

No. 23-12155

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**UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT**

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*August Dekker et al.,*  
Plaintiffs-Appellees,

v.

*Secretary, Florida Agency for Health Care Administration et al.,*  
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325  
(Hinkle, J.)

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**APPELLANTS' APPENDIX – VOLUME V OF XXI**  
**PART 2 OF 2**

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Michael Beato  
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Dated: October 13, 2023

/s/ Mohammad O. Jazil

Mohammad O. Jazil

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*Counsel for Appellants-Defendants*

1 your comments, just like we appreciate the comments  
2 of everyone in this room and all the people that  
3 have made comments on-line and otherwise.

4 I just wanted to make sure -- clear, just so  
5 we're crystal-clear about the purpose of this rule  
6 is that we're not talking about a ban of treatment  
7 for gender dysphoria. We're talking about not  
8 covering through reimbursement in the Florida  
9 Medicaid program for the services that are  
10 enumerated in the rule itself.

11 I also want to make clear that there are other  
12 comprehensive coverage of services for gender  
13 dysphoria currently in the Florida Medicaid  
14 program, and I just want to read a couple of those:  
15 "Community-based health services provided by an  
16 array of provider types; psychiatric services  
17 provided by a physician or other qualified health  
18 care practitioner in office settings, clinics, and  
19 hospitals; emergency services and inpatient  
20 services in hospital settings; behavioral health  
21 services provided in schools and by school  
22 districts."

23 So I just wanted to make sure that everyone  
24 was crystal-clear about the purpose of this rule.  
25 I very much appreciate your comment and the

1           comments of everybody else.

2           A VOICE: Thank you, everyone, for your  
3 participation in this hearing. We will accept  
4 written material or comments until 5:00 p.m. on  
5 Monday, July 11, 2022. Comments may be submitted  
6 by e-mail to  
7 medicaidrulecomments@ahca.myflorida.com.

8           That being our time, this hearing is now  
9 closed. Thank you.

10           (Whereupon, the hearing was concluded.)

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C E R T I F I C A T E

STATE OF FLORIDA )

COUNTY OF LEON )

I hereby certify that the foregoing transcript is of a tape-recording taken down by the undersigned, and the contents thereof were reduced to typewriting under my direction;

That the foregoing pages 02 through 91 represent a true, correct, and complete transcript of the tape-recording;

And I further certify that I am not of kin or counsel to the parties in the case; am not in the regular employ of counsel for any of said parties; nor am I in anywise interested in the result of said case.

Dated this 19th day of July, 2022.



CLARA C. ROTRUCK

Notary Public

State of Florida at Large

Commission Expires:

November 13, 2022

Commission NO.: GG 272880

## Medicaid Certified School Match Program Fee Schedule

**2022**

**\*Reimbursement amount is the Federal Share of these fees. However, reimbursement can also be based on the individual school district's cost and vary from school district to school district.**

<b>Occupational Therapy Services</b>				
<b>Code</b>	<b>Modifier</b>	<b>Description of Service</b>	<b>Maximum Fee</b>	<b>Maximum Allowable Units</b>
97165		Occupational Therapy Evaluation, Low Complexity	\$51.05	1 per year
97166		Occupational Therapy Evaluation, Moderate Complexity	\$51.05	1 per year
97167		Occupational Therapy Evaluation, High Complexity	\$51.05	1 per year
97530		Occupational Therapy Treatment Individual Session	\$17.86	4 per day, 14 per week
97530	HM	Occupational Therapy Individual Session Provided by an Occupational Therapy Assistant	\$14.30	4 per day, 14 per week
97150	GO	Occupational Therapy Group Session by an Occupational Therapist	\$3.47	4 per day, per week
97150	UC	Occupational Therapy Group Session by an Occupational Therapy Assistant	\$2.74	4 per day
97542	GO	Wheelchair Evaluation and Fitting by an Occupational Therapist	\$51.05	1 per 5 years
92597	GO	AAC Initial Evaluation Provided by an Occupational Therapist	\$102.63	1 per 5 years
29799	HA	Application of Casting or Strapping	\$19.56	2 per day



<b>Physical Therapy Services</b>				
<b>Code</b>	<b>Modifier</b>	<b>Description of Service</b>	<b>Maximum Fee</b>	<b>Maximum Allowable Units</b>
97161		Physical Therapy Evaluation, Low Complexity	\$51.05	1 per year
97162		Physical Therapy Evaluation, Moderater Complexity	\$51.05	1 per year
97163		Physical Therapy Evaluation, High Complexity	\$51.05	1 per year
97110		Physical Therapy Treatment Individual Session	\$17.86	4 per day, 14 per week
97110	HM	Physical Therapy Individual Session Provided by a Physical Therapy Assistant	\$14.29	4 per day, 14 per week
97150	GP	Physical Therapy Group Session by a Physical Therapist	\$3.47	4 per day
97150	HM	Physical Therapy Group Session by a Physical Therapist Assistant	\$2.74	4 per day
97542	GP	Wheelchair Evaluation and Fitting by a Physical Therapist	\$51.05	1 per 5 years
92597	GP	AAC Initial Evaluation Provided by a Physical Therapist	\$102.63	1 per 5 years
29799	HA	Application of Casting or Strapping	\$19.56	2 per day

<b>Speech-Language Pathology Services</b>				
<b>Code</b>	<b>Modifier</b>	<b>Description of Service</b>	<b>Maximum Fee</b>	<b>Maximum Allowable Units</b>
92521		Evaluation/ Re-evaluation of speech fluency (e.g., stuttering, cluttering)	\$51.05	1 per 5 months
92522		Evaluation/ Re-evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	\$51.05	1 per 5 months

92523		Evaluation/ Re-evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	\$51.05	1 per 5 months
92524		Evaluation/ Re-evaluation Behavioral and qualitative analysis of voice and resonance	\$51.05	1 per 5 months
92610		Evaluation/Re-Evaluation of oral and pharyngeal swallowing function	\$48.94	1 per 5 months
92507		Speech-Language Pathology Individual Session by a Speech-Language Pathologist	\$17.86	4 per day, 14 per week
92507	HM	Speech-Language Pathology Individual Session Provided by a Speech Therapy Assistant	\$14.30	4 per day, 14 per week
92508		Speech-Language Pathology Group Session by a Speech-Language Pathologist	\$3.47	4 per day 14 per week
92508	HM	Speech-Language Pathology Group Session by a Speech-Language Pathology Assistant	\$3.74	4 per day, 14 per week
92597		AAC Initial Evaluation Provided by a Speech-Language Pathologist	\$102.63	1 per 5 years
92597	GN	AAC Re-Evaluation Provided by a Speech-Language Pathologist	\$52.63	1 per 6 months
92609		AAC Fitting, Adjustment, and Training Visit	\$42.11	8 per year

**TRANSPORTATION**

Transportation fees vary for each school district. They are not included in this appendix, instead each district is notified of its fee.

<b>Behavioral Services</b>					
<b>Code</b>	<b>Modifier 1</b>	<b>Modifier 2</b>	<b>Description of services</b>	<b>Maximum Fee</b>	<b>Maximum Allowable Units</b>
H0031	AH		Psychologist-Individual Service-Evaluation	\$9.66	32 units per school district

					staff member, per day.
H0046	AH		Psychologist-Individual Service-All Else	\$9.66	32 units per school district staff member, per day.
H0046	AH	HQ	Psychologist-Group Service	\$4.95	32 units per school district staff member, per day.
H0031	SE		Certified Behavior Analyst-Individual Service-Evaluation	\$8.00	32 units per school district staff member, per day.
H2019	HA		Certified Behavior Analyst-Individual Service-All Else	\$10.41	32 units per school district staff member, per day.
H2019	HA	HQ	Certified Behavior Analyst-Group Service	\$3.24	32 units per school district staff member, per day.
H0002	HA		Certified Behavior Analyst (Bachelor's Level) and Certified Assistant Behavior Analyst-Individual Service-Evaluation	\$6.70	32 units per school district staff member, per day.
H2014	HA		Certified Behavior Analyst (Bachelor's Level) and Certified Assistant Behavior Analyst-Individual Service-All Else	\$6.70	32 units per school district staff member, per day.
H2014	HA	HQ	Certified Behavior Analyst (Bachelor's Level) and Certified Assistant Behavior Analyst-Group Service	\$3.35	32 units per school district staff member, per day.
H0031	HU		Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors Individual Service - Evaluation	\$8.97	32 units per school district staff member, per day.
H0046	SE		Social Worker (Master's Level);	\$8.97	32 units per school district

			Marriage and Family Therapist; Mental Health and Guidance Counselors-Individual Service-All Else		staff member, per day.
H0046	SE	HQ	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors-Group Service	\$4.25	32 units per school district staff member, per day.
H0002	HN		Social Worker (Bachelor's Level)-Individual Service-Evaluation	\$7.17	32 units per school district staff member, per day.
H0046	HN		Social Worker (Bachelor's Level)-Individual Service-All Else	\$7.17	32 units per school district staff member, per day.
H0046	HN	HQ	Social Worker (Bachelor's Level)-Group Service	\$3.40	32 units per school district staff member, per day.

Nursing Services				
Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
T1002		Nursing Service-Registered Nurse	\$6.20	32 units per nurse or aide, per day
T1003		Nursing Service-Licensed Practical Nurse	\$4.80	32 units per nurse or aide, per day
T1004		Nursing Service-School Health Aide	\$3.80	32 units per nurse or aide, per day
T1002	KO	Medication Administration-Registered Nurse	\$2.07	32 units per nurse or aide, per day
T1003	KO	Medication Administration-Licensed Practical Nurse	\$1.06	32 units per nurse or aide, per day
T1004	KO	Medication Administration-School Health Aide	\$0.80	32 units per nurse or aide, per day

**Behavioral Health Overlay Services Fee Schedule**

**2022**

Description of Service	Procedure Code	Modifier	Maximum Fee	Reimbursement and Service Limitations
Behavioral health overlay services	H2020	HA	\$32.75 per day	<p>Medicaid will not reimburse for behavioral health overlay services when a recipient is absent because he or she is in a Department of Juvenile Justice detention center placement.</p> <p>Medicaid will not reimburse a provider for behavioral health overlay services if the provider has been paid for the provision of the same type of services by another purchasing entity.</p>

Florida Medicaid Community Behavior Health Fee Schedule  
 2022

Description of Service	Procedure Code	Mod	Maximum Fee	Reimbursement and Service Limitations
<u>59G-4.028: Behavioral Health Assessment Services Coverage Policy</u>				
Psychiatric evaluation by a physician	H2000	HP	\$210.00 per evaluation	Medicaid reimburses a maximum of two psychiatric evaluations per recipient, per state fiscal year.
Psychiatric evaluation by a non-physician	H2000	HO	\$150.00 per evaluation	Medicaid reimburses a maximum of two psychiatric evaluations per recipient, per state fiscal year.
Brief behavioral health status exam	H2010	HO	\$14.66 per quarter hour	There is a maximum daily limit of two quarter-hour units. Medicaid reimburses for brief behavioral health status examinations a maximum of 10 quarter-hour units annually (2.5 hours), per recipient, per state fiscal year. A brief behavioral assessment is not reimbursable on the same day that a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed by a qualified treating practitioner.
Psychiatric review of records	H2000		\$26.00 per review	Medicaid reimburses a maximum of two psychiatric reviews of records, per recipient, per state fiscal year. This service may not be billed for review of lab work (see medication management).
In-depth assessment, new patient, mental health	H0031	HO	\$125.00 per assessment	Medicaid reimburses one in-depth assessment, per recipient, per state fiscal year. An in-depth assessment is not reimbursable on the same day for the same recipient as a biopsychosocial evaluation. A bio-psychosocial evaluation is not reimbursable for the same recipient after an in-depth assessment has been completed, unless there is a documented change in the recipient's status and additional information must be gathered to modify the recipient's treatment plan.
In-depth assessment, established patient, mental health	H0031	TS	\$100.00 per assessment	Medicaid reimburses one in-depth assessment, per recipient, per state fiscal year. An in-depth assessment is not reimbursable on the same day for the same recipient as a biopsychosocial evaluation. A bio-psychosocial evaluation is not reimbursable for the same recipient after an in-depth assessment has been completed, unless there is a documented change in the recipient's status and additional information must be gathered to modify the recipient's treatment plan.
In-depth assessment, new patient, substance abuse	H0001	HO	\$125.00 per assessment	Medicaid reimburses one in-depth assessment, per recipient, per state fiscal year. An in-depth assessment is not reimbursable on the same day for the same recipient as a biopsychosocial evaluation. A bio-psychosocial evaluation is not reimbursable for the same recipient after an in-depth assessment has been completed, unless there is a documented change in the recipient's status and additional information must be gathered to modify the recipient's treatment plan.
In-depth assessment, established patient, substance abuse	H0001	TS	\$100.00 per assessment	Medicaid reimburses one in-depth assessment, per recipient, per state fiscal year. An in-depth assessment is not reimbursable on the same day for the same recipient as a biopsychosocial evaluation. A bio-psychosocial evaluation is not reimbursable for the same recipient after an in-depth assessment has been completed, unless there is a documented change in the recipient's status and additional information must be gathered to modify the recipient's treatment plan.

Florida Medicaid Community Behavior Health Fee Schedule  
 2022

Description of Service	Procedure Code	Mod	Maximum Fee	Reimbursement and Service Limitations
Bio-psychosocial Evaluation, mental health	H0031	HN	\$48.00 per assessment	Medicaid reimburses one biopsychosocial evaluation, per recipient, per state fiscal year. A bio-psychosocial evaluation is not reimbursable on the same day for the same recipient as an in-depth assessment.
Bio-psychosocial evaluation, substance abuse	H0001	HN	\$48.00 per assessment	Medicaid reimburses one biopsychosocial evaluation, per recipient, per state fiscal year. A bio-psychosocial evaluation is not reimbursable on the same day for the same recipient as an in-depth assessment.
Psychological testing	H2019		\$15.00 per quarter hour	Medicaid reimburses a maximum of 40 quarter-hour units (10 hours) of psychological testing per state fiscal year.
Limited functional assessment, mental health	H0031		\$15.00 per assessment	Medicaid reimburses a maximum of three limited functional assessments, per recipient, per state fiscal year.
Limited functional assessment, substance abuse	H0001		\$15.00 per assessment	Medicaid reimburses a maximum of three limited functional assessments, per recipient, per state fiscal year.
Treatment plan development, new and established patient, mental health	H0032		\$97.00 per event	Medicaid reimburses for the development of one treatment plan per provider, per state fiscal year. Medicaid reimburses for a maximum total of two treatment plans per recipient per state fiscal year. The reimbursement date for treatment plan development is the day it is authorized by the treating practitioner.
Treatment plan development, new and established patient, substance abuse	T1007		\$97.00 per event	Medicaid reimburses for the development of one treatment plan per provider, per state fiscal year. Medicaid reimburses for a maximum total of two treatment plans per recipient per state fiscal year. The reimbursement date for treatment plan development is the day it is authorized by the treating practitioner.
Treatment plan review, mental health	H0032	TS	\$48.50 per event	Medicaid reimburses a maximum of four treatment plan reviews, per recipient, per state fiscal year. The reimbursement date for a treatment plan review is the day it is authorized by the treating practitioner.
Treatment plan review, substance abuse	T1007	TS	\$48.50 per event	Medicaid reimburses a maximum of four treatment plan reviews, per recipient, per state fiscal year. The reimbursement date for a treatment plan review is the day it is authorized by the treating practitioner.
<a href="#"><u>59G-4.029: Behavioral Health Medication Management Services Coverage Policy</u></a>				
Medication management	T1015		\$60.00 per event	Medicaid reimburses medication management as medically necessary. Medication management is not reimbursable on the same day, for the same recipient, as brief group medical therapy or brief individual medical psychotherapy.
Behavioral health medical screening, mental health	T1023	HE	\$43.62 per event	Medicaid reimburses two behavioral health medical screening services, per recipient, per state fiscal year. Behavioral health-related medical screening services are not reimbursable on the same day, for the same recipient, as behavioral health-related medical services: verbal interactions, medication management.

Florida Medicaid Community Behavior Health Fee Schedule  
 2022

Description of Service	Procedure Code	Mod	Maximum Fee	Reimbursement and Service Limitations
Behavioral health medical screening, substance abuse	T1023	HF	\$43.62 per event	Medicaid reimburses two behavioral health medical screening services, per recipient, per state fiscal year. Behavioral health-related medical screening services are not reimbursable on the same day, for the same recipient, as behavioral health-related medical services: verbal interactions, medication management.
Behavioral health-related medical services: verbal interaction, mental health	H0046		\$15.00 per event	Medicaid reimburses 52 behavioral health-related medical services: medical procedures, per recipient, per state fiscal year. Behavioral health-related medical services: verbal interactions are not reimbursable on the same day as behavioral health screening services.
Behavioral health-related medical services: verbal interaction, substance abuse	H0047		\$15.00 per event	Medicaid reimburses 52 behavioral health-related medical services: medical procedures, per recipient, per state fiscal year. Behavioral health-related medical services: verbal interactions are not reimbursable on the same day as behavioral health screening services.
Behavioral health-related medical services: medical procedures, mental health	T1015	HE	\$10.00 per event	Medicaid reimburses 52 behavioral health-related medical services: medical procedures, per recipient, per state fiscal year.
Behavioral health-related medical services: medical procedures, substance abuse	T1015	HF	\$10.00 per event	Medicaid reimburses 52 behavioral health-related medical services: medical procedures, per recipient, per state fiscal year.
Behavioral health-related medical services: alcohol and other drug screening specimen	H0048		\$10.00 per event	Medicaid reimburses 52 behavioral health – related medical services: alcohol and other drug screening specimen collections, per recipient, per state fiscal year.
Medication-assisted treatment services	H0020		\$67.48 weekly rate	Medicaid reimburses medication assisted treatment services 52 times, per recipient, per state fiscal year. The service is billed one time per seven days. This service is not reimbursable using any other procedure code.
<u>59G-4.031: Behavioral Health Community Support Services Coverage Policy</u>				
Psychosocial rehabilitation services	H2017		\$9.00 per quarter hour	Medicaid reimburses a maximum of 1,920 quarter-hour units (480 hours) of psychosocial rehabilitation services, per recipient, per state fiscal year. These units count against clubhouse service units.
Clubhouse services	H2030		\$5.00 per quarter hour	Medicaid reimburses a maximum of 1920 quarter-hour units (480 hours) annually, per recipient, per state fiscal year. These units count against psychosocial rehabilitation units of service.
<u>59G-4.052: Behavioral Health Therapy Services</u>				
Brief individual medical psychotherapy, mental health	H2010	HE	\$15.00 per quarter hour	There is a maximum daily limit of two quarter-hour units. Medicaid reimburses a maximum of 16 quarter-hour units (4 hours) of brief individual medical psychotherapy, per recipient, per state fiscal year.* Brief individual medical psychotherapy is not reimbursable on the same day, for the same recipient, as brief group medical therapy or medication management.



Florida Medicaid Community Behavior Health Fee Schedule  
 2022

Description of Service	Procedure Code	Mod	Maximum Fee	Reimbursement and Service Limitations
Brief individual medical psychotherapy, substance abuse	H2010	HF	\$15.00 per quarter hour	There is a maximum daily limit of two quarter-hour units. Medicaid reimburses a maximum of 16 quarter-hour units (4 hours) of brief individual medical psychotherapy, per recipient, per state fiscal year. Brief individual medical psychotherapy is not reimbursable on the same day, for the same recipient, as brief group medical therapy or medication management.
Brief group medical therapy	H2010	HQ	\$8.65 per quarter hour	There is a maximum daily limit of two quarter-hour units. Medicaid reimburses a maximum of 18 quarter-hour units (4.5 hours) of group medical therapy, per recipient, per state fiscal year. Brief group medical therapy is not reimbursable on the same day, for the same recipient as brief individual medical psychotherapy or behavioral health-related medical services: verbal interactions, medication management.
Individual and family therapy	H2019	HR	\$18.33 per quarter	Medicaid reimburses a maximum of 104 quarter-hour units (26 hours) of individual and family therapy services, per recipient, per state fiscal year. There is a maximum daily limit of four quarter-hour units (1 hour).
Group therapy	H2019	HQ	\$6.67 per quarter hour	Medicaid reimburses a maximum of 156 quarter-hour units (39 hours) of group therapy services, per recipient, per state fiscal year.
<u>59G-4.370: Behavioral Intervention Services Coverage Policy</u>				
Therapeutic behavioral on-site services, therapy	H2019	HO	\$16.00 per quarter hour	Medicaid reimburses therapeutic behavioral on-site therapy services a maximum combined limit of a total of 36 15-minute units per month (9 hours) by a master's level or certified behavioral analyst.
Therapeutic behavioral on-site services, behavior management	H2019	HN	\$10.00 per quarter hour	Medicaid reimburses therapeutic behavioral on-site behavior management and therapeutic behavioral on-site therapy services for a maximum combined total of 36 15-minute units per month (9 hours) by a master's level practitioner, certified behavioral analyst, or certified associate behavioral analyst.
Therapeutic behavioral on-site services, therapeutic support	H2019	HM	\$4.00 per quarter hour	Medicaid reimburses therapeutic behavioral on-site therapeutic support services for a maximum of 128 quarter-hour units per month (32 hours), per recipient.
Behavioral health day services, mental health	H2012		\$12.50 per hour	Medicaid reimburses a maximum of 190-hour units per recipient, per state fiscal year. Medicaid will not reimburse for behavioral health day services the same day as psychosocial rehabilitation services.
Behavioral health day services, substance abuse	H2012	HF	\$12.50 per hour	Medicaid reimburses a maximum of 190-hour units per recipient, per state fiscal year. Medicaid will not reimburse for behavioral health day services the same day as psychosocial rehabilitation services.
<u>59G-4.127: Florida Assertive Community Treatment (FACT) Services Coverage Policy</u>				
Florida Assertive Community Treatment	H0040		\$27.40 per day	Medicaid reimburses 1 unit per day for 365 or 366 days per state fiscal year per recipient.

## Appendix Attachment

4

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

AUGUST DEKKER, et al.,

Plaintiffs,

v.

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

SIMONE MARSTILLER, et al.,

Defendants.

---

**DECLARATION OF JAMES M. CANTOR, PH.D**

I, James M. Cantor, Ph.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this declaration and would testify completely to those facts if called to do so.

2. I am a neuroscientist and sex researcher, with an internationally recognized record studying the development of human sexuality and atypical sexualities. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research. These publications span the biological and non-biological development of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research.

3. Over my academic career, my posts have included Senior Scientist and Psychologist at the Centre for Addiction and Mental Health (CAMH), Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine,

and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. I am currently the Director of the Toronto Sexuality Centre in Canada. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

4. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

5. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment and treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of

human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

6. I have been retained by the Defendants in the case to describe opinions regarding the science of gender dysphoria and transsexualism, as previously stated in a report that I prepared for the Florida Agency for Healthcare Administration. A copy of that report is attached and incorporated by reference as Exhibit “B.” I also have been asked to respond to criticisms of my report made in declarations. If called to testify in this matter, I would testify truthfully based on my personal experience and knowledge.

7. I have testified in deposition or at trial in the following cases within the last four years:

2022	Roe v Utah High School Activities Assn.	Salt Lake County, UT
2022	Re Commitment of Baunee	Syracuse, NY
2022	PFLAG et al. v Abbott	Travis County, TX
2022	Doe v Texas	Travis County, TX
2022	A.M. v Indiana Public Schools	Southern District, IN
2022	Ricard v Kansas	Geery County, KS
2022	Eknes-Tucker v Alabama	Montgomery County, AL
2022	Hersom & Doe v WVa Health & Human Services	Southern District, WVa
2022	BPJ v West Virginia Board of Education	Southern District, WVa
2021	Cox v Indiana Child Services	Child Services, IN
2021	Cross et al. v Loudoun School Board	Loudoun, VA
2021	Josephson v University of Kentucky	Western District, KY
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, IL
2019	US v Peter Bright	Southern District, NY
2019	Spiegel-Savoie v Savoie-Sexten (Custody Hearing)	Boston, MA
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, IL
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, NY

8. A list of my publications within the past 10 years is provided in my curriculum vitae.

9. I was compensated \$400 per hour for preparing my initial report (“Exhibit “B”), totaling \$9600. I am being compensated at an hourly rate of \$400 per hour for my time preparing this declaration. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

10. My report summarized the scientific evidence which lead to these conclusions:

- The science shows more than one phenomenon can lead to gender dysphoria, distinguishable by their ages of onset. Each type shows distinct epidemiological and demographic patterns, unique psychological and behavioral profiles, and differing responses to treatment options. Much misunderstanding follows from incorrectly extrapolating information about one type to another.
- The science shows neurological and prenatal components to sexual orientation, but not to gender dysphoria. The terms *innate* and *immutable* pertain to sexual orientation, but not to gender dysphoria.
- For *prepubescent* children supported in their biological sex, there have been 11 cohort studies. All 11 showed that feelings of gender dysphoria *desisted* by puberty for most, resolving as gay or lesbian and realizing they had misinterpreted their cross-sex interests.
- For *pubescent* minors undergoing medical transition (puberty blockers or cross-sex hormones) there have been 11 cohort studies. In four, mental health failed to improve or outright deteriorated. In seven, psychotherapy and medical interventions were provided together, and none found advantage to medical over non-medical intervention. Transition may be the best available option for some, but only a small proportion of the total.
- There has been a single cohort study of prepubescent children supported as their cross-sex identity: Feelings of gender dysphoria persisted past puberty for the majority of children, in contrast with studies of children supported in their biological sex.
- Internet surveys of youth show correlations between transition and mental health variables. Tracking cases over time, cohort studies demonstrated, not that mental health improves with transition, but that minors with better mental health are those permitted to transition.
- U.S. medical organizations are increasingly out of line with international consensus. Although initially supportive of early transition, Sweden, Finland, France, U.K., and Australia have issued increasingly strong policies of psychotherapy as the first line treatment, including an outright ban on medical transition of minors in Sweden.
- Youth with gender dysphoria do not show extreme rates of suicide—Suicide remains exceptionally rare. In behavioral science, *suicide* is distinct from *suicidality* (ideation, gestures, and attempts). Suicide occurs primarily among biological males in middle age, uses highly lethal means, and involves an impulsive but sincere intent to die. Suicidality occurs primarily among biological females in adolescence, uses less lethal means, and represents psychological distress, cries for help or attention, or manipulation with emotional blackmail. The evidence is not consistent with transphobia as a substantial cause, but is strongly consistent with other mental health issues being responsible for each of suicidality, generally unstable identity, and other issues.
- The first set of age requirements for transition proposed for minors was the Dutch Protocol. Subsequent guidelines were released by the Endocrine Society and WPATH, lowering ages and repeatedly notes that medical judgement may overrule standards; however, neither document cites any research justifying the loosening of restrictions.

11. Dr. Karasic asserted (without citing scientific support) that “being transgender is not a paraphilic disorder” (Karasic, footnote-2). That assertion is not the whole truth: As detailed in my report, there is a substantial overlap gender identity and the paraphilias, with a well-documented paraphilia called autogynephilia motivating most cases of adult-onset gender dysphoria, but being unrelated to cases of childhood-onset gender dysphoria, which is instead primarily motivated by homosexuality. It is exactly because I am a recognized expert with a history of published, peer-reviewed research in each sexual orientation, gender identity, and the paraphilias that I am uniquely qualified to discuss exactly this point, whereas neither Dr. Olson-Kennedy nor Dr. Karasic has or claims any expertise at all, whether scientific or clinical anecdote, in the paraphilias.

12. Dr. Karasic asserts that “Dr. Cantor focuses on desistance rates of prepubertal children brought into clinics in Toronto and Amsterdam” (Karasic para 75). Despite such language insinuating cherry-picking of evidence on my part, my report actually provides the comprehensive set of every such outcome study available. Moreover, because every single study, without exception, came to the same conclusion, whether from Toronto, from Amsterdam, or from elsewhere, the entire point is moot. The complete listing of all cohort studies of pre-pubescent children is reprinted as Table 1 at the end of the present report. Neither Drs. Karasic nor Olson-Kennedy cites any study to be missing.

13. Dr. Karasic next faults cohort studies of pre-pubescent because they included a combination of children, some with and some with out formal diagnoses of gender dysphoria, and Dr Karasic offers in their place the results of the recent Olson et al. (2022) study. In each of these claims, Dr. Karasic’s report withholds key information that, when revealed, show the precisely opposite conclusions to Dr. Karasic’s claims: First, the evidence shows that having versus not having a formal diagnosis makes no difference in the outcomes of this population. The cohort study following up the Canadian sample directly compared the children with and without a formal diagnosis: Of the 88

children meeting criteria for a formal diagnosis, 13.6% were still gender dysphoric at follow-up, and of the 51 children who did not meet formal criteria, 9.8% were (Singh et al., 2021).

14. Next, the Olson study that Dr. Karasic prefers engaged in exactly the same mixing of diagnostic status to which Karasic objected in the studies he wanted to reject. As noted by Olson et al.: “This study did not assess whether participants met criteria for the DSM-5 diagnosis of Gender Dysphoria in Children. Many parents in this study did not believe that such diagnoses were either ethical or useful and some children did not experience the required distress criterion” (Olson et al., 2022, p. 2). Dr. Karasic is attempting to have it both ways, criticizing or exempting research according to its convenience to his argument rather than providing any unbiased or even consistent accounting of the scientific evidence.

15. Finally, despite Dr. Karasic suggesting that the high persistence rates (97.5%) reported by Olson et al. (2022) should entirely replace the low persistence rates of the 11 other studies, Dr. Karasic left out that Olson et al. (2022) differs from the other 11 studies in being the only one in which the children had already socially transitioned, whereas the other 11 came from clinics that did not permit transition. That is, Olson et al. (2022) is much better explained as evidence that social transition causes a large increase in persistence rates.

16. Dr. Karasic’s language is similarly misleading in describing Olson et al. to be current while all other studies are outdated. Karasic refers to Olson as “a more recent study, which is the only large American prospective study that has been published in the past 35 years” (Karasic para 75). As Table 1 demonstrates, there has actually been a consistent flow of results, show the same result over and over, including as recently as 2021. Dr. Karasic’s emphasis the difference between American versus all international results, however inadvertently, supports the conclusion that differences reflect cultural and social issues rather than medical ones.



17. Dr. Karasic claimed “longitudinal studies show that gender dysphoria in adolescence usually persists” (Karasic, para 76), citing DeVries et al. (2011). That is, once again, not the whole truth: The de Vries study did not pertain to “gender dysphoria in adolescence,” but rather to gender dysphoria *that began in early childhood and continued to persist* in adolescence. Dr. Karasic’s language, whether strategic or just carelessly vague, extrapolates without justification from a very small and specific population to the many times larger group of adolescent-onset cases, who differ on every objective variable available.

18. Dr. Karasic’s reminder that “no medical treatment, let alone irreversible medical and surgical interventions, is used prior to puberty” (para 76) again fails to provide the full evidence. The evidence consistently suggests that each stage of transition makes taking the next step more likely. Prepubescent children permitted to socially transition are more likely to go on to puberty blockers than are children who are not permitted to socially transition. Pubescent age children who begin puberty blockers are more likely to go on to cross-sex hormones than those who do not begin puberty blockers. Etc. By ignoring the clear implications of this clear pattern, Dr. Karasic minimizes the caution required at each decision-making step, whereas a valid risk:benefit analysis must include such clearly foreseeable outcomes.

19. It is not clear on what basis Dr. Karasic believes he contradicts me in his next two points (Karasic, para 75): Already emphasized in my report are that researchers have experimented with puberty blockers for childhood-onset gender dysphoria persisting into adolescence and that evidence regarding childhood-onset should not be generalized to adult-onset or adolescent-onset gender dysphoria.

20. Regarding mental illness, Dr. Karasic cites the (now outdated) 2012 version of the WPATH Standards of Care to assert that “in most cases, having a history of mental illness should not

prevent people from receiving gender-affirming medical and surgical treatment” (para 77). The current (2022) version of the WPATH Standards of Care include<sup>1</sup>:

18.1- We recommend mental health professionals address mental health symptoms that interfere with a person’s capacity to consent to gender-affirming treatment before gender-affirming treatment is initiated.

18.2- We recommend mental health professionals offer care and support to transgender and gender diverse people to address mental health symptoms that interfere with a person’s capacity to participate in essential perioperative care before gender-affirmation surgery.

18.3- We recommend when significant mental health symptoms or substance abuse exists, mental health professionals assess the potential negative impact that mental health symptoms may have on outcomes based on the nature of the specific gender-affirming surgical procedure.

Dr. Karasic does not indicate what in my report is inconsistent with any of this. Dr. Karasic’s assertion begs the question: The vague language of the WPATH standards allow care providers to draw at any arbitrary point any arbitrary line between (for example) what does or does not count as potential interference, with no objective basis and no accounting for consistency.

21. Dr. Karasic contests my use of the phrase “affirmation on demand” because the (outdated) WPATH Standards of Care “requires a comprehensive mental health assessment” (Karasic, para 78). Dr. Karasic is in error to refer to anything in the WPATH documents as a requirement—the document itself is not binding, there does not exist any system for assessing adherence to it, WPATH has no professional disciplinary system for reported violations, and the contents of the WPATH SOC repeatedly explicate that health care providers may provide exceptions to guidelines due to “professional judgment.” As already noted, the sketchy language of the WPATH and repeated indications that care providers may make exceptions without consequence allows any cursory assessment to be deemed “comprehensive” simply by declaring it to be so.

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<sup>1</sup> Coleman et al., 2022, p. S171

22. As already noted, my report summarized all 11 cohort studies of people with childhood onset gender dysphoria that persisted into adolescence. Of these, Dr. Karasic mentions three. In all three, Dr. Karasic's criticism is that they showed evidence of mental health improvement. Thus, in all three, Dr. Karasic makes the same error: That some people in some studies showed some improvement is not the question. The point is that these studies are unable to determine if the mental health improvements were caused by transition or by the mental health treatments that these people were also receiving at the same time.

23. The only, even theoretically possible, exception was reported by Achille et al. (2020). That was a small ( $n = 50$ ) study that conducted very many analyses, using a very liberal statistical threshold, and finding overall that "Given our modest sample size, particularly when stratified by gender, most predictors did not reach statistical significance" (Achille et al., 2020, p. 3). The single analysis that did meet the (liberal) threshold for statistical significance was in the male-to-female group on one of the several mental health measures. In an analysis such as this, it is unclear whether a result is genuine or a statistical fluke, called a "False Positive." That the other studies have failed to replicate the finding indicates it indeed represents a false positive, also called a "Type I Error."

24. Dr. Olson-Kennedy claimed I "incorrectly allege that an increase in numbers of youth presenting for care related to GD provides support for the social contagion theory" (Olson-Kennedy, para 63). My report, however, includes no such allegation: I never mention social contagion at all, and Dr. Olson-Kennedy provides no reference to where I allegedly did.

25. My report does, however, include the following information from the peer-reviewed literature (Cantor, para 48)<sup>2</sup>:

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<sup>2</sup> Footnote-58 of that document is the citation to Littman, 2018, and footnote-29 is the citation to Kaltiala-Heino, et al., 2015; Littman, 2018; and Warrior, et al., 2020.

The majority of cases appear to occur within clusters of peers and in association with increased social media use<sup>58</sup> and especially among people with autism or other neurodevelopmental or mental health issues.<sup>59</sup>

These features—clustering and co-occurrence in people with social difficulties—are indeed consistent with the social contagion theory, but my report never attempts to make that argument. Moreover, although Olson-Kennedy tries to explain why the “increases in numbers” do not support social contagion theory, she offers no alternative explanation for the social group clustering or clinical history of social impediments.

26. Dr. Olson-Kennedy next claimed (Olson-Kennedy, para 67):

Dr. Cantor is wrong to assert that affirmation “increases the probability of unnecessary transition and unnecessary medical risks.” (Cantor ¶ 21). There is no evidence to support the notion that affirmation of gender in pre-pubertal children, or at any age, leads to transition.

That evidence does indeed exist, and it is easily cited: As already indicated, there have been 11 follow-up studies of pre-pubertal children of clinics which did not permit social transition, and the feelings of gender dysphoria desisted 61–88% of cases (Table 1). In direct contrast, Olson et al. (2022) published the follow-up data from children that *did* transition socially before puberty, finding that desistance occurred in only 6%. It is difficult to explain these results in any way other than as social transition greatly increasing the probability of the persistence of gender dysphoria in children. Not only is the allegedly missing evidence easily cited, it was cited by Dr. Karasic (although he indicated a desistance rate of 2.5% instead of 6%).

27. Dr. Olson-Kennedy’s next claim regarding my report was (Olson-Kennedy para 92):

The GAPMS Memo and Dr. Cantor criticize that the diagnosis of gender dysphoria is based, at least in part, on a patient’s self-report. (GAPMS Memo at 19, 24, 28; Cantor ¶¶ 42, 49). This critique demonstrates a fundamental misunderstanding of how gender-affirming care is provided.

Any review of my report reveals it to say no such thing. Paragraph 42 of my report instead states, very clearly, that the systematic and objective procedures used by the original research clinics have been replaced with non-systematic and subjective procedures<sup>3</sup>:

42. The authors of the original Dutch studies were careful not to overstate the implications of their results, “We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria.”<sup>47</sup> Nonetheless, many other clinics and clinicians intrepidly proceeded on the basis of only the perceived positives, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, 1 to 2 years<sup>48</sup>) became approvals after one or two assessment sessions. Validated, objective measures of youths’ psychological functioning were replaced with clinicians’ subjective (and first) opinions, often reflecting only the clients’ own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

Dr. Olson-Kennedy’s commentary regarding the inclusion of self-report evades the point: It is the self-report despite the availability of superior procedures and in addition to the simultaneous degradation of the multiple other safe-guards that demonstrates the loss of safety in the provision of health care with this issue. Moreover, despite my listing very many problems in providing high quality care, Dr. Olson-Kennedy contests only this one aspect.

28. Regarding my paragraph 49, I wrote<sup>4</sup>:

It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.<sup>60</sup>

The only way in which Dr. Olson-Kennedy could find this objectionable would be if she believes it easy to distinguish exactly which of multiple stressors result in exactly which of multiple mental health symptoms. There does not exist any published research leading to such a conclusion.

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<sup>3</sup> Footnote-47 of that report is the citation to de Vries et al., 2011, at 2282; footnote-48 of that report is the citation to de Vries et al., 2011.

<sup>4</sup> Footnote-60 of that document is the citation to Boivin, *et al.*, 2020.

29. Next, Dr. Olson-Kennedy writes, “The GAPMS Memo and Dr. Cantor allege that the provision of puberty delaying medications for the treatment of gender dysphoria are not effective. This is not true” (Olson-Kennedy, para 95). Not only do I not make that claim, it is not scientifically possible to make such a claim. It represents what in science is called “proving the null hypothesis.” In the scientific method, we assume the null hypothesis and retain it until there is evidence requiring us to reject it, and future evidence remains eternally (even if only theoretically) possible.

30. What my report does provide is: first, a depiction of the routine, scientific hierarchy of higher quality to lower quality research and, second, a comprehensive review providing all 11 cohort studies (the highest research quality level currently available in the peer reviewed literature). Among those 11 studies, four found no mental health improvement, five provided psychotherapy at the same time as medicalize transition leaving unknown which resulted in mental health improvement, and two found no superiority of medical intervention over psychotherapy on mental health.

31. Dr. Olson-Kennedy does not appear to contest of this. Rather, her report simply reiterates the portions of the subset of studies suggesting improved mental health and fails to address the central issue—whether those mental health improvements (when detected at all) resulted from mental health treatment or from medicalized transition.

32. Dr. Olson-Kennedy’s report (para 110) is misleading in saying “Dr. Cantor describes several studies...” when I summarized the research literature: What I describe in my report is an exhaustive list including every single cohort study in the literature. It is only with comprehensive evidence that one can avoid biased cherry-picking of the research. Dr. Olson-Kennedy cites no example of any cohort (or higher quality) study that I missed.

33. Dr. Olson-Kennedy objects to the highly plausible and parsimoniously superior idea that mental health treatment is what causes mental health improvement, but the basis of her objection is, however, entirely tangential: I did not, and the studies I cited did not, suggest psychotherapy was

changing *gender identity*, as Dr. Olson-Kennedy mistakes. Rather, and to repeat, I point out the obvious explanation that improvements in mental health resulted from mental health treatment.

34. Dr. Olson-Kennedy also misrepresents the comments from Harry Benjamin's 1966 *The Transsexual Phenomenon*. That text refers to adult, and only to adult, gender dysphoria. Children are never mentioned.

35. In summary, Drs. Karasic and Olson-Kennedy fail to provide any scientifically legitimate analysis of the type provided by experts in the development of human sexuality. Their claims repeatedly extrapolate information from one population to others. Their claims rely on subjective and anecdotal evidence, rejecting the objective evidence. They fail to provide any consideration of alternative explanations to the objective evidence, actively avoiding superior and more parsimonious interpretations. Their reports fail to provide any meaningfully full accounting of the science, instead citing and addressing only selective pieces, with language insinuating the presence of evidence that does not exist.

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**Table 1. Cohort Studies of Gender Dysphoric Children**

2/16	gay	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. <i>American Journal of Psychiatry</i> , 128, 1283–1289.
4/16	trans-/crossdress	
10/16	straight/uncertain	
2/16	trans-	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. <i>Comprehensive Psychiatry</i> , 19, 363–369.
2/16	uncertain	
12/16	gay	
0/9	trans-	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. <i>Journal of Pediatric Psychology</i> , 4, 29–41.
9/9	gay	
2/45	trans-/crossdress	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. <i>Journal of Nervous and Mental Disease</i> , 172, 90–97.
10/45	uncertain	
33/45	gay	
1/10	trans-	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. <i>Archives of Sexual Behavior</i> , 15, 511–517.
2/10	gay	
3/10	uncertain	
4/10	straight	
1/44	trans-	Green, R. (1987). <i>The "sissy boy syndrome" and the development of homosexuality</i> . New Haven, CT: Yale University Press.
43/44	cis-	
0/8	trans-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? <i>Medical Journal of Australia</i> , 146, 565–569.
8/8	cis-	
21/54	trans-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 47, 1413–1423.
33/54	cis-	
3/25	trans-	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. <i>Developmental Psychology</i> , 44, 34–45.
6/25	lesbian/bi-	
16/25	straight	
47/127	trans-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 52, 582–590.
80/127	cis-	
17/139	trans-	Singh, D., Bradley, S. J., and Zucker, K. J. (2021) A follow-up study of boys with gender identity disorder. <i>Frontiers in Psychiatry</i> , 12, 632784. doi: 10.3389/fpsyt.2021.632784
122/139	cis-	

I declare under penalty of perjury that the foregoing is true and correct. Executed this 2<sup>nd</sup> day  
of October 2022.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read "James M. Cantor". The signature is written in a cursive style with a horizontal line extending from the end of the name.

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James M. Cantor, Ph.D

EXHIBIT "A"

# James M. Cantor, PhD

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## EDUCATION

<b>Postdoctoral Fellowship</b> Centre for Addiction and Mental Health • Toronto, Canada	Jan., 2000–May, 2004
<b>Doctor of Philosophy</b> Psychology • McGill University • Montréal, Canada	Sep., 1993–Jun., 2000
<b>Master of Arts</b> Psychology • Boston University • Boston, MA	Sep., 1990–Jan., 1992
<b>Bachelor of Science</b> Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY Concentrations: Computer science, mathematics, physics	Sep. 1984–Aug., 1988

## EMPLOYMENT HISTORY

<b>Director</b> Toronto Sexuality Centre • Toronto, Canada	Feb., 2017–Present
<b>Senior Scientist (Inaugural Member)</b> Campbell Family Mental Health Research Institute Centre for Addiction and Mental Health • Toronto, Canada	Aug., 2012–May, 2018
<b>Senior Scientist</b> Complex Mental Illness Program Centre for Addiction and Mental Health • Toronto, Canada	Jan., 2012–May, 2018
<b>Head of Research</b> Sexual Behaviours Clinic Centre for Addiction and Mental Health • Toronto, Canada	Nov., 2010–Apr. 2014
<b>Research Section Head</b> Law & Mental Health Program Centre for Addiction and Mental Health • Toronto, Canada	Dec., 2009–Sep. 2012
<b>Psychologist</b> Law & Mental Health Program Centre for Addiction and Mental Health • Toronto, Canada	May, 2004–Dec., 2011

**Clinical Psychology Intern** Sep., 1998–Aug., 1999  
Centre for Addiction and Mental Health • Toronto, Canada

**Teaching Assistant** Sep., 1993–May, 1998  
Department of Psychology  
McGill University • Montréal, Canada

**Pre-Doctoral Practicum** Sep., 1993–Jun., 1997  
Sex and Couples Therapy Unit  
Royal Victoria Hospital • Montréal, Canada

**Pre-Doctoral Practicum** May, 1994–Dec., 1994  
Department of Psychiatry  
Queen Elizabeth Hospital • Montréal, Canada

### ACADEMIC APPOINTMENTS

**Associate Professor** Jul., 2010–May, 2019  
Department of Psychiatry  
University of Toronto Faculty of Medicine • Toronto, Canada

**Adjunct Faculty** Aug. 2013–Jun., 2018  
Graduate Program in Psychology  
York University • Toronto, Canada

**Associate Faculty (Hon)** Oct., 2017–Dec., 2017  
School of Behavioural, Cognitive & Social Science  
University of New England • Armidale, Australia

**Assistant Professor** Jun., 2005–Jun., 2010  
Department of Psychiatry  
University of Toronto Faculty of Medicine • Toronto, Canada

**Adjunct Faculty** Sep., 2004–Jun., 2010  
Clinical Psychology Residency Program  
St. Joseph's Healthcare • Hamilton, Canada

## PUBLICATIONS

1. Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, 46, 307–313. doi: 10.1080/0092623X.2019.1698481
2. Shirazi, T., Self, H., Cantor, J., Dawood, K., Cardenas, R., Rosenfield, K., Ortiz, T., Carré, J., McDaniel, M., Blanchard, R., Balasubramanian, R., Delaney, A., Crowley, W., S Marc Breedlove, S. M., & Puts, D. (2020). Timing of peripubertal steroid exposure predicts visuospatial cognition in men: Evidence from three samples. *Hormones and Behavior*, 121, 104712.
3. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. L. (2019). The Screening Scale for Pedophilic Interest-Revised (SSPI-2) may be a measure of pedohebephilia. *Journal of Sexual Medicine*, 16, 1655–1663. doi: 10.1016/j.jsxm.2019.07.015
4. McPhail, I. V., Hermann, C. A., Fernane, S., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2019). Validity in phallometric testing for sexual interests in children: A meta-analytic review. *Assessment*, 26, 535–551. doi: 10.1177/1073191117706139
5. Cantor, J. M. (2018). Can pedophiles change? *Current Sexual Health Reports*, 10, 203–206. doi: 10.1007/s11930-018-0165-2
6. Cantor, J. M., & Fedoroff, J. P. (2018). Can pedophiles change? Response to opening arguments and conclusions. *Current Sexual Health Reports*, 10, 213–220. doi: 10.1007/s11930-018-0167-0z
7. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2018). Age diversity among victims of hebephilic sexual offenders. *Sexual Abuse*, 30, 332–339. doi: 10.1177/1079063216665837
8. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2018). The relationships between victim age, gender, and relationship polymorphism and sexual recidivism. *Sexual Abuse*, 30, 132–146. doi: 10.1177/1079063216630983
9. Stephens, S., Newman, J. E., Cantor, J. M., & Seto, M. C. (2018). The Static-99R predicts sexual and violent recidivism for individuals with low intellectual functioning. *Journal of Sexual Aggression*, 24, 1–11. doi: 10.1080/13552600.2017.1372936
10. Cantor, J. M. (2017). Sexual deviance or social deviance: What MRI research reveals about pedophilia. *ATSA Forum*, 29(2). Association for the Treatment of Sexual Abusers. Beaverton, OR. <http://newsmanager.commpartners.com/atsa/issues/2017-03-15/2.html>
11. Walton, M. T., Cantor, J. M., Bhullar, N., & Lykins, A. D. (2017). Hypersexuality: A critical review and introduction to the “Sexhavior Cycle.” *Archives of Sexual Behavior*, 46, 2231–2251. doi: 10.1007/s10508-017-0991-8
12. Stephens, S., Leroux, E., Skilling, T., Cantor, J. M., & Seto, M. C. (2017). A taxometric analysis of pedophilia utilizing self-report, behavioral, and sexual arousal indicators. *Journal of Abnormal Psychology*, 126, 1114–1119. doi: 10.1037/abn0000291
13. Fazio, R. L., Dyshniku, F., Lykins, A. D., & Cantor, J. M. (2017). Leg length versus torso length in pedophilia: Further evidence of atypical physical development early in life. *Sexual Abuse: A Journal of Research and Treatment*, 29, 500–514. doi: 10.1177/1079063215609936
14. Seto, M. C., Stephens, S., Lalumière, M. L., & Cantor, J. M. (2017). The Revised Screening Scale for Pedophilic Interests (SSPI-2): Development and criterion-related validation. *Sexual Abuse: A Journal of Research and Treatment*, 29, 619–635. doi:

10.1177/1079063215612444

15. Stephens, S., Cantor, J. M., Goodwill, A. M., & Seto, M. C. (2017). Multiple indicators of sexual interest in prepubescent or pubescent children as predictors of sexual recidivism. *Journal of Consulting and Clinical Psychology, 85*, 585–595. doi: 10.1037/ccp0000194
16. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2017). Evidence of construct validity in the assessment of hebephilia. *Archives of Sexual Behavior, 46*, 301–309. doi: 10.1007/s10508-016-0907-z
17. Walton, M. T., Cantor, J. M., & Lykins, A. D. (2017). An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior. *Archives of Sexual Behavior, 46*, 721–733. doi: 10.1007/s10508-015-0606-1
18. Cantor, J. M., Lafaille, S. J., Hannah, J., Kucyi, A., Soh, D. W., Girard, T. A., & Mikulis, D. J. (2016). Independent component analysis of resting-state functional magnetic resonance imaging in pedophiles. *Journal of Sexual Medicine, 13*, 1546–1554. doi: 10.1016/j.jsxm.2016.08.004
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20. Cantor, J. M. (2015). Milestones in sex research: What causes pedophilia? In J. S. Hyde, J. D. DeLamater, & E. S. Byers (Eds.), *Understanding human sexuality* (6<sup>th</sup> Canadian ed.) (pp. 452–453). Toronto: McGraw-Hill Ryerson.
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64. Pilkington, N. W., & Cantor, J. M. (1996). Perceptions of heterosexual bias in professional psychology programs: A survey of graduate students. *Professional Psychology: Research and Practice, 27*, 604–612.

## PUBLICATIONS

### LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine*, 12, 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine*, 12, 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior*, 44, 253–254. doi: 10.1007/s10508-014-0343-x
4. McPhail, I. V., & Cantor, J. M. (2015). Pedophilia, height, and the magnitude of the association: A research note. *Deviant Behavior*, 36, 288–292. doi: 10.1080/01639625.2014.935644
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7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health*, 11, 59–62. doi: 10.1080/14999013.2012.672945
8. Cantor, J. M., & Blanchard, R. (2012). White matter volumes in pedophiles, hebephiles, and teleiophiles [Letter to the Editor]. *Archives of Sexual Behavior*, 41, 749–752. doi: 10.1007/s10508-012-9954-2
9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior*, 40, 863–864. doi: 10.1007/s10508-011-9805-6
10. Zucker, K. J., Bradley, S. J., Own-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex and Marital Therapy*, 34, 287–290.
11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association*, 19(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association*, 19(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association*, 18(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach*. *Journal of Sex and Marital Therapy*, 26, 107–109.

### EDITORIALS

1. Cantor, J. M. (2012). Editorial. *Sexual Abuse: A Journal of Research and Treatment*, 24.

2. Cantor, J. M. (2011). Editorial note. *Sexual Abuse: A Journal of Research and Treatment*, 23, 414.
3. Barbaree, H. E., & Cantor, J. M. (2010). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* (SAJRT) [Editorial]. *Sexual Abuse: A Journal of Research and Treatment*, 22, 371–373.
4. Barbaree, H. E., & Cantor, J. M. (2009). *Sexual Abuse: A Journal of Research and Treatment* performance indicators for 2007 [Editorial]. *Sexual Abuse: A Journal of Research and Treatment*, 21, 3–5.
5. Zucker, K. J., & Cantor, J. M. (2009). Cruising: Impact factor data [Editorial]. *Archives of Sexual Research*, 38, 878–882.
6. Barbaree, H. E., & Cantor, J. M. (2008). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* [Editorial]. *Sexual Abuse: A Journal of Research and Treatment*, 20, 3–4.
7. Zucker, K. J., & Cantor, J. M. (2008). The *Archives* in the era of online first ahead of print [Editorial]. *Archives of Sexual Behavior*, 37, 512–516.
8. Zucker, K. J., & Cantor, J. M. (2006). The impact factor: The *Archives* breaks from the pack [Editorial]. *Archives of Sexual Behavior*, 35, 7–9.
9. Zucker, K. J., & Cantor, J. M. (2005). The impact factor: “Goin’ up” [Editorial]. *Archives of Sexual Behavior*, 34, 7–9.
10. Zucker, K., & Cantor, J. M. (2003). The numbers game: The impact factor and all that jazz [Editorial]. *Archives of Sexual Behavior*, 32, 3–5.

## FUNDING HISTORY

Principal Investigators: Doug VanderLaan, Meng-Chuan Lai  
Co-Investigators: James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska  
Title: *Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*  
Agency: Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2  
Funds: \$650,250 / 5 years (July, 2018)

Principal Investigator: Michael C. Seto  
Co-Investigators: Martin Lalumière, James M. Cantor  
Title: *Are connectivity differences unique to pedophilia?*  
Agency: University Medical Research Fund, Royal Ottawa Hospital  
Funds: \$50,000 / 1 year (January, 2018)

Principal Investigator: Lori Brotto  
Co-Investigators: Anthony Bogaert, James M. Cantor, Gerulf Rieger  
Title: *Investigations into the neural underpinnings and biological correlates of asexuality*  
Agency: Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program  
Funds: \$195,000 / 5 years (April, 2017)

Principal Investigator: Doug VanderLaan  
Co-Investigators: Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker  
Title: *Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*  
Agency: Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program  
Funds: \$952,955 / 5 years (September, 2015)

Principal Investigator: James M. Cantor  
Co-Investigators: Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis  
Title: *Neuroanatomic features specific to pedophilia*  
Agency: Canadian Institutes of Health Research (CIHR)  
Funds: \$1,071,920 / 5 years (October, 2008)

Principal Investigator: James M. Cantor  
Title: *A preliminary study of fMRI as a diagnostic test of pedophilia*  
Agency: Dean of Medicine New Faculty Grant Competition, Univ. of Toronto  
Funds: \$10,000 (July, 2008)

Principal Investigator: James M. Cantor  
Co-Investigator: Ray Blanchard  
Title: *Morphological and neuropsychological correlates of pedophilia*  
Agency: Canadian Institutes of Health Research (CIHR)  
Funds: \$196,902 / 3 years (April, 2006)

## KEYNOTE AND INVITED ADDRESSES

1. Cantor, J. M. (2021, September 28). *No topic too tough for this expert panel: A year in review*. Plenary Session for the 40<sup>th</sup> Annual Research and Treatment Conference, Association for the Treatment of Sexual Abusers.
2. Cantor, J. M. (2019, May 1). *Introduction and Q&A for 'I, Pedophile.'* StopSO 2<sup>nd</sup> Annual Conference, London, UK.
3. Cantor, J. M. (2018, August 29). *Neurobiology of pedophilia or paraphilia? Towards a 'Grand Unified Theory' of sexual interests*. Keynote address to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
4. Cantor, J. M. (2018, August 29). *Pedophilia and the brain: Three questions asked and answered*. Preconference training presented to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
5. Cantor, J. M. (2018, April 13). *The responses to I, Pedophile from We, the people*. Keynote address to the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
6. Cantor, J. M. (2018, April 11). *Studying atypical sexualities: From vanilla to I, Pedophile*. Full day workshop at the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
7. Cantor, J. M. (2018, January 20). *How much sex is enough for a happy life?* Invited lecture to the University of Toronto Division of Urology Men's Health Summit, Toronto, Canada.
8. Cantor, J. M. (2017, November 2). *Pedophilia as a phenomenon of the brain: Update of evidence and the public response*. Invited presentation to the 7<sup>th</sup> annual SBC education event, Centre for Addiction and Mental Health, Toronto, Canada.
9. Cantor, J. M. (2017, June 9). *Pedophilia being in the brain: The evidence and the public's reaction*. Invited presentation to *SEXposium at the ROM: The science of love and sex*, Toronto, Canada.
10. Cantor, J. M., & Campea, M. (2017, April 20). *"I, Pedophile" showing and discussion*. Invited presentation to the 42<sup>nd</sup> annual meeting of the Society for Sex Therapy and Research, Montréal, Canada.
11. Cantor, J. M. (2017, March 1). *Functional and structural neuroimaging of pedophilia: Consistencies across methods and modalities*. Invited lecture to the Brain Imaging Centre, Royal Ottawa Hospital, Ottawa, Canada.
12. Cantor, J. M. (2017, January 26). *Pedophilia being in the brain: The evidence and the public reaction*. Inaugural keynote address to the University of Toronto Sexuality Interest Network, Toronto, Ontario, Canada.
13. Cantor, J. M. (2016, October 14). *Discussion of CBC's "I, Pedophile."* Office of the Children's Lawyer Educational Session, Toronto, Ontario, Canada.
14. Cantor, J. M. (2016, September 15). *Evaluating the risk to reoffend: What we know and what we don't*. Invited lecture to the Association of Ontario Judges, Ontario Court of Justice Annual Family Law Program, Blue Mountains, Ontario, Canada. [Private link only: <https://vimeo.com/239131108/3387c80652>]
15. Cantor, J. M. (2016, April 8). *Pedophilia and the brain: Conclusions from the second generation of research*. Invited lecture at the 10<sup>th</sup> annual Risk and Recovery Forensic Conference, Hamilton, Ontario.

16. Cantor, J. M. (2016, April 7). *Hypersexuality without the hyperbole*. Keynote address to the 10<sup>th</sup> annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
17. Cantor, J. M. (2015, November). *No one asks to be sexually attracted to children: Living in Daniel's World*. Grand Rounds, Centre for Addiction and Mental Health. Toronto, Canada.
18. Cantor, J. M. (2015, August). *Hypersexuality: Getting past whether "it" is or "it" isn't*. Invited address at the 41<sup>st</sup> annual meeting of the International Academy of Sex Research. Toronto, Canada.
19. Cantor, J. M. (2015, July). *A unified theory of typical and atypical sexual interest in men: Paraphilia, hypersexuality, asexuality, and vanilla as outcomes of a single, dual opponent process*. Invited presentation to the 2015 Puzzles of Sexual Orientation conference, Lethbridge, AL, Canada.
20. Cantor, J. M. (2015, June). *Hypersexuality*. Keynote Address to the Ontario Problem Gambling Provincial Forum. Toronto, Canada.
21. Cantor, J. M. (2015, May). *Assessment of pedophilia: Past, present, future*. Keynote Address to the International Symposium on Neural Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP). Berlin, Germany.
22. Cantor, J. M. (2015, March). *Prevention of sexual abuse by tackling the biggest stigma of them all: Making sex therapy available to pedophiles*. Keynote address to the 40<sup>th</sup> annual meeting of the Society for Sex Therapy and Research, Boston, MA.
23. Cantor, J. M. (2015, March). *Pedophilia: Predisposition or perversion?* Panel discussion at Columbia University School of Journalism. New York, NY.
24. Cantor, J. M. (2015, February). *Hypersexuality*. Research Day Grand Rounds presentation to Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada.
25. Cantor, J. M. (2015, January). *Brain research and pedophilia: What it means for assessment, research, and policy*. Keynote address to the inaugural meeting of the Netherlands Association for the Treatment of Sexual Abusers, Utrecht, Netherlands.
26. Cantor, J. M. (2014, December). *Understanding pedophilia and the brain: Implications for safety and society*. Keynote address for The Jewish Community Confronts Violence and Abuse: Crisis Centre for Religious Women, Jerusalem, Israel.
27. Cantor, J. M. (2014, October). *Understanding pedophilia & the brain*. Invited full-day workshop for the Sex Offender Assessment Board of Pennsylvania, Harrisburg, PA.
28. Cantor, J. M. (2014, September). *Understanding neuroimaging of pedophilia: Current status and implications*. Invited lecture presented to the Mental Health and Addiction Rounds, St. Joseph's Healthcare, Hamilton, Ontario, Canada.
29. Cantor, J. M. (2014, June). *An evening with Dr. James Cantor*. Invited lecture presented to the Ontario Medical Association, District 11 Doctors' Lounge Program, Toronto, Ontario, Canada.
30. Cantor, J. M. (2014, April). *Pedophilia and the brain*. Invited lecture presented to the University of Toronto Medical Students lunchtime lecture. Toronto, Ontario, Canada.
31. Cantor, J. M. (2014, February). *Pedophilia and the brain: Recap and update*. Workshop presented at the 2014 annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Cle Elum, WA.
32. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, February). *Functional connectivity in pedophilia*. Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario, Canada.



33. Cantor, J. M. (2013, November). *Understanding pedophilia and the brain: The basics, the current status, and their implications*. Invited lecture to the Forensic Psychology Research Centre, Carleton University, Ottawa, Canada.
34. Cantor, J. M. (2013, November). *Mistaking puberty, mistaking hebephilia*. Keynote address presented to the 32<sup>nd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
35. Cantor, J. M. (2013, October). *Understanding pedophilia and the brain: A recap and update*. Invited workshop presented at the 32<sup>nd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
36. Cantor, J. M. (2013, October). *Compulsive-hyper-sex-addiction: I don't care what we all it, what can we do?* Invited address presented to the Board of Examiners of Sex Therapists and Counselors of Ontario, Toronto, Ontario, Canada.
37. Cantor, J. M. (2013, September). *Neuroimaging of pedophilia: Current status and implications*. McGill University Health Centre, Department of Psychiatry Grand Rounds presentation, Montréal, Québec, Canada.
38. Cantor, J. M. (2013, April). *Understanding pedophilia and the brain*. Invited workshop presented at the 2013 meeting of the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, MN.
39. Cantor, J. M. (2013, April). *The neurobiology of pedophilia and its implications for assessment, treatment, and public policy*. Invited lecture at the 38<sup>th</sup> annual meeting of the Society for Sex Therapy and Research, Baltimore, MD.
40. Cantor, J. M. (2013, April). *Sex offenders: Relating research to policy*. Invited roundtable presentation at the annual meeting of the Academy of Criminal Justice Sciences, Dallas, TX.
41. Cantor, J. M. (2013, March). *Pedophilia and brain research: From the basics to the state-of-the-art*. Invited workshop presented to the annual meeting of the Forensic Mental Health Association of California, Monterey, CA.
42. Cantor, J. M. (2013, January). *Pedophilia and child molestation*. Invited lecture presented to the Canadian Border Services Agency, Toronto, Ontario, Canada.
43. Cantor, J. M. (2012, November). *Understanding pedophilia and sexual offenders against children: Neuroimaging and its implications for public safety*. Invited guest lecture to University of New Mexico School of Medicine Health Sciences Center, Albuquerque, NM.
44. Cantor, J. M. (2012, November). *Pedophilia and brain research*. Invited guest lecture to the annual meeting of the Circles of Support and Accountability, Toronto, Ontario, Canada.
45. Cantor, J. M. (2012, January). *Current findings on pedophilia brain research*. Invited workshop at the San Diego International Conference on Child and Family Maltreatment, San Diego, CA.
46. Cantor, J. M. (2012, January). *Pedophilia and the risk to re-offend*. Invited lecture to the Ontario Court of Justice Judicial Development Institute, Toronto, Ontario, Canada.
47. Cantor, J. M. (2011, November). *Pedophilia and the brain: What it means for assessment, treatment, and policy*. Plenary Lecture presented at the Association for the Treatment of Sexual Abusers, Toronto, Ontario, Canada.
48. Cantor, J. M. (2011, July). *Towards understanding contradictory findings in the neuroimaging of pedophilic men*. Keynote address to 7<sup>th</sup> annual conference on Research in Forensic Psychiatry, Regensburg, Germany.

49. Cantor, J. M. (2011, March). *Understanding sexual offending and the brain: Brain basics to the state of the art*. Workshop presented at the winter conference of the Oregon Association for the Treatment of Sexual Abusers, Oregon City, OR.
50. Cantor, J. M. (2010, October). *Manuscript publishing for students*. Workshop presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
51. Cantor, J. M. (2010, August). *Is sexual orientation a paraphilia?* Invited lecture at the International Behavioral Development Symposium, Lethbridge, Alberta, Canada.
52. Cantor, J. M. (2010, March). *Understanding sexual offending and the brain: From the basics to the state of the art*. Workshop presented at the annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Blaine, WA.
53. Cantor, J. M. (2009, January). *Brain structure and function of pedophilia men*. Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario.
54. Cantor, J. M. (2008, April). *Is pedophilia caused by brain dysfunction?* Invited address to the University-wide Science Day Lecture Series, SUNY Oswego, Oswego, NY.
55. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, September). *MRIs of pedophilic men*. Invited presentation at the 25<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
56. Cantor, J. M., Blanchard, R., & Christensen, B. K. (2003, March). *Findings in and implications of neuropsychology and epidemiology of pedophilia*. Invited lecture at the 28<sup>th</sup> annual meeting of the Society for Sex Therapy and Research, Miami.
57. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, July). *Neuropsychological functioning in pedophiles*. Invited lecture presented at the 27<sup>th</sup> annual meeting of the International Academy of Sex Research, Bromont, Canada.
58. Cantor, J. M., Blanchard, R., Christensen, B., Klassen, P., & Dickey, R. (2001, February). *First glance at IQ, memory functioning and handedness in sex offenders*. Lecture presented at the Forensic Lecture Series, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
59. Cantor, J. M. (1999, November). *Reversal of SSRI-induced male sexual dysfunction: Suggestions from an animal model*. Grand Rounds presentation at the Allan Memorial Institute, Royal Victoria Hospital, Montréal, Canada.

## PAPER PRESENTATIONS AND SYMPOSIA

1. Cantor, J. M. (2020, April). "I'd rather have a trans kid than a dead kid": Critical assessment of reported rates of suicidality in trans kids. *Paper presented at the annual meeting of the Society for the Sex Therapy and Research*. Online in lieu of in person meeting.
2. Stephens, S., Lalumière, M., Seto, M. C., & Cantor, J. M. (2017, October). *The relationship between sexual responsiveness and sexual exclusivity in phallometric profiles*. Paper presented at the annual meeting of the Canadian Sex Research Forum, Fredericton, New Brunswick, Canada.
3. Stephens, S., Cantor, J. M., & Seto, M. C. (2017, March). *Can the SSPI-2 detect hebephilic sexual interest?* Paper presented at the annual meeting of the American-Psychology Law Society Annual Meeting, Seattle, WA.
4. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Victim choice polymorphism and recidivism*. Symposium Presentation. Paper presented at the 34<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
5. McPhail, I. V., Hermann, C. A., Fernane, S. Fernandez, Y., Cantor, J. M., & Nunes, K. L. (2014, October). *Sexual deviance in sexual offenders against children: A meta-analytic review of phallometric research*. Paper presented at the 33<sup>rd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
6. Stephens, S., Seto, M. C., Cantor, J. M., & Goodwill, A. M. (2014, October). *Is hebephilic sexual interest a criminogenic need?: A large scale recidivism study*. Paper presented at the 33<sup>rd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
7. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. (2014, October). *Development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2)*. Paper presented at the 33<sup>rd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, September). *Pedophilia and the brain: White matter differences detected with DTI*. Paper presented at the 13<sup>th</sup> annual meeting of the International Association for the Treatment of Sexual Abusers, Porto, Portugal.
9. Stephens, S., Seto, M., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2014, March). *The role of hebephilic sexual interests in sexual victim choice*. Paper presented at the annual meeting of the American Psychology and Law Society, New Orleans, LA.
10. McPhail, I. V., Fernane, S. A., Hermann, C. A., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2013, November). *Sexual deviance and sexual recidivism in sexual offenders against children: A meta-analysis*. Paper presented at the 32<sup>nd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
11. Cantor, J. M. (2013, September). *Pedophilia and the brain: Current MRI research and its implications*. Paper presented at the 21<sup>st</sup> annual World Congress for Sexual Health, Porto Alegre, Brazil. [Featured among Best Abstracts, top 10 of 500.]
12. Cantor, J. M. (Chair). (2012, March). *Innovations in sex research*. Symposium conducted at the 37<sup>th</sup> annual meeting of the Society for Sex Therapy and Research, Chicago.
13. Cantor, J. M., & Blanchard, R. (2011, August). fMRI versus phallometry in the diagnosis of pedophilia and hebephilia. In J. M. Cantor (Chair), *Neuroimaging of men's object*

- preferences*. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.
14. Cantor, J. M. (Chair). (2011, August). *Neuroimaging of men's object preferences*. Symposium conducted at the 37th annual meeting of the International Academy of Sex Research, Los Angeles.
  15. Cantor, J. M. (2010, October). A meta-analysis of neuroimaging studies of male sexual arousal. In S. Stolerú (Chair), *Brain processing of sexual stimuli in pedophilia: An application of functional neuroimaging*. Symposium presented at the 29<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
  16. Chivers, M. L., Seto, M. C., Cantor, J. C., Grimbos, T., & Roy, C. (April, 2010). *Psychophysiological assessment of sexual activity preferences in women*. Paper presented at the 35<sup>th</sup> annual meeting of the Society for Sex Therapy and Research, Boston, USA.
  17. Cantor, J. M., Girard, T. A., & Lovett-Barron, M. (2008, November). *The brain regions that respond to erotica: Sexual neuroscience for dummies*. Paper presented at the 51st annual meeting of the Society for the Scientific Study of Sexuality, San Juan, Puerto Rico.
  18. Barbaree, H., Langton, C., Blanchard, R., & Cantor, J. M. (2007, October). *The role of age-at-release in the evaluation of recidivism risk of sexual offenders*. Paper presented at the 26<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
  19. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, July). *Pedophilia and brain morphology*. Abstract and paper presented at the 32<sup>nd</sup> annual meeting of the International Academy of Sex Research, Amsterdam, Netherlands.
  20. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006, March). *Child pornography offending is a diagnostic indicator of pedophilia*. Paper presented at the 2006 annual meeting of the American Psychology-Law Society Conference, St. Petersburg, Florida.
  21. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, August). *Interaction of fraternal birth order and handedness in the development of male homosexuality*. Abstract and paper presented at the International Behavioral Development Symposium, Minot, North Dakota.
  22. Cantor, J. M., & Blanchard, R. (2005, July). *Quantitative reanalysis of aggregate data on IQ in sexual offenders*. Abstract and poster presented at the 31<sup>st</sup> annual meeting of the International Academy of Sex Research, Ottawa, Canada.
  23. Cantor, J. M. (2003, August). *Sex reassignment on demand: The clinician's dilemma*. Paper presented at the 111<sup>th</sup> annual meeting of the American Psychological Association, Toronto, Canada.
  24. Cantor, J. M. (2003, June). *Meta-analysis of VIQ-PIQ differences in male sex offenders*. Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
  25. Cantor, J. M. (2002, August). *Gender role in autogynephilic transsexuals: The more things change...* Paper presented at the 110<sup>th</sup> annual meeting of the American Psychological Association, Chicago.

26. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, June). *IQ, memory functioning, and handedness in male sex offenders*. Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
27. Cantor, J. M. (1998, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 106<sup>th</sup> annual meeting of the American Psychological Association.
28. Cantor, J. M. (1997, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 105<sup>th</sup> annual meeting of the American Psychological Association.
29. Cantor, J. M. (1997, August). *Convention orientation for lesbian, gay, and bisexual students*. Paper presented at the 105<sup>th</sup> annual meeting of the American Psychological Association.
30. Cantor, J. M. (1996, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 104<sup>th</sup> annual meeting of the American Psychological Association.
31. Cantor, J. M. (1996, August). *Symposium: Question of inclusion: Lesbian and gay psychologists and accreditation*. Paper presented at the 104<sup>th</sup> annual meeting of the American Psychological Association, Toronto.
32. Cantor, J. M. (1996, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 104<sup>th</sup> annual meeting of the American Psychological Association.
33. Cantor, J. M. (1995, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 103<sup>rd</sup> annual meeting of the American Psychological Association.
34. Cantor, J. M. (1995, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 103<sup>rd</sup> annual meeting of the American Psychological Association.
35. Cantor, J. M. (1994, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 102<sup>nd</sup> annual meeting of the American Psychological Association.
36. Cantor, J. M. (1994, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 102<sup>nd</sup> annual meeting of the American Psychological Association.
37. Cantor, J. M., & Pilkington, N. W. (1992, August). *Homophobia in psychology programs: A survey of graduate students*. Paper presented at the Centennial Convention of the American Psychological Association, Washington, DC. (ERIC Document Reproduction Service No. ED 351 618)
38. Cantor, J. M. (1991, August). *Being gay and being a graduate student: Double the memberships, four times the problems*. Paper presented at the 99<sup>th</sup> annual meeting of the American Psychological Association, San Francisco.

## POSTER PRESENTATIONS

1. Klein, L., Stephens, S., Goodwill, A. M., Cantor, J. M., & Seto, M. C. (2015, October). *The psychological propensities of risk in undetected sexual offenders*. Poster presented at the 34<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
2. Pullman, L. E., Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Why are incest offenders less likely to recidivate?* Poster presented at the 34<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
3. Seto, M. C., Stephens, S. M., Cantor, J. M., Lalumiere, M. L., Sandler, J. C., & Freeman, N. A. (2015, August). *The development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2)*. Poster presentation at the 41<sup>st</sup> annual meeting of the International Academy of Sex Research. Toronto, Canada.
4. Soh, D. W., & Cantor, J. M. (2015, August). *A peek inside a furry convention*. Poster presentation at the 41<sup>st</sup> annual meeting of the International Academy of Sex Research. Toronto, Canada.
5. VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S. Stojanovski, S. O., Takagi, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., & Zucker, K. J. (2015, August). *The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females*. Poster presentation at the 31<sup>st</sup> annual meeting of the International Academy of Sex Research. Toronto, Canada.
6. Cantor, J. M., Lafaille, S. J., Moayedi, M., Mikulis, D. M., & Girard, T. A. (2015, June). *Diffusion tensor imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses*. Harvey Stancer Research Day, Toronto, Ontario Canada.
7. Newman, J. E., Stephens, S., Seto, M. C., & Cantor, J. M. (2014, October). *The validity of the Static-99 in sexual offenders with low intellectual abilities*. Poster presentation at the 33<sup>rd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Lykins, A. D., Walton, M. T., & Cantor, J. M. (2014, June). *An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior*. Poster presentation at the 30<sup>th</sup> annual meeting of the International Academy of Sex Research, Dubrovnik, Croatia.
9. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, November). *The utility of phallometry in the assessment of hebephilia*. Poster presented at the 32<sup>nd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
10. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, October). *The role of hebephilic sexual interests in sexual victim choice*. Poster presented at the 32<sup>nd</sup> annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
11. Fazio, R. L., & Cantor, J. M. (2013, October). *Analysis of the Fazio Laterality Inventory (FLI) in a population with established atypical handedness*. Poster presented at the 33<sup>rd</sup> annual meeting of the National Academy of Neuropsychology, San Diego.
12. Lafaille, S., Hannah, J., Soh, D., Kucyi, A., Girard, T. A., Mikulis, D. M., & Cantor, J. M. (2013, August). *Investigating resting state networks in pedohebephiles*. Poster presented at the 29<sup>th</sup> annual meeting of the International Academy of Sex Research, Chicago.

13. McPhail, I. V., Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2013, August). *Effects of prescription medication on volumetric phallometry output*. Poster presented at the 29<sup>th</sup> annual meeting of the International Academy of Sex Research, Chicago.
14. Murray, M. E., Dyshniku, F., Fazio, R. L., & Cantor, J. M. (2013, August). *Minor physical anomalies as a window into the prenatal origins of pedophilia*. Poster presented at the 29<sup>th</sup> annual meeting of the International Academy of Sex Research, Chicago.
15. Sutton, K. S., Stephens, S., Dyshniku, F., Tulloch, T., & Cantor, J. M. (2013, August). *Pilot group treatment for "procrasturbation."* Poster presented at 39<sup>th</sup> annual meeting of the International Academy of Sex Research, Chicago.
16. Sutton, K. S., Pytyck, J., Stratton, N., Sylva, D., Kolla, N., & Cantor, J. M. (2013, August). *Client characteristics by type of hypersexuality referral: A quantitative chart review*. Poster presented at the 39<sup>th</sup> annual meeting of the International Academy of Sex Research, Chicago.
17. Fazio, R. L., & Cantor, J. M. (2013, June). *A replication and extension of the psychometric properties of the Digit Vigilance Test*. Poster presented at the 11<sup>th</sup> annual meeting of the American Academy of Clinical Neuropsychology, Chicago.
18. Lafaille, S., Moayed, M., Mikulis, D. M., Girard, T. A., Kuban, M., Blak, T., & Cantor, J. M. (2012, July). *Diffusion Tensor Imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses*. Poster presented at the 38<sup>th</sup> annual meeting of the International Academy of Sex Research, Lisbon, Portugal.
19. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010, July). *Sexual arousal to female children in gynephilic men*. Poster presented at the 38<sup>th</sup> annual meeting of the International Academy of Sex Research, Prague, Czech Republic.
20. Cantor, J. M., Girard, T. A., Lovett-Barron, M., & Blak, T. (2008, July). *Brain regions responding to visual sexual stimuli: Meta-analysis of PET and fMRI studies*. Abstract and poster presented at the 34<sup>th</sup> annual meeting of the International Academy of Sex Research, Leuven, Belgium.
21. Lykins, A. D., Blanchard, R., Cantor, J. M., Blak, T., & Kuban, M. E. (2008, July). *Diagnosing sexual attraction to children: Considerations for DSM-V*. Poster presented at the 34<sup>th</sup> annual meeting of the International Academy of Sex Research, Leuven, Belgium.
22. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, October). *Physical height in pedophilia and hebephilia*. Poster presented at the 26<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
23. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, August). *Physical height in pedophilia and hebephilia*. Abstract and poster presented at the 33<sup>rd</sup> annual meeting of the International Academy of Sex Research, Vancouver, Canada.
24. Puts, D. A., Blanchard, R., Cardenas, R., Cantor, J., Jordan, C. L., & Breedlove, S. M. (2007, August). *Earlier puberty predicts superior performance on male-biased visuospatial tasks in men but not women*. Abstract and poster presented at the 33<sup>rd</sup> annual meeting of the International Academy of Sex Research, Vancouver, Canada.
25. Seto, M. C., Cantor, J. M., & Blanchard, R. (2005, November). *Possession of child pornography is a diagnostic indicator of pedophilia*. Poster presented at the 24<sup>th</sup> annual meeting of the Association for the Treatment of Sexual Abusers, New Orleans.

26. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, July). *Interaction of fraternal birth order and handedness in the development of male homosexuality*. Abstract and poster presented at the 31<sup>st</sup> annual meeting of the International Academy of Sex Research, Ottawa, Canada.
27. Cantor, J. M., & Blanchard, R. (2003, July). *The reported VIQ–PIQ differences in male sex offenders are artifactual?* Abstract and poster presented at the 29<sup>th</sup> annual meeting of the International Academy of Sex Research, Bloomington, Indiana.
28. Christensen, B. K., Cantor, J. M., Millikin, C., & Blanchard, R. (2002, February). *Factor analysis of two brief memory tests: Preliminary evidence for modality-specific measurement*. Poster presented at the 30<sup>th</sup> annual meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.
29. Cantor, J. M., Blanchard, R., Paterson, A., Bogaert, A. (2000, June). *How many gay men owe their sexual orientation to fraternal birth order?* Abstract and poster presented at the International Behavioral Development Symposium, Minot, North Dakota.
30. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, November). *Fluoxetine inhibition of male rat sexual behavior: Reversal by oxytocin*. Poster presented at the 26<sup>th</sup> annual meeting of the Society for Neurosciences, Washington, DC.
31. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, June). *An animal model of fluoxetine-induced sexual dysfunction: Dose dependence and time course*. Poster presented at the 28<sup>th</sup> annual Conference on Reproductive Behavior, Montréal, Canada.
32. Cantor, J. M., O'Connor, M. G., Kaplan, B., & Cermak, L. S. (1993, June). *Transient events test of retrograde memory: Performance of amnesic and unimpaired populations*. Poster presented at the 2<sup>nd</sup> annual science symposium of the Massachusetts Neuropsychological Society, Cambridge, MA.



## EDITORIAL AND PEER-REVIEWING ACTIVITIES

### **Editor-in-Chief**

*Sexual Abuse: A Journal of Research and Treatment* Jan., 2010–Dec., 2014

### **Editorial Board Memberships**

*Journal of Sexual Aggression* Jan., 2010–Dec., 2021  
*Journal of Sex Research, The* Jan., 2008–Aug., 2020  
*Sexual Abuse: A Journal of Research and Treatment* Jan., 2006–Dec., 2019  
*Archives of Sexual Behavior* Jan., 2004–Present  
*The Clinical Psychologist* Jan., 2004–Dec., 2005

### **Ad hoc Journal Reviewer Activity**

*American Journal of Psychiatry*  
*Annual Review of Sex Research*  
*Archives of General Psychiatry*  
*Assessment*  
*Biological Psychiatry*  
*BMC Psychiatry*  
*Brain Structure and Function*  
*British Journal of Psychiatry*  
*British Medical Journal*  
*Canadian Journal of Behavioural Science*  
*Canadian Journal of Psychiatry*  
*Cerebral Cortex*  
*Clinical Case Studies*  
*Comprehensive Psychiatry*  
*Developmental Psychology*  
*European Psychologist*  
*Frontiers in Human Neuroscience*  
*Human Brain Mapping*  
*International Journal of Epidemiology*  
*International Journal of Impotence Research*  
*International Journal of Sexual Health*  
*International Journal of Transgenderism*  
*Journal of Abnormal Psychology*  
*Journal of Clinical Psychology*  
*Journal of Consulting and Clinical Psychology*  
*Journal of Forensic Psychology Practice*  
*Journal for the Scientific Study of Religion*  
*Journal of Sexual Aggression*  
*Journal of Sexual Medicine*  
*Journal of Psychiatric Research*  
*Nature Neuroscience*  
*Neurobiology Reviews*  
*Neuroscience & Biobehavioral Reviews*  
*Neuroscience Letters*  
*Proceedings of the Royal Society B*  
*(Biological Sciences)*  
*Psychological Assessment*  
*Psychological Medicine*  
*Psychological Science*  
*Psychology of Men & Masculinity*  
*Sex Roles*  
*Sexual and Marital Therapy*  
*Sexual and Relationship Therapy*  
*Sexuality & Culture*  
*Sexuality Research and Social Policy*  
*The Clinical Psychologist*  
*Traumatology*  
*World Journal of Biological Psychiatry*

## GRANT REVIEW PANELS

- 2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research*, Canada.
- 2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.
- 2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research]*, Germany.
- 2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.
- 2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.
- 2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council*, Australia.
- 2015 Reviewer. *Czech Science Foundation*, Czech Republic.
- 2015 Reviewer, “Off the beaten track” grant scheme. *Volkswagen Foundation*, Germany.
- 2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada
- 2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.
- 2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council*, Australia.
- 2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.
- 2014 Panel Member, Dean’s Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.
- 2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.
- 2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

- 2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine, Canada.*
- 2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2<sup>nd</sup> round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research], Germany.*
- 2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry, Canada.*
- 2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research, Canada.*
- 2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research], Germany.*

## TEACHING AND TRAINING

### PostDoctoral Research Supervision

#### Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

---

Dr. Katherine S. Sutton	Sept., 2012–Dec., 2013
Dr. Rachel Fazio	Sept., 2012–Aug., 2013
Dr. Amy Lykins	Sept., 2008–Nov., 2009

### Doctoral Research Supervision

#### Centre for Addiction and Mental Health, Toronto, Canada

---

Michael Walton • University of New England, Australia	Sept., 2017–Aug., 2018
Debra Soh • York University	May, 2013–Aug, 2017
Skye Stephens • Ryerson University	April, 2012–June, 2016

### Masters Research Supervision

#### Centre for Addiction and Mental Health, Toronto, Canada

---

Nicole Cormier • Ryerson University	June, 2012–present
Debra Soh • Ryerson University	May, 2009–April, 2010

### Undergraduate Research Supervision

#### Centre for Addiction and Mental Health, Toronto, Canada

---

Kylie Reale • Ryerson University	Spring, 2014
Jarrett Hannah • University of Rochester	Summer, 2013
Michael Humeniuk • University of Toronto	Summer, 2012

### Clinical Supervision (Doctoral Internship)

#### Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

---

Katherine S. Sutton • Queen's University	2011–2012
David Sylva • Northwestern University	2011–2012
Jordan Rullo • University of Utah	2010–2011
Lea Thaler • University of Nevada, Las Vegas	2010–2011
Carolyn Klein • University of British Columbia	2009–2010
Bobby R. Walling • University of Manitoba	2009–2010

## TEACHING AND TRAINING

**Clinical Supervision (Doctoral- and Masters- level practica)  
Centre for Addiction and Mental Health, Toronto, Canada**

---

Tyler Tulloch • Ryerson University	2013–2014
Natalie Stratton • Ryerson University	Summer, 2013
Fiona Dyshniku • University of Windsor	Summer, 2013
Mackenzie Becker • McMaster University	Summer, 2013
Skye Stephens • Ryerson University	2012–2013
Vivian Nyantakyi • Capella University	2010–2011
Cailey Hartwick • University of Guelph	Fall, 2010
Tricia Teeft • Humber College	Summer, 2010
Allison Reeves • Ontario Institute for Studies in Education/Univ. of Toronto	2009–2010
Helen Bailey • Ryerson University	Summer, 2009
Edna Aryee • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Iryna Ivanova • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Jennifer Robinson • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Zoë Laksman • Adler School of Professional Psychology	2005–2006
Diana Mandelew • Adler School of Professional Psychology	2005–2006
Susan Wnuk • York University	2004–2005
Hiten Lad • Adler School of Professional Psychology	2004–2005
Natasha Williams • Adler School of Professional Psychology	2003–2004
Lisa Couperthwaite • Ontario Institute for Studies in Education/Univ. of Toronto	2003–2004
Lori Gray, née Robichaud • University of Windsor	Summer, 2003
Sandra Belfry • Ontario Institute for Studies in Education/Univ. of Toronto	2002–2003
Althea Monteiro • York University	Summer, 2002
Samantha Dworsky • York University	2001–2002
Kerry Collins • University of Windsor	Summer, 2001
Jennifer Fogarty • Waterloo University	2000–2001
Emily Cripps • Waterloo University	Summer, 2000
Lee Beckstead • University of Utah	2000

## PROFESSIONAL SOCIETY ACTIVITIES

### OFFICES HELD

- 2018–2019 Local Host. Society for Sex Therapy and Research.
- 2015 Member, International Scientific Committee, World Association for Sexual Health.
- 2015 Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
- 2012–2013 Chair, Student Research Awards Committee, Society for Sex Therapy & Research
- 2012–2013 Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
- 2011–2012 Chair, Student Research Awards Committee, Society for Sex Therapy & Research
- 2010–2011 Scientific Program Committee, International Academy of Sex Research
- 2002–2004 Membership Committee • APA Division 12 (Clinical Psychology)
- 2002–2003 Chair, Committee on Science Issues, APA Division 44
- 2002 Observer, Grant Review Committee • Canadian Institutes of Health Research Behavioural Sciences (B)
- 2001–2009 Reviewer • APA Division 44 Convention Program Committee
- 2001, 2002 Reviewer • APA Malyon-Smith Scholarship Committee
- 2000–2005 Task Force on Transgender Issues, APA Division 44
- 1998–1999 Consultant, APA Board of Directors Working Group on Psychology Marketplace
- 1997 Student Representative • APA Board of Professional Affairs' Institute on TeleHealth
- 1997–1998 Founder and Chair • APA/APAGS Task Force on New Psychologists' Concerns
- 1997–1999 Student Representative • APA/CAPP Sub-Committee for a National Strategy for Prescription Privileges
- 1997–1999 Liaison • APA Committee for the Advancement of Professional Practice
- 1997–1998 Liaison • APA Board of Professional Affairs
- 1993–1997 Founder and Chair • APA/APAGS Committee on LGB Concerns

## PROFESSIONAL SOCIETY ACTIVITIES

### MEMBERSHIPS

- 2017–2021 Member • *Canadian Sex Research Forum*
- 2009–Present Member • *Society for Sex Therapy and Research*
- 2006–Present Member (elected) • *International Academy of Sex Research*
- 2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*
- 2003–2006 Associate Member (elected) • *International Academy of Sex Research*
- 2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity
- 2001–2013 Member • *Canadian Psychological Association (CPA)*
- 2000–2015 Member • *American Association for the Advancement of Science*
- 2000–2015 Member • *American Psychological Association (APA)*
- APA Division 12 (Clinical Psychology)
- APA Division 44 (Society for the Psychological Study of LGB Issues)
- 2000–2020 Member • *Society for the Scientific Study of Sexuality*
- 1995–2000 Student Member • *Society for the Scientific Study of Sexuality*
- 1993–2000 Student Affiliate • *American Psychological Association*
- 1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

## **CLINICAL LICENSURE/REGISTRATION**

Certificate of Registration, Number 3793  
College of Psychologists of Ontario, Ontario, Canada

## **AWARDS AND HONORS**

**2017 Elected Fellow, Association for the Treatment of Sexual Abusers**

**2011 Howard E. Barbaree Award for Excellence in Research**  
Centre for Addiction and Mental Health, Law and Mental Health Program

**2004 fMRI Visiting Fellowship Program at Massachusetts General Hospital**  
American Psychological Association Advanced Training Institute and NIH

**1999–2001 CAMH Post-Doctoral Research Fellowship**  
Centre for Addiction and Mental Health Foundation and Ontario Ministry of Health

**1998 Award for Distinguished Contribution by a Student**  
American Psychological Association, Division 44

**1995 Dissertation Research Grant**  
Society for the Scientific Study of Sexuality

**1994–1996 McGill University Doctoral Scholarship**

**1994 Award for Outstanding Contribution to Undergraduate Teaching**  
“TA of the Year Award,” from the McGill Psychology Undergraduate Student Association



## MAJOR MEDIA

(Complete list available upon request.)

### Feature-length Documentaries

Vice Canada Reports. [Age of Consent](#). 14 Jan 2017.

Canadian Broadcasting Company. [I, Pedophile](#). Firsthand documentaries. 10 Mar 2016.

### Appearances and Interviews

11 Mar 2020. Ibbitson, John. [It is crucial that Parliament gets the conversion-therapy ban right](#). *The Globe & Mail*.

25 Jan 2020. [Ook de hulpvaardige buurman kan verzamelaar van kinderporno zin](#). *De Morgen*.

3 Nov 2019. [Village of the damned](#). *60 Minutes Australia*.

1 Nov 2019. HÅKON F. HØYDAL. [Norsk nettovergriper: – Jeg hater meg selv: Nordmenn laster ned overgrepsmateriale fra nettet – og oppfordrer politiet til å gi amnesti for slike som ham](#).

10 Oct 2019. Smith, T. [Growing efforts are looking at how—or if—#MeToo offenders can be reformed](#). *National Public Radio*.

29 Sep 2019. Carey, B. [Preying on Children: The Emerging Psychology of Pedophiles](#). *New York Times*.

29 Apr 2019. Mathieu, Isabelle. [La poupée qui a troublé les Terre-Neuviens](#). *La Tribune*.

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25 Apr 2018. Yang, J. [Number cited in cryptic Facebook post matches Alek Minassian’s military ID: Source](#). *Toronto Star*.

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27 Nov 2017. Carey, B. [Therapy for Sexual Misconduct? It’s Mostly Unproven](#). *New York Times*.

14 Nov 2017. Tremonti, A. M. [The Current](#). *CBC*.

9 Nov 2017. Christensen, J. Why men use masturbation to harass women. *CNN*.

<http://www.cnn.com/2017/11/09/health/masturbation-sexual-harassment/index.html>

7 Nov 2017. Nazaryan, A. [Why is the alt-right obsessed with pedophilia?](#) *Newsweek*.

15 Oct 2017. Ouatik, B. Découvre. [Pédophilie et science](#). *CBC Radio Canada*.

12 Oct 2017. Ouatik, B. [Peut-on guérir la pédophilie?](#) *CBC Radio Canada*.

11 Sep 2017. Burns, C. [The young paedophiles who say they don’t abuse children](#). *BBC News*.

18 Aug 2017. Interview. *National Post Radio*. Sirius XM Canada.

16 Aug 2017. Blackwell, Tom. [Man says he was cured of pedophilia at Ottawa clinic: ‘It’s like a weight that’s been lifted’: But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished](#). *National Post*.

26 Apr 2017. Zalkind, S. [Prep schools hid sex abuse just like the catholic church](#). *VICE*.

24 Apr 2017. Sastre, P. [Pédophilie: une panique morale jamais n’abolira un crime](#). *Slate France*.

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26 Nov 2016. [Det morke uvettet](#) [“The unknown darkness”]. *Fedrelandsvennen*.

13 July 2016. [Paedophilia: Shedding light on the dark field](#). *The Economist*.

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- 12 Apr 2016. O'Connor, R. [Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'](#). *The Independent*.
- 8 Mar 2016. Bielski, Z. ['The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles](#). *The Globe and Mail*.
- 1 Mar 2016. Elmhirst, S. [What should we do about paedophiles?](#) *The Guardian*.
- 24 Feb 2016. [The man whose brain tumour 'turned him into a paedophile'](#). *The Independent*.
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- 20 Aug 2015. [The Jared Fogle case: Why we understand so little about abuse](#). *Washington Post*.
- 19 Aug 2015. Blackwell, T. [Treat sex offenders for impotence—to keep them out of trouble, Canadian psychiatrist says](#). *National Post*.
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- 13 Jul 2015. [The nature of pedophilia](#). *BBC Radio 4*.
- 9 Jul 2015. [The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children](#). *The Atlantic*.
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- 1 Mar 2013. Kay, J. [The mobbing of Tom Flanagan is unwarranted and cruel](#). *National Post*.
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- 31 Aug 2012. [CNN Newsroom interview with Ashleigh Banfield](#). *CNN*.
- 24 Jun 2012. [CNN Newsroom interview with Don Lemon](#). *CNN*.

### EXPERT WITNESS TESTIMONY

- |          |  |                        |
|----------|--|------------------------|
| 1. 2022  | Roe v Utah High School Activities Assn.          | Salt Lake County, UT   |
| 2. 2022  | Re Commitment of Baunee                          | Syracuse, NY           |
| 3. 2022  | PFLAG, et al. v Abbott                           | Travis County, TX      |
| 4. 2022  | Doe v Texas                                      | Travis County, TX      |
| 5. 2022  | A.M. v Indiana Public Schools                    | Southern District, IN  |
| 6. 2022  | Ricard v Kansas                                  | Geery County, KS       |
| 7. 2022  | Eknes-Tucker v Alabama                           | Montgomery County, AL  |
| 8. 2022  | Hersom & Doe v WVa Health & Human Services       | Southern District, WVa |
| 9. 2022  | BPJ v West Virginia Board of Education           | Southern District, WVa |
| 10. 2021 | Cox v Indiana Child Services                     | Child Services, IN     |
| 11. 2021 | Cross et al. v Loudoun School Board              | Loudoun, VA            |
| 12. 2021 | Josephson v University of Kentucky               | Western District, KY   |
| 13. 2021 | Re Commitment of Michael Hughes (Frye Hearing)   | Cook County, IL        |
| 14. 2019 | US v Peter Bright                                | Southern District, NY  |
| 15. 2019 | Spiegel-Savoie v Savoie-Sexten (Custody Hearing) | Boston, MA             |
| 16. 2019 | Re Commitment of Steven Casper (Frye Hearing)    | Kendall County, IL     |
| 17. 2019 | Re Commitment of Inger (Frye Hearing)            | Poughkeepsie, NY       |
| 18. 2018 | Re Commitment of Little (Frye Hearing)           | Utica, NY              |
| 19. 2018 | Canada vs John Fitzpatrick (Sentencing Hearing)  | Toronto, ON, Canada    |
| 20. 2017 | Re Commitment of Nicholas Bauer (Frye Hearing)   | Lee County, IL         |
| 21. 2017 | US vs William Leford (Presentencing Hearing)     | Warnock, GA            |
| 22. 2015 | Florida v Jon Herb                               | Naples, FL             |
| 23. 2010 | Re Detention of William Dutcher                  | Seattle, WA            |

**EXHIBIT "B"**

# **THE SCIENCE OF GENDER DYSPHORIA AND TRANSSEXUALISM**

**REPORT SUBMITTED TO THE  
FLORIDA AGENCY FOR HEALTHCARE ADMINISTRATION**

**JAMES M. CANTOR, PHD**

**17 MAY 2022**

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## I.Ā Background & Credentials

1.Ā I am a research scientist and clinical psychologist and am currently the Director of the Toronto Sexuality Centre in Canada. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

2.Ā Over my academic career, my posts have included Senior Scientist and Psychologist at the Centre for Addiction and Mental Health (CAMH), Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3.Ā My scientific expertise spans the biological and non-biological development



of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment and treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. Although I was a member of the hospital's adult forensic program, I remained in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple research projects.

## **II. Summary of Conclusions**

- The scientific research consistently demonstrates that there is more than one distinct phenomenon that can lead to gender dysphoria. These types are distinguished by differing epidemiological and demographic patterns, unique psychological and behavioral profiles, and differing responses to the treatment options.
- Studies show that otherwise mentally healthy adults—undergoing thorough assessment (1–2 year Real Life Experience) and supervised by clinics engaged in gate-keeping roles—adjust well to life as the opposite sex.
- Regarding pre-pubescent children with gender dysphoria, there have been 11 outcomes studies. All 11 reported the majority of children to cease to feel dysphoric by puberty. They typically report being gay or lesbian instead.
- Regarding pubescent and adolescent age minors, there have been (also) 11 follow-up studies of puberty blockers and cross-sex hormones. In four, mental health failed to improve at all. In five, mental health improved, but because psychotherapy and medical interventions were both provided, which one caused the improvement could not be identified. The two remaining studies employed methods that did permit psychotherapy effects to be distinguished from medical effects, and neither found medical intervention to be superior to psychotherapy-only.
- The research importantly distinguishes completed suicides—which occur primarily in biological males and involve the intent to die—from suicidal ideation, gestures, and attempts—which occur primarily in biological females and represent psychological distress and cries for help. The evidence is minimally consistent with transphobia being the predominant cause of suicidality. The evidence is very strongly consistent with the hypothesis that other mental health issues, such as Borderline Personality Disorder (BPD), cause suicidality and unstable identities, including gender identity confusion.
- The international consensus of public health care services is that there remains no evidence to support medicalized transition for youth. The responses in the U.S. stand in stark contrast with Sweden, Finland, France, and the United Kingdom, which are issuing increasingly restrictive statements and policies, including bans on all medical transition of minors.

### **III. The Science of Gender Dysphoria and Transsexualism**

6. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria

(cases of *late-onset* gender dysphoria),<sup>1</sup> merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or “rapid-onset” gender dysphoria (ROGD). Very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to another.

### **A. Adult-Onset Gender Dysphoria**

7. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively biological males.<sup>2</sup> They typically report being sexually attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.<sup>3</sup> Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.<sup>4</sup>

#### **1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria**

8. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,<sup>5</sup> Sweden,<sup>6</sup> and the Netherlands.<sup>7</sup>

9. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults

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<sup>1</sup> Blanchard, 1985.

<sup>2</sup> Blanchard, 1990, 1991.

<sup>3</sup> Blanchard, 1988.

<sup>4</sup> Blanchard 1989a, 1989b, 1991.

<sup>5</sup> Blanchard, *et al.*, 1989.

<sup>6</sup> Dhejneberg, *et al.*, 2014.

<sup>7</sup> Wiepjes, *et al.*, 2018.

with gender dysphoria all performed “gate-keeping” procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

10. An important caution applies to interpreting these results: The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

## **2. Mental Health Issues in Adult-Onset Gender Dysphoria**

11. The research evidence on mental health issues in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.<sup>8</sup> A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.<sup>9</sup> There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless demonstrated (1) that rates of mental health issues among people are highly elevated both before *and after* transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients to become “lost to follow-up.” With attrition rates that high, it is unclear to what

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<sup>8</sup> See, e.g., Hepp, *et al.*, 2005.

<sup>9</sup> Dhejne, *et al.*, 2016.

extent the information from the remaining participants would accurately reflect the whole population. The very high rate of “lost to follow-up” leaves open the possibility of considerably more negative results overall.

12.Ā The long-standing and consistent finding that gender dysphoric adults continue to show high rates of mental health issues after transition indicates a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition—that is, transition does not appear to be what causes mental health improvement. Rather, mental health issues should be resolved before any transition, as has been noted in multiple standards of care documents, as detailed in their own section of this report.

## **B. Childhood Onset (Pre-Puberty) Gender Dysphoria**

### **1.Ā Follow-up Studies Show Most Children Desist by Puberty**

13.Ā Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.<sup>10</sup>

14.Ā In total, there have been 11 outcomes studies of these children, listed in Appendix 1. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as “desisters,” whereas children who continue to feel gender dysphoric are often called “persisters.”

15.Ā Notably, in most cases, these children were receiving professional

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<sup>10</sup> Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.*, 2018; Wood, *et al.*, 2013.

psychosocial support across the study period aimed, not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: It is not possible to know to what extent the outcomes were influenced by the psychosocial support or would have emerged regardless. In science, this is referred to as a confound.

16.Ā While the absolute number of those who present as prepubescent children with gender dysphoria and “persist” through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, a clinician cannot take either outcome for granted.

17.Ā It is because of this long-established and unanimous research finding of desistance being probable but not inevitable, that the “watchful waiting” method became the standard approach for assisting gender dysphoric children. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

18.Ā The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. That is, gender identity is not the same as sexual orientation, and it cannot be assumed that gender identity is as unchangeable as is sexual orientation. Such is an empirical question, and there has not yet been any such study.

19.Ā It is also important to note that research has not yet identified any reliable

procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and “affirmation.” Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can be weighted. Such “risk prediction” and “test construction” are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.<sup>11</sup>

20. In contrast, one research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children’s “peer preference, toy preference, clothing preference, gender similarity, and gender identity.”<sup>12</sup> They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, “Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability.”<sup>13</sup> Although the Olson team declared that “social transitions may be predictable from gender identification and preferences,”<sup>14</sup> their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.<sup>15</sup> Both of those are lower than the value of .75, so both of those would be more likely than not

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<sup>11</sup> Singh, *et al.* (2021); Steensma *et al.*, 2013.

<sup>12</sup> Rae, *et al.*, 2019, at 671.

<sup>13</sup> Rae, *et al.*, 2019, at 673.

<sup>14</sup> Rae, *et al.*, 2019, at 669.

<sup>15</sup> Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

to desist, rather than to proceed to transition. That is, Olson’s model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

21. Although it remains possible for some future discovery to yield a method to identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *detransition*. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, “transition-on-demand” increases the probability of unnecessary transition and unnecessary medical risks.

### **2. “Watchful Waiting” and “The Dutch Protocol”**

22. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, The Dutch Protocol,<sup>16</sup> including its “Watchful Waiting” period. Internationally, the Dutch Protocol remains the most empirically supported protocol for the treatment of children with gender dysphoria.

23. The purpose of the protocol was to compromise the conflicting needs among: clients’ initial wishes upon assessment, the long-established and repeated observation that those wishes will change in the majority of (but not in all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

24. The Dutch Protocol was developed over many years by the Netherlands’ child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric

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<sup>16</sup> Delemarre-van de Waal & Cohen-Kettenis (2006).



children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach*.<sup>17</sup> The components of the Dutch Approach are:

- Ã no social transition at all considered before age 12 (watchful waiting period),
- Ã no puberty blockers considered before age 12,
- Ã cross-sex hormones considered only after age 16, and
- Ã resolution of mental health issues before any transition.

25.Ã For youth under age 12, “the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty.”<sup>18</sup>

26.Ã The age cut-offs of the Dutch Approach were not based on any research demonstrating their superiority over other potential age cut-off’s. Rather, they were chosen to correspond to the ages of consent to medical procedures under Dutch law. Nevertheless, whatever the original rationale, the data from this clinic simply contain no information about the safety or efficacy of employing these measures at younger ages.

27.Ã The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child’s parents.

28.Ã Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. “Watchful Waiting” refers to a child’s developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Rather, such children and families typically present with substantial distress involving both gender and non-gender issues, and it is during the watchful waiting period that a child (and other family members as appropriate) would

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<sup>17</sup> de Vries & Cohen-Kettenis, 2012

<sup>18</sup> de Vries & Cohen-Kettenis, 2012, at 301.

undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, “[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic’s psychologists or psychiatrists.”<sup>19</sup> One is actively treating the person, while carefully “watching” the dysphoria.

### **3. Follow-Up Studies of Puberty Blockers and Cross-Sex Hormones**

29. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many outlets have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. In total, there have been 11 prospective outcomes studies following up gender dysphoric children undergoing medically induced suppression of puberty or cross-sex hormone treatment. Four studies failed to find evidence of improvement in mental health functioning at all, and some groups deteriorated on some variables.<sup>20</sup> Five studies successfully identified evidence of improvement, but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.<sup>21</sup> In the remaining two studies, both psychotherapy and medical interventions were provided, but the studies were designed in such a way as to allow the effects of psychotherapy to be separated from the effects of the puberty-blocking medications.<sup>22</sup> As detailed in the following, neither identified benefits of medication over psychotherapy alone.

#### **a. Four studies found no mental health improvement**

30. Carmichael, *et al.* (2021) recently released its findings from the Tavistock

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<sup>19</sup> de Vries, *et al.*, 2011, at 2280-2281.

<sup>20</sup> Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020; Kuper, *et al.*, 2020.

<sup>21</sup> de Vries, *et al.*, 2011; Tordoff, *et al.*, 2022; van der Miesen, *et al.*, 2020.

<sup>22</sup> Achille, *et al.*, 2020; Costa, *et al.*, 2015.

and Portman clinic in the U.K.<sup>23</sup> Study participants were ages 12–15 (Tanner stage 3 for natal males, Tanner stage 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

31. In Kuper, *et al.* (2020), a multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.<sup>24</sup> (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to practice guidelines from the Endocrine Society.<sup>25</sup> Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.<sup>26</sup> Notably, whereas the Dutch Protocol includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).<sup>27</sup>

32. Hisle-Gorman, *et al.* (2021) analyzed military families' healthcare data to compare 963 transgender and gender-diverse youth before versus after hormonal treatment, with their non-gender dysphoric siblings as controls. The study participants included youth undergoing puberty-blocking as well as those undergoing cross-sex hormone treatment, but these subgroups did not differ from each other. Study participants had a mean age of 18 years when beginning the study, but their

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<sup>23</sup> Carmichael, *et al.*, 2021.

<sup>24</sup> Kuper, *et al.*, 2020, at 5.

<sup>25</sup> Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.

<sup>26</sup> Kuper, *et al.*, 2020, at Table 2.

<sup>27</sup> Kuper, *et al.*, 2020, at 4.

initial clinical contacts and diagnoses occurred at a mean age of 10 years. According to the study, “mental health care visits overall did not significantly change following gender-affirming pharmaceutical care,”<sup>28</sup> yet, “psychotropic medication use *increased*,”<sup>29</sup> indicating *deteriorating* mental health.

33. Kaltiala et al. (2020) similarly reported that after cross-sex hormone treatment, “Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems during real-life.”<sup>30</sup> They concluded, “Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development.”<sup>31</sup>

**b. Five studies confounded psychotherapy and medical treatment**

34. The initial enthusiasm for medical blocking of puberty followed largely from early reports from the Dutch clinical research team suggesting at least some mental health improvement.<sup>32</sup> It was when subsequent research studies failed to replicate those successes that it became apparent that the successes were due, not to the medical interventions, but to the psychotherapy that accompanied such interventions in most clinics, including the Dutch clinic.

35. The Dutch clinical research team followed up a cohort of youth at their clinic undergoing puberty suppression<sup>33</sup> and later cross-hormone treatment and surgical sex reassignment.<sup>34</sup> The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and

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<sup>28</sup> Hisle-Gorman, et al., 2021, at 1448.

<sup>29</sup> Hisle-Gorman, et al., 2021, at 1448, emphasis added.

<sup>30</sup> Kaltiala et al., 2020, at 213.

<sup>31</sup> Kaltiala et al., 2020, at 213.

<sup>32</sup> de Vries, *et al.*, 2011; de Vries, *et al.*, 2014

<sup>33</sup> de Vries, *et al.*, 2011.

<sup>34</sup> de Vries, *et al.*, 2014.

general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.<sup>35</sup>

36. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other. The authors of the study were explicit in noting this themselves: “All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents.”<sup>36</sup>

37. In a 2020 update, the Dutch clinic reported continuing to find improvement in transgender adolescents’ psychological functioning, reaching age-typical levels, “after the start of specialized transgender care involving puberty suppression.”<sup>37</sup> Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it again cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors noted again, “The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-

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<sup>35</sup> Biggs, 2020.

<sup>36</sup> de Vries, *et al.* 2011, at 2281.

<sup>37</sup> van der Miesen, *et al.*, 2020, at 699.

term mental health outcomes.”<sup>38</sup>

38. Allen, *et al.* (2019) reported on a sample of 47 youth, ages 13–20, undergoing cross-sex hormone treatment. They reported observing increases in measures of well-being and decreases in measures of suicidality; however, as the authors also noted, “whether a patient is actively receiving psychotherapy” may have been a confounding variable.<sup>39</sup>

39. Tordoff, *et al.* (2022) reported on a sample of youth, ages 13–20 years, treated with either puberty blockers or cross-sex hormones. There were improvements in mental health functioning; however, 62.5% of the sample was again receiving mental health therapy.<sup>40</sup>

**c. Two studies showed no superiority of medical intervention above psychotherapy**

40. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.<sup>41</sup> As those authors concluded, “Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence.”<sup>42</sup> Because psychological support does not pose the physical health risks that hormonal interventions or surgery does (such as loss of reproductive function) however, one

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<sup>38</sup> van der Miesen, *et al.*, 2020, at 703.

<sup>39</sup> Allen, *et al.*, 2019.

<sup>40</sup> Tordoff, *et al.*, 2022, Table 1.

<sup>41</sup> Costa, *et al.*, at 2212 Table 2.

<sup>42</sup> Costa, *et al.*, at 2206.

cannot justify taking on the greater risks of social transition, puberty blockers or surgery without evidence of such treatment producing superior results. Such evidence does not exist. Moreover, this clinical team subsequently released the final version of this preliminary report, finding that neither group actually experienced significant improvement,<sup>43</sup> making moot any discussion of the source any improvement.

41. Achille, *et al.* (2020) at Stony Brook Children’s Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50 of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, “Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional.”<sup>44</sup> The puberty blockers themselves “were introduced in accordance with the Endocrine Society and the WPATH guidelines.”<sup>45</sup> Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, “*most predictors did not reach statistical significance.*”<sup>46</sup> That is, puberty blockers did not improve mental health any more than did mental health care on its own.

#### **d. Conclusions**

42. The authors of the original Dutch studies were careful not to overstate the implications of their results, “We *cautiously* conclude that puberty suppression *may be a valuable element* in clinical management of adolescent gender dysphoria.”<sup>47</sup> Nonetheless, many other clinics and clinicians intrepidly proceeded on the basis of only the perceived positives, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that

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<sup>43</sup> Carmichael, *et al.*, 2021.

<sup>44</sup> Achille, *et al.*, 2020, at 2.

<sup>45</sup> Achille, *et al.*, 2020, at 2.

<sup>46</sup> Achille, *et al.*, 2020, at 3 (italics added).

<sup>47</sup> de Vries, *et al.* 2011, at 2282, italics added.

led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, 1 to 2 years<sup>48</sup>) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

43. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."<sup>49</sup> Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

#### **4. Mental Health Issues in Childhood-Onset Gender Dysphoria**

44. As shown by the outcomes studies, there is little evidence that transition improves the mental well-being of children. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child

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<sup>48</sup> de Vries, *et al.*, 2011.

<sup>49</sup> Tetelepta, 2021.



experiencing depression from social isolation might develop the hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

45.Ā If a child undergoes transition, discovering only then that their mental health or social situations will not in fact change, the medical risks and side-effects (such as sterilization) will have been borne for no reason. If, however, a child resolves the mental health issues first, with the gender dysphoria resolving with it (which the research literature shows to be the case in the large majority), then the child need not undergo transition at all, but retains the opportunity to do so later.

46.Ā Elevated rates of multiple mental health issues among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.<sup>50</sup> A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.<sup>51</sup> When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

47.Ā A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD in youth with gender dysphoria. Studies reviewing medical records of children and adolescents

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<sup>50</sup> Wallien, *et al.*, 2007.

<sup>51</sup> Cohen-Kettenis, *et al.*, 2003, at 46.

referred to gender clinics showed 5–26% to have been diagnosed with ASD.<sup>52</sup> Moreover, those authors gave specific caution on the “considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results.”<sup>53</sup> As noted elsewhere herein, when two or more issues are present at the same time, researchers cannot distinguish when a result is associated with or caused by the issue of interest or one of the side issues.<sup>54</sup> The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported “gender variance.”<sup>55</sup>

### **C. Adolescent-Onset Gender Dysphoria**

#### **1. Features of Adolescent-Onset Gender Dysphoria**

48. In the social media age, a third profile has recently begun to present clinically or socially, characteristically distinct from the two previously identified profiles.<sup>56</sup> Unlike adult-onset or childhood-onset gender dysphoria, this group is predominately biologically female. This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD).<sup>57</sup> The majority of cases appear to occur within clusters of peers and in association with increased social media use<sup>58</sup> and especially among people with autism or other neurodevelopmental or mental health issues.<sup>59</sup>

49. It cannot be easily determined whether the self-reported gender dysphoria

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<sup>52</sup> Thrower, *et al.*, 2020.

<sup>53</sup> Thrower, *et al.*, 2020, at 703.

<sup>54</sup> Cohen-Kettenis *et al.*, 2003, at 51; Skelly *et al.*, 2012.

<sup>55</sup> Janssen, *et al.*, 2016.

<sup>56</sup> Kaltiala-Heino, *et al.*, 2015; Littman, 2018.

<sup>57</sup> Littman, 2018.

<sup>58</sup> Littman, 2018.

<sup>59</sup> Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.

is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.<sup>60</sup> (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.<sup>61</sup> Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to adolescent-onset gender dysphoria. The multiple differences already observed between these groups argue against predicting that features present in one type would generalize to be present in all types of gender dysphoria.

## **2. Social Transition and Puberty Blockers with Adolescent Onset**

50. There do not yet exist prospective outcomes studies either for social transition or for medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective*. It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence versus people

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<sup>60</sup> Boivin, *et al.*, 2020.

<sup>61</sup> Biggs, 2020; Littman, 2018.

whose onset was not until adolescence. (Analogously, there are reports failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria.) Studies selecting groups according to their current age instead of their ages of onset produces confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

### 3. Mental Illness in Adolescent-Onset Gender Dysphoria

51. In 2019, a Special Section appeared in the *Archives of Sexual Behavior* titled, “Clinical Approaches to Adolescents with Gender Dysphoria.” It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria, by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University.<sup>62</sup> The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,<sup>63</sup> with suicide attempts ranging 10 to 45%.<sup>64</sup> Self-injurious thoughts and behaviors range 14–39%.<sup>65</sup> Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.<sup>66</sup> Gender dysphoria also overlaps with Autism Spectrum Disorder.<sup>67</sup>

52. Of particular concern in the context of adolescent onset gender dysphoria is Borderline Personality Disorder (BPD; diagnostic criteria to follow). It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD.<sup>68</sup> That is, some people may be misinterpreting their experiencing of the broader “identity disturbance” of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset

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<sup>62</sup> Janssen, *et al.*, 2019.

<sup>63</sup> Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.

<sup>64</sup> Reisner, *et al.*, 2015.

<sup>65</sup> Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.

<sup>66</sup> de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.

<sup>67</sup> de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.

<sup>68</sup> *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

gender dysphoria, BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

53.Ã DSM-5-TR Diagnostic Criteria for Borderline Personality Disorder:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- 1.ÃFrantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
- 2.ÃA pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
- 3.Ã*Identity disturbance: markedly and persistently unstable self-image or sense of self.*
- 4.ÃImpulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
- 5.Ã*Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
- 6.ÃAffective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- 7.ÃChronic feelings of emptiness.
- 8.ÃInappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- 9.ÃTransient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

54.Ã Mistaking cases of BPD for cases of Gender Dysphoria may prevent such youth from receiving the correct mental health services for their condition, and a primary cause for concern is symptom Criterion 5: Recurrent suicidality. (The research on suicide and suicidality are detailed in their own section herein.)

Regarding the provision of mental health care, the distinction between these conditions is crucial: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality.

55. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. The scientific concern presented by BPD is that it poses a potential confound: Samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

#### **IV. Other Scientific Claims Assessed**

##### **A. Suicide and Suicidality**

56. Social media increasingly circulate demands for transition accompanied by hyperbolic warnings of suicide should there be delay or obstacle. Claims accompany admissions that “I’d rather have a trans daughter than a dead son,” and such threats are treated as the justification for referring to affirming gender transitions as ‘life-saving’ or ‘medically necessary’. Such claims convey only grossly misleading misrepresentations of the research literature, however, deploying terms for their shock value rather than accuracy, and exploiting common public misperceptions about suicide. Indeed, suicide prevention research and public health campaigns repeatedly warn against circulating such exaggerations, due to the risk of copy-cat

behavior they encourage.<sup>69</sup>

57.Ā Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with different clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.<sup>70</sup> *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified by “If you leave me, I will kill myself.” Professing suicidality is also used for attention-seeking or for the support or sympathy it evokes from others, denoting distress much more frequently than an intent to die.

58.Ā Notwithstanding public misconceptions about the frequency of suicide and related behaviors, the highest rates of suicide are among middle-aged and elderly men in high income countries.<sup>71</sup> Biological males are at three times greater risk of death by suicide than are biological females, whereas suicidal ideation, plans, and attempts are three times more common among biological females.<sup>72</sup> In contrast with completed suicides, the frequency of suicidal ideation, plans, and attempts is highest during adolescence and young adulthood, with reported ideation rates spanning 12.1–33%.<sup>73</sup> Relative to other countries, Americans report elevated rates of each of suicidal ideation (15.6%), plans (5.4%), and attempts (5.0%).<sup>74</sup> Suicide attempts occur up to 30

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<sup>69</sup> Gould & Lake, 2013.

<sup>70</sup> Freeman, *et al.*, 2017.

<sup>71</sup> Turecki & Brent, 2016

<sup>72</sup> Klonsky et al., 2016; Turecki & Brent, 2016

<sup>73</sup> Borges et a., 2010; Nock et al., 2008

<sup>74</sup> Klonsky, et al., 2016.

times more frequently than completed suicides.<sup>75</sup> The rate of completed suicides in the U.S. population is 14.5 per 100,000 people.<sup>76</sup> The widely discrepant numbers representing completed suicides versus transient suicidal ideation has left those statistics open to substantial abuse in the media and social media. Despite public media guidelines urging “Avoid dramatic headlines and strong terms such as ‘suicide epidemic,’”<sup>77</sup> that is exactly what mainstream outlets have done.<sup>78</sup>

59. There is substantial research associating sexual orientation with suicidality, but much less so with completed suicide.<sup>79</sup> More specifically, there is some evidence suggesting gay adult men are more likely to die by suicide than are heterosexual men, but there is less evidence of an analogous pattern among lesbian women. Regarding suicidality, surveys of self-identified LGB Americans repeatedly report rates of suicidal ideation and suicide attempts 2–7 times higher than their heterosexual counterparts. Because of this association of suicidality with sexual orientation, one must apply caution in interpreting findings allegedly about gender identity: Because of the overlap between people who self-identify as non-heterosexual and as non-cis-gendered, correlations detected between suicidality and gender dysphoria may instead reflect (be confounded by) homosexuality. Indeed, other authors have made explicit their surprise that so many studies, purportedly of gender identity, entirely omitted measurement or consideration of sexual orientation, creating the situation where features that seem to be associated with gender identity instead reflect the sexual orientation of the members of the sample.<sup>80</sup>

60. Among post-transition transsexuals, completed suicide rates are elevated,

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<sup>75</sup> Bachman, 2018.

<sup>76</sup> World Health Organization, 2022.

<sup>77</sup> Samaritans, 2020.

<sup>78</sup> E.g., MSNBC, 2015, *Trans youth and suicide: An epidemic*.

<sup>79</sup> Haas, *et al.*, 2011.

<sup>80</sup> McNeil, *et al.* (2017)



but are nonetheless rare.<sup>81</sup> Regarding suicidality, there have been three recent, systematic reviews of the research literature.<sup>82</sup> All three included specific methods to minimize any potential effects of cherry-picking findings from within the research literature. Compiling the results of 108 articles reported from 64 research projects, Adams and Vincent (2019) found an overall average rate of 46.55% for suicidal ideation (ranging 18.18%–95.5%) and an overall average rate of 27.19% for suicidal attempts (ranging 8.57%–52.4%). These findings confirmed those reported by McNeil, *et al.* (2017), whose review of 30 articles revealed a range of 37%–83% for suicidal ideation and 9.8%–43% for suicidal attempts. Thus, on the one hand, these ranges are greater than those reported for the mainstream population—They instead approximate the rates reported among sexual orientation minorities. On the other hand, with measures so lacking in reliability that they produce every result from ‘rare’ to ‘almost everyone’, it is unclear which, if any of them, represents a valid conclusion.

61. McNeil *et al.* (2017) observed also the research to reveal rates of suicidal ideation and suicidal attempts to be related—not to transition status—but to the social support received: The studies reviewed showed support to decrease suicidality, but transition not to. Indeed, in some situations, social support was associated with *increased* suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.<sup>83</sup>

62. Marshall *et al.* (2016) identified and examined 31 studies, again finding rates of suicidal ideation and suicide attempts to be elevated, particularly among biological females, indicating that suicidality patterns correspond to biological sex rather than self-identified gender.<sup>84</sup>

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<sup>81</sup> Wiepjes, *et al.*, 2020.

<sup>82</sup> Adams & Vincent, 2019; Marshall, *et al.*, 2016; McNeil, *et al.* (2017).

<sup>83</sup> Bauer, *et al.*, 2015; Canetto, *et al.*, 2021.

<sup>84</sup> Marshall, *et al.*, 2016.

63. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a ‘medical necessity’. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.<sup>85</sup>

64. The scientific study of suicide is inextricably linked to that of mental illness, and Borderline Personality Disorder is repeatedly documented to be greatly elevated among sexual minorities<sup>86</sup>.

### **B. Conversion Therapy**

65. Activists and social media increasingly, but erroneously, apply the term “conversion therapy” moving farther and farther from what the research has reported. “Conversion therapy” (or “reparative therapy” and other names) was the attempt to change a person’s sexual orientation; however, with the public more frequently accustomed to “LGB” being expanded to “LGBTQ+”, the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, this is only very rarely are mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as already shown unanimously by all follow-up studies. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled “conversion therapy.”<sup>87</sup> Indeed, even actions of non-therapists, unrelated

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<sup>85</sup> McNeil, *et al.*, 2017.

<sup>86</sup> Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.

<sup>87</sup> D’Angelo, *et al.*, 2021.

to any therapy, have been labelled conversion therapy, including the prohibition of biological males competing on female teams.<sup>88</sup>

**C. Assessing Demands for Social Transition and Affirmation-Only or Affirmation-on-Demand Treatment in Pre-Pubertal Children.**

66.Ā Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with the other parent.

67.Ā Referring to “affirmation” as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word “affirmation” refers to entirely different actions.

68.Ā It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social transition (and puberty blocking) may not begin until age 12 and cross-sex hormonal and other medical interventions, later.

69.Ā Formal clinical approaches to helping children expressing gender dysphoria

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<sup>88</sup> Turban, 2021, March 16.

employ a gate-keeper model, with decision trees to help clinicians decide when and if the potential benefits of affirmation of the new gender would outweigh the potential risks of doing so. Because the gate-keepers and decision-trees generally include the possibility of affirmation in at least some cases, it is misleading to refer to any one approach as “the affirmation approach.” The most extreme decision-tree would be accurately called *affirmation-on-demand*, involving little or no opportunity for children to explore at all whether the distress they feel is due to some other, less obvious, factor, whereas more moderate gate-keeping would endorse transition only in select situations, when the likelihood of regretting transition is minimized.

70. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of “retrospective” rather than “prospective” studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

#### **D. Assessing the “Minority Stress Hypothesis”**

71. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.<sup>89</sup> The association is not entirely straight-forward, however. For example,

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<sup>89</sup> Meyer, 2003.

although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

72.Ã Minority stress is associated, in large part, with being a visible minority. There is little evidence that transgender populations show the patterns suggested by the hypothesis. For example, the minority stress hypothesis would predict differences according to how visibly a person is discernable as a member of the minority, which often changes greatly upon transition. Biological males who are very effeminate stand out throughout childhood, but in some cases can successfully blend in as adult females; whereas the adult-onset transitioners blend in very much as heterosexual cis-gendered males during their youth and begin visibly to stand out in adulthood, only for the first time.

73.Ã Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.<sup>90</sup> The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

74.Ã A primary criterion for readiness for transition used by the clinics demonstrating successful transition is the absence or resolution of other mental health concerns, such as suicidality. In the popular media, however, indications of mental health concerns are instead often dismissed as an expectable result caused by Sexual Minority Stress (SMS). It is generally implied that such symptoms will resolve

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<sup>90</sup> Meyer, 2003.

upon transition and integration into an affirming environment.

## **V.Ā Assessing Statements from Professional Associations**

### **A. Understanding the Value of Statements from Professional Associations**

75.Ā The value of position statements from professional associations should be neither over- nor under-estimated. In the ideal, an organization of licensed health care professionals would convene a panel of experts who would systematically collect all the available evidence about an issue, synthesizing it into recommendations or enforceable standards for clinical care, according to the quality of the evidence for each alternative. For politically neutral issues, with relevant expertise contained among association members, this ideal can be readily achievable. For controversial issues with no clear consensus, the optimal statement would summarize each perspective and explicate the strengths and weaknesses of each, providing relatively reserved recommendations and suggestions for future research that might resolve the continuing questions. Several obstacles can hinder that goal, however. Committees within professional organizations are typically volunteer activities, subject to the same internal politics of all human social structures. That is, committee members are not necessarily committees of experts on a topic—they are often committees of generalists handling a wide variety of issues or members of an interest group who feel strongly about political implications of an issue, instead of scientists engaged in the objective study of the topic.

76.Ā Thus, documents from professional associations may represent required standards, the violation of which may merit sanctions, or may represent only recommendations or guidelines. A document may represent the views of an association's full membership or only of the committee's members (or majorities thereof). Documents may be based on systematic, comprehensive reviews of the available research or selected portions of the research. In sum, the weight best placed

on any association's statement is the amount by which that association employed evidence versus other considerations in its process.

**B. Misrepresentations of statements of professional associations.**

77. In the presently highly politicized context, official statements of professional associations have been widely misrepresented. In preparing the present report, I searched the professional research literature for documentation of statements from these bodies and from my own files, for which I have been collecting such information for many years. I was able to identify statements from six such organizations. Although not strictly a medical association, the World Professional Association for Transgender Health (WPATH) also distributed a set of guidelines in wide use and on which other organizations' guidelines are based.

78. Notably, despite that all these medical associations reiterate the need for mental health issues to be resolved before engaging in medical transition, only the AACAP members have medical training in mental health. The other medical specialties include clinical participation with this population, but their assistance in transition generally assumes the mental health aspects have already been assessed and treated beforehand.

79. With the broad exception of the AAP, their statements repeatedly noted instead that:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.
- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.
- Social transition is not generally recommended until after puberty.

Although some other associations have published broad statements of moral support for sexual minorities and against discrimination, they did not include any specific standards or guidelines regarding medical- or transition-related care.

### 1. World Professional Association for Transgender Health (WPATH)

80. The WPATH standards as they relate to prepubescent children begin with the acknowledgement of the known rates of desistance among gender dysphoric children:

[I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).<sup>91</sup>

81. That is, “In most children, gender dysphoria will disappear before, or early in, puberty.”<sup>92</sup>

82. Although WPATH does not refer to puberty blocking medications as “experimental,” the document indicates the non-routine, or at least inconsistent availability of the treatment:

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).<sup>93</sup>

83. WPATH neither endorses nor proscribes social transitions before puberty, instead recognizing the diversity among families’ decisions:

Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.<sup>94</sup>

84. It does caution, however, “Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria.”<sup>95</sup>

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<sup>91</sup> Coleman, *et al.*, 2012, at 172.

<sup>92</sup> Coleman, *et al.*, 2012, at 173.

<sup>93</sup> Coleman, *et al.*, 2012, at 173.

<sup>94</sup> Coleman, *et al.*, 2012, at 176.

<sup>95</sup> Coleman, *et al.*, 2012, at 176 (quoting Drummond, *et al.*, 2008; Wallien & Cohen-Kettenis, 2008).



85. The WPATH standards have been subjected to standardized evaluation, the Appraisal of Guidelines for Research and Evaluation (“AGREE II”) method, as part of an appraisal of all published Clinical Practice Guidelines (CPGs) regarding sex and gender minority healthcare.<sup>96</sup> Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that “[t]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research.”<sup>97</sup> The WPATH guidelines were recommended for use. Indeed, the WPATH guidelines received unanimous ratings of “Do not recommend.”<sup>98</sup>

86. Finally, it should be noted that WPATH is in stark opposition to international standards: Public healthcare systems throughout the world have instead been ending the practice of medical transition of minors, responding to the increasingly recognized risks associated with hormonal interventions and the now clear lack of evidence that medical transition was benefitting most children, as opposed to the mental health counseling accompanying transition.

## **2. Endocrine Society (ES)**

87. The 150,000-member Endocrine Society appointed a nine-member task force, plus a methodologist and a medical writer, who commissioned two systematic reviews of the research literature and, in 2017, published an update of their 2009 recommendations, based on the best available evidence identified. The guideline was co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society (PES), and the World Professional Association for Transgender Health (WPATH).

88. The document acknowledged the frequency of desistance among gender

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<sup>96</sup> Dahlen, *et al.*, 2021.

<sup>97</sup> Dahlen, *et al.*, 2021, at 6.

<sup>98</sup> Dahlen, *et al.*, 2021, at 7.

dysphoric children:

Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called “desisters”). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.<sup>99</sup>

89.Ā The statement similarly acknowledges inability to predict desistance or persistence, “With current knowledge, we cannot predict the psychosexual outcome for any specific child.”<sup>100</sup>

90.Ā Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, “In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues.”<sup>101</sup> This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

91.Ā The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: “We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional.”<sup>102</sup>

92.Ā The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician “provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable

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<sup>99</sup> Hembree, *et al.*, 2017, at 3876.

<sup>100</sup> Hembree, *et al.*, 2017, at 3876.

<sup>101</sup> Hembree, *et al.*, 2017, at 3877.

<sup>102</sup> Hembree, *et al.*, 2017, at 3872.

psychological and social outcomes.”<sup>103</sup>

### **3. Pediatric Endocrine Society and Endocrine Society (ES/PES)**

93. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.<sup>104</sup> Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.<sup>105</sup>

94. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society “recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance.”<sup>106</sup> However, the Endocrine Society makes neither statement. Although the two-page PES document mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: “If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action.”<sup>107</sup> Despite the PES asserting it as “medically necessary,” the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: “We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient’s overall health and/or well-being.”<sup>108</sup>

### **4. American Academy of Child & Adolescent Psychiatry (AACAP)**

95. The 2012 statement of the American Academy of Child & Adolescent Psychiatry (AACAP) is not an affirmation-only policy. It notes:

Just as family rejection is associated with problems such as depression,

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<sup>103</sup> Hembree, *et al.*, 2017, at 3877.

<sup>104</sup> PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.

<sup>105</sup> Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al.*, 2017.

<sup>106</sup> Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

<sup>107</sup> Hembree, *et al.* 2017, at 3883.

<sup>108</sup> Hembree, *et al.*, 2017 at 3872, 3894.

suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.<sup>109</sup>

96.Ā The AACAP’s language repeats the description of the use of puberty blockers only as an exception: “For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues.”<sup>110</sup>

97.Ā The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: “In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,”<sup>111</sup> adding that “[c]linicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.”<sup>112</sup>

98.Ā The policy similarly includes a provision for resolving mental health issues: “Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*.”<sup>113</sup> The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).<sup>114</sup>

99.Ā Rather than endorse social transition for prepubertal children, the AACAP

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<sup>109</sup> Adelson & AACAP, 2012, at 969.

<sup>110</sup> Adelson & AACAP, 2012, at 969 (*italics added*).

<sup>111</sup> Adelson & AACAP, 2012, at 963.

<sup>112</sup> Adelson & AACAP, 2012, at 968.

<sup>113</sup> Adelson & AACAP, 2012, at 970 (*italics added*).

<sup>114</sup> Adelson & AACAP, 2012, at 969.

indicates: “There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so.”<sup>115</sup>

### **5. American College of Obstetricians & Gynecologists (ACOG)**

100. The American College of Obstetricians & Gynecologists (ACOG) published a “Committee Opinion” expressing recommendations in 2017. The statement indicates it was developed by the ACOG’s Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: “This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.”<sup>116</sup>

101. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally have a primary health care provider.<sup>117</sup>

102. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE), PES, and the Endocrine Society—and by WPATH.<sup>118</sup> It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: “*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental

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<sup>115</sup> Adelson & AACAP, 2012, at 969.

<sup>116</sup> ACOG, 2017, at 1.

<sup>117</sup> ACOG, 2017, at 1.

<sup>118</sup> ACOG, 2017, at 1, 3.

health professional, has no contraindications to therapy, and displays an understanding of the risks involved.”<sup>119</sup>

103. The “Eligibility and Readiness Criteria” also include, “Diagnosis established for gender dysphoria, transgender, transsexualism.”<sup>120</sup> This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for DSM diagnosis.

104. ACOG’s remaining recommendations pertain only to post-transition, medically oriented concerns. Pre-pubertal social transition is not mentioned in the document, and the outcomes studies of gender dysphoric (prepubescent) children are not cited.

#### **6. American College of Physicians (ACP)**

105. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining “family” by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender health care services in public and private health benefit plans.<sup>121</sup>

106. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting “reparative therapy;” however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that “[s]exual orientation and gender identity are inherently different.”<sup>122</sup> It based this statement on the fact that “the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*.”<sup>123</sup> The APA’s document, entitled “Report of the American Psychological Task Force on appropriate therapeutic responses to

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<sup>119</sup> ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (italics added).

<sup>120</sup> ACOG, 2017, at 3 Table 1.

<sup>121</sup> Daniel & Butkus, 2015a, 2015b.

<sup>122</sup> Daniel & Butkus, 2015b, at 2.

<sup>123</sup> Daniel & Butkus, 2015b, at 8 (italics added).

*sexual orientation*” does not include or reference research on gender identity.<sup>124</sup> Despite citing no research about transgenderism, the ACP nonetheless included in its statement: “Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons.”<sup>125</sup> That is, the inclusion of “T” with “LGB” is based on something other than the existing evidence.

107. There is another statement,<sup>126</sup> which was funded by ACP and published in the *Annals of Internal Medicine* under its “*In the Clinic*” feature, noting that “‘In the Clinic’ does not necessarily represent official ACP clinical policy.”<sup>127</sup> The document discusses medical transition procedures for adults rather than for children, except to note that “[n]o medical intervention is indicated for prepubescent youth,”<sup>128</sup> that a “mental health provider can assist the child and family with identifying an appropriate time for a social transition,”<sup>129</sup> and that the “child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is higher than in their cisgender peers.”<sup>130</sup>

### **7. American Academy of Pediatrics (AAP)**

108. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.<sup>131</sup> Moreover, of all

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<sup>124</sup> APA, 2009 (italics added).

<sup>125</sup> Daniel & Butkus, 2015b, at 8 (italics added).

<sup>126</sup> Safer & Tangpricha, 2019.

<sup>127</sup> Safer & Tangpricha, 2019, at ITC1.

<sup>128</sup> Safer & Tangpricha, 2019, at ITC9.

<sup>129</sup> Safer & Tangpricha, 2019, at ITC9.

<sup>130</sup> Safer & Tangpricha, 2019, at ITC9.

<sup>131</sup> Cantor, 2020.

the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.<sup>132</sup>

109. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. See Appendix 2. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, “Has the AAP responded to Dr Cantor? If not, have you any response now?” The AAP Media Relations Manager, Lisa Black, responded: “We do not have anyone available for comment.”

#### **8. The ESPE-LWPES GnRH Analogs Consensus Conference Group**

110. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).<sup>133</sup> Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

111. The effort concluded that “[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely.”<sup>134</sup> However, gender dysphoria was not explicitly mentioned as one of those other conditions.

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<sup>132</sup> Cantor, 2020, at 1.

<sup>133</sup> Carel et al., 2009.

<sup>134</sup> Carel et al. 2009, at 752.



## VI.Ā International Health Care Consensus

### 1. United Kingdom

112.Ā The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes<sup>135</sup>. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019<sup>136</sup>.

113.Ā The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review<sup>137</sup>. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the “cherry-picking” or selective citation favouring or down-playing any one conclusion<sup>138</sup>. The review’s results were unambiguous: “The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low”<sup>139</sup>, again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as “very low” the quality of evidence regarding “body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment”<sup>140</sup>. The report concluded that of the existing research, “The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding....They suggest little change with GnRH analogues [puberty

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<sup>135</sup> Marsh, 2020; Rayner, 2018.

<sup>136</sup> BBC, 2021; Donnelly, 2019.

<sup>137</sup> National Health Service, 2020, Sept. 22.

<sup>138</sup> National Institute for Health and Care Excellence, 2020.

<sup>139</sup> National Institute for Health and Care Excellence, 2020, p. 4.

<sup>140</sup> National Institute for Health and Care Excellence, 2020, p. 5.

blockers] from baseline to follow-up”<sup>141</sup>.

## 2. Finland

114. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment<sup>142</sup>. That study showed that despite the purpose of medical transition to improve mental health: “Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development”<sup>143</sup>. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

115. Consistent with the evidence, Finland’s health care service (Council for Choices in Health Care in Finland—COHERE) thus ended the surgical transition of minors, ruling in 2020 that “Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors” (COHERE, 2020). The review of the research concluded that “[N]o conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development.” COHERE also greatly restricted access to puberty-blocking and other hormonal treatments, indicating they “may be considered if the need for it continues *after* the other psychiatric symptoms have

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<sup>141</sup> National Institute for Health and Care Excellence, 2020, p. 13.

<sup>142</sup> Kaltiala et al., 2020.

<sup>143</sup> Kaltiala et al., 2020, p. 213.

ceased and adolescent development is progressing normally”<sup>144</sup>. The council was explicit in noting the lack of research needed for decision-making, “There is also a need for more information on the *disadvantages* of procedures and on people who regret them”<sup>145</sup>.

### 3. Sweden

116. Sweden’s national health care policy regarding trans issues has developed quite similarly to that of the UK. (Already in place 20 years ago, Swedish health care policy permitted otherwise eligible minors to receive puberty-blockers beginning at age 14 and cross-sex hormones at age 16.) At that time, only small numbers of minors sought medical transition services. An explosion of referrals ensued in 2013–2014. Sweden’s Board of Health and Welfare reported that, in 2018, the number of diagnoses of gender dysphoria was 15 times higher than 2008 among girls ages 13–17.

117. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research<sup>146</sup>. Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence<sup>147</sup>.

118. The SBU report came to the same conclusions as the UK commission. From 2022 forward, the Swedish National Board or Health and Welfare therefore

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<sup>144</sup> Council for Choices in Health Care in Finland, 2020; italics added.

<sup>145</sup> Council for Choices in Health Care in Finland, 2020; italics added.

<sup>146</sup> Orange, 2020, Feb 22.

<sup>147</sup> Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

“recommends restraint when it comes to hormone treatment...Based on the results that have emerged, the National Board of Health and Welfare’s overall conclusion is that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole”<sup>148</sup>. Neither puberty blockers nor cross-sex hormones would be provided under age 16, and patients ages 16–18 would receive such treatments only within research settings (clinical trials monitored by the appropriate Swedish research ethics board).

#### 4.ÅFrance

119.Å In 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments. “[A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause...such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause”<sup>149</sup>. For hormones, the Académie concluded “the greatest reserve is required in their use,” and for surgical treatments, “[T]heir irreversible nature must be emphasized.” The Académie did not outright ban medical interventions, but warned “the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to “detransition”. Rather than medical interventions, it advised health care providers “to extend as much as possible the psychological support phase.” The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, “underlining the addictive character of excessive consultation of social networks which is both

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<sup>148</sup> Swedish National Board of Health and Welfare, 2022.

<sup>149</sup> Académie Nationale de Médecine, 2022, Feb. 25.

harmful to the psychological development of young people and responsible, for a very important part, of the growing sense of gender incongruence.”

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**CERTIFICATE OF SERVICE**

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023

/s/ Mohammad O. Jazil