore be understood that “chest masculinization”

is a cosmetic procedure that has violated the most essential principle of cosmetic surgery: never sacrifice function for the sake of a cosmetic result.

D. Masculinizing and Feminizing Chest Surgeries are Not “Medically Necessary.”

36. Supporters of “transitioning” treatments justify surgical treatment based upon “medical necessity.” They claim that gender dysphoria can lead to debilitating anxiety and depression, as well as serious incidents of self-harm, including self-mutilation, suicide attempts, and suicide. Yet with only a single exception, in the studies they cite no measures are made of the effects of surgery on what is claimed to constitute the “medical necessity” for these procedures.

37. In contrast, the Branstrom study cited in detail in the Notes Section of this declaration documented no reliable benefits for transgender surgery/hormonal treatments and no reduction in suicide and even an *increase* in serious suicide attempts requiring hospitalization in patients receiving surgery. These recent, long-term, published, peer reviewed, credible research findings are quite contrary to the claims of supporters of “transitioning treatments” — as are the National Science Reviews in this area from England-NICE, Sweden, and Finland. (See detailed citations in the Notes section in this declaration).

38. Scientific rigor would demand an examination of such outcomes as: rates of substance abuse, psychiatric hospitalization, self-harm, or suicide, and how they were changed by surgery. One paper does ask these crucial questions concerning efficacy is a very comprehensive, long term, longitudinal population cohort study which actually shows the opposite of what plaintiffs’ experts’ claims for these patient outcomes. When followed beyond 8 years post operatively, this paper shows patients receiving plaintiffs’ experts’ treatments have the same alarmingly high rates of hospitalization, substance abuse, self-harm, and completed suicide as persons

who have had no medical or surgical intervention. The fact that the citation is included by plaintiffs' experts, but never discussed in his opinion regarding efficacy is troubling. In summary, on the issue of the safety and efficacy of these surgeries, the scientific support is very weak, while the scientific evidence rejecting the hypothesis of efficacy is remarkably strong (See Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden; Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Långström, Mikael Landén; PLOS One February 22, 2011 <https://doi.org/10.1371/journal.pone.0016885>)

39. The surgical removal of the breasts, and the re-contouring of the chest through liposuction is a common procedure for women who seek to present as men. These operations are performed in both men and women, for a variety of reasons, are very safe, and typically performed in the outpatient setting. It is important to understand that the only way of distinguishing cosmetic breast surgery from "medically indicated" surgery is based upon the diagnosis of underlying pathology. For example, breast reduction may be cosmetic, or it may be medically indicated. In both cases, the patient presents with a complaint that her breast are too big. The distinction between cosmetic breast reduction and medically indicated breast reduction is based upon the presenting symptoms of orthopedic problems caused by the weight of the breasts, but even then, the weight of the removed tissue is factored into the objective verification that the surgery was "medically necessary."

40. The same issues are at stake in breast enhancement for men seeking to present as women. Cross-sex hormones will have caused varying degrees of gynecomastia (breast enlargement in men). Surgical enhancement procedures are exactly the same in both men and women.

Medically necessary surgery in women is based upon the diagnosis of an objective medical condition, such as Poland’s syndrome (congenital absence of a breast), surgical absence of the breast following cancer care. In men, the objective diagnosis of gynecomastia might warrant surgery based upon medical necessity, but it would be a removal of tissue. A rare diagnosis of breast cancer in a man might warrant chest wall reconstruction after cancer care. On the other hand, cosmetic surgery of the breast is entirely about the subjective feelings of the patient, and that is all that we have in the case of the self-identified transgender patient.

41. In the case of transgender chest surgery, the diagnosis is based on the patient’s subjective report of dysphoria, but the medical necessity is based on the expectation that surgery will relieve the patient of the risk of, among other things, major depression, self-harm behaviors, and suicide. None of the papers typically cited by supporters of “transitioning treatments” address themselves to the question of medical necessity for either masculinizing surgery, or feminizing surgery. They only address technical issues, management of complications, and subjective outcomes that employ precisely the same language that is used to assess cosmetic surgery of the breast. In summary, the medical necessity of transgender chest surgery is not supported by scientific evidence, and appears to be firmly in the category of cosmetic surgery.

E. Virtually All Transgender Patients are Born with Normal, Healthy Sex Organs and No Scientifically Validated Reason to Surgically Damage Them.

42. Sex is not “assigned at birth” but permanently “assigned” at conception by DNA. Medical technology can be used to determine a fetus’s sex before birth. It is thus not scientifically correct to talk of doctors “assigning” the sex of a child at birth; almost anyone can accurately and reliably identify the sex of an infant by genital inspection with approx 99.9% accuracy. Every nucleated cell of an individual’s body is chromosomally identifiably male or female—XY or XX. Claims that patients can — via hormonal and surgical treatments — obtain a

“sex change” or a “gender transition” process are misleading and scientifically impossible. In reality, the typical “transgender” gender discordant patient has normal healthy sex organs but struggles with gender discordant feelings and perceived identity — a psychiatric and not a medical problem.

F. Detransitioners are Real and Surgeons Have No Diagnostic Tools to Identify Who They Will Be.

43. The phenomenon of desistance or regret experienced later than adolescence or young adulthood, or among older transgender individuals, has to my knowledge not been quantified or well-studied. But it is a real phenomenon. I myself have worked with multiple individuals who have abandoned a trans female identity after living in it for years, and who would describe their experiences as “regret.” More dramatically, a surgical group prominently active in the sexual reassignment field has published a report on a series of seven male-to-female patients requesting surgery to transform their surgically constructed female genitalia back to their original male form. See Djordjevic ML, Bizic MR, Duisin D, Bouman MB, Buncamper M. Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery. *J Sex Med.* 2016 Jun;13(6):1000-7. doi: 10.1016/j.jsxm.2016.02.173. Epub 2016 May 4. PMID: 27156012. Further, there is an increasingly visible online community of young women who have desisted after claiming a male gender identity at some point during their teen years. See, e.g., <https://our-duty.group/2020/04/29/the-detransition-advocacy-network/>. Given the rapid increase in the number of girls presenting to gender clinics within the last few years, the phenomena of regret and desistance by young women deserves careful attention and study.

44. Transgender surgeons have no objective, reliable means of evaluating the diagnostic error rate because there is no body of reliable scientific evidence that can be used to counsel the patient about what their risk of regret is. The ever growing population of de-transitioning

patients suggests that the error rate may be considerable, and the future medico-legal consequences may be proportionate.

45. Valid surgical consent requires that the surgeon is ultimately responsible for the accuracy of the diagnosis. For example, if an endocrinologist refers a patient for thyroidectomy because they have diagnosed a malignant thyroid nodule, the operating surgeon is still obliged to ensure the validity of the diagnosis. He has to entertain alternative diagnoses. Is it a benign nodule? Can it be treated with non-surgical means at lower risk to the patient? What do the scans show? What do the hormone levels show? Having evaluated all the alternative possibilities in the differential diagnosis, the surgeon can then counsel the patient and their family on the options of care, the likelihood of cure, and proper informed consent can be obtained.

46. But the transgender treatment industry, employing scientifically unsupported WPATH guidelines essentially (and unethically) excuse the surgeon from any responsibility for the diagnostic process or its consequences if the diagnosis is incorrect. The 7th edition of the WPATH guidelines requires only two letters written by psychologists, and a period of social transition. There is no action taken to verify the diagnosis on the part of the surgeon. The surgeon has no objective, reliable means by which to anticipate who might benefit or who might be harmed by surgery.

47. By the time a patient presents to a transgender surgeon, they have been the subject of affirmation processes that include everything from social transitioning, to hormonal manipulation. The surgeon is performing permanently life-altering surgical interventions to cure a psychological condition that was diagnosed by the patient, and sometimes the patient made the diagnosis before they even entered puberty. Since the abandonment of frontal lobotomies in 1967, there has been no other psychological-psychiatric condition for which surgery is performed, and

there is no other area of surgical care where the diagnostician is the patient themselves, and the surgeon has no objective, reliable means of confirming or rejecting the diagnosis.

G. I Do Not Engage in Experimental Treatments Lacking Reliable, Credible Scientific Support.

48. As multiple national science reviews and multiple peer reviewed science publications demonstrate, the relevant scientific community has never accepted the reliability, validity, safety or effectiveness of “gender affirmation” treatment procedures — including surgical procedures. Significant medical, ethical, and potential legal problems are created when health care providers employ experimental, unproven, treatment including surgical procedures. Due to the well-documented lack of scientific support and only low quality evidence of efficacy and safety, I will not personally engage in the delivery of experimental gender affirming medical interventions to patients of any age. I will not consider doing such invasive, potentially harmful surgical procedures — that can lead to life-long sterilization of vulnerable patients — until reliable, valid scientific research supports such methods.

49. The transgender treatment industry generates considerable income for hospitals, clinicians, and pharmaceutical companies. Members of the transgender treatment industry have a vested interest in believing that science has already justified their existence. Further, as sterilization is the expected adult outcome of endocrine and surgical treatments of the procedures undertaken in youth prior, the transgender treatment industry must have developed strong rationalizations to justify creating infertility. Will one day the medical profession look at support for transitioning youth in the same manner the eugenics movement is now regarded? (See, Hruz, PW, Mayer, LS, and McHugh, PR, "Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria," The New Atlantis, Number 52, Spring 2017 pp. 3 -36 ; See also,

McHugh, P., Psychiatric Misadventures, *The American Scholar*, Vol. 62, No. 2 (Spring 1993), pp. 316-320

50. In summary, proponents of “affirmation care” for self-identified transgender patients have no body of quality scientific evidence that proves benefit from their interventions. They rely on low to very low quality data when they recommend affirmation therapy. Consensus statements by professional bodies are based upon the lowest category of evidence available. Advocates of “affirmation care” have no long term data to support their therapeutic recommendations, and they never compare their data to the historically proven approach of “watchful waiting.” Advocates for “affirmation care” including medical and surgical intervention, have no objective test, with published error rates, that can be employed to determine who will benefit from their treatments. They rely only on subjective reporting by the patient. Transgender surgery, including “chest masculinization” does not meet the criteria for reconstructive surgery. Because the sole aim of the surgery is the claimed, but unsupported, emotional benefit, it is *by definition* aesthetic (feelings) or cosmetic (appearance) surgery. Chest “masculinization” surgery fails on professional moral grounds because informed consent is impossible (given that there is no way to predict who will benefit), and because function is utterly destroyed in order to achieve a counterfeit form.

IV. PLASTIC SURGERY IS CONCERNED WITH PSYCHOLOGY.

A. Why is Plastic Surgery Concerned with Psychology?

51. Plastic surgery has two areas of activity with broad overlap. The practice of plastic surgery includes reconstructive as well as aesthetic (often called cosmetic) surgery.

52. Reconstructive surgery is ordered to the establishment, or restoration, of normal body structures and their associated functions. The reconstructive process aims at deformities caused by trauma, disease or the management of disease such as cancer surgery, and congenital

deformities. The goal is the restoration of form and function. Sometimes functional restoration is given priority over form, as with the reconstruction of a hand injury in a man. Sometimes functional restoration is impossible, and all that can be offered is aesthetic, as with reconstruction of a facial wound that has resulted in the loss of an eye, where vision cannot be restored, and all that can be offered is a prosthetic eye.

53. Aesthetic (cosmetic) surgery on the other hand is surgery to modify the appearance of an area of the body that is functionally normal, and that has an appearance that, even though it is within the range of normal, causes some degree of annoyance or discomfort to the patient. (For example, prominent ears on a boy.) The ears are functionally normal, and their prominence may even be a recurring family trait, but their prominence is a daily annoyance to the boy; he may even have been given a pejorative nick name. A simple and safe procedure can be performed that reduces the prominence of his ears *without sacrificing any function*, and his daily annoyance is resolved. Form is changed within the range of normal, function is preserved, and the aesthetic (feelings) problem is solved.

54. In the clinical training of plastic surgeons, we learn to carefully evaluate aesthetic patients, not only for the sake of surgical planning, but because we have to understand their motivation for the surgery and how to anticipate potential complications. It is axiomatic in plastic surgery that the most avoidable complication in aesthetic surgery is disappointment and regret on the part of the patient. We are taught that disappointment is first and foremost managed by ensuring that the doctor understands what the patient is seeking to achieve, that the goal is worthy of pursuing, and that the surgeon is likely to achieve the goal.

55. Plastic surgeons are trained to recognize a particular subset of aesthetic patients who at first appear to be seeking some ordinary improvement in appearance, but upon further

evaluation discovers that the patient is seeking cosmetic surgery because they are convinced they are horribly disfigured — and *this* is the reason they feel alone, isolated and depressed. If such a patient has an otherwise normal physical appearance, then the diagnosis of Body Dysmorphic Disorder must be entertained. See (5) Body Dysmorphic Disorder, Andri S. Bjornsson, PhD, Elizabeth R. Didie, PhD, Katharine A. Phillips, MD; Dialogues Clin Neurosci. 2010 Jun; 12(2): 221–232; and Body Dysmorphic Disorder and Cosmetic Surgery Crerand, Canice E. Ph.D.; Franklin, Martin E. Ph.D.; Sarwer, David B. Ph.D. Plastic and Reconstructive Surgery: December 2006 - Volume 118 - Issue 7 - p 167e-180e.

56. Persons who suffer with this condition are seeking a physical explanation for a psychological wound. They are trying to explain their isolation, anxiety, depression, and despair by pointing to their appearance as the cause of their sorrows. Plastic surgeons learn that such patients may be elated at first with their surgery, but they return with complaints that “you didn’t do the surgery right.” They are disappointed because they still experience the anxiety, isolation, depression, and despair, which should not be surprising given the obvious fact that *you cannot heal a psychological wound with cosmetic surgery*.

57. Indeed, to offer cosmetic surgery to a person suffering from Body Dysmorphic Disorder is considered a failure of diagnosis. *To know that a person is suffering from body dysmorphic disorder, and to offer them surgery in spite of that knowledge is malpractice*. The surgeon is taking advantage of a psychologically vulnerable patient for the sake of financial gain. See Cosmetic Surgery and Body Dysmorphic Disorder – An Update B S. Higgins, MD and A. Wysong, MD, MS, Int J Womens Dermatol. 4(1); March 2018.

58. Gender dysphoria is a diagnosis that is based upon the subjective reporting of the affected child. There is no objective test, with known error rates, that can be employed to confirm the diagnosis, or predict who will benefit from any putative therapeutic interventions. There is no chromosomal study, no genetic marker, no gene product, no hormonal abnormality, or any dynamic brain scan that can be used to confirm the diagnosis. Essentially, the transgender treatment industry is offering permanently life altering hormonal manipulation and irreversible surgery based upon a diagnosis that is made by an emotionally stressed adolescent, or even prepubertal child who is being socially transitioned. (See Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria Paul Hruz, MD, PhD. Linacre Quarterly 2020 Feb 87 (1)34-42. doi10.1177/0024363919873762. Epub 2019 Sep 20.)

B. Gender Dysphoria or Gender Identity Disorder is a Logical Subcategory of Body Dysmorphic Disorder.

59. Body dysmorphic disorder is a subcategory of obsessive compulsive disorder. What distinguishes gender identity disorder from other forms of body dysmorphic disorder is that the content of the obsessive thought is the sexed appearance of the patient. The obsessive thought is that they have the wrong genitalia, that they are really the other sex, and if they could change that, their anxiety, isolation, depression, and despair would resolve. Given that the patient is physically normal, and that the patient is seeking a change in appearance in order to resolve a feeling (aesthetic), all transgender surgery, by definition, is cosmetic surgery.

60. To call a “chest masculinization” mastectomy a “chest reconstruction” is not just an imprecision of language. It is intentional deception. Such mastectomy is in no way a restoration of form and function. It is rather the willful destruction of function for the purposes of producing a counterfeit form. What is more, because these mastectomies involve the irreversible destruction of normally functional parts, with associated loss of function, these operations violate

the first and most important principle of plastic surgery: It is bad surgical planning if you compromise function for the sake of a cosmetic result. In this case the compromise of function is actually a 100% loss.

C. There Are Multiple Pathways to Gender Dysphoria.

61. The diagnosis of “gender dysphoria” encompasses a diverse and controversial array of conditions, with widely differing pathways and characteristics depending on age of onset, the complexities introduced by co-occurring mental illnesses, social contagion and other environmental factors, among other things. Data from one population (e.g. adults, those struggling with complex mental illnesses) should not naively be assumed to be easily applicable to others (e.g. children, those changed by social contagion) and other factors. The developmental and mental health patterns for these groups are sufficiently different that data developed in connection with one of them cannot be assumed to be reliably applicable to another. See K. Zucker (2018), The Myth of Persistence: Response to “A Critical Commentary on Follow-Up Studies & ‘Distress’ Theories about Transgender & Gender Non-Conforming Children” by Temple Newhook et al., *Intl J. of Transgenderism* at 10, DOI: 10.1080/15532739.2018.1468293 (“Myth of Persistence”).

V. OPINIONS REGARDING THE SHOCKING OMISSIONS OF PLAINTIFFS’ REPORTS

62. As a physician and surgeon for decades, I have dedicated my life to helping the injured, the wounded, the sick, the vulnerable, and those in distress. As a physician and surgeon, I have a duty to carefully assess the available scientific research literature and determine what surgical procedures have been scientifically proven safe and effective for use on patients — and which procedures are still experimental, potentially dangerous, and may well do more harm than good for patients. Such an assessment requires the prudential review of scientific publications and my being familiar with the ongoing methodological and scientific debates in the field.

63. I have reviewed the plaintiffs’ declarations from Drs. Adkins and Antommaria in this case. Those declarations demonstrate an stunning lack of knowledge or candor regarding the ongoing, raging, international scientific debates over the safety and effectiveness of “gender affirming” medical procedures. Those reports offer no proper disclosure of these controversies and demonstrate no apparent awareness of the serious methodological and ethical defects and controversies exposing the lack of scientific foundations for the transgender treatment industry. Over the past few years, multiple methodological exposes and national reviews in England (NICE), Sweden, and Finland, plus other reviews (e.g., Cochrane, Griffin, Carmichael, etc), have all raised urgent warnings and serious questions about the quality and the integrity of the scientific foundation for this very controversial field.

64. It is troubling that the plaintiffs’ experts both appear to have significant financial and professional conflicts of interest as they themselves have reported in their appended curriculums vitae that much of their practices and incomes are derived from these experimental, unproven, potentially harmful methods and procedures of “gender affirmation transitioning” medical treatments. Further, not only their incomes but their professional reputations, academic positions, journal publications, and association memberships would all collapse if the transgender treatment industry collapsed due to widely noted missing evidence of safety and effectiveness.

65. The following are among the shocking errors, omissions, and failures of the plaintiffs’ expert reports.

A. Failure to Disclose Multiple International Controversies and the Poor Quality of the Evidence

66. The plaintiffs’ experts failed to properly disclose and discuss the international debates and controversies surrounding transgender affirmation methods and procedures discussed above. Indeed, it is difficult to imagine a more inaccurate summary of the state of the embattled,

experimental transgender treatment industry that that reflected in their reports. (See detailed citations in the “Notes” section of this report below).

67. The plaintiffs’ experts failed to properly disclose and discuss multiple peer-reviewed, published exposés of significant methodological defects in research on transgender affirmation methods and procedures. Further, the plaintiffs’ experts failed to properly disclose and discuss recent scientific studies and reviews including the Cochrane Review, the Carmichael study, the Griffin review and the devastating scientific critiques of the ill-fated and recanted Branstrom, et al. study, including the many multiple, detailed, methodologically sophisticated letters to the editor. (See detailed citations in the “Notes” section of this report below).

B. Failure to Acknowledge Comorbidities

68. Plaintiffs’ experts fail to recognize how the existence of comorbidities complicate the treatment of gender dysphoric patients. It is well established in peer-reviewed medical literature that children who experience gender discordance have a very high likelihood of major anxiety disorders, major clinical depression, self-harming behaviors such as cutting, substance abuse. They also have a greater than 30% likelihood of being on the autism spectrum. Under the “affirmation care” model, these issues are more often than not ignored, ascribing all of the child’s problems to their self-diagnosed gender dysphoria. (See Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals, Varun Warriar, David M. Greenberg, Elizabeth Weir, Clara Buckingham, Paula Smith, Meng-Chuan Lai, Carrie Allison & Simon Baron-Cohen ; Nature Communications volume 11, Article number: 3959 (2020), <https://www.nature.com/articles/s41467-020-17794-1>).

C. Failure to Acknowledge the Radically Changing Patient Demographics and Problems for the “Affirmative” Model

69. Plaintiffs’ experts fail to recognize that the demographics of transgender patients have seen a radical transformation in the last several years. Historically, the condition was rare (less than 0.2% of children), had initial presentation in pre-puberty, was almost exclusively boys, and showed a desistance (i.e., abandonment of cross-sex self-identification) rate of over 80% by mid-adolescence, and over 90% when followed into adulthood. See A Follow-Up Study of Boys With Gender Identity Disorder; Devita Singh, Susan J. Bradley, and Kenneth J. Zucker, *Front. Psychiatry*, 29 March 2021.

70. Currently, the majority of newly diagnosed transgender children are natal females (over 50%), initial presentation is in early adolescence to young adulthood, and some reports have the overall prevalence rate rising to somewhere between 2 and 10% of school age children. See Evidence for a Change in the Sex Ratio of Children Referred for Gender Dysphoria: Data From the Gender Identity Development Service in London (2000-2017) Nastasja M de Graaf , Polly Carmichael , Thomas D Steensma , Kenneth J Zucker, *J Sex Med* 2018 Oct;15(10):1381-1383 and also Characteristics of Referrals for Gender Dysphoria Over a 13-Year Period Melinda Chen, M.D., John Fuqua, M.D., and Erica A. Eugster, M.D *J Adolesc Health*. 2016 Mar; 58(3): 369–371. doi: 10.1016/j.jadohealth.2015.11.010). This means that the diagnosis among females has risen by nearly 50-fold in the last five years (See Gender dysphoria in adolescence: current perspectives, Riittakerttu Kaltiala- Heino, Hannah Bergman, Marja Työläjäarvi, and Louise Frisén; *Adolesc Health Med Ther*. 2018; 9: 31–41. Published online 2018 Mar 2. doi: 10.2147/AHMT.S135432).

71. Additionally, there appear to be “outbreaks” of clusters of adolescent females that are connected either by school, or social media that suddenly appear. This was first reported by

Dr. Lisa Littman of Brown University in her 2018 paper which coined the diagnostic term of Rapid Onset Gender Dysphoria. (See Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria, Littman, L. PLOS One, August 16, 2018; <https://doi.org/10.1371/journal.pone.0202330>). She found evidence suggesting that these subjects developed transgender self-identification through a social contagion process that included highly rehearsed speech to be used when speaking to psychologists, counselors, pediatricians, and surgeons. A moment's reflection on this single fact should be enough to dissuade anyone from the idea that transgender self-identification is a biologically determined condition. Has there been a mass mutation in the human genome that would cause a fifty-fold increase among girls? Is there some substance abroad in the world that has radically and swiftly altered childhood brain development? The numbers of affected children would easily place this in the category of a pandemic, given the geographic range of the condition in the western world.

72. The transgender treatment industry has not shown the slightest interest in examining alternative causes, and it offers precisely the same treatment model to children whether they experience gender dysphoria from their first days of character formation in early childhood or at age 14 when their psychosexual development is under the tremendous pressures of puberty. All patients are given “affirmation care” in spite of the fact that we are dealing with wildly different psychological processes. The only variation in treatment plan, from the youngest patient to the oldest, is where along that single line of care they are brought in: social transition, puberty blockers, cross-sex hormones, then surgery.

73. Psychological evaluation and treatment, even of the known psychological comorbidities such as depression and anxiety, bipolar disorder, etc., is a priori decried by the American Psychological Association and other political allies as “conversion therapy,” even if the therapy

is used to reduce depression and anxiety. Therapists are *barred* by “political correctness” from seeking alternative causal explanations and thus less able to avoid confirmation bias. Properly exploring the possibility of alternative diagnoses, such as anxiety disorder, major depression, or autism spectrum, even though part of the standard of care, is labelled as “trans-phobic.”

74. Because the alternative causal explanations identify disorders that are far more treatable, cross-sex identification may, for many patients, be treatable using safe, proven methodologies such as Cognitive Behavioral Therapy (CBT). Instead, “affirmation” advocates claim that CBT — the most tested and validated form of psychotherapy for depression and anxiety relief — is nothing more than “conversion therapy”, or even “psychological torture.” (See APA Resolution on Gender Identity Change Efforts Feb. 2021 <https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf>). The transgender treatment industry maintains emotional chaos in these vulnerable patients, giving rise to a continuing “need” for irreversible, sterilizing, unproven, controversial “transitioning” treatments.

D. The Existence of the “Watchful Waiting” Model of Care

75. Plaintiffs’ expert witnesses failed to acknowledge even the very existence of the “watchful waiting” model of care.

76. Historically, Gender Identity Disorder (now called Gender Dysphoria) was recognized as a sub-category of Obsessive Compulsive Disorder where the child has a persistent, intrusive thought that they are the wrong sex. This makes sense because the content of the thought meets the three criteria of a delusional thought: It is 1) held with absolute certainty, 2) unpersuadable by contrary evidence, and 3) impossible. In the case of the gender discordant child, the content of the delusional thought relates to their sexed self. These children typically presented in pre-puberty, and care were directed at several important issues: Experiences or perceptions that have provoked fear or anxiety (e.g. child abuse including sexual assault) that might be causing

the child to seek safety in the opposite sex presentation; misinterpretation of family dynamics that may have caused a desire to be the other sex; actual abuse events that may have provoked and habituated the obsessive thought.

77. Individual and family counseling directs the child's thoughts and coping processes in the direction of the truth of their nature, which includes their biological sex. Historically, this "watchful waiting" approach resulted in a complete resolution of symptoms in 80% of children by mid-adolescence, and over 90% resolution by early adulthood. (See Psychosexual outcome of gender-dysphoric children. Madeleine S. C. Wallien, P. Cohen-Kettenis 2008 Psychology, Medicine Journal of the American Academy of Child and Adolescent Psychiatry 10.1097/CHI.0b013e31818956b9; and A Follow-up Study of Girls with Gender Identity Disorder, Kelley D Drummond 1, Susan J Bradley 2, Michele Peterson-Badali 1, Kenneth J Zucker; Dev Psychol. 2008 Jan;44(1):34-45. doi: 10.1037/0012-1649.44.1.34).

78. The "watchful waiting" approach is based upon a recognition that at the heart of the transgender process lies a psychological problem, and this perspective finds strong support in both its natural history (80+% resolution without medical or surgical intervention), and the fact that no objective test, having known error rates, has yet been found that can affirm or reject a "transgender" diagnosis.

79. In contrast to the highly successful results of "watchful waiting," we have the presently regnant "affirmation" model. Under the "affirmation" model, the treating physician is essentially forbidden to consider the transgender condition to be a psychological disturbance apart from the unhappiness and associated impaired social functioning caused by the discordance between their objective biological sex and their interior sense of their gender. Treating profes-

sionals, including pediatricians, endocrinologists, psychologists, and surgeons are strongly discouraged from examining alternate theories concerning the diagnosis and causes, such as clinical anxiety apart from gender discordance, major depression, or the social contagion model of causation. The affirmation model proposes that the child's interior sense of their gender is "their true self," and that the problem demands that the appearance of the body must be radically changed so that it "aligns" with the child's subjective sense of being the opposite sex.

80. The startling difference in outcomes between "watchful waiting" and "affirmation" provides a compelling counter argument to the WPATH guidelines. As stated above, "watchful waiting," which includes individual and family counseling, yields successful resolution of gender discordance by natural maturation in over 80% of children by mid adolescence, and over 90% by young adulthood. This is in stark contrast, with "affirmation care" where we find that children who are enrolled in gender clinics are nearly 100% likely to persist in their cross-sex self-identification through childhood into adulthood. Essentially, at least 80% of affected children who would have resolved their problem and gone onto gender congruence, are instead trapped in the transgender treatment enterprise. The proponents of "affirmation care" have no proven test, with known error rates, by which to distinguish the 90% that will resolve their problem from the 10% that will experience persistence of symptoms into adulthood. The probability of misdiagnosis — the error rate for this process — is 90%. This places the transgender treatment enterprise, including endocrinologists and surgeons, in the category of gross malpractice.

81. Plaintiffs' experts claim that in the case of transgender patients, it would be unethical to randomize patients into control groups and treatment groups, given the high rate of self-harm. This is a specious argument for two reasons. First, randomized case/control studies are

not the only alternative to unreliable, retrospective, biased collected case reports with short follow up on which the transgender industry rests. Longitudinal, population based, long term data is available in the world literature that allows us to evaluate the claims made by the gender affirmation treatment model. (See Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden; Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Långström, Mikael Landén; PLOS One February 22, 2011 <https://doi.org/10.1371/journal.pone.0016885>). In fact, that long-term population based data is very the reason why the Tavistock Institute in London and the Karolinska Institute Hospital in Sweden — in a dramatic change — have *restricted* the use of puberty blockers, cross-sex hormones, and transgender surgery in minors. The famed Swedish hospital’s new patient protections require the involvement of research monitoring to protect children from “transitioning” experimental procedures. (See detailed citations in the “Notes” section of this report below).

82. Essentially, the “control group” already exists in the world literature, however the transgender treatment industry ignores this control group, and continues to publish low-quality case-collection studies without controls, with short follow up and massive self-selection biases.

83. Secondly, there is a very long history of results from the “watchful waiting” model against which the “affirmation model” can be compared. But Plaintiffs’ experts entirely ignore this data which shows that the historically proven “watchful waiting” model has a “cure” rate of approximately 90%. The “affirmation care” model hasn’t even proven basic efficacy, much less high rates of efficacy, given the low to very low quality evidence that they continue to rely on. Its proponents publish only subjective results to which they assign numerical values using unproven test instruments that have no known error rates or predictive value. (E.g., as noted

above, the historic Branstrom study and recantation documented no reliable benefits to patients in a 10yr+ follow-up study.) (See detailed citations in the “Notes” section of this report below).

E. Failure to Acknowledge that Relying on “Consensus Statements” is Not Relying on Evidence.

84. As can be seen in the Complaint in this case and the plaintiffs’ expert reports, the primary supports for the “affirmative” approach are the repeated references to “consensus statements” from medical and other associations and the WPATH guidelines. It should be noted that the quality of scientific evidence in medicine can be graded based upon the methodology employed. The methodology of professional consensus seeking is in the lowest category. (See The Levels of Evidence and their role in Evidence-Based Medicine Patricia B. Burns, MPH, Rod J. Rohrich, MD, and Kevin C. Chung, MD, MS. *Plast Reconstr Surg.* 2011 Jul; 128(1): 305–310.)

85. It should further be noted that consensus statements from such organizations as the American Pediatric Association and the Endocrine Society are not obtained by polling the membership of the entire society, but are instead the product of consensus seeking methodology applied to a very small, self-selected sample of members that happen to be on that particular policy committee. Nonetheless, the “consensus statement” is incorrectly presented as though there is majority if not universal agreement by pediatricians and endocrinologists.

86. Furthermore, WPATH intentionally mis-labels its guidelines, calling them “Standards of Care” (See <http://www.wpath.org/publications/soc>). Guidelines are a suggested course of treatment that may or may not produce the desired results, and are therefore not mandatory. Labeling their document as “Standards of Care” implies that they are proven treatment methods of very high efficacy that must be adhered to in order to achieve a known and positive outcome, and that deviations from the “standards of care” has a high probability of a poor outcome, and possible legal consequences.. Given that the guidelines offer no scientifically verified

evidence that their outcomes are consistently and overwhelmingly positive, this is a clear misrepresentation of their actual value. For this reason, whenever the acronym “WPATH” is used in conjunction with the words “standards of care,” the author of such words is intentionally misleading the reader.

87. The WPATH guidelines also seek to define a “professional” in transgender health. In order to be classified as a “professional” you must simply agree with what the WPATH documents state. (See WPATH Standards of Care section VI p.13 – section VII p.33 (defining the “professional” in terms of compliance with WPATH “standards of care”)). This is more characteristic of a cult than a scientific body. Science demands unflinching, ongoing, debate and re-evaluation of hypotheses, quality of data, methodologies, and best practices. In contrast, WPATH demands consensus and compliance with a single, unproven model of care, even when the patients have wildly differing presentations (pre-pubertal vs. adult, co-morbid association with other illness such as autism spectrum etc.).

88. As it happens, among the lead authors of the WPATH guidelines, and their board members, are physicians and surgeons whose practices largely depend on the revenue stream found in transgender services. (WPATH Standards of Care. Pp.109-112 (describing the composition of the committee members, and their consensus methodology used in generating the document)). Essentially, they are saying, “mastectomy is justified in transgender teenage natal females because I said so in the WPATH document that I wrote.” This is a classic *ipse dixit* opinion.

VI. CONCLUDING OPINIONS

89. There are no currently no competently conducted, long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions who are helped by such procedures.

90. There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions who are injured or harmed by such procedures.

91. There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the reliability and validity of assessing gender identity by relying solely upon the expressed desires of a patient.

92. There are no long-term, peer-reviewed published, reliable and valid, research studies documenting any valid and reliable biological, medical, surgical, radiological, psychological, or other objective assessment of gender identity or gender dysphoria.

93. A currently unknown percentage and number of patients reporting gender dysphoria suffer from mental illness(es) that complicate and may distort their judgments and perceptions of gender identity.

94. A currently unknown percentage and number of patients reporting gender dysphoria are suffering social contagion and social pressure processes brought on by a peer group, social media, YouTube role modeling, and/or family dynamics.

95. Patients suffering from gender dysphoria or related issues have a right to be protected from experimental, potentially harmful treatments lacking reliable and valid, peer reviewed, published, long-term scientific evidence of safety and effectiveness.

96. It would be a serious violation of licensing rules, ethical rules, and professional standards of care for a health care professional to provide gender transition or related procedures to any patient without first properly obtaining informed consent including informing the patient and/or guardian(s) of the lack of valid and reliable on the long-term risks and benefits of “affirmative” treatments.

97. A large percentage of children (over 80% in some studies) who questioned their gender identity will, if left alone, develop an acceptance of their natal (biological) sex.

98. Medical treatments may differ significantly by sex according to chromosomal assessment but not gender identity. Misinforming physicians of a patient’s biological sex can have deleterious effects on treatment for medical conditions.

99. Affirmation medical treatments — hormones and surgery — for gender dysphoria and “transitioning” have not been accepted by the relevant scientific communities (biology, genetics, neonatology, medicine, psychology, etc.).

100. “Gender affirmation” assessments and treatments — hormones and surgery — for gender dysphoria and “transitioning” have no known, peer reviewed and published error rates.

101. Political advocates, activist physicians, and medical organizations that operate by voting methodologies (e.g., WPATH, the American Medical Association, the American Academy of Pediatrics, the American Endocrine Society) are not the relevant scientific community, they are politically active professional organizations. These organizations operate via consensus-seeking methodology (voting) and are easily swayed by political ideologies rather than evidence-based scientific methodologies.

102. Experts in legal cases have an ethical obligation to honestly, fairly, and accurately disclose and discuss the international controversies regarding the safety, effectiveness, reliability, and credibility of the gender transition industry. It is astonishing that in their expert declarations, Plaintiffs’ experts failed to disclose and discuss the serious controversies, complex issues, debates, and contrary national science review recommendations in this field. It is difficult to imagine a more inaccurate summary of the state of the embattled, experimental transgender treatment industry. (See detailed citations in Notes section below).

VII. RESEARCH NOTES

To assist in my testimony in this case, I include my notes, references and citations documenting the depth and breadth of the serious controversies in this field. Over the past few years, the glaring defects in the research foundations of the gender transition industry have been exposed for all the world to see.

See, Vrouenraets et al, Early Medical Treatment of Children and Adolescents With Gender Dysphoria: An Empirical Ethical Study, *Journal of Adolescent Health* 57 (2015) 367e373. ...”no consensus exists whether to use these early medical interventions.” The study shows that there is no agreement concerning the causes of gender dysphoria, which give rise to very different treatment strategies that are at times in diametric opposition. As a result of this confusion of explanations, “consensus” regarding treatment is ipso facto impossible. Results: Seven themes give rise to different, and even opposing, views on treatment: (1) the lack of an explanatory model for GD; (2) the unknown nature of GD (normal variation?, social construct?, or mental illness?); (3) the role of physiological puberty in developing gender identity; (4) the role of comorbidity [with severe mental illnesses] ; (5) unknown possible physical or psychological effects of (refraining from) early medical interventions; (6) child competence and decision making authority [to give truly informed consent to be sterilized for experimental procedures?]; and (7) the role of social context ...how GD is perceived. Strikingly, the guidelines are debated both for being too liberal and for being too limiting. Conclusions: As long as debate remains on these seven themes and only limited long-term data are available, there will be no consensus on treatment. Therefore, more systematic interdisciplinary and (worldwide) multi-center research is required. It is striking that plaintiffs’ experts somehow both failed to properly report this ongoing international debate within their claimed field of expertise.

See, Dhejne et al. (2011), Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden, PLOS ONE 6(2) e16885 (“Long Term”); See also, R. K. Simonsen et al. (2016), Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality, Nordic J. of Psychiatry 70(4). Swedish follow-up study of patients who underwent sex-reassignment surgery over a 30-year period found a suicide rate in the post-Sex Reassignment Surgery (SRS) population 19.1 times greater — after affirmation treatment — than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions.

See, Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. medRxiv 2020.12.01.20241653. Self-harm did NOT improve and “no changes in psychological function,” meaning no improvement. (Also, “YSR [Youth Self Report] data at 36 months (n = 6) were not analyzed.” No significant effect on their psychological function, thoughts of self-harm, or body image, a study has found... children experienced reduced growth in height and bone strength by the time they finished their treatment at age 16. The findings, from a study of 44 children treated by the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust in London, have emerged as the trust prepares to appeal against a High Court ruling that led NHS England to pause referrals of under 16s for puberty blockers.

Demographics: no biological explanation. The radical change in patient demographics from early onset in boys to teen girls with rapid onset— has been termed late-, adolescent-, or

rapid-onset gender dysphoria — has now been seen in every gender clinic in the western world, and there has been a huge surge in the number of cases. "National College Health Assessment: ACHA-NCHA [s://www.acha.org/NCHA/ACHANCHA_Data/Publications_and_Reports/NCHA/Data/Publications_and_Reports.aspx?hkey=d5fb767c-d15d-4efc-8c41-3546d92032c5](https://www.acha.org/NCHA/ACHANCHA_Data/Publications_and_Reports/NCHA/Data/Publications_and_Reports.aspx?hkey=d5fb767c-d15d-4efc-8c41-3546d92032c5) See, Kalliala-Heino, Riittakerttu, Hannah Bergman, Marja Työläjäarvi, and Louise Frisen. "Gender Dysphoria in Adolescence: Current Perspectives." *Adolescent Health, Medicine and Therapeutics* Volume9 (March 2018): 31–41. <https://doi.org/10.2147/AHMT.S135432> See, Vries, Annelou L.C. de. "Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents." *Pediatrics* 146, no. 4 (October 2020): e2020010611. <https://doi.org/10.1542/peds.2020-010611>. See, Zucker, Kenneth J. "Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues." *Archives of Sexual Behavior* 48, no. 7 (October 2019): 1983–92. <https://doi.org/10.1007/s10508-019-01518-8>.

Great Britain (NICE), Deborah Cohen and Hannah Barnes, Evidence for puberty blockers use very low, says NICE at <https://www.bbc.com/news/health-56601386> ["The evidence for using puberty blocking drugs to treat young people struggling with their gender identity is "very low", an official review has found. The National Institute of Health and Care Excellence (NICE) said existing studies of the drugs were small and "subject to bias and confounding"

See, Asscheman H, Giltay EJ, Megens JA, et al. A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *Eur J Endocrinol*. 2011;164:635-642. *"There is no evidence that transition reduces suicide when we look past 10 years, and there is some suggestion that **suicide rates may actually increase after the transition***

honeymoon phase is over," says Malone, stressing the importance of providing proper evaluation and appropriate psychological treatment for any suicidal tendencies. (Supports the Branson conclusions after recantation and correction).

Sweden - Review of Gender dysphoria in children and adolescents: an inventory of the literature, SBU Policy Support no 307, 2019 www.sbu.se/en • registrator@sbu.se Contact SBU: Jan Adolfsson, Medical Advisor, Project Manager, jan.adolfsson@sbu.se, English Proofreading: Project group and Jan Adolfsson, SBU [“ No relevant randomized controlled (treatment outcome) trials in children and adolescents were found.”] ; See, also e.g., FINLAND Issues Strict Guidelines for Treating Gender Dysphoria at <https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/>. In 2020, Finland reportedly became the first country in the world to issue new guidelines for this group of patients when it concluded similarly to the UK High Court that there is a lack of quality evidence to support the use of hormonal interventions in adolescents with gender dysphoria.... they also issued the guideline ordering “No surgical interventions are allowed for children under the age of 18”.). As the *methodological quality of the studies was already poor* based on the type of study, thus no actual quality assessment or determination of the degree of evidence was performed.”] ;

See, Cochrane Review (See, Haupt, C., Henke, M. et. al., Cochrane Database of Systematic Reviews Review - Intervention, Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women, 28 November 2020.)

See, Griffin, L., Clyde, K., Byng, R., Bewley, S., Sex, gender and gender identity: a re-evaluation of the evidence. BJPsych Bulletin (2020) doi:10.1192/bjb.2020.73, Cambridge University Press, 21 July 2020, the authors noted the hazardous error of mandating “affirmation treatments” — thus requiring the negligent practice of Confirmation Bias — rather than properly and carefully exploring alternative hypotheses — the standard, required ethical, medical standard of practice. As Griffin discussed, “Attempts to properly explore, formulate and treat coexisting mental illness in gender dysphoric populations, including that relating to childhood trauma, might be considered tantamount to ‘conversion therapy’. Although mental illness is overrepresented in the trans population it is important to note that gender non-conformity itself is not a mental illness or disorder. As there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties. Taking a supportive, exploratory (psychotherapy) approach with gender-questioning patients should not be considered conversion therapy.” In addition, Griffin et al wrote: “Transgender support groups have emphasized the risk of suicide. After controlling for coexisting mental health problems, studies show an increased risk of suicidal behaviour and self-harm in the transgender population, although underlying causality has not been convincingly demonstrated.

See, Dyer, C., Puberty blockers do not alleviate negative thoughts in children with gender dysphoria, finds study BMJ 2021; 372 doi: <https://doi.org/10.1136/bmj.n356> (Published 08 February 2021), BMJ 2021;372:n356 (Puberty blockers used to treat children aged 12 to 15 who

have severe and persistent gender dysphoria had no significant effect on their psychological function, thoughts of self-harm, or body image, a study has found. However, as expected, the children experienced reduced growth in height and bone strength by the time they finished their treatment at age 16)

See, Bränström and Panchankis long term surgical results. NO benefit (data suggests and suggests an increased risk of serious suicide attempts). See, Kalin, N.H., Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender-Affirming Surgeries: A Comment by the Editor on the Process by the Editor-in-Chief The American Journal of Psychiatry, Am J Psychiatry 2020; 177:764; doi: 10.1176/appi.ajp.2020.20060803; See also, Anckarsäter, H., and Gillberg, C., Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery, Am J Psychiatry 2020; 177:764–765; doi: 10.1176/appi.ajp.2020.19111117.

See, e.g., Wold, A. (M.D., Ph.D.) Gender-Corrective Surgery Promoting Mental Health in Persons With Gender Dysphoria Not Supported by Data Presented in Article, Am J Psychiatry 2020; 177:768; doi: 10.1176/appi.ajp.2020.19111170. [among the individuals examined in the Branstrom study discussed here, the risk of being hospitalized for a suicide attempt was 2.4 times HIGHER if they had undergone gender-corrective surgery than if they had not.... the data presented in the Branstrom article do not support the conclusion that surgery is beneficial to mental health in individuals with gender dysphoria.”]

“Therefore, ... the data in the article ... *OVERTURNS the authors’ stated conclusions, suggesting that sex reassignment surgery is in fact associated with INCREASED mental health*

treatment See, Ring, A. (PhD) and Malone, W. , Confounding Effects on Mental Health Observations After Sex Reassignment Surgery, *Am J Psychiatry* 2020; 177:768–769; doi: 10.1176/appi.ajp.2020.19111169.

See, See, Van Mol, A., Laidlaw, M. K., Grossman, M., McHugh, P., Gender-Affirmation Surgery Conclusion Lacks Evidence, *Am J Psychiatry* 177:8, August 2020 ajp.psychiatryonline.org 765. “The study confirms the strong association between psychiatric morbidity and the experience of incongruity between gender identity and biological sex. However, the study does NOT demonstrate that either hormonal treatment or surgery has ANY effect on this morbidity. It seems that the main message of this article is that the incidence of mental health problems and suicide attempts is especially HIGH in the year AFTER the completion of gender-affirming surgery [It is telling that the authors somehow ignored this most essential finding] ...” See, Curtis, D., Study of Transgender Patients: Conclusions Are Not Supported by Findings, *Am J Psychiatry* 2020; 177:766; doi: 10.1176/appi.ajp.2020.19111131.

See, Malone, W. and Roman, S., Calling Into Question Whether Gender-Affirming Surgery Relieves Psychological Distress, *Am J Psychiatry* 2020; 177:766–767; doi: 10.1176/appi.ajp.2020.19111149. “Bränström and Pachankis study on mental health treatment and suicide attempts ... is misleading because the study design is flawed.” “The authors first found what was already known ... the rate of psychiatric morbidity is much higher in persons with gender dysphoria compared with the general population (both before AND after “transitioning”). The authors then explored if the risk for mental health treatment changes as a function of years since starting HORMONAL treatment. They find NO effect (odds ratio = 1.0), but they do find a trend toward INCREASED risk of suicide attempts as a function of years since starting

[gender affirmation] HORMONAL treatment. They somehow failed to publish this essential finding.

See, Landén, M. (M.D., Ph.D.) The Effect of Gender-Affirming Treatment on Psychiatric Morbidity Is Still Undecided, *Am J Psychiatry* 2020; 177:767–768; doi: 10.1176/appi.ajp.2020.19111165. This conclusion is not supported by the data presented in the article.

See, Bränström, R. and Pachankis, J., Toward Rigorous Methodologies for Strengthening Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals 'Mental Health: Response to Letters, *Am J Psychiatry* 2020; 177:769–772; doi: 10.1176/appi.ajp.2020.20050599.

2020 - Sweden, following a national review of transgender science, published a new guideline that is NOT consistent with WPATH protocols nor the opinions of the plaintiffs' experts in this case. <https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/> The Swedish National Guidelines appear quite contrary to the opinions of Plaintiffs Experts and WPATH.

2020 - Finland following a review of transgender science, became the first country in the world to issue new guidelines for this group of patients when it concluded similarly to the UK High Court that *there is a* lack of quality evidence to support the use of hormonal interventions in adolescents with gender dysphoria. This new Finnish guidance prioritizes psychological therapy over treatment with hormones or surgery and suggests different care plans for early-onset vs late-onset childhood gender dysphoria. The 2020 Finland guidelines state "Only limited research

has been conducted on transgender identity and other gender identity conflicts, and comparative studies are very rare.”] The Finland National Guidelines appear quite contrary to the opinions of Plaintiffs Experts and WPATH.

See, <https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/> Finland Clinical Guidelines and Conclusions Three reports were created by COHERE in Finland. The report “Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation” clarifies the roles of different healthcare providers in a situation where a minor is uncertain about their gender identity. They also produced general recommendations for the treatment of transgender people, which applies to adults. And interestingly, a third and separate set of recommendations for the treatment of gender dysphoria related to non-binary people and people with gender identities other than opposite-sex gender identities.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on July 8, 2021.


 Patrick W. Lappert, MD

Curriculum Vitae

Patrick W. Lappert, MD
Board Certified in Surgery and Plastic Surgery
Decatur, AL 35603

Education and Training :

— Bachelor of Arts in Biological Sciences at the University of California, Santa Barbara, 1979. Research in cell membrane physiology with Dr. Philip C. Laris, studying stoichiometry of the sodium: potassium ATPase pump.

— M.D., Doctor of Medicine degree at the Uniformed Services University of the Health Sciences, 1983 at Bethesda, Md.

— General Surgery Residency at the Naval Hospital Oakland/ UC Davis East Bay Consortium, 1987-1991

— Chief Resident, Department of Surgery, Naval Hospital Oakland, 1990-1991.

— Plastic Surgery Residency at the University of Tennessee- Memphis, 1992-1994.

Board Certifications in Medicine :

— Board Certified in Surgery — American Board of Surgery, 1992, in

— Board Certified in Plastic Surgery — American Board of Plastic Surgery, 1997; American Board of Plastic Surgery, 2008.

Medical Staff Appointments :

EXHIBIT A

— Staff General Surgeon at the Naval Hospital Oakland, CA 1991-1992

— Associate Professor of Surgery, UC Davis-East Bay, 1991-1992.

— Plastic and Reconstructive Surgeon, Naval Medical Center, Portsmouth, VA
1994-2002

— Chairman, Department of Plastic and Reconstructive Surgery, Naval Hospital
Portsmouth, VA 1996-2002.

— Clinical Assistant Professor, Department of Surgery, Uniformed Services University of
the Health Sciences, 1995-2002

— Founding Director, Pediatric Cleft Palate and Craniofacial Deformities Clinic, Naval
Hospital Portsmouth, VA 1996-20002

— Founding Director, Wound Care Center, Naval Hospital Portsmouth, VA 1995-2002.

— Staff Plastic Surgeon in Nebraska, and Alabama.

U.S. Surgeon General Service:

— Specialty Leader, Plastic and Reconstructive Surgery, Office of the Surgeon General-
USN, 1997-2002

Faculty Appointments:

— Teaching Faculty at Eastern Virginia Medical School, Division of Plastic Surgery,
1995-2002

Military Service :

- Aviation Officer Candidate, Naval Aviation Schools Command, NAS Pensacola, 1978
- Commissioned an Ensign, MC, USNR 1979 and Commissioned as a Lieutenant, MC, USN 1983 .
- Designated Naval Flight Surgeon, Naval Aerospace Medical Institute, 1985
- Flight Surgeon, Marine Fighter/ Attack Squadron-451
- Radar Intercept Officer in the Marine F-4S Phantom, accumulating 235 flight hours, and trained for qualification as an Air Combat Tactics Instructor.
- Deployed to the Western Pacific as UDP forward deployed fighter squadron in Korea, Japan, and the Philippines.
- Service in the US Navy for 24 years
- Service in the US Marine Corp. for 3 years.
- Retired with the rank of Captain, USN in 2002

Military Awards:

- Navy Commendation Medal - For service with Marine Fighter/Attack Squadron - 451
- Meritorious Unit Citation- 3rd award
- Humanitarian Service Medal - For service in the aftermath of the Loma Prieta earthquake.

Publications - Peer Reviewed Medical Journals :

- Lappert PW. Peritoneal Fluid in Human Acute Pancreatitis. Surgery. 1987 Sep;102(3):553-4

- Toth B, Lappert P. Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning. *J Plastic and Reconstructive Surgery*. 1991; 87: 1048-53
- Lappert P. Patch Esophagoplasty. *J Plastic and Reconstructive Surgery*. 1993; 91 (5): 967-8
- Smoot E C III, Bowen D G, Lappert P, Ruiz J A. Delayed development of an ectopic frontal sinus mucocele after pediatric cranial trauma. *J Craniofacial Surg*. 1995;6(4):327–331.
- Lappert PW. Scarless Fetal Skin Repair: “Unborn Patients” and “Fetal Material”. *J Plastic and Reconstructive Surgery*. 1996 Nov;98(6):1125
- Lappert PW, Lee JW. Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation. *Plastic and Reconstructive Surgery* 1998;102(5):1642-5.

Publications - Medical Textbooks:

- Wound Management in the Military. Lappert PW, Weiss DD, Eriksson E. *Plastic Surgery: Indications, Operations, and Outcomes*, Vol. 1; 53-63. Mosby. St. Louis, MO 2000

Operations and Clinical Experience - Consultations and Discussions : As a physician and surgeon, I have treated many thousands of patients in 7 states and 4 foreign nations. My practice has included Primary Care, Family Medicine, Aerospace Medicine, General Surgery, Reconstructive Surgery for combat injured, cancer reconstructive surgeries including extensive experience with microvascular surgery, Pediatric Congenital Deformity, and the care of chronic wounds. I have practiced in rural medicine, urban trauma centers, military field hospitals, university teaching hospitals, and as a solo private practitioner. In my private practice I have had

occasion to treat many self-identified transgender patients for skin pathologies related to their use of high dose sex steroids, laser therapies for management of facial hair both in transitioners and detransitioners. I have performed breast reversal surgeries for detransitioning patients. My practice is rated as "LGBTQ friendly" on social media. I have consulted with families with children who are experiencing gender discordance. I have given many presentations to professional meetings of educators and counselors on the subject of transgender, and the present state of the science and treatment. I have discussed the scientific issues relevant to the case with many physicians and experts over a number of years and also discussed related issues with parents and others.

EXHIBIT F



AMERICAN SOCIETY OF PLASTIC SURGEONS

[Advocacy](#) / [Advocacy News](#)

State Focus on Gender Affirmation Intensifies

Thursday, February 25, 2021

Policy around transgender care has recently gained considerable attention amid a growing trend of legislation carrying serious professional, financial or criminal penalties for the provision of gender affirmation care. Conversely, although less extensively, efforts to expand coverage for transgender services among both public and third-party payer programs are also taking place.

This period of focused conversation centered on transgender care has been marked by both significant challenges and notable gains in the fight for full access to medically necessary affirming health care.

Background

Gender affirmation is a developing field of medical and surgical practice in which plastic surgeons play a pivotal role, leading the field in many of the physical transformative procedures often involved in gender affirmation.

Like many conditions, gender dysphoria and the process of gender affirmation requires a multidisciplinary approach. Physical, psychological and psychosocial treatment are all components of the gender affirmation process. These components of care – and particularly psychological assessment of gender dysphoria – often begin in childhood and early adolescence. Legislation that seeks to criminalize gender therapy targets this part of the care continuum.

A growing legislative trend

State legislation designed to criminalize gender affirming care first emerged in 2016. The frequency of such bills increased in the years that followed, but 2020 was a particularly active year, seeing six states with bills introduced on the issue. The volume and intent of the legislation between 2016 and 2020 resulted in transgender advocacy groups classifying the bills as "hostile." Last year was also notable because it marked the first instance in which one of the aforementioned bills successfully passed a state legislative chamber.

In 2020, the South Dakota House of Representatives passed legislation prohibiting gender-affirming care for minors and leveling serious consequences for physicians found in violation of the law, including possible jail time. The state's Senate ultimately defeated the bill and prevented it from being enacted into law, but the relative success of the legislation was concerning and may have inspired a number of similar bills that would soon follow.

Less than three months into 2021, 11 pieces of legislation attempting to criminalize gender affirmation therapies have been introduced in 10 states. Alabama, Indiana, Iowa, Mississippi, Missouri, Montana, New Hampshire, Oklahoma, Texas and Utah have each introduced bills seeking to regulate the practice of medicine by banning certain procedures for minors and criminalizing the actions of health care providers who elect to administer gender affirmation care.

While the legislative concepts vary by state, the common threads include a prohibition of gender affirmation care for minors, identification of specific procedures and therapies that cannot be performed by the state's health care practitioners and a stipulation that it is illegal for a minor's parents or guardians to consent to the procedures. Penalties for health care providers, guardians and even school counselors found in violation of the laws vary widely and range from a fine of up to \$500,000, to notifying child protective services and even classification of the guilty party as a felon.

Efforts to expand coverage

Contrary to the disturbing trend of legislation looking so severely at limiting gender-affirming care that it seeks to make criminals out of some of those involved, concerted efforts are also underway to expand coverage for the transgender community.

In one notable example, Aetna announced in January the expansion of its coverage for gender-affirming surgeries for transgender women. The insurer now covers gender-affirming breast augmentation in most plans, bringing coverage for the procedure into alignment with coverage for other surgeries common in transgender patients, such as breast removal or gender-reassignment.

Additionally, several states have worked to expand gender affirmation coverage. On February 12, ASPS wrote a letter in support of an emergency rule from the Wisconsin Department of Health Services that would repeal current restrictions and expand coverage for transgender Medicaid members. Similar amendments were proposed to the Washington Administrative Code and received the support of the Society via public comment in late January after ASPS involvement in the development of the policy that dates back to 2018.

ASPS involvement

ASPS firmly believes that plastic surgery services can help gender dysphoria patients align their bodies with whom they know themselves to be and improve their overall mental health and well-being. In 2021, the Society has actively opposed legislation seeking to criminalize actions by physicians and guardians when minors receive gender affirmation surgery in Missouri, Montana and Alabama and is readying engagement in other states where the issue has emerged. ASPS will continue its efforts to advocate across state legislatures for full access to medically necessary transition care.

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Memo Outlining Evidence for Change for Gender Identity Disorder in the DSM-5

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Introduction

In 2008, when the diagnostic Work Groups for the DSM-5 were established and formally announced by the American Psychiatric Association, one of the first tasks was to review the existing diagnostic categories and to conduct literature reviews. The Gender Identity Disorders (GID) subworkgroup was one of three subworkgroups of the Sexual and Gender Identity Disorders Work Group. Like other working groups, its charge was to evaluate what was, if anything, “good” about the existing diagnosis of GID in the DSM-IV-TR and what, if anything, required changes. The subworkgroup published four literature reviews in which some initial

proposals and recommendations were made (Cohen-Kettenis & Pfäfflin, 2010; Drescher, 2010; Meyer-Bahlburg, 2010; Zucker, 2010). The subworkgroup had feedback from its advisors, from other professionals, and from the public, including three periods of APA-sponsored feedback on the DSM-5 website.

Around mid-way during the DSM-5 preparation period, which ended on 1 December 2012, the Task Force added to the review phase two additional committees. One was a Scientific Review Committee (SRC) and the second was a Clinical and Public Health Committee (CPHC).

The SRC was charged with providing feedback on all proposed changes to the diagnostic criteria that were based on empirical evidence. The CPHC was charged with providing feedback with regard to additional parameters, such as clinical utility and public health concerns.

Each Work Group or subworkgroup of the DSM-5 Task Force justified the proposed changes of diagnostic categories in a report entitled Memo Outlining Evidence for Change (MOEC). With the permission of the American Psychiatric Association, we reproduce here the final version of the MOEC prepared by the GID subworkgroup (“in press” references have been updated and typographical errors corrected). Publication of the MOEC thus makes transparent the argumentation advanced by the subworkgroup for interested readers. Comments on the proposal are welcome in the form of a Letter to the Editor of this Journal.¹

Memo Outlining Evidence for Change

Eleven substantive changes were proposed:

1. Change in name of the diagnosis from GID to Gender Dysphoria (GD).

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2. Decoupling of the GID diagnosis from the Sexual Dysfunctions and Paraphilias (Sexual and Gender Identity Disorders in the DSM-IV-TR) and placement in a separate chapter.
3. Change in the introductory descriptor to the Point A criterion.
4. Merging of what were the Point A and B criteria in the DSM-IV-TR.
5. For children, the A1 criterion is proposed to be a necessary indicator for the GD diagnosis.
6. For children, there are minor wording changes to the diagnostic criteria, especially A1–A6. The wording for A7–A8 has been simplified compared to DSM-IV-TR (examples will be given in the text).
7. For adolescents and adults, the proposed diagnostic criteria are much more detailed than they were in DSM-IV-TR and, like the proposed criteria for children, are polythetic in form.
8. For the Point B criterion (in the current diagnostic proposal for DSM-5), we have proposed a particular change in wording to capture distress, impairment, and increased risk of suffering or disability.
9. Elimination of the sexual attraction specifier for adolescents/adults.
10. Inclusion of a subtype pertaining to the presence (or absence) of a disorder of sex development (DSD). A DSD includes (but covers more than) what, in the past, were termed physical intersex conditions.
11. Inclusion of a “Post-transition” specifier (for adolescents/adults).

For each proposed change, we summarize the reasons and, when based on data, indicate the empirical basis that we believe justifies the change. For some of the proposed changes noted below, we relied on secondary data analyses utilizing the best data available to us since the DSM-5 Task Force did not include GID in its field trials.

Evidence for Change

Change in Name of the Diagnoses to GD in Children and GD in Adolescents and Adults

In response to criticisms in some quarters that the term GID was stigmatizing (Drescher, 2010), we originally proposed to replace it with the term Gender Incongruence. This was also accompanied by a re-definition of the condition (see the Point A descriptor in Tables 2, 3). The new term, Gender Incongruence, was descriptive and avoided any presupposition of the presence of clinically significant distress or impairment as a requirement for the diagnosis (Meyer-Bahlburg, 2010). In part, this presupposition was based on a more general discussion in the DSM-5 Task Force on separating out the distress/impairment criterion,

with these parameters evaluated as separate dimensions (note, however, that it is very likely that the distress/impairment criterion will be retained in DSM-5, so this line of thinking by us has been abandoned—see below). The proposed change in name, and its rationale, was documented on the DSM5.org website in February 2010 at the time of the first round of commentaries by other professionals and the general public, including “consumers” of psychiatric services and by transgender communities and their supporters.

On the open APA website, we received many favorable comments about the proposed name change, particularly with regard to the removal of the “Disorder” label from the name of the diagnosis. We also had support for this name change in an international survey of consumer organizations that we conducted (Vance et al., 2010). However, we also received many comments from reviewers of the open APA website, as well as from members of the World Professional Association for Transgender Health (WPATH, formerly the Harry Benjamin International Gender Dysphoria Association), expressing concerns that the new descriptive term could easily be misread as applying to individuals with gender-atypical behaviors who had no gender identity problem.

Many commentators recommended “gender dysphoria” as a semantically more appropriate term (e.g., De Cuypere, Knudson, & Bockting, 2010) because it captures an aversive emotional component. In this regard, it should be noted that the term “gender dysphoria” has a long history in clinical sexology (see Fisk, 1973) and thus is one that is quite familiar to clinicians who specialize in this area. Thus, in our revised posting of May 4, 2011, we made public a second proposed change in the diagnostic term from GID to GD. This proposed name change is also consistent with the general argument that the diagnostic term should, in a more transparent way, indicate that it pertains to “distress” (dysphoria) and not identity per se (Knudson, De Cuypere, & Bockting, 2010). Indeed, in the September 2011 release of the 7th version of *Standards of Care* issued by WPATH (2011), the term gender dysphoria is used to outline both assessment and therapeutic approaches for children, adolescents, and adults.²

In summary, it is our view that the proposed name change from GID to GD will (1) highlight a conceptual change in the formulation of the diagnosis (which we will amplify in the text description of the diagnosis) and (2) satisfy critics concerned about the stigmatizing use of the “disorder” term in the name of the diagnosis. The proposed name change to GD has been quite favorably received during the second round of public postings, is acceptable to WPATH experts, and is consistent with some other diagnostic terms in the DSM, such as Anorexia Nervosa,

² Subsequently published in Coleman et al. (2011).

Encopresis, and Enuresis, which do not have the term “disorder” in the diagnostic name.

Decoupling of the GID Diagnosis from the Sexual Dysfunctions and Paraphilias

In the DSM-III, the GID diagnosis was placed in the section called Psychosexual Disorders, along with Paraphilias and Psychosexual Dysfunctions (now termed Sexual Dysfunctions). In the DSM-III-R, the three main GID diagnoses (GID of Childhood, Transsexualism, and GID of Adolescence or Adulthood, Nontranssexual Type) were moved to the section termed Disorders Usually First Evident in Infancy, Childhood or Adolescence whereas the Paraphilias and Sexual Dysfunctions appeared in the section termed Sexual Disorders. In the DSM-IV and DSM-IV-TR, the three major diagnostic classes (GID, Sexual Dysfunctions, and the Paraphilias) all appeared in the section termed Sexual and Gender Identity Disorders.

The placement of these three diagnostic classes in the same section in DSM-IV was probably influenced by several considerations, including clinical utility (e.g., that clinicians and researchers who study these phenomena tend to affiliate at common scientific meetings, tend to publish in the same periodicals, and probably have at least some familiarity with all of the conditions more so than clinicians and researchers who specialize in other areas of interest to psychiatry).

Yet, it is also recognized that each of these three diagnostic classes have their own specialists and the theoretical overlap among these conditions is far from complete. For example, sexual dysfunctions are of little direct relevance to GID as it manifests in children. Some critics have also complained that inclusion of GID in a section of the manual that also includes the paraphilias is somewhat stigmatizing.

Although there can be a co-occurrence of one paraphilia, Transvestic Fetishism, with GID in adolescents and adults, it was the consensus of the entire Sexual and Gender Identity Disorders Work Group that the three diagnostic classes be uncoupled, with each having a separate chapter in DSM-5. As of this writing, this recommendation has been accepted by the DSM-5 Task Force.

Change in the Introductory Descriptor to the Point A Criterion

In both GD of Childhood and GD of Adolescence and Adulthood, the proposed introductory descriptor reads as follows: “A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least...” In the DSM-IV-TR, the introductory descriptor reads as follows: “A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).” The reasons for the proposed changes are as follows:

- (a) The use of the term “incongruence” is a descriptive one that better reflects the core of the problem, namely, an incongruence between, on the one hand, the identity that one experiences and/or expresses and, on the other hand, how one is expected to live based on one’s assigned gender (usually at birth) (Meyer-Bahlburg, 2010; Winters, 2005). In our view, this is preferable to the term “cross-gender identification” in that a strictly binary gender identity concept is no longer in line with the spectrum of gender identity variations that one sees clinically.
- (b) The term “sex” has been replaced by assigned “gender” in order to make the criteria applicable to individuals with a DSD (Meyer-Bahlburg, 2009, 2010). During the course of physical sex differentiation, some aspects of biological sex (e.g., 46,XY genes) may be incongruent with other aspects (e.g., the external genitalia); thus, using the term “sex” would be confusing. The change also makes it possible for individuals who have successfully transitioned to the preferred gender to “lose” the diagnosis after satisfactory treatment (see Inclusion of a “Post-transition” specifier below). This resolves a problem that, in the DSM-IV-TR, there is no “exit clause,” meaning that individuals once diagnosed with GID will always be considered to have the diagnosis, regardless of whether they have transitioned and are psychosocially adjusted in the identified gender role (Winters, 2008). The diagnosis without a post-transition specifier will still be applicable to transitioned individuals who have regrets, because they did not feel like the other gender after all. For instance, a natal male living in the female role and having regrets experiences an incongruence between the “newly assigned” female gender and the experienced/expressed (still or again male) gender.
- (c) We recommend deletion of the “perceived cultural advantages” proviso. This was also recommended by our predecessor in the DSM-IV Subcommittee on GID (Bradley et al., 1991). There is no reason to “impute” one causal explanation (in this case, a cultural advantage hypothesis) for GD without mentioning any others (Zucker, 1992, 2010). Deleting this phrase would be consistent with a purely phenomenological approach that eschews any reference to putative underlying causal mechanisms with regard to the diagnostic criteria.
- (d) The 6 month duration was introduced to make at least a minimal distinction between very transient GD (Lindsay, 1994) and persistent GD. The duration criterion was decided upon by clinical consensus. Unfortunately, there is no clear empirical literature supporting this particular period (e.g., 3 vs. 6 months or 6 vs. 12 months). There was, however, consensus in the GID subworkgroup that a lower-bound duration of 6 months would be unlikely to yield false positives.

Merging of the Point A and B Criteria from the DSM-IV-TR

In the DSM-IV-TR, there are two sets of clinical indicators (Criteria A and B). The descriptor for Criterion A was noted above. In DSM-IV-TR, the descriptor for Criterion B reads as follows: “Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.”

This distinction is not supported by factor analytic studies. The existing studies suggest that the concept of GD is best captured by one underlying dimension (Cohen-Kettenis & van Goozen, 1997; Deogracias et al., 2007; Green, 1987; Johnson et al., 2004; Singh et al., 2010; Zucker et al., 1998). Historically, it is of interest to note that our predecessor, the Subcommittee on GID (Bradley et al., 1991) for DSM-IV, had already recommended a merger of the Point A and Point B criteria based, in part, on secondary data analysis (Zucker et al., 1998). For reasons that were never made clear to the Subcommittee, this proposal was rejected. Subsequent to DSM-IV, factor-analytic studies continue to provide evidence in favor of one underlying factor. Mokken scale analysis also supported the merger of the Point A and B criteria (Paap et al., 2011).

For Children, the A1 Criterion Is Proposed to be a Necessary Indicator for the GD Diagnosis

In DSM-IV-TR, there are five symptom indicators for the Point A criterion, of which four (or more) are required to meet the threshold for diagnosis. The A1 criterion reads as follows: “repeatedly stated desire to be, or insistence that he or she is, the other sex.” Given that four symptoms are required to meet threshold for Point A, it is possible that a child would meet threshold based on behavioral surface markers of “cross-gender identification,” i.e., A2–A5. The DSM-IV Subcommittee on GID (Bradley et al., 1991) had argued that there might be a small number of children who showed all the signs of a GID (including the criteria from Point B) (see Table 1), yet did not express the desire to be of the other gender, perhaps because of reasons of social desirability, a harsh social environment, etc. It was therefore argued at the time that the desire to be of the other gender need not be a necessary symptom indicator.

As reviewed in Zucker (2010), some critics of the DSM-IV criteria were concerned that some children who showed pervasive cross-gender behavior (gender nonconformity or gender variance), yet who did not express a desire to be of the other gender, might be inappropriately diagnosed with GID (false positives).

In an attempt to address this criticism, Zucker (2010) conducted a secondary data analysis in which it could be shown that the expressed desire to be of the other gender correlated quite strongly with a series of cross-gender surface behaviors that correspond to the A2–A5 indicators in the DSM-IV. These analyses can be found in Zucker (2010, pp. 484–486). Subsequent to Zucker (2010), we conducted an identical analysis of child

Table 1 DSM-IV-TR criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by at least four (or more) of the following:	1. Repeatedly stated desire to be, or insistence that he or she is, the other sex
	2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex	4. Intense desire to participate in the stereotypical games and pastimes of the other sex
5. Strong preference for playmates of the other sex	In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.	In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.
In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.	C. The disturbance is not concurrent with a physical intersex condition.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Specify if (for sexually mature individuals):
Sexually attracted to males	Sexually attracted to females
Sexually attracted to both	Sexually attracted to neither

patients from a gender identity clinic in Amsterdam (headed by Dr. Cohen-Kettenis, the chair of the GID subworkgroup) and replicated quite precisely the findings reported on by Zucker (2010). These replication findings can be found in Figs. 1–4 of this document. To better understand them, the SRC would find it helpful to first read the findings reported on pp. 484–486 in Zucker (2010).³

It was, therefore, argued that, in DSM-5, the currently proposed A1 criterion be a necessary symptom in making the GD diagnosis. We contend that the presence of this symptom will, if anything, make the diagnosis more restrictive and conservative (Zucker, 2010). Given the critiques leveled at the DSM-IV

³ These figures are not reproduced here but can be found in Zucker (2010).

criteria, it was deemed that reduction of false positives is preferable to false negatives.

The subworkgroup has also recommended that “strong desire” replace “repeatedly stated desire” to capture some children who, in a coercive environment, may not verbalize the desire to be of the other gender. The text will note that the clinician needs to be attentive to the child’s psychosocial environment in considering the presence of this symptom. This will afford the clinician some latitude in forming a judgment about the presence of the A1 indicator.

For Children, There are Minor Wording Changes to the Diagnostic Criteria

For the proposed A2–A8 criteria (see Table 2), there are minor wording changes. For A7 and A8, the wording has been simplified to capture the underlying construct. The desire for the anatomy of the other gender is separated from the rejection of one’s own anatomy. Examples will be provided in the text.

Table 2 Proposed DSM-5 criteria for Gender Dysphoria (in children)

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least 6 of the following indicators (including A1):

1. **A strong desire to be of the other gender or an insistence that he or she is the other gender (or some alternative gender different from one’s assigned gender)**
2. In boys, **a strong preference for cross-dressing or simulating female attire**; in girls, **a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing**
3. **A strong preference for cross-gender roles in make-believe play or fantasy play**
4. **A strong preference for the toys, games, or activities of the other gender**
5. **A strong preference for playmates of the other gender**
6. **In boys, a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; in girls, a strong rejection of typically feminine toys, games, and activities**
7. **A strong dislike of one’s sexual anatomy**
8. **A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender**

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning, or with a significantly increased risk of suffering such distress or disability.

Subtypes

With a DSD

Without a DSD

The proposed changes are in boldface

For Adolescents and Adults, the Proposed Diagnostic Criteria are Much More Detailed than They were in DSM-IV-TR and, Like the Proposed Criteria for Children, are Polythetic in Form

In DSM-IV, the GID criteria for adolescents and adults were somewhat sketchy and, for some, even lacked a reference to intensity or frequency (e.g., “a stated desire to be the other sex”). This has been viewed as problematic (Zucker, 2006).

Although the DSM-IV diagnosis of GID encompasses more than transsexualism, it is still often used as an equivalent to transsexualism (Sohn & Bosinski, 2007). For instance, a man can meet the two core criteria if he only believes he has the typical feelings of a woman and does not feel at ease in the male gender role (see Table 1). The same holds for a woman who just frequently passes as a man (e.g., in terms of first name, clothing, and/or haircut) and does not feel comfortable living as a conventional woman. Someone having a GID diagnosis based on these subcriteria clearly differs from a person who identifies completely with the other gender, can only relax when permanently living in the other gender role, has a strong aversion against the sex characteristics of his/her body, and wants to adjust his/her body as much as technically possible in the direction of the desired gender. Those who are distressed by having problems with just one of the two criteria (e.g., feeling uncomfortable living as a conventional man or woman) will have a GIDNOS diagnosis. This is highly confusing for clinicians. It perpetuates the search for the “true transsexual” in order to identify the right candidates for hormone and surgical treatment instead of facilitating clinicians to assess the type and severity of any type of GD and offer appropriate treatment. Furthermore, in the DSM-IV, gender identity and gender role were described as a dichotomy (either male or female) rather than a multi-category concept or spectrum (Bockting, 2008; Bornstein, 1994; Drescher, 2010; Ekins & King, 2006; Lev, 2007; Røn, 2002). The current formulation makes it more explicit that a conceptualization of GD acknowledging the wide variation of conditions will make it less likely that only one type of treatment is connected to the diagnosis. Taking the above regarding the avoidance of male–female dichotomies into account, in the new formulation, the focus is on the discrepancy between experienced/expressed gender (which can be either male, female, in-between or otherwise) and assigned gender (in most societies male or female) rather than cross-gender identification and same-gender aversion (Cohen-Kettenis & Pfäfflin, 2010).

For the adolescent/adult criteria, we have, therefore, proposed a more nuanced description of the symptom indicators (see Table 3) and they have been written in a polythetic format.

Based on secondary data analysis, we suggest that the presence of at least two indicators (out of 6) is needed to meet the diagnostic criteria for GD. This was based on an analysis of 154 adolescent and adult patients with GID compared to 684 controls (Deogracias et al., 2007; Singh et al., 2010). From a 27-item

Table 3 Proposed DSM-5 criteria for **Gender Dysphoria (in adolescents/adults)**

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least 2 or more of the following indicators:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability
Subtypes
With a DSD
Without a DSD
Specifier
Post-transition, i.e., the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen, namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male, mastectomy, phalloplasty in a natal female).

The proposed changes are in boldface. It should be noted that, for adolescents and adults, the criteria in DSM-IV-TR were written in a relatively vague manner and were not in polythetic format

dimensional measure of gender dysphoria, the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDYQ), we extracted five items that corresponded to the proposed A2–A6 indicators (we could not extract a corresponding item for A1). Each item was rated on a 5-point response scale, ranging from Never to Always, with the past 12 months as the time frame. For the current analysis, we coded a symptom as present if the participant endorsed one of the two most extreme response options (frequently or always) and as absent if the participant endorsed one of the three other options (never, rarely, sometimes). This yielded a true positive rate of 94.2 % and a false positive rate of 0.7 %. These findings suggest that the proposed diagnostic criteria will have a very high true positive rate and a very low false positive rate.

Regarding the A2 criterion, in referring to secondary sex characteristics, anticipation of the development of secondary sex

characteristics has been added for young adolescents. Adolescents increasingly present at gender identity clinics requesting gender reassignment, before the first signs of puberty are visible (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker & Cohen-Kettenis, 2008).

For the Point B Criterion (in the Current Diagnostic Proposal for DSM-5), We have Proposed a Particular Change in Wording to Capture Distress, Impairment, and Increased Risk of Suffering or Disability, Including “A Significantly Increased Risk of Suffering Such Distress or Disability”

This is based on a consensus in the subworkgroup that some adolescents who are planning gender change and are undergoing puberty-blocking hormonal therapy are not distressed when a clear path towards gender change is mapped out for them, but may become strongly distressed if parents or others try to strongly block this path.⁴

Elimination of the Sexual Attraction Specifier for Adolescents/Adults

In DSM-IV, for sexually mature individuals, there is a specifier pertaining to sexual attraction (sexual orientation): sexually attracted to males, sexually attracted to females, sexually attracted to both, sexually attracted to neither.

There is considerable evidence that the sexual attraction specifier (perhaps better characterized as a subtype) is associated with meaningful differences among GD adolescent and adult patients (see, e.g., Blanchard, 1994; Lawrence, 2010; Nieder et al., 2011; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005; Zucker et al., 2012), such as age-of-onset of GD symptoms, degree of expression of cross-gender behavior in childhood, age at presentation for clinical evaluation, marital status, co-occurrence with Transvestic Disorder, etc. These findings likely reflect underlying differences in causal mechanisms among subgroups of GD patients.⁵ This has been particularly so for natal males with GD, who show much more variability in their sexual attraction patterns than do natal females with GD (Kreukels et al., 2012). Lawrence (2010), among others, has provided an exhaustive review on this topic.

The subworkgroup reviewed this literature carefully and came to the conclusion that sexual attraction (sexual orientation) per se

⁴ This proposal did not make its way into the DSM-5 (American Psychiatric Association, 2013). Instead, the DSM-5 adopted a common template with regard to distress/impairment across most diagnoses: “The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning” or “The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.”

⁵ “...differences in casual mechanisms...” could have been phrased as “differences in developmental pathways.”

plays only a minor role in contemporary treatment protocols or decisions. This is very different from what happened clinically in the early years of gender-reassignment surgery decisions that were managed by psychiatrists in specialized gender identity clinics who would only provide treatment to individuals attracted to their own natal sex and would not endorse the medical creation of post-operative “homosexuals.” This change in treatment protocols for adults is reflected in the recent Standards of Care issued by the WPATH (2011).² In the entire document, the term sexual orientation or sexual attraction is not even mentioned, suggesting a contemporary consensus that sexual orientation or sexual attraction is of minimal importance to treatment providers.

Although it is accurate to state, for example, that cases of “regret” after gender-reassignment surgery occur most often among natal males with a gynephilic or bisexual sexual orientation (e.g., Blanchard, Steiner, Clemmensen, & Dickey, 1989; Olsson & Möller, 2006), the absolute percentage of regrets is rather low (Gijs & Brewaeys, 2007; Green & Fleming, 1990; Pfäfflin & Junge, 1992, 1998). As a result, the subworkgroup has recommended deleting this specifier. Because sexual attraction (sexual orientation) subtyping is of interest to researchers in the field, it is recommended that reference to it be addressed in the text (but not as a specifier).⁶ This recommended change (from a specifier to text) should also reduce the widespread suspicion,⁷ especially in LGB (lesbian, gay, bisexual) circles, that the GID diagnosis was originally introduced into the DSM as a cryptic way to maintain the psychopathologization of homosexuality (Drescher, 2010; Zucker & Spitzer, 2005). Lastly, it is noted here that the Paraphilias subworkgroup, for the diagnosis of Transvestic Disorder, has recommended that there be a specifier termed With Autogynephilia (Sexually Aroused by Thought or Image of Self as Female) (Blanchard, 2010) or With Autoandrophilia (Sexually Aroused by Thought or Image of Self as Male) (see www.dsm5.org).

Inclusion of a Subtype Pertaining to the Presence (or Absence) of a DSD

In DSM-III, the presence of a DSD was not an exclusionary criterion for GD, but it became one in DSM-IV.

In the meantime, considerable additional evidence has accumulated that some individuals with a DSD experience GD and may wish to change their assigned gender; the percentage of such individuals who experience GD is syndrome-dependent (Cohen-

Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Mazur, 2005; Meyer-Bahlburg, 1994, 2005, 2009, 2010). From a phenomenologic perspective, DSD individuals with GD have both similarities and differences to individuals with GD with no known DSD (Meyer-Bahlburg, 1994, 2009; Richter-Appelt & Sandberg, 2010). Developmental trajectories also have similarities and differences. The presence of a DSD is suggestive of a specific causal mechanism that may not be present in individuals without a diagnosable DSD.

Inclusion of a “Post-transition” Specifier

For adolescents and adults, we proposed a new specifier provisionally labeled “Post-transition.” The addition of this specifier is prompted by the observation that many individuals, after transition, do not meet any more the criteria set for GD; however, they continue to undergo chronic hormone treatment, further gender-confirming surgery, or intermittent psychotherapy/counseling to facilitate the adaptation to life in the desired gender and the social consequences of the transition. Although the concept of “post-transition” is modeled on the concept “in [partial or full] remission” as used for mood disorders, “remission” has implications in terms of symptom reduction that do not apply directly to GD. Cross-sex hormone treatment of gonadectomized individuals could, of course, be coded as treatment of hypogonadism, but this would not apply to individuals who have not undergone gonadectomy but receive hormone treatments. In the text, we will, however, also mention that the course specifier of “full remission” in its original meaning does apply to many children with the diagnosis of GD and, perhaps, to a small number of adolescents and adults.

Antecedent Validators

Familial Aggregation

Within sex, there is evidence that the broad construct of gender identity/gender role behavior has a heritable component along with evidence for both shared and non-shared environmental influences (Bailey, Dunne, & Martin, 2000; Elizabeth & Green, 1984; Iervolino, Hines, Golombok, Rust, & Plomin, 2005; Knafo, Iervolino, & Plomin, 2005; Mitchell, Baker, & Jacklin, 1989; van Beijsterveldt, Hudziak, & Boomsma, 2006). In terms of the more narrow construct of GID or GD, there is also evidence of a heritable component (Coolidge, Thede, & Young, 2002). In a review of the twin literature on GID, including unpublished case series from specialized gender identity clinics, concordance for GID was significantly higher among MZ twins than among DZ same-sex twins (Heylens et al., 2012). There is also some evidence that GID runs in families when one studies non-twin siblings (Gómez-Gil et al., 2010), but, in terms of absolute numbers, familiarity among non-twin siblings is quite low.

⁶ In Dr. Drescher’s response to a query from the Board of Trustees, he wrote that “The absence of a sexual orientation specifier should not inhibit research in this area, any more than the absence of a ‘gender specifier’ for Major Depression or Schizophrenia inhibits research on sex differences in those (or any other) diagnostic categories.”

⁷ The word “concern” would have been preferable to “suspicion.”

Sociodemographic and Cultural Factors

The prevalence of GD may well be higher among natal males than among natal females. In terms of referral rates in childhood (perhaps an indirect marker of prevalence), the sex ratio has favored boys to girls in a number of samples in the U.S., Canada, and the Netherlands (Cohen-Kettenis et al., 2003; Green, 1987). It is possible that the threshold for referral is lower in boys than in girls, since cross-gender behavior in boys is less tolerated than such behavior is in girls and subject to more social sanctions. However, in one study, the percentage of boys and girls diagnosed with GID was comparable (Cohen-Kettenis et al., 2003), but there is also some evidence that girls referred clinically for gender problems show more extreme behavior than boys on dimensional measures (Zucker, Bradley, & Sanikani, 1997a).

The sex ratio in referral rates, however, appears to narrow by adolescence but males still outnumber females (Garrels et al., 2000; Kreukels et al., 2012; Zucker & Lawrence, 2009; Zucker et al., 2012).

GD appears to be expressed in many cultures, including non-Western countries (e.g., Koon, 2002). In Samoa, for example, the fa'afafine constitute a kind of "third gender" category, who, from a phenomenological perspective, bear striking similarity to the Western category of transsexualism or GD. Fa'afafine are biological males who gradually transition to live in this labeled third gender category. The term itself translates into "in the fashion of a woman" (Bartlett & Vasey, 2006; Besnier, 1994). Interestingly, there is very little indication of a corresponding third gender category for natal females in Samoa.

Compared to base rates in the general population, clinic-referred boys with GD show an overrepresentation among adoptees (Zucker & Bradley, 1998) although it is quite likely that the rate is not higher than in clinic-referred children in general.

Individuals with specific DSD diagnoses are at heightened risk for GD. Chromosomal females who have been exposed to higher than normal levels of prenatal androgen, as in the case of congenital adrenal hyperplasia, have an elevated rate of GD compared to population base rates (Dessens et al., 2005). Chromosomal males with at least some degree of male-typical levels of prenatal androgen exposure, who are nevertheless assigned female at birth because of marked genital ambiguity, also show an elevated risk for GD as do chromosomal males with apparently normal prenatal androgen levels who are assigned female because of a congenital absence of the penis or its extremely poor differentiation as in the case of cloacal exstrophy (Meyer-Bahlburg, 2005).

Environmental Risk Factors

Boys with GD (both children and adolescents) have an excess of brothers and are later born among their siblings, particularly brothers (Blanchard, Zucker, Bradley, & Hume, 1995;

Blanchard, Zucker, Cohen-Kettenis, Gooren, & Bailey, 1996; Schagen, Delemarre-van de Waal, Blanchard, & Cohen-Kettenis, 2012; Zucker et al., 1997b). Similar findings have been reported for adult males with GD, including Samoan fa'afafine (Blanchard & Sheridan, 1992; Gómez-Gil et al., 2011; Green, 2000; Poasa, Blanchard, & Zucker, 2004; VanderLaan & Vasey, 2011). This fraternal birth order effect, which has also been found repeatedly in gay men without GD, has been postulated to result from a progressive maternal immune response to male fetuses that affects the sexual differentiation of the brain but without affecting the sex-dimorphic differentiation of the genitalia (for review, see Blanchard, 2001; Bogaert & Skorska, 2011).

Boys with GD also have a lower birthweight after taking into account the number of older brothers (Blanchard et al., 2002).

Prior Psychiatric History

No data are available for this parameter.

Concurrent Validators

In providing an appraisal of concurrent validators, one line of evidence has been to identify variables in which there is a shift in the direction of the desired gender or a way from the natal gender. Although this model does not necessarily apply to all relevant validators, it is common enough to alert the reader to this underlying conceptual model (for a sketch of this conceptual model, see Meyer-Bahlburg, 2011).

Cognitive, Emotional, Temperamental, and Personality Correlates (Unrelated to the Diagnostic Criteria)

Boys with GD perform relatively more poorly on visual-spatial tasks than on verbal tasks taken from standardized IQ tests (Zucker & Bradley, 1995, pp. 167–171). Two studies of GD adults have also shown that sex-dimorphic cognitive ability patterns appear to be intermediate between that of control males and females (Cohen-Kettenis, van Goozen, Doorn, & Gooren, 1998; van Goozen, Slabbekoorn, Gooren, Sanders, & Cohen-Kettenis, 2002). In one fMRI study, Schöning et al. (2010) showed that GD adult males, during a spatial cognition task, had less activation of the left parietal cortex (BA 40) than control males.

Boys with GD have a lower parent-reported physical activity level (a sex-dimorphic dimension of temperament) than control boys whereas girls with GID have a higher parent-reported activity level than control girls. Indeed, parent-reported activity level of GD children is sex-inverted compared to control children (Zucker & Bradley, 1995, pp. 189–193).

Biological Markers

Genetics There are no published molecular genetic studies of GD patients. It is unusual to find an abnormal sex chromosome karyotype in patients with GD (Inoubli et al., 2011), but it is possible that the prevalence is elevated compared to base rates in the general population. Nonetheless, most specialized gender clinics do not routinely screen for abnormal sex chromosome patterns.

Hormonal Factors In adult natal females with GD, some reports suggested an elevated rate of polycystic ovary syndrome (e.g., Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997; Futterweit, Weiss, & Fagerstorm, 1986), including an astonishing prevalence of 56 % in one Japanese sample (Baba et al., 2007). One recent more rigorous methodological study using the Rotterdam 2003 criteria, however, suggested no elevated rate compared to controls (Mueller et al., 2008).

Sexual differentiation of the mammalian brain is influenced by prenatal sex hormone activity. Consequently, it has been hypothesized that abnormalities in genes that code for sex hormone receptors or for enzymes that catalyze the synthesis or metabolism of sex hormones might show associations with GD/transsexualism. Candidate genes include those coding for the androgen receptor (AR), estrogen receptor alpha (ER α), estrogen receptor beta (ER β), and progesterone receptor (PR) and for the enzymes aromatase (CYP19), 17-alpha-hydroxylase (CYP17), and 5-alpha-reductase, type II (SRD5A2). Most studies have investigated differences between transsexual/GD patients and same-sex controls in mean repeat numbers of specific polymorphisms in candidate genes or in the frequencies of specific mutant alleles or genotypes. None have attempted to differentiate between transsexual/GD subtypes. In these studies, all of the probands studied were GD patients without a co-occurring DSD.

Henningsson et al. (2005) found no significant differences between GD males and same-sex controls for the AR or CYP19 genes, but did find a significant difference for the ER β gene. Hare et al. (2009) examined the same three candidate genes in GD males and same-sex controls, but obtained different results: No significant differences for the CYP19 or ER β genes, but a significant difference for the AR gene, albeit using a one-tailed test; a two-tailed test would have been non-significant (moreover, the “false positive” rate among the controls was substantial). Bentz et al. (2007) reported no differences between GD males and same-sex controls or GD females and same-sex controls for the SRD5A2 gene. Bentz et al. (2008) found no differences between GD males and same-sex controls for CYP17 alleles and genotypes, but did find a significant difference in the case of GD females and same-sex controls. Ujike et al. (2009) detected no significant differences between GD males and same-sex controls or GD females and same-sex controls for the AR, ER α , ER β , PR, or CYP19 genes. In summary, there is mixed evidence

at present that abnormalities related to molecular genetics account for GD/transsexualism: Most investigations have yielded negative results and most positive results have not been replicated by other investigators.

Neuroanatomy Luders et al. (2009) used MRI to compare regional gray matter volumes in 24 GD males (6 androphilic, 18 non-androphilic) and male and female control subjects; the pattern observed in the GD males more closely matched the male controls. Subsequent MRI studies, however, have been more suggestive of an intermediate pattern of sex-dimorphic neural structures between that of control males and control females (Rametti et al., 2011a, b; Savic & Arver, 2011). This has been shown to be particularly true for GD adults with an “early onset” (i.e., in childhood, not adolescence) of GD traits (Savic & Arver, 2011).

The central division of the bed nucleus of the stria terminalis (BSTc), a hypothalamic or limbic nucleus, is sexually dimorphic: significantly larger in men than in women. Zhou, Hofman, Gooren, and Swaab (1995) conducted a postmortem study of six GD males and found that mean BSTc was small in size and in neuron number and female-typical, a sex-reversed pattern. The GD males supposedly included both the androphilic and non-androphilic subtypes. Kruijver et al. (2000) studied the same six GD males and found that mean neuron number in the BSTc was also sex-reversed. Similar postmortem findings in a GD male who had never received hormone therapy suggested that cross-sex hormone therapy could not account for the sex-reversed pattern. Kruijver et al. proposed that “transsexualism may reflect a form of brain hermaphroditism” (p. 2041).

The validity of this putative marker was challenged by the discovery that the BSTc does not become sexually dimorphic until adulthood, long after the symptoms of GD typically appear (Chung, De Vries, & Swaab, 2002). Magnetic resonance imaging (MRI) studies also demonstrated that hormone therapy in MtF transsexuals was associated with significant reductions in the volume of the brain globally and the hypothalamus particularly (Hulshoff Pol et al., 2006). Hulshoff Pol et al. conjectured that, in the Zhou/Kruijver studies, “the altered size of the bed nucleus of the stria terminalis could have been due to the exposure of cross-sex hormones in adult life” (p. S108). Additional information about the sexual orientation of the six Zhou/Kruijver GD males, reported by Garcia-Falgueras and Swaab (2008), was consistent with the hypothesis that all were non-androphilic.

In another study of 11 GD males, Garcia-Falgueras and Swaab (2008) reported that the INAH-3 subnucleus of the hypothalamic uncinate nucleus was similar to that of control females with regard to volume and number of neurons.⁸

⁸ The material in this section was drawn from Lawrence and Zucker (2012).

Cerebral Dominance and Anthropometrics Several studies have identified an elevated rate of left-handedness or non-right-handedness in GD boys and GD adult males (Green & Young, 2001; Zucker, Beaulieu, Bradley, Grimshaw, & Wilcox, 2001). However, it is not yet clear if this elevation is diagnostic-specific or characteristic of clinical populations in general. Note here that these findings, if valid, suggest an “exaggerated” male-typical pattern since natal males are more likely to be left-handed than natal females. Evidence for an elevation in non-right-handedness in GD adult females was also reported by Green and Young (2001).

The ratio between the length of the second and fourth digit (2D:4D) shows a strong sex-dimorphic pattern, with a smaller ratio found in natal males than in natal females. There is some evidence for a masculinized pattern of 2D:4D in adult females with GD, but the evidence is much more mixed with regard to adult males with GD (Wallien, Zucker, Steensma, & Cohen-Kettenis, 2008). One study did not find any evidence for an altered 2D:4D pattern in children with GD (Wallien et al., 2008).

Patterns of Co-morbidity

On standardized parent-report measures of behavior problems, such as the Child Behavior Checklist (CBCL), both boys and girls with GD in clinical samples have rates of behavior problems comparable to that of other clinic-referred children (especially when matched carefully for demographic factors) and higher than that of non-referred children, including siblings (Cohen-Kettenis et al., 2003; Zucker & Bradley, 1995). On the CBCL, boys with GD have a predominance of “internalizing” as opposed to “externalizing” behavior problems whereas for girls with GD the pattern is more equally distributed across these two broad-band types of behavior problems. Similar findings have been obtained using teacher ratings using the Teacher’s Report Form variant of the CBCL (Steensma, Zucker, Kreukels, & Cohen-Kettenis, 2012; Zucker & Bradley, 1995). There is also some evidence that boys with GD have elevated rates of separation anxiety traits (Coates & Person, 1985; Zucker, Bradley, & Lowry Sullivan, 1996). Lastly, one study showed that children with GD had an elevation in skin conductance level, a physiological marker of anxiety, during a psychological challenge task (Wallien, van Goozen, & Cohen-Kettenis, 2007). Adolescents with GD have elevated rates of behavior problems on the Youth Self-Report Form variant of the CBCL compared to non-referred youth (de Vries, Postema, Steensma, & Cohen-Kettenis, 2011; Zucker et al., 2012). Adults with GD also have elevated rates of psychiatric problems although there is a great deal of variance as a function of method and measures (for review, see Lawrence & Zucker, 2012). There is now also emerging evidence of a relation between GD and autism-spectrum disorders (de Vries et al., 2010; Jones et al., 2012). This is of interest because both disorders are

expressed early in development and both show a sex ratio that favors natal males.

Lastly, one important population-based matched cohort study found that the overall morbidity and mortality for GD patients was higher at follow-up than for same-sex controls (Dhejne et al., 2011). There was an increased risk for suicide attempts and a higher rate of psychiatric inpatient care. There was also a higher rate of death, particularly death from suicide.

The higher rate of psychiatric co-morbidity is likely related to a number of factors, including the stigma associated with having GD (e.g., peer ostracism, familial rejection, societal discrimination) as well as generic risk factors, such as the presence of various psychiatric disorders in first-degree relatives.

Predictive Validators

Diagnostic Stability

If one follows children with GD longitudinally, the “persistence” of GD into adolescence and adulthood is variable, ranging from 2 % to 50 % (e.g., Green, 1987; Drummond, Bradley, Badali-Peterson, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008; Zucker, 2011; Zuger, 1984); however, relative to base rates of GD in the general population (however that may be defined), the persistence rate is markedly higher. It should be noted that these follow-up reports cannot be characterized as “natural history” studies, as the children were all seen in clinical settings and one could argue that clinician recommendations, involvement in therapy, etc. contributed, at least in part, to the high rate of “desistance.” Nonetheless, that there is some indication of persistence provides evidence for diagnostic stability.

In adolescents and adults, there is considerable evidence of diagnostic stability. For many adolescents and adults, the gender-related distress does not lessen until there is treatment with contra-sex hormones and/or gender-reassignment surgery and the patient transitions to living in the preferred gender (Gijs & Brewaeys, 2007; Green & Fleming, 1990; Pfäfflin & Junge, 1992, 1998).

Course of Condition

The information here is similar to that for diagnostic stability. In general, it appears that the course of GD becomes more fixed over developmental time, with a narrowing of plasticity as affected individuals reach adolescence or adulthood.

Response to Treatment

By definition, full social transitioning and legal sex/gender reassignment make the diagnostic criteria no longer applicable, although these steps support the behavior pattern that was incongruent with the natal sex. These steps also usually reduce

or relieve the distress of the individual. Note that psychosocial and medical approaches that assist individuals with GD in transitioning to a life-style commensurate with their desired gender has no parallel in any other psychiatric category.

There is a great deal of empirical evidence that, in adolescents and adults, the institution of biomedical treatments, such as cross-sex hormonal therapy or gender-reassignment surgery, reduces the gender dysphoria (e.g., Cohen-Kettenis & van Goozen, 1997; Mate-Kole, Freschi, & Robin, 1990; Smith, van Goozen, & Cohen-Kettenis, 2001). Of course, such treatments would not be applied to clinical patients with other psychiatric conditions, so one cannot argue for specificity effects as one might attempt to demonstrate in a pharmacotherapy trial in which patients with diagnosis A respond to the medication, but patients with diagnosis B do not.

More in line with psychiatric treatment approaches in general, several studies and case reports suggest that some psychological treatment approaches may be associated with “desistance,” i.e., reduction of cross-gender behavior and desires in children (for review, see Zucker, 2007). Yet, there are no randomized controlled studies in which some children with GD were given a particular treatment compared to a no-treatment comparison group or even a “sham” treatment.

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EXHIBIT H

LEWIS'S CHILD AND ADOLESCENT PSYCHIATRY

A Comprehensive Textbook

FIFTH EDITION

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5.14 GENDER VARIANCE AND GENDER DYSPHORIA

CHAPTER 5.14 ■ GENDER DYSPHORIA AND GENDER INCONGRUENCE

JACK L. TURBAN III, ANNELOU L. C. DE VRIES, AND KENNETH J. ZUCKER

INTRODUCTION

Transgender (gender incongruent) youth include children and adolescents who experience a marked incongruence between their gender assigned at birth and their gender identity (1). Since the last edition of this volume, which was published 10 years ago (2), there has been a remarkable increase in attention to transgender issues across the life span. Television has begun to highlight transgender individuals from childhood to adulthood (3,4). News outlets from *The New York Times*

Magazine to *Le Monde* have explored the life experiences of transgender youth (5-7). Legislative bodies have examined transgender rights through restroom access, hate crime legislation, insurance regulations, and antidiscrimination policies, with physicians playing key roles in these discussions (8). Parallel to this growing attention, there has been a marked increase in the establishment of specialized gender identity clinics for children and adolescents in North America and in Europe (9), which likely reflects the marked increase in referrals that has been noted internationally (10-12). At the same time, the scientific literature on gender incongruence has expanded as well.

TABLE 5.14.1

TERMINOLOGY

Term	Definition
Gender assigned at birth/natal sex/birth sex	Gender assigned to an infant at birth, generally based on physical characteristics (genitalia, etc.)
Experienced gender/gender identity	An individual's psychological understanding of one's own gender
Affirmed gender	An individual's psychological understanding of one's own gender, typically referring to one who lives socially as that understood gender
Sexuality/sexual orientation	Refers to the types of individuals toward whom one is romantically and/or sexually attracted
Transgender	Refers to an individual whose gender identity is incongruent with that of one's gender assigned at birth. Sometimes also used as a term for an individual whose gender identity is binary opposite one's gender assigned at birth.
Gender dysphoria	Refers to psychological distress in relationship to one's experienced gender; is also the classification used in the DSM 5 (requiring fulfillment of certain clinical criteria)
Cisgender	Refers to an individual whose experienced gender matches that of one's gender assigned at birth
Gender non-conforming/gender variant	Refers to variation from developmental norms in gender role behavior that may be considered as nongender stereotypical. This may include identifying as both genders or identifying with neither gender, among others.
Transsexual	Typically used to refer to individuals who desire medical interventions to align their physiologies with the gender identities. This term is used synonymously with transgender by some and has largely fallen out of favor (though it was used commonly in the past).

with a flux of new studies on co-occurring psychological functioning, long-term follow-up studies, biologic correlates, and outcomes of medical interventions. Practicing child and adolescent psychiatrists should be familiar with the basics of this field to appropriately assess and treat these patients.

TERMINOLOGY AND DEFINITIONS

Terminology in this specialized area is continuously evolving. This section describes terms and definitions that are in most common usage at this time, but different regions, cultures, and families may have their own preferred terminology (Table 5.14.1).

The term *gender assigned at birth* refers to a newborn's gender (boy, girl, indeterminate), as generally declared by a medical professional. Other relevant terms include *natal sex* and *birth sex*. The term *biologic sex* is somewhat vague, as it is unclear whether it would be based on karyotyping of the sex chromosomes, internal reproductive structures, the configuration of the external genitalia, etc. The vast majority of newborns are assigned the gender of boy or girl through prenatal diagnostics or, at birth, based on genital anatomy. A small number of newborns may be classified as having a "disorder of sex development" (DSD), or what others have called "differences of sex development" (13), congenital conditions in which biologic parameters of sex (e.g., the sex chromosomes, the gonads or the configuration of the external genitalia, etc.) are incongruent with one another. These conditions include complete or partial androgen insensitivity syndrome, mixed gonadal dysgenesis, 5-alpha-reductase deficiency, penile agenesis, and congenital adrenal hyperplasia (CAH), among others. Such patients may experience gender identity issues that can be unique from those experienced by those without a DSD (14).

Experienced gender refers to one's gendered sense of self as a boy, as a girl, or some alternative gender that is different from the traditional boy-girl dichotomy (e.g., "gender fluid," "agender," or "nonbinary"). Other terms include *affirmed gender* (typically used for individuals who have transitioned socially to living as the desired gender). For the majority of individuals,

experienced gender matches the gender assigned at birth. These individuals are referred to as *cisgender*. For some patients, experienced gender is opposite from the gender assigned at birth, and these individuals are referred to as *transgender*.

Transgender, *gender variant*, and *gender nonconforming* are sometimes used as terms for individuals whose experienced gender does not strictly match that of their gender assigned at birth. One who experiences psychological distress in relation to one's gender identity may be referred to as *gender dysphoric*. Gender dysphoria is the diagnostic term that has been adopted in the DSM-5 (see below) (1).

Sexual attraction or *sexual orientation* is a separate concept from gender identity. Sexual orientation refers to the types of individuals toward whom one is romantically or sexually attracted. Terms such as androphilia (attraction to males), gynephilia (attraction to females), biphilia (attraction to males and females), and aphilia (attraction to neither males nor females) are used more commonly nowadays, slowly replacing older terms such as heterosexual, bisexual, homosexual, and asexual. In the scientific literature, the sexual orientation of individuals who identify as transgender can be described in relation to their experienced gender or their gender assigned at birth. For example, an adolescent female who identifies as male and is sexually attracted to females can be described as "heterosexual" in relation to experienced gender but as "homosexual" in relation to birth sex (15). From either a clinical or research perspective, it is critical to identify the referent in describing a patient's sexual orientation. Most individuals who identify as transgender will describe their sexual orientation in relation to their gender identity, not their gender assigned at birth (e.g., a transgender woman who is attracted to men would likely consider herself to be heterosexual).

The "genderbread person" has been developed as an educational tool to clarify the distinctions among *gender assigned at birth*, *experienced gender*, and *sexual orientation* (Figure 5.14.1). Note that as a published educational instrument, this graphic diverges somewhat from the contemporary terminology we described above. Nonetheless, this tool has proven useful for introducing this terminology to families and students new to the topics of gender and sexuality.

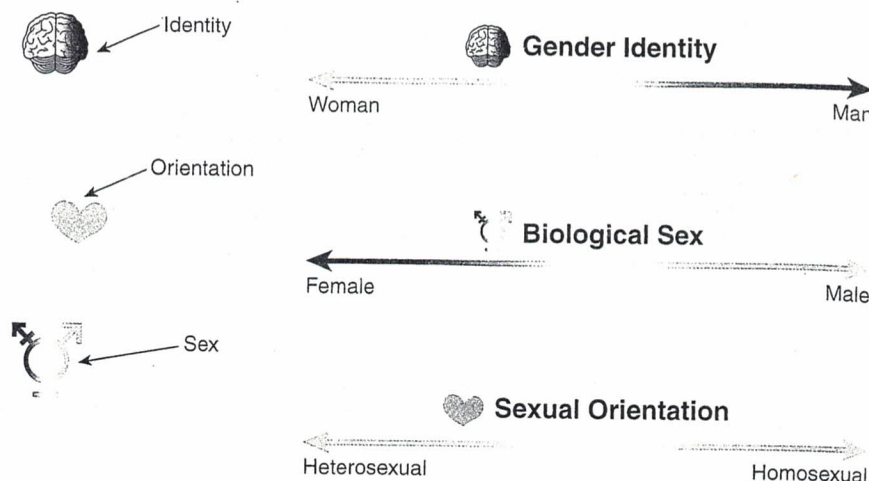


FIGURE 5.14.1. The Genderbread Person. The genderbread person is an educational tool used to explain the distinctions between experienced gender (termed gender identity here), gender assigned at birth (termed biological sex here), and sexual or romantic orientation. This educational tool may be useful for students new to the field and when explaining these phenomena to families with gender incongruent and gender dysphoric children. These terms are further described in Table 5.14.1. (Modified from Killermann S. (2016). *The Genderbread Person*. Available at: itspronouncedmetrosexual.com)

HISTORY OF GENDER IDENTITY AND MEDICINE

John Money (1921–2006) was a psychologist and sexologist whose empirical and theoretical contributions regarding gender identity, gender role, and gender development were innovative and of great influence, beginning in the 1950s. Money originally proposed a theory of “gender neutrality,” suggesting that gender identity was predominantly determined by social factors, including the gender assigned at birth and subsequent socialization processes (16). Money proposed that, for individuals with a DSD, early surgical interventions to correct genital ambiguity were often needed so that a child could then be supported with rearing in the gender assigned at birth.

Over the past few decades, Money’s original theory of gender neutrality at birth has been challenged by various lines of evidence suggesting the importance of biologic factors, particularly patterns of prenatal hormone exposure, in also contributing to gender identity formation and differentiation. For example, chromosomal females with CAH, assigned female at birth are exposed to elevated levels of prenatal testosterone and many of these girls are behaviorally masculinized and a higher percentage than the general population develop gender dysphoria and transition from male to female (17,18).

Perhaps the most widely cited case pertains to a biologically “normal” male (one of a pair of identical twins) who, after a circumcision accident at the age of 7 months led to penile ablation, underwent a vaginoplasty and was socially reassigned to female at the age of 17 months (19,20).

Although this patient was described by Money (21) as a “tomboy” during childhood, subsequent follow-up revealed that the patient rejected estrogen therapy at the time of puberty and subsequently transitioned back to living as a male (19,20). Tragically, this patient committed suicide at the age of 38 (22). The “John-Joan” case, as it was called, has been used as evidence of the importance of biologic factors in contributing to a person’s sense of gender identity. A subsequent summary of seven similar such patients reared as female after traumatic loss of the penis have shown both male and female gender identities in adolescence and adulthood, further complicating the picture (23).

In the 1960s, research into the developmental histories of adults with “transsexualism” suggested that childhood cross-gender identification was common in these individuals (24). This work was then followed by research with children who showed patterns of gender-related behavior similar to the recalled patterns of transsexual adults (24). During this period, there was much less attention given to adolescents with a marked history of cross-gender identification.

By the late 1990s, however, more attention was given to adolescents with a DSM diagnosis of gender identity disorder, including the possibility of treatments with gonadotropin-releasing hormone analogs (GnRHa), as reported by a research team in the Netherlands (25). This approach, described below, was ultimately outlined in the 2009 Endocrine Society Guidelines for the Treatment of Transsexual Persons (26) and in the periodically updated Standards of Care by the World Professional Association for Transgender Health (27). Research into these hormonal interventions has since garnered significant attention, including increased NIH funding to study the long-term benefits and risks of these endocrine treatments (28).

DIAGNOSIS AND ASSESSMENT

Gender identity diagnoses first entered the DSM in its third edition with three diagnoses: transsexualism, gender identity disorder of childhood, and atypical gender identity disorder. The essential feature of these three diagnoses was “an incongruence between anatomic sex and gender identity” (29). Revisions in the DSM-III-R were modest, though in this edition, exclusion of individuals with schizophrenia or a DSD was removed, noting that individuals with either of these diagnoses could also have a gender identity disorder (30).

In the DSM-IV, the three diagnoses from DSM-III were collapsed into the overarching diagnosis “gender identity disorder” with distinct criteria sets for children versus adolescents and adults. This edition also added a criterion stating “The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (31).

The DSM-5 renamed “gender identity disorder” as “gender dysphoria,” aiming to decrease stigma associated with the diagnosis while maintaining a diagnosis that could be used to secure

access to care for those who needed it (32). The DSM-5 removed sexual orientation subtyping, but noted in the text its relevance in understanding variations in developmental trajectories and for research on biologic factors and long-term outcomes (1). The DSM-5 also made an effort to make the childhood diagnosis stricter, requiring more than just gender nonconforming behavior. The new criteria required that a child expresses an actual desire or insistence of being the other gender. The adolescent and adult criteria simultaneously became more inclusive, allowing for nonbinary gender identities that would allow for gender variant, but not strictly binary, transgender adolescents and adults to receive the diagnosis and subsequently access to care.

Current DSM-5 criteria for gender dysphoria in children require a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months'

duration, as evidenced by at least six of eight criteria, one of which must be a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender) (1). Additionally, the patient must experience clinically significant distress or impairment in social, school, or other important areas of functioning as introduced in the DSM-IV (Table 5.14.2). DSM-5 criteria for gender dysphoria in adolescents and adults are similar, though with different requirements for the manifestation of gender dysphoria. This diagnosis requires at least two of six manifestations (Table 5.14.3). For a summary and rationale for the DSM-5 changes, see Zucker et al. (33).

Some have argued for use of the term "gender incongruence," including the Working Group on Sexual Disorders and Sexual Health for the forthcoming 11th edition of the

TABLE 5.14.2

DSM-5 CRITERIA FOR GENDER DYSPHORIA IN CHILDREN AND IN ADOLESCENTS AND ADULTS

Diagnostic Criteria

Gender Dysphoria in Children

302.6 (F64.2)

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
 5. A strong preference for playmates of the other gender.
 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
 7. A strong dislike of one's sexual anatomy.
 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

- With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).
- Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults

302.85 (F64.1)

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 mo duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).
- Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

- **Posttransition:** The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

TABLE 5.14.3

TREATMENT OF TRANSGENDER YOUTH

Timing	Intervention
Prepubertal	No endocrine intervention recommended. Patient should have regular psychotherapy to discuss gender identity and assess possible future need for hormonal intervention.
Early signs of puberty	Pubertal blockade with gonadotropin-releasing hormone analogs to prevent the development of secondary sex characteristics and provide additional time for psychotherapy and consideration regarding partially reversible interventions.
Age 14+ or 16+, depending on the center	Cross-sex hormonal therapy with estrogen or testosterone. Less frequently with other endocrine-acting medications that have less favorable side effect profiles.
Age 18 for most centers	Gender-affirming surgeries may be considered. Note that some surgeries may be performed earlier for select patients (generally mastectomies for transgender males).

International Classification of Diseases. This group suggested that the term gender incongruence highlights that not all transgender individuals experience dysphoria. The group noted that the term gender dysphoria might increase inappropriate stigmatization and pathologization. Only for the practical purpose of preserving access to medical care did the group recognize the necessity of classification. The group additionally argued that the diagnosis be moved out of the chapter on mental health and behavioral disorders and into another section, provisionally termed Conditions Related to Sexual Health (34).

EPIDEMIOLOGY OF GENDER DYSPHORIA AND GENDER NONCONFORMITY

A range of methodologic challenges, including but not limited to shifting terminology and stigma associated with self-identification, have made it difficult to establish the true prevalence of gender dysphoria or gender incongruence.

Prevalence in Adults

In adults, most studies have used the numbers of individuals that seek out clinical care for gender-affirming treatment as a proxy for determining prevalence in a certain country or catchment area. A recent meta-analysis based on 21 studies that applied this method concluded that the prevalence of transsexualism (the definition used in most of these studies) was 6.8 transwomen in 100,000 gender at birth-assigned males (1:14,705) and 2.6 transmen in 100,000 gender at birth-assigned females (1:38,461) (35). A time trend was also found, with recent studies reporting higher prevalence rates. These studies are, of course, limited by the fact that they do not include transgender individuals who do not seek medical care. Indeed, much higher prevalence rates, ranging from 4.2% having an ambivalent gender identity to around 0.5% identifying as transgender and considering medical interventions, are suggested by recent studies that have used broader definitions and probability samples (36–38). A recent population-based survey in the United States found that 0.6% of adults self-identified as transgender, with rates ranging from 0.3% to 0.8% in the states for which data were available. Compared to the older age groups, young adults between 18 and 24 years old were most likely to identify as transgender (39).

Prevalence in Children and Adolescents

Although formal epidemiologic studies of gender dysphoria in children and adolescents have not been conducted, looser or more liberal definitions of “caseness” in children and

adolescents have been examined in several recent studies. In a random sample of 2,730 grade 6 to 8 students from San Francisco, Shields et al. (40) found that 1.3% self-identified as “transgender” in response to the question “What is your gender?” with the other response options being female or male. In a random sample of 8,166 high school students from New Zealand, Clark et al. (41) found that 1.2% self-identified as transgender and 2.5% reported that they were not sure about their gender, in response to the question “Do you think you are a transgender?” which was followed by a definition of the term. Interestingly, another 1.7% reported that they did not understand the question.

In the 1999 standardization sample of the Child Behavior Checklist (CBCL) for children aged 6 to 18 years and the Youth Self-Report (YSR) form, aged 11 to 18 years, there is one item pertaining to gender identity (“Wishes to be of opposite sex”) (42). On the CBCL (total $N = 3,210$), less than 1% of parents of nonreferred boys and 1.2% of nonreferred girls endorsed this item as either somewhat or sometimes true or very true or often true. The percentages were higher for referred boys and girls (2.8% and 5.4%, respectively). On the YSR, about 10% of nonreferred girls and 2% of nonreferred boys endorsed this item compared to about 18% of referred girls and 3% of referred boys. In the prior 1991 CBCL standardization sample, two age groups were reported (4 to 11 and 12 to 18). For the 4 to 11 year olds, 1% of parents of nonreferred boys and girls endorsed this item compared to 3% and 5% of referred boys and girls. For the 12 to 18 year olds, none of the parents endorsed this item for nonreferred boys and girls compared to 2% and 5% of referred boys and girls. Consistent with the original CBCL and YSR standardization studies, two consistent findings emerge: the item is endorsed more often for girls than for boys and it is endorsed more often for referred than for nonreferred children and adolescents.

Gender Assigned at Birth Ratio

Of prepubertal children referred to gender identity clinics, the majority has a male gender assigned at birth. Among 577 Canadian children referred to a gender identity clinic between 1976 and 2011, the male-to-female ratio was 4.49:1 (12). This was significantly higher than the 2.02:1 ratio in the Netherlands (12). These differences are theorized, in part, to be a reflection of increased parental anxiety regarding gender-variant behavior in males compared to females, particularly in North America. For adolescents with gender dysphoria, the gender ratio is much closer to 1:1 and appears to be more consistent across nations (10). Of note, however, there has been a recent temporal shift from more birth-assigned males (prior to 2006) to more birth-assigned females (2006 to 2013), though the ratio remains closer to 2:1 in either direction (10).

BIOLOGIC AND PSYCHOSOCIAL DETERMINANTS

The etiology of cross-gender identification and behavior continues to be elusive. While psychological and social factors were once the focus of study, especially in normative gender development, attention has shifted to biologic mechanisms more recently. At present, the evidence suggests that both psychosocial and biologic elements are involved. A mono-causal mechanism is unlikely and gender dysphoria most likely results from a complex interaction between these factors (43).

Biologic Factors

Twin studies suggest a strong heritable component with additional environmental contributors. In a large-scale CBCL study of Dutch twins ($N = 23,393$) ages 7 and 10 (44), monozygotic (MZ) and dizygotic (DZ) twins were compared and estimated genetic factors contributed to 70% of cross-gender behavior (as assessed via the two CBCL gender items). Another study of 314 MZ and DZ twins (mean ages 9.4 and 10.1 years, respectively) roughly replicated this finding, with genetic factors contributing to 62% of the variance on a DSM-IV-based gender dysphoria scale (45). In a third study of 3,337 Japanese MZ and DZ twins ranging in age from 3 to 26 years (46), there was also strong evidence for genetic factors for females, but much less so for males.

Many studies, both in animals and humans, have shown that differences in brain anatomy and function in cis-gender males and females underlie the sex differences in their behavioral (47). Sex hormones play an important role in these differences. The *organizational* effect, predominantly prenatally but also during puberty, leads to the sex differences in brain structures. On average, males have larger brain volumes, more white matter, gray matter, and cerebrospinal fluid than females, although when corrected for total volume, females have more gray matter and a larger volume of the cortex (48–50).

The sexual differentiation hypothesis suggests that transgender individuals may have brain structures and brain functioning more closely aligned with their experienced gender (51). Postmortem studies have suggested a sex reversal in several hypothalamic nuclei in transgender adults (52,53). More recent neuroimaging techniques have allowed the *in vivo* study of brain morphology and functioning of larger numbers of adolescents and adults with gender incongruent feelings (50,54). Findings of these studies are more mixed. Before they received any medical gender affirmative treatment, brain anatomy with regard to volume, gray and white matter, and cerebrospinal fluid did not differ compared to their birth-assigned sex (50). Differences are, however, found with regard to the white matter microstructure, with results of transgender individuals in between males and females (50). In the realm of functional neuroimaging, task-related imaging studies show that transgender people may have either similar reactions as their experienced gender (e.g., smelling odorous steroids (55)) or activity different from their assigned gender as well as their experienced gender (e.g., mental rotation (56)), or not different from their assigned gender (e.g., verbal fluency (57)). The results so far show that we are still far away from a situation where imaging or other medical testing may serve as a diagnostic tool.

In animal studies, where prenatal hormones can be manipulated, the strong effect of prenatal testosterone on gender role behavior is clear (47). The effects on gender identity, however, can only be studied in humans. Individuals with DSD may be exposed to high levels of prenatal testosterone, and XX individuals with CAH (58) indeed have higher rates of gender

dysphoria and cross-gender identification (18). The majority of female-raised individuals with CAH (~95%), however, appear to develop a female gender identity (17). Other evidence for the importance of prenatal testosterone comes from studies in XY individuals with complete androgen insensitivity syndrome (CAIS) who lack the receptors necessary to respond to endogenous testosterone. The vast majority of these patients develop a female gender identity, suggesting that downstream testosterone signaling may be important for the development of a male gender identity (59). Others have noted that these patients are reared unambiguously as females and that social factors may play a strong role in their female identity formation (60). Some studies have shown that those with CAIS have lower scores on tests of female identity scales (61) and there have been some case reports of gender dysphoria ultimately leading to gender-affirming surgeries (62). This notably could be secondary to the psychological stress of learning about the diagnosis, as well as the possibility of undetected functional androgen receptors (43). Overall, studies of gender identity in individuals with DSD, while implicating androgens in the development of gender identity, have yet to show a simple direct relationship.

Psychosocial Factors

Past literature has investigated the potential role of parental characteristics on the development of gender dysphoria (maternal wish for a child of the opposite gender, paternal absence, and parental psychological functioning, among others). None of these hypotheses have been validated (43). Mothers of gender dysphoric boys have been noted to have higher scores on the Beck Depression Inventory and the Diagnostic Interview for Borderlines (63), but these higher scores might be due to external pressures placed on these parents by unacceptable social environments and such studies cannot determine the direction of causation. One study noted that gender dysphoric boys were rated as more feminine and “beautiful” by blinded college students (64) while another study of gender dysphoric girls showed that these girls were rated as less “cute” (65), raising the question of whether perceived physical appearance and resultant social treatment may contribute to gender incongruence. An alternative interpretation of this data is that those with a more male gender identity might alter their appearances to appear more “masculine” (e.g., culturally masculine haircuts) while those with a more female gender identity alter their appearances to appear more “feminine” (66). Some have suggested that a lack of parental limit-setting, particularly around cross-gender behavior, is associated with gender dysphoria (67), though this again does not prove causation, as more insistence on cross-gender behavior (i.e., transgender identity or stronger cross-gender behavior preferences) may make this limit-setting more difficult. Overall, there have been no proven causative psychosocial factors in the development of gender incongruence. Since studies on normative gender identity development show that cognitive psychological factors and social environment play a role, this may also be the case for gender nonconforming development.

CLINICAL COURSE

Persistence of Gender Dysphoria from Childhood to Adolescence

The natural history of gender identity for children who express gender nonconforming or transgender identities is an area of active research (68). To date, the long-term follow-up studies of clinic-referred children have been based on samples that have

included children who were either threshold or subthreshold for the gender identity diagnosis in DSM-III, III-R, or IV and some of the earliest studies began prior to the availability of formal diagnostic criteria.

These follow-up studies have classified participants as either "persisters" or "desisters" with regard to their cross-gender identification, using various metrics (semi-structured interviews based on DSM criteria for gender identity disorder, dimensional scores on standardized questionnaires, etc.). Ristori and Steensma (69) have provided the most recent summary of 10 follow-up studies, in which the percentage of participants classified as persisters ranged from 2% to 39% (collapsed across natal boys and girls). In one study (70), the percentage of natal girls who were persisters appeared to be substantially higher than the percentage of natal boys (50% vs. 12%), but in two other studies from the same clinic, the percentage was similar across natal sex (71,72).

One criticism of these studies is that either formal diagnostic criteria were not used (because they were not available at the time of the study) or that subthreshold cases were included. Some studies have found that threshold cases were more likely to be classified as persisters (73), but other studies have not (72). It has also been suggested that more recent cohorts (after the year 2000) have found higher rates of persistence (12% to 39% (61,64–66)) than older cohorts (2% to 9% prior to 2000 (74,75)); however, it is not clear if such differences are related to variations in sampling procedures or something more substantive. Comparisons of persisters with desisters have found that the intensity of gender dysphoria (using dimensional metrics), older age at the time of assessment in childhood, a lower social class background, and having a female gender assigned at birth are associated with higher rates of persistence (72,73). Despite this work, it remains difficult to predict, for an individual child, the likelihood of cross-gender identification persistence from childhood into adolescence (73).

Persistence of Gender Dysphoria from Adolescence to Adulthood

In contrast to the low rates of persistence from childhood into adolescence, it appears that the vast majority of transgender adolescents persist in their transgender identity (76).

Childhood Gender-Variant Behavior and Sexual Orientation

Childhood gender-variant behavior has been found to be a strong predictor of a same-sex sexual orientation (using gender assigned at birth as a reference point) in adults. In a study of 879 Dutch boys and girls, gender-variant behavior was assessed using the CBCL and sexual orientation was assessed 24 years later (77). It was found that the prevalence of a same-sex sexual orientation was, depending on the domain (attraction, fantasy, behavior, and identity), between 8.4 and 15.8 times higher in the gender-variant subgroup as compared to the nongender-variant subgroup. In summary, the current literature, though limited as described above, suggests that the majority of gender incongruent prepubescent children will grow up to identify as cisgender individuals with either a bisexual or a same-sex sexual orientation (70,72,74).

ASSOCIATED COEXISTING PSYCHIATRIC CONDITIONS AND BEHAVIORS

Children and adolescents with gender incongruence exhibit higher internalizing and externalizing psychopathology as

compared to nonreferred controls, with internalizing psychopathology being more common, particularly in natal boys (78–84). One hypothesis is that this problem behavior is a result of minority stress and dysphoria toward their gender assigned at birth. These individuals are also subjected to rates of peer bullying as high as 80% (85). Poor peer relations is one of the strongest investigated predictors for behavioral and emotional problems in gender incongruent youth (79). In a study of 105 gender dysphoric Dutch adolescents whose parents completed the Diagnostic Interview Schedule for Children (DISC), 32.4% had one or more psychiatric disorders, with 21% suffering from anxiety, 12.4% from mood disorders, and 11.4% from disruptive disorders (85). A study with the same DISC measure in prepubertal children revealed higher percentages, with 52% having one or more psychiatric disorders other than GD (80).

Chart review studies of gender incongruent youth presenting to specialized gender identity clinics have shown similarly high or even higher rates of psychiatric conditions: mood (12.4% to 64%), anxiety (16.3% to 55%), and disruptive disorders (9% to 11.4%) (82,83,86–88). The prevalence range across studies may be secondary to cultural differences, differing diagnostic criteria, and differing ages of clinical populations. These psychiatric conditions appear to become more common in gender incongruent individuals with increasing age. Some studies have shown that older transgender youth suffer a greater burden of co-occurring psychiatric conditions (82), and that gender incongruent adults suffer a greater burden of co-occurring psychiatric conditions as compared to adolescents (89).

Self-harming Behavior and Suicidality

Self-harming behavior and suicide attempts are prevalent among gender incongruent youth. Gender clinics have reported high rates of past suicide attempts by patients presenting for care: Boston (9.3%, mean age 14.8 (87)), London (10%, mean age 13.5 (82)), Los Angeles (30%, mean age 19.2 (86)). Rates of self-harm and suicidality appear to increase with age within this population (90).

Autism Spectrum Disorder

A number of studies have shown autism spectrum disorder (ASD) symptoms to be over-represented among transgender individuals. Clinical level rates of ASD symptomatology in transgender adults have been reported in the range of approximately 5% to 20% (91–93). A single study of 204 children and adolescents referred for gender dysphoria reported an ASD prevalence of 7.8% as measured by the Diagnostic Interview for Social and Communication Disorders (94). This compares to rates of ASD in the general population of around 1% (95). Two studies found increased gender variance (5.4%, 11.3%), defined by a positive response to "wishes to be of opposite sex" sometimes or often on the CBCL or YSR in referred children, adolescents, and adults with ASD compared to non-referred controls (96,97). However, the same was true for an ADHD-referred control sample (97), raising the issue that a higher probability of gender variance is characteristic of clinic-referred samples in general. Several hypotheses for shared underlying etiology that explains the link between these two conditions have been suggested (98–100).

Clinically, the co-occurrence of gender dysphoria and ASD may complicate transgender care, as diagnosing gender dysphoria can be difficult (e.g., in the context of the rigid thinking that is characteristic of ASD). Case reports have described instances cross-gender identification represented a transient preoccupation in youth with ASD (101). Additionally, language difficulties can make expression of gender dysphoria difficult

for patients with ASD. Nonetheless, a comprehensive narrative review of the literature has shown a role for transition with pubertal blockade and cross-sex hormonal therapy in these patients following an extended diagnostic process (99). By use of a Delphi method, a group of experts on the ASD-gender dysphoria co-occurrence developed initial clinical guidelines assessment and treatment for adolescent transgender care (98). Careful diagnosis of both conditions by specific specialists, collaboration of clinicians from both fields, an extended diagnostic phase, and risk assessment and safety issues are part of the suggested management protocol.

THERAPEUTICS

Treatment of Prepubescent Children

Over the past 10 years, best practice treatment for children with gender dysphoria has been the subject of intense controversy (102). As noted below, there are now three broad approaches that have been delineated in the literature: (1) the oldest one—characterized by Dreger (103) as the “therapeutic model”—consists of efforts, either directly (e.g., via specific suggestions that parents can implement in the day-to-day environment) or indirectly (e.g., psychodynamically informed approaches that treat the putative underlying “causes” of the gender dysphoria) and actively attempt to reduce cross-gender identification (104); (2) an intermediate approach, which some have characterized as “watchful waiting” (105), in which no direct efforts are made to “prohibit” a child’s gender-variant behavior, but one that also advises parents to keep options open about the child’s long-term gender identity and to avoid early social transition; (3) and, more recently, an approach characterized by Ehrensaft (106) as the “affirmative model” that considers all outcomes of gender identity to be equally valid and desirable and allows children who express a desire to socially transition to do so after careful counseling. These approaches have been discussed in great detail in three Task Force reports (107–109), in a special volume of the *Journal of Homosexuality* (102), and various other essays and case reports, the references for which can be found in these major reviews.

For the nonspecialist, there are several key issues to keep in mind when appraising this literature: (1) Some of these approaches may be influenced by particular theoretical formulations regarding the determinants of gender dysphoria and these formulations guide or influence recommended treatment plans; (2) there are no randomized controlled trials that have compared the effects of these treatments with regard to both short-term and long-term outcomes. Indeed, Byne et al. (109) noted that, by and large, “the highest level of evidence... can best be characterized as expert opinion” (p. 762); (3) with some rare exceptions (110), there are no manualized or even semi-manualized treatments that a clinician can follow in developing a therapeutic plan. Thus, the clinician needs to self-educate by reading about the therapeutic model that one intends to follow and tailor it on a case-by-case basis. Below, we provide relatively brief summaries of these three treatment approaches.

Promoting Identification with the Gender Assigned at Birth

This first approach aims, through psychosocial interventions, to reduce the child’s cross-gender identification and gender dysphoria. These treatments (which have been described in the literature since the 1960s) have, however, been quite varied. They include classical behavior therapy, psychodynamic therapy (including psychoanalysis and dynamically informed play psychotherapy), parental counseling, and parent-guided

interventions in the naturalistic environment (e.g., encouragement of peer relations of the same natal sex) (110,111).

Perhaps the underlying assumption of all of these approaches rests on the view that gender identity is not yet fixed in childhood and may be malleable through psychosocial treatments. There is also an implicit assumption or value judgment that might be inferred from this approach, namely that all things considered a child’s long-term adaptation might be easier if he or she could come to feel content with a gender identity that matches their natal sex and to avoid the necessity of a lifelong regimen of cross-sex hormonal treatment and sex-reassignment surgery (or what nowadays is also called gender-affirming surgery).

Critics of this approach have argued that there is nothing inherently “wrong” with a cross-gender identity and have challenged the view that trying to change such an identity is warranted. Indeed, there are now several US states and one province in Canada that have passed legislation stating that it is inappropriate to try and change a minor’s gender identity when the minor is unable to consent to the treatment, but exempt from this directive is “identity exploration” (112). Critics have also rightly noted that some of the earliest proponents of this treatment held the belief that it might also reduce the odds of the child’s later development of a same-sex sexual orientation (113), although other proponents of this treatment rejected this as an ethically defensible treatment goal (111). Another expressed concern has been that this type of treatment might cause a child to feel shame or other negative and maladaptive feelings (108).

Watchful Waiting

The second approach takes an intermediate therapeutic position. On the one hand, it does not recommend an early gender social transition on the grounds that the extant follow-up studies have shown that the majority of children with gender dysphoria desist for one reason or another. On the other hand, it does not explicitly recommend any type of limit-setting on the child’s gender-variant behavior, with the exception that in certain environments it might be risky or dangerous to display such behavior, which Hill et al. (114) described as the “only at home” rule.

This approach also does not privilege one type of long-term outcome over another, noting that it is difficult to predict outcome for an individual child and that the more important focus should be on the child’s general psychosocial adjustment and well-being. This approach does, however, include recommendations to parents that they try to encourage in their child a variety of gender-related interests and social affiliation with children of both genders. In some respects, the “watchful waiting” label is a bit of a misnomer because clinical protocols appear to include information provided to the parents that is more than “wait-and-see.” As noted by de Vries and Cohen-Kettenis (115), appropriate limit-setting with good explanation of why the limits are set to their child may be helpful so that the child will learn “that not all desires will be met,” which is important because “someone’s deepest desire or fantasy to have been born in the body of the other gender will never be completely fulfilled.” Although social transition according to this approach is not recommended at a very young age, an increasing number of children have already socially transitioned when they come to gender identity clinics (115). Some of these children may have no clear memories of a time that they were socially living in the birth-assigned gender and have stopped talking about being born different from their experienced gender. In these cases, it is encouraged that parents create an open situation where the child has the possibility of returning to the birth-assigned gender. It is discussed with the child that when gender identity feelings change, it is

nothing to be ashamed of, that nobody will be angry, that the child may speak out, and that it is good to have tried. A form of psychotherapy that helps the child to verbalize his or her feelings may be advised so that, by the time the child may come back for GnRHa, the child is able to talk about his or her feelings and can give informed consent.

Affirmative Approach

The affirmative approach theorizes that clinician and parental attempts to push children with gender incongruence toward conforming to their gender assigned at birth might produce shame and stigma that can ultimately lead to internalizing psychopathology (108). The approach considers all outcomes of gender identity to be equally desirable and affirms any gender identity the child expresses.

Though similar to the watchful waiting approach, an important departure is in its approach regarding early social transition. In the affirmative model, prepubertal children who ultimately express a desire to socially transition and live full time in their experienced gender (i.e., using cross-gender pronouns, a cross-gender name, cross-gender clothing, etc.) are allowed to do so. The approach to social transition must be carefully individualized with a nuanced understanding of the child's gender identification and the level of support within the child's community; there must also be an open discussion with the child highlighting that despite the social transition that the patient is free to transition back at any time (115).

Some have noted cases where this transition back to living as one's birth gender can be particularly difficult mostly due to fear of peer judgment (116), though this must be weighed against the potential negative consequences of refusing to affirm a child's identity and desire to transition socially. The affirmative model predicts that this lack of affirmation might lead to shame and consequent internalizing psychopathology (117). The therapeutic relationship in these cases could also be negatively affected if the clinician strongly discourages an early transition for a patient who ultimately persists in cross-gender identification.

Critics of social transitions in prepubertal children have raised the question of whether early social transition increases the rates of gender incongruence persistence from childhood into adolescence. Indeed, a multivariate regression analysis revealed that early social transition was associated with persistence (73). However, the direction of this association cannot be determined by this study. While some believe that prepubertal social transition makes children more likely to persist, the alternative interpretation is that those likely to persist are also more likely to undergo early social transition, due to currently unidentified factors. This additionally raises the ethical question of whether persistence should be considered an undesirable outcome. The affirmative model suggests that all outcomes of gender identity are equally desirable.

Separate from the question of persistence is the question of mental health outcomes following social transition. There is a relative paucity of literature studying the effect of prepubertal social transition. One study examined 73 American prepubertal children who were transgender in a binary fashion and allowed to socially transition. Parents of these children completed short forms for anxiety and depression at an unspecified time following the transition (118). Data from these scales revealed that these children had notably lower rates of internalizing psychopathology than previously reported children who did not transition. Furthermore, socially transitioned children in this study showed developmentally normal levels of depression and only minimally elevated (subclinical) levels of anxiety. It is important to note that families in this study had a relatively high median income, raising the question of whether this cohort is representative of a broader sociodemographic cohort (119). Though this early work suggests that socially transitioned children have

better mental health metrics than previously reported children who did not socially transition, future research is needed to fully understand the dynamic and long-term effects of social transition in a broader population (119).

Treatment of Adolescents

Once children have reached puberty, transgender identity persists in the vast majority of cases, and medical intervention is often considered. At present, the effectiveness of an approach that includes puberty suppression and is followed by cross-hormones and surgeries has been evaluated in two studies on the same cohort of Dutch adolescents. The first study evaluated gender dysphoria and psychological functioning at two time points; first, when the 70 adolescents entered the clinic (mean age, 13.65 years), and second, just before they started cross-hormones (mean age, 16.64 years). Of interest, while adolescents improved with regard to psychological functioning on several domains, gender dysphoria did not improve and all adolescents went on with the next step of gender-affirming hormones (120). The second study added a third assessment, around one year after gender affirmative surgeries, when the first 55 adolescents who had been in this treatment protocol had reached young adulthood (mean age, 20.70 years). This time, gender dysphoria was resolved and psychological functioning measures had even further improved with scores that were comparable to normative samples. The same accounted for quality of life, subjective happiness, and satisfaction with life scores (121). These positive results are promising and give trust that starting treatment at a relatively young age is possible. However, the results come from only one clinic and concern a highly selected sample that received support from their parents and often their further school and social environment that started the treatment only after extensive assessment and received further mental health counseling during the years of treatment. Whether the same positive results can be expected for the larger number of adolescents that are treated at clinics that strongly vary in their approach to gender-variant adolescents has yet to be determined.

Assessing Eligibility

According to Endocrine Society Guidelines, hormonally based medical intervention may be initiated at the earliest signs of puberty (i.e., Tanner 2 or 3) (26). Other eligibility criteria include meeting criteria for gender dysphoria (termed gender identity disorder in the 2009 guidelines), experiencing dysphoria toward early pubertal changes, having adequate psychological and social support for treatment, understanding the risks and benefits of treatment, and not suffering from a psychiatric comorbidity that would interfere with treatment (26). To assess eligibility, most clinics offer an assessment by a mental health professional that sees the adolescent and his or her family over a longer period of time before decisions regarding medical interventions are made. This time is used to prepare for the long period of medical treatment with lifelong consequences that is likely to follow and weigh the pros and cons of treatment so that an informed decision can be made. Although many adolescents come with a clear wish for medical treatment, some are not sure yet and want to explore their gender dysphoric feelings more broadly. Sometimes co-occurring psychiatric difficulties like ASD with rigid thinking, severe depression with acute suicidality or anxiety with worrisome avoidance and school refusal, complicate this diagnostic work and make coming to regular medical checkups and taking medication impossible. Treatment of these psychiatric disorders may then be necessary before endocrine intervention. The importance of parental support for the psychological well-being of

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adolescents is widely acknowledged (122). The time that is used for assessment may also be helpful in addressing parents' concerns and improving the adolescent-parent relationship. The time that is needed before medical intervention is provided may vary for each individual case, but tends to be longer when psychosocial comorbidities occur (115,123).

Fully Reversible Interventions (Pubertal Blockade)

The first such intervention (implemented at Tanner 2 or 3 of puberty) is pubertal blockade with GnRHa. Gonadotropin-releasing hormone is produced by neurons in hypothalamus. In prepubertal children, this hormone is secreted at very low levels. At the initiation of puberty, release of gonadotropin-releasing hormone becomes cyclical. This cyclical release of hormone results in release of follicle-stimulating hormone (FSH) and luteinizing hormone (LH) from the anterior pituitary. These hormones then enter the peripheral circulation, where they initiate the production of sex hormones (estrogen in natal women and testosterone in natal men). These hormones then initiate the irreversible development of secondary sex characteristics.

GnRHa (either implants, depot injections, or regular injections) maintain high levels of gonadotropin-releasing hormone in the circulation. Without physiologic cyclical fluctuations in GnRH levels, FSH and LH are not released and all downstream signaling is prevented. This allows the patient to remain in a prepubertal state (124).

Pubertal blockade prevents the development of irreversible secondary sex characteristics (voice deepening, breast development, etc.) and provides additional time for gender dysphoric children to decide if they wish to fully transition physically into the body of the opposite sex. Therefore, it does not need to be considered actual gender affirmative medical treatment, but rather may function as an extended diagnostic phase. If the GnRHa implant is removed or the injections discontinued, the effects of the medication are reversible. With removal or discontinuation of the GnRHa, the patient will undergo natal puberty. Follow-up studies into young adulthood on the first cohort of puberty-suppressed adolescents are reassuring with regard to side effects. Although there was some deprived bone density, there were no concerns regarding liver and kidney functioning and lipid profile (125,126). Some advise clinicians to evaluate bone age for these patients every 3 months (26) and have regular blood monitoring to ensure that the central axis of puberty is sufficiently suppressed (26).

Partially Reversible Interventions (Cross-sex Hormonal Therapy)

Around the age of 16, patients may choose to move onto the next intervention of cross-sex hormonal therapy with estrogen or testosterone, according to Endocrine Society guidelines. Some groups have noted that cross-sex hormones can be instituted earlier, as delaying puberty outside the developmentally appropriate age may cause social problems for these youth (127). Additional criteria for cross-sex hormonal therapy are identical to those for GnRHa in the Endocrine Society guidelines.

Cross-sex hormones will initiate the development of secondary sex characteristics of the desired puberty. These interventions are mostly irreversible and carry a more significant side-effect profile. The most prominent side effect of estrogen therapy is hypercoagulability, though clinicians prescribing these medications should be aware of the full spectrum of side effects. Of note, this hypercoagulability can be particularly problematic for patients undergoing high-risk surgery such as vaginoplasty. Patients on these medications should be regularly monitored for serum hormone concentrations and maintained within normal testosterone and estrogen serum concentrations for their desired gender. Spironolactone has been used for its antiandrogenic properties in select cases but

is generally not considered a first-line treatment given its unfavorable side-effect profile as a diuretic (26).

Irreversible Interventions (Gender-Affirming Surgeries)

At the legal age of adulthood, patients may choose to undergo a variety of surgical interventions, including vaginoplasty, phalloplasty, scrotoplasty, breast augmentation, facial reconstruction, hysterectomy, reduction thyroid chondroplasty, among others. Patients should be carefully counseled on the risks and benefits of surgery. Specific surgical interventions are many and are out of scope for the purpose of this review. Of note, some surgical interventions may be considered earlier in the course of treatment. In the WPATH's Standards of Care, mastectomies are being considered earlier than age 18 (27).

Fertility Considerations

There is a paucity of research on the effects of pubertal blockade and cross-sex hormonal therapy on future fertility. Interested patients should be counseled on fertility preservation options early in treatment. Include LGBT Health study showing that most transgender youth do not desire fertility preservation, however most adults which they had. More longitudinal research needed (128).

SUMMARY

Gender incongruent and gender dysphoric youth represent a vulnerable demographic with high rates of co-occurring psychiatric conditions and suicidal behavior, likely secondary to minority stress and dysphoria related to living in a body that does not match one's experienced gender. Prepubescent children with gender-variant behavior or identification are best supported with psychotherapy. For those children who continue to have strong cross-sex identification in adolescence, pubertal blockade, and cross-sex hormone therapy to align patients' bodies with their identities have been shown to improve mental health outcomes.

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EXHIBIT I

NEWS

Plastic surgeon: Sex-change operation 'utterly unacceptable' and a form of 'child abuse'

Dr. Patrick Lappert, a Catholic deacon in Alabama, says changing a person's sex is a lie and also a moral violation for a physician.



Lisa Bourne

Mon Sep 9, 2019 - 6:42 pm EDT

EDITOR'S NOTE: This story contains explicit content.

September 9, 2019 ([LifeSiteNews](#)) – The idea that you can change someone's sex is a lie, an Alabama-based plastic surgeon said, and pursuing this avenue with children amounts to child abuse.

"It's a form of tyranny, exercising a form of tyranny over our own bodies," Dr. Patrick Lappert said. "And in the case of children, it's child abuse."

Appearing on a recent [broadcast](#) of Relevant Radio's Trending with Timmerie, Lappert said the view that the human body is something that someone owns, that they can do things in order to provoke happiness in themselves, is a self-reverential view divorced from the objective reality of the human person.

Lappert briefly touched on the negative physical effects of same-sex sexual activity, and he also explained in detail the disturbing reality of what happens when a person undergoes so-called sex-change surgery.

He called it "utterly unacceptable" on moral grounds for a plastic surgeon, because it disregards the surgeon's call to balance respect for both form and function of the body in his or her work.

Regarding children, Lappert said, sexualizing them at a young age with these ideas is grooming them for later abuse.

"It's atrocious," he said. "And no one even knows how that's going to play out. There's no body of scientific evidence to even support the safety of doing that to children. But it's being done."

"Children do not have the capacity to consent to those sorts of treatments," Lappert said of sex-change procedures. "You cannot tell a pre-adolescent child anything about their adult life and expect that they're going to understand what you're telling them."

"Their concept of themselves is in the formative years," he continued. "And to ask a child to think of their sexuality when they're pre-adolescent is utterly insane. And it's in fact another great evil that's being inflicted upon children because it's the sexualization of normal chaste friendships of childhood."

Lappert also explained how suggesting to pre-adolescent children that they may be gay sexualizes chaste friendships and prompts them to think this way.

'They will never be the other sex'

Asked “What is a sex change?” Lappert responded, “Well, to begin with, the idea that you can change someone's sex is a lie.”

“Many people have been led to believe by a lot of very clever programs and advertising from plastic surgeons and whatnot that you can actually change a man into a woman or a girl into a boy or anything like that,” he said. “You cannot. Essentially all you can do is you can modify people's bodies both with medicines as well as with surgery to make them appear to be the other sex, but they will never be the other sex.”

Lappert, a board certified general surgeon and plastic and reconstructive surgeon, is a Navy and Marine veteran, as well as a permanent deacon for the Diocese of Birmingham, Alabama. He is also chaplain for the Courage apostolate in the Birmingham diocese.

Experts have said for years that surgery or hormone treatment for gender-confused individuals, and certainly encouraging transgender ideas in children, is not the solution, and can result in exacerbating their condition.

Nonetheless, sex change surgeries have been on the rise, transgender ideology continues to be pushed in schools, civil government, and healthcare associations and institutions, while gender confused individuals are also appearing more and more in pop culture, sports, media, and advertising.

The beginning stages

Lappert said gender confused individuals will typically begin by adopting a lifestyle and persona, change their name, hair and other aspects of their looks, and then move onto other identity components such as changing their driver's license and so on. Then hormonal medications are often introduced, and while sometimes these may initially make someone feel better about their gender confusion, this gives the false impression that surgical intervention will result in success, and taking hormones of the opposite sex over time can have a negative physical impact.

Irreversible

Most of the chemical interventions and cosmetic procedures done to alter a person's face or neck are to a degree reversible. However, Lappert warned, more invasive surgeries, such as mastectomy and procedures involving genitalia, are not.

A counterfeit vagina

In the case of men seeking to present as women, after they've had the other initial interventions performed, a definitive genital surgery includes castration, removal of the testicles, and the opening of the penis and removal of the erectile tissue, which is a procedure called penile inversion. This is where the penis is turned inside out and suspended up in the pelvis, turning it into “a receptive structure,” Lappert explained.

The tissues of the scrotum are then turned into labia, meaning the external genitalia portions of the phallus itself are used to create the labia minora. In creating the receptive structure, the surgeon is trying to preserve the nerves, so that those parts of the genitalia that provoke erotic sensation can do so.

“Which is a very challenging thing to try to do when you're essentially mutilating the penis,” he said, “to try to preserve the neurological support for it, so that the person can have erotic sensation from this counterfeit vagina that you've created.”

“The problem is that this counterfeit vagina doesn't want to keep its dimensions,” said Lappert. “And so you're constantly having to attend to the dilation of it to try to preserve its dimensions and so on. You also are taking the urethra that was in the penis and shortening it down so that it essentially is just an opening at the top of this counterfeit vaginal orifice that you've created.”

This is the most commonly performed operation for males trying to present as female, he said.

A counterfeit penis

In the case of women trying to present as men, it begins with the removal of the ovaries and the uterus, removal of the vagina and the creation of a neo phallus, or a counterfeit penis.

This can be done a couple of different ways, he said, one being a high dose of testosterone, which will produce an enlargement of the clitoris, and then when you have exhausted those very high levels of testosterone, and they've had this effect on the clitoris, an operation is done to lengthen the urethra so that the urethra is extended along the underside of this enlarged clitoris, so that the urine empties at the tip of this structure.

That operation is called a metoidioplasty.

“And essentially what you get there is a small phallus,” said Lappert, “and that's usually supplemented by creating a neo scrotum into which are placed two prosthetic testicles.”

For women seeking a more developed physique, Lappert continued, a neo phallus is produced by what's called a flap operation.

This is where an area of tissue, typically from the leg, is raised up and surgically turned into a cylindrical structure inside of which is a urethral tube. That urethra tube is then connected to the native urethra, which appears at the base of the clitoris. The clitoris tissue itself is draped over the base of this neo phallus and then, again, a counterfeit scrotum with prosthetic testicles.

“And then in that whole apparatus you can also implant malleable or inflatable prosthetics that can produce the appearance of an erection,” explained Lappert. “So that's called a phalloplasty by flap operation.”

The most common flap operation done today is to harvest the skin for the neo phallus from the forearm, said Lappert.

“It's called a radial forearm flap and it's a tremendously disfiguring surgery on the forearm,” he said. “And so these women who are presenting as men will tattoo their forearms to conceal the disfigurement.”

“And then so (ultimately) what you wind up with is a counterfeit phallus or a counterfeit vagina,” stated Lappert.

Why are these counterfeit?

“Because they don't function the way those structures function,” said Lappert. “It's obviously the case with the reproductive organ that what you're doing is you're robbing the person of an essential human capacity of the reproductive faculty. And that's not reversible or retrievable.”

“You cannot preserve the procreative function when you do these operations,” stated Lappert.

A sterile act

The doctor then touched on the spiritual component with these procedures.

“As Catholics, we recognize the human sexual embrace that's having two aspects, its unity and its procreative,” said Lappert. “It unites the two persons in an emotional-spiritual bond. But it's also a fruitful union.”

“Well, (with sex change procedures) you've robbed it of its fruitfulness,” he said. “It's now become a sterile act.”

The erotic sensation is never fully preserved

“The other thing that people don't understand is that because of the surgeries I've just described the desire to preserve erotic sensation from these structures that you're mutilating is never fully met,” said Lappert.

In the nature of our nervous system there is a thing called neural mapping, he continued, meaning even though the physician works to preserve those nerves, the nerves continue to recognize sensations from their original form and function.

“The brain is still thinking that, even though you've turned your penis into a counterfeit vagina, whenever it is stimulated the brain is still thinking that there is a penis down there,” said Lappert. “So here's a person trying to live as a woman hoping that they're going to be able to conduct their lives as women, who enters into a relationship with a man, and then in a sexual act is constantly being reminded by their own bodies that they are in fact still men, and that's a hard one to get over.”

The malpractice of medicine

Lappert also warned that a whole generation of children is being raised whose psychosexual, physical, and neurological development are being stunted in hopes of supporting this cross-sex idea of themselves – pushed by the transgender industry.

He pointed out that if you took 100 children with cross-sex idea of themselves, 91 percent of them will desist.

“Ninety-one percent of them will stop thinking of themselves as the other sex,” said Lappert. “But if you take the same hundred children to a transgender clinic at your local urban center, 100 percent of them will persist in it, which on the face of it tells you that this is this is the malpractice of medicine.”

“If 91 percent of them would have gotten over the disease and 100 percent of them persistent and obviously you're doing something wrong here,” he added. “But nonetheless that's how it's being presented.”

“People are being led to believe that if you have the surgery your sorrows will go away,” said Lappert. “But what's called gender dysphoria, this interior sense of sadness that the persons who suffer with transgender feel, they're being told that if they have all of this medical and surgical therapy, that those bad feelings will go away. And the best study looking into that tells us that that is not the case.”

After a period of observation beyond some eight to 10 years, the suicide rate goes right back to where it was if nothing had been done for these people.

"If you didn't offer them any care at all, you'd have the same suicide rate that people have now after all of the surgical interventions," said Lappert. "And after the excitement dies down, and eight, 10 years later, they're right back to a 40 to 42 percent suicide rate. So that's a huge misrepresentation of benefit that is just not true."

Advocates for gender-confused individuals continually say these individuals need authentic psychological help that focuses upon the source of the confusion.

This kind of surgery is utterly unacceptable

Lappert called sex change surgery "an intentional destruction of a human faculty," and "so on moral grounds from the perspective of a plastic surgeon this kind of surgery is utterly unacceptable."

The language of slavery

Because these procedures result in sterilization, they are tied to assisted reproductive technology, Lappert explained, with patients asked how they want to "preserve their fertility," donating either sperm or ova, should they want children later.

"Those things will be put aside and for future assisted reproductive technology, essentially turning human persons into commodities," Lappert said.

A huge evil

"Because they will be told, you have a right to have a child even though you're having this transgender surgery," he said. "You have a right to have a child. So we're going to do these things for you. Well, that's the language of slavery, to speak of a person that's having a right to another person is the language of slavery."

"It's leading us to seeing the human person as a commodity that is regulated by the government, by government institutions, universities, and by laboratories," Lappert continued. "And that is a huge evil. It's a huge evil and never forget, that transgender surgery is right at the heart of that evil."

"First of all because it utterly perverts our sense of human sexuality," he said. "It internally divides the human person from their very own bodies. And now it's separating the human community from their reproductive faculties, in the era of assisted reproductive technology. So this is diabolical in every sense of the word. Diabolical."

Rejecting objective truth

Encouraging people to pursue sex-change surgery rejects understanding of who the human person is, said Lappert.

“One of the mistakes that people are making in contemporary life is viewing themselves as sort of a spirit creature and their bodies as something that they own or something that they possess,” he said. “They view their own bodies as something that they can do things to in order to provoke happiness in themselves. It's a very self-referential view of the human person and it has at its heart this division of the nature of the human person.”

Plastic surgery can never divorce itself from objective reality just as no form of medical care can separate itself from the objective truth of who the human person is, he said.

“So if I aim to be a good surgeon, then the very first thing I have to understand is the subject upon whom I am working,” Lappert stated. “If I have met grave misunderstandings about the objective reality of that of the person, I'm going to be making some serious mistakes when I embark on medical or surgical care.”

“To view the body as a thing, but somebody that a person owns, to view themselves, their personhood is something separate from their own bodies, is a very grave mistake,” he said. “And then to set about modifying the body in ways that you hope will bring about a lasting happiness can't possibly succeed, because it begins with a lie, it begins with an error about the objective truth of who the human person is.”

The full interview with Dr. Patrick Lappert is available [HERE](#).

Two positive resources for gender-confused and same-sex attracted individuals featured in the discussion were the Roman Catholic Courage apostolate and [Walt Heyer's](#) outreach titled Sex Change Regret. Heyer had transitioned to living as a woman and then returned to living as a man, and now performs outreach for gender-confused people.

Information on Courage is available [HERE](#) and [HERE](#).

The Sex Change Regret website can be accessed [HERE](#).

[James Shupe](#), [formerly Jamie Shupe](#), [ex-transgender and former non-binary person](#), writes about his experience and chronicles transgender issues [HERE](#).

The [National Suicide Prevention Hotline](#) provides free and confidential help and resources to individuals in distress 24/7. The number is [800-273-8255](#).

Additional resources are available [here](#), [here](#) and [here](#).

TOPICS

Gender

TAGGED AS

Gender Confused

Hormone Treatment

Patrick Lappert

Penis

Plastic Surgery

Sex-change Surgery

Transgenders

Vagina

EXHIBIT J

EXHIBIT 15



**Exhibit
0033**

9/30/2021
Dr. Lappert

Transgender Surgery & Christian Anthropology



Deacon Patrick W. Lappert, MD
Birmingham in Alabama
256-303-8509

The Challenge

- “Male and female He created them” has been replaced by a confusion of exceptional cases.
- Aggressive re-characterization of the nature of the human person.
 - Academia, entertainment, law, and even at church.

Finally and above all, man has made stupendous progress in the domination and rational organization of the forces of nature, such that *he **tends to extend this domination** to his own total being; **to his body**, to psychical life, to social life, and even to the laws which regulate the transmission of life.* ~ Humanae vitae 2

The Challenge

- Understand the subject.
- Fluent in the language.
- No shocking surprises.
- Patient, but insisting upon the truth

Human Nature

- The human person: body and spirit together comprising a single nature.
- By our nature we are made for *the other*.
- Possessed of an intellect by which we can know the good, the true, and the beautiful.
- Possessed of a will by which we can choose the good, the true, and the beautiful; *the moral life*.

Human nature

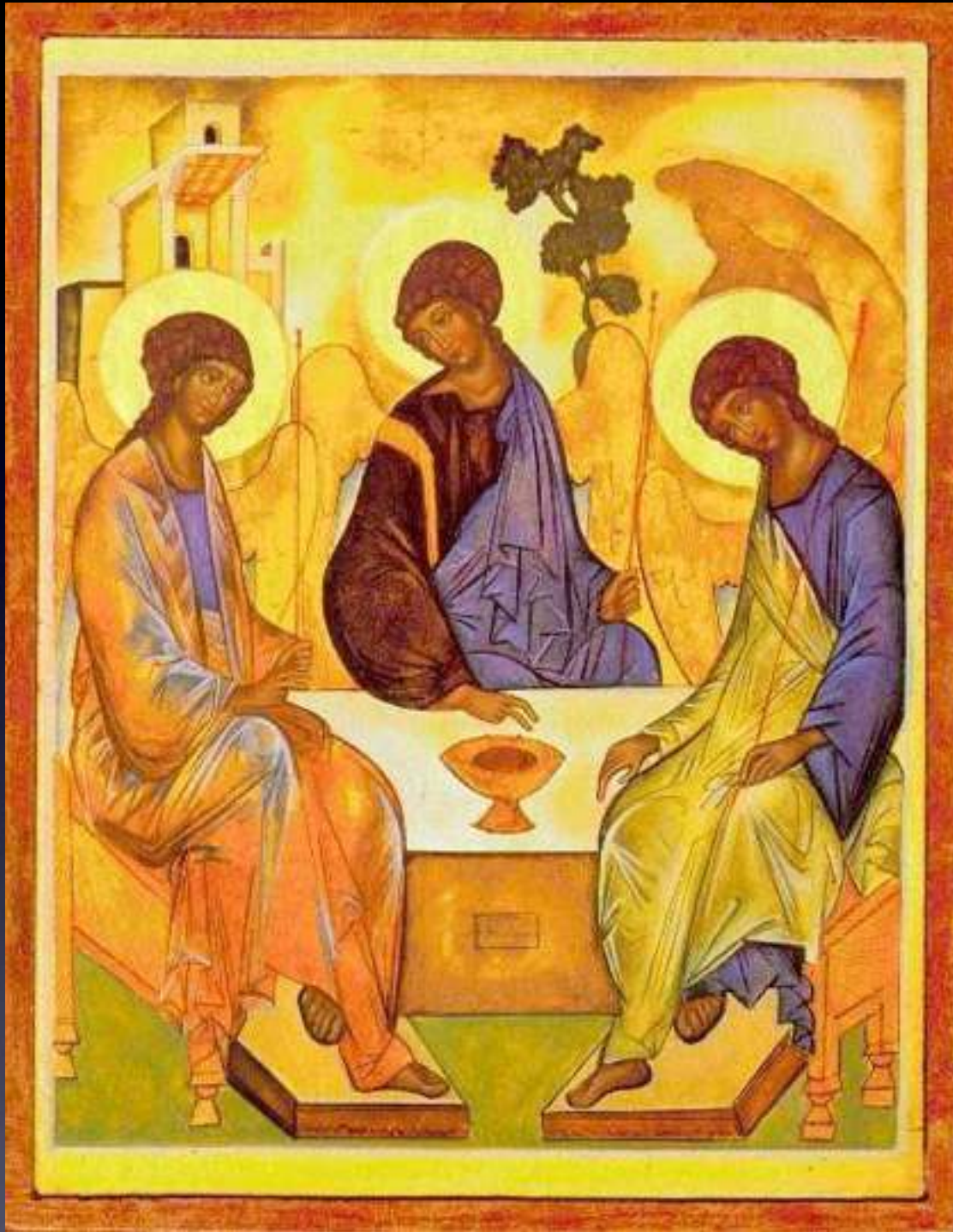
- The moral life: built upon foundational truths.
- Not arbitrary.
- Not repressive, but rather affirming of the intrinsic dignity of the person.

What is a human being?



Human Nature

- The human body
 - The “reproductive system”, and the fulness of humanity.
 - Dimorphism and complementarity.
 - The human family is in our nature.



The Image and Likeness of God

Human Nature

- Why must we consider first the *nature* of the human person?
- Defines the “end” of medical and surgical care.
- Human nature is that which is perfected by the life of grace.
- That which is perfectly realized in the Incarnation of Jesus Christ.

Modern “Gender”

- A confusion of biology, psychology, and political science.
- Use of biology to explain psychology
- Political terms to explain the emotional life.
- Shifting from biological determinism, to freedom of expression.
- Language of “science” counterpoised with rejection of scientific evidence as “tool of oppression”.

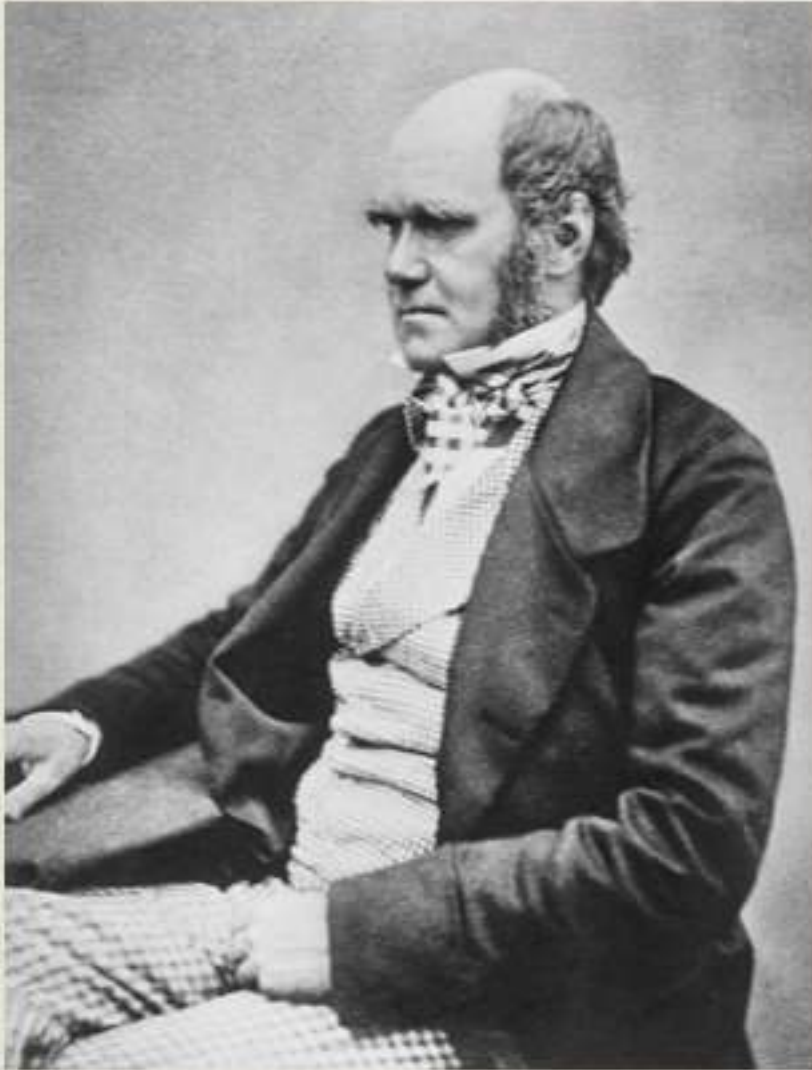
“Great Expectations”

- Science (separate from faith): A “pure” thing.
 - Deeper, “more evolved”
- Technology: domination of nature
 - Capability to modify the person in any way that “choice” demands.
- *Progress*: irresistible power of history leading to liberation from the oppression of the past. Transgenders no longer “outcasts”!

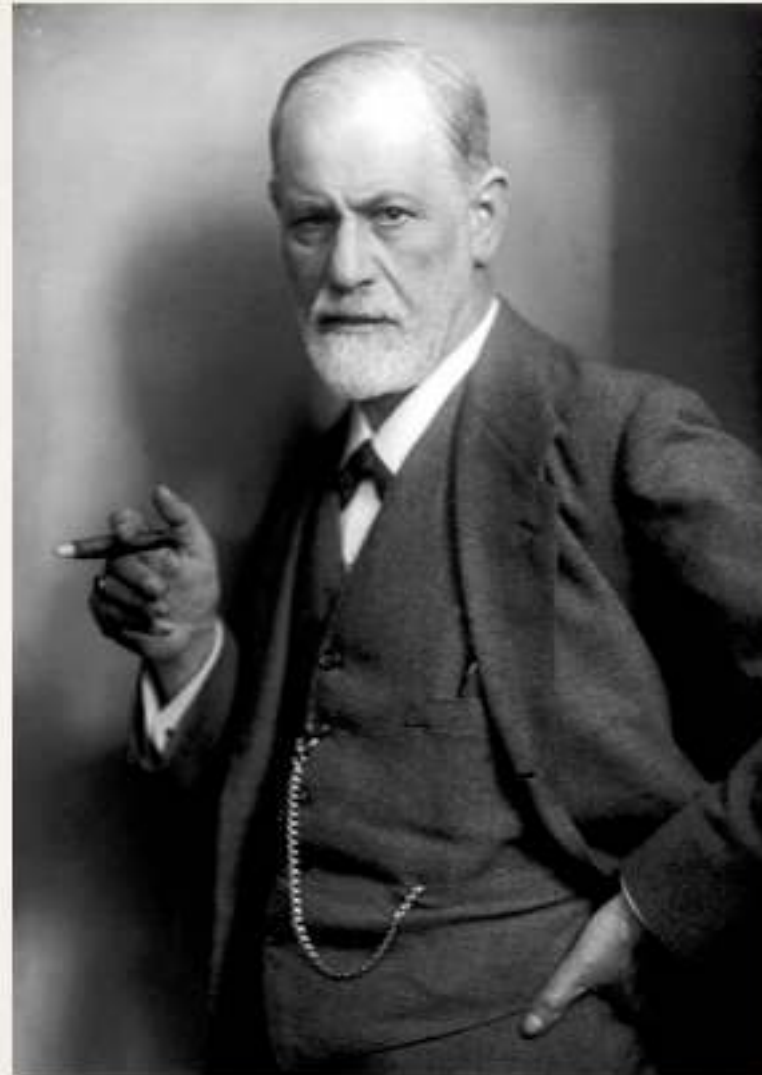
Transgender Language

- Outgrowth of “gender identity” principles.
- Relationship to the “sexual revolution”.
 - The divorce of the two aspects of human sexual union.
- Catholic anthropology vs. materialistic anthropology.

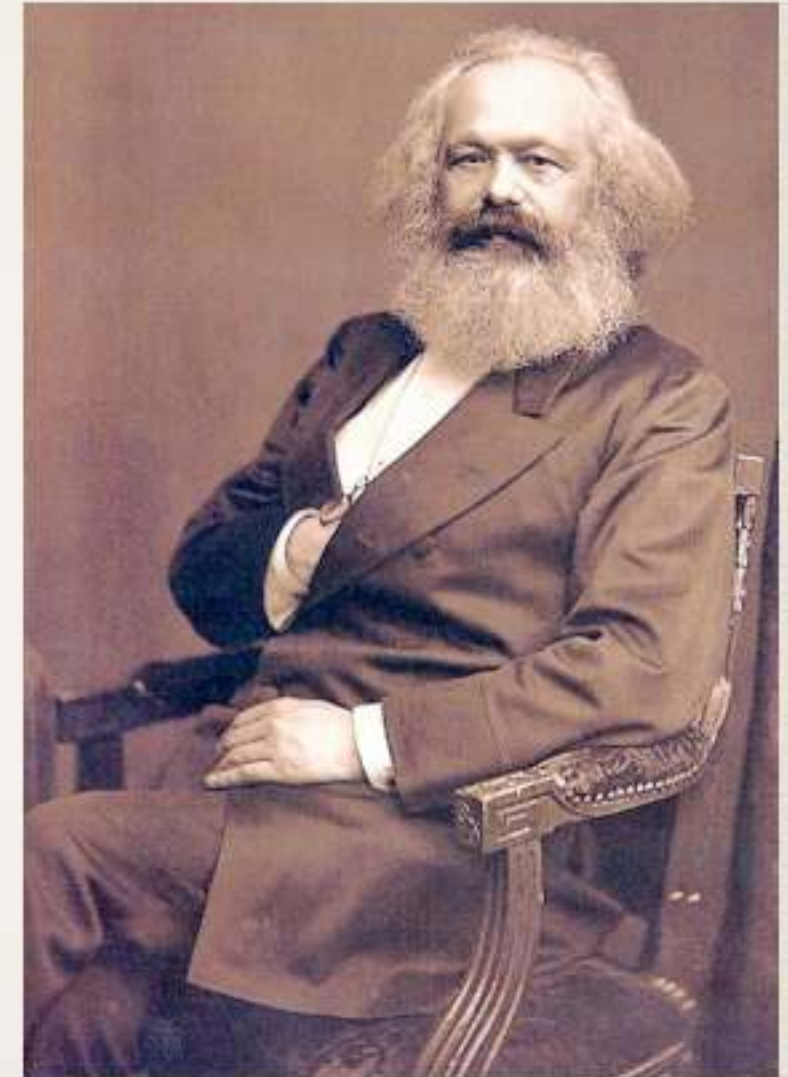
The 3 Stranded Rope



Charles Darwin



Sigmund Freud



Karl Marx

The human person is materially caused, materially driven, and his highest aim and happiness is materially defined.

Psychological Language

- Seeking to give a complete explanation of human behavior, without recourse to theology.
- Man as merely a particularly complicated animal.
- Inherent drives common to animal life.
 - Assorted coping mechanisms to deal with the frustration of those drives. Some are pathological = neurosis / psychosis
- “The Pleasure Principle” ~ Freud

Psychological Language

- The search for “pleasure” is the central instinct:
- Sexual pleasure seen as the zenith.
- The central element in character development:
 - Sexual drive, and sexual experiences are seen as the prime movers in the development of personality and social capacities.
 - Good (pleasurable) experiences = good personality development.

Psychological Language

- Human sexuality is viewed from the standpoint of the *one person, their needs*, and the satisfaction of those needs.
- Any moral perspective on human sexuality seen as an arbitrary social restriction, or “*taboo*”, without foundational truth.
- Belief that much psychopathology can be avoided by changing society, and ignoring moral questions.

Modern Sexuality Sumarized

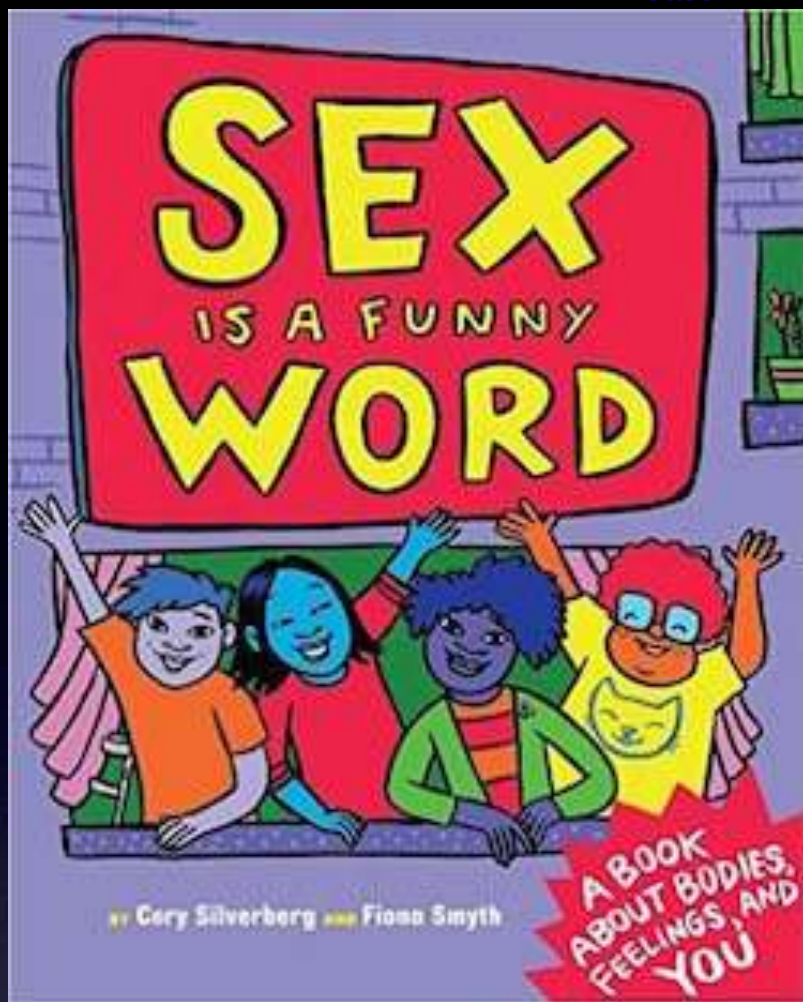
(Lappert's Axioms)

“Adult sexuality” is an endlessly variable, *personal* expression of *individuality*, the purpose of which is to produce joy for that person. It sometimes involves other people, and with alarming frequency, is known to produce other people.

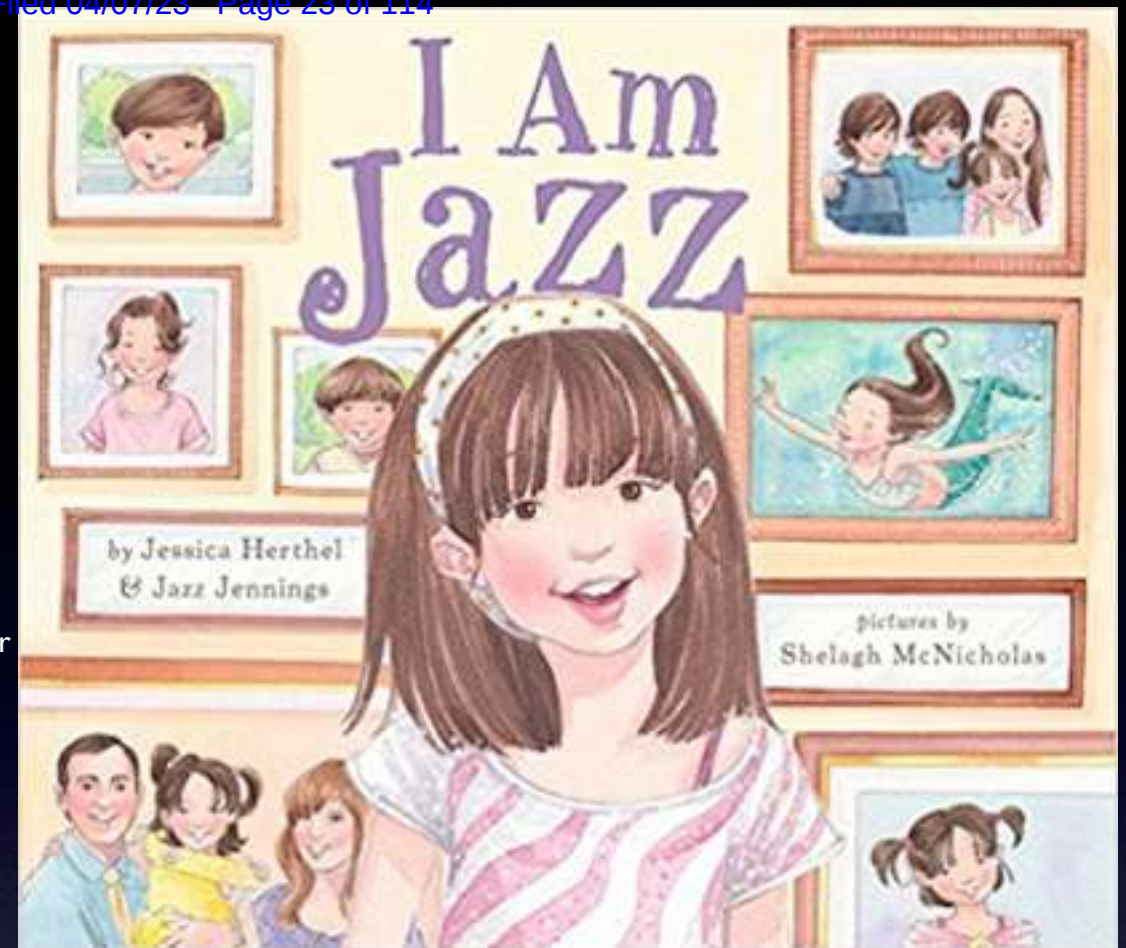
Modern Sexuality Sumarized

(Lappert's Axioms)

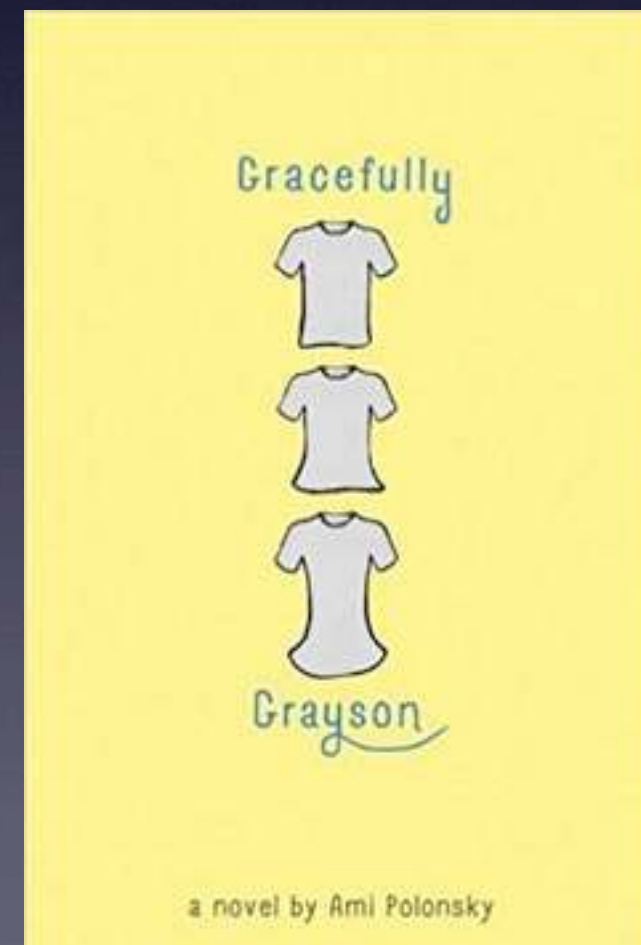
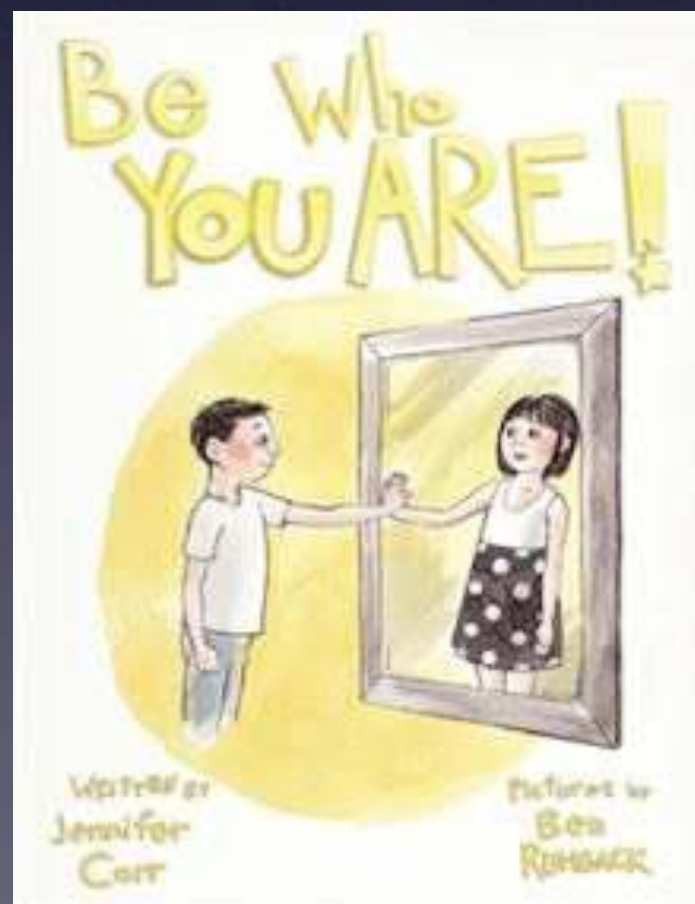
“Adult sexuality”, is the developmental result of “childhood sexuality”, just as adult language is the developmental result of childhood language. For this reason, it has become the habit of psychologists, and teachers to talk to children about “adult” sexual activity.



Recommended for
7- 10 y.o. children



Recommended for
4- 8 y.o. children



Recommended for
9 y.o. children



"I like to say that
I'm a girl stuck
in a boy's body."

Lia, age 9

#GrowingUpTrans

pbs.org/frontline

FRONTLINE

Shaping the Conversation, & Grooming a Generation



Pages

- Home
- Jazz In The News
- Who We Are
- Main
- Mission



- Main
- Mission
- Support Us
- News
- Gallery
- Links
- FAQs
- Contact Us



Jazz Talks Dating With Barbara Walters 20/20 Update 2013
On a Special Edition of "20/20 Saturday," Jazz is a typical 11-year-old girl except for one thing, she was born as a boy.

Making Life Better with Plastic Surgery

- When you “don’t feel right, because something “doesn’t look right”.
- Aesthetics or Reconstruction

Managing the Unseen Wound

- Profound sorrow, anger, anxiety.
- Seeking a material (aesthetic) explanation and remedy.

Body Dysmorphic Disorders

- Broad category of disorders of misperception about physical appearance
 - Anorexia
 - BDD/ Aesthetic surgery patients
 - Seeking limb amputations etc.



CHECK NO
164
OF 172

Brake Pads
& Shoes

OFFER DETAILS

SEARCH INVENTORY

Claim and offer

Science

Neurophilosophy

The science and ethics of voluntary amputation

Should amputation be offered as a treatment to people suffering from Body Integrity Identity Disorder?

Mo Costandi

Wednesday 30 May 2012
13.07 EDT



Shares
107

Comments
74



19...

Body Dysmorphic Disorder

- Type of Obsessive- Compulsive Disorder
 - Depressive presentation
 - Social isolation. “Outcast”
- Treatment
 - SSRIs, Cognitive-Behavioral Therapy

Gender Dysphoria

- The unhappiness associated with the condition because:
 - “I don’t look the way I know I should”
 - “The world does not accept me as I know I really am”
 - Social isolation due to:
 - Incongruous behavior
 - Secret life with associated shame.

Transgender

- Obsessive thinking with varying degrees of “dysphoria”
- Perceiving something that is not objectively there:
- Delusional thinking
- Errors of assumption

Criteria For Delusion

- Karl Jaspers in *General Psychopathology* (1913) The criteria are:
 - certainty (held with absolute conviction)
 - incorrigibility (not changeable by compelling counterargument or proof to the contrary)
 - impossibility or falsity of content (implausible, bizarre or patently untrue)

Co-morbidities:

- Alcohol and drug abuse, depression, incarceration, homelessness, high rate of suicidal ideation.
- Variable in Expression:
 - Private stress management by cross-dressing
 - Public, anonymous cross-sex persona, including sexual contact (sometimes prostitution).
- Transitioning in stages.

Biological Language

- Seeks to establish the material causation for the psychological instincts/ drives
 - Genetic, neuroanatomic, endocrine, etc.
- Seeks to understand the biological basis for “gender”
- Sexual dimorphism/ polymorphism vs. social construct and learned behaviors

Biological Language

- “Evolution” words applied to human sexual functioning.
- Searching for the “adaptive advantage” of fruitless sexual activity.
 - The problem of reconciling a Darwinian view of the human person, and a putative inherited behavior that is annoyingly maladaptive.
- The hope: genetic trait of animal life would silence moral arguments.

Biological Determinism vs. The Moral Life

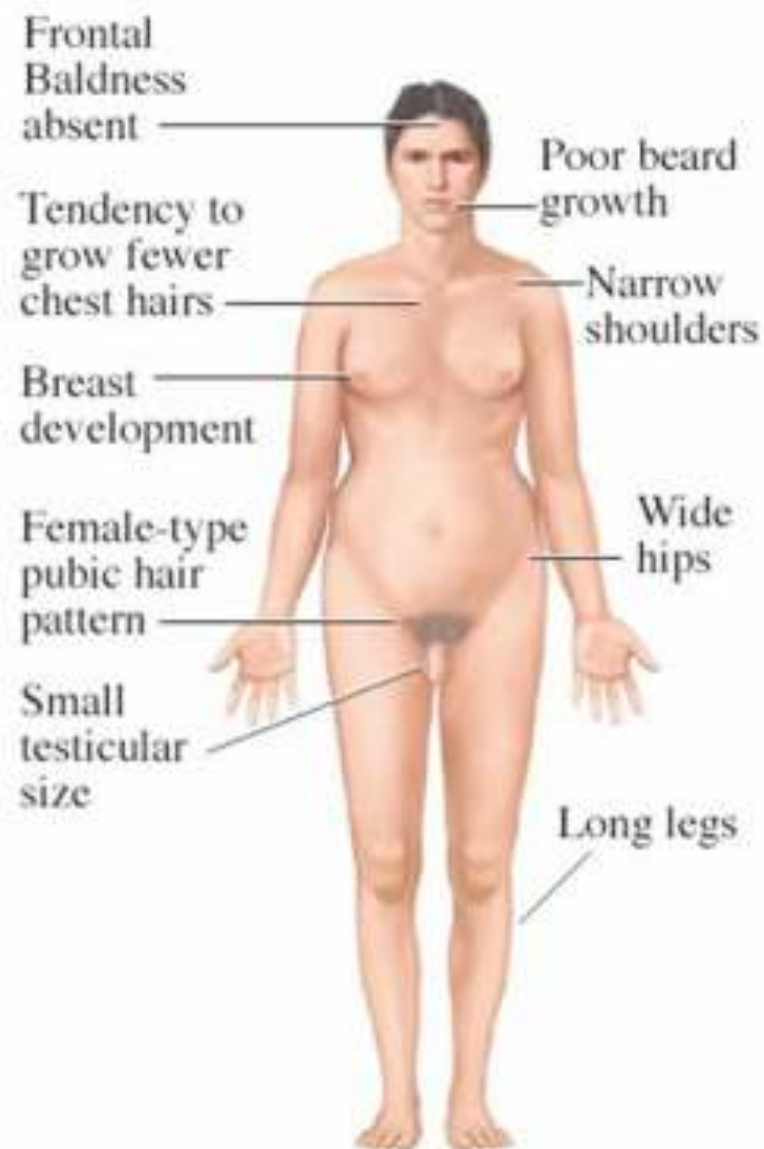


Biological Language

- “Isn’t there a genetic explanation for “transgender?”
- “We learned in school that there are many genetically caused examples of people who are somewhere in between “man” and “woman”.
- Klinefelter’s Syndrome
- Androgen Insensitivity Syndrome (AIS)
- “That is what I have. I am “intersex”, and I choose to be.....”

Biological “Intersex” (Hermaphroditism)

Klinefelter syndrome



- **Lower IQ than sibs**
- **Tall stature**
- **Poor muscle tone**
- **Reduced secondary sexual characteristics**
- **Gynaecomastia (male breasts)**
- **Small testes/infertility**

Clinical Support for Intersex Persons

- Multidisciplinary: Pediatrics, Geneticists, Pediatric Surgery, Urology, Psychology.
- Assessment: Including genital ambiguity, problems with voiding etc.
- Planning based upon “sexual assignment”.

Gender Assignment Surgery (ambiguous genitalia)

- Seeks to remedy structural problems that interfere with voiding.
- Seeks to establish an arrangement of tissue that would make sexual intercourse possible.
- Make reproduction possible only in cases of structural problems of shape, size, and patency.

So...is it biological?

- Genetic, like Klinefelter or ALS?
 - No genetic marker, no mutation.
 - Normal male or female karyotype
- Hormonal?
 - Hormone levels entirely normal for age/sex matched controls
- Anatomical?
 - Brain scans: MRI, PET Scan etc.
 - No structure/ activity that mimics opposite sex.

Nature v. Nurture

- Speculation among “sexologists” working in Intersex Clinics.
- “Gender Identity” is:
 - Malleable, or “fluid”
 - Socially determined
 - Typically produced by “repressive” processes

The “Science” of Gender



Dr. Harry Benjamin



Dr. Alfred Kinsey



Dr. John Money

Nature v. Nurture

- Difficulty in separating the vague and as yet not demonstrated genetic influences from social/ cultural influences.
- Database skewed by selection bias among genetically/ developmentally abnormal patients.

The Twin Study

- The “gold standard” for exclusion of biological determinism (genetic).
- Monozygotic twins raised in different social circumstances.

The Index Case



John Money, PhD

Sexologist in the Intersex Clinic
Johns Hopkins



- Convinces parents to raise their son as a girl.
- “Socialize” strenuously as a girl
- Castrate, and administer estrogen
- Ultimately use reconstructive surgery to produce a neo-vagina.

Published Results in “Peer Reviewed Journals”

- Papers and presentations based upon “long term follow up”.
- “Successful” in every way.
- Torrent of “scientific literature” re: gender roles/ identity etc.
- Political dimension



John Money, PhD

The Reimer Twins



“Brenda” Reimer



“Scientific” Basis of Gender Politics

- Gender “assignment” is a process of repression.
- Forces persons into “binary” model of sexual expression.
- Sexual expression is a form of political expression.
- “Dr. Money’s twin study proves this conclusively!”

Annual Visits to John Money, PhD

- Expected result further drives the intervention.
- Photographs them as he “instructs” them in “sex-play”.
- Fear and anxiety



Truth

- Was eventually given the truth at age 15.
- Enthusiastically embraces boyhood.



The Experiment is Ended

- Hormone replacement due to castration.
- Surgical efforts
- The silence of John Money, PhD



David the Man



Husband, and
adoptive father of
three children

David the Man

- Battle with depression.
- Financial difficulties
- Wife leaves him after 14 years.
- Brother dies of drug overdose.





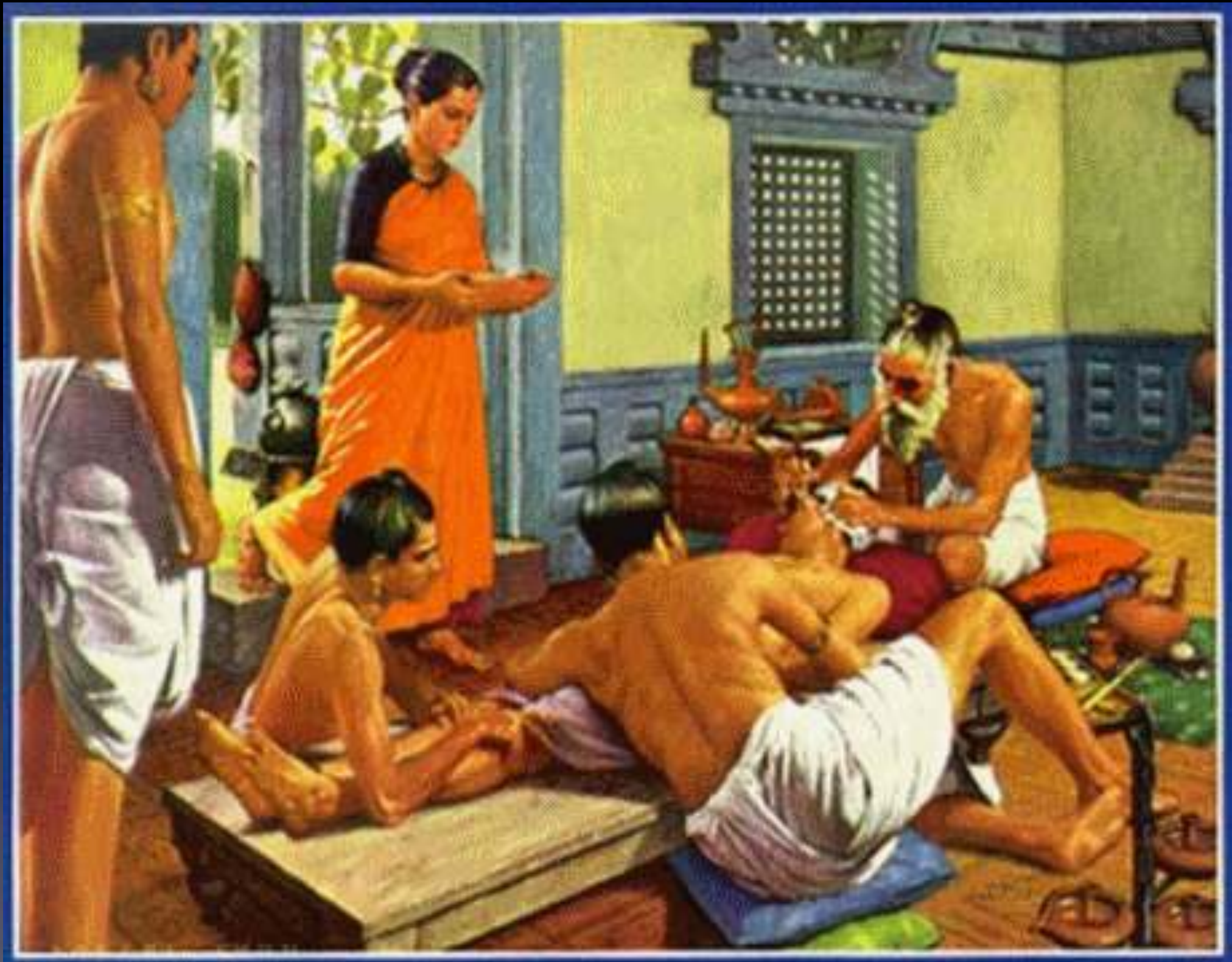
David Reimer 1965- 2004

The Nexus

- Catholic Anthropology
- &
- Plastic/ Reconstructive Surgery

A Quick Review of Plastic Surgery

- The oldest form of surgery
 - Ear reconstruction- India
 - Nasal reconstruction- Italy
 - Restoration of the social outcast.

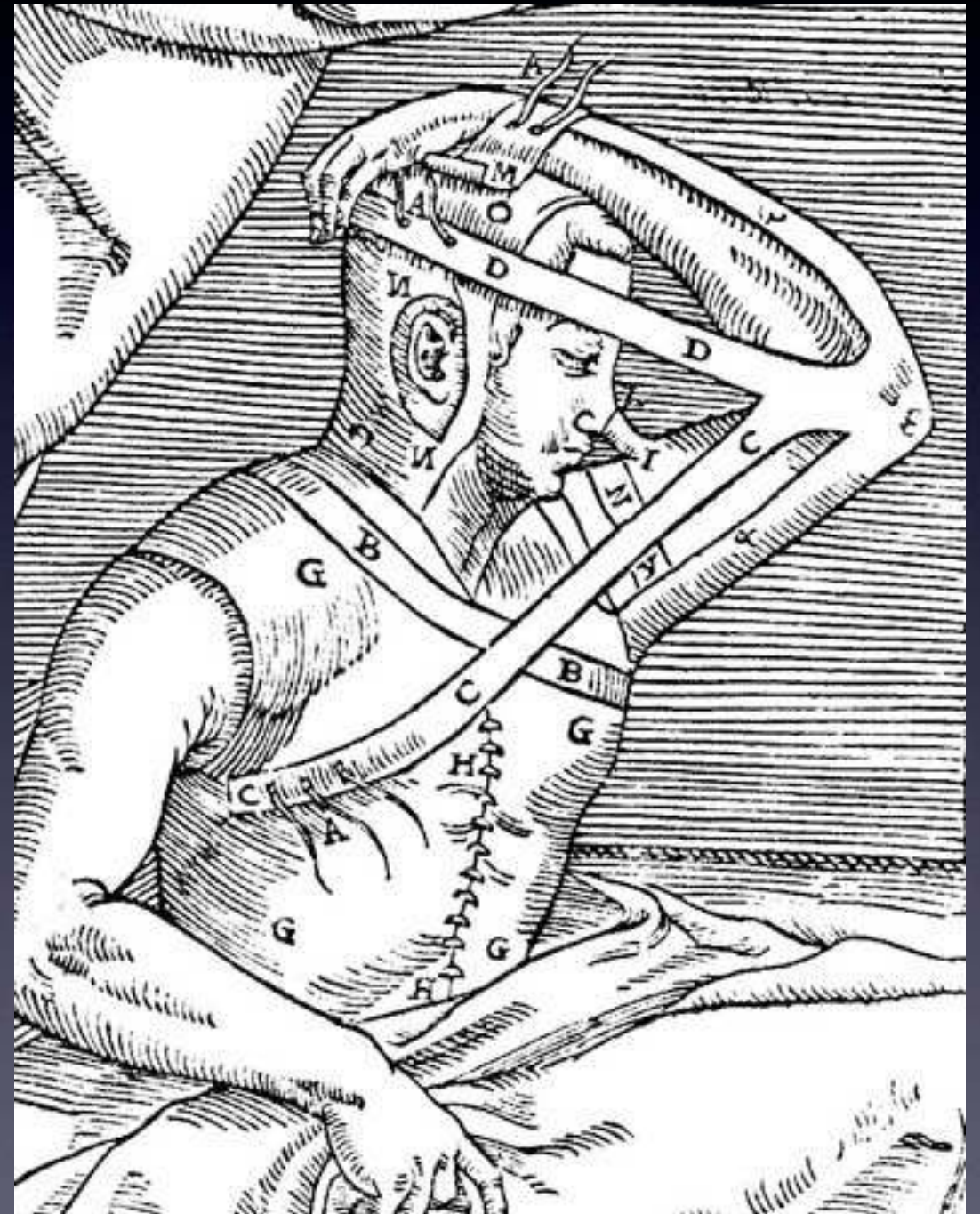


Sushruta- 7th Century BC India



The Mutilation
of Emperor
Justinian II
“Rhinothymos”
695 AD

History-



Plastic & Reconstructive Surgery

- Basic Principles:
 - Establishment or Restoration
 - Form and Function
 - Based upon a thorough understanding of the nature of the missing or injured part, and its relationship to the person.
 - Directed at the “perfection” of the nature of the human person.

Restoration

- Lost due to trauma, or surgical management of malignancy, infection, etc.
- Missing at birth, due to developmental anomalies, or in-utero events.

Missing from trauma

- Adult male: traumatic amputation of non-dominant thumb
- Needs prehensile, helping hand with good grip and fine “key pinch” functions.



Restoration

- Degree of functional restoration is dictated by the intrinsic natural function of the lost part
- Hand:
 - Grasping, pinching, stabilizing, pushing, dominant vs. helping.
- Goals are tailored to the life of the patient

Congenital Cleft Palate

- Congenital malformation of the face with varying degrees of palatal integrity
- Feeding difficulty
- Speech problems
- Hearing problems
- Dental problems





The Cost of Reconstruction

- What will be lost, or compromised in the course of reconstruction?
 - “Donor defect”.
 - Risk vs. benefit

“Transitioning”

(Progressive Expression of Condition)

- Obsessive thoughts leading to compulsive behaviors.
- Interferes with living in the present moment.
- Managing anxiety by unhealthy means.
- Withdrawal, cross-sex dressing/acting in secret.

Transitioning

- Secretive, dysfunctional life leads to conflicts with family, and peers. Causes “dysphoria”.
- Psychological counseling: the broad and the narrow.
- APA: Presumes that “gender non-conforming” is the essential and true nature of the person, therefore health is to be found in giving full expression to the subjectively perceived persona.

Transitioning

- Psychological Testing of “maleness and femaleness” (objective standard).
- Cross-sex identity development: clothing, name, persona.
- Endocrine management
 - Puberty blocking in pre-pubertal children; cross-sex hormones.
- Voice training, hair management.

FIND A DOCTOR

DEPARTMENTS

CONDITIONS

LOCATIONS

YOUR VISIT

Search...

Endocrinologist



Wilma C. Rossi, MD,
MBE



Gender and Sexuality Development Clinic

CONTACT US

“Providers, patient and parents were ready to start hormone therapy with testosterone to help him align his body with who he had always known he was on the inside.”

“While gender-related healthcare can be expensive in the short term, it is recognized to lead directly to improved health outcomes and long-term cost savings.” ~CHOP

The Washington University

Transgender Center

at St. Louis Children's Hospital



E-m



314.454.KIDS (54)

800.678.KIDS (

[Resources](#)[About Us](#)[What to Expect](#)cs.wustl.edu/transgender-center/#

“Your first visit to the Washington University Transgender Center at St. Louis Children's Hospital will take about 60-90 minutes. You'll meet with one of our physicians for an informational discussion about age-appropriate therapies (depending on if the patient has started puberty.) You may be referred to a mental health provider for ongoing psychosocial support and assessment, if indicated. Records from patient's primary care physicians should be sent prior to the first visit, so our doctors can review them for pre-existing conditions that may be affected by hormone therapy.”



Karen Hamon, BSN, RN, CDE

Pronouns: She, Her, Hers

Karen is a Clinical Nurse Coordinator in outpatient care at Washington University School of Medicine, Division of Endocrinology and Diabetes. She received her Bachelor's of Science in Nursing from Goldfarb College of Nursing, Saint Louis University. She also received her Master's of Science in Justice Systems with a minor in Sociology from Truman State University. Karen's prior experience includes staff nursing care in pediatric general medicine floor and as an inpatient diabetes educator at St. Louis Children's Hospital. She joined the Endocrinology and Diabetes Division in 2013 and has won two division awards since then. She is also currently a finalist for the 2023 St. Louis Children's Hospital Nurse Award. Karen is very passionate about social justice issues and jumped at the chance to be part of the



Casey E. Lofquest, MSN, RN, CPNP

Pronouns: She, Her, Hers

Casey is a Pediatric Nurse Practitioner (PNP) in outpatient care at Washington University School of Medicine, Division of Endocrinology and Diabetes. She received both her Bachelor's of Science in Nursing and Master's of Science in Nursing (with a specialty in pediatric nursing), from Saint Louis University. Casey's prior experience includes staff nursing care in pediatric intensive care nursing. She practiced as a PNP in primary care in Arnold, MO, prior to joining the Endocrinology and Diabetes Division. Casey is very passionate about social justice issues and jumped at the chance to be part of the



PHOTOGRAPHY BY GARA DYSON

Jessica, one of the center's patients, with Dr. Christopher Lewis

- Education regarding gender dysphoria and its possible treatments. Gender dysphoria refers to the distress that may accompany the incongruence between one's gender identity and one's assigned sex at birth.
- Administering pubertal blockers, which delay puberty and suppress unwanted and irreversible secondary sexual characteristics; for example, deepening of the voice and facial hair for transgender females and breast development for transgender males.
- Administering cross sex (gender-affirming) hormones that make a person's physical body match their gender identity. These may begin between the ages of 14 and 16 after patients meet readiness and eligibility criteria.

Puberty blocking drugs

Cross-sex hormones

Absence of medical evidence

Human experimentation

Irreversible effects on:

Fertility

Neuropsychiatric/ musculoskeletal development

Desistance data. 9% vs. 100%





Transitioning

- Surgery
 - Secondary surgeries: hair, forehead, nose, jaw, neck, breast. Euphemism: “Top Surgery”.
 - Definitive and final: castration and vaginoplasty, or hysterectomy / oophorectomy and phalloplasty. “Bottom Surgery”.



PSEN University: Gender Affirming Surgeries 101 - Webinar (Includes Gender Affirming 101 Series)

Member Price **\$250.00**

Non-Member Price **\$325.00**

Members Save \$75.00

In Stock

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 **Log In**

Product Description

Presented by: Loren Schechter, MD

About this Course :

This course is a live webinar CME course to be held on **April 18th 2018 at 7pm cst**. This course also includes the 2017 **PSEN University: Gender Affirming 101 for Surgeons - Video Series** which features ten webinar recordings from a

The Surgery

- Top surgery is largely reversible.
- Bottom surgery is irreversible. Fully functioning genital organs are mutilated in order to produce a counterfeit form.
- Form has primacy
- Function is destroyed (donor morbidity)

Grave Matter

- Willful sterilization destroys the procreative aspect.
- Simultaneous degradation of the unitive aspect.
- major loss of sensory apparatus, and persistence of the native neural “map” in the brain.

Grave Matter

- “Banking” of ova and sperm for future in vitro and proxy pregnancies.
- Objectification of children; the “right to a child”.
- Link between “reproductive technology”, & “gender affirmation medicine”.

Plea For Mercy

- Because self-identified transgender persons suffer greatly
- High rate of substance abuse.
- High rate of homelessness.
- High rate of suicide attempt:
 - 18yo - 55yo steady at approx. 40% risk.



"The only way I will rest in peace is if one day transgender people aren't treated the way I was, they're treated like humans, with valid feelings and human rights. Gender needs to be taught about in schools, the earlier the better. My death needs to mean something" - Leelah Alcorn

UK: 48% of trans people under 26 attempt suicide (2014)
US: 41% of trans people attempt suicide (2014)
Canada: 43% of trans people attempt suicide (2012)

The Appeal From Sentiment

DEATH BY EXTREME CHRISTIANITY



Carla Wood Alcorn

Doug Alcorn

LEXIE CANNES STATE OF TRANS

Conservative Christian Parents Triggers Trans Teen Suicide

Compulsion To “Mercy”

- “Everything must be done to help these persons live their new identity”
- Home, school, work
 - Names, pronouns, bathrooms, etc.
 - Health insurance directed toward transitioning, not treatment of OCD.
 - Attempts to diagnose and treat are labeled “hate speech”.

So...it is working,
right?

Evidence Based Medicine

- Over the years, many small retrospective studies.
- Inconsistent criteria for inclusion of patients and the selection of controls
- Much self-selection bias; high drop out rate.
- Small samples and short follow-up
- Varying degrees of “success”. Ranging from “improved in gender dysphoria” to continued elevated psychiatric hospitalization and suicide attempts and death.

The Swedish Study



- * Population cohort study over 30 year period.
- * Age and sex matched cohort.
- * Data from consistent national database.
- * Standardized reporting for identity change, hospitalization, psychiatric diagnosis and co-morbidities, and mortality.

The Swedish Study

Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden

[Cecilia Dhejne](#),¹ [Paul Lichtenstein](#),² [Marcus Boman](#),² [Anna L. V. Johansson](#),² [Niklas Långström](#),^{2,3} and [Mikael Landén](#)^{1,2,4,*}

James Scott, Editor

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Abstract

Go to: Go to:

Context

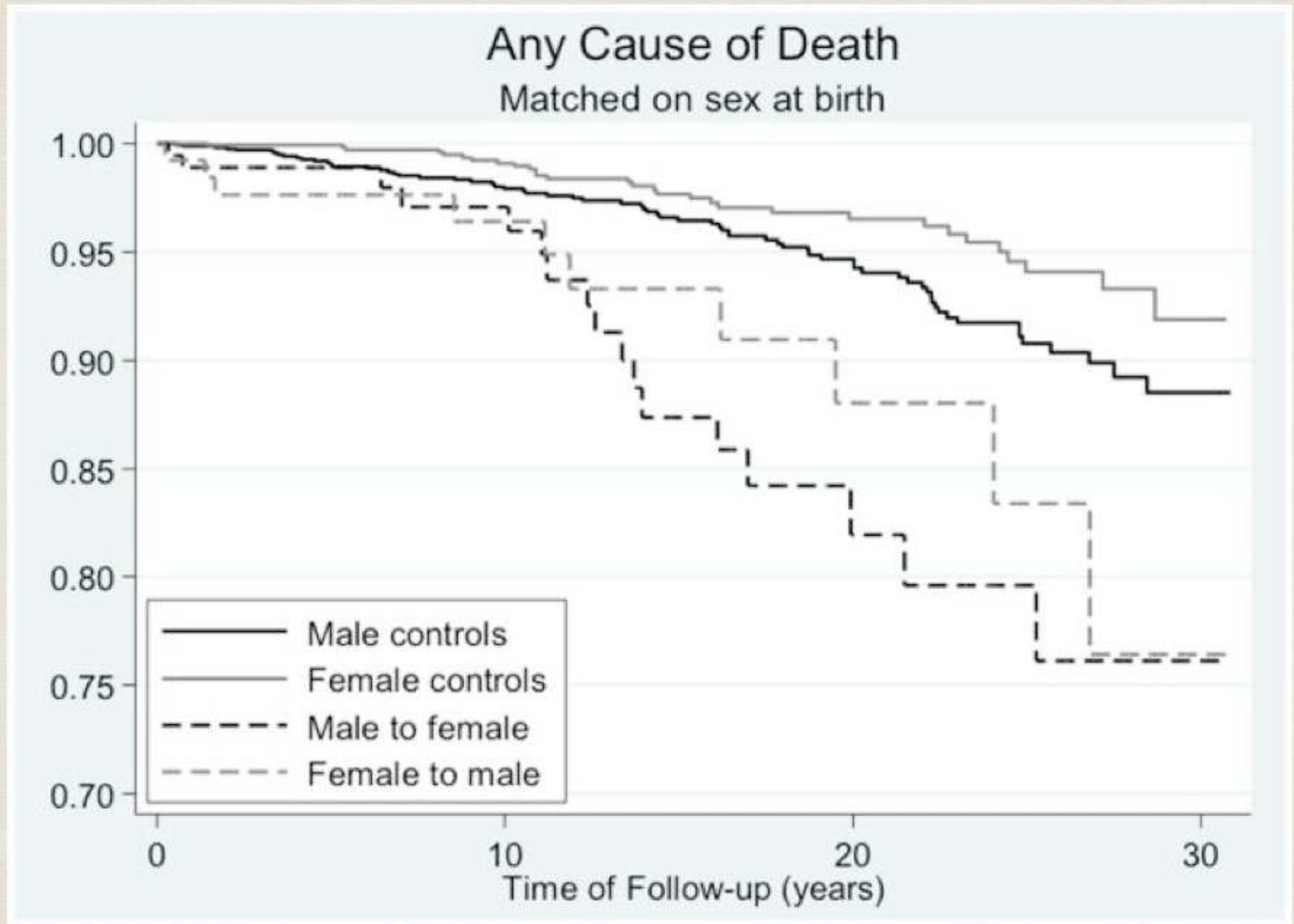
The treatment for transsexualism is sex reassignment, including hormonal treatment and surgery aimed at making the person's body as congruent with the opposite sex as possible. There is a dearth of long term, follow-up studies after sex reassignment.

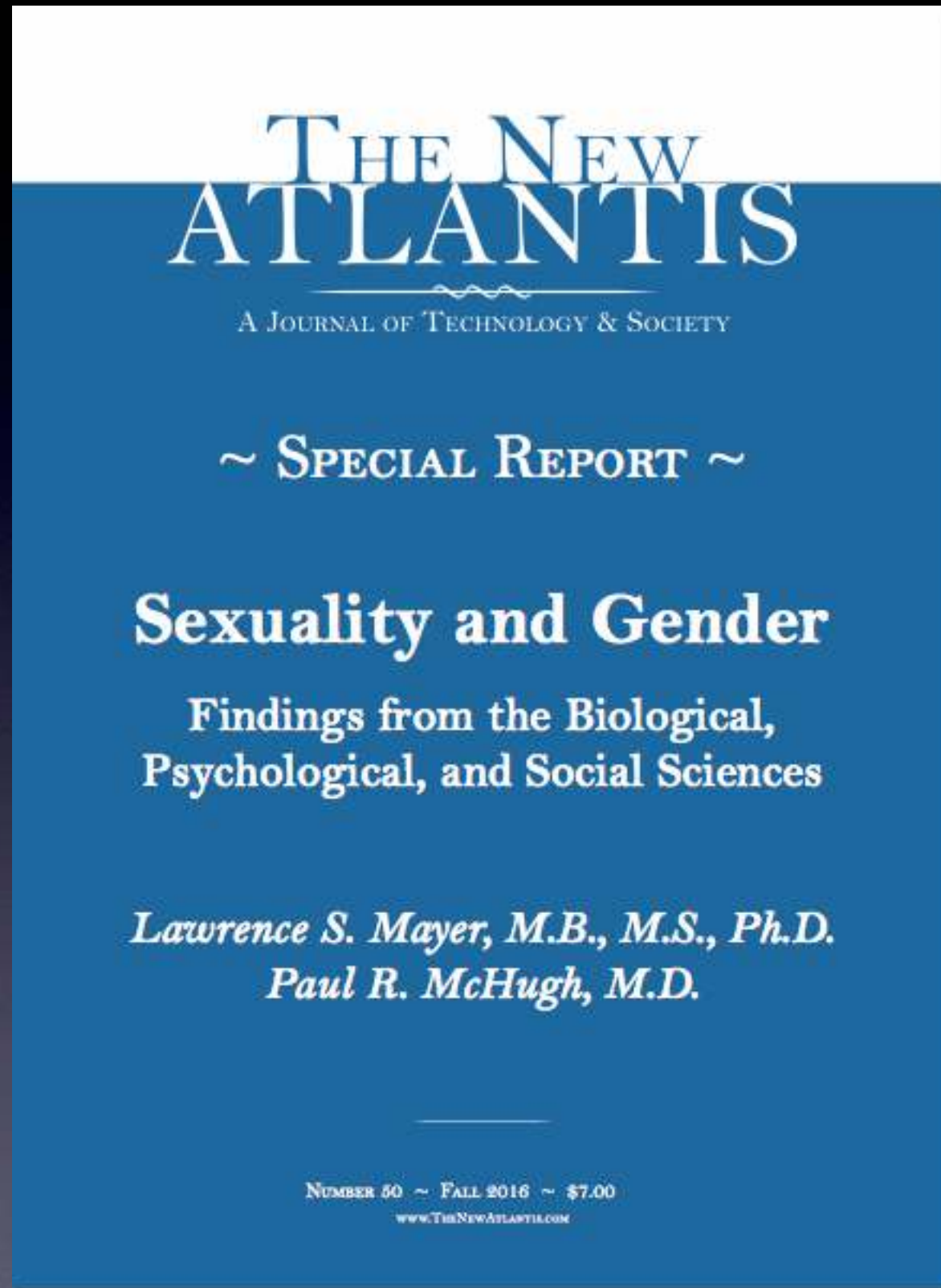
Swedish Study

Table S1. Risk of various outcomes in sex-reassigned subjects in Sweden compared to population controls matched for birth year and *birth sex*.

Outcome	No. of events (male-to-female/ female-to-male)	Crude hazard ratio (95% CI)			Adjusted* hazard ratio (95% CI)		
		All sex- reassignment persons (N=324)	Male-to-female only (N=191)	Female-to- male only (N=133)	All sex- reassignment persons (N=324)	Male-to-female only (N=191)	Female-to-male only (N=133)
Any death	27 (17/10)	2.9 (1.9-4.5)	2.6 (1.5-4.5)	3.7 (1.8-7.7)	2.8 (1.8-4.3)	2.4 (1.4-4.1)	3.8 (1.8-7.9)
Death by suicide	10 (6/4)	19.1 (6.5-55.9)	13.9 (3.9-49.6)	40.0 (4.5-357.9)	N/A	N/A	N/A
Death by cardiovascular disease	9 (6/3)	2.6 (1.2-5.4)	2.3 (0.9-5.7)	3.2 (0.9-11.9)	N/A	N/A	N/A
Death by neoplasm	8 (4/4)	2.1 (1.0-4.6)	1.7 (0.6-4.9)	2.8 (0.9-8.5)	N/A	N/A	N/A
Any psychiatric hospitalisation‡	64 (43/21)	4.2 (3.1-5.6)	4.7 (3.2-6.7)	3.4 (2.1-5.6)	2.8 (2.0-3.9)	3.2 (2.1-4.9)	2.2 (1.3-4.0)
Substance misuse	22 (14/8)	3.0 (1.9-4.9)	2.8 (1.6-5.1)	3.5 (1.6-7.8)	1.7 (1.0-3.1)	1.5 (0.7-3.1)	2.3 (0.9-5.8)
Suicide attempt	29 (22/7)	7.6 (4.7-12.4)	15.4 (7.9-30.2)	2.9 (1.3-6.8)	4.9 (2.9-8.5)	10.4 (4.9-22.1)	1.9 (0.7-4.8)
Any accident	32 (19/13)	1.6 (1.1-2.3)	1.4 (0.9-2.2)	1.9 (1.0-3.4)	1.4 (1.0-2.1)	1.2 (0.7-2.0)	1.8 (1.0-3.3)
Any crime	60 (33/27)	1.9 (1.4-2.5)	1.2 (0.8-1.7)	5.6 (3.5-9.1)	1.3 (1.0-1.8)	0.8 (0.5-1.2)	4.1 (2.5-6.9)
Violent crime	14 (8/6)	2.7 (1.5-4.9)	1.8 (0.8-3.7)	9.9 (3.2-30.7)	1.5 (0.8-3.0)	0.8 (0.3-2.1)	7.2 (2.1-24.4)

Notes: N/A Not applicable due to sparse data. *Adjusted for immigrant status and psychiatric morbidity up to baseline. ‡ Hospitalisations for gender identity disorder were excluded.





A study of the studies.
-Examination of 500 papers in:
epidemiology, genetics,
endocrinology, psychiatry, neuro-
science, embryology, and
pediatrics

“The scientific definition of biological sex is, for almost all human beings, clear, binary, and stable, reflecting an underlying biological reality that is not contradicted by exceptions to sex-typical behavior, and cannot be altered by surgery or social conditioning.”

~ Lawrence S. Mayer, M.B.,M.S., Ph.D.

“The notion that a two-year-old, having expressed thoughts or behaviors identified with the opposite sex, can be labeled for life as transgender has absolutely no support in science.

Indeed, it is iniquitous to believe that all children who have gender-atypical thoughts or behavior at some point in their development, particularly before puberty, should be encouraged to become transgender.”

~Lawrence S. Mayer, M.B.,M.S., Ph.D.



OPEN ACCESS PEER-REVIEWED

RESEARCH ARTICLE

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

Lisa Littman 

Published: August 16, 2018 • <https://doi.org/10.1371/journal.pone.0202330>

Instructions on lying

- “TL;DR find out what they want to hear if they’re gonna give you T and then tell them just that. It’s about getting treatment, not about being true to those around you. It’s not their business and a lot of time doctors will screw stuff up for you.”^a
- “...Get a story ready in your head, and as suggested keep the lie to a minimum. And only for stuff that can’t be verified. Like how you were feeling, but was too afraid to tell anyone including your family.”^b
- “I’d also look up the DSM for the diagnostic criteria for transgender and make sure your story fits it, assuming your psych follows it.”^c

Urgency to transition

- “...If you don’t do it when you are young. You’ll be miserable and unhappy with your body for the rest of your life.”^d

Vague and nonspecific symptoms called signs of GD

- “Signs of indirect gender dysphoria: 1. Continual difficulty with simply getting through the day. 2. A sense of misalignment, disconnect, or estrangement from your own emotions. 3. A feeling of just going through the motions in everyday life, as if you’re always reading from a script. 4. A seeming pointlessness to your life, and no sense of any real meaning or ultimate purpose. 5. Knowing you’re somehow different from everyone else, and wishing you could be normal like them...”^e

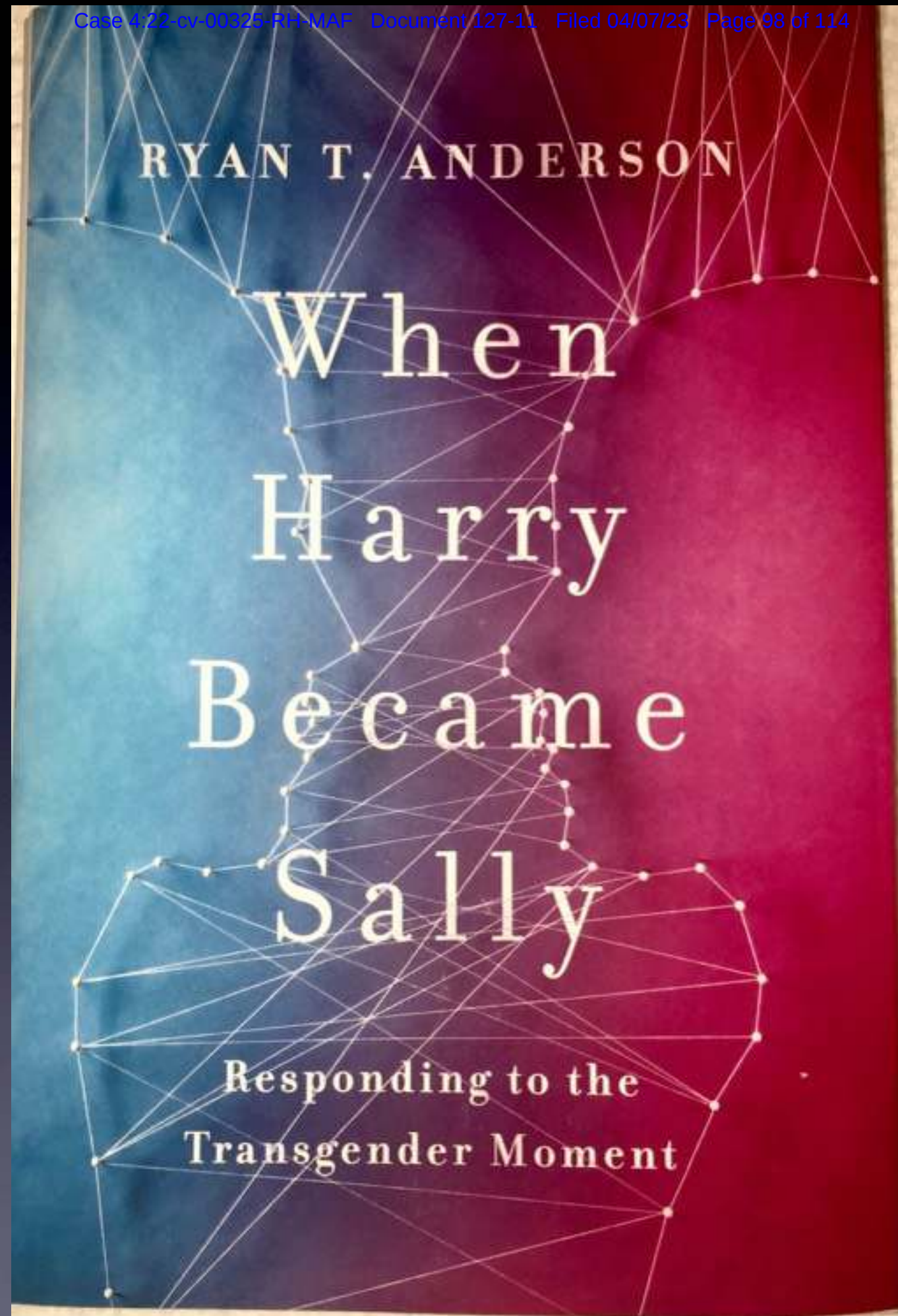
- https://www.reddit.com/r/asktransgender/comments/2nt8gi/having_a_psych_eval_soon/#bottom-comments
- https://www.reddit.com/r/asktransgender/comments/4agt76/is_it_best_to_be_completely_honest_or_lie_a/
- https://www.reddit.com/r/asktransgender/comments/4ihwar/what_things_should_i_never_tell_my_psychologist/
- https://www.reddit.com/r/asktransgender/comments/3gpb94/at_the_final_stage_of_questioning_need_some/#bottom-comments
- <https://transgenderteensurvivalguide.tumblr.com/post/62036014416/that-was-dysphoria-8-signs-and-symptoms-of>

Britain's Youngest Patient



© Sunday Mirror

Although Ms Cooper underwent a thorough psychological assessment and counseling at Hull Royal Infirmary prior to starting her sex change therapy she has suffered such torment living as a woman that she has tried to commit suicide twice.



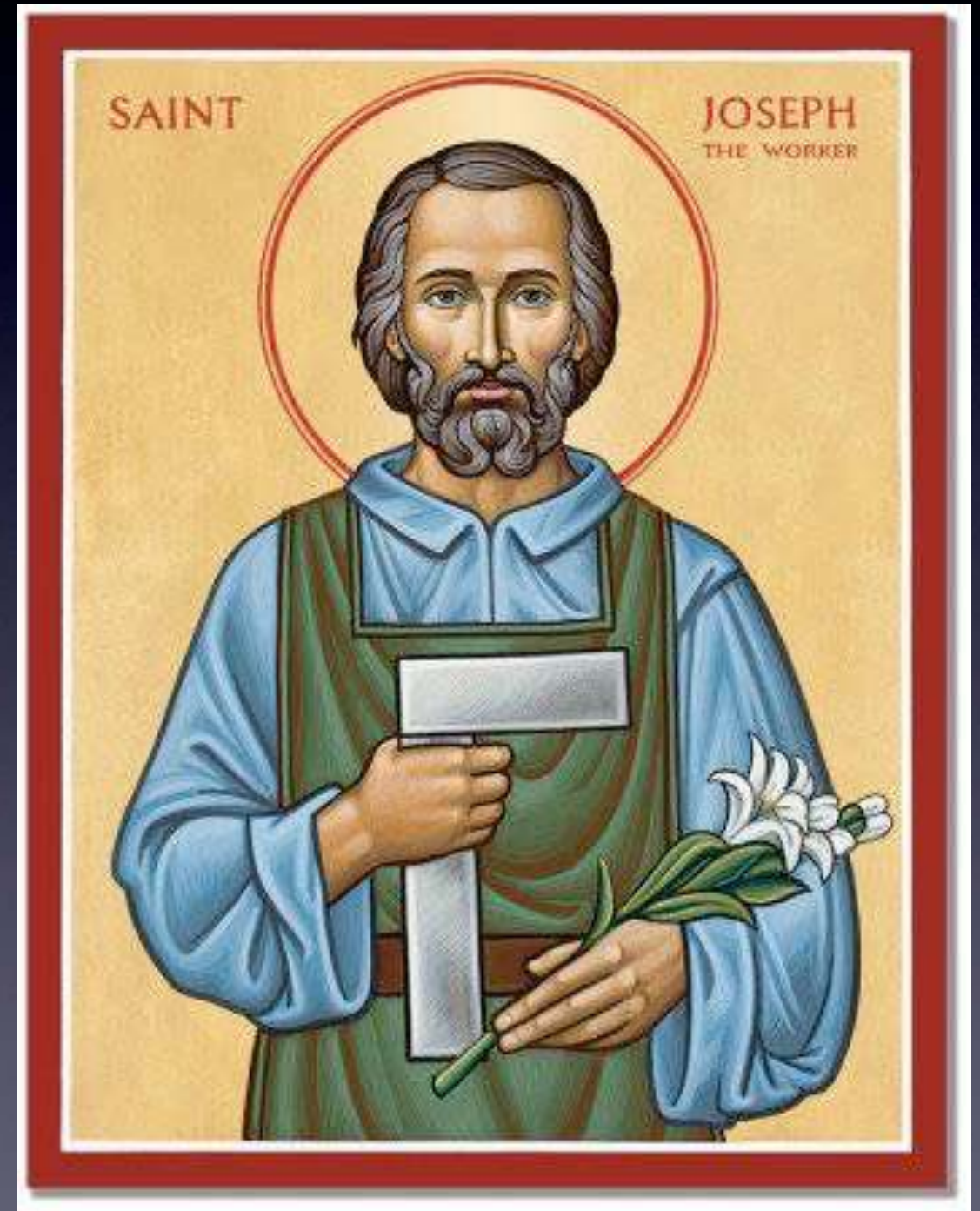
Summary

- Not a new condition. OCD w/ BDD.
- Psychological/ Spiritual wound.
- Ordinary childhood role playing being sexualized/ treated with puberty blockers!
- In many cases, permanently mutilating surgeries.
- A huge engine of public opinion, policy, and enforcement aimed at the family, and the church.

- Transgender persons are at high risk for abuse and self harm.
- Care must be based in a true human anthropology.
- Missteps must be anticipated
- Protection from “blind guides”.
- Fluency in the language, and knowledge about the erroneous science will permit witnessing with patience and fraternal love.

Let Us Pray

God our Father,
creator and ruler of the universe, in
every age you call man to develop and
use his gifts for the good of others.
With Saint Joseph as our example and
guide, help us to do the work you
have asked and come to the rewards
you have promised.
We ask this through our Lord Jesus
Christ, your Son, who lives and reigns
with you and the Holy Spirit, one
God, for ever and ever.
Amen







Let Us Pray

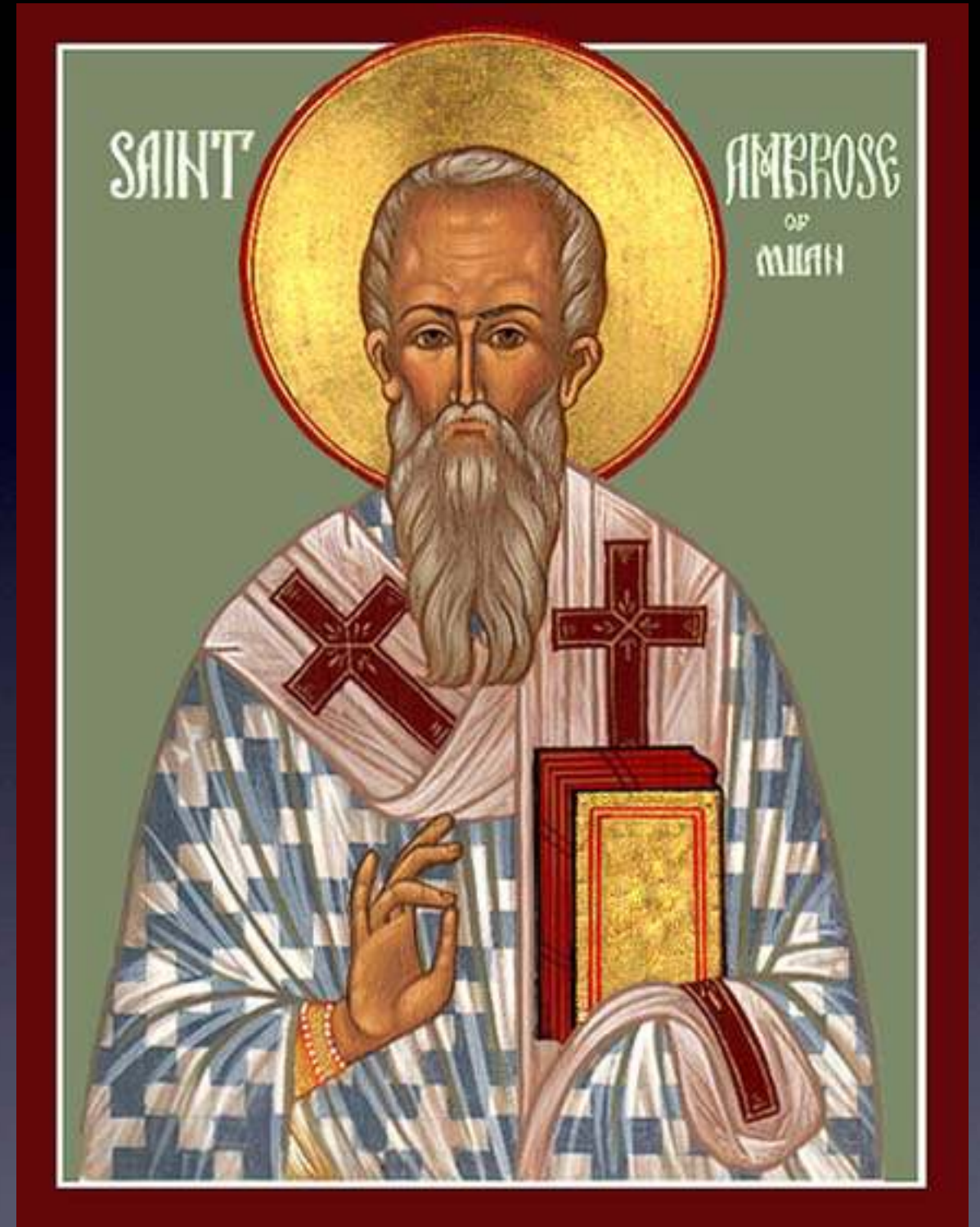
Oh glorious martyrs of Christ, Saints Cosmas and Damian, you gave your lives for the love of God, benefiting your fellow man, and crowning your martyrdom with an open and loyal profession of your faith. You taught us to love God above all things, and to love our fellow man as ourselves, professing always, and without fear, the religion of Jesus. Augmenting amongst the faithful populace many miracles, you are glorious indeed. Through your intercession, which brings about deliverance of these miracles, we pray to you for your aid in all things. May your patronage never be far from us in the illness of our body and soul.

Oh great protectors, Saints Cosmas and Damian, assist us with your love and free us from all evils. Amen



Let Us Pray

Lord,
you made Saint Ambrose
an outstanding teacher of
the Catholic faith and gave
him the courage of an
apostle.
Raise up in your Church
more leaders after your
own heart, to guide us with
courage and wisdom.
We ask this through our
Lord Jesus Christ, your Son,
who lives and reigns with
you and the Holy Spirit,
one God, for ever and ever.
Amen.



Let us Pray

Almighty God, whose deacon
Vincent, upheld by you, was
not terrified by threats nor
overcome by torments:
Strengthen us to endure all
adversity with invincible and
steadfast faith; through Jesus
Christ our Lord, who lives and
reigns with you and the Holy
Spirit, one God, for ever and
ever.
Amen



St. Vincent of Saragossa

Let Us
Pray



殉教



God our Father,
source of strength for all your saints; you led Paul Miki and his companions
through the suffering of the cross to the joy of eternal life.
May their prayers give us courage to be loyal until death in professing our faith.
Through Jesus Christ, your Son, who lives and reigns with you
in the unity of the Holy Spirit, one God, for ever and ever.
Amen.

Let Us Pray

O God, almighty Father, you have consecrated us to the work of bringing our brothers and sisters to the life of grace; there to grow in that perfection of our nature which leads to eternal life.

Grant unto us ,O Lord, an unswerving devotion to the service of those suffering from wounds that keep them from that fullness of life which you intend for all of us.

Do not allow us to be mislead by the deceptions of a world that has lost sight of you, and help us to follow in the obedience of your Son, Jesus Christ, who lives and reigns with you in the unity of the Holy Spirit, One God, for ever, and ever.

Amen





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From Male to Female and Back Again

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Reaching Out to Those
with Sex Change Regret

This is the book you
need in your hands



The Challenge

- Evangelizing people who are being relentlessly misled concerning human sexuality.
- In need of catechesis at all levels.
- In need of pastoral sensitivity to particular wounds.
- In need of the sacraments.



Bl. John Henry Cardinal Newman

Plea For Mercy

- For The Children!
- To prevent suicide!



Let Us Pray

O Mary, Powerful Virgin; thou art the mighty and glorious protector of the Church; Thou art the marvelous **Help of Christians**; Thou art terrible as an army in battle array; Thou alone hast destroyed every heresy in the whole world. In the midst of our struggles, our anguish, and our distress, defend us from the power of the enemy, and at the hour of death, receive our souls into Paradise.

Amen



Transgender Surgery and Christian Anthropology



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