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jblock@bmj.com

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BMJ INVESTIGATION

Gender dysphoria in young people is rising—and so is professional disagreement

More children and adolescents are identifying as transgender and are being offered medical treatment, especially in the US—but some providers and European authorities are urging caution because of a lack of strong evidence. Jennifer Block reports

Jennifer Block *investigations reporter*

Last October the American Academy of Pediatrics (AAP) gathered inside the Anaheim Convention Center in California for its annual conference. Outside, several dozen people rallied to hear speakers including Abigail Martinez, a mother whose child began hormone treatment at age 16 and died by suicide at age 19. Supporters chanted the teen's given name, Yaeli; counter protesters chanted, "Protect trans youth!" For viewers on a livestream, the feed was interrupted as the two groups fought for the camera.

The AAP conference is one of many flashpoints in the contentious debate in the United States over if, when, and how children and adolescents with gender dysphoria should be medically or surgically treated. US medical professional groups are aligned in support of "gender affirming care" for gender dysphoria, which may include gonadotrophin releasing hormone analogues (GnRHa) to suppress puberty; oestrogen or testosterone to promote secondary sex characteristics; and surgical removal or augmentation of breasts, genitals, or other physical features. At the same time, however, several European countries have issued guidance to limit medical intervention in minors, prioritising psychological care.

The discourse is polarised in the US. Conservative politicians, pundits, and social media influencers accuse providers of pushing "gender ideology" and even "child abuse," lobbying for laws banning medical transition for minors. Progressives argue that denying access to care is a transphobic violation of human rights. There's little dispute within the medical community that children in distress need care, but concerns about the rapid widespread adoption of interventions and calls for rigorous scientific review are coming from across the ideological spectrum.[1]

The surge in treatment of minors

More adolescents with no history of gender dysphoria—predominantly birth registered females[2]—are presenting at gender clinics. A recent analysis of insurance claims by Komodo Health found that nearly 18 000 US minors began taking puberty blockers or hormones from 2017 to 2021, the number rising each year.[3 4] Surveys aiming to measure prevalence have found that about 2% of high school aged teens identify as "transgender."[5] These young people are also more likely than their cisgender peers to have concurrent mental health and neurodiverse conditions including depression, anxiety, attention deficit disorders, and autism.[6] In the US, although Medicaid coverage varies by state and by treatment, the Biden administration has warned states that not covering care is in violation of federal law prohibiting discrimination.[7] Meanwhile, the number of private clinics that focus on providing hormones and surgeries has grown from just a few a decade ago to more than 100 today.[4]

As the number of young people receiving medical transition treatments rises, so have the voices of those who call themselves "detransitioners" or "retransitioners," some of whom claim that early treatment caused preventable harm.[8] Large scale, long term research is lacking,[9] and researchers disagree about how to measure the phenomenon, but two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years.[10 11] The World Professional Association for Transgender Health (WPATH) asserts that detransition is "rare."[12]

Chloe Cole, now aged 18, had a double mastectomy at age 15 and spoke at the AAP rally. "Many of us were young teenagers when we decided, on the direction of medical experts, to pursue irreversible hormone treatments and surgeries," she read from her tablet at the rally, which had by this time moved indoors to avoid confrontation. "This is not informed consent but a decision forced under extreme duress."

Scott Hadland, chief of adolescent medicine at Massachusetts General Hospital and Harvard Medical School, dismissed the "handful of cruel protesters" outside the AAP meeting in a tweet that morning. He wrote, "Inside 10 000 pediatricians stand in solidarity for trans & gender diverse kids & their families to receive evidence-based, lifesaving, individualized care."[13]

Same evidence, divergent recommendations

Three organisations have had a major role in shaping the US's approach to gender dysphoria care: WPATH, the AAP, and the Endocrine Society (see box). On 15 September 2022 WPATH published the eighth edition of its Standards of Care for the Health of Transgender and Gender Diverse People, with new chapters on children and adolescents and no minimum age requirements for hormonal and surgical treatments.[2 12] GnRHa treatment, says WPATH, can

be initiated to arrest puberty at its earliest stage, known as Tanner stage 2.

The Endocrine Society also supports hormonal and surgical intervention in adolescents who meet criteria in clinical practice guidelines published in 2009 and updated in 2017.[14] And the AAP's 2018 policy statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, says that "various interventions may be considered to better align" a young person's "gender expression with their underlying identity."[15] Among the components of "gender affirmation" the AAP names social transition, puberty blockers, sex hormones, and surgeries. Other prominent professional organisations, such as the American Medical Association, have issued policy statements in opposition to legislation that would curtail access to medical treatment for minors.[16-19]

These documents are often cited to suggest that medical treatment is both uncontroversial and backed by rigorous science. "All of those medical societies find such care to be evidence-based and medically necessary," stated a recent article on transgender healthcare for children published in *Scientific American*.[20] "Transition related healthcare is not controversial in the medical field," wrote Gillian Branstetter, a frequent spokesperson on transgender issues currently with the American Civil Liberties Union, in a 2019 guide for reporters.[21] Two physicians and an attorney from Yale recently opined in the *Los Angeles Times* that "gender-affirming care is standard medical care, supported by major medical organizations . . . Years of study and scientific scrutiny have established safe, evidence-based guidelines for delivery of lifesaving, gender-affirming care."[22] Rachel Levine, the US assistant secretary for health, told National Public Radio last year regarding such treatment, "There is no argument among medical professionals."[23]

Internationally, however, governing bodies have come to different conclusions regarding the safety and efficacy of medically treating gender dysphoria. Sweden's National Board of Health and Welfare, which sets guidelines for care, determined last year that the risks of puberty blockers and treatment with hormones "currently outweigh the possible benefits" for minors.[24] Finland's Council for Choices in Health Care, a monitoring agency for the country's public health services, issued similar guidelines, calling for psychosocial support as the first line treatment.[25] (Both countries restrict surgery to adults.)

Medical societies in France, Australia, and New Zealand have also leant away from early medicalisation.[26,27] And NHS England, which is in the midst of an independent review of gender identity services, recently said that there was "scarce and inconclusive evidence to support clinical decision making"[28] for minors with gender dysphoria[29] and that for most who present before puberty it will be a "transient phase," requiring clinicians to focus on psychological support and to be "mindful" even of the risks of social transition.[30]

Box: The origins of paediatric gender medicine in the United States

The World Professional Association for Transgender Health (WPATH) began as a US based advocacy group and issued the first edition of the Standards of Care in 1979, when it was serving a small population of mostly adult male-to-female transsexuals. "WPATH became the standard because there was nobody else doing it," says Erica Anderson, a California based clinical psychologist and former WPATH board member. The professional US organisations that lined up in support "looked heavily to WPATH and the Endocrine Society for their guidance," she told *The BMJ*.

The Endocrine Society's guidance for adolescents grew out of clinicians' research in the Netherlands in the late 1990s and early 2000s. Peggy Cohen-Kettenis, a Utrecht gender clinic psychologist, collaborated with endocrinologists in Amsterdam, one of whom had experience of prescribing gonadotrophin releasing hormone analogues, relatively new at the time. Back then, gender dysphoric teens had to wait until the age of majority for sex hormones, but the team proposed that earlier intervention could benefit carefully selected minors.[40]

The clinic treated one natal female patient with triptorelin, published a case study and feasibility proposal, and began treating a small number of children at the turn of the millennium. The Dutch Protocol was published in 2006, referring to 54 children whose puberty was being suppressed and reporting preliminary results on the first 21.[41] The researchers received funding from Ferring Pharmaceuticals, the manufacturer of triptorelin.

In 2007 the endocrinologist Norman Spack began using the protocol at Boston Children's Hospital and joined Cohen-Kettenis and her Dutch colleagues in writing the Endocrine Society's first clinical practice guideline.[42] When that was published in 2009, puberty had been suppressed in just over 100 gender dysphoric young people.[40]

American Academy of Pediatrics (AAP) committee members began discussing the need for a statement in 2014, four years before publication, says Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and the statement's lead author. "The AAP recognised that it had a responsibility to provide some clinical guidance, but more importantly to come out with a statement that said we need research, we need to integrate the principles of gender affirmative care into medical education and into child health," he says. "What our policy statement is not meant to be is a protocol or guidelines in and of themselves."

"Don't call them evidence based"

"The brief history of guidelines is that, going back more than 30 years ago, experts would write articles and so on about what people should do. But formal guidelines as we think of them now were seldom or non-existent," says Gordon Guyatt, distinguished professor in the Department of Health Research Methods, Evidence, and Impact at McMaster University, Ontario.

That led to the movement towards developing criteria for what makes a "trustworthy guideline," of which Guyatt was a part.[31] One pillar of this, he told *The BMJ*, is that they "are based on systematic review of the relevant evidence," for which there are also now standards, as opposed to a traditional narrative literature review in which "a bunch of experts write whatever they felt like using no particular standards and no particular structure."

Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University, says, "An evidence based recommendation requires two steps." First, "an unbiased, thorough, critical systematic review of all the relevant evidence." Second, "some commitment to link the strength of the recommendations to the quality of the evidence."

The Endocrine Society commissioned two systematic reviews for its clinical practice guideline, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*: one on the effects of sex steroids on lipids and cardiovascular outcomes, the other on their effects on bone health.[32,33] To indicate the quality of evidence underpinning its various guidelines, the Endocrine Society employed the GRADE system (grading of recommendations assessment, development, and evaluation) and judged the quality of evidence for all recommendations on adolescents as "low" or "very low."

Guyatt, who co-developed GRADE, found "serious problems" with the Endocrine Society guidelines, noting that the systematic reviews

didn't look at the effect of the interventions on gender dysphoria itself, arguably "the most important outcome." He also noted that the Endocrine Society had at times paired strong recommendations—phrased as "we recommend"—with weak evidence. In the adolescent section, the weaker phrasing "we suggest" is used for pubertal hormone suppression when children "first exhibit physical changes of puberty"; however, the stronger phrasing is used to "recommend" GnRHa treatment.

"GRADE discourages strong recommendations with low or very low quality evidence except under very specific circumstances," Guyatt told *The BMJ*. Those exceptions are "very few and far between," and when used in guidance, their rationale should be made explicit, Guyatt said. In an emailed response, the Endocrine Society referenced the GRADE system's five exceptions, but did not specify which it was applying.

Helfand examined the recently updated WPATH Standards of Care and noted that it "incorporated elements of an evidence based guideline." For one, WPATH commissioned a team at Johns Hopkins University in Maryland to conduct systematic reviews.[34 35] However, WPATH's recommendations lack a grading system to indicate the quality of the evidence—one of several deficiencies. Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and what the results were. But Helfand remarked that neither was made clear in the WPATH guidelines and also noted several instances in which the strength of evidence presented to justify a recommendation was "at odds with what their own systematic reviewers found."

For example, one of the commissioned systematic reviews found that the strength of evidence for the conclusions that hormonal treatment "may improve" quality of life, depression, and anxiety among transgender people was "low," and it emphasised the need for more research, "especially among adolescents."[35] The reviewers also concluded that "it was impossible to draw conclusions about the effects of hormone therapy" on death by suicide.

Despite this, WPATH recommends that young people have access to treatments after comprehensive assessment, stating that the "emerging evidence base indicates a general improvement in the lives of transgender adolescents."[12] And more globally, WPATH asserts, "There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures," procedures that "are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria."[12]

Those two statements are each followed by more than 20 references, among them the commissioned systematic review. This stood out to Helfand as obscuring which conclusions were based on evidence versus opinion. He says, "It's a very strange thing to feel that they had to cite some of the studies that would have been in the systematic review or purposefully weren't included in the review, because that's what the review is for."

For minors, WPATH contends that the evidence is so limited that "a systematic review regarding outcomes of treatment in adolescents is not possible." But Guyatt counters that "systematic reviews are always possible," even if few or no studies meet the eligibility criteria. If an entity has made a recommendation without one, he says, "they'd be violating standards of trustworthy guidelines." Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and lead author of the AAP statement, remarks that the AAP's process "doesn't quite fit the definition of systematic review, but it is very comprehensive."

Sweden conducted systematic reviews in 2015 and 2022 and found the evidence on hormonal treatment in adolescents "insufficient and inconclusive."[24] Its new guidelines note the importance of factoring the possibility that young people will detransition, in which case "gender confirming treatment thus may lead to a deteriorating of health and quality of life (i.e., harm)."

Cochrane, an international organisation that has built its reputation on delivering independent evidence reviews, has yet to publish a systematic review of gender treatments in minors. But *The BMJ* has learnt that in 2020 Cochrane accepted a proposal to review puberty blockers and that it worked with a team of researchers through 2021 in developing a protocol, but it ultimately rejected it after peer review. A spokesperson for Cochrane told *The BMJ* that its editors have to consider whether a review "would add value to the existing evidence base," highlighting the work of the UK's National Institute for Health and Care Excellence, which looked at puberty blockers and hormones for adolescents in 2021. "That review found the evidence to be inconclusive, and there have been no significant primary studies published since."

In 2022 the state of Florida's Agency for Health Care Administration commissioned an overview of systematic reviews looking at outcomes "important to patients" with gender dysphoria, including mental health, quality of life, and complications. Two health research methodologists at McMaster University carried out the work, analysing 61 systematic reviews and concluding that "there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people." The body of evidence, they said, was "not sufficient" to support treatment decisions.

Calling a treatment recommendation "evidence based" should mean that a treatment has not just been systematically studied, says Helfand, but that there was also a finding of high quality evidence supporting its use. Weak evidence "doesn't just mean something esoteric about study design, it means there's uncertainty about whether the long term benefits outweigh the harms," Helfand adds.

"Evidence itself never tells you what to do," says Guyatt. That's why guidelines must make explicit the values and preferences that underlie the recommendation.

The Endocrine Society acknowledges in its recommendations on early puberty suppression that it is placing "a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm."[14]

WPATH acknowledges that while its latest guidelines are "based upon a more rigorous and methodological evidence-based approach than previous versions," the evidence "is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion." In the absence of high quality evidence and the presence of a patient population in need—who are willing to take on more personal risk—consensus based guidelines are not unwarranted, says Helfand. "But don't call them evidence based."

An evidence base under construction

In 2015 the US National Institutes of Health awarded a $5.7m (£4.7m; €5.3m) grant to study "the impact of early medical treatment in transgender youth."[36] The abstract submitted by applicants said that the study was "the first in the US to evaluate longitudinal

outcomes of medical treatment for transgender youth and will provide essential evidence-based data on the physiological and psychosocial effects and safety" of current treatments. Researchers are following two groups, one of participants who began receiving GnRHa in early puberty and another group who began cross sex hormone treatment in adolescence. The study doesn't include a concurrent no-treatment control group.

Robert Garofalo, chief of adolescent medicine at the Lurie Children's Hospital in Chicago and one of four principal investigators, told a podcast interviewer in May 2022 that the evidence base remained "a challenge . . . it is a discipline where the evidence base is now being assembled" and that "it's truly lagging behind [clinical practice], I think, in some ways." That care, he explained, was "being done safely. But only now, I think, are we really beginning to do the type of research where we're looking at short, medium, and long term outcomes of the care that we are providing in a way that I think hopefully will be either reassuring to institutions and families and patients or also will shed a light on things that we can be doing better."[37]

While Garofalo was doing the research he served as "contributor" on the AAP's widely cited 2018 policy statement, which recommends that children and adolescents "have access to comprehensive, gender-affirming, and developmentally appropriate health care," including puberty blockers, sex hormones, and, on a case-by-case basis, surgeries.[15]

Garofalo said in the May interview, "There is universal support for gender affirming care from every mainstream US based medical society that I can think of: the AMA, the APA, the AAP. I mean, these organisations never agree with one another." Garofalo declined an interview and did not respond to *The BMJ*'s requests for comment.

The rush to affirm

Sarah Palmer, a paediatrician in private practice in Indiana, is one of five coauthors of a 2022 resolution submitted to the AAP's leadership conference asking that it revisit the policy after "a rigorous systematic review of available evidence regarding the safety, efficacy, and risks of childhood social transition, puberty blockers, cross sex hormones and surgery." In practice, Palmer told *The BMJ*, clinicians define "gender affirming" care so broadly that "it's been taken by many people to mean go ahead and do anything that affirms. One of the main things I've seen it used for is masculinising chest surgery, also known as mastectomy in teenage patients." The AAP has told *The BMJ* that all policy statements are reviewed after five years and so a "revision is under way," based on its experts' own "robust evidence review."

Palmer says, "I've seen a quick evolution, from kids with a very rare case of gender dysphoria who were treated with a long course of counselling and exploration before hormones were started," to treatment progressing "very quickly—even at the first visit to gender clinic—and there's no psychologist involved anymore."

Laura Edwards-Leeper, a clinical psychologist who worked with the endocrinologist Norman Spack in Boston and coauthored the WPATH guidelines for adolescents, has observed a similar trend. "More providers do not value the mental health component," she says, so in some clinics families come in and their child is "pretty much fast tracked to medical intervention." In a study of teens at Seattle Children's Hospital's gender clinic, two thirds were taking hormones within 12 months of the initial visit.[38]

The British paediatrician Hilary Cass, in her interim report of a UK review into services for young people with gender identity issues, noted that some NHS staff reported feeling "under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters."

Eli Coleman, lead author of WPATH's Standards of Care and former director of the Institute for Sexual and Gender Health at the University of Minnesota, told *The BMJ* that the new guidelines emphasised "careful assessment prior to any of these interventions" by clinicians who have appropriate training and competence to assure that minors have "the emotional and cognitive maturity to understand the risks and benefits." He adds, "What we know and what we don't know has to be explained to youth and their parents or caregivers in a balanced way which really details that this is the evidence that we have, that we obviously would like to have more evidence, and that this is a risk-benefit scenario that you have to consider."

Joshua Safer, director of the Center for Transgender Medicine and Surgery at Mount Sinai Hospital in New York and coauthor of the Endocrine Society guidelines, told *The BMJ* that assessment is standard practice at the programme he leads. "We start with a mental health evaluation for anybody under the age of 18," he says. "There's a lot of talking going on—that's a substantial element of things." Safer has heard stories of adolescents leaving a first or second appointment with a prescription in hand but says that these are overblown. "We really do screen these kids pretty well, and the overwhelming majority of kids who get into these programmes do go on to other interventions," he says.

Without an objective diagnostic test, however, others remain concerned. The demand for services has led to a "perfunctory informed consent process," wrote two clinicians and a researcher in a recent issue of the *Journal of Sex and Marital Therapy*,[39] in spite of two key uncertainties: the long term impacts of treatment and whether a young person will persist in their gender identity. And the widespread impression of medical consensus doesn't help. "Unfortunately, gender specialists are frequently unfamiliar with, or discount the significance of, the research in support of these two concepts," they wrote. "As a result, the informed consent process rarely adequately discloses this information to patients and their families."

For Guyatt, claims of certainty represent both the success and failure of the evidence based medicine movement. "Everybody now has to claim to be evidence based" in order to be taken seriously, he says—that's the success. But people "don't particularly adhere to the standard of what is evidence based medicine—that's the failure." When there's been a rigorous systematic review of the evidence and the bottom line is that "we don't know,'" he says, then "anybody who then claims they do know is not being evidence based."

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EXHIBIT 120

The Hijacking of Pediatric Medicine

The American Academy of Pediatrics claims to support the health of all children. Many doctors are appalled by its prescriptions.

Aaron Sibarium
10 hr ago

(Bertrand Guay via Getty Images)

Editor's Note:

One of the main focuses of this newsletter's reporting is the way time-honored institutions of American life have been hijacked or corrupted.

We have documented the ideological takeover of American medicine and the law. We have exposed how many of our schools are indoctrinating children rather than educating them. And we have reported on legacy news organizations that put politics ahead of the public they purport to serve.

Today, we're teaming up with reporter Aaron Sibarium and our friends at the Free Beacon to take a hard look at the American Academy of Pediatrics. The AAP is the nation's leading organization of pediatricians. Millions of families follow its pronouncements on children's health without skepticism or second-guessing.

Should they?

Thousands of pediatricians convened in Anaheim, Calif., in early October for the American Academy of Pediatrics's (AAP) annual conference. The group, which boasts 67,000 members in the U.S. and around the world describes itself as "dedicated to the health of all children."

So some audience members were shocked when Dr. Morissa Ladinsky, an associate professor of pediatrics at the University of Alabama at Birmingham, lauded a transgender teenager for committing suicide.

In an address about "standing up for gender-affirming care," Ladinsky eulogized Leelah Alcorn, an Ohio 17-year-old who, in Ladinsky's words, "stepped boldly in front of a tractor trailer, ending her life," in 2014, after leaving a suicide note that "went viral, literally around the world."

Ladinsky's remarks were captured on video by a horrified onlooker, Oregon pediatrician Dr. Julia Mason, who expressed outrage on Twitter that Ladinsky was "glorifying suicide," an act she described as "unprofessional and dangerous."

That isn't just Mason's opinion. Technically speaking, it is also the official stance of the AAP, whose website for parents, healthychildren.org, explicitly warns that "glorifying suicide" can have a "'contagious' effect" and inspire others to take their own lives.

Reached for comment, Ladinsky expressed "regret" about her choice of words and said it was "never my intent" to glorify self-harm.

But how did this esteemed doctor wind up telling a group of physicians that a teen had, as she put it, "boldly ended her life"?

In any large organization, some members are bound to hold fringe views. But Ladinsky, who has devoted her career in part to facilitating the gender transition of teenagers, including by challenging state laws that restrict the kinds of treatment physicians can provide to them, is hardly an outlier at the AAP. And the AAP is an organization that matters a great deal.

Founded in 1930 as an offshoot of the American Medical Association, the AAP is first and foremost a standard-setting body. It outlines best practices for the nation's pediatricians, advises policy-makers on public health issues, and, for many parents, is the premier authority on raising healthy kids.

In recent years, it has also become a participant in America's culture wars. Judges have deferred to the group's expertise in high-stakes court cases about children with gender dysphoria, who the AAP says can start socially transitioning at "any" age. During the height of Covid, schools masked toddlers—including toddlers with speech delays—based on the guidance of the AAP. Sports leagues and after-school programs mandated the Covid vaccine after the AAP strongly recommended it, even as concerns mounted about its association with myocarditis, or inflammation of the heart muscle, in young males.

Though the organization's guidelines are framed as the consensus position of the AAP's members, only a handful of physicians had a role in shaping them. Instead, insiders say, the AAP is deferring to small, like-minded teams of specialists ensconced in children's hospitals, research centers, and public health bureaucracies, rather than seeking the insights of pediatricians who see a wide cross-section of America's children.

They also say a longstanding left-wing bias—over two thirds of pediatricians are registered Democrats—has accelerated, turning the organization into a more overtly political body that now pronounces on issues from climate change to immigration. As rates of gender dysphoria exploded and the Covid-19 pandemic hit, that bias seeped into the organization's medical policy recommendations, unchecked by discussion or debate.

This story is based on dozens of interviews with pediatricians, academics, and current and former AAP members, including several with leadership positions in the AAP. It shows how a small group of doctors with virtually unaccountable power can exert

tremendous influence over public policy, especially when a new crisis—be it moral or virological—gives them an emergency mandate. A mandate affecting the lives of millions of families.

'Political Science Over True Science'

In the last week of June 2020, with no end to the pandemic in sight, the AAP took a strong stance against school closures.

"The importance of in-person learning is well-documented, and there is already evidence of the negative impacts on children because of school closures in the spring of 2020," the group said in a statement, which listed a litany of maladies—learning loss, food insecurity, isolation, depression, physical and sexual abuse, substance use, suicidal ideation—that could result from prolonged shutdowns. "[A]ll policy considerations for the coming school year should start with a goal of having students physically present in school."

Then, on July 6, then President Trump tweeted: "SCHOOLS MUST OPEN IN THE FALL!!!"

Over the next week, administration officials from Vice President Mike Pence to Education Secretary Betsy DeVos cited the AAP in the course of pressuring local officials to reopen schools.

It didn't take long for the AAP to buckle. By July 10, the organization issued a follow-up statement—this one co-authored with the teachers unions—suggesting that in-person schooling would be impossible without "substantial new investments" from the federal government. Most European children, meanwhile, returned to the classroom.

It was a microcosm the AAP's handling of the pandemic: From masking toddlers to boosters for 12-year-olds, the group's guidelines were consistently out of sync with those of the rest of the world, but very much in line with the demands of anti-Trump partisans.

"The AAP cared much more about political science than true science," one pediatrician said.

When schools began to reopen, at first in red states, the group advised that every child, including toddlers, should remain masked for the duration of the day—despite the fact that the AAP had until then stressed the importance of facial cues for early childhood development—even as most other Western countries opted against masking young kids.

The organization didn't just recommend masks; it lobbied politicians to require them.

In an August 2021 email obtained by *Common Sense* and the *Washington Free Beacon,* the Colorado chapter of the AAP, acting on the policy recommendations adopted by the national organization, urged members to contact the state's governor expressing support for a mask mandate in Colorado public schools. Three months later, the Iowa chapter submitted an amicus brief challenging a state law that prohibited school mask mandates.

These moves prompted outrage from many rank-and-file pediatricians, several of whom contacted AAP leaders with concerns about the group's Covid recommendations, emails obtained by *Common Sense* and the *Free Beacon* show. Masks "really hinder speech and socialization for the child care/preschool set," one pediatrician, who requested anonymity, wrote to Lee Beers, the then-president of the AAP, in April 2021, noting that for these reasons the World Health Organization advises against masking children under six.

Beers forwarded the email to Heather Fitzpatrick, a member of the AAP's Covid-19 response team, who thanked the concerned pediatrician for sharing the perspective but did not follow up on the substance. Other doctors reported similar stonewalling.

As recently as August 2022, the AAP tweeted that "there is no evidence" that masks can harm childhood language development.

But prior to the pandemic, the AAP itself had argued that seeing faces is critical for early childhood development.

According to *Developmental and Behavioral Pediatrics*, a book published by the AAP in 2018, visually impaired children "are slower to acquire adjectives and verbs" than their sighted peers, and, at younger ages, are less likely to smile because "smiling is learned by seeing others smile"—findings that raise obvious concerns about masks in schools. In the August 2022 tweet, however, the AAP asserted that "visually impaired children develop speech and language at the same rate as their peers."

Another AAP publication, this one geared toward parents and available at least since 2013, emphasized the link between "face time" and "emotional health"—only for the document to disappear from the AAP's website during the pandemic. An AAP spokesperson attributed the disappearance to a "web content migration" and said it had "nothing to do with AAP's mask guidance," telling *Reuters* that the document would be republished on a new platform.

It never was: When *Common Sense* and the *Free Beacon* asked to be directed to the document's new home, a spokesperson for the AAP said it "was removed because it was outdated."

The AAP has also been exceptionally aggressive in its promotion of Covid-19 boosters for children, which have been linked to myocarditis, a potentially dangerous heart condition, especially in young men. The link is strong enough, and the risk of pediatric Covid low enough, that most European countries did not offer healthy adolescents a third shot, let alone a fourth, while a few stopped vaccinating healthy children against Covid entirely.

The AAP didn't stop at advocating a third dose of the original vaccine, however. In September, it recommended that every child 12 years and older additionally receive the updated, "bivalent" Covid booster— regardless of whether they also had natural immunity from contracting Covid, and despite the fact that healthy children rarely become seriously ill from the virus.

Parents hesitant about the new booster, which was only tested in eight mice, were told they shouldn't be. The AAP's booster recommendations do not include an exemption for children with a history of myocarditis, unless the condition was vaccine-related, because, as an article on healthychildren.org, an AAP publication for parents, puts it: "Compared to the potential risks of Covid-19 infection in kids, myocarditis appears to be quite rare."

What the group doesn't tell parents is that all of these recommendations were the product of approximately a dozen doctors on an ad hoc "COVID-19 response team," which operated in such an opaque manner that many AAP members were unaware of its existence.

"I have no idea who made these decisions," said Eliza Holland, a pediatrician at UVA Children's hospital. "I wasn't even aware a Covid committee exists," another pediatrician said.

There is no record of the Covid-19 response team anywhere on the AAP's website, and the organization declined to provide a list of its members. Even AAP officials who knew about the committee could only name a handful of people on it, based on sporadic interactions with the group.

One name that kept coming up was Yvonne Maldonado, the former chair of the AAP's committee on infectious disease and a professor of pediatrics at Stanford Medicine.

While not the head of the response team, Maldonado appears to have been in the driver's seat on many of its key decisions. She was quoted in AAP press releases about the pandemic and, from August 2021 to June 2022, served as the AAP's main representative on the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, which draws up vaccine recommendations for children.

Maldonado, who did not respond to request for comment, also ran clinical trials of Pfizer's mRNA vaccine at Stanford —a job for which she would have been paid, according to the company's guidelines on clinical trials.

The AAP said that Maldonado complied with all of its conflict of interest disclosure policies. But her work with Pfizer may help explain why the AAP and CDC—while notionally separate institutions—have issued nearly identical recommendations on the Covid vaccine, parlaying the views of a few academics into a government-wide consensus that has affected millions of children.

"Very few people are behind these sweeping policies," said Ram Duriseti, an associate professor of emergency medicine at Stanford Medicine. "Every public health department aligns with CDC policy—and on kids and Covid, the CDC is going to defer to the AAP."

Convened in the early days of the coronavirus as a kind of emergency stopgap, the AAP's Covid-19 response team had near dictatorial power over the organization's pandemic policy. Typically, the AAP will not take a position without first soliciting feedback from all sections of the group that might be impacted by it— say, infectious diseases, endocrinology, and cardiology —to ensure the guidance reflects a thorough cost-benefit analysis.

That did not happen on the high-stakes issues posed by the pandemic. Instead, three knowledgeable AAP members said, the Covid-19 response team issued recommendations without consulting other parts of the AAP, in the hope of staying ahead of the virus.

"The norms for developing communications and policies are normally very robust," a former AAP official said. "But the disaster framework subverted a lot of those norms."

Multiple AAP higher-ups, including an officer in the cardiology section, which normally reviews all policies related to heart functioning, said their teams were never consulted about the group's Covid recommendations, including the recommendations about the vaccine.

"At this point we knew about myocarditis," the cardiologist said, "but they didn't ask for our opinion."

In an email to the *Free Beacon* and *Common Sense,* the AAP claimed to have consulted cardiologists "on a variety of topics" throughout the pandemic, but declined to specify whether the vaccine was one of them.

For some doctors, the response team's composition was just as concerning as its lack of transparency. Several of its members, including Maldonado, work in children's hospitals, which by definition see kids who are sicker than average, including from Covid.

The result, some AAP members said, is that the bureaucrats crafting Covid policy had a skewed perception of the disease's pediatric risks, while rank-and-file pediatricians were seeing the 99.9 percent of kids who didn't require hospitalization—at least not for the virus.

"Our psych unit was full the entire pandemic," said Nicole Johnson, a doctor at University Hospitals Rainbow Babies & Children's in Cleveland. "Kids were waiting for beds to open in the psych unit while there were no kids in the Covid ward."

There was also a tendency, implicit in the response team's mandate, to focus more on the effects of Covid than the consequences of lockdowns. Lockdowns, while not formally endorsed by the AAP, were not vigorously opposed by it either.

"Primary care physicians see kids gain weight as we try to keep them safe from Covid," said Todd Porter, a pediatrician from Denver, Colorado who left the AAP over its Covid policies, adding that some of his patients put on more than 30 pounds during the pandemic. "But people in medical bureaucracies just see case counts."

Opposing those bureaucracies—and the Covid policies they formulated—became a professional risk. One pediatrician said her bosses threatened to fire her for tweeting critically about the AAP's vaccine recommendations. "They hauled me into the office and asked me if I wanted to work there," the doctor said, adding that she knew of colleagues who were terrified of speaking out. Another pediatrician described how the

president of her state AAP chapter told her to pipe down about Covid restrictions if she didn't want to lose funding for an academic program.

"Had I replied 'F you,' I wouldn't have gotten the grants, and I wouldn't have been able to help my program," the pediatrician said.

'The AAP says kids under 10 can't cross the street by themselves, but they can change their gender.'

The pandemic showed how a small group of like-minded doctors, acting with virtually no oversight, can push extreme policies through the AAP based on very little evidence. The group's guidance on gender dysphoria offers a similar lesson.

In 2016, the AAP established a committee on "LGBT Health & Wellness" to support "children with variations in gender presentation." Four of the committee's six members —Jason Rafferty, Brittany Allen, Michelle Forcier, and Ilana Sherer—work in pediatric gender clinics that prescribe puberty blockers to patients as young as 10 and cross-sex hormones to patients as young as 14.

Those treatments are part of the broader model of "gender-affirming" care that the AAP endorsed in its 2018 policy statement, "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents." The statement, which represents the official position of the AAP, was written by a single doctor, Rafferty, and does not appear to have been reviewed by anyone else at the organization: Rafferty "conceptualized," "drafted," "reviewed," "revised," and "approved" the manuscript himself, a note at the end of the paper reads. Rafferty did not respond to a request for comment.

"There was clearly no fact-checking," one longtime AAP member said. "The AAP thought trans was the next civil rights crusade and got boondoggled by enthusiastic young doctors."

The 2018 statement was an extraordinary departure from the international medical consensus. Most European countries do not encourage social or physical transition until a child's gender dysphoria has persisted for quite some time—an approach known as

"watchful waiting"—in part because the dysphoria desists on its own in the majority of cases, particularly once puberty hits.

Rafferty, however, called watchful waiting "outdated" and endorsed a "gender-affirming" paradigm, in which transitioning is on the table almost as soon as a child identifies as transgender. Some of the studies he cited to support that conclusion—including a practice guideline from the American Academy of Child and Adolescent Psychiatry—actually undercut it, arguing that, more often than not, "sex-reassignment" should be deferred until adulthood.

Though the policy statement conceded that puberty blockers may pose "long-term risks" to "bone metabolism and fertility," it did not recommend any prerequisites for obtaining drugs. They could be given out at the earliest stages of puberty—meaning to children as young as 9—and, Rafferty insisted, were "reversible."

Since then, the gap between the AAP and the rest of the world has only grown. Many European countries, including Britain, Finland, Sweden, and the Netherlands, are now curtailing or entirely eliminating the use of puberty blockers in children with gender dysphoria, citing both long-term health risks and a lack of evidence that they alleviate the condition. The AAP has nonetheless maintained its support for the drugs—which it claims have the backing of the "most prominent medical organizations worldwide"—while rejecting calls for more gatekeeping.

"The AAP says kids under 10 can't cross the street by themselves," one pediatrician said, referencing the group's official recommendations on pedestrian safety, "but they can change their gender. How does that make sense?"

The contrast points to a broader tension within AAP guidance: On most kitchen table issues, from diet to screen time to exercise, the group has long encouraged a kind of safetyism, stressing the need for parental supervision and the pitfalls of pubescent judgment. Yet on trans issues, it has done nearly the opposite, suggesting that minors are mature enough to transition without their parents' knowledge or consent.

"A family may deny access to care that raises concerns about the youth's welfare and safety," Rafferty's statement says. "In such rare situations, pediatric providers may want

to familiarize themselves with relevant local consent laws and maintain their primary responsibility for the welfare of the child." It's a stark departure from the way the group talks about other forms of body modification: one AAP report recommends that "adolescents speak with their parents" before getting tattoos, because they are "permanent," "difficult to remove," and "involve significant consequences."

By 2019, Rafferty's guidance was eliciting quiet concern among rank-and-file doctors affiliated with the AAP. "Normie pediatricians were like, 'what's going on,'" one doctor said, recalling the hushed conversations she had in the hallways of the AAP's 2019 national conference, which featured a panel on gender-affirming care. Gender specialists, on the other hand, "considered themselves life-saving heroes."

Rather than promoting dialogue or compromise between the two camps, the AAP sought to stifle dissent. In October, it urged the Department of Justice to investigate critics of "gender affirming" care, arguing they were spreading "disinformation" that puts lives at risk. That move came after the organization barred the Society for Evidence-based Gender Medicine, which advocates the watchful waiting approach, from being an exhibitor at its national conference last year. In August, it also blocked a resolution calling for a review of the AAP's current guidance on puberty blockers, which the head of Boston Children's Hospital's gender clinic, Jeremi Carswell, says are "given out like candy" at her clinic.

The stifling of dissent has created an illusory medical consensus that nonetheless exerts extraordinary influence over public policy and debate. Courts have cited the AAP in cases about transgender children—*Eknes-Tucker v. Marshall*, for example, in which an Alabama District Court blocked a law banning puberty blockers, cross sex hormones, and gender reassignment surgeries for transgender minors (the case is now on appeal). Talking heads, meanwhile, have invoked the AAP to shut down criticism of childhood gender transition.

In October, Jon Stewart berated Arkansas Attorney General Leslie Rutledge after her state passed a law similar to Alabama's, arguing that she was bucking the AAP's "peer-reviewed" guidelines. Banning puberty blockers would be as backwards as banning chemotherapy, Stewart said. He did not mention that the Swedish National Board of

Health and Welfare had, in February, recommended halting hormonal gender treatment for minors except in tightly limited circumstances.

The National Institutes of Health has funded one study on the long-term effects of puberty blockers, which is being conducted by four university-affiliated gender clinics—including the one at Boston Children's, the place that acknowledged prescribing blockers "like candy." The study, which began in 2015, has yet to report its findings, and the authors have not declared any conflicts of interests.

The Death of Expertise

At stake in all this, said Marty Makary, a surgeon and public policy researcher at Johns Hopkins Medicine, is not just lockdowns or puberty blockers but the credibility of the medical establishment itself.

"The AAP still puts out many important recommendations that parents should follow," Makary said, citing the group's support for the measles vaccine and its guidance on preventing sudden infant death syndrome. "If parents start to distrust the AAP because of its politicization, I worry we'll see more pediatric deaths."

There is some evidence, albeit anecdotal, to justify Makary's fears. In particular, several pediatricians said that the AAP's zealotry around the Covid vaccine had raised parental concerns about other, more well-established vaccinations. One reported seeing "a lot more hesitancy around routine immunizations," including for measles, after schools in her area started requiring the Covid vaccine based on the AAP's guidance. Another said she'd been inundated with requests for a second opinion by parents who "who don't trust their own physicians on vaccines," both Covid and non-Covid.

"I have to tell them the other vaccines are good," the pediatrician added.

Other doctors described families–including families in deep blue areas–who have developed a reflexive distrust of anything the AAP says.

"I now hear parents mock the AAP over even non-political guidance like breastfeeding recommendations," a pediatrician in Portland, Oregon said. "They're just tuning

everything out."

For Vinay Prasad, a professor of epidemiology and biostatistics at the University of California, San Francisco, it's hard to blame them.

"The reason to trust modern doctors over ancient healers is that more of what we tell you to do is justified by well-done studies," Prasad said. "But how do we hold that perch when we just make stuff up?"

Aaron's last piece for Common Sense was about the takeover of the American legal system. You can follow him on Twitter here.

A guest post by

Aaron Sibarium

Aaron Sibarium is a staff writer at the Washington Free Beacon.

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373 Comments

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SP 10 hr ago · *edited 9 hr ago*

The whole thing is so insane. Last month I took my 13 and 14 year-old children to their (now former) pediatrician. While there the nurse handed them a survey and a second survey hidden under that one. Thankfully, I went back to the exam room with my kids. Then nurse said, "if the second survey makes you uncomfortable, you don't have to fill it out." That piqued my interest so I took a look. The survey was all about how you identify...have so many options!! Then it went to ask about sexual orientation....so many options. I was pissed! I took both of the surveys and gave them back to the nurse. I told her that she needs to let parents know ahead of time about this survey. Then I took a picture right in front of her and told her

EXHIBIT 121

THE WALL STREET JOURNAL.

COMMENTARY

The American Academy of Pediatrics' Dubious Transgender Science

As other countries turn away from hormones and surgery, the AAP won't even allow a debate.

By Julia Mason and Leor Sapir

A spate of headlines this month declared that America's surge in transgender identification wasn't being caused by a social contagion. These articles were prompted by a new study by Jack Turban and colleagues in Pediatrics, flagship journal of the American Academy of Pediatrics. The study claimed that social influence isn't the reason that as many as 9% of America's youth now call themselves transgender. Thus, Dr. Turban argues, efforts in conservative states to regulate on-demand puberty blockers, cross-sex hormones and surgery must be resisted.

Yet Dr. Turban's study is deeply flawed and likely couldn't have survived a reasonable peer-review process. The swift response from the scientific community made both points

clear—with even those who support hormones and surgery for gender-dysphoric youth noting that Dr. Turban's shoddy science undermined their cause.

Nevertheless, the media have promoted his work as a refutation of the claim that the wildfire spread of transgender identity is an example of social contagion—a phenomenon in which members of a group (mostly young and female) mutually influence one another's emotions and behavior.

The Turban study rejects the social-contagion theory on the grounds that more biological boys than girls identified as trans in 2017 and 2019, according to data collected from 19 states by the Centers for Disease Control and Prevention's Youth Risk Behavior Survey. But the researchers who helped design the CDC questionnaire explicitly warned that youths who identify as transgender may list their sex as their gender identity, making it impossible to discern who is male-to-female or female-to-male (a limitation Dr. Turban has acknowledged in the past).

In this latest study, he cites three sources suggesting that respondents interpret "sex" as "sex assigned at birth"—even though none of those studies says anything of the sort. To use a flawed sex statistic in an attempt to set aside the well-documented phenomenon of gender-dysphoric female teens' flooding clinics is so amateurish that one can't help but suspect bad faith.

The AAP has been giving Dr. Turban a platform for years, despite the mistakes that plague his research. Pediatrics published his highly flawed 2020 study alleging that puberty blockers reduce suicide in teens. The journal even chose the article as its "Best of 2020" despite receiving rebuttals that pointed out the rate of attempted suicide rate was twice as high among the puberty-blocked group and Dr. Turban hadn't controlled for the possibility that better mental-health outcomes might be the result of factors other than hormonal intervention.

In his correspondence with physicians who asked how such a study could be named best of the year, Lewis First, editor in chief of Pediatrics, said that award is based on "website views and article downloads," not "editorial choices." In response to a rebuttal from one of us (Julia Mason), who warned that the AAP was encouraging the misleading idea that sex can literally be changed, a reviewer said that her statement shouldn't be published as it could be "offensive to the pediatric readership of the journal." Pediatrics seems to be basing its editing choices on political calculation and the sensibilities of trans-identified teens. One wonders how many pediatricians who rely on the journal for professional guidance are aware of these criteria.

The AAP has ignored the evidence that has led Sweden, Finland and most recently the

U.K. to place severe restrictions on medical transition for minors. The largest pediatric gender clinic in the world, the U.K.'s Gender Identity Development Service, was ordered to shut down in July after an independent review expressed concerns about clinicians rushing minors to medical transition. Medical societies in France, Belgium and Australia have also sounded the alarm. The U.S. is an outlier on pediatric gender medicine.

A major reason for this is the capture of institutions such as the AAP. Last year a resolution was submitted to the AAP's annual leadership forum to inform the academy's 67,000 members about the growing international skepticism of pediatric gender transition. It asked for a thoughtful update to the current practice of affirmation on demand.

Even though the resolution was in the top five of interest based on votes by members cast online, the AAP's leadership voted it down. In their newsletter, they decried the resolution as transphobic and noted that only 57 members out of 67,000 had endorsed it. The following year, however, when only 53 members backed a resolution that supported affirmative intervention, the AAP allowed the motion to go through, saying that the previous year's measure was "soundly defeated" while this year's received "broad support." When members submitted another resolution to conduct a review of the evidence, the AAP enforced for the first time a rule that shut down member comments, effectively burying it.

The AAP has stifled debate on how best to treat youth in distress over their bodies, shut down efforts by critics to present better scientific approaches at conferences, used technicalities to suppress resolutions to bring it into line with better-informed European countries, and put its thumb on the scale at Pediatrics in favor of a shoddy but politically correct research agenda. Its preference for fashionable political positions over evidence-based medicine is a disservice to member physicians, parents and children.

Dr. Mason is a pediatrician. Mr. Sapir is a fellow at the Manhattan Institute.

EXHIBIT 122

The New York Times https://www.nytimes.com/2023/08/03/health/aap-gender-affirming-care-evidence-review.html

Medical Group Backs Youth Gender Treatments, but Calls for Research Review

The American Academy of Pediatrics renewed its support of gender care for minors while commissioning a fresh look at the evidence.

By Azeen Ghorayshi

Aug. 3, 2023, 4:57 p.m. ET

The American Academy of Pediatrics backed gender-related treatments for children on Thursday, reaffirming its position from 2018 on a medical approach that has since been banned in 19 states.

But the influential group of doctors also took an extra step of commissioning a systematic review of medical research on the treatments, following similar efforts in Europe that found uncertain evidence for their effectiveness in adolescents.

Critics across the political spectrum — including a small but vocal group of pediatricians — have been calling for a closer look at the evidence in recent years, particularly as the number of adolescents who identify as transgender has rapidly increased.

The treatments are relatively new, and few studies have tracked their long-term effects. Health bodies in England and Sweden have limited access to the treatments after carrying out systematic reviews, the gold standard for evaluating medical research.

“The board has confidence that the existing evidence is such that the current policy is appropriate,” said Mark Del Monte, the chief executive of the A.A.P. “At the same time, the board recognized that additional detail would be helpful here.”

As for the policy changes in Europe, he said, “they engaged in their process, we’re engaging in our process.”

After completing the review, he said, the group will issue additional clinical guidance for doctors and likely update its recommendations.

All 16 board members of the A.A.P., which represents 67,000 pediatricians across the United States, voted to reaffirm the 2018 guidelines at a meeting on Thursday in Itasca, Ill. The vote comes at a time of intense political pressures on transgender people and the doctors who care for them.

Over the past two years, Republican lawmakers across the country have banned what’s known as gender-affirming care, which can include psychotherapy, puberty-blocking drugs, hormones and, rarely, surgeries. Opponents of the care argue that it is experimental and children lack the maturity to consent to it.

The A.A.P. has roundly condemned the legislative bans as a dangerous intrusion into complex medical decisions between doctors and families, and has filed amicus briefs to support the many legal challenges brought against the bans by civil rights groups.

Much of the academy’s support for gender-affirming care rests on its 2018 previous position statement, which said the treatments were essential and should be covered by health insurers. Transgender adolescents have high rates of anxiety, depression and suicide attempts, and early evidence suggested that gender-affirming care could improve their mental health.

Position statements like those voted on today remain valid for five years before they are up for review, at which point they may be reaffirmed, retired or revised in light of new evidence. One example of such a reversal is the academy’s 2017 endorsement of infant peanut consumption, based on a landmark study showing that early exposure could help prevent lethal allergies.

Some scientists criticized the decision to continue to recommend the treatments for young people before completing a rigorous review.

The move is “very clearly putting the cart before the horse,” said Dr. Gordon Guyatt, a clinical epidemiologist at McMaster University who helped develop the field of evidence-based medicine.

Based on previous systematic reviews, Dr. Guyatt said, the A.A.P.’s report will most likely find low-quality evidence for pediatric gender care. “The policies of the Europeans are much more aligned with the evidence than are the Americans’,” he said.

In June, England’s National Health Service announced that it would restrict the use of puberty blockers to clinical trials because “there is not enough evidence to support their safety or clinical effectiveness as a routinely available treatment.” Last year, Sweden’s national health care oversight body similarly determined that, on the basis of its systematic review, “the risks of puberty-inhibiting and gender-affirming hormone treatment for those under 18 currently outweigh the possible benefits.”

In the United States, a small group of pediatricians has pushed for a similar review from the A.A.P., one of the few institutions with enough centralized power to influence health care practices. Dr. Julia Mason, a pediatrician in Gresham, Ore., co-founded a group called the Society for Evidence-Based Gender Medicine that has been highly critical of gender treatments for minors. Since 2020, she said, she has unsuccessfully lobbied the academy’s leadership to commission a systematic review.

Dr. Mason said she was pleased the group finally decided to take a close look at the data. “We are making strong recommendations based on weak evidence,” she said.

But Dr. Marci Bowers, a gynecologic and reconstructive surgeon and the president of the World Professional Association for Transgender Health, was heartened by the A.A.P.’s endorsement of the care, which she said profoundly improves many children’s lives.

“They know this population,” said Dr. Bowers, who is a transgender woman. “They know the stories. Anecdotally, it’s overwhelmingly positive.”

She also pointed out that doctors in many specialties, and particularly in pediatrics, routinely use medicines that haven’t yet been tested in large and rigorous clinical trials. And Europe, unlike many U.S. states, has not banned the care entirely.

“What they’re saying is this population needs to be studied,” she said, referring to European policies. “And I agree with that.”

Azeen Ghorayshi covers the intersection of sex, gender and science for The Times. More about Azeen Ghorayshi

EXHIBIT 123

CULTURE WARS | FEB. 7, 2016

How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired

By Jesse Singal

Dr. Kenneth Zucker, a psychologist, is pictured at the Center for Addiction and Mental Health in Toronto in 2006. Zucker encourages children to be content with their gender. (Jim Ross/The New York Times) Photo: Jim Ross/The New York Times/Redux

On paper, Dr. Kenneth Zucker isn't the sort of person who gets suddenly and unceremoniously fired. For decades, the 65-year-old psychologist had led the Child Youth and Family Gender Identity Clinic (GIC), in Toronto, one of the most well-known clinics in the world for children and adolescents with gender dysphoria — that is, the feeling that the body they were born with doesn't fit their true gender identity. Zucker had built up quite a CV during his time leading the clinic: In addition to being one of the most frequently cited names in the research literature on gender dysphoria and gender-identity development, and the editor of the prestigious journal *Archives of Sexual Behavior*, he took a leading role helping devise diagnostic and treatment guidelines for gender dysphoric and transgender individuals. He headed the group which developed the DSM-5's criteria for its "gender dysphoria" entry, for example, and also helped write the most recent "standards of care" guidelines for the World Professional Association for Transgender Health — one of the bibles for clinicians who treat transgender and gender-dysphoric patients.

An impressive career, yes, but it's doubtful any of this gave him much comfort on December 15. That was when he was called in from vacation for an 8:30 a.m. meeting with his employer, the Centre for Addiction and Mental Health (CAMH), one of the largest mental health and addiction research hospitals in Canada. Given the long-brewing investigation of his clinic by the hospital, it's unlikely Zucker was feeling optimistic about what awaited him in downtown Toronto.

The GIC, which operates out of CAMH, pronounced "Cam-H," had been standing firm against a changing tide in the world of psychological treatment for children with gender dysphoria. The "gender-affirmative" approach, which focuses on identifying young transgender children and helping them socially transition — that is, express their gender to others through their everyday clothes, name changes, or other means — has been on the rise in recent years, and has become the favored protocol of many activists and clinicians. GIC clinicians, who saw clients between ages 3 and 18, had a much more cautious stance on social transitioning for their younger clients — they believed that in many cases, it was preferable to first "help children feel comfortable in their own bodies," as they often put it, since in the GIC's view gender is quite malleable at a young age and gender dysphoria will likely resolve itself with time.

Many activists see this approach as a rejection of young children's transgender identities, and Zucker as its regressive standard-bearer. As a result, the GIC had been tarred for years as a "conversion" or "reparative" therapy clinic — terms which conjure images of outfits operated out of backwoods shacks in the Bible Belt. Responding to what felt like a surge in this line of criticism from activists, CAMH had agreed in February of 2015 to commission an External Review that would evaluate the clinic's operations, and possibly, Zucker and his staffers knew, determine its future. CAMH had already taken actions suggesting that that future might be dim: In June of 2014, the hospital closed the GIC's approximately 80-family waitlist (for being too long, administrators said), and about two months before Zucker's vacation was interrupted, the clinic's only other full-time staffer, the psychologist Dr. Hayley Wood, was laid off on her first day back from maternity leave. (Wood declined to comment for this article.)

And now, the meeting: According to a source close to Zucker, he was met at CAMH by Christina Bartha, executive director of the hospital's Underserved Populations Program. She gave the psychologist a three-ring binder: the long-awaited External Review. Bartha instructed Zucker to read it in her presence, and to offer up any comments he had about it. Not far into the report, Zucker told Bartha that he had noticed a factual error. Bartha responded that the review would be posted on the hospital's website that afternoon, as-is — no changes. Zucker continued reading and saw that the reviewers had interviewed a handful of activists and clinicians who had claimed that the GIC was

engaging in conversion therapy; that photos were taken of patients without their consent and then disseminated; and that former clients said they felt traumatized and ashamed as a result of their time there. Then, Zucker got to a truly bizarre allegation: A former patient, at the time an adolescent transitioning from female to male who was seeking a sex-reassignment surgery referral, said that Zucker had asked him to take his shirt off, laughed when he had done so, and then told him, "You're a hairy little vermin!" The incident had never happened. Zucker looked at Bartha and, in disbelief, said something like, "So, you are going to post this on the website?" Yes, Bartha responded. Meaning that in a few hours, Zucker's many detractors would read about how he had cruelly mocked the body of a young trans person.

Zucker told Bartha there was no point in continuing the exercise. Sometime around 9:00 or 9:15, Bartha left, and she was replaced by a human resources staffer who informed Zucker that he was fired, effective immediately. He was told it wouldn't be a good idea for him to retrieve his coat and keys from his office — someone would grab them for him. Zucker was presented with materials on how to find a new job, and that was that. (Zucker's attorney, John Adair, confirmed this account of his dismissal, while a CAMH spokeswoman and Bartha didn't respond to a request for comment. Through Adair, Zucker otherwise declined to comment for this article.)

For transgender activists in North America and around the world, the ouster of one of their biggest enemies in the field of mainstream sex research was a spectacular victory. Sweeter still, they found out later that day that CAMH would be "winding down" the GIC entirely, with an eye toward eventually retooling and reopening it with input from its critics. Years of activism, years of hearing and telling stories about what Zucker's clinic did to vulnerable, gender-questioning young people, had finally paid off. The activists had won what seemed like a satisfying end to a simple, sad story. "Infamous Reparative Therapy Clinic For Transgender Youth Set To Close" trumpeted ThinkProgress. "Hooray! A Big, Bad Conversion Therapy Clinic For Trans Youth In Canada Is Shutting Down," went the MTV headline. Good prevailed over evil, in other words. Those innocent children would never suffer again.

Zucker, his colleagues, and their many allies in the world of academic sex research see things differently. To them, the real scandal here is how CAMH responded to a sustained campaign of political pressure: by allowing a vital scientific question — vital not only to gender-dysphoric and transgender young people, but to anyone who is a parent or will one day become one — to be decided by activists on the basis of flimsy, anonymous allegations. They think the activists' claims about the clinic are unfounded, and argue that the controversy has more to do with adult agendas than with genuine concern for gender-dysphoric children and youth. As Dr. Jack Drescher, a psychiatrist with a research focus on gender-identity issues, explained in an email, this fight resembles many other culture-war battles: "[C]hildren serve as proxies for the competing value systems of adults." Indeed, some parents of GIC patients feel that as a result of the clinic's closing, their children have been cut off from a place that was — despite rumors to the contrary — a safe, nurturing environment for young people to explore their emerging gender identities.

The External Review, Zucker's allies believe, was just a sloppily executed pretense for submitting to political pressure. "There was likely a desire on the part of the [CAMH] administration to close the clinic, and the review was designed to allow them to do just that," wrote Dr. Susan Bradley, who founded the GIC in 1975 before handing the reins over to Zucker about a decade later, in an email.

And if you look closely at what really happened — if you read the review (which CAMH has now pulled off of its website), speak with the activists who effectively wrote large swaths of it, examine the scientific evidence, and talk to former GIC clinicians and the parents of patients they worked with, it's hard not to come to an uncomfortable, politically incorrect conclusion: Zucker's defenders are right. This was a show trial.

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In 2016, there's fairly solid agreement about the proper course of treatment for otherwise healthy, stable young people who have persistent gender dysphoria, and who are either approaching puberty or older than that: You help them transition to their true gender. The process is different from person to person, but for an 11-year-old, it might include a round of puberty-blocking hormones to prevent the development of secondary sex characteristics and buy time to figure out the best course of transition, followed by the administration of male or female hormones, and, later on, possibly sex-reassignment surgery or surgeries.

With kids who are still years away from the onset of puberty, though, there's a charged controversy about what's best. That's because here, two seemingly conflicting truths collide: Trans people deserve to have their identities recognized and respected; and research suggests that most gender-dysphoric kids will, in the long run, end up identifying as cisgender. In other words, a sizable percentage of them aren't transgender in the same, usually permanent way trans adults are.

Clinicians who work with gender-dysphoric kids operate on unsteady ground, then. Do you accept the idea that many young kids really *are* trans, or assume that their dysphoria is likely to dissipate as they grow older? At the moment, the prevailing trend is toward the former, which is known as a "gender-affirmative" approach (the GIC's approach doesn't really have its own name). The basic idea is that it's important to identify trans kids at a young age and provide them with a relatively seamless path toward a social transition. "When it comes to treating kids who have reached puberty and beyond, there aren't that many differences in the way we practice," said Dr. Diane Ehrensaft, director of Mental Health and founding member of the Child and Adolescent Gender Center in San Francisco, and a leading practitioner of the gender-affirmative approach. "But when you back up to children who haven't reached puberty, we part ways completely."

There's *some* agreement. Everyone thinks, for example, that kids can get confused about the difference between gender identity and gender expression. A boy might wrongly decide that since he doesn't like football and girls also don't like football, he must be a girl. Dr. Johanna Olson-Kennedy, who works at Children's Hospital Los Angeles and is another leading gender-affirmative clinician, said that sometimes interviews with new gender-questioning clients reveal, pretty quickly, that they aren't trans. "And it's clear, it's clear," she said. "I think that once you see hundreds and hundreds of kids you get a feeling for kids that are and kids that aren't."

So to Olson-Kennedy and other like-minded clinicians, some kids *are* expressing a deep-seated identity that needs to be affirmed. How do you make this vital distinction? The gender-affirmers have a key phrase: if a child is "insistent, persistent, and consistent" in signalling over an extended period that they were assigned the wrong gender at birth, that's a strong indication they're transgender. And to Ehrensaft, the *way* children express this can also offer valuable clues: There's a meaningful distinction between a natal (biologically male) boy saying "I *am* a girl" as opposed to "I *wish* I were a girl." Kids who are actually trans, in Ehrensaft's view, are also "not happy with the bodies they have and are distressed that God got it wrong or their parents got it wrong." "That's just a profile," she said. "It's not set in stone. But it's a profile, the indicators that this child is transgender, not just uncomfortable with the gender mores of the culture."

GIC clinicians, on the other hand, believe that statements about gender identity have important diagnostic value in understanding a child, but *aren't* solid evidence of a stable underlying gender identity — though it depends a bit on age. All else being equal, the younger a kid is, the less solidified their gender identity is and the less face-value information their statements about it convey.

In a 2012 *Journal of Homosexuality* article, Zucker and his colleagues described their approach as "A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder," referring to the DSM-IV's name for the condition now known as gender dysphoria. You might notice that that this mouthful of a description tilts pretty heavily toward the nurture side of the nature-nurture equation. That's because the authors believe that messages from family, peers, and society do a huge amount of the work of helping form, reinforce, and solidify gender identities, and that at young ages these identities tend to be quite malleable. There's great potential for confusion. A young boy might notice his new baby sister getting more attention than he is, and start dressing like a girl in a bid to be noticed. His parents, not knowing what to do, might go along with this, inadvertently reinforcing the notion that he's a girl — a notion which, according to the GIC model, probably doesn't come from a deep-seated kernel of gender identity, but rather mostly from social reinforcement and family dynamics.

GIC clinicians, then, put much less faith in the linguistic clues that Ehrensaft and others view as meaningful, and much more in the power of external influences to spark or contribute to childhood gender dysphoria — even gender dysphoria that is, well, insistent, persistent, and consistent. "Sometimes it will take years for gender dysphoria to resolve and for kids to be able to look back and say it doesn't fit anymore," one former GIC clinician, who didn't want to be named, told me. "My sample size is not huge, but I've had many kids who have been quite insistent and have felt as though it" — meaning a transgender identity — "didn't fit within several years."

Since from the standpoint of GIC clinicians it was not always straightforward to ascertain the factors contributing to gender dysphoria, the assessment process there was rather comprehensive — usually three visits entailing in-depth psychological evaluations of patient and parents alike. Parents were sometimes encouraged to tweak family tendencies and habits that could be contributing to their child's distress, which ruffled some feathers. (The idea that a child with gender dysphoria even *needs* a full psychological examination is now seen as inappropriate by some.)

In defending their approach, Zucker and his colleagues point frequently to the small but consistent body of research suggesting that something like three-quarters of children with gender dysphoria will "desist" — they'll eventually come to feel comfortable with their natal gender (and will also, relative to the general population, have an increased likelihood of eventually identifying as gay or bisexual). Some trans activists have howled at this claim — they believe that desistance is a transphobic myth entirely. But while these activists (and some researchers)* have tried to poke holes in the consistent findings about gender-dysphoria desistance, they just haven't come up with scientifically convincing explanations for why the studies would all be wrong, and all in the same way. (Some skeptics argue that these studies lump in many kids who aren't *that* gender dysphoric and who therefore weren't going to become trans anyway, but that's just not true, especially when it comes to the more recent samples.)

Because of all of this, the GIC operated from a fundamentally different stance than its gender-affirmative counterparts. All else being equal, clinicians there viewed it as preferable for a child to become comfortable with his or her natal gender rather than for them to socially transition, since once a social transition is underway, it becomes self-reinforcing — children naturally respond to the messages they get from parents and peers and society. If the child was probably going to desist anyway, why nudge them prematurely toward accepting a cross-gender identity? "There are clinics in Britain, Germany, France and in the US who follow a similar approach," Bradley, the GIC's founder, said in an email. "We may have been one of the oldest and largest." That said, the GIC did frequently help patients, particularly older ones, transition to and live as their felt gender, providing a wide range of services that included hormone referrals. (In discussing this controversy, I'm oversimplifying a bit, leaving out a middle-ground approach known as "watchful waiting." The basic idea is to take a more passive role, to attempt to simply observe a child's developing preferences and behavior in a supportive manner rather than intervene. The GIC clinicians I spoke with questioned this idea on a basic conceptual level, because to them it implies a false neutrality. If your child insists on

dressing up as a girl every day, and you "watchfully wait" by allowing them to continue to do so, they believe you're effectively reinforcing the behavior. "What does that even mean?" asked Dr. Allison Owen-Anderson, a psychologist at the Toronto District School Board who spent 10 years at the GIC as a student and full-time staff psychologist, of this approach. "How do they operationalize 'watchful waiting'? People need to answer questions" about how to respond to their children, she said.)

GIC clinicians were wary of too-early transitions in part because they might necessitate later *de*-transition back to a child's natal gender. This marks another point of significant disagreement with many gender-affirmers. Ehrensaft and Olson-Kennedy both reject the idea that there's much downside to this. "Everybody seems very anxious" about de-transitioning, said Ehrensaft, but there's no irreversible medical intervention that early on, anyway — it's just nail polish, clothes, and stuff like that. "We don't have any data to indicate that that would necessarily be problematic," she said. "What we do have data to indicate is, what makes it difficult if kids change their mind is the social reaction to that."

That's a distinction GIC clinicians don't recognize. "I totally disagree with that," said the anonymous former clinician of the idea that de-transitioning isn't a big deal. When kids socially transition, she explained, their parents not only become their champions to teachers and other parents, but also often start engaging in trans advocacy that comes to define them in important ways. If the child starts to sense that their dysphoria is desisting, they're faced with either sticking with a gender identity that no longer feels like it fits or telling their parents, as the clinician put it, "This whole life that you've created for yourself as an advocate, I don't want to be part of that anymore." There's also, of course, the fact that schools and family members are part of the process too, so de-transitioning requires notifying *them* as well. In this view, a too-early transition really might limit a child's future options because of the social or familial costs of transitioning back. And eventually, as a kid gets older, the prospect of nontrivial medical procedures to help them physically transition enters the picture.

So how did the GIC attempt to help kids feel more comfortable with their bodies? Owen-Anderson explained that the expression/identity dichotomy was key. If a boy "didn't like rough and tumble [play] … and really enjoyed playing with sort of stereotypically feminine toys, and there seemed to be a real rigidity around that — so that means *I need to be girl* — then that wasn't conceptualized as healthy," she said. "It's a black-and-white, concrete viewpoint." In cases like these, the therapist would help the child better understand the shades of gray: What you *do* doesn't necessarily dictate who you *are*. For younger clients, play therapy was the backbone of these efforts. "It wasn't clinician-directed, what the kid should be thinking or doing," said Owen-Anderson. "It was question-asking around how to explore those aspects, but also allowing the child to lead, to see where they led you in terms of exploring their internal world through play."

Honest critics of the GIC wouldn't disagree with any of these practices, which formed a sizable chunk of the clinic's activities. What they did disagree with, and rather vehemently, was the fact that Zucker and his colleagues would sometimes work with parents to try to nudge kids to play with a wider range of toys, find like-minded peers of the same gender rather than only hang out with children of the other gender, or spend less time wearing certain types of clothes. To Owen-Anderson and other former GIC clinicians, such "limit-setting" goes back to the question of rigidity and self-reinforcing behavior. If a little kid decides that since he is gentle and enjoys playing with dolls, he must be a girl, and then his parents allow him to only dress like a girl and exclusively play with other girls, that identity is going to reinforce itself. Limits helped prevent this rigidity from setting in, went the thinking. (It's important to note that in many cases, particularly ones where children had already socially transitioned by the time they arrived at the clinic, Zucker and his colleagues didn't utilize this approach at all.) GIC clinicians told me that one common limit-setting approach would be to work with parents to help a gender-dysphoric boy find other gentle, less aggressive boys to hang

out with, rather than spend all his time with girls. And a GIC parent told me that when she explained to GIC clinicians that her little boy was obsessed with a Barbie book and insisted it be read to him at every bedtime, they suggested a new routine of reading him that book, and then reading him another book after.

Countless critics have argued that what went on at the GIC was far more draconian than this — one activist, for example, claimed that according to GIC protocol, "parents must shame or punish feminine boys who play with dolls, make art using pink or purple colors, draw pictures of girls, or seek out girls as playmates." But if you look around, there's little solid evidence of this. One of the only accounts I found that came anywhere close to describing such a strict approach was a 2008 NPR story in which the reporter, Alix Spiegel, explained that Carol, the mom of a young natal male GIC patient obsessed with "girl" toys, was given firm instructions by Zucker:

> [T]o treat Bradley, Zucker explained to Carol that she and her husband would have to radically change their parenting. Bradley would no longer be allowed to spend time with girls. He would no longer be allowed to play with girlish toys or pretend that he was a female character. Zucker said that all of these activities were dangerous to a kid with gender-identity disorder. He explained that unless Carol and her husband helped the child to change his behavior, as Bradley grew older, he likely would be rejected by both peer groups. Boys would find his feminine interests unappealing. Girls would want more boyish boys. Bradley would be an outcast.
> Carol resolved to do her best. Still, these were huge changes. By the time Bradley started therapy he was almost 6 years old, and Carol had a house full of Barbie dolls and Polly Pockets. She now had to remove them. To cushion the blow, she didn't take the toys away all at once; she told Bradley that he could choose one or two toys a day.

Bradley responded to this all, Spiegel reported, in a heartbreaking way: by hoarding his dwindling supply of girl-toys everywhere he could, and drawing photos of the "toys and interests he no longer had access to." It sounds bad, but Carol herself now doesn't think this story accurately captures her GIC experience, which she speaks of glowingly (more on this later). "I don't know where we would be without Dr. Zucker," she told Science of Us.

To the clinic's most ardent detractors, it doesn't necessarily matter whether or not the limits were absolute, anyway. Many of them believe that even moderate limit-setting with regard to gendered activities, dress, or peers could traumatize children by interfering with their expression of their gender identity. Naturally, former GIC clinicians dispute the idea that they were harming their clients. "A child not wanting something nice to end is not the same as being traumatized by it," wrote Dr. Devita Singh, a clinical psychologist whose dissertation (PDF) was based on her time at the GIC and tracked the long-term outcomes of former patients there, in an email. "A parent would not simply extend the amount of time a child spends watching TV simply because the child is upset, especially if the parent is making that decision in the best developmental interest of the child."

Critics of the clinic find such comparisons offensive. Failing to affirm a child's gender identity, they argue, is a vastly different — and more serious — act than telling them they can't watch TV or wear a dinosaur costume to school. GIC clinicians view this as a conceptual error: The critics are conflating sexual *orientation* — which can't be changed, which is part of the reason we view attempts to mess with it it as unethical — and gender *identity*, which they say isn't some hardwired thing, but is instead formed from a variety of factors. "You're not born with a certain gender identity," said Owen-Anderson, "so it's not as though it's an expression of some innate factor." Ehrensaft and Olson-Kennedy disagree: Both think that even very young kids have a *real* gender identity inside them, though the two clinicians differ on the specifics. (There isn't any solid scientific evidence to support this view, though that doesn't preclude future discoveries, of course.)

So Zucker and his colleagues can't even agree with their critics on basic terms and definitions — on what a "reparative therapy" accusation even *means* in the context of childhood gender identity. Had CAMH decided to investigate all this in an open-minded, careful, scientifically informed way, and had the hospital done so transparently, it would have benefited everyone.

That wasn't what happened.

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It isn't entirely clear why activists' efforts to shut down the GIC and oust Zucker came to a head last year, but it was likely a confluence of factors. In January of 2015, a group from Rainbow Health Ontario, an influential local LGBT organization, brought their concerns over the GIC's practices to CAMH. On January 14, 2015, *NOW* magazine published an article by Jake Pyne, a trans activist and scholar who helped lead the charge against the GIC — he would later be interviewed by the co-authors of the External Review, and was also present at the meeting with Rainbow Health — that connected the GIC's practices to the high-profile, then-recent suicide of Leelah Alcorn, a 17-year-old trans woman who had been exposed to religiously oriented reparative therapy. There was also at least one online petition calling for Zucker to be fired (there had been others in the past), as well as further anti-GIC activism surrounding Bell Canada's annual Bell Let's Talk mental health awareness-raising event in late January. And in the summer, Ontario passed Bill 77, legislation that made it illegal to "provide any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age." Although language exempting "services that provide… facilitation of a person's coping, social support or identity exploration or development" was inserted into Bill 77 and likely would have shielded the GIC from possible legal jeopardy, coverage of the legislation's debate and passage still helped spread allegations about the clinic.

Singh and Zucker at the 2011 International Academy of Sex Research conference in Los Angeles.

Whatever the causes, the climate was getting heated, and that might partially account for the gap between the February 5 announcement of the review and its commencement in June. Bradley, the GIC founder, said that at one point Dr. Peter Szatmari, a CAMH administrator and a consultant to the External Review, told her CAMH couldn't find people willing to serve on it, which Bradley took to mean that "it was too politically charged."

Eventually, CAMH tapped the psychiatrists Dr. Suzanne Zinck from Halifax and Dr. Antonio Pignatiello, who is Toronto-based. Those in the Zucker camp maintain that neither was sufficiently qualified to conduct a comprehensive review of the GIC. In a letter written by ten leading sex and gender researchers and eventually signed publicly by hundreds more and then sent to the CAMH Board of Trustees, the authors note that Zinck and Pignatiello have "no track record of empirical studies or other serious scholarship in childhood gender issues." Though it's an admittedly crude metric, Google Scholar appears to support this critique: A search for "'Kenneth Zucker' gender dysphoria" returns about 364 hits; similar searches for Zinck and Pignatiello return one and zero, respectively.

Whether or not the External Review's authors had the requisite expertise to do their jobs well, the review itself wasn't in-depth. According to the document, Zinck and Pignatiello spent about eight hours interviewing people — time spread among Zucker and his staffers and trainees, their colleagues elsewhere at CAMH, former patients and parents, and activists. There's no sign they observed any actual therapy sessions, and in a brief phone interview, Pignatiello confirmed to me that neither he nor Zinck contacted any of the eight GIC-sympathetic experts Zucker suggested to them.

The consensus among those who know Zucker is that while he's a gifted clinician and researcher, he isn't great at playing politics. He is, well, an old-school white male research scientist: "He responds to every question with a methodical three-part answer," noted Hanna Rosin in a 2008 article in *The Atlantic*, "often ending by climbing a chair to pull down a research paper he's written." Over the summer of 2015, more than one friend and colleague tried to explain to Zucker that he needed to defend himself more assertively (though he was in part stymied from doing so by a restrictive CAMH media policy). But while Zucker may lack certain self-preservation instincts, or may have wrongly believed his perch atop the sex-research hierarchy afforded him protection from activist pressure, a close reading of the External Review suggests none of this really mattered at that point. The review is a markedly unprofessional document that takes many of the worst claims about the GIC at face value — without bothering to check them.

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The most spectacular allegation found its way into the review via Pyne, who had remembered hearing it from "Adam," a trans man in his mid-30s. Pyne asked Adam if he'd be willing to talk to the reviewers, and Adam emailed his story about being called a "hairy little vermin" to Zinck in July. Pyne put me in touch with Adam, and we spoke about what he had gone through. He said the incident took place in the late 1990s, when he was about 17 or 18, toward the end of the process of determining whether he'd get a referral for sex-reassignment surgery (he wrote to Zinck that the incident had taken place about a decade ago, but he told me he was more confident that it had happened in the late 1990s). His account was peppered with specifics: that he had met with a staff psychologist, that he'd had to provide proof of "real-life experience" — documentation that he'd already been living as a male for some time — and that he'd dealt with a frustratingly rude receptionist at the clinic. He remembered the full names of the psychologist and the receptionist.

Adam told me that when he walked into a room to find out about his referral, Zucker and others were there — "Doctors, researchers, who knows?" he said. Zucker quickly asked him to take off his shirt, and Adam, confused by the request but understanding that the clinician making it held great power over his future, complied, at which point Zucker laughed and called him a "hairy little vermin."

As Science of Us reported two weeks ago, various details of Adam's account indicated that he couldn't have actually been victimized by Zucker. For one thing, the staffers he mentioned never worked in Zucker's clinic. For another, the scenario itself never would have happened, since Zucker's clinic never made surgery referrals (it did refer patients to the Adult Gender Identity Clinic at CAMH, which could later on refer them for surgery). Nor would a patient at Zucker's youth clinic have been asked to provide proof of (adult) real-life experience.

Eventually, Adam and I were able to determine that it had likely been a different clinician elsewhere who had made the offensive remark, though at first Adam was unsure and maintained that maybe it had been Zucker after all. The *eureka* moment came during an improvised photo lineup. At one point I sent Adam a recent photo of "Smith," the clinician who was the more likely culprit, without telling him who it was, renaming the file to avoid any giveaways. I asked Adam to open the attachment and tell me his reaction.

It was instantaneous. "Oh my gosh!" he said. "That second photo right there? Oh my God. Oh my God. Sorry. Yeah. Holy shit. Holy shit. Hold on, hold on. Why is that — oh my God. I, I, I feel — who is this, this one in the second photo? I feel like this is the guy." I told him it was Smith. "That's [Smith]? Okay, then it must have been [Smith]. Yeah, it was this man." Given Adam's inaccurate accusation of Zucker, I'm leaving certain details vague here to protect the identity of that other clinician (with whom I was unable to get in touch). But Adam is now sure that it wasn't

Zucker who made the offensive remark to him, and said he was planning on sending CAMH a note letting them know he had erred, though he didn't respond to a follow-up email asking him if he had.

All it took to debunk Adam's inflammatory claim was to listen to his story; almost immediately, details popped out that would have raised red flags for anyone familiar with the GIC. Some of those details, such as the name of the staff psychologist who didn't work with Zucker and the surgery-referral context, were in the very email Adam sent Zinck — he forwarded me her thank-you note and his email was beneath it. But the reviewers, Adam said, "did not go into it, they did not ask me questions, they did not contact me further" other than sending the thank-you note. (The surgery-referral reference also should have jumped out at anyone who read the External Review and was familiar with Zucker's clinic.)

----- Forwarded Message -----
From: "Zinck, Suzanne" [redacted]
To: [redacted]
Sent: Thursday, July 30, 2015 9:55 AM
Subject: Re: my experience at the gender clinic

Dear Mr. [redacted]

Thank you for the written submission describing your experiences at the Child & Youth Gender Identity Clinic at what is now CAMH. I have shared your submission with the other reviewer. This information will be in summary in the report and your confidentiality will be maintained.

Sincerely,

Suzanne Zinck, MD, FRCPC

On Jul 21, 2015, at 12:17 PM, [redacted] wrote:

> Hello Suzanne,
>
> I Hope this day finds you well!
>
> I am writing about my experience at the gender clinic. Approximately 10 years ago I went to the gender clinic at CAMH. I met and had appointments with a few people including [redacted] and Dr. Zucker and someone else. At my final appointment where I was in I think Dr. Zuckers office where I was about to find out if I got the approval,I went in and 3 people were there. I recall Dr. Zucker asking me a few questions then him asking me to take my shirt off and when I did he laughed and said "you're a hairy little vermin!" Then he asked me if I wanted to know if I got the approval and then like as if it was a game he said it in a "playful" yet completely unprofessional manner " "goooing once gooooing twice aaaaand you got it!" I was anxious and just wanted to get out of there even though I was happy with my approval even though at that time they were not paying for it but putting people on a list in case it was re enlisted(also which Dr. Zucker said he didn't think it would ever get re enlisted /paid for by the Ontario government ever again). I felt weird and bothered about the indecent. Looking back now I now realize how inappropriate, hurtful, and unprofessional this was. I just wanted to take the time to share this with you. Thank you in advance for reading this. If you have any questions feel free to contact me.
>
> Thank you,
>
> [redacted]

The letter from Adam to Zinck.

This all may prove legally problematic for CAMH administrators or for the review's authors. "Under Canadian law it may not be a sufficient defence to say that a defamatory statement was simply an 'allegation'," Peter A. Downard, a

senior counsel at the Toronto office of the Fasken Martineau law firm and a defamation expert, said in an email. If a court determines the claim "caused actual harm … the defence will have to have a different and better answer." In that case, the defendants would have to prove that "reasonable steps to verify the accuracy of the defamatory statement [were taken], and that the defendant was fair to the person defamed, for example, by giving them an opportunity to comment." According to Downard, "[i]f a court is not satisfied on those points, everyone who participated in the publication may have liability exposure."

This possible libel is the most serious single problem with the External Review, but it's just one of many. It simply does not read, at any point, like a serious attempt to evaluate the Gender Identity Clinic, and it is riddled with sloppiness. From very early on, there are simple errors — CAMH's legal counsel is described as "Kristen Sharpe" four times in the document, when her actual name is Kristin Taylor, and the reviewers note that the clinic has been around for "approximately 30 years" when it was actually founded more than 40 years ago, in 1975. More importantly, Zinck and Pignatiello quote Zucker as stating that "70% of the children we see are sub-threshold for [gender dysphoria]." Whether Zucker misspoke or the authors mistranscribed, this is exactly backwards — 70 percent of the children at the GIC *did* meet the clinical criteria for the condition (a statistic mentioned in the 2008 article and confirmed to me by former GIC clinicians). If the reviewers believed that just 30 percent of them met the criteria — they didn't respond to an email about this — that would imply they fundamentally misunderstood what the clinic did and why it was treating most of its patients at all.

There's also a striking dearth of patient or parent voices. The GIC assessed more than 1,350 kids and adolescents in its decades of existence, a former clinician told me — tossing in a conservative estimate of parents, that's a pool of at least 2,600 patients and parents the reviewers could have drawn from to get firsthand accounts. Yet Zinck and Pignatiello appear to have spoken in person with just nine or ten GIC patients or parents, total — the in-person section of the External Review isn't written clearly enough for the number to be certain, but it's probably nine. They also corresponded with two more (only one an actual patient, we now know), for a total of 11. The seven parents Zinck and Pignatiello interviewed, as well as one teen former client, "only had positive feedback to give," though no specifics are provided in the report. Other than Adam's, there were only two complaints: A patient claimed Zucker said they were "too smart to be trans" — Zucker's lawyer declined to comment — and a parent said she felt dismissed by Zucker and that he didn't connect her to other resources.

Despite the near-absence of *verifiable* complaints, the document is larded with serious second-hand accusations delivered via Zinck and Pignatiello's interview subjects — the sorts of charges which aren't normally tossed about casually given that they can lead to potentially serious professional censure, or even legal action. In the review, anonymous clinicians who say they've worked with former GIC patients claim that many of those former patients "report traumatic experiences related to their assessment and have persistent, internalized shame about their gender identity and desires to express it that are related to their treatment"; that GIC clinicians performed cognitive and psychological testing without obtaining proper consent; and that they took photos of patients without consent, and, in one case, displayed photos of a client's painted nails at a transgender health conference. There's no evidence any of these claims were fact-checked — neither CAMH nor Zinck and Pignatiello responded to my emails asking about this, and according to two attendees at a recent internal CAMH meeting, an administrator there told staffers that the hospital did not think it would have been appropriate to fact-check any of the report's claims given that it was conducted independently. And because CAMH insisted that many participants in the review be rendered anonymous, the claims feel watered-down: Zinck and Pignatiello are reporting that an anonymous clinician reported that an anonymous former patient reported that… (According to Pignatiello, the final version of the document they sent in was published on the website untouched by CAMH. There had been one or more prior rounds of edits starting around

late August, but he said those mostly involved CAMH's requests that many names be redacted, and that the hospital didn't try to intervene editorially beyond that).

Some of the accusations in the review may not even *be* accusations in the light of full context. The authors highlight that a patient-chart review "revealed a 9 year old patient being asked about what made him sexually excited during his… initial assessment," implying that this was inappropriate since the patient was in foster care and had experienced trauma. But oftentimes, foster homes and group homes would refer to the clinic young children who were exhibiting sexualized behavior. "We would never vaguely ask a child that age about their 'sexual fantasies,'" explained Owen-Anderson in an email, but there might be clinical reasons to ask a child why he or she had become aroused in a specific situation. The reviewers also criticize the GIC for using one-way mirrors — a standard practice in teaching hospitals that other CAMH clinics and offices continue to engage in.

In addition, Zinck and Pignatiello write that "the clinic's standardized assessment includes play therapy to assess and treat any anxiety and/or depression symptoms," and later criticize the GIC's use of play therapy as a means of treating anxiety. But several former GIC clinicians claimed that here the reviewers are flubbing two details about how the clinic operated. "I think assessment and therapy are being conflated by the reviewers," wrote Singh in an email. She said that play therapy "was not used as part of the assessment process," meaning the initial, in-depth assessment which often led to a slate of regular therapy sessions. And according to Owen-Anderson, while play therapy "was used as a way to explore a child's inner world" during regular sessions, it was simply "never used to treat anxiety." GIC clinicians did, of course, often employ other methods to help patients deal with anxiety (including by prescribing medication, in some cases).

Zinck and Pignatiello lay their cards on the table toward the end of the External Review: "The GIC's therapeutic focus on 'understanding why' someone is the way they are, is described by former patients, current therapists of former clients and parents as 'disturbing' and 'harmful'. One participant described that being told by a clinician that there is a need for ongoing treatment or assessment to 'understand why you are the way you are' is problematic in and of itself." This is in the section summarizing *their* concerns based on their interviews and research: Two professional psychiatrists are concerned that it's harmful or improper to help patients in a mental-health clinic understand why they are the way they are.

Finally, on the accusation that has clung to the GIC for years, Zinck and Pignatiello write that "We cannot state that the clinic does not practice reparative approaches (if not outright therapies) with respect to influencing gender identity development." They don't bother to explain how reparative therapy would even be defined in this context, which seems crucial given the bedrock debate over gender-identity development. The charge is left unresolved — but in a way which still *suggests* malfeasance — and not treated with an iota of the gravity it deserves.

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When CAMH found out that the most serious allegation in its External Review was false in late January, it responded by yanking the review offline but replacing it with a "Summary" of the document in which some of the potentially defamatory claims are excised. In one instance, the summary appears to retroactively alter one of the External Review's conclusions to make it more credible-sounding. The initial document noted that "The clinic was developed over 30 years ago, when play therapy was a dominant assessment and treatment modality in child and adolescent mental health clinics in North America and parts of Europe. The research knowledge and clinical guidelines have evolved and society's understanding and acceptance of the diversity of gender expression and identity have changed, but GIC's approach has not." In the Summary, that rather serious allegation of ossification is softened significantly:

"Research knowledge and clinical guidelines have evolved, particularly in the last five years." Nowhere in the original document is there any mention of a five-year period. And more importantly, nowhere in the Summary is it noted that the document being summarized was pulled offline for leveling a false accusation.

Even before Science of Us debunked the "hairy little vermin" claim, CAMH was attempting to de-emphasize the review's importance. Last month, I asked Kwame McKenzie, the hospital's Medical Director of Underserved Populations and the administrator who has been the public face of the decision to shut down the GIC, to explain a very confusing chart in the document that seems to accuse the GIC of potentially engaging in "reparative-type" activities, but in such a vague way that it's hard to understand what's going on. He said he wasn't sure what the chart meant, but suggested it was time to move on from the External Review. "You're trying to understand the chart in detail, and we're all moving on and trying to do something else," he said, telling me he'd check to see if the reviewers themselves had time to decrypt the chart for me (I never heard back). He said the review was "just one piece of advice. We have lots of other pieces of advice and experience that we use to make a decision."

One person who did seem to think the External Review was quite important was, well, McKenzie himself a couple months ago. The CAMH press release published December 15 started with the sentence "CAMH is announcing plans to change the gender identity services it provides to children and youth, following an independent clinical review of its Child Youth and Family (CYF) Gender Identity Clinic released today," and included an apology from McKenzie to the community. "As a clinician and also as a parent, hearing those sorts of comments and reading those sorts of testimonies is quite disturbing," McKenzie told Daily Xtra, a Canadian LGBT-focused newspaper, that day. The next day, he went on a Canadian Broadcasting Corporation show to discuss the situation, and in response to host Matt Galloway's first question — why he had apologized — McKenzie immediately jumped to the review's findings, and then referenced them repeatedly during the interview. "It always takes an external review to do things properly," he said at one point.

It's clear, then, that at the time of the shutdown, the External Review ensured that CAMH's decision would be framed in media coverage as having stemmed from an "independent" or "external" investigation — which it consistently was. The weight of that decision was shifted, at least partially, onto the shoulders of Zinck and Pignatiello.

So given the External Review's crucial role in the chain of events that led to the GIC's closure, it's worth asking exactly how it came to be so filled with what is basically gossip. One answer is that advocates virulently opposed to Zucker effectively wrote large chunks of it. Not literally, of course, but since Zinck and Pignatiello simply copied those advocates' claims into the document without — apparently — checking or pushing back on any of them, the outcome was more or less the same.

One of the activists interviewed was Pyne, who two weeks ago was served with paperwork from Zucker and his attorney indicating that they might sue him and the Toronto *Star* for defamation over a column he wrote for the paper, likely his claim that the GIC's approach "is now linked to a range of dismal outcomes, including a staggering rate of suicidal behaviour." (This is false.)

Two others contributors who, like Pyne, were rendered anonymous by CAMH, are LeeAndra Miller and Hershel Russell. Both are clinicians who ascribe to the GIC what feel like almost supernatural powers to harm anyone who comes too close to it. For instance, Pyne told me in an email that Miller "once said that in her local support group for trans youth, she can tell which ones have been to the CAMH clinic before they tell her. They are the ones with lasting shame problems, she says. The younger they went, the deeper the shame, she has said."

When I asked Miller to describe the problems she has encountered in the 70–80 former GIC patients she said she has worked with over the years (she has been practicing since 2000), she spoke for seven minutes straight, listing an array of jaw-dropping charges: In addition to the photo stuff, children were taught to be ashamed of themselves; the GIC drove a wedge between parents and children; and the GIC made its former patients too ashamed of their identities to seek out trans support services.

But there's some data which complicates the theory that the GIC was engaged in psychological brutality. For her dissertation research, Devita Singh cold-called 113 former patients or parents for whom she could track down their current contact information. Seventy percent agreed to come into the clinic to answer some follow-up questions, talk about their experiences, and so on, and another significant chunk provided at least "some follow-up data on [the patient's] gender identity and sexual orientation" via phone, as she writes. Singh argued in an email that "[s]uch willingness to return to the clinic and to contribute to the research does not fit with the criticisms being made of the GIC."

I asked Miller how she squared those numbers with the horror stories. One of her hypotheses concerned the fact that children at the GIC often didn't see Zucker himself during their regular sessions, but instead a staff psychologist or trainee. *Those* clinicians "are typically warm and caring," Miller explained. A lot of her former clients spoke highly of their GIC therapists, in fact. "But then there would also be these one-line — not one-line, but these moments where something *would* get said to them directly, right, that would sit in the sea of all the support and feeling cared about. And so this is what made a lot of the clients internalize those very negative messages." In this somewhat confusing view, the GIC offered its clients a "sea of… support" punctuated occasionally with traumatizing one-off comments.

Her other theory was that sometimes GIC patients themselves didn't even *know* they'd been traumatized by the clinic, at least not at first. People made to feel ashamed at a young age, she explained, "don't necessarily have the analysis that the reason they feel shame is because of different messages that have been given to them that they're not even that aware of that they've received until they unpacked it years later. How easy is it for people who are coming from that shame to actually voice complaints?" So the realization that the GIC had harmed a given patient can, for some of those patients, only be accessed after they "unpack" their feelings. In the case of Miller's patients, presumably she would help them do this unpacking — help them realize that they were traumatized at the GIC despite the fact that they themselves were unaware said traumatization had taken place.

The door to Zucker's office at the Gender Identity Clinic.

Russell offered a similar theory. He said he'd only worked with a few former GIC clients, but agreed with Miller's assessment that the clinic had produced a yearslong torrent of dysfunction among those clients — though in many cases they couldn't remember what had happened to them there since they were so young at the time. Russell said that one example of how the GIC's practices produced adults who, in his view, later developed deep senses of shame, had trouble engaging in sexual relationships, and grappled with various other problems had to do with the clinic's use of one-way mirrors: "Stories like, 'They had toys there that I knew were boys' toys, so I knew that was what I was supposed to play with, so I did, and then I saw a wig and I really wanted to check it out and I did just a minute but then I put it back but then I thought *Oh God, they're watching me — they're watching me*,'" he said. "Those kinds of stories." I wanted to make sure I had this right: Russell was saying that the act of offering a child a wide variety of toys to play with in a clinical setting is shame-inducing because the child can discern, on a deep level, that they are being judged for their toy choices on a gendered basis?

Yes, he confirmed — that was what he meant.

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Maybe Singh's data leave something out. And the fact that some of the activists who helped write the External Review view Dr. Zucker as Dr. Evil's more evil cousin doesn't mean that they're necessarily wrong about the GIC having harmed its patients, of course. But overall, it just wasn't easy to find direct evidence that the GIC was doing what its critics claimed. As I reported this story, I repeatedly emphasized to Pyne, Russell, Miller, and Adam — all of whom are tapped into Ontario's LGBT activist and social networks in various ways — that it was important for me to get as many *first-hand* accounts of problems at the GIC as possible. These accounts failed to materialize. Other than Adam, Pyne connected me with one adult former patient and one parent of a former patient who said they had had bad experiences. The patient, who went to the GIC when he was 18, was upset by what he saw as a very in-depth assessment process and insensitive questions about his sexual history. These are common, valid complaints among

trans people who feel forced to interact with "gatekeeping" medical bureaucracies in order to gain access to services some of them view as life-saving, but they don't necessarily mean the GIC had engaged in wrongdoing — there are often clinically sound reasons for asking patients personal questions (in all settings, not just when it comes to transgender care). The parent, meanwhile, told me that Zucker's clinic had tried to force her transgender daughter to act more like a boy, but then sent me an assessment Zucker had written in which he said *exactly the opposite*: Since the child had already socially transitioned, limit-setting didn't make sense as an approach.

Parents who supported Zucker, on the other hand, seemed quite eager to reach out. I spoke with five mothers of GIC patients or former patients who went into CAMH to defend Zucker (out of the seven parents who did, total), and they told me all about their experiences with him and his clinic. None was happy about the closing, and none could point to any examples of Zucker or the other clinicians acting unprofessionally or disrespectfully. Their children, all but one in their teens or younger, are in very different places, reflecting the wide range of clients who were seen at the GIC, but all of them, their parents insisted, had been helped by the GIC and what they said was a nurturing, exploration-focused environment. Pyne had told me that parental transphobia might partially explain the popularity of the clinic, as well as its lengthy waitlist, but among these parents it didn't seem to be a factor: One mom (whose kid went to the GIC decades ago, and only briefly) had some old-fashioned views about transsexuality, but none of the other parents exhibited a whiff of discernible transphobia. One currently *has* a trans kid, and another has a 7-year-old without a set gender identity who may well end up identifying as trans in the years ahead.

The parents felt like they were offered only a perfunctory opportunity to defend Zucker — the report states they were given ten minutes each — and those whose children were still active GIC patients said they felt like they'd been suddenly cut off from a vital source of support for their kids. (Some of the moms wanted me to only use their first names or a nickname, while others wanted me to use fake names — fake names, which I also used for all the children, are in quotes.)

One mom, Merry, said CAMH had simply disappeared from sight rather than keep patients and their families in the loop. "I have not heard a word from them," she told me last month, and her daughter had missed a number of her weekly appointments. She complained that "no one has contacted us … So all this bullshit talk about transparency — there was no follow-through. I have not heard anything." Sam, another parent, agreed. "I'm pissed off," she said. Her son will likely be starting puberty-blockers in about a year, and the closure of the clinic could greatly complicate things. McKenzie assured me of the current patients that "nobody's left in a lurch — we would never do that," but when I ran that comment by Merry she called it "laughable." (Merry said that on January 27, CAMH finally initiated contact about figuring out options for her and her child — six weeks after suddenly cutting off their access to the GIC.)

"Amanda" said that while she was upset about CAMH's treatment of Zucker, she was more concerned for his younger colleagues, particularly Hayley Wood, the psychologist she said had changed her son's life by helping him learn how to express himself. "It's bad enough for Dr. Zucker, but maybe he was thinking of winding down his practice in a few years," she said. "But what about Hayley, who's just essentially starting out, and now her name is linked inextricably in the world of the Internet with this stuff, and with what turns out to be a completely untrue allegation? What about her? It just boggles the mind."

Then there's Carol, the mom from the NPR story, who exuded appreciation for Zucker. She said that the story she was featured in ignored the "outlying reasons why [Bradley] was also in therapy." Specifically, she said, Bradley had become extremely obsessional in his playing with dolls and dress-up clothes, making it increasingly difficult for him to socialize with anyone — even his two younger brothers. Zucker's approach for fixing the situation was to start at home: If Bradley could be weaned off the toys he was obsessed with and taught to enjoy some of the same gender-

neutral ones his brothers liked — Legos or toy animals — that could help reconnect him with his siblings, and, in turn, make it easier for him to develop friendships outside the home. Carol emphasized to me that none of the limitations were permanent —"the [girl] toys were all replaced with some more gender-neutral toys, and then we reintroduced all the toys," albeit slowly. She insisted that there "was never an attempt to skew him in the other direction and give him male-oriented toys. Never. It was more introduce him to neutral toys so he could socialize better with all kinds of kids, because he had become really uncomfortable with mixed peer groups."

In Carol's eyes, Zucker's approach worked. By age 8, Bradley's dysphoria had resolved itself — though it's impossible to say, of course, whether this was due to his time at the GIC — and over the years his social skills improved measurably. These days, he's a well-adjusted gay 13-year-old boy who is very involved with music (he and his mom talk about One Direction a lot). Carol said she also wanted to push back against the notion that Zucker imposed his views on parents. He "was very knowledgeable," she said, "but he also still allowed us to parent, and he wasn't saying 'You must … do this or do that.'" (I corresponded with NPR's Spiegel about all of this, and I think the most likely explanation for the divide between her story and Carol's current understanding of her GIC experience is that at the time Spiegel spoke with Carol, Carol was dealing with the most stressful part of her son's therapeutic process, so certain nuances may not have been fully communicated.)

Overall, Carol said she appreciated how "protective" of her son Zucker was — it was important to the clinician that "the kids not be used as poster children for whatever cause was happening in the schools at the time, and I thought he was right — [Bradley's] still so young," she said. "He's still figuring things out — to be one way or another is sort of his personal journey. He doesn't need to be paraded around."

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In Devita Singh's dissertation, she points out that "If it were possible to know with certainty whether a child with [gender dysphoria] will persist or desist, then the clinical approach [could] be modified to best match the child's needs." Were these categories easy to discern, it might make sense, for example, to shift future persisters onto the social-transition track relatively quickly, while helping the future desisters explore their gender identity, GIC-style, with an eye toward loosening their rigid concepts of gender.

At the moment, though, the research on all this is quite thin. "Insistent, persistent, and consistent" sounds like a reasonable way to tell kids who are "actually" trans from future desisters, but Singh notes in her dissertation that there's an extreme dearth of the sorts of careful long-term studies required to understand why some children desist and others don't. While there's some early, emerging evidence that severity of childhood gender dysphoria can predict persistence, some of it from Singh's dissertation, she also found in her research that plenty of GIC clients who exhibited rather severe gender dysphoria later went on to desist. So in the view of her and other GIC clinicians, there's nowhere near enough data for anyone to be making big decisions based solely or primarily on how insistent a 5-year-old is that they were born the wrong gender — especially given that these clinicians can also point to specific examples from their own professional experience of kids who appeared to be quite gender dysphoric at a specific point in time, but later grew up to be cisgender.

But the politics are racing ahead of the science anyway. It has simply been decided, in some quarters, that firm childhood statements of gender dysphoria are signals of real, meaningful identity, and need to be respected as such. In a sense, this is understandable: For decades trans adults have faced the potent, dehumanizing obstacle of denialism, of people telling them they aren't *really* who they say they are, that they're actually mentally ill or perverted or whatever

else. The problem is that there's solid scientific evidence — not infallible, but solid — to suggest that kids really *are* a different category.

As I was trying to reconcile the seemingly irreconcilable — one side telling me that the GIC was a nightmare factory that had traumatized multiple generations of Ontario's trans youth; the other side, including parents with firsthand experience, insisting that the GIC was a warm, nurturing environment in which children could explore the sometimes-tricky concept of gender identity under the guidance of empathetic clinicians — two of those parents' stories kept jumping out at me.

One was Amanda's. In the wake of her GIC experience, she disagrees with the trend toward believing that kids' statements about gender identity should necessarily be taken at face value rather than deeply explored or questioned.

In an email, she explained:

> I think I told you that the most important thing I learned from Dr. Zucker (during my weekly conversations with him) was the importance of asking "Why?" For instance, had I asked that when [my son] told me that he wanted to cut off his penis with a pair of scissors, who knows what I would have learned? But I didn't ask because I thought I knew precisely what he meant. Applying an adult perspective, and my own views on gender, I immediately concluded that that remark was a rejection of his birth gender. But maybe he had a urinary tract infection and his penis was sore. Or maybe he had been wearing a pair of pants that he had outgrown and they were uncomfortable in the crotch. Or maybe having a penis made him feel like he didn't fit in with his sisters and cousin, and he thought that if he looked more like them then they would all get along better instead of squabbling. Who knows. But we should at least have had the conversation. The same way we would if he had said "I'm sad" or "I'm angry."

Her experience was hard-earned. Amanda explained that after "Rory's" initial assessment, Zucker told her that he wasn't sure Rory's issues were actually attributable, at root, to a gender-identity issue, but that he was pretty sure Rory had autism spectrum disorder. To that point, Rory had received various other diagnoses, but this was the first time a clinician had diagnosed him with ASD, and "it was very helpful to have that information," Amanda said. After years of therapy with Hayley Wood — "it turned his life around," according to Amanda — Rory is an artsy boy with a YouTube channel who no longer has gender dysphoria.

"Rena's" experience was similar. Her daughter "Rachel" *insisted*, from a very young age, that she was a boy, and was absolutely obsessed with boy stuff. After assessing her at the GIC, Zucker referred Rachel to a regular therapist closer to home (the family lives far from Toronto) — not to attempt to "fix" her gender nonconformity, nor to nudge her toward transitioning, but rather to "work on her self-confidence and what she likes about herself," as Rena put it. That therapist didn't quite agree with Zucker's methods — she'd send Rena news clippings about young children who had socially transitioned, which Rena took as a none-too-subtle hint that that was her preferred approach — but, to her credit, Rena said she kept her personal beliefs out of her sessions with Rachel. Five years later, Rachel appears to have settled into a cisgender identity. Rena has some stark visual evidence of her daughter's trajectory: Each of the last five years, she has asked her to fill in a circle with three colors representing how much she feels like a girl, a boy, or a tomboy. "Last year," Rena told me, "it was just this speck that was a boy. And this year she sat there for quite some time, and then she came to me and said, 'There's no part of me that feels like a boy.'"

It's impossible to know what the treatment course would have been for these children if their parents had started their clinical journeys by going to a gender-affirmative specialist, rather than to the GIC. But Rena, for her part, is positive

that the advice would have been for Rachel to transition. "Absolutely," she said. "It would have cemented who she identified as instead of keeping the door open and allowing her to land in a different place from a maturity perspective, for her to be able to make the choice truly herself. I just think that that would have denied her the opportunity to make that choice."

It seems as though many parents, clinicians, and others face significant pressure to embrace the gender-affirmative approach these days. According to an influential strain of trans politics, Zucker's more nuanced, "Why?"-focused method is offensive. This sounds like a caricature, but right there in the External Review that helped get him fired and his clinic shuttered, two professional psychiatrists state that asking "why" is improper. What needs to be done is to accept the child for who they are, and anything less than that is ignorant, if not bigoted.

This places a heavy burden on parents who aren't sure who their children are, or who don't accept the notion that a 5-year-old, even an insistent and strong-willed one, has a set identity in the same way adults do. The current politics leave them behind, because their stories don't fit neatly into the binary in which trans identities are either accepted or rejected, full stop. There's no natural political grouping for parents of desisters, because desisting isn't an identity-politics lodestone in the way persisting is. "We're quieter," said Amanda of parents of kids whose gender dysphoria desists. "There are a bunch of us scattered around, and we're not acting collectively." As Merry put it, "I feel like sometimes there's no middle ground. You're either trans or you're not, and you can't be this kid who is just kind of exploring."

But the activists and clinicians celebrating the ouster of Zucker and the shuttering of his clinic *are* acting collectively, and to them all these questions are really just fronts for transphobia, the seeming complexities have been resolved, and it's time to move on. "The controversy is over, and at this point we are mopping up the pieces," said Russell. "There was a controversy. It's over. They lost."

Samuel Lieberman contributed research.

**This article has been corrected to show that the co-author of a Slate article critiquing the desistance literature was actually named Dr. Kristina Olson of the University of Washington, not, as originally stated, Dr. Johanna Kennedy-Olson.*

TAGS: TRANSGENDER CAMH GENDER IDENTITY CLINIC SEX MORE

EXHIBIT 124

Colin Wright

Anatomy of a Scientific Scandal

Under pressure, a journal once notable for its courage retracts a major paper on the social roots of gender-related distress—all over a minor, inconsistently applied technicality.

/ Eye on the News / The Social Order Jun 12 2023

The scientific method is the best way for humans to investigate phenomena, acquire new knowledge, and correct mistaken beliefs. Scientific journals play a vital role in this process, encouraging rational, evidence-based debate and the pursuit of truth above all. But since the inner workings of these journals remain largely opaque, citizens, policymakers, and science journalists can struggle to discern when politics has compromised a given publication—especially when ideological agendas are couched in scientific language and given the veneer of scientific authority.

Medical journals writ large are on the brink of such ideological capture, if they haven't already succumbed to it. Findings that contradict the prevailing "gender-affirming" model of care for transgender-identifying youth, or offer even mild critiques, have become nearly impossible to publish. Still, rare exceptions exist, including the *Archives of Sexual Behavior* (*ASB*), a journal published by Springer Nature. This publication has distinguished itself by its willingness to facilitate viewpoint diversity in gender medicine—until now.

An alarming recent event highlights the vulnerability of the scientific endeavor to politics. *ASB* is a primary target for activist researchers who will not tolerate dissent from their views, and a months-long campaign by activists to pressure Springer Nature into retracting an *ASB* paper that they didn't like has culminated in success. While the activists' desire to censor inconvenient research should come as no surprise, Springer Nature's capitulation to their demands represents a profound betrayal of scientific integrity and the publisher's commitment to truth.

The paper in question, "Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases," was authored by researchers Suzanna Diaz (a pseudonym) and Michael Bailey and published in *ASB* on March 29. Rapid Onset Gender Dysphoria (ROGD), a newly proposed pathway to gender dysphoria, was first described by the researcher Lisa Littman in 2018; the theory may help explain the documented surge in cases of gender dysphoria among adolescents and young adults who had previously exhibited no gender-related issues. Littman proposed and provided supporting evidence that social factors have at least partly caused the surge, especially among girls.

Such a hypothesis might appear plausible, or at least a straightforward empirical matter to be decided through evidence-based examination. But it violates the dominant narrative favored by medicalization

activists that the rise in trans identities stems from an increase in societal acceptance of "gender diversity." Evidence supporting ROGD would call into question the "gender-affirming" model of care, an approach premised on the notion that kids can know their "gender identity" from very early on and will rarely, if ever, change their minds about it. This philosophical belief system, which flies in the face of centuries of accumulated wisdom on human development, has been pithily summarized with the phrase: "trans kids know who they are." The affirmative model guides health-care providers to "affirm" (i.e., agree with) a child's self-declared identity and facilitate access to hormones and surgeries, all in order to align the child's body with his or her felt gender identity. Consequently, activists have exerted intense efforts to undermine ROGD research at every opportunity.

Littman's 2018 paper generated intense backlash from activists, who successfully pressured the journal that published her findings (*PLoS One*) to take the unusual step of initiating a second round of post-publication peer review. The paper was republished with a "correction" that offered a more detailed explanation of its methodology, specifically focusing on its dependency on parental reports, and a clarification that ROGD is not a clinical diagnosis. Importantly, however, the paper's central conclusions concerning the probable role of social influences remained unchanged. Activists repeatedly disrupted further attempts by Littman to explore ROGD using online surveys.

But Diaz and Bailey's new paper lent further credence to the ROGD hypothesis. They examined parental reports of 1,655 potential ROGD cases through an online survey. The sample size dwarfed that of Littman's original study, which was based on 256 parental reports. This data bolstered Littman's findings about the onset of gender dysphoria after puberty, predominantly in girls, in conjunction with preexisting mental-health conditions, heavy social-media usage, and peer influence. They also corroborated Littman's 2018 finding that an overwhelming majority (90 percent) of concerned parents are politically progressive, undermining the common narrative that criticisms and concerns about gender affirmation originate in conservatism.

What else did the paper find? In the sample, gender dysphoria manifests approximately two years earlier in females compared with males. Females are more than twice as likely to pursue social transition. However, among those who experienced gender dysphoria for at least one year, males were more likely to undergo hormonal interventions. Moreover, a majority of parents reported feeling coerced by gender specialists to affirm their child's new identity and endorse his or her transition. Parents who facilitated their child's social transition reported that the child's mental health "deteriorated considerably after social transition," and that their relationship with their child suffered.

These findings are crucial. They provide further corroboration to a growing body of evidence supporting the ROGD theory, indicating the need for a new, specialized treatment approach for youth with gender-related distress. Clinicians widely acknowledge the existence of this new cohort. Anna Hutchinson, formerly a leading therapist in the United Kingdom's Gender Identity Development Service, clearly

described a trend of adolescents "without any notable symptom history [of gender dysphoria] prior to or during the early stages of puberty." "Littman's description [of ROGD] aligns with our clinical experiences from within the consulting room," she said. Most recently, England's public health authority, the National Health Service, just issued new treatment specifications warning about treating youth with late-onset gender dysphoria medically, noting that "there is even greater uncertainty in terms of the supporting clinical evidence base, less established clinical practice and less known about the natural history of gender dysphoria" for this novel patient group.

The suppression of research into ROGD undermines scientific inquiry into a live matter of urgent public concern. It prevents doctors and clinicians from basing their prescribed treatments on evidence as opposed to ideology. As Diaz and Bailey found, however, the activist drive for suppression is constant and aggressive.

On April 18, only weeks after the paper was published, Bailey received a list of questions from the executive committee of the International Academy of Sex Research (IASR) about the Institutional Review Board (IRB) ethics-approval process at Northwestern University, where Bailey works. The following day, a message from IASR's Executive Committee began circulating on its listserv notifying recipients of "significant concerns about the ethical conduct and integrity of the editorial process" at *ASB*. Members were told that IASR was consulting with the journal's editor and its publisher, Springer Nature, to address these concerns.

Springer Nature reached out to Bailey on April 28. "Some questions have been raised about the article," the publisher wrote, "and we are investigating them together with our Research Integrity Group." The email's focus was entirely on the IRB ethics approval process obtained before publication, which is a formal procedure that applies to all proposed research on human subjects to ensure it is conducted ethically and that participants are properly safeguarded. Springer asked Bailey to "provide details regarding the protocol you submitted to your IRB for evaluation and any relevant documentation regarding the evaluation process."

Two weeks later, on May 5, an open letter addressed to both the IASR and Springer Nature was published. The letter called for the removal of Kenneth Zucker from his position as editor-in-chief at *ASB* in response to his decision to publish Diaz and Bailey's study. The letter had 100 main signatories, including Marci Bowers, president of the World Professional Association for Transgender Health, and a slew of other academics and medical professionals. All threatened that they would "no longer submit to the journal, act as peer reviewers, or serve in an editorial capacity until Dr Zucker is replaced with an editor who has a demonstrated record of integrity on LGBTQ+ matters and, especially, trans matters." Specifically, the letter asserted that Zucker's decision to publish the study "threatens the foundations of research ethics" because the paper's authors had not obtained IRB ethics approval before data collection and publication.

That same day, FAIR in Medicine, a nonpartisan professional network that advocates "the highest ethical standards in medical practice," sponsored a counter-letter. This document underscored their support for Dr. Kenneth Zucker and called for an "academically robust and unbiased editorial process" at ASB and the "uninterrupted publication" of Diaz and Bailey's study. Rather than capitulating to activists' "censorious demands," FAIR in Medicine urged for an "open debate about the paper." The counter-letter garnered over 2,000 signatures, including notable figures such as Stanford health professor Jay Bhattacharya, New York University psychologist Jonathan Haidt, and ROGD researcher Lisa Littman, among others.

Bailey promptly addressed the concerns regarding IRB ethics approval. The initial survey data used in the study, he explained, was gathered by the paper's lead author, the pseudonymous Diaz, who is not affiliated with an institution that requires IRB approval for such a project. Moreover, Northwestern's IRB representative informed Bailey that, though the IRB could not retrospectively approve the pre-collected data, it would permit him to coauthor a paper on those data provided they were expunged of all personal identifiable information. Significantly, Springer's own policy explicitly states that in situations where "a study has not been granted ethics committee approval prior to commencing. . . . The decision on whether to proceed to peer review in such cases is at the Editor's discretion." Thus, all efforts to undermine the study or discredit Zucker's decision to review and publish it on the grounds of IRB considerations appeared futile.

So the pressure campaign changed tactics. On May 23, Springer sent an email to Diaz and Bailey thanking them for responding to its previous questions, but also informing them that the paper would nevertheless be retracted "due to noncompliance with our editorial policies around consent":

> The participants of the survey have not provided written informed consent to participate in scholarly research or to have their responses published in a peer reviewed article. Additionally, they have not provided consent to publish to have their data included in this article.

Diaz and Bailey were given until May 26 to provide a written response expressing their agreement or disagreement with both the retraction and its phrasing. This response, Springer had said, would then be incorporated into the retraction notice. To be clear, Springer wasn't inviting Diaz and Bailey to contest the retraction decision; it was merely offering a chance to reflect the authors' stance on the matter.

The activist playbook here was simple: get the Diaz and Bailey paper retracted over a technicality, then spin the retraction as an invalidation of the study's main findings. Such a tactic was successfully used on Littman's 2018 ROGD paper; the journal's decision to re-review the paper and issue a "correction" has been repeatedly and disingenuously leveraged by proponents of "gender-affirming" care to declare the study "debunked."

A retraction of Diaz and Bailey's study could have an even more disastrous effect. It would not only cause the retraction of an important contribution to the ongoing scientific debate over transgender identification among youth but also signal the ideological capture of a scientific publishing giant that controls hundreds of journals that shape our knowledge base.

With so much on the line, Diaz and Bailey fought back. On May 25, Bailey penned a comprehensive appeal letter to Springer editors, highlighting the irrationality of their impulsive and "capricious decision" to retract his paper—an act he perceives as an attempt to "silence the critical conversation around gender issues." In Bailey's view, this retraction not only threatens to inflict professional, reputational, and financial harm upon him but also undermines Springer Nature's pivotal role "as a source for fair, unbiased publication of scholarly articles addressing the urgent gender issues facing society today." He further exhorted Springer to resist external influences, assess the highlighted issues objectively, and realign with the journal's core mission of "advancing discovery."

Bailey raised three major objections to Springer's decision to retract the paper. First, he contested the grounds for retraction as an ever-changing "moving target." Initially, Springer's concern hinged on a potential ethics violation arising from the absence of IRB approval brought to its attention by activists. When this challenge proved to be without merit, the focus abruptly shifted to concerns about the informed consent of the study's participants.

Second was Springer's assertion that the study's participants did not provide "written consent to participate in scholarly research or to have their responses published in a peer reviewed article." As Bailey explained, the parents who took part in the survey were enthusiastic about contributing data related to ROGD, given the scarcity of information on this novel presentation of gender dysphoria. The introduction of the survey, taken by all participating parents, mentions the dearth of data on the topic and the need for parents to "seek out this information on our own" to "help us gain a better understanding" of this new phenomenon. Upon completion of the survey, parents were informed that their "answers will help us gain a better understanding of which children are more vulnerable to Rapid Onset Gender Dysphoria and what we can do to help them better." The data, parents were told, would be made public online once a sufficiently large sample size was achieved.

The parents were not only eager to provide information to enhance understanding of ROGD but also well-aware that the anonymized results would be published online. Bailey emphasized in his rebuttal: "The sole intent of parental participation in the survey was to inform the scientific community about the novel presentation of gender dysphoria among youth with no prior history of the condition."

Despite this, Springer chose to disregard the spirit of the consent requirement. Consent for the publication of anonymized data on a public website, it alleged, does not equate to consent for that data's publication in a scholarly peer-reviewed article. But consenting to have one's data published on a website managed by

unskilled volunteers is a much bigger risk than having one's information managed and published by an academic publisher staffed with dedicated professionals trained in thorough data analyses and human subject protections. As Bailey stated:

> Had the participants originally consented to only participate in future peer-reviewed academic research, but later their responses appeared on a non-academic website with much lower quality standards, one could claim that the original consent was invalid. However, in this case, just the opposite happened—the respondents' wishes were respected with additional quality standards in place. To be clear, the consent matched the intended use of the data provided.

It strains credulity to think that the participants' consent does not extend to a situation in which their data are being handled with more care and caution than what they had initially agreed to.

Third and finally, Bailey pointed out Springer's inconsistent application of their putative consent policy. He cited "a slew of 'scholarly publications' [by Springer] based on survey research in which the respondents did not provide explicit permission for 'scholarly research' use—and often apparently did not provide consent for any research purpose at all." Examples included at least six publications using data from a health survey conducted by the American College Health Association that "included intensely personal questions relating [to] substance use, sexual behaviors, and other highly sensitive topics." Additionally, at least seven publications used data from a Youth Behavior Risk Survey (YRBS), and no fewer than six used data from the 2015 United States Transgender Survey (USTS). Bailey found these studies after a cursory skim of the literature, suggesting that many more such instances exist.

The day after Bailey's appeal submission, Springer paused the retraction to deliberate internally. Soon after, Springer notified Bailey that it had "concluded that this retraction is necessary on the basis of lack of informed consent." Part of the proposed retraction notice reads, "The participants of the survey have not provided written informed consent to participate in scholarly research or to have their responses published in a peer reviewed article."

Surprisingly, Springer thanked Bailey for bringing to its attention the 19 other papers that appeared not to have obtained both written Consent to Participate and Consent to Publish from their survey participants. According to Springer, these studies were now being investigated. (In contrast with Bailey and Diaz's ROGD paper, investigation of ethics violations by authors supportive of "gender-affirming care" seem to take much longer: an investigation into an article by activist-researcher Jack Turban has been ongoing for more than a year.) Springer also dismissed Bailey's concern about potential damage to his reputation, stating that the retraction simply "reflects findings relating to the research itself and not the author/s conduct," and that it "is not intended to be punishment."

It was a startling response. Such retractions, regardless of their reasoning, are routinely exploited by activists to tarnish the reputation of the involved researchers. Lisa Littman's original paper on ROGD was merely "corrected," and no results or conclusions changed; nonetheless, she has been smeared relentlessly online and in the press. Brown University, Littman's employer at the time, felt compelled to affirm its "long-standing support for members of the trans community" in response to the paper's publication. One science writer critiqued Littman's study as "scientifically specious" and claimed that "ROGD provides political cover for those who wish to rollback trans rights and healthcare." The controversy even led to Littman losing her consulting job following demands for her dismissal by local clinicians.

Springer's acknowledgement that it is investigating the 19 papers that Bailey had highlighted sets a profound new precedent that could be devastating to the research community, especially concerning transgender research, as much of the existing literature is dependent on survey data unlikely to have garnered written consent both to participate and to have the research published in an academic journal.

In any case, many thousands of research papers published by Springer likely do not meet the standards that the Diaz and Bailey study is being arbitrarily held to. Take, for instance, Turban, a researcher often cited by proponents of the "gender affirmation" model of care. Turban published a study in a Springer journal discussing the unique inpatient needs and experiences of adolescents who identify as transgender. While the study's methods claim to have obtained informed consent to *participate* in the study, nowhere does it mention having obtained explicit permission "to have their responses published in a peer reviewed article," a requirement Springer now apparently deems necessary to apply retrospectively. Will Springer extend its scrutiny to Turban's paper, demanding documented proof of explicit written consent from every participant for the publication of their data?

It is unclear whether Springer truly comprehends the enormity of its decision to single out the Diaz and Bailey paper for retraction over a minor, inconsistently applied technicality.

Part of the problem with retracted papers is that the journal owns the copyright to the content, which makes it impossible for the authors to resubmit the article to another scientific publication. In this case, serendipity was on Bailey and Diaz's side. When they originally published with *ASB*, a grant from the Society for Evidence-Based Gender Medicine (SEGM)—a U.S.-based nonprofit professional organization committed to raising the bar on the quality of evidence in gender medicine—enabled the publication under a Creative Commons Attribution 4.0 International License. While Springer retains the copyright, this license "permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license, and indicate if changes were made."

In the wake of the retraction, Bailey and Diaz are re-submitting the manuscript to the *Journal of Open Inquiry in Behavioral Science* (JOIBS), a fledgling publication founded by scholars devoted to the principles

of "free inquiry and truth seeking" and the belief that ideas ought to be scrutinized rather than suppressed. Regrettably, among medical journals this commitment appears to be increasingly the exception, not the rule.

Colin Wright is an evolutionary biologist and fellow at the Manhattan Institute.

Author's Note: The original version of this article failed to mention FAIR in Medicine's counter-letter, which significantly helped to raise awareness of the issue. I consider FAIR in Medicine an important ally, and my omitting them from the original story was a serious oversight.

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EXHIBIT 125

Full Length Conceptual Essay

PRi

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Discursive stickiness: Affective institutional texts and activist resistance

Erica Ciszek
University of Texas at Austin, USA

Richard Mocarski
University of Nebraska at Kearney, USA

Sarah Price
Florida Gulf Coast University, USA

Elaine Almeida
University of Wisconsin, USA

Abstract

Pushing the bounds of public relations theory and research, we explore how institutional texts have produced and reified stigmas around gender transgression and how these texts are bound up in moments of activism and resistance. We considered how different discursive and material functions get "stuck" together by way of texts and how this sticking depends on a history of association and institutionalization. Activism presents opportunities to challenge institutional and structural stickiness, and we argue that public relations can challenge the affective assemblages that comprise and perpetuate these systems, unsettling the historical discourses that have governed institutions by establishing new communicative possibilities.

Keywords

Activism, agency, resistance, stickiness, transgender

Corresponding author:
Erica Ciszek, Moody College of Communication, University of Texas at Austin, 300 W. Dean Keeton, Austin, TX 78712, USA.
Email: eciszek@utexas.edu

Pushing the bounds of public relations theory and research, we explore how institutional texts have produced and reified stigmas around gender transgression and how these texts are bound up in moments of activism and resistance. We focus on the Diagnostic and Statistical Manual of Mental Disorders (DSM)—a handbook used by behavioral health-care professionals in the United States and much of the world—linking lived experiences of transgender people to the history of the epistemological violence perpetrated in the DSM that reifies hegemonic norms of gender, sex, and sexuality. Importantly, the DSM is not a benign text; journalist Reese (2013) critiques the DSM, drawing attention to the bureaucracy implicated in the text:

> The American Psychiatric Association owns the DSM. They aren't only responsible for it: they own it, sell it, and license it. The DSM is created by a group of committees. It's a bureaucratic process. In place of scientific findings, the DSM uses expert consensus to determine what mental disorders exist and how you can recognize them. Disorders come into the book the same way a law becomes part of the book of statutes. People suggest it, discuss it, and vote on it. Homosexuality was deleted from the DSM by a referendum. A straight up vote: yes or no. It's not always that explicit, and the votes are not public. In the case of the DSM-5, committee members were forbidden to talk about it, so we'll never really know what the deliberations were. They all signed non-disclosure agreements. (para 15).

In this article, we contend that the DSM creates the web of language from which we come to understand and communicate about gender variance in the United States, and this language is rooted in institutional discourse and extends to the practices of public relations and activism. We then turn to the connections between discourse, activism, and power-plays among and between key stakeholders. We orient this argument in queer theorist Sarah Ahmed's (2004) concept of stickiness, demonstrating how the affect of disgust gets attached to transgender subjectivity within an institutional text and is carried out performatively within material landscapes. The purpose of this paper is threefold: (1) we argue that institutional texts, because of their prominence as world-defining documents, are important public relations discourses; (2) by historicizing this text, we can see how these documents leave behind a trail of the past, remnants of power, and hegemony; and (3) we demonstrate how activism resists the stickiness of these texts.

A note about terminology and context: "Transgender" is a contemporary term that emerged in recent years to indicate a wide variety of people whose gender identity or expression transgresses the rules of binary gender. We use the term "transgender" to refer to what Susan Stryker, a leading voice in the field of transgender studies and longtime advocate for transgender visibility and rights, refers to as individuals who "move away from the gender they were assigned at birth, people who cross over (trans-) the boundaries constructed by their culture to define and contain gender" (Stryker, 2008: 1). Transgender, according to sociologist Monro (2005: 3) "explodes the notion that male and female are discrete categories." This conceptualization, as other gender scholars have noted, undergirds a historical discussion that allows for a "history sensitive to a wide range of identities and experiences" (Tebbutt, 2012: 506). We also use the phrase "gender transgressive," which transgender activist and legal scholar Spade (2003) argues encapsulates myriad identities and experiences and is not limited to narrow understandings of sex and gender. As historian and transgender activist Beemyn (2013) explains:

"Any attempt to write 'transgender history' is complicated by the contemporary nature of the term 'transgender'" (p. 113). We recognize that applying terms and concepts of gender variance from the early-20th century is problematic (Boag, 2005), for these categories, as historian Cleves (2014) notes are indebted to "a very modern regime of knowledge and power," (p. 461) particularly the role of medicine in defining the category. Spade (2003) draws our attention to the contentious and oppressive relationship between gender transgressive people and medical establishments. Additionally, because culture is a major variable in attitudes toward gender transgression, it is important to note this essay comes from a U.S. perspective using U.S. examples.

In this article, we attend to both discursivity and materiality of the DSM as an institutional text, first in our examination of medical texts and then in our analysis of a moment of resistance. We bring to light the normative linkages brought into power through medicine and legitimized and leveraged through promotion. We make visible these linkages and provide an anecdote that highlights the disruptive power of activism. We start by presenting Ahmed's concept of stickiness and then pivot to the literature on activism and public relations as a space where affect theory can inform an intervention. We are interested in how the DSM, as a discursive object, generates affect and how it travels through institutional texts via affective transfer, as well as how activists challenge this affect. Our analysis is inspired by Ahmed's (2010, 2014) work on affect as sticky, presenting a framework to attend to the production and transference of emotions through institutional texts. We draw on Ahmed's notion that affect is performative, and we point to the ways in which affect is contagious and has the ability to stick. Regarding the stickiness of affect, Ahmed (2014: 91) writes:

> Stickiness involves a form of relationality, or a 'withness,' in which the elements that are 'with' get bound together. One can stick by a friend. One can get stuck in traffic. Some forms of stickiness are about holding things together. Some are about blockages or stopping things moving. When a sign or object becomes sticky it can function to 'block' the movement (of other things or signs) and it can function to bind (other things or signs) together. . .Stickiness then is about what objects do to other objects – it involves the transference of affect – but it is a relation of 'doing.'

Stickiness, according to Ahmed, involves the transference of affect, and for Ahmed, objects become sticky, or logged with affect, and pickup traces of where they have been. We argue that institutional discourses and frameworks, like those of pathology put forth in the DSM, sustain a particular kind of affective relation, that of pathology, to social norms and texts that govern bodies and material realities. We conclude with an anecdote in which transgender activists employ public relations to block the binding of pathology to transgender subjectivity. We wish to highlight that the vanguard of this activism was transgender women of color. The intersection of race and gender is vital to understanding the manifestation of this activism, as the resistance mounted was multi-pronged in regards to which vectors of power the activism unmasked. Given the history of the DSM as a white-centric text (Thomas, 2014) where non-white identies have been othered (Cermele et al., 2001), paired with the high incidence of physical and institutional violence against transgender women of color, the anecdote demonstrates displays of agency in response to multifaceted hegemonic vectors of silence.

Tracing gender variance in institutional discourses

For nearly the last 70 years, the DSM has been used to identify, classify, and categorize mental illness, diagnoses that are social and contextual. It is a text that holds much power, as it is used by clinicians, researchers, regulatory agencies, health insurance companies, pharmaceutical companies, and policy makers. According to the American Psychiatric Association, the DSM is significant because it provides a common language for "clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders" (DSM–5: Frequently Asked Questions, 2019, para 1). To understand the bearing of the DSM in shaping the stigmatization of transgender individuals and the subsequent impact on material conditions for these persons, we must first ground our understanding of how health care functions in the United States. The dominant model of health care in the western world is the single-disease model of health, also known as the biomedical model (Wade and Halligan, 2004). The biomedical model of health is a reductionist framework that creates a myopic and non-reflexive orientation toward health that may create malady where arguably none exists. The medical establishment has the power to construct and shape identity, classifying what is considered normal and abnormal (Foucault, 1965), a classification that can have long-term societal impacts that range from positive (e.g. vaccinations against smallpox) to negative (e.g. stigmatization of sexualities). The diagnosis and treatment of behaviors is predicated on medical and psychiatric classification (Foucault, 1965). In short, medicine is socially constructed, and, therefore, the history of a gender variance is a journey that reveals mechanisms of hegemonic power, structures in which public relations plays a role. Importantly, in a cultural and political context in which medical care remains inaccessible to many and particularly low-income transgender people of color, medical care associated with gender confirmation is administered through gender-regulating processes—often guided by the DSM—that reinforce oppressive gender binaries. Thus, in acknowledgement of these contexts, we proceed with caution when approaching the historically interwoven systems and structures of medical and communicative realms that continue to shape the lives and experiences of transgender people.

This history of the clinicalization of gender transgression in the United States illuminates some of the parallels between medical and psychiatric institutions and how these texts are linked to very public and promotional moments in history. Importantly, we do not intend to group any past figures or classifications with modern identity categories; rather, we understand them as historical and contextual, serving as a framework for contemporary transgeder activism. By way of publicity and promotion, in the early 1950s, American Christine Jorgensen was the first person widely known for having sex reassignment surgery, and she became the face of transsexuality. Jorgensen's story was the subject of a front-page story of the *New York Daily News* and appeared in mainstream magazines like *Time* and *Newsweek*, and she became a celebrity using her platform to advocate for transsexuals. Importantly, as historian Skidmore (2011) chronicles, Jorgensen distanced herself from "deviant" groups, providing the press with a narrative of white respectability that was distinct from stories of homosexuality or cross-dressing. Within the backdrop of Jorgensen's publicity, in the 1960s, clinicians in the United States began to develop criteria for gender identity programs, most notably with the publication

of endocrinologist Harry Benjamin's *The Transsexual Phenomenon* and the opening of the first gender identity clinic at Johns Hopkins University in 1966. Prior to this time, clinicians provided individuals surgical interventions on the basis of correcting what they considered anomalies (Stone, 1991), often grounding diagnoses in the DSM.

To date, there are eight iterations of the DSM: DSM-I (1952), DSM-II (1968), DSM-II sixth printing (1973), DSM-III (1980), DSM-III-R (1987), DSM-IV (1994), DSM-IV-TR (2000), and DSM-V (2013). We argue the DSM is an institutional text that catalogs and codifies gender transgression; it is a reification of authoritative knowledge production that, through its various iterations, produces remnants of stigma that travel through time. These texts demonstrate how institutional discourses have shaped and continue to shape contemporary gendered subjectivities. Since the publication of its first edition in 1952, the DSM has created pathways through diagnostic classifications that link gender variance to other pathological categories. For example, the pathology of gender variance can be traced to the first iteration of the DSM where transgenderism was listed in the "Sexual Deviation" section (000-x63), a list derived from "cases formally classed as 'psychopathic personality with pathologic sexuality'" (1952: 39). Specifically transvestism, or what at the time was understood as cross-dressing, listed alongside homosexuality, pedophilia, fetishism, and sexual sadism—which includes rape, assault, and mutilation. A formal diagnosis of transsexualism as a psychiatric disorder did not appear in the DSM until the third iteration published in 1980, identifed as "Gender Identity Disorder," categorized as an Axis I mental illness—disorders most commonly found in the public. In 2008, as part of the revision and update of the DSM, the American Psychiatric Association appointed a Work Group on Sexual and Gender Identity Disorders resulting in concern among the lesbian, gay, bisexual, and transgender (LGBT) community, largely focused on the status of the diagnostic categories of Gender Identity Disorder. As with homosexuality in the 1970s[1], activists maintained that it is wrong to label expressions of gender variance as symptoms of a mental disorder. While some activists contend the perpetuation of Gender Identity Disorder (GID) diagnoses in the DSM would further stigmatize and cause harm to transgender individuals, other advocates in the transgender community expressed concern that removing GID could lead to the denial of medical and surgical care for transgender individuals (see Drescher, 2010). In the latest iteration of DSM V, the introduction to the section on Gender Dysphoria reads: "The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines." This quote encapsulates the historical and contextual nature of discourses surrounding gender variance and the contested nature of representing gender variance.

Inclusion of gender variance in the DSM is complex and arguably a double-edged sword. On one hand, classifying gender variance as a disorder "open[ed] many door[s]" (Arune, 2004: 115), providing access to hormone therapy and gender affirmation surgeries in countries with state health programs. Conversely, through the anchoring of gender variance in the DSM, it could be argued that gender transgressive individuals have had the "misfortune to become objects of medical concern" (Brown and Tucker, 2010: 230), embodying the stigma of a mental disorder (Arune, 2004). Furthermore, the history of the DSM as a normative text includes embedded understandings of hegemonic race, which can serve as a framework for systemic racism, as has been documented

by scholars (Alarcón et al., 2009; Cermele et al., 2001; Loring and Powell, 1988). This misfortune, when coupled with other vectors of hegemonic power, can serve to further erase and stigmatize groups such as transgender women of color.

Although the DSM was developed within an American context, it is applied in a range of countries across the globe. Edited by the American Psychiatric Association (APA), the DSM has positioned itself as "the most authoritative text on mental health in the Western culture" (Crowe, 2000: 69) with influence in health domains and on social practices including legal fields and insurance (see Harper, 2013; Lafrance and Mckenzie-Mohr, 2013). The DSM is a powerful tool within a hegemonic block, and we argue that its temporal nature creates a stickiness through the editions of the text that allows it to have such a prominent place. These texts and the institutional practices they are implicated in are social forms, and it is through repetition, as queer theorist Butler (1993) reminds us, that norms materialize. Within the context of materialization, Ahmed is interested in how different figures of speech get stuck together and how this sticking relies upon histories of association. We argue the DSM functions as a vector of hegemonic power that sets the guidelines for transgressive behavior, defining gender norms as those that are linked to normative or dominant understandings of sex. We argue that through circulation and repetition of the DSM, the pathology of gender transgression generates stickiness, and activists challenge this stickiness through public relations.

Activism in public relations

While promotional and persuasive communication has long been part of the work of activism and social movements (see Coombs and Holladay, 2007; Heath and Waymer, 2009), public relations research has experienced a swell in activism scholarship over the past decade (see Adi, 2019). Heath and Waymer remind us that that "obtaining the democratic exchange long championed by public relations" required "seeing how and when activists engage in the dialogue that occurs on various issues" (2009: 195). Activism requires the development of oppositional consciousness, contesting dominant ideologies, and providing "symbolic blueprints" for collective action and social change (Morris and Braine, 2001: 26). Activists use a variety of public relations strategies and tactics, including boycotts, demonstrations, and symbolic events, to galvanize attention and influence public opinion and policy. Historically, scholars have studied activists to understand their communication practices, their strategies, their ideological motivations, and the power differences between them and the organizations they are resisting (Manheim and Holt, 2015). From a tactical perspective, scholars note how activists mobilize resources and power to influence decision-making, employing techniques such as persuasion, negotiation, pressure, and/or force (Kim and Sriramesh, 2009). Public relations literature on activism has tended to focus on organizational perspectives and management of activist groups (Brown, 2010; Smith and Ferguson, 2010), with a recent shift to looking at how practitioners function as activists (Holtzhausen, 2007, 2012) and how activists engage in public relations practice (Ciszek, 2015, 2017).

While traditionally public relations research has positioned activists as "an antagonistic force" (Coombs and Holladay, 2012: 82), aside from a handful of contemporary projects (e.g. De Moya and Bravo, 2016; Stokes and Atkins-Sayre, 2018; Toledano, 2016),

until fairly recently few studies have looked at how activists use public relations to achieve their objectives. Activists play an important role and often function as pressure groups that influence and shape society. Coombs and Holladay contend:

> Activists seek to change organizations in some fashion and that requires them to utilize power and persuasion. Typically, activists are marginalized by and have much less power than organizations. Through public relations, activists can attempt to build power and to persuade organizations to alter their behaviors and policies (2012, 882).

Reconceptualizing the activist role, Holtzhausen (2007, 2012) carves out a space in public relations theory for exploring resistance and dissent to normative power structures. Holzthausen (2012) conceptualized public relations activism as public relations which resists power structures, employs dissent, and incorporates subaltern voices to challenge normative practices. In this article, we come at activist public relations by way of Ahmed's notion of stickiness to articulate and explicate the ways activists utilize public relations to unstick the structural and discursive connections between ideas, values, and objects surrounding transgender subjectivity. We look at the instutionalization of gender transgression, turning to a moment of activist resistance, and contributing a non-corporate context for the discussion of how activists use public relations. We attend to the webs of power and institutional logics that transgender individuals are located within, illustrating through one example how activists utilize materiality as a form of resistance.

Activism, agency, and resistance

In 2017, one author attended the United States regional conference of the Professional Association for Transgender Health (USPATH) in Los Angeles in the presence of clinicians, researchers, and TGD advocates.[2] At this conference, Drs. Kenneth Zucker, Heino Meyer-Bahlburg, Dan Karasic, and Vilanayur Ramachanfran, a group of controversial psychologists of sexual orientation and gender identity, presented a session entitled "Development of Gender Variations: Features and Factors," in which they discussed myriad cases. The purpose of the session was to lay out potential clinical implications for working with transgender clients. However, the tenor of the session was one of caution and liability, with panelists (particularly Zucker) questioning the increase in prevalence of transgender identifying persons. Zucker, the lead of the DSM-V Sub-Work Group on Sexual and Gender Identity Disorders, has had a long career working with gender-diverse clients, but he is viewed by transgender activists as harmful for his ties to conversion techniques (see Serano, 2016). Zucker is famous for his contested corrective reparative therapy for gender-variant children, where as part of his research he forced children assigned female at birth not to play with trucks and soldiers and children assigned male at birth not to play with dolls (Ashley, 2020). In 2015, Zucker's practice of gender conversion psychotherapies on transgender children was famously shut down (Hayes, 2018), shrouding Zucker and his supporters in a veil of stigma. Social work and gender studies scholar Jake Pyne and other transgender advocates and scholars contend that at the heart of Zucker's approach is an understanding of gender diverse children as disordered, casting a specter of shame over their behaviors (and over parents' tolerance of it) and seeking

"redemption, success, and normality for the gender problematic child" (Pyne, 2014: 88). Despite these critiques, Zucker maintains a private clinical psychology practice focused on gender dysphoria, and holds the position of Professor in the Department of Psychiatry at the University of Toronto.

At the 2017 conference, Zucker presented his hypothesis on the increased prevalence of transgender persons, pointing to desistance (a false claim by Zucker that 80% of adolescents who transition desist; see Winters, 2016) and regrets of clients (psychological faults of clients, including sexual fixations). Zucker's presentation embodies a performative iteration of the stickiness of pathology. Despite his controversial practices, his research passed the peer review process that governs WPATH conferences, and he was given authority and power to hold a forum which was buttressed by his position as the lead of the Sexual and Gender Identity Disorders working group. Importantly, no space was made for transgender persons on this panel, reifying the othering of gender transgressive people. Furthermore, this lack of inclusion echoes the institutional documents that govern the *treatment* of gender transgressive bodies, as the authors and users of these documents are almost exclusively cisgender, individuals whose gender is the same as their birth-assigned sex (Aultman, 2014). The term cisgender emerged in the 1990s from trans activist discourses that critiqued the hegemony surrounding sex and gender and gained popularity among activists and scholars.

The fragility and vulnerability of this space was demonstrated by the cisgender heteronormativity governing it. As Butler (2004) notes, "the regulation of gender has always been part of the work of heterosexist normativity" (p. 186), and this wielding of control continued the hegemonic formations of power. However, what resulted next demonstrates the ways in which activism can exploit fissures of logic within hegemonic webs of power. During the panel, Lina Riparia, a transgender woman of color, led a walkout where protesters used their voices to drown out Zucker's presentation. Importantly, this protest led to hegemonic rebukes; specifically, hotel security removed the protesters from the premises. As a result, activists employed public relations: issuing press releases, hosting community forums, and engaging in performative strategies that challenged the stickiness of pathology. Activists demanded Zucker's symposium be cancelled and for the WPATH Executive Board to provide an explanation and apology for his presence at this conference and the 2016 WPATH conference in Amsterdam. In a statement, transgender people of color asked for a formal apology both in person and on the USPATH/WPATH website from the USPATH/WPATH board for calling security on transgender conference attendees for exercising their right to protest. Additionally, activists demanded that WPATH hire transgender people as paid consultants, give local transgender communities input into planned conferences and promise that gender transgressive persons will be given seats on WPATH committees, including the scientific committees that decide which academic papers are accepted for conferences. This example embodies what transgender scholar Keegan (2020) calls a moment of resistance "gendered self-fashioning" (p. 61) by gender transgressive people who have existed both within and against the systems that have classified them. Importantly, this was not a forum for dialog; it was a space cultivated by and for transgender women of color to vocalize their demands to the USPATH executive board. Transgender women of color demanded to be listened to and for conference organizers to acknowledge the institutional erasure and

violence against gender transgressive persons, and they called into focus the historical dissymmetry and marginalization that governs a conference focused on transgender people.

The protesters' presence was, in and of itself, an exposure of the fissures in logic in Zucker's presentation and the institutions that supported him, as it demonstrated how those with lived experiences as transgender did not conform to the constitution of normative gender that Zucker reified in his presentation. As a member of the DSM board, Zucker functions as a hegemonic vector of power. Zucker, the flagbearer of the DSM's power over transgender subjectivities, was withdrawn from the program and was institutionally rebuked through this removal. Transgender women of color used their material and embodied experiences to challenge medical and institutional hegemony. The protest was enough for several transgender women of color to gain the attention of conference organizers. During a meeting with USPATH organizers held the next morning, these women were given the floor to air their grievances with Zucker's presence at the conference. Transgender women of color refused to concede power to white and cisgender individuals, noting as one activist, Danielle Castro, emphasized during the meeting:

> Trans women of color are being pushed out to the sidelines even though we are tokenized and asked to participate in ways that exploit us to your benefit. That's not going to happen anymore. We are taking back our power and taking back our voice. . . . It's time to include us in meaningful paid and respected ways. We're not here for a dog and pony show. We've gone to school. We're working in professional settings. And it's high time our voices are respected as such.

The transgender women of color shared their list of requirements and reinforced the need for each of their demands to be immediately addressed by USPATH organizers. These demands included a formal apology posted on USPATH's social media pages and website and shared publicly at the conference, the dismissal of the individuals who called security to stop the protesters, and removal of Zucker from the conference, specifically cancelling his upcoming session. Additioally, activists called for the organization to employ transgender women of color as paid consultants throughout all levels of the USPATH and WPATH working on transgender health and conference organization. This meeting embodied the creation of "third space feminism," or what Golombisky (2015) called womanist tactics, to "get things done" (p. 407), but importantly did not include "harmonizing and coordinating" or "dialog," as it was not designed as a dialogic space between activists and organizers, rather it functioned as space for agency and dissent. This is embodied by the comments of Bamby Salcedeo, the president and CEO of the TransLatin@Coalition:

> Even though we are here in a peaceful manner, I think it's important that we understand that these are serious demands that we are presenting to all of you. We're actually expecting direct results that will change the landscape of the current violence that we're continuing to face institutionally, and within our society.

This uprising resulted in the cancelation of Zucker's panels, the issuing of a public apology to these women and to TGD conference attendees, and the instatement of a new

panel of and by transgender women of color. In this panel discussion, transgender women of color articulated their lived experiences to a standing-room-only audience, working to challenge, and unstick the pathology from its roots in institutional erasure and marginalization. They demanded accountability, respect, and safety. In this way, activist public relations that utilizes materiality functions as a way to disrupt stickiness across temporal planes. Therefore, activism is a resistance to institutional power, and this example embodies the discursive struggle that underpins the work of cultural intermediation that is anchored in the acquisition of power (Thompson, 2016).

In opposition to the hegemonically sanctioned discourses, activists were able to reclaim space and, through public relations techniques, dispel fallacies through narratives of their own lived realities. During the public apology issued by USPATH and the conference organizers, transgender women of color led the presentation by inviting those who stand in solidarity with trans women of color and the protesters to join the presenters onstage. The majority of the audience stood up and moved to the stage, demonstrating solidarity, and support for transgender women of color. Conference organizers and board members publicly apologized for Zucker's presence at the conference and their part in perpetuating the mistreatment of and violence against transgender women of color in particular, and they promised to incorporate transgender women of color into each level of WPATH's organization. Although this public apology was generally well-received, the leading activists Danielle Castro and Bamby Salecedo reiterated the importance of practicable action and material change throughout the organization, instead of limiting the apology to a single moment of solidarity. Slecedo reiterated this need for tangible change, asserting:

> I want for us to acknowledge and remember this time. Right? This is a show of solidarity. This is what solidarity looks like [. . .] We can change the landscape of our community if we really are intentional.

Surrounded on stage by transgender protesters, supporters, and allies, the transgender women of color controlled the direction and tenor of the public apology and discussion of institutional change. Centering their voices and lived experiences, the activists directly confronted the pathologization of and violence against transgender women of color and concluded with a chant of "Trans Power!" This embodied performance of agency and solidarity serves to "unstick" the association of pathology and trangender subjectivity, especially for transgender women of color. This USPATH case demonstrates how activists utilized public relations to bring key stakeholders together to pressure decision-makers to challenge the hegemonic iterations of pathology and bring about institutional change. The protest of Zucker's panel, the public apology at the conference, and the resulting panel by transgender women highlight the fissures of logic within the hegemonic orderings perpetuated by the DSM. Furthermore, these actions lay bare the racialized patholigization of institutional bodies and documents, as the organizers of these actions deliberately centered their racial identities and both the epistimioloical and physical violence perpetuated against them in their efforts. Specifically, they called attention to the inordinate levels of violence perpetuated against transgender women of color, the lack of transgender representation in positions of power in governing health institutions,

and the tokenization of their bodies for these organizations. In short, these efforts exposed a vertable cross-section of fissures of logic, setting the stage for measurable action and progress, and through activist public relations, transgender women of color took power back both materially and discursively.

This anecdote necessitates that we do not reduce transgender persons to historical victims; rather, we need to understand them as complex individuals that challenge our expectations and continuously resist the historic erasure and pathologization placed upon them by dominant health discourses. Their communication became affectively sticky to the extent that it gave rise to new capacities for thinking, doing, and being. In this instance, through their physical presence and opposition, transgender women of color "intervene[d] in and reconfigure[d] contexts. . .informing and mediating ways of knowing and acting" (Trimble, 2010: 300). This is a moment that illuminates the performance of institutional legitimacy that was challenged and apended. These activists center their lived reality, signaling a shift away from the textual to the material. Therefore, activist public relations that utilizes materiality functions as a way to disrupt stickiness across temporal planes.

We conclude with this example of the dance between hegemony and resistance, highlighting a moment of opposition. Opposition is active, not passive, and according to philosopher McWhorter (1999), is the way to enact change and to untie us from the systems of normalization:

> Opposition. . . involves a great deal more than resistance. Resistance is merely negative, a no to domination. Opposition involves something positive, a departure from dominating networks. It involves the production of a different sort of self and a different sort of community—selves and communities not bound by the dictates of sexual identification. . .Opposition, then, is not just a matter of re-creating ourselves or of creating counterculture; opposition will involve changing the dominant culture as well. And, therefore, opposition entails exercising power over other people to force them to allow us to do our self-transformative work. (p. 191).

McWhorter furthers our understanding of how to build new systems, demonstrating that in order to displace systems, we must use the systems of power already in place. In other words, the tools of the system must be inverted to reflect the fissures of the system. In this example, the USPATH conference functioned as a tool of hegemonic power, through tacit support (e.g. providing individuals like Zucker a platform) and explicit support (e.g. by upholding the WPATH standards of care). In this example, Zucker's panel represents a fissure in the logic of transgender intelligibility, as transgender women of color lay bare the illogic of this panel.

The conference served as a stage for hegemonic reification of transgender intelligibility and resistance, and the perspectives of transgender women of color provide a critical counter voice to the white cisnormativity that has produced and upheld structural and institutional violence and exclusion of trans people of color.

We argue that affect theory provides a framework to understand how discursive texts like the DSM are used performatively and have material consequences that perpetuate and reify existing pathology, and affect theory also allows us to understand how social actors, like the transgender women of color at the 2017 WPATH conference, challenge these discourses to reclaim agency, and ownership of their identities. Ahmed (2014) reminds us of "the way in

which a signifier, rather than simply naming something that already exists, works to generate that which it apparently names" (p. 92). Therefore, this moment of activism is a successful performative utterance, as it is grounded in norms already in existence, but it opens up the future, challenging the temporality of the hegemonic vectors of power like Zucker and the DSM. Importantly, a successful performative utterance relies on the citation of norms and conventions already in existence; it opens up the future by repeating past conventions.

Activists, like the transgender women of color in the aforementioned anecdote, may be well-positioned to do public relations work, facilitating change through strategic communications. Like our analysis above demonstrates, to assist in this move, activists must exploit the fissures of logic within these discourses. Turning back to McWhorter, in protest, transgender women of color first leveraged their own material existence to expose this fallacy and then utilized the conference platform, the very tools of hegemonic power, to tell their stories in contrast to the dominant discourses bull-horned by USPATH. Ahmed asks us to consider why social transformation is so difficult to achieve and why power relations are enduring even in the face of collective resistance. Activism, like that at USPATH, presents opportunities to challenge institutional and structural stickiness. In this manuscript we considered how different discursive and material functions get "stuck" together by way of texts and how this sticking depends on a history of association and institutionalization. We argue that public relations can challenge the affective assemblages that comprise and perpetuate these systems, unsettling the historical discourses that have governed gender variance by establishing new communicative possibilities.

Pulling it all together

This article challenges the public relations research that has traditionally focused on activist impact on corporate performance (Adi, 2019), and it acknowledges activists' achievements in institutional and structural change. As Weaver (2019) reminds us, "recent work that has reinterpreted activism as part of PR history is not without challenge or controversy" (p. 12). On the one hand, historically there was considerable resistance to the notion of activism as public relations work, because according to Grunig and those in the "Excellence" camp the role of public relations was to help mitigate negative impacts on corporations from potential activists (see Ciszek, 2015). On the other hand, some activists may not agree with being associated with public relations, because they might regard the term as tainted with corporate ideologies (see Coombs and Holladay, 2012). While some scholars point to consensus oriented communicative actions within activism and public relations (e.g. advocacy, dialog, engagement), other scholars emphasize the importance of dissensus where dissymmetrical relationships exist (Ciszek and Logan, 2018; Place and Ciszek, 2021). Our article argues that sometimes facilitating "understanding, sharing and forgiveness" (Toledano, 2016: 280) should not be the goal of activist public relations, especially within the historical context of groups whose lives and identities have been pathologized and marginalized.

Public relations has the opportunity to challenge the stickiness of affect, moving discourses of marginality away from structures of oppression. Affect is implicated in communicative practices, and to challenge sticky assemblages, new forms of communication are needed that present alternative potentialities. We contend public relations is an

affective practice, whereby communicators—including activists—can bring together different cognitive, social, cultural, and affective dimensions to shift the discourse around gender variance and create opportunities for future research and theory-building. There has been a "deafening silence in public relations practice and research on transgender perspectives" (Ciszek, 2018: 7), and thinking through an affective lens allows us to better understand the how public relations can challenge pathology and marginalization.

Both practically and theoretically, one of the most important implications of this manuscript is a consideration of how affective markers of institutional texts stick across time and space and how they may be challenged by activist public relations. As an institutional text, the DSM produces and circulates power. But power is not all encompassing and can be challenged through moments of activism and resistance. The potential impacts of reflective, community-generated public relations include the destabilization of institutions that are undergirded by texts like the DSM and are perpetuated through affective stickiness. Paradoxically, since documents like the DSM are created to navigate hegemonic terrain, resistance often recreates the power structure of that which it resists. In this manuscript we raise theoretical questions as to how we understand and reproduce affect, arguing that the DSM has planted the seeds for larger forms of institutional erasure and violence. Future research should examine how institutional texts influence and are influenced by power and agency, and how these texts shape the production and consumption of meaning. If, as Ahmed argues, affect is realized in and through its constant repetition, it can also be detached and reconstituted. Public relations scholars should explore the role of affect in promotional communication, attending to the role public relations plays in perpetuating and challenging institutional and structural stickiness. This article demonstrates the rich opportunities to study the flow of discursive texts in shaping the understanding of historically marginalized groups and the resulting material and institutional conditions that shape the experiences of these populations.

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ORCID iDs

Erica Ciszek https://orcid.org/0000-0001-6402-7649

Sarah Price https://orcid.org/0000-0003-0843-6688

Notes

1. While homosexuality was removed from the DSM-II in 1973, not long thereafter, the Gender Identity Disorder (GID) diagnoses found their way into DSM-III in 1980.
2. It should be noted that WPATH is the largest organization focused on transgender health and publishes the influential standards of care document (currently on its seventh edition), which is utilized by clinicians and insurance companies to dictate the terms of affirmation care for gender transgressive persons. These standards of care include the guidance that persons seeking hormone care should seek a behavioral health provider for a letter that states their mental health is sufficient. Further, for gender affirmation surgeries, letters from two behavioral health providers are required in these standards.

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Author biographies

Erica Ciszek is an Assistant Professor at the Stan Richards School of Advertising & Public Relations at the University of Texas at Austin. Her research explores the intersections of public relations, activism and social change.

Richard Mocarski is the Chief Research Officer at the University of Nebraska at Kearney and the co-founder of the community-based participatory research collaborative Trans Collaborations. His work focuses on the importance of agency and voice for members health disparate communities for the navigation of the health system.

Sarah Price is an Assistant Professor of Communication at Florida Gulf Coast University. Her research takes a rhetorical and mixed methodological approach to the intersections of gender, embodiment, and health of marginalized communities.

Elaine Almeida is a graduate student at the University of Wisconsin-Madison's school of Journalism and Mass Communication. She is currently pursuing scholarship and community work that emphasizes digital webs of healing for men of color.

EXHIBIT 126

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The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018)

Kenneth J. Zucker

Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada

ABSTRACT
Temple Newhook et al. (2018) provide a critique of recent follow-up studies of children referred to specialized gender identity clinics, organized around rates of persistence and desistance. The critical gaze of Temple Newhook et al. examined three primary issues: (1) the terms persistence and desistance in their own right; (2) methodology of the follow-up studies and interpretation of the data; and (3) ethical matters. In this response, I interrogate the critique of Temple Newhook et al. (2018).

KEYWORDS
Desistance; developmental psychiatry; DSM-5; gender dysphoria; gender identity disorder; persistence; transgender

Prolegomenon

As Temple Newhook et al. (2018) noted in the Introduction to their critical essay, they focused on "…the four most recent follow-up studies…which are most often cited as evidence for desistance theories" with regard to children variously labeled as "transgender," "gender non-conforming," etc.[1]

Four thoughts: (1) From an historical perspective, are Temple Newhook et al., in fact, "systematically [not] engaging scholarly literature" by eliding a critical discussion of the earlier studies, particularly the follow-up by Green (1987) (for references to the other "early" studies, see Ristori and Steensma [2016, Table 1])? In my view, this is a form of empirical and intellectual erasure, which should be problematized. (2) With regard to the analysis of persistence vs. desistance rates, I would not have included the study by Steensma, Biemond, de Boer, and Cohen-Kettenis (2011), since it was an intentionally selective sample and not representative of the potential pool of clients seen at the Amsterdam clinic between the years 2000 and 2007. Perhaps even more importantly, some of the participants in Steensma et al. (2011) were part of the earlier study by Wallien and Cohen-Kettenis (2008) (T. D. Steensma, personal communication, March 29, 2018); hence, Temple Newhook et al. in their Table 1 are doing a partial "duplicate" counting of the follow-up data from the Dutch clinic. (3) I think that Temple Newhook et al. should have included the follow-up study by Singh (2012), since it contains the largest number of children ($n = 139$ birth-assigned males[2]) among the recent follow-up studies (and, for that matter, any follow-up study). Temple Newhook et al. appear to implicitly devalue the Singh study (which they do not even reference) because it has not yet been published in a peer-reviewed journal.[3] However, a doctoral dissertation approved by a decent university with three Ph.D. committee members and an external Ph.D. examiner should not be ignored. (4) Temple Newhook et al. used the phrase "desistance theories," which is a bit odd. The first step is to summarize the data on persistence and desistance. The second step would be to theorize or hypothesize not only why desistance occurs when it does, but also to theorize or hypothesize why persistence occurs when it does. In my view, this is no trivial matter because, as I will discuss below, there might be very good reasons to predict that, in at least some subgroups of contemporary transgender children (or as Meadow [in press] calls them, "trans kids"), the rate of persistence is going to be much higher than reported in the follow-up studies to date.

CONTACT Kenneth J. Zucker ken.zucker@utoronto.ca Department of Psychiatry, University of Toronto, Toronto, Ontario, M5T 1R8, Canada.

On the terms persistence and desistance

Temple Newhook et al. (2018) offer up a brief discussion of the etymology of the word desistance, which I appreciated. Here, I will offer up how I think the terms persistence and desistance became part of the linguistic landscape with regard to children with a diagnosis of gender identity disorder/gender dysphoria.[4] At the 2003 meeting of the Harry Benjamin International Gender Dysphoria Association (now the World Professional Association for Transgender Health) in Gent, Belgium, I was a Discussant in a symposium and the title of my talk was "Persistence and desistance of gender identity disorder in children" (Zucker, 2003). As far as I can remember, I stumbled across the terms persistence and desistance after reading a paper by August, Realmuto, Joyce, and Hektner (1999), who reported on the rates of persistence and desistance of oppositional defiant disorder in a community sample of children with a diagnosis of attention-deficit hyperactivity disorder. At the time, the terms sounded pretty cool to me and they have been used for a long time now in clinical developmental child and adolescent psychology/psychiatry research (e.g., Farrington, 1991; Simonoff et al., 2013; Verhulst & Althaus, 1988).

For scholars writing about gender dysphoria, the terms caught on. Of course, there is no law that says these terms should be privileged. One could use alternative terms like continuation vs. discontinuation (persistence and desistance have fewer syllables), continuation vs. "in remission," etc. "In remission" is a bit too medical for my taste, but it is not necessarily an incorrect term. One could even add the term "recurrence" for those children and adolescents where gender dysphoria desists but then recurs. In any case, the "real" objection to the term "desistance" is that some clinicians, some researchers, and some activists simply don't like the empirical fact that there are some children who received the DSM-5 diagnosis of gender dysphoria (or its predecessor DSM-III/DSM-IV labels gender identity disorder of childhood or gender identity disorder) who do not continue to have "it" when they are older. That is really the crux of the discourse implicit in Temple Newhook et al.'s attempt to "reconstruct" the extant empirical literature, which the most ardent critics like to call "junk science" (e.g., Ford, 2017; Tannehill, 2016).

The data

Temple Newhook et al. (2018) use an 80% desistance rate "from a prior transgender identity" as the launching pad for their critique of the literature. I have two problems with this: one that is perhaps semantics; the other is empirical.

The term "transgender identity" is hardly an objective label for a child's gendered subjectivity. It is a label imposed by Temple Newhook et al. Of course, there may have been some children in the reviewed follow-up studies who self-identified as "trans" or "transgender" (in childhood) but I suspect that they constituted a (small) minority. And, of course, there are, no doubt, many children nowadays who would meet the DSM-5 diagnostic criteria for gender dysphoria and who self-identify as "trans" or whose parents label them as "trans" or whose clinician labels them as "trans." But a transgender identity is not isomorphic with a mental health diagnosis of gender dysphoria or even the alternative label of gender incongruence proposed for the forthcoming ICD-11 (Drescher, Cohen-Kettenis, & Reed, 2016). One could use alternative wording to summarize the data, at least as how Temple Newhook et al. see them: Of X children referred to specialized gender identity clinics at one of two academic health science centers, the majority of whom met DSM criteria for gender identity disorder of childhood or gender identity disorder, "[a]n oft-accepted interpretation of [the] findings is that approximately 80%" did not appear to have, at the time of follow-up, the developmentally equivalent adolescence or adulthood diagnosis.

Temple Newhook et al. could have done a bit of a better job in summarizing the Wallien and Cohen-Kettenis (2008) and Steensma, McGuire, Kreukels, Beekman, and Cohen-Kettenis (2013a) data by providing separate percentages by birth-assigned sex in Row 13 ("Reported desistance rate") of Table 1. In Wallien and Cohen-Kettenis, the persistence rate for birth-assigned males was 20.3% and for birth-assigned females was 50.0%. In Steensma et al., the corresponding percentages were 29.1% and 50.0%, respectively. Singh (2012), who used a methodology very similar to Drummond, Bradley, Peterson-Badali, and Zucker (2008), found a persistence rate of 12.2%. Green's (1987) study, which is arguably the most important of the "earlier" follow-up studies, found a persistence rate of 2.2% (see, for example, Zucker and Bradley [1995, pp. 283–287]). In the two Dutch studies, the

persistence rate for birth-assigned females was 2.46 and 1.71 times more likely than it was for birth-assigned males. In contrast, in the two Toronto studies, the persistence rate was similar for birth-assigned females and males. These variations deserve scrutiny and thought.

These follow-up studies were the ones used by the Gender Identity Disorders Subworkgroup to summarize the extant follow-up data in the DSM-5, where it was asserted that the "Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30.0%. In natal females, persistence has ranged from 12% to 50%" (American Psychiatric Association, 2013, p. 455). I would have preferred that Temple Newhook et al. relied on this statement rather than make vague reference to "…the media…[the] lay public, and in [unnamed] medical and scientific journals" or they could have referenced the summary article by Ristori and Steensma (2016).

I must confess having some trouble in understanding Row 7 (T1-desistant/N) in Temple Newhook et al.'s Table 1. For example, in Row 7 for Drummond et al. (2008), they give a figure of 59%. This appears to have been derived by counting the 22 participants seen for follow-up who were classified as desisters and dividing by 37 (the total number of eligible participants, of whom 12 were not part of the follow-up study because they could not be traced, their parents did not want them to take part in the study, etc.: 22/37 = 59% instead of 22/25 = 88% (as reported in Row 13).[5] The 59% figure could be interpreted as implying that as many as 41% of the potential participants could have been persisters, which is an absurd inference with no empirical basis.

Methodological and interpretive issues

Sampling

Temple Newhook et al. (2018) expressed concern about the "broad inclusion criteria" in the follow-up studies and that they were not "a representative group of transgender children." That is true. Until there is a formal epidemiological, population-based study of children who meet diagnostic criteria for gender dysphoria, it would be prudent to limit any claims about generalizability to clinic-referred samples seen during the same period of time during which the extant follow-up studies were conducted (cf. Steensma, van der Ende, Verhulst, & Cohen-Kettenis, 2013b). One could say the very same thing about contemporary samples of trans children recruited via support groups, conferences, word of mouth, etc., as in the recent studies by Olson's research group (e.g., Durwood, McLaughlin, & Olson, 2017; Olson, Durwood, DeMeules, & McLaughlin, 2016; see also Kuvalanka, Weiner, Munroe, Goldberg, & Gardner, 2017; Meadow, 2011).

Temple Newhook et al. (2018) also asserted the following:

> …this research was limited to children whose parents chose to bring them to a clinic for diagnosis and treatment and thus may have believed the child's difference was a problem, and one that required psychological treatment. Children whose parents affirmed their gender (or who did not wish to…access clinical treatment for any reason) were likely not included in these studies.

Ok, well Temple Newhook et al. (2018) were not entirely sure about this ("may have believed…likely not included…"). In Toronto, there is no question that some parents/many parents were concerned about their child's gender identity development. Others were not sure how they felt – they wanted professional advice. Others were not concerned at all but brought their child anyway (for different reasons). It would certainly be important in future studies to see how parental attitudes about their child's gender-variant behavior/gender dysphoria are associated with long-term developmental outcomes. In Steensma et al. (2013a), Temple Newhook et al. are, in my view, wrong about their "affirmation" argument because some of the children in that study "socially transitioned" from one gender to another prior to puberty, which one can only assume occurred in the context of "supportive" parents. One definition of "supportive" in the *Oxford Dictionary of Current English* (Soares, 2001) is "encouraging."

Changes in diagnostic criteria

A second issue noted by Temple Newhook et al. (2018) is that diagnostic criteria have changed over time, between the DSM-III in 1980 and the DSM-5 in 2013. That is true. Indeed, Temple Newhook et al. state that "…these studies included children who, by current DSM-5 standards, would not likely have been categorized as transgender (i.e., they would not meet

the criteria for gender dysphoria) and therefore…it is not surprising that they would not identify as transgender at follow-up." There is a lot to unpack in this statement. First, even using the earlier criteria for the diagnosis of gender identity disorder of childhood/gender identity disorder, not all of the referred children were threshold for the diagnosis (see below). Second, it is an empirical question about what the degree of overlap would be if one used DSM-III, DSM-III-R, DSM-IV, and DSM-5 criteria to classify children referred for possible gender dysphoria. I doubt that anyone will ever do such a study, so it is not worth ruminating about it. It is my clinical opinion that the similarities across the various iterations of the DSM are far greater than the differences (Zucker, 2010) and, as part of the work done by the Subcommittee on Gender Identity Disorders for the DSM-IV, provided one example of this (Zucker et al., 1998).

One minor point about changes in the diagnostic criteria: Temple Newhook et al. stated that "Evidence of the actual distress of gender dysphoria…was dropped as a requirement for [Gender Identity Disorder] in the DSM-IV…" This is wrong. Criterion D reads as follows: "The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 1994, p. 538). Of course, how exactly one operationalizes distress is a complex matter, as I have discussed elsewhere (e.g., Zucker, 1992, 2005).

Predictors of developmental psychosexual trajectories

An important point discussed by Temple Newhook et al. (2018) is that not all children seen in the follow-up studies were threshold for the DSM diagnosis in childhood (see also Olson, 2016). Indeed, they quoted from Drummond et al. (2008) the following:

> …40% of the girls were not judged to have met the complete DSM criteria for GID [Gender Identity Disorder] at the time of childhood assessment…it could be argued that if some of the girls were subthreshold for GID in childhood, then one might assume that they would not be at risk for GID in adolescence or adulthood. (p. 42)

Since I was a co-author of Drummond et al., how could I disagree with this statement?

Ten years later, here is how. On the one hand, the clinical reality is more complicated than this statement suggests. For example, there is ample contemporary clinical experience that there are many adolescents who come in the front-door for evaluation who meet the diagnostic criteria for gender dysphoria, but, retrospectively, would not have met the complete DSM-5 criteria in childhood (either by their own self-report, by their parent's perspective, or both). Some of these adolescents would not have met any of the criteria. Other adolescents (particularly birth-assigned females in my opinion) had some degree of gender-variant behavior during childhood (sometimes markedly so), but not at the level where they would have been threshold for the diagnosis because they did not express the desire to be of the other gender or some alternative gender different from their assigned gender. Thus, I would argue that degree of gender-variant behavior in childhood (with or without the presence of gender dysphoria per see) is a potential predictor of gender dysphoria in adolescence or adulthood that should not be too readily dismissed (see, e.g., Scholinski, 1997; https://dylanscholinski.weebly.com/bioinfocv.html).

On the other hand, what can we learn about the predictive value of the childhood diagnosis with regard to persistence? Table 1 shows the percentage of children classified as persisters or desisters from four follow-up studies as a function of whether or not they were threshold or subthreshold for the diagnosis in childhood. Of the 127 children who were subthreshold for the diagnosis, only 9 (7.1%) were classified as persisters. Of the 241 children who were threshold for the diagnosis, 79 (32.8%) were classified as persisters. This yields a sensitivity rate of 89.7%, which is pretty good, but a specificity rate of 42.1%, which is not so good. In absolute terms, that 7% of the subthreshold cases were classified as "persisters" at follow-up is low; nonetheless, a 7% "prevalence" rate would be substantially higher than the base rate in the general population, if, for example, one relies on some recent epidemiological studies of high-school students or

Table 1. Gender dysphoria ("persistence") at follow-up as a function of diagnostic status in childhood.

		Persistence	
		Yes	No
DSM diagnosis in childhood	Yes	79 (32.8%)	162 (67.2%)
	No	9 (7.1%)	118 (92.9%)

Note. Data from Drummond et al. (2008), Singh (2012), Steensma et al. (2013a), and Wallien and Cohen-Kettenis (2008). DSM diagnosis in childhood: Yes = threshold for the diagnosis of gender identity disorder of childhood/gender identity disorder in DSM-III, DSM-III-R, or DSM-IV. No = subthreshold.

adults who self-identify as transgender (Clark et al., 2014; Eisenberg et al., 2017; Guss, Williams, Reisner, Austin, & Katz-Wise, 2017; Wilson, Choi, Herman, Becker, & Conron, 2017). The relatively low specificity rate challenges the "No True Scotsman" argument (https://en.wikipedia.org/wiki/No_true_Scotsman), namely that desisters were not truly gender-dysphoric to begin with, so there was nothing to desist from. Only persisters were truly gender-dysphoric in childhood. But unless one wants to completely dismiss the validity of the childhood criteria, one must contemplate the fact that 67% of children who met the criteria in childhood were classified as desisters at follow-up.

In this regard, I would like to make one additional point about the Steensma et al. (2013a) study, which Temple Newhook et al. did not appreciate. Because Steensma et al. conducted what might be characterized as a relatively short-term follow-up study, they had to select from their patient pool those who were, at the time of the initial assessment, relatively old (M age, 9.15 years). Indeed, when compared to the other three follow-up studies, their probands were, on average, the oldest at the time of the childhood assessment. In other words, patients seen in the clinic at relatively younger ages were not yet old enough to be eligible to participate in the follow-up study. It is conceivable that children seen at a relatively younger age might be more likely to desist than children seen at a relatively older age.

It should, of course, be recognized that the use of the DSM diagnosis as a categorical metric (unless one does a symptom count, which no one has done) has its limitations. Accordingly, both Steensma et al. (2013a) and Singh (2012) also used dimensional metrics as predictors of persistence vs. desistance, including a childhood measure of gender identity (Wallien et al., 2009; Zucker et al., 1993), consistent with Temple Newhook et al.'s incisive reference to Schreier and Ehrensaft (2016): "Want to know a child's gender? Ask." Indeed, I have been asking for a long time (per Wallien et al., 2009 and Zucker et al., 1993).

In Singh (2012; see also Zucker, 2017), three demographic variables (age at assessment, IQ, and parent's social class background) and a composite measure of gender behavior from the childhood assessment were used in a multinomial logistic regression to predict persistence at the time of follow-up. In Table 2, the persisters (all of whom were classified as biphilic or androphilic in their sexual orientation) were compared to the desisters who were classified as (cisgender) biphilic or androphilic in their sexual orientation. It can be seen that age at assessment (older) was weakly related to prediction of persistence ($p = .09$), but that social class (lower social class background) and degree of gender-variant behavior in childhood were both significant predictors of persistence ($p < .001$ and .02, respectively). In Steensma et al. (2013a), for birth-assigned males, age at the time of assessment (older), several measures of gender-variant behavior, and whether or not the child was classified as having either a partial or complete gender role social transition prior to puberty significantly predicted persistence. For birth-assigned females, two measures of gender-variant behavior, but not age at the time of assessment or classification as having either a partial or complete gender role social transition, predicted persistence.

These studies suggest that dimensional measurement of gender-variant behavior, including measures of the child's self-reported gender identity/gender dysphoria, within a population of clinic-referred children, has the potential to predict persistence, albeit imperfectly. The data also have therapeutic implications, which I will discuss further below.

Age at the time of follow-up

I have no quarrel with Temple Newhook et al.'s (2018) cautionary remark about the relatively young age at the time of follow-up in the four core studies (in Drummond et al., 2008: M age, 23.24 years; range, 15–36; in Wallien and Cohen-Kettenis, 2008: M age, 18.9 years; range, 16–28; Singh, 2012: M age, 20.5 years; range, 13–39; Steensma et al., 2013a: M age, 16.14 years; range, 15–19). In Green's (1987) earlier follow-up study, the mean age at follow-up was 19 years (range, 14–24). However, to my knowledge, no serious

Table 2. Demographic and gender behavior predictors: multinomial logistic regression for the bisexual/androphilic persisters.

Predictor	β	SE	Wald	p	Exp (B)
Age	.26	.16	2.90	.09	1.30
IQ	.02	.03	.58	ns	1.02
Social class	−.12	.03	13.28	<.001	.89
Gender z-score	1.32	.55	5.82	.02	3.74

Note. Reference group was the bisexual/androphilic desisters ($n = 16$). For the bisexual/androphilic persisters, $n = 66$. Data from Singh (2012; see also Zucker, 2017). Social Class was measured with the Hollingshead (1975) Four-Factor Index of Social Status (absolute range, 8–66). The Gender metric was a combination of several dimensional measures administered at the baseline assessment in childhood. Exp (B), sometimes written e^B, is the multiplicative change in the odds of membership in the persister group for a one-unit increase in the corresponding predictor; thus, $100 \times (e^B - 1)$ represents the percentage change in the odds for a one-unit increase in that predictor.

scholar has claimed that "by default" it can be assumed that the desisters have been "…'correctly' categorized as cisgender for their lifetime." That is an empirical question. I certainly have seen some adolescent patients who, for example, "fluctuate" between self-identification as transgender vs. gay. For example, one young birth-assigned male with whom I worked self-identified as trans at the age of 13 but by age 15 self-identified as gay, stating "I was having a hard time accepting myself as a gay boy…I wanted to be normal" (i.e., a girl who was sexually attracted to boys); or some adolescents who initially self-identify as gay and later on shift to a transgender identity; or some adolescents who initially identify as cisgender heterosexual and then shift to cisgender gay. Temple Newhook et al., however, then go on to cite Reed, Rhodes, Schofield, and Wylie (2009): "Research has found that many trans-identified individuals come out or transition later in adulthood."

On this point, I am not sure if Temple Newhook et al. are being intentionally deceptive or do not fully appreciate that we have known for a long time that, among birth-assigned males, there are two developmental pathways leading to gender dysphoria in adulthood: early-onset (the object of this exercise) and late-onset (e.g., Blanchard, 1989, 1991; Blanchard, Clemmensen, & Steiner, 1987; Lawrence, 2010, 2017).[6] Using late-onset patients as an argument for the possibility that early-onset patients will only come out or transition in adulthood does not strike me as particularly compelling – it borders on pure sophistry, mixing apples with oranges. Nonetheless, I have no problem with the suggestion that longer term follow-up studies would be worthwhile.

Patients "lost" to follow-up

Temple Newhook et al. (2018) worry about the significance of patients lost to follow-up. Agreed. In Drummond et al. (2008; see also Drummond, 2006) and Singh (2012), an effort was made to evaluate the "internal validity" (Campbell & Stanley, 1969) of the samples by comparing those who participated in the follow-up study with those who did not on a number of demographic variables, a general measure of behavioral and emotional problems, and measures of gender-variant behavior at the time of the assessment in childhood. The data strongly suggested that there were minimal differences between those who participated in the study and those who did not. This is important. For example, suppose that the patients not seen at the time of follow-up had significantly more gender-variant behavior or were disproportionately more likely to meet the full criteria for a DSM diagnosis in childhood. Then one would indeed be worried that the followed-up sample was not representative of the entire pool of patients; it would threaten the internal validity of the sample. But this was not the case.

Authentic identities

Temple Newhook et al. (2018) make the argument that "Assertion of a cisgender identity at any point in the life cycle is often assumed to be valid and invalidates any previous assertion of transgender identity…a transgender identity is only viewed as valid if it is static and unwavering throughout the life course…" This is an absurd claim – one that is not even referenced. Who exactly makes this assertion? Who exactly is doing the invalidating? I don't think that any of the authors of the four core studies have ever made this type of assertion. Identity is a subjective construction (Zucker & VanderLaan, 2016). Of course, some "identities" are more stable and "authentic" than others (consider, for example, the chaotic subjectivities of some people with a diagnosis of borderline personality disorder [e.g., Jørgenson, 2006, 2010]). One birth-assigned male who I assessed at the age of 7 had transitioned socially around a year prior, in a sort of passive way. This child's mother asked: "So, do you want to be a boy or a girl?" The child's response was "What do you want me to be?" In my view, exploration of this child's "true" or authentic self could be explored in a psychotherapeutic safe space.

Conflation of gender identity and sexual orientation

Temple Newhook et al. (2018) argued that the follow-up studies "conflate" gender identity and sexual orientation, citing Drescher and Pula (2014) as guilty of making this conflation. This is a ridiculous assertion. In the four core follow-up studies, gender identity/gender dysphoria and sexual orientation (in relation to natal sex) were assessed with distinct measures. I am really baffled why Temple Newhook et al. make this claim. Temple Newhook et al. also suggested that the follow-up studies were too binary in their evaluations. If one makes a DSM diagnostic judgment of

gender dysphoria (present vs. absent), then, yes, one has made a binary diagnostic decision (that is the way the DSM rocks and rolls for all diagnoses). However, for many years now, I have, with colleagues, used a dimensional measure of gender identity/gender dysphoria (Deogracias et al., 2007; Singh et al., 2010), which can, in principle, capture gendered shades of grey. However, in using a binary cut-off score of caseness (cf. Wing, Bebbington, & Robins, 1981), sensitivity and specificity were shown to be quite high when comparing adolescents and adults seen in specialized gender identity clinics vs. comparison groups (Deogracias et al., 2007; Singh et al., 2010; see also Singh, McMain, & Zucker, 2011). Given the apparent increase of patients who self-identify as "non-binary" (e.g., Beek, Kruekels, Cohen-Kettenis, & Steensma, 2015; Koehler, Eyssel, & Nieder, 2018; Richards et al., 2016), employing dimensional measures of gender identity/gender dysphoria should always accompany the use of a binary diagnostic system, such as the DSM-5.

Generalization to contemporary samples of transgender children

It is not clear to me if there will be any additional follow-up studies from other specialized gender identity clinics who assessed children during a similar period of time as the four core studies, where the year of initial assessment ranged from 1975 to 2008 (the Gender Identity Development Service in London or the patients seen in-person or via internet consultation at the Children's National Medical Center in Washington, DC come to mind as having samples where such a follow-up study could be done).

The recent proliferation of gender identity clinics in North America, Europe, and elsewhere should, in theory, allow for new follow-up studies of contemporary samples (Hsieh & Leinger, 2014), along with samples obtained from outside clinical settings, as in the studies by Olson's research group (op. cit.). With the emergence in the last 10–15 years of a pre-pubertal gender social transition as a type of psychosocial treatment – initiated by parents on their own (without formal clinical consultation) or with the support/advice of professional input (e.g., Ehrensaft, 2014; Vanderburgh, 2009; Wong & Drake, 2017) – it is not clear if the desistance rates reported in the four core studies will be "replicated" in contemporary samples. Indeed, the data for birth-assigned males in Steensma et al. (2013a) already suggest this: of the 23 birth-assigned males classified as persisters, 10 (43%) had made a partial or complete social transition prior to puberty compared to only 2 (3.6%) of the 56 birth-assigned males classified as desisters. Thus, I would hypothesize that when more follow-up data of children who socially transition prior to puberty become available, the persistence rate will be extremely high. This is not a value judgment – it is simply an empirical prediction. Just like Temple Newhook et al. (2018) argue that some of the children in the four follow-up studies included those who may have received treatment "to lower the odds" of persistence, I would argue that parents who support, implement, or encourage a gender social transition (and clinicians who recommend one) are implementing a psychosocial treatment that will increase the odds of long-term persistence.

Meditations on ethics

Do contextual effects matter?

Temple Newhook et al. (2018) identified putative ethical concerns about the reviewed follow-up studies. They begin with the rhetorical statement that "research itself is an intervention." I am not quite sure what Temple Newhook et al. mean. The *Oxford Dictionary of Current English* (Soares, 2001) defines intervention as an "action…to improve or control a situation." In developmental clinical psychology and psychiatry, there are, of course, hundreds of research studies in which patients are assigned to a treatment group and some type of control group (e.g., a sham psychosocial treatment, placebo, wait-list, etc.), but the core follow-up studies were not part of any formal therapeutic (an "intervention") protocol. Now, of course, it could be argued that participation in a research study per se might have an effect on an individual and that is why ethics protocols must weigh the benefits and risks of participation. Suppose one is conducting a survey on suicidality among adolescents from the general population. It is conceivable that answering questions about suicidal thoughts might cause distress, so it is common that the protocol would give the adolescent options as to whom they could talk to about such feelings.

Temple Newhook et al. (2018) then drill down and assert that "These studies took place in the context of gender clinics in which children were put through a

substantial degree of testing over periods of months or years." I can't speak for my Dutch colleagues, but, with regard to the Toronto follow-studies, on what basis do Temple Newhook et al. make this claim? Zucker, Wood, Singh, and Bradley (2012, Tables 1 and 2) provided a summary of their clinical assessment protocol, at least around the time that their article was published. It included a family assessment interview (3 hours), an individual interview with the child (1 hour), and psychological testing (4 hours). A feedback session, often with parents alone, was estimated at 1–2 hours. I view this protocol as comprehensive and thorough, yet Temple Newhook et al. write as if it was some kind of psychological waterboarding. The "testing" hardly took place over periods of months or years.[7] Other than to imply some kind of clinical malevolence, I really don't understand what Temple Newhook et al. are trying to say. As far as I know, there is no "gold standard" for what constitutes a clinically sound assessment for children referred for gender dysphoria. If Temple Newhook et al. want to bid for an assessment hegemony, they should propose one and open it up to debate.

With regard to the children who participated in the follow-up studies, I can say this. Some of these children and their families were seen for an assessment and never seen again until the family was contacted for the follow-up (in Drummond et al., 2008, the mean interval between the baseline assessment and follow-up was 14.34 years; in Singh [2012], the mean interval was 12.88 years). Other children (and their parents) were seen for a long time in therapy (sometimes in the clinic; sometimes with clinicians in the community) because they needed it. But, to be clear, there was a lot of variability in how much clinical contact there was with families between the time of the assessment in childhood and the follow-up.

Temple Newhook et al. (2018) stated that there was "…an absence of information about whether research participation was optional and if steps were taken to ensure that children could decline research consent while continuing to received needed services." In the Toronto follow-up studies, I will make it perfectly clear the answer to this query. Yes, participation in the follow-up studies was optional and, yes, patients could decline to participate. Of the 25 participants in Drummond et al. (2008) at the time of follow-up, none were in treatment in the clinic. The one exception was an adolescent who returned to the clinic for reasons unrelated to gender identity and, at the time, was enrolled in the study. To be transparent, both studies were approved by the Institutional Review Boards at the Centre for Addiction and Mental Health and the University of Toronto. The consent form for the Drummond et al. (2008) study can be found in Drummond (2006, Appendix C); for the Singh (2012) study, Appendix F.

Do therapeutic models matter?

> …we cannot rule out the possibility that early successful treatment of childhood GID [Gender Identity Disorder] will diminish the role of a continuation of GID into adulthood. If so, successful treatment would also reduce the need for the long and difficult process of sex reassignment which includes hormonal and surgical procedures with substantial medical risks and complications. (Meyer-Bahlburg, 2002, p. 362)

> Relatively little dispute exists regarding the prevention of transsexualism, though evidence about the effectiveness of treatment in preventing adult transsexualism is also virtually nonexistent. (Cohen-Kettenis & Pfäfflin, 2003, p. 120)

> Over the last decade, we have seen a sea change in approach to pediatric transgender care, with the gender affirmative model now widely adopted as a preferred practice… (Chen, Edwards-Leeper, Stancin, & Tishelman, 2018, p. 74)

Temple Newhook et al. (2018) critique the follow-up studies in relation to therapeutic models that have been described in some detail elsewhere (deVries & Cohen-Kettenis, 2012; Zucker et al., 2012). Therapeutic models, one would hope, are informed by a conceptual/theoretical formulation about gender identity development, which, in turn, might be applied to help children, one way or the other, reduce their gender dysphoria (see also Ehrensaft, 2012, 2014; Menvielle, 2012; Pyne, 2014; Turban & Ehrensaft, 2017). A very significant problem in the field is that there are no randomized control trials (RCT) with regard to treatment of children with gender dysphoria, as has been noted in several authoritative reviews (American Academy of Child and Adolescent Psychiatry, 2012; American Psychological Association, 2015; Byne et al., 2012; see also Dreger, 2009; Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016; Green, 2017). And there won't be, because many, if not most, parents would refuse to have their children randomized into

different treatment arms (and, quite frankly, I don't blame them). A parent who would like their child's gender dysphoria reduced via psychotherapeutic methods would refuse to allow their child assigned to a gender social transition treatment approach. A parent who would like their child's gender dysphoria reduced via a gender social transition would refuse to have their child assigned to a psychotherapeutic approach. It is possible that some parents would agree to randomize their child to a "wait-and-see" (Menvielle, Tuerk, & Perrin, 2005) or "watchful waiting" (Zucker, 2008) approach as opposed to their preferred therapeutic approach, but, to my knowledge, no one has attempted such a partial RCT.

Now, of course, it would not come as a surprise if Temple Newhook et al. (2018) took umbrage at the mere idea of a treatment arm designed to reduce a child's gender dysphoria via psychotherapeutic methods. They might, for example, offer up the following from the seventh edition of the Standards of Care:

> Treatment aimed at trying to change a person's gender identity…to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964)….Such treatment is no longer considered ethical." (Coleman et al., 2011, p. 175)

Yet, on the very same page of the Standards, one finds the following: "Psychotherapy should focus on reducing a child's…distress related to the gender dysphoria…" (p. 175) or "Mental health professionals…. should give ample room for clients to explore different options for gender expression" (p. 175). The lack of internal consistency between the first statement and the second and third statements is rather astonishing. Moreover, the "without success" remark offers up two citations as authoritative proof. One was a reference to a 5-year-old boy seen by a psychoanalyst in Beverly Hills, California (see also Greenson, 1966) and other was a reference to the use of faradic aversion treatments on birth-assigned male adults said to be "transvestites with moderate transsexualism" (Gelder & Marks, 1969, p. 394). Personally, I prefer the following summary statements about therapeutics with regard to children with gender dysphoria:

> Different clinical approaches have been advocated for childhood gender discordance….There have been no randomized controlled trials of any treatment….the proposed benefits of treatment to eliminate gender discordance…must be carefully weighed against… possible deleterious effects. (American Academy of Child and Adolescent Psychiatry, 2012, pp. 968–969)

> Very few studies have systematically researched any given mode of intervention with respect to an outcome variable in GID and no studies have systematically compared results of different interventions….In light of the limited empirical evidence and disagreements…among experts in the field…recommendations supported by the available literature are largely limited to the areas [reviewed] and would be in the form of general suggestions and cautions… (Byne et al., 2012, p. 772)

> …because no approach to working with [transgender and gender nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with pre-pubertal children. Lack of consensus about the preferred approach to treatment may be due, in part, to divergent ideas regarding what constitutes optimal treatment outcomes… (American Psychological Association, 2015, p. 842)

In the Drummond et al. (2008) study, no effort was made to attempt a link between therapeutic intervention and outcome:

> It [was] beyond the scope of this report to describe the types of therapies (as well as their frequency and duration) that the girls and/or their parents may have received between the assessment in childhood and the follow-up (e.g., by a therapist within the Gender Identity Service at the Centre for Addiction and Mental Health or in the community). From the participants' clinic files, 13 of the 25 girls had at least some contact with our clinic during the interval between assessment and follow-up (e.g., as therapy clients or for a reassessment). Of the 25 girls and/or their parents, 18 had been in some type of therapy or counseling during the interval between assessment and follow-up; of these, 5 were patients of staff within the Gender Identity Service, and the remainder were seen by a professional in the community. (p. 36)

The same could be said for Singh's (2012) sample and, to my knowledge, the Dutch group as well.

Temple Newhook et al. (2018) go on to state that "It is important to acknowledge that discouraging social transition [with reference to the Dutch team's putative therapeutic approach] is itself an intervention with the potential to impact research findings…" Fair enough. But Temple Newhook et al. (2018) curiously suppress the inverse: encouraging social transition is itself an intervention with the potential to impact findings. I find this omission astonishing.

Harm, harm, and more harm

Temple Newhook et al. (2018) argue that attempts to delay or defer a gender social transition may cause harm and that such harm has been underestimated. Much of what it is argued here is, shall we say, "anecdotal" with the use of brief clinical clips. Fine. One has to start somewhere with an argument. Deep into this section, Temple Newhook et al. cite the work of Olson and her research group (op. cit.), stating that:

> Emergent research on the health and well-being of trans children who are affirmed in their gender identity… indicates mental health outcomes equivalent with cisgender peers….this is in stark contrast to the high levels of psychological distress and behavioral problems documented among children who were discouraged from asserting their identities in childhood.

This is a gross oversimplification, an oversimplification that Temple Newhook et al. require in order to assimilate their interpretation of the data into their theoretical/ethical argumentation. Disclosure: I think that the work of Olson's research group is excellent, including the studies that have assessed various parameters of gender development (e.g., Dunham & Olson, 2016; Fast & Olson, 2018; Olson & Enright, 2017; Olson & Gülgöz, 2017; Olson, Key, & Eaton, 2015). However, the Olson et al. (2016) study on mental health measurement has serious methodological flaws, which affect the interpretation of the data (cf. Turban, 2017). First, as noted earlier, the sample was not representative of socially transitioned children in general. Second, the mental health outcome data were assayed at some unspecified time interval after the social transition had occurred. Thus, although the children had, on average, scores in the nonclinical range, it is completely unclear if they would have had similar scores prior to the social transition. In other words, Olson et al. had "post-treatment" data, but no "pre-treatment" data.

The reference to the high levels of distress among children who were discouraged from "asserting their identities in childhood" is without any empirical documentation. For example, the reference to the study by Cohen-Kettenis, Owen, Kaijser, Bradley, and Zucker (2003) did not measure whether or not parents (or others) encouraged, discouraged, or were neutral with regard to the gender-variant behavior/gender dysphoria of their children. Cohen-Kettenis et al. (2003) examined other correlates of behavioral and emotional problems, but not the one that Temple Newhook et al. (2018) assert. So, here, Temple Newhook et al. have defaulted to rhetoric and dogma. In my own research over the years in which I have measured behavioral and emotional problems among children referred for gender dysphoria, I have always noted that there is a great deal of variability in clinical range problems. Gender-referred children under the age of 6 years, for example, do not show, on average, a great deal of behavioral and emotional problems (see, e.g., Zucker & Bradley, 1995, pp. 79–103; Singh, Bradley, & Zucker, 2011; for review, see Zucker, Wood, & VanderLaan, 2014). The determinants of mental health issues in children with gender dysphoria are multifactorial and should not be reduced to the simple narrative of parental support.

In general, it is of course extremely important to have systematic longer-term follow-up data on children with gender dysphoria with regard to their general well-being and psychosocial adaptation, not just information about rates of persistence vs. desistance. So, on this point, I agree with Temple Newhook et al. (2018). Drummond, Bradley, Peterson-Badali, VanderLaan, and Zucker (2018) evaluated the presence of clinical range behavioral/emotional problems and psychiatric diagnoses in the Drummond et al. (2008) cohort. Using the Child Behavior Checklist or Adult Behavior Checklist as rated by their mothers, 39.1% had clinical range scores; on the Youth Self-Report or the Adult Self-Report, 33.3% had clinical range scores. On either the Diagnostic Interview for Children and Adolescents (DICA) or the Diagnostic Interview Schedule (DIS), the participants had, on average, 2.67 diagnoses (range, 0–10). On the one hand, 33% did not meet criteria for any diagnosis; on the other hand, 46% met criteria for three or more diagnoses. (Of the three participants classified as persisters at follow-up, they had 0, 3, and 5 DICA/DIS diagnoses, respectively.) From the childhood assessment, five variables were significantly associated with a composite Psychopathology Index (PI) at follow-up: a lower IQ, living in a non-two-parent or reconstituted family, a composite behavior problem index, and poor peer relations. At follow-up, degree of concurrent homoeroticism (in relation to birth sex) and a composite index of gender dysphoria were both associated with the composite PI. Drummond et al. (2018) summarized their data as follows:

> …girls referred for gender dysphoria show, on average, a general psychiatric vulnerability as they grow up. It is,

however, important to keep in mind that there [was] variability in this vulnerability and that not all gender-dysphoric girls manifest clinical range psychopathology, both at the time of assessment in childhood and at the time of follow-up….our data suggest that it is important to consider…an integrative, holistic approach in the clinical care of these patients, which not only tracks their long-term psychosexual development, but also their mental health in general. (p. 182)

At the end of their long ethical discourse about harm, Temple Newhook et al. (2018) conclude that "…longitudinal studies about identity 'desistance' or 'persistence' are not the best tools for understanding the needs of gender-nonconforming children." Although I agree it should not be the only metric for understanding the needs of children with a diagnosis of gender dysphoria, the implicit message is something like this: Research on persistence and desistance should be suppressed: it should just disappear without a trace. This is empirical and intellectual "no platforming" at its worst. I find this ominous, but not surprising.

Notes

1 I wrote the first draft of this essay "masked" to the identity of the authors. In the interest of transparency, now that I know who the authors are, two points: The second author, Tosh, has been no fan of mine, as exemplified in the scholarly title of an essay penned for the *Psychology of Women Section Review* of The British Psychological Society entitled "'Zuck off'! A commentary on the protest against Ken Zucker and his 'treatment' of childhood gender identity disorder" (Tosh, 2011). The fourth author, Pyne, has not exactly been a fan either. In March 2016, I filed a "statement of claim" (in plain English, a lawsuit) against Pyne and the *Toronto Star Newspapers* for a piece written by Pyne (2015). As noted in the *Toronto Star* on December 19, 2017, "This material was subject to legal complaint by Dr. Kenneth J. Zucker, which has been resolved" (https://www.thestar.com/opinion/commentary/2015/12/17/discredited-treatment-of-trans-kids-at-camh-shouldnt-shock-us.html).

2 Per Bouman et al. (2017), the term "birth assigned sex" was suggested as part of the language policy for the 2017 meeting of the European Professional Association for Transgender Health. It was recommended over the terms "natal male or natal female." Natal is defined as in "relation to the...time of one's birth" (Soares, 2001). In the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), terms such as "natal girls" and "natal boys" were used. It seems to me that all of these options are reasonable.

3 If one googles "Devita Singh doctoral dissertation," the pdf of the dissertation is the first entry (see also https://search.library.utoronto.ca/details?9017513).

4 I use the diagnostic term "gender identity disorder," along with the diagnostic term "gender dysphoria" because the former was the diagnostic label at the time of the follow-up studies that are reviewed.

5 The ethics protocol was such that parents were contacted first to let them know about the study and if they were willing to let us talk to the potential participants. In part, this was because we had no way or knowing if all of the adolescents or adults would have even remembered having been seen in the clinic as a child.

6 Late-onset birth-assigned females with gender dysphoria have, in recent years, become a very salient part of the clinical landscape, particularly among adolescents (see, e.g., Littman, 2017). They are not, however, exactly parallel with some aspects of the gender developmental histories of late-onset birth-assigned males.

7 It is true, however, that, several decades ago, we did a study in which 44 children referred to the clinic and their siblings were seen for psychological testing at a one-year follow-up (median interval, 371 days) that evaluated the evidence for stability and change in gender-typed behavior (Zucker, Bradley, Doering, & Lozinski, 1985). So what? It is common in specialized clinical programs at academic health science centers to conduct such types of follow-ups. Over the subsequent years, some children might have been seen for follow-up assessment, including psychological testing, on an as needed basis for clinical reasons. At times, such a re-assessment may have been for reasons completely unrelated to the child's gender identity (e.g., a learning disability, a psychopharmacology consult, etc.). So what? This is nothing more than being clinically responsible for the well-being of one's clients.

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EXHIBIT 127

The WPATH Files

PSEUDOSCIENTIFIC SURGICAL AND HORMONAL EXPERIMENTS ON CHILDREN, ADOLESCENTS, AND VULNERABLE ADULTS

By Mia Hughes

ENVIRONMENTAL PROGRESS
NATURE, PEACE & FREEDOM FOR ALL

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EXECUTIVE SUMMARY

The World Professional Association for Transgender Health (WPATH) enjoys the reputation of being the leading scientific and medical organization devoted to transgender healthcare. WPATH is globally recognized as being at the forefront of gender medicine.

However, throughout this report, we will show that the opposite is true. Newly released files from WPATH's internal messaging forum, as well as a leaked internal panel discussion, demonstrate that the world-leading transgender healthcare group is neither scientific nor advocating for ethical medical care. These internal communications reveal that WPATH advocates for many arbitrary medical practices, including hormonal and surgical experimentation on minors and vulnerable adults. Its approach to medicine is consumer-driven and pseudoscientific, and its members appear to be engaged in political activism, not science.

While there is a place in medicine for risky experiments, these can only be justified if there is a reliable, objective diagnosis; no other treatment options are available, and if the outcome for a patient or patient group is dire.[1] However, contrary to WPATH's claims, gender medicine does not fall into this category. The psychiatric condition of gender dysphoria is not a fatal illness, and the best available studies show that in the case of minors, with watchful waiting and compassionate support, most will either grow out of it or learn to manage their distress in ways less detrimental to their health.[2,3,4]

As such, this report will prove that sex-trait modification procedures on minors and people with mental health disorders, known as "gender-affirming care," are unethical medical experiments. This experiment causes harm without justification, and its victims are some of society's most vulnerable people. Their injuries are painful and life-altering. WPATH-affiliated healthcare providers advocate for the destruction of healthy reproductive systems, the amputation of healthy breasts, and the surgical removal of healthy genitals as the first and only line of treatment for minors and mentally ill people with gender dysphoria, eschewing any attempt to reconcile the patient with his or her birth sex. This report will show that this is a violation of medical ethics and, as is revealed by its own internal communications, WPATH does not meet the standards of evidence-based medicine. It will further show that the ethical requirement to obtain informed consent is being violated, with members admitting that children and adolescents cannot comprehend the lifelong consequences of sex-trait modification interventions, and in some cases, due to poor health literacy, neither can their parents.

Given the extent of the medical malpractice WPATH endorses, our report will conclude by calling on the U.S. government to oversee a bipartisan national inquiry to investigate how activists with little respect for the Hippocratic Oath could have risen to such prominence as to set the Standards of Care for an entire field of medicine, leading to the medical abuse of minors and vulnerable adults.

1 Earl, J. "Innovative Practice, Clinical Research, and the Ethical Advancement of Medicine." [In eng]. Am J Bioeth 19, no. 6 (Jun 2019): 7-18. https://doi.org/10.1080/15265161.2019.1602175.

2 Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder [Original Research]. Frontiers in Psychiatry, 12, 287. https://doi.org/10.3389/fpsyt.2021.632784

3 Steensma, T., & Cohen-Kettenis, P. "Gender Transitioning before Puberty?". Archives of sexual behavior 40 (03/01 2011): 649-50. https://doi.org/10.1007/s10508-011-9752-2.

4 Green, R. The Sissy Boy Syndrome the Development of Homosexuality. Yale University Press, 1987. doi:10.2307/j.ctt1ww3v4c. http://www.jstor.org/stable/j.ctt1ww3v4c.

PREFACE TO THE WPATH FILES

By Michael Shellenberger, Founder and President, Environmental Progress

Readers may rightly wonder why an environmental organization is publishing a report on what is known as "gender medicine." The short answer is that we are pro-human environmentalists, and our mission is to incubate ideas, leaders, and movements for nature, peace, and freedom for all. We thus work on a wide range of issues, from climate change to homelessness to freedom of speech, all of which constitute important aspects of our "environment."

The longer answer is that I felt the WPATH Files needed to be analyzed and put in a broader historical context than possible through a series of news articles. I received the WPATH Files from a source or sources who contacted me because they had seen my work on the Twitter Files.

We are releasing all of the unedited files precisely as I received them. Nothing has been removed or added by our team, but we have organized the files to improve accessibility. We have included dates where available in the files. All discussions in the files occurred within the last four years. We are leaving only the names of the president of WPATH, most surgeons, and other prominent members unredacted. While everyone aware of the information revealed by the WPATH Files is, to some extent, responsible, we did not feel that everyone in the conversations needed to be named. The files are preceded by a report that summarizes, analyzes, and draws implications from the information they contain.

The WPATH Files are semi-private conversations inside WPATH's internal online forum for discussing specific medical cases. This forum runs on software provided by DocMatter. I made clear to the source or sources that while I welcomed all or any information they chose to share, I would not and did not solicit or encourage anyone to retrieve any information from WPATH or any other organization. All information came to me unsolicited.

We are well within our legal rights to publish the WPATH Files. Like any publisher, Environmental Progress is governed by what's known as the Pentagon Papers Principle, established by the Supreme Court in 1971. Under the Court's ruling, interpreting the First Amendment to the United States Constitution, Americans can publish information, even if it was obtained illegally, so long as we do not encourage anyone to break the law in obtaining the information.

At a moral level, we feel duty-bound to publish the WPATH Files and do everything within our power to encourage as wide an audience as possible to access them. We believe they show that WPATH is neither a scientific nor medical organization and should not be treated as one.

ACKNOWLEDGMENTS

The author would like to acknowledge, first and foremost, the source or sources of the WPATH Files. They behaved nobly in their effort to protect children and vulnerable adults from harm.

Second, she would like to acknowledge Alex Gutentag and Michael Shellenberger; their contributions to this report went far beyond editing.

Third, she would like to thank Lily Markle and Phoebe Smith for their fact-checking, proofing, and general assistance.

Finally, the author would like to thank the Environmental Progress Board of Directors and financial supporters. Thank you for thinking outside the box of "the environment" to extend your concern to vulnerable people everywhere.

INTRODUCTION

Over the past decade, there has been a huge surge in the number of young people identifying as transgender and being referred to pediatric and adult gender clinics. A thorough analysis of all the possible explanations for this change is beyond the scope of this report, but there are two opposing viewpoints worth describing briefly. On one side, activists argue that the sudden increase is due to shifting societal attitudes and greater acceptance of the transgender community, making it easier for transgender people to come out of the closet and live as their true, authentic selves. On the other side, critics of gender-affirming care for minors favor the rapid-onset gender dysphoria hypothesis, which argues that there is strong peer and online influence as well as maladaptive coping mechanisms involved in the adoption of a transgender identity.

This "social genesis" or "social contagion" argument is supported by the fact that adolescent girls and young women now make up most of the referrals to gender clinics when, in the past, it was predominantly young boys and adult men. Teenage girls and young women have been at the forefront of almost every social contagion in recorded history, including contagions of hysteria, eating disorders, cutting, and dissociative identity disorder. The social contagion argument is also supported by the high prevalence of mental health and neurocognitive disorders among trans-identified youth, and the fact that these problems typically precede the onset of gender issues. Despite receiving criticism from activists, the rapid onset gender dysphoria theory has been endorsed by gender clinicians across the West.[5,6,7]

However, this report does not delve into the cultural factors responsible for the rising numbers. Instead, our focus narrows in on the conduct of WPATH members and the type of medical care the leading transgender health group endorses. The scope of this report is the potential harm inflicted upon adolescents and vulnerable adults within gender-affirming clinics.

WPATH is considered the leading authority on the care and treatment of individuals who have gender dysphoria and/or identify as transgender. WPATH publishes internationally respected Standards of Care, which it claims represent a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria. Medical and mental health professionals worldwide look to these guidelines as the best available resource to guide them in caring for transgender and gender-diverse patients.

But the WPATH Files show something entirely different. Before discussing what they show, we recommend the reader turn to the files and read them in their entirety. They are complete from what a source or sources provided to us.

Now, we will put the WPATH Files in a wider historical and ethical context.

5 Hutchinson, A., Midgen, M., & Spiliadis, A. (2019). In Support of Research Into Rapid-Onset Gender Dysphoria. Archives of Sexual Behavior, 49. https://doi.org/10.1007/s10508-019-01517-9

6 Kaltiala, R. (2023). 'Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It.'. The Free Press. https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor

7 Levine, S. B. (2019). Informed Consent for Transgendered Patients. J Sex Marital Ther, 45(3), 218-229. https://doi.org/10.1080/0092623x.2018.1518885

A BRIEF HISTORY OF TRANSGENDER MEDICINE AND THE EARLY DAYS OF WPATH

The experiment to modify the sex characteristics of people suffering from the psychiatric disorder called gender dysphoria began in the early years of the 20th century with the pioneering work of German sexologist Magnus Hirschfeld. A gay man who engaged in cross-dressing, Hirschfeld coined the term transvestite in his 1910 book *Die Transvestiten* and regarded both homosexuals and transvestites to be "sexual intermediaries."[8, 9]

Hirschfeld oversaw the world's first attempt at "sex-reassignment" surgery performed on Martha/Karl Baer in 1906. While little is known about the precise nature of the surgery because the records were lost during the 1933 Nazi book-burning of Hirschfeld's research,[10, 11] it is believed to have been a metoidioplasty, which is the creation of a pseudo-phallus out of an enlarged clitoris. Baer is thought to have had a disorder of sexual development (DSD) and was reportedly genetically male.[12,13]

In 1919, Hirschfeld opened the Institute for Sexual Science in Berlin, which was a first-of-its-kind clinic providing counseling and treatment for "physical and psychological sexual disorders" as well as, in particular, for "sexual transitions."[14] Notably, Einar Wegener, or Lili Elbe, whose story was popularized in the film *The Danish Girl*, underwent surgical castration in Berlin under Hirschfeld's supervision in 1930.[15, 16] This was the first in a series of surgeries culminating in a womb transplant in 1931. Elbe died of heart failure three months after the final surgery, most likely due to organ rejection.[17,18]

That same year, Dora Richter underwent vaginoplasty, also under the care of Hirschfeld.[19] Erwin Gohrbandt performed Richter's surgery, which is considered the world's first successful male-to-female sex reassignment.[20,21] Gohrbandt then went on to join the Luftwaffe and participated in the hypothermia experiments conducted at Dachau concentration camp.[22]

Despite medical advances such as the development of antibiotics and the ability to create synthetic hormones, interest in sex-reassignment procedures waned over the next couple of decades, only to be rejuvenated in the 1950s with the sensational case of Christine Jorgensen.

On December 1, 1952, the New York Daily News ran a front-page story under the headline "Ex-GI Becomes

8 Matte, N. "International Sexual Reform and Sexology in Europe, 1897–1933." Canadian Bulletin of Medical History 22, no. 2 (2005): 253-70. https://doi.org/10.3138/cbmh.22.2.253.

9 Hill, Darryl B. "Sexuality and Gender in Hirschfeld's Die Transvestiten: A Case of the" Elusive Evidence of the Ordinary"." Journal of the History of Sexuality 14, no. 3 (2005): 316-32. https://muse.jhu.edu/article/195723.

10 "6 May 1933: Looting of the Institute of Sexology." Holocaust Memorial Day Trust, https://www.hmd.org.uk/resource/6-may-1933-looting-of-the-institute-of-sexology/.

11 "Karl M Baer: First Transgender Person to Undergo Female-to-Male (Ftm) Surgery." Let Her Fly, 2022, https://letherfly.org/karl-m-baer-the-first-person-in-the-world-to-undergo-sex-change-surgery/.

12 Funke, J. "The Case of Karl M.[Artha] Baer: Narrating 'Uncertain'sex." In Sex, Gender and Time in Fiction and Culture, 132-53: Springer, 2011.

13 "Recalling the First Sex Change Operation in History: A German-Israeli Insurance Salesman." Haaretz, 2015, https://www.haaretz.com/israel-news/2015-12-05/ty-article/.premium/the-first-sex-change-surgery-in-history/0000017f-f3fd-d5bd-a17f-f7ffa4970000?lts=1698264422989.

14 "The First Institute for Sexual Science (1919-1933)." Magnus-Hirschfeld-Gesellschaft, https://magnus-hirschfeld.de/ausstellungen/institute/.

15 "Publication History." Lili Elbe Digital Archive, http://lilielbe.org/narrative/publicationHistory.html.

16 "Books of the Times; Radical Change and Enduring Love." The New York Times, 2000, https://www.nytimes.com/2000/02/14/books/books-of-the-times-radical-change-and-enduring-love.html.

17 "Lili Elbe (Einar Wegener), 1882-1931." Danmarks Historien, https://danmarkshistorien.dk/vis/materiale/lili-elbe-einar-wegener-1882-1931/

18 "Lili Elbe." Biography 2022, https://www.biography.com/artists/lili-elbe.

19 Hirschfeld, https://www.hirschfeld.in-berlin.de/institut/en/personen/pers_34.html.

20 Abraham, F. "Genital Reassignment on Two Male Transvestites." International Journal of Transgenderism 2 (1998): 223-26. https://editions-ismael.com/wp-content/uploads/2017/10/1931-Felix-Abraham-Genital-Reassignment-on-Two-Male-Transvestites.pdf.

21 "Pioneers of Gender Reassignment Surgery." LGBT Health and Wellbeing, https://www.lgbthealth.org.uk/blog/pioneers-gender-reassignment-surgery/#:~:text=It%20was%20Dora%20Richter%20in,region%20to%20a%20poor%20family.

22 "The Nazi Doctors and the Nuremberg Code." Oxford University Press, 36. http://www.columbia.edu/itc/history/rothman/COL476I1854.pdf.

Blonde Beauty."[23] Jorgensen had traveled to Denmark the year before and, under the care of Dr. Christian Hamburger, underwent a series of surgeries involving castration and the creation of a semblance of external female genitalia.[24,25,26]

In 1953, after returning home to the US, Jorgensen became a patient of Dr. Harry Benjamin, a German endocrinologist with an interest in transsexualism, as it was known at the time.[27] Benjamin's career in medicine had had a disreputable beginning when, in 1913, he arrived in New York as the assistant of a quack peddling "turtle treatment," a fake tuberculosis vaccine.[28] Benjamin had no formal training in sexology, but as a lifelong friend of Hirschfeld, he had a fascination for the subject, and by the 1950s, his practice was almost exclusively focused on transsexualism.[29]

While Jorgensen brought fame and attention to Benjamin's obscure interest in transsexualism, it was another patient who brought the other essential element: money. Reed (Rita) Erickson, a female who transitioned to live as a man, became Benjamin's patient in 1963. Heir to a fortune, Erickson's philanthropic organization, Erickson Educational Foundation (EEF), funded the first three International Symposiums on Gender Identity as well as the newly formed Harry Benjamin Foundation.[30] This enhanced Benjamin's professional status, lending credibility to his sex change experiment. Benjamin coined and popularized the term "transsexual" with his 1966 book, *The Transsexual Phenomenon*.

Another of Erickson's philanthropic endeavors was to fund North America's first gender clinic at Johns Hopkins Hospital in Baltimore.[31] It was at this clinic that Dr. John Money conducted his unethical experiments on children born with disorders of sexual development, the most famous case being that of the Reimer twins. As a baby, David Reimer was the victim of a catastrophic medical accident when the cauterizing equipment malfunctioned during his circumcision, amputating his penis. Money convinced David's parents to raise him as a girl, an experiment that failed[32] and ultimately resulted in David committing suicide at age 38. His twin brother Brian had died two years previously of an overdose.

But Money didn't just experiment on children. During the same period, he attempted to perform sex changes on adults, claiming great success. But when Dr. Paul McHugh became psychiatrist-in-chief at Johns Hopkins in 1975, he commissioned a follow-up study of the adults who had undergone these procedures, which found that while most of the patients claimed to be satisfied and experiencing no regret, there was little change in their psychological functioning. McHugh concluded that Johns Hopkins was, therefore, wasting scientific and technical resources by cooperating with a mental illness rather than trying to study, cure, and prevent it.[33] The clinic was shut down in

23 "Ex Gi Becomes Blonde Beauty." Newspapers by Ancestry, https://www.newspapers.com/article/daily-news-ex-gi-becomes-blonde-beauty/25375703/.

24 Hamburger, C., Sturup, G. K., & Dahl-Iversen, E. "Transvestism; Hormonal, Psychiatric, and Surgical Treatment." [In eng]. J Am Med Assoc 152, no. 5 (May 30 1953): 391-6. https://doi.org/10.1001/jama.1953.03690050015006.

25 "A Gender-Affirming Surgery Gripped America in 1952: 'I Am Your Daughter'." The Washington Post, 2023, https://www.washingtonpost.com/history/2023/06/12/first-transgender-surgery-christine-jorgensen/.

26 Hadjimatheou, C. "Christine Jorgensen: 60 Years of Sex Change Ops." BBC News 30 (2012). https://www.bbc.com/news/magazine-20544095.

27 Schaefer, L. C., & Wheeler, C. C. "Harry Benjamin's First Ten Cases (1938–1953): A Clinical Historical Note." Archives of Sexual Behavior 24, no. 1 (1995/02/01 1995): 73-93. https://doi.org/10.1007/BF01541990.

28 Newspapers by Ancestry, https://www.newspapers.com/article/altoona-tribune/3750641/.

29 "Trans Medical Care at the Office of Dr. Harry Benjamin." NYC LGBT Historic Sites Project, 2023, https://www.nyclgbtsites.org/site/trans-medical-care-at-the-office-of-dr-harry-benjamin/.

30 "Reed Erickson and the Erickson Educational Foundation." University of Victoria, https://www.uvic.ca/transgenderarchives/collections/reed-erickson/index.php.

31 Ibid (n.30)

32 Diamond, M., & Sigmundson, H. K. "Sex Reassignment at Birth: Long-Term Review and Clinical Implications." Archives of Pediatrics & Adolescent Medicine 151, no. 3 (1997): 298-304. https://doi.org/10.1001/archpedi.1997.02170400084015.

33 "Surgical Sex." First Things, 2004, https://www.firstthings.com/article/2004/11/surgical-sex?s=04&fbclid=IwAR2ULl9vuPZZQAjVMDFQub4PZ9S78mVMtDf6ssJoHdl8qRnuJS0myHEVbzA.

1979.

Even Erickson's own story has no happily ever after, lending weight to McHugh's conclusions. After commencing hormonal and surgical sex change interventions under the care of Benjamin, Erickson developed a drug addiction and endured a lifelong battle with substance abuse. What followed was four failed marriages and a life of turmoil. Erickson's EEF folded in 1977, and the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was formed in 1978, which would later become WPATH.

HBIGDA published its first Standards of Care (SOC) in 1979, followed closely by SOC2 in 1980, SOC3 in 1981, and SOC4 in 1990.[34] In its early days, HBIGDA members at least attempted to pursue science and an understanding of this complex psychiatric disorder and the various psychological, hormonal, and surgical interventions available as a form of treatment. But around the late 1990s, the group took a turn.

Dr. Stephen B. Levine was the chair of the SOC5 committee in 1998 and recommended that the guidelines require patients to obtain two letters from mental health professionals before commencing hormones.[35] Dr. Richard Green, HBIGDA president at the time, was unhappy with this requirement and so immediately commissioned SOC6, which was published just three years later and was almost identical but advised only one letter from a mental health professional.[36]

In the intervening years, activists began to overtake HBIGDA, and in 2002, Dr. Levine resigned his membership due to his "regretful conclusion that the organization and its recommendations had become dominated by politics and ideology, rather than by scientific process, as it was years earlier."[37] In 2007, the organization changed its name to the World Professional Association for Transgender Health. This change was significant. At the stroke of a brush, a loose affiliation of people had appointed themselves as the leading international authority on gender medicine.

With the publication of its SOC7 in 2012, the ideological shift identified by Levine was evident. SOC7 recommended puberty blockers as a fully reversible pause for adolescents despite the fact that the experiment was still in its earliest stages and no such conclusion could be drawn. Also, while on the one hand, SOC7 encouraged caution and psychotherapy that affirms the transgender identity, on the other, the guidance endorsed the "informed consent model of care,"[38] which omits the need for psychotherapy and enables healthcare professionals to provide hormones on demand.[39] This came two years after WPATH had issued a statement calling for the "de-psychopathologization of gender variance worldwide," which framed being transgender as a normal, healthy variation of human existence.[40] SOC7 followed on from this, suggesting that any mental health issue in a person identifying as transgender is due to "minority stress," a result of prejudice and discrimination in society.[41]

Then, a year after the publication of SOC7, in line with WPATH, the American Psychiatric Association (APA) released the 5th edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5), in which "gender identity disorder" was renamed "gender

34 "History and Purpose." WPATH, https://www.wpath.org/soc8/history.

35 Levine, S., Brown, G., Coleman, E., Cohen-Kettenis, P., Joris Hage, J., Maasdam, J., Petersen, M., Pfäfflin, F., & Schaefer, L. "The Hbigda Standards of Care for Gender Identity Disorders." Journal of Psychology & Human Sexuality 11 (12/06 1999). https://doi.org/10.1300/J056v11n02_01.

36 O'Malley, S. & Ayad, S. Pioneers Series: We Contain Multitudes with Stephen Levine. Podcast audio. Gender: A Wider Lens Podcast2022. https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-stephen-levine, 40:00.

37 "Dekker V Weida, Et. Al." 34-35. https://ahca.myflorida.com/content/download/21427/file/Dekker_v_Weida_Levine_Report.pdf.

38 "Standards of Care-7th Version." WPATH, 35. https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf.

39 Reisner, S. L., Bradford, J., Hopwood, R., Gonzalez, A., Makadon, H., Todisco, D., Cavanaugh, T., et al. "Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health." Journal of Urban Health 92, no. 3 (2015): 584-92. https://doi.org/10.1007/s11524-015-9947-2.

40 "Wpath / Uspath Public Statements." WPATH, 2023, https://www.wpath.org/policies.

41 Ibid (n.38 p.4)

dysphoria." This redefinition shifted the focus of diagnosis from the identity itself to the distress and difficulty in social functioning arising from the incongruity between the mind and body.

In the decade that passed between the publication of SOC7 and SOC8 in 2022, WPATH veered into new terrain. Just two days after SOC8 was published in September 2022, the group hastily removed almost all lower age requirements from the document,[42] in a bid to avoid malpractice lawsuits.[43] SOC8 also contains a chapter on nonbinary medical interventions, which include recommendations on nullification procedures to create a smooth, sexless appearance for people who identify as neither male nor female and penis-preserving vaginoplasties for those patients who desire both sets of genitals.

Of note, an earlier draft of SOC8 had contained a chapter on ethics, but this was cut from the final version. However, it was the inclusion of a whole chapter on eunuch as a valid gender identity, eligible for hormonal and surgical castration, that sent shockwaves through the medical profession and provided the catalyst for the Beyond WPATH declaration, now signed by more than 2,000 concerned individuals, many of whom are clinicians working with gender diverse young people.[44] The declaration states that WPATH has discredited itself with its SOC8 and can no longer be viewed as a trustworthy source of clinical guidance in the field of gender medicine.

At Environmental Progress, we echo this call and go one step further, calling for reputable medical organizations like the American Academy of Pediatrics (AAP), the American Psychiatric Association (APA), and the American Medical Association (AMA) to cut ties with the organization and to abandon its guidelines in favor of ethical, evidence-based medicine.

The author of this report contacted each member who appears in the files and a leaked panel discussion requesting comment. However, despite these efforts, only one member of WPATH responded, and that response contained legal threats. Also, a source or sources shared an internal email showing WPATH advising against replying and informing the recipients that WPATH was seeking legal counsel.

42 "Wpath Explained." Genspect, 2022, https://genspect.org/wpath-explained/.

43 "Wpath Explains Why They Removed Minimum Age Guidelines for Children to Access Transgender Medical Treatments: So Doctors Won't Get Sued." The Daily Wire, 2022, https://www.dailywire.com/news/wpath-explains-why-they-removed-minimum-age-guidelines-for-children-to-access-transgender-medical-treatments-so-doctors-wont-get-sued.

44 "Beyond Wpath." Beyond WPATH, 2022, https://beyondwpath.org/.

WPATH HAS MISLED THE PUBLIC

WPATH advocates for minors to have access to gender-affirming care, which is the treatment pathway involving puberty blockers, cross-sex hormones, and surgeries that are intended to align the young person's body with their self-declared transgender identity. Implicit in this endorsement is the fact that adolescents can sufficiently comprehend the full implications of these treatments, and their parents can provide legal informed consent.

The organization at the forefront of transgender health care claims that clinical guidelines for youth with self-declared transgender identities "support the use of interventions for appropriately assessed minors."[45]

WPATH advises healthcare providers to use the World Health Organization's International Classification of Diseases (ICD-11) classification of "gender incongruence" over the DSM-5's "gender dysphoria." This recommendation is motivated by the fact that the ICD-11 diagnosis is categorized as a "condition related to sexual health" and not a mental disorder, a move intended to destigmatize transgender identities further.

A diagnosis of gender incongruence is even easier to obtain than one of gender dysphoria because all the patient needs to experience is a marked incongruence between their internal sense of self and their biological sex. There is no requirement for the presence of distress as a criterion, meaning a patient's "embodiment goals" can be deemed medically necessary care.

But while WPATH publicly supports minors and their families consenting to these hormonal and surgical treatments based on a nebulous inner sense of self, privately, some members admit that consent is not possible. Behind closed doors, WPATH-affiliated healthcare professionals confess that their practices are based on improvisation, that children cannot comprehend them, and that the consent process is not ethical. Thus, WPATH is dishonest with the public and knowingly operates without transparency.

WPATH Knows Children Do Not Understand the Effects of Hormone Therapy

WPATH's Standards of Care 8 recommends adolescents who have received a diagnosis of "gender incongruence" have access to puberty blockers, cross-sex hormones, and surgeries so long as the young person "demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment."

However, in video footage obtained by Environmental Progress of an internal WPATH panel titled Identity Evolution Workshop held on May 6, 2022, panel members admit to the impossibility of getting proper informed consent for hormonal interventions from their young patients.[46]

During the panel, Dr. Daniel Metzger, a Canadian endocrinologist, discussed the challenges faced when attempting to obtain consent from adolescents seeking this medical treatment. Metzger reminded those assembled that gender doctors are "often explaining these sorts of things to people who haven't even had biology in high school yet," adding that even adult patients often have very little medical understanding of the effects of these interventions.

Metzger describes young patients attempting to pick and choose the physical effects of hormone therapy, with some wanting a deeper voice without facial hair or to take estrogen without developing breasts. This suggests a very poor understanding of the workings of the human body and the treatment pathway on the part of adolescent

45 Leibowitz, S., Green, J., Massey, R., Boleware, A. M., Ehrensaft, D., Francis, W., Keo-Meier, C., et al. "Statement in Response to Calls for Banning Evidence-Based Supportive Health Interventions for Transgender and Gender Diverse Youth." International Journal of Transgender Health 21, no. 1 (2020/01/02 2020): 111-12. https://doi.org/10.1080/15532739.2020.1703652. https://shorturl.at/bDGUZ

46 Massey, R., Berg, D., Ferrando, C., Green, J., & Metzger, D. (2022, May 6th) WPATH GEI Identity Evolution Workshop [internal panel].

patients, something noted by the WPATH expert.

"It's hard to kind of pick and choose the effects that you want," concluded Metzger. "That's something that kids wouldn't normally understand because they haven't had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y, and that's not always possible."

Metzger tells his young patients that they might not "be binary, but hormones are binary." He describes having to explain to children and even adults that "you can't get a deeper voice without probably a bit of a beard" and "you can't get estrogen to feel more feminine without some breast development."

There was agreement among the panel of experts about children's inability to comprehend the powerful and life-altering effects of the hormone therapy they are seeking. Another prominent WPATH member, Dianne Berg, a child psychologist and co-author of the child chapter of SOC8, chimed in to say that they wouldn't expect children and young adolescents to grasp the effects of the treatment because it is "out of their developmental range to understand the extent to which some of these medical interventions are impacting them."

The immaturity of these patients was further demonstrated when Berg said, "They'll say they understand, but then they'll say something else that makes you think, oh, they didn't really understand that they are going to have facial hair."

Yet, publicly, WPATH never discusses any of this. On the rare occasion that WPATH makes public statements, sex-trait modification interventions are presented as age-appropriate, essential medical care, and any opposition to such interventions is framed as transphobia.

"Anti-transgender health care legislation is not about protections for children but about eliminating transgender persons on a micro and macro scale," said WPATH President Dr. Marci Bowers in a May 2023 statement opposing US bans on gender-affirming care for minors. "It is a thinly veiled attempt to enforce the notion of a gender binary."[47]

It is the responsibility of parents to provide legal consent before a doctor can block a child's puberty or administer irreversible cross-sex hormones, but during the panel, Berg provides evidence that even some parents do not have sufficient levels of health literacy to comprehend the effects of this treatment protocol, and she admits that current practices are not ethical.

"What really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for," said Berg. She suggests a solution is to "normalize" that it is okay not to understand right away and to encourage patients to ask questions. That way, gender-affirming healthcare providers can do a "real informed consent process" rather than what is currently happening, which Berg thinks is "not what we need to be doing ethically."

WPATH Knows Children Cannot Consent to Iatrogenic Fertility Loss

Another crucial aspect of the informed consent process that these WPATH members confess is being violated is the issue of allowing minors to consent to a treatment pathway that could result in sterility. WPATH's SOC8 stipulates that doctors must inform the young person about "the potential loss of fertility and available options to preserve fertility." By advocating for adolescents in early puberty to have access to hormonal interventions that could leave them sterile, the world-leading transgender health group is implying that minors have the cognitive capacity to make such a decision about their future.

However, on the inside, prominent WPATH members confess that it is impossible for adolescents to understand the gravity of the decision. Dr. Ren Massey, a psychologist and co-author of the adolescent chapter of the latest

47 "Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in the Us." WPATH, 2023, https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH_WPATH%20Statement%20re_%20GAHC%20march%208%202023.pdf.

standards of care, told the panel that, according to SOC8, "it's encouraged, and ethical, to talk about fertility preservation options," stressing that it is "even important for youth who are going on puberty blockers because many of those youth will go directly onto affirming hormone therapies which will eliminate the development of their gonads producing sperm or eggs," a function that the young patients may desire "if they want to be partners with somebody else later in contributing genetic material for reproduction."

Metzger responded that "it's always a good theory that you talk about fertility preservation with a 14-year-old, but I know I'm talking to a blank wall," adding, "they'd be like, ew, kids, babies, gross."

"Or, the usual answer is, 'I'm just going to adopt.' And then you ask them, well, what does that involve? Like, how much does it cost? 'Oh, I thought you just like went to the orphanage, and they gave you a baby.'"

This remark was met with smiles and nods from the panel. These comments prove that WPATH members are aware that the young patients who will lose their fertility as a consequence of gender-affirming treatments don't yet understand what they are sacrificing. They do not understand how they may come to want biological children of their own one day, nor do they even understand how adoption works or how arduous it can be to conceive a baby via in vitro fertilization.

These private comments are in stark contrast to WPATH's public stance. In a recent statement opposing US bans on sex-trait modification interventions for minors, WPATH said, "the benefits that these medically necessary interventions have for the overwhelming majority of youth … are well-documented. Providers who collaboratively assess youths' understanding of themselves, their gender identity, and their ability to make informed decisions regarding medical/surgical interventions (which are not offered prior to puberty and never without the youth's assent) play a very important role in minimizing future regret." However, WPATH members know this level of understanding is simply not possible, making WPATH's statement dishonest.

What's more, members are aware that there is already research showing significant reproductive regret among a cohort of Dutch patients who were some of the first to undergo early puberty suppression.

Metzger told the panel about data presented by Dutch researchers at a recent meeting of the Pediatric Endocrine Society. "Some of the Dutch researchers gave some data about young adults who had transitioned and [had] reproductive regret, like regret, and it's there," he said, "and I don't think any of that surprises us."

One reason Metzger is not surprised is that he has observed regret in his own patients.

"I think now that I follow a lot of kids into their mid-twenties, I'm like, 'Oh, the dog isn't doing it for you, is it?' They're like, 'No, I just found this wonderful partner, and now want kids' and da da da. So I think, you know, it doesn't surprise me," said Metzger.

In fact, the preliminary findings of the research to which Metzger appears to be referring were presented a few months later at WPATH's International Symposium in Montreal in September 2022.[48] The team of Dutch researchers gave a presentation of the results of the first long-term study of young people who had their puberty suppressed, and as Metzger suggested, the results were far from encouraging.

In a segment titled, Reflecting on the Importance of Family Building and Fertility Preservation, Dr. Joyce Asseler revealed that 27% of the young people who had undergone early puberty suppression followed by cross-sex hormones and surgical removal of the testes or ovaries, now, at an average age of 32, regret sacrificing their fertility, or as the Dutch researchers worded it, "find their infertility troublesome." A further 11% are unsure about

48 Steensma, T. D., de Rooy, F. B. B., van der Meulen, I. S., Asseler, J. D., & van der Miesen, A. I. R. (2022, September 16–20). Transgender Care Over the Years: First Long-Term Follow-Up Studies and Exploration of Sex Ratio in the Amsterdam Child and Adolescent Gender Clinic [Conference presentation].

how they feel about their infertility, and while none opted for fertility preservation in the form of freezing their eggs or sperm before embarking upon medical transition as adolescents, 44% of the natal females and 35% of the natal males would now choose fertility preservation if they could go back in time. The majority, 56%, of study participants either have the desire for children or have already "fulfilled this desire," presumably by adoption.

The 27% regret rate is also very likely an underestimate. Asseler quotes one participant who did not find their infertility "troublesome," who responded, "I can find it troublesome, but it's too little too late. Unfortunately, I can't change it, even if I would like to." Also, like most other studies in this field, this one suffers from a high loss to follow-up, with 50.7% of eligible participants failing to take part, so we cannot know the true regret rate in this cohort of young people.

Berg remarked that the issue of 9-year-olds grappling with understanding lifelong sterility has her "stumped," and Metzger acknowledged that "most of the kids are nowhere in any kind of a brain space to really talk about it in a serious way." This bothers the WPATH expert, who just wants "kids to be happy, happier, in the moment."

While prioritizing the alleviation of a child's distress in the present moment at the cost of their future fertility is deeply misguided, Metzger makes further comments indicating that WPATH's gender-affirming care doesn't even accomplish this dubious goal. Metzger says putting a nine-year-old on puberty blockers before they get to the age of developing their sexual identity "cannot be great," and admits that gender-affirming doctors are "to a degree robbing these kids of that sort of early-to-mid pubertal sexual stuff that's happening with their cisgender peers."

Adolescence is a difficult time for any young person as they yearn for acceptance among their peers. Erik Erikson, a child psychoanalyst, stated that the primary goal of adolescence is to establish identity.[49] He viewed adolescence as a time of confusion and experimentation. Building on Erikson's work, Canadian developmental psychologist James Marcia coined the term "identity moratorium," describing the stage of adolescence as an exploration rather than a time for a young person to commit to any single cause or identity.[50]

Identity development during this crucial phase relies heavily on social interactions, and the experience of isolation and loneliness is especially distressing for a young person still finding their way in the world. Therefore, Metzger's comments show that WPATH is knowingly promoting a medical treatment that might exacerbate an adolescent's social challenges rather than alleviate them, meaning this medical intervention, which comes at such an enormous cost, fails even to achieve Metzger's misguided aim of making kids "happier in the moment."

What's more, a thread in WPATH's internal messaging forum provides proof that some adolescents with developmental delays are being put on puberty blockers. A physician-assistant and professor at Yale School of Medicine posted in the group asking for advice about a developmentally delayed 13-year-old who was already on puberty blockers but may not reach the "emotional and cognitive developmental bar set by [SOC8] within the typical adolescent time frame if at all" to give cognitive consent to cross-sex hormones. The Yale professor and practicing clinician wanted to know when it would be ethical to allow the young patient to progress to "gender-affirming hormone therapy."

A psychiatrist from Nova Scotia replied that the "guiding principle would be weighing [the] harm of acting vs not acting." This WPATH member defined "harm" as halting puberty suppression and advised that puberty blockers cannot be continued indefinitely without a sex steroid hormone as well. A Pennsylvania therapist replied saying, "[k]ids with intellectual disabilities are able to consent to other surgeries," and wondered if there was

49 Erikson, E. H. (1968). Identity: youth and crisis. Norton & Co.

50 Kroger, J., & Marcia, J. (2011). The Identity Statuses: Origins, Meanings, and Interpretations. In (pp. 31-53). https://doi.org/10.1007/978-1-4419-7988-9_2

important context missing from the original post.

An activist and law professor at the University of Alberta shared a paper to help the Yale professor solve this ethical conundrum. "Regardless of patients' capacity, there is usually nobody better positioned to make medical decisions that go to the heart of a patient's identity than the patients themselves," says the paper, adding that because "gender uniquely pertains to personal identity and self-realisation, parents…are rarely better positioned to make complex medical decisions."[51]

Because parents are usually "cisgender," meaning not transgender, they "rarely have an intimate appreciation of transness or gender dysphoria, and never have an intimate appreciation of the patient's gender subjectivity," reads the paper. By contrast, patients, even developmentally delayed adolescents, have an "intimate understanding of their own gender subjectivity" and will almost always have a "substantial, although limited, appreciation" of the risk of harm and infertility.

Therefore, according to this logic, minors who identify as transgender, even those with severe mental health issues or developmental delays, can "appreciate both sides of the equation," meaning they are better positioned than their parents to make complex medical decisions that will have life-long consequences.

This political activist, who has no medical training, is a frequent contributor to the conversations inside the WPATH forum. However, this opinion is, in fact, in line with WPATH's official stance on allowing adolescents with developmental delays to give cognitive consent to experimental sex-trait modification interventions. In a 2022 public statement, WPATH called delaying or withholding puberty blockers and cross-sex hormones from adolescents with coexisting autism, other developmental differences, or mental health problems "inequitable, discriminatory, and misguided."[52]

Robbing adolescents of their developing sexual identities poses another problem for the panel of WPATH experts. As Metzger notes, this cohort's sexual urges are suppressed, meaning they are not "learning how to masturbate." However, these same healthcare providers are tasked with discussing fertility preservation options with their patients who are not developmentally equipped to understand the process. In the case of natal males, the freezing of sperm requires that the adolescent has reached this crucial developmental stage. Especially for boys, the logic of early intervention dictates that puberty be suppressed as soon as possible, meaning before endogenous hormones have had a chance to make the body fertile.

Berg is aware of this problem, telling the group, "In some ways, the stuff that you need to do to be able to preserve your fertility might be beyond where a youth is at in terms of their sexual development, and yet, that's kind of what's needing to happen."

In traditional pediatrics, this type of conversation would only occur in oncology. Fertility preservation is offered to children with certain disorders of sexual development (DSDs) and other rare health conditions,[53] but it is only cancer treatment and gender-affirming medicine that cause iatrogenic infertility, meaning it is the treatment protocol that destroys the young person's fertility. Prior to the advent of gender-affirming care, the only justifiable reason for sterilizing a minor was a potentially life-threatening cancer diagnosis.

In a WPATH public statement from 2020, which was co-authored by two of the Identity Evolution Workshop

51 Ashley, F. (2023). Youth should decide: the principle of subsidiarity in paediatric transgender healthcare. J Med Ethics, 49(2), 110-114. https://doi.org/10.1136/medethics-2021-107820 https://pubmed.ncbi.nlm.nih.gov/35131805/

52 WPATH, ASIAPATH, EPATH, PATHA, and USPATH Response to NHS England in the United Kingdom (UK). (2022). https://www.wpath.org/media/cms/Documents/Public%20Policies/2022/25.11.22%20AUSPATH%20Statement%20reworked%20for%20WPATH%20Final%20ASIAPATH.EPATH.PATHA.USPATH.pdf?_t=1669428978

53 Rodriguez-Wallberg, K. A., Marklund, A., Lundberg, F., Wikander, I., Milenkovic, M., Anastacio, A., Sergouniotis, F., Wånggren, K., Ekengren, J., Lind, T., & Borgström, B. (2019). A prospective study of women and girls undergoing fertility preservation due to oncologic and non-oncologic indications in Sweden-Trends in patients' choices and benefit of the chosen methods after long-term follow up. Acta Obstet Gynecol Scand, 98(5), 604-615. https://doi.org/10.1111/aogs.13559

panelists, the leading transgender health group claims that "in general, mental health and medical professionals conduct evaluations of each youth/family to ensure that interventions used to promote emotional and psychological wellness in these youth are appropriate and meet the young person's specific mental health and medical needs."[54]

"As a result, professionals with experience and training to understand adolescent development and family dynamics are poised to understand the underlying factors behind a specific clinical presentation," said WPATH. "The best interests of the child are always paramount for any responsible licensed provider."

Compare that to what WPATH members say when they think the public is not listening. Jamison Green, a trans rights activist, former WPATH president, and one of the co-authors of the statement, told the panel that many patients may never even see an endocrinologist and are instead getting their "hormones prescribed through their primary care provider who doesn't really know necessarily everything about trans care."

Green believes these primary care providers are just "trying to be supportive" but explains that because the field of gender medicine is "new" and "contentious," patients, even well-educated adults who are accessing care for the first time, will hastily glance at the informed consent form, not take any of the information in, and say, "show me where to sign. Cause this is my moment, I gotta grab it."

This comment is in complete contradiction to WPATH's official statement claiming that a team of medical and mental health professionals carefully evaluates young patients. And this doesn't just happen with access to hormones. Green makes the same remarks regarding patients consenting to life-altering surgeries.

"People also are afraid many times about surgery, and so they can read other people's descriptions about surgery, and they'll miss details, or they'll miss the most important piece of information for them simply because they're afraid to read it," explained Green.

54 Ibid (n.45)

WPATH IS NOT A SCIENTIFIC GROUP

WPATH presents itself to the world as a scientific organization. The group describes its "Standards of Care" as being "based on the best available science and expert professional consensus."

In a 2022 speech in Texas, the US Assistant Secretary for Health, Admiral Rachel Levine said that WPATH's approach to medicine is "free of any agenda other than to ensure that medical decisions are informed by science."[55] In an op-ed in the New York Times from April, 2023, WPATH President Bowers argued that the "field of transgender medicine is evolving rapidly, but it is every bit as objective- and outcome-driven as any other specialty in medicine."[56]

"Allow the remaining scientific questions to be answered by knowledgeable researchers, without the influence of politics and ideology," Bowers implored.

However, the scientific method is a systematic approach to establishing facts through rigorous testing and experimentation. In the realm of medical research, this process entails observing a medical condition requiring intervention and formulating a hypothesis regarding a potentially effective treatment. This hypothesis is then put to the test through rigorously controlled trials, preferably ones that are both randomized and double-blind, meaning the participants are randomly assigned to different groups, and neither the participants nor the researchers know which group is receiving the treatment and which is receiving a placebo or alternative intervention. The final crucial step in the process is a follow-up, meaning all participants must be monitored over a sufficient duration and the results carefully analyzed to gauge the treatment's efficacy and safety.

The WPATH Files contain abundant evidence that the world-leading transgender health group does not respect the well-established scientific process.

Even the term "standards of care" is a misnomer when applied to WPATH's SOC7 and SOC8. "Standard of care" is a legal term, not a medical term, and represents "the benchmark that determines whether professional obligations to patients have been met."[57] Failure to meet the standard of care is medical negligence, which can result in significant consequences for healthcare providers.

However, from WPATH's SOC7 onwards, there are no "standards." A 2021 systematic review of clinical guidelines in gender medicine did not merely rate SOC7 as low quality but also rated it as "do not recommend."[58] The review concluded with the hope that the upcoming SOC8 would improve on SOC7's numerous shortcomings, but instead, SOC8 strayed even further from meeting the definition of a standard of care.

WPATH's SOC8 gives gender-affirming healthcare providers permission to do whatever the patient requests, in the absence of scientific evidence, safe in the knowledge that insurance companies will offer coverage because every intervention is defined as "medically necessary." Simultaneously, these providers believe themselves to be protected from malpractice lawsuits because they adhere to these approved "standards of care" that, in truth, contain no actual "standards" since all criteria are optional.

The Weak Evidence Base for Puberty Suppression

Nowhere is WPATH's disregard for the scientific

55 Levine, R. (2022). Remarks by HHS Assistant Secretary for Health ADM Rachel Levine for the 2022 Out For Health Conference. U.S. Department of Health and Human Services. https://www.hhs.gov/about/news/2022/04/30/remarks-by-hhs-assistant-secretary-for-health-adm-rachel-levine-for-the-2022-out-for-health-conference.html

56 "What Decades of Providing Trans Health Care Have Taught Me." The New York Times, 2023, https://www.nytimes.com/2023/04/01/opinion/trans-healthcare-law.html.

57 Vanderpool, D. (2021). The Standard of Care. Innov Clin Neurosci, 18(7-9), 50-51. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8667701/#:~:text=The%20standard%20of%20care%20is%20a%20legal%20term%2C%20not%20a,legal%20standard%20varies%20by%20state.

58 Dahlen, S., Connolly, D., Arif, I., Junejo, M. H., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. BMJ Open, 11(4), e048943. https://doi.org/10.1136/bmjopen-2021-048943

process more evident than in its support for adolescent sex-trait modification involving puberty blockers, cross-sex hormones, and surgeries for minors suffering from gender dysphoria. The world's most prominent transgender healthcare group endorses this controversial treatment protocol, and the WPATH Files contain abundant evidence demonstrating just how little is known about the drugs and their long-term effects.

In the 2023 paper, The Myth of Reliable Research,[59] Abbruzzese et al. argue that the practice of performing sex-trait modifications on minors through the use of puberty blockers, cross-sex hormones, and surgeries is an experiment that "escaped the lab" before there was any strong scientific evidence to support it.

Rather than being "evidence-based" as WPATH claims, Abbruzzese et al. explain that pediatric sex-trait modification was an "innovative practice" embarked upon by researchers in a Dutch clinic in the late 1980s-early 1990s. The "innovative practice" framework allows clinicians to implement untested yet encouraging interventions in cases where leaving the condition untreated could have dire consequences, when established treatments appear ineffective, and when the patient population is small.

Innovative practice is a double-edged sword because while it has the potential to advance medicine rapidly, it is also capable of causing harm. Hence, it is an ethical requirement to follow innovative experiments with strict clinical trials to demonstrate that the treatment's advantages outweigh the associated risks.

The clinical trial stage is imperative to avoid a phenomenon called runaway diffusion, "whereby the medical community mistakes a small innovative experiment as a proven practice, and a potentially non-beneficial or harmful practice 'escapes the lab,' rapidly spreading into general clinical settings."[60]

Runaway diffusion is what happened with pediatric gender medicine. Based on a study group of just 55 participants, which suffered from high selection bias, and a study design so methodologically flawed that its results should have been completely invalidated, the international medical community began suppressing the puberty of adolescents suffering from gender dysphoria. The vital step of undertaking controlled research aimed at validating the hypothesized substantial and enduring psychological advantages was completely skipped.

In fact, as early as 2001, WPATH, then HBIGDA, endorsed the treatment in its Standards of Care 6, even though, at that time, the scientific evidence for the protocol consisted of just a single case study involving one young patient.[61,62,63] Then, before the second stage of the deeply flawed Dutch experiment had been completed, WPATH again endorsed the treatment in its Standards of Care 7 in 2012, thereby influencing the medical community and leading to the widespread adoption of the protocol.[64]

The speed of the runaway diffusion increased dramatically when the innovative medical experiment collided with the sudden surge of adolescents identifying as transgender in the mid-2010s.

While The Myth of Reliable Research specifically criticizes the adolescent sex-trait modification experiment, there have never been any properly controlled trials in the

59 Abbruzzese, E., Levine, S. B., & Mason, J. W. "The Myth of "Reliable Research" in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That Has Followed." Journal of Sex & Marital Therapy 49, no. 6 (2023): 673-99. https://doi.org/10.1080/0092623x.2022.2150346.

60 Ibid (n.59)

61 Biggs, M. "The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence." Journal of Sex & Marital Therapy 49, no. 4 (2023): 348-68. https://doi.org/10.1080/0092623x.2022.2121238.

62 Meyer III, W., Bockting, W.O., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., Gooren, L., et al. "The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version." Journal of Psychology & Human Sexuality 13, no. 1 (2002): 1-30. https://www.cpath.ca/wp-content/uploads/2009/12/WPATHsocv6.pdf.

63 Cohen-Kettenis, P. T., & van Goozen, S. H. "Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent." [In eng]. Eur Child Adolesc Psychiatry 7, no. 4 (Dec 1998): 246-8. https://doi.org/10.1007/s007870050073.

64 Ibid (n.38 p.18)

wider field of gender medicine, which also consistently lacks long-term data. Studies that show a positive outcome for sex-trait modification procedures have a very short follow-up period, and those that attempt to monitor how patients fare years after undergoing hormonal and surgical interventions are compromised by a high percentage of study participants lost to follow-up. The few attempts at long-term follow-up for adults who have undergone sex-trait modification interventions do not show positive outcomes, with individuals showing social difficulties and a significantly elevated rate of completed suicides and mental health issues.[65,66,67,68] While each of these studies has its methodological limitations, the findings cast serious doubt on any claims that sex-trait modification interventions result in overwhelmingly positive outcomes for patients. Not surprisingly, systematic reviews of the research on sex trait modification in minors have consistently found "low" or "very low" quality evidence for benefits.

Evidence in the Files of WPATH's Lack of Respect for the Scientific Process

A discussion in the WPATH Files involving WPATH's president, Dr. Marci Bowers, demonstrates the pseudoscientific, experimental nature of pediatric hormonal and surgical sex-trait modification. Bowers makes it abundantly clear that there is no scientific rigor to the treatment protocol when discussing how little is known about the impact puberty blockers have on the future sexual function of natal males.

In January 2022, WPATH President Bowers admitted in the forum that the effect of puberty blockers on fertility and "the onset of orgasmic response" is not yet fully understood. Also, Bowers conceded that there are "problematic surgical outcomes" for natal males who have their puberty blocked early.

In fact, almost everything Bowers contributed to the discussion board about fertility, puberty blockers, and sexual intimacy is proof that the leading transgender health group advocates for an unregulated experiment on young people.

Bowers told the group that the "fertility question has no research" and recommended that "Unless pre-pubertal dysphoria is enormous, allowing for a small amount of puberty before blockers might be preferable in the long run."

In this context, the use of the word "might" suggests that these doctors are improvising, experimenting without a structured framework, and, because of inadequate follow-up, failing to track the outcome of their experiment. This type of guesswork is acceptable in a small experiment but unethical when every major American medical association recommends the treatment and the wider medical community has already adopted it.

Bowers then said the question of whether or not these young males will be able to achieve orgasm later in life was "thornier," with the WPATH president admitting that all personal clinical experience up to that point indicated that boys who have their puberty blocked at Tanner Stage 2, the beginning of pubertal development, are completely unable to orgasm. "Clearly, this number needs documentation, and the long-term sexual health of these individuals needs to be tracked," said Bowers.

In other words, Bowers is aware that gender-affirming healthcare providers are robbing young natal males of the ability to orgasm and, therefore, their future ability to form long-term intimate relationships, which is an essential part of a fulfilling and happy life for most people. What's more, gender-affirming doctors are choosing this drastic medical

65 "Mistaken Identity." The Guardian, 2004, https://www.theguardian.com/society/2004/jul/31/health.socialcare.

66 Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. "Long-Term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden." PLoS ONE 6, no. 2 (2011): e16885. https://doi.org/10.1371/journal.pone.0016885.

67 Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. "Quality of Life 15 Years after Sex Reassignment Surgery for Transsexualism." Fertility and Sterility 92, no. 5 (2009): 1685-89.e3. https://doi.org/10.1016/j.fertnstert.2008.08.126.

68 "Part 3: Gender Identity." Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences, The New Atlantis, 2016, https://www.thenewatlantis.com/publications/part-three-gender-identity-sexuality-and-gender.

intervention as the first line of treatment for this vulnerable cohort of young people while ignoring the scientific literature that shows most children would overcome their dysphoria if allowed to grow and develop naturally without medical intervention.[69,70,71] While this literature predates the newly emerged adolescent-onset cohort, all existing knowledge about adolescent identity development strongly supports allowing these young patients the chance to grow and mature before making drastic, life-altering decisions.[72]

If WPATH, as Bowers claimed in the New York Times, were every bit as objective- and outcome-driven as any other specialty in medicine, these questions would have been answered before the group recommended the treatment protocol be rolled out into wider medical practice.

Bowers also mentioned the "problematic surgical outcomes" faced by these patients. Here, the WPATH president is referring to the fact that natal males who have their puberty suppressed at Tanner Stage 2 typically require a more complicated vaginoplasty surgery than the standard penile inversion.

In a fully developed adult male, vaginoplasty involves inversion of the penis, using the penile skin to line the surgical cavity that is meant to resemble a vagina. But in natal males who have their puberty blocked, the penis remains in a child-like state, meaning there is insufficient penile tissue to use during the procedure. Therefore, the surgeon must harvest tissue from a different part of the body. The most common technique uses a piece of the patient's colon, or less frequently, surgeons will use the peritoneum lining, which is the lining of the abdominal cavity. Some gender surgeons are even experimenting with using tilapia fish skin.[73]

There are two notable examples of the "problematic surgical outcomes" that can ensue as a result of these riskier surgeries. The first is the tragic death of an 18-year-old natal male who participated in the pioneering Dutch trial and died of necrotizing fasciitis.[74] This devastating outcome resulted from surgeons opting to use a section of the teen's intestines to construct the pseudo-vagina, a measure necessitated by the patient's lack of male puberty. This one death represents an almost 2% fatality rate associated with surgery in the Dutch study. In any other field of medicine, such a high fatality rate would result in the experiment instantly being halted and carefully studied to investigate what went wrong.

Then there is the story of Jazz Jennings, the trans-identified natal male star of the reality TV show I Am Jazz. Jennings was also one of the first children to take part in the puberty suppression experiment, and when it came time for vaginoplasty, Jazz also had insufficient penile tissue, making it necessary to use part of Jazz's peritoneum lining and a section of thigh skin. Bowers was the surgeon who performed the operation. Days after the surgery, the pseudo-vagina came apart, causing Jazz intense pain and requiring three corrective surgeries.

One study found that 71% of the natal males who had undergone puberty suppression at Tanner Stages 2-3 required the riskier form of intestinal vaginoplasty.[75] Another study found one-quarter of males who undergo

69 Ibid (n.2)

70 Ibid (n.4).

71 Wallien, M. S., & Cohen-Kettenis, P. T. "Psychosexual Outcome of Gender-Dysphoric Children." [In eng]. J Am Acad Child Adolesc Psychiatry 47, no. 12 (Dec 2008): 1413-23. https://doi.org/10.1097/CHI.0b013e31818956b9.

72 Ibid (n.49); Ibid (n.50)

73 Slongo, H., Riccetto, C. L. Z., Junior, M. M., Brito, L. G. O., & Bezerra, L. "Tilapia Skin for Neovaginoplasty after Sex Reassignment Surgery." [In eng]. J Minim Invasive Gynecol 27, no. 6 (Sep-Oct 2020): 1260. https://doi.org/10.1016/j.jmig.2019.12.004.

74 Negenborn, V. L., van der Sluis, W. B., Meijerink, W., & Bouman, M. B. "Lethal Necrotizing Cellulitis Caused by Esbl-Producing E. Coli after Laparoscopic Intestinal Vaginoplasty." [In eng]. J Pediatr Adolesc Gynecol 30, no. 1 (Feb 2017): e19-e21. https://doi.org/10.1016/j.jpag.2016.09.005.

75 van der Sluis, W. B., de Nie, I., Steensma, T. D., van Mello, N. M., Lissenberg-Witte, B. I., & Bouman, M. B. "Surgical and Demographic Trends in Genital Gender-Affirming Surgery in Transgender Women: 40 Years of Experience in Amsterdam." [In eng]. Br J Surg 109, no. 1 (Dec 17 2021): 8-11. https://doi.org/10.1093/bjs/znab213.

this type of vaginoplasty require follow-up corrective surgery.[76]

Further evidence of the uncertainty surrounding the puberty suppression experiment is present in the WPATH Files. In February 2022, a Seattle psychologist asked the forum for information about the impact puberty blockers have on a young person's height. The psychologist was confused after reading and hearing "some conflicting information." The patient who sparked the inquiry was a 10-year-old "premenarche" natal female who identified as a boy. The child was concerned that taking puberty blockers would stunt growth, so the psychologist asked the forum if starting the drugs so young could have a negative impact.

The reply from a pediatric endocrinologist demonstrates that the whole experiment is based on guesswork. She explains that blockers suppress puberty to keep growth plates open longer, so younger teens have more time to grow, but the typical adolescent growth spurt is also blocked. To remedy this, the endocrinologist says she gives a low dose of testosterone to these young teenage girls and gradually increases the dose, hoping that the growth plates don't close.

It's relevant at this point to note that the puberty suppression experiment began because transgender adult males were dissatisfied with the results of their medical transition because they did not "pass" well as women due to a "never disappearing masculine appearance."[77] Therefore, the Dutch researchers came up with the idea to use gonadotropin-releasing hormone agonists (GnRHa) to block the testosterone surge of male puberty in the hopes of achieving more feminine appearances in adulthood. The increased risk of false positives due to early intervention was noted, but the cosmetic advantages to adult natal males who identify as women were deemed more important.[78]

In 2014, Delemarre-van de Waal reviewed the puberty suppression experiment, stating that "an early intervention in a male-to-female transsexual may result in a more acceptable female final height." The word height was mentioned no fewer than 23 times in the paper.[79] There was only one mention of loss of fertility. As one researcher later noted, the "words orgasm, libido, and sexuality do not appear" even once.[80]

However, the aforementioned exchange in the WPATH Files indicates that natal females may experience poorer outcomes from having their puberty blocked. Testosterone use typically brings about convincing cosmetic changes in females who identify as male, making height the biggest challenge trans-identified natal females face when trying to pass as men. Since natal females constitute the majority of referrals to pediatric gender clinics, if it is indeed true that these drugs negatively affect the height of female patients, it calls into question the validity of the original hypothesis for their use.

What's more, the superficial focus on "passing" as a member of the opposite sex ignores the reality of human sexuality. A transgender person who passes when out in public is still going to experience difficulty finding a romantic partner because of the limitations of sex-trait modification interventions. For those who do not opt for genital surgery, their outward appearance is incongruent with their genitals, and for those who do opt for full surgical transition, there are limitations of what such

76 Bouman, M. B., van der Sluis, W. B., Buncamper, M. E., Özer, M., Mullender, M. G., & Meijerink, W. "Primary Total Laparoscopic Sigmoid Vaginoplasty in Transgender Women with Penoscrotal Hypoplasia: A Prospective Cohort Study of Surgical Outcomes and Follow-up of 42 Patients." [In eng]. Plast Reconstr Surg 138, no. 4 (Oct 2016): 614e-23e. https://doi.org/10.1097/prs.0000000000002549.

77 Waal, H., & Cohen-Kettenis, P. "Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects." European Journal of Endocrinology - EUR J ENDOCRINOLOGY 155 (10/30 2006). https://doi.org/10.1530/eje.1.02231.

78 Ibid (n.77)

79 Delemarre-van de Waal, H. A. "Early Medical Intervention in Adolescents with Gender Dysphoria." In Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge, edited by Baudewijntje P. C. Kreukels, Thomas D. Steensma and Annelou L. C. de Vries, 193-203. Boston, MA: Springer US, 2014. https://link.springer.com/chapter/10.1007/978-1-4614-7441-8_10#citeas

80 Ibid (n.61)

surgeries can achieve. In either case, the ability to form long-term sexual relationships is drastically compromised.

If WPATH were indeed a scientific organization dedicated to ensuring that its members provide the best possible care for patients suffering from gender dysphoria, including minors and those with serious psychiatric comorbidities, it would fund proper clinical trials to assess the safety, effectiveness, risks, and benefits of the treatment protocol for which it so strenuously advocates. An essential part of these trials would be long-term follow-up to measure the impact of allowing adolescents to compromise their health, fertility, and sexual function at such a young age.

WPATH IS NOT A MEDICAL GROUP

WPATH Has Abandoned the Hippocratic Oath

For over 2,500 years, physicians have been guided by the Hippocratic oath to first do no harm. While this exact adage is not present in the original text from 5th century BC Greece, the pledge is a distillation of the oath's overarching message to consider the benefit of patients and "abstain from whatever is deleterious and mischievous."

The phrase "First, do no harm," or its Latin translation, "Primum non nocere," is the bedrock upon which medical ethics standards are built, and it has provided a moral and ethical compass for physicians for thousands of years. While medicine and technology have advanced beyond recognition since the days of Hippocrates, the oath's guiding principle has always remained the same: the benefits of a medical treatment must always outweigh any harm.

Throughout the ages, medical professionals have sought to balance taking risks with patient safety, and still, to this day, that can be challenging, especially in high-stakes areas of medicine such as cancer treatment. In fact, it is appropriate to compare WPATH's gender-affirming care to cancer treatment because both protocols involve the use of powerful drugs that have a profound impact on future health and reproductive function, as well as, in many cases, the surgical removal of body parts.

But while most people would agree that doctors are justified in administering treatments such as chemotherapy that could result in sterility or amputating body parts if a child or young person has cancer and the surgery could save the patient's life, the ethics of sterilizing a young person suffering from the poorly defined psychiatric disorder called gender dysphoria, or amputating healthy parts of their body, are far more questionable.

Evidence Showing the Harmful Effects of Wrong-Sex Hormones

WPATH members adhere to the belief that attempting to help a patient overcome their feelings of gender incongruence and reconcile with their birth sex amounts to conversion therapy.[81] Therefore, the mental and medical professionals inside the leading transgender health group advocate for affirmation alongside invasive and harmful hormonal and surgical interventions as the first and only line of treatment for patients, including minors and the severely mentally ill, despite knowing the detrimental effects.

Inside the WPATH forum, there were plenty of discussions about the effects of cross-sex hormones on the sexual function of natal females, as well as natal males who had been allowed to go through puberty and were, therefore, able to orgasm.

For example, in the discussion thread dated March 24, 2022, a nurse practitioner asked about a "young patient" who developed pelvic inflammatory disease after three years of testosterone. The natal female "has atrophy with the persistent yellow discharge we often see as a result," the nurse wrote. Vaginal atrophy is the thinning, drying, and inflammation of the vaginal walls that occurs when a woman has less estrogen, typically after menopause. For many women, vaginal atrophy not only makes intercourse painful but also leads to distressing urinary symptoms.

Pelvic Inflammatory Disease (PID) is a serious condition which can lead to severe and potentially life-threatening health issues, including the spread of infection to other body parts as well as abscesses of the ovaries and fallopian tubes. It significantly raises the risk of ectopic pregnancy, which can also be life-threatening. As well, PID can negatively impact fertility. The longer PID remains untreated, the higher the likelihood of enduring

81 Ibid (n.52)

serious long-term health problems and infertility, and prolonged PID infections can result in permanent scarring of the reproductive organs. The condition can result in the need for a hysterectomy.

In the replies, one WPATH member shared a story about young natal females developing "pelvic floor dysfunction, and even pain with orgasm." A trans-identified natal female lawyer and prominent trans activist shared a personal account of developing a condition after years on testosterone that caused "splits in the skin which bled, and were excruciating." And another trans-identified natal female member described "bleeding after penetrative sex," painful orgasms, and an atrophied uterus.

Natal males don't fare any better on estrogen, either. When a doctor posted asking for "any insight as to why some transwomen may experience significant pain with erections post hormone therapy," the replies indicated that this is not an uncommon problem.

A trans-identified natal male counselor confirmed having experienced painful erections while taking estradiol and described "trying to avoid having them because of this," explaining that even when the erections were not painful, "they were physically uncomfortable and not pleasurable." A registered nurse told of natal male patients who described erections as "feeling like broken glass."

This is the treatment pathway WPATH endorses for adolescents. These exchanges indicate that gender-affirming healthcare providers are knowingly permitting young patients to compromise their sexual function when they do not have the maturity or experience to comprehend the implications of such a decision in the context of a long-term relationship. These youth are being allowed to sacrifice a crucial component of their sexual identity before they have any understanding of the impact the loss will have on their adult life.

Doctors on the forum also found that cross-sex hormones had severe adverse effects on some young people. In December 2021, a doctor described a 16-year-old patient who had developed large liver tumors after being on norethindrone acetate to suppress menstruation for several years and testosterone for one year. "Pt found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7cm - and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones," the doctor wrote.

Another doctor replied to this with an anecdote about a female colleague who, after about 8-10 years of taking testosterone, developed hepatocarcinomas. "To the best of my knowledge, it was linked to his hormone treatment," said the doctor, who had no more details because the cancer was so advanced that her colleague died a couple of months later.

The risk of female patients on testosterone developing hepatocellular carcinomas has been noted before. In 2020, The Lancet published a case study of a 17-year-old trans-identified natal female with a large hepatocellular carcinoma (HCC), the most common type of primary liver cancer which is most often seen in men and people with chronic liver diseases, such as cirrhosis caused by hepatitis B or hepatitis C infection. The 17-year-old had been on testosterone for 14 months, but her team had advised her to stop taking the hormone due to the "possible effects it might be having on the tumour." The outcome for the patient is not known, but the case study concluded by stating that the "relationship between exogenous testosterone and development and progression of HCC in peripubertal transgender patients is unknown."[82]

Researchers have also documented a second unusual case of liver cancer in a trans-identified natal female. This patient was 47 years old at the time of diagnosis and was found to have cholangiocarcinoma, a rare cancer of the bile duct that is normally only seen in older people.[83]

82 Lin, A. J., Baranski, T., Chaterjee, D., Chapman, W., Foltz, G., & Kim, H. "Androgen-Receptor-Positive Hepatocellular Carcinoma in a Transgender Teenager Taking Exogenous Testosterone." The Lancet 396, no. 10245 (2020): 198. https://www.thelancet.com/article/S0140-6736(20)31538-5/fulltext

83 Pothuri, V. S., Anzelmo, M., Gallaher, E., Ogunlana, Y., Aliabadi-Wahle, S., Tan, B., Crippin, J. S., & Hammill, C. H. "Transgender Males on Gender-Affirming Hormone Therapy and Hepatobiliary Neoplasms: A Systematic Review." Endocrine Practice 29, no. 10 (2023/10/01/ 2023): 822-29. https://pubmed.ncbi.nlm.nih.gov/37286102/.

The relatively unexpected ages in these two cases, absence of risk factors, and known association between exogenous testosterone and liver tumors prompted an investigation of existing literature on the relationship between gender-affirming hormone therapy and cancer of the liver. The systematic review was inconclusive, however, due to lack of available evidence."The available evidence is limited by the rarity of these tumor types [and] the historical lack of access to [gender-affirming hormone therapy]."[84]

It is not only liver cancer that is of concern for natal females taking exogenous testosterone. A 2022 cohort study demonstrated a high percentage of abnormal Pap tests in Natal females receiving testosterone. The researchers concluded that "[t]estosterone seems to induce changes in squamous cells and shifts in vaginal flora."[85] Other studies have suggested links between testosterone use and increased risk of heart attacks.[86,87]

In light of the significant increase in teenage girls and young women identifying as transgender and seeking testosterone therapy in recent years, coupled with WPATH's gender-affirming care model, there is an urgent need to investigate any potential life-threatening connections. Furthermore, the "informed consent model of care" endorsed by WPATH has streamlined access to this potent and potentially deadly hormone. In some states, for women as young as 18, it is as straightforward as signing a consent form at Planned Parenthood.[88]

Also, a 2018 study conducted by Kaiser Permanente found that natal males on estrogen had a 5.2% risk of a blood clot in the lungs or legs, a heart attack, or a stroke within a mean of 4 years after initiating estrogen (but the increased risk begins as early as one year), and the risks rise the longer a trans-identified natal male takes estrogen.[89]

The paucity of good quality research in the field of gender medicine was exposed in the 2020 Cochrane Library systematic review of the scientific literature on the safety and efficacy of cross-sex hormone therapy for natal males.[90] The review revealed that not one of the studies within the entire body of literature even reached the classification of very low quality, and as a result, not a single study fulfilled the inclusion criteria set by the review.

"Despite more than four decades of ongoing efforts to improve the quality of hormone therapy for [natal males] in transition, we found that no RCTs or suitable cohort studies have yet been conducted to investigate the efficacy and safety of hormonal treatment approaches for [natal males] in transition," wrote the researchers. "The evidence is very incomplete, demonstrating a gap between current clinical practice and clinical research."

Given the lack of scientific literature to indicate that cross-sex hormone therapy is safe and effective, as well as the number of known negative side effects and the possible serious negative outcomes, it is unethical for WPATH to advocate for minors and the severely mentally ill to bypass psychotherapy and have immediate access to these powerful drugs.

84 Ibid (n.83)

85 Lin, L. H., Zhou, F., Elishaev, E., Khader, S., Hernandez, A., Marcus, A., & Adler, E. "Cervicovaginal Cytology, Hpv Testing and Vaginal Flora in Transmasculine Persons Receiving Testosterone." [In eng]. Diagn Cytopathol 50, no. 11 (Nov 2022): 518-24. https://doi.org/10.1002/dc.25030.

86 Alzahrani, T., Nguyen, T., Ryan, A., Dwairy, A., McCaffrey, J., Yunus, R., Forgione, J., Krepp, J., Nagy, C., Mazhari, R., & Reiner, J. (2019). Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population. Circulation: Cardiovascular Quality and Outcomes, 12(4). https://doi.org/10.1161/circoutcomes.119.005597

87 Nota, N. M., Wiepjes, C. M., De Blok, C. J. M., Gooren, L. J. G., Kreukels, B. P. C., & Den Heijer, M. (2019). Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. Circulation, 139(11), 1461-1462. https://doi.org/10.1161/circulationaha.118.038584

88 "I Want to Transition. How Old Do You Have to Be to Get Hrt?" Planned Parenthood, 2023, https://www.plannedparenthood.org/blog/i-want-to-transition-how-old-do-you-have-to-be-to-get-hrt.

89 Getahun, D., Nash, R., Flanders, W. D., Baird, T. C., Becerra-Culqui, T. A., Cromwell, L., Hunkeler, E., Lash, T. L., Millman, A., Quinn, V. P., Robinson, B., Roblin, D., Silverberg, M. J., Safer, J., Slovis, J., Tangpricha, V., & Goodman, M. (2018). Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. Ann Intern Med, 169(4), 205-213. https://doi.org/10.7326/m17-2785n

90 Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. Cochrane Database of Systematic Reviews(11). https://doi.org/10.1002/14651858.CD013138.pub2

Doctors Improvising and Experimenting

As already shown, WPATH advocates for an unregulated experiment to be conducted on minors who are experiencing gender-related distress. There is no reliable evidence to support the safety and efficacy of puberty suppression for trans-identified adolescents. However, there is further evidence in the files that WPATH members are engaged in improvisation and experimentation rather than rigorous science.

For example, in the discussion threads concerning the debilitating reproductive organ pain experienced by both male and female patients due to hormone therapy, the advice is consistently anecdotal and little more than guesswork. In the thread about the young natal female who had required emergency room care for pelvic inflammatory disease (PID) after three years on testosterone, the New York nurse told the group that the estrogen cream "appears to have stopped working," and the patient has persistent yellow discharge. "Has anyone had luck with estrace tablets vs cream?" the nurse asked, seemingly in lieu of consulting scientific literature.

The replies contain vague anecdotal recommendations that topical creams can help a few patients, and a couple of trans-identified natal females tell of remedies that helped relieve some of their symptoms. A Michigan family physician tells the forum of the success she had treating two natal females with an antispasmodic drug to relieve their painful orgasms, specifying that the drug should be taken 30-60 minutes before orgasm.

However, anecdotes are not science, and no one in the forum provided links to actual scientific literature providing evidence-based recommendations for managing these painful iatrogenic symptoms.

The reason for this is there is no reliable science to consult. A 2021 review of the relevant literature states that the "field of transgender medicine is relatively new, and little is known of the effects of testosterone therapy," but did note that natal females on testosterone therapy frequently experience symptoms of vaginal atrophy similar to those of the post-menopausal state, including dryness, irritation, bleeding with vaginal penetration (sex or medical examination), and dyspareunia (pain during intercourse). The authors acknowledge that these symptoms can have "a substantial impact on quality of life" and may require local estrogen-based therapy, but "the efficacy of this approach has not been documented" in trans-identified natal females.[91]

Worse, a 2023 study found that testosterone use increases a natal female's libido while at the same time increasing pain during intercourse, with over 60% of participants reporting genital pain or discomfort during sexual activity. The researchers noted that the majority of trans-identified natal females experience "vulvovaginal" pain during sexual activity and concluded that "[g]iven this high burden, there is an urgent need to identify effective and acceptable interventions for this population."[92]

In the thread discussing an endocrinologist's question about why some trans-identified natal males experience "significant pain with erections post hormone therapy" and whether this pain was likely to persist after undergoing vaginoplasty, the responses were once again vague and anecdotal, with WPATH members speculating that the discomfort could be linked to factors such as tissue atrophy and thinning of penile skin, and infrequent erections. Some members even admitted to never addressing this concern with their patients. A trans-identified natal male counselor shared a personal anecdote about experiencing this symptom and indicated that it was resolved through penis amputation.

"My guess (and it's just a guess, I'm not a medical

91 Krakowsky, Y., Potter, E., Hallarn, J., Monari, B., Wilcox, H., Bauer, G., Ravel, J., & Prodger, J. L. "The Effect of Gender-Affirming Medical Care on the Vaginal and Neovaginal Microbiomes of Transgender and Gender-Diverse People." [In eng]. Front Cell Infect Microbiol 11 (2021): 769950. https://doi.org/10.3389/fcimb.2021.769950.

92 Tordoff, D. M., Lunn, M. R., Chen, B., Flentje, A., Dastur, Z., Lubensky, M. E., Capriotti, M., & Obedin-Maliver, J. "Testosterone Use and Sexual Function among Transgender Men and Gender Diverse People Assigned Female at Birth." [In eng]. Am J Obstet Gynecol (Sep 9 2023). https://doi.org/10.1016/j.ajog.2023.08.035.

person) would be that the pain is related to erectile tissue in [the] penis and that the removal of that tissue during vaginoplasty addresses the problem," said the counselor.

In another thread, a nurse practitioner told the group about a female patient who identified as non-binary and was requesting "masculinizing hormone therapy." The patient had asked about taking Finasteride, a 5α-reductase inhibitor used to treat prostatic hyperplasia (BPH) and male pattern hair loss, to prevent "bottom growth."

Bottom growth is a term used to describe the permanent enlargement of the clitoris due to testosterone use. This can cause significant pain and sensitivity.[93] The replies are once again a chorus of speculation, with no one providing any scientific literature to back up the experimental use of the drug for this purpose. One doctor from Massachusetts said she would "be interested to hear if others have tried using it to block clitoral growth," and a family physician from Manchester, who had also had a patient request the drug, had not been able to find any evidence to support using it for this reason. "Any resources, evidence or advice would be appreciated," he concluded.

In fact, Finasteride is mentioned in SOC8 as a possible treatment option for undesired male pattern hair loss in female patients on testosterone, but the authors caution that it "may impair clitoral growth and the development of facial and body hair."

There were plenty of examples of improvisation in our leaked panel discussion as well, where Dr. Cecile Ferrando, a surgeon, tells the assembled WPATH members that she experiments with "underdosing" natal females with testosterone. She explains that these females desire "cessation of menses" but not virilization. Ferrando added that these young women in their twenties "err on the masculine side of the spectrum but don't want to be fully masculinized." The gender surgeon tells the group that her experimental use of a Schedule III controlled substance improves the young women's "state of being" and "sense of wellbeing."

It's not just adults who are being experimented on either. Massey shares an account of a confused young patient being treated by equally confused healthcare providers. The child has been on puberty blockers for about two years, and her pediatric endocrinologist wants her to stay on a little longer. "The kid is vacillating, really not wanting facial hair," but unsure about having menstrual cycles, "and kind of vacillates about whether breast development, chest development, bothers them or not and which pronouns they use," explains Massey.

"So, is there more, um, benefit of staying on blockers or letting the kid switch back to their endogenous estrogen? Or is it better to go low-dose testosterone or what? You know, and at what point in time?" asks the confused therapist.

"So, if the kid doesn't want facial hair but maybe doesn't mind their chest growing, and they're planning on having chest surgery anyways. So we may want to be creative in how we help folks approach these situations that are complex," Massey concludes. It is safe to say that most parents do not want confused doctors being "creative" when it comes to performing life-altering medical interventions on their children.

Metzger describes putting 13-year-olds on cross-sex hormones as "like a journey," with the child's doctor "coming along for the ride." He explains that he lets his teenage patients lead when it comes to their hormone doses, asking them each time they show up for an appointment what they want to do with their hormones. He noted that "kids do shift with time, particularly the non-binary kids," who often end up not wanting to be as masculine as they first thought. "They find that there's a happy dose that's gotten rid of their periods or whatever, and that they're happy on that dose," he added. While it might seem odd to put a child in the driving seat in this way, it is entirely consistent with WPATH's affirmative

93 Wierckx, K., Van Caenegem, E., Schreiner, T., Haraldsen, I., Fisher, A., Toye, K., Kaufman, J. M., & T'Sjoen, G. (2014). Cross-Sex Hormone Therapy in Trans Persons Is Safe and Effective at Short-Time Follow-Up: Results from the European Network for the Investigation of Gender Incongruence. The Journal of Sexual Medicine, 11(8), 1999-2011. https://doi.org/10.1111/jsm.12571

model of care, which strives to help patients achieve their unique, and often shifting, "embodiment goals."

However, despite clear evidence that gender-affirming healthcare providers are experimenting on the patients in their care, WPATH's official stance is that these treatments are evidence-based. Interestingly, WPATH deliberately refrains from using the term "experimental" in its SOC8, all the while acknowledging the absence of evidence to support its recommendations.

For example, in the adolescent chapter, when addressing all the uncertainties surrounding whether or not gender identity is fixed from birth or part of a "developmental process," the authors concede that "[f]uture research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups."[94] In other words, there is no science to support the idea that gender identity is fixed or to justify permanently altering a young person's body using drugs and surgeries. Therefore, the whole treatment protocol is "experimental," except for the fact that it doesn't even meet that low bar because a real experiment involves control groups and diligent follow-up, neither of which occurs in WPATH's field of gender-affirming medicine. Of note, every European systematic review of the evidence for adolescent sex-trait modification interventions to date has concluded that the treatments are experimental.

What's more, WPATH is aware that this experiment is not just confined to minors. In the adult chapter of SOC8, the authors state that the "criteria in this chapter have been significantly revised from SOC-7 to reduce requirements and unnecessary barriers to care. It is hoped that future research will explore the effectiveness of this model."[95]

In the aforementioned section discussing the possible use of Finasteride to prevent unwanted side effects of testosterone use in females, the authors conclude that "[s]tudies are needed to assess the efficacy and safety of 5α-reductase inhibitors in transgender populations." Similar phrasing, synonymous with "experimental," can be found throughout SOC8.

The deliberate avoidance of the term "experimental" is due to the fact that experimental medicine is not covered by health insurance, and one of the primary objectives of WPATH's SOC8 is to secure insurance coverage, an aim the leading transgender health group prioritizes over adhering to best medical practices.

WPATH Members Causing Surgical Harm

WPATH members are also causing surgical harm to their patients, including minors and those suffering from severe mental illness. In a discussion that took place in May 2023, a Colombian surgeon was unsure how to proceed with a 14-year-old natal male who was requesting vaginoplasty surgery.

As previously stated, vaginoplasty is a major surgery that entails amputating the penis and using the penile tissue to create a pseudo-vagina. The procedure comes with a high complication rate, a long recovery time, and requires lifelong dilation of the surgical site to prevent the wound from closing.

Also, dilation, the physical insertion of a dilator to maintain the depth of the cavity, can cause discomfort and pain and must be performed three times a day in the immediate post-op period. This can take as much as 2 to 2.5 hours a day.[96] As the patient recovers, dilation needs to gradually taper off, but the surgical site needs to be dilated once a week for life.

Dr. Christine McGinn replied, recommending that he "tread lightly" because many hospitals are now banning

94 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. LC., Deutsch, M. B., Ettner, R., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." International Journal of Transgender Health 23, no. sup1 (2022): S45. https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

95 Ibid (n.94 p.33)

96 "Use It or Lose It: The Importance of Dilation Following Vaginoplasty." MTF Surgery, 2023, https://www.mtfsurgery.net/dilation.htm.

surgeries for those under 18. McGinn reported performing about 20 vaginoplasties on patients under 18 over a 17-year period and confessed that "not all…had perfect outcomes," adding that, "None of these patients have regretted their decision ***that I am aware of.***" (emphasis added)

McGinn then explained that the "ones who had trouble" were the ones who were unable to adhere to the dilation schedule and suffered from vaginal stricture as a result, adding that patients over 18 can have the same dilation difficulties.

Vaginal stricture, or neovaginal stenosis, is a common complication following penile inversion vaginoplasty. A 2021 study found that almost 15% of males who underwent vaginoplasty at Mount Sinai Hospital had to have one or more revision surgeries due to neovaginal stenosis, 73.5% of whom had been unable to adhere to the post-op dilation schedule.[97] Vaginoplasty revision surgery is more difficult due to scar tissue, which also makes dilation post-revision surgery more challenging and painful.[98]

Neovaginal stenosis is just one of many complications that can arise after vaginoplasty. A 2018 review of the data on vaginoplasty complications provides a long list of all the possible complications, ranging from minor, aesthetic issues to severe complications such as rectal injuries and serious urinary dysfunction.[99]

Also, in May 2023, a gynecologist in the WPATH forum described a patient who, after penile inversion vaginoplasty, was leaking prostate secretions through the urethra and was finding it bothersome. The replies inform the gynecologist that there is no remedy, but one nursing lecturer, who self-described as a "woman of trans experience," suggested telling the distressed patient to "enjoy the ride," adding, "It's the ultimate physical sign of orgasm…what's not to like?"

These exchanges prove that WPATH surgeons are aware of these adverse outcomes post-vaginoplasty and yet still not only recommend minors undergo such drastic surgeries but also do no follow-up to monitor how the young patients fare later in life. An ethical surgeon performing any experimental procedures on minors would only do so in cases of the highest need, in the strictest of clinical trial settings, and with diligent follow-up of patients well into adulthood to evaluate the impact of such a drastic procedure on their adult functioning. A surgeon who is truly dedicated to delivering the highest quality of care would express genuine concern for their patient's capacity to establish and maintain long-term intimate relationships following genital surgery. But saying "that I am aware of" indicates that McGinn is just assuming the young patients recover well while having no way of knowing if the experiment resulted in a positive outcome.

But despite having no evidence that genital surgery improves life for natal males who undergo the procedure as adolescents, McGinn still believes that the ideal time for a young person to have this major, life-altering surgery is "the summer before their last year of high school," a sentiment shared by WPATH President Bowers, who in the replies expressed reluctance to perform the procedure on someone so young but agreed that "sometime before the end of high school does make some sense in that they are under the watch of parents in the home they grew up in."

As well, there is evidence in the files of members doing surgical harm to severely mentally ill patients. In an undated message thread, a therapist expresses concern about referring her "trans clients with serious mental illness" for surgery due to difficulty in predicting their future stability, "in particular, given the extensive recovery period and 'postnatal' care required for vaginoplasty."

A California marriage and family therapist replied, saying it depends on many factors, such as how much

97 Kozato, A., Karim, S., Chennareddy, S., Amakiri, U, O., Ting, J., Avanessian, B., Safer, J. D., et al. "Vaginal Stenosis of the Neovagina in Transfeminine Patients after Gender-Affirming Vaginoplasty Surgery." Plastic and Reconstructive Surgery – Global Open 9, no. 10S (2021). https://journals.lww.com/prsgo/fulltext/2021/10001/vaginal_stenosis_of_the_neovagina_in_transfeminine.103.aspx.

98 "Vaginal Depth and Avoiding Stenosis." Gender Bands, 2021, https://www.genderbands.org/post/marinating-vaginal-depth-and-avoiding-stenosis.

99 Ferrando, C. A. "Vaginoplasty Complications." [In eng]. Clin Plast Surg 45, no. 3 (Jul 2018): 361-68. https://pubmed.ncbi.nlm.nih.gov/29908624/.

support the mentally ill person has, whether they have a safe place to recover, and whether or not they understand instructions such as "dilate, wash, monitor." She added that in the last 15 years, she had only declined to write one referral letter, and that was mainly because "the person evaluated was in active psychosis and hallucinated during the assessment session."

"Other than that - nothing - everyone got their assessment letter, insurance approval, and are living (presumably) happily ever after," said the therapist, who has referred for genital surgery people diagnosed with major depressive disorder, c-PTSD, and who are homeless.

Here, the therapist's use of the word "presumably," like the previous surgeon's "that I am aware of," indicates no systematic follow-up of patients, which would be reasonable to expect from a surgeon who knows he or she is doing something risky, invasive and experimental. Without follow-up, there is no way to know whether the severely mentally ill person was able to cope with the arduous 2+ hours a day of post-op dilation, the long recovery period, and the lifelong impact of the surgery on the patient's physical health and ability to form intimate relationships. WPATH-affiliated surgeons do not appear to have even the slightest curiosity about the outcome for such patients.

While the therapist was right to be concerned about the level of support patients have during the immediate post-op period, her contribution demonstrates the myopic thinking of gender-affirming healthcare providers. WPATH members typically focus on short-term patient satisfaction from the drastic, life-altering interventions they endorse and appear to have little concern for how the patient will fare in 20, 30, or 40 years.

WPATH members are also willing to allow people with serious degenerative diseases to undergo sex trait modification surgeries. One New Jersey nurse practitioner in the files asked for advice regarding a 22-year-old natal male with Becker Muscular Dystrophy who wished to begin taking estrogen and later undergo vaginoplasty. While the nurse could find no obstacles to proceeding with "gender affirming hormone therapy," concerns were raised about the potential risks associated with anesthesia during the surgical procedure. Notably, there was no indication of the nurse expressing concern about the impact of vaginoplasty on the patient's overall health or ability to manage the extended post-operative recovery period.

Others inside the forum object to surgical restrictions based on high body mass index (BMI). It is widely recognized that obesity increases the risks associated with surgery, leading to complications such as prolonged operative time, increased risk of surgical site infections, and various other complications.[100,101] Therefore, it is standard practice for surgeons to have a BMI cap for elective surgeries.[102]

However, inside WPATH, some members are unhappy about obese female patients being denied elective bilateral mastectomies. A research associate within the group suggested that this denial is the result of "systemic fatphobia" and challenged the conventional belief that the patients' obesity directly contributes to adverse outcomes, instead suggesting that it was the result of "weight bias" influencing how patients are cared for and operated on. While acknowledging the "high prevalence of eating disorders in trans individuals," this WPATH member expressed concern that withholding surgery could potentially exacerbate these issues.

A Washington social worker contributed an anecdote about a "client seeking top surgery" who had been told to lose weight. This apparently triggered "disordered eating."

100 Tsai, A., & Schumann, R. (2016). Morbid obesity and perioperative complications. Curr Opin Anaesthesiol, 29(1), 103-108. https://doi.org/10.1097/aco.0000000000000279

101 Osman, F., Saleh, F., Jackson, T. D., Corrigan, M. A., & Cil, T. (2013). Increased Postoperative Complications in Bilateral Mastectomy Patients Compared to Unilateral Mastectomy: An Analysis of the NSQIP Database. Annals of Surgical Oncology, 20(10), 3212-3217. https://doi.org/10.1245/s10434-013-3116-1

102 Farquhar, J. R., Orfaly, R., Dickeson, M., Lazare, D., Wing, K., & Hwang, H. (2016). Quantifying a care gap in BC: Caring for surgical patients with a body mass index higher than 30. British Columbia Medical Journal, 58(6).

The social worker was considering contacting Dr. Mosser, a San Francisco surgeon and WPATH member, who does not have a BMI limit. Dr. Mosser's website states that he has performed elective bilateral mastectomies on patients with a BMI as high as 65.[103]

In 2022, Dr. Sidhbh Gallagher, a WPATH-affiliated surgeon famous for making quirky TikTok videos promoting her services to her hundreds of thousands of young followers, in which she refers to bilateral mastectomies as "yeet the teets," received backlash from several obese patients who claim to have experienced severe post-op complications.[104,105] One young patient told a harrowing tale of the surgical incision opening and a resulting infection that almost proved fatal.[106]

Dismantling Guardrails

WPATH's aversion to caution and dislike of psychiatric gatekeeping is evident in the files. In an undated thread, a psychotherapist expressed her dissatisfaction with the group regarding a surgeon's requirement of two referral letters from her before amputating the healthy breasts of a 17-year-old girl. To the psychotherapist, this seemed like "extra extra gatekeeping."

The letters appear to be little more than a formality for insurance purposes, but in the replies, a therapist suggested the reason could be that the insurance company wanted evidence that the "status of the client" had not changed over time.

However, the rest of the replies are a chorus of agreement that the request is unnecessary gatekeeping, with one even suggesting reporting the insurer to the local state regulator "for their clinically unsound coverage determination requirements."

A Florida non-binary counselor with they/them pronouns replied, offering her services. She told the therapist that she provides consultation specifically regarding letter writing. "If you're interested in consultation with a provider of lived experience, I'm happy to chat further," said the counselor. "I've written quite a few second letters and have written letters for minors as well," she added.

In another undated thread, a Virginia therapist with "several trans clients with serious mental illness" such as "bipolar disorder and autism or schizoaffective disorder" asked the group for advice on what criteria to use to determine whether or not a patient was ready for surgery. She was particularly concerned about "clients" with serious mental illness being capable of adhering to "post-surgical dilation protocols."

A California therapist replied that "as gender affirmative practitioners, we always consider harm reduction as our primary lens," meaning it is necessary to ask "what will happen to these patients if they do NOT undergo their affirmative treatment, which is also a medical necessity." This therapist said she was personally "not invested" in SOC7's requirement that mental illness be "well controlled" before the patient is allowed to consent to surgeries such as vaginoplasty and bilateral mastectomies. In fact, this thinking was in line with WPATH's official stance, as the group removed the requirement from its SOC8.

A trans-identified natal male therapist joined the discussion to say that according to WPATH's SOC7, the "letter of support" was primarily to establish the persistence of the patient's gender dysphoria and that "denying necessary surgical care (even for the severely mentally ill) encroaches strongly on a patient's autonomy."

This shift towards viewing the involvement of mental

103 Mosser, S. Top Surgery Eligibility FAQ. Gender Confirmation Center. https://www.genderconfirmation.com/eligibility-faq/#:~:text=Mosser%20does%20not%20have%20a,the%20patient%27s%20primary%20care%20physician

104 Gallagher, S. (2024). GenderSurgeon. https://www.tiktok.com/@gendersurgeon?lang=en

105 Buttons, C. (2024). TikTok Doc's Trans Patients Post More Gruesome Stories Of Post-Op Complications. The Daily Wire. https://www.dailywire.com/news/tiktok-docs-trans-patients-post-more-gruesome-stories-of-post-op-complications

106 Rylan. (2022). Top Surgery with Dr. Gallagher Almost Cost Me My Life. Medium. https://rylan545.medium.com/top-surgery-with-dr-gallagher-almost-cost-me-my-life-d68cda71c543

health professionals as superfluous began with Dr. Richard Green commissioning HBIGDA's SOC6 immediately after Dr. Stephen Levine's SOC5 had specified two referral letters were needed before starting hormones. Whereas Levine advocated for guardrails to be placed around access to medical transition in an effort to minimize regret, WPATH, since Green's day, has been intent on dismantling those safety measures.

WPATH Members Trivializing Detransitioner Stories of Harm

Gender-affirming healthcare providers have always maintained that the regret rate for sex-trait modification interventions is very low, but this belief is based on deeply flawed research.[107,108,109] Due to sloppy, inadequate follow-up, the true detransition rate is unknown, but recent studies indicate it is rising.[110,111,112,113] Several small studies provide valuable insights into the detransition experience.[114,115,116,117] As well, an increasing number of young people are speaking out about the harm they experienced at the hands of gender-affirming healthcare providers.[118,119,120] Yet many WPATH members in the forum remain in denial about the damage done, dismissing or trivializing the lifetime of regret now faced by many young people.

In response to a post by a Washington DC psychologist about a "distraught and angry" 17-year-old detransitioned girl who had been on testosterone for more than two years and felt she was "brainwashed," several WPATH members appear in the replies. There is talk of detransition being just another step in a patient's "gender journey" and not necessarily involving regret. By this self-serving logic, it is impossible for clinicians practicing the affirmative model to ever be wrong in their diagnosis or treatment decisions.

The notion of the "gender journey" to describe regret and detransition is used to insulate gender-affirming clinicians from criticism and accountability. Within the realm of gender-affirming care, as long as the healthcare provider affirms the regret and detransition phase as part of the "journey," any potential errors or misjudgments are considered acceptable.

As well, on more than one occasion, the WPATH

107 Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. "Regret after Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence." [In eng]. Plast Reconstr Surg Glob Open 9, no. 3 (Mar 2021): e3477. https://doi.org/10.1097/gox.0000000000003477.

108 "At What Point Does Incompetence Become Fraud?" Genspect, 2022, https://genspect.org/at-what-point-does-incompetence-become-fraud/.

109 Dhejne, C., Öberg, K., Arver, S., & Landén, M. "An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960-2010: Prevalence, Incidence, and Regrets." [In eng]. Arch Sex Behav 43, no. 8 (Nov 2014): 1535-45. https://doi.org/10.1007/s10508-014-0300-8.

110 Cohn, J. "The Detransition Rate Is Unknown." Archives of Sexual Behavior 52, no. 5 (2023): 1937-52. https://doi.org/10.1007/s10508-023-02623-5. https://dx.doi.org/10.1007/s10508-023-02623-5.

111 Irwig, M. S. "Detransition among Transgender and Gender-Diverse People—an Increasing and Increasingly Complex Phenomenon." The Journal of Clinical Endocrinology & Metabolism 107, no. 10 (2022): e4261-e62. https://doi.org/10.1210/clinem/dgac356.

112 Hall, R., Mitchell, L., & Sachdeva, J. "Access to Care and Frequency of Detransition among a Cohort Discharged by a Uk National Adult Gender Identity Clinic: Retrospective Case-Note Review." [In eng]. BJPsych Open 7, no. 6 (Oct 1 2021): e184. https://doi.org/10.1192/bjo.2021.1022.

113 Boyd, I., Hackett, T., & Bewley, S. "Care of Transgender Patients: A General Practice Quality Improvement Approach." [In eng]. Healthcare (Basel) 10, no. 1 (Jan 7 2022). https://doi.org/10.3390/healthcare10010121.

114 Littman, L. (2021). Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. Archives of Sexual Behavior, 50(8), 3353-3369. https://doi.org/10.1007/s10508-021-02163-w

115 Mackinnon, K. R., Gould, W. A., Enxuga, G., Kia, H., Abramovich, A., Lam, J. S. H., & Ross, L. E. (2023). Exploring the gender care experiences and perspectives of individuals who discontinued their transition or detransitioned in Canada. PLOS ONE, 18(11), e0293868. https://doi.org/10.1371/journal.pone.0293868

116 Littman, L., O'Malley, S., Kerschner, H., & Bailey, J. M. (2023). Detransition and Desistance Among Previously Trans-Identified Young Adults. Archives of Sexual Behavior. https://doi.org/10.1007/s10508-023-02716-1

117 Vandenbussche, E. (2022). Detransition-Related Needs and Support: A Cross-Sectional Online Survey. Journal of Homosexuality, 69(9), 1602-1620. https://doi.org/10.1080/00918369.2021.1919479

118 Reddit, 2023, https://www.reddit.com/r/detrans/.

119 "'I Literally Lost Organs:' Why Detransitioned Teens Regret Changing Genders." New York Post, 2022, https://nypost.com/2022/06/18/detransitioned-teens-explain-why-they-regret-changing-genders/.

120 "Why This Detransitioner Is Suing Her Health Care Providers." Public, 2023, https://public.substack.com/p/why-this-detransitioner-is-suing?utm_source=%2Fsearch%2Fmichelle&utm_medium=reader2.

members pass the blame to the young person. Another psychologist talks of a female patient who is still in high school and has decided to detransition, claiming that the girl "acknowledges that [she] was the driver in getting [her] to this point."

WPATH President Bowers then echoed this psychologist's opinion, stating that all medical treatments have regret rates that are typically much higher than for gender transition, and "patients need to own and take active responsibility for medical decisions, especially those that have potentially permanent effects." Bowers added that "legislatures and the media [do not] go after breast augmentation, tubal ligation or facelifts." Here, Bowers inadvertently concedes that sex-trait modification procedures are elective, cosmetic procedures, like facelifts and breast augmentation, which also often result in lifelong sterility, like tubal ligation.

However, a minor does not have the cognitive capacity to understand those "potentially permanent effects" and, therefore, cannot give cognitive consent, and the leaked panel discussion proves that WPATH members are aware of that fact. In many cases, a person suffering from severe mental illness also does not have the necessary decision-making capacity to assess the risks and life-long consequences of the treatment. In these circumstances, responsibility rests with the healthcare professionals who misdiagnosed the patient and neglected their duty to secure proper informed consent. In no other branch of medicine is the patient blamed for consenting to a treatment based on a misdiagnosis.

Furthermore, in the United States, it is highly unlikely that any medical professional would permit a healthy adolescent girl to provide consent for tubal ligation. This is because it is widely recognized that although many teenagers may strenuously insist that they never want children, such feelings are likely to change over time as the young person matures and their priorities shift. Metzger's "oh, the dog's not doing it for you now" remark during the panel proves that he and his fellow WPATH panelists understand this perfectly well.

If there were suddenly a surge of teenagers being given vasectomies and tubal ligation on demand, or if plastic surgeons were selling breast augmentation and facelifts to adolescents as a remedy for their mental disorders, it is certain that both the media and legislatures would weigh in on the issue.

Suspiciously Low Regret Rates

Bowers's comment that "all medical treatments have a regret rate higher than medical transition" should give WPATH members pause for thought. The statement, on the surface, appears to be true. A recent systematic review of regret rates following "gender affirmation" surgery found regret to be less than 1% for natal females who had undergone mastectomies and/or phalloplasty and less than 2% for natal males who had undergone vaginoplasty.[121] However, leaving aside the fact that the studies in this review had high loss to follow-up and/or extremely short follow-up periods, unusually narrow definitions of regret and detransition, and that the review contained an extraordinary number of errors even for a field of research known for sloppy practices, given the high rate of serious complications and the dramatic impact these procedures have on a person's ability to form intimate relationships, these numbers are suspiciously low.[122]

The case study of one of the earliest participants of the Dutch puberty suppression experiment sheds some light on why this might be. The study describes the natal female's level of satisfaction and psychological functioning at age 35.[123] The patient did not regret undergoing hormonal and surgical sex-trait modification but reported dealing with significant shame related to her genital appearance,

121 Ibid (n.107)

122 Ibid (n.108)

123 Cohen-Kettenis, P. T., Schagen, S. E., Steensma, T. D., de Vries, A. L., & Delemarre-van de Waal, H. A. "Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-Up." [In eng]. Arch Sex Behav 40, no. 4 (Aug 2011): 843-7. https://doi.org/10.1007/s10508-011-9758-9.

experiencing depressive episodes, and having difficulty maintaining long-term relationships. In a previous follow-up study, performed just two years after surgery when the patient was age 20, high levels of satisfaction were recorded, and the female patient was pleased with the outcome of the metoidioplasty.[124] Metoidioplasty is a surgical procedure that involves constructing a small pseudo-penis out of an enlarged clitoris. When a natal female takes testosterone, the clitoris becomes permanently enlarged.

This case study highlights the problem with self-reporting when it comes to regret rates in the field of gender medicine. People who embark on sex-trait modification interventions often sacrifice their health, fertility, sexual function, and healthy body parts in the quest to find peace in their bodies. It's highly probable that, despite experiencing unfavorable outcomes, severe complications, and a clear adverse impact on their ability to establish intimate relationships, many will persist in convincing both themselves and others that their decision was not a mistake. This reluctance to acknowledge regret may stem from a reluctance to confront the consequences of their choices.

Indeed, the early Dutch clinicians were well aware of this possibility. In the first follow-up study of patients who at the time were referred to as transsexuals, conducted approximately 15 years after the Netherlands began offering sex trait modification interventions, the majority of participants reported being happy and feeling no regret despite researchers noting that improvement in "actual life situations [was] not always observed."[125] In the 1988 paper, the researchers considered the possibility that in an effort to reduce cognitive dissonance, participants who had undergone hormonal and surgical interventions "simply cannot accept the notion that all has been in vain. The self-reported happiness may have been distorted wishful thinking."

As already shown, studies that don't rely solely on self-report but instead measure factors such as social functioning and mental health status indicate far less positive outcomes.[126]

When more people regret knee replacement surgery than penis amputation, or more women regret undergoing prophylactic mastectomies for breast cancer risk than gender-affirming mastectomies, these surprising outcomes should raise red flags in a medical organization dedicated to scientific truth.[127,128,129,130] Rather than being proof that sex-trait modification surgeries are the cure for gender distress, these low regret rates are cause for investigation.

Permanently Medicalizing Transient Identities

Passing the blame onto minors isn't the only way WPATH members minimize the harm done to detransitioners. On November 6, 2021, a medical student responded to a member who shared a 2021 study of detransitioners in the forum, arguing that it was important to emphasize it is "okay for gender and interest in medical options to change over time for each individual," likening irreversible sex change interventions to tattoos or minor plastic surgeries.[131] The student then went on to suggest

125 Kuiper, B., & Cohen-Kettenis, P. (1988). Sex reassignment surgery: a study of 141 Dutch transsexuals. Arch Sex Behav, 17(5), 439-457. https://doi.org/10.1007/bf01542484

126 Ibid (n.68)

127 Mahdi, A., Svantesson, M., Wretenberg, P., & Hälleberg-Nyman, M. "Patients' Experiences of Discontentment One Year after Total Knee Arthroplasty-a Qualitative Study." [In eng]. BMC Musculoskelet Disord 21, no. 1 (Jan 14 2020): 29. https://doi.org/10.1186/s12891-020-3041-y.

128 Olson-Kennedy, J., Warus, J., Okonta, V., Belzer, M., & Clark, L. F. "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults." JAMA Pediatrics 172, no. 5 (2018): 431. https://doi.org/10.1001/jamapediatrics.2017.5440.

129 Borgen, P. I., Hill, A. D., Tran, K. N., Van Zee, K. J., Massie, M. J., Payne, D, & Biggs, C. G. "Patient Regrets after Bilateral Prophylactic Mastectomy." [In eng]. Ann Surg Oncol 5, no. 7 (Oct-Nov 1998): 603-6. https://doi.org/10.1007/bf02303829.

130 Bruce, L., Khouri, A. N., Bolze, A., Ibarra, M., Richards, B., Khalatbari, S., Blasdel, G., et al. "Long-Term Regret and Satisfaction with Decision Following Gender-Affirming Mastectomy." JAMA Surgery 158, no. 10 (2023): 1070-77. https://doi.org/10.1001/jamasurg.2023.3352.

131 Ibid (n.114)

that learning "new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made."

However, the procedures many of these patients undergo are far more extreme than a tattoo or a nose job. In the replies to the post about the distraught and angry detransitioned 17-year-old, a gynecologist from Barcelona explained she also had a patient wishing to detransition who was seeking vaginoplasty reversal surgery. This procedure involves surgically removing the pseudo-vagina and performing phalloplasty surgery, which is the creation of a non-functional pseudo-penis using skin stripped from the patient's forearm or thigh.[132,133] It is doubtful any individual would find that cause for celebration.

Many detransitioners feel intense anger and grief regarding the irreversible changes wrought by gender-affirming care. They mourn the loss of their body parts and the experiences, such as bearing children or breastfeeding, that have been taken from them.

An Ontario family physician is the only WPATH member in the files who respects the experience of detransitioners and dares to challenge Bowers and her colleagues on their disrespectful framing of detransition. She told the group her detransitioned patients were all young women who were allowed to change their bodies in permanent ways at a time in their lives when "their physical and sexual identities were in developmental flux." Most had comorbidities that were not fully addressed and were rushed into irreversible medical interventions. The physician described this group of patients as being "immersed in their own suffering, loss and grief."

The fact that a significant number of WPATH members downplay this distressing ordeal by implying that medical professionals did not err in misdiagnosing these youths and subjecting them to unnecessary, invasive procedures serves as proof that WPATH lacks ethical integrity.

In fact, there are members within WPATH who acknowledge that some teenagers are mistaking their emerging homosexuality as a gender identity issue. During the panel, Massey described young patients who, after exploring their sexuality, "got to clarify some of their gender identity issues."

This is one of the many risks associated with WPATH's approach to gender medicine. In bypassing exploratory psychotherapy, or indeed just not allowing children to grow and mature but instead immediately placing adolescents on the medical conveyor belt, WPATH-affiliated healthcare providers are inadvertently engaging in a new form of conversion therapy, sterilizing gay and lesbian teens before they have had a chance to understand and accept their sexuality.[134] Data from gender clinics and numerous studies indicate that children and adolescents suffering from gender dysphoria are disproportionately likely to grow up to be homosexual adults, and recent studies of detransitioners likewise show that a significant proportion are also

132 Djordjevic, M. L., Bizic, M. R., Duisin, D., Bouman, M. B., & Buncamper, M. "Reversal Surgery in Regretful Male-to-Female Transsexuals after Sex Reassignment Surgery." [In eng]. J Sex Med 13, no. 6 (Jun 2016): 1000-7. https://doi.org/10.1016/j.jsxm.2016.02.173.

133 "Phalloplasty for Gender Affirmation." Johns Hopkins Medicine, 2023, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/phalloplasty-for-gender-affirmation.

134 "Current Debates." Gender Identity Development Service, 2023, https://gids.nhs.uk/gender-identity-and-sexuality/#:~:text=For%20young%20people,males%20or%20females.

homosexual.[135,136,137,138,139,140]

The unethical and unscientific slant of WPATH is also evident in the way detransition is framed by some within the forum. On November 10, 2021, a research coordinator in the forum suggested that the very idea of detransitioning is "problematic" because it "frames being cisgender as the default and reinforces transness as a pathology." The young member argued that "it makes more sense to frame gender as something that can shift over time, and figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions make [sic] change over time."

However, it raises serious ethical questions when surgeons are tasked with the removal of healthy body parts, especially when such procedures are in pursuit of aligning a young person's physical form with an identity that is recognized as unstable and as yet unsettled.

Of yet more concern is the possibility that some young people are adopting a transgender identity as a trauma response, and WPATH-affiliated professionals are permanently medicalizing these distressed individuals. In malpractice lawsuits filed by Prisha Mosley and Isabelle Ayala, the trauma of being the victim of sexual assault at a young age is described as a contributing factor in the adoption of a transgender identity. Inside WPATH, members are aware of this possibility, yet still, the group's official position is immediate affirmation and access to drugs and surgeries if that is what the patient desires.[141] This approach also has opportunity costs, as the focus on gender identity and medical interventions may divert attention from the essential therapy needed to effectively address and manage the underlying trauma in these young individuals.

In a September 2021 thread in the forum, a counselor noted that "[t]rauma is common among trans clients," and several replies indicated that others had observed this trend as well. In the panel discussion, Metzger and his colleagues discuss a young person who, like Mosley and Ayala, began identifying as transgender after "an unfortunate, traumatic sexual event." Massey talks about the hope that the therapists involved could "help the young person distinguish between the assault and their gender identity" but points out the difficulty of this task because "there are times working with young people where they don't even disclose an assault or some type of sexually coercive or unpleasant experience."

Massey states that "even good therapists" are going to be limited at times, unable to get everything that's going on with a child. "Sometimes even adults don't bring it forward, so it's a high bar to cross sometimes to try to catch everything that may be affecting somebody's view of themselves and across domains of their life experiences."

WPATH Has Broken the Chain of Trust in Medicine

In medicine, there is a concept called the "chain of trust."[142,143] Doctors must be able to trust that their professional training is grounded in robust scientific evidence because, given the limited time available to medical professionals, it is not feasible for them to thoroughly investigate every aspect (diagnosis, prognosis,

135 Ibid (n.70)

136 Ibid (n.2)

137 Ibid (n.114)

138 Vandenbussche, E. "Detransition-Related Needs and Support: A Cross-Sectional Online Survey." Journal of Homosexuality 69, no. 9 (2022/07/29 2022): 1602-20. https://doi.org/10.1080/00918369.2021.1919479.

139 Drescher, J., & Pula, J. (2014). Ethical issues raised by the treatment of gender-variant prepubescent children. Hastings Cent Rep, 44 Suppl 4, S17-22. https://doi.org/10.1002/hast.365

140 Cantor, J. M. (2020). Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. J Sex Marital Ther, 46(4), 307-313. https://doi.org/10.1080/0092623x.2019.1698481

141 "Active and Resolved Cases." Campbell Miller Payne, 2023, https://cmppllc.com/our-cases, Isabelle Ayala and Prisha Mosley's Cases.

142 "Heidi Larson, Vaccine Anthropologist." The New Yorker, 2021, https://www.newyorker.com/science/annals-of-medicine/heidi-larson-vaccine-anthropologist.

143 Herman, R. (1994). RESEARCH FRAUD BREAKS CHAIN OF TRUST. The Washington Post. https://www.washingtonpost.com/archive/lifestyle/wellness/1994/04/19/research-fraud-breaks-chain-of-trust/ffd456e7-b8f7-496e-9b02-6c41c30dfd0a/

and treatment) of every illness. For medicine to function efficiently, doctors must be confident that those who issue practice guidelines have diligently and rigorously evaluated all the relevant evidence for the safety and efficacy of treatments.[144]

WPATH has broken the chain of trust in gender medicine. WPATH presents itself as scientific but is in fact an advocacy group promoting risky, experimental, and cosmetic procedures in the guise of well-researched and "medically necessary" care. WPATH is held up as the source of all knowledge about gender-affirming care, but the scientific basis for their recommendations is exceptionally weak. The group exists solely to shield doctors from legal liability, through the creation of guidelines it conveniently calls "standards of care," and to ensure insurance coverage for sex-trait modification procedures.

Due to its outward appearance as a professional medical association, complete with a peer-reviewed journal and bibliography of scientific literature, the wider medical community places its trust in WPATH's "Standards of Care." WPATH and its members have also influenced the position statements and practice guidelines of the American Academy of Pediatrics (AAP), the American Psychological Association (APA), and The Endocrine Society.

Further down the chain, parents and vulnerable patients trust the recommendations of their pediatricians, endocrinologists, and mental health professionals– clinicians who are either themselves WPATH-affiliated or who look to their WPATH-influenced professional associations for guidance on how to deal with children who feel distressed about their bodies.

144 O'Malley, S. & Ayad, S. Pioneers Series: We Contain Multitudes with Stephen Levine. Podcast audio. Gender: A Wider Lens Podcast2022. https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-stephen-levine, 34:53.

WPATH HAS NO RESPECT FOR MEDICAL ETHICS

Traditional medical ethics is more than just "first, do no harm." The guiding principle of Hippocratic medicine is that illness places the afflicted into a compromised state against their will and preference. It is in this compromised state that the person enters into the doctor-patient relationship. Therefore, the patient must be able to trust that their doctor will use his or her knowledge and expertise only for the purpose of healing or ameliorating symptoms and easing suffering, always with the priority of minimizing harm.

Throughout most of medical history, medicine did not involve intentionally destroying a healthy, functioning bodily system. It is only in the 20th century that a new pseudo-medical approach has emerged that views the patient more as a consumer and the doctor as a supplier of pharmaceutical and surgical interventions tasked with fulfilling the patient's desires, which are quickly defined as needs. In the past, the emphasis on autonomy in medical ethics was meant to act as a shield: there were things a doctor could not do to you without your consent. Nowadays, and especially in gender medicine, autonomy acts as a sword: in its name, there is nothing a doctor may deny you.

The consumer-driven model of autonomy involves giving the patient whatever he or she wants, so long as certain criteria are met: The clinician is technically capable of doing it; the patient wants it for whatever reason; it's legal, and the patient can pay for it.

This consumer-driven approach to healthcare is the model adopted by WPATH. The world-leading transgender health group advocates for a transition-on-demand style of care, valuing patient autonomy over avoidance of harm. WPATH's SOC8 more closely resembles a shopping list of risky and invasive cosmetic interventions, with each chapter concluding that the procedures are medically necessary if the patient so desires.

Such recommendations extend as far as non-binary "nullification" surgeries to create a smooth, sexless appearance or "bi-genital" surgeries involving the creation of a second set of genitals. There is also a chapter on people who identify as eunuchs and seek chemical or surgical castration as a means to affirm their "eunuch identities." Within the WPATH Files, there are discussions regarding these "non-standard" procedures and how to manage them. However, notably absent from these discussions is any consideration of the ethical concerns surrounding surgeries that destroy healthy reproductive organs in pursuit of creating bespoke anatomical features that do not exist in nature.

The Ethics of Informed Consent

Informed consent in medicine is the process by which a healthcare provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention.[145]

Obtaining informed consent in medicine is a process that should include three primary components: first, the provision of accurate, up-to-date information regarding the nature of the condition, the proposed treatment, and all available alternatives; second, an evaluation of the patient's understanding, and when applicable, the caregiver's understanding of the presented information and their ability to make informed medical decisions; and third, obtaining signatures confirming that informed

145 Shah, P., Thornton, I., Turrin, D., & Hipskind, JE. "Informed Consent.[Updated 2020 Aug 22]." StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing (2021). https://www.ncbi.nlm.nih.gov/books/NBK430827/#:~:text=Introduction,undergo%20the%20procedure%20or%20intervention.

consent has been secured.[146,147]

A discussion about *all* potential risks of a treatment, as well as all the uncertainties surrounding the benefits, is an integral part of informed consent. This involves addressing general risks, risks specific to the procedure, possible consequences of not undergoing treatment, and exploring alternative treatment options.

Minors Cannot Consent to Sex Trait Modification Procedures

WPATH members believe that minors can understand and give cognitive consent to sex-trait modification interventions that could have a life-long impact on their health, fertility, and future sexual function. In the files, the chief medical officer from Texas advised a concerned therapist to allow a troubled 13-year-old girl to begin testosterone therapy; a therapist discussed starting a 10-year-old girl on puberty blockers; WPATH President Bowers openly admitted that natal male children are being left anorgasmic for life; and one surgeon reported performing 20 vaginoplasties on minors.

Minors lack the maturity and cognitive capacity to understand the risks associated with such interventions and the long-term implications for their well-being. Additionally, their limited or nonexistent sexual experiences make it impossible for them to grasp the magnitude of what they are forfeiting. The leaked panel discussion proves that WPATH members know this. Yet, WPATH continues to advocate for placing minors, some as young as nine years old, on this irreversible medical pathway.

As a way to rationalize allowing minors to consent to sex-trait modification treatments, the full effects of which they could not possibly comprehend, some of the Identity Evolution Workshop panelists drew an analogy with treating childhood-onset diabetes.

"When a kid takes diabetic medication, do they have to understand everything about their pancreas and everything that's happening?" Berg asked the panel rhetorically. Later, Green said, "If you have a known condition, like diabetes, you don't have to understand every nuance about what the insulin is going to do to you in order to give informed consent."

However, the analogy is flawed for several reasons. In order to obtain a diabetes diagnosis, there is a biological test to confirm the illness. The cause is known; the treatment protocol is well-studied; the outcome of treating with insulin is understood, and the risks involved in not treating are clear. Indeed, if left untreated, the illness is fatal. Insulin therapy also does not result in lifelong sterility, nor does it impact a young person's future sexual function. It is a treatment with solid scientific evidence that the benefits greatly outweigh the risks, making the informed consent process straightforward.

But the same cannot be said for using puberty blockers and cross-sex hormones to help young adolescents manage their discomfort with their sex. There is no diagnostic test to confirm a diagnosis of gender dysphoria; instead, it is based on a young person's subjective sense of self that is constantly changing and evolving. Likewise, there is no way to predict which children and adolescents will persist in their transgender identities as adults. There is also no good-quality scientific evidence to support the use of puberty blockers as a remedy for this poorly defined disorder, and there are no long-term outcome studies demonstrating that the benefits outweigh the risks; in fact, there is mounting evidence to the contrary.

The combination of puberty blockers and cross-sex hormones could leave a young patient sterile for life, and the drugs come with a host of known and anticipated side effects, including brittle bones, cognitive impairment, and heightened risk of cancer and cardiovascular disease, as well as uncertainty concerning resolution of gender dysphoria.

146 "Informed Consent." AMA Code of Medical Ethics, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent.

147 Katz, A. L., and Webb, S. A. "Informed Consent in Decision-Making in Pediatric Practice." [In eng]. Pediatrics 138, no. 2 (Aug 2016). https://doi.org/10.1542/peds.2016-1485.

What's more, all studies from the era of gender medicine pre-dating the puberty suppression experiment show that most children, if not affirmed and socially and medically transitioned, will desist and reconcile with their birth sex during or after puberty.[148] Although there is at present no scientific literature available regarding persistence rates for the recently emerged adolescent-onset cohort, which currently comprises the majority of referrals to pediatric gender clinics, existing knowledge about adolescent development suggests significant uncertainty regarding the stability of this group's transgender identities into adulthood.[149]

That experts within WPATH cannot see the difference between the two treatment protocols is further proof that members of this organization do not have a solid understanding of science.

Misinformed Parents Cannot Give Informed Consent

For legal reasons, it falls to parents to sign the consent form for their child's sex-trait modification hormonal and surgical interventions, but WPATH's public and private communications indicate that members are misinforming parents about the experimental treatment protocol.

Parents can only give informed consent if they are told the truth about every stage of the "transition" process, starting with social transition.

Changing names and pronouns is often portrayed as a harmless, non-medical step to alleviate a child's distress. It is sold to parents as completely reversible at any time, but all available evidence suggests the contrary.

Social transition has a powerful iatrogenic effect, meaning affirming a child's transgender identity and allowing a change of name and pronouns serves to concretize the identity in the young person's mind, making desistance far less likely. Historically, in the absence of social transition, the majority of gender dysphoric children would naturally desist and reconcile with their birth sex during or after puberty.[150,151,152] Most would come out as gay.

In her interim report for the independent review of England's youth gender service, Dr. Hilary Cass noted this iatrogenic effect, stating that social transition is not a "neutral act" but rather "it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning."[153]

However, in March 2023, WPATH made a public statement in response to Missouri Attorney General Andrew Bailey's emergency regulation banning sex-trait modification for minors, citing a July 2022 article published by the American Academy of Pediatrics. The paper by Dr. Kristina R. Olson et al. showed five years after their initial social transition, 97.5% of youth who identify as transgender continued to do so.[154,155] This article, WPATH appears to believe, is evidence that these young people are truly transgender and, therefore, deserving of medical treatment. In truth, what it shows is that social transition serves to lock in the transgender identity.

While it is not necessary to sign a consent form before

148 Cantor, J. M. (2016). Do trans- kids stay trans- when they grow up? http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html

149 Ibid (n.49); Ibid (n.50)

150 Ibid (n.2)

151 Ibid (n.3)

152 Kaltiala-Heino, R., Bergman, H., Työläjärvi, M., & Frisén, L., "Gender Dysphoria in Adolescence: Current Perspectives." [In eng]. Adolesc Health Med Ther 9 (2018): 31-41. https://doi.org/10.2147/ahmt.S135432.

153 "The Cass Review: Independent Review of Gender Identity Services for Children and Young People: Interim Report." 2022, 62. https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf.

154 WPATH. (2023). USPATH and WPATH Confirm Gender-Affirming Health Care is Not Experimental; Condemns Legislation Asserting Otherwise. WPATH. https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH_WPATH%20Response%20to%20AG%20Bailey%20Emergency%20Regulation%2003.22.2023.pdf

155 Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender Identity 5 Years After Social Transition. Pediatrics, 150(2). https://doi.org/10.1542/peds.2021-056082

a minor socially transitions, if WPATH members are failing to warn parents of the iatrogenic effect of social transition, the parents' decision is not an informed one.

The next step of the transition pathway for a minor is puberty blockers, and again, there is evidence that WPATH members are not providing parents with the most up-to-date information about this intervention. In January 2022, Bowers described puberty blockers as "fully reversible" despite the fact that by this point, there was abundant evidence to the contrary.

In fact, very early in the puberty suppression experiment, it was noted that almost every adolescent who commences puberty blockers proceeded to cross-sex hormones, when historical data showed that most children would cease to identify as members of the opposite sex after puberty.[156, 157,158] This means that puberty suppression is almost certainly the first step in a longer treatment protocol, not a mere "window of time" for the adolescent to think about his or her identity. Therefore, it cannot be called "fully reversible."

Massey's comments in the May 2022 panel discussion prove that people within WPATH understand this. The WPATH therapist stressed the importance of discussing "fertility preservation" with youth who are going on puberty blockers because many of those youth will go directly onto affirming hormone therapies that will eliminate the development of their gonads producing sperm or eggs."

Clinicians and researchers have long recognized that the cognitive development that occurs as a result of endogenous puberty is the remedy for childhood gender dysphoria. This was noted by the Dutch clinicians who pioneered puberty suppression and who also happen to be members of WPATH. Blocking puberty, therefore, means blocking the natural cure to gender dysphoria.

Metzger's comments during the panel indicate that, privately, WPATH members understand this negative impact of freezing adolescents in a child-like state. When Metzger spoke about "robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their cisgender peers," he was referring to robbing children of the same developmental process that would almost certainly have enabled them to overcome their dysphoria naturally.

Therefore, any WPATH-affiliated healthcare professional who tells parents that puberty blockers are "fully reversible" is providing inaccurate information and consequently failing to obtain proper informed consent.

Furthermore, true informed consent can only be obtained if the healthcare provider informs parents that the evidence base for the life-altering interventions of puberty suppression, cross-sex hormones, and surgeries is low quality, as has been found by every systematic review to date;[159,160,161,162] and that other countries that once offered gender-affirming care have since drastically scaled back the practice due to concerns about iatrogenic harm. These parents must also understand the often debilitating side effects and long-term serious health risks of cross-sex

156 Ibid (n.2)

157 Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. "Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspectsthis Paper Was Presented at the 4th Ferring Pharmaceuticals International Paediatric Endocrinology Symposium, Paris (2006). Ferring Pharmaceuticals Has Supported the Publication of These Proceedings." European Journal of Endocrinology 155, no. Supplement_1 (2006): S131-S37. https://doi.org/10.1530/eje.1.02231. https://doi.org/10.1530/eje.1.02231.

158 Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. "Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the Uk." PLOS ONE 16, no. 2 (2021): e0243894. https://doi.org/10.1371/journal.pone.0243894. https://dx.doi.org/10.1371/journal.pone.0243894.

159 Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., et al. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline." [In eng]. J Clin Endocrinol Metab 102, no. 11 (Nov 1 2017): 3869-903. https://doi.org/10.1210/jc.2017-01658.

160 "Nice Evidence Reviews." The Cass Review, https://cass.independent-review.uk/nice-evidence-reviews/.

161 "Hormonbehandling Vid Könsdysfori - Barn Och Unga." SBU UTVÄRDERAR, 2022, https://www.sbu.se/contentassets/ea4e698fa0c4449aaae964c5197cf940/hormonbehandling-vid-konsdysfori_barn-och-unga.pdf.

162 "One Year since Finland Broke with Wpath "Standards of Care"." Society for Evidence Based Gender Medicine, 2021, https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors.

hormones before the consent form is signed.

Lastly, many parents are told inaccurate suicide statistics. They are informed that if they don't consent to their child undergoing experimental sex-trait modification, there exists a substantial risk of suicide. The ultimatum, "You can either have a living son or a dead daughter?" is put to parents in gender clinics all over North America.[163,164,165] This constitutes coercion, emotional blackmail, and medical malpractice. Rather than proper informed consent, it is misinformed consent obtained under duress.

The Transition-or-Suicide Myth

WPATH members, and gender-affirming clinicians in general, often frame sex trait modification as "life-saving" care and assert that without it, transgender-identified youth and adults are at high risk of suicide.

Many trans activists perpetuate this transition-or-suicide narrative. "Gender-affirming care is medical care. It is mental health care. It is suicide prevention care. It improves quality of life, and it saves lives," said Admiral Rachel Levine during a 2022 speech in Texas.[166] "Fifty percent of transgender youth attempt suicide before they are age 21," claimed Jeannette Jennings, mother of transgender reality TV star Jazz, in a 2016 interview published in the American Academy of Pediatrics (AAP) journal.[167]

But how much truth is there to the claim that gender-affirming care is "suicide prevention care"? The answer is very little. It's important to distinguish the difference between suicide ideation (or thoughts), suicide attempts, and completed suicides. The term "suicidality" is often used to refer to all three phenomena despite the important differences between them. For example, middle-aged men are at higher risk of death by suicide than adolescents of both sexes, but adolescent girls and young women exhibit the highest rates of non-lethal suicidal gestures, which could be better interpreted as cries for help.

As indicated in surveys, transgender-identified youth are at elevated risk for suicidality and suicide.[168] Crucially, however, completed suicide in this population is extremely rare, and elevated suicidality is most likely because of comorbid psychopathology, which is extremely common and independently linked to suicidal ideation and behavior. In short, there is no suicide epidemic striking transgender-identified youth, and the claim that "gender" is the cause of and solution to this group's suicidal tendencies is a classic mistaking of correlation for causation.[169]

Research showing a higher rate of suicidality among trans-identified young people usually compares the transgender cohort to the general adolescent population who have no mental health issues. When trans-identified youth are compared to adolescents with similar mental health problems, there is little difference in suicidality.[170]

As well, the elevated suicide risk exists at all stages of the transition process. During a two-year study funded by the National Institutes of Health (NIH) of 315 American youth undergoing "gender-affirming hormone therapy," there were two completed suicides, and 11 youth reported

163 "Affidavit of Jamie Reed."11. https://ago.mo.gov/wp-content/uploads/2-07-2023-reed-affidavit-signed.pdf.

164 "Chloe Cole V. Kaiser Permanente." Dhillon Law Group, 2023, https://www.dhillonlaw.com/lawsuits/chloe-cole-v-kaiser-permanente/.

165 "Active and Resolved Cases: Ayala V. American Academy of Pediatrics." Campbell Miller Payne, 2023, 26. https://cmppllc.com/our-cases.

166 "Remarks by Hhs Assistant Secretary for Health Adm Rachel Levine for the 2022 out for Health Conference." U.S. Department of Health and Human Services, 2022, https://www.hhs.gov/about/news/2022/04/30/remarks-by-hhs-assistant-secretary-for-health-adm-rachel-levine-for-the-2022-out-for-health-conference.html.

167 "Trans Teen Shares Her Story." Pediatrics in Review, 2016, https://publications.aap.org/pediatricsinreview/article-abstract/37/3/99/34959/Trans-Teen-Shares-Her-Story?redirectedFrom=fulltext?autologincheck=redirected.

168 Toomey, R. B., Syvertsen, A. K., & Shramko, M. "Transgender Adolescent Suicide Behavior." [In eng]. Pediatrics 142, no. 4 (Oct 2018). https://doi.org/10.1542/peds.2017-4218.

169 Biggs, M. "Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom." [In eng]. Arch Sex Behav 51, no. 2 (Feb 2022): 685-90. https://doi.org/10.1007/s10508-022-02287-7.

170 de Graaf, N. M., Steensma, T. D., Carmichael, P., VanderLaan, D. P., Aitken, M., Cohen-Kettenis, P. T., de Vries, A. L. C., et al. "Suicidality in Clinic-Referred Transgender Adolescents." [In eng]. Eur Child Adolesc Psychiatry 31, no. 1 (Jan 2022): 67-83. https://doi.org/10.1007/s00787-020-01663-9.

considering suicide.[171] These deaths are all the more striking, considering that the researchers screened participants for suicidality. Despite these tragic outcomes, the authors, many of whom are considered some of WPATH's most prominent members, concluded that gender-affirming hormones "improved appearance congruence and psychosocial functioning." In the UK, one study showed four completed suicides, representing 0.03% of youth referred to the Gender Identity Development Service (GIDS) between 2010 and 2020. Two out of the four patients were already in the care of the service, and two were on the waiting list.[172]

What's more, we know that autism,[173] eating disorders,[174] and other mental health issues[175] result in elevated suicide risk for young people. We also know that many adolescents who identify as transgender disproportionately suffer from these very same psychiatric comorbidities and, in many cases, the other mental health issues started long before the teen announced a transgender identity.[176] It is, therefore, theoretically possible that youth already at an elevated risk of suicide and suicidality are drawn to identify as transgender because they see medical transition as a solution to their mental distress, as several detransitioner testimonies indicate.[177,178,179] In such a scenario, sex-trait modification interventions would do nothing to reduce or eliminate suicide risk and, in fact, in the long run, may increase the risk if the young, mentally unwell person comes to regret undergoing hormonal and surgical procedures.

There is also concern from some experts that many cases of adolescent-onset gender dysphoria are actually cases of borderline personality disorder (BPD). Symptoms of BPD include "identity disturbance" and "recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviour."[180] According to Canadian sexologist James Cantor, "BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population." Therefore, Cantor argues, "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."[181]

In such cases, misdiagnosing BPD as adolescent-onset gender dysphoria and allowing the young person to undergo hormonal and surgical interventions would do nothing to reduce suicidal behavior and could, in fact, lead to a worsening of such behavior. Indeed, a malpractice lawsuit filed by a detransitioned young woman by the name of Prisha Mosley alleges that her BPD was ignored. Instead, her healthcare team convinced her that sex-trait modification interventions would resolve her severe mental

171 Chen, D., Berona, J., Chan, Y., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones." New England Journal of Medicine 388, no. 3 (2023): 240-50. https://doi.org/10.1056/nejmoa2206297.

172 Biggs, M. (2022). Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom. Arch Sex Behav, 51(2), 685-690. https://doi.org/10.1007/s10508-022-02287-7

173 O'Halloran, L., Coey, P., & Wilson, C. "Suicidality in Autistic Youth: A Systematic Review and Meta-Analysis." Clinical Psychology Review 93 (2022/04/01/ 2022): 102144. https://www.sciencedirect.com/science/article/pii/S0272735822000290.

174 Smith, A. R., Zuromski, K. L., & Dodd, D. R. "Eating Disorders and Suicidality: What We Know, What We Don't Know, and Suggestions for Future Research." [In eng]. Curr Opin Psychol 22 (Aug 2018): 63-67. https://doi.org/10.1016/j.copsyc.2017.08.023.

175 Galaif, E. R., Sussman, S., Newcomb, M. D., & Locke, T. F. "Suicidality, Depression, and Alcohol Use among Adolescents: A Review of Empirical Findings." [In eng]. Int J Adolesc Med Health 19, no. 1 (Jan-Mar 2007): 27-35. https://doi.org/10.1515/ijamh.2007.19.1.27.

176 Diaz, S., and Bailey, J. M. "Retracted Article: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases." Archives of Sexual Behavior 52, no. 3 (2023): 1031-43. https://doi.org/10.1007/s10508-023-02576-9.

177 Ibid (n.141)

178 "Luka Hein V. Unmc Physicians." Liberty Center, https://libertycenter.org/cases/hein-v-unmc/.

179 "Kiefel First Amendment Complaint ", 2022, https://static1.squarespace.com/static/5f232ea74d8342386a7ebc52/t/63a0afdfc02f9322762974cf/1671475168006/Kiefel+First+Amended+Complaint+%28file+stamped%29.pdf.

180 Biskin, R. S., & Paris, J. (2012). Diagnosing borderline personality disorder. Cmaj, 184(16), 1789-1794. https://doi.org/10.1503/cmaj.090618

181 "The Science of Gender Dysphoria and Transsexualism." 2022: 22. https://ahca.myflorida.com/content/download/4865/file/AHCA_GAPMS_June_2022_Attachment_D.pdf.

distress. Her lawyers allege that this "substantially and permanently compounded Prisha's physical suffering and mental anguish."[182]

In a small study of 28 Canadian detransitioners, two participants had a co-existing BPD diagnosis, with one young woman expressing frustration that her BPD was only diagnosed after she had undergone a bilateral mastectomy and her mental health deteriorated.[183] Another detransitioned woman from Canada who has filed a malpractice lawsuit against her healthcare team also received a BPD diagnosis years after being misdiagnosed as transgender and undergoing hormonal and surgical sex trait modification interventions.[184]

Thus, the transition-or-suicide narrative is, as Finland's leading expert on pediatric gender medicine has put it, "purposeful disinformation," the spreading of which is "irresponsible."[185] Using suicide threats to influence parents in their decisions over healthcare for their children is a violation of medical ethics and amounts to malpractice. It also makes the false promise that these experimental interventions will eliminate the risk of suicide for the young person when no evidence exists to support such a claim.

As previously mentioned, the few long-term follow-up studies of the adult transgender population also do not indicate that sex-trait modification interventions eliminate or greatly reduce the risk of suicide. A Swedish study[186] of 324 individuals who had undergone genital surgery between 1973 and 2003 revealed rates of completed suicide post-surgical transition to be greatly elevated over the general population, with trans-identified natal females 40 times more likely to die by suicide and trans-identified natal males 19 times more likely.[187,188]

The largest study conducted to date on the 8,263 patients who passed through the gender clinic in Amsterdam from 1972 to 2017 found that both male and female transgender people had a quadruple rate of suicide and concluded that "the suicide risk in transgender people is higher than in the general population and seems to occur during every stage of transitioning."[189]

A recent long-term Danish study concluded that people who have undergone sex-trait modification interventions in Denmark have a 3.5 times increased rate of completed suicide post "transition" compared to the general population and 7.7 times the rate of suicide attempts.[190] Another long-term Dutch study found male-to-female transsexuals had a sixfold increased risk of suicide after undergoing sex-trait modification procedures.[191]

Therefore, the sex-trait modification experiment advocated for by WPATH cannot be considered "harm reduction" or "life-saving," and it is unethical for any medical or mental health professional to assert otherwise. It is also unethical to offer minors and adults with severe mental illness harmful, irreversible medical interventions without first attempting to address their psychiatric

182 "Active and Resolved Cases: Mosely V. Emerson, Et Al." Campbell Miller Payne, 2023, 2. https://cmppllc.com/our-cases.

183 Ibid (n.115)

184 Humphreys, A. (2023). Ontario detransitioner who had breasts and womb removed sues doctors. National Post. https://nationalpost.com/news/canada/michelle-zacchigna-ontario-detransitioner-sues-doctors

185 Mutanen, A. (2023). A professor who treats adolescent gender anxiety says no to minors' legal gender correction. Helsingin Sanomat. https://www.hs.fi/tiede/art-2000009348478.html

186 Ibid (n.66)

187 Ibid (n. 186)

188 Levine, S. B., Abbruzzese, E., & Mason, J. W. "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults." Journal of Sex & Marital Therapy 48, no. 7 (2022): 706-27. https://doi.org/10.1080/0092623x.2022.2046221.

189 Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. "Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017)." [In eng]. Acta Psychiatr Scand 141, no. 6 (Jun 2020): 486-91. https://doi.org/10.1111/acps.13164.

190 Erlangsen, A., Jacobsen, A. L., Ranning, A., Delamare, A. L., Nordentoft, M., & Frisch, M. "Transgender Identity and Suicide Attempts and Mortality in Denmark." JAMA 329, no. 24 (2023): 2145-53. https://doi.org/10.1001/jama.2023.8627.

191 Asscheman, H., Giltay, E. J., Megens, J. A., de Ronde, W. P., van Trotsenburg, M. A., & Gooren, L. J. "A Long-Term Follow-up Study of Mortality in Transsexuals Receiving Treatment with Cross-Sex Hormones." [In eng]. Eur J Endocrinol 164, no. 4 (Apr 2011): 635-42. https://doi.org/10.1530/eje-10-1038.

problems through less invasive means.

Allowing Severely Mentally Ill Patients to Consent to Life-Altering Medical Interventions

Some patients discussed in the files do not appear to have been in a state of sound mind when deciding to undergo sex-trait modification procedures, meaning that it is doubtful that they would have been able to weigh the long-term impact on their future health and sexual function.

Several message threads suggest that WPATH members are allowing mentally unstable people to consent to hormones and surgeries. In an undated post, a nurse practitioner from Halifax, NS, described a patient with very complex mental health issues, including PTSD, major depressive disorder (MDD), observed dissociations, and schizoid typical traits. The nurse told the group that the patient is eager to start hormones, but psychiatry is recommending holding off.

"My practice is based fully on the informed consent model however this case has me perplexed; struggling internally as to what is the right thing to do," said the nurse.

Dr. Dan Karasic of the University of California San Francisco (UCSF), the lead author of the mental health chapter of WPATH's SOC8, was baffled by the nurse's perplexity. "I'm missing why you are perplexed," said Karasic. "The mere presence of psychiatric illness should not block a person's ability to start hormones if they have persistent gender dysphoria, capacity to consent, and the benefits of starting hormones outweigh the risks."

While Karasic is correct that the mere presence of mental illness does not automatically mean a patient is incapable of consenting to a medical procedure, it is questionable that a patient in such a state could rationally weigh up the long-term implications of irreversible cross-sex hormones. Also, given the aforementioned negative impact of these hormones on a patient's sexual function, it is doubtful that the benefits outweigh the risks, even in a healthy individual. People suffering from mental illness often struggle to form long-term romantic relationships. Hormone therapy places an enormous medical burden on the body and impairs sexual function, making life more difficult for a mentally ill person already struggling.

However, in the files, Karasic's opinion enjoys the support of his fellow members, with the aforementioned California therapist reporting having patients with DID, MDD, bipolar, and schizophrenia that "do just fine on HRT" and an orchiectomy making a "huge difference" to the life of a homeless person. An orchiectomy is the surgical removal of the testes. But again, without long-term follow-up, it is impossible to know if these claims of success are accurate.

There are other therapists in the WPATH Files discussing patients suffering from dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), being allowed to consent to sex-trait modification procedures. The MPD epidemic of the 1980s and 1990s was iatrogenic in nature, meaning it was created and spread by misguided therapists. After the scandal collapsed under the weight of lawsuits, MPD was rebranded as DID, and as a diagnosis, its occurrence decreased significantly. However, there has been a recent resurgence, with TikTok providing an important vector for the contagion and certain WPATH members embracing DID "alter" identities as deserving of affirmation along with transgender identities.[192]

In 2017, Karasic gave a presentation at the conference of WPATH's US branch, USPATH, about the importance of affirming "plural" identities.[193] During the presentation, the prominent WPATH psychiatrist detailed case studies of patients with DID who had undergone hormonal and/or surgical sex trait modification interventions.

One patient was a male who identified as

192 #dissociativeidentitydisorder. (2024). TikTok. https://www.tiktok.com/tag/dissociativeidentitydisorder?lang=en

193 Not plural-phobic: USPATH psychiatrist promotes transition for multiple personalities. (2017). 4thWaveNow. https://4thwavenow.com/2017/12/29/not-plural-phobic-uspath-psychiatrist-promotes-transition-for-multiple-personalities/

"genderqueer" and underwent "flat front" nullification surgery, or the amputation of the genitals to create a smooth, sexless appearance. This male suffered from bipolar disorder and "alcohol use disorder" and was treated with spironolactone, an anti-androgen hormone blocker, followed by estradiol, or synthetic estrogen. Karasic reported that the patient had seven alters, two of which were "agender" and one female. "Alters were in agreement about surgery," Karasic assured the audience.

Another DID patient was a 27-year-old male who identified as a "genderqueer system." A system is multiple distinct personalities sharing one body. This particular patient, who was diagnosed with autism in childhood, had 85 "headmates," with the primary "front" alter being female. The patient was on estradiol along with a drug to prevent breast growth and had undergone an orchiectomy at age 25.

Karasic told the audience he had had several patients who identified as trans and plural, which he put down to his reputation "as a psychiatrist who was not plural phobic." This is the caliber of expert WPATH felt appropriate to appoint as the lead author of its SOC8 mental health chapter.

At WPATH's 2022 International Symposium in Montreal, a team of researchers presented the preliminary findings of their research into the confluence of transgender and "plural" identities.[194] The team grappled with the complexity of obtaining informed consent for sex-trait modification hormones and surgeries from patients with hundreds of alters, many with differing gender identities. Their research quoted an individual called The Redwoods, who identifies as nine separate people sharing a "trans body," explaining the difficulties faced by patients who were forced to choose between their gender dysphoria diagnosis and their DID diagnosis "because providers wrongly believed you could not be both."

The research team drew few solid conclusions but recommended affirmation of both trans and plural identities, which could lead to "gender and plural euphoria," as well as the suggestion that plurals have their separate personalities use an app to talk to each other to reach an agreement about hormonal and surgical sex trait modification interventions. The lead researcher appears in the WPATH Files in a thread dated September 2021, discussing the "robust community developing of people who identify as plural" as well as "plural positivity" conferences. He stated there was a "general consensus that mental health and medical providers need more training on this topic so they can provide affirming care."

Inside the WPATH forum, members grapple with how to manage "trans clients" with DID when "not all the alters have the same gender identity," with one North Carolina psychologist stressing that it was "imperative to get all the alters who would be affected by HRT to be aware and consent to the changes."

"Ethically, if you do not get consent from all alters you have not really received consent and you may be open to being sued later, if they decide HRT or surgery was not in their best interest," said the psychologist. This reply was one of only two mentions of ethics in the whole WPATH Files.

Another therapist admitted lying about her patients' diagnosis of DID in referral letters, calling it "complicated PTSD" instead because she didn't "think surgeons would blink at that as much as DID." But she also confessed that two patients with DID whom she had referred for hormones now experience regret and feel that "their decision to start hormones was colored by trauma and DID and now, after more therapy and understanding, wish they had dug deeper before starting hormones."

These two cases of regret demonstrate how WPATH's approach of prioritizing "gender" and bypassing exploratory psychotherapy that seeks to uncover the origins of distress risks setting patients up for iatrogenic harm and later regret.

McGinn, the aforementioned surgeon who has

194 Wolf-Gould, C., Flynn, S., McKie, S. (2022, September 16-20). An Exploration of Transgender and Plural Experiences [Conference presentation].

performed 20 vaginoplasties on minors, joined the discussion to report performing two "vulvovaginoplasty" surgeries and one bilateral mastectomy on patients suffering from DID and happily stated that all three "did ok out to the six-month mark."

However, once again, a follow-up period of six months is not long enough to declare the surgeries a success. In the short term, there may be misleading signs of improved mental well-being, but how will the patient, particularly one who consented while in a state of severe mental instability, feel about their genital surgery or bilateral mastectomy in 10, 20, or 30 years? Gender-affirming healthcare providers never seem to ask this vital question and yet claim to be providing ethical medical care.

A Virginia doctor in the forum was of the opinion that as long as persistent gender dysphoria is present, those with severe mental health issues such as bipolar disorder, autism, and schizoaffective disorder should be allowed to consent to vaginoplasty. "It would be great if every patient could be perfectly cleared prior to every surgical intervention, but at the end of the day it is a risk/benefit decision," she said, shrugging off the possibility that the severely mentally unwell patients may be unable to cope with the grueling dilation schedule and may suffer serious complications as a result.

In fact, within all the files, the sole instance where WPATH members express concern regarding the potential dangers and adverse effects of a medical procedure is found in a conversation involving a trans-identified natal male interested in hormone-induced lactation purely for the sake of experiencing it, with no intention of nursing an infant. From the information given, the patient appears to be otherwise mentally well, but his doctor described having ethical issues with this request, as it was not without some risk.

The replies echoed the doctor's concerns, with one doctor calling the request unethical because it was a "medical intervention that is not necessary" and a San Francisco ethicist calling the reason for the intervention "questionable." The ethicist reminded the doctor that he is a professional "to whom society gives certain privileges" in exchange for his "prudent use of resources" and his "commitment to interventions where benefits outweigh risk and to 'at least do no harm.'"

"I understand your patient's desire to experience lactation as one function of her womanhood," continued the ethicist. "But that is [an] insufficient reason, in my estimation, to intervene medically." While this expert in medical ethics is not required to comment on every post within the forum, it is telling that she does not appear in any of the discussions regarding allowing people with severe mental illness to consent to vaginoplasty or threads concerning the creation of second sets of genitals for people who identify as non-binary, reminding WPATH surgeons to do no harm. Nor does she comment in message threads about drastic hormone interventions for minors that will leave them anorgasmic for life, reminding WPATH doctors that benefits must outweigh risks. By comparison, the male's request to induce lactation just to experience it is trivial.

Notably, all the WPATH members in the discussion avoid tackling the uncomfortable truth about the patient's motivation. The man being discussed in the forum may fit the description of having physiologic autogynephilia, meaning his desire to lactate may have been for erotic purposes.

Contrast how members talk about the natal male wishing to use drugs to induce lactation with the discussion about a 13-year-old girl who identified as non-binary and wished to begin taking testosterone. Her therapist was worried that 13 was too young and also mentioned a "possible complication," which was that "there is some purposeful malnutrition and restrictive eating for a more non-binary appearance."

But instead of recommending addressing the eating disorder and general mental health issues before starting the distressed teenager on such a powerful hormone, or indeed questioning the ethics of allowing an obviously troubled girl to consent to the irreversible effects of testosterone, a pediatric endocrinologist informed the

therapist that WPATH has removed all the minimum age requirements in its latest standards of care. Then, a chief medical officer of a health center in Texas cautioned that "waiting appears to increase the rate of suicide" because the patient would have to deal with "menstrual periods and complete breast development." The expert in medical ethics is conspicuously absent from the discussion.

Minority Stress

WPATH's belief system has a built-in answer to the problem of high rates of psychiatric comorbidities before and after transition as well as post-transition suicides. That answer is the minority stress model. According to WPATH, the mental health issues experienced by members of the transgender community before, during, and after sex-trait modification interventions are the result of living in a transphobic society, in other words, the stress of being a member of an oppressed minority.[195] Research produced by some WPATH members claims that gender-affirming care can resolve psychiatric comorbidities such as depression, anxiety, suicidality, or even autism.[196,197,198]

The minority stress hypothesis, borrowed from the gay rights movement, has never been empirically verified in the context of transgender medicine, but it serves as a way for gender-affirming healthcare providers to deny culpability when a person regrets their transition or when the transition doesn't improve their mental health.[199] It enables these doctors to blame society for being intolerant, rather than themselves for allowing a minor or a mentally unstable adult to undergo drastic, life-altering medical interventions. As well, because "intolerance" is defined by the activist clinician-researchers themselves in ever more implausible ways, minority stress is essentially an unfalsifiable and, thus, unscientific theory. It is thus also an all-too-convenient insurance policy for gender clinicians against malpractice allegations.

In fact, Sweden serves as a counter-argument to the minority stress model. As a highly tolerant nation, if the minority stress model were correct, we would expect to see far lower rates of mental illness and suicidal behavior among the transgender population, but the opposite is true. The long-term Swedish study found post-op transgender adults had a significantly elevated risk of suicide as well as increasing mortality rates.[200]

Realistic Expectations

Numerous studies indicate that many adolescents experiencing adolescent-onset gender dysphoria suffer from multiple psychiatric comorbidities that pre-date the onset of distress about their sex.[201,202,203,204] Detransitioner testimony supports the hypothesis that some mentally distressed people could be drawn to self-diagnosing as transgender after being led to believe that sex-trait modification procedures are a miracle cure for all their

195 Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. M. "Minority Stress, Distress, and Suicide Attempts in Three Cohorts of Sexual Minority Adults: A U.S. Probability Sample." PLOS ONE 16, no. 3 (2021): e0246827. https://doi.org/10.1371/journal.pone.0246827.

196 Turban, J. L. "Potentially Reversible Social Deficits among Transgender Youth." [In eng]. J Autism Dev Disord 48, no. 12 (Dec 2018): 4007-09. https://doi.org/10.1007/s10803-018-3603-0.

197 Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation." [In eng]. Pediatrics 145, no. 2 (Feb 2020). https://doi.org/10.1542/peds.2019-1725.

198 Turban, J. L., & van Schalkwyk, G. I. ""Gender Dysphoria" and Autism Spectrum Disorder: Is the Link Real?" [In eng]. J Am Acad Child Adolesc Psychiatry 57, no. 1 (Jan 2018): 8-9.e2. https://doi.org/10.1016/j.jaac.2017.08.017.

199 Mayer, L. S., and McHugh, P. R. "Part Two: Sexuality, Mental Health Outcomes, and Social Stress." Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences, The New Atlantis 50 (2016): 73-75. https://www.thenewatlantis.com/publications/part-two-sexuality-mental-health-outcomes-and-social-stress-sexuality-and-gender.

200 Ibid (n.66)

201 Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. "Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development." [In eng]. Child Adolesc Psychiatry Ment Health 9 (2015): 9. https://doi.org/10.1186/s13034-015-0042-y.

202 Bechard, M., VanderLaan, D. P., Wood, H., Wasserman, L., & Zucker, K. J. "Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study." [In eng]. J Sex Marital Ther 43, no. 7 (Oct 3 2017): 678-88. https://doi.org/10.1080/0092623x.2016.1232325.

203 Kozlowska, K., Chudleigh, C., McClure, G., Maguire, A. M., & Ambler, G. R., "Attachment Patterns in Children and Adolescents with Gender Dysphoria." Frontiers in psychology (2021): 3620. https://www.frontiersin.org/articles/10.3389/fpsyg.2020.582688/full.

204 Ibid (n.176)

psychological suffering.[205]

In the files, there is evidence that WPATH members encourage such false hopes. A Montana trans-identified natal female therapist said that "receiving gender-affirming care can often significantly stabilize client's [sic] mental health." The California therapist who claimed surgical castration made a huge difference in the life of a homeless person told the forum that withholding hormones can intensify mental health symptoms and suggested hormone therapy is "harm reduction and so doing nothing is not a 'neutral option.'"

WPATH's SOC8 also states that "studies suggest mental health symptoms experienced by [transgender/gender diverse] people tend to improve" following sex-trait modification interventions despite there being no good quality research to support this claim.[206]

Suggesting that hormonal and surgical sex-trait modification interventions can improve depression, PTSD, and even schizophrenia is a breach of the requirement to present accurate information to the patient when obtaining informed consent. It is akin to a cosmetic surgeon telling a patient that a nose job is the remedy for depression or breast augmentation is the cure for bipolar disorder.

Due to such false promises, people suffering from gender dysphoria often have unrealistic expectations about undergoing sex-trait modification procedures. The anticipation and excitement about starting cross-sex hormones or having a mastectomy or genital surgery often become a focal point for the distressed mind, with individuals pinning their hopes on these medical procedures to resolve all their pain and suffering. WPATH members endorsing sex-trait modification drugs and surgeries as a cure for mental distress do little to dispel these fantasies.

However, it does not have to be this way. Approximately two decades ago, at the Portman adult gender clinic in London, a British psychiatrist demonstrated that giving trans-identified patients a realistic idea of what sex-trait modification can achieve is a highly effective strategy for quelling the desire for medical intervention and minimizing transition regret.

Dr. Az Hakeem ran therapy groups that combined patients wishing to embark upon surgical transition with post-operative transsexuals who regretted their surgeries. In an interview, he described the pre-operative group as one of excitement and euphoria and the post-operative group as one of "mourning, depression, and sadness."

"The typical pattern was gender dysphoria, transgender euphoria, and then transgender dysphoria," Hakeem said of the post-op regretters. "They realized they didn't really feel that authentic in their transgender identity, so they were still feeling just as inauthentic, but just in a different body." Hakeem observed that this process took, on average, seven years, which casts further doubt on the validity of short-term follow-up studies showing high patient satisfaction post-transition rates.[207]

Meyer and Hoopes of Johns Hopkins made the same observation in 1974. They described an "initial phase of elation" that extended for two to five years post-transition, but after that honeymoon period is over, "the patient is overtaken by the painful realization that nothing has really changed except certain elements of body configuration."[208] This honeymoon period has also been observed more recently.[209]

The aforementioned first Dutch follow-up study in 1988 described those in the early stages of the sex trait

205 Ibid (n.177-179)

206 Ibid (n.94)

207 Hughes, M. (2023). Dr. Az Hakeem: Trans Is the New Goth. Public. https://public.substack.com/p/dr-az-hakeem-trans-is-the-new-goth#details

208 Meyer, J. K., Hoopes, J. E., & Meyer, J. K. "The Gender Dysphoria Syndromes: A Position Statement on So-Called "Transsexualism"." Plastic and Reconstructive Surgery 54, no. 4 (1974). https://journals.lww.com/plasreconsurg/fulltext/1974/10000/the_gender_dysphoria_syndromes__a_position.9.aspx.

209 Nobili, A., Glazebrook, C., & Arcelus, J. "Quality of Life of Treatment-Seeking Transgender Adults: A Systematic Review and Meta-Analysis." Reviews in Endocrine and Metabolic Disorders 19, no. 3 (2018): 199-220. https://doi.org/10.1007/s11154-018-9459-y.

modification journey as "taking a loan on the future," and the study concluded that "[sex reassignment surgery] is no panacea." The researchers observed that the "[a]lleviation of gender problems does not automatically lead to a happy and lighthearted life" and that, on the contrary, "SRS can lead to new problems."[210]

It is essential that people wishing to embark upon life-altering sex-trait modification procedures be brought face-to-face with this reality. There is no evidence in the files that WPATH members realistically prepare patients for the difficulties of life after hormonal and surgical body modification. By contrast, Hakeem's innovative approach proved very effective, with almost all of his preoperative patients ultimately not undergoing surgery because they understood the limitations of their "fantasy solution," and the small number who went through with it had much more realistic expectations.

Consumer-Driven Gender Embodiment

There has been a significant increase in the number of young people identifying as "non-binary" in recent years, and WPATH now advocates for these individuals to be eligible for hormonal and surgical sex-trait modification interventions.[211]

The nonbinary chapter of WPATH's SOC8 states that healthcare providers must avoid overly focusing on gender-related distress because "it is also important to consider experiences of increased comfort, joy, and self-fulfillment that can result from self-affirmation and access to care."[212]

Gender nullification surgeries, defined by WPATH as "procedures resulting in an absence of external primary sexual characteristics," and bigenital surgeries, such as the creation of a pseudo-vagina cavity without amputating the penis, are the end result of activists overtaking WPATH. In WPATH's SOC8, there is a shopping list of extreme body modification procedures which includes options such as vaginoplasty "with retention of penis and/or testicle" and "flat front" procedures.[213] These surgeries do not even meet the definition of experimental, as they are not being studied in any controlled manner.

Members inside the WPATH messaging forum discuss best practices for these "non-standard" procedures.

When Dr. Thomas Satterwhite, a renowned California surgeon, asks for the group's input for "non-standard" procedures such as "top surgery without nipples, nullification, and phallus-preserving vaginoplasty," no one raised any ethical questions about the destruction of perfectly healthy reproductive organs to fulfill customized body modification desires. Instead, members of the group policed Satterwhite's language, with one therapist arguing that such procedures could also be "selected by those with binary gender identities;" another therapist who identifies as non-binary agreed and called his language "cisgenderist," and a trans-identified natal female med school student stressed the importance of "de-gendering" sex-trait modification procedures. In the SOC8, these procedures are euphemistically referred to as "individually customized" surgeries.

Further demonstrating WPATH's priorities when it comes to radical and untested surgeries, Dr. Rajveer S. Purohit outlined the important topics to discuss with patients before their nullification surgery, such as whether they want orgasms or not and if they want to sit while urinating. Completely absent from the discussion was any mention of the impact such drastic procedures will have on a patient's fertility, sexual function, ability to form long-term stable romantic partnerships or general state of health.

210 Ibid (n.125)

211 Chew, D., Tollit, M. A., Poulakis, Z., Zwickl, S., Cheung, A. S., & Pang, K. C. "Youths with a Non-Binary Gender Identity: A Review of Their Sociodemographic and Clinical Profile." The Lancet Child & Adolescent Health 4, no. 4 (2020): 322-30. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(19)30403-1/fulltext.

212 Ibid (n.94)

213 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, E., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." [In eng]. Int J Transgend Health 23, no. Suppl 1 (2022): Ch. 13. https://doi.org/10.1080/26895269.2022.2100644.

In one post, Satterwhite gives a disturbing account of a patient who became "dangerous and threatening" while still undergoing post-op care as a result of "undiagnosed mood disorders that did not surface until post-op." This is proof that not every patient benefits from extreme body modification procedures being available on demand with no prior psychological assessment or psychotherapeutic support.

Valuing Patient Autonomy Over Risk Aversion

WPATH places a high value on patient autonomy and a low value on minimizing potential harm. Or rather, it conceptualizes harm, as in "do no harm," as unfulfilled consumer desire.

In 2022, the aforementioned activist professor who believes developmentally delayed minors ought to be allowed to consent to life-altering experimental hormones and surgeries, posted in the forum in defence of "trans people whose embodiment goals do not fit dominant expectations," such as those who want "mastectomies without nipples, mastectomies for people who do not want breasts from estrogen [and] vagina-preserving phalloplasties."

The professor, who has previously described "trans embodiment as a free-form artistic expression of gender," and believes teenagers should have the right to treat their body like a "gendered art piece,"[214] demonstrates the flawed beliefs held within WPATH when claiming that transgender health care is about creating bodies that "challenge cisnormativity."

"Trans health is about bodily autonomy, not normalizing bodies," said the activist professor in the files. "We didn't reject the idea that you can't change your gender only to double down on the idea that gender is binary and defined by genitals."

In a separate discussion about "non-standard" surgeries, a Minnesota therapist who believes WPATH needs a "different way of looking at gender that is not through a cisgenderist gaze" asked the group, "If adult patients have body autonomy, what is the issue with having top surgery without nipples, for example?" adding that "[s]urgical tattoos can help if the patient changes their mind later."

These comments are a clear indication that WPATH is not scientific. Medical professionals devoted to providing ethical care to their patients should not destroy healthy reproductive organs in pursuit of creating smooth, sexless bodies or second sets of genitals. Such highly invasive, life-altering procedures are not an attempted remedy for a recognised psychiatric condition but are instead consumer-driven extreme body modification masquerading as medicine. This is a violation of medical ethics and the Hippocratic Oath.

A Brave New World

Many WPATH members see themselves as being on the vanguard of a new medical frontier. A British psychiatrist took exception to Satterwhite's use of the term "non-standard," suggesting that such interventions "may become standard in the future."

A California physician who once famously quipped that if teenage girls later in life regret having their healthy breasts amputated, they can just "go and get them,"[215] replied to say that the field of gender care will soon be "overhauled by younger people," something she is thankful for. She called for medical and surgical interventions to be reframed as an individual's "embodiment of gender" rather than being "responsive to the poorly defined 'gender dysphoria.'"

In the Identity Evolution Workshop, Berg even discussed embodiment goals for children as a guide for medical decision-making. "Embodiment is certainly a concept that I'm using a lot more of with my adolescents and children," said the prominent WPATH expert.

214 Ashley, F. "Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising." [In eng]. J Med Ethics 45, no. 7 (Jul 2019): 480-82. https://doi.org/10.1136/medethics-2018-105293.

215 "[Physician] Explains Why Mastectomies for Healthy Teen Girls Is No Big Deal." Youtube, 2019, https://www.youtube.com/watch?v=5Y6espcXPJk.

Despite the unusual nature of the non-binary procedures, the files contain evidence that insurance companies provide coverage for these experimental body modification surgeries, as shown when Satterwhite tells the group that his clinic in San Francisco is consistently able to get insurance coverage for his patients. Dr. Daniel Dugi of Oregon Health and Science University confirms also having no trouble getting insurance coverage.

There have been two cases in Ontario, Canada of non-binary individuals winning the right to have the surgical creation of a second set of fake-genitals paid for by the province's taxpayers, decisions that will pave the way for such procedures to be covered by provincial health insurance.[216,217] In *Ks v Ontario*, the non-binary chapter of WPATH's SOC8 is quoted extensively throughout, and the Ontario Health Services Appeal and Review Board adopted the logic and vocabulary of WPATH in its ruling, stating that gender diverse presentations may lead to "individually customized surgical requests" that ought to be covered by provincial health plans.[218]

While realizing extreme body modification goals may be very gratifying for a person, at least in the short term, governments and insurance companies should not confuse this with medicine and necessary medical care. Non-binary surgeries demonstrate WPATH's total abandonment of science and medicine in pursuit of unrestrained consumerism.

A counselor from Virginia predicted a "wave of non-binary affirming requests for surgery" and informed the group he had worked with "clients who identify as non-binary, agender, and Eunuchs" who had requested "atypical surgical procedures, many of which either don't exist in nature or represent the first of their kind."

Perhaps the best indication that WPATH has lost its way as a medical organization is the group's decision to include an entire chapter in its SOC8 dedicated to gender-affirming care for people who identify as eunuchs. In the glossary, the world-leading transgender health group defines eunuch-identified men as individuals "assigned male at birth" who feel that "their true self is best expressed by the term eunuch. Eunuch-identified individuals generally desire to have their reproductive organs surgically removed or rendered non-functional."

The Eunuch chapter contains not only the claim that children can be eunuch-identified, but also a hyperlink to the Eunuch Archives website where anonymous men with castration fetishes congregate and share their child castration fantasies.[219] In April 2023, on TikTok, a popular WPATH-affiliated gender surgeon advertised gender-affirming care for people who identify as eunuch to her 250K+ young followers.[220]

During WPATH's 2022 International Symposium in Montreal, the coauthor of the SOC8 eunuch chapter spoke about the first "eunuch-identified" patient he ever saw, who was a 19-year-old man living in his parent's basement, who "may have been on the autism Asperger's spectrum," and wanted to revert to a prepubertal state.[221] The young man didn't explicitly identify as a eunuch. The WPATH expert had applied the label to him. "I deduced it just because it was on my radar," he explained to the audience. In other words, instead of viewing this patient as a troubled individual in need of deep psychotherapeutic support, the WPATH expert labeled him a eunuch-identified person in need of gender-affirming surgical castration. Reframing such serious psychiatric disorders as "identities" to be affirmed and resolved with chemical and surgical

216 "Ks V Ontario (Health Insurance Plan)." CanLII, 2023, https://www.canlii.org/en/on/onhsarb/doc/2023/2023canlii82181/2023canlii82181.html?searchUrlHash=AAAAAQANdmFnaW5vcGxhc3R5IAAAAAAB&resultIndex=1.

217 "Ohip Reverses Course, Will Fund Gender-Affirming Surgery for Ottawa Public Servant." The Globe and Mail, 2023, https://www.theglobeandmail.com/canada/article-ohip-gender-affirming-surgery-case/#:~:text=OHIP%20has%20reversed%20its%20stance,procedure%20for%20nearly%20a%20year.

218 Ibid (n.216)

219 Ibid (n.94 p. 88-89)

220 GenderSurgeon (2023). #testicleremoval #orchiectomy #eunuch. https://www.tiktok.com/@gendersurgeon/video/7218932161934822702

221 "Of Eunuchs and Wannabes." Year Zero, 2022, https://wesleyyang.substack.com/p/of-eunuchs-and-wannabes.

castration is an enormous breach of medical ethics and a clear indication that WPATH does not have the health and well-being of patients as its priority.

At the end of the Eunuch session, which was held in the grand salon of the conference venue, not off in a side room, Satterwhite and Dr. Thomas W. Johnson, the lead author of the SOC8 Eunuch chapter, and its co-author, Dr. Michael Irwig, had an interesting conversation. Satterwhite took to the microphone and told of how Johnson had helped him overcome his emotional discomfort in one of his earliest cases of a gay man who wanted to be castrated. He asked Johnson for advice on how to "get more surgeons on board" with performing this type of procedure, explaining that he'd had a mixed response from fellow attendees at the conference to his willingness to perform "non-standard" genital surgery.

After commending Satterwhite for "being open to new ideas," Johnson said he hoped "having the [eunuch] chapter in the Standards of Care will open the possibilities," that surgeons will see it and "say, yep, this is something that I ought to be willing to consider." Irwig agreed, saying it was "huge" that eunuch was now in the SOC, because now doctors wouldn't have to fear losing their license for castrating these psychologically troubled men.

"The more sessions like this we have, the more educated people will get, and then we'll get more people like you to be able to do this," said Irwig to Satterwhite.

PAST CASES OF PSEUDOSCIENTIFIC HORMONAL AND SURGICAL EXPERIMENTS ON CHILDREN AND VULNERABLE ADULTS

History is full of examples of the medical world getting things catastrophically wrong and yet taking decades to face up to the mistake and self-correct. Today's scandal perpetrated by WPATH combines elements of past attempts to cure mental illness by surgical means such as lobotomy and ovariotomy with the misguided experiment by pediatric endocrinologists to correct the height of tall girls and short boys using puberty blockers and hormones. There is also the scandal in the recent past of a surgeon amputating the healthy legs of men with body integrity identity disorder that bears a striking resemblance to the type of medical care WPATH endorses.

Examining historical medical blunders offers insights into the current scandal unfolding in gender clinics. By distancing ourselves from our cultural biases and preconceptions, a clearer view of the ease with which doctors are led astray emerges.

Lobotomy

A case study comparing the pseudoscientific surgical destruction of healthy brains in the 20th century and the pseudoscientific surgical destruction of healthy genitals of vulnerable people today

In the mid-20th century, a widely held belief in the medical world was that the most effective and humane treatment for mental illness was the lobotomy: a brutal surgical procedure that involved blindly swinging sharp instruments in the brain to sever the frontal lobe connections.

Despite the obvious dangers and devastating side effects, the medical community rapidly embraced the practice of performing lobotomies as a treatment for a wide range of mental disorders, including depression, obsessive-compulsive disorder (OCD), epilepsy, and schizophrenia.

Lobotomists were not vilified; rather, they were held in high regard by many. Antonio Egas Moniz, the inventor of the lobotomy, was honored with the Nobel Prize in 1949 for his contribution to medicine. Walter Freeman and James Watts, who popularized the procedure in the United States, were warmly received at annual American Medical Association (AMA) meetings, where they set up "psychosurgery" exhibits providing information about their brain-mutilating surgery.

While there was early opposition to the brutality and imprecision of the procedure, little of it was published in medical journals because, at the time, to criticize fellow doctors was viewed as unethical. Instead, the prestigious New England Journal of Medicine gave the procedure scientific validity by publishing an article touting the operation as being based "on sound physiological observation."[222]

The popular press also played a crucial role. In 1936, the New York Times called the procedure "a turning point in treating mental cases," predicting that Freeman and Watts were likely "going down in medical history as another shining example of therapeutic courage," and in 1937, claimed the surgery "cuts away sick parts of the human personality and transforms wild animals into gentle creatures."[223,224] Over the next five years, lobotomy was frequently featured in popular publications, including Reader's Digest, Time, and Newsweek. The narrative

222 "The Surgical Treatment of Certain Psychoses." New England Journal of Medicine 215, no. 23 (1936): 1088-88. https://sci-hub.ru/10.1056/NEJM193612032152311.

223 "Find New Surgery Aids Mental Cases; Drs. Freeman and Watts Say Operation on Brain Has Eased Abnormal Worry. 6 Selected Patients Gain No Data yet Available on Permanent Effects, Scientists Tell Southern Medical Group." The New York Times, 1936, https://www.nytimes.com/1936/11/21/archives/find-new-surgery-aids-mental-cases-drs-freeman-and-watts-say.html.

224 "Surgery Used on the Soul-Sick Relief of Obsessions Is Reported; New Brain Technique Is Said to Have Aided 65% of the Mentally Ill Persons on Whom It Was Tried as Last Resort, but Some Leading Neurologists Are Highly Skeptical of It." The New York Times, 1937, https://www.nytimes.com/1937/06/07/archives/surgery-used-on-the-soulsick-relief-of-obsessions-is-reported-new.html.

overall was positive, downplaying the barbaric reality of the procedure.[225]

Many desperate patients and their families sought lobotomies after reading these articles. Conditions in mental asylums at the time were deplorable, and alternative remedies for mental illness, such as insulin coma therapy and electroshock therapy, were also harsh and often violent. Therefore, even though a lobotomy often left patients in a state of "surgically induced childhood," to many, this was preferable to the other options available.

At no point during lobotomy's rapid rise in popularity did any of the significant American medical associations, including the American Psychiatric Association and the American Medical Association, stand in official opposition to the surgery.

Freeman, who invented the "transorbital lobotomy," which involved hammering a surgical instrument resembling an ice pick through a patient's eye socket and into the brain, considered his procedure a success if his patients were able to leave the asylum and be cared for at home "at the level of a domestic invalid or household pet."[226] He also became convinced that the earlier the procedure was performed, the better because of the misguided belief that patients were destined to deteriorate otherwise. This meant he advocated for the surgery as a first line of treatment for those with only mild mental illness.

Many of Freeman's patients didn't even meet his questionable measure of success, with some ending up permanently disabled and approximately 15% dying.[227] In 1941, Rosemary Kennedy, sister of President John F. Kennedy, became Freeman's most famous victim when her lobotomy left her condemned to live out the rest of her days in a private psychiatric hospital, unable to care for herself, barely able to speak, and with no memory of her family.[228]

But what is arguably Freeman's most egregious crime was that he performed lobotomies on children, 19 in total, with 11 such cases described in the 1950 edition of his book, *Psychosurgery*.[229,230] The youngest was just four years old, and two out of the 11 died of cerebral hemorrhages.

Even as Moniz was awarded the Nobel Prize in 1949 for the invention of lobotomy, and in its reporting, the New York Times declared that "surgeons now think no more of operations on the brain than they do of removing an appendix,"opposition to the procedure was starting to mount.[231] Critics highlighted the severe side effects experienced by many patients, raised concerns about the criteria used to measure success, and accused surgeons of conducting procedures without preliminary psychiatric evaluations.

However, it was the invention of the antipsychotic drug Chlorpromazine that triggered lobotomy's precipitous fall in popularity because, all along, it was the lack of humane alternative treatments that had caused psychiatrists to go to such desperate lengths.

In 1967, after what was destined to be his last patient died of a brain hemorrhage, a disgraced Freeman was stripped of his hospital privileges. He spent the rest of his days driving across the US, tracking down his patients and their families, searching for proof that his beloved procedure had helped and not harmed.

The horrifying story of lobotomy should have served as a cautionary tale for the medical world, illustrating the dire consequences that can occur when doctors swiftly embrace novel, innovative procedures without first subjecting them to thorough scientific scrutiny to establish their value, safety, and effectiveness.

225 Diefenbach, G., Diefenbach, D., Baumeister, A., & West, M. "Portrayal of Lobotomy in the Popular Press: 1935-1960." Journal of the history of the neurosciences 8 (05/01 1999): 60-9. https://doi.org/10.1076/jhin.8.1.60.1766.

226 Whitaker, R. Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill. Basic Books, 2001. https://archive.org/details/madinamericabads00whit

227 "Lobotomy: The Brain Op Described as 'Easier Than Curing a Toothache'." BBC News, 2021, https://www.bbc.com/news/stories-55854145.

228 "Postmodern Lobotomy Blues." Compact Magazine, 2023, https://compactmag.com/article/postmodern-lobotomy-blues.

229 "The Lobotomist." PBS, 2008, 48:20. https://www.pbs.org/wgbh/americanexperience/films/lobotomist/.

230 Offit, P. A. Pandora's Lab: Seven Stories of Science Gone Wrong. National Geographic Books, 2017.

231 "Explorers of the Brain." The New York Times, 1949, https://www.nytimes.com/1949/10/30/archives/explorers-of-the-brain.html.

But 70 years later, we find ourselves without the moral high ground. In the age of evidence-based medicine, we once again find ourselves witness to a medical world performing surgical mutilation on healthy bodies in the quest to cure mental illness. But instead of targeting the brain, today's surgeons target the genitals.

In both medical scandals, the victims are either minors or the mentally ill (or both), and the surgeries performed result in permanent disfigurement and disability. The most fortunate of Freeman's patients managed to live semi-independent lives, holding down low-skilled jobs, but most weren't so lucky. Many had their long-term memory destroyed and struggled even with the most basic tasks. Many were left permanently disabled.

In today's scandal, in the best-case scenario, male patients are left with a cavity that needs to be dilated for life and drastically reduced sexual function. The less fortunate endure severe complications, such as neovaginal stenosis, urinary issues, and fistulas. Ritchie Herron, a detransitioned man who underwent vaginoplasty during a mental health crisis, describes his life post-surgery as a living nightmare. "There is no dignity in living like this," said the 32-year-old victim of today's medical crime, who suffers from ongoing pain, numbness, and urinary dysfunction.[232,233]

Female patients undergo a procedure called phalloplasty that involves surgeons harvesting tissue from a donor site, usually the forearm but sometimes the thigh, and using the tissue to fashion a non-functional pseudo-penis. The surgery comes with an extraordinarily high complication rate and typically requires a full hysterectomy and vaginectomy, which is the surgical removal of the vagina.[234, 235]A 2021 study of 129 females who underwent the risky procedure to construct a pseudo-penis found the group reported 281 complications requiring 142 revisions.[236]

Both lobotomies and genital surgeries also involve the destruction of a core part of a person's humanity. Freeman and Watts noted that each of their patients lost "something by this operation, some spontaneity, some sparkle, some flavor of the personality." Today's gender surgeons are attacking an equally important aspect of what makes us human. Our sexual identities are an intrinsic part of who we are, making the amputation of genitals akin to performing a sexual lobotomy.

Gender surgeons, like the lobotomists who came before them, bypass ethical requirements that a surgical intervention be proven safe and beneficial before it is rolled out into mainstream medical practice. No long-term studies existed to prove that the benefits of lobotomy outweighed the harms, and the same can be said for today's genital surgeries. The few long-term studies that exist show significantly impaired social functioning, high rates of mental illness, and elevated suicide risk. Yet despite the lack of good quality science to support such drastic life-altering surgeries, just as the AMA and the APA did not openly condemn the medical crime of lobotomy, today those same organizations endorse minors and mentally ill adults undergoing genital amputation at the hands of WPATH surgeons. The reason is that they regard sex trait modification as a "human rights" issue first and foremost, and only secondarily, if at all, as a medical question.

In 1941, the New York Times described lobotomy patients as having "worries, persecution complexes, suicidal intentions, obsessions, indecisiveness and nervous

232 "'Heartbroken' Father Sues NHS to Stop Autistic Son's Sex Change." The Telegraph, 2023, https://www.telegraph.co.uk/news/2023/06/04/nhs-gender-clinic-judicial-review-autistic-son-sex-change/.

233 Ritchie, "This Isn't Even the Half of It. And This Isn't Regret Either, This Is Grief and Anger…," @TullipR, June 13, 2022, 2:57 PM, https://twitter.com/TullipR/status/1536422563458465793?s=20.

234 Rashid, M., & Tamimy, M. S. "Phalloplasty: The Dream and the Reality." [In eng]. Indian J Plast Surg 46, no. 2 (May 2013): 283-93. https://doi.org/10.4103/0970-0358.118606.

235 Wierckx, K., Van Caenegem, E., Elaut, E., Dedecker, D., Van de Peer, F., Toye, K., Weyers, S., et al. "Quality of Life and Sexual Health after Sex Reassignment Surgery in Transsexual Men." [In eng]. J Sex Med 8, no. 12 (Dec 2011): 3379-88. https://doi.org/10.1111/j.1743-6109.2011.02348.x.

236 Robinson, I. S., Blasdel, G., Cohen, O., Zhao, L. C., & Bluebond-Langner, R. "Surgical Outcomes Following Gender Affirming Penile Reconstruction: Patient-Reported Outcomes from a Multi-Center, International Survey of 129 Transmasculine Patients." [In eng]. J Sex Med 18, no. 4 (Apr 2021): 800-11. https://doi.org/10.1016/j.jsxm.2021.01.183.

tensions literally cut out of their minds with a knife by a new operation on the brain," giving the brutal surgery the air of a miracle cure.[237] Almost a century later, in the WPATH forum, the California therapist told her colleagues of the remarkable healing power of surgical castration for her mentally ill patients, who were put "on the road to emotional recovery" and presumably lived happily ever after.

Today, many patients report being satisfied with the outcome of their genital surgery despite being plagued by complications and experiencing significant social and romantic difficulties. Likewise, many families were genuinely grateful to Freeman for helping their loved ones despite the enormous burden of care placed upon them by the surgery and the devastating impact on the patient. Both situations suggest a certain level of self-deception, or what the early Dutch researchers worried was happiness "distorted by wishful thinking." Families who consented to their loved one undergoing a lobotomy would have an incentive to cling to the belief that it was the right decision, wilfully ignoring the obvious signs that it wasn't. Many adolescents, or their parents, as well as vulnerable adults may face a similar internal struggle today.

To understand how the medical world could have so swiftly endorsed lobotomies and why families and even the victims may have been grateful for the procedure, it is necessary to paint a picture of life for the severely mentally ill at the turn of the 20th century. This was an era long before the invention of antipsychotic drugs when the outlook for the mentally ill was bleak. Most ended up in overcrowded, understaffed mental asylums where the conditions were deplorable. Those suffering from the worst cases were kept restrained and in isolation, sometimes for years on end. One investigation of mental asylums in the United States found patients crammed naked in a dark room, the floor filthy with human waste.[238]

The field of psychiatry's desperation in the early decades of the 20th century gave rise to several brutal somatic remedies, from insulin coma therapy[239] to malaria therapy,[240] as well as the more widely-known electroshock treatments. These were risky and violent, and success was uncertain. It was in this context that news of Moniz's groundbreaking psychosurgery emerged. Psychiatrists, asylum staff, families, and the patients themselves were desperate for a solution. When lobotomy enabled patients to leave the asylum and be cared for at home by loved ones, or at least allowed the most violent cases to escape the confines of isolation and move freely within the ward, many saw it as a humane option. This resulted in a powerful, willful blindness to the barbaric nature of the procedure and its associated side effects.

But the world of today's victims could not be more different. The minors and vulnerable adults seeking surgical solutions to their poorly defined psychiatric condition are not confined to mental asylums, restrained in straitjackets, or chained to walls in isolation wards. They are not subjected to electroconvulsive shock therapy and face a lifetime of confinement and misery. Most are simply caught up in a mad cultural moment, suffering from a culture-bound mental illness that has produced an identity that is almost certainly transient.

For these young patients who still have their whole lives ahead of them, there is an ethical, non-invasive approach to treatment available with a strong track record of success: watchful waiting, coupled with psychotherapy as needed. All available evidence from the time before WPATH politicized gender medicine indicates that the majority of minors suffering from distress about their sex

237 "Turning the Mind inside Out." Saturday Evening Post, 1941, https://picryl.com/media/turning-the-mind-inside-out-saturday-evening-post-24-may-1941-page-18-2d7a77.

238 Maisel, A. Q. "Bedlam 1946: Most Us Mental Hospitals Are a Shame and a Disgrace." Life Magazine 20, no. 18 (1946): 102-18. https://mn.gov/mnddc/parallels2/prologue/6a-bedlam/bedlam-life1946.pdf.

239 Jones, K. "Insulin Coma Therapy in Schizophrenia." Journal of the Royal Society of Medicine 93, no. 3 (2000): 147-49. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1297956/pdf/10741319.pdf.

240 "The Psychiatrist Who Gave His Patients Malaria." Psychology Today, 2023, https://www.psychologytoday.com/ca/blog/psychiatry-a-history/202303/the-psychiatrist-who-gave-his-patients-malaria .

will reconcile with their bodies during or after puberty–assuming they are not socially transitioned and medicalized. Watchful waiting, caring support, and allowing the young person to grow and mature is the humane alternative to WPATH's "gender lobotomy." [241]

The scientific literature on adults is less conclusive, but for the severely mentally ill patients seeking genital surgery, deep psychotherapeutic work to alleviate their complex mental health issues and uncover the origin of their gender distress is preferable to ignoring all comorbidities and leaping directly to genital mutilation. Often, as Dr. Az Hakeem at the Portman clinic demonstrated, bringing the patients face-to-face with the reality of genital surgery is enough to quell the patient's obsessive desire.

But because WPATH is not a medical group seeking to find the best way to care for people suffering from gender dysphoria, its members consider attempting to avert the need for invasive, life-altering surgical intervention to be "conversion therapy." So instead, WPATH members advocate for surgical interventions as the only line of treatment, even for minors and the severely mentally ill, much the same as Freeman and his colleagues believed lobotomy was the only hope for the poor unfortunate souls confined to mental asylums.

Freeman saw himself as the savior of the severely mentally ill, believing that he gave hope to the hopeless. At the height of his career, he could never have imagined a day when his miraculous cure would be reviled and considered an atrocity. The same can be said for WPATH and its members. Spurred on by the thought of themselves as civil rights heroes fighting on behalf of the oppressed, they see themselves as being on the cutting edge of medicine, providing necessary medical care to patients in need. However, we believe that adolescents and vulnerable adults undergoing the surgical destruction of healthy genitals is destined to be recorded in history as a crime of equal or even greater magnitude than the lobotomy.

Ovariotomy

A case study comparing the attempt to cure mental illness with gynecological surgery in the 19th century with today's attempt to cure mental illness with gynecological surgeries and bilateral mastectomies

One of the greatest medical scandals of the 19th century was the practice of removing healthy ovaries as the treatment for a variety of mental illnesses in women, ranging from "menstrual madness," nymphomania, masturbation, and "all cases of insanity." This practice, known as ovariotomy, enjoyed the support of many of the leading gynecologists and psychiatrists of the era, and it is estimated that over 100,000 women had their healthy ovaries removed between 1872 and 1900.[242] This being a time long before the invention of antibiotics and adequate surgical cleanliness procedures, approximately 30% of the women died as a result of this medically unnecessary operation.[243]

The practice had its origins in reflex theory, the pseudoscientific idea that the spine connected all organs in the body, meaning one organ could produce symptoms in a distant organ, including the brain. This logic caused patients to become fixated on organs that had nothing to do with their symptoms and resulted, during the period we will describe, in droves of women seeking the removal of their ovaries as a means to resolve their mental distress.

This, combined with the era's fashionable belief that a variety of complaints, including hysteria, neurasthenia (what would today be called chronic fatigue syndrome), menstrual madness (premenstrual dysphoric disorder, or PMDD), and lunacy, were the result of masturbation and nymphomania, set the scene for the ovaries to be implicated in women's mental disorders. And from implicating the ovaries in the cause of mental disorders, it was a natural progression that surgeons should want to

241 Ibid (n.2-4)

242 Studd, J. "Ovariotomy for Menstrual Madness and Premenstrual Syndrome--19th Century History and Lessons for Current Practice." [In eng]. Gynecol Endocrinol 22, no. 8 (Aug 2006): 411-5. https://doi.org/10.1080/09513590600881503.

243 Longo, L. D. "The Rise and Fall of Battey's Operation: A Fashion in Surgery." Bulletin of the History of Medicine 53, no. 2 (1979): 256.

remove them as a treatment.

In 1872, within the space of just weeks, two ovariotomies were performed on opposite sides of the Atlantic. German Alfred Hegar performed the world's first on a healthy woman as a treatment for psychological distress, but his patient died a week later of peritonitis. Not a month later, English gynecologist Lawson Tait and American Robert Battey, unaware of Hegar's attempt, removed the ovaries of a woman who suffered from menstrual symptoms and convulsions that left her in a semi-comatose state. She almost met the same fate as Hegar's patient after developing sepsis but later recovered and was pronounced cured of her female woes.

The procedure was destined to take Battey's name and became known as Battey's Operation. Battey believed that madness in women was "not infrequently caused by uterine and ovarian disease." Battey is believed to have performed the procedure on several hundred women between 1872 and 1888, and it enjoyed a period of immense popularity in most of Europe and across the US, with women having their ovaries excised for a range of disorders from epilepsy to hysterical vomiting. It was considered a therapy to prevent "moral decline."

According to medical historian Edward Shorter, justification for performing this life-threatening surgery on women was found in data that was gathered, without statistical controls, showing that a disproportionate number of mentally ill women suffered from pelvic lesions. For instance, one study carried out by Russian gynecologist Valentin Magnan found that 35 out of his 45 patients with mental illness or hysteria had various genital lesions, and only 4 had no gynecological abnormality.[244] Of course, these findings were meaningless in the absence of a control group, but this was an era long before the development of evidence-based medicine.

Thus, the medical world rapidly adopted the dangerous, potentially deadly treatment, and it wasn't long before psychiatrists were recommending the surgery for "all cases of lunacy." It became so popular that psychiatric hospitals opened operating rooms where surgeons could remove the ovaries of female inmates.[245]

Supporters of ovariotomy considered it "one of the unequalled triumphs of surgery," and considered anyone who sought to deny women this medically necessary treatment to be "wanting in humanity" and "guilty of criminal neglect of patients."[246] This was the view held by the leading surgeons of the time, including Lawson Tait, one of the pioneers of the procedure. By its opponents, the operation was called "pernicious and dreadful,"[247] and the surgeons performing it "gynecological perverts."[248]

A sham surgery performed by James Israel in Paris in 1880 wasn't enough to dampen the enthusiasm. Israel claimed to have cured a woman by making an incision and sewing it back up, thereby proving the placebo effect and psychosomatic nature of the symptoms.[249] But Hegar is said to have performed an ovariotomy on her later that year to cure her of her incessant vomiting. Hegar then encouraged German surgeons to embrace the procedure, which, according to gynecologist and medical historian John Studd, is an indication that it was seen as being on the cutting edge of medicine.[250]

Women who had imbibed the popular reflex theory of the day, and begun to fixate on their reproductive organs as the source of their mental distress, began presenting to

244 Shorter, E. From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era. Simon and Schuster, 2008: 210. https://www.simonandschuster.ca/books/From-Paralysis-to-Fatigue/Edward-Shorter/9780029286678.

245 "Removal of the Ovaries, Etc., in Public Institutions for the Insane." Journal of the American Medical Association XX, no. 9 (1893): 258-58. https://doi.org/10.1001/jama.1893.02420360034006.

246 Ibid (n.243)

247 Ibid (n.243)

248 Barnesby, N. Medical Chaos and Crime. M. Kennerley, 1910. https://catalog.libraries.psu.edu/catalog/39665261.

249 Studd, J. "Ovariotomy for Menstrual Madness and Premenstrual Syndrome--19th Century History and Lessons for Current Practice." [In eng]. Gynecol Endocrinol 22, no. 8 (Aug 2006): 411-5. https://doi.org/10.1080/09513590600881503.

250 Ibid (n.249)

gynecologists requesting to be "Battey-ized" as the procedure gained in popularity.[251]

Dr. William Goodell called for the surgery to be performed for "all cases of insanity," an opinion supported by others, assuring his fellow gynecologists: "If the operation be not followed by a cure, the surgeon can console himself with the thought that he has brought about a sterility in a woman who might otherwise have given birth to an insane progeny."[252] Goodell believed that such a woman was destined to "transmit the taint of insanity to her children and her children's children for many generations."[253]

Some medical reports included the self-reported satisfaction of women who had undergone the surgery. One woman told of how she was so desperate before the operation that she almost took her own life but stated that she was "a well, happy, and cheerful girl" after having her healthy ovaries removed.[254]

Geroge H. Rohé, an ovariotomy enthusiast, operated for a wide range of mental disorders, including cases of epilepsy, melancholia, and hysterical mania. He believed his patients were able to give "valid consent" during "lucid intervals."[255]

This unbridled enthusiasm for the surgery eventually brought its fall from grace. An investigation in 1893 into the presence of a surgical ward at the State Hospital for the Insane in Norristown, Pennsylvania, opened to perform "bilateral oophorectomy," as ovariotomy was otherwise known, concluded that the operation was "illegal… experimental [in] character…brutal and inhumane, and not excusable on any reasonable ground." This report marked the beginning of the end of ovariotomy to treat mental disorders.[256] Leading gynecologists started to speak out in opposition. By the end of the century, Battey's operation was largely forgotten.

Like in the case of lobotomy, the medical world should have learned a crucial lesson from the ill-fated history of ovariotomy. Surgeons should have recognized the peril of hastily embracing new procedures with profound, life-long effects on vulnerable patients. Furthermore, it ought to have alerted doctors to the role of medical influence in shaping symptoms of patients, often women, who internalize doctors' beliefs, causing them to manifest psychosomatic symptoms and seek surgical solutions. And yet, astonishingly, in the 21st century, we are once again observing another such event, one that bears a disconcerting resemblance to the ovariotomy blunder.

There are many striking parallels between the surgeons who removed women's healthy ovaries as a treatment for mental distress in the 19th century and the WPATH doctors today who are advocating for surgeons to remove the healthy breasts and reproductive organs of teenage girls and young women also as a treatment for their mental distress.

While from the outset ovariotomy was horribly misguided, the surgeons at least began with a certain level of caution. The procedure was initially indicated for conditions such as menstrual madness, epilepsy, nymphomania, and masturbation, but later became the treatment for all forms of insanity, including for hysteria, the psychiatric epidemic of the age.

Sex-trait modification procedures for people who identify as transgender followed the same trajectory. Medical intervention was initially reserved for only the most persistent of gender dysphoria cases. However, when activists captured WPATH, hormonal interventions

251 Shorter, E. From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era. Simon and Schuster, 2008: 221. https://www.simonandschuster.ca/books/From-Paralysis-to-Fatigue/Edward-Shorter/9780029286678.

252 MacCormac, W., & Makins, G. H. Transactions of the International Medical Congress, Seventh Session, Held in London, August 2d to 9th, 1881. Vol. 4: JW Kolckmann, 1881. https://babel.hathitrust.org/cgi/pt?id=mdp.39015007091385&seq=315.

253 Goodell, W. "Clinical Notes on the Extirpation of the Ovaries for Insanity." American Journal of Psychiatry 38, no. 3 (1882). https://sci-hub.ru/10.1176/ajp.38.3.294.

254 Ibid (n.243 p.256)

255 Ibid (n.243 p.261)

256 Ibid (n. 243 p. 262)

became the first line of treatment because psychotherapy to help the patient reconcile with his or her birth sex was deemed conversion therapy. As we have seen in the discussions in the WPATH Files, prolonged testosterone use in women leads to uterine atrophy and the need for a hysterectomy, with some opting to have their healthy ovaries removed along with their uterus. The medical attack on the reproductive organs of adolescent girls and vulnerable women in the 21st century may have added one more step along the way, but that doesn't make this any less of a medical crime.

An eerie echo of the past can be heard in the Identity Evolution Workshop, when, more than a century after the ovariotomy scandal ended, Ferrando discussed "early oophorectomy" with her fellow WPATH members. The WPATH-affiliated surgeon described explaining to young women that with "early removal of the ovaries" comes the need for lifelong hormone supplements for cardiovascular and bone health.

"So those are the things that we think about in this cohort of 20-year-olds in whom we're removing the ovaries," said Ferrando.

In fact, just like the ovariotomists of the past, Ferrando has no reliable science to guide her in treating these young patients. A 2019 review of the literature to support the practice of removing the healthy ovaries of young women who identify as men found the supporting evidence to be "lacking" and described an urgent need for research into the "metabolic and cardiovascular risk" to these female patients.[257]

The removal of ovaries from Victorian women did not alleviate their mental health issues, as their psychological struggles were not rooted in their ovaries. Similarly, the removal of healthy breasts and reproductive organs today often does not resolve the challenges faced by adolescent girls and vulnerable women, many of whom come to realize too late that their mental distress was related to coexisting psychiatric disorders, autism, trauma, or difficulty accepting their emerging homosexual orientation.

Much like women in the 19th century who internalized the reflex theory narrative, fixating on their reproductive organs as the root cause of their mental distress and subsequently requesting ovarian removal surgeries, vulnerable women and girls in the 21st century are now embracing the narrative of the modern trans rights movement that tells them if they hate their female bodies, it is an indication of the need for surgical alteration. Once again, they are fixating on their reproductive organs, and this time their breasts too, as the source of their anguish and seeking a surgical solution.

In Shorter's analysis, the unwavering conviction that one needs a surgical procedure represents a psychosomatic symptom, wherein the patient coalesces their vague and troubling sensations into a fixed diagnosis. Victorian women, influenced by the prevailing reflex theory, perceived their various feelings of sadness and anxiety through this cultural perspective. They interpreted these symptoms as being an indication of unhealthy ovaries, and once convinced of this belief, they firmly believed that undergoing an ovariotomy would alleviate all their mental anguish.

Today, many teenage girls are interpreting their normal pubertal woes as a sign they are transgender because they are viewing their suffering through a cultural lens that teaches them that their distress is an indication that they were born in the wrong body and that sex-trait modification procedures are the only solution. Once they latch onto this explanation, they become preoccupied with the idea of removing their breasts and reproductive organs, firmly believing that these surgical procedures will alleviate all their emotional difficulties, bringing them health and happiness.

Thus, the WPATH members who endorse such thinking and facilitate teenage girls and young women in

257 Reilly, Z. P., Fruhauf, T. F., & Martin, S. J. (2019). Barriers to Evidence-Based Transgender Care: Knowledge Gaps in Gender-Affirming Hysterectomy and Oophorectomy. Obstetrics & Gynecology, 134(4), 714-717. https://doi.org/10.1097/aog.0000000000003472

altering their bodies based on entirely unfounded beliefs are akin to the gynecologists and psychiatrists of the 19th century who enabled the women seeking the medically unnecessary removal of their healthy ovaries.

Ovariotomy enjoyed the support of many of the most respected surgeons of the time, including J. Marion Sims, Lawson Tait, and Spencer Wells. This endorsement lent an aura of credibility to the procedure despite the absence of sound scientific justification for the removal of healthy organs. Today, the surgical removal of breasts and reproductive organs as a solution for a woman's psychological distress is supported by all significant American medical associations, even though these procedures likewise lack a solid foundation in scientific research.

Doctors who opposed ovariotomy were accused of being "wanting in humanity" and "guilty of criminal neglect of patients" when, in truth, the procedure was pseudoscientific, extremely risky, and entirely ineffective. Doctors who oppose the removal of healthy body parts as a cure for gender dysphoria are vilified in much the same way, facing accusations of transphobia and hate and the possible loss of their livelihood.

The surgeons removing healthy ovaries to cure mental illness lived in an age long before the development of evidence-based medicine and rigorous scientific standards. This was the Wild West of medicine, with scalpel-happy surgeons, many excited by the new possibilities opened up by the invention of anesthetics, trying out new surgical techniques with no oversight or regulation. It was only when the ovariotomists overstepped the mark by opening surgical wards in mental asylums that the practice drew widespread condemnation and was brought to an end.

But gender surgeons today have no such excuse for their unethical behavior. Today, we expect medical professionals to adhere to strict protocols. We expect randomized controlled trials and meticulous follow-up. There are no such studies to prove that removing the healthy breasts and reproductive organs of teenage girls and young women is safe, ethical, and effective in relieving their mental distress.

A medical experiment based upon an untested article of belief was unacceptable in the 19th century. It is unforgivable today.

Apotemnophilia

A case study comparing the desire to have healthy limbs amputated with the desire to have surgically-created abnormal genitalia

In 2000, a surgeon in Scotland made headlines when it was revealed that he had performed leg amputations on two men who were physically healthy but afflicted with a psychiatric condition known as apotemnophilia, or what is now more commonly referred to as body integrity identity disorder (BIID).[258]

In 1997, Dr. Robert Smith amputated the healthy lower leg of a man at Falkirk and District Royal Infirmary, and two years later, in 1999, Smith amputated the healthy leg of a second man.[259] He was set to amputate the leg of a third man, Dr. Gregg Furth, a New York child psychologist, when the hospital ethics board investigated his actions and ruled that the procedures were unethical. The NHS removed his funding, and Smith was banned from further mutilating healthy bodies.

Dr. Russell Reid, a psychiatrist based in London, had diagnosed the men with "apotemnophilia," a rare psychiatric condition characterized by an intense fixation on having healthy limbs amputated. Typically, this obsession focuses on one leg, although some patients express a desire to remove both legs, an arm, or occasionally specific fingers or toes. Paradoxically, those afflicted with this disorder assert that they do not feel complete with all four limbs or all ten digits, believing their true identity is that of an amputee. According to Dr. Reid,

258 "Surgeon Defends Amputations." BBC News, 2000, http://news.bbc.co.uk/2/hi/uk_news/scotland/625680.stm.

259 Dyer, C. "Surgeon Amputated Healthy Legs." [In eng]. Bmj 320, no. 7231 (Feb 5 2000): 332. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1127127/.

traditional psychotherapy "doesn't make a scrap of difference in these people."[260]

Many researchers, including Reid, have noted the obvious parallel with transgenderism, or transsexualism as it was known during the early 2000s when the controversy surrounding Smith's surgeries triggered a flurry of interest in this obscure psychiatric condition.[261,262]

The term apotemnophilia, literally "love of amputation," was coined by the infamous Dr. John Money in the 1970s. Noting the erotic motivation of many, or perhaps most, of these patients, Money categorized the disorder as a paraphilia, or in other words, a sexual deviancy, recognizing that these individuals achieved sexual fulfillment by fantasizing about being an amputee, or indeed actually becoming one. Many apotemnophiles also suffer from what Money termed acrotomophilia, which is to be sexually attracted to amputees.

Smith described the two leg amputations he performed on his apotemnophile patients as being the most rewarding operations of his career and said he felt no regret at satisfying the men's wishes.[263] He argued that the surgeries were life-saving, claiming that apotemnophiles will either attempt to perform the amputation themselves or go to extraordinary lengths to self-inflict injuries, such as with dry ice, guns, or chainsaws, in a desperate bid to force surgeons to amputate.[264,265]

Indeed, in 1998, 79-year-old Philip Bondy of New York paid $10,000 to John Brown, a surgeon in Tijuana, to have his left leg amputated. He died two days later of gangrene, and Brown was charged with second-degree murder. It was reported during Brown's trial that Bondy wished to have his leg amputated to fulfill a "sexual craving." Brown had lost his medical license in 1977 after three patients nearly died from sex-change surgeries he had reportedly performed in locations such as a garage and a hotel.[266]

Another case is that of a 55-year-old American man who amputated his own arm using a home-made guillotine.[267] Further examples can be found in the 2003 documentary Whole, which featured the stories of a Florida man who shot himself in the leg so that it would need to be amputated and that of a man from Liverpool, England who packed his leg in dry ice. The latter called his amputation a "body correction surgery."[268,269] Smith also appears in the documentary, arguing that refusing to amputate a healthy limb is a violation of the Hippocratic Oath. "The Hippocratic oath says first do your patients no harm," he said, before going on to explain that the real harm is to refuse to help such a patient, "leaving him in a state of permanent mental torment," when all it would take for him "to live a satisfied and happy life" would be to amputate.

This unusual psychiatric disorder is not new. Since the late 1800s, there have been cases described in medical literature of men and women being sexually attracted to amputees or people with other disabilities, as well as people

260 "Complete Obsession." BBC Home, 2000, https://www.bbc.co.uk/science/horizon/1999/obsession_script.shtml.

261 Lawrence, A. A. "Clinical and Theoretical Parallels between Desire for Limb Amputation and Gender Identity Disorder." [In eng]. Arch Sex Behav 35, no. 3 (Jun 2006): 263-78. https://doi.org/10.1007/s10508-006-9026-6.

262 Bailey, M. J., Hsu, K. J., & Jang, H. H. "Elaborating and Testing Erotic Target Identity Inversion Theory in Three Paraphilic Samples." Archives of Sexual Behavior (2023/07/06 2023). https://doi.org/10.1007/s10508-023-02647-x. https://doi.org/10.1007/s10508-023-02647-x.

263 Elliott, C. "A New Way to Be Mad." Atlantic monthly (Boston, Mass.: 1971) (12/01 2000): 73-84.

264 "Healthy Limbs Cut Off at Patients' Request." The Guardian, 2000, https://www.theguardian.com/society/2000/feb/01/futureofthenhs.health.

265 First, M. B. "Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder." [In eng]. Psychol Med 35, no. 6 (Jun 2005): 919-28. https://doi.org/10.1017/s0033291704003320.

266 "Ex-Doctor Tried in Amputation-Fetish Death." Tampa Bay Times, 1999, https://www.tampabay.com/archive/1999/09/29/ex-doctor-tried-in-amputation-fetish-death/.

267 Dua, A. (2010). Apotemnophilia: ethical considerations of amputating a healthy limb. J Med Ethics, 36(2), 75-78. https://doi.org/10.1136/jme.2009.031070

268 Gilbert, M. "Whole." 2003. https://www.imdb.com/title/tt0429245/.

269 Henig, R. M. "At War with Their Bodies, They Seek to Sever Limbs." New York Times 22 (2005): F6. https://www.nytimes.com/2005/03/22/health/psychology/at-war-with-their-bodies-they-seek-to-sever-limbs.html.

who pretend to be disabled or wish to become disabled.[270] But it was the dawn of the Internet era that drew attention to this group of individuals with such unusual sexual interests, and online chat rooms provided a place for like-minded people to congregate and share their amputation fantasies and desires.

Online, they call themselves devotees, pretenders, and wannabes (DPWs). Devotees are non-disabled people who are sexually attracted to people with disabilities; pretenders are non-disabled people who act out having a disability, usually with the aid of crutches, wheelchairs and leg braces; and wannabes are people who actually wish to become disabled.

A 2005 study by Dr. Michael First of 52 sufferers of BIID found that the primary reason for desiring the amputation of a healthy limb was the feeling that it would "correct a mismatch between the person's anatomy and sense of his or her 'true' self (identity)."[271]

Some examples of the answers study participants gave include: "[After the amputation] I would have the identity that I've always seen myself as," and "I feel myself complete without my left leg…I'm overcomplete with it." The most strikingly similar statement to the "born in the wrong body" narrative of today's transgender rights movement was: "I felt like I was in the wrong body; that I am only complete with both my arm and leg off on the right side."[272]

Despite a small amount of scientific literature to suggest that BIID sufferers benefit from having safe access to amputations, to our knowledge, there are no surgeons in North America, or indeed the developed world, willing to perform such extreme elective operations. Even in this day and age, when WPATH-approved genital and breast amputations are commonplace and even performed on minors, the idea of amputating healthy limbs is reviled by most people.

In the WPATH Files, a discussion thread makes the obvious comparison between BIID and gender dysphoria, with an Australian clinician noting that it is "clear these individuals do display some characteristics similar to trans people." However, not everyone inside WPATH agrees. Bowers was questioned on the topic in a 2022 documentary and denied any similarity between the two disorders, calling apotemnophilia "a mental diagnosis and a psychiatric condition" and describing those who seek amputation of a healthy limb as "kooky."[273]

However, the similarities are clear. In the 2005 New York Times article with the headline, At War With Their Bodies, They Seek to Sever Limbs, Dr. First, author of the aforementioned 2005 study, compared the amputation of healthy limbs to sex-reassignment surgery. "When the first sex reassignment was done in the 1950's, it generated the same kind of horror," said First. "Surgeons asked themselves, 'How can I do this thing to someone that's normal?' The dilemma of the surgeon being asked to amputate a healthy limb is similar."[274]

But as First pointed out, the analogy falls short of being perfect. "It's one thing to say someone wants to go from male to female; they're both normal states," he said. "To want to go from a four-limbed person to an amputee feels more problematic. That idea doesn't compute to regular people."

While there are many parallels with traditional sex-reassignment surgeries, including similarities between

270 Bruno, R. L. "Devotees, Pretenders and Wannabes: Two Cases of Factitious Disability Disorder." Sexuality and Disability 15, no. 4 (1997/12/01 1997): 243-60. https://doi.org/10.1023/A:1024769330761. https://doi.org/10.1023/A:1024769330761.

271 First, M. B. "Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder." [In eng]. Psychol Med 35, no. 6 (Jun 2005): 919-28. https://doi.org/10.1017/s0033291704003320.

272 Ibid (n.271)

273 "What Is a Woman?". 2022. https://www.dailywire.com/videos/what-is-a-woman.

274 Henig, R. M. "At War with Their Bodies, They Seek to Sever Limbs." New York Times 22 (2005): F6. https://www.nytimes.com/2005/03/22/health/psychology/at-war-with-their-bodies-they-seek-to-sever-limbs.html.

apotemnophilia and autogynephilia,[275] which is a paraphilia that drives some men to seek medical sex changes, perhaps a closer parallel can be drawn with those who desire their healthy male or female genitals to be reconfigured into abnormal states such as nullification and bigenital surgeries, as well as those seeking to become eunuchs.

The surgeries described by Satterwhite and his devoted followers in the WPATH Files involve creating a type of body that does not exist in nature, in the same way that turning a four-limbed person into an amputee creates a type of body that is abnormal. This ought to generate a feeling of horror in any surgeon dedicated to the Hippocratic Oath, not to mention in all policymakers, insurance companies, and the general public at large.

The amputation of a healthy limb is viewed by most as a violation of the Hippocratic Oath. Still, it is at least a relatively straightforward surgical procedure with few complications and risks, and BIID is also a recognised psychiatric disorder. The same cannot be said for the amputation of healthy genitalia or the creation of a second set of genitals in the service of meeting body modification goals and experiencing "gender euphoria." As well, an apotemnophile who undergoes an amputation can get a prosthesis that functions reasonably well, but there is no such prosthesis that can replace an amputated penis.

In the nullification surgeries offered by Satterwhite and discussed in the WPATH Files, a surgeon amputates the healthy genitalia of a man to create a smooth, sexless body. This pointless form of extreme body modification not only drastically impacts the man's sexual function and destroys his ability to father children, but it also impacts his urinary and endocrine system, two vitally important bodily systems with far-reaching implications for his future health and well-being.

Then there are the "bigenital" surgeries, such as the "phallus-preserving vaginoplasty" and "vagina-preserving phalloplasty," procedures also discussed in the WPATH Files and performed by WPATH surgeons like Satterwhite. These surgeries to create a non-functional second set of genitals come with an extremely high risk of complications. Furthermore, such radical cosmetic surgeries will have a dramatic impact on the patient's health and ability to form long-term romantic partnerships.

Thus, when we compare the detrimental impact that nullification and bigenital surgeries have on a person's sexual identity, which is an intrinsic part of their humanity, coupled with the risks that such surgeries entail, it is clear that the medical crime committed by WPATH-affiliated surgeons is far greater than that of Dr. Robert Smith in Scotland in the 1990s. The NHS Ethics Committee rightly banned Smith from performing further amputations, and we call for WPATH's consumer-driven gender-affirming care to be banned by ethics committees in every town and city across the US and globally.

Another important difference is in the response from the popular press. When the amputations performed by Dr. Smith were revealed, reporting was largely negative. Falkirk and District Royal Infirmary's decision to prevent Smith from carrying out further amputations was in part related to the negative publicity. However, in today's media landscape, non-binary identities are celebrated and gender-affirming care is portrayed as "life-saving." Articles rarely describe the specifics of genital surgeries, but the overall message is consistently positive in today's mainstream press. This helps to increase awareness of these identities and generates desire for genital surgeries. If, in the 1990s, the press had reported favorably about people with innate amputee identities and framed the amputations as a human right and life-saving, it is certainly possible that society would have witnessed an increase in people identifying as amputees and seeking elective amputations.

Both people desiring limb amputation and people desiring abnormal genitalia seek extreme elective surgery to align their bodies with their subjective identity. But, the

275 Lawrence, A. A. "Clinical and Theoretical Parallels between Desire for Limb Amputation and Gender Identity Disorder." [In eng]. Arch Sex Behav 35, no. 3 (Jun 2006): 263-78. https://doi.org/10.1007/s10508-006-9026-6.

origins of that internal sense of self appear to be very different. Apotemnophiles often report seeing an amputee in childhood and, from that moment on, become obsessed with the idea of being an amputee. For many, this obsession then became sexual at the onset of puberty. Similarly, autogynephiles report an obsession with cross-dressing in childhood, beyond the typical dress-up most children engage in, and feeling a thrill of excitement coupled with shame and embarrassment.[276] The sexual element likewise only began at puberty. Even the "eunuch-identified" men described in the bizarre WPATH 2022 Eunuch session were disproportionately likely to have grown up on farms and, therefore, to have witnessed animals castrated. Johnson and Irwig even borrowed language from online apotemnophile communities, describing the men seeking "eunuch calm" as "wannabes."[277]

But those seeking nullification and bigenital surgeries will never have come across people with no genitals or both sets of genitals in their childhood because such a type of person did not exist until WPATH's genre of gender medicine came into being. A parallel cannot be drawn with "intersex" individuals or people with differences of sexual development (DSDs), as such conditions are now known. Individuals with DSDs do not have no genitals or both sets of genitals, and many within the intersex community find the comparison deeply offensive.

While it is not possible to transform a man into a woman by inverting his penis, nor a woman into a man by amputating her breasts and creating a pseudo-penis out of her forearm, such extreme surgeries are at least an attempted remedy, albeit a very misguided one, for a recognized psychiatric disorder. WPATH's non-binary surgeries lack any medical justification and are merely extreme consumer-driven body modifications.

Engineering Children's Height With Hormones

A case study comparing the past scandal of pediatric endocrinologists attempting to correct the height of tall girls and short boys with today's scandal of pediatric endocrinologists attempting to correct gender-nonconformity in children

In the 1950s, pediatric endocrinologists embarked upon an experiment to correct the height of abnormally tall and short children using hormones. This was in the early days of endocrinology when endocrinologists had the air of miracle workers. With the discovery of insulin, this new and exciting branch of medicine had brought diabetics back from the brink of death, and a few short years later, used cortisone to give mobility to crippled arthritics.

So when synthetic estrogen (DES) was developed, and scientists found a way to extract human growth hormone (hGH) from the pituitaries of cadavers, pediatric endocrinologists got swept up in the excitement of discovery and turned their attention to "correcting" the height of tall girls and short boys.

Initially, this experiment was confined only to those suffering from medical conditions such as gigantism and dwarfism. But, soon, endocrinologists broadened their patient pool to include healthy children who didn't measure up to the height standards of the day.

Despite imprecise height prediction methods, a paucity of research into the psychosocial benefits, and a complete absence of evidence about long-term safety and effectiveness, thousands of healthy children were subjected to this treatment. The treatments weren't lacking opposition, though, with some questioning whether abnormal height was a medical problem or just a social impediment.

The media played a role in spreading the word about this new and exciting solution to the woes of being either too tall or too short. Australian pediatrician Norman Wettenhall spearheaded the experiment to correct the height of girls destined to be tall. In 1964, Australian media uncritically reported his success in treating twenty-five tall girls. The Sydney Sun ran a front-page story featuring "two of Australia's growth-controlled girls," who were described

276 Lawrence, A. A. Men Trapped in Men's Bodies: Narratives of Autogynephilic Transsexualism. Springer Science & Business Media, 2012.
277 Ibid (n.221)

as "happy, pretty teenagers who have been prevented from growing embarrassingly tall" by estrogen therapy.[278] This article and others neglected to mention the often debilitating side effects of the treatment, which included weight gain, depression, intense nausea, ovarian cysts, and spontaneous lactation. What ensued was a surge of parents seeking treatment for their daughters, many of whom were mothers who were unhappy with their own tall stature.

While Wettenhall was conducting his experiment in Australia, a group of researchers in the US, headed by Alfred Wilhemi, a chemist at Yale, were crudely processing pituitary glands harvested from morgues, grinding the glands in a blender and then drying them into a powder that would later be injected into short children, the majority of whom were boys. The Food and Drug Administration (FDA) allowed this experiment, and the NIH established and funded a national pituitary collection program. An unlikely coalition of parents of short children and commercial airline pilots worked together to gather pituitaries from coroners and fly them, stored in acetone and on dry ice, to the processing plant.[279]

But then, in 1984, tragedy struck. Those who had been treated with hGH started to die of Creutzfeldt-Jakob disease (CJD), a devastating fatal illness caused by a prion that had gone undetected during processing.[280] It was discovered that fears that hGH injections could spread CJD had been ignored for years.[281] Pituitary-derived hGH was swiftly removed from the market and replaced by a synthetic form, although many pediatric endocrinologists initially thought the ban was too severe and an overreaction. Some parents even acquired pituitary-derived hGH from other sources after being informed of the risk.[282]

There was now unlimited supply of synthetic human growth hormone, and some pediatric endocrinologists began experimenting with a combination of puberty blockers and hGH to give the child more time to grow.

Genentech, the drug company that won FDA approval for synthetic hGH, set about expanding its off-label use to treat healthy children of short stature, financing a journal, funding studies on growth, sponsoring symposiums, courting pediatric endocrinologists and funding height screening programs in American schools.[283] This eventually led to Genentech becoming the first drug company in history to face criminal prosecution by the FDA for illegally promoting off-label, resulting in one of the largest financial penalties ever paid in the industry.[284,285]

At the same time, the harmful effects of estrogen therapy were being exposed, with links to cancer and disorders of the reproductive system.[286] In 1976, the New York Times ran an article downplaying the dangers, quoting a pediatric endocrinologist who claimed the therapy was safe for tall girls because they typically took the hormone for a shorter period of time and another saying, "the choice is to be overly tall or to take a risk that is almost nonexistent."[287,288]

278 Cohen, S., & Cosgrove, C. Normal at Any Cost: Tall Girls, Short Boys, and the Medical Industry's Quest to Manipulate Height, 32. Penguin, 2009.

279 Ibid (n.278 p.78)

280 "National Hormone & Pituitary Program (Nhpp): Information for People Treated with Pituitary Human Growth Hormone." National Institute of Diabetes and Digestive and Kidney Diseases 2021, https://www.niddk.nih.gov/health-information/endocrine-diseases/national-hormone-pituitary-program.

281 Ibid (n. 279 p.275)

282 Ibid (n. 279 p.143)

283 Ibid (n.279 ch.8)

284 Conrad, P., & Potter, D. "Human Growth Hormone and the Temptations of Biomedical Enhancement." Sociology of Health & Illness 26, no. 2 (2004): 184-215. https://doi.org/10.1111/j.1467-9566.2004.00386.x.

285 Ibid (n.279 p.188)

286 Herbst, A. L., Ulfelder, H., & Poskanzer, D. C. "Adenocarcinoma of the Vagina." New England Journal of Medicine 284, no. 16 (1971): 878-81. https://doi.org/10.1056/nejm197104222841604. https://dx.doi.org/10.1056/nejm197104222841604.

287 Ziel, H. K., & Finkle, W. D. "Increased Risk of Endometrial Carcinoma among Users of Conjugated Estrogens." [In eng]. N Engl J Med 293, no. 23 (Dec 4 1975): 1167-70. https://doi.org/10.1056/nejm197512042932303.

288 "The Use of Estrogen as a Growth Inhibitor in over-Tall Girls Is Being Questioned." The New York Times, 1976, https://www.nytimes.com/1976/02/11/archives/the-use-of-estrogen-as-a-growth-inhibitor-in-overtall-girls-is.html.

However, this turned out to be false. An investigation into the Tall Girls scandal began in 2000. Researchers tracked down hundreds of women and found higher rates of infertility,[289] and increased risk of endometriosis. The researchers saw cancers in the group as well, but due to the small sample size, they couldn't conclude the effects of the treatment on cancer risk.[290]

As well, while short-term follow-up studies [291,292] had shown high rates of satisfaction in the girls who had undergone treatment, the investigation in 2000 revealed that 99.1% of the women who had not received treatment were happy they hadn't taken the hormone, compared to a regret rate of 42.1% for those who had, with the researchers concluding that 56% were "less than satisfied."[293] Many of the parents expressed profound guilt at what they had done to their daughters.

While the tall girls were still dealing with fertility issues and disorders of the reproductive system, and those treated with pituitary-derived hGH were still living with a potential death sentence hanging over their heads, the field of pediatric endocrinology moved on to its next reckless experiment, once again using hormonal interventions to mold children into gender-stereotype norms. This time, their attempt involved a whole rewrite of what it means to be human and a complete disregard for biological reality. However, the new adventure was eerily similar to its predecessor.

At the center of both scandals, there are healthy children who are different, who don't measure up to what is considered "normal" for the culture of their particular time and place, and there is a medical world willing to embark upon an experiment to engineer normality. Gender nonconformity is no more a medical condition than being taller or shorter than the average height. Of note, in both scandals, adults who are unhappy with aspects of their appearance are the ones calling for children to be experimented on.

As well, there are off-label drugs being prescribed to healthy children without any knowledge of the drugs' safety, effectiveness, or benefits. However, the height-manipulation therapy experiment occurred long before the development of evidence-based medicine when it was common for doctors to test out ideas on patient groups without prior controlled testing. Neither for DES nor hGH were there any controlled trials or long-term follow-up studies before the drugs were rolled out for widespread use, but this was normal for the era.

It is the same for the puberty suppression experiment, which was rolled out into general medical practice based on the questionable results of a deeply flawed study of just 55 adolescents, with psychological data only available for 32 participants. This is reminiscent of Wettenhall's claims of success with just 25 tall girls, which led to the widespread adoption of estrogen therapy to correct height.

In the original Dutch paper, sponsored by Ferring Pharmaceuticals, a maker of puberty blockers, de Waal and Cohen-Kettenis even discuss the opportunity to "manipulate growth." Regarding height, the researchers point out that while a natal female's growth spurt will be hampered, the fusion of the growth plates will also be delayed. "Since females are about 12 cm shorter than males, we may intervene with growth-stimulating

289 Venn, A., Bruinsma, F., Werther, G., Pyett, P., Baird, D., Jones, P., Rayner, J., & Lumley, J. "Oestrogen Treatment to Reduce the Adult Height of Tall Girls: Long-Term Effects on Fertility." The Lancet 364, no. 9444 (2004): 1513-18. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)17274-7/fulltext.

290 Ibid (n.279 p.345)

291 Crawford, J. D. "Treatment of Tall Girls with Estrogen." Pediatrics 62, no. 6 (1978): 1189-95. https://doi.org/10.1542/peds.62.6.1189.

292 De Waal, W. J., Torn, M., De Muinck Keizer-Schrama, S. M., Aarsen, R. S., & Drop, S. L. "Long Term Sequelae of Sex Steroid Treatment in the Management of Constitutionally Tall Stature." Archives of Disease in Childhood 73, no. 4 (1995): 311-15. https://doi.org/10.1136/adc.73.4.311. https://dx.doi.org/10.1136/adc.73.4.311.

293 Pyett, P., Rayner, J., Venn, A., Bruinsma, F., Werther, G., & Lumley, J. "Using Hormone Treatment to Reduce the Adult Height of Tall Girls: Are Women Satisfied with the Decision in Later Years?". Social Science & Medicine 61, no. 8 (2005/10/01/ 2005): 1629-39. https://doi.org/https://doi.org/10.1016/j.socscimed.2005.03.016.

treatment in order to adjust the female height to an acceptable male height," they theorized at the time.[294]

The girls who were given DES experienced high rates of fertility issues many years later and an increased risk of endometriosis. These side effects were not foreseen by the endocrinologists who gave the hormone to these previously healthy girls.

It is possible, but surely unlikely, that the Dutch researchers who first embarked upon the adolescent sex-trait modification experiment also did not foresee the impact the treatment would have on the fertility and sexual function of their patients. However, the WPATH documents reveal that gender-affirming medical and mental health professionals today are well aware of the detrimental impact of puberty blockers and hormones on this important aspect of their young patients' lives. From the discussions about vaginal atrophy as a result of prolonged testosterone use and descriptions of natal males having erections that feel like "broken glass," to Bowers's comments about natal males facing a lifetime of being infertile and anorgasmic, the documents clearly show that WPATH members know that the cross-sex hormone therapy their professional association endorses negatively affects a patient's fertility and sexual function.

Just as Wilhemi and his fellow researchers did not anticipate that their treatment might pose a potential threat to the lives of their previously healthy patients, the Dutch researchers likewise did not foresee that suppressing puberty would result in the tragic death of one of the original study participants.[295] Like their predecessors administering contaminated hGH to healthy children, gender doctors had been aware of what Bowers refers to in the files as "problematic surgical outcomes" since at least 2005, but this was not enough to halt the experiment.[296]

Also reminiscent of the CJD crisis, the anecdote in the WPATH Files about the natal female who appears to have died of liver cancer brought on by prolonged testosterone use, as well as the Lancet case study of the 17-year-old with liver cancer, raise serious concerns. Just as the CJD nightmare didn't surface until decades after the children had been treated, we may face another such catastrophe in the coming years as the risks of prolonged testosterone use in females begin to manifest.

In both scandals, there is a lack of good quality long-term research. During the height-modification scandal, clinicians conducted short-term follow-ups and reported high satisfaction rates. However, follow-up studies done before the women had reached the age that they might start to regret compromising their fertility have only limited worth. The long-term follow-up study conducted in 2000 found much higher rates of regret and dissatisfaction among the women.

There is the same lack of adequate long-term data for the hormonal interventions for adolescent sex-trait modification. Today's experiment has a much greater detrimental impact on the young participants. Discussions in the files show that WPATH is aware that this treatment protocol is creating a generation of sexually dysfunctional young people.

Many of the short-term studies with reported high patient satisfaction rates are cited by gender-affirming clinicians as proof that sex-trait modification procedures are beneficial. But these are just as inadequate as the short-term studies during the height-modification scandal. For the data to be worthwhile, gender doctors need to follow up with their patients long into adulthood, when the true impact of sacrificing their fertility and sexual function is felt. But we are already seeing a trend similar to the tall girls

294 Ibid (n.157)

295 Ibid (n.74)

296 "Consensus Report on Symposium in May 2005." gires, 2005, https://www.gires.org.uk/consensus-report-on-symposium-in-may-2005/.

experiment: the longer the follow-up period, the higher the regret rate for sex-trait modification interventions.[297,298] The preliminary findings of the Dutch long-term follow-up already indicate that fertility regret is significant.[299]

During inquiries into the CJD tragedy, a British court found that the UK Department of Health should have taken action in the summer of 1977 after warnings about CJD contamination were sounded, and an Australian investigation set the cut-off date at 1980. It's difficult to pin down exactly when gender-affirming doctors should have been aware that their puberty suppression experiment was causing harm. Very early on, it was noted that all, or almost all, children were progressing to irreversible cross-sex hormones,[300] and the "problematic surgical outcomes" were recorded in scientific literature as early as 2008.[301] However, a firm line can be drawn with the findings of Sweden, Finland and England's systematic reviews in 2019 and 2020.[302,303,304] Each of these pre-dated the comments made by Bowers in the forum and those of the panelists in the Identity Evolution Workshop.

One of the most striking differences between the two scandals is the impact of the therapy on the young person's future chance of forming long-term romantic partnerships. The parents signing their children up for height-modification hormone therapy did so out of the well-intentioned belief that it would increase the chances that their children would find a romantic partner, lasting love, and marriage.

Conversely, the parents signing their children up for today's sex-trait modification hormone therapy don't seem to consider the fact that they are potentially ruining their child's future ability to form intimate relationships. Or, more likely, they do consider it, but they are coerced into agreeing by the transition-or-suicide lie that gender-affirming medical and mental health professionals tell reluctant parents.

The length of time the young people were to take hormones is also vastly different. For the height-modification experiment, the children could be on hormones for years, but as soon as they reached their final adult height, treatment immediately stopped. WPATH advocates for pediatric endocrinologists today to turn adolescents into lifelong medical patients, dependent on wrong-sex hormones for the rest of their lives, without any evidence that this treatment protocol is safe.

The clinicians in the 1950s and 1960s couldn't foresee a world where being tall would be socially acceptable for women and even admired, or the possibility that very tall or very short adults could develop resilience to conquer their perceived social disadvantage. Today, WPATH members cannot foresee their adolescent patients growing up, reconciling with their birth sex and no longer identifying as transgender, but the ever-growing number of detransitioners suggests this is not a rare occurrence. However, the young people having their bodies permanently altered by WPATH-influenced clinicians are not able to turn back the clock and undo the damage.

297 Hall, R., Mitchell, L., & Sachdeva, J. "Access to Care and Frequency of Detransition among a Cohort Discharged by a Uk National Adult Gender Identity Clinic: Retrospective Case-Note Review." BJPsych Open 7, no. 6 (2021). https://doi.org/10.1192/bjo.2021.1022. https://dx.doi.org/10.1192/bjo.2021.1022.

298 Boyd, I., Hackett, T., & Bewley, S. "Care of Transgender Patients: A General Practice Quality Improvement Approach." Healthcare 10, no. 1 (2022): 121. https://doi.org/10.3390/healthcare10010121. https://dx.doi.org/10.3390/healthcare10010121.

299 Ibid (n.48)

300 Ibid (n.294)

301 Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. "The Treatment of Adolescent Transsexuals: Changing Insights." [In eng]. J Sex Med 5, no. 8 (Aug 2008): 1892-7. https://doi.org/10.1111/j.1743-6109.2008.00870.x.

302 "Gender Dysphoria in Children and Adolescents: An Inventory of the Literature." Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019, https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/.

303 "Lääketieteelliset Menetelmät Sukupuolivariaatioihin Liittyvän Dysforian Hoidossa. Systemaattinen Katsaus." Summaryx, 2019, https://palveluvalikoima.fi/documents/1237350/22895008/Valmistelumuistion+Liite+1.+Kirjallisuuskatsaus.pdf/5ad0f362-8735-35cd-3e53-3d17a010f2b6/Valmistelumuistion+Liite+1.+Kirjallisuuskatsaus.pdf?t=1592317703000.

304 Ibid (n.160)

CONCLUSION

As this report has shown, WPATH is not a medical organization. It is not engaged in a scientific quest to discover the best possible way to help vulnerable individuals who are suffering from gender-related distress. Instead, it is a fringe group of activist clinicians and researchers masquerading as a medical group, advocating for a reckless hormonal and surgical experiment to be performed on some of the most vulnerable members of society.

It would be criminal for a surgeon to sever the spinal cord of a person who identified as a quadriplegic or to blind a sighted patient who identified as blind. It is just as unethical to destroy healthy reproductive systems and amputate the healthy breasts and genitals of mentally unwell people. To do so without first even attempting to help the person overcome their mental illness, without realistically preparing the individual for the grueling post-op period or warning of the life-long negative effect that the procedures will have on their long-term health and ability to form intimate relationships amounts to medical negligence of the highest order.

Thus, there can be no doubt that we are currently witnessing one of the greatest crimes in the history of modern medicine. The scandal of WPATH's gender-affirming care combines all the elements of the four past medical misadventures outlined in our case studies.

Doctors cannot be trusted to regulate themselves. They, too, are human and possess the same inherent biases and vulnerabilities as the rest of us. This is especially true when groupthink takes hold and dissent is silenced. When a doctor stakes his or her reputation on a given treatment, it can lead to powerful conflicts of interest and confirmation bias, preventing even the most well-intentioned and competent physician from seeing the obvious harm being inflicted on patients. Bowers's claim in the New York Times, that the field of transgender medicine is "every bit as objective- and outcome-driven as any other specialty in medicine," demonstrates how blind WPATH's leadership is to the reality of the organization's unethical approach to medicine.

We have regulatory bodies to maintain ethical standards, and we therefore call on medical ethics boards across the US and the rest of the world to conduct urgent, unbiased, transparent, and rigorous reviews of the sex-trait modification interventions WPATH endorses. We also call on the APA, the AMA, the AAP, and The Endocrine Society to set politics aside and condemn the pseudoscientific, unethical medical practices of WPATH.

Furthermore, we call upon the US government to launch an official non-partisan inquiry into how an organization with such disregard for medical ethics and the scientific process was ever granted the authority to establish global standards of care in a field of medicine. We advocate for this drastic action due to the unwarranted prestige, undue influence, and resulting danger posed by WPATH.

WPATH serves no purpose, contributes nothing beneficial to the field of gender medicine, and leads medical and mental health professionals astray. Several European nations have already abandoned the group's guidelines, indicating the extent to which WPATH has become obsolete.

Political activism and medicine should never mix. An organization in pursuit of political goals is one not in pursuit of patient health. The WPATH Files contain abundant evidence that the organization is an activist group, not a scientific one. From the Alberta professor stating that trans health care is about challenging cisnormativity to Satterwhite and his supporters ignoring the ethical concerns of non-binary surgeries and focusing on the importance of using politically correct language, it is clear that WPATH prioritizes politics over science.

The medical world self-corrects by open discussion, scientific debate, and diligent investigation. None of these factors is present within the WPATH Files. Instead, there is political discourse and policing of language. When one

clinician posted a study about detransitioners, WPATH's president cautions that "acknowledgment that de-transition exists to even a minor extent is considered off limits for many in our community." Given the complexity of gender medicine, the controversy surrounding the treatments, and the drastic, life-altering effects of the hormonal and surgical interventions endorsed by WPATH, it is especially disconcerting that the Ontario family physician was the lone dissenting voice in all the files.

A medical organization that cannot face up to the devastating harm its treatments are causing is a danger to the patients it claims to serve. The unwillingness to acknowledge the victims of this medical scandal, the refusal to recognize the growing body of evidence showing that the risks of gender-affirming care greatly outweigh any supposed benefit, and the extreme beliefs of many of its members indicate that WPATH will never be able to correct its course. The internal communications demonstrate that the organization is corrupt to its core.

Currently, lawmakers, judges, insurance companies, and public health providers are duped into trusting WPATH's guidelines as a result of the broken chain of trust. These stakeholders are not aware that the political activists within WPATH are promoting a reckless, consumer-driven transition-on-demand approach to extreme body modification, even for minors and the severely mentally ill. It is for this reason that we believe the medical world must reject WPATH's guidelines.

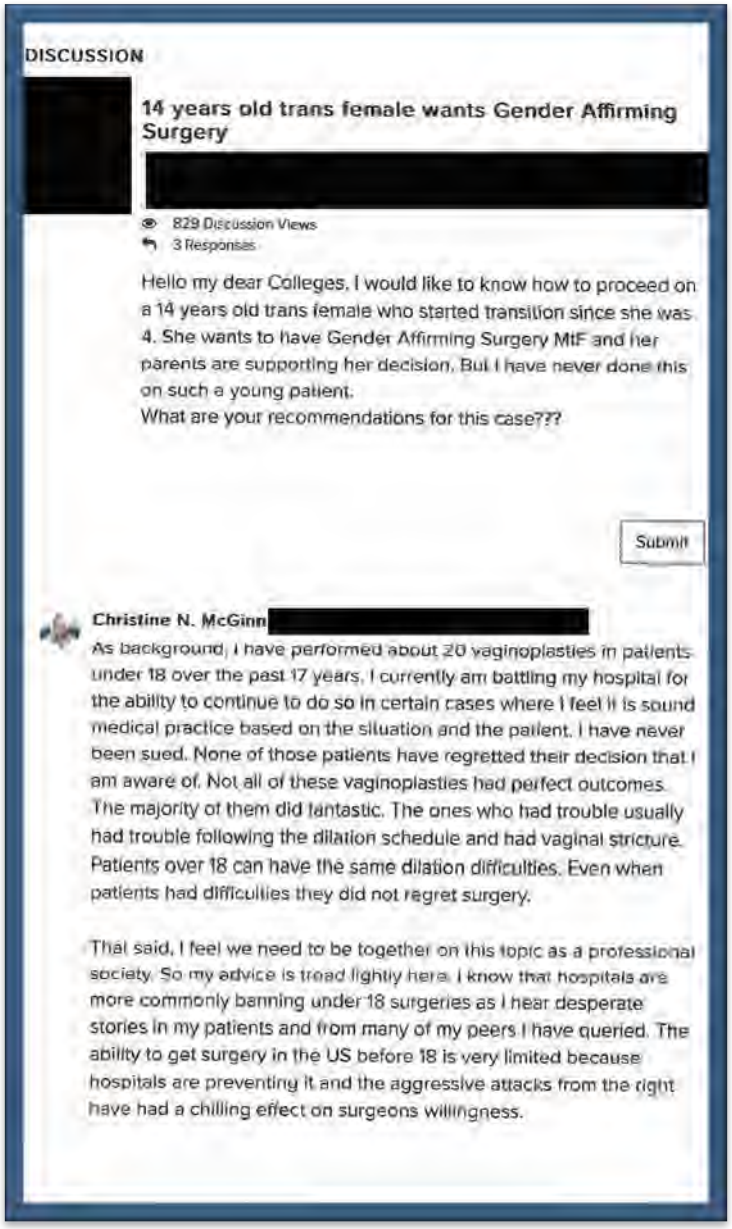
Gender dysphoria is a complex psychiatric condition, and there is no easy answer as to the best way to ease the pain of those afflicted. It is beyond the scope of this report to attempt to find such a solution. However, it is possible to state with unequivocal certainty that the World Professional Association of Transgender Health does not advocate for the best possible care for this vulnerable patient cohort, and the detrimental impact of WPATH's actions over the past two decades has rendered the organization irredeemable. It is now imperative to usher in a new era in gender medicine, one that prioritizes the health and well-being of patients as its foremost objective.

TABLE OF CONTENTS

The WPATH Files appear in full below. We have organized the files for accessibility, but we have not edited, removed, or added any material. Dates are included when available, and all discussions occurred within the last four years. Members' names are redacted, except in the case of the WPATH president, surgeons, and other prominent members. The files are unedited and nothing has been removed or added.

1) GENDER AFFIRMING SURGERY FOR MINORS

a) WPATH members discuss transition surgery for a 14-year-old



DISCUSSION

[redacted]

14 years old trans female wants Gender Affirming Surgery

[redacted]

829 Discussion Views
3 Responses

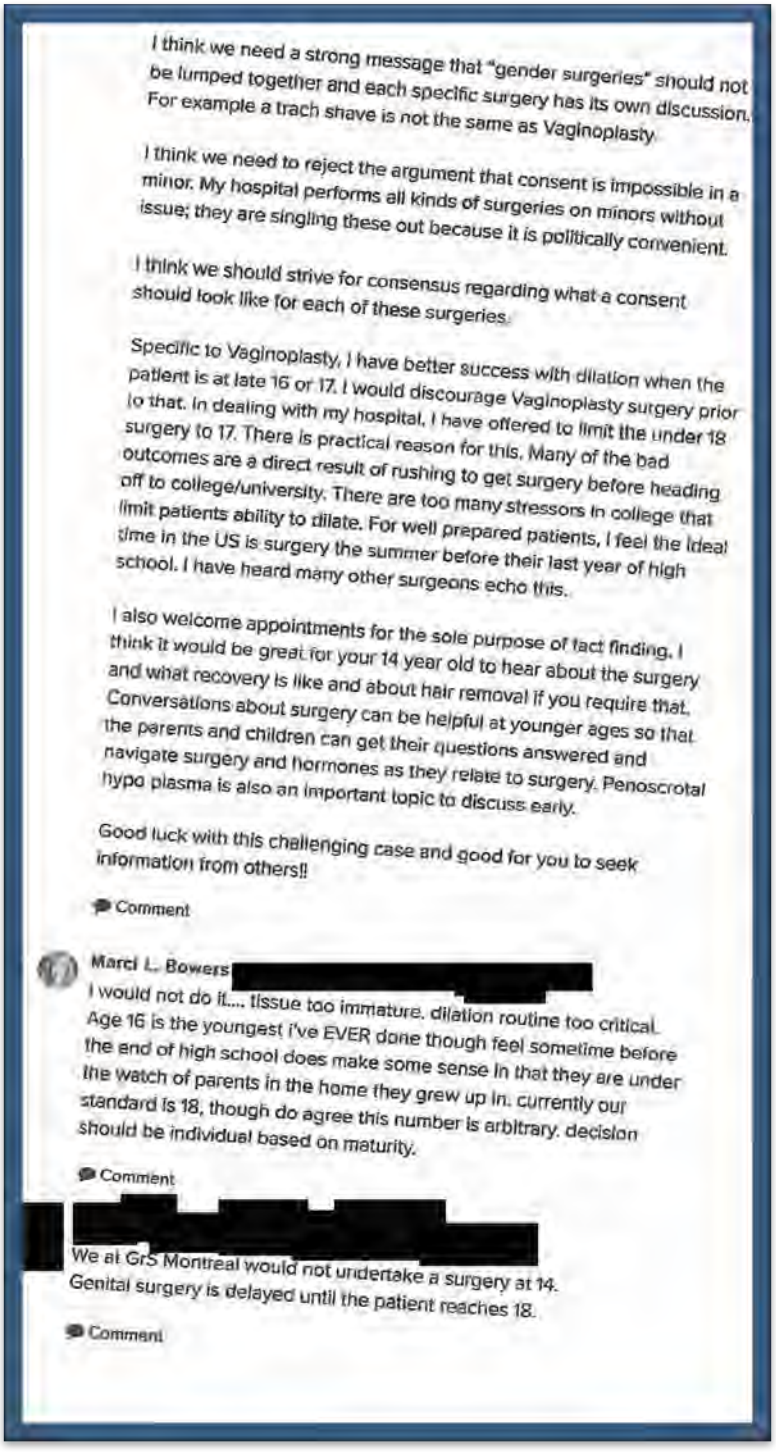
Hello my dear Colleges, I would like to know how to proceed on a 14 years old trans female who started transition since she was 4. She wants to have Gender Affirming Surgery MtF and her parents are supporting her decision. But I have never done this on such a young patient.
What are your recommendations for this case???

Submit

Christine N. McGinn [redacted]

As background, I have performed about 20 vaginoplasties in patients under 18 over the past 17 years. I currently am battling my hospital for the ability to continue to do so in certain cases where I feel it is sound medical practice based on the situation and the patient. I have never been sued. None of those patients have regretted their decision that I am aware of. Not all of these vaginoplasties had perfect outcomes. The majority of them did fantastic. The ones who had trouble usually had trouble following the dilation schedule and had vaginal stricture. Patients over 18 can have the same dilation difficulties. Even when patients had difficulties they did not regret surgery.

That said, I feel we need to be together on this topic as a professional society. So my advice is tread lightly here. I know that hospitals are more commonly banning under 18 surgeries as I hear desperate stories in my patients and from many of my peers I have queried. The ability to get surgery in the US before 18 is very limited because hospitals are preventing it and the aggressive attacks from the right have had a chilling effect on surgeons willingness.



I think we need a strong message that "gender surgeries" should not be lumped together and each specific surgery has its own discussion. For example a trach shave is not the same as Vaginoplasty.

I think we need to reject the argument that consent is impossible in a minor. My hospital performs all kinds of surgeries on minors without issue; they are singling these out because it is politically convenient.

I think we should strive for consensus regarding what a consent should look like for each of these surgeries.

Specific to Vaginoplasty, I have better success with dilation when the patient is at late 16 or 17. I would discourage Vaginoplasty surgery prior to that. In dealing with my hospital, I have offered to limit the under 18 surgery to 17. There is practical reason for this. Many of the bad outcomes are a direct result of rushing to get surgery before heading off to college/university. There are too many stressors in college that limit patients ability to dilate. For well prepared patients, I feel the ideal time in the US is surgery the summer before their last year of high school. I have heard many other surgeons echo this.

I also welcome appointments for the sole purpose of fact finding. I think it would be great for your 14 year old to hear about the surgery and what recovery is like and about hair removal if you require that. Conversations about surgery can be helpful at younger ages so that the parents and children can get their questions answered and navigate surgery and hormones as they relate to surgery. Penoscrotal hypo plasma is also an important topic to discuss early.

Good luck with this challenging case and good for you to seek information from others!!

Comment

Marci L. Bowers [redacted]

I would not do it.... tissue too immature. dilation routine too critical. Age 16 is the youngest i've EVER done though feel sometime before the end of high school does make some sense in that they are under the watch of parents in the home they grew up in. currently our standard is 18, though do agree this number is arbitrary. decision should be individual based on maturity.

Comment

[redacted]

We at GrS Montreal would not undertake a surgery at 14. Genital surgery is delayed until the patient reaches 18.

Comment

2) MENTAL HEALTH CONCERNS

a) WPATH members discuss amputation for patients with body integrity identity disorder (BIID)

Hi [redacted]

Sorry for the long delay in replying. Thank you for your thoughts about this. Yours is exactly the question that I hope to answer through consultation. There seems to be little research about this condition, although it does seem that amputation has provided relief for several clients. My assumption is that it will be very difficult to find surgeons willing to do an amputation and to get health insurance funding for the procedure.

I agree with an affirmative approach, however, my main concern is my own lack of experience to differentially diagnose this from other mental health concerns that may be at play here. As it turns out, there has been a change in the portion of the body causing distress.

[redacted]

Generally speaking, I've found in speaking with people who are experiencing BIID that this tends to be often a lifelong issue that is as persistent as gender identity and as unlikely to be resolved without surgical intervention. However, for ethical reasons, medical professionals are generally unlikely to help facilitate the surgical interventions that would be necessary to align the bodies of people with BIID with their minds. In the few publicized cases where this has occurred, however, the patient is typically satisfied and happy with the outcome. As you're probably aware, if a person with BIID becomes desperate enough, they may attempt to self-amputate or engineer an injury that would require medical intervention to obtain the body they feel they need, or they may seek out people who would perform surgery on them illicitly. All of these are dangerous. However, logical reasoning and detailed examination of the concrete risks involved with trying to do either of these things tends to keep the person from taking actions that might result in unintended negative consequences (like death or an incomplete or different disability than the one intended). Talk therapy may prevent self-harm, but it is not likely to make the feelings of BIID go away without surgical intervention. Still, it may keep your client safe.

Comment

[redacted]

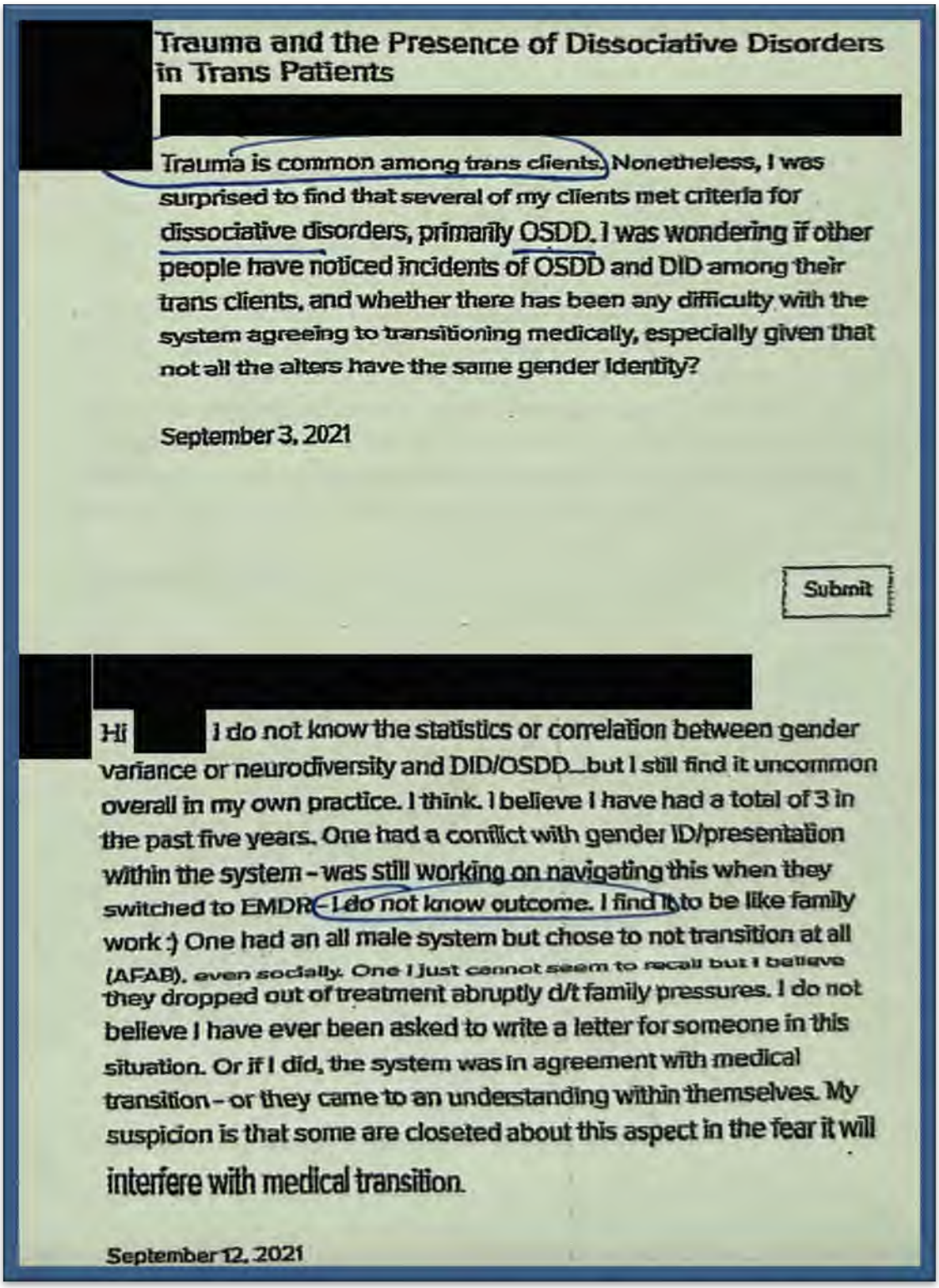
Hi [redacted]

Thank you so much for sharing your experience and thoughts about this topic. It is greatly appreciated.

[redacted]

It's fascinating. I have no easy answers. But it is clear these individuals do display some characteristics similar to trans people. The body issues obviously. But also that the unhappiness is long lasting, resistant to other (reparative?) interventions, the possibility of self-surgery etc). I fear one may have here a group of particularly unfortunate individuals to whom medical science is as hostile as was once the case with trans people.

b) WPATH members discuss trauma and dissociative orders in trans patients



Trauma and the Presence of Dissociative Disorders in Trans Patients

[redacted]

Trauma is common among trans clients. Nonetheless, I was surprised to find that several of my clients met criteria for dissociative disorders, primarily OSDD. I was wondering if other people have noticed incidents of OSDD and DID among their trans clients, and whether there has been any difficulty with the system agreeing to transitioning medically, especially given that not all the alters have the same gender identity?

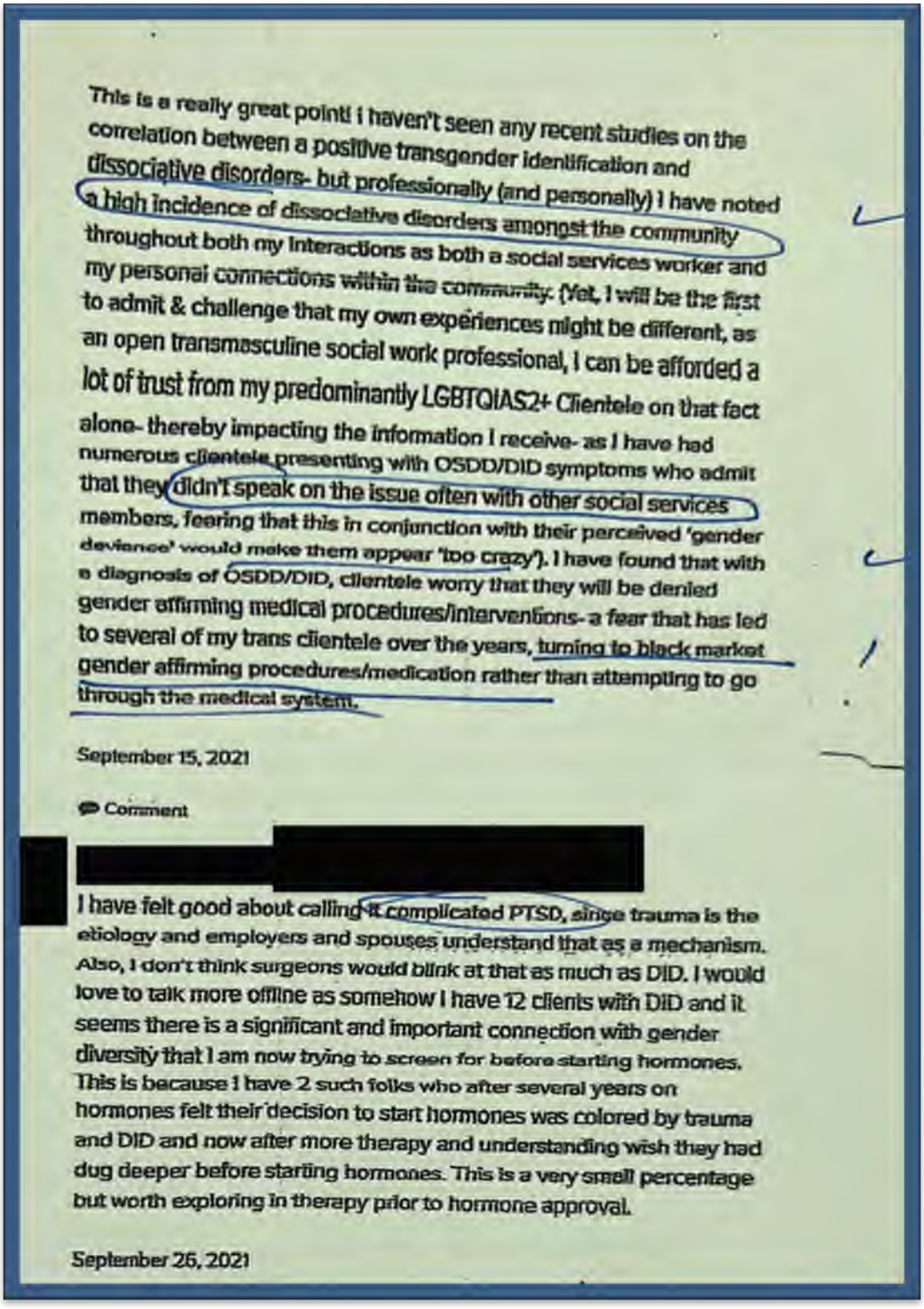
September 3, 2021

Submit

[redacted]

Hi [redacted] I do not know the statistics or correlation between gender variance or neurodiversity and DID/OSDD...but I still find it uncommon overall in my own practice. I think. I believe I have had a total of 3 in the past five years. One had a conflict with gender ID/presentation within the system - was still working on navigating this when they switched to EMDR - I do not know outcome. I find it to be like family work :) One had an all male system but chose to not transition at all (AFAB), even socially. One I just cannot seem to recall but I believe they dropped out of treatment abruptly d/t family pressures. I do not believe I have ever been asked to write a letter for someone in this situation. Or if I did, the system was in agreement with medical transition - or they came to an understanding within themselves. My suspicion is that some are closeted about this aspect in the fear it will interfere with medical transition.

September 12, 2021



This is a really great point! I haven't seen any recent studies on the correlation between a positive transgender identification and dissociative disorders- but professionally (and personally) I have noted a high incidence of dissociative disorders amongst the community throughout both my interactions as both a social services worker and my personal connections within the community. (Yet, I will be the first to admit & challenge that my own experiences might be different, as an open transmasculine social work professional, I can be afforded a lot of trust from my predominantly LGBTQIAS2+ Clientele on that fact alone- thereby impacting the information I receive- as I have had numerous clientele presenting with OSDD/DID symptoms who admit that they didn't speak on the issue often with other social services members, fearing that this in conjunction with their perceived 'gender deviance' would make them appear 'too crazy'). I have found that with a diagnosis of OSDD/DID, clientele worry that they will be denied gender affirming medical procedures/interventions- a fear that has led to several of my trans clientele over the years, turning to black market gender affirming procedures/medication rather than attempting to go through the medical system.

September 15, 2021

Comment

[redacted]

I have felt good about calling it complicated PTSD, since trauma is the etiology and employers and spouses understand that as a mechanism. Also, I don't think surgeons would blink at that as much as DID. I would love to talk more offline as somehow I have 12 clients with DID and it seems there is a significant and important connection with gender diversity that I am now trying to screen for before starting hormones. This is because I have 2 such folks who after several years on hormones felt their decision to start hormones was colored by trauma and DID and now after more therapy and understanding wish they had dug deeper before starting hormones. This is a very small percentage but worth exploring in therapy prior to hormone approval.

September 26, 2021

[redacted]

With one client who had DID we worked on all altars giving consent to HRT before it was started. They had alters who were both male and female gender and it was imperative to get all alters who would be effected by HRT to be aware and consent to the changes. Ethically, if you do not get consent from all alters you have not really received consent and you may be open to being sued later, if they decide HRT or surgery was not in their best interest.

October 7, 2021

Comment

[redacted]

Thanks [redacted] for raising this issue and for those who have responded.

I too have seen a relatively small but significant number of trans and gender diverse clients with DID; and have noticed an increase in the number of new clients with dissociative experience (cPTSD).

I am curious about how we collectively - clients, therapist, treating physicians & surgeons - adequately respond to this. It concerns me that some individuals may not disclose for fear of denied access to treatment, yet I am also concerned about transition (even when all known parts/alters agree).

Is there a way those of us working with dissociative clients could work together to more fully describe the scope and approaches in this area?

October 17, 2021

[redacted] Hi [redacted]

I wondered if anyone responded to your request of working together in this area. I think you've raised this multiple times over the years. Gender health specialists really need to be working with clinicians with extensive experience in dissociation. I know these are both areas where you've worked extensively. I do not know if this new platform has the ability to create small groups, but if we could set up some sort of ongoing discussion on this topic it would be great.

November 11, 2021

[redacted]

Hello,

Would it be worthwhile to consider looking at the International Society for the Study of Trauma and Dissociation (https://www.isst-d.org/) and beginning a dialogue to see if there is something that can be be looked at as a collective?

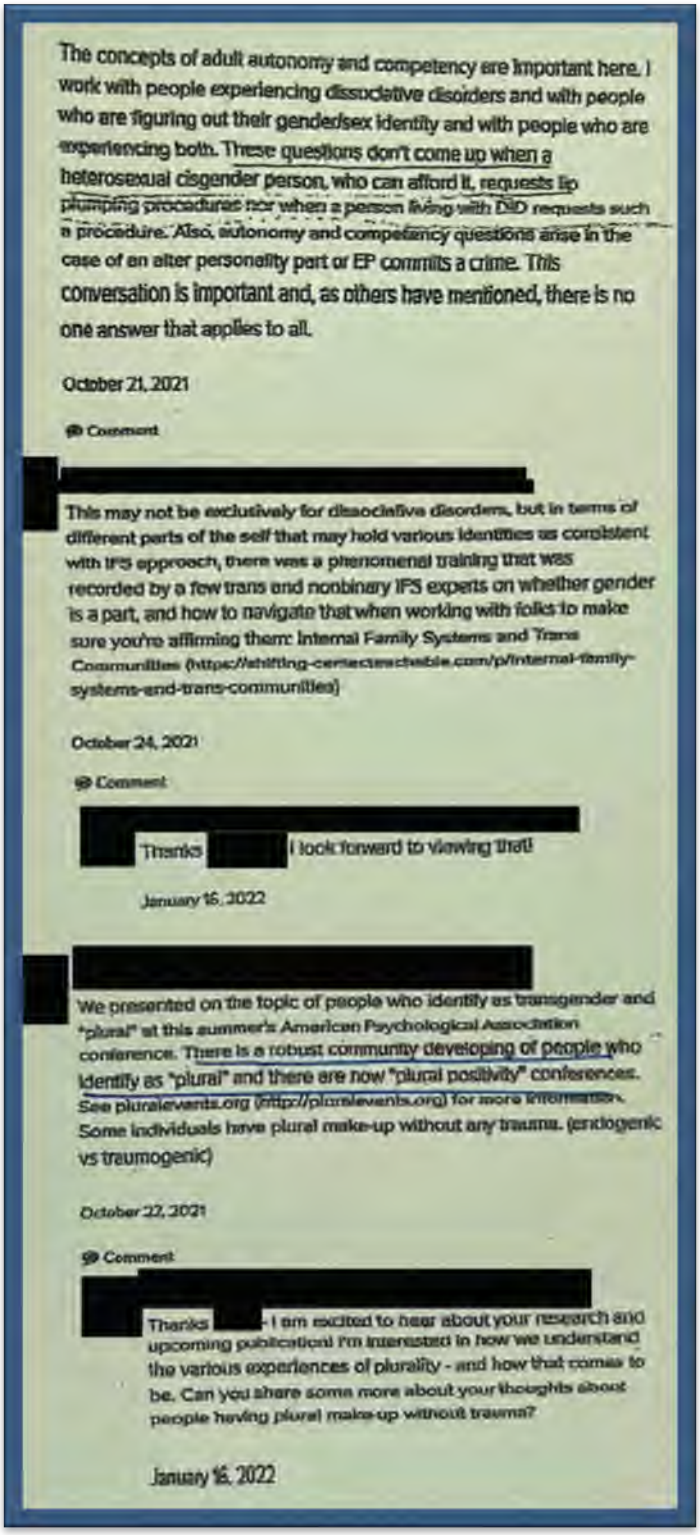
I have a large number of clients who have DDNOS/DID/c-PTSD or have dissociation on some level as part of their experience who are transitioning and are trans or gender diverse. I use EMDR in my practice and I have found that ISST-D to be helpful though not as inclusive as I would like. Would this be worth consideration and a potential way to define more approaches or interventions that are used/that could be talked about in this context?

October 17, 2021

Comment

[redacted] I am grateful for your response, and I hope it prompts more discussion about this issue. Personally, I am pursuing training in treating trauma and dissociative disorders, as well as consulting with a specialist in these disorders, but it is difficult, and dissociative disorders are, after all, covert. I too would love to hear from others how we as clinicians and as clinical support teams can work with these clients to honor their gender identity and their fractured ego identities.

October 18, 2021



The concepts of adult autonomy and competency are important here. I work with people experiencing dissociative disorders and with people who are figuring out their gender/sex identity and with people who are experiencing both. These questions don't come up when a heterosexual cisgender person, who can afford it, requests lip plumping procedures nor when a person living with DID requests such a procedure. Also, autonomy and competency questions arise in the case of an alter personality part or EP commits a crime. This conversation is important and, as others have mentioned, there is no one answer that applies to all.

October 21, 2021

Comment

[redacted]

This may not be exclusively for dissociative disorders, but in terms of different parts of the self that may hold various identities as consistent with IFS approach, there was a phenomenal training that was recorded by a few trans and nonbinary IFS experts on whether gender is a part, and how to navigate that when working with folks to make sure you're affirming them: Internal Family Systems and Trans Communities (https://shifting-consciousness.com/p/internal-family-systems-and-trans-communities)

October 24, 2021

Comment

[redacted] Thanks [redacted] I look forward to viewing that!

January 16, 2022

[redacted]

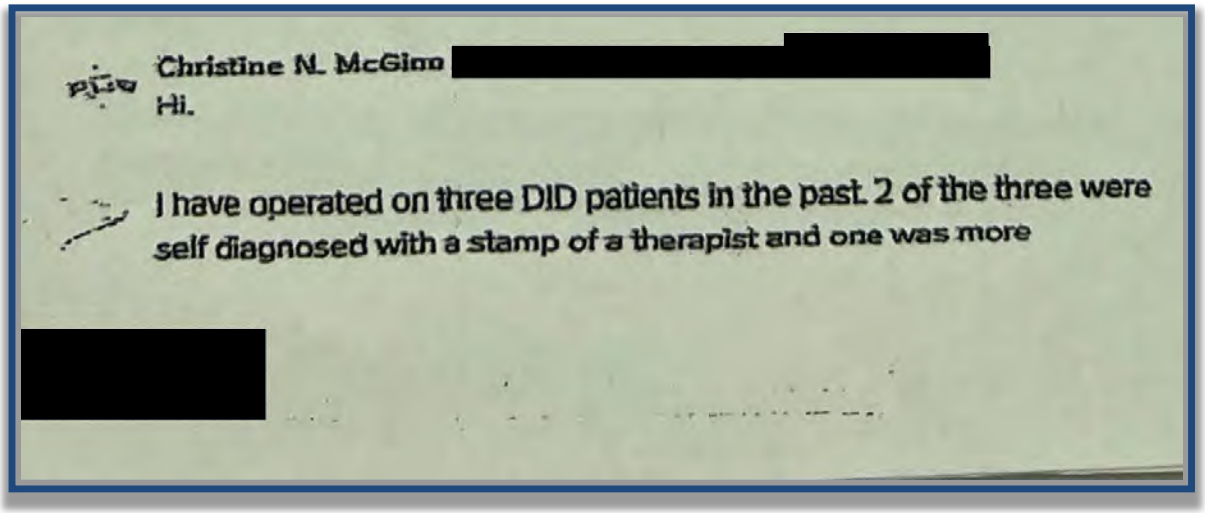
We presented on the topic of people who identify as transgender and "plural" at this summer's American Psychological Association conference. There is a robust community developing of people who identify as "plural" and there are now "plural positivity" conferences. See pluralevents.org (http://pluralevents.org) for more information. Some individuals have plural make-up without any trauma. (endogenic vs traumogenic)

October 22, 2021

Comment

[redacted] Thanks [redacted] - I am excited to hear about your research and upcoming publication! I'm interested in how we understand the various experiences of plurality - and how that comes to be. Can you share some more about your thoughts about people having plural make-up without trauma?

January 16, 2022

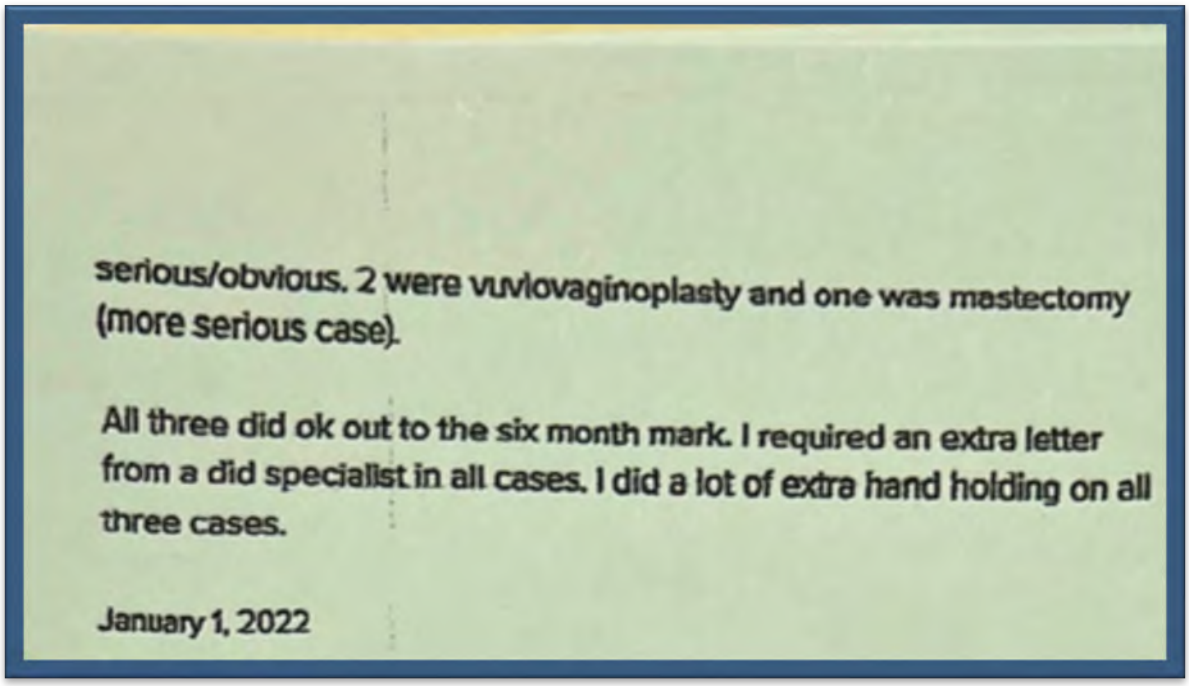


Christine N. McGinn [redacted]

Hi.

I have operated on three DID patients in the past. 2 of the three were self diagnosed with a stamp of a therapist and one was more

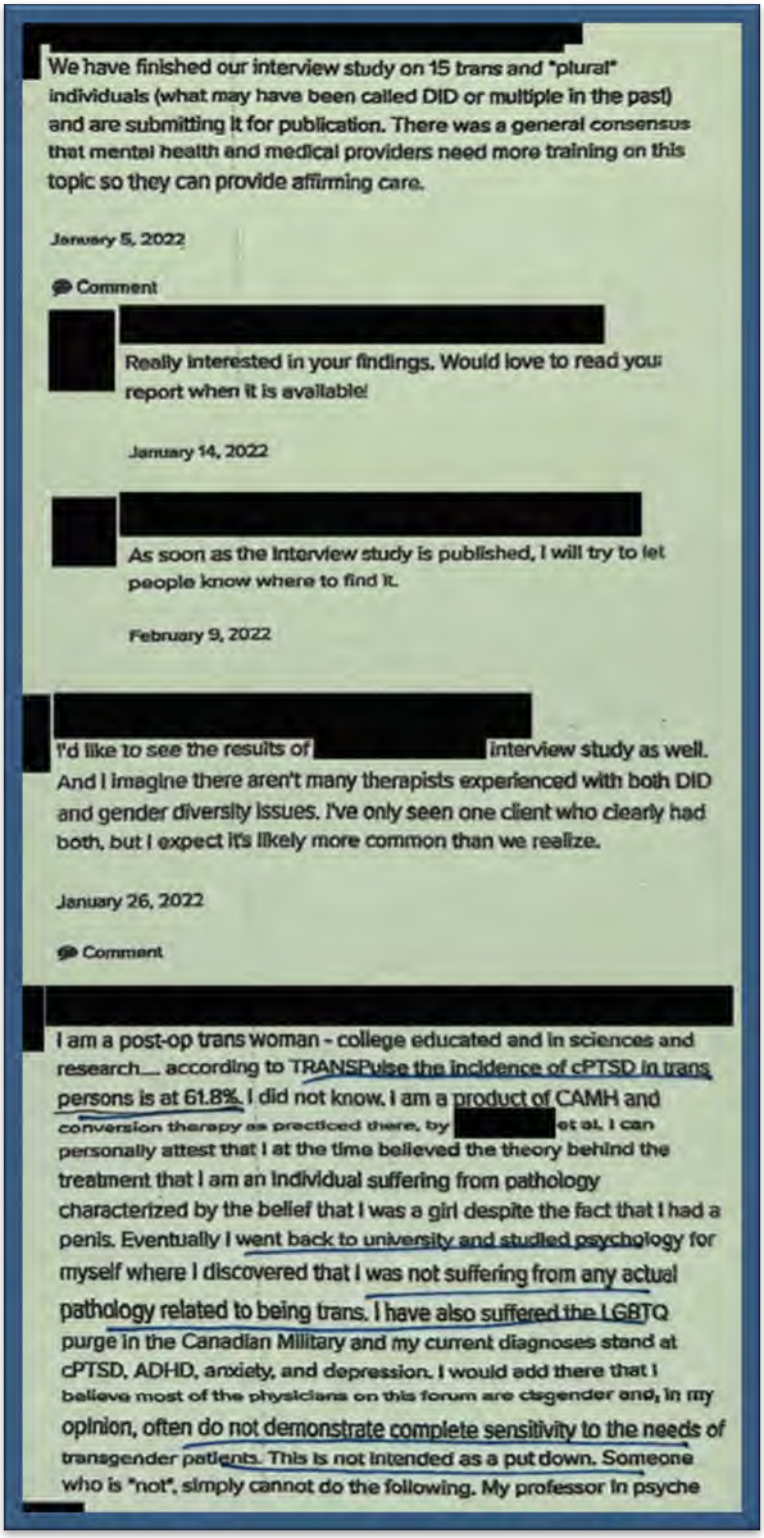
[redacted]



serious/obvious. 2 were vuvlovaginoplasty and one was mastectomy (more serious case).

All three did ok out to the six month mark. I required an extra letter from a did specialist in all cases. I did a lot of extra hand holding on all three cases.

January 1, 2022



[redacted]

We have finished our interview study on 15 trans and "plural" individuals (what may have been called DID or multiple in the past) and are submitting it for publication. There was a general consensus that mental health and medical providers need more training on this topic so they can provide affirming care.

January 5, 2022

Comment

[redacted]

Really interested in your findings. Would love to read your report when it is available!

January 14, 2022

[redacted]

As soon as the interview study is published, I will try to let people know where to find it.

February 9, 2022

[redacted]

I'd like to see the results of [redacted] interview study as well. And I imagine there aren't many therapists experienced with both DID and gender diversity issues. I've only seen one client who clearly had both, but I expect it's likely more common than we realize.

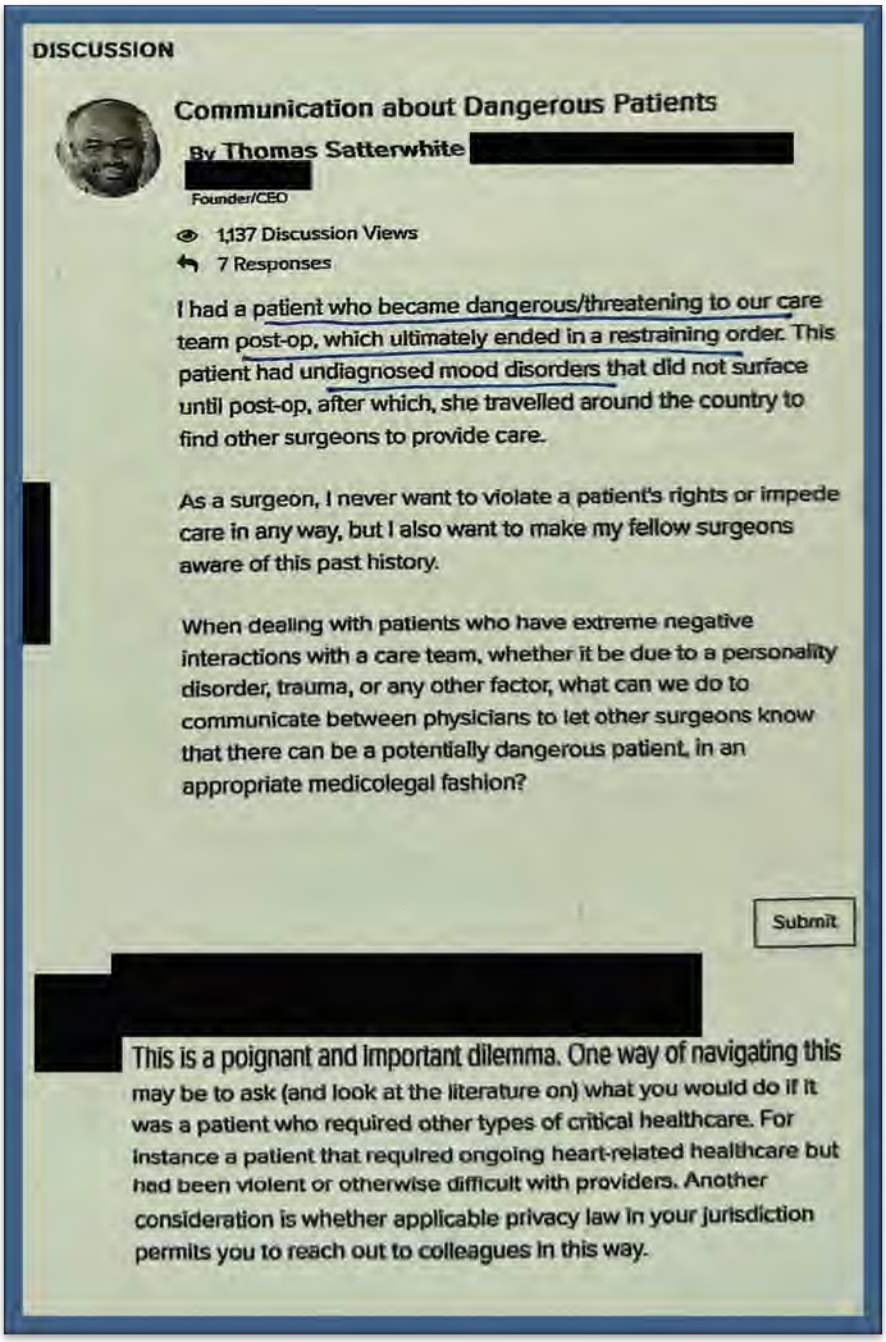
January 26, 2022

Comment

[redacted]

I am a post-op trans woman - college educated and in sciences and research... according to TRANSPulse the incidence of cPTSD in trans persons is at 61.8%. I did not know. I am a product of CAMH and conversion therapy as practiced there, by [redacted] et al. I can personally attest that I at the time believed the theory behind the treatment that I am an individual suffering from pathology characterized by the belief that I was a girl despite the fact that I had a penis. Eventually I went back to university and studied psychology for myself where I discovered that I was not suffering from any actual pathology related to being trans. I have also suffered the LGBTQ purge in the Canadian Military and my current diagnoses stand at cPTSD, ADHD, anxiety, and depression. I would add there that I believe most of the physicians on this forum are cisgender and, in my opinion, often do not demonstrate complete sensitivity to the needs of transgender patients. This is not intended as a put down. Someone who is "not", simply cannot do the following. My professor in psyche

c) WPATH members discuss a patient with undiagnosed mood disorders who threatened medical staff



DISCUSSION

Communication about Dangerous Patients

By Thomas Satterwhite [redacted]

[redacted]
Founder/CEO

1,137 Discussion Views
7 Responses

I had a patient who became dangerous/threatening to our care team post-op, which ultimately ended in a restraining order. This patient had undiagnosed mood disorders that did not surface until post-op, after which, she travelled around the country to find other surgeons to provide care.

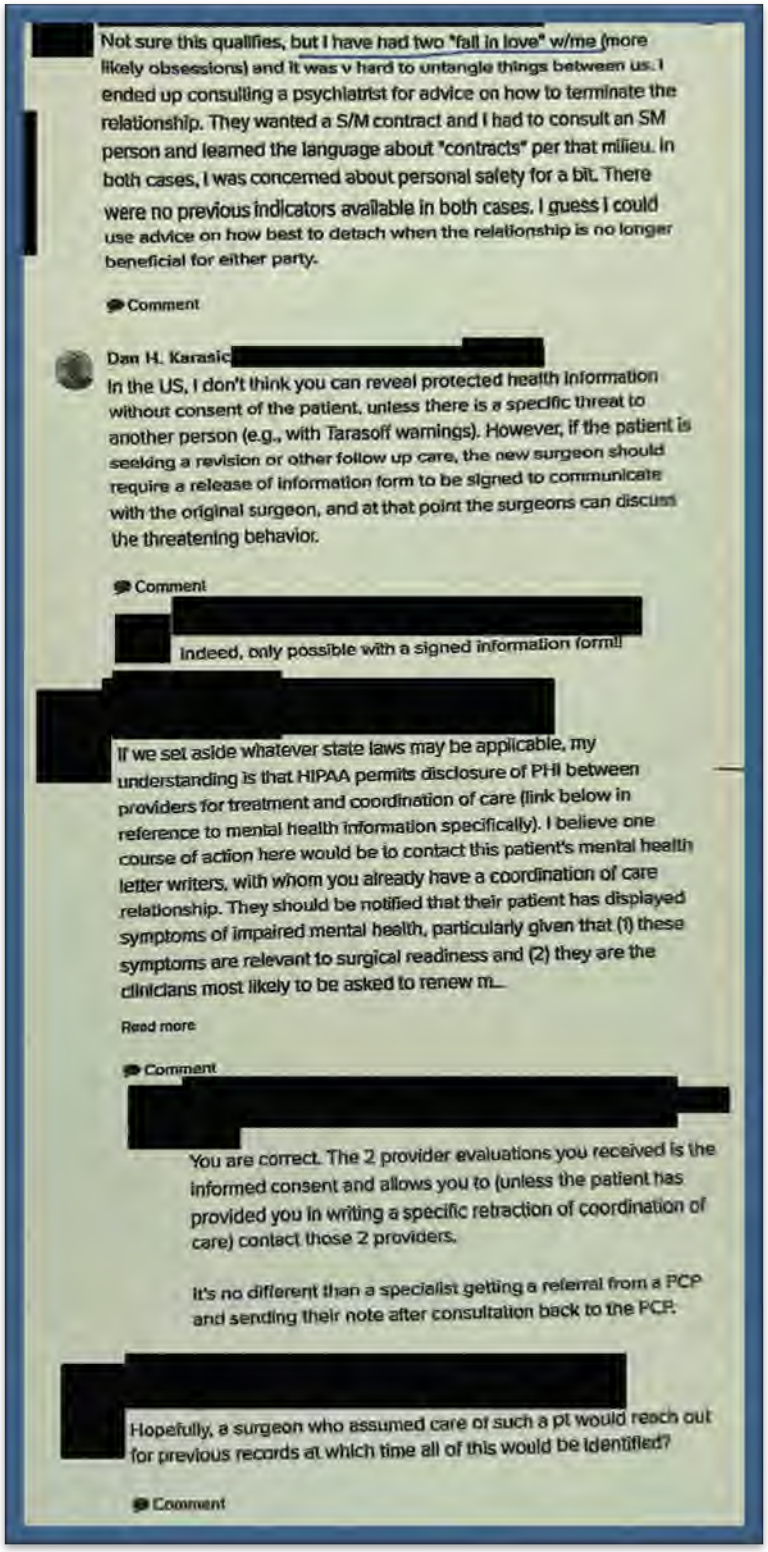
As a surgeon, I never want to violate a patient's rights or impede care in any way, but I also want to make my fellow surgeons aware of this past history.

When dealing with patients who have extreme negative interactions with a care team, whether it be due to a personality disorder, trauma, or any other factor, what can we do to communicate between physicians to let other surgeons know that there can be a potentially dangerous patient, in an appropriate medicolegal fashion?

Submit

[redacted]

This is a poignant and important dilemma. One way of navigating this may be to ask (and look at the literature on) what you would do if it was a patient who required other types of critical healthcare. For instance a patient that required ongoing heart-related healthcare but had been violent or otherwise difficult with providers. Another consideration is whether applicable privacy law in your jurisdiction permits you to reach out to colleagues in this way.



[redacted] Not sure this qualifies, but I have had two "fall in love" w/me (more likely obsessions) and it was v hard to untangle things between us. I ended up consulting a psychiatrist for advice on how to terminate the relationship. They wanted a S/M contract and I had to consult an SM person and learned the language about "contracts" per that milieu. In both cases, I was concerned about personal safety for a bit. There were no previous indicators available in both cases. I guess I could use advice on how best to detach when the relationship is no longer beneficial for either party.

Comment

Dan H. Karasic [redacted]
In the US, I don't think you can reveal protected health information without consent of the patient, unless there is a specific threat to another person (e.g., with Tarasoff warnings). However, if the patient is seeking a revision or other follow up care, the new surgeon should require a release of information form to be signed to communicate with the original surgeon, and at that point the surgeons can discuss the threatening behavior.

Comment

[redacted] Indeed, only possible with a signed information form!!

[redacted] If we set aside whatever state laws may be applicable, my understanding is that HIPAA permits disclosure of PHI between providers for treatment and coordination of care (link below in reference to mental health information specifically). I believe one course of action here would be to contact this patient's mental health letter writers, with whom you already have a coordination of care relationship. They should be notified that their patient has displayed symptoms of impaired mental health, particularly given that (1) these symptoms are relevant to surgical readiness and (2) they are the clinicians most likely to be asked to renew m...

Read more

Comment

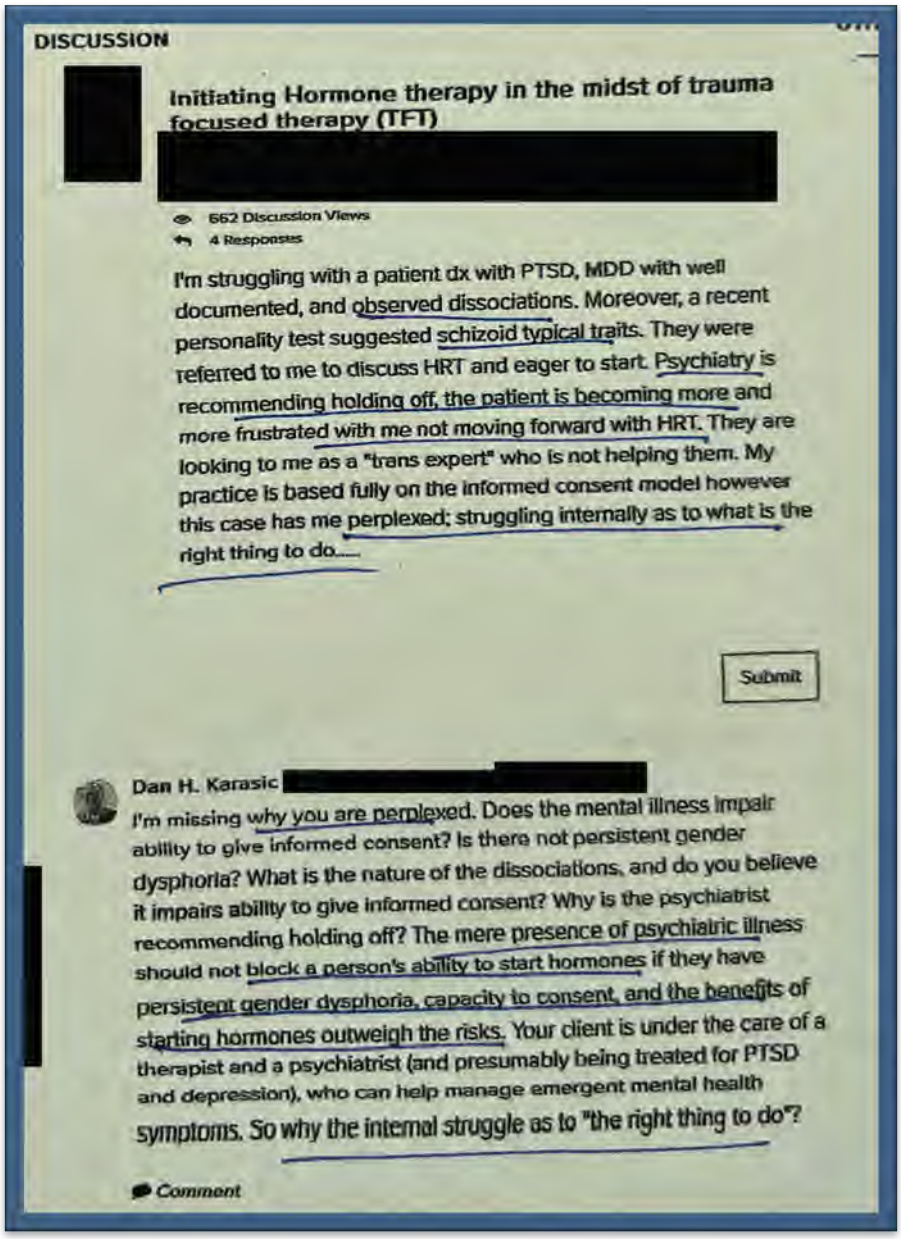
[redacted] You are correct. The 2 provider evaluations you received is the informed consent and allows you to (unless the patient has provided you in writing a specific retraction of coordination of care) contact those 2 providers.

It's no different than a specialist getting a referral from a PCP and sending their note after consultation back to the PCP.

[redacted] Hopefully, a surgeon who assumed care of such a pt would reach out for previous records at which time all of this would be identified?

Comment

d) WPATH members discuss initiating hormone therapy for a patient with trauma



DISCUSSION

[redacted]

Initiating Hormone therapy in the midst of trauma focused therapy (TFT)

[redacted]

662 Discussion Views
4 Responses

I'm struggling with a patient dx with PTSD, MDD with well documented, and observed dissociations. Moreover, a recent personality test suggested schizoid typical traits. They were referred to me to discuss HRT and eager to start. Psychiatry is recommending holding off, the patient is becoming more and more frustrated with me not moving forward with HRT. They are looking to me as a "trans expert" who is not helping them. My practice is based fully on the informed consent model however this case has me perplexed; struggling internally as to what is the right thing to do....

Submit

Dan H. Karasic [redacted]

I'm missing why you are perplexed. Does the mental illness impair ability to give informed consent? Is there not persistent gender dysphoria? What is the nature of the dissociations, and do you believe it impairs ability to give informed consent? Why is the psychiatrist recommending holding off? The mere presence of psychiatric illness should not block a person's ability to start hormones if they have persistent gender dysphoria, capacity to consent, and the benefits of starting hormones outweigh the risks. Your client is under the care of a therapist and a psychiatrist (and presumably being treated for PTSD and depression), who can help manage emergent mental health symptoms. So why the internal struggle as to "the right thing to do"?

Comment

[redacted]

Understood,

But I don't see how HT would interfere negatively with the symptoms your patient is experiencing, nor with trauma focused therapy. In fact, withholding HT can make the patient experience more distress and thus intensified symptoms. I've had patients/clients with diagnosed DID, MDD, bipolar, schizophrenia, etc., who do just fine on HT. Think of it this way - would you deny a cisgender patient with the same psychiatric dx hormone therapy if they were hypogonadic? This is harm reduction and so doing nothing is not a "neutral option."

Comment

[redacted]

I agree with other comments. Start slow, be careful. With severe PTSD with dissociations, if the client isn't making progress with current psych, switch. They might have better ideas on calming the glutamate receptor such as use of NAC, Lithium, memantine to slow down the triggering and dissociation. It is good this client has someone who cares, which is the most important thing they need.

Comment

[redacted]

I agree with previous comments, and I strongly recommend reading this article on the matter: Kinnon R. MacKinnon, Daniel Grace, Stella L. Ng, Suzanne R. Sicchia & Lori E. Ross (2020): "I don't think they thought I was ready": How pre-transition assessments create care inequities for trans people with complex mental health in Canada, International Journal of Mental Health, DOI: 10.1080/00207411.2019.1711328 (Abstract (https://www.tandfonline.com/doi/abs/10.1080/00207411.2019.1711328))

e) A WPATH member questions the surgical readiness of patients displaying serious mental illness

CUSSION

[redacted]

Serious Mental Illness and Readiness for Medical/Surgical Transition

[redacted]

4,670 Discussion Views
5 Responses

I have several trans clients with serious mental illness. For example, bipolar disorder and autism or schizoaffective disorder. Even though these clients have a well-established trans gender identity, their likely stability post initiation of HRT or surgery is difficult to predict. What criteria do other people use to determine whether or not they can write a letter supporting surgical transition for this population? In particular, given the extensive recovery period and postnatal care required for vaginoplasty, have other clinicians found that their clients with serious mental illness can follow post-surgical dilation protocols?

Submit

[redacted]

Thank you for posting this [redacted]. I have a number of cases of folks with significant mental health issues (with various markers of "stability") including Autism Spectrum, PTSD/C-PTSD, Psychosis. I think part of our role is in treatment planning toward mental health sx stability pre and post medical interventions including surgery. In my mind this necessitates interdisciplinary, collaborative care and planning.

To be frank, I have a few who are (or will likely be) in a sort of holding pattern because of the lack of mental health and other support resources that I am recommending.

Does anyone know of literature on medical AND psychological outcomes for these/similar issues?

[redacted]
Hello,

It depends on many factors that equally affect those without any psychiatric concerns - do they have a support system with actual humans to help them on a daily basis, do they have a safe place to recover, and do they understand instructions such as dilate, wash, monitor - or do they have one or two persons who can help? Also - autism is neurodivergence on a spectrum with variability in function but not classified as "serious mental illness." In addition, as gender affirmative practitioners, we always consider harm reduction as our primary lens - in other words, what will happen to these patients if they do NOT undergo their affirmative treatment, which is also a medical necessity?

In my practice, I have found that those with diagnosed psychiatric concerns, e.g., schizophrenia controlled by medication, usually have a prior support system of sorts and can get help. But I have also intervened on behalf of people who have been diagnosed with major depressive disorder, cPTSD, homeless and got at least an orchiectomy – which made a huge difference in their lives and put them on the road to emotional recovery and enabled them to seek assistance (and yes, they were successful). To me, the letter is an assessment of mental capacity to provide informed consent; if such capacity clearly does not exist, the patient needs to be informed and a new appointment for changes in psychiatric meds or at least one discussion with their treating psychiatrist need to happen. I am personally not invested in the "well controlled" criterion phrase unless absolutely necessary, and I believe it's disappearing in the SOC v 8 version. Meanwhile, in the last 15 years I had to regrettably decline writing only one letter, mainly b/c the person evaluated was in active psychosis and hallucinated during the assessment session. Other than that - nothing - everyone got their assessment letter, insurance approval, and are living [presumably] happily ever after.

Comment

[redacted]
Correct me if I'm wrong, but my impression is that the SOC7 recommend a letter stipulates: "While the SOC allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional." The letter of support is primarily to establish the primary/durable indication for surgery: gender dysphoria. And while this likely qualifies as an individualized approach, I'm concerned that denying necessary surgical care (even for the severely mentally ill) encroaches strongly on a patient's autonomy– presuming the patient in question has capacity to make their own medical decisions.

If you've already established persistent gender dysphoria to your own threshold of assessment, then the role of mental health here may simply be one of "optimization" rather than clearance. Any medical doctor would do the same prior to necessary operations by a surgeon as well. It would be great if every patient could be perfectly cleared prior to every surgical intervention, but at the end of the day it is a risk/benefit decision between you, the patient, the surgeon, and any other resources/family you can recruit to help promote the best outcome for the person(s) in question. If a patient can't follow a

dilation schedule, they may lose depth, but as long as they're capable of making that decision of sound mind while fully informed of the risks, then that may be all you can do. Please keep in mind that any surgeon should also be assessing for risks and ability for a person to recover optimally since they are more intimately familiar with post-operative complications, so you're not alone in your fear of complicated outcomes.

Comment

[redacted]

It is my understanding that for top surgery (roughly) that medical and mental health issues need to be "reasonably well-controlled" and for genital surgery, the issues need to be "well-controlled" according to SOC 7. However, there is not a clear line on what well-controlled versus reasonably well-controlled are. It's a clinical judgment from the best I can tell, and I use consultations with my WPATH Mentors (they are so awesome and have so many years of experience to bounce things off of) to determine this if I have concerns. I think an interdisciplinary team approach to helping someone get what they need. Also, I like to adopt the "and" framework rather than the "or" framework for this. Someone can have schizophrenia and be ready for surgery...it is just a matter of what you see concerns are, communicating those concerns, and working in a patient-centered way with a team (ideally) to help them get to close to the goals as possible for surgery readiness. I also believe that collaboration with the surgeon(s) is ideal because their staff can help support with aftercare realities and a plan for pre and post-op care. I also am reminded that it has been pointed out to me that withholding care (letters of referral, etc.) is more problematic when compared to the provider's feelings about the potential for stability after surgery and/or difficulty with following through with aftercare instructions. things like exploring minimal depth vaginoplasty are also an option. I say all of this in the most client-centered and supportive way to help patients get what they need for care. Thank you!

Comment

[redacted]

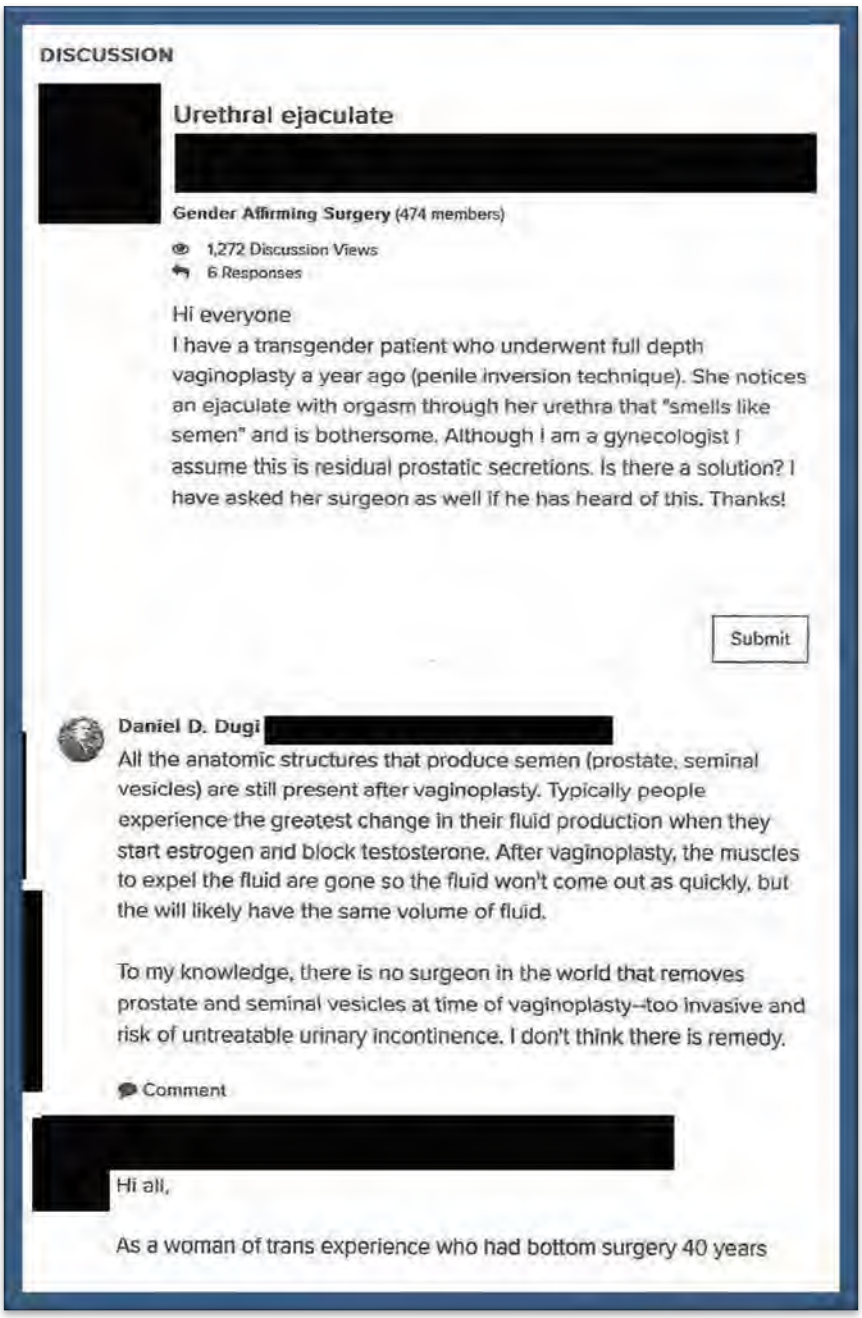
My feeling is that, in general, mental illness is not a reason to withhold needed medical care from clients. Doing so just increases the day-to-day level of distress these clients are called upon to manage, in the form of gender dysphoria. In contrast, receiving gender-affirming care can often significantly stabilize client's mental health.

My assumption is that you're asking this question because you're taking seriously your responsibility to care for and guide your clients. Unfortunately, though, I think the broader context in which this question even exists is one in which we, as mental health professionals, have been put inappropriately into gatekeeper roles. I'm not aware of any other medical procedure that requires the approval of a therapist. I think requiring this for trans clients is another way that our healthcare system positions gender-affirming care as "optional" or only for those who can prove they deserve it.

Even if your clients might struggle with some of the needs and challenges that come with surgeries, for example, I believe that they will likely be better off in the long run. More importantly, I also believe that they have the right to access that care if they choose.

3) SURGICAL OR HEALTHCARE COMPLICATIONS

a) A WPATH member reports their concerns regarding their patient's urethral ejaculate



DISCUSSION

[redacted]

Urethral ejaculate

[redacted]

Gender Affirming Surgery (474 members)

1,272 Discussion Views

6 Responses

Hi everyone

I have a transgender patient who underwent full depth vaginoplasty a year ago (penile inversion technique). She notices an ejaculate with orgasm through her urethra that "smells like semen" and is bothersome. Although I am a gynecologist I assume this is residual prostatic secretions. Is there a solution? I have asked her surgeon as well if he has heard of this. Thanks!

Submit

Daniel D. Dugi [redacted]

All the anatomic structures that produce semen (prostate, seminal vesicles) are still present after vaginoplasty. Typically people experience the greatest change in their fluid production when they start estrogen and block testosterone. After vaginoplasty, the muscles to expel the fluid are gone so the fluid won't come out as quickly, but the will likely have the same volume of fluid.

To my knowledge, there is no surgeon in the world that removes prostate and seminal vesicles at time of vaginoplasty--too invasive and risk of untreatable urinary incontinence. I don't think there is remedy.

Comment

[redacted]

Hi all,

As a woman of trans experience who had bottom surgery 40 years

ago, I say enjoy the ride. In my experience, it's the ultimate physical sign of orgasm...what's not to like?

Comment

[redacted]

Hello [redacted]

With classic vaginoplasty, the prostate and the seminal vesicle remain in the body. Therefore, it is quite possible that during orgasm, seminal secretion, of course without sperm (because the testicles are removed), runs out of the urethra.

Comment

[redacted]

I suggest you consult your surgeon!
Patient may need revision Bbecause muscle of ejaculation did not cut it off.
Maybe testes still, and when patient is feeling they want to have sexual activity her canal will narrow, I guess!
Please return to surgeon and have physical examination.

Comment

[redacted]

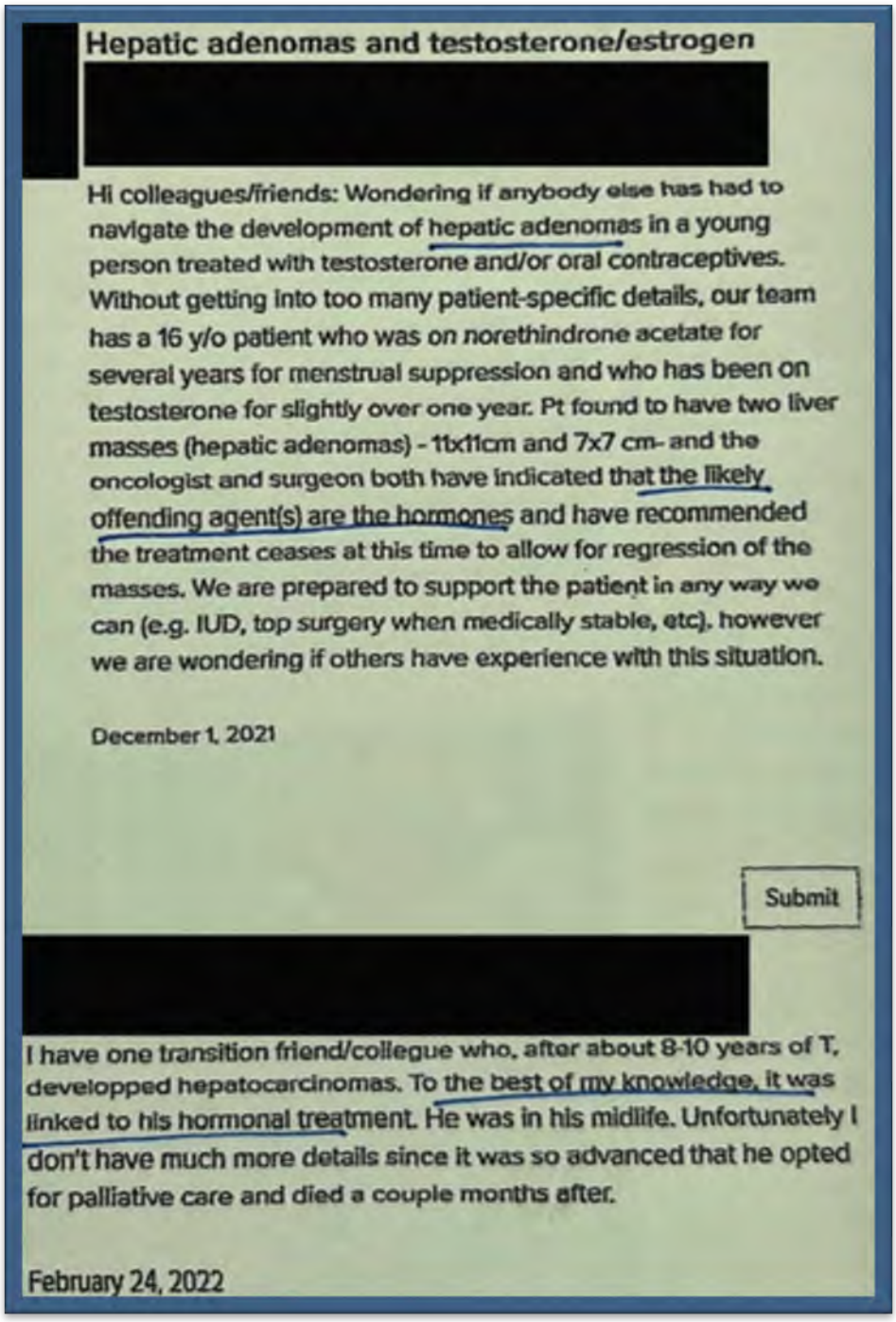
It's true that the secretion from the prostate is still functioning after the surgery and some cases the transex hormone and the removal of testicles can lower the function of the prostate but in some cases have to wait for that result and some cases will bother the sexual activities. For the cases that have much water I have to inform the patients and accept it or use the cleaning gel to reduce the smell. Wait for other surgeons discussion.

Comment

[redacted]

Hello
Yes it is prostatic fluid. the only way to eliminate it would be by a prostatic resection with all the posible consequences that it comes with it. It is important to advice patients abput this before surgery, so they know it could happen

b) A WPATH member discusses the development of hepatic adenomas on a client taking testosterone/estrogen



Hepatic adenomas and testosterone/estrogen

[redacted]

Hi colleagues/friends: Wondering if anybody else has had to navigate the development of hepatic adenomas in a young person treated with testosterone and/or oral contraceptives. Without getting into too many patient-specific details, our team has a 16 y/o patient who was on norethindrone acetate for several years for menstrual suppression and who has been on testosterone for slightly over one year. Pt found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7 cm- and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones and have recommended the treatment ceases at this time to allow for regression of the masses. We are prepared to support the patient in any way we can (e.g. IUD, top surgery when medically stable, etc). however we are wondering if others have experience with this situation.

December 1, 2021

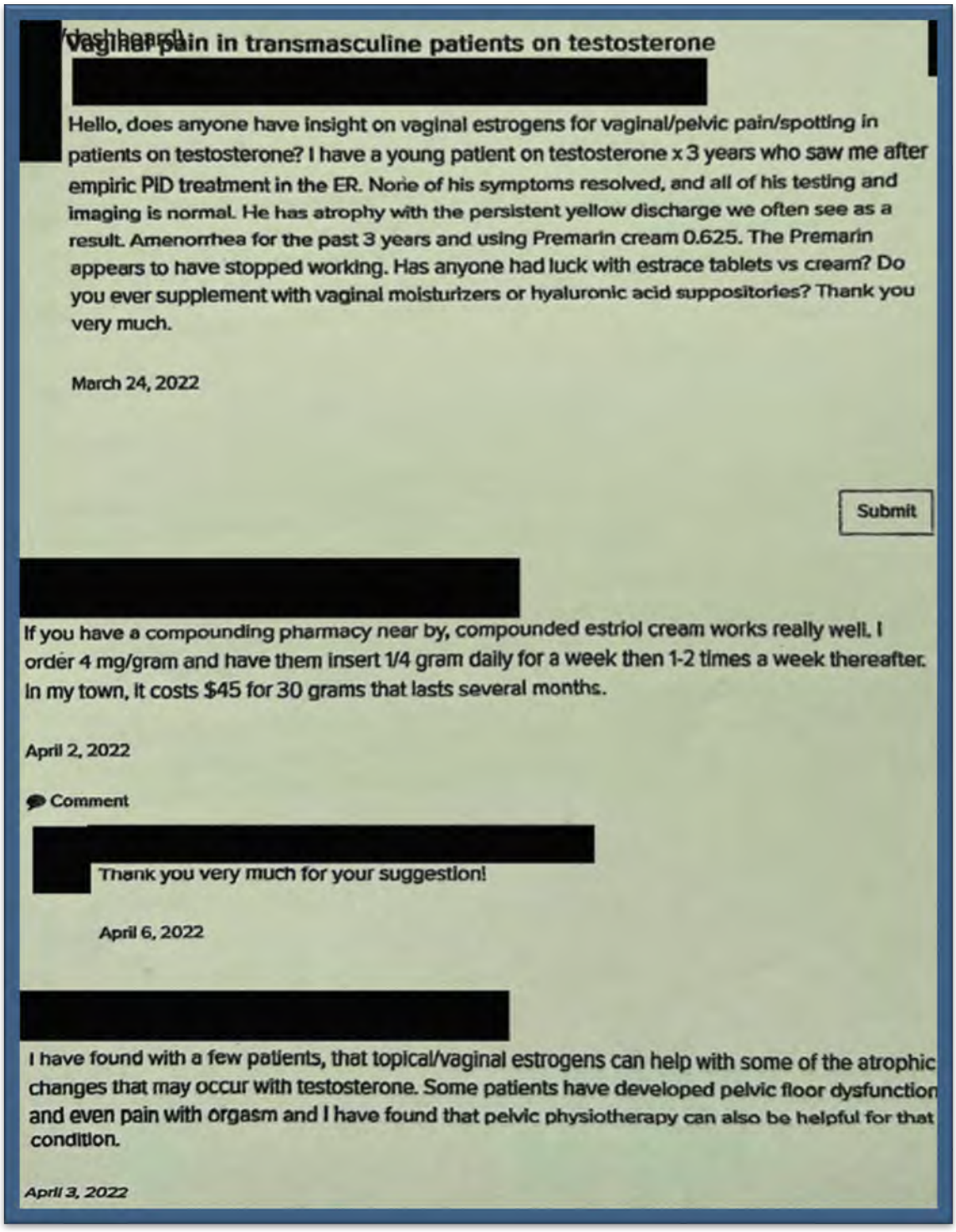
Submit

[redacted]

I have one transition friend/collegue who, after about 8-10 years of T, developped hepatocarcinomas. To the best of my knowledge, it was linked to his hormonal treatment. He was in his midlife. Unfortunately I don't have much more details since it was so advanced that he opted for palliative care and died a couple months after.

February 24, 2022

c) A WPATH member reports their young patient is experiencing vaginal pain on testosterone



(dashboard)
Vaginal pain in transmasculine patients on testosterone

[redacted]

Hello, does anyone have insight on vaginal estrogens for vaginal/pelvic pain/spotting in patients on testosterone? I have a young patient on testosterone x 3 years who saw me after empiric PID treatment in the ER. None of his symptoms resolved, and all of his testing and imaging is normal. He has atrophy with the persistent yellow discharge we often see as a result. Amenorrhea for the past 3 years and using Premarin cream 0.625. The Premarin appears to have stopped working. Has anyone had luck with estrace tablets vs cream? Do you ever supplement with vaginal moisturizers or hyaluronic acid suppositories? Thank you very much.

March 24, 2022

Submit

[redacted]

If you have a compounding pharmacy near by, compounded estriol cream works really well. I order 4 mg/gram and have them insert 1/4 gram daily for a week then 1-2 times a week thereafter. In my town, it costs $45 for 30 grams that lasts several months.

April 2, 2022

Comment

[redacted]

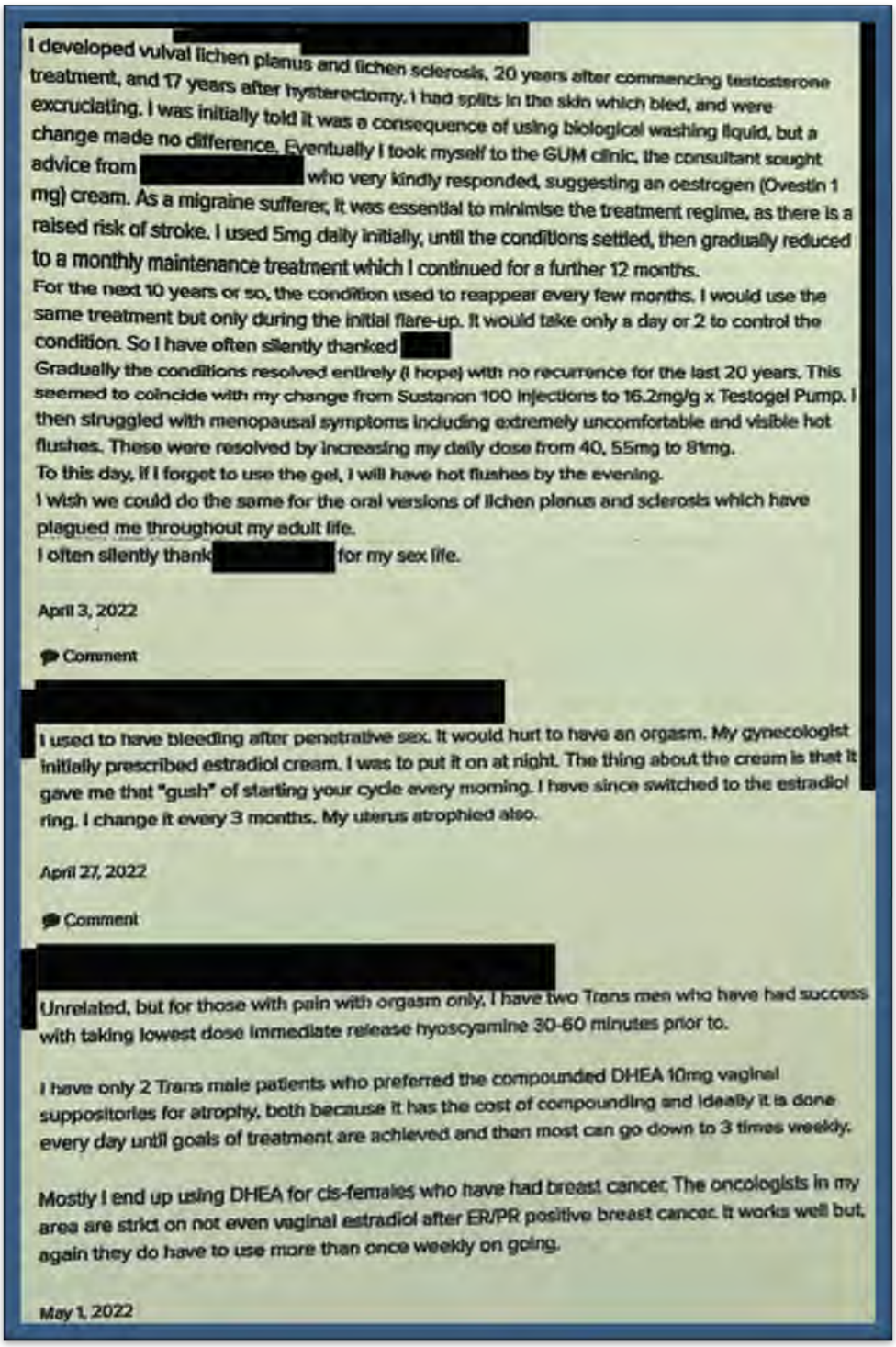
Thank you very much for your suggestion!

April 6, 2022

[redacted]

I have found with a few patients, that topical/vaginal estrogens can help with some of the atrophic changes that may occur with testosterone. Some patients have developed pelvic floor dysfunction and even pain with orgasm and I have found that pelvic physiotherapy can also be helpful for that condition.

April 3, 2022



I developed vulval lichen planus and lichen sclerosis, 20 years after commencing testosterone treatment, and 17 years after hysterectomy. I had splits in the skin which bled, and were excruciating. I was initially told it was a consequence of using biological washing liquid, but a change made no difference. Eventually I took myself to the GUM clinic, the consultant sought advice from [redacted] who very kindly responded, suggesting an oestrogen (Ovestin 1 mg) cream. As a migraine sufferer, it was essential to minimise the treatment regime, as there is a raised risk of stroke. I used 5mg daily initially, until the conditions settled, then gradually reduced to a monthly maintenance treatment which I continued for a further 12 months.
For the next 10 years or so, the condition used to reappear every few months. I would use the same treatment but only during the initial flare-up. It would take only a day or 2 to control the condition. So I have often silently thanked [redacted]
Gradually the conditions resolved entirely (I hope) with no recurrence for the last 20 years. This seemed to coincide with my change from Sustanon 100 injections to 16.2mg/g x Testogel Pump. I then struggled with menopausal symptoms including extremely uncomfortable and visible hot flushes. These were resolved by increasing my daily dose from 40, 55mg to 81mg.
To this day, if I forget to use the gel, I will have hot flushes by the evening.
I wish we could do the same for the oral versions of lichen planus and sclerosis which have plagued me throughout my adult life.
I often silently thank [redacted] for my sex life.

April 3, 2022

Comment

[redacted]

I used to have bleeding after penetrative sex. It would hurt to have an orgasm. My gynecologist initially prescribed estradiol cream. I was to put it on at night. The thing about the cream is that it gave me that "gush" of starting your cycle every morning. I have since switched to the estradiol ring. I change it every 3 months. My uterus atrophied also.

April 27, 2022

Comment

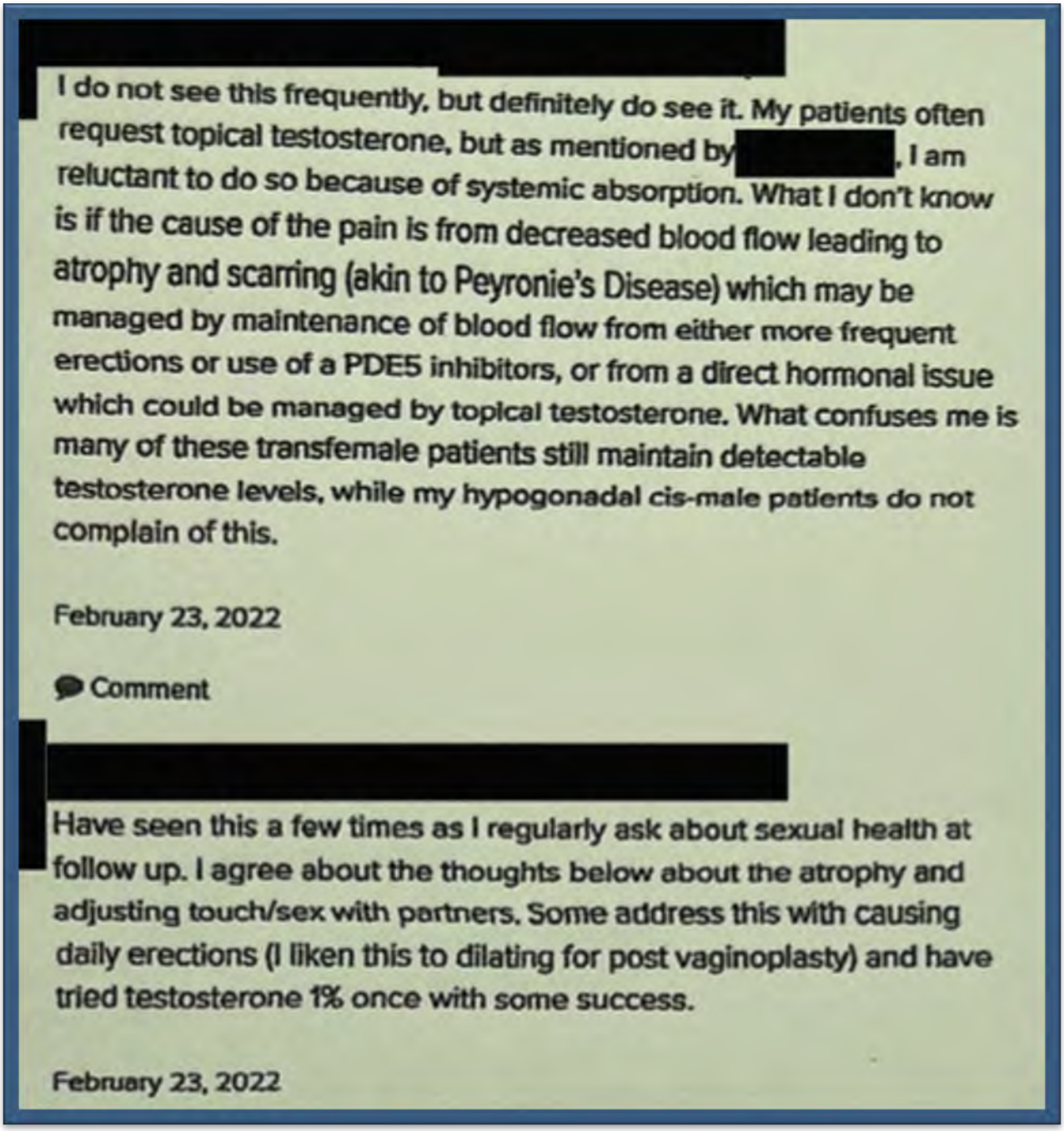
[redacted]

Unrelated, but for those with pain with orgasm only, I have two Trans men who have had success with taking lowest dose immediate release hyoscyamine 30-60 minutes prior to.

I have only 2 Trans male patients who preferred the compounded DHEA 10mg vaginal suppositories for atrophy, both because it has the cost of compounding and ideally it is done every day until goals of treatment are achieved and then most can go down to 3 times weekly.

Mostly I end up using DHEA for cis-females who have had breast cancer. The oncologists in my area are strict on not even vaginal estradiol after ER/PR positive breast cancer. It works well but, again they do have to use more than once weekly on going.

May 1, 2022



[redacted]

I do not see this frequently, but definitely do see it. My patients often request topical testosterone, but as mentioned by [redacted], I am reluctant to do so because of systemic absorption. What I don't know is if the cause of the pain is from decreased blood flow leading to atrophy and scarring (akin to Peyronie's Disease) which may be managed by maintenance of blood flow from either more frequent erections or use of a PDE5 inhibitors, or from a direct hormonal issue which could be managed by topical testosterone. What confuses me is many of these transfemale patients still maintain detectable testosterone levels, while my hypogonadal cis-male patients do not complain of this.

February 23, 2022

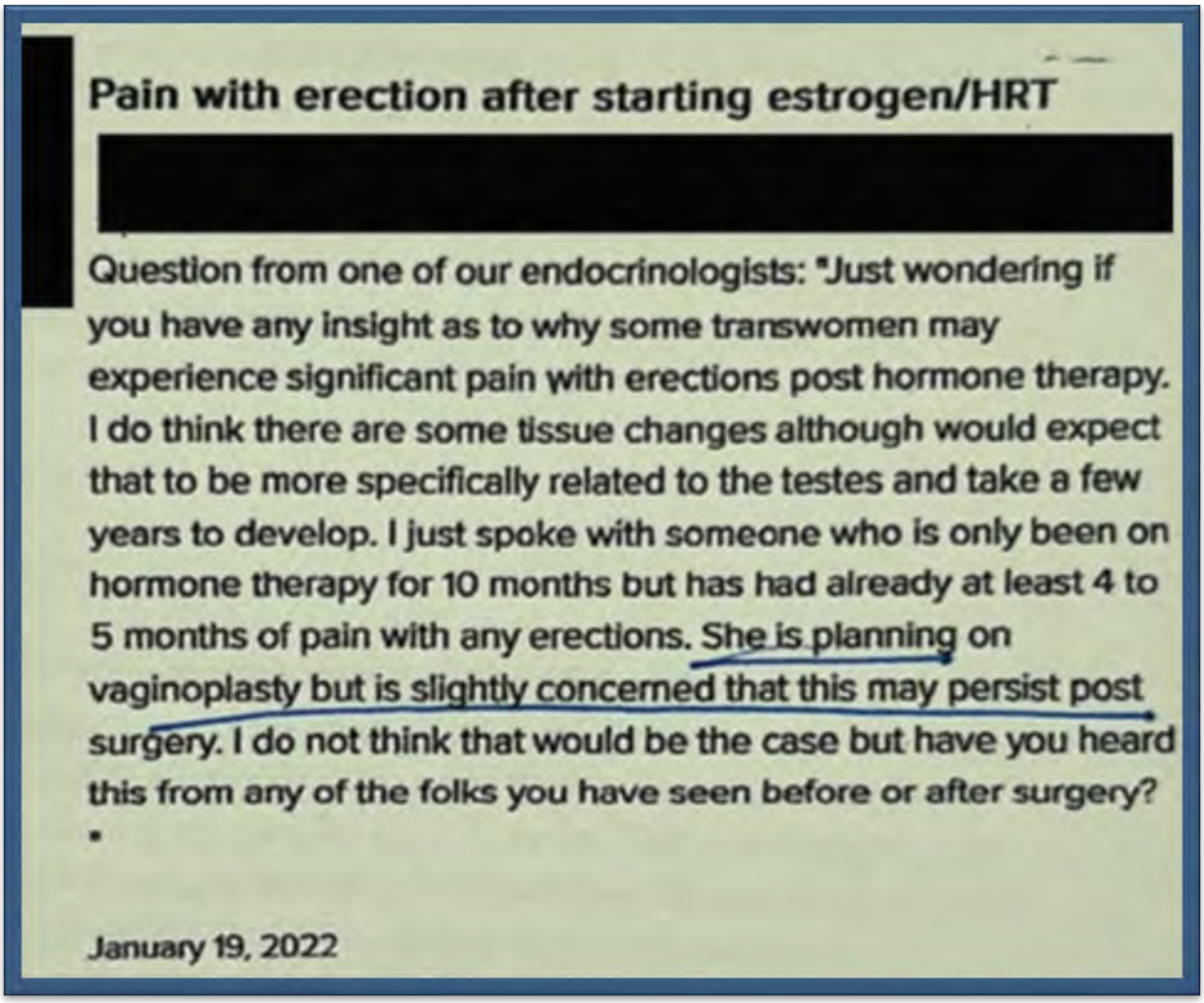
Comment

[redacted]

Have seen this a few times as I regularly ask about sexual health at follow up. I agree about the thoughts below about the atrophy and adjusting touch/sex with partners. Some address this with causing daily erections (I liken this to dilating for post vaginoplasty) and have tried testosterone 1% once with some success.

February 23, 2022

d) WPATH members discuss erection pain in a patient on estrogen



Pain with erection after starting estrogen/HRT

[redacted]

Question from one of our endocrinologists: "Just wondering if you have any insight as to why some transwomen may experience significant pain with erections post hormone therapy. I do think there are some tissue changes although would expect that to be more specifically related to the testes and take a few years to develop. I just spoke with someone who is only been on hormone therapy for 10 months but has had already at least 4 to 5 months of pain with any erections. She is planning on vaginoplasty but is slightly concerned that this may persist post surgery. I do not think that would be the case but have you heard this from any of the folks you have seen before or after surgery?

January 19, 2022

[redacted]

Responding first as a post-op trans woman myself. I certainly had pain with erections when I was taking estradiol before my surgery. Erections were pretty uncommon during this period, and I tended to try to avoid having them because of this...even when they were not painful, they were physically uncomfortable and not pleasurable (not because of dysphoria, the issue was physical sensation). Since vaginoplasty (I'm four years out at this point) I've had no problem at all. Arousal is positive and without pain.

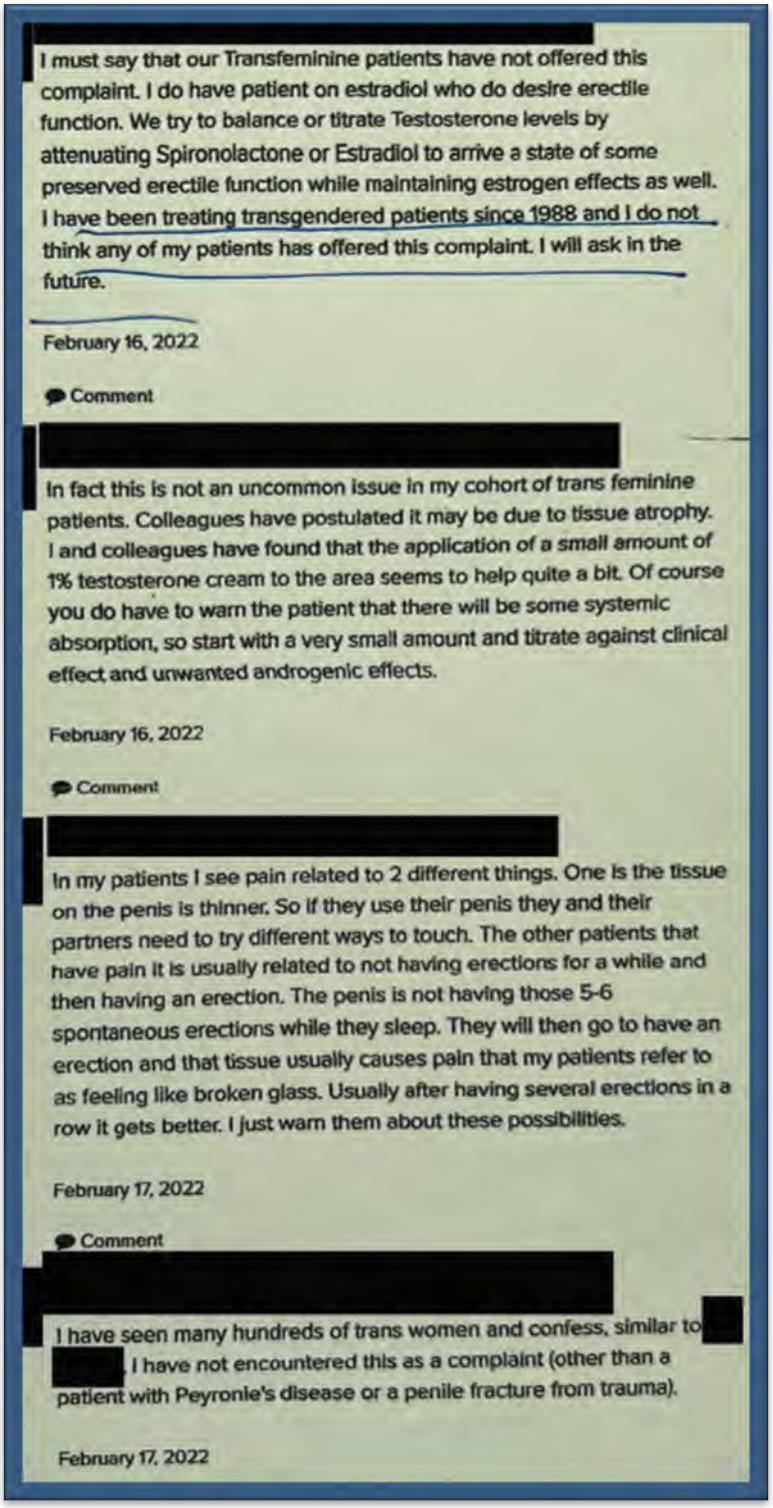
Speaking as a clinician, a portion of my trans feminine clients on HRT describe similar discomfort and/or pain. But no one I've ever talked to who is post-op has ever described this pain continuing.

My guess (and it's just a guess, I'm not a medical person) would be that the pain is related to erectile tissue in penis and that the removal

[redacted]

of that tissue during vaginoplasty addresses the problem.

January 23, 2022



I must say that our Transfeminine patients have not offered this complaint. I do have patient on estradiol who do desire erectile function. We try to balance or titrate Testosterone levels by attenuating Spironolactone or Estradiol to arrive a state of some preserved erectile function while maintaining estrogen effects as well. I have been treating transgendered patients since 1988 and I do not think any of my patients has offered this complaint. I will ask in the future.

February 16, 2022

Comment

[redacted]

In fact this is not an uncommon issue in my cohort of trans feminine patients. Colleagues have postulated it may be due to tissue atrophy. I and colleagues have found that the application of a small amount of 1% testosterone cream to the area seems to help quite a bit. Of course you do have to warn the patient that there will be some systemic absorption, so start with a very small amount and titrate against clinical effect and unwanted androgenic effects.

February 16, 2022

Comment

[redacted]

In my patients I see pain related to 2 different things. One is the tissue on the penis is thinner. So if they use their penis they and their partners need to try different ways to touch. The other patients that have pain it is usually related to not having erections for a while and then having an erection. The penis is not having those 5-6 spontaneous erections while they sleep. They will then go to have an erection and that tissue usually causes pain that my patients refer to as feeling like broken glass. Usually after having several erections in a row it gets better. I just warn them about these possibilities.

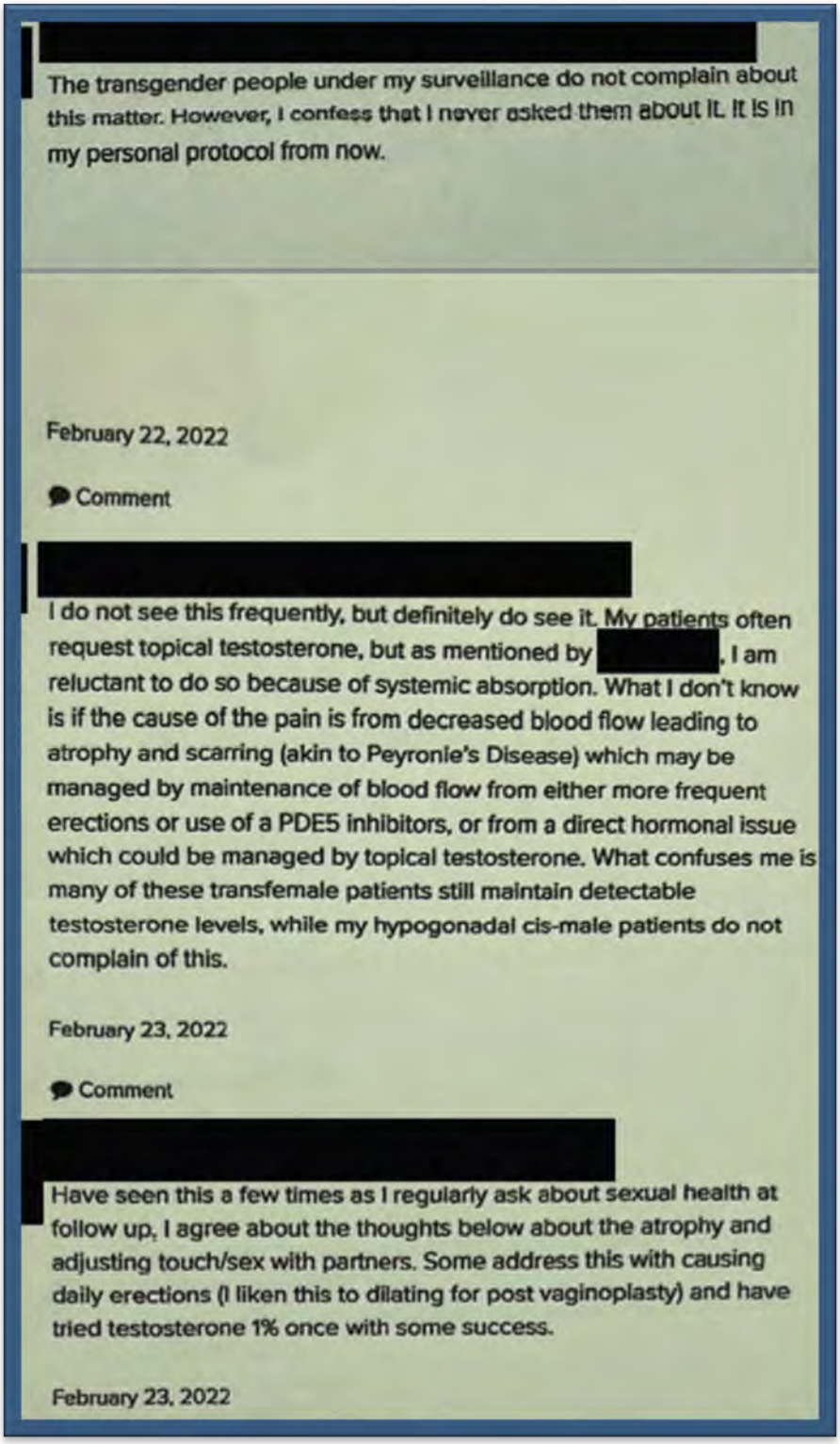
February 17, 2022

Comment

[redacted]

I have seen many hundreds of trans women and confess, similar to [redacted], I have not encountered this as a complaint (other than a patient with Peyronie's disease or a penile fracture from trauma).

February 17, 2022



[redacted]

The transgender people under my surveillance do not complain about this matter. However, I confess that I never asked them about it. It is in my personal protocol from now.

February 22, 2022

Comment

[redacted]

I do not see this frequently, but definitely do see it. My patients often request topical testosterone, but as mentioned by [redacted], I am reluctant to do so because of systemic absorption. What I don't know is if the cause of the pain is from decreased blood flow leading to atrophy and scarring (akin to Peyronie's Disease) which may be managed by maintenance of blood flow from either more frequent erections or use of a PDE5 inhibitors, or from a direct hormonal issue which could be managed by topical testosterone. What confuses me is many of these transfemale patients still maintain detectable testosterone levels, while my hypogonadal cis-male patients do not complain of this.

February 23, 2022

Comment

[redacted]

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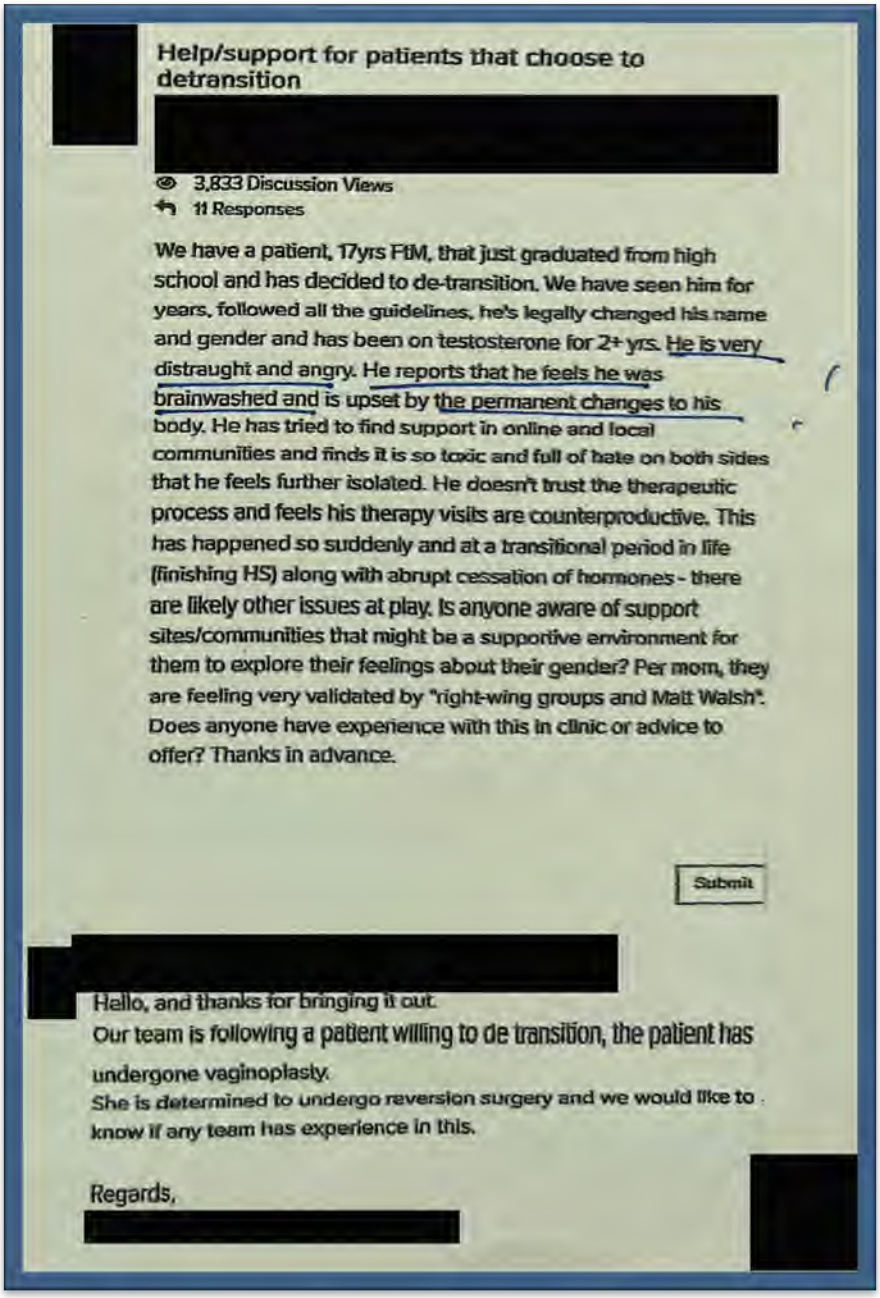
February 23, 2022

4) DETRANSITION CONCERNS

a) A WPATH member reports a patient who reports feeling "brainwashed" into transition



[redacted]

Help/support for patients that choose to detransition

[redacted]

3,833 Discussion Views
11 Responses

We have a patient, 17yrs FtM, that just graduated from high school and has decided to de-transition. We have seen him for years, followed all the guidelines, he's legally changed his name and gender and has been on testosterone for 2+ yrs. He is very distraught and angry. He reports that he feels he was brainwashed and is upset by the permanent changes to his body. He has tried to find support in online and local communities and finds it is so toxic and full of hate on both sides that he feels further isolated. He doesn't trust the therapeutic process and feels his therapy visits are counterproductive. This has happened so suddenly and at a transitional period in life (finishing HS) along with abrupt cessation of hormones - there are likely other issues at play. Is anyone aware of support sites/communities that might be a supportive environment for them to explore their feelings about their gender? Per mom, they are feeling very validated by "right-wing groups and Matt Walsh". Does anyone have experience with this in clinic or advice to offer? Thanks in advance.

Submit

[redacted]

Hello, and thanks for bringing it out.
Our team is following a patient willing to de transition, the patient has undergone vaginoplasty.
She is determined to undergo reversion surgery and we would like to know if any team has experience in this.

Regards,

[redacted]

[redacted]

I have a patient I am currently seeing in psychotherapy who is also in high school and, medically at least, has opted to pursue a similar path. However, throughout discussion on this change in course with me and with his parents (also AFAB), he is framing it quite differently. Instead of even using the term "detransition," he is simply describing this as a turn in his gender journey. He does not regret the course he has taken so far, and acknowledges that he was the driver in getting him to this point. He also has had a very supportive environment (home, school, friends, therapy) that has allowed him to appreciate his ability to have agency in his journey, but simply says that, for now at least, he needs to take a breath, pause the T, and see how that feels to him (e.g., will it feel gender-congruent).

I don't have any suggestions for any group, as this young person has found what he needs in his support network and has not expressed a need for any additional support group. I would, however, be very interested in any suggestions others may have for your person.

[redacted]

Comment

[redacted]

Maybe this young person needs to engage in anti-trans platforms as a place where she (pronoun?) can connect with her anger and feel less alone. The isolation you describe is pretty typical I think, which is why I am considering starting a support group (if there are enough people interested in joining). I worked with a 16 year old who detransitioned after being on T for more that 2 years and having top surgery. She was very angry and actively engaged in anti-trans online groups. In her case, as well as with the 20 year old I am currently working with, they believe their issue was really body dysmorphia rather than gender dysphoria, and both had presented as being very appropriate for hormones and surgery.

I don't know what to recommend for your patient, especially since it sounds like she believes therapy is counterproductive. If I end up starting a support group, however, I would be happy to talk with you about whether she might benefit from joining.

Thanks,

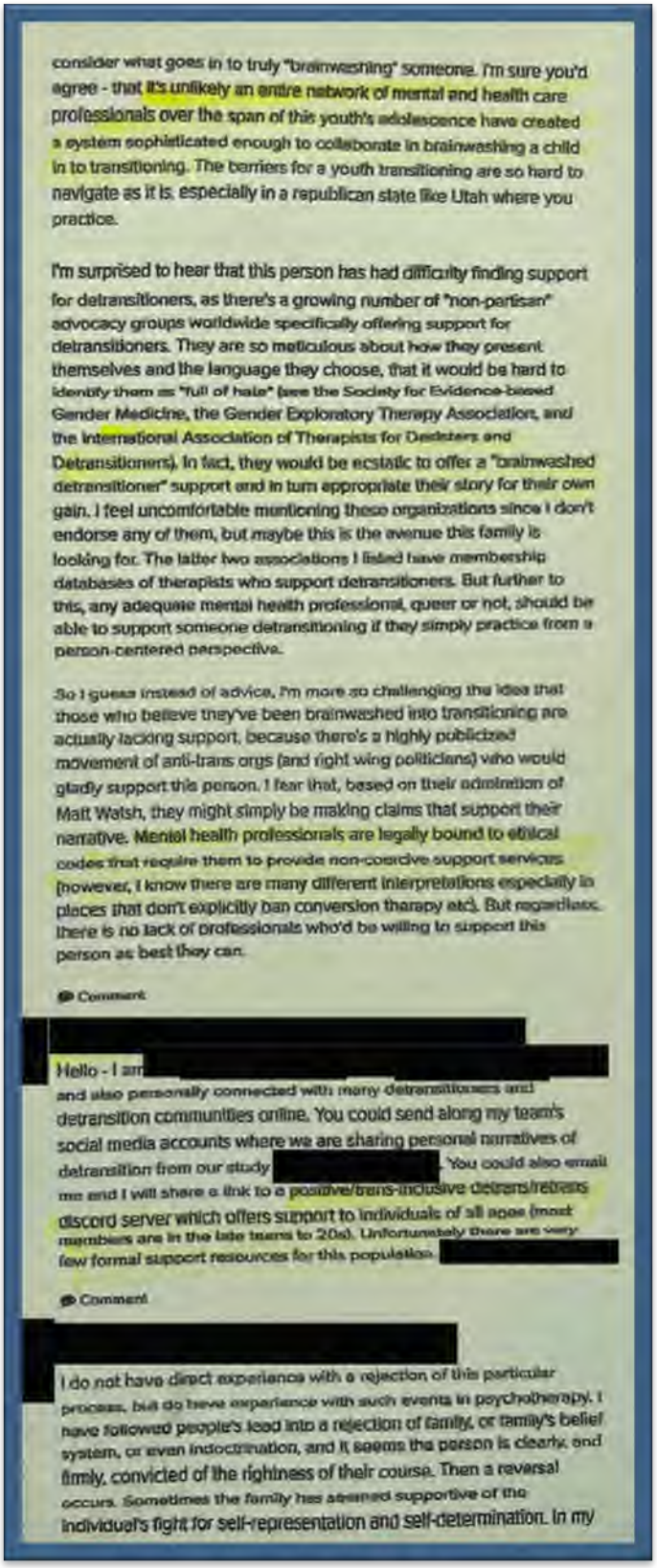
[redacted]

Comment

[redacted]

Hi there, I am not a medical professional - I'm just a queer therapist who specializes in working with queer people, including those who navigate the transition process and gender affirming procedures.

I want to offer this portion of my response as a disclaimer. While I've supported people who've detransitioned or just experience fluidity in their gender over time, I've never witnessed someone claiming to be brainwashed. In my experience, these stories have come from people who have an active agenda against the rights of trans people and a truly insignificant number of people who've detransitioned and believe that their singular experience is part of a greater conspiracy to "turn the kids gay/trans". I think in this case it's also important to critically



consider what goes in to truly "brainwashing" someone. I'm sure you'd agree - that it's unlikely an entire network of mental and health care professionals over the span of this youth's adolescence have created a system sophisticated enough to collaborate in brainwashing a child in to transitioning. The barriers for a youth transitioning are so hard to navigate as it is, especially in a republican state like Utah where you practice.

I'm surprised to hear that this person has had difficulty finding support for detransitioners, as there's a growing number of "non-partisan" advocacy groups worldwide specifically offering support for detransitioners. They are so meticulous about how they present themselves and the language they choose, that it would be hard to identify them as "full of hate" (see the Society for Evidence-based Gender Medicine, the Gender Exploratory Therapy Association, and the International Association of Therapists for Desisters and Detransitioners). In fact, they would be ecstatic to offer a "brainwashed detransitioner" support and in turn appropriate their story for their own gain. I feel uncomfortable mentioning these organizations since I don't endorse any of them, but maybe this is the avenue this family is looking for. The latter two associations I listed have membership databases of therapists who support detransitioners. But further to this, any adequate mental health professional, queer or not, should be able to support someone detransitioning if they simply practice from a person-centered perspective.

So I guess instead of advice, I'm more so challenging the idea that those who believe they've been brainwashed into transitioning are actually lacking support, because there's a highly publicized movement of anti-trans orgs (and right wing politicians) who would gladly support this person. I fear that, based on their admiration of Matt Walsh, they might simply be making claims that support their narrative. Mental health professionals are legally bound to ethical codes that require them to provide non-coercive support services (however, I know there are many different interpretations especially in places that don't explicitly ban conversion therapy etc). But regardless, there is no lack of professionals who'd be willing to support this person as best they can.

Comment

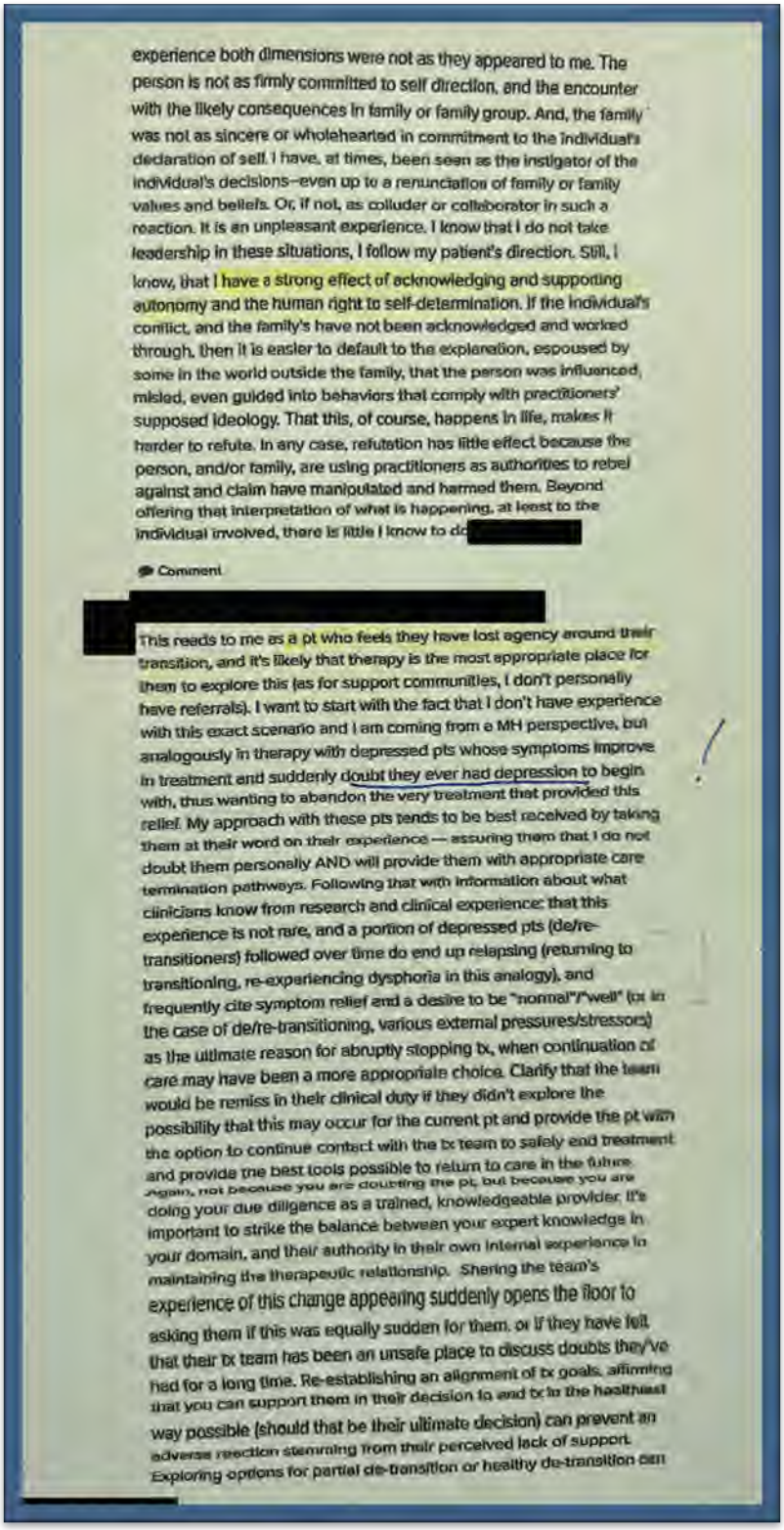
[redacted]

Hello - I am [redacted] and also personally connected with many detransitioners and detransition communities online. You could send along my team's social media accounts where we are sharing personal narratives of detransition from our study [redacted]. You could also email me and I will share a link to a positive/trans-inclusive detrans/retrans discord server which offers support to individuals of all ages (most members are in the late teens to 20s). Unfortunately there are very few formal support resources for this population. [redacted]

Comment

[redacted]

I do not have direct experience with a rejection of this particular process, but do have experience with such events in psychotherapy. I have followed people's lead into a rejection of family, or family's belief system, or even indoctrination, and it seems the person is clearly and firmly convicted of the rightness of their course. Then a reversal occurs. Sometimes the family has seemed supportive of the individual's fight for self-representation and self-determination. In my

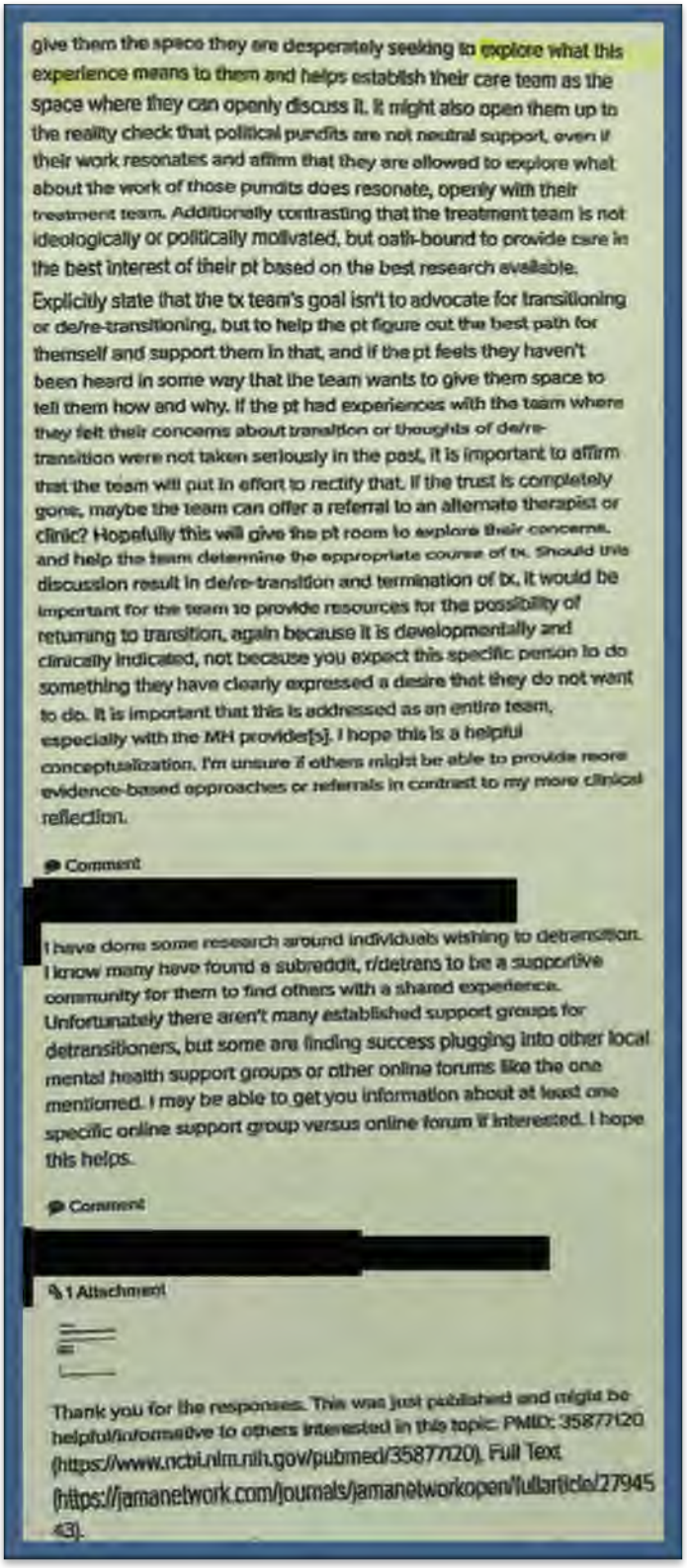


experience both dimensions were not as they appeared to me. The person is not as firmly committed to self direction, and the encounter with the likely consequences in family or family group. And, the family was not as sincere or wholehearted in commitment to the individual's declaration of self. I have, at times, been seen as the instigator of the individual's decisions–even up to a renunciation of family or family values and beliefs. Or, if not, as colluder or collaborator in such a reaction. It is an unpleasant experience. I know that I do not take leadership in these situations, I follow my patient's direction. Still, I know, that I have a strong effect of acknowledging and supporting autonomy and the human right to self-determination. If the individual's conflict, and the family's have not been acknowledged and worked through, then it is easier to default to the explanation, espoused by some in the world outside the family, that the person was influenced, misled, even guided into behaviors that comply with practitioners' supposed ideology. That this, of course, happens in life, makes it harder to refute. In any case, refutation has little effect because the person, and/or family, are using practitioners as authorities to rebel against and claim have manipulated and harmed them. Beyond offering that interpretation of what is happening, at least to the individual involved, there is little I know to do [redacted]

Comment

[redacted]

This reads to me as a pt who feels they have lost agency around their transition, and it's likely that therapy is the most appropriate place for them to explore this (as for support communities, I don't personally have referrals). I want to start with the fact that I don't have experience with this exact scenario and I am coming from a MH perspective, but analogously in therapy with depressed pts whose symptoms improve in treatment and suddenly doubt they ever had depression to begin with, thus wanting to abandon the very treatment that provided this relief. My approach with these pts tends to be best received by taking them at their word on their experience — assuring them that I do not doubt them personally AND will provide them with appropriate care termination pathways. Following that with information about what clinicians know from research and clinical experience: that this experience is not rare, and a portion of depressed pts (de/re-transitioners) followed over time do end up relapsing (returning to transitioning, re-experiencing dysphoria in this analogy), and frequently cite symptom relief and a desire to be "normal"/"well" (or in the case of de/re-transitioning, various external pressures/stressors) as the ultimate reason for abruptly stopping tx, when continuation of care may have been a more appropriate choice. Clarify that the team would be remiss in their clinical duty if they didn't explore the possibility that this may occur for the current pt and provide the pt with the option to continue contact with the tx team to safely end treatment and provide the best tools possible to return to care in the future. Again, not because you are doubting the pt, but because you are doing your due diligence as a trained, knowledgeable provider. It's important to strike the balance between your expert knowledge in your domain, and their authority in their own internal experience in maintaining the therapeutic relationship. Sharing the team's experience of this change appearing suddenly opens the floor to asking them if this was equally sudden for them, or if they have felt that their tx team has been an unsafe place to discuss doubts they've had for a long time. Re-establishing an alignment of tx goals, affirming that you can support them in their decision to end tx in the healthiest way possible (should that be their ultimate decision) can prevent an adverse reaction stemming from their perceived lack of support. Exploring options for partial de-transition or healthy de-transition can



give them the space they are desperately seeking to explore what this experience means to them and helps establish their care team as the space where they can openly discuss it. It might also open them up to the reality check that political pundits are not neutral support, even if their work resonates and affirm that they are allowed to explore what about the work of those pundits does resonate, openly with their treatment team. Additionally contrasting that the treatment team is not ideologically or politically motivated, but oath-bound to provide care in the best interest of their pt based on the best research available.

Explicitly state that the tx team's goal isn't to advocate for transitioning or de/re-transitioning, but to help the pt figure out the best path for themself and support them in that, and if the pt feels they haven't been heard in some way that the team wants to give them space to tell them how and why. If the pt had experiences with the team where they felt their concerns about transition or thoughts of de/re-transition were not taken seriously in the past, it is important to affirm that the team will put in effort to rectify that. If the trust is completely gone, maybe the team can offer a referral to an alternate therapist or clinic? Hopefully this will give the pt room to explore their concerns, and help the team determine the appropriate course of tx. Should this discussion result in de/re-transition and termination of tx, it would be important for the team to provide resources for the possibility of returning to transition, again because it is developmentally and clinically indicated, not because you expect this specific person to do something they have clearly expressed a desire that they do not want to do. It is important that this is addressed as an entire team, especially with the MH provider[s]. I hope this is a helpful conceptualization. I'm unsure if others might be able to provide more evidence-based approaches or referrals in contrast to my more clinical reflection.

Comment

[redacted]

I have done some research around individuals wishing to detransition. I know many have found a subreddit, r/detrans to be a supportive community for them to find others with a shared experience. Unfortunately there aren't many established support groups for detransitioners, but some are finding success plugging into other local mental health support groups or other online forums like the one mentioned. I may be able to get you information about at least one specific online support group versus online forum if interested. I hope this helps.

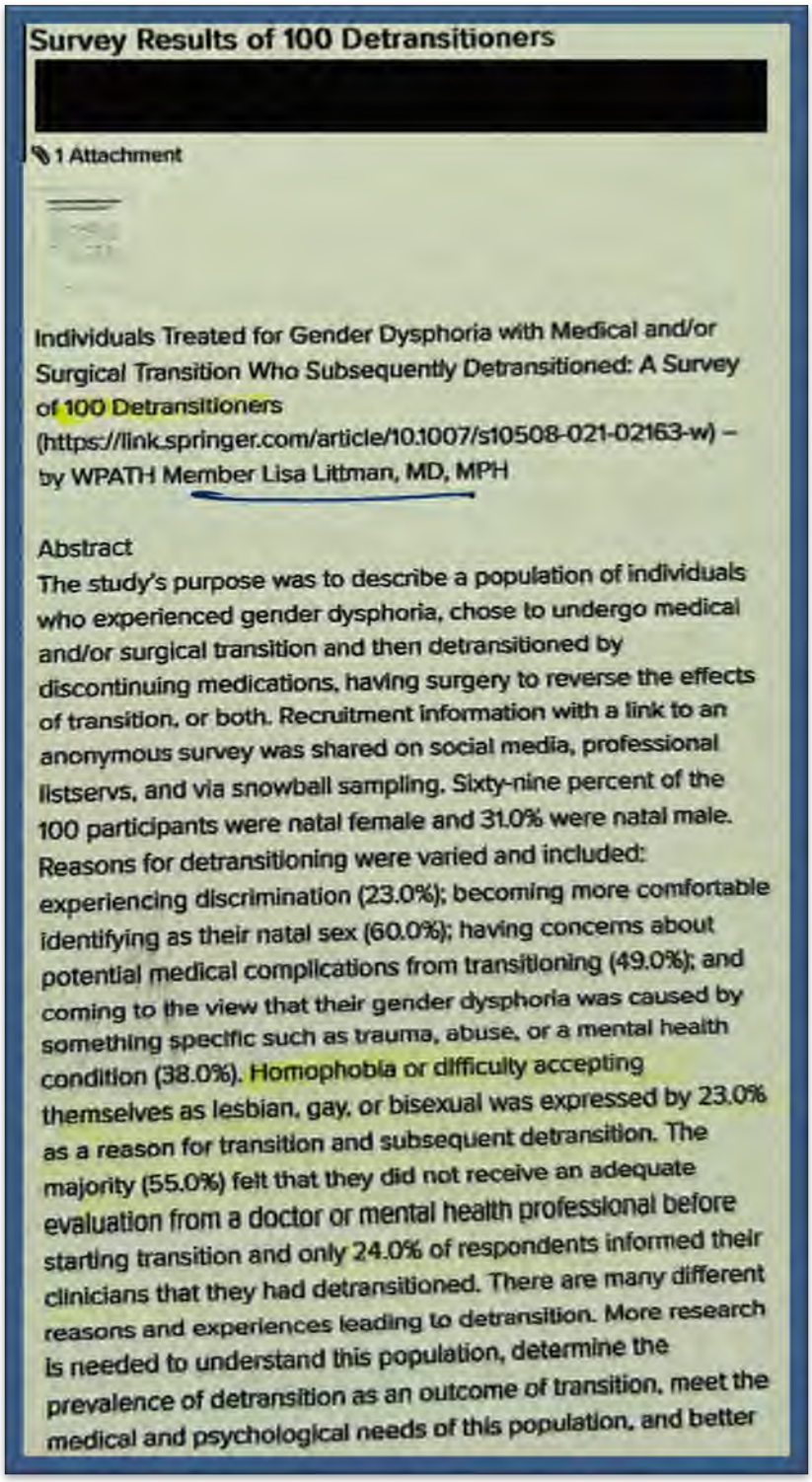
Comment

[redacted]

1 Attachment

Thank you for the responses. This was just published and might be helpful/informative to others interested in this topic: PMID: 35877120 (https://www.ncbi.nlm.nih.gov/pubmed/35877120). Full Text (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794543).

b) A WPATH member discusses another WPATH member's new study on detransitioners



Survey Results of 100 Detransitioners

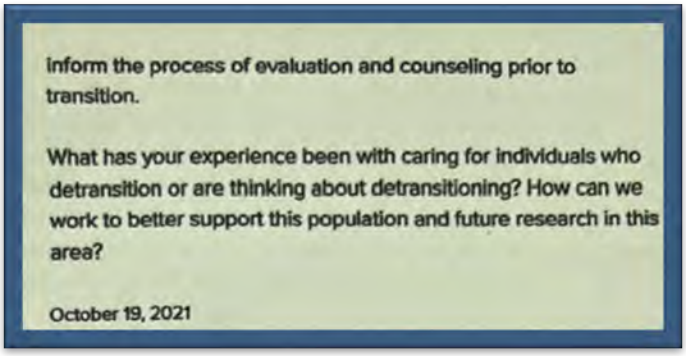
[redacted]

1 Attachment

Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners (https://link.springer.com/article/10.1007/s10508-021-02163-w) – by WPATH Member Lisa Littman, MD, MPH

Abstract

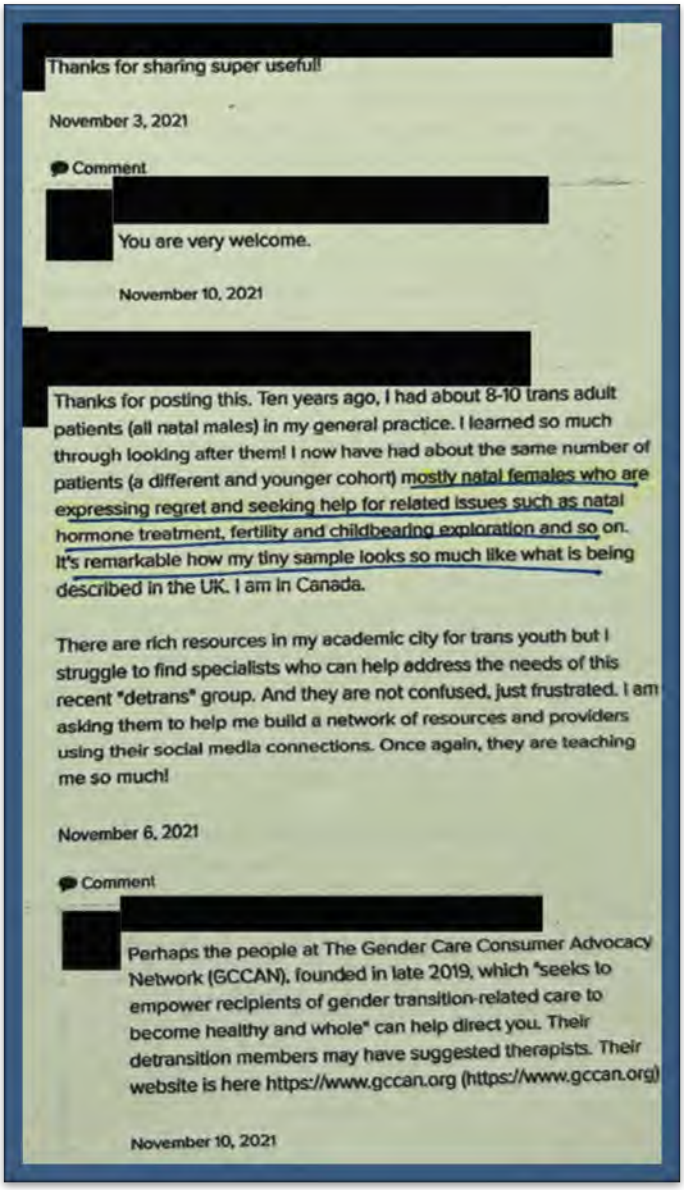
The study's purpose was to describe a population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both. Recruitment information with a link to an anonymous survey was shared on social media, professional listservs, and via snowball sampling. Sixty-nine percent of the 100 participants were natal female and 31.0% were natal male. Reasons for detransitioning were varied and included: experiencing discrimination (23.0%); becoming more comfortable identifying as their natal sex (60.0%); having concerns about potential medical complications from transitioning (49.0%); and coming to the view that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition (38.0%). Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed by 23.0% as a reason for transition and subsequent detransition. The majority (55.0%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition and only 24.0% of respondents informed their clinicians that they had detransitioned. There are many different reasons and experiences leading to detransition. More research is needed to understand this population, determine the prevalence of detransition as an outcome of transition, meet the medical and psychological needs of this population, and better



inform the process of evaluation and counseling prior to transition.

What has your experience been with caring for individuals who detransition or are thinking about detransitioning? How can we work to better support this population and future research in this area?

October 19, 2021



[redacted] Thanks for sharing super useful!

November 3, 2021

Comment

[redacted] You are very welcome.

November 10, 2021

[redacted] Thanks for posting this. Ten years ago, I had about 8-10 trans adult patients (all natal males) in my general practice. I learned so much through looking after them! I now have had about the same number of patients (a different and younger cohort) mostly natal females who are expressing regret and seeking help for related issues such as natal hormone treatment, fertility and childbearing exploration and so on. It's remarkable how my tiny sample looks so much like what is being described in the UK. I am in Canada.

There are rich resources in my academic city for trans youth but I struggle to find specialists who can help address the needs of this recent "detrans" group. And they are not confused, just frustrated. I am asking them to help me build a network of resources and providers using their social media connections. Once again, they are teaching me so much!

November 6, 2021

Comment

[redacted] Perhaps the people at The Gender Care Consumer Advocacy Network (GCCAN), founded in late 2019, which "seeks to empower recipients of gender transition-related care to become healthy and whole" can help direct you. Their detransition members may have suggested therapists. Their website is here https://www.gccan.org (https://www.gccan.org)

November 10, 2021

My thought is that the framing around "detransition" is really important. Given the history of pathologizing and medicalizing transgender identity, this idea of detransition often makes it feel like a mistake has been made in some capacity. This is often used to justify further increasing barriers to accessing care, or unintentionally furthering the belief that as providers, we should gatekeep access to medical transition. I'm not saying this is what you're saying of course, it's just what I hear about often in the media and by providers who don't have significant experience working with transgender patients.

And when I think about the ways we are trying to move toward destigmatization and informed-consent models of trans health care, I think it's important to emphasize the way it is okay for gender and interest in medical options to change over time for each individual. I think about the many "irreversible" procedures that we allow adults to easily access in our society (cis-gender people getting plastic surgery, tattoos, etc.). And for example, the rates of surgical regret for cis-gender people getting plastic surgery (like breast augmentation) is not used as a reason why we should create more barriers for cis-gender people having (informed) access to surgery. The most recent study I saw examining post-surgical regret for cis-gender women getting breast augmentation was 47.2% expressed mild, moderate, or strong surgical regret.

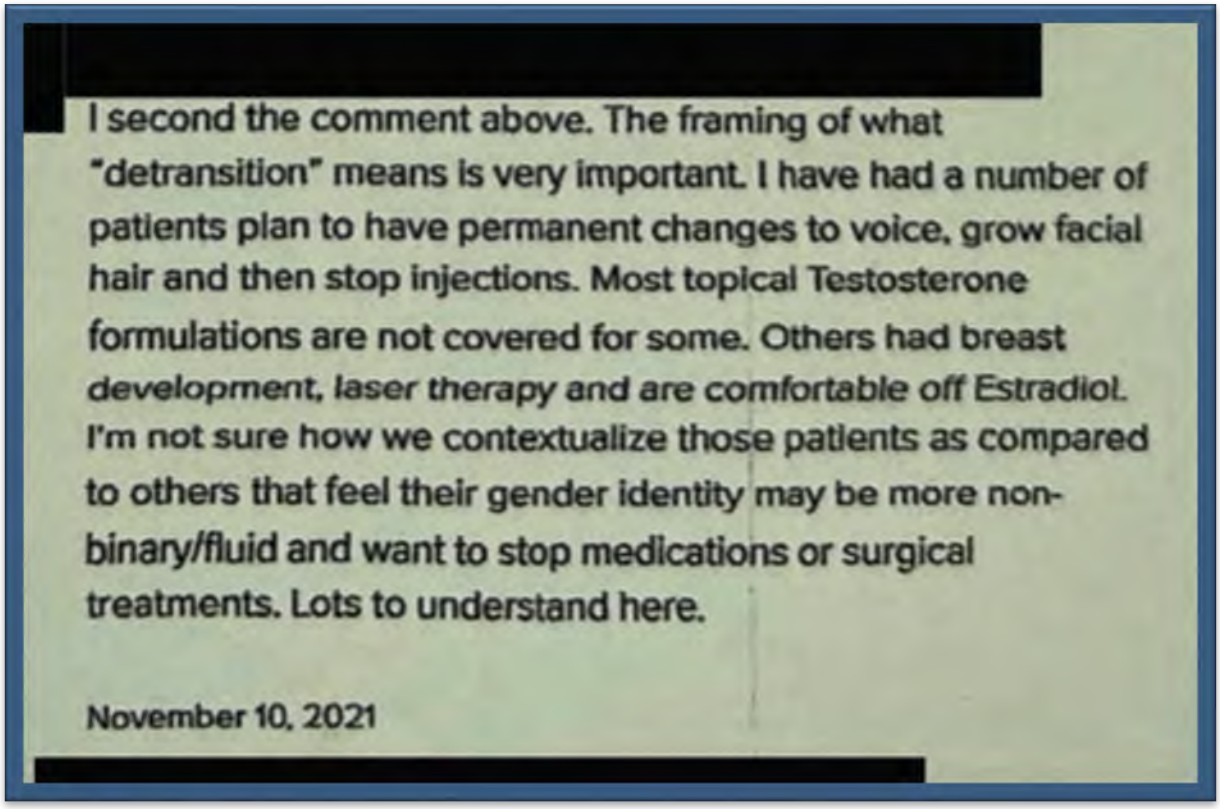
And then interpersonally, the people I know who have "detransitioned" by medical standards have stopped taking hormones because they had medical complications (DVT/PE, hypertension, etc.), or hate needles, or originally took hormones to get some of the irreversible changes (eg. voice change) but never intended to stay on them long term. All of those people would be considered "detransitioners" but didn't feel like they made a mistake.

To get back to your original question on how to support patients thinking about this, I think the best we can do is support each individual and be careful with how we let this be framed by the general public. Learning new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made. Of course, if an individual patient feels that they made a mistake, we can support them through that as well, but hopefully we can be careful with not letting that change the way others receive care. Those are just my general thoughts!

November 6, 2021

Comment

[redacted] I second the comment above. The framing of what "detransition" means is very important. I have had a number of patients plan to have permanent changes to voice, grow facial hair and then stop injections. Most topical Testosterone formulations are not covered for some. Others had breast development, laser therapy and are comfortable off Estradiol. I'm not sure how we contextualize those patients as compared to others that feel their gender identity may be more non-binary/fluid and want to stop medications or surgical treatments. Lots to understand here.



[redacted]

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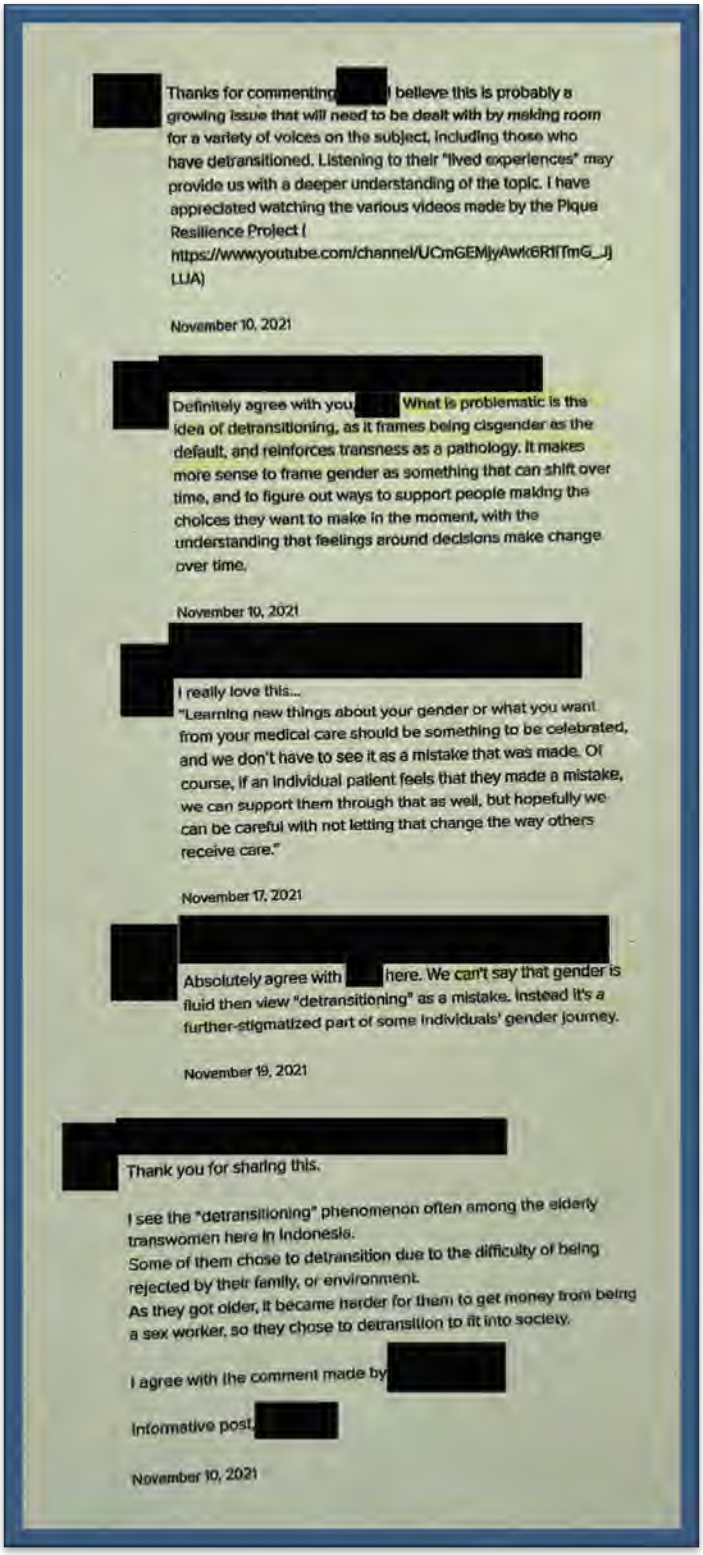
November 10, 2021

[redacted]



[redacted] Thanks for commenting [redacted] I believe this is probably a growing issue that will need to be dealt with by making room for a variety of voices on the subject, including those who have detransitioned. Listening to their "lived experiences" may provide us with a deeper understanding of the topic. I have appreciated watching the various videos made by the Pique Resilience Project (https://www.youtube.com/channel/UCmGEMjyAwk6R1fTmG_JLUA)

November 10, 2021

[redacted] Definitely agree with you [redacted] What is problematic is the idea of detransitioning, as it frames being cisgender as the default, and reinforces transness as a pathology. It makes more sense to frame gender as something that can shift over time, and to figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions make change over time.

November 10, 2021

[redacted] I really love this...
"Learning new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made. Of course, if an individual patient feels that they made a mistake, we can support them through that as well, but hopefully we can be careful with not letting that change the way others receive care."

November 17, 2021

[redacted] Absolutely agree with [redacted] here. We can't say that gender is fluid then view "detransitioning" as a mistake. Instead it's a further-stigmatized part of some individuals' gender journey.

November 19, 2021

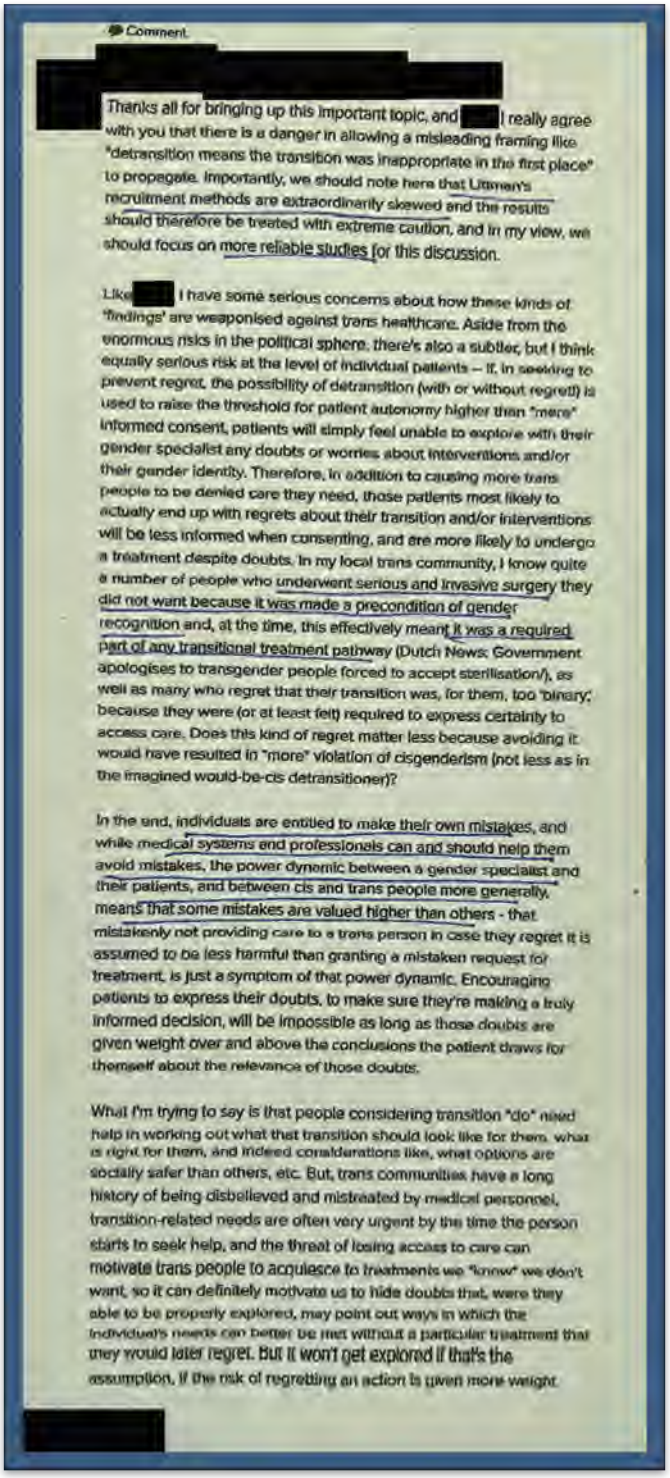
[redacted] Thank you for sharing this.

I see the "detransitioning" phenomenon often among the elderly transwomen here in Indonesia.
Some of them chose to detransition due to the difficulty of being rejected by their family, or environment.
As they got older, it became harder for them to get money from being a sex worker, so they chose to detransition to fit into society.

I agree with the comment made by [redacted]

Informative post [redacted]

November 10, 2021



Comment

[redacted]

Thanks all for bringing up this important topic, and [redacted] I really agree with you that there is a danger in allowing a misleading framing like "detransition means the transition was inappropriate in the first place" to propegate. Importantly, we should note here that Littman's recruitment methods are extraordinarily skewed and the results should therefore be treated with extreme caution, and in my view, we should focus on more reliable studies for this discussion.

Like [redacted] I have some serious concerns about how these kinds of 'findings' are weaponised against trans healthcare. Aside from the enormous risks in the political sphere, there's also a subtler, but I think equally serious risk at the level of individual patients – if, in seeking to prevent regret, the possibility of detransition (with or without regret) is used to raise the threshold for patient autonomy higher than "mere" informed consent, patients will simply feel unable to explore with their gender specialist any doubts or worries about interventions and/or their gender identity. Therefore, in addition to causing more trans people to be denied care they need, those patients most likely to actually end up with regrets about their transition and/or interventions will be less informed when consenting, and are more likely to undergo a treatment despite doubts. In my local trans community, I know quite a number of people who underwent serious and invasive surgery they did not want because it was made a precondition of gender recognition and, at the time, this effectively meant it was a required part of any transitional treatment pathway (Dutch News: Government apologises to transgender people forced to accept sterilisation/), as well as many who regret that their transition was, for them, too "binary," because they were (or at least felt) required to express certainty to access care. Does this kind of regret matter less because avoiding it would have resulted in "more" violation of cisgenderism (not less as in the imagined would-be-cis detransitioner)?

In the end, individuals are entitled to make their own mistakes, and while medical systems and professionals can and should help them avoid mistakes, the power dynamic between a gender specialist and their patients, and between cis and trans people more generally, means that some mistakes are valued higher than others - that mistakenly not providing care to a trans person in case they regret it is assumed to be less harmful than granting a mistaken request for treatment, is just a symptom of that power dynamic. Encouraging patients to express their doubts, to make sure they're making a truly informed decision, will be impossible as long as those doubts are given weight over and above the conclusions the patient draws for themself about the relevance of those doubts.

What I'm trying to say is that people considering transition *do* need help in working out what that transition should look like for them, what is right for them, and indeed considerations like, what options are socially safer than others, etc. But, trans communities have a long history of being disbelieved and mistreated by medical personnel, transition-related needs are often very urgent by the time the person starts to seek help, and the threat of losing access to care can motivate trans people to acquiesce to treatments we "know" we don't want, so it can definitely motivate us to hide doubts that, were they able to be properly explored, may point out ways in which the individual's needs can better be met without a particular treatment that they would later regret. But it won't get explored if that's the assumption. If the risk of regretting an action is given more weight

[redacted]

than the risk of regretting inaction.

So the first thing we can do to support detransitioners, retransitioners and everyone, is to make discussing doubts and complexity a normal part of the gender consult and not something that will prevent the patient from making their own informed choice. Another thing we need to do is to investigate what detransitioners want, because at present the focus of much research seems to be to use their existence to invalidate that of (other) trans people. Do they want interventions to reverse something? Are they just re-rejecting the gender binary after being shoved from one end of it to the other? If so, do they need [redacted] medical/social/legal/psychological support to do so? How can we reduce the discrimination against transitioning/ed people that often precipitates a (temporary?) detransition? Most of all, how can we support detransitioners to benefit from the experience, to help them celebrate and implement the self-knowledge they've gained, and not to see themselves as "traitors" (to trans people or to their AGAB), "failures" or "mistakes"?

Your original response:
'Thanks all for bringing up this important topic, and [redacted] really agree with you that there is a danger in allowing a misleading framing like "detransition means the transition was inappropriate in the first place" to propagate. Importantly, we should note here that Littman's recruitment methods are extraordinarily skewed and the results should therefore be treated with extreme caution. She is not the champion of detransitioners she would like to think, and in my view, discussions centering on her work will not help anyone, and we should focus on more reliable sources.

Like [redacted] I have some serious concerns about how these kinds of 'findings' are weaponised against trans healthcare. Aside from the enormous risks in the political sphere, there's also a subtler, but I think equally serious risk at the level of individual patients -- if, in seeking to prevent regret, the possibility of detransition (with or without regret!) is used to raise the threshold for patient autonomy higher than "mere" informed consent, patients will simply feel unable to explore with their gender specialist any doubts or worries about interventions and/or their gender identity. Therefore, in addition to causing more trans people to be denied care they need, those patients most likely to actually end up with regrets about their transition and/or interventions will be less informed when consenting, and are more likely to undergo a treatment despite doubts. In my local trans community, I know quite a number of people who underwent serious and invasive surgery they did not want because it was made a precondition of gender recognition and, at the time, this effectively meant it was a required part of any transitional treatment pathway (Dutch News: Government apologises to transgender people forced to accept sterilisation/), as well as many who regret that their transition was, for them, too 'binary,' because they were (or at least felt) required to express certainty to access care. Does this kind of regret matter less because avoiding it would have resulted in "more" violation of cisgenderism (not less as in the imagined would-be-cis detransitioner)?

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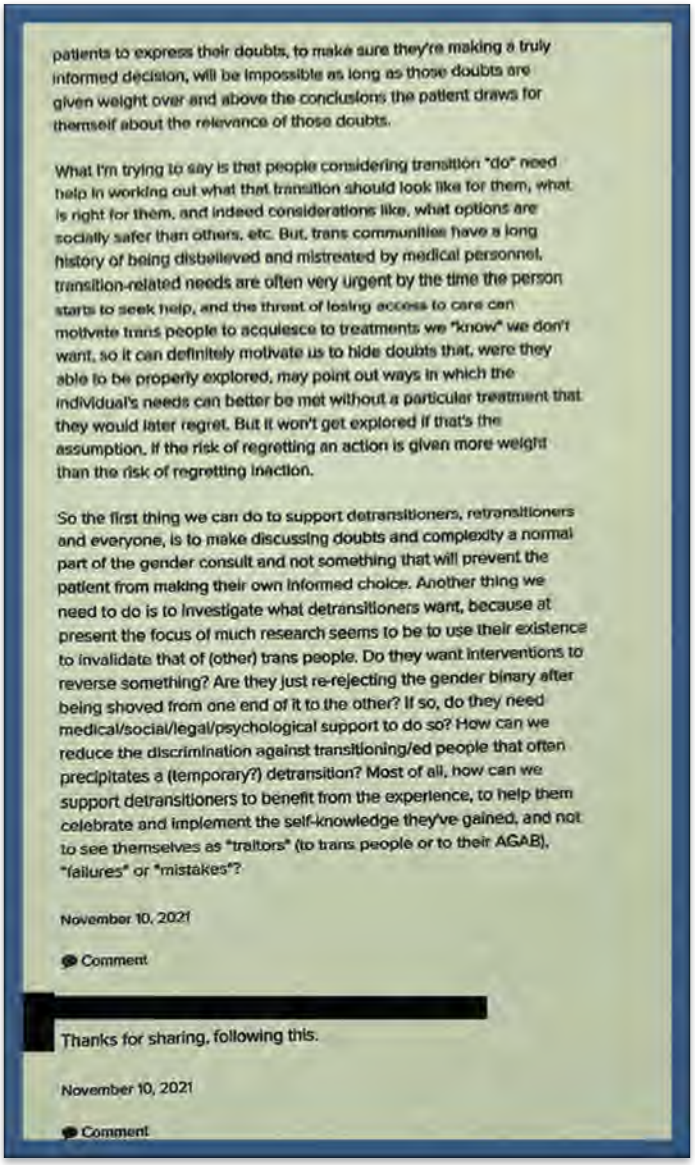

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November 10, 2021

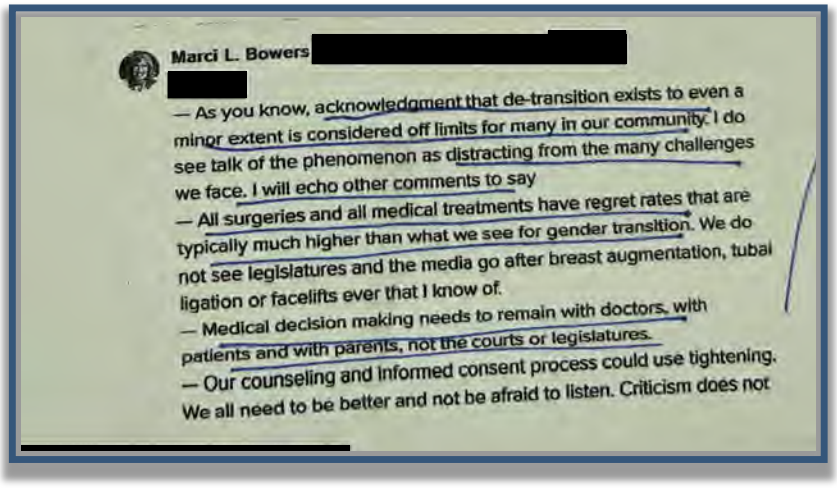
Comment

[redacted]

Thanks for sharing, following this.

November 10, 2021

Comment



Marci L. Bowers [redacted]

— As you know, acknowledgment that de-transition exists to even a minor extent is considered off limits for many in our community. I do see talk of the phenomenon as distracting from the many challenges we face. I will echo other comments to say

— All surgeries and all medical treatments have regret rates that are typically much higher than what we see for gender transition. We do not see legislatures and the media go after breast augmentation, tubal ligation or facelifts ever that I know of.

— Medical decision making needs to remain with doctors, with patients and with parents, not the courts or legislatures.

— Our counseling and informed consent process could use tightening. We all need to be better and not be afraid to listen. Criticism does not

[redacted]

mean blame, it means we need to do better for our patients.
— Patients need to own and take active responsibility for medical decisions, especially those that have potentially permanent effects.

November 10, 2021

[redacted]

Three points to address here:

1. "Framing" of detransitioning by society is unrelated to the experience of people who made decisions in their earlier years (under 25 usually). These are young adults who made decisions to change their bodies in irreversible ways, at a time in their lives then their physical and sexual identities were in developmental flux. Many, if not most, had co-morbidities that were not fully addressed before transition was offered to them. They were rushed; they all report that feeling. And their feelings are what this discussion should be about; it has nothing to do with public "framing." "Detransition" can be called something else: regret, a change of heart, whatever. But the way it is interpreted by our community of care providers should not be weaponized to discount these real experiences by claiming they are being used as "gatekeeping" devices. The detransitioned adults I look after, if anything, are very much immersed in their own suffering, loss and grief.
2. It was stated that aesthetic plastic surgery (rhinoplasty, breast augmentation, etc.) and tattoos as "easily accessible" in society; in fact, they are only easily accessible to the privileged few who can afford them – adults or older youth with access to some degree of "luxury" funds. The hormonal and surgical interventions now so easily available to young, impulsive, mentally and cognitively unstable youth are being funded (in some countries, publicly) and advocated by registered health professionals, "framed" as "life-saving" when, to my knowledge, this claim is based on very loosely drawn conclusions from very weak data.
3. If, in fact, rates of regret for breast augmentation are as high as 47%, when chosen by compos mentis adults, that worries me deeply. I fear that rates of regret of gender transition, especially as it relates to future sexual health and fertility in adults who make these irreversible decisions at such a young age may, in fact, be even higher.

November 11, 2021

Comment:

[redacted]

Some excellent points made. I have seen over 600 transgender patients over the past 25+ years: more recently than distantly. Of that number, I have had perhaps 4 detransition. I say perhaps because I have a couple whose identity depends upon when you ask: for example, a natal male now in her late 40's who transitioned to female 20 years ago but has stopped therapy to detransition more than once; she (currently female) feels guilt for transitioning (religious) and loses family support when female. After many months the dysphoria is too severe, and she resumes estrogen. It is of course likely that some individuals have detransitioned and not informed me. Overall I do think the number who detransition is small and should not mean we have done something "wrong" (Agree with [redacted]).
I am a little concerned that, as access to transitioning has gotten easier recently (obviously still many barriers) that there will be greater numbers. The majority of patients I see now are below 25 years old and clearly very dysphoric. However, I am seeing some who come to

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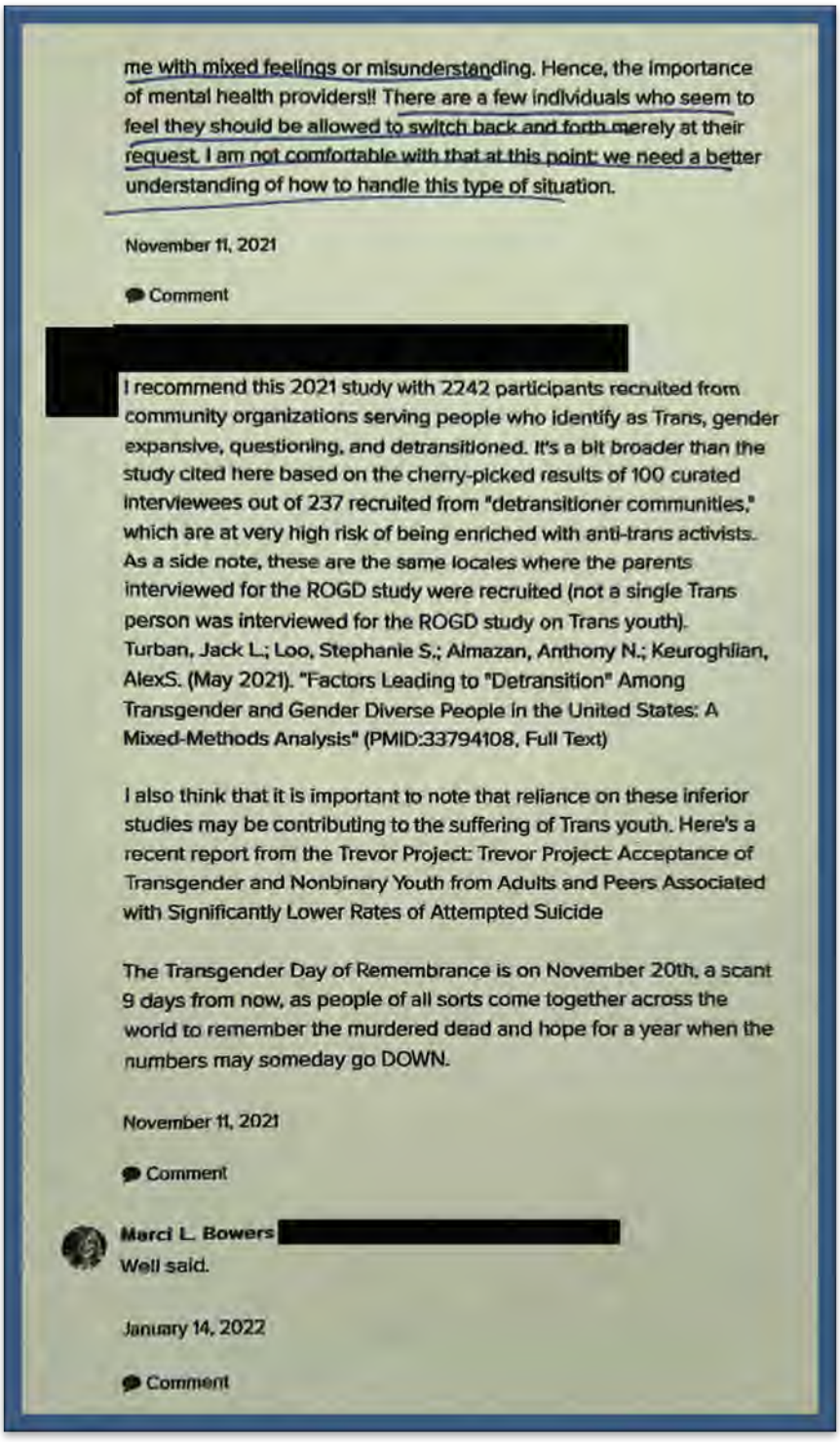
November 11, 2021



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November 11, 2021

Comment

[redacted]

I recommend this 2021 study with 2242 participants recruited from community organizations serving people who identify as Trans, gender expansive, questioning, and detransitioned. It's a bit broader than the study cited here based on the cherry-picked results of 100 curated interviewees out of 237 recruited from "detransitioner communities," which are at very high risk of being enriched with anti-trans activists. As a side note, these are the same locales where the parents interviewed for the ROGD study were recruited (not a single Trans person was interviewed for the ROGD study on Trans youth).
Turban, Jack L.; Loo, Stephanie S.; Almazan, Anthony N.; Keuroghlian, AlexS. (May 2021). "Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis" (PMID:33794108, Full Text)

I also think that it is important to note that reliance on these inferior studies may be contributing to the suffering of Trans youth. Here's a recent report from the Trevor Project: Trevor Project: Acceptance of Transgender and Nonbinary Youth from Adults and Peers Associated with Significantly Lower Rates of Attempted Suicide

The Transgender Day of Remembrance is on November 20th, a scant 9 days from now, as people of all sorts come together across the world to remember the murdered dead and hope for a year when the numbers may someday go DOWN.

November 11, 2021

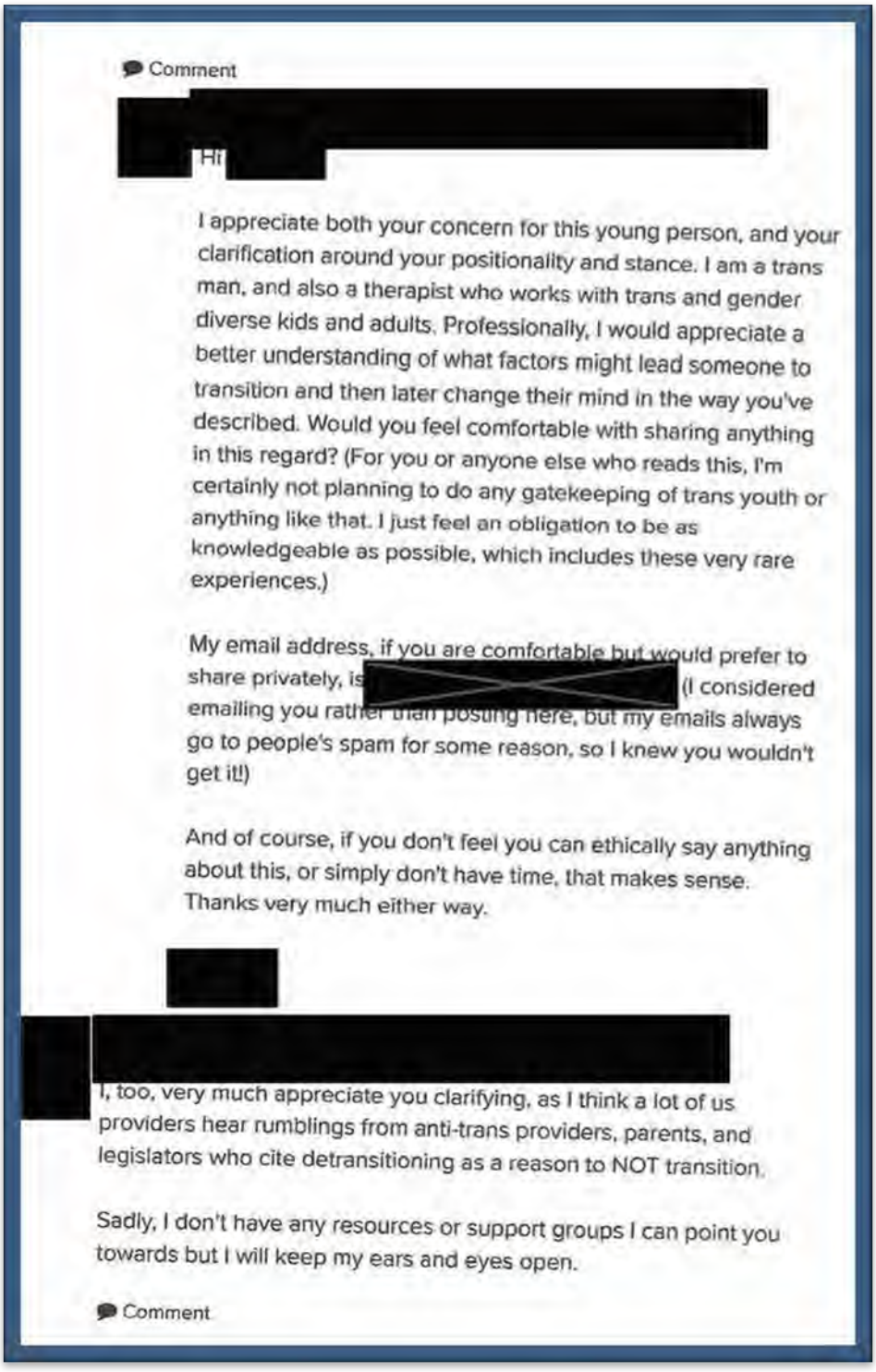
Comment

Marci L. Bowers [redacted]
Well said.

January 14, 2022

Comment

c) WPATH members seek clarification on detransition



Comment

[redacted] Hi [redacted]

I appreciate both your concern for this young person, and your clarification around your positionality and stance. I am a trans man, and also a therapist who works with trans and gender diverse kids and adults. Professionally, I would appreciate a better understanding of what factors might lead someone to transition and then later change their mind in the way you've described. Would you feel comfortable with sharing anything in this regard? (For you or anyone else who reads this, I'm certainly not planning to do any gatekeeping of trans youth or anything like that. I just feel an obligation to be as knowledgeable as possible, which includes these very rare experiences.)

My email address, if you are comfortable but would prefer to share privately, is [redacted] (I considered emailing you rather than posting here, but my emails always go to people's spam for some reason, so I knew you wouldn't get it!)

And of course, if you don't feel you can ethically say anything about this, or simply don't have time, that makes sense. Thanks very much either way.

[redacted]

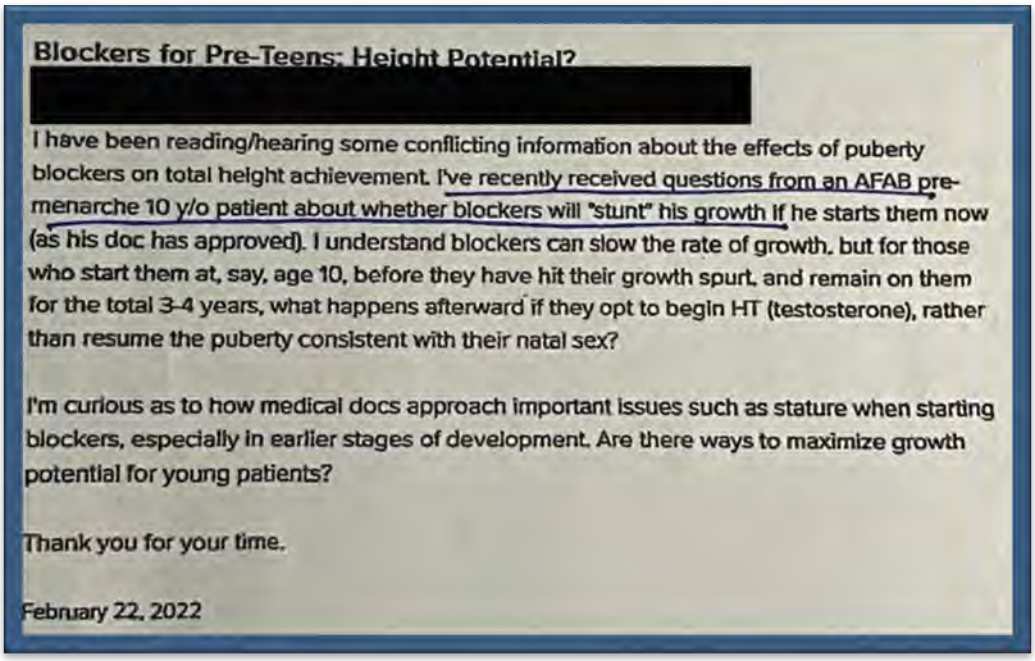
[redacted] I, too, very much appreciate you clarifying, as I think a lot of us providers hear rumblings from anti-trans providers, parents, and legislators who cite detransitioning as a reason to NOT transition.

Sadly, I don't have any resources or support groups I can point you towards but I will keep my ears and eyes open.

Comment

5) PUBERTY SUPPRESSION TACTICS

a) A WPATH member questions the effects of puberty blockers on total height achievement for a 10-year-old patient



Blockers for Pre-Teens: Height Potential?

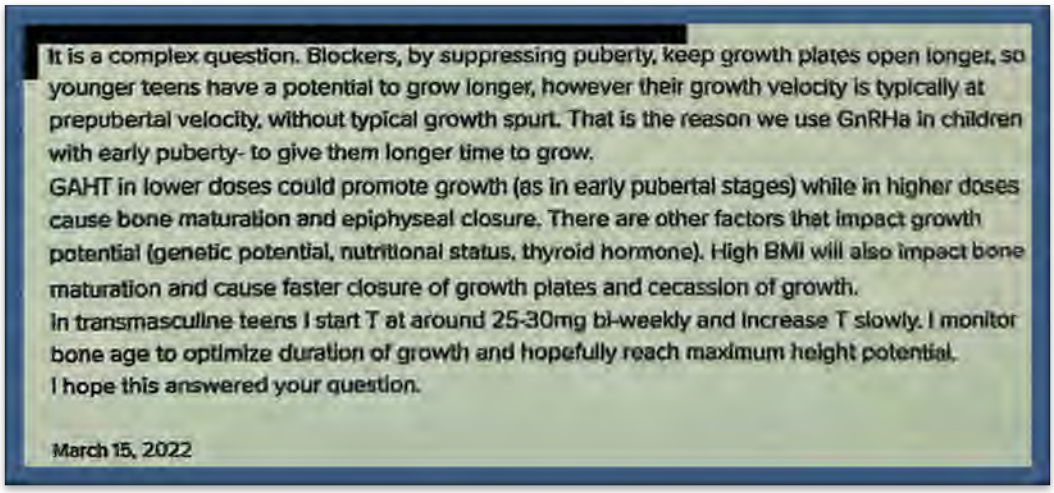
[redacted]

I have been reading/hearing some conflicting information about the effects of puberty blockers on total height achievement. I've recently received questions from an AFAB pre-menarche 10 y/o patient about whether blockers will "stunt" his growth if he starts them now (as his doc has approved). I understand blockers can slow the rate of growth, but for those who start them at, say, age 10, before they have hit their growth spurt, and remain on them for the total 3-4 years, what happens afterward if they opt to begin HT (testosterone), rather than resume the puberty consistent with their natal sex?

I'm curious as to how medical docs approach important issues such as stature when starting blockers, especially in earlier stages of development. Are there ways to maximize growth potential for young patients?

Thank you for your time.

February 22, 2022



[redacted]

It is a complex question. Blockers, by suppressing puberty, keep growth plates open longer, so younger teens have a potential to grow longer, however their growth velocity is typically at prepubertal velocity, without typical growth spurt. That is the reason we use GnRHa in children with early puberty- to give them longer time to grow.

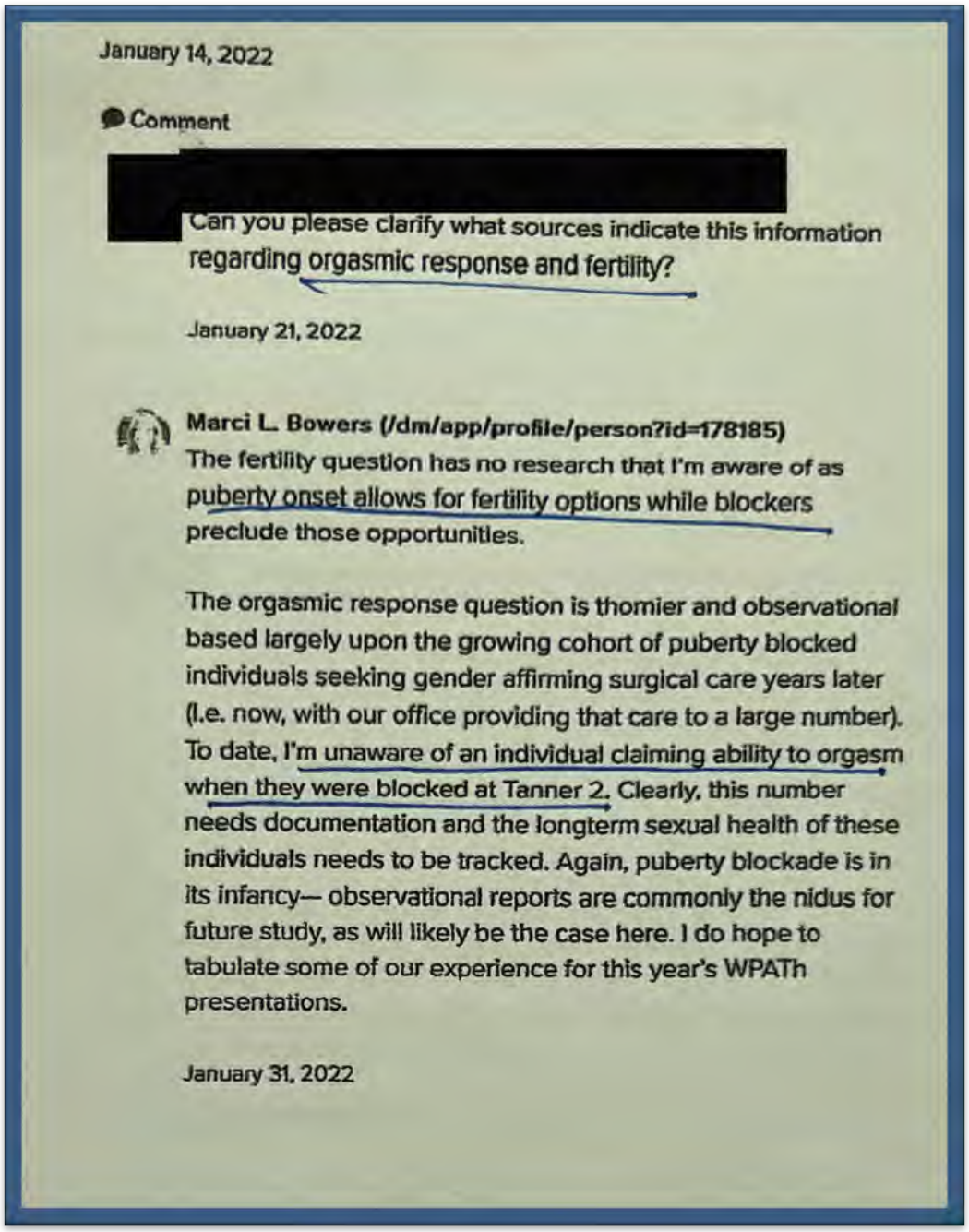
GAHT in lower doses could promote growth (as in early pubertal stages) while in higher doses cause bone maturation and epiphyseal closure. There are other factors that impact growth potential (genetic potential, nutritional status, thyroid hormone). High BMI will also impact bone maturation and cause faster closure of growth plates and cecassion of growth.

In transmasculine teens I start T at around 25-30mg bi-weekly and increase T slowly. I monitor bone age to optimize duration of growth and hopefully reach maximum height potential.

I hope this answered your question.

March 15, 2022

b) WPATH members discuss how puberty blockers preclude fertility options for trans patients



January 14, 2022

Comment

[redacted] Can you please clarify what sources indicate this information regarding orgasmic response and fertility?

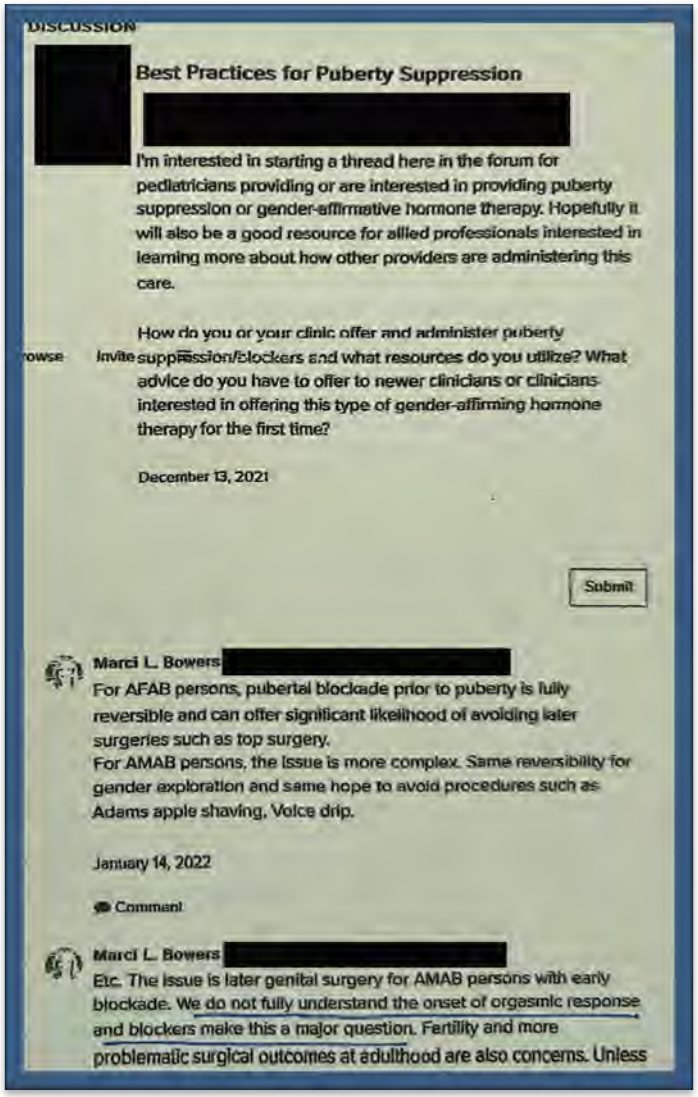
January 21, 2022

Marci L. Bowers (/dm/app/profile/person?id=178185)
The fertility question has no research that I'm aware of as puberty onset allows for fertility options while blockers preclude those opportunities.

The orgasmic response question is thornier and observational based largely upon the growing cohort of puberty blocked individuals seeking gender affirming surgical care years later (I.e. now, with our office providing that care to a large number). To date, I'm unaware of an individual claiming ability to orgasm when they were blocked at Tanner 2. Clearly, this number needs documentation and the longterm sexual health of these individuals needs to be tracked. Again, puberty blockade is in its infancy— observational reports are commonly the nidus for future study, as will likely be the case here. I do hope to tabulate some of our experience for this year's WPATh presentations.

January 31, 2022

c) WPATH members share best practices for puberty suppression and hormone therapy



DISCUSSION

[redacted]

Best Practices for Puberty Suppression

[redacted]

I'm interested in starting a thread here in the forum for pediatricians providing or are interested in providing puberty suppression or gender-affirmative hormone therapy. Hopefully it will also be a good resource for allied professionals interested in learning more about how other providers are administering this care.

How do you or your clinic offer and administer puberty suppression/blockers and what resources do you utilize? What advice do you have to offer to newer clinicians or clinicians interested in offering this type of gender-affirming hormone therapy for the first time?

December 13, 2021

Submit

Marci L. Bowers [redacted]

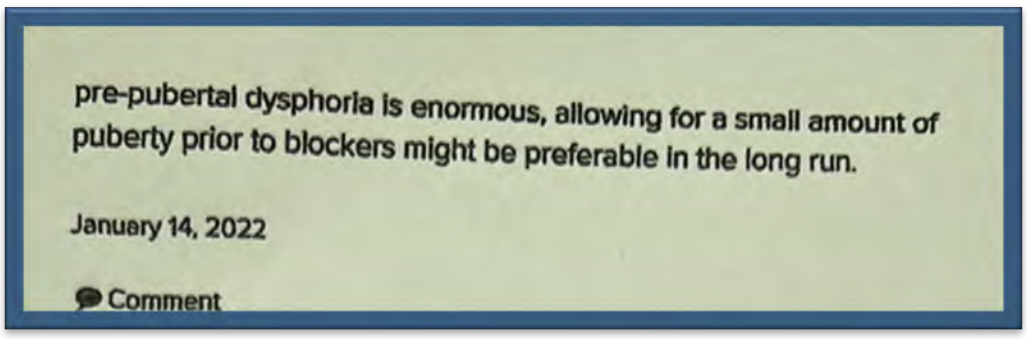
For AFAB persons, pubertal blockade prior to puberty is fully reversible and can offer significant likelihood of avoiding later surgeries such as top surgery.
For AMAB persons, the issue is more complex. Same reversibility for gender exploration and same hope to avoid procedures such as Adams apple shaving, Voice drip.

January 14, 2022

Comment

Marci L. Bowers [redacted]

Etc. The issue is later genital surgery for AMAB persons with early blockade. We do not fully understand the onset of orgasmic response and blockers make this a major question. Fertility and more problematic surgical outcomes at adulthood are also concerns. Unless



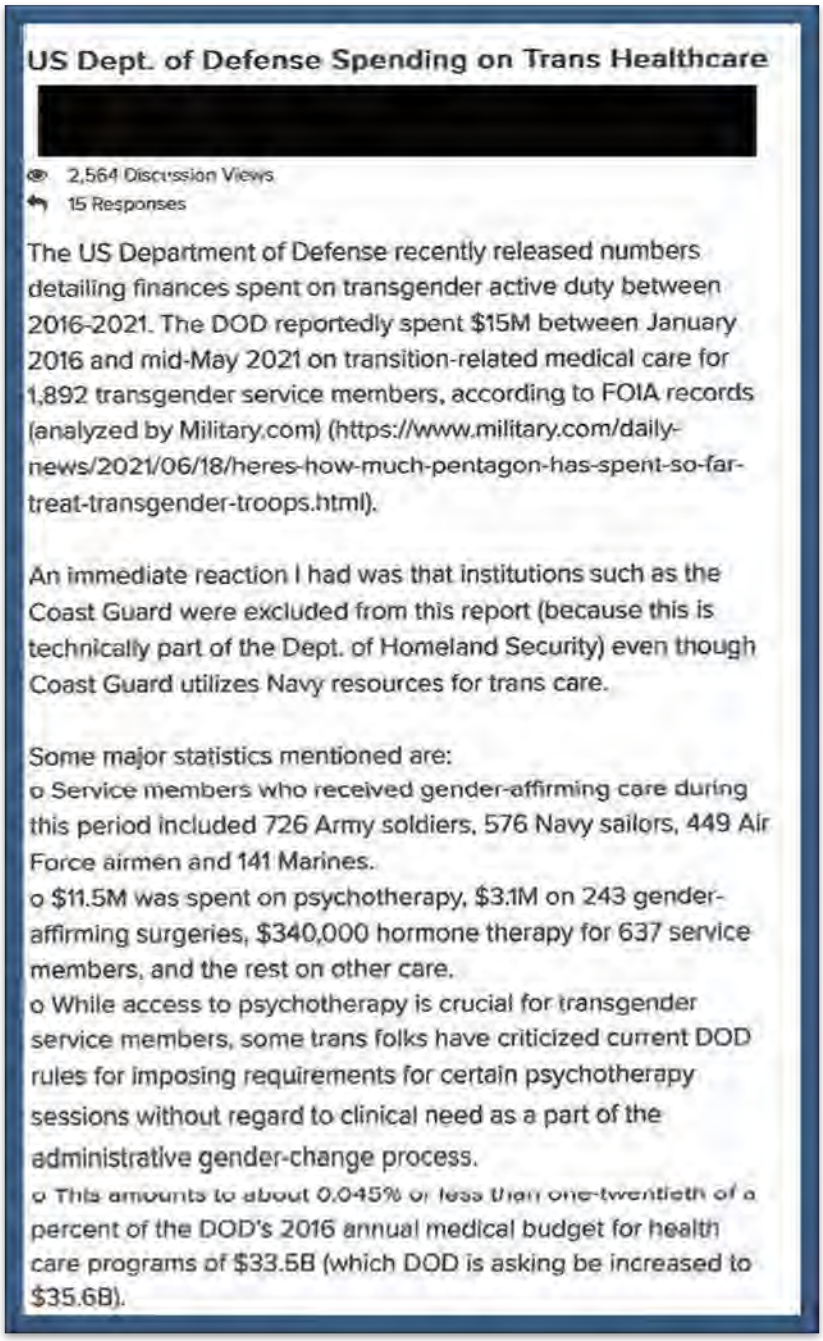
pre-pubertal dysphoria is enormous, allowing for a small amount of puberty prior to blockers might be preferable in the long run.

January 14, 2022

Comment

6) DOD SPENDING ON TRANS HEALTHCARE

a) WPATH members overview the Department of Defense's (DOD) newest report on trans healthcare finances



US Dept. of Defense Spending on Trans Healthcare

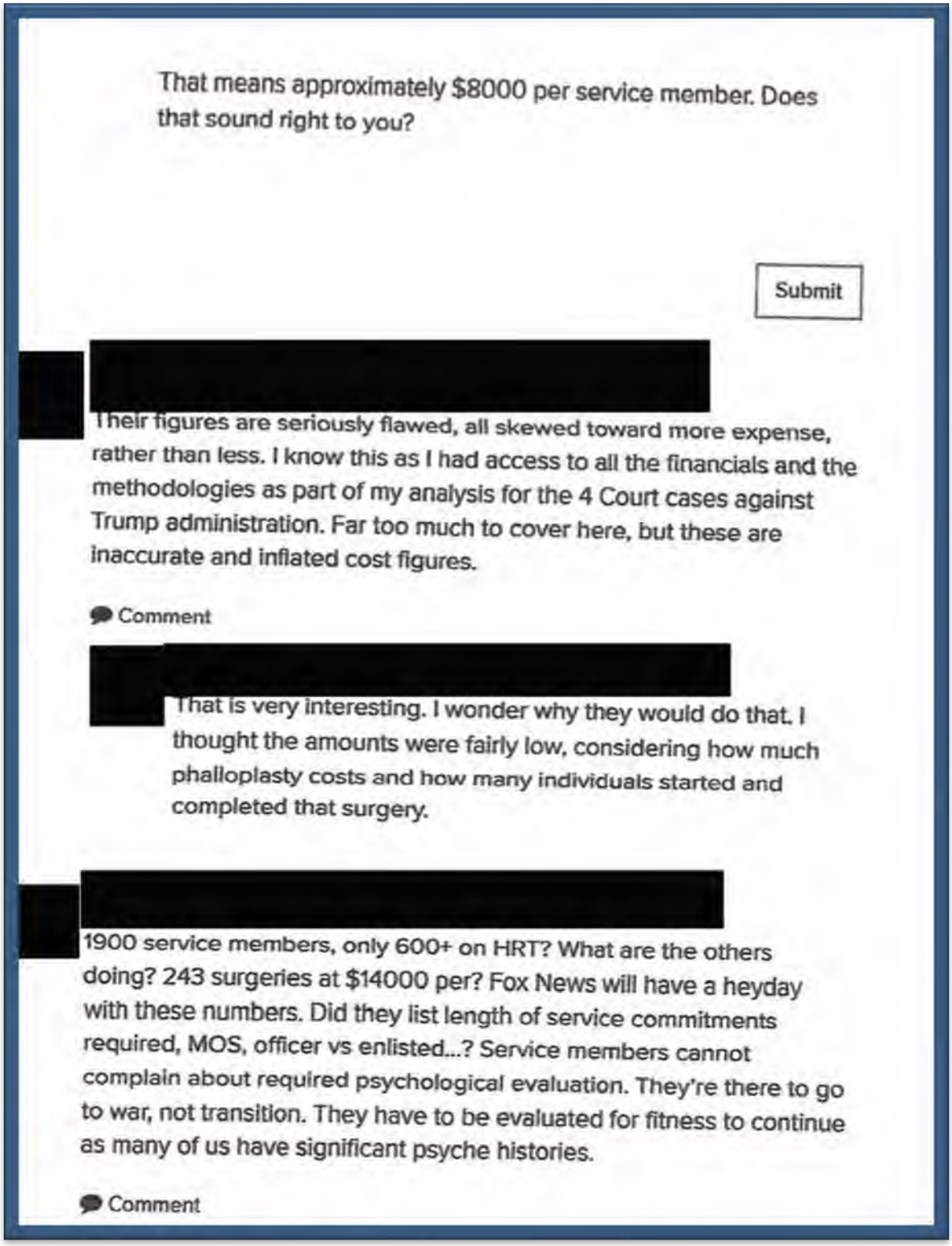
[redacted]

2,564 Discussion Views
15 Responses

The US Department of Defense recently released numbers detailing finances spent on transgender active duty between 2016-2021. The DOD reportedly spent $15M between January 2016 and mid-May 2021 on transition-related medical care for 1,892 transgender service members, according to FOIA records (analyzed by Military.com) (https://www.military.com/daily-news/2021/06/18/heres-how-much-pentagon-has-spent-so-far-treat-transgender-troops.html).

An immediate reaction I had was that institutions such as the Coast Guard were excluded from this report (because this is technically part of the Dept. of Homeland Security) even though Coast Guard utilizes Navy resources for trans care.

Some major statistics mentioned are:
o Service members who received gender-affirming care during this period included 726 Army soldiers, 576 Navy sailors, 449 Air Force airmen and 141 Marines.
o $11.5M was spent on psychotherapy, $3.1M on 243 gender-affirming surgeries, $340,000 hormone therapy for 637 service members, and the rest on other care.
o While access to psychotherapy is crucial for transgender service members, some trans folks have criticized current DOD rules for imposing requirements for certain psychotherapy sessions without regard to clinical need as a part of the administrative gender-change process.
o This amounts to about 0.045% or less than one-twentieth of a percent of the DOD's 2016 annual medical budget for health care programs of $33.5B (which DOD is asking be increased to $35.6B).



That means approximately $8000 per service member. Does that sound right to you?

Submit

[redacted]

Their figures are seriously flawed, all skewed toward more expense, rather than less. I know this as I had access to all the financials and the methodologies as part of my analysis for the 4 Court cases against Trump administration. Far too much to cover here, but these are inaccurate and inflated cost figures.

Comment

[redacted]

That is very interesting. I wonder why they would do that. I thought the amounts were fairly low, considering how much phalloplasty costs and how many individuals started and completed that surgery.

[redacted]

1900 service members, only 600+ on HRT? What are the others doing? 243 surgeries at $14000 per? Fox News will have a heyday with these numbers. Did they list length of service commitments required, MOS, officer vs enlisted...? Service members cannot complain about required psychological evaluation. They're there to go to war, not transition. They have to be evaluated for fitness to continue as many of us have significant psyche histories.

Comment

First, thank you for all that you do for the trans military community, it's a community that is close to my heart.

I 100% agree with you. Being in NC, I have worked with more trans military personnel since 2008 than I can count. Before Obama, I had commands send me their soldiers, sailors, air-wingers, and marines because they knew their folks needed help. All on the "down-low" or looked the other way.

Obama came into office and made it possible for military personnel (and their families) to receive trans care.....unfortunately, they were ill-equipped, untrained, backlogged, and often times just bigots.

I started seeing a surge in commands finding me and sending me their military personnel (some of my enlisted folks commanding officers paid out of their own pocket to see me....warmed my heart). They just knew their trans military folks were some of the hardest working people they had and if they just got this off their "plate" they'd be even better (cost benefit analysis I suppose).

Now this is active duty.

On the VA side, I received so many referrals from the Salisbury VA.

Again, they were backlogged and there was no one trained to help these trans vets. This went on for a few years until I got a phone call from one of their psychologist saying she needed help but that was told that the VA system would no longer be referring trans veterans to me. She asked if I would speak to her supervisor (I can't remember if he was a psychologist or a psychiatrist) regarding providing them some training. I did and he made it very clear that my services for trans vets were no longer needed nor was the training I offered. He went on to say he established a "Transgender Task Force" (sorry I thought it was a bit much, strange, and so military). This person was unfamiliar with WPATH, its protocols, the SOCs.

After a few months, the trans vets started to return stating that their hormones were d/c'd because they were still trying to coordinate or figure out how to prescribe and in the interim put into a trans group.

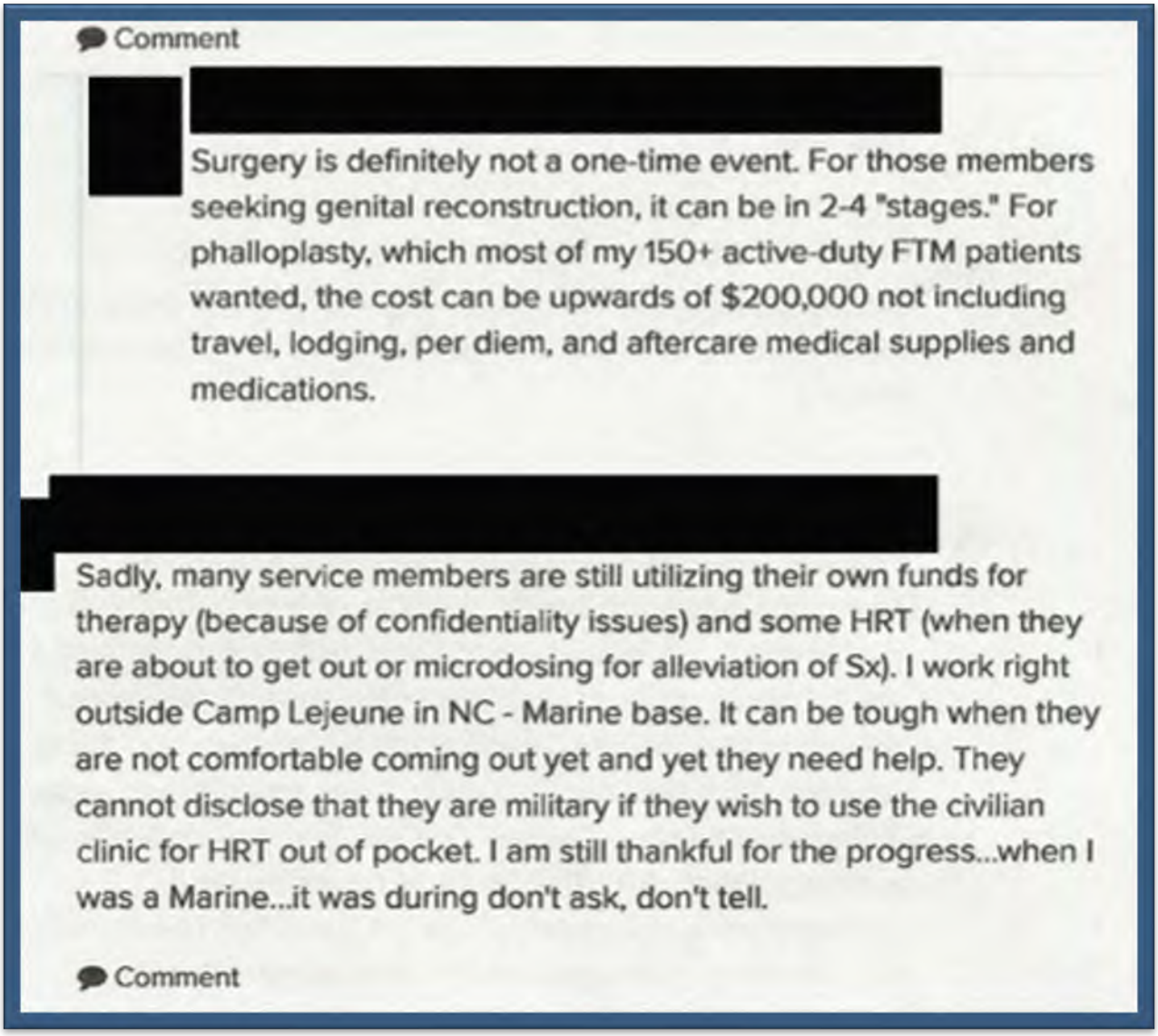
If they weren't paying out of pocket, I was still billing the VA but for PTSD and a doc in Winston Salem, NC worked to help me keep them on their hormones.

All this to say their numbers are absolutely wrong. If Officers, trans military members, and military vets were paying out of their own pockets, the DoD couldn't have possibly spent that amount.

Granted, it's not like I saw 100,000 people. Over the years, I know enough to feel comfortably saying, therapy is not required, hormones are cheap, and surgery, well that's a one time event. Trans care is far more affordable and far easier to manage than treating active duty, veterans, and/or their family members who have chronic illness's.

Even if that number is true (we all know it's not), it is still such a tiny tiny tiny part of their budget. I guess my other argument is, Did they assess the numbers for treating for PTSD, hypertension, diabetes, or mental health in general?

Their skewed numbers boils down to not wanting to pay for and justifying medically neglecting those that served protecting our freedom.



Comment

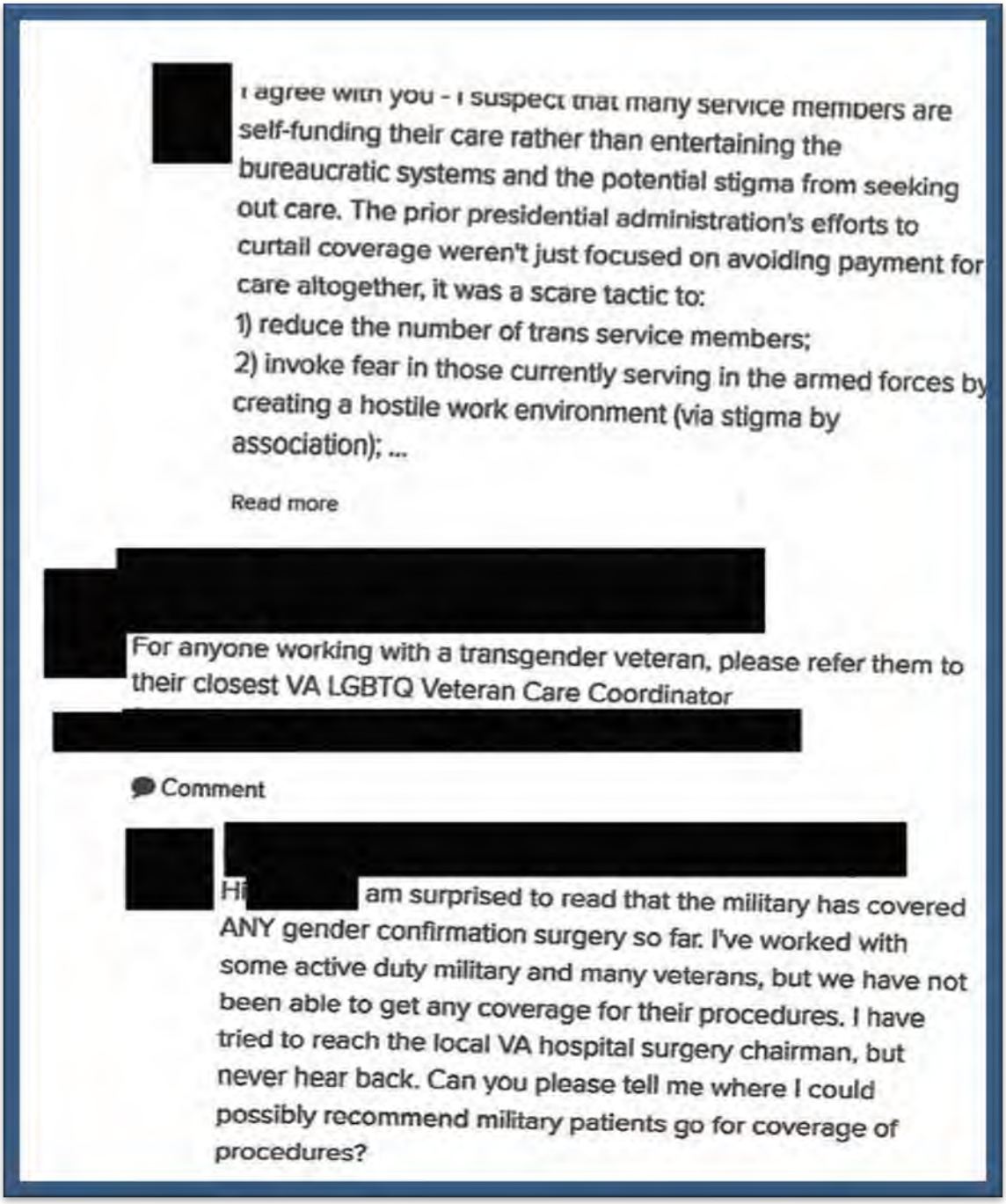
[redacted]

Surgery is definitely not a one-time event. For those members seeking genital reconstruction, it can be in 2-4 "stages." For phalloplasty, which most of my 150+ active-duty FTM patients wanted, the cost can be upwards of $200,000 not including travel, lodging, per diem, and aftercare medical supplies and medications.

[redacted]

Sadly, many service members are still utilizing their own funds for therapy (because of confidentiality issues) and some HRT (when they are about to get out or microdosing for alleviation of Sx). I work right outside Camp Lejeune in NC - Marine base. It can be tough when they are not comfortable coming out yet and yet they need help. They cannot disclose that they are military if they wish to use the civilian clinic for HRT out of pocket. I am still thankful for the progress...when I was a Marine...it was during don't ask, don't tell.

Comment



[redacted] I agree with you - I suspect that many service members are self-funding their care rather than entertaining the bureaucratic systems and the potential stigma from seeking out care. The prior presidential administration's efforts to curtail coverage weren't just focused on avoiding payment for care altogether, it was a scare tactic to:
1) reduce the number of trans service members;
2) invoke fear in those currently serving in the armed forces by creating a hostile work environment (via stigma by association); ...

Read more

[redacted] For anyone working with a transgender veteran, please refer them to their closest VA LGBTQ Veteran Care Coordinator [redacted]

Comment

[redacted] Hi [redacted] am surprised to read that the military has covered ANY gender confirmation surgery so far. I've worked with some active duty military and many veterans, but we have not been able to get any coverage for their procedures. I have tried to reach the local VA hospital surgery chairman, but never hear back. Can you please tell me where I could possibly recommend military patients go for coverage of procedures?

[redacted] for Veterans reach out to their nearest LGBTQ Veteran Care Coordinator

[redacted]

For military members, they must connect with their military branches' TG Care Team Case Manager. They must follow the Defense Health Administration (DHA) protocol for getting referred to the Team (usually by their primary care provider or mental health provider). DHA requires a complex and thorough referral for the bottom surgery (TRICARE covered)...

Read more

[redacted] any suggestions for care coordination for those in the military, active duty? i.e. transgender service members wanting surgery

[redacted] Hi [redacted] For active-duty personnel wishing to access Command Approved gender transition the best approach is to encourage those individuals to speak with their Command mental health provider or primary care provider to secure a referral to their military branch medical team handling those referrals. Each branch of the military has set up the process differently. The Navy has two TG Care Teams (San Diego, CA and Portsmouth, VA). The CA Team has two case managers/care coordinators. The VA Team, last I heard, does not. The Navy teams process the referrals remotely and...

Read more

[redacted]

Also, because of the high need for transgender resources, if you are a clinician/therapist - you might be able to get special contract to work with transgender service-connected members if you cannot get paneled with Tricare.

Here are a couple sites that also might be helpful for trans service members:
SPARTA Pride (https://spartapride.org/) - certain bases will have chapters such as we do here in Camp Lejeune NC
Transgender American Veterans Association (https://transveteran.org/)

Comment

[redacted]

Feel like this information is also entirely useless out of context. How much do they spend on insulin and diabetic care? How much do they spend on mental health care for PTSD diagnosis? There are a lot of things that I'm sure they're paying money for and without any context behind these numbers or any ability to compare them people are just going to see them and make what they will of them.

Comment

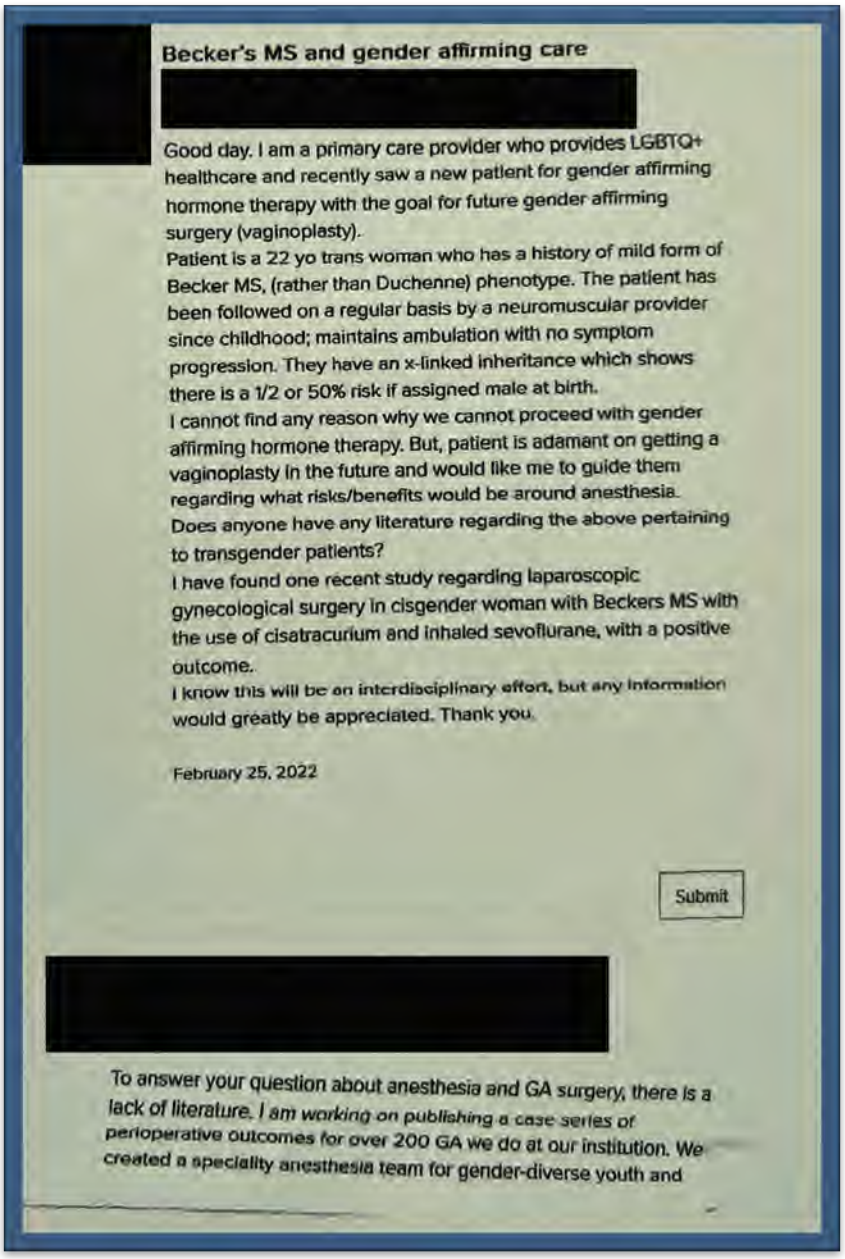
[redacted]

I will have to go back into my records to figure out what we estimated the military costs would be back before they made the decision to cover services. There was a cost study by the Palm Center that I was asked to review before they sent it to the DoD. I did and I thought their figures were wrong and told them so. If I recall right, I thought they were estimating too high. But it could be the other way. But they probably weren't so very wrong that it really mattered. Especially because it does not matter how little is spent on transgender care; as far as the public is concerned even a dime per person is too much.

...

7) SURGICAL RISK AND PRIOR HEALTH CONDITIONS

a) WPATH members discuss the risk for a patient that has Becker Muscular Dystrophy (BMD) to undergo transition surgery



Becker's MS and gender affirming care

[redacted]

Good day. I am a primary care provider who provides LGBTQ+ healthcare and recently saw a new patient for gender affirming hormone therapy with the goal for future gender affirming surgery (vaginoplasty).
Patient is a 22 yo trans woman who has a history of mild form of Becker MS, (rather than Duchenne) phenotype. The patient has been followed on a regular basis by a neuromuscular provider since childhood; maintains ambulation with no symptom progression. They have an x-linked inheritance which shows there is a 1/2 or 50% risk if assigned male at birth.
I cannot find any reason why we cannot proceed with gender affirming hormone therapy. But, patient is adamant on getting a vaginoplasty in the future and would like me to guide them regarding what risks/benefits would be around anesthesia.
Does anyone have any literature regarding the above pertaining to transgender patients?
I have found one recent study regarding laparoscopic gynecological surgery in cisgender woman with Beckers MS with the use of cisatracurium and inhaled sevoflurane, with a positive outcome.
I know this will be an interdisciplinary effort, but any information would greatly be appreciated. Thank you.

February 25, 2022

Submit

[redacted]

To answer your question about anesthesia and GA surgery, there is a lack of literature. I am working on publishing a case series of perioperative outcomes for over 200 GA we do at our institution. We created a speciality anesthesia team for gender-diverse youth and

developed Enhanced Recovery after Surgery ERAS and anesthesia management guidelines for chest reconstruction, phalloplasty, metoidioplasty and vaginoplasty procedures. There are risks with transgender patients who have co-exisiting morbidities such as DM and may affect anesthesia and pain management. Please feel free to reach out to me to discuss more.

March 1, 2022

Comment

[redacted]

Thank you for your response. I just may take you up on your offer! I will be in touch. Are the EAS and anesthesia management guidelines are accessible to folks outside of the organization?

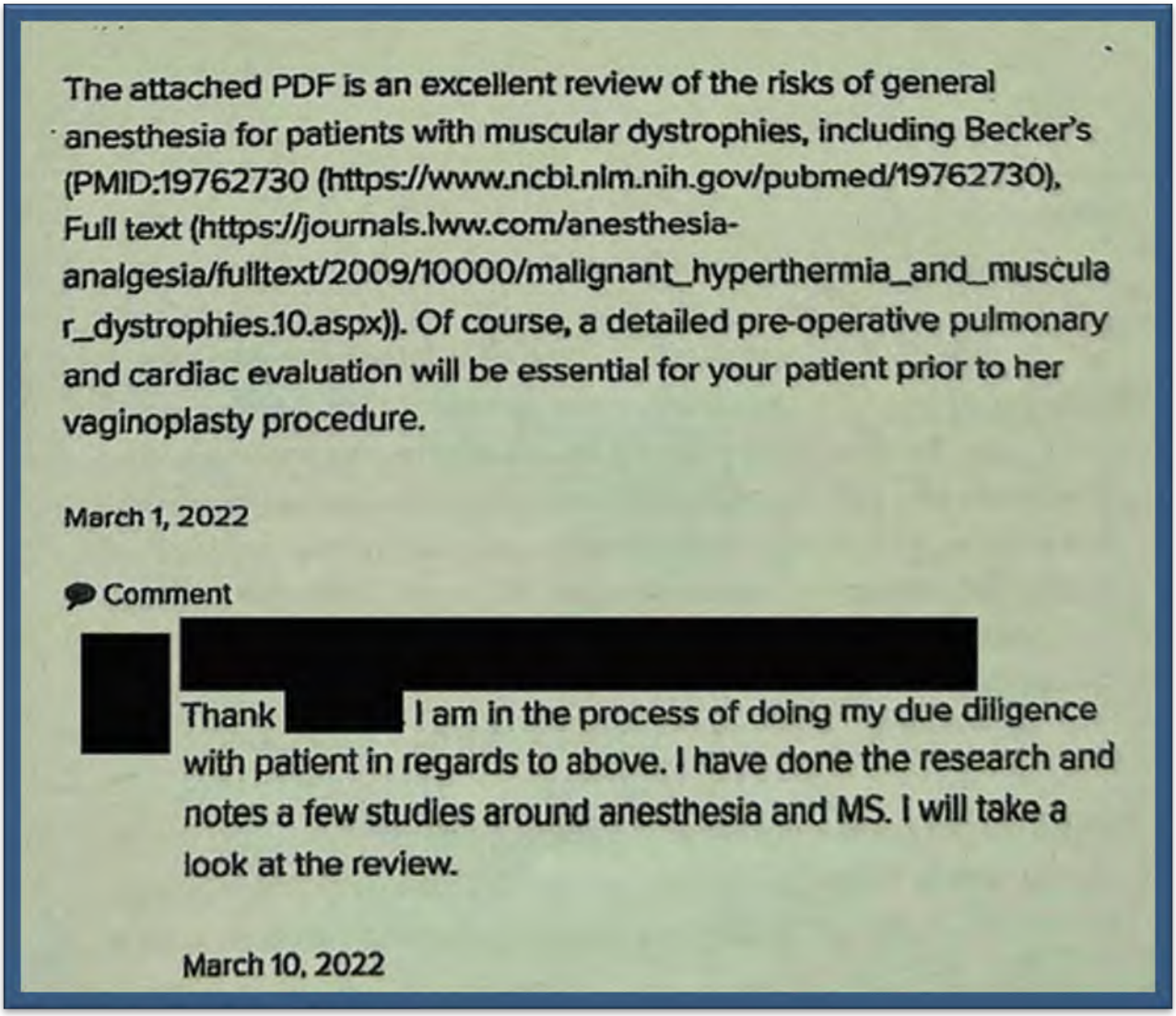
March 10, 2022

[redacted]

Please see our attached article (and link) the Gender Affirming Surgical Program (GASPP) in the Department of Anesthesiology, Critical Care and Pain Medicine at Boston Children's Hospital has done to advance the perioperative care for transgender youth.

A Single Center Case Series of Gender-Affirming Surgeries and the Evolution of a Specialty Anesthesia Team (https://www.mdpi.com/2077-0383/11/7/1943)

March 31, 2022



The attached PDF is an excellent review of the risks of general anesthesia for patients with muscular dystrophies, including Becker's (PMID:19762730 (https://www.ncbi.nlm.nih.gov/pubmed/19762730), Full text (https://journals.lww.com/anesthesia-analgesia/fulltext/2009/10000/malignant_hyperthermia_and_muscular_dystrophies.10.aspx)). Of course, a detailed pre-operative pulmonary and cardiac evaluation will be essential for your patient prior to her vaginoplasty procedure.

March 1, 2022

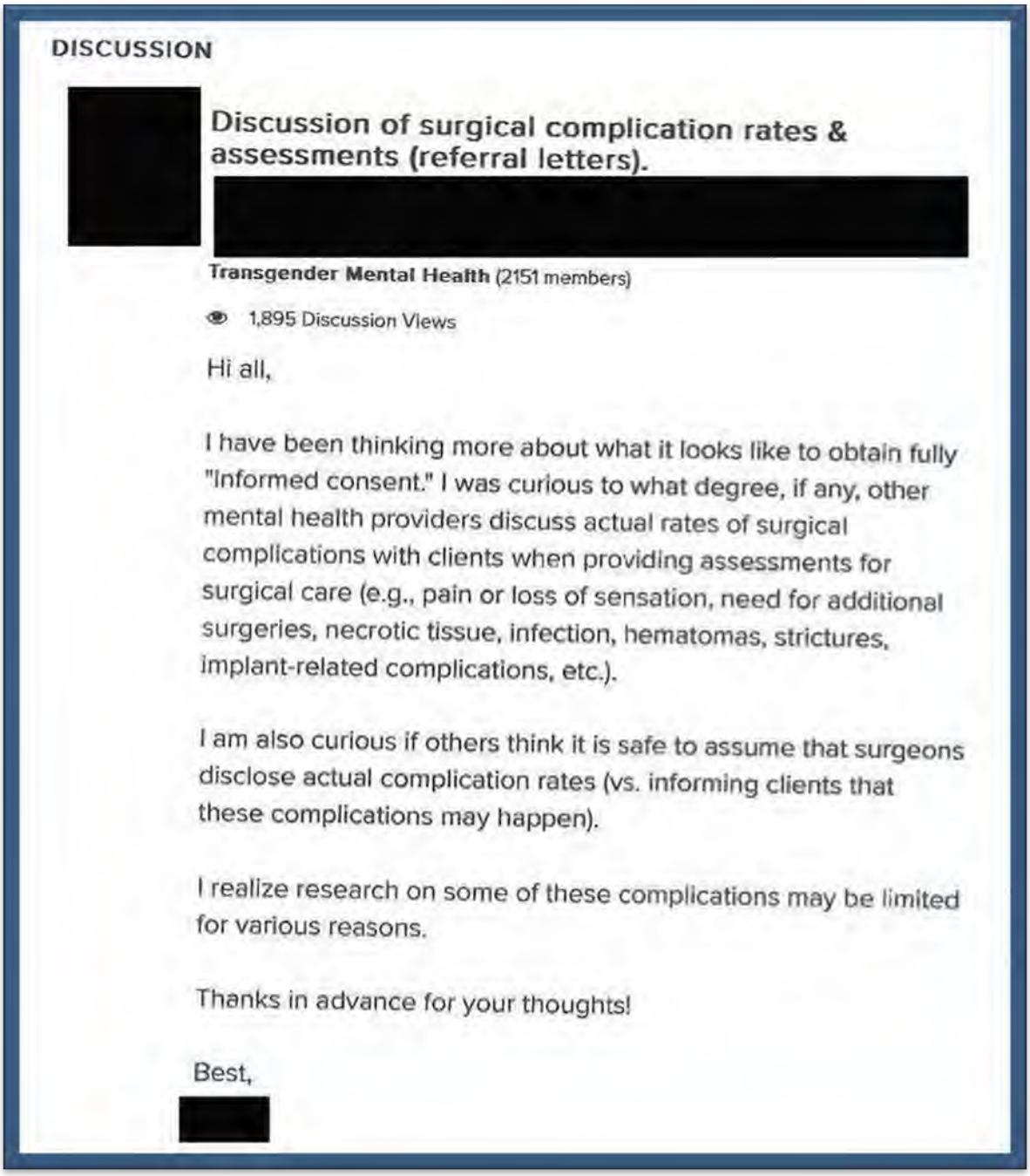
Comment

[redacted] Thank [redacted] I am in the process of doing my due diligence with patient in regards to above. I have done the research and notes a few studies around anesthesia and MS. I will take a look at the review.

March 10, 2022

8) COMPLICATION RATES AND INFORMED CONSENT

a) A WPATH member poses questions regarding standards for informed consent and the reality of complication rates



DISCUSSION

[redacted]

Discussion of surgical complication rates & assessments (referral letters).

[redacted]

Transgender Mental Health (2151 members)

1,895 Discussion Views

Hi all,

I have been thinking more about what it looks like to obtain fully "Informed consent." I was curious to what degree, if any, other mental health providers discuss actual rates of surgical complications with clients when providing assessments for surgical care (e.g., pain or loss of sensation, need for additional surgeries, necrotic tissue, infection, hematomas, strictures, implant-related complications, etc.).

I am also curious if others think it is safe to assume that surgeons disclose actual complication rates (vs. informing clients that these complications may happen).

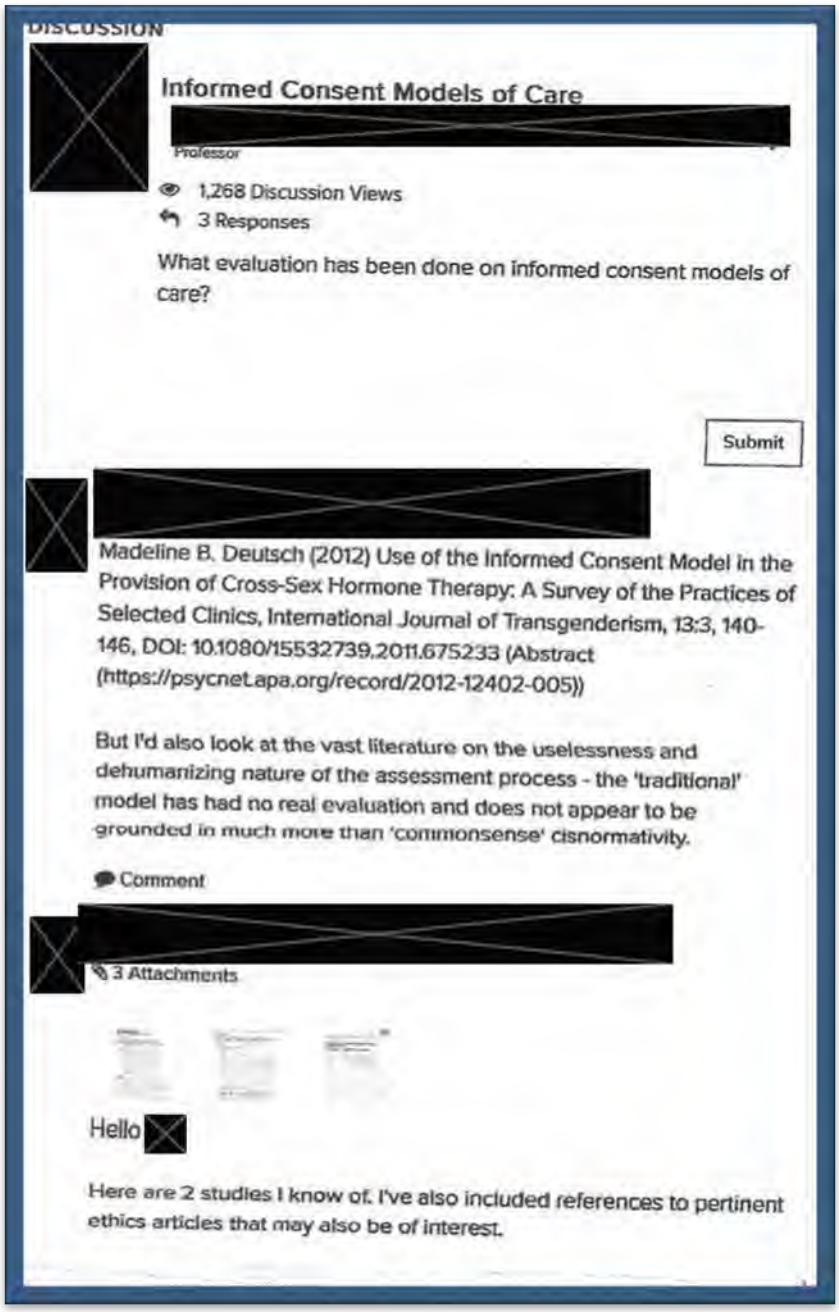
I realize research on some of these complications may be limited for various reasons.

Thanks in advance for your thoughts!

Best,

[redacted]

b) A WPATH member explains that the traditional model of informed consent is cis-normative



DISCUSSION

[redacted]

Informed Consent Models of Care

[redacted]

Professor

1,268 Discussion Views

3 Responses

What evaluation has been done on informed consent models of care?

Submit

[redacted]

Madeline B. Deutsch (2012) Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics, International Journal of Transgenderism, 13:3, 140-146, DOI: 10.1080/15532739.2011.675233 (Abstract (https://psycnet.apa.org/record/2012-12402-005))

But I'd also look at the vast literature on the uselessness and dehumanizing nature of the assessment process - the 'traditional' model has had no real evaluation and does not appear to be grounded in much more than 'commonsense' cisnormativity.

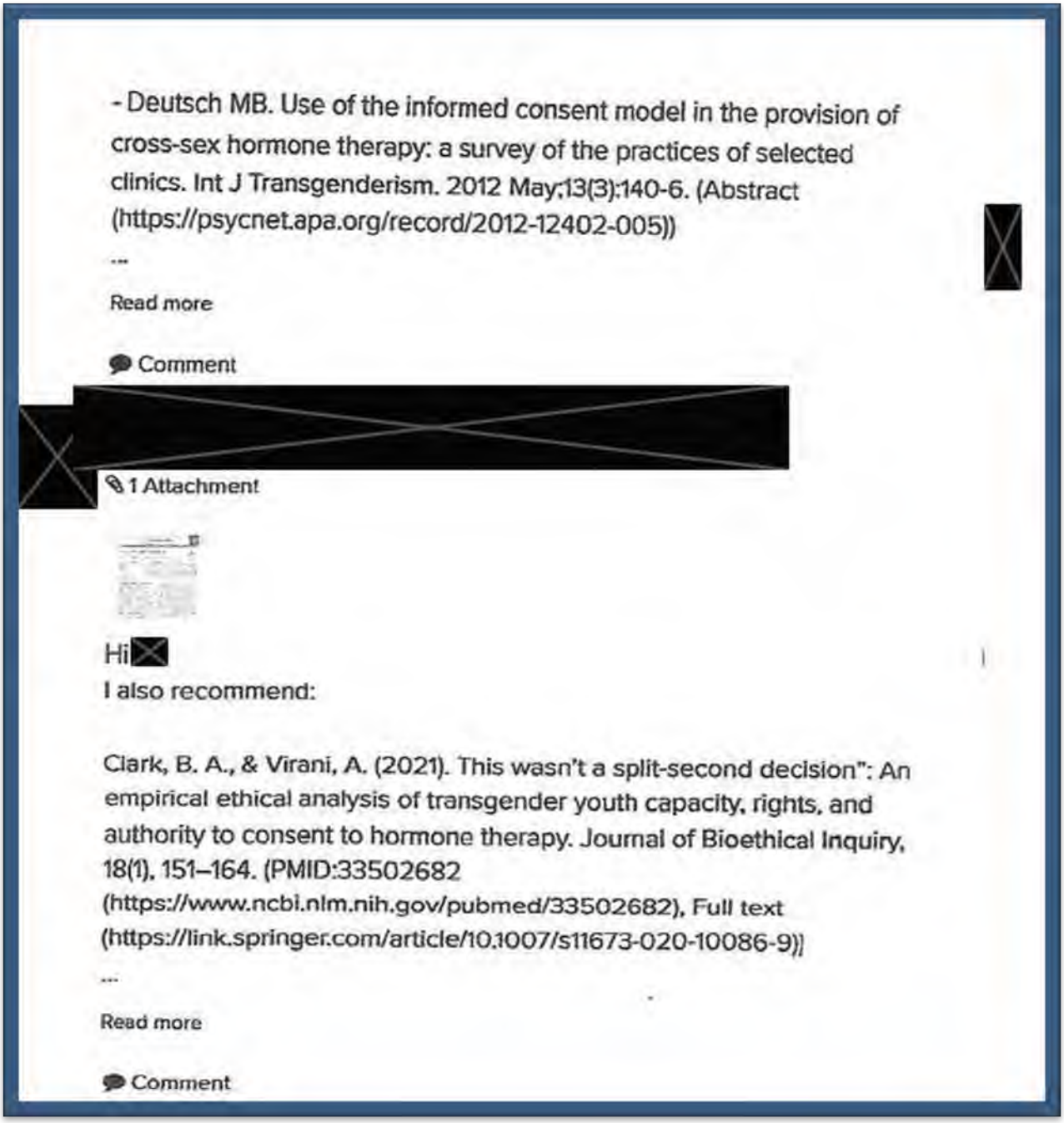
Comment

[redacted]

3 Attachments

Hello [redacted]

Here are 2 studies I know of. I've also included references to pertinent ethics articles that may also be of interest.



- Deutsch MB. Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. Int J Transgenderism. 2012 May;13(3):140-6. (Abstract (https://psycnet.apa.org/record/2012-12402-005))

...

Read more

Comment

[redacted]

1 Attachment

Hi [redacted]

I also recommend:

Clark, B. A., & Virani, A. (2021). This wasn't a split-second decision": An empirical ethical analysis of transgender youth capacity, rights, and authority to consent to hormone therapy. Journal of Bioethical Inquiry, 18(1), 151–164. (PMID:33502682 (https://www.ncbi.nlm.nih.gov/pubmed/33502682), Full text (https://link.springer.com/article/10.1007/s11673-020-10086-9))

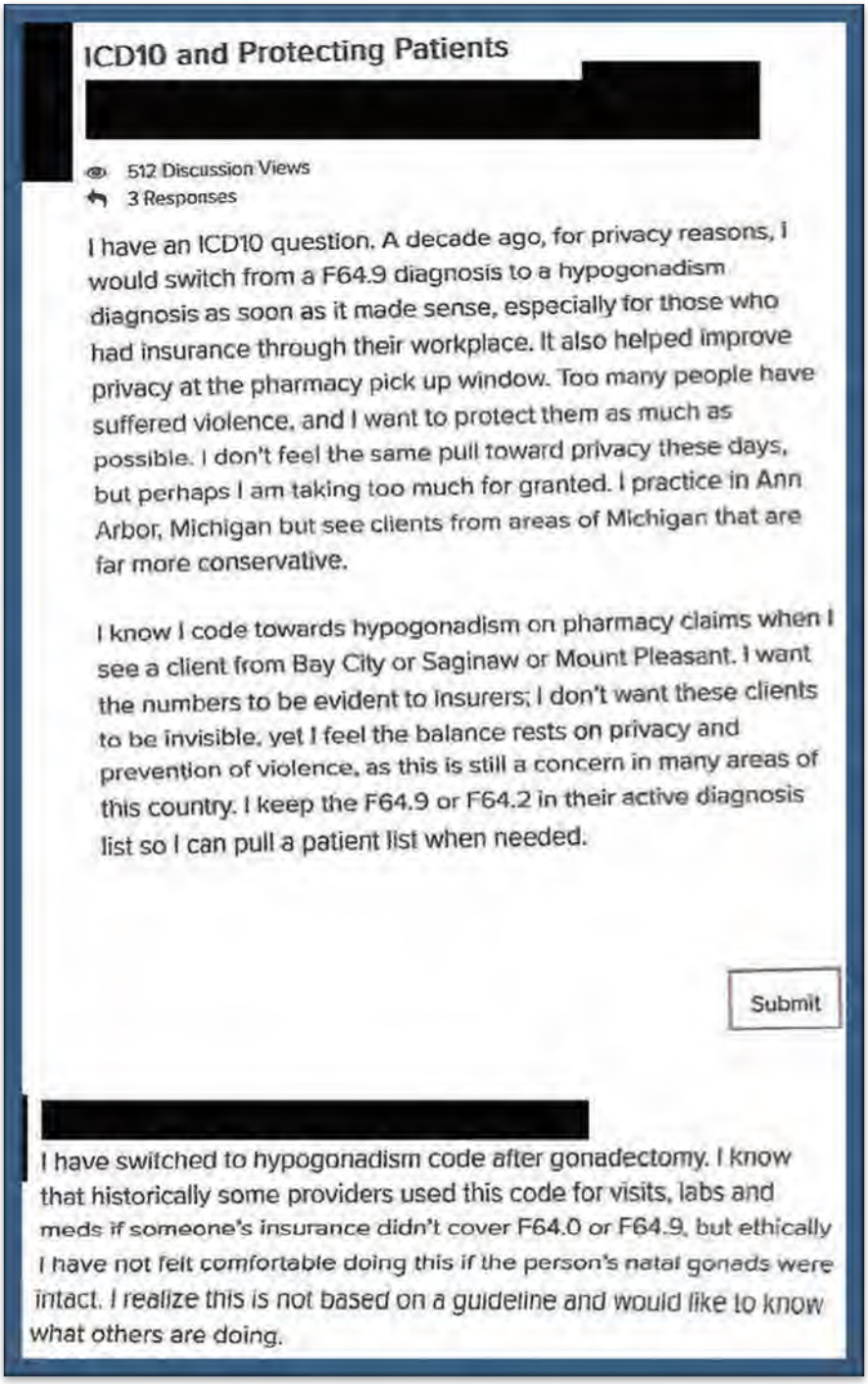
...

Read more

Comment

9) INSURANCE IN GENDER MEDICINE INTERVENTIONS

a) A WPATH member expresses concerns regarding data privacy in conservative areas



ICD10 and Protecting Patients

[redacted]

512 Discussion Views
3 Responses

I have an ICD10 question. A decade ago, for privacy reasons, I would switch from a F64.9 diagnosis to a hypogonadism diagnosis as soon as it made sense, especially for those who had insurance through their workplace. It also helped improve privacy at the pharmacy pick up window. Too many people have suffered violence, and I want to protect them as much as possible. I don't feel the same pull toward privacy these days, but perhaps I am taking too much for granted. I practice in Ann Arbor, Michigan but see clients from areas of Michigan that are far more conservative.

I know I code towards hypogonadism on pharmacy claims when I see a client from Bay City or Saginaw or Mount Pleasant. I want the numbers to be evident to insurers; I don't want these clients to be invisible, yet I feel the balance rests on privacy and prevention of violence, as this is still a concern in many areas of this country. I keep the F64.9 or F64.2 in their active diagnosis list so I can pull a patient list when needed.

Submit

[redacted]

I have switched to hypogonadism code after gonadectomy. I know that historically some providers used this code for visits, labs and meds if someone's insurance didn't cover F64.0 or F64.9, but ethically I have not felt comfortable doing this if the person's natal gonads were intact. I realize this is not based on a guideline and would like to know what others are doing.

[redacted]

What happened to endocrine disorder NOS as an alternative?

Comment

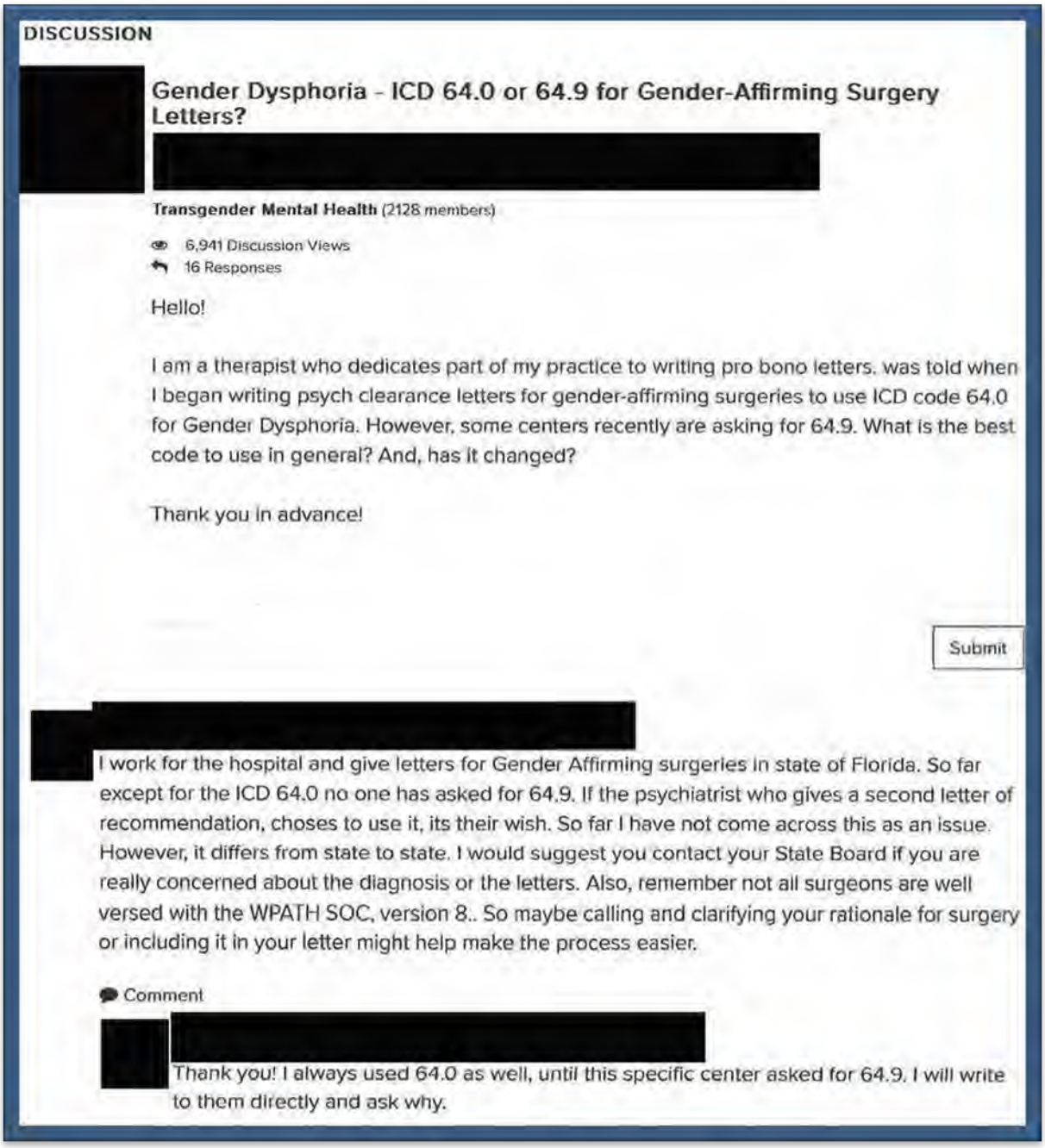
[redacted]

This is challenging to navigate - while the hypogonadism and endocrine disorder NOS are helpful to offer privacy and safety, justifying these codes to an insurer frequently results in an insurer pushing back for lab work justifying low testosterone or low estrogen at certain intervals (usually with an annual PA for controlled substances). For someone on long-term hormone therapy, justifying this is nearly impossible without going off of their hormones for a period of time to meet an insurer's required lab levels for coverage.

I would advise asking your patients directly about their comfort, explaining to them the logistical issues associated with obtaining medications (i.e. coding, concerns with privacy), and creating a course of action in collaboration with the patient. Presuming that a patient has coverage for gender-affirming care in their plan, I would consider keeping gender dysphoria-related ICD-10 coding (most insurers will not require bloodwork for this diagnosis) and advising requesting meds through their insurer's preferred mail order pharmacy - this negates potential conflict or safety issues with a less affirming pharmacist in their area. Another benefit of a mail-order option is that a patient can obtain a 90 day supply of their meds, also reducing potential pharmacist-patient contact.

Comment

b) WPATH members discuss how to classify gender dysphoria using ICD for insurance benefits



DISCUSSION

[redacted]

Gender Dysphoria - ICD 64.0 or 64.9 for Gender-Affirming Surgery Letters?

[redacted]

Transgender Mental Health (2128 members)

6,941 Discussion Views

16 Responses

Hello!

I am a therapist who dedicates part of my practice to writing pro bono letters. was told when I began writing psych clearance letters for gender-affirming surgeries to use ICD code 64.0 for Gender Dysphoria. However, some centers recently are asking for 64.9. What is the best code to use in general? And, has it changed?

Thank you in advance!

Submit

[redacted]

I work for the hospital and give letters for Gender Affirming surgeries in state of Florida. So far except for the ICD 64.0 no one has asked for 64.9. If the psychiatrist who gives a second letter of recommendation, choses to use it, its their wish. So far I have not come across this as an issue. However, it differs from state to state. I would suggest you contact your State Board if you are really concerned about the diagnosis or the letters. Also, remember not all surgeons are well versed with the WPATH SOC, version 8.. So maybe calling and clarifying your rationale for surgery or including it in your letter might help make the process easier.

Comment

[redacted]

Thank you! I always used 64.0 as well, until this specific center asked for 64.9. I will write to them directly and ask why.

[redacted] Insurance isn't taking 64.0 for me.

Comment

[redacted] Interesting!

[redacted] Did it used to?

[redacted] It may have to do with wording. F64.0 in the DSM is Gender dysphoria in an adult or adolescent but in ICD-10 its title is Transexualism and F64.9 is gender identity disorder, unspecified. If you're reading diagnostic criteria in both the DSM and ICD 10, F64.0 is the most accurate but F64.9 isn't inaccurate. I know in our EMR if you search the diagnosis with DSM title it only comes up as F64.9. I end up manually coding F64.0 and then modifying language to match DSM.

Comment

[redacted] "F64.0 is the most accurate but F64.9 isn't inaccurate" - that is exactly the thesis statement here! I wonder if we can list two F diagnosis to cover all bases.

[redacted] This tracks with what I have noticed as well. My EHR will list Dual role transvestism, and my staff cannot figure out how to change the wording in our system. So I have moved to using F64.9 more often for that reason.

[redacted] It sounds like you are writing for gender care services that specify they want a diagnosis. As my writing style for letters has evolved over the years, I have made an effort not to use a diagnosis when sending information to insurance companies. And so far, I haven't been contacted and asked for a diagnosis. Instead, my letters read something like "X meets the recommended World Professional Association for Transgender Health (WPATH) Standards of Care guidelines for the type of surgery he is pursuing." Then I outline all of the criteria and provide information to support that the person fits the criteria.

Comment

[redacted] Interesting [redacted] I did not know they would be approved without the diagnosis!

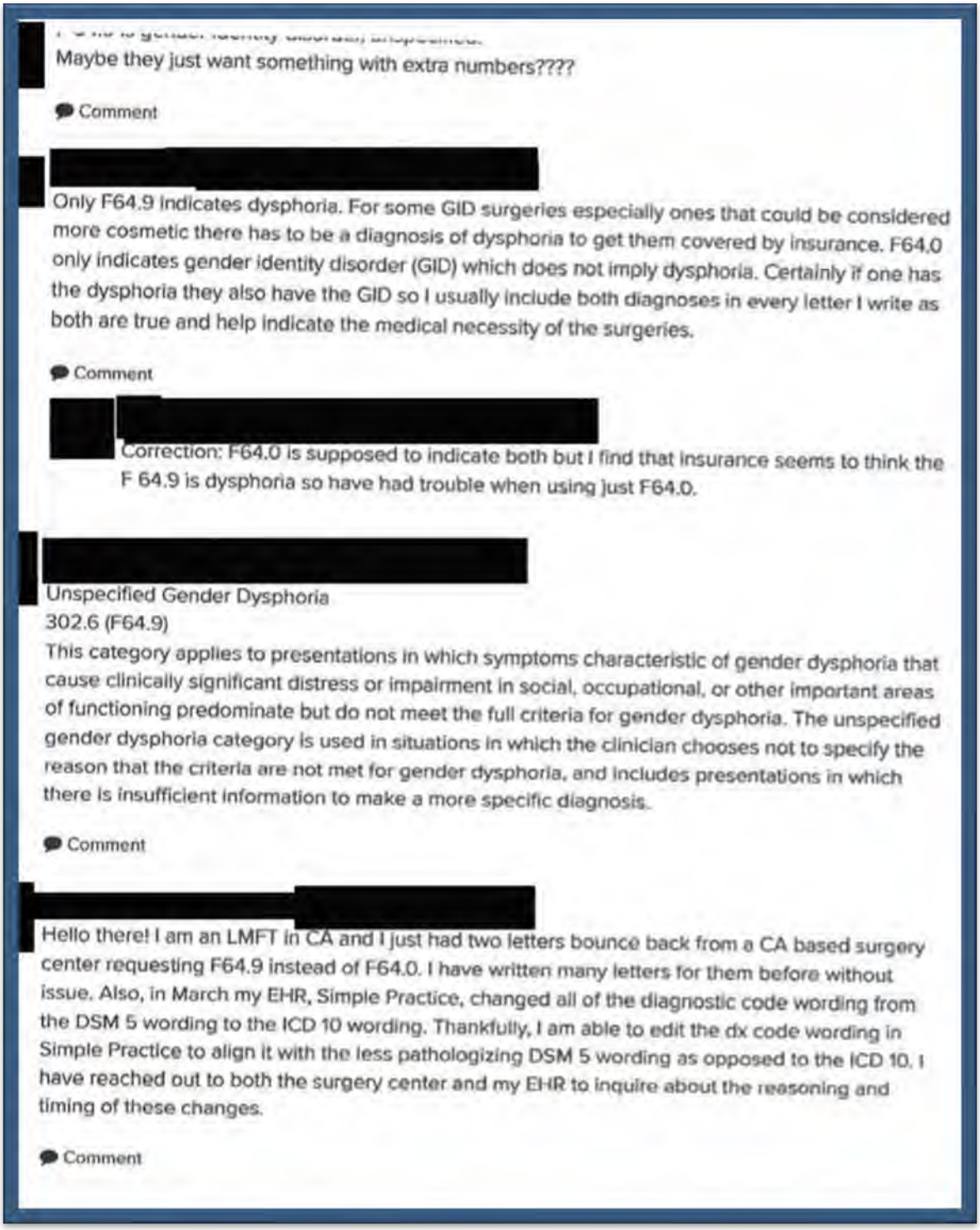
[redacted] LPC-MHSP in Tennessee here.

I've so far (fingers crossed) never had a letter rejected (mostly BCBS, United). I've never this far used F64.0—"Transsexualism" if I'm remembering correctly—as it hasn't yet described clients I've seen seeking letters. I've been using F64.9, which in some electronic health care systems (I've called mine about this and griped about it to them) automatically defaults to "Gender Identity Disorder" but in the coding of DSM-V, I see as being "gender dysphoria in adolescents and adults." So I put that title in with the proper F64.9. So far so good.

In my letters I've been specifically identifying both the ICD-10 code for insurance purposes and...

Read more

Comment



[redacted] is gender identity disorder, unspecified.

Maybe they just want something with extra numbers????

Comment

[redacted]

Only F64.9 indicates dysphoria. For some GID surgeries especially ones that could be considered more cosmetic there has to be a diagnosis of dysphoria to get them covered by insurance. F64.0 only indicates gender identity disorder (GID) which does not imply dysphoria. Certainly if one has the dysphoria they also have the GID so I usually include both diagnoses in every letter I write as both are true and help indicate the medical necessity of the surgeries.

Comment

[redacted]

Correction: F64.0 is supposed to indicate both but I find that insurance seems to think the F 64.9 is dysphoria so have had trouble when using just F64.0.

[redacted]

Unspecified Gender Dysphoria
302.6 (F64.9)
This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

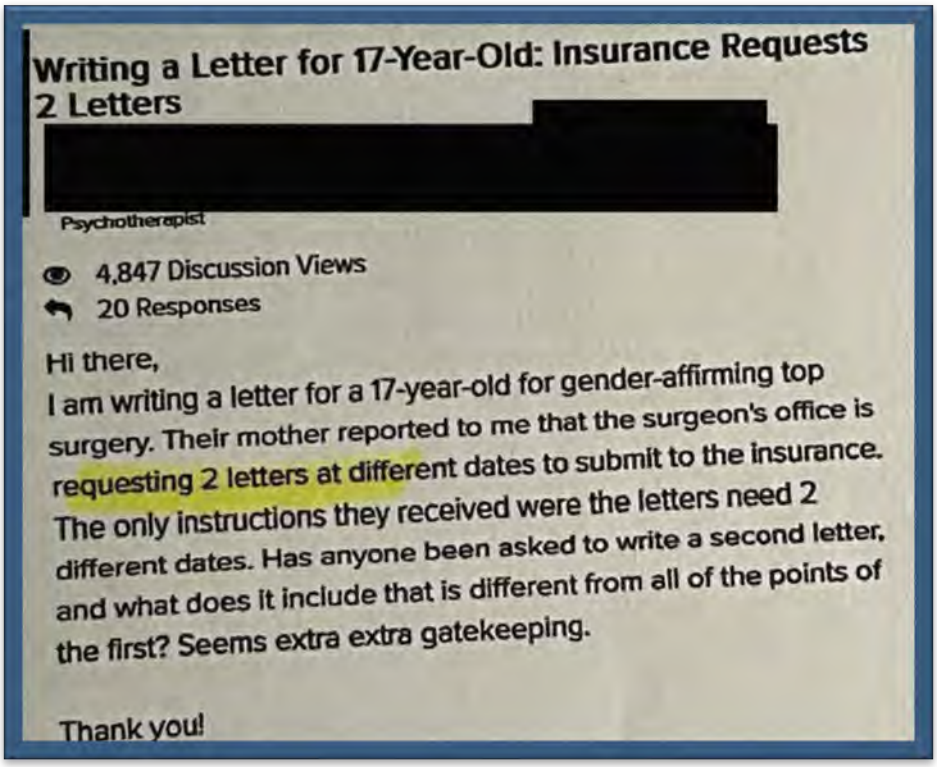
Comment

[redacted]

Hello there! I am an LMFT in CA and I just had two letters bounce back from a CA based surgery center requesting F64.9 instead of F64.0. I have written many letters for them before without issue. Also, in March my EHR, Simple Practice, changed all of the diagnostic code wording from the DSM 5 wording to the ICD 10 wording. Thankfully, I am able to edit the dx code wording in Simple Practice to align it with the less pathologizing DSM 5 wording as opposed to the ICD 10. I have reached out to both the surgery center and my EHR to inquire about the reasoning and timing of these changes.

Comment

c) WPATH members characterize a two-letter requirement for transition surgery as gatekeeping



Writing a Letter for 17-Year-Old: Insurance Requests 2 Letters

[redacted]

Psychotherapist

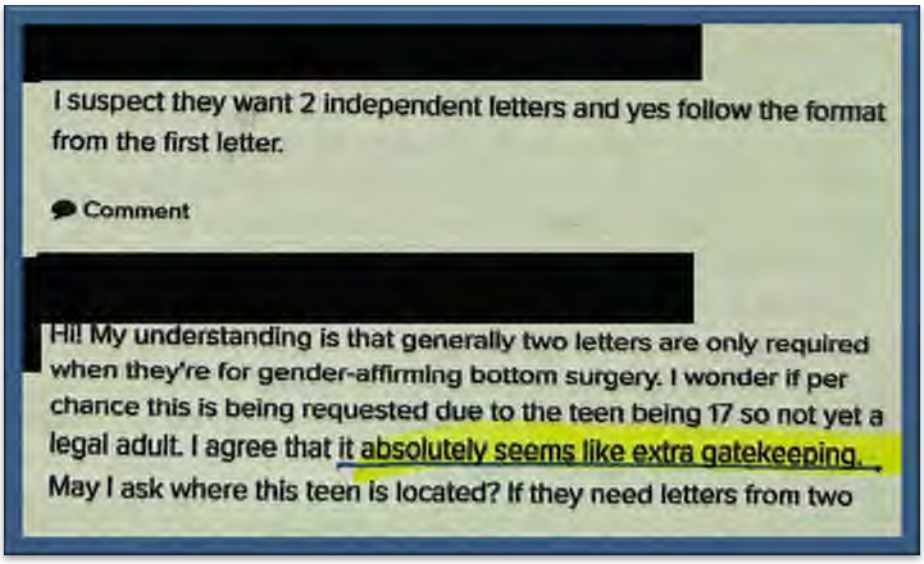
4,847 Discussion Views

20 Responses

Hi there,

I am writing a letter for a 17-year-old for gender-affirming top surgery. Their mother reported to me that the surgeon's office is requesting 2 letters at different dates to submit to the insurance. The only instructions they received were the letters need 2 different dates. Has anyone been asked to write a second letter, and what does it include that is different from all of the points of the first? Seems extra extra gatekeeping.

Thank you!



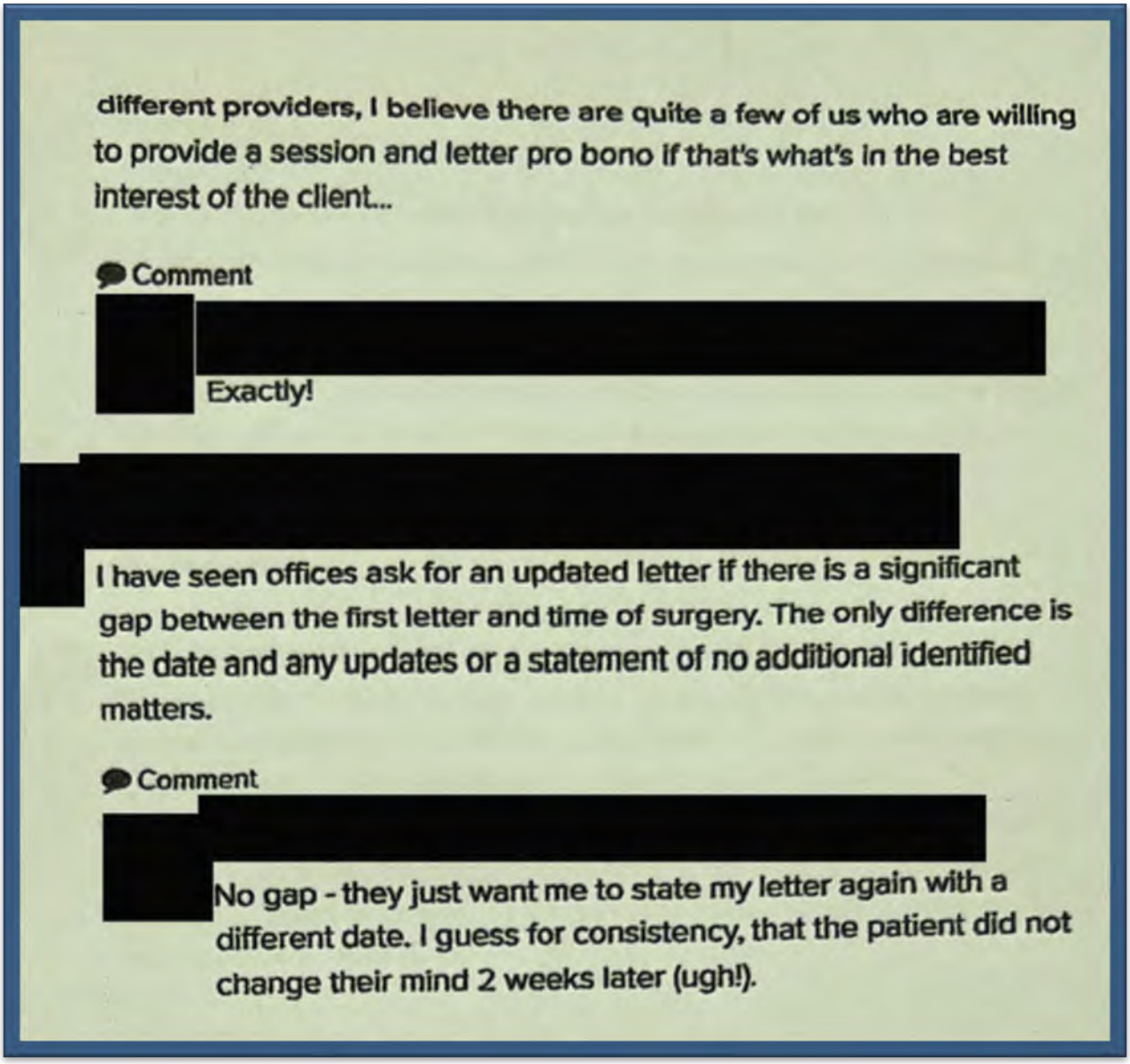
[redacted]

I suspect they want 2 independent letters and yes follow the format from the first letter.

Comment

[redacted]

Hi! My understanding is that generally two letters are only required when they're for gender-affirming bottom surgery. I wonder if per chance this is being requested due to the teen being 17 so not yet a legal adult. I agree that it absolutely seems like extra gatekeeping. May I ask where this teen is located? If they need letters from two



different providers, I believe there are quite a few of us who are willing to provide a session and letter pro bono if that's what's in the best interest of the client...

Comment

[redacted] Exactly!

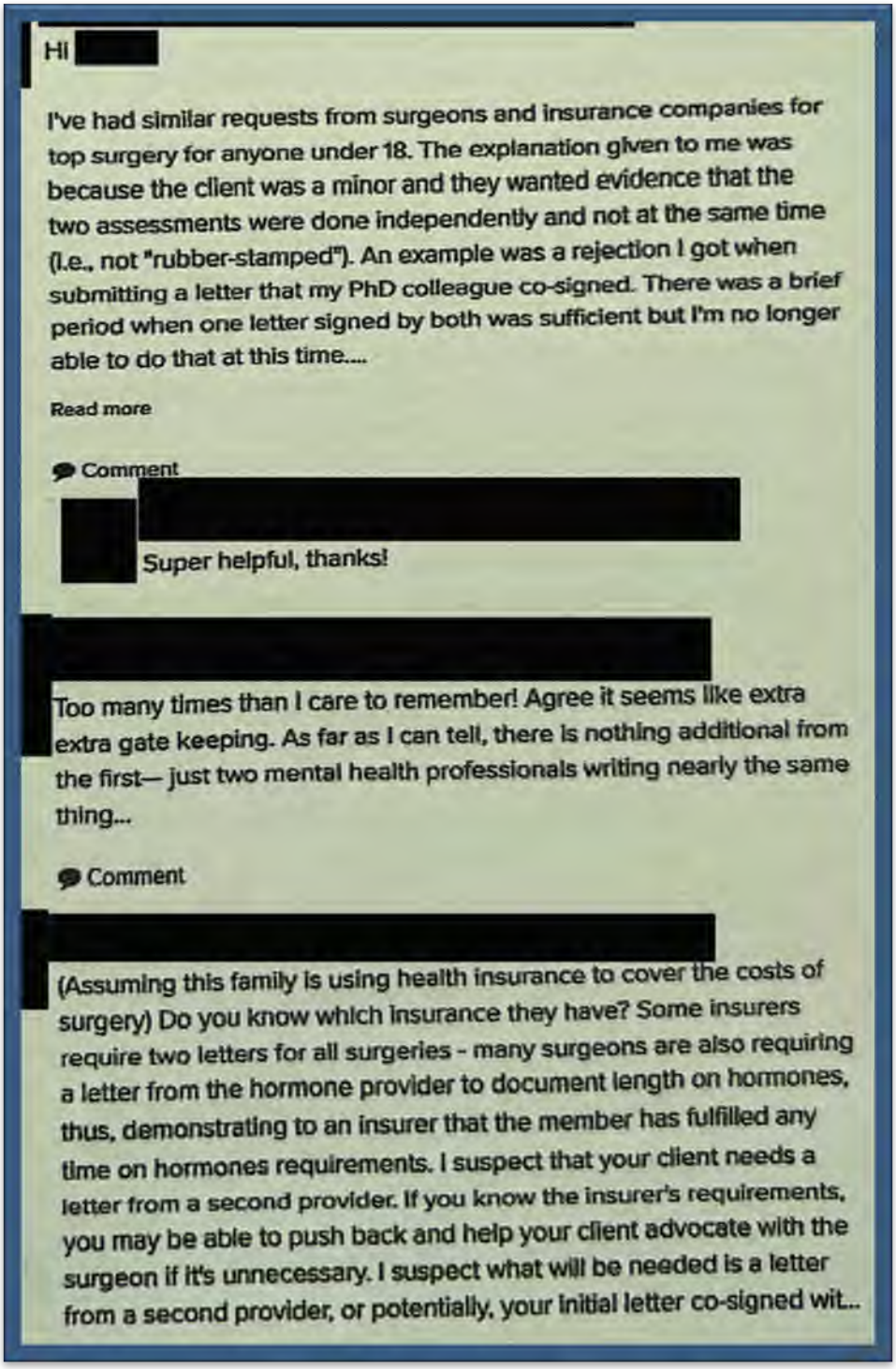
[redacted]

I have seen offices ask for an updated letter if there is a significant gap between the first letter and time of surgery. The only difference is the date and any updates or a statement of no additional identified matters.

Comment

[redacted]

No gap - they just want me to state my letter again with a different date. I guess for consistency, that the patient did not change their mind 2 weeks later (ugh!).



Hi [redacted]

I've had similar requests from surgeons and insurance companies for top surgery for anyone under 18. The explanation given to me was because the client was a minor and they wanted evidence that the two assessments were done independently and not at the same time (i.e., not "rubber-stamped"). An example was a rejection I got when submitting a letter that my PhD colleague co-signed. There was a brief period when one letter signed by both was sufficient but I'm no longer able to do that at this time....

Read more

Comment

[redacted] Super helpful, thanks!

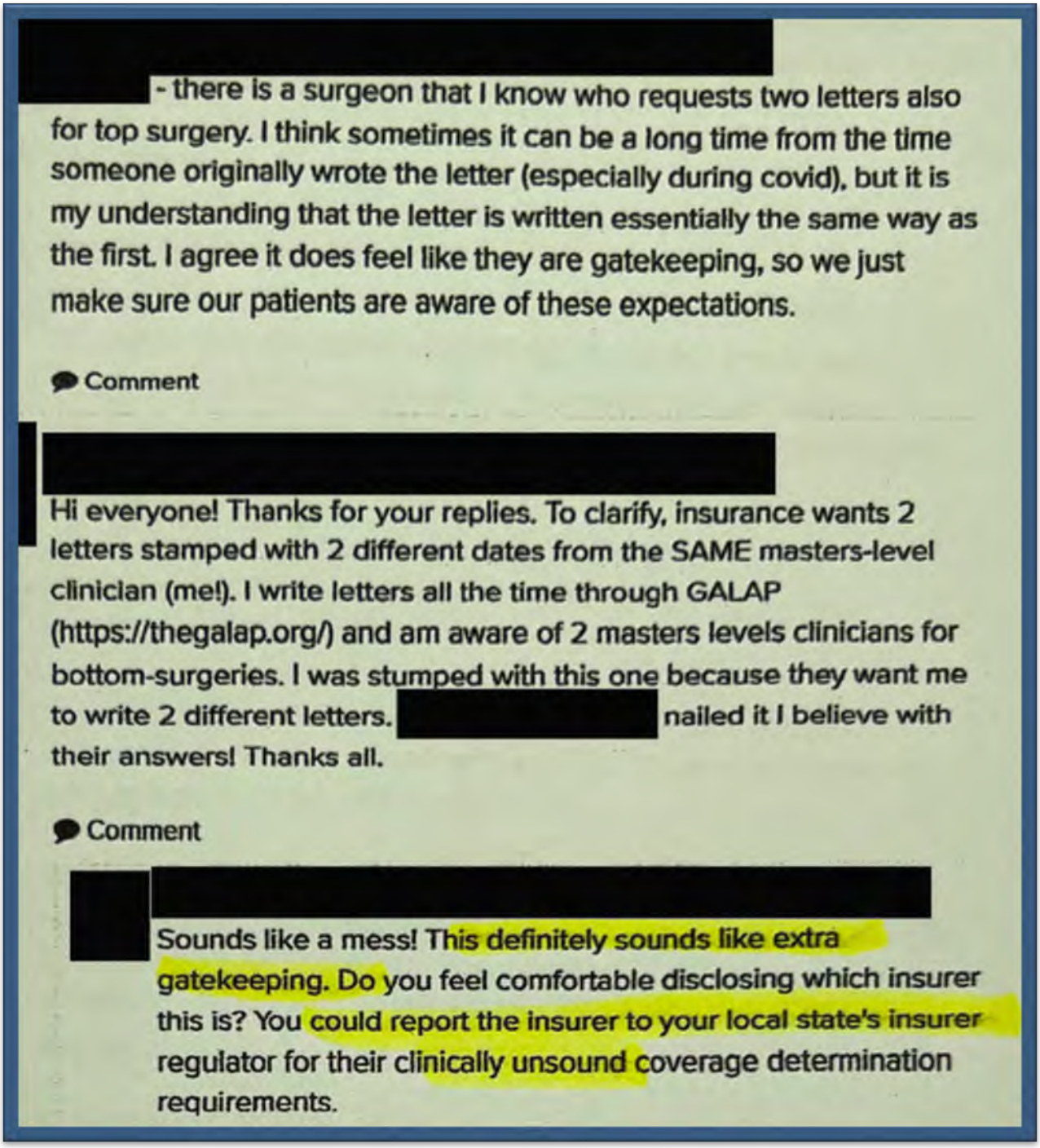
[redacted]

Too many times than I care to remember! Agree it seems like extra extra gate keeping. As far as I can tell, there is nothing additional from the first— just two mental health professionals writing nearly the same thing...

Comment

[redacted]

(Assuming this family is using health insurance to cover the costs of surgery) Do you know which insurance they have? Some insurers require two letters for all surgeries - many surgeons are also requiring a letter from the hormone provider to document length on hormones, thus, demonstrating to an insurer that the member has fulfilled any time on hormones requirements. I suspect that your client needs a letter from a second provider. If you know the insurer's requirements, you may be able to push back and help your client advocate with the surgeon if it's unnecessary. I suspect what will be needed is a letter from a second provider, or potentially, your initial letter co-signed wit...



[redacted] - there is a surgeon that I know who requests two letters also for top surgery. I think sometimes it can be a long time from the time someone originally wrote the letter (especially during covid), but it is my understanding that the letter is written essentially the same way as the first. I agree it does feel like they are gatekeeping, so we just make sure our patients are aware of these expectations.

Comment

[redacted]

Hi everyone! Thanks for your replies. To clarify, insurance wants 2 letters stamped with 2 different dates from the SAME masters-level clinician (me!). I write letters all the time through GALAP (https://thegalap.org/) and am aware of 2 masters levels clinicians for bottom-surgeries. I was stumped with this one because they want me to write 2 different letters. [redacted] nailed it I believe with their answers! Thanks all.

Comment

[redacted]

Sounds like a mess! This definitely sounds like extra gatekeeping. Do you feel comfortable disclosing which insurer this is? You could report the insurer to your local state's insurer regulator for their clinically unsound coverage determination requirements.

[redacted]

In my experience working with the transgender community for over twenty years, usually when a second letter is requested, it is to be written by an independent qualified professional who conducts a one or two visit consultation to confirm the treating professional's diagnosis of Gender Dysphoria and opinion that the patient is eligible and ready for Gender Confirmation Surgery. While many surgeons will accept a single letter for top surgery my guess is that this particular surgeon may want to make absolutely certain that surgery is indicated for this patient because of his young age....

Read more

Comment

[redacted]

I have not heard of a request for two letters from the same provider for the same procedure before. The only thing I can think of is to show that the status of the client did not change over time?

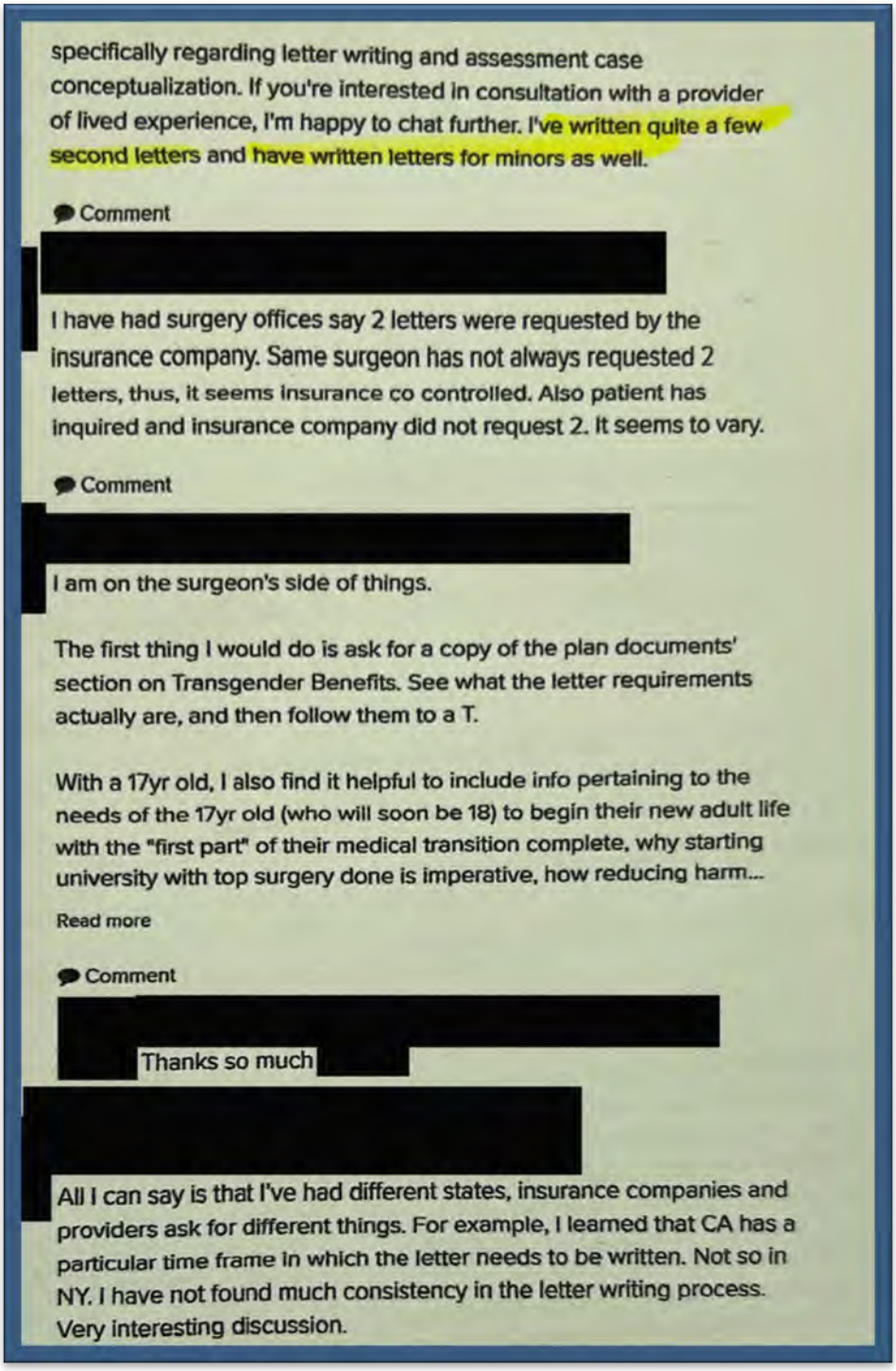
Comment

[redacted]

Same thought, thanks!

[redacted]

I'm [redacted] (they/them) and I provide professional consultation



specifically regarding letter writing and assessment case conceptualization. If you're interested in consultation with a provider of lived experience, I'm happy to chat further. I've written quite a few second letters and have written letters for minors as well.

Comment

[redacted]

I have had surgery offices say 2 letters were requested by the insurance company. Same surgeon has not always requested 2 letters, thus, it seems insurance co controlled. Also patient has inquired and insurance company did not request 2. It seems to vary.

Comment

[redacted]

I am on the surgeon's side of things.

The first thing I would do is ask for a copy of the plan documents' section on Transgender Benefits. See what the letter requirements actually are, and then follow them to a T.

With a 17yr old, I also find it helpful to include info pertaining to the needs of the 17yr old (who will soon be 18) to begin their new adult life with the "first part" of their medical transition complete, why starting university with top surgery done is imperative, how reducing harm...

Read more

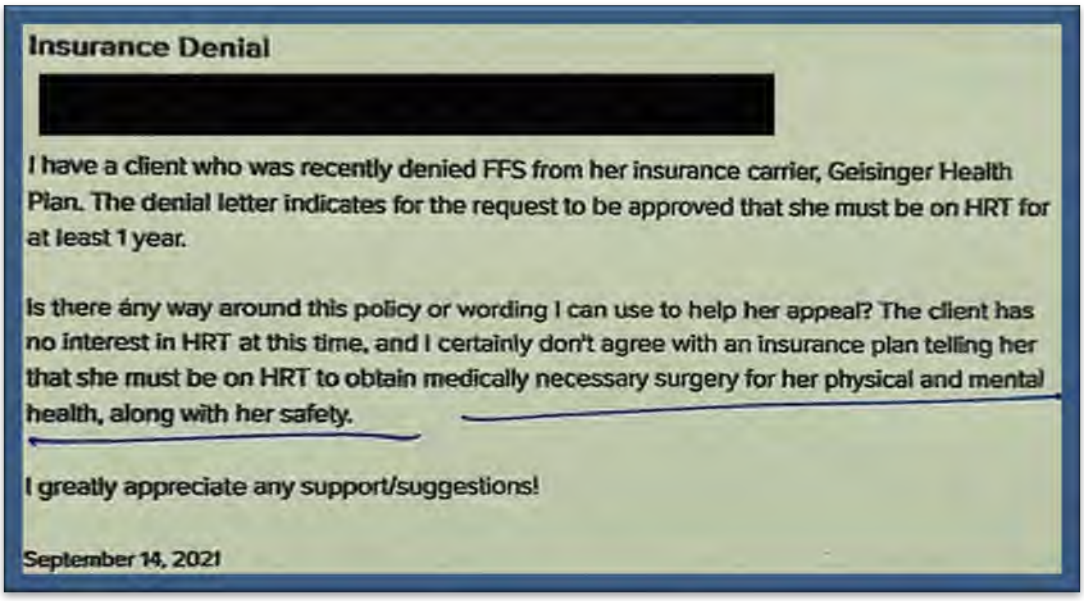
Comment

[redacted]

Thanks so much [redacted]

All I can say is that I've had different states, insurance companies and providers ask for different things. For example, I learned that CA has a particular time frame in which the letter needs to be written. Not so in NY. I have not found much consistency in the letter writing process. Very interesting discussion.

d) A WPATH member states that surgery is necessary for mental and physical health despite insurance denial, seeking a way to circumvent the insurance policy



Insurance Denial

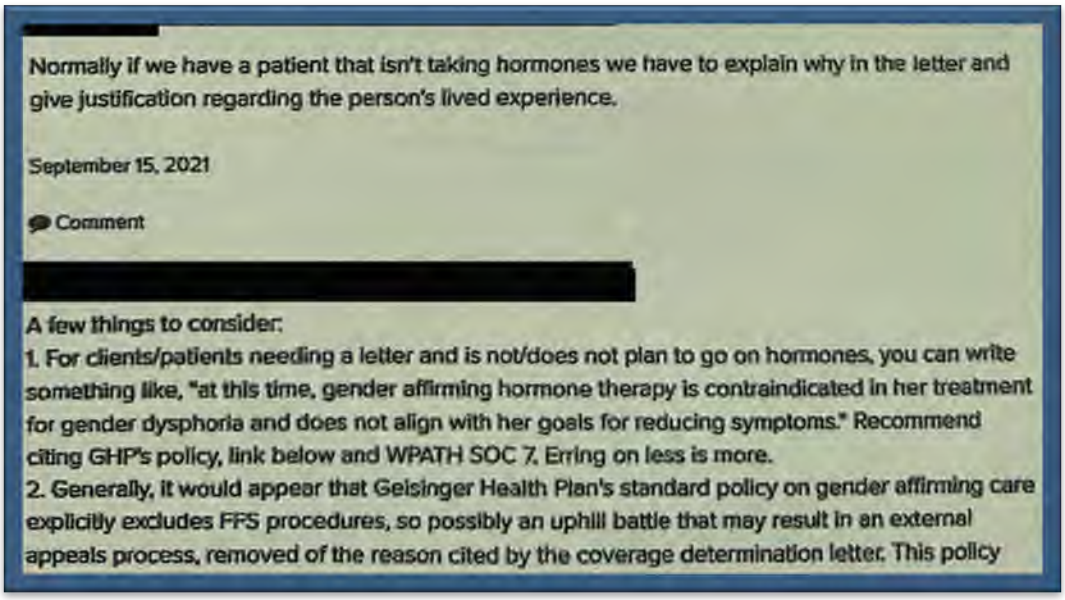
[redacted]

I have a client who was recently denied FFS from her insurance carrier, Geisinger Health Plan. The denial letter indicates for the request to be approved that she must be on HRT for at least 1 year.

Is there any way around this policy or wording I can use to help her appeal? The client has no interest in HRT at this time, and I certainly don't agree with an insurance plan telling her that she must be on HRT to obtain medically necessary surgery for her physical and mental health, along with her safety.

I greatly appreciate any support/suggestions!

September 14, 2021



[redacted]

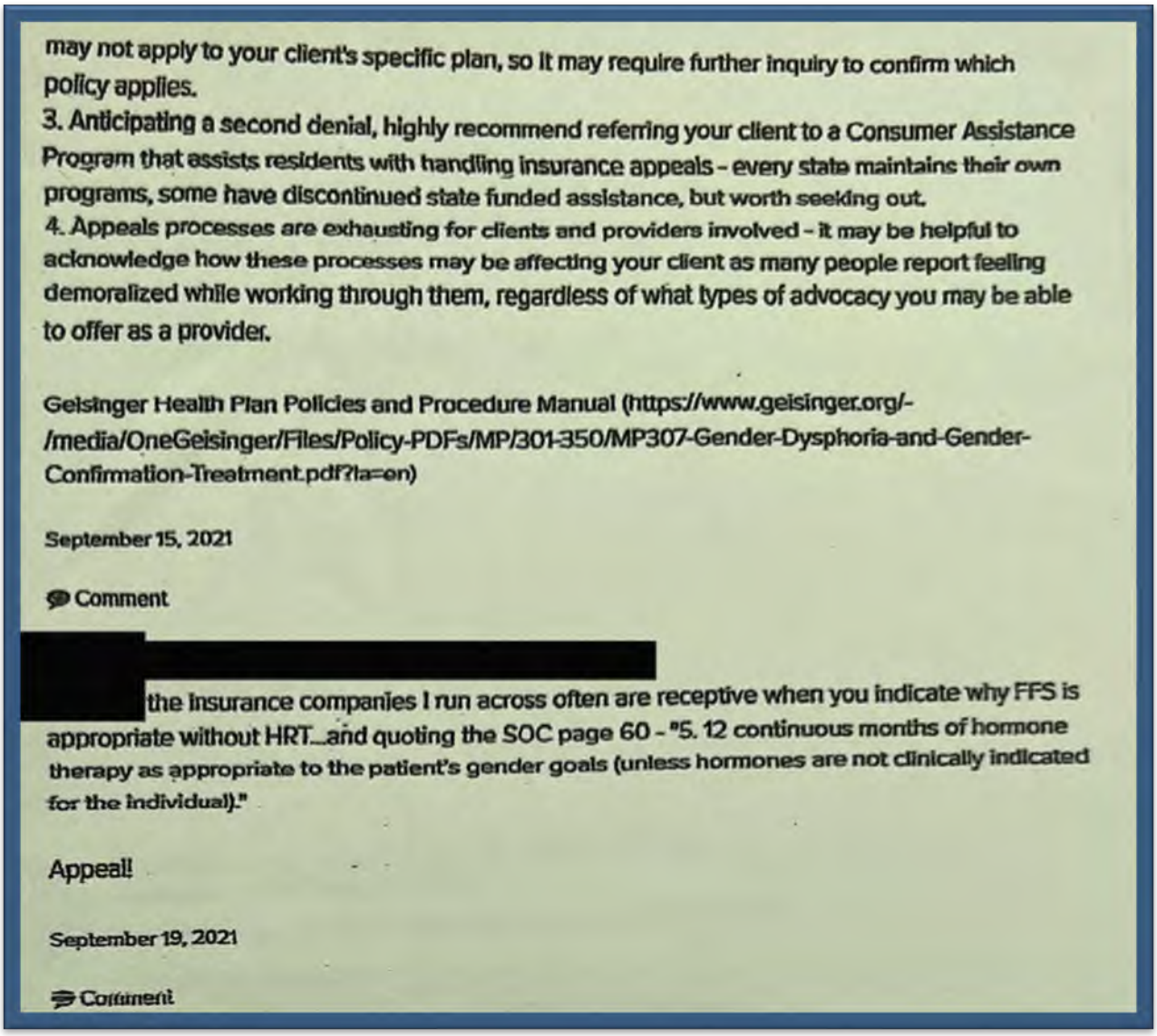
Normally if we have a patient that isn't taking hormones we have to explain why in the letter and give justification regarding the person's lived experience.

September 15, 2021

Comment

[redacted]

A few things to consider:
1. For clients/patients needing a letter and is not/does not plan to go on hormones, you can write something like, "at this time, gender affirming hormone therapy is contraindicated in her treatment for gender dysphoria and does not align with her goals for reducing symptoms." Recommend citing GHP's policy, link below and WPATH SOC 7. Erring on less is more.
2. Generally, it would appear that Geisinger Health Plan's standard policy on gender affirming care explicitly excludes FFS procedures, so possibly an uphill battle that may result in an external appeals process, removed of the reason cited by the coverage determination letter. This policy



may not apply to your client's specific plan, so it may require further inquiry to confirm which policy applies.
3. Anticipating a second denial, highly recommend referring your client to a Consumer Assistance Program that assists residents with handling insurance appeals - every state maintains their own programs, some have discontinued state funded assistance, but worth seeking out.
4. Appeals processes are exhausting for clients and providers involved - it may be helpful to acknowledge how these processes may be affecting your client as many people report feeling demoralized while working through them, regardless of what types of advocacy you may be able to offer as a provider.

Geisinger Health Plan Policies and Procedure Manual (https://www.geisinger.org/-/media/OneGeisinger/Files/Policy-PDFs/MP/301-350/MP307-Gender-Dysphoria-and-Gender-Confirmation-Treatment.pdf?la=en)

September 15, 2021

Comment

[redacted] the insurance companies I run across often are receptive when you indicate why FFS is appropriate without HRT...and quoting the SOC page 60 - "5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual)."

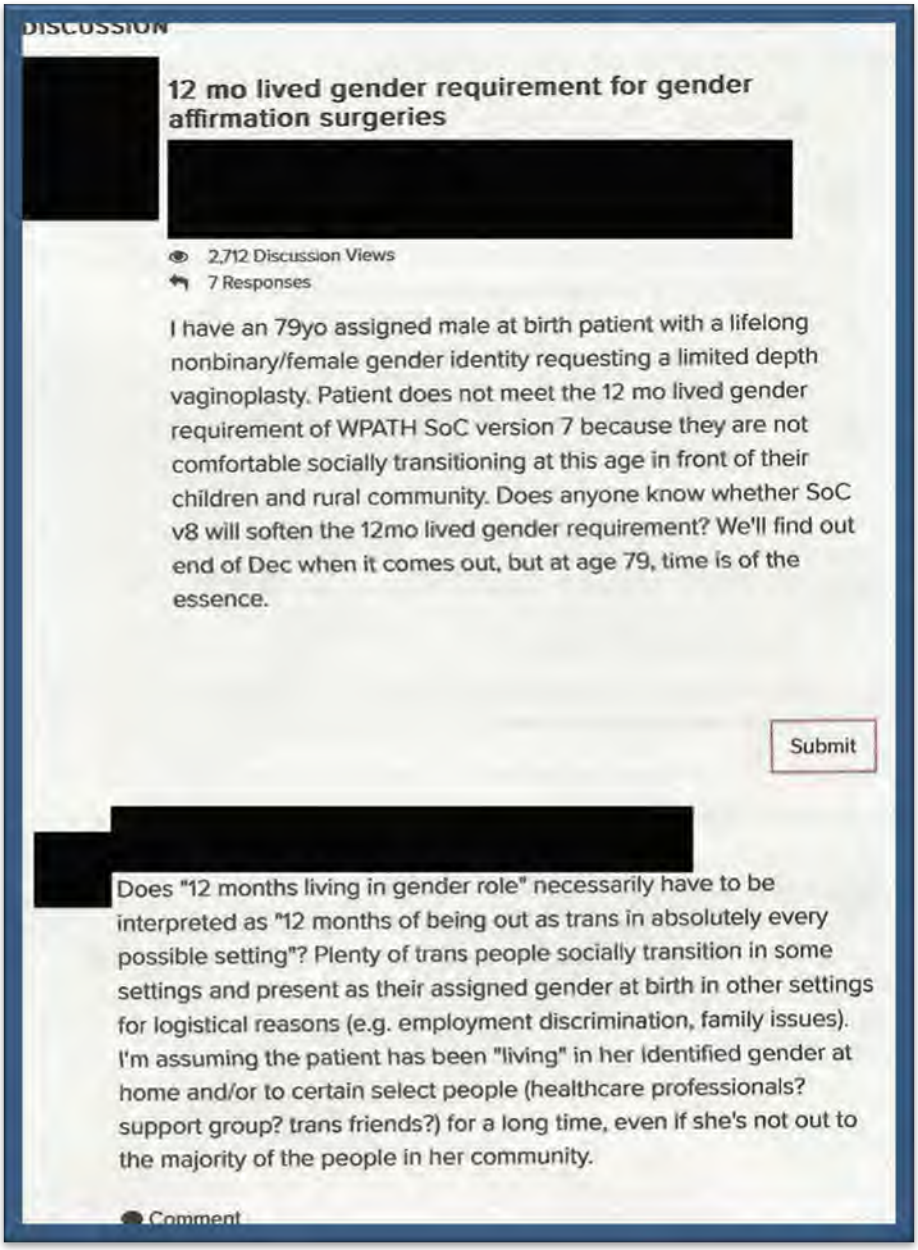
Appeal!

September 19, 2021

Comment

10) LIVED EXPERIENCE GUIDELINES FOR TRANSITION

a) WPATH members discuss potential vaginoplasty in elderly patient



DISCUSSION

[redacted]

12 mo lived gender requirement for gender affirmation surgeries

[redacted]

2,712 Discussion Views

7 Responses

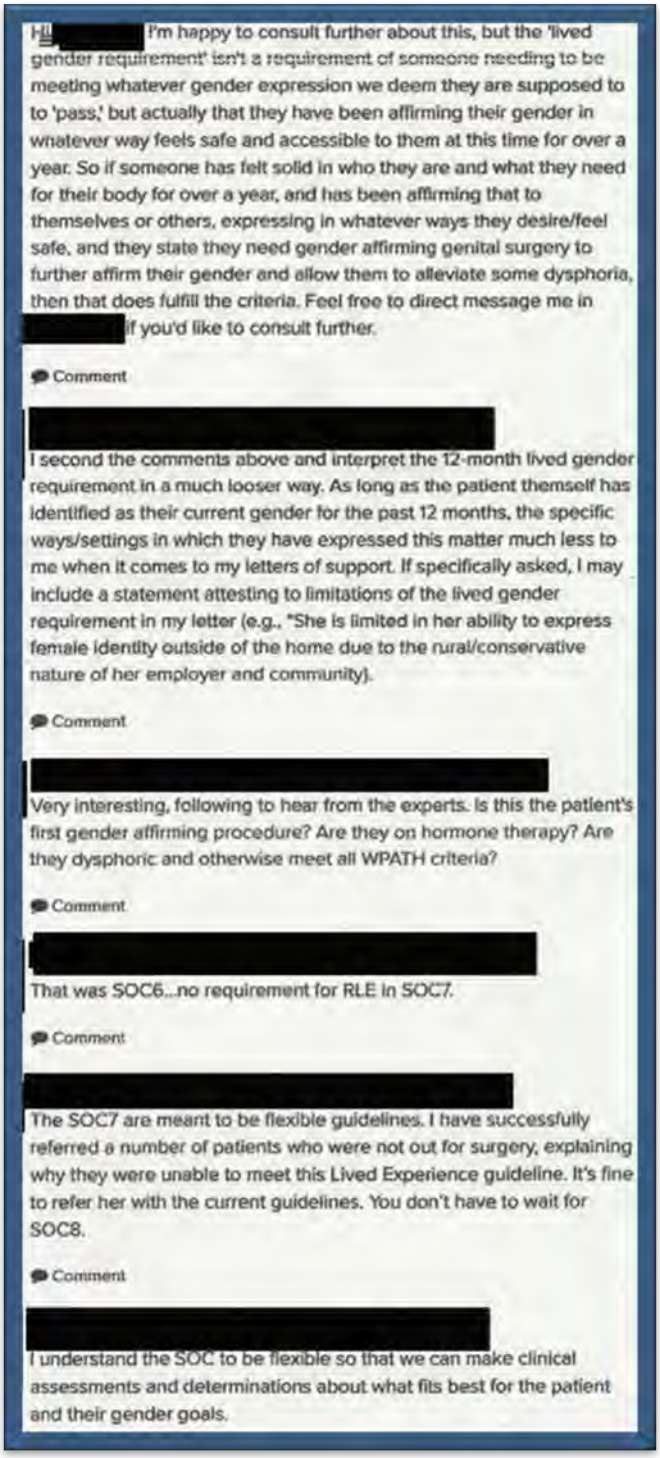
I have an 79yo assigned male at birth patient with a lifelong nonbinary/female gender identity requesting a limited depth vaginoplasty. Patient does not meet the 12 mo lived gender requirement of WPATH SoC version 7 because they are not comfortable socially transitioning at this age in front of their children and rural community. Does anyone know whether SoC v8 will soften the 12mo lived gender requirement? We'll find out end of Dec when it comes out, but at age 79, time is of the essence.

Submit

[redacted]

Does "12 months living in gender role" necessarily have to be interpreted as "12 months of being out as trans in absolutely every possible setting"? Plenty of trans people socially transition in some settings and present as their assigned gender at birth in other settings for logistical reasons (e.g. employment discrimination, family issues). I'm assuming the patient has been "living" in her identified gender at home and/or to certain select people (healthcare professionals? support group? trans friends?) for a long time, even if she's not out to the majority of the people in her community.

Comment



Hi [redacted] I'm happy to consult further about this, but the 'lived gender requirement' isn't a requirement of someone needing to be meeting whatever gender expression we deem they are supposed to to 'pass,' but actually that they have been affirming their gender in whatever way feels safe and accessible to them at this time for over a year. So if someone has felt solid in who they are and what they need for their body for over a year, and has been affirming that to themselves or others, expressing in whatever ways they desire/feel safe, and they state they need gender affirming genital surgery to further affirm their gender and allow them to alleviate some dysphoria, then that does fulfill the criteria. Feel free to direct message me in [redacted] if you'd like to consult further.

Comment

[redacted]

I second the comments above and interpret the 12-month lived gender requirement in a much looser way. As long as the patient themself has identified as their current gender for the past 12 months, the specific ways/settings in which they have expressed this matter much less to me when it comes to my letters of support. If specifically asked, I may include a statement attesting to limitations of the lived gender requirement in my letter (e.g., "She is limited in her ability to express female identity outside of the home due to the rural/conservative nature of her employer and community).

Comment

[redacted]

Very interesting, following to hear from the experts. Is this the patient's first gender affirming procedure? Are they on hormone therapy? Are they dysphoric and otherwise meet all WPATH criteria?

Comment

[redacted]

That was SOC6...no requirement for RLE in SOC7.

Comment

[redacted]

The SOC7 are meant to be flexible guidelines. I have successfully referred a number of patients who were not out for surgery, explaining why they were unable to meet this Lived Experience guideline. It's fine to refer her with the current guidelines. You don't have to wait for SOC8.

Comment

[redacted]

I understand the SOC to be flexible so that we can make clinical assessments and determinations about what fits best for the patient and their gender goals.

[redacted]

Very interesting, following to hear from the experts. Is this the patient's first gender affirming procedure? Are they on hormone therapy? Are they dysphoric and otherwise meet all WPATH criteria?

Comment

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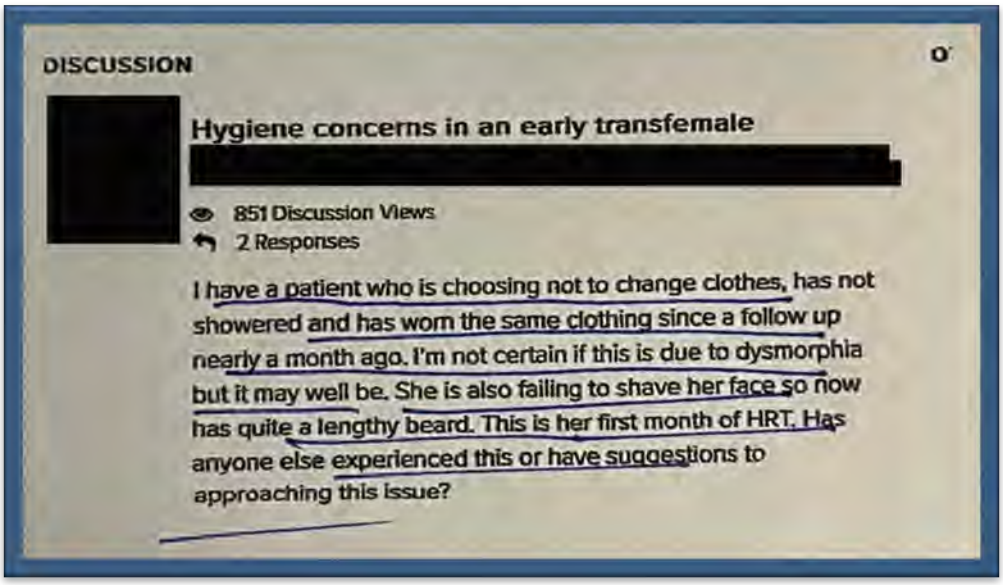
Comment

[redacted]

I understand the SOC to be flexible so that we can make clinical assessments and determinations about what fits best for the patient and their gender goals.

11) HYGIENE CONCERNS

a) WPATH members discuss lack of hygiene in a patient after hormone replacement therapy (HRT)



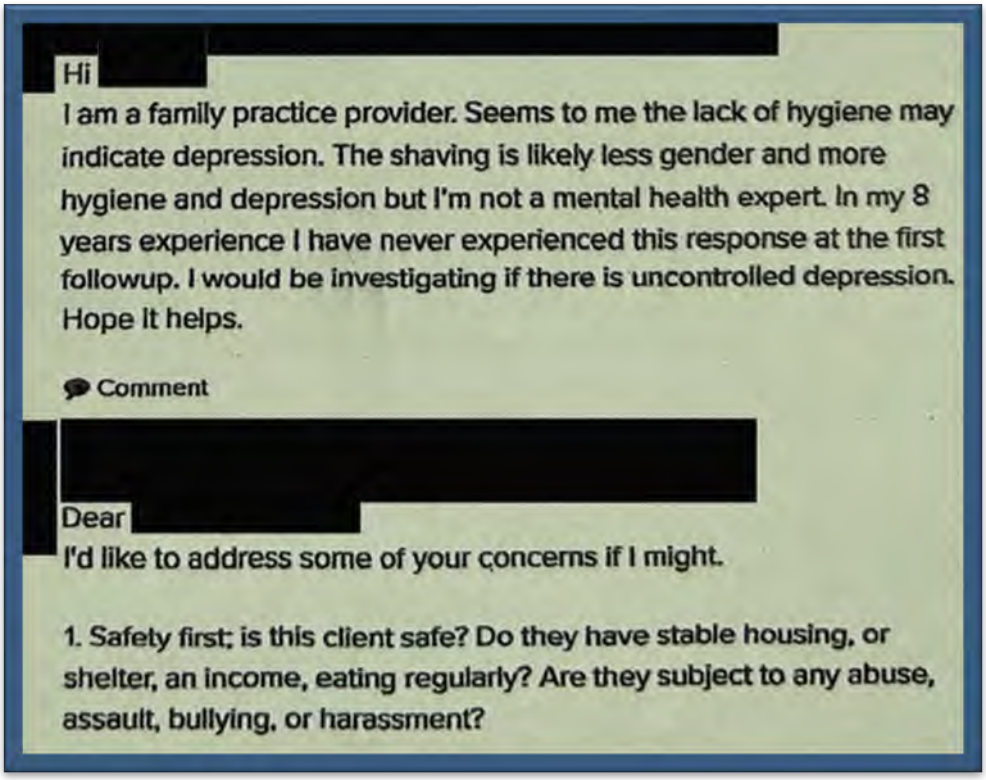
DISCUSSION

[redacted]

Hygiene concerns in an early transfemale [redacted]

851 Discussion Views
2 Responses

I have a patient who is choosing not to change clothes, has not showered and has worn the same clothing since a follow up nearly a month ago. I'm not certain if this is due to dysmorphia but it may well be. She is also failing to shave her face so now has quite a lengthy beard. This is her first month of HRT. Has anyone else experienced this or have suggestions to approaching this issue?



Hi [redacted]

I am a family practice provider. Seems to me the lack of hygiene may indicate depression. The shaving is likely less gender and more hygiene and depression but I'm not a mental health expert. In my 8 years experience I have never experienced this response at the first followup. I would be investigating if there is uncontrolled depression. Hope it helps.

Comment

[redacted]

Dear [redacted]

I'd like to address some of your concerns if I might.

1. Safety first; is this client safe? Do they have stable housing, or shelter, an income, eating regularly? Are they subject to any abuse, assault, bullying, or harassment?

2. Secondly, when you say "early", is this early in the therapeutic process, early in transition, or early in your work with her? I ask because each requires different answers. I'm going to answer "early in work with you." You've diagnosed GD or were referred by someone who had, yes? You've probably done an assessment and BDI; is this person experiencing elevated levels of frustration, anxiety, or depression? Do they have a history of suicidality? There are so many triggers that can push the associated symptomology of gender dysphoria into crisis; have any of these occurred?

3. Regarding the unchanged clothing, does this person have much of a wardrobe? It is very common for Trans folk to maintain THREE wardrobes, particularly Trans women, one of male drag for situations where they are not out, one of female garb matching their gender identity for spaces they're able to present authentically, and garments, usually female, but of an androgynous cut that may be worn anywhere. She may not have many clothes in the second category. She may be very early in transition, still struggling with self-acceptance and cycling through stages of clothing purges.

4. Poor hygiene instantly brings to mind safety again, as in risk of self-harm, elevated depression, suicidality, but also safety as in no stable housing or access to shower facilities or laundry, or not out in housing situation and therefore constrained in dressing space and options due to fear of violence.

5. Has she been diagnosed with dysmorphia? GD diagnostics do contain elements of dissatisfaction ranging to disgust with natal biology matching gender designation at birth rather than actual experienced/lived gender/gender identity but aren't usually referred to with the term "dysmorphia" unless that is a separate diagnosis specific to particular areas of anatomy. Usually, gender dysphoria includes a critical focus upon genitalia or any prominent and visible secondary sex characteristic of GDAB biology. For Trans women, this includes beard shadow, shoulder width, hand size, chin prominence, laryngeal promontory, or other features which may be difficult to alter or conceal and therefore particularly stressful at this stage.

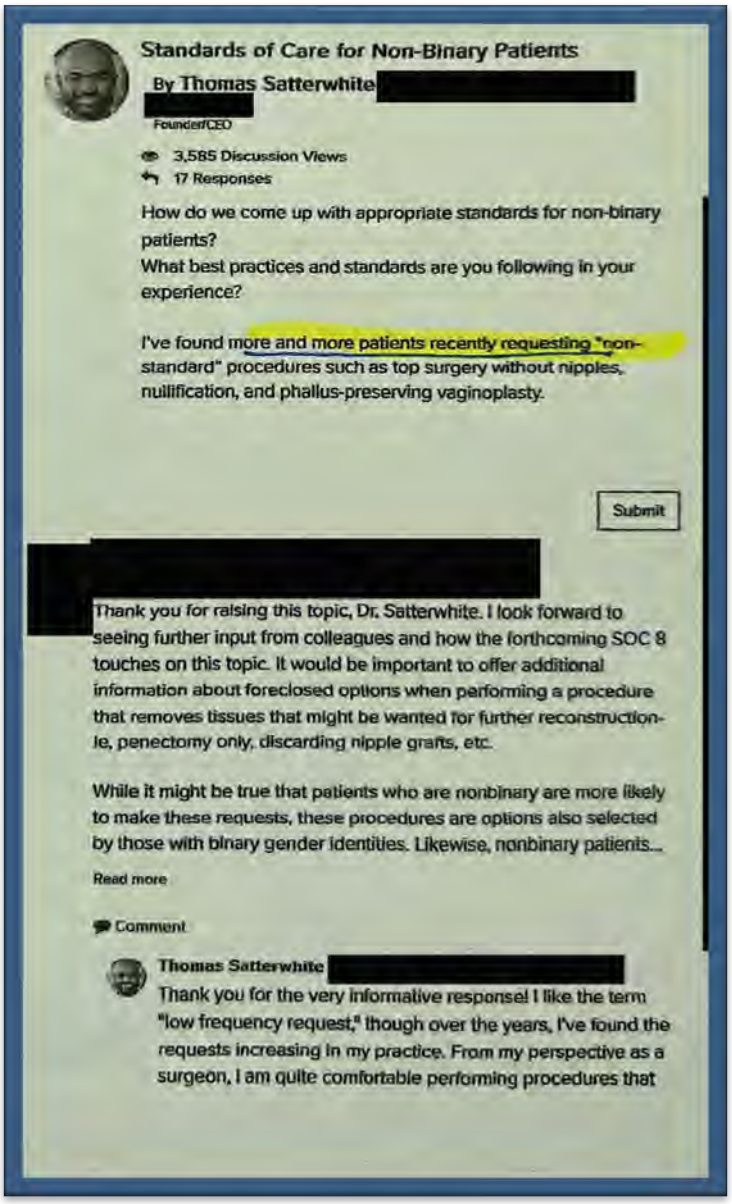
6. Again, with the cessation of shaving, does she have access to adequate shaving supplies and safe space to use them? Or is it possible that this is part of a struggle with self-acceptance and might represent a "flight into masculinity" paradigm? Also, remember race can figure as well. Black Trans women often have different issues managing beard growth, skin appearance, hair and removal methods, and may require elements that could be expensive or unavailable, such as specialty depilatories suitable for multiple skin types.

7. Frequently in the very early days of GAHT, folks experience a boost of positivity, hopefulness, find it easier to regulate, and often describe this concrete and tangible action forward as "gender euphoria." This can be true even if circumstances such as work or family may prevent them from presenting in their experienced gender and may have to continue living part or full time in their GDAB gender presentation.

I hope some of these observations prove useful.

12) NON-STANDARD MEDICAL PROCEDURES

a) WPATH members discuss appropriate standards of care for nonbinary patients, particularly when they request non-standard procedures



Standards of Care for Non-Binary Patients

By Thomas Satterwhite [redacted]

Founder/CEO

3,585 Discussion Views

17 Responses

How do we come up with appropriate standards for non-binary patients?
What best practices and standards are you following in your experience?

I've found more and more patients recently requesting "non-standard" procedures such as top surgery without nipples, nullification, and phallus-preserving vaginoplasty.

Submit

[redacted]

Thank you for raising this topic, Dr. Satterwhite. I look forward to seeing further input from colleagues and how the forthcoming SOC 8 touches on this topic. It would be important to offer additional information about foreclosed options when performing a procedure that removes tissues that might be wanted for further reconstruction- ie, penectomy only, discarding nipple grafts, etc.

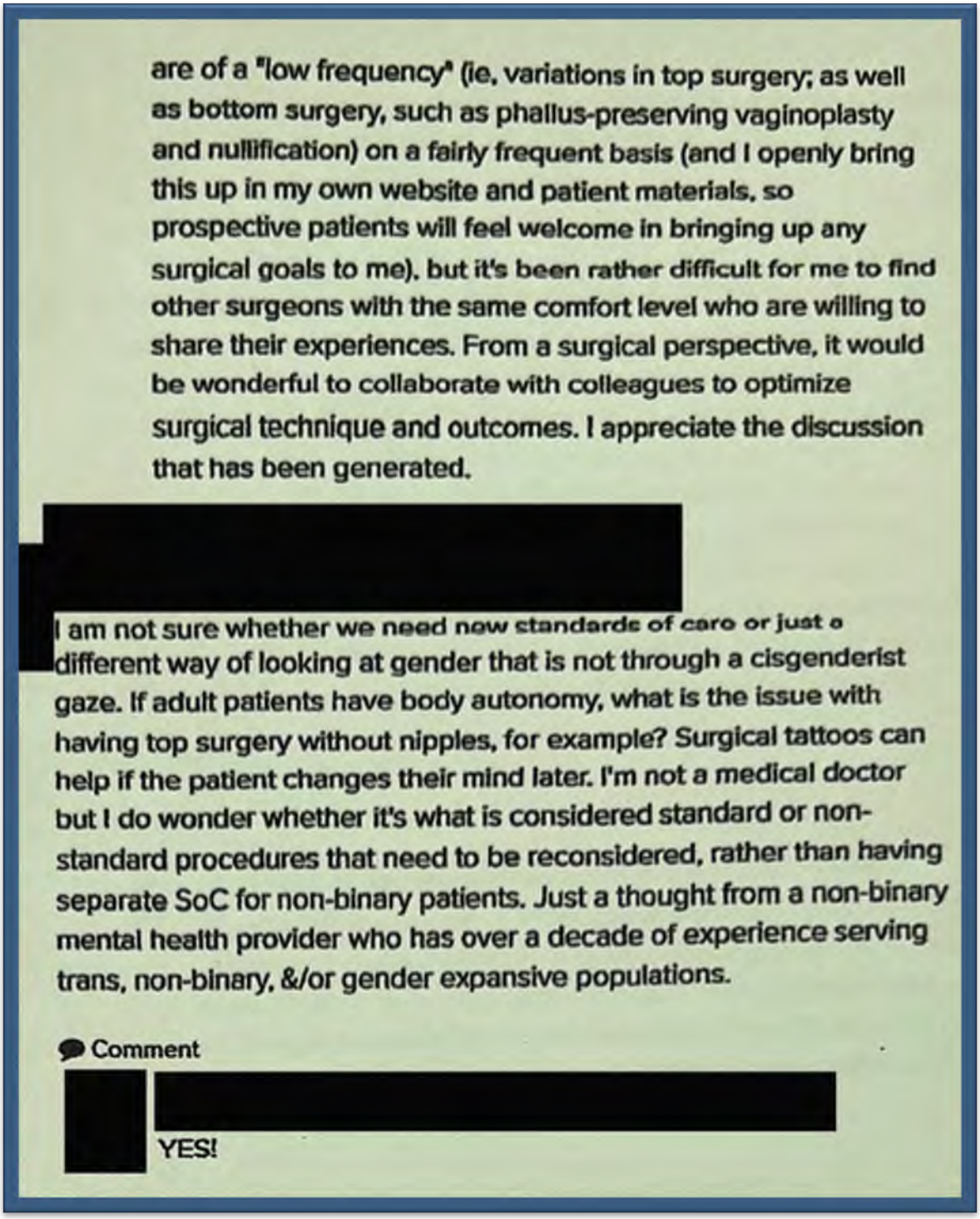
While it might be true that patients who are nonbinary are more likely to make these requests, these procedures are options also selected by those with binary gender identities. Likewise, nonbinary patients...

Read more

Comment

Thomas Satterwhite [redacted]

Thank you for the very informative response! I like the term "low frequency request," though over the years, I've found the requests increasing in my practice. From my perspective as a surgeon, I am quite comfortable performing procedures that



are of a "low frequency" (ie, variations in top surgery; as well as bottom surgery, such as phallus-preserving vaginoplasty and nullification) on a fairly frequent basis (and I openly bring this up in my own website and patient materials, so prospective patients will feel welcome in bringing up any surgical goals to me), but it's been rather difficult for me to find other surgeons with the same comfort level who are willing to share their experiences. From a surgical perspective, it would be wonderful to collaborate with colleagues to optimize surgical technique and outcomes. I appreciate the discussion that has been generated.

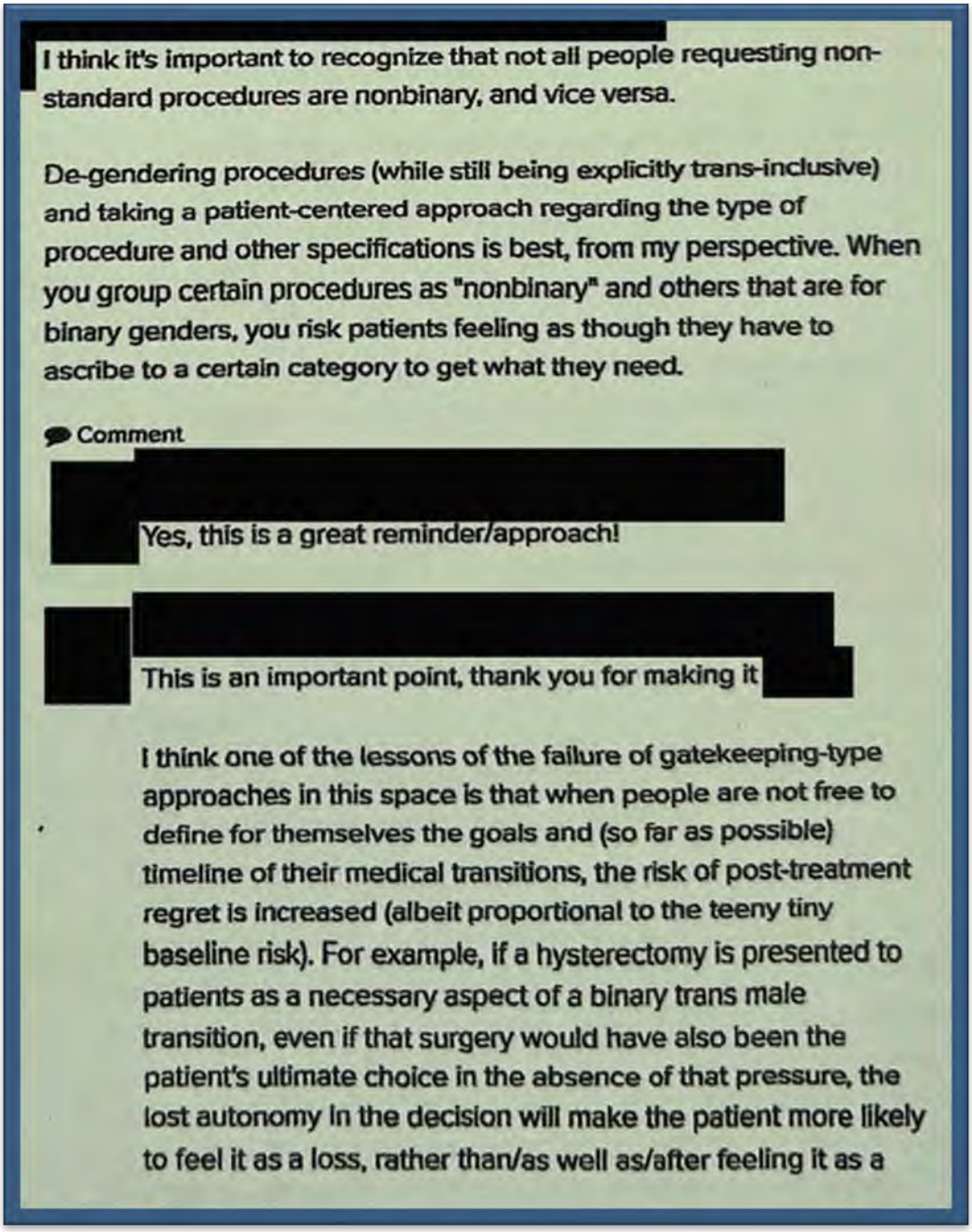
[redacted]

I am not sure whether we need new standards of care or just a different way of looking at gender that is not through a cisgenderist gaze. If adult patients have body autonomy, what is the issue with having top surgery without nipples, for example? Surgical tattoos can help if the patient changes their mind later. I'm not a medical doctor but I do wonder whether it's what is considered standard or non-standard procedures that need to be reconsidered, rather than having separate SoC for non-binary patients. Just a thought from a non-binary mental health provider who has over a decade of experience serving trans, non-binary, &/or gender expansive populations.

Comment

[redacted]

YES!



I think it's important to recognize that not all people requesting non-standard procedures are nonbinary, and vice versa.

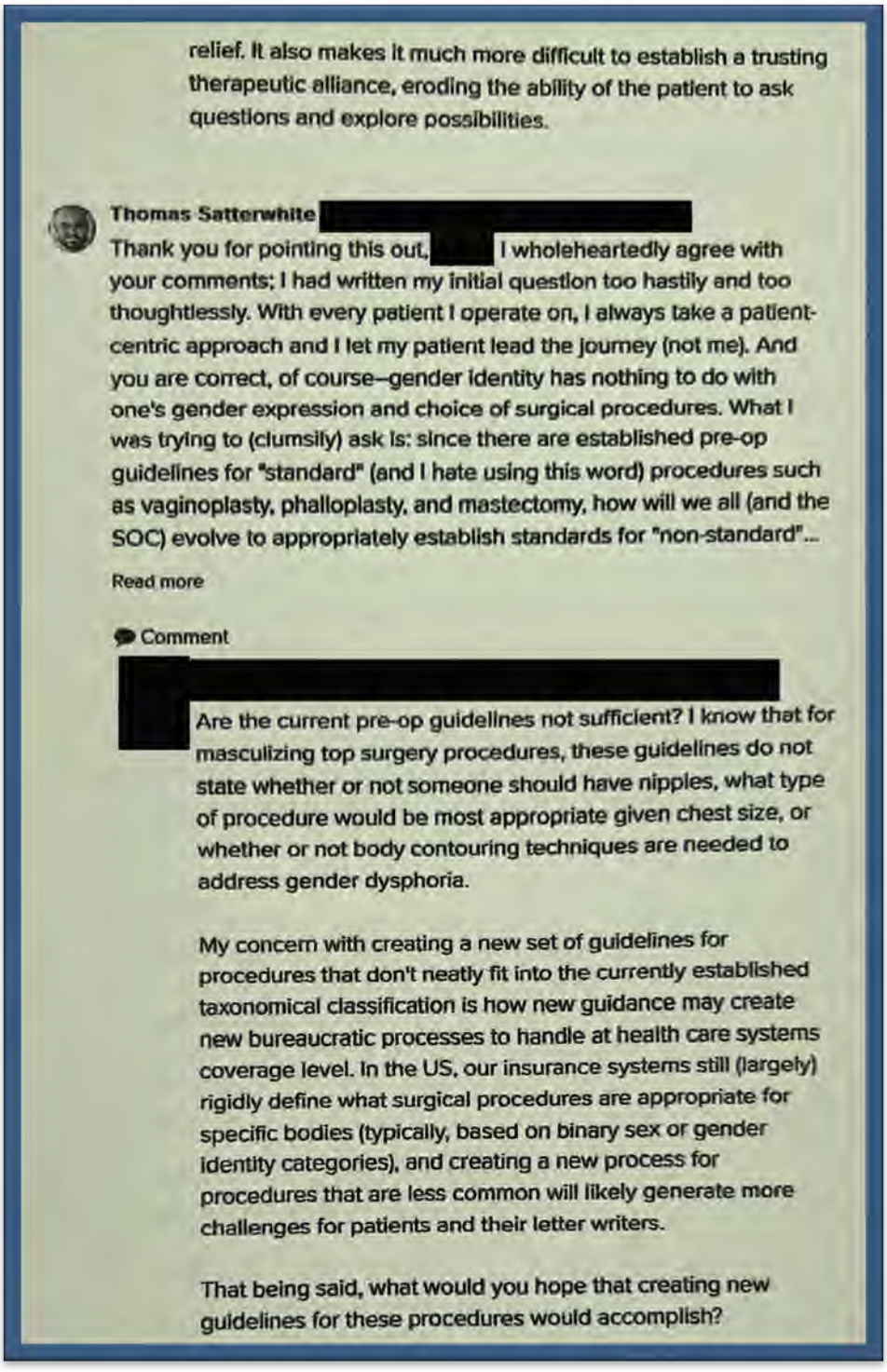
De-gendering procedures (while still being explicitly trans-inclusive) and taking a patient-centered approach regarding the type of procedure and other specifications is best, from my perspective. When you group certain procedures as "nonbinary" and others that are for binary genders, you risk patients feeling as though they have to ascribe to a certain category to get what they need.

Comment

[redacted] Yes, this is a great reminder/approach!

[redacted] This is an important point, thank you for making it [redacted]

I think one of the lessons of the failure of gatekeeping-type approaches in this space is that when people are not free to define for themselves the goals and (so far as possible) timeline of their medical transitions, the risk of post-treatment regret is increased (albeit proportional to the teeny tiny baseline risk). For example, if a hysterectomy is presented to patients as a necessary aspect of a binary trans male transition, even if that surgery would have also been the patient's ultimate choice in the absence of that pressure, the lost autonomy in the decision will make the patient more likely to feel it as a loss, rather than/as well as/after feeling it as a



relief. It also makes it much more difficult to establish a trusting therapeutic alliance, eroding the ability of the patient to ask questions and explore possibilities.

Thomas Satterwhite [redacted]

Thank you for pointing this out, [redacted] I wholeheartedly agree with your comments; I had written my initial question too hastily and too thoughtlessly. With every patient I operate on, I always take a patient-centric approach and I let my patient lead the journey (not me). And you are correct, of course–gender identity has nothing to do with one's gender expression and choice of surgical procedures. What I was trying to (clumsily) ask is: since there are established pre-op guidelines for "standard" (and I hate using this word) procedures such as vaginoplasty, phalloplasty, and mastectomy, how will we all (and the SOC) evolve to appropriately establish standards for "non-standard"...

Read more

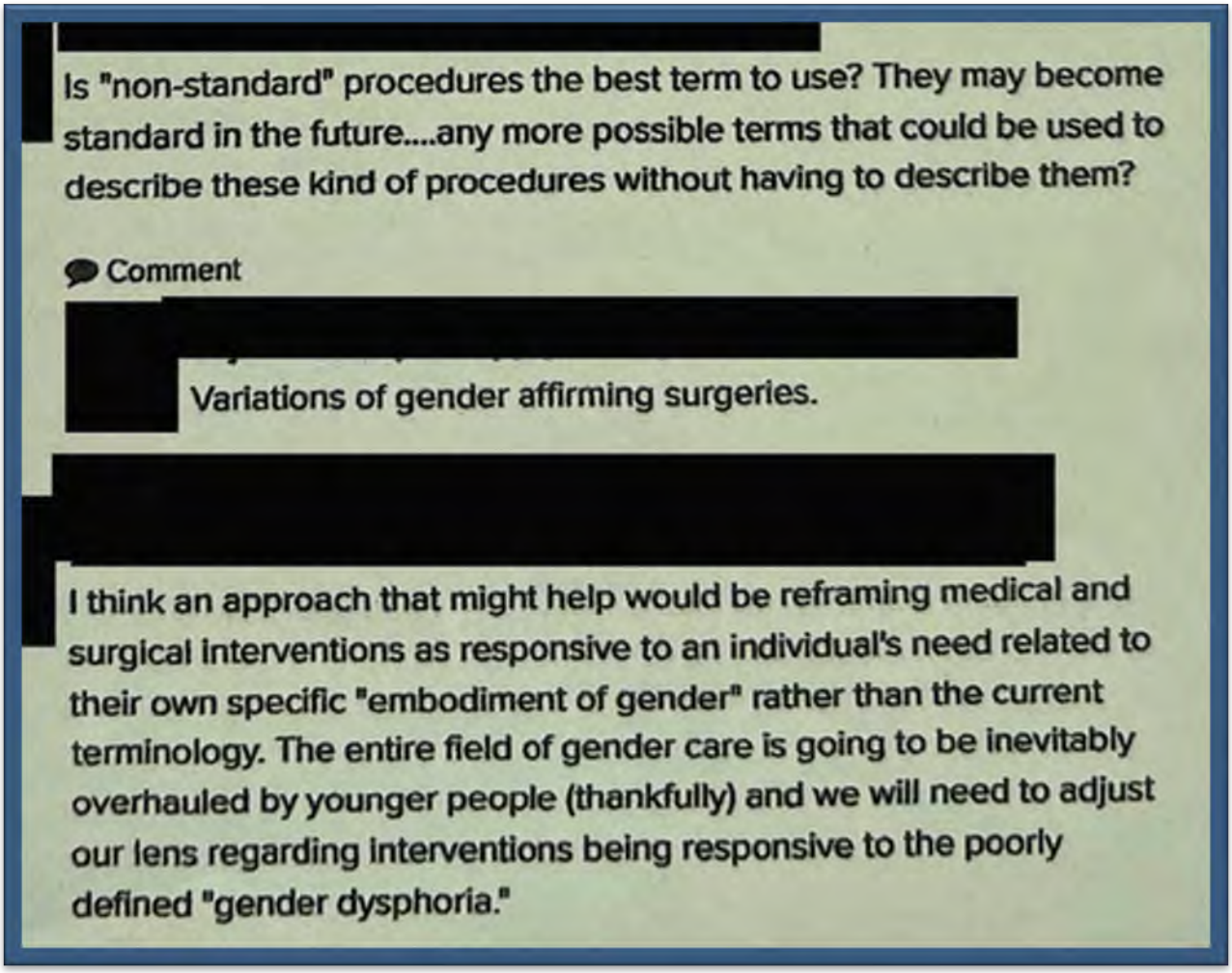
Comment

[redacted]

Are the current pre-op guidelines not sufficient? I know that for masculizing top surgery procedures, these guidelines do not state whether or not someone should have nipples, what type of procedure would be most appropriate given chest size, or whether or not body contouring techniques are needed to address gender dysphoria.

My concern with creating a new set of guidelines for procedures that don't neatly fit into the currently established taxonomical classification is how new guidance may create new bureaucratic processes to handle at health care systems coverage level. In the US, our insurance systems still (largely) rigidly define what surgical procedures are appropriate for specific bodies (typically, based on binary sex or gender identity categories), and creating a new process for procedures that are less common will likely generate more challenges for patients and their letter writers.

That being said, what would you hope that creating new guidelines for these procedures would accomplish?



[redacted]

Is "non-standard" procedures the best term to use? They may become standard in the future....any more possible terms that could be used to describe these kind of procedures without having to describe them?

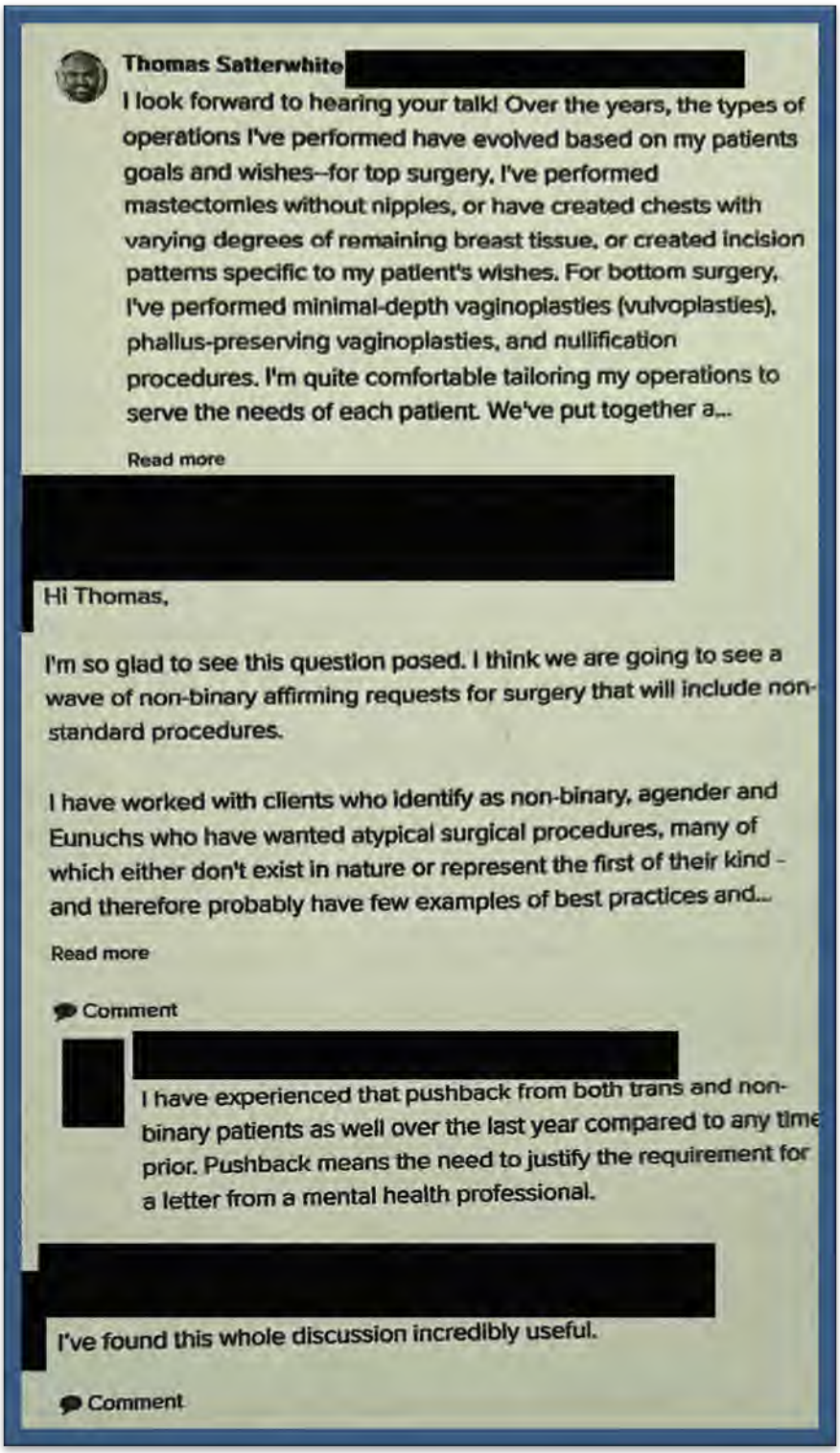
Comment

[redacted]

Variations of gender affirming surgeries.

[redacted]

I think an approach that might help would be reframing medical and surgical interventions as responsive to an individual's need related to their own specific "embodiment of gender" rather than the current terminology. The entire field of gender care is going to be inevitably overhauled by younger people (thankfully) and we will need to adjust our lens regarding interventions being responsive to the poorly defined "gender dysphoria."



Thomas Satterwhite [redacted]

I look forward to hearing your talk! Over the years, the types of operations I've performed have evolved based on my patients goals and wishes--for top surgery, I've performed mastectomies without nipples, or have created chests with varying degrees of remaining breast tissue, or created incision patterns specific to my patient's wishes. For bottom surgery, I've performed minimal-depth vaginoplasties (vulvoplasties), phallus-preserving vaginoplasties, and nullification procedures. I'm quite comfortable tailoring my operations to serve the needs of each patient. We've put together a...

Read more

[redacted]

Hi Thomas,

I'm so glad to see this question posed. I think we are going to see a wave of non-binary affirming requests for surgery that will include non-standard procedures.

I have worked with clients who identify as non-binary, agender and Eunuchs who have wanted atypical surgical procedures, many of which either don't exist in nature or represent the first of their kind - and therefore probably have few examples of best practices and...

Read more

Comment

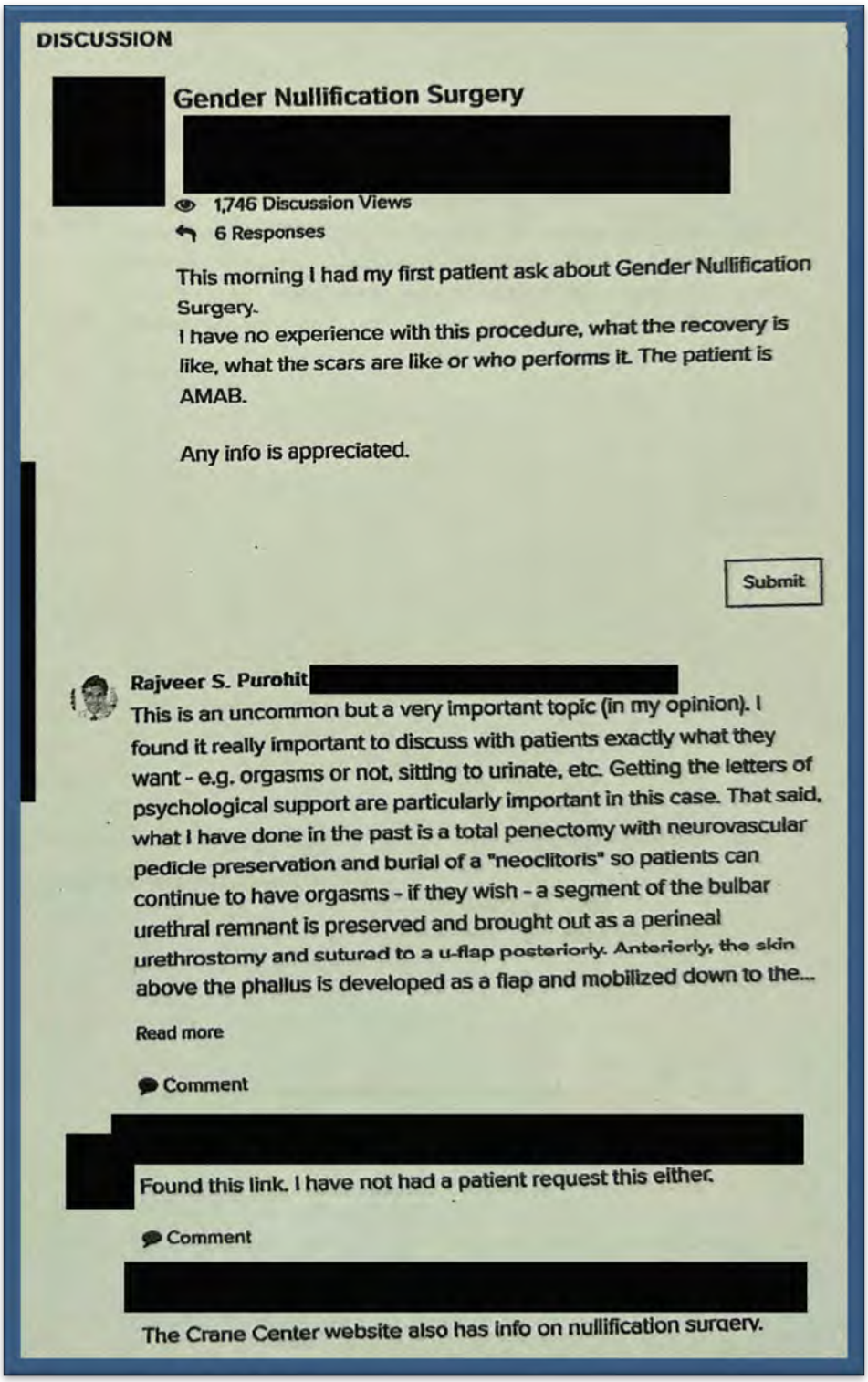
[redacted]

I have experienced that pushback from both trans and non-binary patients as well over the last year compared to any time prior. Pushback means the need to justify the requirement for a letter from a mental health professional.

[redacted]

I've found this whole discussion incredibly useful.

Comment



DISCUSSION

[redacted] Gender Nullification Surgery

[redacted]

1,746 Discussion Views

6 Responses

This morning I had my first patient ask about Gender Nullification Surgery.
I have no experience with this procedure, what the recovery is like, what the scars are like or who performs it. The patient is AMAB.

Any info is appreciated.

Submit

Rajveer S. Purohit [redacted]
This is an uncommon but a very important topic (in my opinion). I found it really important to discuss with patients exactly what they want - e.g. orgasms or not, sitting to urinate, etc. Getting the letters of psychological support are particularly important in this case. That said, what I have done in the past is a total penectomy with neurovascular pedicle preservation and burial of a "neoclitoris" so patients can continue to have orgasms - if they wish - a segment of the bulbar urethral remnant is preserved and brought out as a perineal urethrostomy and sutured to a u-flap posteriorly. Anteriorly, the skin above the phallus is developed as a flap and mobilized down to the...

Read more

Comment

[redacted]
Found this link. I have not had a patient request this either.

Comment

[redacted]
The Crane Center website also has info on nullification surgery.

[redacted] I actually just came here to ask about this. I had an AFAB client bring it up to me today and I had never heard of it. I did find a couple of doctors via Google who provide it, but I would love to have more basic info about it!

Comment

Thomas Satterwhite [redacted]

Hi [redacted] This is a procedure that we perform in our practice (Align Surgical Associates). We are based in San Francisco. We've been able to consistently get insurance coverage for many of our patients. Our website contains information on the procedures, and we do have information/photos on post op results (on "nullification" and other variations in genital gender affirming surgery) that can be viewed here: Gender Expansive Bottom Surgery (https://www.alignsurgical.com/gallery/gender-expansive-bottom-surgery/)

...

Comment

Daniel D. Dugi [redacted]

We also offer this at OHSU in Portland, Oregon. Incision/scar pattern depends on patient choice of approach–we offer two approaches depending on patient goals. Haven't had a problem getting insurance coverage so far.

Comment

I hope everyone had a lovely time at the conference; it was a pleasure meeting many of you!

I wanted to make as post to open a discussion on a topic that has been subject of some tensions at the conference. Providers have delightfully presented about new techniques that are being developed to serve trans people whose embodiment goals do not fit dominant expectations—mastectomies without nipples, mastectomies for people who do not want breasts from estrogen, vagina-preserving phalloplasties, etc.

These new 'non-standard' surgeries are for many a fantastic development. Some, however, are concerned by them. People's discomfort with non-standard surgeries often turn on them being 'weird', them reflecting 'uncertainty' or 'lack of commitment' to transition, or them risking the ire of conservatives.

When thinking about non-standard surgeries, I think it is crucial for us to go back to the basics of trans health. Why do people seek out trans health? It's to have a body that feels comfortable to them, that feels like them, that feels like home—or, at least, as close to it as possible. Trans health is not and should not be about creating bodies that are socially acceptable, bodies that do not challenge cisnormativity. Trans health is about bodily autonomy, not about normalizing bodies. We didn't reject the idea that you can't change your gender only to double down on the idea that gender is binary and defined by genitals!

Conservatives are scary and I understand the fear that non-standard surgeries will be weaponized against access to care. However, it is far from clear that offering individualized surgeries will lead to the downfall of trans care. First, they already think all trans surgeries are mutilation so non-standard surgeries aren't a big difference or religious conservatives. Second, individualizing surgeries reinforces our counter-narrative that trans care is not about pushing people into fitting stereotypes but about finding what fits each person best. I also don't think it would be fair to throw those who want non-standard surgeries under the bus—they're not less important or less deserving because what they want is different. Isn't making space for difference why we got into trans health in the first place? And if we reject those surgeries for being 'weird' or politically unpopular, can we trust ourselves to stand up for the other subgroups that religious conservatives target?

Food for thought.

[redacted]

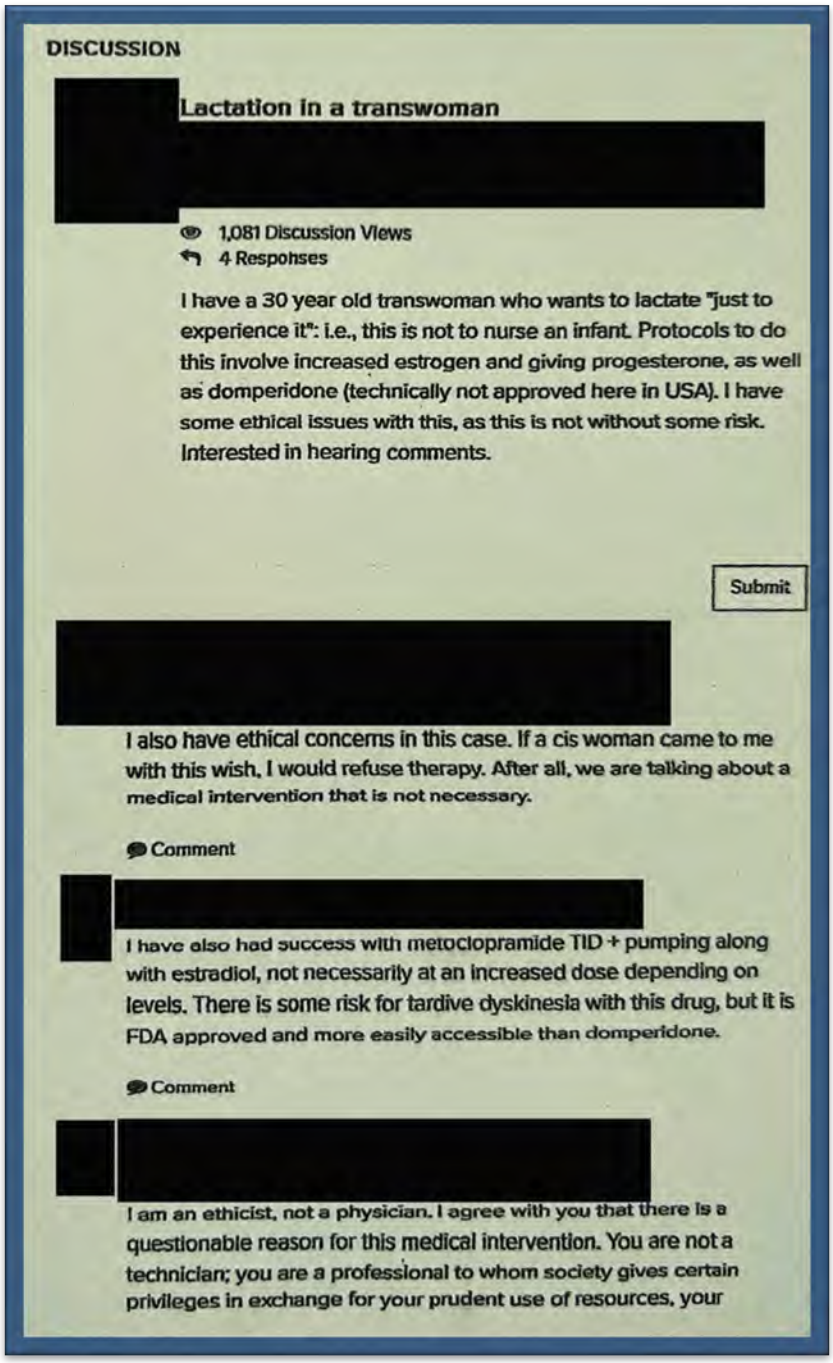
Add to this discussion either by replying to this email or by using the button below.

Reply To Discussion

Advisors of the Community: [redacted]
[redacted] Marci L. Bowers, [redacted]

13) LACTATION CONCERNS

a) A WPATH member discusses risk in providing a trans patient with lactation capabilities via surgery



DISCUSSION

[redacted] Lactation in a transwoman [redacted]

1,081 Discussion Views
4 Responses

I have a 30 year old transwoman who wants to lactate "just to experience it": i.e., this is not to nurse an infant. Protocols to do this involve increased estrogen and giving progesterone, as well as domperidone (technically not approved here in USA). I have some ethical issues with this, as this is not without some risk. Interested in hearing comments.

Submit

[redacted]

I also have ethical concerns in this case. If a cis woman came to me with this wish, I would refuse therapy. After all, we are talking about a medical intervention that is not necessary.

Comment

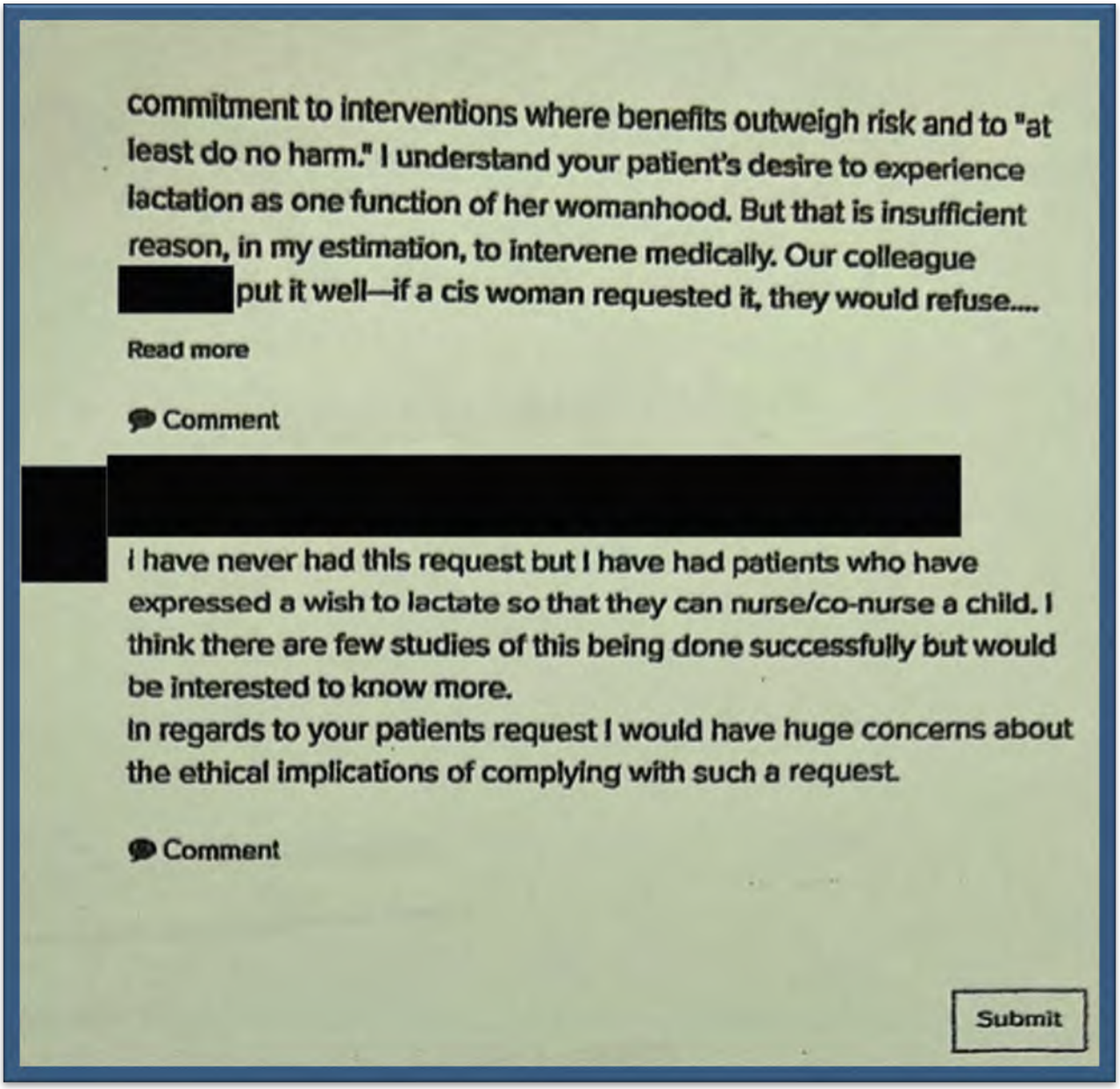
[redacted]

I have also had success with metoclopramide TID + pumping along with estradiol, not necessarily at an increased dose depending on levels. There is some risk for tardive dyskinesia with this drug, but it is FDA approved and more easily accessible than domperidone.

Comment

[redacted]

I am an ethicist, not a physician. I agree with you that there is a questionable reason for this medical intervention. You are not a technician; you are a professional to whom society gives certain privileges in exchange for your prudent use of resources, your



commitment to interventions where benefits outweigh risk and to "at least do no harm." I understand your patient's desire to experience lactation as one function of her womanhood. But that is insufficient reason, in my estimation, to intervene medically. Our colleague [redacted] put it well—if a cis woman requested it, they would refuse....

Read more

Comment

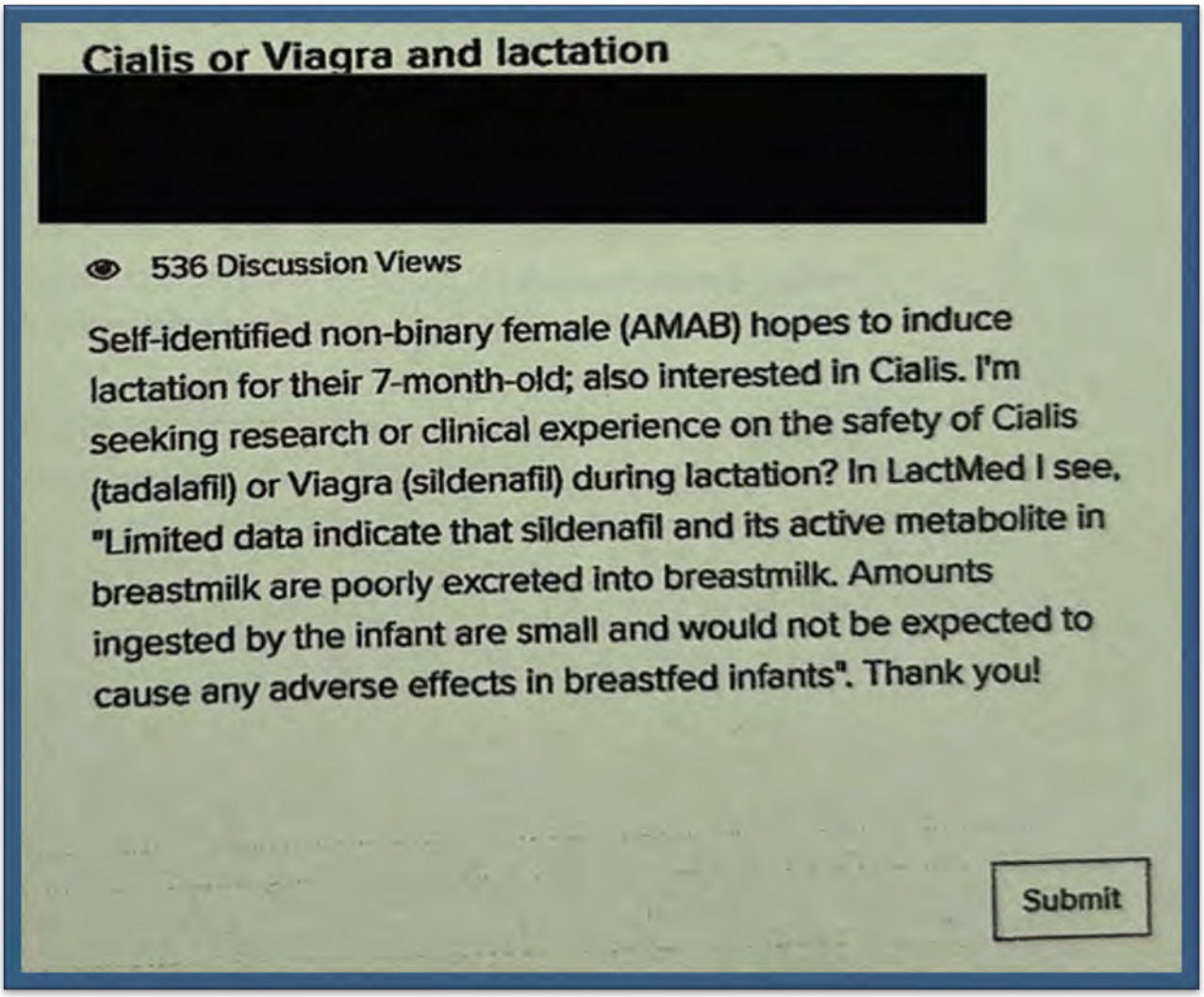
[redacted]

I have never had this request but I have had patients who have expressed a wish to lactate so that they can nurse/co-nurse a child. I think there are few studies of this being done successfully but would be interested to know more.
In regards to your patients request I would have huge concerns about the ethical implications of complying with such a request.

Comment

Submit

b) A nonbinary female expresses a desire to induce lactation and take Cialis



Cialis or Viagra and lactation

[redacted]

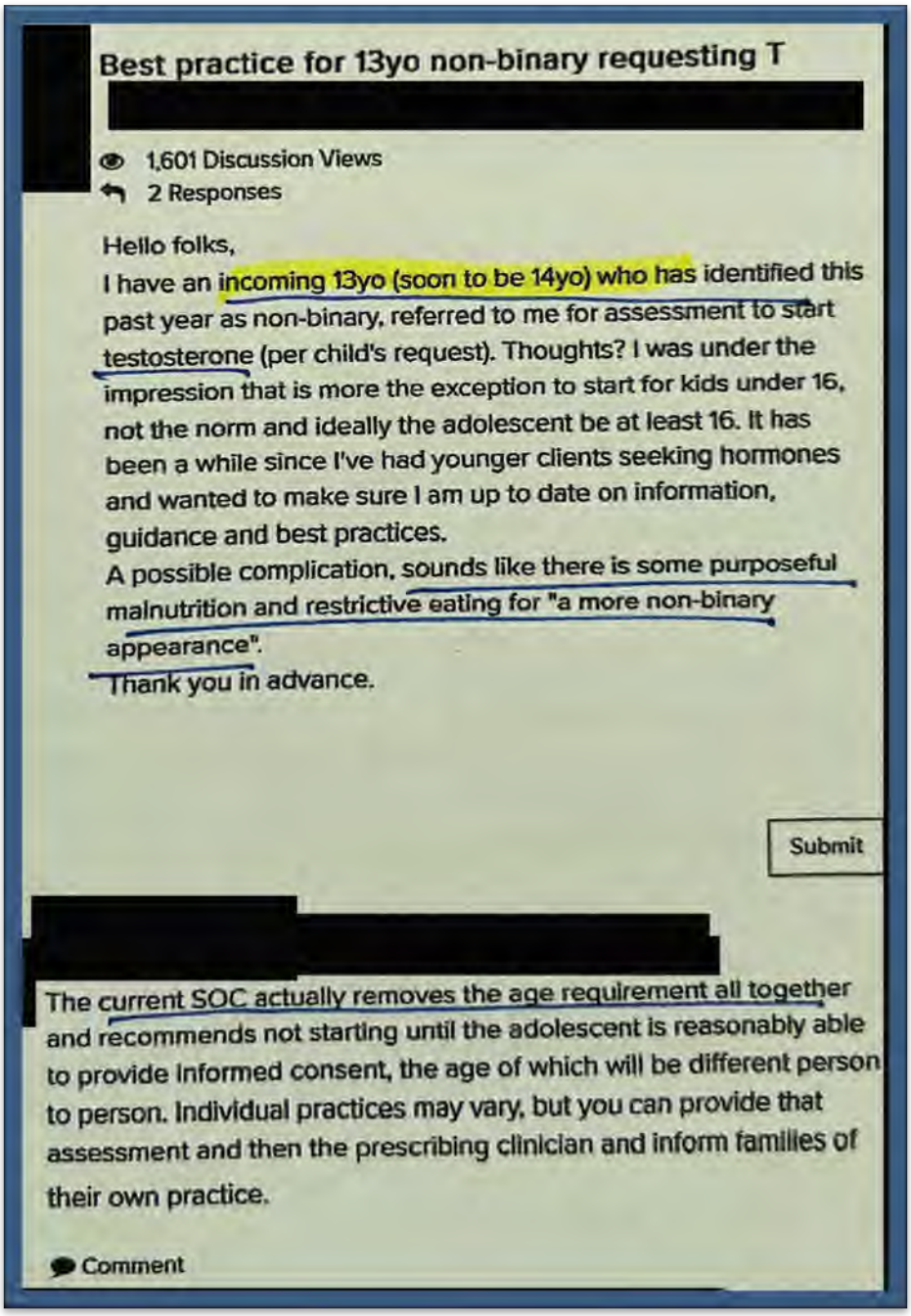
536 Discussion Views

Self-identified non-binary female (AMAB) hopes to induce lactation for their 7-month-old; also interested in Cialis. I'm seeking research or clinical experience on the safety of Cialis (tadalafil) or Viagra (sildenafil) during lactation? In LactMed I see, "Limited data indicate that sildenafil and its active metabolite in breastmilk are poorly excreted into breastmilk. Amounts ingested by the infant are small and would not be expected to cause any adverse effects in breastfed infants". Thank you!

Submit

14) NON-BINARY HEALTHCARE FOR MINORS

a) WPATH members discuss a nonbinary 13-year-old patient requesting HRT



Best practice for 13yo non-binary requesting T

[redacted]

1,601 Discussion Views

2 Responses

Hello folks,

I have an incoming 13yo (soon to be 14yo) who has identified this past year as non-binary, referred to me for assessment to start testosterone (per child's request). Thoughts? I was under the impression that is more the exception to start for kids under 16, not the norm and ideally the adolescent be at least 16. It has been a while since I've had younger clients seeking hormones and wanted to make sure I am up to date on information, guidance and best practices.

A possible complication, sounds like there is some purposeful malnutrition and restrictive eating for "a more non-binary appearance".

Thank you in advance.

Submit

[redacted]

The current SOC actually removes the age requirement all together and recommends not starting until the adolescent is reasonably able to provide informed consent, the age of which will be different person to person. Individual practices may vary, but you can provide that assessment and then the prescribing clinician and inform families of their own practice.

Comment

[redacted]

You bring up some very interesting issues. At what age should transition begin, and what are the problems associated with possible detransition is a person who is so young.

I usually recommend that the person be living as the other sex for 6-12 months since they may find that they are uncomfortable with the sex that they feel is appropriate. Also, they need at least one supportive parent involved.

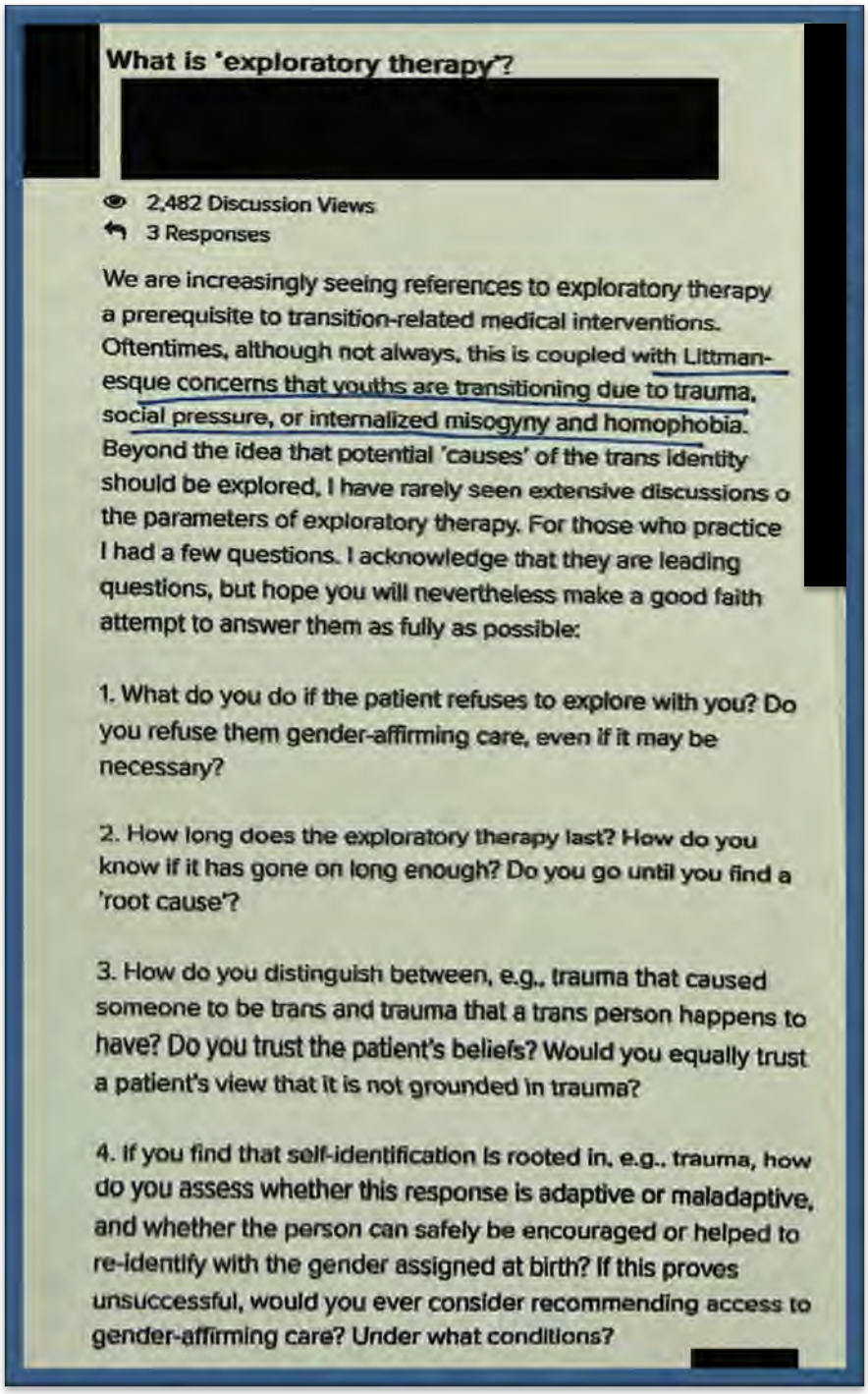
It is very difficult to ask that they wait until age 16 because by then they will be dealing with menstrual periods and complete breast development. Waiting appears to increase the rate of suicide attempts.

After much experience as a pediatric endocrinologist, I would not rule out treating if the person is living as a male and is convinced that transition would be correct for him.

Comment

15) CAUSE FOR TRANSITION AND EXPLORATORY THERAPY

a) A WPATH member questions if there is a root cause driving transition



What is 'exploratory therapy'?

[redacted]

2,482 Discussion Views
3 Responses

We are increasingly seeing references to exploratory therapy a prerequisite to transition-related medical interventions. Oftentimes, although not always, this is coupled with Littman-esque concerns that youths are transitioning due to trauma, social pressure, or internalized misogyny and homophobia. Beyond the idea that potential 'causes' of the trans identity should be explored, I have rarely seen extensive discussions o the parameters of exploratory therapy. For those who practice I had a few questions. I acknowledge that they are leading questions, but hope you will nevertheless make a good faith attempt to answer them as fully as possible:

1. What do you do if the patient refuses to explore with you? Do you refuse them gender-affirming care, even if it may be necessary?

2. How long does the exploratory therapy last? How do you know if it has gone on long enough? Do you go until you find a 'root cause'?

3. How do you distinguish between, e.g., trauma that caused someone to be trans and trauma that a trans person happens to have? Do you trust the patient's beliefs? Would you equally trust a patient's view that it is not grounded in trauma?

4. If you find that self-identification is rooted in, e.g., trauma, how do you assess whether this response is adaptive or maladaptive, and whether the person can safely be encouraged or helped to re-identify with the gender assigned at birth? If this proves unsuccessful, would you ever consider recommending access to gender-affirming care? Under what conditions?

[redacted]

5. If a patient re-identifies as cisgender, do you wind-down the therapy or do you continue at the same pace to ensure their re-identification is genuine and not a coping or adaptive response? Why or why not?

6. Relatedly, do you consider self-identification as transgender more suspect or deserving of exploration than self-identification as cisgender? Why or why not? How is this reflected in exploratory therapy?

7. Is there any evidence that exploratory therapy leads to better outcomes, however you define them, or that it can successfully identify youths who aren't 'truly trans,' youths whose identification is maladaptive, and/or youths who would be harmed by accessing gender-affirming interventions?

8. Do you believe that transition-related medical interventions such as hormones can be offered in parallel to exploratory therapy either as a means of reducing present gender dysphoria or as a way of helping the individual explore their gender and whether gender-affirming care is right for them? Do you think social and medical transition being temporary is an inherently undesirable outcome? Why or why not? Is this related to an intuition that bodies that have undergone medical transition are less desirable and should be avoided if possible?

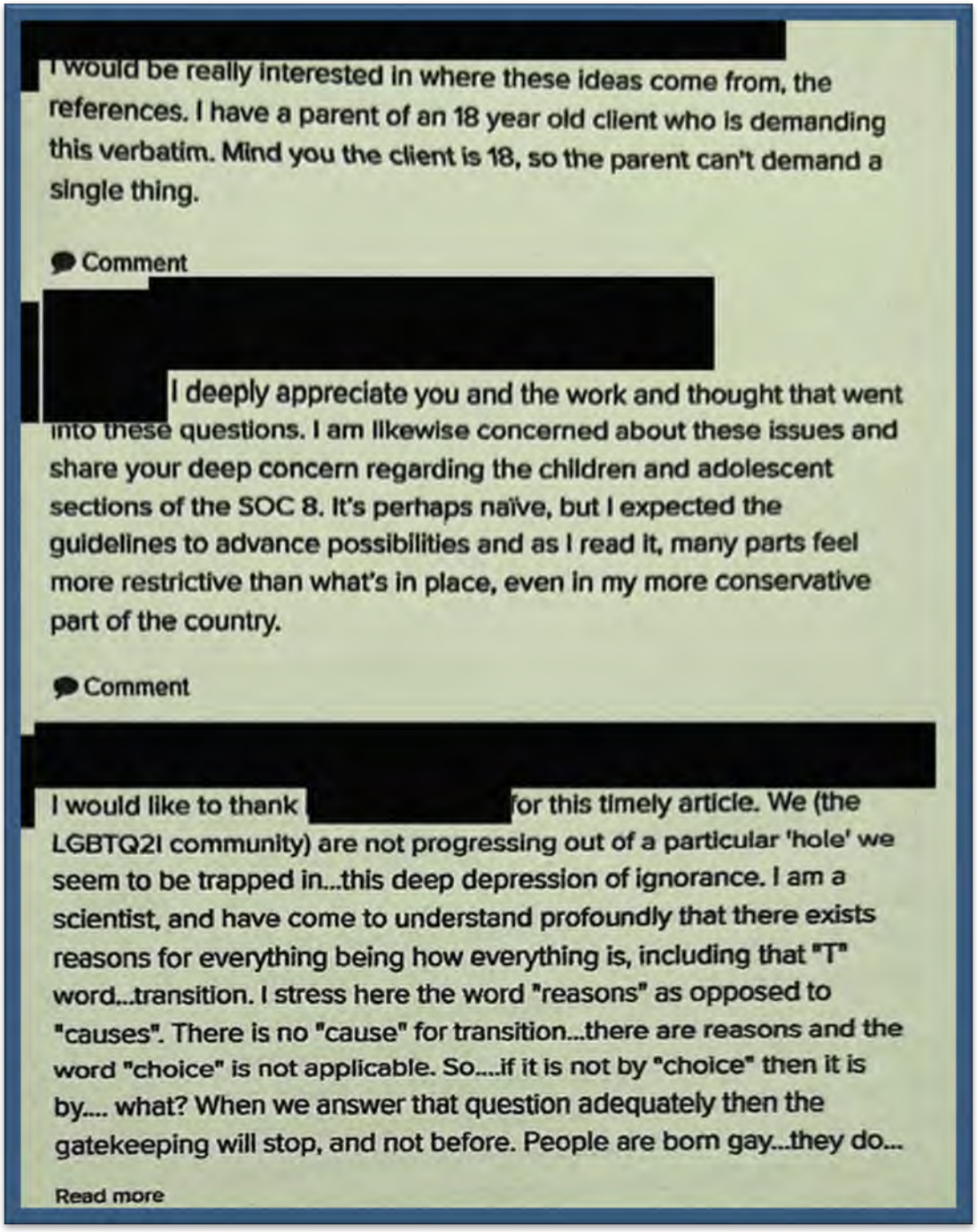
9. What do you make of the distress of the numerous youths who are 'truly' trans, who we have reasons to believe are a strong majority and will experience ongoing distress during? Based on the recent Littman study, the high end of non-disclosure of detransition to clinician is around 75% and the high end of detransition estimates is around 3%. Even assuming the correctness of these higher bound estimates, we would still have 88% of individuals not detransitioning.

9. Given your concern about precipitated and premature affirmation as a foreclosure of gender identity and exploration, what are your thoughts on encouraging puberty blockers more broadly to all questioning or even perhaps all cisgender kids? Would your answer change if we were 100% certain that puberty blockers had no long-term side effects?

10. Do you believe that such exploratory therapy can create psychological and emotional pressures to re-identify with the gender they were assigned at birth?

11. Do you believe that such exploratory therapy can create psychological and emotional pressures to lie, misrepresent, or otherwise engage in the therapy in bad faith so as to ensure access to sought interventions? Do you believe this could lead patients to suppress doubts and worries and, as a result, make less-than-informed decisions on accessing gender-affirming care?

Thank you ahead of time for your answers.



I would be really interested in where these ideas come from, the references. I have a parent of an 18 year old client who is demanding this verbatim. Mind you the client is 18, so the parent can't demand a single thing.

Comment

I deeply appreciate you and the work and thought that went into these questions. I am likewise concerned about these issues and share your deep concern regarding the children and adolescent sections of the SOC 8. It's perhaps naïve, but I expected the guidelines to advance possibilities and as I read it, many parts feel more restrictive than what's in place, even in my more conservative part of the country.

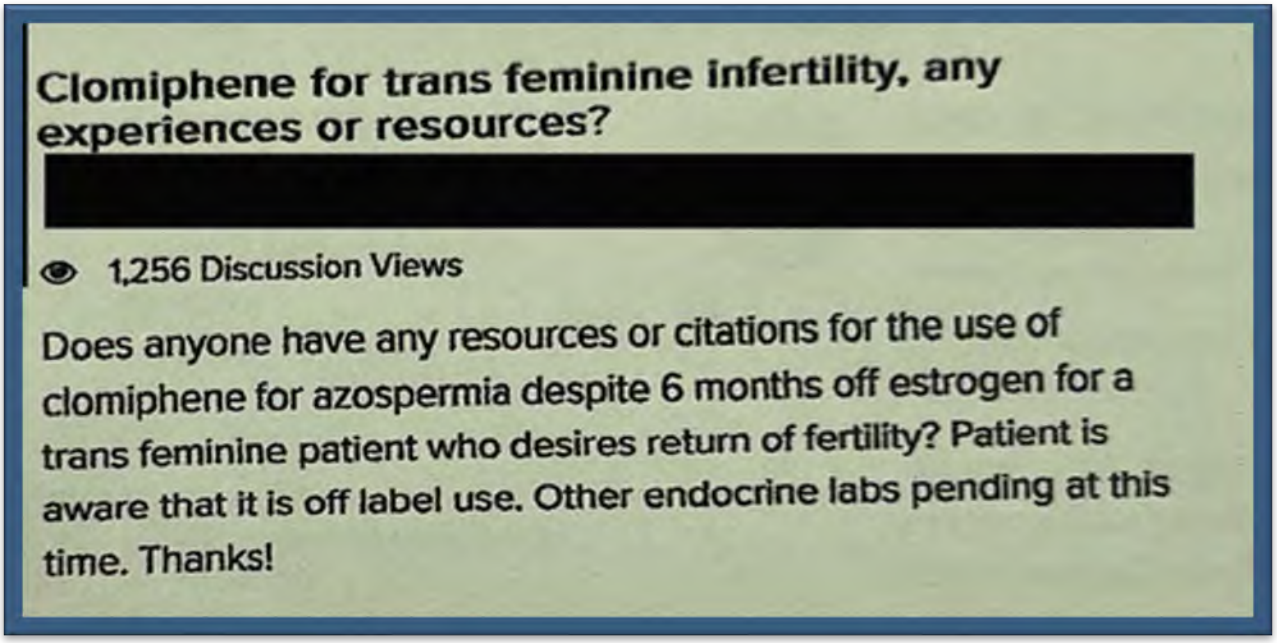
Comment

I would like to thank for this timely article. We (the LGBTQ2I community) are not progressing out of a particular 'hole' we seem to be trapped in...this deep depression of ignorance. I am a scientist, and have come to understand profoundly that there exists reasons for everything being how everything is, including that "T" word...transition. I stress here the word "reasons" as opposed to "causes". There is no "cause" for transition...there are reasons and the word "choice" is not applicable. So....if it is not by "choice" then it is by.... what? When we answer that question adequately then the gatekeeping will stop, and not before. People are born gay...they do...

Read more

16) FERTILITY ISSUES

a) A WPATH member seeks resources for infertility treatments



Clomiphene for trans feminine infertility, any experiences or resources?

[redacted]

1,256 Discussion Views

Does anyone have any resources or citations for the use of clomiphene for azospermia despite 6 months off estrogen for a trans feminine patient who desires return of fertility? Patient is aware that it is off label use. Other endocrine labs pending at this time. Thanks!

17) RESOURCES FOR MINORS ON TRANS HEALTHCARE

a) WPATH members discuss a school psychologist searching for gender resources for students

Resources on Gender

[redacted]

I was contacted by a psychologist who works at a school (K-8) and is looking for general info on gender. The purpose is to help their students (and parents) understand what gender is and to allow them the freedom to explore. In speaking to her, I realized that my plethora of resources is almost all for kids who already identify as trans. Does anyone know of any resources for children that help them understand gender, or that answer questions parents may have about gender?

February 14, 2022

Submit

[redacted] from a few years ago, and I now work with the Trans community as a woman of trans experience. I have put some resources together that you might find helpful. They are not targeted at children, but would be helpful for parents and teachers. [redacted] Gender Education (https:[redacted]gender-education)

I also have a book on transitioning coming out soon. I hope you can find something helpful.

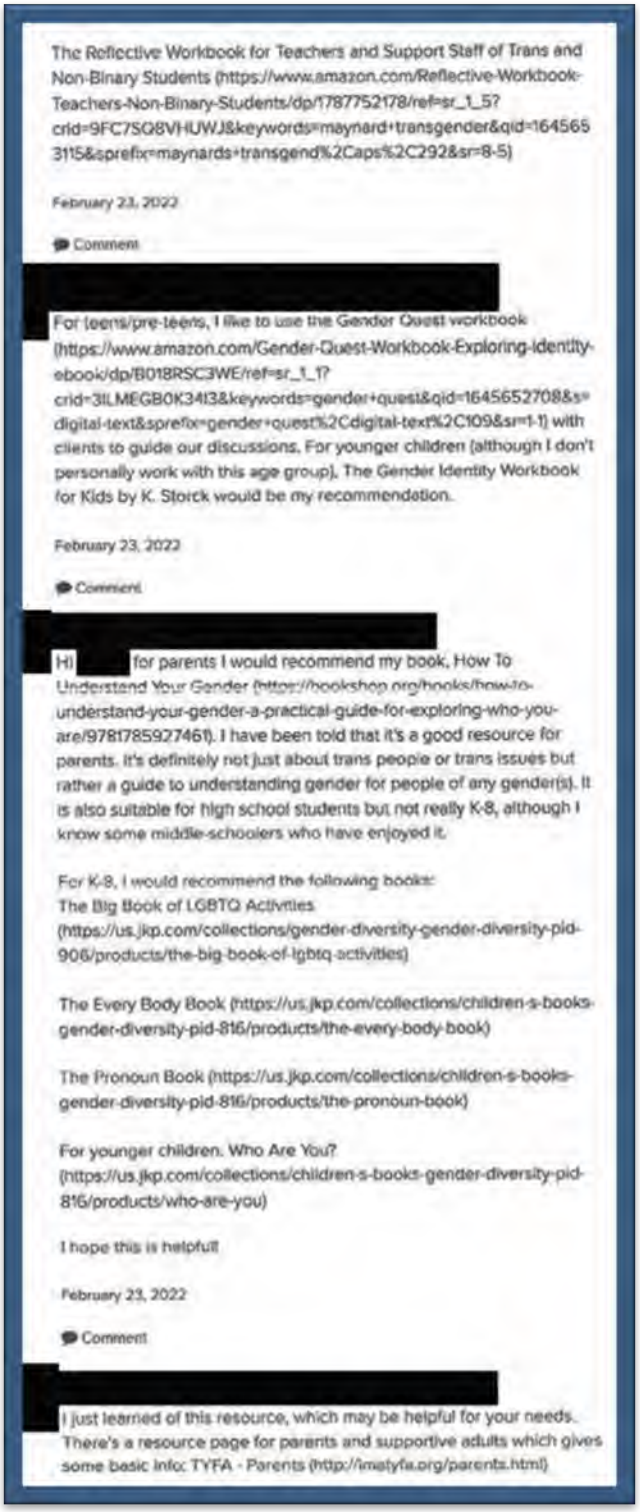
February 23, 2022

Comment

[redacted]

These 2 books are great.

The Reflective Workbook for Parents and Families of Transgender and Non-Binary Children: Your Transition as Your Child Transitions (https://www.amazon.com/Reflective-Workbook-Families-Transgender-Non-Binary/dp/1787752364/ref=sr_1_4?crid=9FC7SQ8VHUWJ&keywords=maynard+transgender&qid=164565



The Reflective Workbook for Teachers and Support Staff of Trans and Non-Binary Students (https://www.amazon.com/Reflective-Workbook-Teachers-Non-Binary-Students/dp/1787752178/ref=sr_1_5?crid=9FC7SQ8VHUWJ&keywords=maynard+transgender&qid=1645653115&sprefix=maynards+transgend%2Caps%2C292&sr=8-5)

February 23, 2022

Comment

[redacted]

For (teens/pre-teens, I like to use the Gender Quest workbook (https://www.amazon.com/Gender-Quest-Workbook-Exploring-Identity-ebook/dp/B018RSC3WE/ref=sr_1_1?crid=3ILMEGB0K3413&keywords=gender+quest&qid=1645652708&s=digital-text&sprefix=gender+quest%2Cdigital-text%2C109&sr=1-1) with clients to guide our discussions. For younger children (although I don't personally work with this age group), The Gender Identity Workbook for Kids by K. Storck would be my recommendation.

February 23, 2022

Comment

[redacted]

Hi [redacted] for parents I would recommend my book, How To Understand Your Gender (https://bookshop.org/books/how-to-understand-your-gender-a-practical-guide-for-exploring-who-you-are/9781785927461). I have been told that it's a good resource for parents. It's definitely not just about trans people or trans issues but rather a guide to understanding gender for people of any gender(s). It is also suitable for high school students but not really K-8, although I know some middle-schoolers who have enjoyed it.

For K-8, I would recommend the following books:
The Big Book of LGBTQ Activities (https://us.jkp.com/collections/gender-diversity-gender-diversity-pid-906/products/the-big-book-of-lgbtq-activities)

The Every Body Book (https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/the-every-body-book)

The Pronoun Book (https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/the-pronoun-book)

For younger children, Who Are You? (https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/who-are-you)

I hope this is helpful!

February 23, 2022

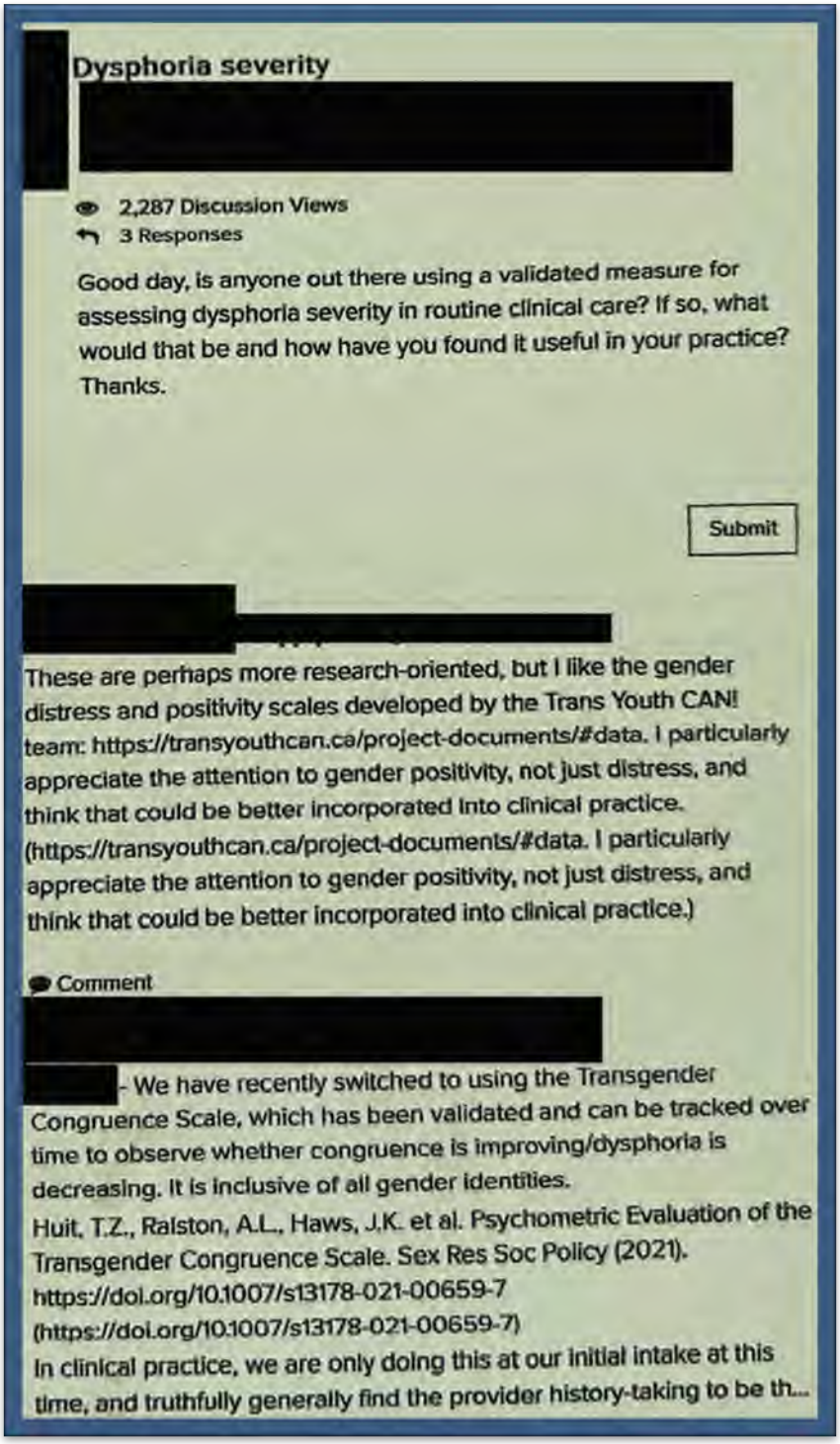
Comment

[redacted]

I just learned of this resource, which may be helpful for your needs. There's a resource page for parents and supportive adults which gives some basic info: TYFA - Parents (http://imatyfa.org/parents.html)

18) EVALUATING DYSPHORIA SEVERITY

a) WPATH members discuss finding validated measures for gender dysphoria severity



Dysphoria severity

[redacted]

2,287 Discussion Views

3 Responses

Good day, is anyone out there using a validated measure for assessing dysphoria severity in routine clinical care? If so, what would that be and how have you found it useful in your practice? Thanks.

Submit

[redacted]

These are perhaps more research-oriented, but I like the gender distress and positivity scales developed by the Trans Youth CAN! team: https://transyouthcan.ca/project-documents/#data. I particularly appreciate the attention to gender positivity, not just distress, and think that could be better incorporated into clinical practice. (https://transyouthcan.ca/project-documents/#data. I particularly appreciate the attention to gender positivity, not just distress, and think that could be better incorporated into clinical practice.)

Comment

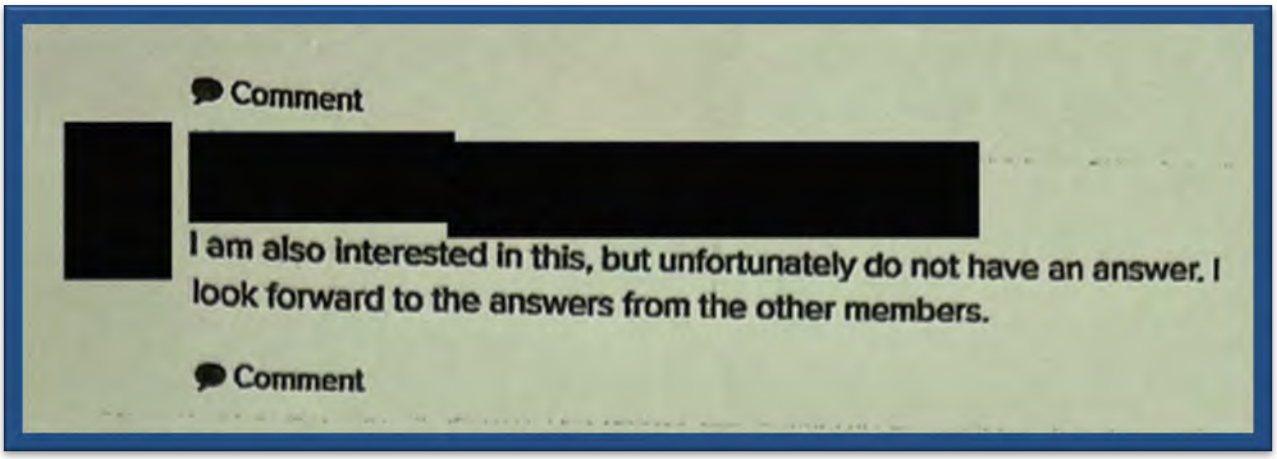
[redacted]

[redacted] - We have recently switched to using the Transgender Congruence Scale, which has been validated and can be tracked over time to observe whether congruence is improving/dysphoria is decreasing. It is inclusive of all gender identities.

Huit, T.Z., Ralston, A.L., Haws, J.K. et al. Psychometric Evaluation of the Transgender Congruence Scale. Sex Res Soc Policy (2021). https://doi.org/10.1007/s13178-021-00659-7 (https://doi.org/10.1007/s13178-021-00659-7)

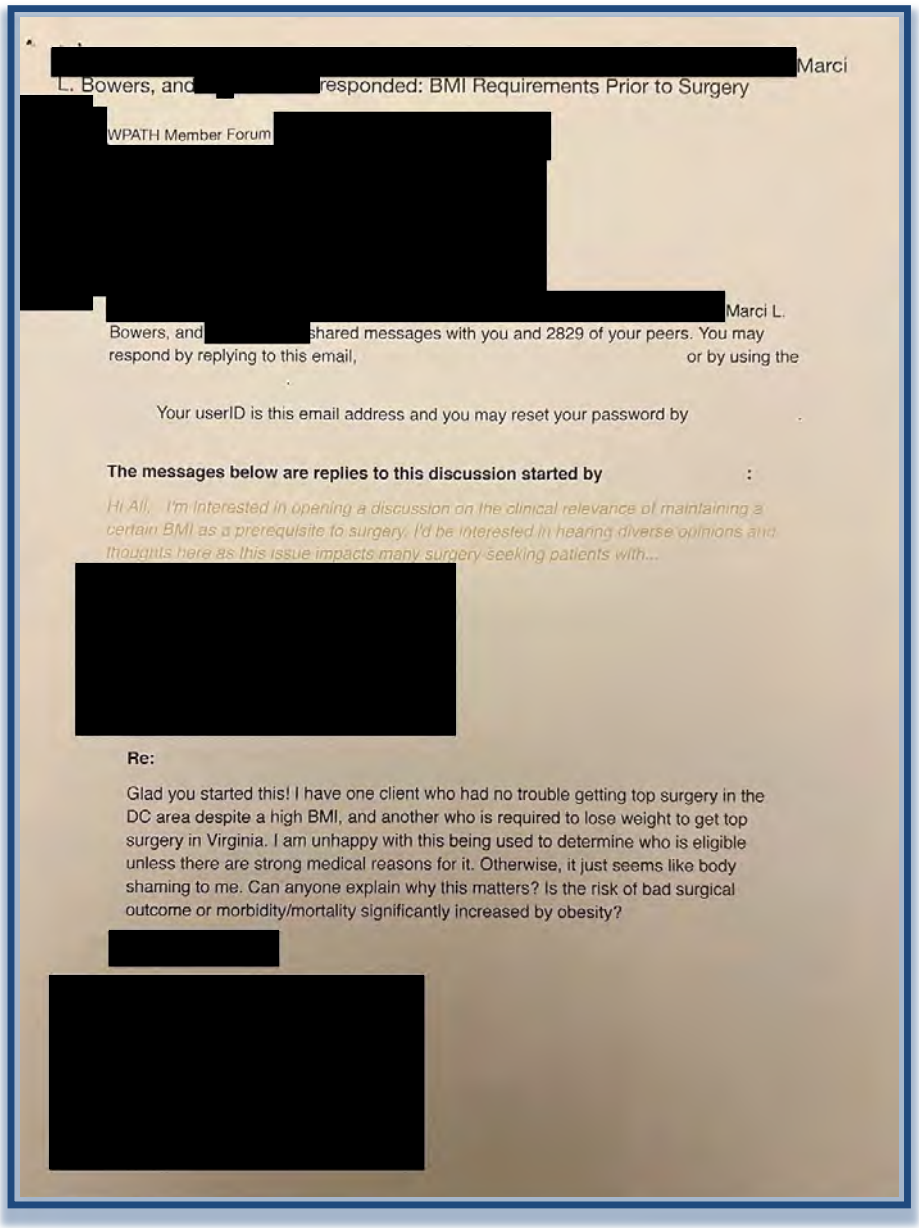
In clinical practice, we are only doing this at our initial intake at this time, and truthfully generally find the provider history-taking to be th...

b) A WPATH member expresses a lack of validated measures to determine gender dysphoria severity



19) BMI REQUIREMENTS PRIOR TO SURGERY

a) WPATH members discuss the clinical relevance of maintaining a certain BMI as a prerequisite to surgery



[redacted] Marci L. Bowers, and [redacted] responded: BMI Requirements Prior to Surgery

[redacted] WPATH Member Forum [redacted]

[redacted] Marci L. Bowers, and [redacted] shared messages with you and 2829 of your peers. You may respond by replying to this email, or by using the

Your userID is this email address and you may reset your password by

The messages below are replies to this discussion started by :

Hi All, I'm interested in opening a discussion on the clinical relevance of maintaining a certain BMI as a prerequisite to surgery. I'd be interested in hearing diverse opinions and thoughts here as this issue impacts many surgery seeking patients with...

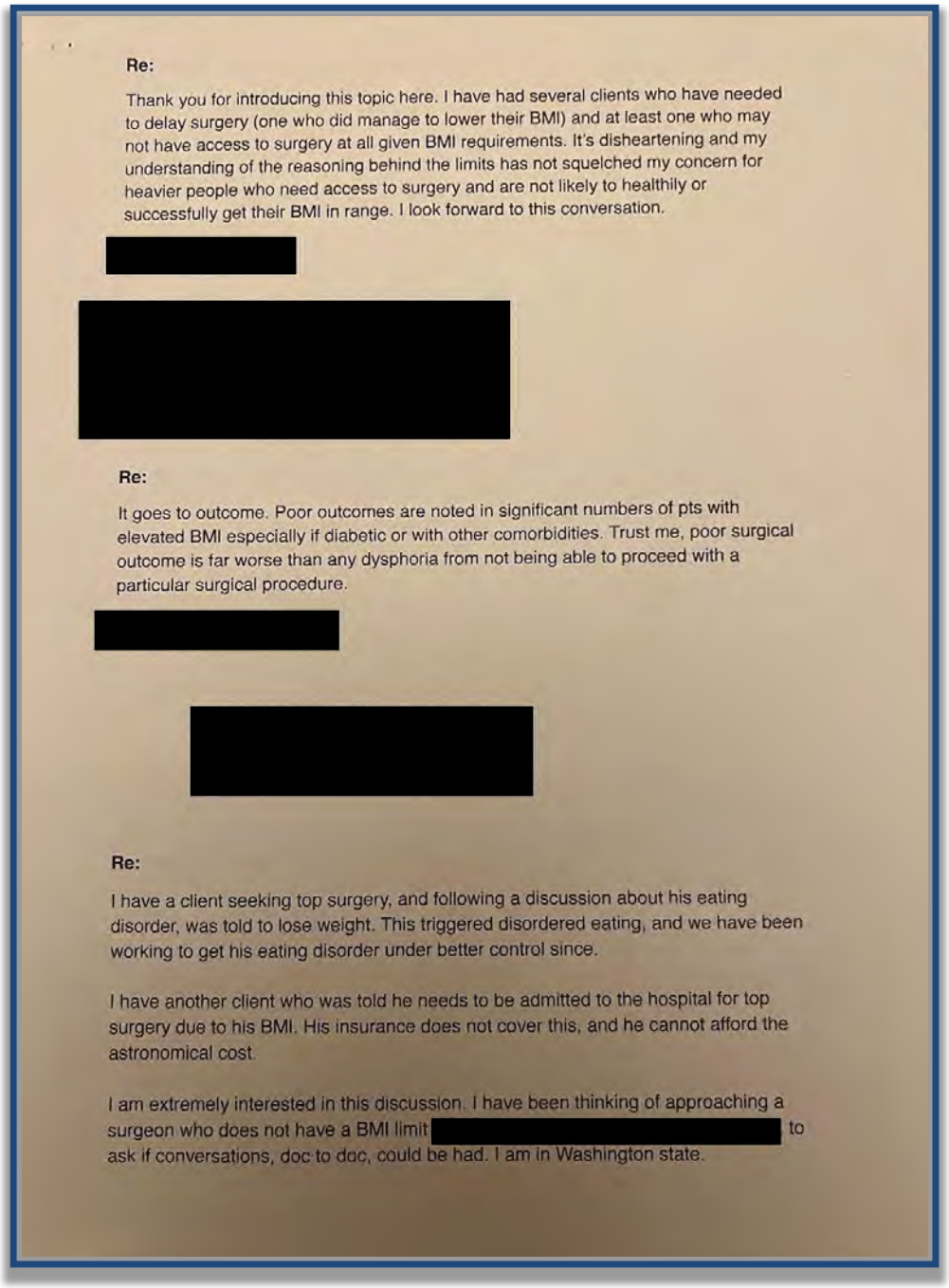
[redacted]

Re:

Glad you started this! I have one client who had no trouble getting top surgery in the DC area despite a high BMI, and another who is required to lose weight to get top surgery in Virginia. I am unhappy with this being used to determine who is eligible unless there are strong medical reasons for it. Otherwise, it just seems like body shaming to me. Can anyone explain why this matters? Is the risk of bad surgical outcome or morbidity/mortality significantly increased by obesity?

[redacted]

[redacted]



Re:

Thank you for introducing this topic here. I have had several clients who have needed to delay surgery (one who did manage to lower their BMI) and at least one who may not have access to surgery at all given BMI requirements. It's disheartening and my understanding of the reasoning behind the limits has not squelched my concern for heavier people who need access to surgery and are not likely to healthily or successfully get their BMI in range. I look forward to this conversation.

[redacted]

[redacted]

Re:

It goes to outcome. Poor outcomes are noted in significant numbers of pts with elevated BMI especially if diabetic or with other comorbidities. Trust me, poor surgical outcome is far worse than any dysphoria from not being able to proceed with a particular surgical procedure.

[redacted]

[redacted]

Re:

I have a client seeking top surgery, and following a discussion about his eating disorder, was told to lose weight. This triggered disordered eating, and we have been working to get his eating disorder under better control since.

I have another client who was told he needs to be admitted to the hospital for top surgery due to his BMI. His insurance does not cover this, and he cannot afford the astronomical cost.

I am extremely interested in this discussion. I have been thinking of approaching a surgeon who does not have a BMI limit [redacted] to ask if conversations, doc to doc, could be had. I am in Washington state.

Thank you.

[redacted]

[redacted]

Re:

My understanding for the BMI requirements is that they are clinically relevant to decrease the likelihood of post operative complications. A high (or low) BMI increases the risk for poor post surgical outcomes for ANY surgery, not just gender-affirming surgeries.

[redacted]

Transgender Surgery, Obstetrics and Gynecology
Dr. Marci L Bowers, MD

Re:

High BMI (greater than 40) is associated with lesser outcomes, longer operative times. But we truly do try not to fat shame patients. That said, weight loss is a great thing with surgery as a carrot towards better health and surgical outcomes. I'd truly pressed, we can make it work out safely.

- Marci L. Bowers

[redacted]

Re:

The recommendations for BMI thresholds for gender affirming surgery are mostly extrapolated from other similar procedures, though overall there is little quality data regarding surgeries on patients at higher BMIs regardless of the surgery (trans or not),

due to systemic fatphobia and lack of quality care for people who are at higher BMIs. Poor health and disease is blamed on high BMI, people are told to lose weight before surgery, etc., and thus nothing is done to actually treat people at higher BMIs because the first go-to solution is to ask people to lose weight before doing anything else.

I think a great next-step toward a solution would be for surgeons who are doing surgeries on patients at higher BMIs to publish their data about the outcomes. Additionally it would be great for providers to be educated on the low success rates of sustainable weight loss and take that into account when prescribing it to patients prior to surgery, and instead try to figure out other alternatives to allow patients to have surgery safely. I don't dispute the fact that outcomes are riskier at higher BMIs, but I do dispute that it is the fault of adiiposity itself rather than weight bias influencing how patients at higher BMIs are cared for and operated on.

[redacted]

[redacted]

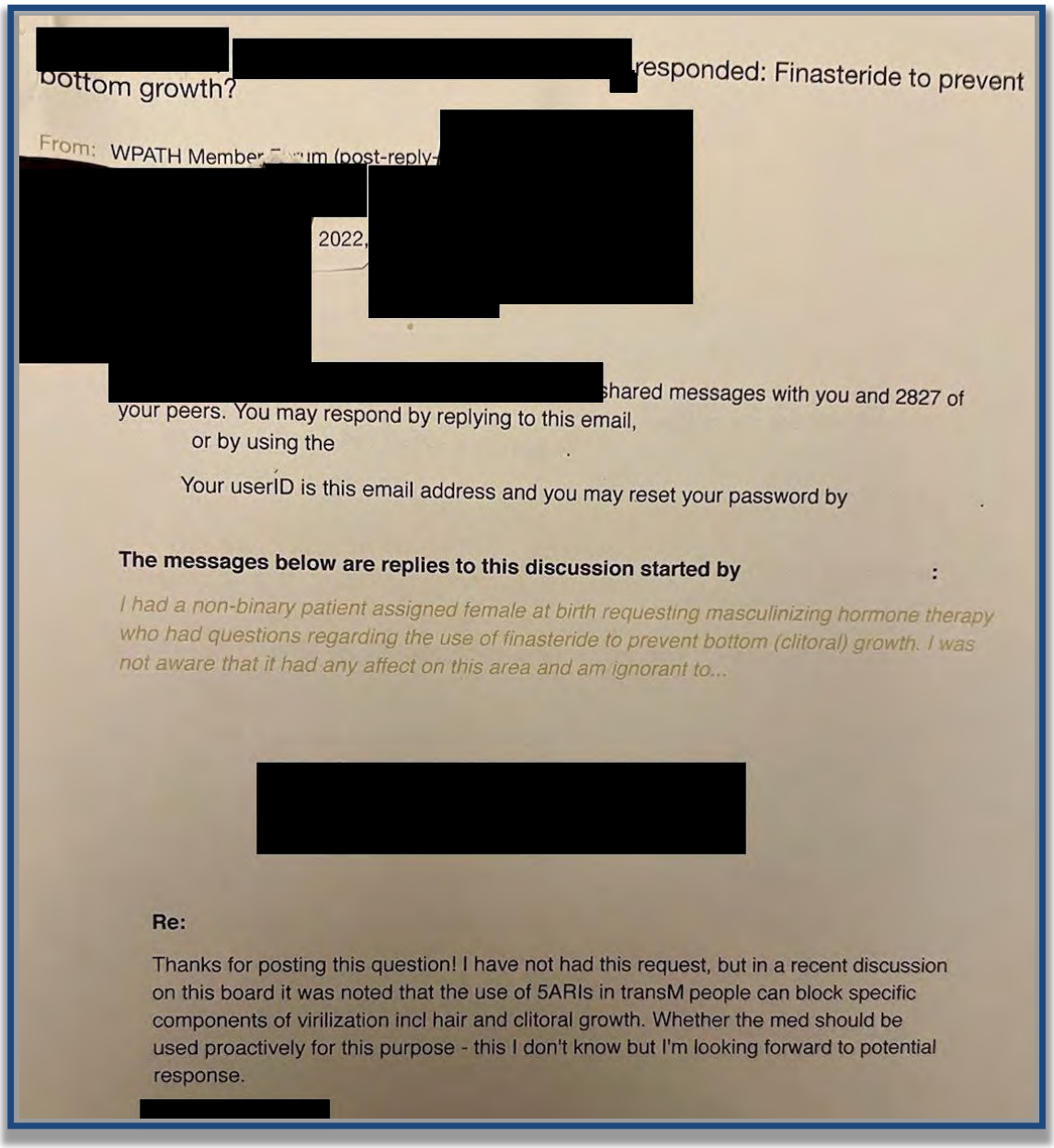
Re:

I do want to add on, I recognize that this is a systemic issue and not the fault of any individual provider. I think most people are doing the best they can with the info they have to provide safe surgeries. However that doesn't also mean positive change can't take place to allow patients at every size to have surgery safely and to learn more about how best to support patients at higher body weights without defaulting to weight loss as a first option. Like you mentioned it is also important to take into account the high prevalence of eating disorders in trans individuals and that recommending weight loss to access surgery can exacerbate this.

[redacted]

20) HORMONE COMPLICATIONS

a) WPATH members discuss the use of Finasteride to prevent bottom (clitoral) growth



[redacted] responded: Finasteride to prevent bottom growth?

From: WPATH Member [redacted]

2022, [redacted]

[redacted] shared messages with you and 2827 of your peers. You may respond by replying to this email, or by using the

Your userID is this email address and you may reset your password by

The messages below are replies to this discussion started by [redacted] :

I had a non-binary patient assigned female at birth requesting masculinizing hormone therapy who had questions regarding the use of finasteride to prevent bottom (clitoral) growth. I was not aware that it had any affect on this area and am ignorant to...

[redacted]

Re:

Thanks for posting this question! I have not had this request, but in a recent discussion on this board it was noted that the use of 5ARIs in transM people can block specific components of virilization incl hair and clitoral growth. Whether the med should be used proactively for this purpose - this I don't know but I'm looking forward to potential response.

[redacted]

Re:

I haven't had experience with this use of finasteride or this request in particular, but my understanding is that finasteride blocks the conversion of testosterone to dihydrotestosterone (DHT). DHT is primarily a hormone important for embryological development and in the adult cis-male is active in scalp hair follicles and prostate tissue primarily. I would guess that clitoral growth would occur to some extent in response to testosterone even in the presence of finasteride, but will be interested to hear if others have tried using it to block clitoral growth.

[redacted]

[redacted]

Re:

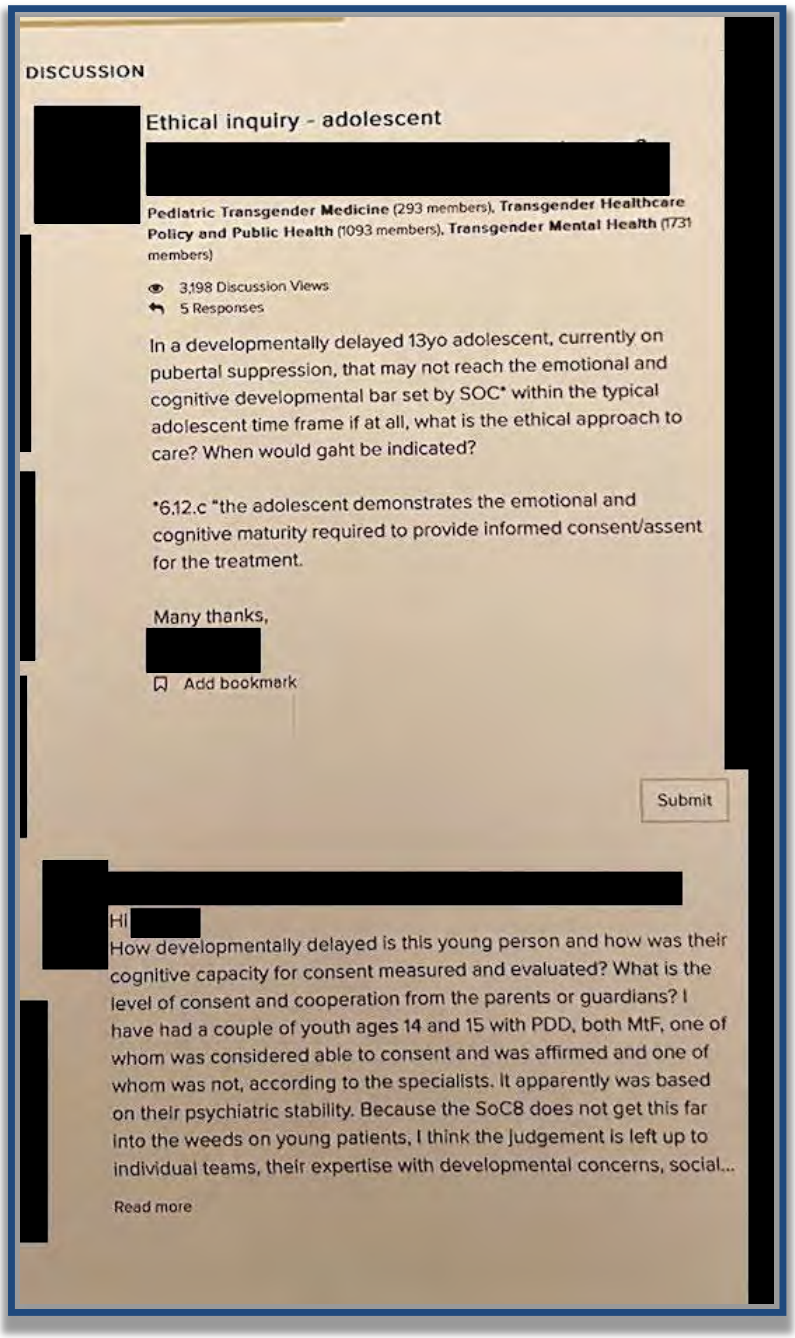
I have had a similar patient who is requesting finasteride to prevent bottom growth whilst starting testosterone.

We have not been able to find any evidence for this but it is clearly something that is being discussed in the community.

It has been difficult to give them a definitive answer. Any resources, evidence or advice would be appreciated.

21) ETHICAL GUIDELINES TO ADOLESCENT CARE

a) WPATH members discuss the Standards of Care (SOC) ethics for treating a developmentally delayed, 13-year-old



DISCUSSION

Ethical inquiry - adolescent

[redacted]

Pediatric Transgender Medicine (293 members), Transgender Healthcare Policy and Public Health (1093 members), Transgender Mental Health (1731 members)

3,198 Discussion Views
5 Responses

In a developmentally delayed 13yo adolescent, currently on pubertal suppression, that may not reach the emotional and cognitive developmental bar set by SOC* within the typical adolescent time frame if at all, what is the ethical approach to care? When would gaht be indicated?

*6.12.c "the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.

Many thanks,

[redacted]

Add bookmark

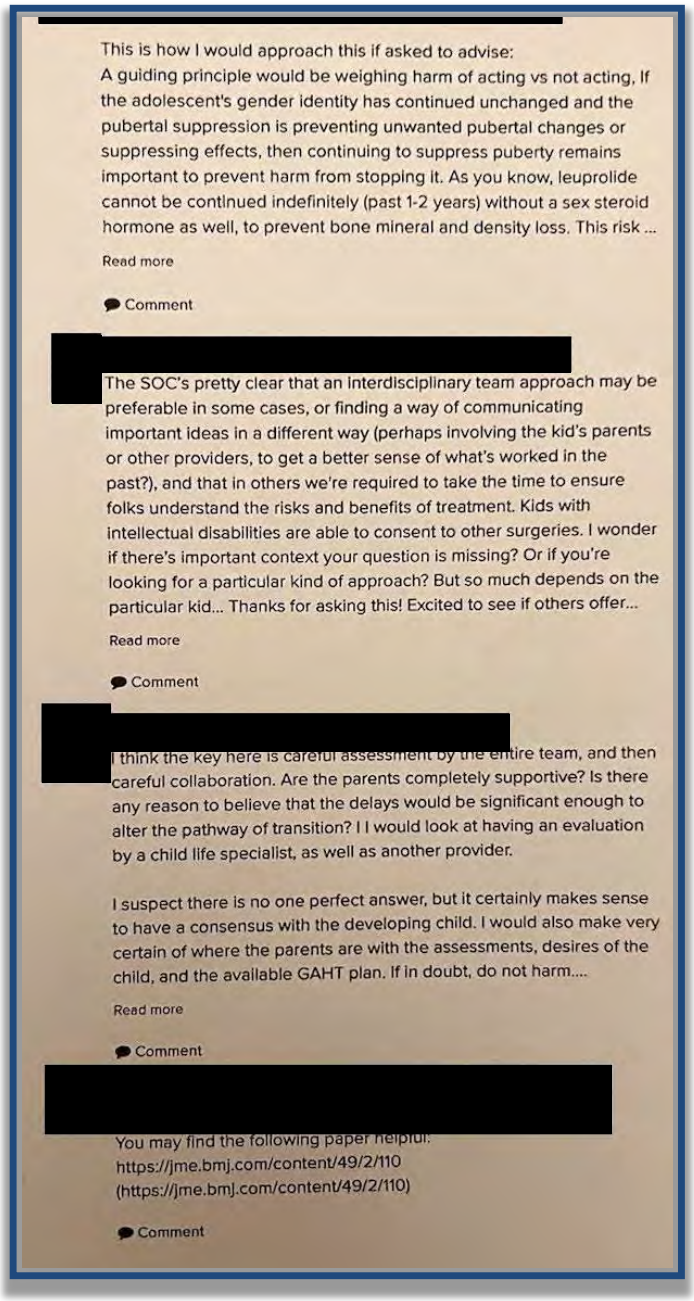
Submit

[redacted]

Hi [redacted]

How developmentally delayed is this young person and how was their cognitive capacity for consent measured and evaluated? What is the level of consent and cooperation from the parents or guardians? I have had a couple of youth ages 14 and 15 with PDD, both MtF, one of whom was considered able to consent and was affirmed and one of whom was not, according to the specialists. It apparently was based on their psychiatric stability. Because the SoC8 does not get this far into the weeds on young patients, I think the judgement is left up to individual teams, their expertise with developmental concerns, social...

Read more



[redacted]

This is how I would approach this if asked to advise:
A guiding principle would be weighing harm of acting vs not acting, If the adolescent's gender identity has continued unchanged and the pubertal suppression is preventing unwanted pubertal changes or suppressing effects, then continuing to suppress puberty remains important to prevent harm from stopping it. As you know, leuprolide cannot be continued indefinitely (past 1-2 years) without a sex steroid hormone as well, to prevent bone mineral and density loss. This risk ...

Read more

Comment

[redacted]

The SOC's pretty clear that an interdisciplinary team approach may be preferable in some cases, or finding a way of communicating important ideas in a different way (perhaps involving the kid's parents or other providers, to get a better sense of what's worked in the past?), and that in others we're required to take the time to ensure folks understand the risks and benefits of treatment. Kids with intellectual disabilities are able to consent to other surgeries. I wonder if there's important context your question is missing? Or if you're looking for a particular kind of approach? But so much depends on the particular kid... Thanks for asking this! Excited to see if others offer...

Read more

Comment

[redacted]

I think the key here is careful assessment by the entire team, and then careful collaboration. Are the parents completely supportive? Is there any reason to believe that the delays would be significant enough to alter the pathway of transition? I I would look at having an evaluation by a child life specialist, as well as another provider.

I suspect there is no one perfect answer, but it certainly makes sense to have a consensus with the developing child. I would also make very certain of where the parents are with the assessments, desires of the child, and the available GAHT plan. If in doubt, do not harm....

Read more

Comment

[redacted]

You may find the following paper helpful:
https://jme.bmj.com/content/49/2/110
(https://jme.bmj.com/content/49/2/110)

Comment

Transcript: Identity Evolution Workshop held on May 6, 2022

A different recording of a 1 minute and 30 second clip from the panel discussion (which is 1 hour and 22 minutes in total) was leaked into the public domain over a year ago. The video in the WPATH Files is a new recording, has a different layout, and has no connection to the previous leak. The time stamp of the previously released portion of the WPATH video is 23:16 - 24:43. This is the first time the panel discussion has been made publicly available in full.

CLIP 1

Cecile Ferrando: Transmasculine patients. And we talk about, you know, early oophorectomy, so early removal of the ovaries and what that means in somebody who is taking testosterone therapy but may not be on testosterone their whole lives. And I simply sort of explain the need to have to supplement, you know, in order to have cardiovascular protection, bone health, good bone health as they get older.

Um, so those are the things that we think about in this cohort of 20 year olds in whom we're removing the ovaries. There's some concern that long term, if they ever stop their testosterone, they could be at, um, um, at metabolic risk, which is just something that needs to be considered. But historically, we have a patient population that also doesn't seek out medical care.

So there's that sort of confounding factor too, which makes it a little bit trickier. Um, but at the end of the day, it's about informed consent. And on my end, I'm just managing patients who have sought out treatment in alternative ways. Um, and that those are, those, those can be pretty challenging.

Ren Massey: Thanks, Cecile. Would anybody else like to add some observations?

Dan Metzger: I think, you know, when we, when we start people on, um, testosterone or estrogen, uh, you know, we, we try to be as clear as we can, um, about the stuff that's going to be permanent and the stuff that's, that's going to go backwards. So if you started testosterone, your voice is going to change. That's permanent, but you might get more muscly, but then that's not permanent if you were to stop.

Um, I think the thing you have to remember about kids is that we're often explaining these sorts of things to people who haven't even had biology in high school yet. And, and, um, uh, and I know I've, I've heard others in, in this kind of a, in this kind of a setting say, well, we think adults are like really slick biologically.

And in fact, lots of people have very little medical understanding of stuff like that. We just put medical professionals and. mental health professionals take for granted. So I think we have to be, um, more concrete than we think we need to be. Um, short of surgical stuff, you know, I think, I think, um, uh, and the permanent physical changes that happen with testosterone or estrogen, um, you know, you might get some breast development that maybe you would later regret.

Uh, but I think, um, it's reasonably safe to, to be on hormone X for a while and then stop and go back to your, to your natal hormones. Provided you haven't had some sort of a gonadectomy, then, as Cecile mentioned, that's a different issue if you're hormone less, um, so, um, I think that is important, um, for people to know, and I think we also, like, just in general, you know, people want this, but they don't want this, but they want this, but they don't want this from a hormone, and I'm like, well, you know, you might not be binary, but hormones are binary, and so, you know, you can't get a deeper voice without probably a bit of a beard.

It doesn't work that way, or you can't, um, you can't, uh, you know, get estrogen to feel more feminine without some breast development. It, that doesn't, that doesn't work very well. And there are different ways of trying to get around some of these things, but in general, um, you know, when you give a hormone, it's going to do what hormones do.

It's going to act on a receptor, the receptors are everywhere, and you're going to get some sort of a physiologic effect, and it's hard to kind of pick and choose the effects that you want. And, and I know that that's, um, I know that that's, uh, like something that kids wouldn't, wouldn't normally understand because they haven't had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y,

and that's not always possible.

CLIP 2

Ren Massey: Thanks, Dan. Yes, expectations and informed consent. We have a lot of work to do here, even as mental health professionals, um, in my work, I, even before having folks start on hormones, I go over a lengthy, um, information about the effects of the different kinds of hormone therapies, uh, just so they, I have the clarity that they have some sense of understanding what they're going to because even the good hormone docs here in my area.

Don't always take the time, or it's easy for us to make assumptions that people understand. You know, but that estrogen is not going to make somebody's voice go higher. Or if you're a certain age, testosterone is not going to make you taller. So, um, manage expectations, I think is really important. Uh, it looks like Dianne's ready to say something.

Dianne Berg: Yeah, I just wanted to piggyback on all of the importance that comes up with the informed consent. Um,

I often see people who, because there's such a backlog of therapists to do some of the mental health therapeutic support, I often see people who have already engaged in some sort of, and this is again with youth, who've already engaged in some sort of medical, um, Intervention. And so one of the things I do is I just kind of I'm sitting with the youth and their parents and I say, Oh, well, so tell me more about what you know about that medical intervention.

And kind of like what Dan was saying, you know, children and young adolescents, we wouldn't really expect them. It's kind of a developmental it's out of their developmental range sometimes to understand the extent to which some of these medical interventions are impacting them. And so I think I, I try to kind of do whatever I can to help them understand best, best I can.

But what really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for. And so I think informed consent has to happen very differently for parents. That it has to happen for

children and early adolescents and adolescents, but it needs to happen and it needs to be a process and, and I think therapists are in a really good position to do that process because we have a lot more time.

with our people than like the 20 to 20 minute medical appointment the way that and that's another problem is the way the medical system works is is there's often very little time. So I think it's really one of our roles is to really do that and to really suss that out and take quite a bit of time to do that and it's more than just like we certainly provide information but then you kind of have to listen to what the the youth is doing with that information to to kind of not, not catch them, but to pick up on the ways that they're not really understanding what, because they'll say they understand, but then they'll say something else that makes you think, Oh, they didn't really understand that they, that they are going to have facial hair, right?

Because they say something else that makes you think, Oh, they didn't get that point, but they'll say they totally get it.

CLIP 3

Dianne Berg: This comment on is that I worked in a, um, an intersex or disorders of sex development clinic for a number of years as the psychologist. And I would come in to the session with the parents and usually these were very young kids. So I wasn't really working with the kids. I was more working with the parents and, and I would come in there after the, after the medical doctor had, after the pediatric endocrinologist had been in there and done, had been in there for an hour and had talked with them.

Um, and. The pediatric endocrinologist came out and said, yeah, they totally get it on board. I don't have any concerns about their understanding. I would go in and I would say, okay, so tell me what you learned from, and they'd just be like, 'We have no idea what they were talking about.' Because they, they feel deferential.

Part of it is that they feel less deferential to the kind of doctor I am than the kind of doctor, the medical doctor is. And so, and because they really are seeking the care, they're just gonna. Say they know when they really, they really aren't picking up on what's happening. And so I think the more we can normalize that it is okay to not get this right away.

It is okay to have questions is, you know, the more we're going to actually do a real informed consent process. Then what I think has been currently happening and that I think is frankly, not what we need to be doing ethically.

Ren Massey: Thanks, Dianne. I appreciate those comments. Um, anything you want to add in there, Gaya?

Gaya Chelvakumar: I would just say I agree with all the comments that have been made. I think the informed consent process is so important and definitely that it's a process is really important to recognize that it's not one conversation at one point in time that is many conversations over time, um, and that those conversations don't have to stop once the Medicaid and intervention has been started, that those conversations can be ongoing even after the intervention has occurred.

Um, even asking how they feel about changes that are happening and, and having discussions about is this something you want to continue with to not, um, you know, informed consent is such an important piece of starting any intervention and it's so, it's so hard. And I often wonder about what you mentioned, Dianne, about people saying they understand when they don't, just because they're so focused on the intervention that, um, They're afraid to share things that they might not be understanding about the information we're sharing with them and how, how to address that I think is very, is very important.

I will say just personally my practice, it has evolved, how in the medical setting. I think we have these Conversations and, um, around informed consent has evolved a lot over time as well, just recognizing a couple of different things, you know, that identities may shift and transition needs may shift, um, that also has shifted how we have, I think, conversations around, um, around informed consent and starting an intervention.

But it's so important and just that it's a process and it's a continual conversation, I think, is the biggest thing.

CLIP 4

Dianne Berg: And Gaia, I don't know if other people do, but I really struggle with, with, because I kind of want The kids that I work with, whether they're nine to, you know, 13

and looking at puberty suppression or hormones in some ways to be a little pediatric endocrinologist, like I, I want them to understand it at that level, um, in an age appropriate way.

And I struggle with that on one level because it's like, well, when a kid takes diabetic medication, do they have to understand? everything about their pancreas and everything that's happening and all of all of that do we do we do that same process around other medical kinds of things and so is this an unfair So, I just struggle with that line, um, and I just kind of wanted to, to say that because I'm not quite sure what to do about that.

The other thing that, that I, that I really like to do is I like to have the children or the young adult or the young adolescent or the adolescent come up with questions that they have for their medical doctor. So let's, let's, let's write a great question. Write that down. Write that down. We're going to ask that you ask that the next time you come back so that they're, they're really, I think, um, one of the things we have in one of the papers that we published is how important it is to instill a level of autonomy into Okay.

Children and adolescents about their medical care and transgender people about their medical care that they get to be assertive. They get to ask questions. They get to be really well informed. And so we want to start that very young by having children like, ask a question, write down what you think and ask the doctor.

You can ask the doctor. Well, I can't really. Yes, you can. Yes, you can. You get to ask the doctor anything that you want to ask them. Um, and so really instilling that way of thinking about medical care, I think is important.

CLIP 5

Gaya Chelvakumar: Important point two is just collaboration between the medical team and the mental health care providers so that there can be also ongoing discussions between team members. So if, when mental health providers are having conversations around expectations around Medicaid, it's just like, Hey, you may want to spend a little more time talking about this, or this is an area that the, there seems to be some confusion about, or parents or child are really, um, concerned about, I think.

In this, in this area of healthcare right now, multidisciplinary care is so important and being able to collaborate with each other is so, is so important and so helpful, um, because sometimes we're not, you know, maybe in the context of a medical appointment, the conversations that need to happen can't happen and then maybe there needs to be further conversations with, with a mental health provider to help make sure parents and children have all the information they need to make the best decisions for themselves.

Yeah, I agree. It's so helpful to be on these on these panels just to hear where everyone's at because I think we all are struggling with how to do this and that in the best way without overburdening our patients and families as well.

Jamison Green: But our health care system doesn't If I may jump in here, our health care system doesn't encourage this.

I mean, if you have a clinic, like already, like a university setting where Dianne is, or where Cecile is even, and I'm not sure where you are exactly, Dan, but I know many people providing this care are independent practitioners, and they're referring their clients to surgeons. Uh, across the country and their endocrinologist might be their actual May, they may not never, they may never have a, an endocrinologist.

They may be able to get their hormones prescribed through their primary care provider who doesn't really know necessarily everything about Transcare. They're basically trying to be supportive and you know, our health care system. It leaves us in the lurch all the time. And so to create, I agree that we don't necessarily need to be able to have If you have a known condition, like diabetes, you don't have to understand every nuance about what the insulin is going to do to you in order to give informed consent.

You need, but, because there's so much experience with that. But in this field, this is all new, this is all contentious, and that's where we run into problems. because everyone's afraid. And I know for a fact, people, even adults, even well educated, older adults, accessing care for the first time, sit down with the person who's going to prescribe their hormones, and they look at an informed consent form that says your hormones are going to do this, this, and this. They don't take any of that in yet because they're so scared that they're not going to get what they need. They, they just so, show me where to sign. Cause I'm, this is my moment, I gotta grab it. And they don't really take in the information.

CLIP 6

Jamison Green: And people also are afraid many times about surgery and so they can read other people's descriptions about surgery and they'll miss details or they'll miss the, the, uh, the most important piece of information for them simply because they're afraid to read it. You know, it's just how human beings work.

So I think at the same time we're fighting against The community's desire to have less gatekeeping, less professional intrusion, less spending time in doctor's offices. And how do we manage that and make sure that everybody's got the right level of education to make good decisions for themselves? So this is a problem that we're facing.

And this is where I think some of the detransition comes in. Because the over medicalization, as well as Uh, over binarying, as well as just the pressures that people are under because of the opposition creates a dynamic that's very, very hard for all of us to work in. Trans people and clinicians, very, very hard.

So I think these dialogues are crucial and we need to take them outside of this space ultimately as well.

Ren Massey: All right. So I'm, I'm sorry. Did you want to go ahead?

Dan Metzger: Good. We can do it after the.

Ren Massey: Yeah, I was going to suggest you this great conversation. I have more comments, but I'm like, ah, people probably need a break attendees as well as panelists. So, uh, I've asked for a 12 minute break. And we will reconvene back here and look forward to seeing y'all back here in a little bit. Thanks.

CLIP 7

Ren Massey: I think we're pretty close to on time for that 12 minutes. Appreciate everybody being back here. Um, I'm wondering if, uh, well, I wanted to share just a little bit about informed consent. And then after, if anybody else wants to chime in, feel

free to. I saw a little bit going on there. I do think that that's a really important part of what we can do to help folks.

Um, in terms of their decision making processes and also, you know, just to start out with, I make it clear to people that I don't have an investment, whether they're youth, whether it's parents. Whether it's adults that I have no investment in what their gender identity is even just because transitioning was right for me doesn't mean that it's right for somebody else.

And that's not a bias that I have. And, um, I hope that that gives people from the start a sense of safety in, um, considering a range of options in, um, in terms of gender identity and gender expression possibilities. Uh, when we do get to talking about, um, hormonal and medical interventions for those who, uh, are considering those options. You know, one important thing I believe is to make sure we address fertility preservation. If you all have looked at the drafts of the standards of care coming out, S. O. C. Eight. Hopefully next month, you'll see, you know, a number of places where it's encouraged and ethical to talk about fertility preservation options And that's even for youth who are going on puberty blockers, because many of those youth Thank you for nodding heads. Many of those youth will go directly on to affirming hormone therapies, which may eliminate Or will eliminate, you know the development of you know, they're gonads producing sperm or eggs that are going to be able to be usable if they want to be partners with somebody else later in contributing genetic material for reproduction

CLIP 8

Ren Massey: I start even with puberty blockers to talk about fertility and a useful tool has been John Strang's TYFAQ, the Trans Youth Fertility Attitudes Questionnaire. It's not necessarily standardized to my knowledge, but it's a mechanism for discussing. There's a parent version and a child, a youth version for discussing some fertility issues just over, I think it's 16 questions.

And then also my informed consent process, I will include, um, as a non medical person, but somebody in the healthcare profession with a lot of. experience and knowledge and G. E. I. S. Under my belt attend all these conferences. Always learn something. I cover the reversible and irreversible effects and the potential risks to the best of my again.

I'm a lay person as far as being not a medical provider. Um, knowledge and I base that on the standards of care seven and we're gonna have the new ones coming out as I mentioned as well as the interim guidelines. Uh, the latest being in 2017. And there are some other resources out there. So, um, I see somebody put a file up there but there Are ways I think we can all go over this.

And also just finally, I'll just add that I go over it with the youth separately from the parents. Uh, and then with the parents separately from the youth, ideally, and then bring them all together. Make sure we're all on the same page of under what we understand. Um, Limitations acknowledged, and, uh, you know, they're often having questions, and I say you have to ask your hormone provider, the consultant you're, uh, going to be meeting with about, uh, certain questions.

So there are certainly, I stay within my lane, but I do think that part of the multidisciplinary nature of this work is being well versed in these things, at least to a certain level, and that's part of why we have a multidisciplinary panel here.

CLIP 9

Ren Massey: wants to, I see somebody added the QIFAQ in there. Anybody wants to add any comments on that before we move on and we could potentially start looking at cases in a little bit? Does anybody want to add anything to what I said? Looks like Dan might.

Dan Metzger: I, I was just gonna say, you know, like, like it's always a good theory that you talk about fertility preservation with a 14 year old, but I know I'm talking to a blank wall. And the same would happen for a cisgender kid, right? They'd be like, Ew, kids, babies, gross. Or, or the usual SPAC answer is I'm going to adopt. I'm just going to adopt. And then you ask them, well, what does that involve? Like, how much does it cost? Oh, I thought you just like went to the orphanage and they gave you a baby.

No, it's not quite like that. Um, but, um, and I was just trying to find it, but I can't, I can't quickly locate it because I only have is like a picture of a slide, but apparently last week at the Pediatric Endocrine Society, uh, some of the Dutch researchers started, uh, gave some data about, um, young adults who had transitioned and reproductive regret, like regret, and it's there.

Um, and I don't think any of that surprises us. I don't remember any of the numbers or anything. I just, again, I have a picture of a slide. But hopefully this is something that will get published in the next while. But, um, you know, I think, I think now that I follow a lot of kids into their mid twenties, I'm always like, Oh, the dog isn't doing it for you, right?

Yeah, they're like, no, I just found this, you know, wonderful partner and now we're kids and da da da. So I think, you know, it doesn't surprise me, but I don't know still what to do for the 14 year olds. The parents have it on their minds, but the 14 year olds, you just... It's like talking with diabetic complications with a 14 year old. They don't care. They're not going to die. They're, they're going to live forever. Right? So I think, I think when we're doing informed consent, I know that that's still a big lacuna of, of that we're just, we do it. We try to talk about it, but most of the kids are nowhere in any kind of a brain space to really, really, really talk about it in a serious way. I, that's always bothered me, but you know, we still want the kids to. Be happy, happier in the moment, right?

CLIP 10

Dianne Berg: I appreciate that much less with a 9, 10 or 11 year old who's, who's, um, who's starting puberty suppression. And like Ren said, if they continue on then, and, and I mean, it's, it's like developmentally not in their space to be able to have, have to think about that. And it shouldn't be, um, right. And so I think it is.

I think it is a real growing edge in our field to kind of figure out how we can, how we can approach that. Um, I'm definitely a little stumped on it.

Gaya Chelvakumar: I'll just add one more complication in there is that then if you do have, which doesn't commonly happen, but if you are interested in preserving fertility, then the options for for doing that, depending on age and stage of development also can be. From a medical standpoint, may or may not be possible, but then from a financial standpoint, also may or may not be possible, and that's another complexity to the, adds another layer of complexity to these discussions as well, and that's at any age, I guess.

Dianne Berg: And from a social and sexual standpoint, right? Um, in some ways, the stuff that you need to do to be able to preserve your fertility might be beyond kind of what a youth, where a youth is at in terms of their sexual development, and yet.

That's kind of what's needing to happen and, um, yeah,

Ren Massey: yeah, I don't think that we have all the answers and I appreciate y'all's comments, bringing, you know, highlighting the nuances and the challenges here. I find a range of. Maturity levels and having thought about this or not having thought about it. Um, again, depending also on the age and the cognitive maturity, emotional maturity.

Um, I still, I know you all do these kinds of things too. I think that it's better to give them the information and have them, Be able to reconcile, like we wish we could afford this, but at this point we can't. And so we will proceed down this avenue anyway, but not later on then find out, Oh, nobody ever told me that I couldn't, you know, do that.

CLIP 11

Ren Massey: Like, why didn't somebody tell us? And so I think that there's a shift in the field, but I just think we need the spotlight that, um, it's part of the discussion in the informed consent process for youth as well as adults. Um, And back to the thing I said the very beginning of after the break, part of also trying to make sure people have a sense of I have no investment in where their gender identity or identities land is because that part in this study where people said they didn't go back to the same provider, that that bothers me, I would like people to feel like they can continue with me whoever they are.

Um, if I can help in other issues, you know, a few of the folks I've worked with, it's been, um, some of what Dianne was saying earlier, you know, their sexuality got to clarify some of their gender identity issues. And, um, they, I've been pleased when they've gotten clear. Okay. Maybe I'm not trans, maybe I'm non binary, maybe I'm cis, um, and maybe this was more of a sexuality issue.

And they were willing to continue to work with me as they explored sexuality issues. You know, I want people to feel like they don't have to perform a certain gender to be

working with me. Um, that I want to be inclusive and supportive of all aspects of their being, so. All right.

CLIP 12

Ren Massey: Any other thoughts before we maybe look at cases? Alright, as, as we shift to cases, then, uh, this is always the tricky part for me to work on.

Dianne Berg: I'm sorry, Ren, can we just, Melissa Goldstein is just asking if anyone has great resources for fertility and preservation especially. Oh, Gaia just put it, did you just put it in?

Gaya Chelvakumar: I just popped in one article that starts to discuss some of it.

Ren Massey: I'm, I'm glad. I think, I think that that's a knowledge, right? And there isn't a ton of, of that existing. So I just wanted to acknowledge that. Yeah. All right. Thank you. Um, it's wonderful how we've got all these wonderful resources here. All right. So, uh, bear with me a second. I am going to try to share screen to, uh, go over some cases that our panelists have, uh, put together.

And this is the part where I always grapple.

CLIP 13

Ren Massey: Read the case of DJ. Give me a thumbs up, panelists.

Okay. All right. So I'm wondering if panelists have any comments or thoughts you all want to start with in getting this discussion going around this young person and their experience.

Oh, sorry, Randall. I'll read the next one.

Dan Metzger: To me, this is a not an untypical story. I mean, this person's got some significant mental health stuff, which is, you know, that they need to deal with. It

sounds like they had an unfortunate sexual traumatic sexual event, which that sounds probably pretty horrible. But to me, this is a kid who, who, who. Um, got a false start and, uh, and, um, maybe it wasn't in a place where they were fully supported or they feel fully supported.

Um, but to me, this is not de transitioning. This is just a kid working through crap. And, um, I mean, I obviously may feel sorry for the kid, but to me, this is not like something that should hit the news as a, you know, a system problem. You know, assuming that this kid's been getting the mental health care that they need.

To me, this is like, not an untypical story. Um, and with a happy ending. So, yay.

CLIP 14

Dianne Berg: highlights the importance of having ongoing support and following kids over time, um, so that you're getting as much of the picture as you possibly can. And, and so kind of the important role of, of behavioral health, mental health, um, component. Um, I think, I think oftentimes mental health can get a really bad rap.

Um, in terms of that, we're trying to do things that we're not actually trying to do and, and so I think this is a good case that kind of exemplifies if you're following this kid and meeting relatively recently, relatively, um, often with them, you're going to kind of be seeing this in real time and be going through this with them and be helping them to process and figure out kind of the meaning that it has for them.

Um, And hopefully as you have enough of a rapport, I don't know if it happened in this case, but that it looks like the, the person didn't disclose some of the bullying and the traumatic sexual event until a year later. The hope would be that if we can build enough rapport over time with kids in whatever specialty we have.

That, that we would learn about that in more real time than a year later, and that we would be able to be, you know, kind of just doing it as part of the regular process of checking in about all spheres of life. Um, so it really highlights the importance of that for certain, for certain youth.

CLIP 15

Ren Massey: comment. I noticed an observation or a wish that, uh, therapists involved in able to Help the young person distinguish between the assault and their gender identity. I think, um, that there are times working with young people where they don't even disclose an assault or some type of sexually, Coercive or unpleasant experience.

It may not even have been coercive, but it may be almost like self coerced. They thought they were supposed to do X, and so they, like, I guess this is how people interact sexually, and so they showed up voluntarily, like this other person at

the moment, um, wasn't coercing them, but they were kind of trying to get themselves to learn about sex. And so they may have done things they didn't even feel comfortable with. And so they don't want to talk about it with therapists. So, I mean, um Even good therapists, you know, we're going to be limited at times where we're, uh, we can't get everything that's going on with our kids that we're working with.

And sometimes the adults also don't bring it forward. So, um, it's a, it's a high bar to cross sometimes to try to catch everything that. may be affecting somebody's view of themselves and across domains of their life experiences.

CLIP 16

Gaya Chelvakumar: And I'll just echo Brennan and Dianne's statement. I think the case to me just highlights the need for, in addition to continued, you know, ongoing care, but also maybe like leaving the door open, that if this is your decision at this point in time, but that may change and we're, you know, we're here to support you, whatever your decision is, and that you can always, you know, continue to see us continue to see the team, um, you know, keeping, keeping engaged with young people and letting them know that they can, It's okay to change your mind.

It's okay to, to come back and knowing that, um, people sometimes have to disclose things in their own time as well. So that while we hope things are disclosed in real time, sometimes people just aren't in a place to face, to face their trauma and what's going on. And so even more so becomes important, I think, to have that ongoing care.

Um, and even if there is an ongoing care, at least leaving the door open, young people, or adults even, are in a place where they want, where they want to reengage that that door is still open?

Dianne Berg: Yeah, there, there was a comment. There was a comment in the chat about, um, sometimes our, our discomfort with asking questions, particularly pertaining to sexuality.

And I, and I think that that's, that's really true. I mean, we have not gotten to the place yet where it's just part of, Every typical kind of area that you inquire about, and I think that that's really important, um, and is, is part of, and, and to not, and to not frame sexuality, I think the other thing that happens with sexuality is it gets framed as negative, all the things that we shouldn't be doing, um, rather than having a positive, kind of positive take on sexuality, and so how with, with youth and, are adults.

Do we just naturally feed that into the conversation? And how do we as clinicians get comfortable with sexuality and sexuality themes? Um, in a society that isn't very comfortable with it, but isn't comfortable with it in appropriate ways is very comfortable with it in some ways that probably aren't very healthy.

And so how do we teach people to do that? I think that's one of the benefits that That I have working in a sexual health kind of clinic that has a gender component to it. And I think that's really important.

CLIP 17

Ren Massey: All right, thanks. Going, going, gone. Move on to our next case. Okay, if I can get my screen share to cooperate with me. Ah, here we go. All right. Cases. This is a collective consideration. Several trans men in their late 20s, early 30s have done a range of social and medical interventions. They're now clear that in hindsight, if they had come out ten years later, they may not have taken all the medical transition steps that they did if the option of a non binary identity had been on the table.They don't like to be seen by others as male, but given the physical changes, don't feel like they have a choice. There are different intensities of how upsetting this is to them, but a common theme is not likened to be perceived as male by others to the extent they are seen as male. I found this really interesting.

Who would like to jump into this conversation?

Dan Metzger: This is a bit beyond my age group, but I think one thing that they could do, uh, medically is to talk with their hormone provider to see if there's a way. I'm presuming these people are still on testosterone, if they are, that they could at least lower the dose to something that's still bone protective and still would make them feel okay, but maybe wouldn't, uh, would less stimulate, uh, you Like facial hair growth or or the other kinds of things.

I mean, their voice is not going to change, obviously, but, uh, there might be some room to play with the testosterone dosage just to make things a little bit less, uh, um, less masculine.

CLIP 18

Cecile Ferrando: Um, so I think this is about goal setting. Um, so you know, while I'm a surgeon, I do a lot of testosterone implants for patients. So I do testopel implants. Um, and, um, when I talk to a lot of patients, the majority of the patients I see, they are seeking, um, realization, masculinization. So I dose them to sort of physiologic levels.

Um, but I have sort of this, um, cohort of patients that is seeking sort of, you know, underdosing, but wants testosterone, um, supplementation. Um, so we sit and we talk about. The goals of therapy, understanding whether, you know, I have to explain to them that sometimes underdosing can, um, will not lead to cessation of menses, which is sometimes the actual goal, like not virilization, but cessation of menses.

And so, in those situations, we talk about, you know, what other things we can do that, um, that may not have sort of either feminizing effects, you know, a lot of our, Transmasculine patients don't want to be on oral contraceptive pills, etc. So sometimes I'll underdose testosterone in a pellet form. Um, and also, um, place an IUD in those patients.

And so it's really sort of about discussing what their goals are. I'm now seeing younger patients. So not necessarily patients who were dosed on, on doses of testosterone and who are now working backwards. But I have a couple of patients in their twenties who.

Sort of err on the side of the masculine side on the spectrum, but don't want to be fully masculinized.

So I'll underdose them as well. And, you know, I think that there's a physiologic component to this improving their, their sort of state of being and giving them a sense of wellbeing. But also I think that there's this component of, um, I feel like I'm taking some steps towards masculinization, but not completely.

So that makes me feel good. And I think that there's. Also, I think we, um, uh, actually to this crowd, I'm not gonna say undervalue. I think, um, uh, people in my, um, from where I'm coming from undervalue the importance of giving a patient a sense of control of their transition and their care plan, which is not a foreign concept when we talk about.

You know, paternalism and autonomy, but certainly when it comes to this type of care, allowing patients to have some control over what it how their transition is or what it is, is really important. So even in patients who've been on high dosing who want to work backwards, but like Dan just pointed out, sometimes you can't reverse everything.

Right. So there's some masculinization that will have already have occurred, but perhaps just the giving a patient the sense of being able to control what's going to happen down the road is really important.

CLIP 19

Cecile Ferrando: testosterone dosing. For me it's easier in the pellet form because you can really sort of dose to certain levels. It's in my, from my experience, easier to control than intramuscular and subcutaneous dosing. But it's about goal setting and discussing and so much can just come from a discussion of I understand that what your goals are and let me see if I can help you achieve them.

Certainly that conversation is easier when it comes to hormones than it is surgery.

Dianne Berg: There are a little bit, I think what it comes up, what comes up for me is helping people to explore socioculturally what it means to be masculine, feminine, male, female, um, because there's kind of the internal sense of it and then there's also

the the way that that gets perceived in the world and It sounds like for some of, for some of these folks, like, for whatever reason, it's more about how they're being perceived by others and maybe, maybe kind of what others are then attributing to them or assuming about them because they're, they're interpreting them as male when maybe that's those things, those, those aspects of maleness are not what they, aspire to or what they want.

And so I think it's, it's, it's all about kind of that, that therapy around what does it mean in our culture to be kind of, what does gender, what does gender mean in our culture? And how is that going to play out for how you see yourself and how others see you? So it's kind of those deeper, those deeper conversations.

CLIP 20

Ren Massey: I just want to add something here. I appreciate what you were just saying, Dianne. One of my adjustments with my transition was, um, losing, um, automatically being perceived as safe. by females who I was meeting for the first time. And, uh, it was a very strange experience to be walking in a parking lot, you know, following a woman out in the parking lot from the grocery store, and to realize, oh, she's looking over her shoulder to, like, see, am I following her?

Am I a threat? Or to be in an elevator and... have, you know, somebody kind of scoot just about as far away as they can. And, um, it, it was, it was, it was a loss, candidly, not to be, uh, perceived or assumed to be safe anymore. Um, so I can easily see that some of these things would be, um, really distressing, um, social impacts of, um.

Being perceived as masculine in our culture. So, looks like you wanted to say something there.

CLIP 21

Dianne Berg: Around kind of the other way too, right? I mean, so many of my trans feminine adult and even adolescent clients, um, Talk a lot about They they they hear

about it theoretically, but it's not until it happens that they really get it like not being paid Not being given as much airtime as they Become perceived as a woman.

Um, you know kind of all the the things that feminists have been saying for a really long time, I think, start to become more clear to people. And, and I think those are some losses or just some, some realizations around how gender plays out in, in sociocultural spaces. And And kind of what is that going to mean and how does how what meaning does that have for people.

So I think it, I think it goes both ways because gender is such a powerful mediator, whether we like it or not, it's such a powerful mediator of sociocultural spaces and interactions and environment.

Ren Massey: Yeah, I'm going to add to that, you know. A lot of us are youth or focused or heavy in our practices. Um, or young adults and, and minors.

Um, but One of my mentees, who I think is on this, um, meeting today and some other folks have talked to me about, you know, and I've even had clients as well who were adults who were assigned male at birth and found the loss of privilege and safety that they experienced in the world, um, was really disturbing.

And particularly some of the older folks. Um, we're actually, um, de transitioning, re transitioning for, for reasons of fitting in not just either around job stuff, but sometimes to be able to go into assisted care facilities with less hassle. And a greater sense of safety. So I think there are other issues, again, outside pressure sometimes, it may not even be the internal experience, that we need to be able to be aware of supporting people for in different contexts that we may be encountering.

CLIP 22

Ren Massey: So um, yeah, one of the thing I would like to highlight on this case, I think that it underscores that from the in the outset, we also may help people explore more non binary options. You know, I have a young person I'm working with right now, um, who's been on blockers for about two years. Mother's anxious for the kid to come off.

Pediatric endocrinologist is saying maybe go a little longer. Um, and the kid is vacillating. Um, really not wanting facial hair. Um, but... about having menstrual cycles and kind of vacillates about whether breast development, chest development bothers them or not, and which pronouns they use. And we all know that chest surgery is pretty inevitable, or at least it looks like that, because that has consistently been a bothersome thing.

So, is there more, um, benefit of staying on blockers or letting the kid... switch back to their endogenous estrogen? Or is it better to go low dose testosterone or what? You know, and at what point in time? So, um, if the kid doesn't want facial hair, but maybe doesn't mind their chest growing and they're planning on having chest surgery anyways.

So we may want to, you know, be creative in how we help folks approach these. Situations that are complex.

CLIP 23

Ren Massey: All right. So, um, I'm going to shift to the next one. I see we got a few other comments on, yeah, what people wanting. And being perceived male can happen very fast. Yes. All right. Let me try to get my screen to cooperate again. Okay. I'm going to read case three in S. 14 years, 11 months, assigned male at birth who identified as female preferred by previous mental health provider for gender dysphoria in the past year.

No significant medical history. Gender history and initial presentation, patient reported that a year prior to presentation a friend came out as bisexual and patient reports it clicked. Hey, that's what I'm feeling. Did not initially share this with anyone, but then six months later told mom about being bisexual.

Felt this confused mom. Around the same time, patient also reported feeling, looking pretty, cute and pretty. wearing female clothing. Reports always having felt this way, but never acted on the impulse to express self using feminine clothing. Patient reports that one month after school started, came to the conclusion they were trans.

Patient disclosed to an online friend first then told girlfriend who encouraged patient to tell mother. When patient told mom about identifying as transgender reports that mom's reaction was unsurprised. Patient had been trying out different names and eventually chose the name Nora. Patient reported feeling dysphoric and that sadness goes hand in hand with dysphoria.

Patient reported interest in starting gender affirming hormones but felt the gender affirming surgery was scary. Felt that mother was supportive of starting hormones, but father was not, and this could be a barrier. Extensive mental health history, starting at age 4, including aggression, ADHD, oppositionality, depression, anxiety, and challenges with behavior.

hospitalizations.

At 15 years, 10 months, the family is open to the patient starting spironolactone, but not ready to provide consent for estrogen. The patient's excited to start medication. Patient continued to follow the mental health provider two or three month intervals. At six month follow up after starting spironolactone, patient started, uh, reported that they felt more male and was feeling comfortable with he him pronouns.

Reported that I felt like a boy who wants to, I feel like a boy who wants to wear nail polish. Patient wanted to stop spironolactone and not interested in pursuing estrogen at this time. Plan for patient to continue to follow the mental health provider. Has follow up appointment in two weeks.

CLIP 24

Ren Massey: Anybody want to jump in here?

Dan Metzger: I, I'm, so again, another kind of happy ending. Kids happy. Um, parents are happy. I, I, I think it's important to remember that not all kids are as smart as every other kid or as in tune with their bodies or minds or minds of kids.

CLIP 25

Dan Metzger: sophisticated as other kids. Some kids like just get things and some kids don't and it takes a little bit longer. And the point is just because you're 15 doesn't mean you know everything. And I, I, I mean, I talk to this all the time, right? You're 15. That's great. But, um, you're probably going to know more than when you're 16.

You actually better know more when you're 16 than when you're 15. So I think it is kind of important to get, uh, uh, And this is our, you know, what our, what our assessors do is to get a level of sort of capacity of not just able to consent for stuff, but like they're understanding where they are. And do they understand that there's a difference between sexuality and gender and being trans and, and, and being, you know, cross dresser.

Um, that, that, that there's more than one way of. You know, liking nail polish. You don't have to be a girl to like nail polish. You can just be a boy and wear nail polish, whatever. So I think, you know, when these kinds of kids are working with their mental health professional, I think it is important for somebody to also really see, well, like, this is a kid that's kind of, not changed, but, you know, well, it's changed their direction three or four times within a short period of time.

That's not somebody you're going to want to rush in to do something permanent with. You're going to want to make sure that the kid, Really is starting to, you know, I have a clear direction of where they're heading before you do something and as well, you know, to make sure that the family are coming along with the kid.

CLIP 26

Gaya Chelvakumar: I will also add that like an anti androgen like spironolactone is a nice place to start because it's something that probably is not going to give you, you know, irreversible changes. And so, you know, if needed to help kind of clarify needs and goals and identity, it's a nice, nice medication to use.

Dan Metzger: Yeah, I would second that, you know, like if this was a kid that was clearly binary and, and wanting to move forward, you know, then we would probably use Lupron because Lupron works better. It's way more expensive. But I think Lupron without a plan of moving towards estrogen for this kid would just make this kid feel crappy, probably because he's, she, sorry, is well through puberty.

Um, so she's probably just going to feel like whatever a teenage kid would feel when they have their testosterone taken away, kind of, you know, whatever, menopausal. So I, I think, um, Just to, just to, just to affirm, I think Spyro is a really good way to go because it's harmless. It's cheap. It works to, for the beard.

It's not going to prevent the bigger boy changes that happen with male puberty, but, um, it is a nice way to kind of ease into things and often, um, for families, for, for parents that are kind of holding back, it's a nice way to move forward. That's, you know, affordable, cheap, safe, and reversible.

Dianne Berg: I'm noticing a lot of stuff in the chat, but I think the medical people could maybe address that kind of comes from how fast testosterone maybe works and does low dose affect that can just noticing that.

Dan Metzger: Yeah, so it's true. I mean, we all, you know, Adult men all have the same testosterone levels, but there's clearly a different range of like how hairy you are or how fast you go bald or whatever.

And it doesn't have to do with your testosterone levels. It may have to do a bit with your testosterone receptors and a million other things that you inherit, um, in your genes. So, so, you know, I, I always kid the Persian, the Persian kids that come and see me, I'm like, don't even look at the bottle. You're going to get a beard.

Like, because we know it's going to happen really fast, and then some of the poor Asian kids, you know, they try forever, they could barely get a mustache going, like their brothers, and so, um, you know, but everybody's the same level, it's all the same dose, so, um, you, you, you do have to let people know that just because you're taking dose X is not, doesn't mean you're going to get results Y to, to, to the same extent.

And the same is true, of course, for, for, for, for girls taking estrogen, you know, breast

CLIP 27

Dan Metzger: Level. Level provided your estrogen levels more or less in the nor in, in a, you know, in a normal range. It has much more to do with other genetic factors and body weight and stuff like that.

Ren Massey: Alright, great. So I think we have time maybe to go into one more case and um, then we may have some time for some concluding comments. Let's see. The biggest challenge is always there, the technology. Actually, the technology user is the biggest challenge. Okay, case four. An AMAB person assigned male at birth, who is now 13, who early on identified as binary trans girl and took all social transition steps.

Medically, the client is on Lupron and she's not been in a rush to start estrogen. However, she's been very invested in doing so at some point in the future. Within the last six months, this youth has begun to identify more as non binary, trying out different pronouns and names. She's very avoidant to have any discussions about What the shift toward non binary gender identity may or may not mean in terms of the decision she's always thought she would make in terms of medical transition.

When brooch will shut down and no longer engage. Have had some success processing when discussions are framed from an embodiment lens.

Dianne Berg: I can say a little bit about this case. I'm not sure whether it's one that I submitted and it just got kind of morphed and changed, um, which is totally fine. Um, but I think the thing that comes up for me, if it is kind of based on one of the cases is, um, But it was very difficult to, to kind of, um, the youth always kind of had it in their mind how their transition was going to work.

I'm going to do this. So I'm going to do this. So I'm going to do this. Then I'm going to do this. And, and it was all a very binary related kind of transition process and how they were thinking about it. And then as they, as they began to kind of try on. Different non binary identities and, and,

um, they started to kind of talk to people, uh, at least with the, with the, um, kid that I worked with.

CLIP 28

Dianne Berg: Where we kind of got to was a general not wanting to talk about things because they were just kind of at that place. But also that they really thought that if they said anything about this and really delved into it, it would mean that their options

for any of that medical transition that they had always thought they were going to do would be off the table.

And so they were like, I can't, I don't want to explore that the non binary shift, because if I explore that, that means that I'm never going to be able to get estrogen or I'm never going to be able, and it was kind of like having some education around. No, it doesn't mean that what it means is we are trying to meet your embodiment goals.

And if your embodiment goals are such that you need a certain type of medical intervention, then you need that medical intervention and we can move forward with that. And you don't have to be afraid that, um, That your identity is going to drive necessarily drive your medical decision. It's more about your embodiment goals are going to are going to drive some of the medical decision making.

And so I don't know. That's kind of how we were able to get through that impasse. Um, So I don't know what other people kind of have to say about that. But, um, embodiment is certainly a concept that I'm using a lot more of with my adolescence and Children.

CLIP 29

Dan Metzger: I, you know, like sort of 13 and a half is sort of our, like a kind of cut off where we, where we're okay to do hormones, if everything, it seems like it's going to work. Um, but I always told the kids, God, you're 13, you don't know everything. Um, I don't expect to know everything. And this is like a journey and you're going to take us, you know, we're coming along for the ride.

And, you know, we start this, it doesn't mean you have to continue. It doesn't mean you have to go up. every single time you come, I'm going to ask you what you want to do with your hormones. Are you happy where they are? And kids do shift with time. A lot of the, particularly the non binary kids, um, um, think that they want to be initially more vascularized than they end up wanting to be.

And they find that there's a happy dose that's gotten rid of their periods or whatever, and that they're happy on that dose. And they don't necessarily want to push forward

as they had thought that they might at the beginning. So. I think it's important that you just lay that out right at the beginning.

You do not, you do not have to have all the answers. You know, even an 18 year old, you do not have to have all the answers. Let's work with all we got today, and you keep letting me know, and I'm going to keep pestering you, you know, what do you want to do about this? What do about this? Or you're not ready to make any decisions, you don't even want to talk about it today.

Fine, let's just leave it in the same. And I think the kids need that space to, to know that A, they're in charge. Uh, B, I'm a little bit pushing them to think about it, like, by asking them, and, and C, you know, they have permission to go backwards, stay where they are, go forwards to, to whatever degree, and, um, and I think that, uh, I think that the kids, um, I think there are kids who are a little bit timid at the beginning, and they don't feel, they can, I, I feel that there is a group of kids who say they're non binary because they're not, Really ready to go full on.

And as they go, they actually find, no, this is working for me. I'm, I really actually do want to go to the, to the end of the binary there. But, um, I think, I think you just got to let kids have that, that permission to do that.

CLIP 30

Ren Massey: I'll just add in that, uh, this actually reminds me of a successful 30 something I have, um, you know, who's, uh, very accomplished in their field and is, uh, was first aware in the last few years really more about their gender identity and, um, thinking, you know, they were identifying as a woman. Uh, and when the first came really more open to their awareness about six months ago.

Um, took him a couple months to call me, then a couple months on my waiting list. And I've been seeing the person, I don't know, a couple months now. And They were hesitant to acknowledge maybe a non binary space might be good, maybe a fluid space might be good. And it's hard to tell how much feels true to their gender versus how much is external factors, and that's kind of stuff we're sorting through with time.

Um, and I think they're feeling some relief to know that there are a range of medical options, and we're not, The, the fortunate thing is this person is not in a rush rush and has some ways of being able to express, um, their feminine side, uh, with their significant other and friends and, and one of their family members, uh, from their family of origin.

But, um, I, I, my main point is in adults as well as young people. I mean, mature, more mature adults, like 30 somethings.

All right, so if we don't have any other comments on this one, actually, I would really like it if we could get to the next case and then we could close up.

CLIP 31

Dianne Berg: I'm just noticing that Jameson is telling us that we should talk, look more at the chat. Jameson, is there a particular thing?

Jason: I was just wanted to draw your attention to the Q& A box as well as the chat. There are questions in the Q& A stream as well as in the chat. So just, just to make sure that.

Dianne Berg: Thank you. I didn't even know about that.

Jason: Yep. Yep. I've answered a few, but, um, the clinical ones I can't.

Dianne Berg: Okay. While we look at the q amp a there's a couple coming up in the chat just about that embodiment discussion. Yes. It's, it's a, it's a growing edge for me. And so I certainly don't want to. To misspeak, but my understanding and what I'm trying to kind of incorporate in my clinical practice is in some ways moving away from, um, what is your identity and therefore because you have this identity, you're going to want to do these particular medical interventions to change your body, not having it be as identity driven, because I think that's been the historical basis of kind of how things have operated.

And instead, regardless of your identity, What, what do you think about your body and what do you want your body to be able to be and how do you feel in your body and,

and what's going to help your, your, you feel better about being in your body and how do we address some of that? Um, regardless of what your identity is, and that might mean medical, that might mean lifting weights, that might mean eating better, I mean, there's a whole range, but it just kind of goes shifting your thinking from identity driven interventions to more, um, for some people, more body driven interventions.

It is kind of my, is what I would try to say about that.

CLIP 32

Ren Massey: Kind of related to that, Dianne, there are some questions about co occurring diagnoses or considerations in the Q& A section, and I would just say it's hard to do it justice in a little bit of time here, but, you know, when there are co occurring conditions of any type, I am more cautious and take a slower approach in terms of.

Um, questions to in considering both identity and embodiment. Um, and, you know, may ask people and encourage people to look at things from all of those kinds of perspectives. Um, and maybe try to get creative in asking them to. You know, just as an example, who is somebody who you'd like to look like who, um, not somebody who's a TV star who's super attractive, but just like kind of an average looking person, you know, um, so that we're not engaging in a fantasy realm of transition expectations with like facial hair, no facial hair, chest of wet socks, flat, brown, small, wet.

And, um, sometimes those discussions. are very helpful, especially with folks who may struggle with the identity piece. Um, and, uh, I think that also just we have to be careful when we recognize there are folks who may have things that make understanding identity uh, more fluid or complex or more challenging.

So I just Take a lot more caution. That's what I would say.

Alright, um, I'm going to try to get us to that very last one.

CLIP 33

Dianne Berg: Not wanting to take up more space, but since other people aren't jumping in, I think it just speaks to the importance of the intersection between sexuality and gender and how, um, I think that the field of gender, it feels like the fields are very separate as someone who's in both of ASAC certified person.

I'm, you know, I go to a lot of the sexuality conferences that are starting to. Care more about gender and I think in the gender conferences. There's there's very little focus on actually sexuality and so I think for me this case just Exemplifies a way that they intersect and I think there's lots of ways that they intersect and I know that WPATH Is gonna do a specialty thing on sexual pleasure which I think is is awesome and And so I think just for me, I want to, I just want to point out that that, that intersection, we don't, we don't often do a good job with that.

And I think that's someplace that we could, that we could be doing better.

Dan Metzger: You know, I totally agree. And I'm sure putting a kid on a blocker at age nine, and then letting them get to the age of whatever, when they're developing a sexual identity, can that be. Uh, cannot be great, right? So I think I think that the other people brought this up that we are to a degree robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their with their cisgender peers.

That's not happening because we've got the one loop running and their you know, their brains are just not thinking that way. There's no, you know, they're getting older and smarter about, you know, math, but they're not learning how their body works. They're learning how to masturbate because they don't, because they don't have the urge to do that, right?

And all of a sudden they're, you know, they're, they're way many years behind their peers trying to like figure their sex stuff out.

CLIP 34

Ren Massey: Yeah, I'll, uh, add somebody asked when that sexual health workshops going to be, um, we're in the process of developing a number of new workshops this year. Um, as we're updating the foundations curriculum for Montreal, where we'll present the SOC eight, um, based, uh, foundations course for the first time.

Uh, in the meantime, we have a number of. Uh, workshops this summer, including the one Dianne referred to on sexual health, and I believe it's going to be July 29th. Um, I'm pretty sure that's the date we got lined up in, uh, I'm trying to remember. I think it's like eight to 11 Pacific time, 8:00 AM to 11 Pacific time.

But, um, I'm, I'm not gonna bet my life on that. Um, but um, we also have. Some other comments about sexuality and neuroticism, not neuroticism, eroticism. Um, and, uh, you know, I think that that is some of the complexity of gender and sexuality. Both. being processes of discovery and evolution, um, for a lot of, you know, tweenagers and teenagers.

And, uh, so it's not surprising sometimes that they need some help discerning those things. Looks like you wanted to say something, Dianne.

Dianne Berg: Well, I think for adults, historically, if, if people with some sort of gender. Identity have, have, have mentioned anything about their sexuality, it, um, or if they there's always been, at least I have had many clients tell me, I did not tell you the truth about, about a lot of things about my sexuality, because I figured if I told you that.

You would gatekeep and assume it was a fetish or assume it was, um, you know, some of the terms that we no longer are using. And so I think there is a huge historical context. To to sexuality being seen as a being seen in a way that does act that does create barriers access to access to care, and I just want I think it's very important that we acknowledge that historical context, um, and that we work against that historical context, um, by talking more about positive sexuality and pleasure and that that they can go together and that it's okay.

Um, and not create barriers to care because people have that belief that that's what we're going to do.

CLIP 35

Jamison Green: Yes, and gender and sex are two different things, but gender informs your sexuality tremendously. And, uh, no matter who you are, trans people, cis people, male, female, non binary, all those things are really informative to each other. And

when you deny any aspect of it, you are limiting yourself. Uh, to a certain extent, you're, you're cutting off parts of yourself if you pretend it doesn't exist.

And clinically, we've been told, trans people have been told historically, Oh no, don't talk about that. So, it's really, really something that our professions need to combat. Thank you, Dianne. That's good.

Ren Massey: All right, so I'm going to end with a question. I'm going to stop my screen share here, and I'm going to bring this up to my panelists really quickly.

If anybody has any closing thoughts, one question that we didn't get to was steps to support folks who have regret or interventions. I think it's such a new area. We don't have data on it. to my knowledge, but it looks like a lot of folks are looking for support and I would say we need to normalize their exploration just as we would normalize people considering transitioning to a gender different than what they were assigned at birth and to get them supports to do that.

Um, and again, try not to other, other people in the process, not to marginalize or. Put down other people. If other folks have a quick comment.

All right, that that's to be continued in our ongoing growth in the field. I want to thank all of the attendees. Uh, I appreciate the great input, the questions, the comments, the exchange, the thought provoking, um, dialogue among all of us. I want to thank the production staff, Mike Evans and Cheryl Field.

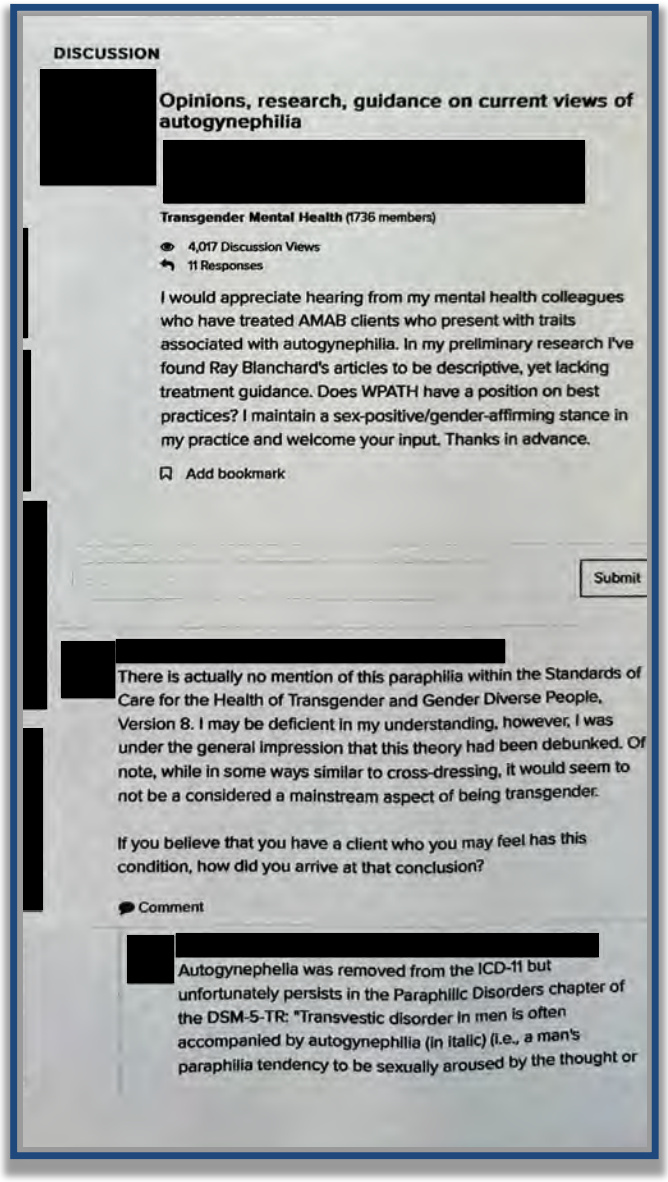
Y'all are awesome. And our WPATH staff as well, Tricia, Kat, Rebecca. Wayne and Jamie. Uh, I see Tricia, Kat, and Rebecca doing the heavy lifting today. And then I thank all of my colleagues for being here and the thought you put in in advance and for taking part in this conversation to try to advance health care for our trans and gender questioning clients.

Thank you.

23) APPENDIX: ADDITIONAL FILES

THE FOLLOWING FILES WERE SHARED WITH ENVIRONMENTAL PROGRESS BY A SOURCE OR SOURCES AFTER OUR REPORT AND INITIAL ANALYSIS WERE COMPLETED. WE HAVE ADDED THESE ADDITIONAL FILES BELOW AND ENCOURAGE THE READER TO REVIEW THEM AS WELL.

a) A WPATH member seeks guidance on transgender client who presents with traits associated with autogynephilia



DISCUSSION

[redacted] Opinions, research, guidance on current views of autogynephilia

[redacted]

Transgender Mental Health (1736 members)

4,017 Discussion Views
11 Responses

I would appreciate hearing from my mental health colleagues who have treated AMAB clients who present with traits associated with autogynephilia. In my preliminary research I've found Ray Blanchard's articles to be descriptive, yet lacking treatment guidance. Does WPATH have a position on best practices? I maintain a sex-positive/gender-affirming stance in my practice and welcome your input. Thanks in advance.

Add bookmark

Submit

[redacted] There is actually no mention of this paraphilia within the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. I may be deficient in my understanding, however, I was under the general impression that this theory had been debunked. Of note, while in some ways similar to cross-dressing, it would seem to not be a considered a mainstream aspect of being transgender.

If you believe that you have a client who you may feel has this condition, how did you arrive at that conclusion?

Comment

[redacted] Autogynephelia was removed from the ICD-11 but unfortunately persists in the Paraphilic Disorders chapter of the DSM-5-TR: "Transvestic disorder in men is often accompanied by autogynephilia (in italic) (i.e., a man's paraphilia tendency to be sexually aroused by the thought or

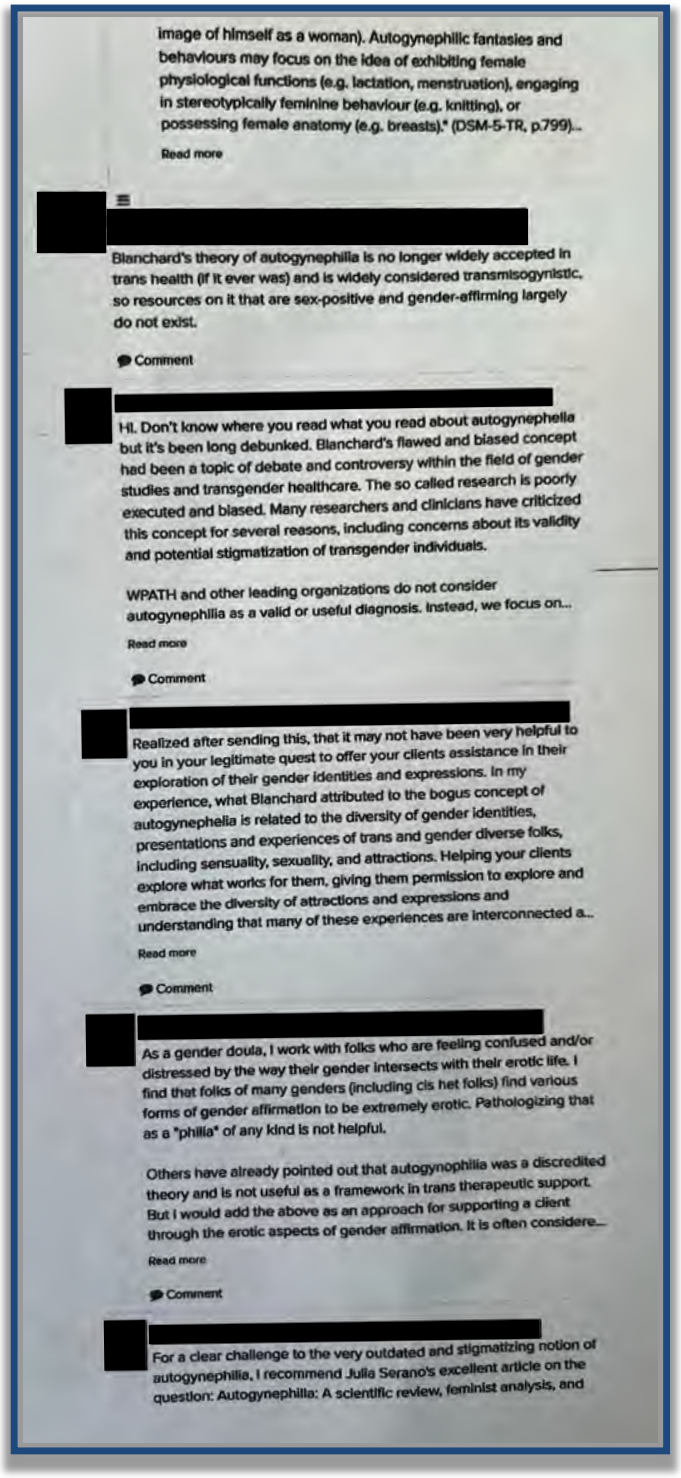


image of himself as a woman). Autogynephilic fantasies and behaviours may focus on the idea of exhibiting female physiological functions (e.g. lactation, menstruation), engaging in stereotypically feminine behaviour (e.g. knitting), or possessing female anatomy (e.g. breasts)." (DSM-5-TR, p.799)...

Read more

[redacted]

Blanchard's theory of autogynephilia is no longer widely accepted in trans health (if it ever was) and is widely considered transmisogynistic, so resources on it that are sex-positive and gender-affirming largely do not exist.

Comment

[redacted]

Hi. Don't know where you read what you read about autogynephelia but it's been long debunked. Blanchard's flawed and biased concept had been a topic of debate and controversy within the field of gender studies and transgender healthcare. The so called research is poorly executed and biased. Many researchers and clinicians have criticized this concept for several reasons, including concerns about its validity and potential stigmatization of transgender individuals.

WPATH and other leading organizations do not consider autogynephilia as a valid or useful diagnosis. Instead, we focus on...

Read more

Comment

[redacted]

Realized after sending this, that it may not have been very helpful to you in your legitimate quest to offer your clients assistance in their exploration of their gender identities and expressions. In my experience, what Blanchard attributed to the bogus concept of autogynephelia is related to the diversity of gender identities, presentations and experiences of trans and gender diverse folks, including sensuality, sexuality, and attractions. Helping your clients explore what works for them, giving them permission to explore and embrace the diversity of attractions and expressions and understanding that many of these experiences are interconnected a...

Read more

Comment

[redacted]

As a gender doula, I work with folks who are feeling confused and/or distressed by the way their gender intersects with their erotic life. I find that folks of many genders (including cis het folks) find various forms of gender affirmation to be extremely erotic. Pathologizing that as a "philia" of any kind is not helpful.

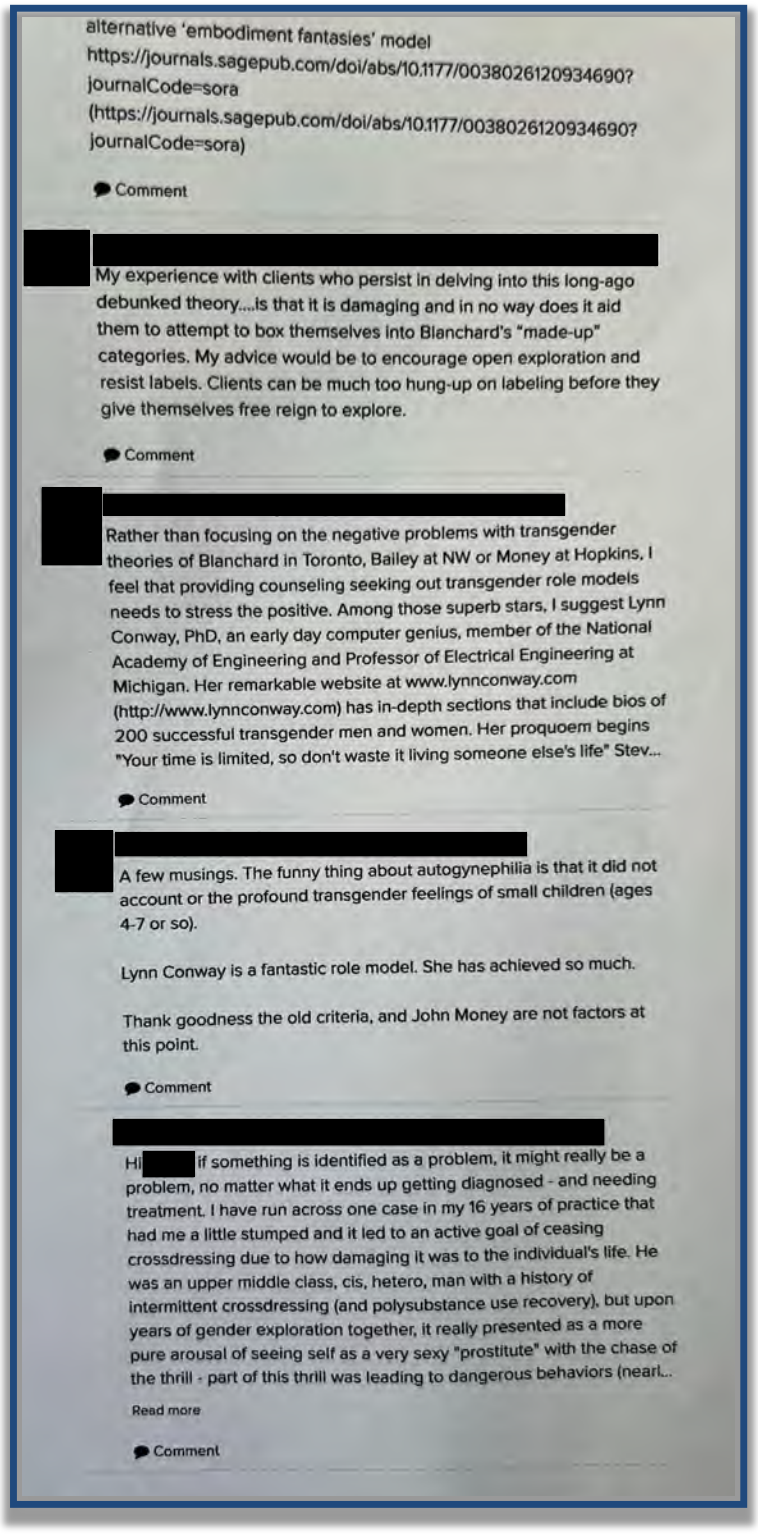
Others have already pointed out that autogynophilia was a discredited theory and is not useful as a framework in trans therapeutic support. But I would add the above as an approach for supporting a client through the erotic aspects of gender affirmation. It is often considere...

Read more

Comment

[redacted]

For a clear challenge to the very outdated and stigmatizing notion of autogynephilia, I recommend Julia Serano's excellent article on the question: Autogynephilia: A scientific review, feminist analysis, and



alternative 'embodiment fantasies' model
https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?journalCode=sora
(https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?journalCode=sora)

Comment

[redacted]
My experience with clients who persist in delving into this long-ago debunked theory....is that it is damaging and in no way does it aid them to attempt to box themselves into Blanchard's "made-up" categories. My advice would be to encourage open exploration and resist labels. Clients can be much too hung-up on labeling before they give themselves free reign to explore.

Comment

[redacted]
Rather than focusing on the negative problems with transgender theories of Blanchard in Toronto, Bailey at NW or Money at Hopkins, I feel that providing counseling seeking out transgender role models needs to stress the positive. Among those superb stars, I suggest Lynn Conway, PhD, an early day computer genius, member of the National Academy of Engineering and Professor of Electrical Engineering at Michigan. Her remarkable website at www.lynnconway.com (http://www.lynnconway.com) has in-depth sections that include bios of 200 successful transgender men and women. Her proquoem begins "Your time is limited, so don't waste it living someone else's life" Stev...

Comment

[redacted]
A few musings. The funny thing about autogynephilia is that it did not account or the profound transgender feelings of small children (ages 4-7 or so).

Lynn Conway is a fantastic role model. She has achieved so much.

Thank goodness the old criteria, and John Money are not factors at this point.

Comment

[redacted]
Hi [redacted] if something is identified as a problem, it might really be a problem, no matter what it ends up getting diagnosed - and needing treatment. I have run across one case in my 16 years of practice that had me a little stumped and it led to an active goal of ceasing crossdressing due to how damaging it was to the individual's life. He was an upper middle class, cis, hetero, man with a history of intermittent crossdressing (and polysubstance use recovery), but upon years of gender exploration together, it really presented as a more pure arousal of seeing self as a very sexy "prostitute" with the chase of the thrill - part of this thrill was leading to dangerous behaviors (nearl...

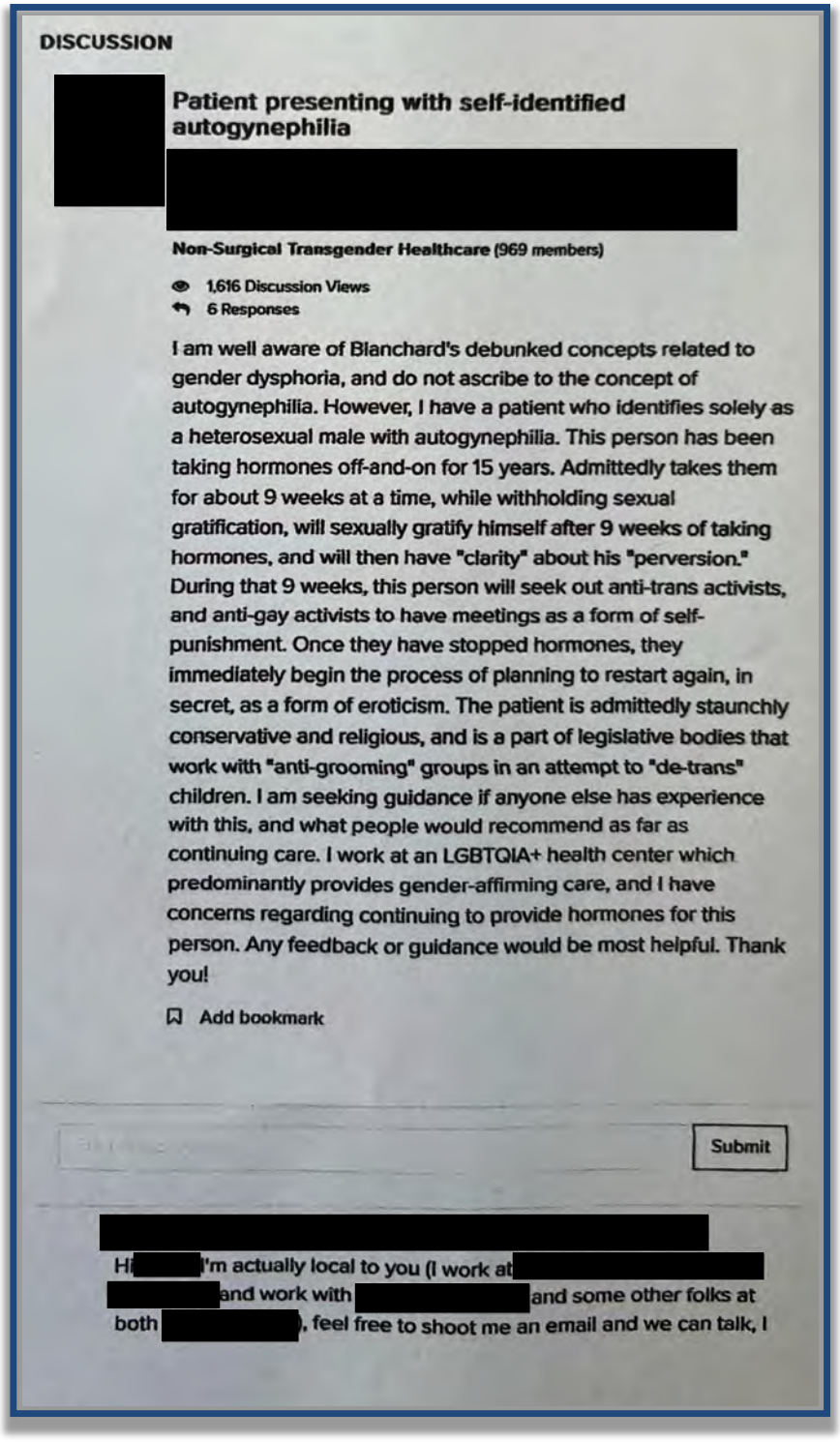
Read more

Comment

pure arousal of seeing self as a very sexy "prostitute" with the chase of the thrill - part of this thrill was leading to dangerous behaviors (nearly failing college/work impact d/t periods/days of constantly changing undergarments, times of driving 80 miles an hour while rapidly changing clothes, stealing anything from bras to even a wedding dress, manipulating others with stories to get more "sexy" validation vs gender validation). He determined the need to cease and we did work on that with overall success and reported benefit. We followed treatment planning similar to substance abuse treatment and we found that an SSRI assisted with the intrusive/oc thoughts that he was having. Good on you for reaching out for consultation :)

Comment

b) A WPATH member seeks guidance on patient who identifies solely as a heterosexual male with autogynephilia



DISCUSSION

[redacted] **Patient presenting with self-identified autogynephilia**

[redacted]

Non-Surgical Transgender Healthcare (969 members)

1,616 Discussion Views
6 Responses

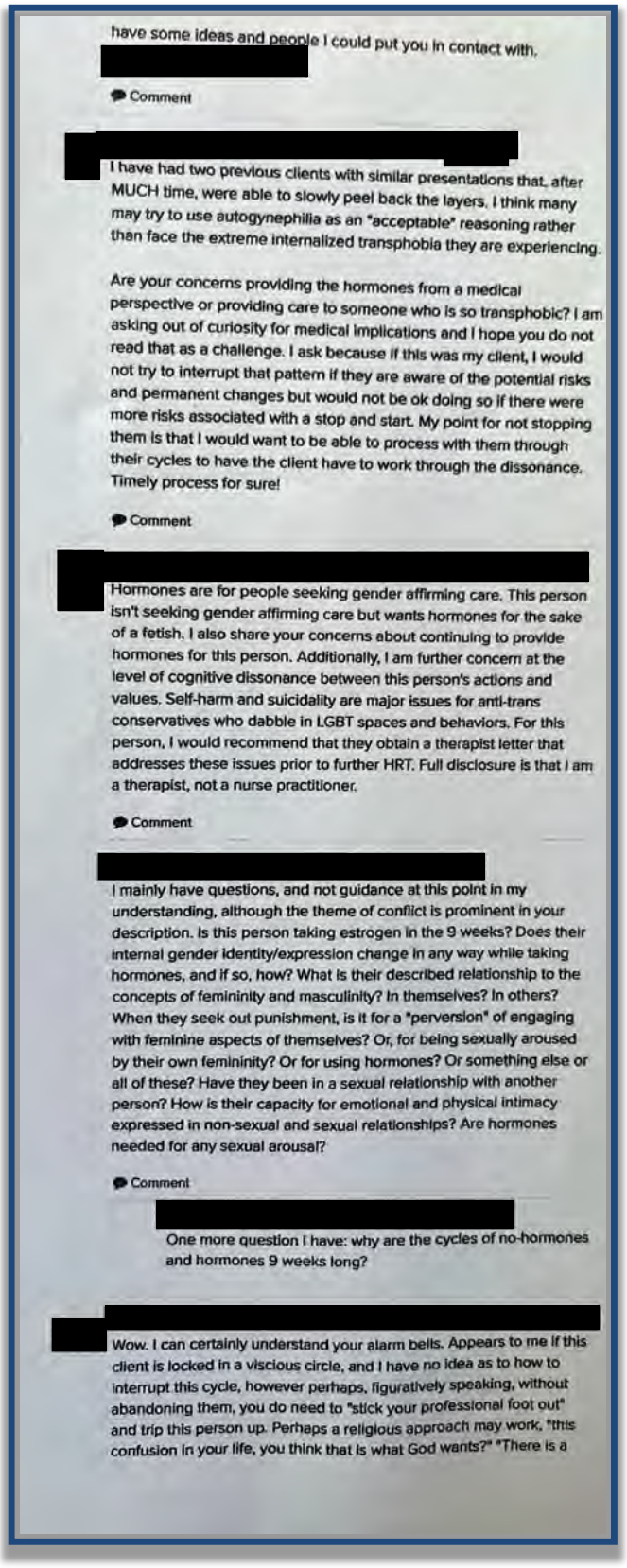
I am well aware of Blanchard's debunked concepts related to gender dysphoria, and do not ascribe to the concept of autogynephilia. However, I have a patient who identifies solely as a heterosexual male with autogynephilia. This person has been taking hormones off-and-on for 15 years. Admittedly takes them for about 9 weeks at a time, while withholding sexual gratification, will sexually gratify himself after 9 weeks of taking hormones, and will then have "clarity" about his "perversion." During that 9 weeks, this person will seek out anti-trans activists, and anti-gay activists to have meetings as a form of self-punishment. Once they have stopped hormones, they immediately begin the process of planning to restart again, in secret, as a form of eroticism. The patient is admittedly staunchly conservative and religious, and is a part of legislative bodies that work with "anti-grooming" groups in an attempt to "de-trans" children. I am seeking guidance if anyone else has experience with this, and what people would recommend as far as continuing care. I work at an LGBTQIA+ health center which predominantly provides gender-affirming care, and I have concerns regarding continuing to provide hormones for this person. Any feedback or guidance would be most helpful. Thank you!

Add bookmark

Submit

[redacted]

Hi [redacted] I'm actually local to you (I work at [redacted] and work with [redacted] and some other folks at both [redacted]), feel free to shoot me an email and we can talk, I



have some ideas and people I could put you in contact with. [redacted]

Comment

[redacted]

I have had two previous clients with similar presentations that, after MUCH time, were able to slowly peel back the layers. I think many may try to use autogynephilia as an "acceptable" reasoning rather than face the extreme internalized transphobia they are experiencing.

Are your concerns providing the hormones from a medical perspective or providing care to someone who is so transphobic? I am asking out of curiosity for medical implications and I hope you do not read that as a challenge. I ask because if this was my client, I would not try to interrupt that pattern if they are aware of the potential risks and permanent changes but would not be ok doing so if there were more risks associated with a stop and start. My point for not stopping them is that I would want to be able to process with them through their cycles to have the client have to work through the dissonance. Timely process for sure!

Comment

[redacted]

Hormones are for people seeking gender affirming care. This person isn't seeking gender affirming care but wants hormones for the sake of a fetish. I also share your concerns about continuing to provide hormones for this person. Additionally, I am further concern at the level of cognitive dissonance between this person's actions and values. Self-harm and suicidality are major issues for anti-trans conservatives who dabble in LGBT spaces and behaviors. For this person, I would recommend that they obtain a therapist letter that addresses these issues prior to further HRT. Full disclosure is that I am a therapist, not a nurse practitioner.

Comment

[redacted]

I mainly have questions, and not guidance at this point in my understanding, although the theme of conflict is prominent in your description. Is this person taking estrogen in the 9 weeks? Does their internal gender identity/expression change in any way while taking hormones, and if so, how? What is their described relationship to the concepts of femininity and masculinity? In themselves? In others? When they seek out punishment, is it for a "perversion" of engaging with feminine aspects of themselves? Or, for being sexually aroused by their own femininity? Or for using hormones? Or something else or all of these? Have they been in a sexual relationship with another person? How is their capacity for emotional and physical intimacy expressed in non-sexual and sexual relationships? Are hormones needed for any sexual arousal?

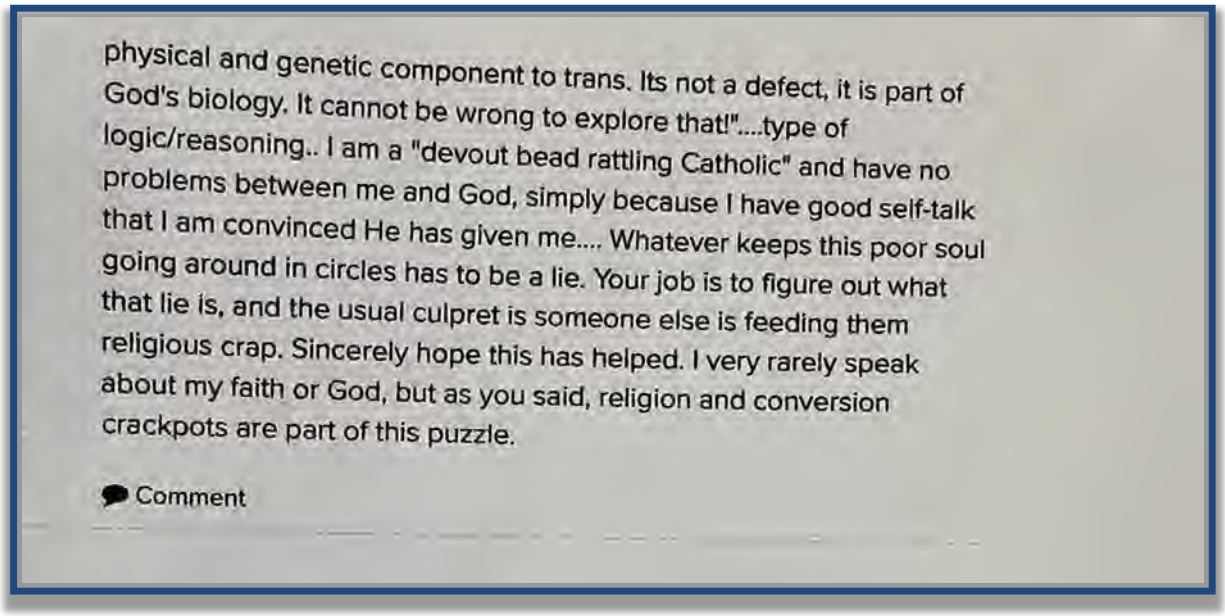
Comment

[redacted]

One more question I have: why are the cycles of no-hormones and hormones 9 weeks long?

[redacted]

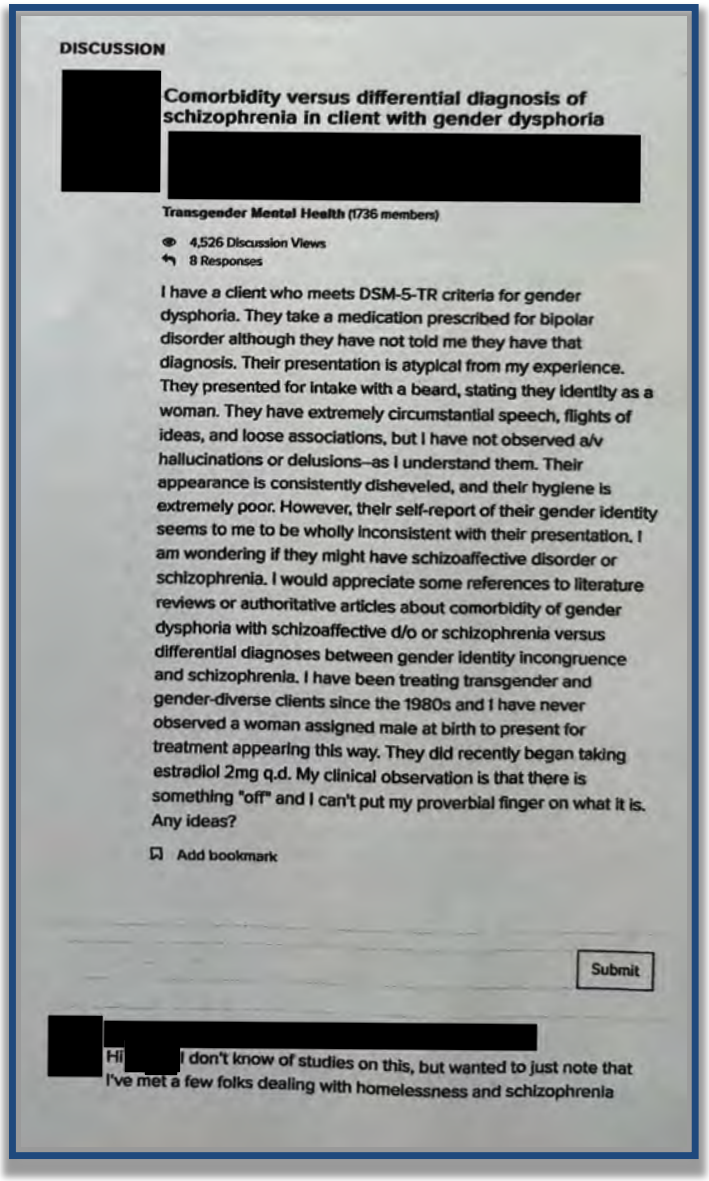
Wow. I can certainly understand your alarm bells. Appears to me if this client is locked in a viscious circle, and I have no idea as to how to interrupt this cycle, however perhaps, figuratively speaking, without abandoning them, you do need to "stick your professional foot out" and trip this person up. Perhaps a religious approach may work, "this confusion in your life, you think that is what God wants?" "There is a



physical and genetic component to trans. Its not a defect, it is part of God's biology. It cannot be wrong to explore that!"....type of logic/reasoning.. I am a "devout bead rattling Catholic" and have no problems between me and God, simply because I have good self-talk that I am convinced He has given me.... Whatever keeps this poor soul going around in circles has to be a lie. Your job is to figure out what that lie is, and the usual culpret is someone else is feeding them religious crap. Sincerely hope this has helped. I very rarely speak about my faith or God, but as you said, religion and conversion crackpots are part of this puzzle.

Comment

c) A WPATH member seeks clarification on comorbidity versus differential diagnosis for client with gender dysphoria and schizophrenia



DISCUSSION

[redacted]

Comorbidity versus differential diagnosis of schizophrenia in client with gender dysphoria

[redacted]

Transgender Mental Health (1736 members)

4,526 Discussion Views
8 Responses

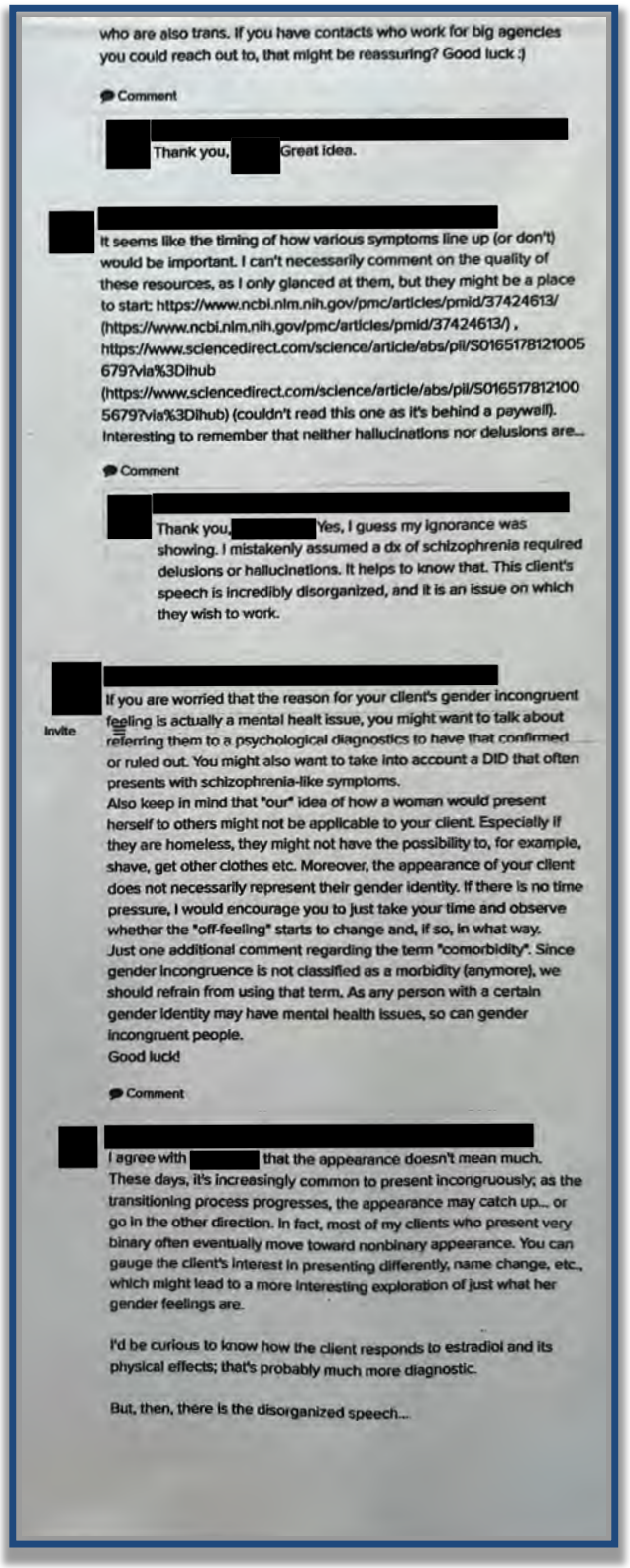
I have a client who meets DSM-5-TR criteria for gender dysphoria. They take a medication prescribed for bipolar disorder although they have not told me they have that diagnosis. Their presentation is atypical from my experience. They presented for intake with a beard, stating they identify as a woman. They have extremely circumstantial speech, flights of ideas, and loose associations, but I have not observed a/v hallucinations or delusions–as I understand them. Their appearance is consistently disheveled, and their hygiene is extremely poor. However, their self-report of their gender identity seems to me to be wholly inconsistent with their presentation. I am wondering if they might have schizoaffective disorder or schizophrenia. I would appreciate some references to literature reviews or authoritative articles about comorbidity of gender dysphoria with schizoaffective d/o or schizophrenia versus differential diagnoses between gender identity incongruence and schizophrenia. I have been treating transgender and gender-diverse clients since the 1980s and I have never observed a woman assigned male at birth to present for treatment appearing this way. They did recently began taking estradiol 2mg q.d. My clinical observation is that there is something "off" and I can't put my proverbial finger on what it is. Any ideas?

Add bookmark

Submit

[redacted]

Hi [redacted] I don't know of studies on this, but wanted to just note that I've met a few folks dealing with homelessness and schizophrenia



who are also trans. If you have contacts who work for big agencies you could reach out to, that might be reassuring? Good luck :)

Comment

[redacted] Thank you, [redacted] Great idea.

[redacted] It seems like the timing of how various symptoms line up (or don't) would be important. I can't necessarily comment on the quality of these resources, as I only glanced at them, but they might be a place to start: https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/37424613/ (https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/37424613/) , https://www.sciencedirect.com/science/article/abs/pii/S0165178121005679?via%3Dihub (https://www.sciencedirect.com/science/article/abs/pii/S0165178121005679?via%3Dihub) (couldn't read this one as it's behind a paywall). Interesting to remember that neither hallucinations nor delusions are...

Comment

[redacted] Thank you, [redacted] Yes, I guess my ignorance was showing. I mistakenly assumed a dx of schizophrenia required delusions or hallucinations. It helps to know that. This client's speech is incredibly disorganized, and it is an issue on which they wish to work.

[redacted] Invite

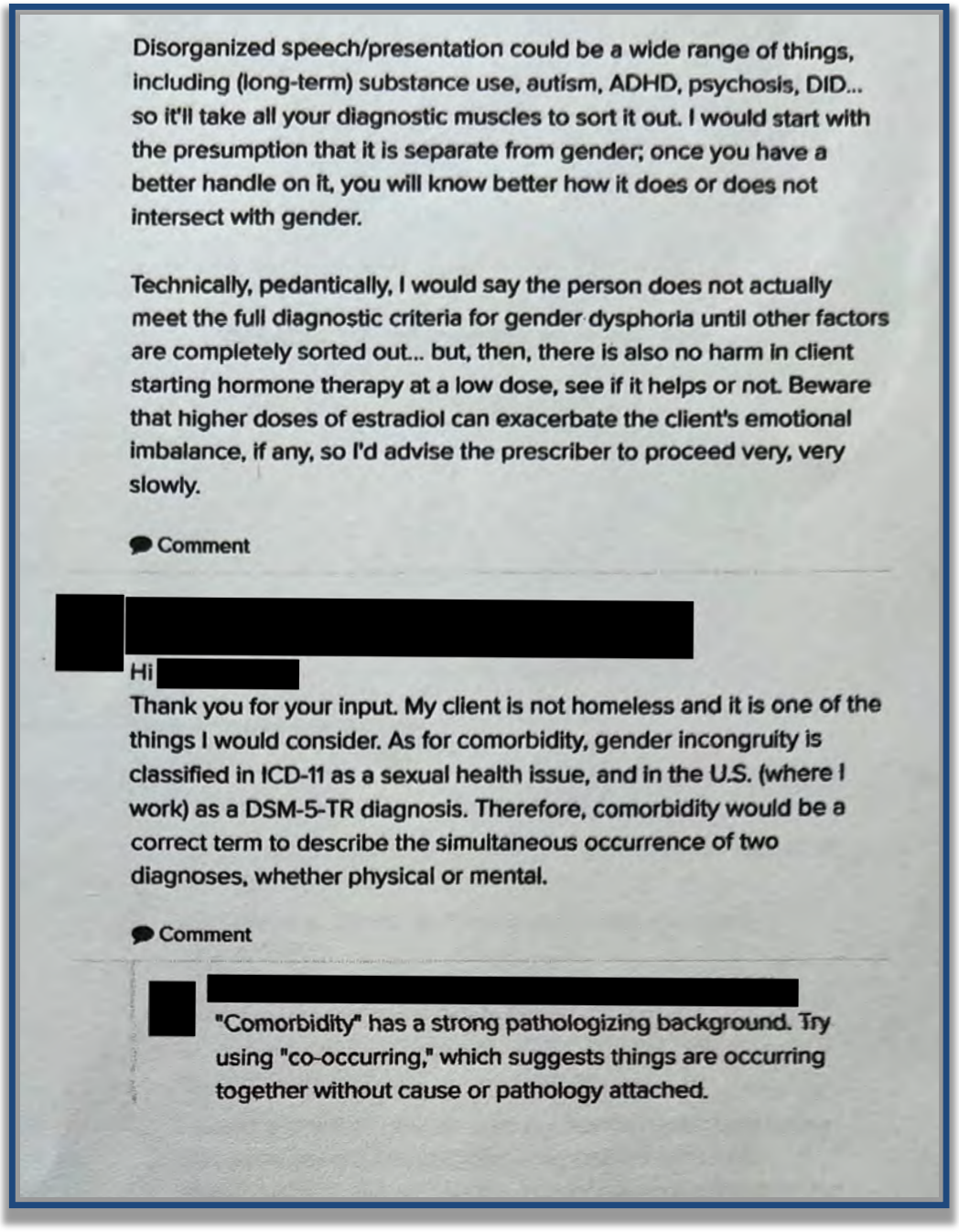
If you are worried that the reason for your client's gender incongruent feeling is actually a mental healt issue, you might want to talk about referring them to a psychological diagnostics to have that confirmed or ruled out. You might also want to take into account a DID that often presents with schizophrenia-like symptoms.
Also keep in mind that "our" idea of how a woman would present herself to others might not be applicable to your client. Especially if they are homeless, they might not have the possibility to, for example, shave, get other clothes etc. Moreover, the appearance of your client does not necessarily represent their gender identity. If there is no time pressure, I would encourage you to just take your time and observe whether the "off-feeling" starts to change and, if so, in what way.
Just one additional comment regarding the term "comorbidity". Since gender incongruence is not classified as a morbidity (anymore), we should refrain from using that term. As any person with a certain gender identity may have mental health issues, so can gender incongruent people.
Good luck!

Comment

[redacted] I agree with [redacted] that the appearance doesn't mean much. These days, it's increasingly common to present incongruously; as the transitioning process progresses, the appearance may catch up... or go in the other direction. In fact, most of my clients who present very binary often eventually move toward nonbinary appearance. You can gauge the client's interest in presenting differently, name change, etc., which might lead to a more interesting exploration of just what her gender feelings are.

I'd be curious to know how the client responds to estradiol and its physical effects; that's probably much more diagnostic.

But, then, there is the disorganized speech...



Disorganized speech/presentation could be a wide range of things, including (long-term) substance use, autism, ADHD, psychosis, DID... so it'll take all your diagnostic muscles to sort it out. I would start with the presumption that it is separate from gender; once you have a better handle on it, you will know better how it does or does not intersect with gender.

Technically, pedantically, I would say the person does not actually meet the full diagnostic criteria for gender dysphoria until other factors are completely sorted out... but, then, there is also no harm in client starting hormone therapy at a low dose, see if it helps or not. Beware that higher doses of estradiol can exacerbate the client's emotional imbalance, if any, so I'd advise the prescriber to proceed very, very slowly.

Comment

[redacted]

Hi [redacted]

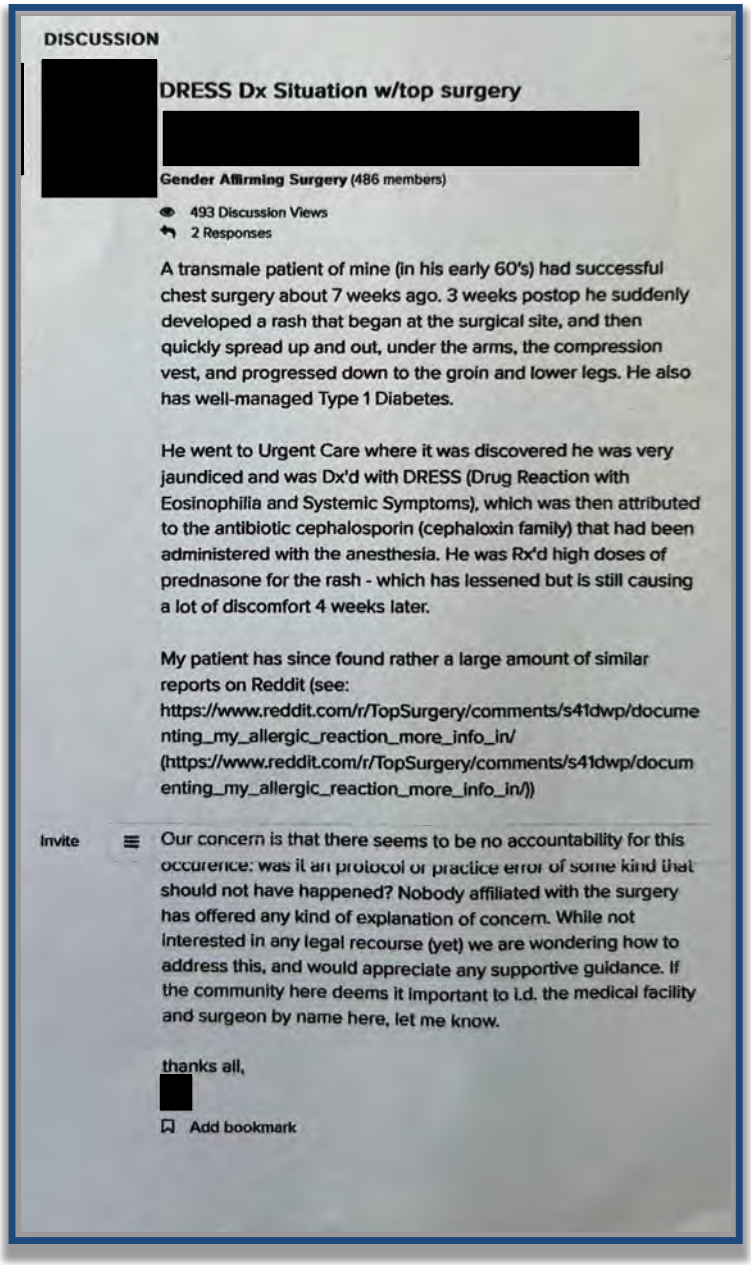
Thank you for your input. My client is not homeless and it is one of the things I would consider. As for comorbidity, gender incongruity is classified in ICD-11 as a sexual health issue, and in the U.S. (where I work) as a DSM-5-TR diagnosis. Therefore, comorbidity would be a correct term to describe the simultaneous occurrence of two diagnoses, whether physical or mental.

Comment

[redacted]

"Comorbidity" has a strong pathologizing background. Try using "co-occurring," which suggests things are occurring together without cause or pathology attached.

d) A WPATH member discusses surgical complication of transgender patient after top surgery



DISCUSSION

[redacted]

DRESS Dx Situation w/top surgery

[redacted]

Gender Affirming Surgery (486 members)

493 Discussion Views
2 Responses

A transmale patient of mine (in his early 60's) had successful chest surgery about 7 weeks ago. 3 weeks postop he suddenly developed a rash that began at the surgical site, and then quickly spread up and out, under the arms, the compression vest, and progressed down to the groin and lower legs. He also has well-managed Type 1 Diabetes.

He went to Urgent Care where it was discovered he was very jaundiced and was Dx'd with DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms), which was then attributed to the antibiotic cephalosporin (cephaloxin family) that had been administered with the anesthesia. He was Rx'd high doses of prednasone for the rash - which has lessened but is still causing a lot of discomfort 4 weeks later.

My patient has since found rather a large amount of similar reports on Reddit (see: https://www.reddit.com/r/TopSurgery/comments/s41dwp/documenting_my_allergic_reaction_more_info_in/ (https://www.reddit.com/r/TopSurgery/comments/s41dwp/documenting_my_allergic_reaction_more_info_in/))

Invite

Our concern is that there seems to be no accountability for this occurence: was it an protocol or practice error of some kind that should not have happened? Nobody affiliated with the surgery has offered any kind of explanation of concern. While not interested in any legal recourse (yet) we are wondering how to address this, and would appreciate any supportive guidance. If the community here deems it important to i.d. the medical facility and surgeon by name here, let me know.

thanks all,

[redacted]

Add bookmark

[redacted]

Hi!

It seems an allegic reaction to the antibiotic administered. It is always possible. Good that he referred to urgent care and he received adequate medications. The supportive guidance is that he should disclose the reaction at next medical consultation, and eventually be tested for allergy to the antibiotics.

Strange that he developed the reaction 3 weeks later...

Anyway, everything is possible following medications and surgery, including anaphylactic shock to drugs, as well as necrotising fasciitis following surgery or minor trauma. You can check up these two conditions.

Our work is difficult ! But we must do it! For the benefit of the patients !

Comment

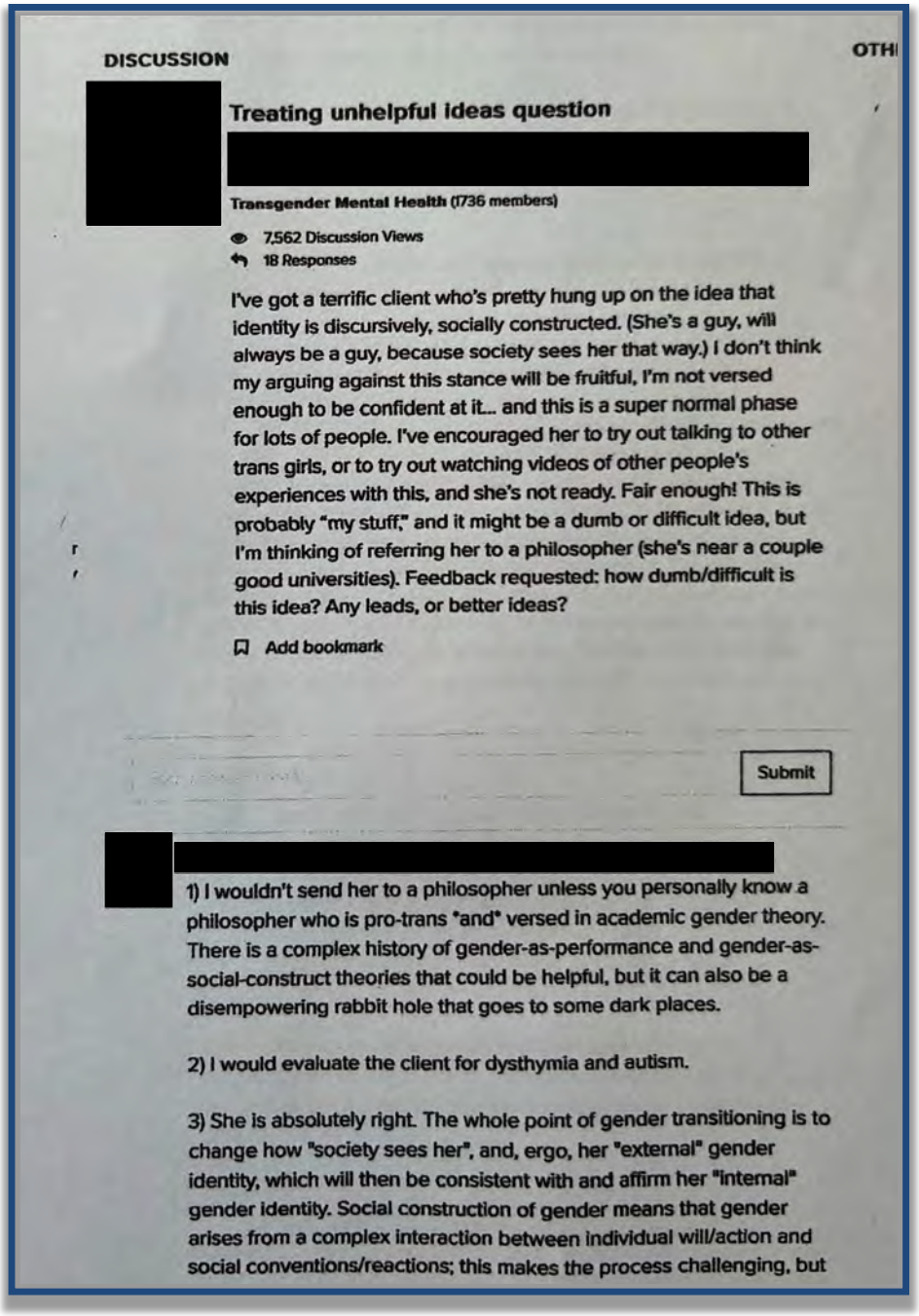
[redacted]

Thanks very much for your sensitive comments. My patient reports reading that many others report the same delay in symptoms of several weeks - of course this is anecdotal and to my knowledge there has been no focused research on such issues yet.

However – Is it not odd that such a possible adverse and potentially dangerous reaction was not assessed before the surgery?

Please feel free to continue to add to this conversation as you ponder it. I have posted this case before the Surgeon's Group here at WPATH, and am looking forward to their responses, too.

e) A WPATH member seeks advice on sending patient to a philosopher to help change their views on gender identity



DISCUSSION

OTH

[redacted]

Treating unhelpful ideas question

[redacted]

Transgender Mental Health (1736 members)

7,562 Discussion Views

18 Responses

I've got a terrific client who's pretty hung up on the idea that identity is discursively, socially constructed. (She's a guy, will always be a guy, because society sees her that way.) I don't think my arguing against this stance will be fruitful, I'm not versed enough to be confident at it... and this is a super normal phase for lots of people. I've encouraged her to try out talking to other trans girls, or to try out watching videos of other people's experiences with this, and she's not ready. Fair enough! This is probably "my stuff," and it might be a dumb or difficult idea, but I'm thinking of referring her to a philosopher (she's near a couple good universities). Feedback requested: how dumb/difficult is this idea? Any leads, or better ideas?

Add bookmark

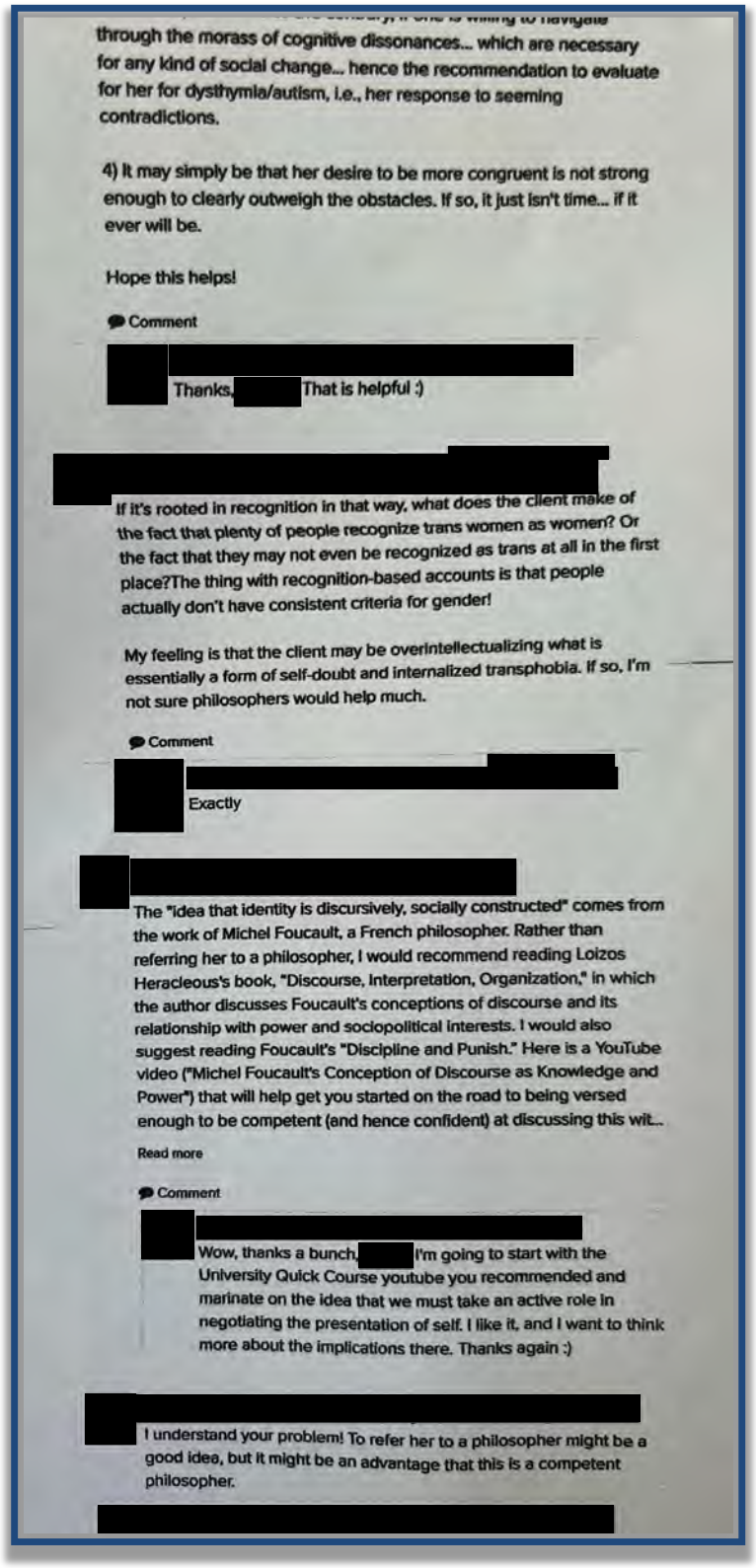
Submit

[redacted]

1) I wouldn't send her to a philosopher unless you personally know a philosopher who is pro-trans *and* versed in academic gender theory. There is a complex history of gender-as-performance and gender-as-social-construct theories that could be helpful, but it can also be a disempowering rabbit hole that goes to some dark places.

2) I would evaluate the client for dysthymia and autism.

3) She is absolutely right. The whole point of gender transitioning is to change how "society sees her", and, ergo, her "external" gender identity, which will then be consistent with and affirm her "internal" gender identity. Social construction of gender means that gender arises from a complex interaction between individual will/action and social conventions/reactions; this makes the process challenging, but



through the morass of cognitive dissonances... which are necessary for any kind of social change... hence the recommendation to evaluate for her for dysthymia/autism, i.e., her response to seeming contradictions.

4) It may simply be that her desire to be more congruent is not strong enough to clearly outweigh the obstacles. If so, it just isn't time... if it ever will be.

Hope this helps!

Comment

[redacted] Thanks, [redacted] That is helpful :)

[redacted] If it's rooted in recognition in that way, what does the client make of the fact that plenty of people recognize trans women as women? Or the fact that they may not even be recognized as trans at all in the first place?The thing with recognition-based accounts is that people actually don't have consistent criteria for gender!

My feeling is that the client may be overintellectualizing what is essentially a form of self-doubt and internalized transphobia. If so, I'm not sure philosophers would help much.

Comment

[redacted] Exactly

[redacted] The "idea that identity is discursively, socially constructed" comes from the work of Michel Foucault, a French philosopher. Rather than referring her to a philosopher, I would recommend reading Loizos Heracleous's book, "Discourse, Interpretation, Organization," in which the author discusses Foucault's conceptions of discourse and its relationship with power and sociopolitical interests. I would also suggest reading Foucault's "Discipline and Punish." Here is a YouTube video ("Michel Foucault's Conception of Discourse as Knowledge and Power") that will help get you started on the road to being versed enough to be competent (and hence confident) at discussing this wit...

Read more

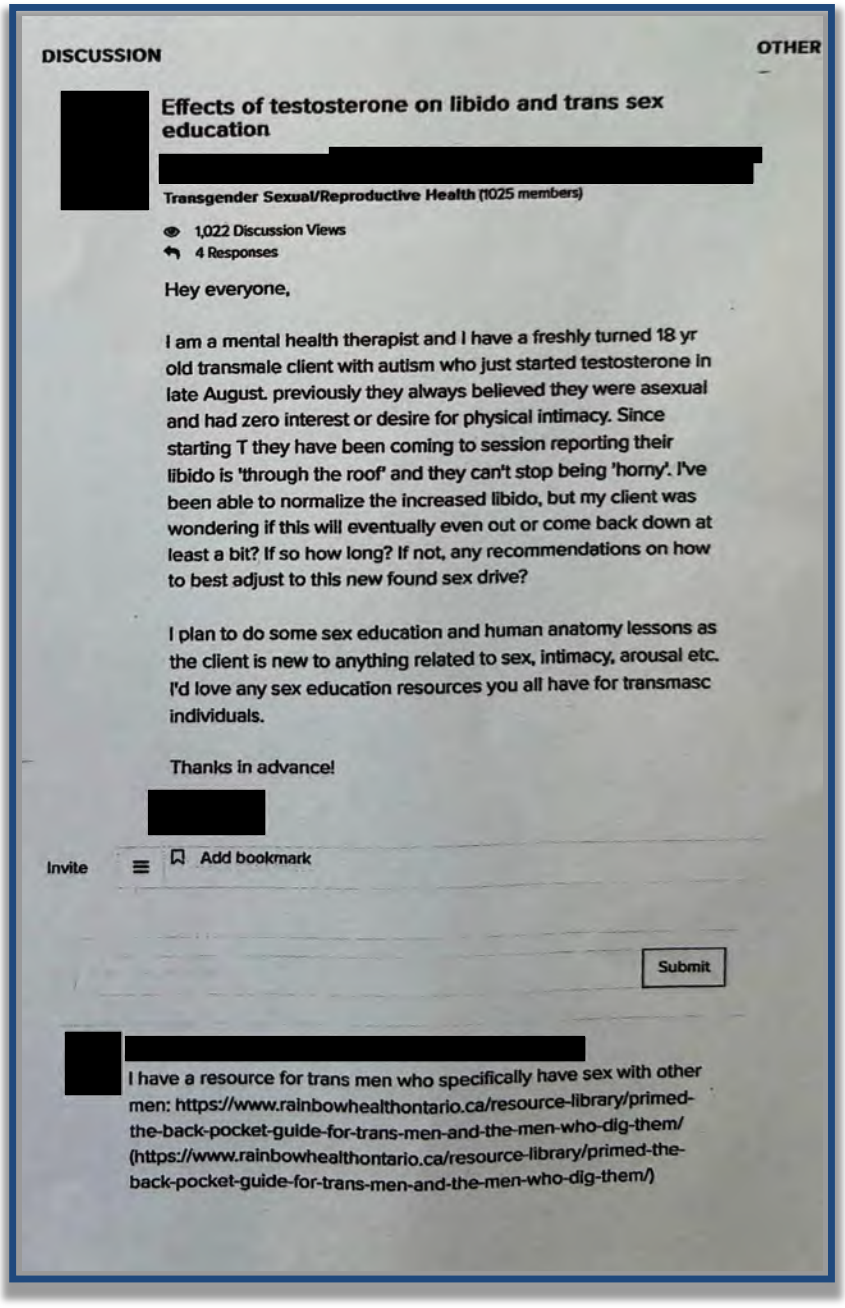
Comment

[redacted] Wow, thanks a bunch, [redacted] I'm going to start with the University Quick Course youtube you recommended and marinate on the idea that we must take an active role in negotiating the presentation of self. I like it, and I want to think more about the implications there. Thanks again :)

[redacted] I understand your problem! To refer her to a philosopher might be a good idea, but it might be an advantage that this is a competent philosopher.

[redacted]

f) A WPATH member seeks guidance for client whose libido has drastically increased on testosterone



DISCUSSION OTHER

[redacted] **Effects of testosterone on libido and trans sex education**

[redacted]

Transgender Sexual/Reproductive Health (1025 members)

1,022 Discussion Views
4 Responses

Hey everyone,

I am a mental health therapist and I have a freshly turned 18 yr old transmale client with autism who just started testosterone in late August. previously they always believed they were asexual and had zero interest or desire for physical intimacy. Since starting T they have been coming to session reporting their libido is 'through the roof' and they can't stop being 'horny'. I've been able to normalize the increased libido, but my client was wondering if this will eventually even out or come back down at least a bit? If so how long? If not, any recommendations on how to best adjust to this new found sex drive?

I plan to do some sex education and human anatomy lessons as the client is new to anything related to sex, intimacy, arousal etc. I'd love any sex education resources you all have for transmasc individuals.

Thanks in advance!

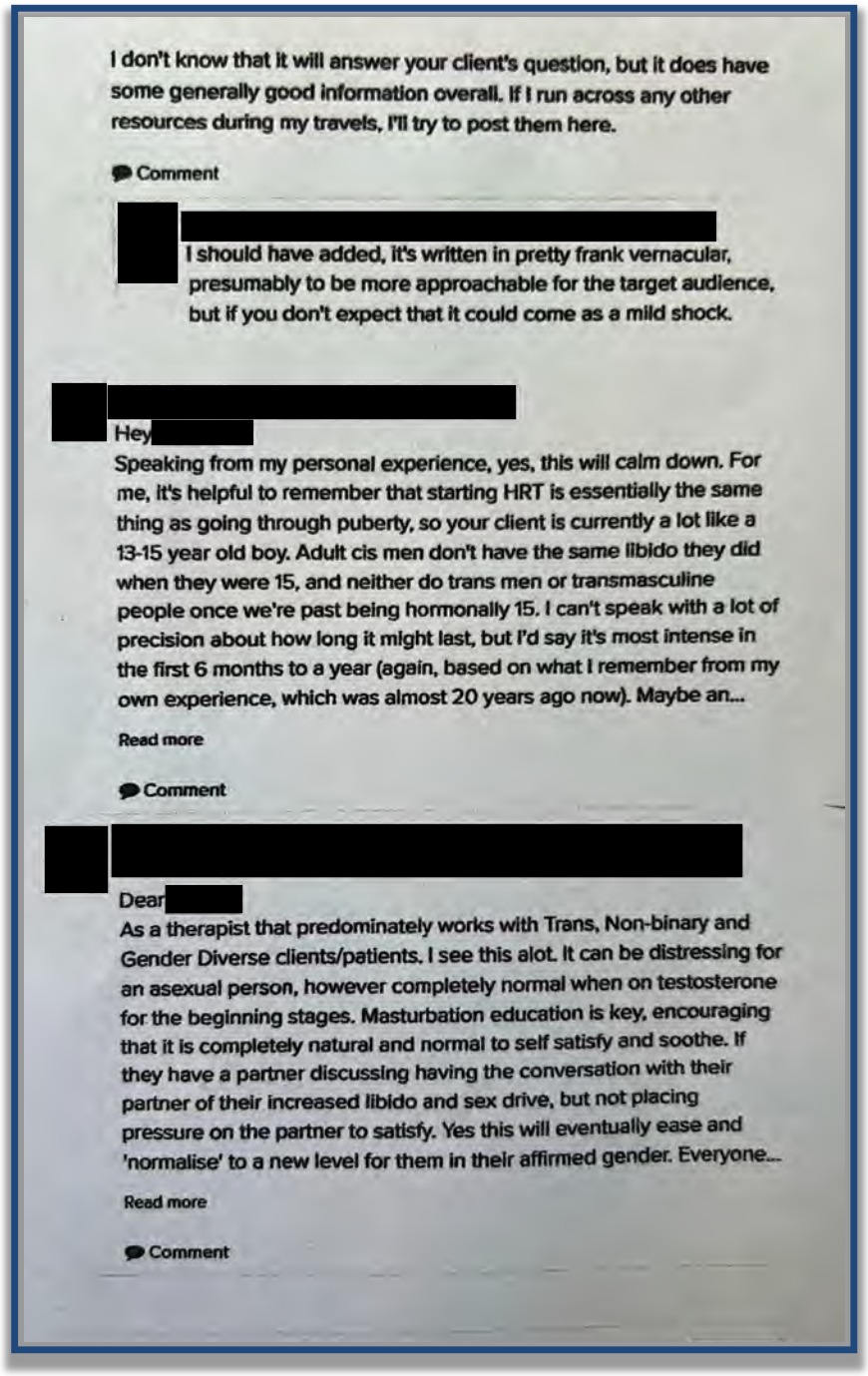
[redacted]

Invite ≡ Add bookmark

Submit

[redacted]

I have a resource for trans men who specifically have sex with other men: https://www.rainbowhealthontario.ca/resource-library/primed-the-back-pocket-guide-for-trans-men-and-the-men-who-dig-them/ (https://www.rainbowhealthontario.ca/resource-library/primed-the-back-pocket-guide-for-trans-men-and-the-men-who-dig-them/)



I don't know that it will answer your client's question, but it does have some generally good information overall. If I run across any other resources during my travels, I'll try to post them here.

Comment

[redacted]
I should have added, it's written in pretty frank vernacular, presumably to be more approachable for the target audience, but if you don't expect that it could come as a mild shock.

[redacted]
Hey [redacted]
Speaking from my personal experience, yes, this will calm down. For me, it's helpful to remember that starting HRT is essentially the same thing as going through puberty, so your client is currently a lot like a 13-15 year old boy. Adult cis men don't have the same libido they did when they were 15, and neither do trans men or transmasculine people once we're past being hormonally 15. I can't speak with a lot of precision about how long it might last, but I'd say it's most intense in the first 6 months to a year (again, based on what I remember from my own experience, which was almost 20 years ago now). Maybe an...

Read more

Comment

[redacted]
Dear [redacted]
As a therapist that predominately works with Trans, Non-binary and Gender Diverse clients/patients. I see this alot. It can be distressing for an asexual person, however completely normal when on testosterone for the beginning stages. Masturbation education is key, encouraging that it is completely natural and normal to self satisfy and soothe. If they have a partner discussing having the conversation with their partner of their increased libido and sex drive, but not placing pressure on the partner to satisfy. Yes this will eventually ease and 'normalise' to a new level for them in their affirmed gender. Everyone...

Read more

Comment

[redacted]

Hey [redacted]

Speaking from my personal experience, yes, this will calm down. For me, it's helpful to remember that starting HRT is essentially the same thing as going through puberty, so your client is currently a lot like a 13-15 year old boy. Adult cis men don't have the same libido they did when they were 15, and neither do trans men or transmasculine people once we're past being hormonally 15. I can't speak with a lot of precision about how long it might last, but I'd say it's most intense in the first 6 months to a year (again, based on what I remember from my own experience, which was almost 20 years ago now). Maybe an endocrinologist can speak on this question with a broader knowledge base.

I hope this is helpful in supporting your client as they try to adjust to their new experience of their body and figure out what to expect in the future!

[redacted]

Comment

[redacted]

Dear [redacted]

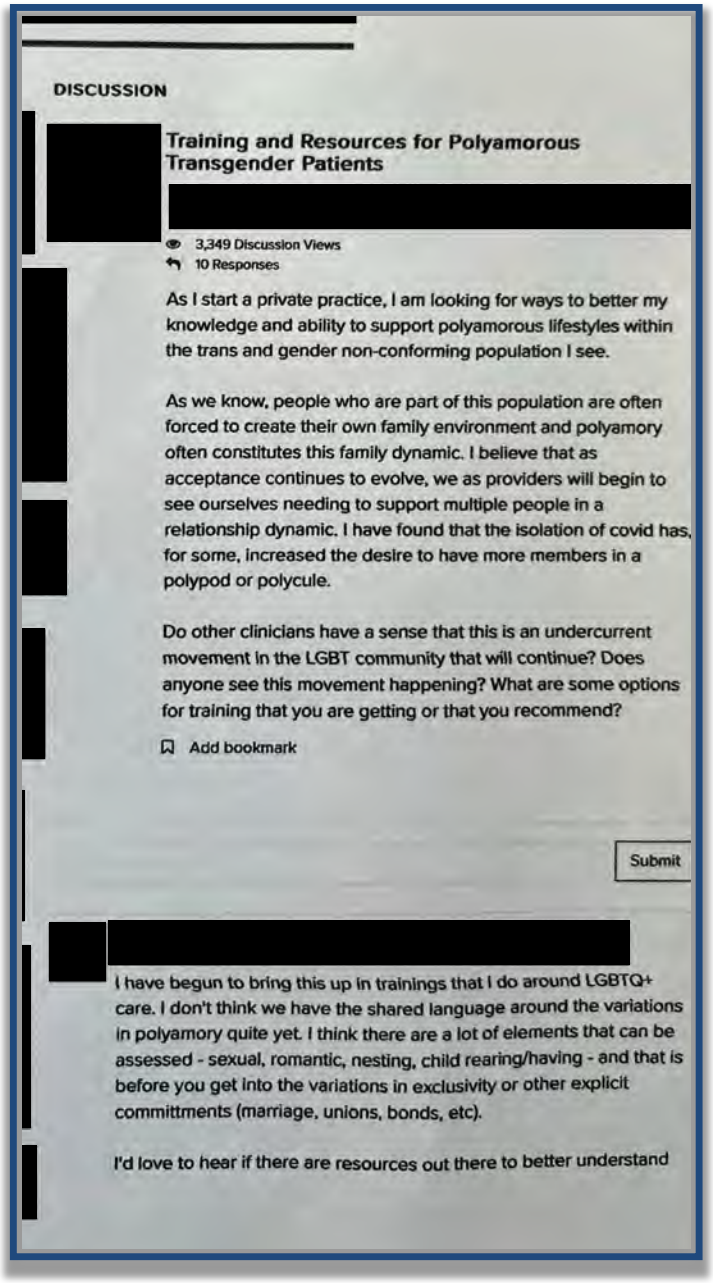
As a therapist that predominately works with Trans, Non-binary and Gender Diverse clients/patients. I see this alot. It can be distressing for an asexual person, however completely normal when on testosterone for the beginning stages. Masturbation education is key, encouraging that it is completely natural and normal to self satisfy and soothe. If they have a partner discussing having the conversation with their partner of their increased libido and sex drive, but not placing pressure on the partner to satisfy. Yes this will eventually ease and 'normalise' to a new level for them in their affirmed gender. Everyone is different and it last varying times for each person. It is a 'second' puberty but a 'first' puberty in their affirmed gender, so it's about exploring with them the 'newness' in the experience of being. Doing alot of somatic body work and being in the here and now. it's important for them to explore their sexuality now at this stage providing psychoeducation that sexuality is fluid and every changing and may now be abrosexual i.e. fluctuating between being asexual and then not sometimes. Don't make things too clinical and medical, it's all about the experience.

queersextherapy on Instagram would be most suitable for them especially that they are a young person. It provides body positive, quick, easy and simple psycho education on the matter, and recently did a post a couple of weeks ago on being asexual and experiencing sexual desires that may be overwhelming.

I also specialise in GSRD, I don't know where you are based but I am happy to see clients online as well, for short periods if needs be. I have a programme called [redacted] where they can see me for 6weeks or more for focused support within their transition.

Comment

g) A WPATH member seeks guidance to better support polyamorous lifestyles within the transgender and gender non-conforming population



DISCUSSION

Training and Resources for Polyamorous Transgender Patients

[redacted]

3,349 Discussion Views
10 Responses

As I start a private practice, I am looking for ways to better my knowledge and ability to support polyamorous lifestyles within the trans and gender non-conforming population I see.

As we know, people who are part of this population are often forced to create their own family environment and polyamory often constitutes this family dynamic. I believe that as acceptance continues to evolve, we as providers will begin to see ourselves needing to support multiple people in a relationship dynamic. I have found that the isolation of covid has, for some, increased the desire to have more members in a polypod or polycule.

Do other clinicians have a sense that this is an undercurrent movement in the LGBT community that will continue? Does anyone see this movement happening? What are some options for training that you are getting or that you recommend?

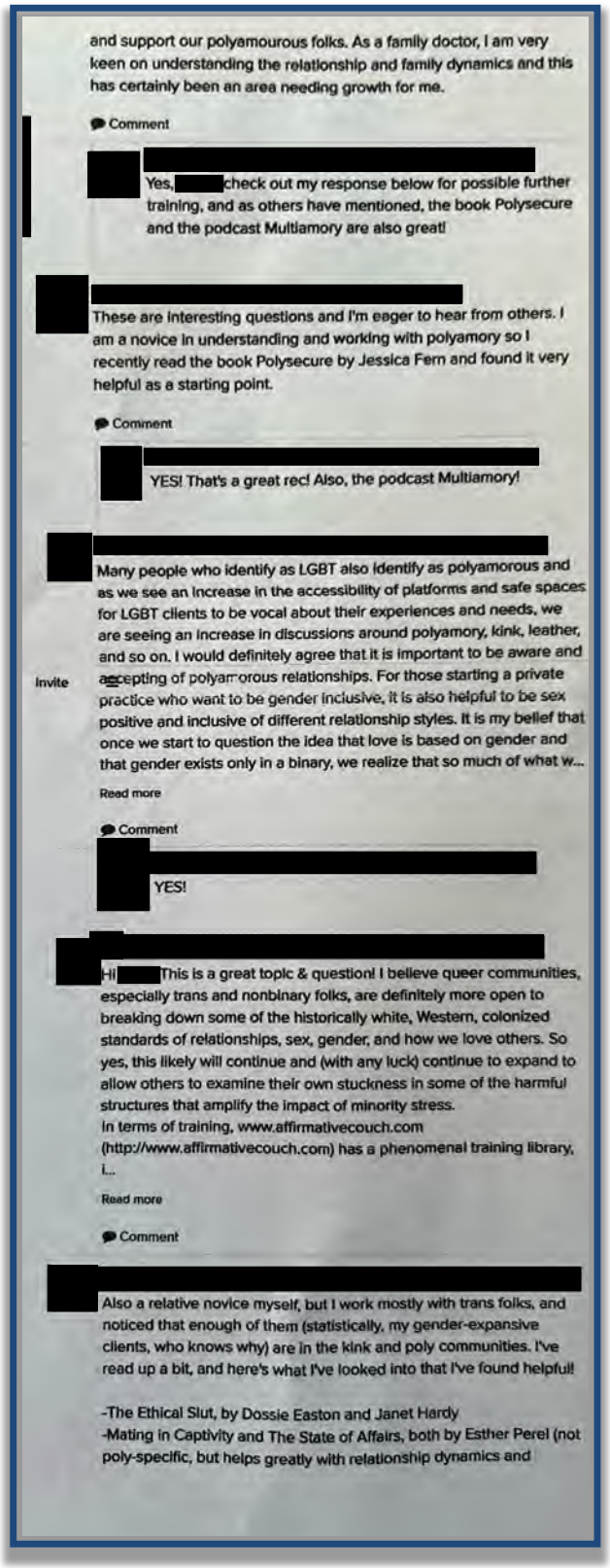
Add bookmark

Submit

[redacted]

I have begun to bring this up in trainings that I do around LGBTQ+ care. I don't think we have the shared language around the variations in polyamory quite yet. I think there are a lot of elements that can be assessed - sexual, romantic, nesting, child rearing/having - and that is before you get into the variations in exclusivity or other explicit committments (marriage, unions, bonds, etc).

I'd love to hear if there are resources out there to better understand



and support our polyamourous folks. As a family doctor, I am very keen on understanding the relationship and family dynamics and this has certainly been an area needing growth for me.

Comment

[redacted] Yes, [redacted] check out my response below for possible further training, and as others have mentioned, the book Polysecure and the podcast Multiamory are also great!

[redacted] These are interesting questions and I'm eager to hear from others. I am a novice in understanding and working with polyamory so I recently read the book Polysecure by Jessica Fern and found it very helpful as a starting point.

Comment

[redacted] YES! That's a great rec! Also, the podcast Multiamory!

[redacted] Many people who identify as LGBT also identify as polyamorous and as we see an increase in the accessibility of platforms and safe spaces for LGBT clients to be vocal about their experiences and needs, we are seeing an increase in discussions around polyamory, kink, leather, and so on. I would definitely agree that it is important to be aware and accepting of polyamorous relationships. For those starting a private practice who want to be gender inclusive, it is also helpful to be sex positive and inclusive of different relationship styles. It is my belief that once we start to question the idea that love is based on gender and that gender exists only in a binary, we realize that so much of what w...

Invite

Read more

Comment

[redacted] YES!

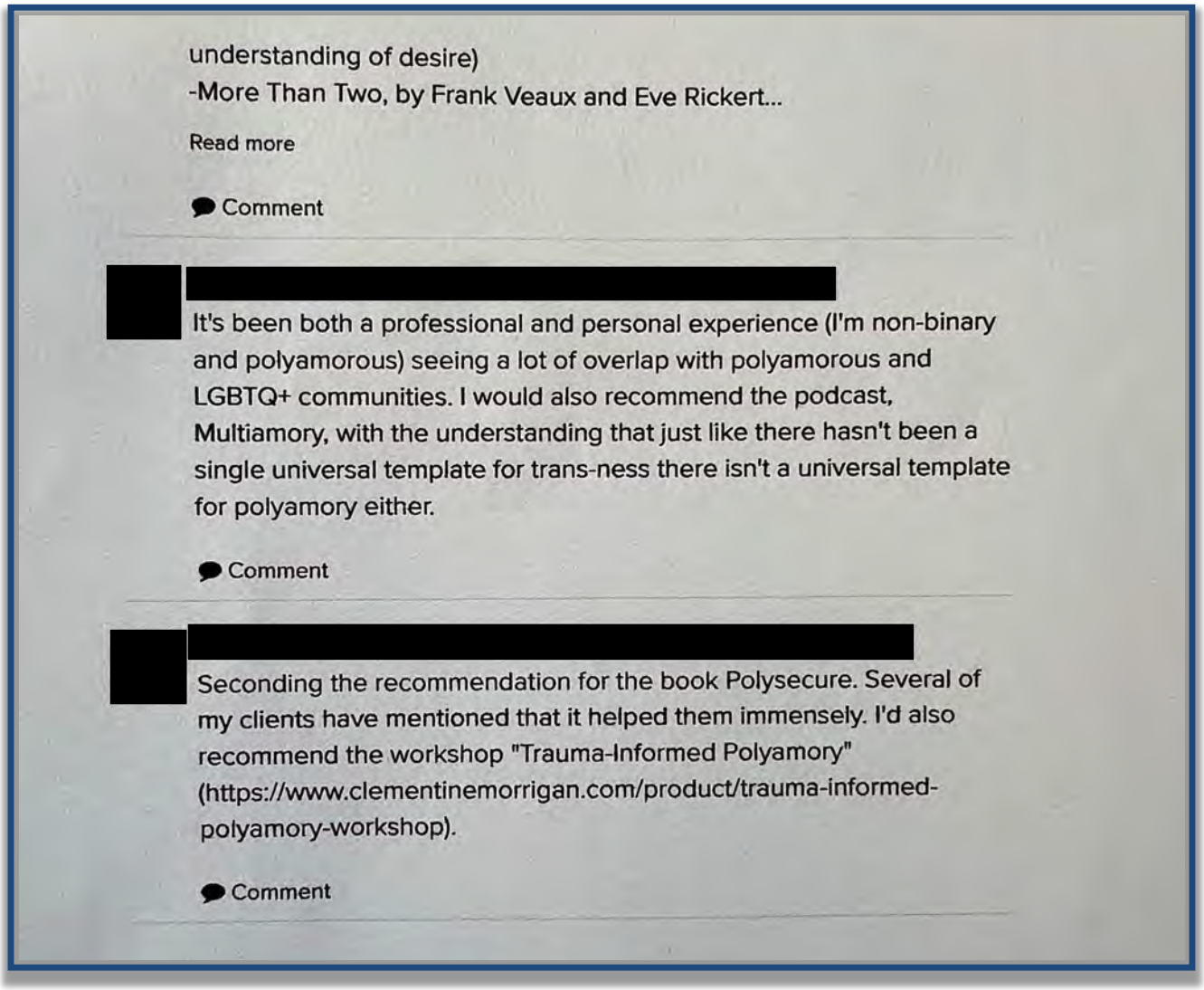
[redacted] Hi [redacted] This is a great topic & question! I believe queer communities, especially trans and nonbinary folks, are definitely more open to breaking down some of the historically white, Western, colonized standards of relationships, sex, gender, and how we love others. So yes, this likely will continue and (with any luck) continue to expand to allow others to examine their own stuckness in some of the harmful structures that amplify the impact of minority stress.
In terms of training, www.affirmativecouch.com (http://www.affirmativecouch.com) has a phenomenal training library, i...

Read more

Comment

[redacted] Also a relative novice myself, but I work mostly with trans folks, and noticed that enough of them (statistically, my gender-expansive clients, who knows why) are in the kink and poly communities. I've read up a bit, and here's what I've looked into that I've found helpful!

-The Ethical Slut, by Dossie Easton and Janet Hardy
-Mating in Captivity and The State of Affairs, both by Esther Perel (not poly-specific, but helps greatly with relationship dynamics and



understanding of desire)
-More Than Two, by Frank Veaux and Eve Rickert...

Read more

Comment

[redacted]

It's been both a professional and personal experience (I'm non-binary and polyamorous) seeing a lot of overlap with polyamorous and LGBTQ+ communities. I would also recommend the podcast, Multiamory, with the understanding that just like there hasn't been a single universal template for trans-ness there isn't a universal template for polyamory either.

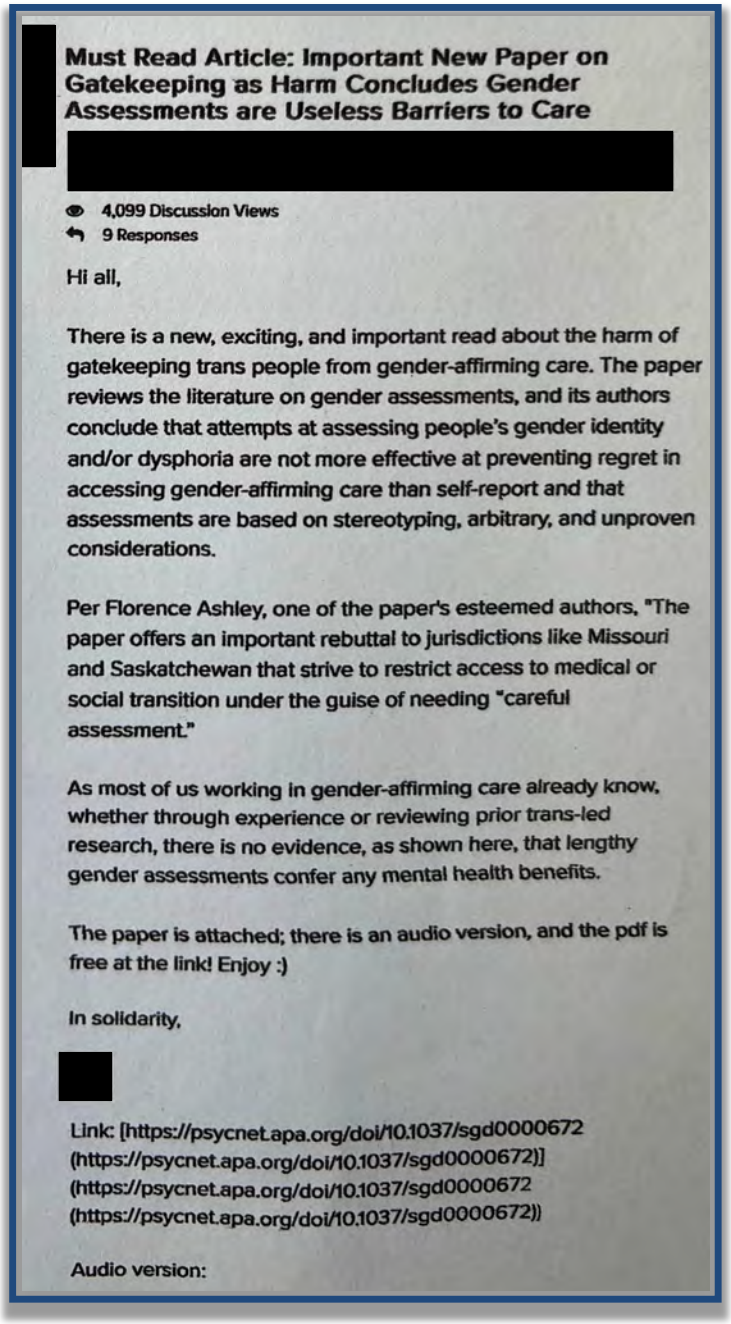
Comment

[redacted]

Seconding the recommendation for the book Polysecure. Several of my clients have mentioned that it helped them immensely. I'd also recommend the workshop "Trauma-Informed Polyamory" (https://www.clementinemorrigan.com/product/trauma-informed-polyamory-workshop).

Comment

h) WPATH members debate the conclusions of a new research paper on the harm of gatekeeping transgender people from gender-affirming care



Must Read Article: Important New Paper on Gatekeeping as Harm Concludes Gender Assessments are Useless Barriers to Care

[redacted]

4,099 Discussion Views
9 Responses

Hi all,

There is a new, exciting, and important read about the harm of gatekeeping trans people from gender-affirming care. The paper reviews the literature on gender assessments, and its authors conclude that attempts at assessing people's gender identity and/or dysphoria are not more effective at preventing regret in accessing gender-affirming care than self-report and that assessments are based on stereotyping, arbitrary, and unproven considerations.

Per Florence Ashley, one of the paper's esteemed authors, "The paper offers an important rebuttal to jurisdictions like Missouri and Saskatchewan that strive to restrict access to medical or social transition under the guise of needing "careful assessment."

As most of us working in gender-affirming care already know, whether through experience or reviewing prior trans-led research, there is no evidence, as shown here, that lengthy gender assessments confer any mental health benefits.

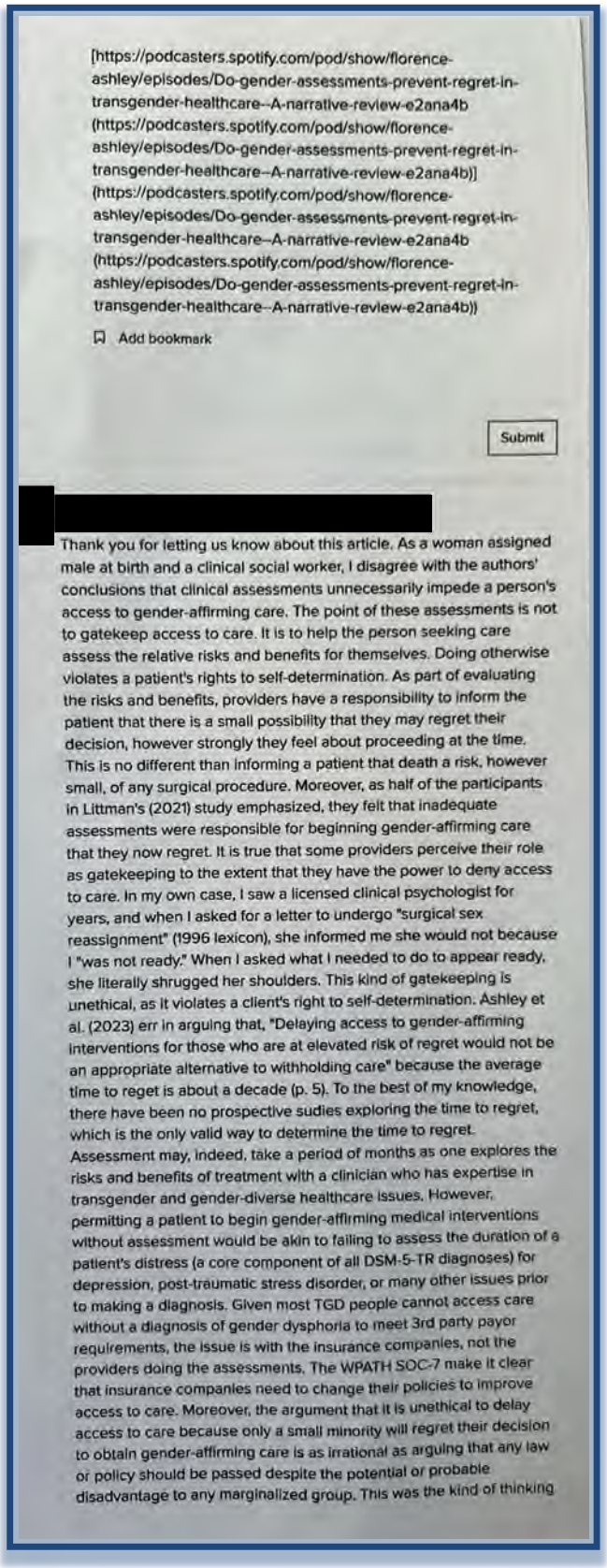
The paper is attached; there is an audio version, and the pdf is free at the link! Enjoy :)

In solidarity,

[redacted]

Link: [https://psycnet.apa.org/doi/10.1037/sgd0000672 (https://psycnet.apa.org/doi/10.1037/sgd0000672)] (https://psycnet.apa.org/doi/10.1037/sgd0000672 (https://psycnet.apa.org/doi/10.1037/sgd0000672))

Audio version:



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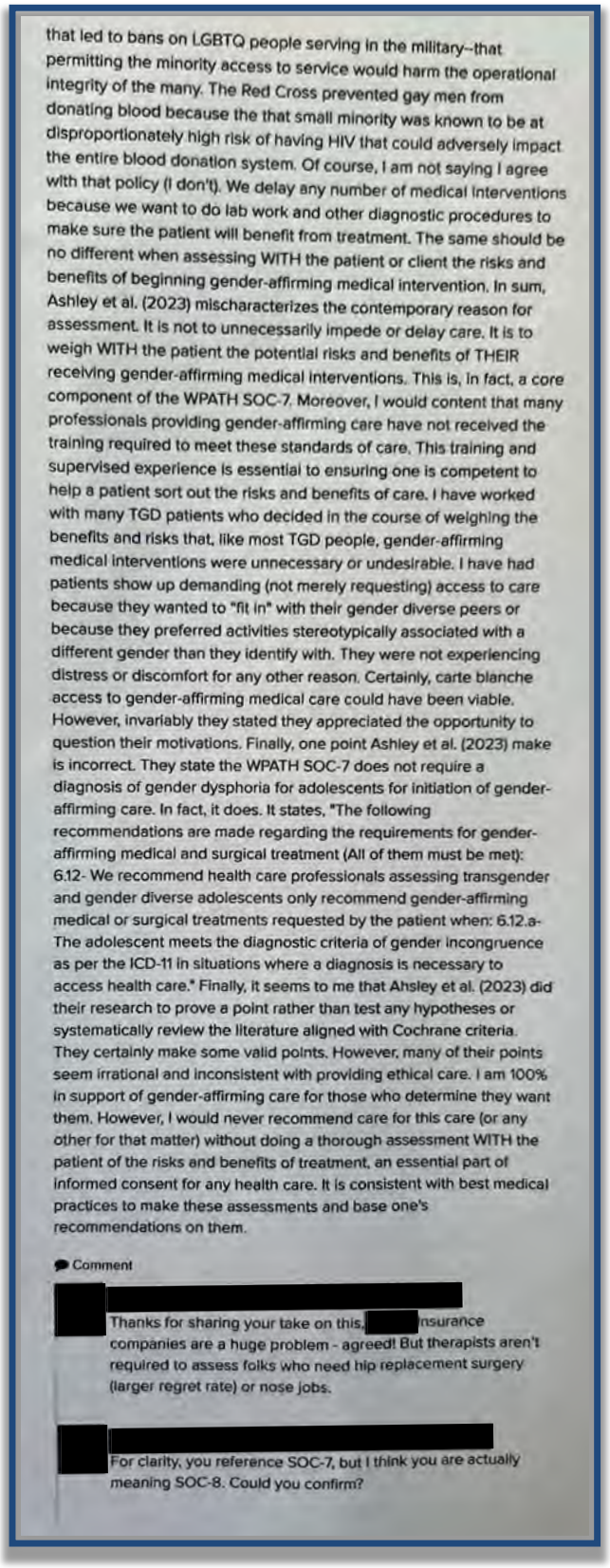
[redacted]

Thank you for letting us know about this article. As a woman assigned male at birth and a clinical social worker, I disagree with the authors' conclusions that clinical assessments unnecessarily impede a person's access to gender-affirming care. The point of these assessments is not to gatekeep access to care. It is to help the person seeking care assess the relative risks and benefits for themselves. Doing otherwise violates a patient's rights to self-determination. As part of evaluating the risks and benefits, providers have a responsibility to inform the patient that there is a small possibility that they may regret their decision, however strongly they feel about proceeding at the time. This is no different than informing a patient that death a risk, however small, of any surgical procedure. Moreover, as half of the participants in Littman's (2021) study emphasized, they felt that inadequate assessments were responsible for beginning gender-affirming care that they now regret. It is true that some providers perceive their role as gatekeeping to the extent that they have the power to deny access to care. In my own case, I saw a licensed clinical psychologist for years, and when I asked for a letter to undergo "surgical sex reassignment" (1996 lexicon), she informed me she would not because I "was not ready." When I asked what I needed to do to appear ready, she literally shrugged her shoulders. This kind of gatekeeping is unethical, as it violates a client's right to self-determination. Ashley et al. (2023) err in arguing that, "Delaying access to gender-affirming interventions for those who are at elevated risk of regret would not be an appropriate alternative to withholding care" because the average time to reget is about a decade (p. 5). To the best of my knowledge, there have been no prospective sudies exploring the time to regret, which is the only valid way to determine the time to regret. Assessment may, indeed, take a period of months as one explores the risks and benefits of treatment with a clinician who has expertise in transgender and gender-diverse healthcare issues. However, permitting a patient to begin gender-affirming medical interventions without assessment would be akin to failing to assess the duration of a patient's distress (a core component of all DSM-5-TR diagnoses) for depression, post-traumatic stress disorder, or many other issues prior to making a diagnosis. Given most TGD people cannot access care without a diagnosis of gender dysphoria to meet 3rd party payor requirements, the issue is with the insurance companies, not the providers doing the assessments. The WPATH SOC-7 make it clear that insurance companies need to change their policies to improve access to care. Moreover, the argument that it is unethical to delay access to care because only a small minority will regret their decision to obtain gender-affirming care is as irrational as arguing that any law or policy should be passed despite the potential or probable disadvantage to any marginalized group. This was the kind of thinking



that led to bans on LGBTQ people serving in the military--that permitting the minority access to service would harm the operational integrity of the many. The Red Cross prevented gay men from donating blood because the that small minority was known to be at disproportionately high risk of having HIV that could adversely impact the entire blood donation system. Of course, I am not saying I agree with that policy (I don't). We delay any number of medical interventions because we want to do lab work and other diagnostic procedures to make sure the patient will benefit from treatment. The same should be no different when assessing WITH the patient or client the risks and benefits of beginning gender-affirming medical intervention. In sum, Ashley et al. (2023) mischaracterizes the contemporary reason for assessment. It is not to unnecessarily impede or delay care. It is to weigh WITH the patient the potential risks and benefits of THEIR receiving gender-affirming medical interventions. This is, in fact, a core component of the WPATH SOC-7. Moreover, I would content that many professionals providing gender-affirming care have not received the training required to meet these standards of care. This training and supervised experience is essential to ensuring one is competent to help a patient sort out the risks and benefits of care. I have worked with many TGD patients who decided in the course of weighing the benefits and risks that, like most TGD people, gender-affirming medical interventions were unnecessary or undesirable. I have had patients show up demanding (not merely requesting) access to care because they wanted to "fit in" with their gender diverse peers or because they preferred activities stereotypically associated with a different gender than they identify with. They were not experiencing distress or discomfort for any other reason. Certainly, carte blanche access to gender-affirming medical care could have been viable. However, invariably they stated they appreciated the opportunity to question their motivations. Finally, one point Ashley et al. (2023) make is incorrect. They state the WPATH SOC-7 does not require a diagnosis of gender dysphoria for adolescents for initiation of gender-affirming care. In fact, it does. It states, "The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met): 6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when: 6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care." Finally, it seems to me that Ahsley et al. (2023) did their research to prove a point rather than test any hypotheses or systematically review the literature aligned with Cochrane criteria. They certainly make some valid points. However, many of their points seem irrational and inconsistent with providing ethical care. I am 100% in support of gender-affirming care for those who determine they want them. However, I would never recommend care for this care (or any other for that matter) without doing a thorough assessment WITH the patient of the risks and benefits of treatment, an essential part of informed consent for any health care. It is consistent with best medical practices to make these assessments and base one's recommendations on them.

Comment

[redacted]

Thanks for sharing your take on this, [redacted] nsurance companies are a huge problem - agreed! But therapists aren't required to assess folks who need hip replacement surgery (larger regret rate) or nose jobs.

[redacted]

For clarity, you reference SOC-7, but I think you are actually meaning SOC-8. Could you confirm?

[redacted] [redacted] thanks for this full some response. As an MD providing care to detransitioners, and as an MD who has provided care for trans adults for almost 2 decades, I completely agree. We have a novel population now, like it or not. If we are not careful, the roll-backs on care at rhe government levels, in response to a loss or lack of gatekeeping/proper assessments by the system will lead to a loss of services for consenting, fully informed adults. Individuals under 18 (really under 26, in my opinion), are an unknown, especially those with what appears to be adolescent onset GD. We truly have no idea what to expect and in Canada, the majority of GAC programs are not following them into adulthood. So the sloppy approach to delivering this care will come back to bite us all, I am sure. Even in Canada we are seeing a rising political right-leaning reaction to these inadequate approaches to a significant intervention. We have a choice. Either we do a better job at the health care level or we put ourselves at risk of having politics make these decisions for us. That is the most terrifying to envision.

[redacted]

Your response seems to conflate informed consent discussions and gender assessments as a requirement for care. The article is about gender assessments as a requirement for care.

As for not using a Cochrane review, it would have been completely pointless because there are virtually no studies that actually bear on gender assessments' role in preventing regret and would meet rigorous inclusion criteria.

...

Read more

[redacted]

As a transgender man, I tend to agree with the move toward informed consent. In my own experiences, I never had any difficulties with care providers who provided gender affirming care on an informed consent basis. I faced enormous difficulties (trauma, unwanted surgical results, additional surgery) after receiving care from a provider who relied on the SOC.

The rigidity of the SOC vs informed consent puts a fear in patients that they will be turned away from the care they know they need because of the least irregularity in their narrative or their desired outcome. It's getting better, but there have been times when people would practice for their appointments with friends to avoid saying the wrong thing. A system based on informed consent would eliminate these situations and fears.

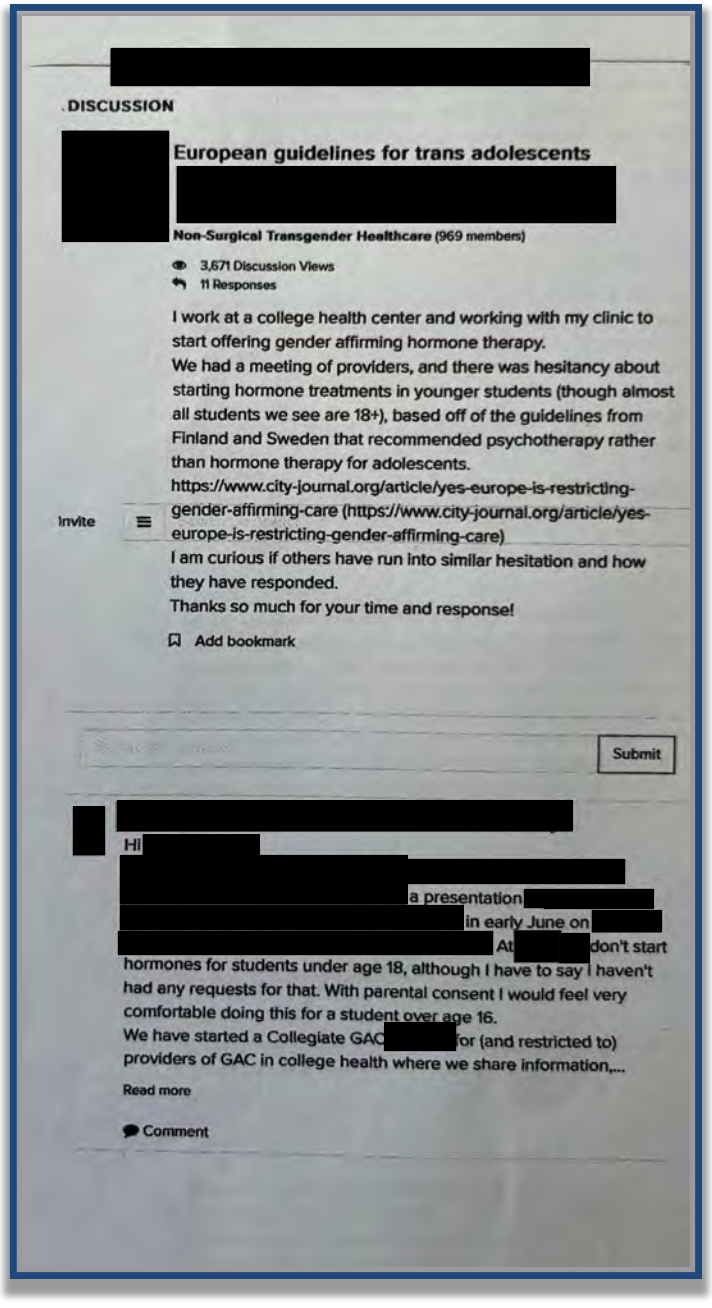
The ability to speak freely with one's providers is more readily assured under informed consent than in a system with rigid gatekeeping. It is incredibly important to be able to communicate openly without fear of losing access to care.

We look back at the times when trans people had to pretend to be straight to receive care, for instance, and consider that abhorrent at best and a violation of their basic human rights at worst. Someday, the gatekeeping that is considered normal now may look very much much the same.

The sooner this is identified, the better.

Comment

i) A WPATH member discusses certain European providers' hesitancy about starting hormone treatments in younger students



[redacted]

DISCUSSION

[redacted] European guidelines for trans adolescents [redacted]

Non-Surgical Transgender Healthcare (969 members)

3,671 Discussion Views
11 Responses

I work at a college health center and working with my clinic to start offering gender affirming hormone therapy.
We had a meeting of providers, and there was hesitancy about starting hormone treatments in younger students (though almost all students we see are 18+), based off of the guidelines from Finland and Sweden that recommended psychotherapy rather than hormone therapy for adolescents.
https://www.city-journal.org/article/yes-europe-is-restricting-gender-affirming-care (https://www.city-journal.org/article/yes-europe-is-restricting-gender-affirming-care)
I am curious if others have run into similar hesitation and how they have responded.
Thanks so much for your time and response!

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[redacted]

Hi [redacted] a presentation [redacted] in early June on [redacted] At [redacted] don't start hormones for students under age 18, although I have to say I haven't had any requests for that. With parental consent I would feel very comfortable doing this for a student over age 16.
We have started a Collegiate GAC [redacted] for (and restricted to) providers of GAC in college health where we share information,...

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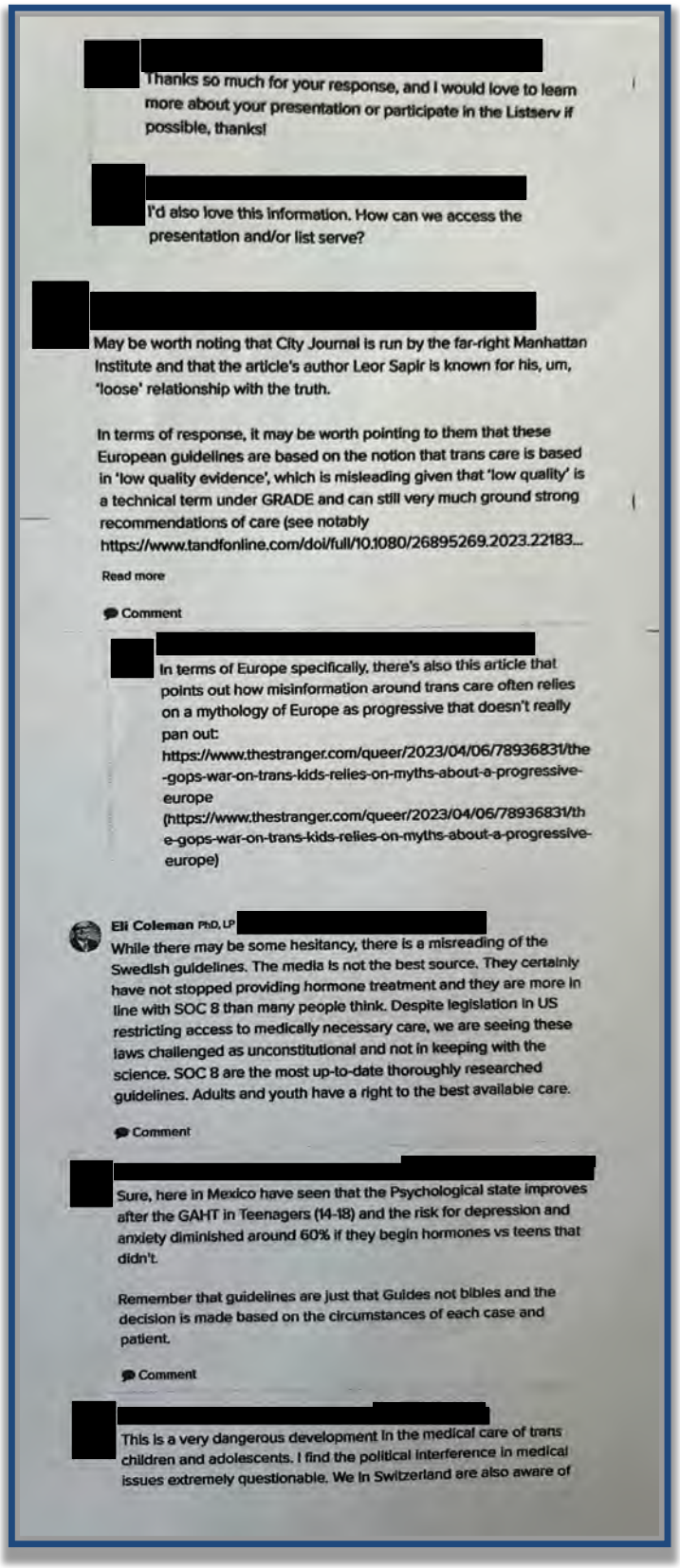
Comment



[redacted] Thanks so much for your response, and I would love to learn more about your presentation or participate in the Listserv if possible, thanks!

[redacted] I'd also love this information. How can we access the presentation and/or list serve?

[redacted] May be worth noting that City Journal is run by the far-right Manhattan Institute and that the article's author Leor Sapir is known for his, um, 'loose' relationship with the truth.

In terms of response, it may be worth pointing to them that these European guidelines are based on the notion that trans care is based in 'low quality evidence', which is misleading given that 'low quality' is a technical term under GRADE and can still very much ground strong recommendations of care (see notably https://www.tandfonline.com/doi/full/10.1080/26895269.2023.22183...

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Comment

[redacted] In terms of Europe specifically, there's also this article that points out how misinformation around trans care often relies on a mythology of Europe as progressive that doesn't really pan out: https://www.thestranger.com/queer/2023/04/06/78936831/the-gops-war-on-trans-kids-relies-on-myths-about-a-progressive-europe (https://www.thestranger.com/queer/2023/04/06/78936831/the-gops-war-on-trans-kids-relies-on-myths-about-a-progressive-europe)

Eli Coleman PhD, LP [redacted] While there may be some hesitancy, there is a misreading of the Swedish guidelines. The media is not the best source. They certainly have not stopped providing hormone treatment and they are more in line with SOC 8 than many people think. Despite legislation in US restricting access to medically necessary care, we are seeing these laws challenged as unconstitutional and not in keeping with the science. SOC 8 are the most up-to-date thoroughly researched guidelines. Adults and youth have a right to the best available care.

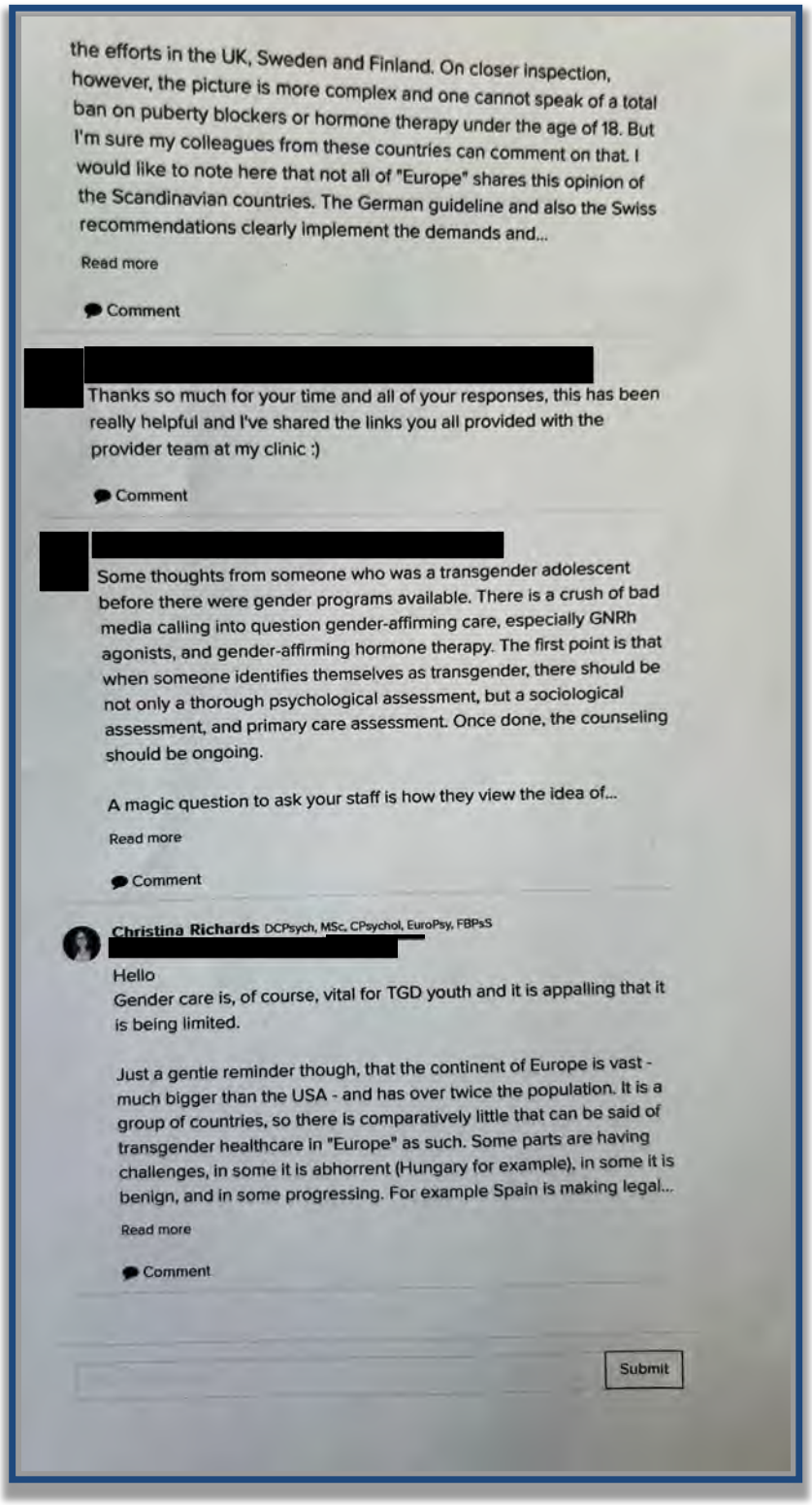
Comment

[redacted] Sure, here in Mexico have seen that the Psychological state improves after the GAHT in Teenagers (14-18) and the risk for depression and anxiety diminished around 60% if they begin hormones vs teens that didn't.

Remember that guidelines are just that Guides not bibles and the decision is made based on the circumstances of each case and patient.

Comment

[redacted] This is a very dangerous development in the medical care of trans children and adolescents. I find the political interference in medical issues extremely questionable. We in Switzerland are also aware of



the efforts in the UK, Sweden and Finland. On closer inspection, however, the picture is more complex and one cannot speak of a total ban on puberty blockers or hormone therapy under the age of 18. But I'm sure my colleagues from these countries can comment on that. I would like to note here that not all of "Europe" shares this opinion of the Scandinavian countries. The German guideline and also the Swiss recommendations clearly implement the demands and...

Read more

Comment

[redacted]

Thanks so much for your time and all of your responses, this has been really helpful and I've shared the links you all provided with the provider team at my clinic :)

Comment

[redacted]

Some thoughts from someone who was a transgender adolescent before there were gender programs available. There is a crush of bad media calling into question gender-affirming care, especially GNRh agonists, and gender-affirming hormone therapy. The first point is that when someone identifies themselves as transgender, there should be not only a thorough psychological assessment, but a sociological assessment, and primary care assessment. Once done, the counseling should be ongoing.

A magic question to ask your staff is how they view the idea of...

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Comment

Christina Richards DCPsych, MSc, CPsychol, EuroPsy, FBPsS

[redacted]

Hello
Gender care is, of course, vital for TGD youth and it is appalling that it is being limited.

Just a gentle reminder though, that the continent of Europe is vast - much bigger than the USA - and has over twice the population. It is a group of countries, so there is comparatively little that can be said of transgender healthcare in "Europe" as such. Some parts are having challenges, in some it is abhorrent (Hungary for example), in some it is benign, and in some progressing. For example Spain is making legal...

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EXHIBIT 128

Transcript: Identity Evolution Workshop held on May 6, 2022

A different recording of a 1 minute and 30 second clip from the panel discussion (which is 1 hour and 22 minutes in total) was leaked into the public domain over a year ago. The video in the WPATH Files is a new recording, has a different layout, and has no connection to the previous leak. The time stamp of the previously released portion of the WPATH video is 23:16 - 24:43. This is the first time the panel discussion has been made publicly available in full.

Clip 1

Cecile Ferrando: Transmasculine patients. And we talk about, you know, early oophorectomy, so early removal of the ovaries and what that means in somebody who is taking testosterone therapy but may not be on testosterone their whole lives. And I simply sort of explain the need to have to supplement, you know, in order to have cardiovascular protection, bone health, good bone health as they get older.

Um, so those are the things that we think about in this cohort of 20 year olds in whom we're removing the ovaries. There's some concern that long term, if they ever stop their testosterone, they could be at, um, um, at metabolic risk, which is just something that needs to be considered. But historically, we have a patient population that also doesn't seek out medical care.

So there's that sort of confounding factor too, which makes it a little bit trickier. Um, but at the end of the day, it's about informed consent. And on my end, I'm just managing patients who have sought out treatment in alternative ways. Um, and that those are, those, those can be pretty challenging.

Ren Massey: Thanks, Cecile. Would anybody else like to add some observations?

Dan Metzger: I think, you know, when we, when we start people on, um, testosterone or estrogen, uh, you know, we, we try to be as clear as we can, um, about the stuff that's going to be permanent and the stuff that's, that's going to go backwards. So if you started testosterone, your voice is going to change. That's permanent, but you might get more muscly, but then that's not permanent if you were to stop.

Um, I think the thing you have to remember about kids is that we're often explaining these sorts of things to people who haven't even had biology in high school yet. And, and, um, uh, and I know I've, I've heard others in, in this kind of a, in this kind of a setting say, well, we think adults are like really slick biologically.

And in fact, lots of people have very little medical understanding of stuff like that. We just put medical professionals and. mental health professionals take for granted. So I think we have to be, um, more concrete than we think we need to be. Um, short of surgical stuff, you know, I think, I think, um, uh, and the permanent physical changes that happen with testosterone or estrogen, um, you know, you might get some breast development that maybe you would later regret.

Uh, but I think, um, it's reasonably safe to, to be on hormone X for a while and then stop and go back to your, to your natal hormones. Provided you haven't had some sort of a gonadectomy, then, as Cecile mentioned, that's a different issue if you're hormone less, um, so, um, I think that is important, um, for people to know, and I think we also, like, just in general, you know, people want this, but they don't want this, but they want this, but they don't want this from a hormone, and I'm like, well, you know, you might not be binary, but hormones are binary, and so, you know, you can't get a deeper voice without probably a bit of a beard.

It doesn't work that way, or you can't, um, you can't, uh, you know, get estrogen to feel more feminine without some breast development. It, that doesn't, that doesn't work very well. And there are different ways of trying to get around some of these things, but in general, um, you know, when you give a hormone, it's going to do what hormones do.

It's going to act on a receptor, the receptors are everywhere, and you're going to get some sort of a physiologic effect, and it's hard to kind of pick and choose the effects that you want. And, and I know that that's, um, I know that that's, uh, like something that kids wouldn't, wouldn't normally understand because they haven't had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y, and that's not always possible.

Clip 2

Ren Massey: Thanks, Dan. Yes, expectations and informed consent. We have a lot of work to do here, even as mental health professionals, um, in my work, I, even before having folks start on hormones, I go over a lengthy, um, information about the effects of the different kinds of hormone therapies, uh, just so they, I have the clarity that they have some sense of understanding what they're going to because even the good hormone docs here in my area.

Don't always take the time, or it's easy for us to make assumptions that people understand. You know, but that estrogen is not going to make somebody's voice go higher. Or if you're a certain age, testosterone is not going to make you taller. So, um, manage expectations, I think is really important. Uh, it looks like Dianne's ready to say something.

Dianne Berg: Yeah, I just wanted to piggyback on all of the importance that comes up with the informed consent. Um,

I often see people who, because there's such a backlog of therapists to do some of the mental health therapeutic support, I often see people who have already engaged in some sort of, and this is again with youth, who've already engaged in some sort of medical, um, Intervention. And so one of the things I do is I just kind of I'm sitting with the youth and their parents and I say, Oh, well, so tell me more about what you know about that medical intervention.

And kind of like what Dan was saying, you know, children and young adolescents, we wouldn't really expect them. It's kind of a developmental it's out of their developmental range sometimes to understand the extent to which some of these medical interventions are impacting them. And so I think I, I try to kind of do whatever I can to help them understand best, best I can.

But what really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for. And so I think informed consent has to happen very differently for parents. That it has to happen for children and early adolescents and adolescents, but it needs to happen and it needs to be a process and, and I think therapists are in a really good position to do that process because we have a lot more time.

with our people than like the 20 to 20 minute medical appointment the way that and that's another problem is the way the medical system works is is there's often very little time. So I think it's really one of our roles is to really do that and to really

suss that out and take quite a bit of time to do that and it's more than just like we certainly provide information but then you kind of have to listen to what the the youth is doing with that information to to kind of not, not catch them, but to pick up on the ways that they're not really understanding what, because they'll say they understand, but then they'll say something else that makes you think, Oh, they didn't really understand that they, that they are going to have facial hair, right?

Because they say something else that makes you think, Oh, they didn't get that point, but they'll say they totally get it.

Clip 3

Dianne Berg: This comment on is that I worked in a, um, an intersex or disorders of sex development clinic for a number of years as the psychologist. And I would come in to the session with the parents and usually these were very young kids. So I wasn't really working with the kids. I was more working with the parents and, and I would come in there after the, after the medical doctor had, after the pediatric endocrinologist had been in there and done, had been in there for an hour and had talked with them.

Um, and. The pediatric endocrinologist came out and said, yeah, they totally get it on board. I don't have any concerns about their understanding. I would go in and I would say, okay, so tell me what you learned from, and they'd just be like, 'We have no idea what they were talking about.' Because they, they feel deferential.

Part of it is that they feel less deferential to the kind of doctor I am than the kind of doctor, the medical doctor is. And so, and because they really are seeking the care, they're just gonna. Say they know when they really, they really aren't picking up on what's happening. And so I think the more we can normalize that it is okay to not get this right away.

It is okay to have questions is, you know, the more we're going to actually do a real informed consent process. Then what I think has been currently happening and that I think is frankly, not what we need to be doing ethically.

Ben Massey: Thanks, Dianne. I appreciate those comments. Um, anything you want to add in there, Gaya?

Gaya Chelvakumar: I would just say I agree with all the comments that have been made. I think the informed consent process is so important and definitely that it's a process is really important to recognize that it's not one conversation at one point in time that is many conversations over time, um, and that those conversations don't have to stop once the Medicaid and intervention has been started, that those conversations can be ongoing even after the intervention has occurred.

Um, even asking how they feel about changes that are happening and, and having discussions about is this something you want to continue with to not, um, you know, informed consent is such an important piece of starting any intervention and it's so, it's so hard. And I often wonder about what you mentioned, Dianne, about people saying they understand when they don't, just because they're so focused on the intervention that, um, They're afraid to share things that they might not be

understanding about the information we're sharing with them and how, how to address that I think is very, is very important.

I will say just personally my practice, it has evolved, how in the medical setting. I think we have these Conversations and, um, around informed consent has evolved a lot over time as well, just recognizing a couple of different things, you know, that identities may shift and transition needs may shift, um, that also has shifted how we have, I think, conversations around, um, around informed consent and starting an intervention.

But it's so important and just that it's a process and it's a continual conversation, I think, is the biggest thing.

Clip 4

Dianne Berg: And Gaia, I don't know if other people do, but I really struggle with, with, because I kind of want The kids that I work with, whether they're nine to, you know, 13 and looking at puberty suppression or hormones in some ways to be a little pediatric endocrinologist, like I, I want them to understand it at that level, um, in an age appropriate way.

And I struggle with that on one level because it's like, well, when a kid takes diabetic medication, do they have to understand? everything about their pancreas and everything that's happening and all of all of that do we do we do that same process around other medical kinds of things and so is this an unfair So, I just struggle with that line, um, and I just kind of wanted to, to say that because I'm not quite sure what to do about that.

The other thing that, that I, that I really like to do is I like to have the children or the young adult or the young adolescent or the adolescent come up with questions that they have for their medical doctor. So let's, let's, let's write a great question. Write that down. Write that down. We're going to ask that you ask that the next time you come back so that they're, they're really, I think, um, one of the things we have in one of the papers that we published is how important it is to instill a level of autonomy into Okay.

Children and adolescents about their medical care and transgender people about their medical care that they get to be assertive. They get to ask questions. They get to be really well informed. And so we want to start that very young by having children like, ask a question, write down what you think and ask the doctor.

You can ask the doctor. Well, I can't really. Yes, you can. Yes, you can. You get to ask the doctor anything that you want to ask them. Um, and so really instilling that way of thinking about medical care, I think is important.

Clip 5

Gaya Chelvakumar: Important point two is just collaboration between the medical team and the mental health care providers so that there can be also ongoing discussions between team members. So if, when mental health providers are having conversations around expectations around Medicaid, it's just like, Hey, you may want to spend a little more time talking about this, or this is an area that the, there seems to be some confusion about, or parents or child are really, um, concerned about, I think.

In this, in this area of healthcare right now, multidisciplinary care is so important and being able to collaborate with each other is so, is so important and so helpful, um, because sometimes we're not, you know, maybe in the context of a medical appointment, the conversations that need to happen can't happen and then maybe there needs to be further conversations with, with a mental health provider to help make sure parents and children have all the information they need to make the best decisions for themselves.

Yeah, I agree. It's so helpful to be on these on these panels just to hear where everyone's at because I think we all are struggling with how to do this and that in the best way without overburdening our patients and families as well.

Jamison Green: But our health care system doesn't If I may jump in here, our health care system doesn't encourage this.

I mean, if you have a clinic, like already, like a university setting where Dianne is, or where Cecile is even, and I'm not sure where you are exactly, Dan, but I know many people providing this care are independent practitioners, and they're referring their clients to surgeons. Uh, across the country and their endocrinologist might be their actual May, they may not never, they may never have a, an endocrinologist.

They may be able to get their hormones prescribed through their primary care provider who doesn't really know necessarily everything about Transcare. They're basically trying to be supportive and you know, our health care system. It leaves us in the lurch all the time. And so to create, I agree that we don't necessarily need to be able to have If you have a known condition, like diabetes, you don't have to understand every nuance about what the insulin is going to do to you in order to give informed consent.

You need, but, because there's so much experience with that. But in this field, this is all new, this is all contentious, and that's where we run into problems. because

everyone's afraid. And I know for a fact, people, even adults, even well educated, older adults, accessing care for the first time, sit down with the person who's going to prescribe their hormones, and they look at an informed consent form that says your hormones are going to do this, this, and this. They don't take any of that in yet because they're so scared that they're not going to get what they need. They, they just so, show me where to sign. Cause I'm, this is my moment, I gotta grab it. And they don't really take in the information.

Clip 6

Jamison Green: And people also are afraid many times about surgery and so they can read other people's descriptions about surgery and they'll miss details or they'll miss the, the, uh, the most important piece of information for them simply because they're afraid to read it. You know, it's just how human beings work.

So I think at the same time we're fighting against The community's desire to have less gatekeeping, less professional intrusion, less spending time in doctor's offices. And how do we manage that and make sure that everybody's got the right level of education to make good decisions for themselves? So this is a problem that we're facing.

And this is where I think some of the detransition comes in. Because the over medicalization, as well as Uh, over binarying, as well as just the pressures that people are under because of the opposition creates a dynamic that's very, very hard for all of us to work in. Trans people and clinicians, very, very hard.

So I think these dialogues are crucial and we need to take them outside of this space ultimately as well.

Ren Massey: All right. So I'm, I'm sorry. Did you want to go ahead?

Dan Metzger: Good. We can do it after the.

Ren Massey: Yeah, I was going to suggest you this great conversation. I have more comments, but I'm like, ah, people probably need a break attendees as well as panelists. So, uh, I've asked for a 12 minute break. And we will reconvene back here and look forward to seeing y'all back here in a little bit. Thanks.

Clip 7

Ren Massey: I think we're pretty close to on time for that 12 minutes. Appreciate everybody being back here. Um, I'm wondering if, uh, well, I wanted to share just a little bit about informed consent. And then after, if anybody else wants to chime in, feel free to. I saw a little bit going on there. I do think that that's a really important part of what we can do to help folks.

Um, in terms of their decision making processes and also, you know, just to start out with, I make it clear to people that I don't have an investment, whether they're youth, whether it's parents. Whether it's adults that I have no investment in what their gender identity is even just because transitioning was right for me doesn't mean that it's right for somebody else.

And that's not a bias that I have. And, um, I hope that that gives people from the start a sense of safety in, um, considering a range of options in, um, in terms of gender identity and gender expression possibilities. Uh, when we do get to talking about, um, hormonal and medical interventions for those who, uh, are considering those options. You know, one important thing I believe is to make sure we address fertility preservation. If you all have looked at the drafts of the standards of care coming out, S. O. C. Eight. Hopefully next month, you'll see, you know, a number of places where it's encouraged and ethical to talk about fertility preservation options And that's even for youth who are going on puberty blockers, because many of those youth Thank you for nodding heads. Many of those youth will go directly on to affirming hormone therapies, which may eliminate Or will eliminate, you know the development of you know, they're gonads producing sperm or eggs that are going to be able to be usable if they want to be partners with somebody else later in contributing genetic material for reproduction

Clip 8

Ren Massey: I start even with puberty blockers to talk about fertility and a useful tool has been John Strang's TYFAQ, the Trans Youth Fertility Attitudes Questionnaire. It's not necessarily standardized to my knowledge, but it's a mechanism for discussing. There's a parent version and a child, a youth version for discussing some fertility issues just over, I think it's 16 questions.

And then also my informed consent process, I will include, um, as a non medical person, but somebody in the healthcare profession with a lot of. experience and knowledge and G. E. I. S. Under my belt attend all these conferences. Always learn something. I cover the reversible and irreversible effects and the potential risks to the best of my again.

I'm a lay person as far as being not a medical provider. Um, knowledge and I base that on the standards of care seven and we're gonna have the new ones coming out as I mentioned as well as the interim guidelines. Uh, the latest being in 2017. And there are some other resources out there. So, um, I see somebody put a file up there but there Are ways I think we can all go over this.

And also just finally, I'll just add that I go over it with the youth separately from the parents. Uh, and then with the parents separately from the youth, ideally, and then bring them all together. Make sure we're all on the same page of under what we understand. Um, Limitations acknowledged, and, uh, you know, they're often having questions, and I say you have to ask your hormone provider, the consultant you're, uh, going to be meeting with about, uh, certain questions.

So there are certainly, I stay within my lane, but I do think that part of the multidisciplinary nature of this work is being well versed in these things, at least to a certain level, and that's part of why we have a multidisciplinary panel here.

Clip 9

Ren Massey: wants to, I see somebody added the QIFAQ in there. Anybody wants to add any comments on that before we move on and we could potentially start looking at cases in a little bit? Does anybody want to add anything to what I said? Looks like Dan might.

Dan Metzger: I, I was just gonna say, you know, like, like it's always a good theory that you talk about fertility preservation with a 14 year old, but I know I'm talking to a blank wall. And the same would happen for a cisgender kid, right? They'd be like, Ew, kids, babies, gross. Or, or the usual SPAC answer is I'm going to adopt. I'm just going to adopt. And then you ask them, well, what does that involve? Like, how much does it cost? Oh, I thought you just like went to the orphanage and they gave you a baby.

No, it's not quite like that. Um, but, um, and I was just trying to find it, but I can't, I can't quickly locate it because I only have is like a picture of a slide, but apparently last week at the Pediatric Endocrine Society, uh, some of the Dutch researchers started, uh, gave some data about, um, young adults who had transitioned and reproductive regret, like regret, and it's there.

Um, and I don't think any of that surprises us. I don't remember any of the numbers or anything. I just, again, I have a picture of a slide. But hopefully this is something that will get published in the next while. But, um, you know, I think, I think now that I follow a lot of kids into their mid twenties, I'm always like, Oh, the dog isn't doing it for you, right?

Yeah, they're like, no, I just found this, you know, wonderful partner and now we're kids and da da da. So I think, you know, it doesn't surprise me, but I don't know still what to do for the 14 year olds. The parents have it on their minds, but the 14 year olds, you just... It's like talking with diabetic complications with a 14 year old. They don't care. They're not going to die. They're, they're going to live forever. Right? So I think, I think when we're doing informed consent, I know that that's still a big lacuna of, of that we're just, we do it. We try to talk about it, but most of the kids are nowhere in any kind of a brain space to really, really, really talk about it in a serious way. I, that's always bothered me, but you know, we still want the kids to. Be happy, happier in the moment, right?

Clip 10

Dianne Berg: I appreciate that much less with a 9, 10 or 11 year old who's, who's, um, who's starting puberty suppression. And like Ren said, if they continue on then, and, and I mean, it's, it's like developmentally not in their space to be able to have, have to think about that. And it shouldn't be, um, right. And so I think it is.

I think it is a real growing edge in our field to kind of figure out how we can, how we can approach that. Um, I'm definitely a little stumped on it.

Gaya Chelvakumar: I'll just add one more complication in there is that then if you do have, which doesn't commonly happen, but if you are interested in preserving fertility, then the options for for doing that, depending on age and stage of development also can be. From a medical standpoint, may or may not be possible, but then from a financial standpoint, also may or may not be possible, and that's another complexity to the, adds another layer of complexity to these discussions as well, and that's at any age, I guess.

Dianne Berg: And from a social and sexual standpoint, right? Um, in some ways, the stuff that you need to do to be able to preserve your fertility might be beyond kind of what a youth, where a youth is at in terms of their sexual development, and yet.

That's kind of what's needing to happen and, um, yeah,

Ren Massey: yeah, I don't think that we have all the answers and I appreciate y'all's comments, bringing, you know, highlighting the nuances and the challenges here. I find a range of. Maturity levels and having thought about this or not having thought about it. Um, again, depending also on the age and the cognitive maturity, emotional maturity.

Um, I still, I know you all do these kinds of things too. I think that it's better to give them the information and have them, Be able to reconcile, like we wish we could afford this, but at this point we can't. And so we will proceed down this avenue anyway, but not later on then find out, Oh, nobody ever told me that I couldn't, you know, do that.

Clip 11

Ren Massey: Like, why didn't somebody tell us? And so I think that there's a shift in the field, but I just think we need the spotlight that, um, it's part of the discussion in the informed consent process for youth as well as adults. Um, And back to the thing I said the very beginning of after the break, part of also trying to make sure people have a sense of I have no investment in where their gender identity or identities land is because that part in this study where people said they didn't go back to the same provider, that that bothers me, I would like people to feel like they can continue with me whoever they are.

Um, if I can help in other issues, you know, a few of the folks I've worked with, it's been, um, some of what Dianne was saying earlier, you know, their sexuality got to clarify some of their gender identity issues. And, um, they, I've been pleased when they've gotten clear. Okay. Maybe I'm not trans, maybe I'm non binary, maybe I'm cis, um, and maybe this was more of a sexuality issue.

And they were willing to continue to work with me as they explored sexuality issues. You know, I want people to feel like they don't have to perform a certain gender to be working with me. Um, that I want to be inclusive and supportive of all aspects of their being, so. All right.

Clip 12

Ren Massey: Any other thoughts before we maybe look at cases? Alright, as, as we shift to cases, then, uh, this is always the tricky part for me to work on.

Dianne Berg: I'm sorry, Ren, can we just, Melissa Goldstein is just asking if anyone has great resources for fertility and preservation especially. Oh, Gaia just put it, did you just put it in?

Gaya Chelvakumar: I just popped in one article that starts to discuss some of it.

Ren Massey: I'm, I'm glad. I think, I think that that's a knowledge, right? And there isn't a ton of, of that existing. So I just wanted to acknowledge that. Yeah. All right. Thank you. Um, it's wonderful how we've got all these wonderful resources here. All right. So, uh, bear with me a second. I am going to try to share screen to, uh, go over some cases that our panelists have, uh, put together.

And this is the part where I always grapple.

Clip 13

Ren Massey: Read the case of DJ. Give me a thumbs up, panelists.

Okay. All right. So I'm wondering if panelists have any comments or thoughts you all want to start with in getting this discussion going around this young person and their experience.

Oh, sorry, Randall. I'll read the next one.

Dan Metzger: To me, this is a not an untypical story. I mean, this person's got some significant mental health stuff, which is, you know, that they need to deal with. It sounds like they had an unfortunate sexual traumatic sexual event, which that sounds probably pretty horrible. But to me, this is a kid who, who, who. Um, got a false start and, uh, and, um, maybe it wasn't in a place where they were fully supported or they feel fully supported.

Um, but to me, this is not de transitioning. This is just a kid working through crap. And, um, I mean, I obviously may feel sorry for the kid, but to me, this is not like something that should hit the news as a, you know, a system problem. You know, assuming that this kid's been getting the mental health care that they need.

To me, this is like, not an untypical story. Um, and with a happy ending. So, yay.

Clip 14

Dianne Berg: highlights the importance of having ongoing support and following kids over time, um, so that you're getting as much of the picture as you possibly can. And, and so kind of the important role of, of behavioral health, mental health, um, component. Um, I think, I think oftentimes mental health can get a really bad rap.

Um, in terms of that, we're trying to do things that we're not actually trying to do and, and so I think this is a good case that kind of exemplifies if you're following this kid and meeting relatively recently, relatively, um, often with them, you're going to kind of be seeing this in real time and be going through this with them and be helping them to process and figure out kind of the meaning that it has for them.

Um, And hopefully as you have enough of a rapport, I don't know if it happened in this case, but that it looks like the, the person didn't disclose some of the bullying and the traumatic sexual event until a year later. The hope would be that if we can build enough rapport over time with kids in whatever specialty we have.

That, that we would learn about that in more real time than a year later, and that we would be able to be, you know, kind of just doing it as part of the regular process of checking in about all spheres of life. Um, so it really highlights the importance of that for certain, for certain youth.

Clip 15

Ren Massey: comment. I noticed an observation or a wish that, uh, therapists involved in able to Help the young person distinguish between the assault and their gender identity. I think, um, that there are times working with young people where they don't even disclose an assault or some type of sexually, Coercive or unpleasant experience.

It may not even have been coercive, but it may be almost like self coerced. They thought they were supposed to do X, and so they, like, I guess this is how people interact sexually, and so they showed up voluntarily, like this other person at

the moment, um, wasn't coercing them, but they were kind of trying to get themselves to learn about sex. And so they may have done things they didn't even feel comfortable with. And so they don't want to talk about it with therapists. So, I mean, um Even good therapists, you know, we're going to be limited at times where we're, uh, we can't get everything that's going on with our kids that we're working with.

And sometimes the adults also don't bring it forward. So, um, it's a, it's a high bar to cross sometimes to try to catch everything that. may be affecting somebody's view of themselves and across domains of their life experiences.

Clip 16

Gaya Chelvakumar: And I'll just echo Brennan and Dianne's statement. I think the case to me just highlights the need for, in addition to continued, you know, ongoing care, but also maybe like leaving the door open, that if this is your decision at this point in time, but that may change and we're, you know, we're here to support you, whatever your decision is, and that you can always, you know, continue to see us continue to see the team, um, you know, keeping, keeping engaged with young people and letting them know that they can, It's okay to change your mind.

It's okay to, to come back and knowing that, um, people sometimes have to disclose things in their own time as well. So that while we hope things are disclosed in real time, sometimes people just aren't in a place to face, to face their trauma and what's going on. And so even more so becomes important, I think, to have that ongoing care.

Um, and even if there is an ongoing care, at least leaving the door open, young people, or adults even, are in a place where they want, where they want to reengage that that door is still open?

Dianne Berg: Yeah, there, there was a comment. There was a comment in the chat about, um, sometimes our, our discomfort with asking questions, particularly pertaining to sexuality.

And I, and I think that that's, that's really true. I mean, we have not gotten to the place yet where it's just part of, Every typical kind of area that you inquire about, and I think that that's really important, um, and is, is part of, and, and to not, and to not frame sexuality, I think the other thing that happens with sexuality is it gets framed as negative, all the things that we shouldn't be doing, um, rather than having a positive, kind of positive take on sexuality, and so how with, with youth and, are adults.

Do we just naturally feed that into the conversation? And how do we as clinicians get comfortable with sexuality and sexuality themes? Um, in a society that isn't very comfortable with it, but isn't comfortable with it in appropriate ways is very comfortable with it in some ways that probably aren't very healthy.

And so how do we teach people to do that? I think that's one of the benefits that That I have working in a sexual health kind of clinic that has a gender component to it. And I think that's really important.

Clip 17

Ren Massey: All right, thanks. Going, going, gone. Move on to our next case. Okay, if I can get my screen share to cooperate with me. Ah, here we go. All right. Cases. This is a collective consideration. Several trans men in their late 20s, early 30s have done a range of social and medical interventions. They're now clear that in hindsight, if they had come out ten years later, they may not have taken all the medical transition steps that they did if the option of a non binary identity had been on the table.They don't like to be seen by others as male, but given the physical changes, don't feel like they have a choice. There are different intensities of how upsetting this is to them, but a common theme is not likened to be perceived as male by others to the extent they are seen as male. I found this really interesting.

Who would like to jump into this conversation?

Dan Metzger: This is a bit beyond my age group, but I think one thing that they could do, uh, medically is to talk with their hormone provider to see if there's a way. I'm presuming these people are still on testosterone, if they are, that they could at least lower the dose to something that's still bone protective and still would make them feel okay, but maybe wouldn't, uh, would less stimulate, uh, you Like facial hair growth or or the other kinds of things.

I mean, their voice is not going to change, obviously, but, uh, there might be some room to play with the testosterone dosage just to make things a little bit less, uh, um, less masculine.

Clip 18

Cecile Ferrando: Um, so I think this is about goal setting. Um, so you know, while I'm a surgeon, I do a lot of testosterone implants for patients. So I do testopel implants. Um, and, um, when I talk to a lot of patients, the majority of the patients I see, they are seeking, um, realization, masculinization. So I dose them to sort of physiologic levels.

Um, but I have sort of this, um, cohort of patients that is seeking sort of, you know, underdosing, but wants testosterone, um, supplementation. Um, so we sit and we talk about. The goals of therapy, understanding whether, you know, I have to explain to them that sometimes underdosing can, um, will not lead to cessation of menses, which is sometimes the actual goal, like not virilization, but cessation of menses.

And so, in those situations, we talk about, you know, what other things we can do that, um, that may not have sort of either feminizing effects, you know, a lot of our, Transmasculine patients don't want to be on oral contraceptive pills, etc. So sometimes I'll underdose testosterone in a pellet form. Um, and also, um, place an IUD in those patients.

And so it's really sort of about discussing what their goals are. I'm now seeing younger patients. So not necessarily patients who were dosed on, on doses of testosterone and who are now working backwards. But I have a couple of patients in their twenties who. Sort of err on the side of the masculine side on the spectrum, but don't want to be fully masculinized.

So I'll underdose them as well. And, you know, I think that there's a physiologic component to this improving their, their sort of state of being and giving them a sense of wellbeing. But also I think that there's this component of, um, I feel like I'm taking some steps towards masculinization, but not completely.

So that makes me feel good. And I think that there's. Also, I think we, um, uh, actually to this crowd, I'm not gonna say undervalue. I think, um, uh, people in my, um, from where I'm coming from undervalue the importance of giving a patient a sense of control of their transition and their care plan, which is not a foreign concept when we talk about.

You know, paternalism and autonomy, but certainly when it comes to this type of care, allowing patients to have some control over what it how their transition is or what it is, is really important. So even in patients who've been on high dosing who

want to work backwards, but like Dan just pointed out, sometimes you can't reverse everything.

Right. So there's some masculinization that will have already have occurred, but perhaps just the giving a patient the sense of being able to control what's going to happen down the road is really important.

Clip 19

Cecile Ferrando: testosterone dosing. For me it's easier in the pellet form because you can really sort of dose to certain levels. It's in my, from my experience, easier to control than intramuscular and subcutaneous dosing. But it's about goal setting and discussing and so much can just come from a discussion of I understand that what your goals are and let me see if I can help you achieve them.

Certainly that conversation is easier when it comes to hormones than it is surgery.

Dianne Berg: There are a little bit, I think what it comes up, what comes up for me is helping people to explore socioculturally what it means to be masculine, feminine, male, female, um, because there's kind of the internal sense of it and then there's also the the way that that gets perceived in the world and It sounds like for some of, for some of these folks, like, for whatever reason, it's more about how they're being perceived by others and maybe, maybe kind of what others are then attributing to them or assuming about them because they're, they're interpreting them as male when maybe that's those things, those, those aspects of maleness are not what they, aspire to or what they want.

And so I think it's, it's, it's all about kind of that, that therapy around what does it mean in our culture to be kind of, what does gender, what does gender mean in our culture? And how is that going to play out for how you see yourself and how others see you? So it's kind of those deeper, those deeper conversations.

Clip 20

Ren Massey: I just want to add something here. I appreciate what you were just saying, Dianne. One of my adjustments with my transition was, um, losing, um, automatically being perceived as safe. by females who I was meeting for the first time. And, uh, it was a very strange experience to be walking in a parking lot, you know, following a woman out in the parking lot from the grocery store, and to realize, oh, she's looking over her shoulder to, like, see, am I following her?

Am I a threat? Or to be in an elevator and... have, you know, somebody kind of scoot just about as far away as they can. And, um, it, it was, it was, it was a loss, candidly, not to be, uh, perceived or assumed to be safe anymore. Um, so I can easily see that some of these things would be, um, really distressing, um, social impacts of, um.

Being perceived as masculine in our culture. So, looks like you wanted to say something there.

Clip 21

Dianne Berg: Around kind of the other way too, right? I mean, so many of my trans feminine adult and even adolescent clients, um, Talk a lot about They they they hear about it theoretically, but it's not until it happens that they really get it like not being paid Not being given as much airtime as they Become perceived as a woman.

Um, you know kind of all the the things that feminists have been saying for a really long time, I think, start to become more clear to people. And, and I think those are some losses or just some, some realizations around how gender plays out in, in sociocultural spaces. And And kind of what is that going to mean and how does how what meaning does that have for people.

So I think it, I think it goes both ways because gender is such a powerful mediator, whether we like it or not, it's such a powerful mediator of sociocultural spaces and interactions and environment.

Ren Massey: Yeah, I'm going to add to that, you know. A lot of us are youth or focused or heavy in our practices. Um, or young adults and, and minors.

Um, but One of my mentees, who I think is on this, um, meeting today and some other folks have talked to me about, you know, and I've even had clients as well who were adults who were assigned male at birth and found the loss of privilege and safety that they experienced in the world, um, was really disturbing.

And particularly some of the older folks. Um, we're actually, um, de transitioning, re transitioning for, for reasons of fitting in not just either around job stuff, but sometimes to be able to go into assisted care facilities with less hassle. And a greater sense of safety. So I think there are other issues, again, outside pressure sometimes, it may not even be the internal experience, that we need to be able to be aware of supporting people for in different contexts that we may be encountering.

Clip 22

Ren Massey: So um, yeah, one of the thing I would like to highlight on this case, I think that it underscores that from the in the outset, we also may help people explore more non binary options. You know, I have a young person I'm working with right now, um, who's been on blockers for about two years. Mother's anxious for the kid to come off.

Pediatric endocrinologist is saying maybe go a little longer. Um, and the kid is vacillating. Um, really not wanting facial hair. Um, but... about having menstrual cycles and kind of vacillates about whether breast development, chest development bothers them or not, and which pronouns they use. And we all know that chest surgery is pretty inevitable, or at least it looks like that, because that has consistently been a bothersome thing.

So, is there more, um, benefit of staying on blockers or letting the kid... switch back to their endogenous estrogen? Or is it better to go low dose testosterone or what? You know, and at what point in time? So, um, if the kid doesn't want facial hair, but maybe doesn't mind their chest growing and they're planning on having chest surgery anyways.

So we may want to, you know, be creative in how we help folks approach these. Situations that are complex.

Clip 23

Ren Massey: All right. So, um, I'm going to shift to the next one. I see we got a few other comments on, yeah, what people wanting. And being perceived male can happen very fast. Yes. All right. Let me try to get my screen to cooperate again. Okay. I'm going to read case three in S. 14 years, 11 months, assigned male at birth who identified as female preferred by previous mental health provider for gender dysphoria in the past year.

No significant medical history. Gender history and initial presentation, patient reported that a year prior to presentation a friend came out as bisexual and patient reports it clicked. Hey, that's what I'm feeling. Did not initially share this with anyone, but then six months later told mom about being bisexual.

Felt this confused mom. Around the same time, patient also reported feeling, looking pretty, cute and pretty. wearing female clothing. Reports always having felt this way, but never acted on the impulse to express self using feminine clothing. Patient reports that one month after school started, came to the conclusion they were trans.

Patient disclosed to an online friend first then told girlfriend who encouraged patient to tell mother. When patient told mom about identifying as transgender reports that mom's reaction was unsurprised. Patient had been trying out different names and eventually chose the name Nora. Patient reported feeling dysphoric and that sadness goes hand in hand with dysphoria.

Patient reported interest in starting gender affirming hormones but felt the gender affirming surgery was scary. Felt that mother was supportive of starting hormones, but father was not, and this could be a barrier. Extensive mental health history, starting at age 4, including aggression, ADHD, oppositionality, depression, anxiety, and challenges with behavior.

hospitalizations.

At 15 years, 10 months, the family is open to the patient starting spironolactone, but not ready to provide consent for estrogen. The patient's excited to start medication. Patient continued to follow the mental health provider two or three month intervals. At six month follow up after starting spironolactone, patient started, uh, reported that they felt more male and was feeling comfortable with he him pronouns.

Reported that I felt like a boy who wants to, I feel like a boy who wants to wear nail polish. Patient wanted to stop spironolactone and not interested in pursuing estrogen at this time. Plan for patient to continue to follow the mental health provider. Has follow up appointment in two weeks.

Clip 24

Ren Massey: Anybody want to jump in here?

Dan Metzger: I, I'm, so again, another kind of happy ending. Kids happy. Um, parents are happy. I, I, I think it's important to remember that not all kids are as smart as every other kid or as in tune with their bodies or minds or minds of kids.

Clip 25

Dan Metzger: sophisticated as other kids. Some kids like just get things and some kids don't and it takes a little bit longer. And the point is just because you're 15 doesn't mean you know everything. And I, I, I mean, I talk to this all the time, right? You're 15. That's great. But, um, you're probably going to know more than when you're 16.

You actually better know more when you're 16 than when you're 15. So I think it is kind of important to get, uh, uh, And this is our, you know, what our, what our assessors do is to get a level of sort of capacity of not just able to consent for stuff, but like they're understanding where they are. And do they understand that there's a difference between sexuality and gender and being trans and, and, and being, you know, cross dresser.

Um, that, that, that there's more than one way of. You know, liking nail polish. You don't have to be a girl to like nail polish. You can just be a boy and wear nail polish, whatever. So I think, you know, when these kinds of kids are working with their mental health professional, I think it is important for somebody to also really see, well, like, this is a kid that's kind of, not changed, but, you know, well, it's changed their direction three or four times within a short period of time.

That's not somebody you're going to want to rush in to do something permanent with. You're going to want to make sure that the kid, Really is starting to, you know, I have a clear direction of where they're heading before you do something and as well, you know, to make sure that the family are coming along with the kid.

Clip 26

Gaya Chelvakumar: I will also add that like an anti androgen like spironolactone is a nice place to start because it's something that probably is not going to give you, you know, irreversible changes. And so, you know, if needed to help kind of clarify needs and goals and identity, it's a nice, nice medication to use.

Dan Metzger: Yeah, I would second that, you know, like if this was a kid that was clearly binary and, and wanting to move forward, you know, then we would probably use Lupron because Lupron works better. It's way more expensive. But I think Lupron without a plan of moving towards estrogen for this kid would just make this kid feel crappy, probably because he's, she, sorry, is well through puberty.

Um, so she's probably just going to feel like whatever a teenage kid would feel when they have their testosterone taken away, kind of, you know, whatever, menopausal. So I, I think, um, Just to, just to, just to affirm, I think Spyro is a really good way to go because it's harmless. It's cheap. It works to, for the beard.

It's not going to prevent the bigger boy changes that happen with male puberty, but, um, it is a nice way to kind of ease into things and often, um, for families, for, for parents that are kind of holding back, it's a nice way to move forward. That's, you know, affordable, cheap, safe, and reversible.

Dianne Berg: I'm noticing a lot of stuff in the chat, but I think the medical people could maybe address that kind of comes from how fast testosterone maybe works and does low dose affect that can just noticing that.

Dan Metzger: Yeah, so it's true. I mean, we all, you know, Adult men all have the same testosterone levels, but there's clearly a different range of like how hairy you are or how fast you go bald or whatever.

And it doesn't have to do with your testosterone levels. It may have to do a bit with your testosterone receptors and a million other things that you inherit, um, in your genes. So, so, you know, I, I always kid the Persian, the Persian kids that come and see me, I'm like, don't even look at the bottle. You're going to get a beard.

Like, because we know it's going to happen really fast, and then some of the poor Asian kids, you know, they try forever, they could barely get a mustache going, like their brothers, and so, um, you know, but everybody's the same level, it's all the same dose, so, um, you, you, you do have to let people know that just because

you're taking dose X is not, doesn't mean you're going to get results Y to, to, to the same extent.

And the same is true, of course, for, for, for, for girls taking estrogen, you know, breast

Clip 27

Dan Metzger: Level. Level provided your estrogen levels more or less in the nor in, in a, you know, in a normal range. It has much more to do with other genetic factors and body weight and stuff like that.

Ren Massey: Alright, great. So I think we have time maybe to go into one more case and um, then we may have some time for some concluding comments. Let's see. The biggest challenge is always there, the technology. Actually, the technology user is the biggest challenge. Okay, case four. An AMAB person assigned male at birth, who is now 13, who early on identified as binary trans girl and took all social transition steps.

Medically, the client is on Lupron and she's not been in a rush to start estrogen. However, she's been very invested in doing so at some point in the future. Within the last six months, this youth has begun to identify more as non binary, trying out different pronouns and names. She's very avoidant to have any discussions about What the shift toward non binary gender identity may or may not mean in terms of the decision she's always thought she would make in terms of medical transition.

When brooch will shut down and no longer engage. Have had some success processing when discussions are framed from an embodiment lens.

Dianne Berg: I can say a little bit about this case. I'm not sure whether it's one that I submitted and it just got kind of morphed and changed, um, which is totally fine. Um, but I think the thing that comes up for me, if it is kind of based on one of the cases is, um, But it was very difficult to, to kind of, um, the youth always kind of had it in their mind how their transition was going to work.

I'm going to do this. So I'm going to do this. So I'm going to do this. Then I'm going to do this. And, and it was all a very binary related kind of transition process and how they were thinking about it. And then as they, as they began to kind of try on. Different non binary identities and, and,

um, they started to kind of talk to people, uh, at least with the, with the, um, kid that I worked with.

Clip 28

Dianne Berg: Where we kind of got to was a general not wanting to talk about things because they were just kind of at that place. But also that they really thought that if they said anything about this and really delved into it, it would mean that their options for any of that medical transition that they had always thought they were going to do would be off the table.

And so they were like, I can't, I don't want to explore that the non binary shift, because if I explore that, that means that I'm never going to be able to get estrogen or I'm never going to be able, and it was kind of like having some education around. No, it doesn't mean that what it means is we are trying to meet your embodiment goals.

And if your embodiment goals are such that you need a certain type of medical intervention, then you need that medical intervention and we can move forward with that. And you don't have to be afraid that, um, That your identity is going to drive necessarily drive your medical decision. It's more about your embodiment goals are going to are going to drive some of the medical decision making.

And so I don't know. That's kind of how we were able to get through that impasse. Um, So I don't know what other people kind of have to say about that. But, um, embodiment is certainly a concept that I'm using a lot more of with my adolescence and Children.

Clip 29

Dan Metzger: I, you know, like sort of 13 and a half is sort of our, like a kind of cut off where we, where we're okay to do hormones, if everything, it seems like it's going to work. Um, but I always told the kids, God, you're 13, you don't know everything. Um, I don't expect to know everything. And this is like a journey and you're going to take us, you know, we're coming along for the ride.

And, you know, we start this, it doesn't mean you have to continue. It doesn't mean you have to go up. every single time you come, I'm going to ask you what you want to do with your hormones. Are you happy where they are? And kids do shift with time. A lot of the, particularly the non binary kids, um, um, think that they want to be initially more vascularized than they end up wanting to be.

And they find that there's a happy dose that's gotten rid of their periods or whatever, and that they're happy on that dose. And they don't necessarily want to push forward as they had thought that they might at the beginning. So. I think it's important that you just lay that out right at the beginning.

You do not, you do not have to have all the answers. You know, even an 18 year old, you do not have to have all the answers. Let's work with all we got today, and you keep letting me know, and I'm going to keep pestering you, you know, what do you want to do about this? What do about this? Or you're not ready to make any decisions, you don't even want to talk about it today.

Fine, let's just leave it in the same. And I think the kids need that space to, to know that A, they're in charge. Uh, B, I'm a little bit pushing them to think about it, like, by asking them, and, and C, you know, they have permission to go backwards, stay where they are, go forwards to, to whatever degree, and, um, and I think that, uh, I think that the kids, um, I think there are kids who are a little bit timid at the beginning, and they don't feel, they can, I, I feel that there is a group of kids who say they're non binary because they're not, Really ready to go full on.

And as they go, they actually find, no, this is working for me. I'm, I really actually do want to go to the, to the end of the binary there. But, um, I think, I think you just got to let kids have that, that permission to do that.

Clip 30

Ren Massey: I'll just add in that, uh, this actually reminds me of a successful 30 something I have, um, you know, who's, uh, very accomplished in their field and is, uh, was first aware in the last few years really more about their gender identity and, um, thinking, you know, they were identifying as a woman. Uh, and when the first came really more open to their awareness about six months ago.

Um, took him a couple months to call me, then a couple months on my waiting list. And I've been seeing the person, I don't know, a couple months now. And They were hesitant to acknowledge maybe a non binary space might be good, maybe a fluid space might be good. And it's hard to tell how much feels true to their gender versus how much is external factors, and that's kind of stuff we're sorting through with time.

Um, and I think they're feeling some relief to know that there are a range of medical options, and we're not, The, the fortunate thing is this person is not in a rush rush and has some ways of being able to express, um, their feminine side, uh, with their significant other and friends and, and one of their family members, uh, from their family of origin.

But, um, I, I, my main point is in adults as well as young people. I mean, mature, more mature adults, like 30 somethings.

All right, so if we don't have any other comments on this one, actually, I would really like it if we could get to the next case and then we could close up.

Clip 31

Dianne Berg: I'm just noticing that Jameson is telling us that we should talk, look more at the chat. Jameson, is there a particular thing?

Jason: I was just wanted to draw your attention to the Q& A box as well as the chat. There are questions in the Q& A stream as well as in the chat. So just, just to make sure that.

Dianne Berg: Thank you. I didn't even know about that.

Jason: Yep. Yep. I've answered a few, but, um, the clinical ones I can't.

Dianne Berg: Okay. While we look at the q amp a there's a couple coming up in the chat just about that embodiment discussion. Yes. It's, it's a, it's a growing edge for me. And so I certainly don't want to. To misspeak, but my understanding and what I'm trying to kind of incorporate in my clinical practice is in some ways moving away from, um, what is your identity and therefore because you have this identity, you're going to want to do these particular medical interventions to change your body, not having it be as identity driven, because I think that's been the historical basis of kind of how things have operated.

And instead, regardless of your identity, What, what do you think about your body and what do you want your body to be able to be and how do you feel in your body and, and what's going to help your, your, you feel better about being in your body and how do we address some of that? Um, regardless of what your identity is, and that might mean medical, that might mean lifting weights, that might mean eating better, I mean, there's a whole range, but it just kind of goes shifting your thinking from identity driven interventions to more, um, for some people, more body driven interventions.

It is kind of my, is what I would try to say about that.

Clip 32

Ren Massey: Kind of related to that, Dianne, there are some questions about co occurring diagnoses or considerations in the Q& A section, and I would just say it's hard to do it justice in a little bit of time here, but, you know, when there are co occurring conditions of any type, I am more cautious and take a slower approach in terms of.

Um, questions to in considering both identity and embodiment. Um, and, you know, may ask people and encourage people to look at things from all of those kinds of perspectives. Um, and maybe try to get creative in asking them to. You know, just as an example, who is somebody who you'd like to look like who, um, not somebody who's a TV star who's super attractive, but just like kind of an average looking person, you know, um, so that we're not engaging in a fantasy realm of transition expectations with like facial hair, no facial hair, chest of wet socks, flat, brown, small, wet.

And, um, sometimes those discussions. are very helpful, especially with folks who may struggle with the identity piece. Um, and, uh, I think that also just we have to be careful when we recognize there are folks who may have things that make understanding identity uh, more fluid or complex or more challenging.

So I just Take a lot more caution. That's what I would say.

Alright, um, I'm going to try to get us to that very last one.

Clip 33

Dianne Berg: Not wanting to take up more space, but since other people aren't jumping in, I think it just speaks to the importance of the intersection between sexuality and gender and how, um, I think that the field of gender, it feels like the fields are very separate as someone who's in both of ASAC certified person.

I'm, you know, I go to a lot of the sexuality conferences that are starting to. Care more about gender and I think in the gender conferences. There's there's very little focus on actually sexuality and so I think for me this case just Exemplifies a way that they intersect and I think there's lots of ways that they intersect and I know that WPATH Is gonna do a specialty thing on sexual pleasure which I think is is awesome and And so I think just for me, I want to, I just want to point out that that, that intersection, we don't, we don't often do a good job with that.

And I think that's someplace that we could, that we could be doing better.

Dan Metzger: You know, I totally agree. And I'm sure putting a kid on a blocker at age nine, and then letting them get to the age of whatever, when they're developing a sexual identity, can that be. Uh, cannot be great, right? So I think I think that the other people brought this up that we are to a degree robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their with their cisgender peers.

That's not happening because we've got the one loop running and their you know, their brains are just not thinking that way. There's no, you know, they're getting older and smarter about, you know, math, but they're not learning how their body works. They're learning how to masturbate because they don't, because they don't have the urge to do that, right?

And all of a sudden they're, you know, they're, they're way many years behind their peers trying to like figure their sex stuff out.

Clip 34

Ren Massey: Yeah, I'll, uh, add somebody asked when that sexual health workshops going to be, um, we're in the process of developing a number of new workshops this year. Um, as we're updating the foundations curriculum for Montreal, where we'll present the SOC eight, um, based, uh, foundations course for the first time.

Uh, in the meantime, we have a number of. Uh, workshops this summer, including the one Dianne referred to on sexual health, and I believe it's going to be July 29th. Um, I'm pretty sure that's the date we got lined up in, uh, I'm trying to remember. I think it's like eight to 11 Pacific time, 8:00 AM to 11 Pacific time.

But, um, I'm, I'm not gonna bet my life on that. Um, but um, we also have. Some other comments about sexuality and neuroticism, not neuroticism, eroticism. Um, and, uh, you know, I think that that is some of the complexity of gender and sexuality. Both. being processes of discovery and evolution, um, for a lot of, you know, tweenagers and teenagers.

And, uh, so it's not surprising sometimes that they need some help discerning those things. Looks like you wanted to say something, Dianne.

Dianne Berg: Well, I think for adults, historically, if, if people with some sort of gender. Identity have, have, have mentioned anything about their sexuality, it, um, or if they there's always been, at least I have had many clients tell me, I did not tell you the truth about, about a lot of things about my sexuality, because I figured if I told you that.

You would gatekeep and assume it was a fetish or assume it was, um, you know, some of the terms that we no longer are using. And so I think there is a huge historical context. To to sexuality being seen as a being seen in a way that does act that does create barriers access to access to care, and I just want I think it's very important that we acknowledge that historical context, um, and that we work against that historical context, um, by talking more about positive sexuality and pleasure and that that they can go together and that it's okay.

Um, and not create barriers to care because people have that belief that that's what we're going to do.

Clip 35

Jamison Green: Yes, and gender and sex are two different things, but gender informs your sexuality tremendously. And, uh, no matter who you are, trans people, cis people, male, female, non binary, all those things are really informative to each other. And when you deny any aspect of it, you are limiting yourself. Uh, to a certain extent, you're, you're cutting off parts of yourself if you pretend it doesn't exist.

And clinically, we've been told, trans people have been told historically, Oh no, don't talk about that. So, it's really, really something that our professions need to combat. Thank you, Dianne. That's good.

Ren Massey: All right, so I'm going to end with a question. I'm going to stop my screen share here, and I'm going to bring this up to my panelists really quickly.

If anybody has any closing thoughts, one question that we didn't get to was steps to support folks who have regret or interventions. I think it's such a new area. We don't have data on it. to my knowledge, but it looks like a lot of folks are looking for support and I would say we need to normalize their exploration just as we would normalize people considering transitioning to a gender different than what they were assigned at birth and to get them supports to do that.

Um, and again, try not to other, other people in the process, not to marginalize or. Put down other people. If other folks have a quick comment.

All right, that that's to be continued in our ongoing growth in the field. I want to thank all of the attendees. Uh, I appreciate the great input, the questions, the comments, the exchange, the thought provoking, um, dialogue among all of us. I want to thank the production staff, Mike Evans and Cheryl Field.

Y'all are awesome. And our WPATH staff as well, Tricia, Kat, Rebecca. Wayne and Jamie. Uh, I see Tricia, Kat, and Rebecca doing the heavy lifting today. And then I thank all of my colleagues for being here and the thought you put in in advance and for taking part in this conversation to try to advance health care for our trans and gender questioning clients.

Thank you.